Rules & Policies Agenda for Board Meeting
February 9, 2022

A. Rule Review Update
B. Controlled Substance Prescribing Rules
C. Licensure Protocols
D. Telehealth Discussion
E. Legislative Update
MEMORANDUM

TO:       Betty Montgomery, President
          Members, State Medical Board of Ohio

FROM:    Kimberly C. Anderson, Chief Legal Counsel

RE:      Rule Review Update

DATE:    February 1, 2022

Attached please find the Rule Schedule and Spreadsheet for February 2022.

**Requested Action**: No action requested.
RULES TO FEBRUARY BOARD MEETING

For Final Adoption
None

Pending with CSI
4731-38-01

For Approval - Initial Circulation
4731-11-09  4731-37-01

CSI Update and Circulation
4731-11-03  4731-11-04  4731-11-04.1

RULES FOR REVIEW AT MASSAGE THERAPY ADVISORY COUNCIL

4731-1-01  4731-1-02  4731-1-03
4731-1-04  4731-1-05  4731-1-07
4731-1-08  4731-1-09  4731-1-10
4731-1-11  4731-1-12  4731-1-15
4731-1-16  4731-1-17  4731-1-18
4731-1-19

RULES FOR REVIEW AT PHYSICIAN ASSISTANT POLICY COMMITTEE

4731-18-01  4731-18-02  4731-18-03
4731-11-03  4731-11-04  4731-11-04.1
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<th>CSI recommendation</th>
<th>JCARR filing</th>
<th>Rules Hearing</th>
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MEMORANDUM

TO: Betty Montgomery, President
    Members, State Medical Board of Ohio

FROM: Kimberly C. Anderson, Chief Legal Counsel

RE: Controlled Substance Prescribing Rules- 4731-11-03, 4731-11-04, 4731-11-04.1

DATE: February 3, 2022

The above referenced rules were discussed at the January Board meeting and the Board recommended obtaining feedback on the weight loss rules from the Board of Pharmacy and the PAPC. The rules are scheduled to be reviewed by the PAPC on February 4, 2022 and a verbal update will be provided to the Board.

The draft 4731-11-04 was provided to the Board of Pharmacy and the comments are attached and have been incorporated into the draft rule. Specifically, the word, “dispensing” has been replaced with “personally furnishing” in paragraphs (C)(2), (3), and (4). The personal furnishing limits contained in Section 4729.291, Ohio Revised Code, have been incorporated into paragraph (C)(2), and the definition of “dosage unit” from Rule 4729:5-19-01, Ohio Administrative Code has been included in paragraph (C)(2).

Although the rules are pending at CSI, the changes proposed are significant. I recommend withdrawing the current rules from CSI and sending the draft rules for initial review with stakeholders.

**Recommended Action:** Circulate the draft rules for initial review by stakeholders to obtain comments.
4731-11-03  Utilization of anabolic steroids, schedule II controlled substance cocaine hydrochloride, and schedule II controlled substance stimulants.

(A) A physician shall not:

(1) Utilize anabolic steroids, growth hormones, testosterone or its analogs, human chorionic gonadotropin ("HCG"), or other hormones for the purpose of enhancing athletic ability.

(2) Utilize the schedule II controlled substance cocaine hydrochloride for a purpose other than one of the following:

   (a) As a topical anesthetic in situations in which it is properly indicated; or

   (b) For in-office diagnostic testing for pupillary disorders.

(3) Utilize a schedule II controlled substance stimulant in any of the following circumstances:

   (a) For purposes of weight reduction or control;

   (b) When the physician knows or has reason to believe that a recognized contra-indication to its use exists; or

   (c) In the treatment of a patient who the physician knows or should know is pregnant, except if the following criteria are met:

      (i) After the physician's medical assessment the physician and patient determine that the benefits of treating the patient with a schedule II controlled substance stimulant outweigh the risks, and

      (ii) The basis for the determination is documented in the patient record.

(B) Utilizing a schedule II controlled substance stimulant:

(1) Before initiating treatment utilizing a schedule II controlled substance stimulant, the physician shall perform all of the following:

   (a) Obtain a thorough history;
(b) Perform an appropriate physical examination and mental status examination of the patient; and

(c) Rule out the existence of any recognized contra-indications to the use of the controlled substance stimulant to be utilized.

(2) A physician may utilize a schedule II controlled substance stimulant only for one of the following purposes:

(a) The treatment of narcolepsy, idiopathic hypersomnia, and hypersomnias due to medical conditions known to cause excessive sleepiness;

(b) The treatment of abnormal behavioral syndrome (attention deficit hyperactivity disorder, hyperkinetic syndrome), and/or related disorders;

(c) The treatment of major or mild neurocognitive disorder due to traumatic brain injury or substance/medication-induced major or mild neurocognitive disorder; drug-induced or trauma-induced brain dysfunction;

(d) The differential diagnostic psychiatric evaluation of depression;

(e) The treatment of depression shown to be refractory to other therapeutic modalities, including pharmacologic approaches, such as antidepressants;

(f) As adjunctive therapy in the treatment of the chronic pain, as defined in rule 4731-11-01 of the administrative code, following:

   (i) Chronic severe pain;

   (ii) Closed head injuries;

   (iii) Cancer-related fatigue;

   (iv) Fatigue experienced during the terminal stages of disease;

   (v) Depression experienced during the terminal stages of disease; or

   (vi) Intractable pain, as defined in rule 4731-21-01 of the Administrative Code.
The treatment of binge eating disorder.

(3) Upon ascertaining or having reason to believe that the patient has a history of or shows a propensity for alcohol or drug abuse, or that the patient has consumed or disposed of any controlled substance other than in strict compliance with the treating physician's directions, the physician shall perform both of the following:

(a) Reappraise the desirability of continued utilization of schedule II controlled substance stimulants and shall document in the patient record the factors weighed in deciding to continue their use; and

(b) Actively monitor such patient for signs and symptoms of drug abuse and drug dependency.

(C) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following:

(1) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code;

(2) "Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code;

(3) "A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.
Kim,

Thanks for the opportunity to provide input on this. Just to follow up on our brief discussion yesterday, the items we are proposing would be to swap the “personal furnishing” where it references “dispensing” by a prescriber, edit to remove conflicts with 4729.291 and the prescribing limitations set forth in that statute. The recommendation was to specifically reference the provisions of 4729.291 to alleviate a need for the prescriber to cross-reference by hand, or at a minimum incorporate the statutory reference. A final recommendation would be to reference the definition of “dosage unit” and incorporate it into the personal furnishing restrictions so it is also expressly stated without need for additional research. That definition can be found in (D) of OAC 4729-5-19-01:

(D) "Dosage unit" means any of the following:

1. A single pill, capsule, ampule, or tablet;
2. In the case of a liquid solution, one milliliter;
3. In the case of a cream, lotion or gel, one gram; or
4. Any other form of administration available as a single unit.

We did not have any concern or input with the other provisions of the rule as drafted. Compliance is compiling some short synopses of the situations they have encountered during inspections at IV-Hydration clinics, and questions that have come in from those entity types as well as other ‘medical spas.’ It hasn’t been as part of case investigations necessarily, but from a variety of encounters, so it may take a little longer to get you that, but they are working on it.

Let us know if you have any questions or need anything additional. Thanks!

Nicole
Nicole & Cameron,

The Medical Board’s weight loss rules have been pending at CSI while the Board has been reviewing information received from bariatric physicians. The physicians have been especially concerned with the strict FDA labeling requirements that prevent phentermine prescribing after 12 weeks. According to information provided by the physicians, the 12 week limitation no longer meets the standard of care for the treatment of obesity.

Recently, the Board asked me to draft a version of 4731-11-04 which would allow for phentermine prescribing beyond 12 weeks with provisions that would prevent overprescribing, abuse, and diversion of the medication. Attached please find a first draft of the revised weight loss rule which eliminates the 12 week prescribing limit and the requirement to strictly follow the FDA labeling requirement. It also includes provisions so that physician assistants could prescribe, combined the short term and chronic weight management rules, allowed for flexibility for telehealth visits, and added some interim requirements when the prescribing extends past 3 months. Rule 4731-11-04.1 is proposed to be rescinded since it will no longer be necessary.

The Board reviewed this draft at its meeting last week, and requested that I send this draft to your agency for comments. We are also soliciting comments from the Board’s Physician Assistant Policy Committee.

The Board has appreciated the support of the Board of Pharmacy with respect to these rules and would like your input at the beginning of this process. We have not yet sent this draft to our stakeholders as we would first like to address any comments or concerns that you may have. Please let me know if you would like to discuss or if you need additional information.

Thank you.

Kim

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Ohio Revised Code
Section 4729.291 Drugs personally furnished by prescriber.
Effective: April 12, 2021
Legislation: Senate Bill 260 - 133rd General Assembly

(A) Except when provided under section 4731.97 of the Revised Code, when a licensed health professional authorized to prescribe drugs personally furnishes drugs to a patient pursuant to division (B) of section 4729.29 of the Revised Code, the prescriber shall ensure that the drugs are labeled and packaged in accordance with state and federal drug laws and any rules and regulations adopted pursuant to those laws. Records of purchase and disposition of all drugs personally furnished to patients shall be maintained by the prescriber in accordance with state and federal drug statutes and any rules adopted pursuant to those statutes.

(B) When personally furnishing to a patient RU-486 (mifepristone), a prescriber is subject to sections 2919.123 and 2919.124 of the Revised Code.

(C)(1) Except as provided in divisions (D) and (E) of this section, no prescriber shall do either of the following:

(a) In any thirty-day period, personally furnish to or for patients, taken as a whole, controlled substances in an amount that exceeds a total of two thousand five hundred dosage units;

(b) In any seventy-two-hour period, personally furnish to or for a patient an amount of a controlled substance that exceeds the amount necessary for the patient's use in a seventy-two-hour period.

(2) The state board of pharmacy may impose a fine of not more than five thousand dollars on a prescriber who fails to comply with the limits established under division (C)(1) of this section. A separate fine may be imposed for each instance of failing to comply with the limits. In imposing the fine, the board's actions shall be taken in accordance with Chapter 119. of the Revised Code.

(D) None of the following shall be counted in determining whether the amounts specified in division (C)(1) of this section have been exceeded:
(1) Methadone personally furnished to patients for the purpose of treating drug dependence or addiction, if the prescriber meets the conditions specified in 21 C.F.R. 1306.07;

(2) Buprenorphine personally furnished to patients for the purpose of treating drug dependence or addiction as part of an opioid treatment program licensed under section 5119.37 of the Revised Code.

(3) Controlled substances personally furnished to research subjects by a facility conducting clinical research in studies approved by a hospital-based institutional review board or an institutional review board accredited by the association for the accreditation of human research protection programs.

(E) Division (C)(1) of this section does not apply to a prescriber who is a veterinarian.
Controlled substances for the treatment of obesity.

(A) A prescriber may utilize a schedule III or IV controlled substance for the treatment of obesity only if it has an F.D.A approved indication for this purpose and then only in accordance with all of the provisions of this rule.

(B) Before initiating treatment for obesity utilizing any schedule III or IV controlled substance, the prescriber shall complete all of the following requirements:

1. The prescriber shall review the prescriber's own records of prior treatment or review the records of prior treatment by another treating physician, prescriber, dietitian, or weight-loss program to determine the patient's past efforts to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, intensive behavioral therapy, and exercise, without the utilization of controlled substances, and that the treatment has been ineffective.

2. The prescriber shall complete and document the findings of all of the following:
   a. Obtain a thorough history;
   b. Perform an appropriate examination of the patient;
   c. Determine the patient's BMI;
   d. Rule out the existence of any recognized contraindications to the use of the controlled substance to be utilized;
   e. Assess and document the patient's freedom from signs of drug or alcohol abuse, and the presence or absence of contraindications and adverse side effects.
   f. Access OARRS for the patient's prescription history during the preceding twelve month period and document in the patient's record the receipt and assessment of the report received; and
   g. Develop and record in the patient record a treatment plan that includes, at a minimum, a diet and exercise program for weight loss.

3. The prescriber shall not initiate treatment utilizing a controlled substance for the treatment of obesity upon ascertaining or having reason to believe any one or more of the following:
   a. The patient has a history of or shows a propensity for alcohol or drug abuse, or has made any false or misleading statement to the prescriber physician related to the patient's use of drugs or alcohol;
   b. The patient has consumed or disposed of any controlled substance other
than in strict compliance with the treating prescriber's directions;

(c) The prescriber knows or should know the patient is pregnant;

(d) The patient has a BMI of less than thirty, unless the patient has a BMI of at least twenty seven with comorbid factors, including Type 2 diabetes, cardio vascular disease, hypertension, hyperlipidemia, obstructive sleep apnea, nonalcoholic fatty liver disease, osteoarthritis, or major depression;

(e) The patient has any condition that would contraindicate the use of the controlled substance to be utilized;

(f) The review of the prescriber's own records of prior treatment or review of records of prior treatment provided by another physician, prescriber, dietitian, or weight-loss program indicate that the patient made less than a substantial good faith effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, intensive behavioral therapy, and exercise without the utilization of controlled substances.

(C) A prescriber may utilize a schedule III or IV controlled substance that bears appropriate F.D.A. approved labeling for weight loss, in the treatment of obesity as an adjunct, in a regimen of weight reduction based on caloric restriction, provided that:

(1) The prescriber shall assess the patient, at a minimum, every thirty days for the first three months of utilization of controlled substances for weight reduction, and shall record in the patient record information demonstrating the patient's continuing efforts to lose weight, the patient's dedication to the treatment program and response to treatment, and the presence or absence of contraindications, adverse effects, and indicators of possible substance abuse that would necessitate cessation of treatment utilizing controlled substances.

(2) The prescriber shall not personally furnish or prescribe more than a 30-day supply of controlled substances, at one time, for weight reduction or chronic weight management. For any controlled substance that is personally furnished, the prescriber shall not exceed a total of two thousand five hundred dosage units in any thirty-day period and shall not in any seventy-two hour period, personally furnish an amount that exceeds the amount necessary for the patient’s use in a seventy-two hour period. Dosage unit means any of the following:

(a) A single pill, capsule, ampule, or tablet;

(b) In the case of a liquid solution, one milliliter;
(c) In the case of a cream, lotion or gel, one gram; or

(d) Any other form of administration available as a single unit.

(3) The prescriber shall not personally furnish or prescribe additional controlled substances to treat obesity for a patient who has not achieved a weight loss of at least 5% of the patient’s initial weight, during the initial three months of treatment using controlled substances to treat obesity.

(4) The prescriber may personally furnish or prescribe controlled substances to treat obesity when the prescriber observes and records that the patient significantly benefits from the controlled substances and has no serious adverse effects related to the drug regimen. A patient significantly benefits from the controlled substances when weight is reduced or when weight loss is maintained and any existing co-morbidity is reduced.

(a) The prescriber shall assess the patient at least once every three months and shall check the patient’s weight, blood pressure, pulse, heart and lungs. The findings shall be entered in the patient’s record.

(b) For the continuation of Schedule III or IV controlled substances designated as FDA short term use controlled substances beyond three months, the patient must continue to lose weight during the active weight reduction treatment or maintain goal weight. The prescriber shall document the patient’s weight loss or maintenance in the record.

(c) The prescriber shall document the patient’s progress with the treatment plan.

(d) The prescriber shall access OARRS in accordance with rules 4731-11-11 and 4730-2-10 of the Administrative Code.

(5) The prescriber shall discontinue utilizing all controlled substances for purposes of weight reduction immediately upon ascertaining or having reason to believe:

(a) That the patient has made any false or misleading statement to the prescriber relating to the patient's use of drugs or alcohol;

(b) That the patient has consumed or disposed of any controlled substance other than in strict compliance with the treating physician's directions;

(c) That the patient has failed to lose weight while under treatment with a controlled substance or controlled substances for weight reduction over a period of thirty days during the current course of treatment, which determination shall be made by weighing the patient at least every
thirtieth day, except that a patient who has never before received treatment for obesity utilizing any controlled substance who fails to lose weight during the first thirty days of the first such treatment attempt may be treated for an additional thirty days:

(d) That the patient has repeatedly failed to comply with the prescriber's treatment recommendations;

(e) That the patient demonstrates any signs that the controlled substance is not safe for or well tolerated by the patient; or

(f) That the prescriber knows or should know the patient is pregnant.

(D) A violation of any provision of this rule, as determined by the board, shall constitute the following:

(1) For a physician:

   (a) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code;

   (b) "Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code; and

   (c) "A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(2) For a physician assistant:

   (a) "A departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to a patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code;

   (b) "Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4730.25 of the Revised Code; and

   (c) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the
board," as that clause is used in division (B)(3) of section 4730.25 of the Revised Code.
4731-11-04 Controlled substances: Utilization of short term anorexiant for weight reduction.

(A) A physician shall utilize a schedule III or IV controlled substance short term anorexiant for purposes of weight reduction only if it has an F.D.A. approved indication for this purpose and then only in accordance with all of the provisions of this rule.

(B) Before initiating treatment for weight reduction utilizing any schedule III or IV controlled substance short term anorexiant, the physician shall complete all of the following requirements:

(1) The physician shall review the physician's own records of prior treatment or review the records of prior treatment by another treating physician, dietician, or weight-loss program to determine the patient's past efforts to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, intensive behavioral therapy, and exercise, without the utilization of controlled substances, and that the treatment has been ineffective.

(2) The physician shall complete and document the findings of all of the following:

(a) Obtain a thorough history;

(b) Perform an appropriate physical examination of the patient;

(c) Determine the patient's BMI;

(d) Rule out the existence of any recognized contraindications to the use of the controlled substance to be utilized;

(e) Assess and document the patient's freedom from signs of drug or alcohol abuse, and the presence or absence of contraindications and adverse side effects.

(f) Access OARRS for the patient's prescription history during the preceding twelve month period and document in the patient's record the receipt and assessment of the report received; and

(g) Develop and record in the patient record a treatment plan that includes, at a minimum, a diet and exercise program for weight loss.
(3) The physician shall not initiate treatment utilizing a controlled substance short term anorexiant upon ascertaining or having reason to believe any one or more of the following:

(a) The patient has a history of or shows a propensity for alcohol or drug abuse, or has made any false or misleading statement to the physician related to the patient's use of drugs or alcohol;

(b) The patient has consumed or disposed of any controlled substance other than in strict compliance with the treating physician's directions;

(c) The physician knows or should know the patient is pregnant;

(d) The patient has a BMI of less than thirty, unless the patient has a BMI of at least twenty seven with comorbid factors;

(e) The review of the physician's own records of prior treatment or review of records of prior treatment provided by another physician, dietician, or weight-loss program indicate that the patient made less than a substantial good faith effort to lose weight in a treatment program utilizing a regimen of weight reduction based on caloric restriction, nutritional counseling, intensive behavioral therapy, and exercise without the utilization of controlled substances.

(C) A physician may utilize a schedule III or IV controlled substance short term anorexiant, that bears appropriate F.D.A. approved labeling for weight loss, in the treatment of obesity as an adjunct, in a regimen of weight reduction based on caloric restriction, provided that:

(1) The physician shall personally meet face-to-face with the patient, at a minimum, every thirty days when controlled substances are being utilized for weight reduction, and shall record in the patient record information demonstrating the patient's continuing efforts to lose weight, the patient's dedication to the treatment program and response to treatment, and the presence or absence of contraindications, adverse effects, and indicators of possible substance abuse that would necessitate cessation of treatment utilizing controlled substances.

(2) The controlled substance short term anorexiant is prescribed strictly in accordance with the F.D.A. approved labeling. If the F.D.A. approved labeling of the controlled substance short term anorexiant being utilized for weight loss states that it is indicated for use for "a few weeks," the total course of treatment using that controlled substance shall not exceed twelve
weeks. That time period includes any interruption in treatment that may be permitted under paragraph (C)(3) of this rule.

(3) A physician shall not initiate a course of treatment utilizing a controlled substance short term anorexiant for purposes of weight reduction if the patient has received any controlled substance for purposes of weight reduction within the past six months. However, the physician may resume utilizing a controlled substance short term anorexiant following an interruption of treatment of more than seven days if the interruption resulted from one or more of the following:

(a) Illness of or injury to the patient justifying a temporary cessation of treatment; or

(b) Unavailability of the physician; or

(c) Unavailability of the patient, if the patient has notified the physician of the cause of the patient's unavailability.

(4) After initiating treatment, the physician may elect to switch to a different controlled substance short term anorexiant for weight loss based on sound medical judgment, but the total course of treatment for any short term anorexiant combination of controlled substances each of which is indicated for "a few weeks" shall not exceed twelve weeks.

(5) The physician shall not initiate or shall discontinue utilizing all controlled substance short term anorexiant for purposes of weight reduction immediately upon ascertaining or having reason to believe:

(a) That the patient has a history of or shows a propensity for alcohol or drug abuse, or has made any false or misleading statement to the physician relating to the patient's use of drugs or alcohol;

(b) That the patient has consumed or disposed of any controlled substance other than in strict compliance with the treating physician's directions;

(c) That the patient has failed to lose weight while under treatment with a controlled substance or controlled substances over a period of thirty days during the current course of treatment, which determination shall be made by weighing the patient at least every thirtieth day, except that a patient who has never before received treatment for obesity utilizing
any controlled substance who fails to lose weight during the first thirty
days of the first such treatment attempt may be treated for an additional
thirty days;

(d) That the patient has repeatedly failed to comply with the physician’s
treatment recommendations; or

(e) That the physician knows or should know the patient is pregnant.

(D) A violation of any provision of this rule, as determined by the board, shall constitute
the following:

(1) "Failure to maintain minimal standards applicable to the selection or
administration of drugs," as that clause is used in division (B)(2) of section
4731.22 of the Revised Code;

(2) "Selling, giving away, personally furnishing, prescribing, or administering
drugs for other than legal and legitimate therapeutic purposes," as that clause
is used in division (B)(3) of section 4731.22 of the Revised Code; and

(3) "A departure from, or the failure to conform to, minimal standards of care of
similar practitioners under the same or similar circumstances, whether or not
actual injury to a patient is established," as that clause is used in division
(B)(6) of section 4731.22 of the Revised Code.
Controlled substances: utilization for chronic weight management.

TO BE RESCINDED

(A) A physician shall determine whether to utilize a controlled substance anorexiant for purposes of chronic weight management as an adjunct to a reduced calorie diet and increased physical activity. The determination shall be made in compliance with the provisions of this rule.

(1) Before initiating treatment utilizing any controlled substance anorexiant, the physician shall complete all of the following requirements:

(a) Obtain a thorough history;

(b) Perform a physical examination of the patient;

(c) Determine the patient's BMI;

(d) Review the patient's attempts to lose weight in the past for indications that the patient has made a substantial good faith effort to lose weight in a regimen for weight reduction based on caloric restriction, nutritional counseling, intensive behavioral therapy, and exercise without the utilization of controlled substance anorexiants. The review shall include available records from the physician's own prior treatment of the patient, prior treatment provided by another physician, prior participation in a weight-loss program, or prior treatment by a dietitian;

(e) Rule out the existence of any recognized contraindications to the use of the controlled substance anorexiant to be utilized;

(f) Assess and document the patient's freedom from signs of drug or alcohol abuse;

(g) Access OARRS and document in the patient's record the receipt and assessment of the information received; and

(h) Develop and record in the patient record a treatment plan that includes, at a minimum, a diet and exercise program for weight loss.

(2) The physician shall not initiate treatment utilizing a controlled substance anorexiant upon ascertaining or having reason to believe any one or more of the following:
(a) The patient has a history of, or shows a propensity for, alcohol or drug abuse, or has made any false or misleading statement to the physician or physician assistant relating to the patient's use of drugs or alcohol;

(b) The patient has consumed or disposed of any controlled substance other than in strict compliance with the treating physician’s directions; or

(c) The physician knows or should know the patient is pregnant.

(3) The physician shall not initiate treatment utilizing a controlled substance anorexiant if any of the following conditions exist:

(a) The patient has an initial BMI of less than thirty, unless the patient has an initial BMI of at least twenty seven with comorbid factors.

(b) The review of the patient's attempts to lose weight in the past indicates that the patient has not made a substantial good faith effort to lose weight in a regimen for weight reduction based on caloric restriction, nutritional counseling, intensive behavioral therapy, and exercise without the utilization of controlled substance anorexiants. The review shall include available records from the physician's own prior treatment of the patient, prior treatment provided by another physician, prior participation in a weight-loss program, or prior treatment by a dietitian.

(4) The physician shall prescribe the controlled substance anorexiant strictly in accordance with the F.D.A. approved labeling;

(5) Throughout the course of treatment with any controlled substance anorexiant the physician shall comply with rule 4731-11-11 of the Administrative Code and the physician assistant shall comply with rule 4730-2-10 of the Administrative Code.

(B) A physician shall provide treatment utilizing a controlled substance anorexiant for weight management in compliance with paragraph (A) of this rule and the following:

(1) The physician shall meet face-to-face with the patient for the initial visit and at least every thirty days during the first three months of treatment. If the F.D.A. approved labeling for the controlled substance anorexiant requires induction of treatment at one dose and an increase to a higher dose after a stated period of less than thirty days, the physician may give the patient a prescription for
the higher dose at the initial visit and the first thirty day period then starts from the date the prescription for the higher dose may be filled.

(2) Following the initial visit and two follow-up visits, the treatment may be continued under one of the following means:

(a) The physician may authorize refills for the controlled substance anorexiant up to five times within six months after the initial prescription date;

(b) The treatment may be provided by a physician assistant in compliance with this rule, the supervisory plan or policies of the healthcare facility, and the physician assistant formulary adopted by the board.

(3) When treatment for chronic weight management is provided by a physician assistant, the following requirements apply:

(a) The supervising physician shall personally review the medical records of each patient to whom the physician assistant has prescribed a controlled substance anorexiant following each visit; and

(b) A physician assistant shall not initiate utilization of a different controlled substance anorexiant, but may recommend such change for the supervising physician's initiation.

(4) A physician shall discontinue utilizing any controlled substance anorexiant immediately upon ascertaining or having reason to believe:

(a) That the patient has repeatedly failed to comply with the physician's treatment recommendations; or

(b) That the patient is pregnant.

(C) A violation of any provision of this rule, as determined by the board, shall constitute the following as applicable:

(1) For a physician:

(a) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of
(b) "Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code; and

(c) "A departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(2) For a physician assistant:

(a) "A departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to a patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code;

(b) "Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4730.25 of the Revised Code; and

(c) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the board," as that clause is used in division (B)(3) of section 4730.25 of the Revised Code.
MEMORANDUM

TO: Board Members

FROM: Joe Turek, Deputy Director

DATE: 2/3/2022

RE: Licensure Protocols Pursuant to Rule 4731-30-03 (Approval of Licensure Applications)

Background

The amendments to rule 4731-30-02, effective January 31, 2022, provide that the secretary and supervising member of the board may approve the use of protocols whereby, if the deputy director of licensure, or the deputy director’s designee, finds that the parameters of an approved protocol are met:

(1) A waiver pursuant to the provisions of rule 4731-6-05 of the Administrative Code may be deemed granted (in relation to the USMLE/COMLEX attempt and time-limit requirements)

(2) It may be deemed that an applicant’s education, post-graduate medical training, experience, or other qualifications, is equivalent to the graduate medical education requirements set forth in section 4731.09 of the Revised Code.

(3) It may be deemed that an applicant has demonstrated fitness to resume practice due to inactivity under the applicable provisions of the Revised Code and Administrative Code.

Issue

Licensure staff has worked with the secretary and supervising member to draft protocols pursuant to this rule. The protocol addressing waiver & equivalency requests is new while the protocols addressing fitness to practice are revisions from those that were approved by the Board in November 2019. The experience staff has had applying the previous protocols over the last two-plus years has informed the changes and staff believes that the proposed protocols are now more limited in scope, more objective, easier to apply, and more realistic. The most notable changes to those protocols are as follows:

- The physician fitness to practice protocol eliminates the distinction between being out of practice from two to five years versus more than five years. The protocol has also been simplified and now only permits the staff to find fitness to practice under a more limited set of facts.

- The allied fitness to practice protocol also eliminates the distinction between being out of practice from two to five years versus more than five years. It further amends the number of hours certain types of practitioners must have worked to be deemed an active
practitioner. These changes were made in consideration of the potential for patient harm, whether there is a requirement for a practitioner to maintain a certification/registration, whether minimal standards complaints for the profession are common, and practical considerations such as whether a type of practice is typically engaged in on a part-time basis.

- The allied fitness to practice protocol provides alternative means by which a massage therapist or respiratory care professional could be found to be fit to practice other than by successfully retaking the MBLEx or CSE examinations.

The draft protocols are attached.

**Recommendation**

Staff believes that the draft protocols are appropriate and will decrease the time to license issuance for qualified and safe practitioners.

While rule 4731-30-02 authorizes the secretary and supervising member to approve these protocols, staff believed it was prudent to seek feedback from the full board before final adoption.
PHYSICIAN LICENSURE PROTOCOL – WAIVER AND EQUIVALENCY REQUESTS

Purpose of Protocol:

The purpose of this protocol is to permit timely and efficient processing of applications for licensure submitted by physicians who are requesting (1) a waiver of the USMLE and COMLEX attempt/time limits pursuant to rule 4731-6-05 of the Ohio Administrative Code and/or (2) a determination of graduate medical education equivalency pursuant to section 4731.09 of the Ohio Revised Code. Rule 4731-3-03 permits the Secretary and Supervising Member of the Board to grant requests for waivers and graduate medical education equivalency, and to approve protocols whereby the deputy director of licensure, or the deputy director’s designee, may deem such requests granted.

General Provisions / Scenarios for Use:

This protocol is for use by the deputy director of licensure, or the deputy director’s designee, and applies to applications for licensure submitted by physicians who have exceeded the USMLE and COMLEX attempt/time limits and/or who have not completed the required graduate medical education (as defined in section 4731.04 of the Ohio Revised Code).

Protocol Instructions:

(A) A physician who has not passed all steps of the USMLE or all levels of the COMLEX within a ten-year period, but who holds current specialty board certification from a member board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), may be granted a waiver.

(B) A physician who has exceeded the maximum number of attempts for any step or level established by the National Board of Medical Examiners (NBME) or the National Board of Osteopathic Medical Examiners (NBOME), as effective on the date of application for a license may be granted a waiver if the applicant meets one of the following requirements:

(1) The applicant holds current specialty board certification from a member board of the ABMS or by the AOA; or

(2) The applicant demonstrates that a step or level was completed within the maximum number of attempts permitted by the NBME or the NBOME, at the time the step or level was successfully completed, provided that the applicant did not exceed six attempts for the step or level.

(C) An applicant’s request for a graduate medical education equivalency determination may be deemed to have been approved if the applicant has completed at least one year of graduate medical education (as defined in section 4731.04 of the Revised Code) at the PGY-2 level or above, and at least two years of post-graduate medical training in a non-U.S. jurisdiction.
Purpose of Protocol:
The purpose of this protocol is to permit timely and efficient processing of initial license applications and restoration applications submitted by physicians who have not been engaged in the practice of the profession for more than two years. Rule 4731-30-03 permits the Secretary and Supervising Member of the Board to determine whether an applicant has demonstrated fitness to resume practice, and to approve protocols whereby the deputy director of licensure, or the deputy director’s designee, may deem that an applicant has made such demonstration.

General Provisions / Scenarios for Use:
This protocol is for use by the deputy director of licensure, or the deputy director’s designee, and applies to initial or restoration applications submitted by physicians who have not been engaged in the practice of the profession for more than two years and are subject to the fitness to resume practice provisions of section 4731.222 of the Revised Code.

For purposes of this protocol, an applicant will be deemed not to have been an “active practitioner” (as that term is used in the aforementioned section of the Revised Code), and therefore subject to this protocol if the applicant has not practiced for at least 1,000 hours (approximately six months of full-time work) during the two-year period immediately preceding submission of the application.

For purposes of this protocol, an “active practitioner” includes physicians who have been engaged as clinical faculty at a medical, osteopathic, or podiatric school, or who have been engaged in the practice of administrative medicine.

Protocol Instructions:
It may be deemed that a physician who has not been engaged in the practice of the profession during the two-year period immediately preceding submission of the application has demonstrated fitness to resume practice if:

1. The applicant has practiced for at least 2,000 hours during the three-year period immediately preceding submission of the application; and

2. The applicant meets one of the following requirements:

   a. The applicant has time-limited board certification by a member board of the American Board of Medical Specialties (ABMS) or by the American Osteopathic Association (AOA), the certification is active, and the applicant is participating in Maintenance of Certification (MOC) or Osteopathic Continuous Certification (OCC); or

   b. The applicant has lifetime board certification by a member board of the ABMS or by the AOA; and
(i) The applicant is voluntarily participating in MOC or OCC; or

(ii) The applicant holds an active license in another state whose continuing medical education (CME) requirements for renewal are at least equal to those of Ohio, and the applicant has completed the required hours of CME to maintain that license; or

(iii) The applicant is applying for license restoration and has completed the required hours of CME to renew a license during the twenty-four months preceding the board’s receipt of the application for restoration.

This protocol supersedes that which was approved by the board on November 13, 2019.
ALLIED LICENSURE PROTOCOL – FITNESS TO PRACTICE

Purpose of Protocol:
The purpose of this protocol is to permit timely and efficient processing of initial license applications and restoration applications submitted by non-physician practitioners who have not been engaged in the practice of their profession for more than two years. Rule 4731-30-03 permits the Secretary and Supervising Member of the Board to determine whether an applicant has demonstrated fitness to resume practice, and to approve protocols whereby the deputy director of licensure, or the deputy director’s designee, may deem that an applicant has made such demonstration.

General Provisions / Scenarios for Use:
This protocol is for use by the deputy director of licensure, or the deputy director’s designee, and applies to initial or restoration applications submitted by non-physician practitioners who have not been engaged in the practice of their profession for more than two years and are subject to the fitness to resume practice provisions of sections 4730.28, 4731.222, 4759.063, 4760.061, 4761.061, 4762.061, 4774.061, and 4778.071 of the Revised Code.

For purposes of this protocol, an applicant will be deemed not to have been a “active practitioner” (as that term is used in the aforementioned sections of the Revised Code), and therefore subject to this protocol if the applicant has not practiced for at least the following number of hours during the two-year period immediately preceding submission of the application:

1. If the applicant is an anesthesiologist assistant, physician assistant, or respiratory care professional, 1000 hours.
2. If the applicant is an acupuncturist, dietitian, genetic counselor, or radiologist assistant, 500 hours.
3. If the applicant is a massage therapist, 100 hours.

Protocol Instructions:

(A) It may be deemed that a non-physician practitioner who has not been engaged in the practice of the practitioner’s profession during the two-year period immediately preceding submission of the application has demonstrated fitness to resume practice:

1. If the applicant is a massage therapist, the applicant meets one of the following requirements:
   a. The applicant has passed the Massage & Bodywork Licensing Examination within the past two years; or
   b. The applicant holds current board certification with the National Certification Board for Therapeutic Massage & Body Work.
(2) If the applicant is a respiratory care professional, the applicant meets one of the following requirements:

(a) The applicant has passed the Clinical Simulation Examination within the past two years; or

(b) The applicant is participating in the National Board for Respiratory Care’s credential maintenance program and holds a current Registered Respiratory Therapist (RRT) credential; or

(c) The applicant holds a non-expiring RRT credential and has completed at least 20 hours of respiratory care continuing education within the last two years.

(3) If the applicant is a physician assistant, the applicant holds current certification from the National Commission on Certification of Physician Assistants.

(4) If the applicant is a dietitian, the applicant holds current registration with the Commission on Dietetic Registration.

(5) If the applicant is an acupuncturist, the applicant holds a current and active designation from the national certification commission for acupuncture and oriental medicine as a diplomate in acupuncture or diplomate in oriental medicine.

(6) If the applicant is an anesthesiologist assistant, the applicant holds certification by the National Commission for the Certification of Anesthesiologist Assistants.

(7) If the applicant is a radiologist assistant, the applicant holds both a current license as a radiographer under Chapter 4773 of the Revised Code, and certification as a registered radiologist assistant from the American Registry of Radiologic Technologists.

(8) If the applicant is a genetic counselor, the applicant holds certification with the American Board of Genetic Counseling as a genetic counselor or is a diplomate of the American Board of Medical Genetics.

(B) If the applicant does not meet the applicable requirement in paragraph (A) above, the Deputy Director of Licensure, or his/her designee, may request that the applicant pass the applicable examination, obtain the applicable certification/registration, or complete the applicable continuing education. If the applicant complies with the request within six months, the applicant shall be deemed to have demonstrated fitness to practice.

This protocol supersedes that which was approved by the board on November 13, 2019.
MEMORANDUM

TO: Betty Montgomery, President, State Medical Board of Ohio
    Members, State Medical Board of Ohio

FROM: Nathan T. Smith, Senior Legal and Policy Counsel

DATE: February 4, 2022

RE: Telehealth rules proposed for initial circulation

At the January 12, 2022 Medical Board meeting, Board staff presented a preliminary draft of two new telehealth rules (4731-37-01 and 4731-11-09) for Board discussion. Based on Board feedback, the following changes are proposed to OAC 4731-37-01:

1. Add the phrase “parent or guardian” to all paragraphs about informed consent to cover those situations where a patient’s parent or guardian would be consenting rather than the patient;
2. In (B)(3), to clarify when telephone calls would be appropriate as synchronous communication, add: “Telephone calls, as a synchronous communication technology, may only be used for telehealth services when all of the elements of a bona fide health care visit meeting the standard of care are performed. Telephone calls that are routine or simply involve communication of information without patient interaction do not constitute a telehealth service.”

Also, Board staff informally sought feedback on the draft of the rules from the following stakeholders: Ohio State Medical Association, Ohio Hospital Association, Cleveland Clinic, University Hospitals, Ohio Health, Mercy Health, MetroHealth, OSU Wexner Medical Center, Ohio Osteopathic Association, Ohio Foot and Ankle Medical Association, Ohio Society for Respiratory Care, Ohio Academy for Nutrition and Dietetics, Ohio Association of Physician Assistants, Ohio Psychiatric Physicians Association, Ohio Association of Community Health Centers, OneFifteen, Ohio chapter of American Academy of Pediatrics, Ohio Academy of Family Physicians, Ohio Medicaid, Ohio Department of Mental Health and Addiction Services, Academy of Medicine of Cleveland and Northern Ohio, Nationwide Children’s Hospital, Cincinnati Children’s Hospital, Teladoc, American Telemedicine Association, hims & hers, Central Ohio Primary Care, and University of Toledo Medical Center and Affiliated Hospitals.

The feedback to the proposed rules was generally very positive with most comments focused on the operability and feasibility of technical requirements. The most commented on provision from the preliminary draft was the referral provision in 4731-37-01(B)(4). Proposed changes to that provision balance comments regarding patient safety, continuity of care, feasibility for health care professionals, and access to care by providing specific requirements based on the different levels of care needed.
Feedback from these stakeholders is ongoing and will continue throughout the rulemaking process. The feedback provided from many of these stakeholders has informed the following proposed changes and additions to the proposed rules:

### OAC 4731-37-01

1. Change to the definition of telehealth services in (A)(1) that clarifies that the rule’s requirements pertaining to telehealth consultation apply to formal consulting between health care professionals.
2. Change to the definition of asynchronous communication in (A)(3) to make it more inclusive to audio files or video images as well as to improve readability;
3. Change to definition of remote monitoring device in (A)(4) and (F)(2)(b) to include medical devices that have received FDA authorization in addition to those that have received FDA clearance or approval.
4. Change from term “informed consent” to the broader term of “consent for treatment” in (A)(7), (C), (D), and (F) because of the specialized legal definition of informed consent pertaining to surgical or medical procedures in R.C. 2317.54.
5. Clarification in (A)(7), (C), and (D) that consent for treatment may be documented by the health care professional rather than require a patient signature on a form.
6. Changes to the continuity of care provision in (B)(4) to provide specific language addressing the varying levels of in-person care and referrals including: immediate care, non-immediate care, referral to a specialist, and emergency care.
7. Change to clarify a health care professional’s obligation to forward a patient’s medical record upon patient’s authorization.
8. Change in (D)(3) to allow an emergency exception to the requirement that the health care professionals consulting regarding a patient have received and reviewed all of the relevant medical records of the patient.
9. Change in (F)(1) to eliminate the requirement for a physician or physician assistant to document that the laws of the state in which the patient is located allow for the physician or physician assistant to provide telehealth services in that state.

### 4731-11-09

1. Change to the definition of mental health condition in (A)(4) to allow flexibility in using the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, instead of specifying the Fifth Edition.

### Rules incorporating the new telehealth rule OAC 4731-37-01

There are no changes proposed to the following rules as proposed at the January 12, 2022 Board meeting which incorporate OAC 4731-37-01 into the respective chapters for physician assistants, dietitians, respiratory care professionals, and genetic counselors: Rule 4730-1-07 Miscellaneous provisions, 4730-2-07 Standards for Prescribing, Rule 4759-11-01 Miscellaneous Provisions, Rule 4761-15-01 Miscellaneous provisions, and Rule 4778-1-06 Miscellaneous provisions.
**Enforcement of current rules in the context of new rulemaking and telehealth legislation**

The new telehealth law (Sub. H.B. 122) becomes effective on March 23, 2022. R.C. 4743.09(B)(1) authorizes the Medical Board to adopt rules necessary to implement the new law. While the Board is trying to expeditiously move the telehealth rules through the rulemaking process, these rules will not be ready for adoption for at least several more months.

The Ohio General Assembly provided the following uncodified language to bridge the time period between when the statute becomes effective and when new rules implementing the law are adopted. Section 6 of Sub. HB 122 states: “Beginning on the effective date of this section, a health care professional licensing board, as defined in section 4743.09 of the Revised Code, may suspend the enforcement of any rules that the board has in effect on the effective date of this section regarding the provision of telehealth and in-person services by a health care professional under the board's jurisdiction, and requirements for the prescribing of controlled substances, while the board amends or adopts new rules that are consistent with the provisions of this act.”

This uncodified language allows the Board to launch its new rules in a less confusing manner than if it reverted to enforcing its current rules that conflict with portions of the new telehealth law for only a few months before implementing new rules. It minimizes uncertainty and confusion to patients, health care professionals, and health care systems.

**Actions Requested:**

1. Discuss and approve proposed rules with any changes for initial circulation, including referral for discussion to Physician Assistant Policy Committee, Dietetics Advisory Council, and Respiratory Care Advisory Council.
2. Discuss and approve a Board statement of intent regarding utilization of the statutory language allowing for Medical Board suspension of enforcement of its rules regarding telehealth, in-person services, and requirements for the prescribing of controlled substances while the Board amends or adopts new telehealth rules.
(A) As used in Chapters 4730, 4731, 4759, 4761, and 4778 of the Administrative Code:

(1) Telehealth services means health care services provided through the use of information and communication technology by a health care professional licensed in Ohio, within the professional's scope of practice, who is located at a site other than the site where the patient is receiving the services or the site where another health care professional with whom the provider of the services is formally consulting regarding the patient is located.

(2) Synchronous communication technology means audio and/or video technology that permits two-way, interactive, real-time electronic communication between the health care professional and the patient or between the health care professional and the consulting health care professional regarding the patient.

(3) Asynchronous communication technology, also called store and forward technology, means the transmission of a patient’s stored clinical data from an originating site to the site where the health care professional is located. The health care professional at this distant site can review the stored clinical data at a later time from when the data is sent and without the patient being present. Stored clinical data that may be transmitted via asynchronous communication technology means video clips, sound/audio files, or photo images that may be sent along with electronic records and written records about the patient’s medical condition. Asynchronous communication technology does not include telephone calls, images transmitted via facsimile machines, and text messages, such as in electronic mail, without either visual or audio files of the patient included with the text message. Photographs or video images that are visualized by a telecommunications system must be both specific to the patient’s medical condition and sufficient for furnishing or confirming a diagnosis and/or a treatment plan.

(4) Remote monitoring device means a medical device cleared, approved, or authorized by the United States food and drug administration for the specific purpose which the health care professional is using it and which reliably transmits data electronically and automatically.

(5) Health care professional means:

(a) a physician assistant licensed under Chapter 4730, of the Revised Code;

(b) a physician licensed under Chapter 4731, of the Revised Code to practice medicine and surgery, osteopathic medicine and surgery, or podiatric medicine and surgery;

(c) a dietitian licensed under Chapter 4759, of the Revised Code;
(d) a respiratory care professional licensed under Chapter 4761 of the Revised Code; or

(e) a genetic counselor licensed under Chapter 4778 of the Revised Code.

(6) "Certified nurse practitioner" means an advanced practice registered nurse who holds a current, valid license issued under Chapter 4723 of the Revised Code and is designated as a certified nurse practitioner in accordance with section 4723.42 of the Revised Code.

(7) "Consent for treatment" means a process of communication between a patient or the parent or guardian of a patient and the health care professional discussing the risks and benefits of, and alternatives to, treatment through a remote evaluation that results in the patient's or parent or guardian's agreement to treatment that is documented in the medical record or signed authorization for the patient to be treated through an evaluation conducted through appropriate technology, as specified in this rule, when the health care professional is in a location remote from the patient.

(B) A health care professional may provide telehealth services to a patient located in this state. The health care professional shall comply with all of the following requirements:

(1) The standard of care for a telehealth visit is the same as the standard of care for an in-person visit.

(2) The health care professional shall follow all standard of care requirements which include but are not limited to the standard of care requirements in paragraph (C) of this rule.

(3) The health care professional may provide the telehealth services through the use of synchronous or asynchronous communication technology provided that the standard of care for an in-person visit can be met for the patient and the patient's medical condition through the use of the technology selected. Telephone calls, as a synchronous communication technology, may only be used for telehealth services when all of the elements of a bona fide health care visit meeting the standard of care are performed. Telephone calls that are routine or simply involve communication of information without patient interaction do not constitute a telehealth service.

(4) If a health care professional determines at any time during the provision of telehealth services that a telehealth visit will not meet the standard of care for the medical condition of the patient or if additional in-person care is necessary, the health care professional shall do the following:

(a) If the patient must be seen immediately but not in an emergency room, the
health care professional shall immediately schedule the patient for an in-person visit with the health care professional and promptly conduct that visit or refer the patient for an in-person visit with one of the following licensed health care professionals who can provide the services in-person that are appropriate for the patient and the condition for which the patient presents:

(i) another health care professional with whom the health care professional has a cross-coverage agreement.

(ii) in the case of a physician, a physician assistant with whom the physician has a supervision agreement or a certified nurse practitioner with whom the physician has a standard care arrangement; or

(iii) in the case of a physician assistant, a physician with whom the physician assistant has a supervision agreement.

(b) If the patient does not need to be seen immediately, the health care professional shall schedule the patient for an in-person visit and conduct that visit within an amount of time that is appropriate for that patient and their condition presented.

(c) If the patient must be seen by a specialist other than the health care professional, the health care professional shall make a referral to a specialist, licensed in this state, whom the healthcare professional knows has an appropriate scope of practice and is capable of conducting an in-person visit appropriate for the diagnosis and treatment of the patient’s condition and ensure that all necessary medical files are shared upon request.

(d) If the patient needs emergency care, the health care professional shall help the patient identify the closest emergency room and provide notification to the emergency room of the patient’s potential arrival.

(e) The health care professional shall document the in-person visit or the referral in the patient’s medical record.

(f) All referrals must be made in an amount of time that is appropriate for that patient and their condition presented.

(C) A health care professional must comply with all standard of care requirements to provide telehealth services to a patient including but not limited to:

(1) The health care professional shall verify the patient’s identity and physical location in Ohio and communicate the health care professional’s name and licensure information to the patient.
(2) The health care professional shall document the patient or the patient's parent or guardian's consent for treatment through telehealth;

(3) The health care professional shall provide the telehealth services in a manner that complies with the privacy and security requirements for the patient and their protected health information required by the law of this state and federal law. Also, the health care professional shall ensure that any username or password information and any electronic communications between the health care professional and the patient are securely transmitted and stored.

(4) If applicable, the health care professional shall request the patient's authorization and, if granted, forward the medical record to the patient's primary care provider or other health care provider or refer the patient to an appropriate health care provider or health care facility;

(5) The health care professional shall, through interaction with the patient, complete a medical evaluation that is appropriate for the patient and the condition with which the patient presents and that meets the minimal standards of care for an in-person visit, which may include portions of the evaluation having been conducted by other Ohio licensed healthcare providers acting within the scope of their professional license;

(6) The health care professional shall establish or confirm, as applicable, a diagnosis and treatment plan, which for those health care professionals designated as prescribers in section 4729.01 of the Revised Code, includes documentation of the necessity for the utilization of a prescription drug. The diagnosis and treatment plan shall include the identification of any underlying conditions or contraindications to the recommended treatment;

(7) The health care professional shall promptly document in the patient's medical record the patient's or patient's parent or guardian's consent for treatment through telehealth, pertinent history, evaluation, diagnosis, treatment plan, underlying conditions, any contraindications, and any referrals to appropriate health care providers, including primary care providers or health care facilities;

(8) The health care professional shall provide appropriate follow-up care or recommend follow-up care with the patient's primary care provider, other appropriate health care provider, or health care facility in accordance with the minimal standards of care;

(9) The health care professional shall make the medical record of the visit available to the patient upon request.

(D) A health care professional must comply with the following requirements to provide telehealth services that involve consultation with another health care professional:
(1) The referring health care professional shall document the consent for treatment of the patient or the patient's parent or guardian before seeking the telehealth services consultation with the consulting health care professional;

(2) The consulting health care professional must meet the licensure or certification requirements in division (C) of section 4743.09 of the Revised Code; and

(3) The health care professionals involved in the consultation must have received and reviewed all medical records of the patient relevant to the medical condition which is the subject of the consultation before the consultation occurs, unless this is not possible due to an emergency situation.

(E) While providing telehealth services, a health care professional that is a physician or a physician assistant who holds a valid prescriber number issued by the state medical board and who has been granted physician-delegated prescriptive authority shall comply with the following requirements regarding prescription drugs:

(1) the physician or physician assistant may only prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug that is not a controlled substance to a patient through the provision of telehealth services by complying with all requirements of this rule;

(2) the physician or physician assistant may only prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug to a patient that is a controlled substance through the provision of telehealth services by complying with the following requirements:

   (a) federal law governing prescription drugs that are controlled substances;

   (b) the requirements of this rule; and

   (c) the requirements in rule 4731-11-09 of the Administrative Code.

(F) A health care professional that is a physician or physician assistant may provide the following additional telehealth services:

(1) A physician or physician assistant may provide telehealth services to a patient located outside of this state if permitted by the laws of the state in which the patient is located. The physician or physician assistant shall confirm and document in the medical record the location of the patient.

(2) A physician or physician assistant may provide telehealth services through the use of remote monitoring devices provided that:

   (a) the patient or the patient's parent or guardian gives consent for treatment to the use of remote monitoring devices;
(b) the medical devices that enable remote monitoring have been cleared, approved, or authorized by the United States food and drug administration for the specific purpose for which the physician or physician assistant are using it for the patient, and the remote monitoring devices otherwise comply with all federal requirements.

(G) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following:

(1) For a physician:

(a) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code;

(b) "Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code; or

(c) "A departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.

(2) For a physician assistant:

(a) "A departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to a patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code;

(b) "Failure to comply with the requirements of this chapter, Chapter 4731, of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4730.25 of the Revised Code; or

(c) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731, of the Revised Code, or the rules adopted by the board," as that clause is used in division (B)(3) of section 4730.25 of the Revised Code.

(3) For a dietitian:

(a) "Violating or attempting to violate, directly or indirectly, or assisting in or
abetting the violation of, or conspiring to violate, any provision of this chapter or the rules adopted by the board," as that clause is used in division (A)(1) of section 4759.07 of the Revised Code; or

(b) "A departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (A)(11) of section 4759.07 of the Revised Code.

(4) For a respiratory care professional:

(a) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter or the rules adopted by the board," as that clause is used in division (A)(7) of section 4761.09 of the Revised Code; or

(b) "A departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (A)(10) of section 4761.09 of the Revised Code.

(5) For a genetic counselor:

(a) "Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4778.14 of the Revised Code;

(b) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the board," as that clause is used in division (B)(3) of section 4778.14 of the Revised Code; or

(c) "A departure from, or failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances whether or not actual injury to the patient is established," as that clause is used in division (B)(4) of section 4778.14 of the Revised Code.
Controlled substance and telehealth prescribing.

(A) As used in this rule:

(1) Hospice care means the care of a hospice patient as that term is defined in section 3712.01 of the Revised Code.

(2) Palliative care has the same meaning as in section 3712.01 of the Revised Code.

(3) Medication assisted treatment and substance use disorder have the same meanings as in rule 4731-33-01 of the Administrative Code.

(4) Mental health condition means any mental health condition, illness, or disorder as determined by the diagnostic criteria in the most recent version of the "Diagnostic and Statistical Manual of Mental Disorders".

(5) Emergency situation means a situation involving an “emergency medical condition” as that term is defined in section 1753.28 of the Revised Code.

(B) A physician or a physician assistant who holds a valid prescriber number issued by the state medical board and who has been granted physician-delegated prescriptive authority must comply with federal law governing prescription drugs that are controlled substances to prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug that is a controlled substance to a person.

(C) When the physician or physician assistant, who holds a valid prescriber number issued by the state medical board and who has been granted physician-delegated prescriptive authority, prescribes, personally furnishes, otherwise provides, or causes to be provided a prescription drug that is a controlled substance during the provision of telehealth services, the physician or physician assistant must comply with all requirements in rule 4731-37-01 of the Administrative Code.

(D) The physician or physician assistant shall conduct a physical examination of a new patient as part of an initial in-person visit before prescribing a schedule II controlled substance to the patient except as provided in paragraph (E) of this rule.

(E) As an exception to paragraph (D) of this rule, a physician or physician assistant may prescribe a controlled substance to a new patient as part of the provision of telehealth services for any of the following patient medical conditions and situations:

(1) The medical record of a new patient indicates that the patient is receiving hospice or palliative care;

(2) The patient has a substance use disorder, and the controlled substance is FDA approved for and prescribed for medication assisted treatment or to treat opioid use disorder.
(3) The patient has a mental health condition and the controlled substance prescribed is prescribed to treat that mental health condition; or

(4) The physician or physician assistant determines in their clinical judgment that the new patient is in an emergency situation provided that the following occurs:

(a) the physician or physician assistant prescribes only the amount of a schedule II controlled substance to cover the duration of the emergency or an amount not to exceed a three-day supply whichever is shorter;

(b) after the emergency situation ends, the physician or physician assistant conducts the physical examination as part of an initial in-person visit before any further prescribing of a drug that is a schedule II controlled substance.

(F) When prescribing a controlled substance through the provision of telehealth services under one of the exceptions in paragraph (E) of this rule, the physician or physician assistant shall document one of the reasons listed in paragraph (E) for the prescribing in the medical record of the new patient in addition to the documentation already required to meet the standard of care in rule 4731-37-01 of the Administrative Code.

(G) Nothing in this rule shall be construed to imply that one in-person physician examination demonstrates that a prescription has been issued for a legitimate medical purpose within the course of professional practice.

(H) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following:

(1) For a physician:

(a) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code;

(b) "Selling, giving away, personally furnishing, prescribing, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code; or

(c) "A departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.
For a physician assistant:

(a) "A departure from, or failure to conform to, minimal standards of care of similar physician assistants under the same or similar circumstances, regardless of whether actual injury to a patient is established," as that clause is used in division (B)(19) of section 4730.25 of the Revised Code;

(b) "Failure to comply with the requirements of this chapter, Chapter 4731. of the Revised Code, or any rules adopted by the board," as that clause is used in division (B)(2) of section 4730.25 of the Revised Code; or

(c) "Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, Chapter 4731. of the Revised Code, or the rules adopted by the board," as that clause is used in division (B)(3) of section 4730.25 of the Revised Code.

(I) This rule shall not apply to any prescribing situations specifically authorized by the Revised Code or Administrative Code.

(J) For purposes of this rule, "patient" means a person for whom the physician or physician assistant provides healthcare services or the person's representative.
Prescribing to persons not seen by the physician.

TO BE RESCINDED

(A) Except as provided in paragraph (D) of this rule, a physician shall not prescribe, personally furnish, otherwise provide, or cause to be provided, any controlled substance to a person on whom the physician has never conducted a physical examination.

(B) Except as provided in paragraph (C) of this rule, a physician shall not prescribe, personally furnish, otherwise provide, or cause to be provided, any prescription drug that is not a controlled substance to a person on whom the physician has never conducted a physical examination.

(C) A physician may prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug that is not a controlled substance to a person on whom the physician has never conducted a physical examination and who is at a location remote from the physician by complying with all of the following requirements:

1. The physician shall establish the patient's identity and physical location;

2. The physician shall obtain the patient's informed consent for treatment through a remote examination;

3. The physician shall request the patient's consent and, if granted, forward the medical record to the patient's primary care provider or other health care provider, if applicable, or refer the patient to an appropriate health care provider or health care facility;

4. The physician shall, through interaction with the patient, complete a medical evaluation that is appropriate for the patient and the condition with which the patient presents and that meets the minimal standards of care, which may include portions of the evaluation having been conducted by other Ohio licensed healthcare providers acting within the scope of their professional license;

5. The physician shall establish or confirm, as applicable, a diagnosis and treatment plan, which includes documentation of the necessity for the utilization of a prescription drug. The diagnosis and treatment plan shall include the identification of any underlying conditions or contraindications to the recommended treatment;

6. The physician shall document in the patient's medical record the patient's consent to treatment through a remote evaluation, pertinent history, evaluation, diagnosis, treatment plan, underlying conditions, any
contraindications, and any referrals to appropriate health care providers, including primary care providers or health care facilities;

(7) The physician shall provide appropriate follow-up care or recommend follow-up care with the patient's primary care provider, other appropriate health care provider, or health care facility in accordance with the minimal standards of care;

(8) The physician shall make the medical record of the visit available to the patient;

(9) The physician shall use appropriate technology that is sufficient for the physician to conduct all steps in this paragraph as if the medical evaluation occurred in an in-person visit.

(D) A physician may prescribe, personally furnish, otherwise provide, or cause to be provided a prescription drug that is a controlled substance to a person on whom the physician has not conducted a physical examination and who is at a location remote from the physician in any of the following situations:

(1) The person is an active patient, as that term is defined in paragraph (D) of rule 4731-11-01 of the Administrative Code, of an Ohio licensed physician or other health care provider who is a colleague of the physician and the drugs are provided pursuant to an on call or cross coverage arrangement between them and the physician complies with all steps of paragraph (C) of this rule;

(2) The patient is physically located in a hospital or clinic registered with the United States drug enforcement administration to personally furnish or provide controlled substances, when the patient is being treated by an Ohio licensed physician or other healthcare provider acting in the usual course of their practice and within the scope of their professional license and who is registered with the United States drug enforcement administration to prescribe or otherwise provide controlled substances in Ohio.

(3) The patient is being treated by, and in the physical presence of, an Ohio licensed physician or healthcare provider acting in the usual course of their practice and within the scope of their professional license, and who is registered with the United States drug enforcement administration to prescribe or otherwise provide controlled substances in Ohio.

(4) The physician has obtained from the administrator of the United States drug enforcement administration a special registration to prescribe or otherwise provide controlled substances in Ohio.
(5) The physician is the medical director, hospice physician, or attending physician for a hospice program licensed pursuant to Chapter 3712. of the Revised Code and both of the following conditions are met:

(a) The controlled substance is being provided to a patient who is enrolled in that hospice program, and

(b) The prescription is transmitted to the pharmacy by a means that is compliant with Ohio board of pharmacy rules.

(6) The physician is the medical director of, or attending physician at, an institutional facility, as that term is defined in rule 4729-17-01 of the Administrative Code, and both of the following conditions are met:

(a) 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

(b) The prescription is transmitted to the pharmacy by a means that is compliant with Ohio board of pharmacy rules.

(E) Nothing in this rule shall be construed to imply that one in-person physician examination demonstrates that a prescription has been issued for a legitimate medical purpose within the course of professional practice.

(F) A violation of any provision of this rule, as determined by the board, shall constitute any or all of the following:

1) "Failure to maintain minimal standards applicable to the selection or administration of drugs," as that clause is used in division (B)(2) of section 4731.22 of the Revised Code;

2) "Selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes," as that clause is used in division (B)(3) of section 4731.22 of the Revised Code; or

3) "A departure from or the failure to conform to minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in division (B)(6) of section 4731.22 of the Revised Code.
(G) For purposes of this rule, "informed consent" means a process of communication between a patient and physician discussing the risks and benefits of, and alternatives to, treatment through a remote evaluation that results in the patient's agreement or signed authorization to be treated through an evaluation conducted through appropriate technology when the physician is in a location remote from the patient.

(H) This rule shall not apply to any prescribing situations specifically authorized by the Revised Code or Administrative Code.

(I) For purposes of this rule, "patient" means a person for whom the physician provides healthcare services or the person's representative.
Miscellaneous provisions.

For purposes of Chapter 4730. of the Revised Code and Chapters 4730-1 and 4730-2 of the Administrative Code:

(A) An adjudication hearing held pursuant to the provisions of Chapter 119. of the Revised Code shall be conducted in conformance with the provisions of Chapter 4731-13 of the Administrative Code.

(B) The provisions of Chapters 4731-4, 4731-11, 4731-13, 4731-14, 4731-15, 4731-16, 4731-17, 4731-18, 4731-23, 4731-25, 4731-26, 4731-28, 4731-29, and 4731-35, and 4731-37 of the Administrative Code are applicable to the holder of a physician assistant license issued pursuant to section 4730.12 of the Revised Code, as though fully set forth in Chapter 4730-1 or 4730-2 of the Administrative Code.
Standards for prescribing.

(A) A physician assistant who holds a prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician may prescribe a drug or therapeutic device provided the prescription is in accordance with all of the following:

(1) The extent and conditions of the physician-delegated prescriptive authority, granted by the supervising physician who is supervising the physician assistant in the exercise of the authority;

(2) The requirements of Chapter 4730. of the Revised Code;

(3) The requirements of Chapters 4730-1, 4730-2, 4730-4, 4731-11, and 4731-37 of the Administrative Code; and

(4) The requirements of state and federal law pertaining to the prescription of drugs and therapeutic devices.

(B) A physician assistant who holds a prescriber number who has been granted physician-delegated prescriptive authority by a supervising physician shall prescribe in a valid prescriber-patient relationship. This includes, but is not limited to:

(1) Obtaining a thorough history of the patient;

(2) Conducting a physical examination of the patient;

(3) Rendering or confirming a diagnosis;

(4) Prescribing medication, ruling out the existence of any recognized contraindications;

(5) Consulting with the supervising physician when necessary; and

(6) Properly documenting these steps in the patient's medical record.

(C) The physician assistant's prescriptive authority shall not exceed the prescriptive authority of the supervising physician under whose supervision the prescription is being written, including but not limited to, any restrictions imposed on the physician's practice by action of the United States drug enforcement administration or the state medical board of Ohio.
(D) A physician assistant holding a prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician to prescribe controlled substances shall apply for and obtain the United States drug enforcement administration registration prior to prescribing any controlled substances.

(E) A physician assistant holding prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician shall not prescribe any drug or device to perform or induce an abortion.

(F) A physician assistant holding prescriber number and who has been granted physician-delegated prescriptive authority by a supervising physician shall include on each prescription the physician assistant's license number, and, where applicable, shall include the physician assistant's DEA number.
For purposes of Chapter 4759. of the Revised Code and rules promulgated thereunder:

(A) An adjudication hearing held pursuant to the provisions of Chapter 119. of the Revised Code shall be conducted in conformance with the provisions of Chapter 4731-13 of the Administrative Code.

(B) The provisions of Chapters 4731-4, 4731-8, 4731-13, 4731-15, 4731-16, 4731-26, and 4731-28, and 4731-37 of the Administrative Code are applicable to the holder of a license or limited permit issued pursuant to Chapter 4759. of the Revised Code, as though fully set forth in agency 4759 of the Administrative Code.
Miscellaneous provisions.

For purposes of Chapter 4761. of the Revised Code and rules promulgated thereunder:

(A) An adjudication hearing held pursuant to the provisions of Chapter 119. of the Revised Code shall be conducted in conformance with the provisions of Chapter 4731-13 of the Administrative Code.

(B) The provisions of Chapters 4731-4, 4731-8, 4731-13, 4731-15, 4731-16, 4731-17, 4731-26, and 4731-28, and 4731-37 of the Administrative Code are applicable to the holder of a license or limited permit issued pursuant to Chapter 4761. of the Revised Code, as though fully set forth in agency 4761 of the Administrative Code.
For purposes of Chapter 4778. of the Revised Code and rules promulgated thereunder, the provisions of Chapters 4731-13, 4731-16, 4731-26, and 4731-28, and 4731-37 of the Administrative Code are applicable to the holder of a license to practice as a genetic counselor issued under Chapter 4778. of the Revised Code, as though fully set forth in Chapter 4778-1 or Chapter 4778-2 of the Administrative Code.
SMBO Legislative Update:
February 2022

Recent activity:

Upcoming Marijuana legislation:

Marijuana group gathered 136,729 valid signatures as part of the state’s initiated statute process as certified by the Ohio Secretary of State’s Office. The measure proposing the legalization of recreational marijuana will now be sent to the Ohio House and Senate who have four months to introduce legislation.

**HB 60 – Authorize medical marijuana for autism spectrum disorder (Rep. Brent and Rep. Seitz) Allows:** Autism Spectrum Disorder to be included in qualifying conditions. 1/25/22: 5th hearing held and voted out of House Health Committee to rules committee to await House floor assignment. If passed by House will go to Senate to be assigned to committee.

**SB 261- changes to Medical Marijuana law: memo sent to Board with details**
Passed by Senate. This bill now will go to the House for consideration.

Bill as passed by the Senate: Transfers portions of the Medical Marijuana Program from the Board of Pharmacy to the Department of Commerce; Expands the types of qualifying medical conditions; Adds a telehealth provision; Modifies the requirement that an CTR applicant demonstrate they don’t have ownership or investment interest with an entity licensed as a dispensary; Allows the medical director of a dispensary who is a licensed CTR to recommend medical marijuana.

Regards emergency prescription refills.

Of Note:
- Increases from one to three the number of times that a pharmacist may dispense, without a prescription, certain drugs to a specific patient within a 12-month period.

**Status:** Passed out the House 5/5/2021. Third Senate Health hearing 10/6/2021. 1/26/22, voted out of Senate Health Committee with one technical amendment from LSC. In Senate Rules committee waiting for House floor assignment.
Sub HB 51 - Valuation determinations for property damage from natural events with language to reauthorize remote hearing authority for Ohio public entities. Contains emergency clause.

Of Note:
- Public bodies could choose to meet remotely through June 30 under legislation passed by the Senate on Wednesday with an emergency clause. Now goes back to the House for concurrence.

Actively Monitoring

To make changes to the laws governing massage establishments and massage therapy.

Of note:
- Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.


HB 286 – Court of Common Pleas (Rep. Bill Seitz) (companion SB 189)
To generally change the venue in which appeal from an agency order is proper to the local court of common pleas.

Of note:
- Modifies the current Administrative Procedure Act by generally providing that a party adversely affected by an order of an agency may appeal from the order to the court of common pleas of the county in which the place of business of the party is located or the county in which the party is a resident.
- Removes the current provision that any party adversely affected by an order of an agency issued pursuant to any other adjudication may appeal, with certain exceptions, to the Franklin County Court of Common Pleas.


HB 451-Physician administered drugs.

Of note:
- That measure prohibited pharmacists from sending certain "non-selfinjectable" cancer drugs directly to patients, who then had to take them to a physician's office to have the drugs administered.

SB 189 – Change venue for appeal from an agency order (Sen. Lang and Sen. McColley) (companion SB 286)

Of Note:
- To generally change the venue in which appeal from an agency order is proper to the local court of common pleas.
- Modifies the current Administrative Procedure Act by generally providing that a party adversely affected by an order of an agency may appeal from the order to the court of common pleas of the county in which the place of business of the party is located or the county in which the party is a resident.
- Removes the current provision that any party adversely affected by an order of an agency issued pursuant to any other adjudication may appeal, with certain exceptions, to the Franklin County Court of Common Pleas.


HB 495- Create Patient Protection Act (Representative Gross)

Of Note:
- Requires specified health care professionals licensed under ORC 4730 (including physicians, PA’s, anesthesiology assistants, limited branch licensees, acupuncturists and genetic counselors) to offer patients medical chaperones and to establish certain mandatory reporting requirements for health care professionals.

Status: Introduced in the House and referred to the House Families Aging and Human Services 11/23/21

SB 131 – Occupational Licensing (Reciprocity) (Sen. Roegner and Sen. McColley) (companion HB 203)
To require an occupational licensing authority to issue a license or government certification to an applicant who holds a license, government certification, or private certification or has satisfactory work experience in another state under certain circumstances.

Of Note:
- Requires automatic licensure of out of state applicants that meet certain criteria.


HB 203 – Occupational Licenses (Rep. Powell) (companion SB 131)
To require an occupational licensing authority to issue a license or government certification to an applicant who holds a license, government certification, or private certification or has satisfactory work experience in another state under certain circumstances.

Of Note:
- Requires automatic licensure of out of state applicants that meet certain criteria.

To Regulate the practice of surgical assistants.

**Of Note:**  
- Creates a new license type for surgical assistants to be overseen by the Medical Board.


To revise the law governing the practice of anesthesiologist assistants.

**Of Note:**  
- Adds anesthesiologist assistants to the list of individuals authorized to prescribe drugs or dangerous drugs or drug therapy related devices during professional practice.
- Adds anesthesiologist assistant list of practitioners from which a respiratory care therapist may receive orders or prescriptions.

**Status**: First House Health Hearing 10/12/2021, no other hearings.

Regarding drug offenses and treatment.

**Of Note:**  
- Proposes to reduce the abuse of prescription opioids, establish addiction treatment facilities, increase penalties for drug trafficking violations, modify penalties for drug possession, require an offender convicted of a drug possession or drug trafficking offense involving certain drugs to be subject to ten years of post-release control, allow a criminal defendant who has a severe substance use disorder involving certain drugs to be confined by a state detoxification provider while awaiting trial, create restitution work programs, and make an appropriation.
- Limits opioid prescriptions for acute pain to three days. Then, re-examination of the patient is required, and the prescriber may issue a new prescription for more than 3 days.
- Allows health related licensing board to adopt rules specifying circumstances under which a prescriber may issue an initial prescription for an opioid to treat acute pain in an amount that exceeds three days.
- In addition to the three-day limit, allows health related licensing board to adopt rules otherwise limiting the amount of an opioid that may be prescribed in a single prescription.

Closely monitoring

**HB 451- Physician administered drugs (Rep Gayle Manning, Rep Scott Oelslager)**

**Of Note:**
- Legislation prohibits a health benefit plan from requiring that physician-administered drugs be dispensed by a pharmacy or affiliated pharmacy.

**Status:** First hearing with sponsor testimony in House Insurance Committee- 1/26/22


To exempt certain mental health care providers' residential and familial information from disclosure under the Public Records Law.

**Of Note:**
- Adds forensic mental health providers, mental health evaluation providers, and regional psychiatric hospital employees to the list of professions, consolidated in continuing law into the term "designated public service worker," whose residential and familial information is exempted from disclosure under the Public Records Law.

**Status:** Passed out the House 2/4/2021. Second Senate Health hearing 10/6/2021.


To extend certain timelines for qualified civil immunity and expand immunity to include hearing aid dealers and hearing aid fitters; to authorize emergency medical technicians to administer COVID-19 tests; to expressly cover COVID-19 vaccine injuries under the workers' compensation system.

**Of Note:**
- Sunsets June 30, 2023
- Provides vaccine mandate exemption for vaccines that have not received an FDA biologics license.
- Most public and private sector would be able to receive exemptions:
  a) Medical contraindications; - shall provide a written statement from primary care provider
  b) Natural immunity: - responsible for any costs or fees associated with demonstrating natural immunity to the employer.
  c) Reasons of conscience, including religious convictions. -shall provide a written statement

SB 9 – Regulations (Sen. McColley and Sen. Roegner)
To reduce regulatory restrictions in administrative rules.

Of Note:
  • Requires certain agencies to reduce the number of regulatory restrictions in their administrative rules.
  • This applies to administrative agencies only and does not currently impact the Medical Board.


HB 138 – Emergency Medical Services (Rep. Baldridge)
Regarding the scope of emergency medical services provided by emergency medical service personnel.

Of Note:
  • Eliminates the enumeration of specific services that may be provided by emergency medical services (EMS) personnel.
  • Requires the State Board of Emergency Medical, Fire, and Transportation Services to establish the scope of practice for EMS personnel through rulemaking.
  • Permits EMS personnel to comply with a do-not-resuscitate order issued by a physician assistant or advanced practice registered nurse.
  • Requires the medical director or cooperating physician advisory board of each EMS organization to establish protocols for EMS personnel to follow when providing services at all times.


Regarding electronic prescriptions and schedule II-controlled substances.

Of Note:
  • Requires that all schedule II drugs be prescribed electronically.


SB 55 – Massage Therapy (Sen. Brenner) (companion bill HB 81)
To make changes to the laws governing massage establishments and massage therapy.

Of Note:
  • Requires any individual practicing massage within the state to obtain the current massage therapy license issued by the State Medical Board.

Status: Passed out of Senate Health Committee 5/19/2021 to Senate Rules Committee.
SB 150 – Physician Contracts (Sen. Johnson and Sen. Williams)
To prohibit the use of noncompete provisions in physician employment contracts.

Of Note:
• Would prohibit the use of noncompete provisions in physician employment contracts.


HB 64 – Regards fraudulent assisted reproduction (Rep. Powell)
To create the crime of fraudulent assisted reproduction and civil actions for an assisted reproduction procedure without consent.

Of Note:
• Prohibits a health care professional from purposely or knowingly using human reproductive material from a donor while performing an assisted reproduction procedure if the person receiving the procedure has not expressly consented to the use of that donor’s material.
• Creates the crime of fraudulent assisted reproduction, making it a third-degree felony and allows for civil action against a fertility doctor within ten years of the offense.


SB 151 – Infant Medical Treatment (Sen. Johnson)
To establish standards for the medical treatment of certain infants and to name the act Emery and Elliot’s Law.

Of Note:
• Outlines medical treatment for mothers and infants in emergency situations or infants with a disability.


SB 48 – Cultural Competency (Sen. Maharath and Sen. Antonio)
To require certain health care professionals to complete instruction in cultural competency.

Of Note:
• Requires certain health care professionals to complete instruction in cultural competency and provide proof of completion at initial application for licensure and at renewal.
• Includes: dentists, nurses, pharmacists, physicians, psychologists, and social workers.

HB 160 – Health Estimates (Health care price transparency) (Rep. Holmes)
Regarding the provision of health care cost estimates.

Of Note:
• Authorizes the relevant regulatory boards to impose administrative remedies on a health plan issuer or health care provider who fails to comply with the bill’s health care price transparency provisions.


To authorize public bodies to meet via teleconference and video conference.

Of Note:
• Allows public bodies to meet and hold hearings via teleconference or video conference.
• Requires public bodies to provide the public with access to meetings and hearings commensurate with the method in which the meeting is being conducted.


SB 123 – Abortion (Sen. Roegner and Sen. O’Brien)
To enact the Human Life Protection Act to prohibit abortions based upon a condition precedent.

Of Note:
• Prohibits, as the crime of criminal abortion, a person from purposely causing or inducing an abortion by using a drug or substance or an instrument or other means.
• Provides that criminal abortion is a felony of the fourth degree.
• Provides an affirmative defense to a criminal abortion charge if the physician performed or induced the abortion, or attempted to do so, under the determination that it was necessary to prevent the woman’s death or a serious risk of the substantial and irreversible impairment of a major bodily function.
• Requires the State Medical Board to revoke a physician’s license to practice if the physician is guilty of abortion manslaughter, criminal abortion, or promoting abortion.


SB 161 – Surgical Smoke (Sen. Brenner)
Regards surgical smoke.

Of Note:
• Requires that not later than one year after the effective date of enactment, each ambulatory surgical facility shall adopt and implement a policy designed to prevent human exposure to surgical smoke during any planned surgical procedure that is likely to generate surgical smoke.
• The policy shall include the use of a surgical smoke evacuation system.

To license and regulate art therapists and music therapists.

Of Note:
- Creates a new license type for music therapists to be regulated under the Medical Board


To modify the laws governing the practice of advanced practice registered nurses and to designate these provisions as the Better Access, Better Care Act.

Of Note:
- Would allow an APRN who has completed 2,000 clinical practice hours under a standard care arrangement the option to practice without a collaboration agreement.
- Allows an APRN who has not completed the required hours to enter into a standard care arrangement with an APRN who has completed 2,000 clinical practice hours.


To authorize a pregnant minor to consent to receive health care to maintain or improve her life or the life of the unborn child she is carrying.

Of Note:
- Allows a pregnant minor to consent to receive health care, such as prenatal health care, health care during delivery, post-delivery health care, and family planning services, to maintain or improve her life or the life of the unborn child she is carrying.
- States that the bill does not remove or limit any person’s responsibility under Ohio law to report child abuse or neglect.


To license and regulate art therapists and music therapists.

Of Note:
- Creates a new license type for music therapists to be regulated under the Medical Board

Regarding pretreatment notice about the possibility of reversing a mifepristone abortion.

Of Note:
- Prohibits a physician from performing a mifepristone abortion without both informing the patient of the possibility to reverse the mifepristone abortion if she changes her mind and providing information from the Department of Health website on assistance with reversing the effects of the mifepristone abortion
- Criminalizes violations of the previous requirements as a misdemeanor of the first degree.
- Allows a patient who a mifepristone abortion is performed on to file a wrongful death suit against an individual who fails to inform the patient of the possibility of reversal.


HB 388 – Vaccine Refusal (Rep. Jordan)
To prohibit taking certain actions against an individual because the individual refuses to be vaccinated against a disease.

Of Note:
- Prohibits certain discriminatory actions against unvaccinated people

Status: Introduced in the House 8/12/2021.

To regulate the practice of certified professional midwives and to name this act the Ohio Midwife Practice Act.

Of Note:
- Regulates the practice of certified professional midwives


HB 496 – Regulate the Practice of Certified Midwives (Rep. Koehler)
To regulate the practice of certified nurse-midwives, certified midwives, and certified professional midwives

Of Note:
- Regulates the practice of certified professional midwives

Operationalizing

HB 122, Telemedicine

• Of Note: Passed and signed by Governor. Effective date 03/22/2022. Preliminary administrative rules to implement law being worked on by Board and staff with input from stakeholders.

SB 6 — Join Interstate Medical Licensure Compact (Sen. Roegner and Sen. Steve Huffman)

Of Note:
• Actively working through implementation


HB 110 — State Operating Budget (Rep. Oelslager)
Creates appropriations for FY 2022-2023.

Of Note:
• The Medical Board budget request was granted in the first version of the bill and remained in the final version.


Enacted but no operational changes needed

HB 6 — Modify laws governing certain professions due to COVID-19 (Rep. Roemer)
To modify the laws governing certain health professionals and educator preparation programs due to COVID-19.

Of Note:
• Allows pharmacists to administer immunization for influenza, COVID-19, and any other disease but only pursuant to prescription for persons seven or older.
• Allows pharmacists to administer immunizations for a disease to those 13 and older.
• Allows podiatrists to administer vaccinations for individuals seven and older for influenza and COVID-1.


To revise the law governing the practice of athletic training.

Of note:
• Makes changes to the law governing the practice of athletic training, including by requiring an athletic trainer to practice under a collaboration agreement with a physician or podiatrist.
• Amendment was included in the final version to prohibit an athletic trainer from administering intratendinous and intra-articular injections.