



Scott Walker,
Governor
Dave Ross, Secretary

MEDICAL EXAMINING BOARD
Room 121A, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
January 20, 2016

The following agenda describes the issues that the Board plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Board.

AGENDA

8:00 A.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

- A) Adoption of Agenda (1-5)**
- B) Minutes of December 16, 2015 – Review and Approval (6-12)**
- C) Administrative Updates**
 - 1) Department and Staff Updates
 - 2) Board Members – Term Expiration Dates
 - a) Mary Jo Capodice – 07/01/2018
 - b) Greg Collins – 07/01/2016
 - c) Rodney Erickson – 07/01/2015 (Appointed for Second Term)
 - d) Suresh Misra – 07/01/2015
 - e) Carolyn Oglund Vukich – 07/01/2017
 - f) Michael Phillips – 07/01/2017
 - g) David Roelke – 07/01/2017
 - h) Kenneth Simons – 07/01/2018
 - i) Sridhar Vasudevan – 07/01/2016
 - j) Timothy Westlake – 07/01/2016
 - k) Russel Yale – 07/01/2016
 - l) Robert Zondag – 07/01/2018
 - m) Bradley Kudick – Effective 07/01/2016 (Public Member)**
 - 3) Introductions, Announcements and Recognition
 - 4) Wis. Stat. s 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
 - 5) Informational Items
- D) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments (13-18)**
- E) 8:00 A.M. Public Hearing on Clearinghouse Rule 15-087 Relating to Telemedicine (19-33)**
 - 1) Review and Respond to Clearinghouse Report and Public Hearing Comments
- F) Legislative/Administrative Rule Matters (34-36)**

- 1) Emergency/Permanent Scope for Med 13 Relating to Prescribing CME
- 2) Update on Pending Legislation and Possible and Pending Rulemaking Projects
- 3) **TELEPHONE APPEARANCE – William Rosandick, Vice Chair, Wisconsin Respiratory Care Practitioners Examining Council – Continuing Education**

G) Legislative Report (37-38)

- 1) Senate Bill 268/Assembly Bill 364 – Prescriber PDMP Reporting
- 2) Senate Bill 269/Assembly Bill 365 – Law Enforcement PDMP Reporting
- 3) Senate Bill 271/Assembly Bill 367 – Methadone Reporting
- 4) Senate Bill 272/Assembly Bill 366 – Pain Clinic Certification
- 5) Assembly Bill 427/Act 115 – Opioid Antagonists
- 6) Assembly Bill 659/Senate Bill 522 – Opioid Treatment Programs
- 7) Assembly Bill 660/Senate Bill 520 – Medical Examining Board Authority
- 8) Senate Bill 568 – Government Operations and Consumer Protection

H) Report from Opioid Prescribing Committee – Relating to a Proposed Pain Management Continuing Medical Education Requirement (39)

I) Federation of State Medical Boards (FSMB) Matters (40-51)

- 1) Collateral Impacts of Board Orders – FSMB Resolution
- 2) Draft Report on Marijuana and Medical Regulation – Request for Board Comments

J) Screening Panel Report

K) Newsletter Matters

L) Informational Items (52)

- 1) National Conference of State Legislatures (NCSL) Partnership Project on Telehealth: Telehealth Policy Trends and Considerations

M) Items Added After Preparation of Agenda

- 1) Introductions, Announcements and Recognition
- 2) Administrative Updates
- 3) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
- 4) Education and Examination Matters
- 5) Credentialing Matters
- 6) Practice Matters
- 7) Future Agenda Items
- 8) Legislation/Administrative Rule Matters
- 9) Liaison Report(s)
- 10) Newsletter Matters
- 11) Annual Report Matters
- 12) Informational Item(s)
- 13) Disciplinary Matters
- 14) Presentations of Petition(s) for Summary Suspension
- 15) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
- 16) Presentation of Proposed Decisions
- 17) Presentation of Interim Order(s)
- 18) Petitions for Re-Hearing
- 19) Petitions for Assessments
- 20) Petitions to Vacate Order(s)
- 21) Petitions for Designation of Hearing Examiner
- 22) Requests for Disciplinary Proceeding Presentations

- 23) Motions
- 24) Petitions
- 25) Appearances from Requests Received or Renewed
- 26) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports

N) Future Agenda Items

O) Public Comments

P) APPEARANCE – Kelley Sankbeil, Records Management Supervisor – Monitoring and Professional Assistance Procedure Presentation

CONVENE TO CLOSED SESSION to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.).

Q) Monitoring Matters (53-95)

- a) Jose Araujo, M.D. – Requesting Full License **(55-73)**
- b) Mazin Elias, M.D. – Requesting Full License **(74-95)**

R) APPEARANCE – Review of Administrative Warning WARN00000416 DLSC Case Number 13 MED 308 (96-107)

S) APPEARANCE – Application Review – Fidelis Ikegwonu (108-212)

- 1) Requesting Board Authorization to Re-Take the USMLE

T) Request for Waiver of 24 Months of ACGME/AOA Approved Post Graduate Training (213)

- 1) Nikolaos Chatzizacharias

U) Deliberation on Division of Legal Services and Compliance (DLSC) Matters

1) Complaints

- a) 14 MED 473 – Victor Ruiz, M.D. **(214-216)**
- b) 15 MED 607 – Paul Awa, M.D. **(217-219)**

2) Administrative Warnings

- a) 15 MED 286 – J.M.P., R.C.P **(220-221)**
- b) 15 MED 335 – S.R. **(222-225)**
- c) 15 MED 383 – M.A.S. **(226-227)**

3) Proposed Stipulations, Final Decisions and Orders

- a) 13 MED 367 – Gregg M. Gaylord, M.D. **(228-233)**
- b) 14 MED 120 – Eleazar M. Kadile, M.D. **(234-240)**
- c) 14 MED 454 – Michael D. O’Reilly, M.D. **(241-246)**
- d) 15 MED 227 – Andrew J. Weddle, D.O. **(247-252)**

4) Case Closings

- a) 13 MED 469 **(253-258)**
- b) 14 MED 246 **(259-268)**
- c) 15 MED 052 **(269-271)**
- d) 15 MED 144 **(272-279)**
- e) 15 MED 154 **(280-304)**

- f) 15 MED 183 **(305-307)**
- g) 15 MED 252 **(308-311)**
- h) 15 MED 278 **(312-316)**
- i) 15 MED 356 **(317-319)**

V) Proposed Final Decisions and Orders

- 1) In the Matter of the Disciplinary Proceedings Against Jonathan G. Peterson, M.D., Respondent, DHA Case Number SPS-14-0093 DLSC Case Number 14 MED 029, Including Objections and Response to Objections **(320-336)**
- 2) In the Matter of the Disciplinary Proceedings Against Roger A. Pellmann, M.D., Respondent, DHA Case Number SPS-15-0057 DLSC Case Number 15 MED 025, Including Objections and Response to Objections **(337-351)**

W) PLANNED PARENTHOOD OF WISCONSIN, INC., et al., Plaintiffs-appellees, v. BRAD D. SCHIMEL, Attorney General of Wisconsin, et al., Defendants-Appellants – Consulting with Amber Cardenas, Board Legal Counsel (352-353)

X) Deliberation of Items Added After Preparation of the Agenda

- 1) Education and Examination Matters
- 2) Credentialing Matters
- 3) Disciplinary Matters
- 4) Monitoring Matters
- 5) Professional Assistance Procedure (PAP) Matters
- 6) Petition(s) for Summary Suspensions
- 7) Proposed Stipulations, Final Decisions and Orders
- 8) Administrative Warnings
- 9) Proposed Decisions
- 10) Matters Relating to Costs
- 11) Complaints
- 12) Case Closings
- 13) Case Status Report
- 14) Petition(s) for Extension of Time
- 15) Proposed Interim Orders
- 16) Petitions for Assessments and Evaluations
- 17) Petitions to Vacate Orders
- 18) Remedial Education Cases
- 19) Motions
- 20) Petitions for Re-Hearing
- 21) Appearances from Requests Received or Renewed

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

- Y) Open Session Items Noticed Above not Completed in the Initial Open Session
- Z) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate
- AA) Delegation of Ratification of Examination Results and Ratification of Licenses and Certificates

ADJOURNMENT

ORAL INTERVIEW OF CANDIDATE(S) FOR LICENSURE

ROOM 124D/E

11:15 A.M., OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING

**CLOSED SESSION – Reviewing Applications and Conducting Oral Interviews of One (1) Candidate
for Licensure – Dr. Westlake & Dr. Roelke**

NEXT MEETING DATE FEBRUARY 17, 2016

**MEDICAL EXAMINING BOARD
TELECONFERENCE/VIRTUAL MEETING MINUTES
December 16, 2015**

PRESENT: Greg Collins; Rodney Erickson, M.D.; Suresh Misra, M.D., Carolyn Ogland Vukich, M.D.; Michael Phillips, M.D.; David Roelke, M.D.; Kenneth Simons, M.D.; Sridhar Vasudevan, M.D. (*Attended in person,*) Timothy Westlake, M.D.(*joined at 8:03 a.m.;*) Russell Yale, M.D., Robert Zondag

EXCUSED: Mary Jo Capodice, D.O.

STAFF: Tom Ryan, Executive Director; Nifty Lynn Dio, Bureau Assistant; and other Department staff

CALL TO ORDER

Kenneth Simons, Chair, called the meeting to order at 8:01 a.m. A quorum of ten (10) members was confirmed.

ADOPTION OF AGENDA

Amendments to the Agenda:

- *Item S.3.d: Correct spelling of Jehn Riesch, M.D. to **John** Riesch, M.D.*
- *Added 14 MED 610*
- *R.1 changing duplicate wording*

MOTION: Sridhar Vasudevan moved, seconded by Greg Collins, to adopt the agenda as amended. Motion carried unanimously.

(Timothy Westlake joined the meeting at 8:03 a.m.)

MINUTES OF NOVEMBER 18, 2015 – REVIEW AND APPROVAL

Amendments to the Minutes:

- *Page 8, add space between Timothy and Westlake, Westscott Krieger Motion*

MOTION: Suresh Misra moved, seconded by Carolyn Ogland Vukich, to approve the minutes of November 18, 2015 as amended. Motion carried unanimously.

ADMINISTRATIVE UPDATES

Appoint Screening Panel and Interview Panels, January – June 2016

MOTION: David Roelke moved, seconded by Russell Yale, to affirm the schedule of appointed screening and interview panels for the period of January to June of 2016. Motion carried unanimously.

INTERSTATE MEDICAL LICENSURE COMPACT

Chair Appointment of Commissioners

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to rescind the November motion regarding the appointment of commissioners to the Interstate Medical Licensure Compact. Motion carried unanimously.

(Kenneth Simons appointed Robert Zondag and Kenneth Simons as Commissioners to the Interstate Medical Licensure Compact)

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to affirm the Chair's appointment of Robert Zondag and Kenneth Simons as Commissioners to the Interstate Medical Licensure Compact. Motion carried unanimously.

FEDERATION OF STATE MEDICAL BOARDS (FSMB) MATTERS

FSMB 2016 House of Delegates and Annual Meeting – April 28-30, 2016 in San Diego, CA – Consider Attendance

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, to designate the Board Chair to serve as the Board's delegate, or a designated alternate, if needed, and the Executive Director to attend the FSMB 2016 House of Delegates and Annual Meeting on April 28-30, 2016 in San Diego, CA and to authorize travel. Motion carried unanimously.

Consider MEB Recommendations for Nominations for 2016 FSMB Elections and Committee Appointments

MOTION: Michael Phillips moved, seconded by Suresh Misra, to recommend Kenneth Simons as a candidate for 2016 FSMB Board of Directors Elections. Motion carried unanimously.

FSMB One-Day Symposium – March 8, 2016 in Dallas/Fort Worth, TX – Consider Attendance

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, to authorize Amber Cardenas or other department staff to attend the FSMB One-Day Symposium on March 8, 2016 in Dallas/Fort Worth, TX and to authorize travel. Motion carried unanimously.

CLOSED SESSION

MOTION: Carolyn Ogland Vukich moved, seconded by David Roelke, to convene to Closed Session to deliberate on cases following hearing (§ 19.85 (1) (a), Stats.); to consider licensure or certification of individuals (§ 19.85 (1) (b), Stats.); to consider closing disciplinary investigations with administrative warnings (§ 19.85 (1) (b), Stats. and § 448.02 (8), Stats.); to consider individual histories or disciplinary data (§ 19.85 (1) (f), Stats.); and to confer with legal counsel (§ 19.85 (1) (g), Stats.). The Chair read the language of the motion aloud for the record. The vote of each member was ascertained by voice vote. Roll Call Vote: Greg Collins – yes; Rodney Erickson – yes; Suresh Misra – yes; Carolyn Ogland Vukich – yes; Michael Phillips – yes; David Roelke – yes; Kenneth Simons – yes; Sridhar Vasudevan – yes; Timothy Westlake – yes; Russell Yale – yes, and Robert Zondag – yes. Motion carried unanimously.

The Board convened into Closed Session at 8:48 a.m.

RECONVENE TO OPEN SESSION

MOTION: Suresh Misra moved, seconded by Greg Collins, to reconvene in Open Session at 10:32 a.m. Motion carried unanimously.

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION

MOTION: Suresh Misra moved, seconded by David Roelke, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

AMENDMENT TO OCTOBER 21, 2015 MOTION FOR REQUEST FOR WAIVER OF C.E. REQUIREMENTS – W.D.J.

Consider Citation Correction

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to amend the motion dated October 21, 2015 regarding W. Dudley Johnson, M.D.'s denial for waiver of continuing education requirement reason from **Wis. Stat. § 448.05(2)(c)** to read **Wis. Stat. § 448.13(1)(b) and Wis. Admin Code § Med 13.02(2)**. Motion carried unanimously.

REQUEST FOR WAIVER OF 24 MONTHS OF ACGME/AOA APPROVED POST GRADUATE TRAINING

Toshio Takayama

MOTION: Carolyn Ogland Vukich moved, seconded by Russell Yale, to defer this matter pending receipt of additional information. Motion carried unanimously.

MOTION: Michael Phillips moved, seconded by Rodney Erickson, to designate Legal Counsel to follow up as necessary and report back to the Board. Motion carried unanimously.

DELIBERATION ON DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC) MATTERS

Petition for Extension of Time

15 MED 002 – David Houlihan, M.D. and Ronda Davis, M.D.

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to grant the Petition and Request for an Extension of Time in the matter of DLSC Case number 15 MED 002 against David Houlihan, M.D. and Ronda Davis, M.D. Motion carried unanimously.

Complaints

14 MED 466 – Robin M. Reichert, M.D.

MOTION: David Roelke moved, seconded by Suresh Misra, to find probable cause to believe that Robin M. Reichert, M.D., DLSC case number 14 MED 466, has committed unprofessional conduct, and therefore to issue the Complaint and hold

a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried unanimously.

14 MED 487 – Dale R. Tavris, M.D.

MOTION: Suresh Misra moved, seconded by Michael Phillips, to find probable cause to believe that Dale R. Tavris, M.D., DLSC case number 14 MED 487, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried

15 MED 002 – David J. Houlihan, M.D.

MOTION: Sridhar Vasudevan moved, seconded by David Roelke, to find probable cause to believe that David J. Houlihan, M.D., DLSC case number 15 MED 002, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried unanimously.

15 MED 002 – Ronda D. Davis, M.D.

MOTION: Robert Zondag moved, seconded by Michael Phillips, to find probable cause to believe that Ronda D. Davis, M.D., DLSC case number 15 MED 002, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried unanimously.

15 MED 034 – Robert J. DeFatta, M.D.

MOTION: Suresh Misra moved, seconded by Rodney Erickson, to find probable cause to believe that Robert J. DeFatta, M.D., DLSC case number 15 MED 034, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried unanimously.

Administrative Warning

15 MED 228 – D.L.P., D.O.

MOTION: Michael Phillips moved, seconded by David Roelke, to issue an Administrative Warning in the matter of DLSC case number 15 MED 228 (D.L.P.) Motion carried unanimously.

Proposed Stipulations, Final Decisions and Orders

13 MED 251 – Madelaine T. Tully, M.D.

MOTION: Suresh Misra moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against

Madelaine T. Tully, M.D., DLSC case number 13 MED 251. Motion carried unanimously.

14 MED 015 – John G. Hoffmann, M.D.

MOTION: Greg Collins moved, seconded by Carolyn Ogland Vukich, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against John G. Hoffmann, M.D., DLSC case number 14 MED 015. Motion carried unanimously.

14 MED 450 – Christopher Moore, M.D.

MOTION: Greg Collins moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Christopher Moore, M.D., DLSC case number 14 MED 450. Motion carried unanimously.

15 MED 141 – Daniel Royal, D.O.

MOTION: David Roelke moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Daniel Royal, D.O., DLSC case number 15 MED 141. Motion carried unanimously.

15 MED 365 – Todd H. Chaffin, M.D.

MOTION: Greg Collins moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Todd H. Chaffin, M.D., DLSC case number 15 MED 365. Motion carried.

(David Roelke recused himself for deliberation and voting in the matter concerning Todd H. Chaffin, M.D., DLSC case number 15 MED 365.)

14 MED 610 – Daniel T. O'Connor

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Daniel T. O'Connor, M.D., DLSC case number 14 MED 610. Motion carried unanimously.

Monitoring

Luann Moraski, D.O. – Requesting to Remove Limitations

MOTION: Sridhar Vasudevan moved, to grant the request of Luann Moraski, D.O. for removal of 'limitation' from license. Motion failed due to lack of a second.

MOTION: Greg Collins moved, seconded by Suresh Misra, to deny the request of Luann Moraski, D.O. for removal of **limited** from license. **Reason for Denial:** Respondent Needs to Comply with the terms of the order dated September 18,

2013. Motion carried. Opposed: Carolyn Ogland Vukich, Sridhar Vasudevan.
Recused: Kenneth Simons

(Kenneth Simons recused himself for deliberation and voting in the matter concerning Luann Moraski, D.O.)

MOTION: Sridhar Vasudevan moved, seconded by Michael Phillips, to authorize Legal Counsel to research the implications of and potential options to change Limited Licensure. Motion carried unanimously.

MOTION: David Roelke moved, seconded by Sridhar Vasudevan, to authorize the Chair to develop a resolution for submission to the FSMB House of Delegates Annual Meeting, April 2016 on the implications of limited licensure. Motion carried unanimously.

Michael Panzer, M.D. – Requesting to Remove Limitation and Rescind Reprimand

MOTION: Timothy Westlake moved, seconded by Sridhar Vasudevan, to grant the request of Michael Panzer, M.D. to remove the license limitation and deny the request to rescind the reprimand. Motion carried unanimously.

Mark Petrovani, M.D. – Requesting Reduction of Drug Screens

MOTION: Michael Phillips moved, seconded by Greg Collins, to deny the request of Mark Petrovani, M.D. for reduction of drug screens. **Reason for Denial:** Failure to comply with the terms of the order dated November 19, 2014 (Missed call-ins.) Motion carried. Opposed: Erickson

John Riesch, M.D. – Requesting to Remove Limitations

MOTION: Michael Phillips moved, seconded by Carolyn Ogland Vukich, to deny the request of John Riesch, M.D. for removal of limitations. **Reason for Denial:** Failure to comply with the order dated November 19, 2014. Motion carried.

(Sridhar Vasudevan recused himself for deliberation and voting in the matter concerning John Riesch, M.D.)

Case Closings

CASE CLOSING(S)

MOTION: Suresh Misra moved, seconded by David Roelke, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 13 MED 295 – K.C. ***Insufficient Evidence***
2. 13 MED 303 – A.S.K. ***Prosecutorial Discretion (P2)***
3. 13 MED 402 – P.P.P. ***Insufficient Evidence***
4. 14 MED 102 – H.F.G. ***Prosecutorial Discretion (P7)***
5. 14 MED 352 – UNKNOWN ***Insufficient Evidence***
6. 15 MED 322 – J.H.S. ***Prosecutorial Discretion (P5-Flag)***

Motion carried unanimously.

MOTION: Michael Phillips moved, seconded by Carolyn Ogland Vukich, to refer DLSC case number 13 MED 402 to any appropriate entity for further investigation. Motion carried unanimously.

DELEGATION OF RATIFICATION OF EXAMINATION RESULTS AND RATIFICATION OF LICENSES AND CERTIFICATES

MOTION: Suresh Misra moved, seconded by Michael Phillips, to delegate ratification of examination results to DSPS staff and to ratify all licenses and certificates as issued. Motion carried unanimously.

ADJOURNMENT

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:34 a.m.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nifty Lynn Dio, Bureau Assistant		2) Date When Request Submitted: 12/23/15 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting									
3) Name of Board, Committee, Council, Sections: Medical Examining Board											
4) Meeting Date: 01/20/2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Administrative Updates 1. Election of Officers 2. Liaison Appointments and Delegated Authorities									
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A									
10) Describe the issue and action that should be addressed: 1. Elect Officers for 2016 2. The Chair Appoints Liaisons 3. The Board should consider continuation or modification of previously delegated authorities											
11) Authorization <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; border-bottom: 1px solid black;">Nifty Lynn Dio</td> <td style="width: 30%; border-bottom: 1px solid black; text-align: right;">12/23/15</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Signature of person making this request</td> <td style="border-bottom: 1px solid black; text-align: right;">Date</td> </tr> <tr> <td style="border-bottom: 1px solid black;">Supervisor (if required)</td> <td style="border-bottom: 1px solid black; text-align: right;">Date</td> </tr> <tr> <td colspan="2" style="border-bottom: 1px solid black;">Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date</td> </tr> </table>				Nifty Lynn Dio	12/23/15	Signature of person making this request	Date	Supervisor (if required)	Date	Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date	
Nifty Lynn Dio	12/23/15										
Signature of person making this request	Date										
Supervisor (if required)	Date										
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date											
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.											

Medical Examining Board

2015 ELECTION RESULTS	
Board Chair	Kenneth Simons
Vice Chair	Timothy Swan -Timothy Westlake
Secretary	Mary Jo Capodice

APPOINTMENT OF LIAISONS, ALTERNATES, AND DELEGATED AUTHORITY

2015 LIAISON APPOINTMENTS	
Professional Assistance Procedure Liaison	Mary Jo Capodice <i>Alternate: Michael Phillips</i>
Office of Education and Exams Liaison	Timothy Westlake <i>Alternate: Timothy Swan-Greg Collins</i>
Website Liaison	Timothy Swan -Robert Zondag <i>Alternate: Greg Collins</i>
Credentialing Liaison	Timothy Westlake, Mary Jo Capodice <i>Alternates: Rodney Erickson, Sridhar Vasudevan</i>
Legislative Liaison	Timothy Swan , Timothy Westlake, Kenneth Simons, Sridhar Vasudevan
Maintenance of Licensure Liaison	Rodney Erickson, Carolyn Ogland Vukich <i>Alternate: Mary Jo Capodice</i>
Newsletter Liaison	Kenneth Simons <i>Alternate: Timothy Swan Timothy Westlake</i>
Monitoring Liaison	Sridhar Vasudevan <i>Alternate: Mary Jo Capodice</i>
Continuing Education Liaison	Rodney Erickson <i>Alternate: Michael Phillips</i>
Rules Liaison	Timothy Swan -Russell Yale <i>Alternate: Greg Collins</i>
Prescription Drug Monitoring Program Liaison	Timothy Westlake <i>Alternate: Sridhar Vasudevan</i>

MOTION: Suresh Misra moved, seconded by Timothy Westlake, to affirm the Chair's appointment of Liaisons for 2015. Motion carried unanimously.

DELEGATED AUTHORITY MOTIONS

- MOTION:** Robert Zondag moved, seconded by Suresh Misra, that, in order to facilitate the completion of assignments between meetings, the Board delegates its authority by order of succession to the Chair, highest ranking officer, or longest serving member of the Board, to appoint liaisons to the Department to act in urgent matters, make appointments to vacant liaison, panel and committee positions, and to act when knowledge or experience in the profession is required to carry out the duties of the Board in accordance with the law. Such actions will be reported to the Board at the next meeting. Motion carried unanimously.
- MOTION:** Robert Zondag moved, seconded by Suresh Misra, to delegate to the Board's Councils and/or its liaison(s) the authority to review applications and conduct examinations or interviews of candidates for licensure and to make recommendations regarding the licensure of applicants based upon the application reviews and examinations or interviews. Recommended credential denials should be considered by the Medical Examining Board. This delegation motion is not intended to be exhaustive of the Councils' advisory authority. Motion carried unanimously.
- MOTION:** Robert Zondag moved, seconded by Suresh Misra, that Board Counsel or another Department attorney is formally authorized to serve as the Board's designee for purposes of Wis. Admin. Code SPS § 1.08(1). Motion carried unanimously.
- MOTION:** Robert Zondag moved, seconded by Michael Phillips, that the full Board delegates authority to the Chair or chief presiding officer, or longest serving member of the Board, by order of succession, to sign documents on behalf of the Board. In order to carry out the duties of the Board, the Chair, chief presiding officer, or longest serving member of the Board, has the ability to delegate this signature authority for purposes of facilitating the completion of assignments during or between meetings. The Chair, chief presiding officer, or longest serving member of the Board delegates the authority to Executive Director or designee to sign the name of any Board member on documents as necessary and appropriate. Motion carried unanimously.
- MOTION:** Timothy Swan moved, seconded by Timothy Westlake, to adopt the Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor document as presented in today's agenda packet. Motion carried unanimously.

Proposed Changes for 2016

2015 ELECTION RESULTS	
Board Chair	Kenneth Simons
Vice Chair	Timothy Westlake
Secretary	Mary Jo Capodice

APPOINTMENT OF LIAISONS, ALTERNATES, AND DELEGATED AUTHORITY

LIAISON APPOINTMENTS	
Professional Assistance Procedure Liaison	Mary Jo Capodice <i>Alternate: Michael Phillips</i>
Office of Education and Exams Liaison	Timothy Westlake <i>Alternate: David Roelke</i>
Website Liaison	Robert Zondag <i>Alternate: Greg Collins</i>
Credentialing Liaison	David Roelke, Rodney Erickson <i>Alternates: Russell Yale, Carolyn Ogland Vukich</i>
Legislative Liaison	Timothy Westlake, Kenneth Simons, Greg Collins
Maintenance of Licensure Liaison	Rodney Erickson, Carolyn Ogland Vukich <i>Alternate: Mary Jo Capodice</i>
Newsletter Liaison	Kenneth Simons <i>Alternate: Robert Zondag</i>
Monitoring Liaison	Mary Jo Capodice <i>Alternate: Sridhar Vasudevan</i>
Continuing Education Liaison	Rodney Erickson <i>Alternate: David Roelke</i>
Rules Liaison	Russell Yale <i>Alternate: David Roelke</i>
Prescription Drug Monitoring Program Liaison	Timothy Westlake <i>Alternate: Sridhar Vasudevan</i>
Travel Liaison	<i>Alternate: Greg Collins</i>
Controlled Substances Committee	Mary Jo Capodice, Rodney Erickson, Carolyn Ogland Vukich, Sridhar Vasudevan, Timothy Westlake

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Kelley Sankbeil Monitoring Supervisor Division of Legal Services and Compliance		2) Date When Request Submitted: January 4, 2016 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: January 20, 2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Delegation to Monitoring Liaison and Department Monitor	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Delegated Authority Motion: <p style="text-align: center;"><i>“_____ moved, seconded by _____ to adopt/reject the Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor document as presented in today’s agenda packet.”</i></p>			
11) Authorization <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">  </div> <div style="width: 35%; text-align: right;"> January 4, 2016 </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Signature of person making this request </div> <div style="width: 35%; text-align: right;"> Date </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Supervisor (if required) </div> <div style="width: 35%; text-align: right;"> Date </div> </div> <hr/> <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> Executive Director signature (indicates approval to add post agenda deadline item to agenda) </div> <div style="width: 35%; text-align: right;"> Date </div> </div>			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

Roles and Authorities Delegated to the Monitoring Liaison and Department Monitor

The Monitoring Liaison (“Liaison”) is a Board/Section designee who works with department monitors to enforce Board/Section orders as explained below.

Current Authorities Delegated to the Monitoring Liaison

The Liaison may take the following actions on behalf of the Board/Section:

1. Grant a temporary reduction in random drug screen frequency upon Respondent’s request if he/she is unemployed and is otherwise compliant with Board/Section order. The temporary reduction will be in effect until Respondent secures employment in the profession. The Department Monitor (“Monitor”) will draft an order and sign on behalf of the Liaison.
2. Grant a stay of suspension if Respondent is eligible per the Board/Section order. The Monitor will draft an order and sign on behalf of the Liaison.
3. Remove the stay of suspension if there are repeated violations or a substantial violation of the Board/Section order. In conjunction with removal of any stay of suspension, the Liaison may prohibit Respondent from seeking reinstatement of the stay for a specified period of time. The Monitor will draft an order and sign on behalf of the Liaison.
4. Grant or deny approval when Respondent proposes continuing/remedial education courses, treatment providers, mentors, supervisors, change of employment, etc. unless the order specifically requires full-Board/Section approval.
5. Grant a maximum of one 90-day extension, if warranted and requested in writing by Respondent, to complete Board/Section-ordered continuing education.
6. Grant a maximum of one extension or payment plan for proceeding costs and/or forfeitures if warranted and requested in writing by Respondent.
7. Grant full reinstatement of licensure if Respondent has fully complied with all terms of the order without deviation. The Monitor will draft an order and obtain the signature or written authorization from the Liaison.
- 8. Grant or deny a request to appear before the Board/Section in closed session.**

Current Authorities Delegated to the Department Monitor

The Monitor may take the following actions on behalf of the Board/Section, draft an order and sign:

1. Grant full reinstatement of licensure if CE is the sole condition of the limitation and Respondent has submitted the required proof of completion for approved courses.
2. Suspend the license if Respondent has not completed Board/Section-ordered CE and/or paid costs and forfeitures within the time specified by the Board/Section order. The Monitor may remove the suspension and issue an order when proof completion and/or payment have been received.

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sharon Henes Administrative Rules Coordinator		2) Date When Request Submitted: 7 January 2016 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 20 January 2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Public Hearing on Clearinghouse Rule 15-087 relating to telemedicine Review and respond to Clearinghouse Report and Public Hearing comments	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Hold Public Hearing at 8:00 a.m. Discuss any public hearing comments. Review, discuss and respond to any Clearinghouse comments.			
11) Authorization			
<i>Sharon Henes</i>		<i>7 January 2016</i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF RULEMAKING : PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE : MEDICAL EXAMINING BOARD
MEDICAL EXAMINING : ADOPTING RULES
BOARD : (CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Medical Examining Board to create chapter Med 24 relating to telemedicine.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

None.

Statutory authority:

Sections 15.08 (5) (b), 227.11 (2) (a), and 448.40 (1), Stats.

Related statute or rule:

None.

Explanation of agency authority:

Section 15.08 (5) (b), Stats., provides examining boards, “shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . .”

Section 227.11 (2) (a), Stats., sets forth the parameters of an agency’s rule-making authority, stating an agency, “may promulgate rules interpreting provisions of any statute enforced or administered by the agency. . .but a rule is not valid if the rule exceeds the bounds of correct interpretation.”

Section 448.40 (1), Stats., provides that the Medical Examining Board “may promulgate rules to carry out the purposes of this subchapter, including rules requiring the completion of continuing education, professional development, and maintenance of certification or performance improvement or continuing medical education programs for renewal of a license to practice medicine and surgery.”

Plain language analysis:

The current administrative code is silent with regards to telemedicine practice. The proposed rule will define telemedicine, explain how a valid physician-patient relationship can be established in a telemedicine setting, and identify technology requirements for physicians who use electronic communications, information technology or other means of interaction with patients who are not physically present. The proposed rule will specify out-of-state physicians to hold a valid Wisconsin medical license in order to diagnose and treat patients located in Wisconsin.

Summary of, and comparison with, existing or proposed federal regulation:

2015 HR 691 - Telehealth Modernization Act of 2015 – the proposed bill seeks to establish a federal standard for telehealth and serve as guidance for states, subject to a number of specified conditions.

Comparison with rules in adjacent states:

Illinois: Illinois statutes require an individual who engages in telemedicine to hold a medical license issued by the state of Illinois. Telemedicine is defined as including but not limited to rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this State. Telemedicine specifically does not include periodic consultations between a licensee and a person outside the State of Illinois, a second opinion provided to a licensee; and the diagnosis or treatment services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice medicine (225 Ill. Comp. Stat. Ann. s. 60/49.5). The telemedicine provisions are scheduled to be repealed on December 31, 2015.

Iowa: Iowa Administrative Code 653-13.11 establishes the standards of practices of physicians who use telemedicine. Similar to the proposed rule, Iowa Administrative Code defines telemedicine, explains how a valid physician-patient relationship can be established in a telemedicine setting, and identifies technology requirements for physicians who use electronic communications, information technology or other means of interaction with patients who are not physically present. The rule requires out-of-state physicians to have a valid Iowa medical license in order to diagnose and treat patients located in Iowa.

Michigan: Michigan statutes and administrative code are silent with regards to the provision of telemedicine services. The standards are the same as in-person care.

Minnesota: Minnesota does not have any unique laws regulating the practice of telemedicine. Standards are the same as in person care (Minn. Stat. s. 147.032).

Summary of factual data and analytical methodologies:

Other states’ requirements as well as the Federation of State Medical Boards model policy were reviewed when drafting the proposed rule change.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact analysis:

The rule were posted for public comment on the economic impact of the proposed rule, including how this proposed rule may affect businesses, local government units, and individuals, for a period of 14 days. No comments were received.

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis document is attached.

Effect on small business:

These proposed rules do not have an economic impact on small businesses, as defined in s. 227.114 (1), Stats. The Department’s Regulatory Review Coordinator may be contacted by email at Eric.Esser@wisconsin.gov, or by calling (608) 267-2435.

Agency contact person:

Katie Vieira, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8935, Madison, Wisconsin 53708; telephone 608-261-4472; email at Kathleen.Vieira@wisconsin.gov.

Place where comments are to be submitted and deadline for submission:

Comments may be submitted to Katie Vieira, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8935, or by email to Kathleen.Vieira@wisconsin.gov. Comments must be received on or before the public hearing on January 20, 2016 to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. Chapter Med 24 is created to read:

CHAPTER MED 24

TELEMEDICINE

Med 24.01 Authority and purpose. The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11, and 448.40, Stats., and govern the standards of practice for the practice of medicine using telemedicine.

Med 24.02 Definitions. For the purposes of this chapter:

(1) “Asynchronous store-and-forward transmission” means the collection of a patient’s relevant health information and the subsequent transmission of the data from an originating site to a health care provider at a distant site without the presence of the patient.

(2) “Board” means the medical examining board.

(3) “In-person encounter” means that the physician and the patient are in the physical presence of each other and are in the same physical location during the physician-patient encounter.

(4) “Licensee” means an individual licensed by the board.

(5) “Telemedicine” means the practice of medicine using electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine includes asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology. Telemedicine shall not include the provision of medical services only through an audio-only telephone, e-mail messages, facsimile transmissions, or U.S. mail or other parcel service, or any combination thereof.

(6) “Telemedicine technologies” means technologies and devices enabling secure electronic communications and information exchanges between a licensee in one location and a patient in another location with or without an intervening health care provider.

Med 24.03 Practice guidelines. A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

Med 24.04 Wisconsin medical license required. A physician who uses telemedicine in the diagnosis and treatment of a patient located in Wisconsin shall hold an active Wisconsin medical license.

Med 24.05 Standards of care and professional ethics. A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

Med 24.06 Scope of practice. A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee's scope of practice, including the licensee's education, training, experience, ability, licensure, and certification.

Med 24.07 Identification of patient and physician. A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

Med 24.08 Physician-patient relationship. The physician-patient relationship begins when a person with a health-related matter seeks assistance from a licensee, the licensee agrees to undertake diagnosis and treatment of the person, and the person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. A valid physician-patient relationship may be established through any of the following:

(1) An in-person medical interview and physical examination where the standard of care would require an in-person encounter.

(2) A consultation with another licensee, or other health care provider, who has an established relationship with the patient and who agrees to participate in, or supervise, the patient's care.

(3) Telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

Med 24.09 Medical history and physical examination. A licensee shall perform a medical interview and physical examination for each patient. The medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not

constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

Med 24.10 Nonphysician health care providers. If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall ensure that all of the following are met:

(1) Systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice.

(2) The licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

Med 24.11 Informed consent. In accordance with ch. Med 18, a licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

Med 24.12 Coordination of care. A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physicians for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physicians.

Med 24.13 Follow-up care. A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

Med 24.14 Emergency services. A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

Med 24.15 Medical records. A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient in accordance with ch. Med 21, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee

shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

Med 24.16 Privacy and security. A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential. Written protocols shall be established by the licensee meet all of the following:

- (1) Written protocols shall address all of the following:
 - (a) Privacy.
 - (b) Health care personnel who will process messages.
 - (c) Hours of operation.
 - (d) Types of transactions that will be permitted electronically.
 - (e) Required patient information to be included in the communication, including patient name, identification number and type of transaction.
 - (f) Archiving and retrieval.
 - (g) Quality oversight mechanisms.

(2) The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

Med 24.17 Technology and equipment. The board recognizes that three broad categories of telemedicine technologies exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

(1) The technology and equipment utilized in the provision of telemedicine services must comply with all relevant safety laws, rules, regulations, and codes for technology and technical safety for devices that interact with patients or are integral to diagnostic capabilities.

(2) The technology and equipment utilized in the provision of telemedicine services must be of sufficient quality, size, resolution and clarity such that the licensee can safely and effectively provide the telemedicine services.

(3) The technology and equipment utilized in the provision of telemedicine services must be compliant with the Health Insurance Portability and Accountability Act.

Med 24.18 Disclosure and functionality of telemedicine services. A licensee who uses telemedicine shall disclose all of the following information to the patient:

(1) Types of services provided.

(2) Contact information for the licensee.

(3) Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services.

(4) Limitations in the drugs and services that can be provided via telemedicine.

(5) Fees for services, cost-sharing responsibilities, and how payment is to be made, if these differ from an in-person encounter.

(6) Financial interests, other than fees charged, in any information, products, or services provided by the licensee.

(7) Appropriate uses and limitations of the technologies, including in emergency situations.

(8) Uses of and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies.

(9) To whom patient health information may be disclosed and for what purpose.

(10) Rights of patients with respect to patient health information.

(11) Information collected and passive tracking mechanisms utilized.

Med 24.19 Patient access and feedback. A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

(1) To access, supplement and amend patient-provided personal health information.

(2) To provide feedback regarding the quality of the telemedicine services provided.

(3) To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

Med 24.20 Financial interests. Advertising or promotion of goods or products from which the licensee receives direct remuneration, benefit or incentives other than the fees for the medical services is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

Med 24.21 Circumstances where the standard of care may not require a licensee to personally interview or examine a patient. Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

(1) Situations in which the licensee prescribes medications on a short-term basis for a new patient and has scheduled or is in the process of scheduling an appointment to personally examine the patient.

(2) For institutional settings, including writing initial admission orders for a newly hospitalized patient.

(3) Call situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient.

(4) Cross-coverage situations in which a licensee is taking call for another licensee who has an established physician-patient relationship with the patient.

(5) Situations in which the patient has been examined in person by an advanced registered nurse practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship.

(6) Emergency situations in which the life or health of the patient is in imminent danger.

(7) Emergency situations that constitute an immediate threat to the public health including, but not limited to, empiric treatment or prophylaxis to prevent or control an infectious disease outbreak.

(8) Situations in which the licensee has diagnosed a sexually transmitted disease in a patient and the licensee prescribes or dispenses antibiotics to the patient's named sexual partners for the treatment of the sexually transmitted disease as recommended by the U.S. Centers for Disease Control and Prevention.

(9) For licensed or certified nursing facilities, residential care facilities, intermediate care facilities, assisted living facilities and hospice settings.

Med 24.22 Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited. Prescribing to a patient based solely on an Internet request or Internet questionnaire such as a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited.

Med 24.23 Medical abortion. Nothing in this rule shall be interpreted to contradict or supersede the requirements under ch. Med 11.

SECTION 2. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Medical Examining Board

1. Type of Estimate and Analysis

Original Updated Corrected

2. Administrative Rule Chapter, Title and Number

Med 24 Telemedicine

3. Subject

Relating to telemedicine

4. Fund Sources Affected

GPR FED PRO PRS SEG SEG-S

5. Chapter 20, Stats. Appropriations Affected

6. Fiscal Effect of Implementing the Rule

No Fiscal Effect Increase Existing Revenues Increase Costs
 Indeterminate Decrease Existing Revenues Could Absorb Within Agency's Budget
 Decrease Cost

7. The Rule Will Impact the Following (Check All That Apply)

State's Economy Specific Businesses/Sectors
 Local Government Units Public Utility Rate Payers
 Small Businesses (if checked, complete Attachment A)

8. Would Implementation and Compliance Costs Be Greater Than \$20 million?

Yes No

9. Policy Problem Addressed by the Rule

The current administrative code is silent with regards to telemedicine practice. The proposed rule will define telemedicine, explain how a valid physician-patient relationship can be established in a telemedicine setting, and identify technology requirements for physicians who use electronic communications, information technology or other means of interaction with patients who are not physically present. The proposed rule will specify out-of-state physicians to hold a valid Wisconsin medical license in order to diagnose and treat patients located in Wisconsin.

10. Summary of the businesses, business sectors, associations representing business, local governmental units, and individuals that may be affected by the proposed rule that were contacted for comments.

This proposed rule was posted for a period of 14 days to solicit comments from the public. No businesses, business sectors, associations representing businesses, local governmental units, or individuals contacted the department about the proposed rule during that time period.

11. Identify the local governmental units that participated in the development of this EIA.

None. This rule does not affect local government units.

12. Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)

The rule will not have an economic or fiscal impact on specific businesses, business sectors, public utility rate payers, local government units, or the state's economy as a whole.

13. Benefits of Implementing the Rule and Alternative(s) to Implementing the Rule

Telemedicine is a rapidly growing practice. These rules will provide medical practitioners with necessary guidance with

regards to the standards for telemedicine practice.

14. Long Range Implications of Implementing the Rule

This rule will allow medical practitioners to utilize telemedicine with the confidence of complying with clear requirements delineated in administrative code.

15. Compare With Approaches Being Used by Federal Government

2015 HR 691 - Telehealth Modernization Act of 2015 – the proposed bill seeks to establish a federal standard for telehealth and serve as guidance for states, subject to a number of specified conditions.

16. Compare With Approaches Being Used by Neighboring States (Illinois, Iowa, Michigan and Minnesota)

Illinois statutes require an individual who engages in telemedicine to hold a medical license issued by the state of Illinois. Telemedicine is defined as including but not limited to rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this State. Telemedicine specifically does not include periodic consultations between a licensee and a person outside the State of Illinois, a second opinion provided to a licensee; and the diagnosis or treatment services provided to a patient in Illinois following care or treatment originally provided to the patient in the state in which the provider is licensed to practice medicine (225 Ill. Comp. Stat. Ann. s. 60/49.5). The telemedicine provisions are scheduled to be repealed on December 31, 2015.

Iowa Administrative Code 653-13.11 establishes the standards of practices of physicians who use telemedicine. Similar to the proposed rule, Iowa Administrative Code defines telemedicine, explains how a valid physician-patient relationship can be established in a telemedicine setting, and identifies technology requirements for physicians who use electronic communications, information technology or other means of interaction with patients who are not physically present. The rule requires out-of-state physicians to have a valid Iowa medical license in order to diagnose and treat patients located in Iowa.

Michigan statutes and administrative code are silent with regards to the provision of telemedicine services. The standards are the same as in-person care.

Minnesota does not have any unique laws regulating the practice of telemedicine. Standards are the same as in person care (Minn. Stat. s. 147.032).

17. Contact Name

Katie Vieira

18. Contact Phone Number

(608) 261-4472

This document can be made available in alternate formats to individuals with disabilities upon request.



WISCONSIN LEGISLATIVE COUNCIL RULES CLEARINGHOUSE

Scott Grosz
Clearinghouse Director

Terry C. Anderson
Legislative Council Director

Margit Kelley
Clearinghouse Assistant Director

Jessica Karls-Ruplinger
Legislative Council Deputy Director

CLEARINGHOUSE RULE 15-087

Comments

[NOTE: All citations to “Manual” in the comments below are to the Administrative Rules Procedures Manual, prepared by the Legislative Reference Bureau and the Legislative Council Staff, dated December 2014.]

2. Form, Style and Placement in Administrative Code

a. The introductory clause should be phrased as a complete sentence, i.e. “The Medical Examining Board proposes an order to create chapter Med 24 relating to telemedicine.”. [s. 1.02 (1), Manual.]

b. In s. Med 24.02 (5), the phrase “shall not include” should be revised to read “does not include”.

c. In s. Med 24.09, the agency should revise the use of the phrase “may not be in-person”. Generally, the phrase “may not” is used to prohibit an action. [s. 1.01 (2), Manual.] However, that does not appear to be the agency’s intended result. Rather, it appears that the agency wishes to authorize the performance of a physical examination via telemedicine, under certain circumstances.

d. In s. Med 24.16 (2), the agency should select “shall” or “may” rather than “should”. [s. 1.01 (2), Manual.]

e. In s. Med 24.21 (2) and (9), would clarity be improved if the agency placed the phrase “treatments provided in” after “For”? Additionally, the agency should delete “but not limited to” after “including” in s. Med 24.21 (7). [s. 1.01 (9) (f), Manual.] More generally, given its applicability “whether or not the circumstances involve the use of telemedicine”, should the content of s. Med 24.21 be included in a chapter titled “Telemedicine”?

f. The agency should insert a comma after “questionnaire” and delete “a” after “or” in s. Med 24.22 (title). Additionally, it appears the content of s. Med 24.22 duplicates a portion of the content of s. Med. 24.09.

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. In s. Med 24.10 (2), the agency should clarify its expectation regarding the meaning of “available”. Should the agency specify a standard for response time?

b. In s. Med 24.12, to improve clarity, the agency could add a phrase such as “for the telemedicine encounter” after “medical record”.

c. In s. Med 24.16 (intro.), should “that” precede “meet” in the last sentence?

d. In s. Med 24.19 (intro.), how does the agency intend to determine whether patient access is “easy”?

e. In s. Med 24.20, could the agency identify the state and federal laws that prohibit financial interest in advertised or promoted goods or products?

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Sharon Henes Administrative Rules Coordinator		2) Date When Request Submitted: 7 January 2016 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 20 January 2016	5) Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Legislation and Rule Matters – Discussion and Consideration 1. Emergency/Permanent Scope for Med 13 Relating to Prescribing CME 2. Update on Pending Legislation and Possible and Pending Rulemaking Projects	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:			
11) Authorization			
<i>Sharon Henes</i>		<i>7 January 2016</i>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date			
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATEMENT OF SCOPE

Medical Examining Board

Rule No.: Med 13

Relating to: Continuing Medical Education for Prescribing Opioids

Rule Type: Emergency and Permanent

1. Finding/nature of emergency (Emergency Rule only):

This rule will establish continuing education requirements for physicians relating to the prescription of opioids. These requirements will be another component to the current statewide initiatives addressing prescription drug abuse, and are in the best interest of public health and safety.

As normal rule-making procedures will not allow these requirements to be established until 2017, an expeditious promulgation of this rule is needed to ensure public health and safety.

2. Detailed description of the objective of the proposed rule:

The objective of the proposed rule is to promote best practices in the prescription of opioids. The proposed rule would define the requirements for the completion of continuing education hours relating to prescribing opioids as a portion of the biennial training requirements for physicians.

3. Description of the existing policies relevant to the rule, new policies proposed to be included in the rule, and an analysis of policy alternatives:

Section 448.13 of the Wisconsin Statutes requires the completion of at least 30 hours of continuing medical education for biennial registration. Wisconsin Administrative Code Chapter Med 13 more precisely defines the requirements for continuing medical education. The chapter lists acceptable sources of continuing education, sets the standards for evidence of compliance with the requirements, and allows the Board to waive and audit the completion of continuing education requirements. The proposed rule would define the requirements for the completion of continuing education hours specific to prescribing opioids. The alternative to this rule change is to leave Chapter Med 13 as written which does not address the growing concern with prescription drug abuse.

4. Detailed explanation of statutory authority for the rule (including the statutory citation and language):

Section 15.08 (5) (b), Stats., provides examining boards, "shall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . ."

Section 227.11 (2) (a), Stats., sets forth the parameters of an agency's rule-making authority, stating an agency, "may promulgate rules interpreting provisions of any statute enforced or administered by the agency. . .but a rule is not valid if the rule exceeds the bounds of correct interpretation."

Section 448.40 (1), Stats., provides that the Medical Examining Board "may promulgate rules to carry out the purposes of this subchapter, including rules requiring the completion of continuing education, professional development, and maintenance of certification or performance improvement or continuing medical education programs for renewal of a license to practice medicine and surgery."

Rev. 3/6/2012

5. Estimate of amount of time that state employees will spend developing the rule and of other resources necessary to develop the rule:

40 hours

6. List with description of all entities that may be affected by the proposed rule:

Wisconsin licensed physicians

7. Summary and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

None.

8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):

The proposed rule will have minimal to no economic impact on small businesses and the state's economy as a whole.

Contact Person: Dale Kleven, Administrative Rules Coordinator, Dale2.Kleven@wisconsin.gov, (608) 261-4472

Approved for publication:

Approved for implementation:

Authorized Signature

Authorized Signature

Date Submitted

Date Submitted

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nifty Lynn Dio, Bureau Assistant		2) Date When Request Submitted: 01/07/2016 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 01/20/2016	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Legislative Report	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: Prescriber PDMP Reporting: Senate Bill 268 - http://docs.legis.wisconsin.gov/2015/proposals/sb268 Assembly Bill 364 - http://docs.legis.wisconsin.gov/2015/proposals/ab364 Law Enforcement PDMP Reporting: Senate Bill 269 - http://docs.legis.wisconsin.gov/2015/proposals/sb269 Assembly Bill 365 - http://docs.legis.wisconsin.gov/2015/proposals/ab365 Methadone Reporting: Senate Bill 271 - http://docs.legis.wisconsin.gov/2015/proposals/sb271 Assembly Bill 367 - http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab367 Pain Clinic Certification Senate Bill 272 - http://docs.legis.wisconsin.gov/2015/proposals/sb272 Assembly Bill 366 - http://docs.legis.wisconsin.gov/2015/proposals/reg/asm/bill/ab366 Opioid Antagonists Assembly Bill 427 - http://docs.legis.wisconsin.gov/2015/proposals/ab427 Act 115 - https://docs.legis.wisconsin.gov/2013/related/acts/115.pdf Opioid Treatment Programs: Assembly Bill 659 - http://docs.legis.wisconsin.gov/2015/related/proposals/ab659 Senate Bill 522 - http://docs.legis.wisconsin.gov/2015/proposals/sb522 Medical Examining Board Authority: Assembly Bill 660 - http://docs.legis.wisconsin.gov/2015/related/proposals/ab660 Senate Bill 520 - http://docs.legis.wisconsin.gov/2015/proposals/sb520 Government Operations and Consumer Protection: Senate Bill 568 - http://docs.legis.wisconsin.gov/2015/proposals/sb568			

**State of Wisconsin
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11)	Authorization
Nifty Lynn Dio	01/14/2016
Signature of person making this request	Date
Supervisor (if required)	Date
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date	
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AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted: 1/4/2016	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 1/20/2016	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Report from Opioid Prescribing Committee	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing? No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: The Opioid Prescribing Committee will present a report from its December meeting. The Board should discuss the Committee's recommendations, which are set forth in the following motions: <p style="margin-left: 40px;">MOTION: Sridhar Vasudevan moved, seconded by Timothy Westlake, to recommend to the Full Board a two hour safe and responsible opioid prescribing CME requirement for all licensees. Motion carried unanimously.</p> <p style="margin-left: 40px;">MOTION: Sridhar Vasudevan moved, seconded by Timothy Westlake, to request DSPS staff draft a Scope Statement for emergency rules relating to CME, for the Full Board to approve in January 2016. Motion carried unanimously.</p>			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nifty Lynn Dio, Bureau Assistant		2) Date When Request Submitted: 01/12/2016 Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 01/20/2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Federation of State Medical Boards (FSMB) Matters 1. Collateral Impacts of Board Orders – FSMB Resolution	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: <p>A substitute resolution offered in lieu of <u>Resolution 14-1; Establish Study Group Regarding Collateral Consequences of Board Actions</u> submitted by the North Carolina Medical Board was ADOPTED:</p> <p><i>Resolved</i>; That the Federation of State Medical Boards (FSMB) will continue to communicate with credentialing bodies, and other entities that use public board action reports as a basis for their actions to explore ways to accomplish their missions while taking measured, appropriate and proportionate action in response to public board actions involving a physician.</p>			
11) Authorization			
Nifty Lynn Dio		01/12/2016	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda) Date			
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[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

From: Lisa A. Robin (FSMB)
Subject: FW: Synergy article by Jim Wilson on Collateral Consequences

I reached out to the past president of NAMSS, Linda Waldorf, to discuss the issue of collateral damages/unintended consequences of board sanctions. She was very helpful and in sum, indicated that generally hospitals are more thoughtful and consider board actions on an individual basis; however, payers seem much more inclined to remove physicians from their provider panels based on an action.

Lisa Robin
Chief Advocacy Officer
Federation of State Medical Boards

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Unintended Collateral Consequences

By James A. Wilson, Attorney at Law

Quiz on page XX; Worksheet on page XX

Medical disciplinary actions — particularly those taken by state licensing boards — almost always prompt inquiries by other credentialers. The extent of possible consequences is alarming. Often times, Medical Services Professionals (MSPs) are the first ones to notify physicians of their obligations to report such actions and of the possible further evaluation and ramifications.

For example, I know a physician who agreed with his state medical board that he would no longer perform a single procedure not commonly performed by members of his specialty anyway. Unfortunately, his specialty board considered this to be a restriction on his license, and it suspended his board certification. Because his hospital required board certification, he lost his hospital privileges. Because his job required hospital privileges, he lost his job. In the end, by agreeing to stop performing a single procedure, he lost his ability to practice altogether.

I continue to learn of new issues that I have not previously encountered, but below are the major ones that have come to my attention. Because of the number and complexity of issues, these matters require careful management for the affected physician. As you will see, these issues are intertwined: an issue with one often presents an issue with several others.

Employment

The employment relationship may be one of the most important keys to a physician's continued successful practice. Many disciplinary actions, even severe ones, can be endured if the employment relationship stays intact. However, most employment contracts for healthcare professionals provide as cause for termination a number of issues possibly implicated by a disciplinary action. Typical provisions include:

- Unprofessional or unethical conduct
- Intoxication on duty

- Illegal possession of drugs on duty
- Conduct damaging to the employer's reputation
- Jeopardizing the health or welfare of patients
- Failure to maintain a current unrestricted license
- Failure to maintain a DEA registration
- Failure to maintain hospital privileges
- Failure to maintain board certification
- Failure to maintain provider numbers
- Failure to maintain malpractice insurance
- Conviction of a crime
- Recurring absence

Even if the agreement's for-cause termination provisions are not implicated, most agreements have a not-for-cause provision that allows termination for any reason or no reason, typically with sixty to ninety days notice.

Privileges

Depending somewhat on the specialty, hospital privileges may be second only to employment as the most important relationships to continued successful practice. Nearly all hospitals ask about disciplinary actions at renewal time. Some hospital bylaws obligate physicians to disclose disciplinary actions within a short period of time. The National Practitioner Data Bank (NPDB) has a Continuous Query service, and many state boards have a similar subscription service, so hospitals usually learn of a disciplinary action very quickly.

Most hospital bylaws provide as cause for automatic relinquishment of privileges a number of disciplinary actions. Typical provisions include:

- Failure to maintain a current unrestricted license
- Failure to maintain a DEA registration
- Failure to maintain board certification
- Failure to maintain provider numbers
- Failure to maintain malpractice insurance
- Conviction of a crime

Other State Licensing Boards

Many physicians are licensed in more than one jurisdiction, and a few are licensed in another profession. I have had clients who did not remember all such licenses, particularly inactive ones. Some states — Florida and Virginia, for example — require prompt self-disclosures of disciplinary actions. Boards that have a website “profile” typically require prompt self-updating of a physician’s profile. Penalties for non-compliance can be severe.

Nearly any public action taken by one state licensing board will give other states grounds to take action. Many state boards will take action even against inactive licenses. State medical boards have a clearinghouse at the Federation of State Medical Boards for the sharing of board actions on a near real-time basis. Therefore, all other state medical boards can learn of another state’s disciplinary action almost immediately.



Nearly any public action taken by one state licensing board will give other states grounds to take action.

Drug Enforcement Administration

Disciplinary actions involving controlled substances likely will attract the attention of the Drug Enforcement Administration (DEA), leading to possible action against the practitioner’s DEA registration. Losing state authority to prescribe renders one ineligible for a DEA registration. Some states issue controlled substance prescribing authorizations separately from the practitioner’s license. Disciplinary actions could affect this state authorization, too.

Medicare/Medicaid

Governmental payers may take action based on disciplinary actions taken by other agencies. There are rules requiring self-reporting. For Medicare:

Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:

- (1) Within 30 days —
 - (i) A change of ownership;
 - (ii) Any adverse legal action; or
 - (iii) A change in practice location.

42 C.F.R. § 424.516(d).

The regulations define “final adverse action” to include “[s]uspension or

revocation of a license to provide health care by any State licensing authority.” (42 C.F.R. § 424.502.) Adverse actions also include exclusions and debarments from billing governmental agencies. The full definition is as follows:

Final adverse action means one or more of the following actions:

- (1) A Medicare-imposed revocation of any Medicare billing privileges;
- (2) Suspension or revocation of a license to provide healthcare by any State licensing authority;
- (3) Revocation or suspension by an accreditation organization;
- (4) A conviction of a Federal or State felony offense (as defined in § 424.535(a)(3)(i)) within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
- (5) An exclusion or debarment from participation in a Federal or State healthcare program.

42 C.F.R. § 424.502.

CMS’ instructions describe the reporting requirement slightly differently:

1. Any revocation or suspension of a license to provide health care by any State licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.
2. Any revocation or suspension of accreditation.
3. Any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State healthcare program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

4. Any current Medicare payment suspension under any Medicare billing number.

To self-report, practitioners may use either the paper application CMS-855i or file a Medicare Enrollment Application at [Medicare’s website](#). There is a good [video in the tutorials section](#) of the PECOS website. The 2:45 mark of the video is particularly good, as it shows the portion of the PECOS change website for “final adverse action” information.

Some of Medicare’s local contractors have been vigorous about enforcement. Some take the position that suspensions must be reported to them within 30 days, and some impose a one-year bar for even a brief suspension. Some impose a three-year bar for failure to report.

There are similar rules for Medicaid, generally found in provider agreements or state administrative code rules.



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Many specialty boards require prompt notification of a disciplinary action.

Tricare, the federal program for the military, similarly has strict credentialing requirements that they have begun to enforce.

When a license is suspended, the federal government has the authority to exclude the practitioner from participating in essentially all governmental healthcare programs, placing the practitioner on the list of excluded individuals list. I have begun to see them do so routinely in suspensions greater than six months in length. The government can impose a minimum period of exclusion of no less than the length of the licensing action, although a longer minimum (beyond the period of suspension) is possible. Reinstatement is not guaranteed and must be applied for. The reinstatement application process takes a few weeks at minimum.

Managed Care Organizations/ Insurance Credentials

Problems with a state license sometimes lead to insurance deselection or refusal to recredential. Some provider agreements include a duty to tell the payer promptly of any disciplinary action. Typical provisions include a requirement to report "changes in status of any information relating to your credentials, licenses, privileges, and certifications..., as well as changes in professional liability or other insurance as soon as possible but no later than ten (10) business days of your discovery of any such changes" or a duty to "notify the company within ten (10) days of the knowledge of any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on licenses, certifications, permits or accreditation by any government or accrediting entity[.]"

National Practitioner Data Bank

Federal law requires that most credentialing bodies report disciplinary actions to the National Practitioner Data Bank (NPDB). Although self-query of the databank is an option for physicians, they are notified when

a report is entered and have the right to submit comments. Under current law, access to the NPDB is limited to credentialers, and the public has no access. Credentialers routinely review NPDB entries.

There are several clearinghouses, generally associated with national organizations of state boards such as the Federation of State Medical Boards (FSMB), into which public actions are placed. These clearinghouses are available to the public although not widely known.

Board Certification and Specialty Societies

Many specialty boards require prompt notification of a disciplinary action. Many have policies stating that any restriction in hospital privileges or medical license to be disqualifying. Some regard temporary licenses as disqualifying. Board certification can be particularly important because increasingly hospital privileges depend upon it.

Malpractice Insurance

Malpractice insurance policies typically require prompt reporting of investigations. All, or nearly all, will ask about investigations at renewal time. Sometimes disciplinary action, or even just investigations, lead to the cancellation or non-renewal of malpractice insurance.

Media

Increasingly, it seems, disciplinary actions come to the attention of the media. If the matter attracts media attention while it is pending, the attention itself and public reaction thereto can have a significant impact on the action.

Professional Corporations or Professional Limited Liability Companies

Suspension of a license, in some states even for a brief period of time, makes the physician ineligible to own shares in a professional corporation or be a member

of a professional limited liability company. This can have the effect of requiring a physician to "sell out" of his or her practice when disciplined. This transaction may be hard to reverse and may have significant financial consequences.

Litigation

A public disciplinary action often attracts lawsuits, especially for malpractice. Investigative information may be discoverable in malpractice and other civil actions.

Service as an Expert Witness

Expert witnesses could be asked at deposition or trial whether they have or have had any complaint, investigations, or some similar question that calls upon them to disclose the matter. Objections could be mounted protecting them from answering, but there may be no way to prevent being made to disclose details of the matter. Records of such proceedings persist and could indelibly stain a reputation. For these reasons, disciplined practitioners and those under investigation typically should not serve as expert witnesses.

In summary, extensive problems can befall a physician who is disciplined by any entity, sometimes even if the original discipline is itself fairly mild. These collateral consequences should be carefully considered by any physician facing disciplinary sanctions. For MSPs, it is valuable to have a working knowledge of these potential consequences as you help physicians manage difficult and sometime completely unexpected situations. ■



Jim Wilson got his start in this area of law in 1994 when he became the first in-house chief prosecutor and general counsel to the North Carolina Medical Board, where he remained until

the end of 2000. He started his solo practice in Durham, North Carolina, in January 2001. He represents healthcare professionals in obtaining licenses, defending licensing board disciplinary investigations and charges, in hospital privilege disputes, HMO and other health insurance credentialing and de-selection, DEA registration and show cause proceedings, Medicare exclusion, NPDB reporting and disputes, and military medical credentialing.

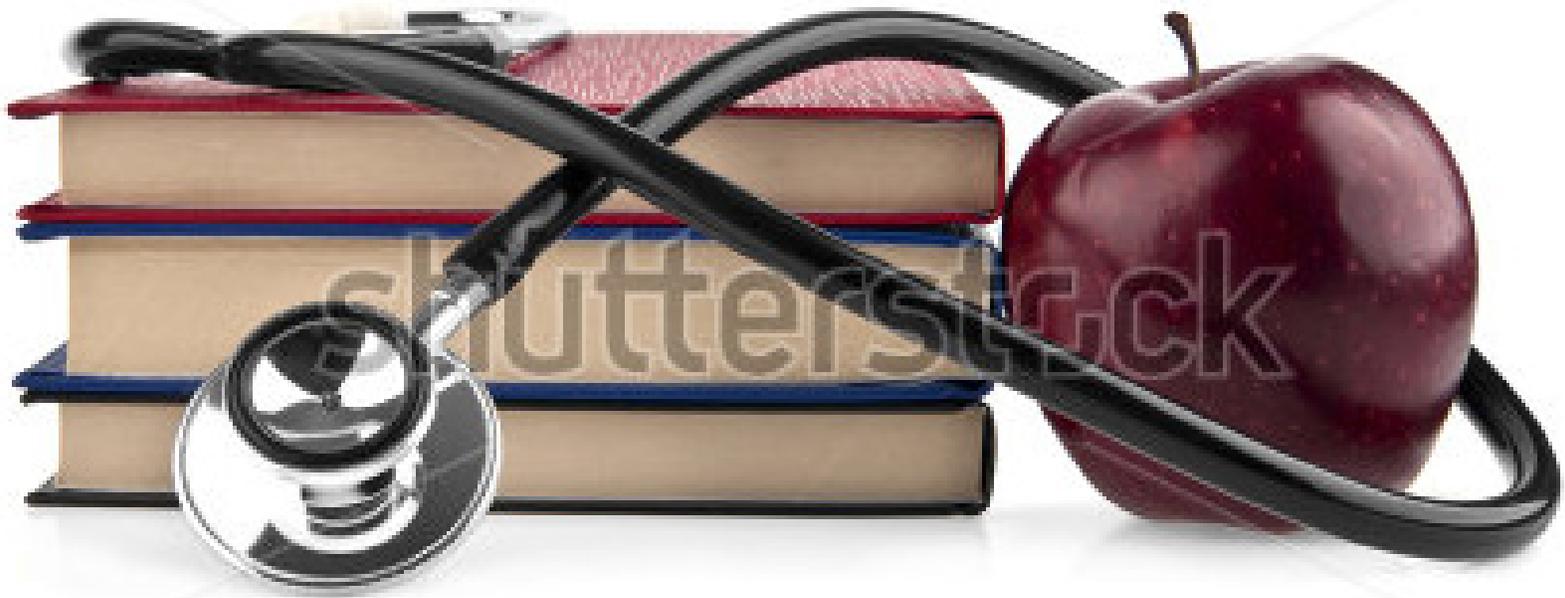
NAMSS CE QUIZ: Unintended Collateral Consequences

See worksheet on page 28.

1. Being acutely aware of the reporting obligations, delineated within the Bylaws, is essential for all members of a Medical Staff.
 - a. True
 - b. False
2. A physician's history of past complaints or adverse actions could be used to discount his opinions when serving as an expert witness in a legal proceeding.
 - a. True
 - b. False
3. Investigative information collected as part of a public disciplinary action is never discoverable in malpractice actions.
 - a. True
 - b. False
4. Suspension of a professional license may result in the physician's ineligibility to own shares in a professional corporation or be a member of a professional limited liability company.
 - a. True
 - b. False
5. Some specialty certification boards have policies which result in termination of certification for physicians when restrictions are placed upon their medical license.
 - a. True
 - b. False
6. There are no Clearinghouses associated with state licensing boards, therefore the public has no access to information regarding adverse actions against physicians.
 - a. True
 - b. False
7. Managed care provider agreements typically include a duty to tell the payer promptly of any disciplinary action, to include licensure, privileges, and certification.
 - a. True
 - b. False
8. The federal government has the authority to exclude a practitioner from participating in governmental healthcare programs and/or place the practitioner on the list of excluded individuals, when their professional license is suspended.
 - a. True
 - b. False
9. CMS' reporting instructions do not require notification to the government when a license is surrendered while a formal disciplinary proceeding is pending before a state licensing authority.
 - a. True
 - b. False
10. Typically, organizations that standardize credentialing have data entry specifications to ensure that data entered into the credentialing database is performed consistently.
 - a. True
 - b. False

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Click the SYNERGY Quizzes link in the Headlines section of www.namss.org.



The New National Practitioner Guidebook: Is More Necessarily Better?

By S. Allan Adelman

On April 6, 2015, the National Practitioner Data Bank (NPDB) released a revised version of the [National Practitioner Data Bank Guidebook](#). This is the first revision to the Guidebook since it was published in 2001. In preparation for this new Guidebook, the NPDB released a draft version of the new Guidebook for comment late in 2013 and, since then, everyone has been eagerly waiting to see what changes would be made.

The changes in the new Guidebook are extensive — it expanded from 123 to 223 pages. Although there are revisions throughout the Guidebook, this article will focus on some of the more significant changes to Section E that deal with NPDB reports for adverse clinical privileging actions. (Section E alone has

been expanded from 36 to 105 pages.) In addition to professional review actions relating to clinical privileges, Section E includes guidance regarding reporting medical malpractice payments, reports regarding adverse professional society membership actions, state licensure actions, peer review organization actions, and exclusions from participation in federal health programs. These additional reporting obligations will not be addressed in this article. Because of the extensive changes, readers are encouraged to consult the new Guidebook when confronted with reporting or other issues related to the NPDB.

Administrative Actions

Although the prior Guidebook stated that “administrative actions” should

not be reported to the NPDB, the new Guidebook gives more definitive guidance by explaining that such actions include situations where a hospital requires board certification as a condition of holding clinical privileges or a physician’s privileges are automatically revoked for failure to maintain board certification. Such actions would not constitute a “professional review action” because they are not related to the professional competence or professional conduct of the physician. The new Guidebook also gives examples of “threshold criteria,” which, if not met, would result in denial of appointment or reappointment that should not be reported to the NPDB. The examples given are minimum professional liability coverage, board certification, geographic proximity to

the hospital and performance of a minimum number of procedures required for a particular privilege.

Another example in the new Guidebook of an administrative action that is not reportable is the situation where a physician's privileges are suspended at one hospital in a system, and the bylaws of a second hospital in the same system provide that a suspension at any hospital in the system will result in automatic suspension at the second hospital. The new Guidebook says that such an automatic suspension at the second hospital is an administrative action that is not reportable to the NPDB (p. E-44).

Investigations

Perhaps the most significant addition to the Guidebook is its expanded discussion of what constitutes an "investigation." Determining when an investigation begins and ends is essential in deciding when NPDB reporting requirements apply, especially when a practitioner has resigned. Whether a report is required may hinge on whether the practitioner resigned while under investigation or in return for an investigation or professional review action not being conducted. The new Guidebook makes it clear that the NPDB gives an "expansive" interpretation to the word "investigation." The new Guidebook still recognizes that bylaw provisions may be instructive in determining what is reportable; however, the new Guidebook also makes it clear that "for NPDB reporting purposes, the term 'investigation' is not controlled by how that term may be defined in a healthcare entity's bylaws or policies and procedures" (p. E-34). In contrast, the previous Guidebook had given significant deference to the provisions in medical staff bylaws in determining whether actions were reportable.

Even though the new Guidebook somewhat dilutes the amount of deference that will be given to bylaw provisions in determining whether a practitioner resigned while under investigation, hospitals should still retain any bylaw language they currently have that defines when an investigation begins for NPDB reporting purposes, or consider adding such language if it is not already in place.

The "Guidelines for Investigations" in the previous Guidebook have been largely retained and still state that "routine reviews" are not considered investigations and that to be an investigation, the activity "should [generally] be the precursor to a professional review action" (pp. E-34-5). However, the new investigation guidelines do not contain the previous statement that "an investigation must be carried out by the healthcare entity, not an individual on the staff." Instead, the new Guidebook states that "[t]he NPDB considers an investigation to run from the start of an inquiry until a final decision on a clinical privileges action is reached." Applying this language in an "expansive" way seems to lead to the conclusion that if a department chair receives a telephone call about an unanticipated adverse clinical outcome, an "investigation" would be considered to be initiated the moment the department chair does anything to start obtaining information about the reported incident. Traditionally, such "preliminary inquiries" have not been considered to be investigations. The new Guidebook would apparently indicate that such initial inquiries to simply find out whether there is an issue that needs to be investigated may themselves be considered the start of the investigation.

The new Guidebook contains some language that might indicate that Focused Professional Practice Evaluations (FPPEs) are now considered to be an investigation for NPDB reporting purposes if a practitioner resigns while under an FPPE. The new Guidebook states:

A routine, formal peer review process under which the healthcare entity evaluates, against clearly defined measures, the privilege-specific competence of all practitioners is not considered an investigation for the purposes of reporting to the NPDB (p. E-34).

This language would seem to be intended to make it clear that Ongoing Professional Practice Evaluations (OPPEs) are not considered to be investigations. Moreover, presumably this language would cover the routine review of cases by quality improvement committees so that every time a case is flagged for review by a quality or

peer review committee it is not considered to be an "investigation." Further, initial FPPEs for new clinical privileges as required by The Joint Commission would meet the definition of "routine" and would not be considered an investigation. But the following language in the new Guidebook suggests an FPPE for current medical staff member applicants might be an investigation:

However, if a formal, targeted process is used when issues related to a *specific practitioner's* professional competence or conduct are identified, this is considered an investigation for the purposes of reporting to the NPDB (p. E-34). (Emphasis in original.)

The first concern created by this language is that it is unclear whether it is intended to capture FPPEs involving current medical staff members, thereby making a resignation while under an FPPE reportable to the NPDB. However, note that the 2013 draft Guidebook contained the following language:

However, if a formal, targeted process is used when issues related to a specific practitioner's professional competence or conduct are identified, ***or when a need to monitor a physician's performance is triggered based on a single event or pattern of events related to professional competence or conduct***, this is considered an investigation for the purposes of reporting to the NPDB.

The language in bold italics was deleted from the final version of the new Guidebook, which could be interpreted as an indication that FPPEs are not considered to be investigations since FPPEs are commonly used to "monitor" a physician's performance. It is also noteworthy that the draft Guidebook contained a question and answer that expressly said that an FPPE was considered to be an investigation and a report to the NPDB was required if a physician resigned while the FPPE was ongoing. However, in the final new Guidebook, that question (p. E-47, No. 24) has been revised to delete any reference to an FPPE being an investigation. That revision would seem to signal that the NPDB is not considering FPPEs used for monitoring to be investigations for reporting purposes. It is important for hospitals to review their

FPPE policy, and how they are implementing FPPEs, to determine whether they would be considered to be a “monitoring” tool that may not be considered an investigation.

A second concern is that the language would turn a routine review by a quality or peer review committee into an investigation for NPDB reporting purposes if the committee targeted a particular physician. For example, if a peer review committee determined that it needed an external review of a practitioner’s charts to determine whether there were quality of care issues that should be addressed, it is unclear whether that would be considered to be an investigation for NPDB reporting purposes. A possible way to address that concern might be to have standard criteria in peer review policies for obtaining outside reviews so that most external reviews become “routine.”

One way to avoid creating an issue regarding whether there is a need to report a physician who resigns while under an FPPE is to consider whether the review or monitoring that is taking place is really an FPPE. Simply saying that you are going to review a physician’s next few cases, or telling a physician that they should discuss any high-risk procedures with the department chair, does not necessarily need to be called an FPPE. Not all oversight or quality improvement activities are FPPEs. In fact, FPPEs frequently do not meet the criteria in the “Investigation Guidelines” in the Guidebook that the action be a precursor to a professional review action. In fact, the actions being taken are more often than not an effort to avoid a professional review action by helping a physician improve their practice. It has been our experience that people often inappropriately use the term FPPE when they are actually engaging in what would be better termed a “quality improvement plan.”

The new Guidebook maintains, and re-emphasizes, the NPDB’s position that it is irrelevant whether a physician is aware that an investigation is underway. If a practitioner resigns while there is an ongoing investigation, the fact that the practitioner had no idea there was an ongoing investigation does not mean that the resignation is not reportable.

Resignation of “Temporary Privileges”

The new Guidebook contains a new section addressing reports to be made when “temporary privileges” are terminated or surrendered. The term “temporary privileges” would include privileges given to a practitioner while awaiting final approval of an application for appointment to the medical staff. The Guidebook states that “for the purpose of reporting to the NPDB, no distinction is made between temporary clinical privileges (including but not limited to emergency and disaster clinical privileges) and clinical privileges” (p. E-32). However, the new section goes on to say that if temporary privileges are limited to a specific amount of time, such as, say, *locum tenens* privileges for a set period of time, and the practitioner is under investigation when the temporary privileges expire, no report to the NPDB is required (pp. E-61-62).

Summary Suspension

The new Guidebook attempts to clear up some of the confusion created by the old Guidebook regarding when a summary suspension is reportable. The new guidebook states:

For purposes of reporting a summary suspension to the NPDB, if the summary suspension is confirmed by the review body, the action is considered to have taken effect when it is first imposed by the hospital official. If a summary suspension is in effect for more than 30 days before an action is taken by the authorized hospital committee or body, it must be reported to the NPDB (p. E-33).

That statement is consistent with the additional statement that “if the authorized hospital committee or body vacates the summary suspension, the entity must void the previous report submitted to the NPDB.” However, it should be noted that the new Guidebook still contains a statement from the old Guidebook that a summary suspension must be reported if it is “in effect or imposed” for more than 30 days. The word “imposed” is potentially confusing and misleading because a summary suspension could be “imposed” for more than 30 days but then rescinded before it was in effect for more than 30 days, in which event it would not

be reportable. Both the Healthcare Quality Improvement Act (43 U.S.C. 11133(a)(1)(B)(i)) and the implementing regulations (45 C.F.R. 60.12(a)(i)) provide that a report to the NPDB is required whenever a professional review action is taken “that adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days.” The statute and regulations do not require reports for action that “could” affect privileges for longer than 30 days.

Proctors

The new Guidebook has a significant change regarding whether the imposition of a proctorship results in a reportable restriction of privileges. Like the old Guidebook, the new Guidebook states that if a physician must obtain approval from a proctor in order to perform a procedure, such a requirement amounts to a restriction of privileges, which has to be reported if it lasted for more than 30 days. However, the new Guidebook goes on to state that if a physician cannot do a procedure “without the proctor being present and watching the physician or dentist,” that also amounts to a restriction of privileges (p. E-37).

Therefore, if the terms of a proctorship included a requirement that the proctor must be present before the physician could perform a procedure, a report to the NPDB would be required if the physician resigned while the proctoring was still ongoing or if the proctorship lasted more than 30 days. To avoid this potential land mine, hospitals may want to state that proctors should be notified of proposed procedures so they can arrange to be present, but avoid any statement that a proctor is “required” to be present before a procedure can be performed.

Withdrawal of Initial Application

Consistent with the previous Guidebook, the new Guidebook states that voluntary withdrawal of an application for initial appointment and privileges before a final professional review action (which has been interpreted as meaning final action by the governing body) is not “generally” reportable. However, the Guidebook does not describe any situation where withdrawal of an initial application before final action

would be reportable. The new Guidebook confuses the issue in its question-and-answer section, where it states:

Q: A physician applied for a medical staff appointment at a hospital but then withdrew the application before a final decision was made by the hospital's governing body. The physician was not being specifically investigated by the hospital. Should the withdrawal of the application be reported to the NPDB? (Emphasis added.)

A: No. Absent a particular investigation, the voluntary withdrawal of an application for medical staff appointment or clinical privileges should not be reported to the NPDB (pp. E-40-41).

It is difficult to understand how there could be an "investigation" of a practitioner seeking initial privileges beyond the review and evaluation that is part of the initial credentialing process. It is unclear what is meant by "absent a particular investigation" and whether there are any circumstances when withdrawal of an initial application before final action is taken would be reportable. Absent some further guidance from the NPDB to the contrary, it would seem that a new applicant can still withdraw an application at any time before final action is taken by the governing body without a report to the NPDB being required. However, it would be helpful if bylaws and credentials procedure manuals made it clear that reviewing all aspects of an application is part of the routine evaluation process and not unique to a particular practitioner.

Professional Conduct

The new Guidebook continues to defer to individual hospitals for the determination of whether conduct amounts to professional conduct that adversely affects or could adversely affect the health or welfare of a patient. That determination can control whether there is a reportable professional review action. The new Guidebook, in the question-and-answer section, provides an example of a hospital denying a practitioner's application for initial appointment because the practitioner provided false information on an application. The Guidebook states:

If, in the opinion of the MEC, the practitioner's falsification of his application *could* adversely affect the health or welfare of a patient, and the action is the result of a professional review, the action must be reported to the NPDB (p. E-42).

Similarly, it would be up to the individual hospital to determine whether a suspension for more than 30 days for failing to complete medical records or inappropriately "cutting and pasting" medical records was professional conduct that adversely affected or could have adversely affected the health or welfare of a patient (pp. E-44, 49).

Termination of Employment

A very helpful clarification in the new Guidebook relates to the question of whether a report must be filed with the NPDB if the employment of a physician at a hospital is terminated and the result is that the physician's clinical privileges at the hospital are automatically ended. The new Guidebook says that as long as no professional review action was taken by the hospital, and the only action was employment related, the automatic termination of privileges because of the termination of employment is not reportable. This would be true even if the employment termination is due to quality of care issues. However, when deciding whether to use a termination of employment process rather than a professional review action, hospitals should consider that even though the termination of employment process avoids the hearing procedures in the medical staff bylaws, the employment actions may not constitute protected peer review or professional review actions and consequently may be discoverable and not have the benefit of the immunity provisions of the Health Care Quality Improvement Act.

Many questions remain unanswered, such as:

- Does an agreement not to exercise privileges during an investigation, without actually surrendering the privileges, constitute a "resignation" while under investigation?
- Is a requirement that a surgeon operate only with a qualified first assistant a restriction of privileges?

- Does a resignation while subject to a "quality improvement plan" count as a resignation while under investigation? An example of a quality improvement plan might be a limit on the number of patients the physician could have in the hospital at any point in time or a requirement that all surgical cases must be discussed with the department chair in advance.
- Is a report required if a lapse of clinical privileges occurs at the end of a two-year appointment because there has been a recommendation by the medical executive committee that the physician not be reappointed, but the physician's current two-year appointment ends before a hearing can be held and final action is taken by the hospital's governing body?
- Is taking a leave of absence while under investigation considered a resignation of privileges?
- When does the review of an application for reappointment become an investigation if the physician resigns before final action is taken on the reappointment application? For example, if a physician discloses on an application for reappointment that they have had three malpractice cases during the last two years and the credentials committee requests additional information about the cases, has a "routine review" become an "investigation"?

A further reading of the new Guidebook will undoubtedly result in the identification of still more changes and nuances than what have been addressed in this article. Moreover, it should always be kept in mind that the Guidebook is simply that — a guide — and does not have the force of law. While there is no requirement to follow the guidance in the Guidebook, it does provide insight into how the NPDB will interpret its governing laws and regulations and the courts will often give defense to an agency's interpretation. ■



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**State of Wisconsin
Department of Safety & Professional Services**

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Nifty Lynn Dio, Bureau Assistant		2) Date When Request Submitted: 12/08/2015 <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 01/20/2016	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Draft Report on Marijuana and Medical Regulation <ul style="list-style-type: none"> • Request for Board Comments 	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: FSMB has requested comments from the Board regarding the draft report: <i>Model Guidelines for the Recommendation of Marijuana in Patient Care</i> The FSMB requests that comments be submitted by January 22, 2016 https://www.fsmb.org/Media/Default/PDF/Report_of_Workgroup_on_Marijuana_and_Medical_Regulation_DRAFT_FOR_COMMENT_12_1.pdf			
11) Authorization			
Nifty Lynn Dio		12/08/2015	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

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4) Meeting Date: 01/20/2016	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? National Conference of State Legislatures (NCSL) Partnership Project on Telehealth: Telehealth Policy Trends and Considerations	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: http://www.ncsl.org/documents/health/telehealth2015.pdf			
11) Authorization			
Nifty Lynn Dio		12/14/2015	
Signature of person making this request		Date	
Supervisor (if required)		Date	
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