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**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**July 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 (1-4)**
- B) Minutes of June 15, 2016 – Review and Approval (5-10)**
- C) Administrative Updates**
  - 1) Department and Staff Updates
  - 2) Board Members – Term Expiration Dates
    - a) Mary Jo Capodice – 07/01/2018
    - b) Michael Carton – 07/20/2020
    - c) Rodney Erickson – 07/01/2015 (*Reappointed, not yet confirmed*)
    - d) Bradley Kudick – 07/01/2020
    - e) Lee Ann Lau – 07/01/2020
    - f) Suresh Misra – 07/01/2015
    - g) Carolyn Ogland Vukich – 07/01/2017
    - h) Michael Phillips – 07/01/2017
    - i) David Roelke – 07/01/2017
    - j) Kenneth Simons – 07/01/2018
    - k) Timothy Westlake – 07/01/2016 (*Reappointed, not yet confirmed*)
    - l) Russel Yale – 07/01/2016 (*Reappointed, not yet confirmed*)
    - m) Robert Zondag – 07/01/2018
  - 3) Introductions, Announcements and Recognition
  - 4) Wis. Stat. § 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
  - 5) Informational Items
- D) Welcome New Members**
- E) Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments (11)**
  - 1) Alternate Website Liaison
  - 2) Alternate Monitoring Liaison
  - 3) Alternate PDMP Liaison
  - 4) Disciplinary Guidelines Committee
- F) Legislation and Rule Matters – Discussion and Consideration (12-40)**
  - 1) Guidelines Regarding Best Practices in Prescribing Controlled Substances
    - a) Report from Dr. Westlake on the July 13, 2016 Meeting of the Controlled Substances Board

- b) Review of Opioid Prescribing Guideline Outline
- 2) Review of Draft Rule Language for Med 13 Relating to Continuing Medical Education for Prescribing Opioids
- 3) Proposals for Med 1 Relating to General Update and Cleanup of Rules
  - a) Criteria the Board May Use to Determine if an Applicant is Required to Take an Oral Examination
  - b) Passing Grade for the Oral Examination
- 4) Update on Podiatry Rules
  - a) Pod 1, 4, and 8 Relating to Informed Consent
  - b) Pod 2 Relating to Overtreatment of Patients
- 5) Update on Pending Legislation and Possible and Pending Rulemaking Projects

**G) Report From the Telemedicine Rule Committee (41)**

- 1) Wall Street Journal Article – “How Telemedicine is Transforming Health Care”

**H) Interstate Medical Licensure Compact Commission – Report from Wisconsin’s Commissioners**

**I) Federation of State Medical Boards (FSMB) Matters (42-43)**

- 1) New Position Statements and Policy on Issues Impacting the Regulation of Medical Practice in the United States

**J) Speaking Engagement(s), Travel, or Public Relation Request(s), and Report(s) (44-53)**

- 1) Citizen Advocacy Center 2016 Annual Meeting on September 17-18, 2016 in Portland, Oregon – Consider Attendance

**K) Screening Panel Report**

**L) Consideration of Credentialing Delegated Authority (54-56)**

**M) Medical Examining Board – Division of Legal Services and Compliance Annual Report – Board Review and Approval (57-69)**

**N) Newsletter Matters**

**O) Informational Items**

**P) 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

Q) Future Agenda Items

R) Public Comments

**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.).**

**S) APPEARANCE – DLSC Attorney Yolanda McGowan and Attorney Jason Franckowiak on Behalf of Lorriane Ash, D.O. – Review of Administrative Warning WARN00000512/DLSC Case Number 15 MED 171 (70-74)**

**T) Full Board Review**

- 1) Application of Frank Miller, M.D. (75-133)

**U) Petition for Examination in DLSC Case No. 14 MED 581, Nanette J. Liegeois, M.D. (134-311)**

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

- 1) Monitoring
- 2) **Complaints**
  - a) 14 MED 302 – D.J.H. (312-323)
- 3) **Administrative Warnings**
  - a) 14 MED 358 – A.C.P. (324-325)
  - b) 15 MED 462 – J.B.V. (326-327)
  - c) 16 MED 101 – D.F.S. (328-329)
- 4) **Proposed Stipulations, Final Decisions and Orders**
  - a) 15 MED 316 – Erik T. Branstetter, D.O. (330-335)
  - b) 15 MED 452 – Emmanuel Fantone, M.D. (336-341)
- 5) **Case Closings**
  - a) 14 MED 244 (342-345)
  - b) 15 MED 300 (346-364)
  - c) 15 MED 304 (365-374)
  - d) 15 MED 380 (375-381)
  - e) 15 MED 450 (382-384)
  - f) 15 MED 459 (385-388)
  - g) 15 MED 465 (389-398)
  - h) 15 MED 468 (399-401)
  - i) 16 MED 034 (402-407)
  - j) 16 MED 067 (408-413)
  - k) 16 MED 153 (414-424)
  - l) 16 MED 183 (425-427)

**W) Proposed Final Decision and Order in the Matter of Disciplinary Proceedings Against Michel H. Malek, M.D., Respondent, DHA Case No. SPS-16-0022/DLSC Case No. 15 MED 278 (428-435)**

**X) Open Cases**

**Y) Consulting With Legal Counsel**

- 1) PLANNED PARENTHOOD OF WISCONSIN, INC., et al., Plaintiffs-appellees, v. BRAD D. SCHIMMEL, Attorney General of Wisconsin, et al., Defendants-Appellants

**Z) 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**

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

**ADJOURNMENT**

**ORAL EXAMINATION OF THREE (3) CANDIDATES FOR LICENSURE**

**ROOM 124D/E**

**10:30 A.M., OR IMMEDIATELY FOLLOWING THE FULL BOARD MEETING**

**CLOSED SESSION** – Reviewing Applications and Conducting Oral Examinations of three (3) Candidates for Licensure – Dr. Erickson & Dr. Westlake

**NEXT MEETING DATE AUGUST 17, 2016**

**MEDICAL EXAMINING BOARD  
MEETING MINUTES  
JUNE 15, 2016**

**PRESENT:** Mary Jo Capodice, D.O.; Greg Collins; Rodney Erickson, M.D.; Suresh Misra, M.D. (*via GoToMeeting*;) Carolyn Ogland Vukich, M.D.; Michael Phillips, M.D.; David Roelke, M.D.; Sridhar Vasudevan, M.D. (*via GoToMeeting*;) Timothy Westlake, M.D.; Robert Zondag (*via GoToMeeting*)

**EXCUSED:** Kenneth Simons, M.D.; Russell Yale, M.D.

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

**CALL TO ORDER**

Timothy Westlake, Vice Chair, called the meeting to order at 8:03 a.m. A quorum of ten (10) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments to the Agenda:**

- *Item C.1.n: Correct Effective date to 07/20/2016*
- *Added to Item E: Comments by Dr. Vasudevan & CDC Guidelines and Guideline Purpose*

**MOTION:** Mary Jo Capodice moved, seconded by Carolyn Ogland Vukich, to adopt the agenda as amended. Motion carried unanimously.

**MINUTES OF MAY 18, 2016 – REVIEW AND APPROVAL**

**MOTION:** Sridhar Vasudevan moved, seconded by Michael Phillips, to approve the minutes of May 18, 2016 as published. Motion carried unanimously.

**LEGISLATIVE/ADMINISTRATIVE RULE MATTERS**

**Guidelines Regarding Best Practices in Prescribing Controlled Substances**

*(Rodney Erickson recused himself and left the room for the discussion of guidelines and continuing education requirements.)*

*Review Guidelines from Other Sources*

**MOTION:** Mary Jo Capodice moved, seconded by Carolyn Ogland Vukich, to delegate Timothy Westlake to work with DSPS staff to draft guidelines for Board consideration. Motion carried unanimously.

*Guidelines Drafting Points for Consideration*

**MOTION:** Michael Phillips moved, seconded by David Roelke, to authorize Timothy Westlake to share the documents presented to the Board with the Controlled Substances Board at the next Controlled Substances Board meeting. Motion carried unanimously.

**MOTION:** David Roelke moved, seconded by Mary Jo Capodice, to delegate Timothy Westlake to work with DSPS staff to draft continuing education rules for Board consideration. Motion carried unanimously.

### **FEDERATION OF STATE MEDICAL BOARDS (FSMB) MATTERS**

#### **Appointment of Dr. Simons to FSMB Workgroup on Board Education, Service and Training**

**MOTION:** Carolyn Ogland Vukich moved, seconded by Mary Jo Capodice, to authorize Kenneth Simons' participation in the FSMB Workgroup on Board Education, Service and Training. Motion carried unanimously.

### **SPEAKING ENGAGEMENTS, TRAVEL, OR PUBLIC RELATION REQUESTS, AND REPORTS**

**MOTION:** David Roelke moved, seconded by Michael Phillips, to delegate Mary Jo Capodice to attend the AAOE Business meeting on July 21, 2016 in Chicago, IL and to authorize travel. Motion carried unanimously.

### **CLOSED SESSION**

**MOTION:** David Roelke moved, seconded by Sridhar Vasudevan, 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: Mary Jo Capodice – yes; Greg Collins – yes; Rodney Erickson – yes; Suresh Misra – yes; Carolyn Ogland Vukich – yes; Michael Phillips – yes; David Roelke – yes; Sridhar Vasudevan – yes; Timothy Westlake – yes; and Robert Zondag – yes. Motion carried unanimously.

The Board convened into Closed Session at 8:06 a.m.

### **RECONVENE TO OPEN SESSION**

**MOTION:** Carolyn Ogland Vukich moved, seconded by Greg Collins, to reconvene in Open Session at 9:10 a.m. Motion carried unanimously.

### **VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION**

**MOTION:** Carolyn Ogland Vukich moved, seconded by David Roelke, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

### **APPEARANCE – DLSC ATTORNEY YOLANDA MCGOWAN AND SCOTT HATHAWAY, D.O.**

#### **Review of Administrative Warning WARN00000470/DLSC Case Number 15 MED 052**

**MOTION:** Mary Jo Capodice moved, seconded by Carolyn Ogland Vukich, to table the Administrative Warning in the matter of DLSC Case No. 15 MED 052 (S.H.) until the July 20, 2016 meeting. Motion carried unanimously.

*(S.H. failed to appear for the Administrative Warning review of 15 MED 052)*

### **FULL BOARD REVIEW OF CANDIDATES FOR LICENSURE**

#### **Adnan Qureshi, M.D.**

**MOTION:** Sridhar Vasudevan moved, seconded by Michael Phillips, to grant a license to practice medicine and surgery to Adnan Qureshi, M.D., once all requirements are met. Motion carried unanimously.

### **FULL BOARD REVIEW FOR VISITING PHYSICIAN LICENSURE**

#### **Shivashankar Damodaran, M.D.**

**MOTION:** David Roelke moved, seconded by Greg Collins, to grant a visiting physician license to Shivashankar Damodaran, M.D., once all requirements are met. Motion carried unanimously.

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

#### **Robert J. Abatecola, M.D.**

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to grant a waiver of the 24 months of ACGME/AOA approved post-graduate training, to Robert J. Abatecola, per Wis. Stat. §448.05(2)(c). Motion carried unanimously.

**MOTION:** Rodney Erickson moved, seconded by David Roelke, to grant a license to practice medicine and surgery to Robert J. Abatecola, once all requirements are met. Motion carried unanimously.

#### **Alan Beamsley, D.O.**

**MOTION:** Michael Phillips moved, seconded by Sridhar Vasudevan, to grant a waiver of the 24 months of ACGME/AOA approved post-graduate training, to Alan Beamsley, per Wis. Stat. §448.05(2)(c). Motion carried unanimously.

**MOTION:** Mary Jo Capodice moved, seconded by Michael Phillips, to grant a license to practice medicine and surgery to Alan Beamsley, once all requirements are met. Motion carried unanimously.

### **VOLUNTARY SURRENDER REQUESTS**

**MOTION:** David Roelke moved, seconded by Michael Phillips, to approve the voluntary surrender request of Wayne Belling, D.O., Ileen Gilbert, M.D. and Jason B. Terrell, M.D. Motion carried unanimously.

#### **Kendall Capecchi, M.D.**

**MOTION:** Carolyn Ogland Vukich moved, seconded by Michael Phillips, to table the voluntary surrender request of Kendall Capecci, M.D. Motion carried unanimously.

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

**Administrative Warnings**

*15 MED 102 – M.P.G.*

**MOTION:** Sridhar Vasudevan moved, seconded by Greg Collins, to issue an Administrative Warning in the matter of DLSC Case No. 15 MED 102 against M.P.G. Motion carried unanimously.

*15 MED 407 – G.Z.*

**MOTION:** Greg Collins moved, seconded by Michael Phillips, to issue an Administrative Warning in the matter of DLSC Case No. 15 MED 407 against G.Z. Motion carried unanimously.

*16 MED 069 – S.M.H.*

**MOTION:** Carolyn Ogland Vukich moved, seconded by Sridhar Vasudevan, to issue an Administrative Warning in the matter of DLSC Case No. 16 MED 069 against S.M.H. Motion carried unanimously.

**Proposed Stipulations, Final Decisions and Orders**

*14 MED 261 – Mark C. Bender*

**MOTION:** Sridhar Vasudevan moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Mark C. Bender, DLSC Case No. 14 MED 261. Motion carried unanimously.

*14 MED 308 – David M. Hammond-Koskey, P.A.*

**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 David M. Hammond-Koskey, P.A., DLSC Case No. 14 MED 308. Motion carried unanimously.

*15 MED 098 – Meenakshi S. Bhillakar, M.D.*

**MOTION:** Sridhar Vasudevan moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Meenakshi S. Bhillakar, M.D., DLSC Case No. 15 MED 098. Motion failed.

**MOTION:** Michael Phillips moved, seconded by Sridhar Vasudevan, to table the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Meenakshi S. Bhillakar, M.D., DLSC Case No. 15 MED 098. Motion carried unanimously.

*15 MED 263 – Slawomir J. Puskarski, M.D.*

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Slawomir J. Puskarski, M.D., DLSC Case No. 15 MED 263. Motion carried unanimously.

*15 MED 430 – Peter M. Ruess, M.D.*

**MOTION:** Mary Jo Capodice moved, seconded by Carolyn Ogland Vukich, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Peter M. Ruess, M.D., DLSC Case No. 15 MED 430. Motion carried unanimously.

*16 MED 015 – Hongyung Choi, M.D.*

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Hongyung Choi, M.D., DLSC Case No. 16 MED 015. Motion carried unanimously.

### Case Closings

#### **CASE CLOSING(S)**

**MOTION:** Mary Jo Capodice moved, seconded by Michael Phillips, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 15 MED 214 (M.D.B.) – **No Violation**
2. 15 MED 294 (I.M.M.) – **No Violation**
3. 15 MED 319 (J.C.G.) – **No Violation**
4. 16 MED 018 (M.M.S. & K.D.B.) – **No Violation**
5. 16 MED 095 (Z.A.) – **No Violation**

Motion carried unanimously.

#### **ORDER FIXING COSTS**

### Victor Ruiz, M.D.

**MOTION:** David Roelke moved, seconded by Rodney Erickson, to adopt the Order Fixing Costs in the matter of disciplinary proceedings against Victor Ruiz, M.D., Respondent, DLSC Case No. 14 MED 473. Motion carried unanimously.

### Dale Tavis, M.D.

**MOTION:** David Roelke moved, seconded by Carolyn Ogland Vukich, to adopt the Order Fixing Costs in the matter of disciplinary proceedings against Dale Tavris, M.D., Respondent, DLSC Case No. 14 MED 487. Motion carried unanimously.

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

**MOTION:** Mary Jo Capodice 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.

*(Sridhar Vasudevan excused himself from the meeting at 9:42 a.m.)*

**ADJOURNMENT**

**MOTION:** Michael Phillips moved, seconded by David Roelke, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 10:40 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 On behalf of Tom Ryan, Executive Director		2) Date When Request Submitted:  07/11/2016  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:  07/20/2016	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page?  <b>Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments</b>	
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 ( <a href="#">Fill out Board Appearance Request</a> ) <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:  The Chair shall appoint replacements for Mr. Collins and Dr. Vasudevan as highlighted below:  Website Liaison: Robert Zondag, <b>Greg Collins – Alternate</b> Monitoring Liaison: Mary Jo Capodice, <b>Sridhar Vasudevan – Alternate</b> PDMP Liaison: Timothy Westlake, <b>Sridhar Vasudevan – Alternate</b> Disciplinary Guidelines Committee: Kenneth Simons, <b>Greg Collins</b>			
11) Authorization			
<b>Nifty Lynn Dio</b>		<b>07/11/2016</b>	
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  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  <b>Dale Kleven Administrative Rules Coordinator</b>		2) Date When Request Submitted:  <b>7/8/16</b>  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:  <b>Medical Examining Board</b>			
4) Meeting Date:  <b>7/20/16</b>	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? <b>Legislation and Rule Matters – Discussion and Consideration</b> <b>1. Guidelines Regarding Best Practices in Prescribing Controlled Substances</b> a. Report From Dr. Westlake on the July 13, 2016 Meeting of the Controlled Substances Board b. Review of Opioid Prescribing Guideline Draft <b>2. Review of Draft Rule Language for Med 13 Relating to Continuing Medical Education for Prescribing Opioids</b> <b>3. Proposals for Med 1 Relating to General Update and Cleanup of Rules</b> a. Criteria the Board May Use to Determine if an Applicant is Required to Take an Oral Examination b. Passing Grade for the Oral Examination <b>4. Update on Podiatry Rules</b> a. Pod 1, 4, and 8 Relating to Informed Consent b. Pod 2 Relating to Overtreatment of Patients <b>5. Update on Pending Legislation and Possible and Pending Rulemaking Projects</b>	
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 ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  3.a. The Board will review the existing criteria under Med 1.06 (1) (a) for possible updates b. As required under s. 448.05 (6) (a), Stats., the Board must specify passing grades for any and all examinations required.			
11) <i>Dale Kleven</i> <hr/> Signature of person making this request		Authorization  <i>July 8, 2016</i> <hr/> Date	
<hr/> Supervisor (if required)		<hr/> Date	
<hr/> 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.			

# Wisconsin Opioid Prescribing Guideline Draft

**Scope and purpose of the guideline:** To help providers make informed decisions about acute and chronic pain treatment -pain lasting longer than three months or past the time of normal tissue healing. The guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care. Although not specifically designed for pediatric pain, many of the principals upon which they are based could be applied there, as well.

Opioids pose a potential risk to all patients. The guideline encourages providers to implement best practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients.

## **1) Identify and treat the cause of the pain, use non-opioid therapies**

Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

## **2) Start low and go slow**

When opioids are used, prescribe the lowest possible effective dosage and start with immediate-release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

## **3) Close follow-up**

Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

## **What's included in the guideline?**

The guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the guideline include:

### **1) Determining when to initiate or continue opioids**

- Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
- Establishment of treatment goals
- Discussion of risks and benefits of therapy with patients

### **2) Opioid selection, dosage, duration, follow-up and discontinuation**

- Selection of immediate-release or extended-release and long-acting opioids
- Dosage considerations
- Duration of treatment
- Considerations for follow-up and discontinuation of opioid therapy

### **3) Assessing risk and addressing harms of opioid use**

- Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk
- Review of prescription drug monitoring program (PDMP) data
- Use of urine drug testing
- Considerations for co-prescribing benzodiazepines
- Arrangement of treatment for opioid use disorder

# Prescription Opioid Guideline

1. Pain is a subjective experience and at present, physicians lack options to objectively quantify pain severity other than by patient reported measures including pain intensity. While accepting the patient's report of pain, the clinician must simultaneously decide if the magnitude of the pain complaint is commensurate with causative factors and if these have been adequately evaluated and addressed with non-opioid therapy.

2. In treating acute pain, if opioids are at all indicated, the lowest dose and fewest number of opioid pills needed should be prescribed. In most cases, less than 3 days' worth are necessary, and rarely more than 5 days' worth. Left-over pills in medicine cabinets are often the source for illicit opioid abuse in teens and young adults. When prescribing opioids, physicians should consider writing two separate prescriptions for smaller amounts of opioids with specific refill dates, rather than a single large prescription. Most patients do not fill the second prescription, thus limiting opioid excess in a patient's home and potential misuse.

3. A practitioner's first priority in treating a patient in pain is to identify the cause of the pain and, if possible, to treat it. While keeping the patient comfortable during this treatment is important, it is critical to address to the extent possible the underlying condition as the primary objective of care.

- a. Patients unwilling to obtain definitive treatment for the condition causing their pain should be considered questionable candidates for opioids. If opioids are prescribed to such patients, documentation of clear clinical rationale should exist.
- b. Opioids should not be prescribed unless there is a medical condition present which would reasonably be expected to cause pain severe enough to require an opioid. For conditions where this is questionable, use of other treatments instead of opioids should be strongly considered.
- c. Consultation should be considered if diagnosis of and/or treatment for the condition causing the pain is outside of the scope of the prescribing practitioner.

4. Opioids should not necessarily be the first choice in treating acute or chronic pain.

- a. Acute pain: Evidence for opioids is weak. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments should be attempted prior to initiating opioid therapy. Although opioids could be simultaneously prescribed if it is apparent from the patient's condition that he/she will need opioids in addition to these. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.
- b. Acute pain lasting beyond the expected duration: A complication of the acute pain issue (surgical complication, nonunion of fracture, etc.) should be ruled out. If complications are ruled out, a transition to non-opioid therapy (tricyclic antidepressant, serotonin/norepinephrine re-uptake inhibitor, anticonvulsant, etc.) should be attempted.
- c. Chronic pain: Evidence for opioids is poor. Other treatments such as acetaminophen, anti-inflammatories, and non-pharmacologic treatments (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) should be utilized. Multiple meta-analyses demonstrate that the benefits of opioids are slight, while annualized mortality rates dramatically increased. There are few if any treatments in medicine with this poor a risk/benefit ratio, and there should be adequate clinical indication to indicate why chronic opioid therapy was chosen in a given patient. Note: There is no high-quality evidence to support opioid therapy longer than 6 months in

duration. Despite this fact, it is considered acceptable although not preferable to continue patients on treatment who have been on chronic opioid therapy prior to this Guideline's release and who have shown no evidence of aberrant behavior.

- d. Patients unwilling to accept non-pharmacological and/or nonnarcotic treatments (or those providing questionably credible justifications for not using them) should not be considered candidates for opioid therapy.

5. Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored. Physicians should avoid prescribing controlled substances for patients who have run out of previously prescribed medication or have had previous prescriptions lost or stolen.

6. Physicians should avoid using intravenous or intramuscular opioid injections for patients with exacerbations of chronic non-cancer pain in the emergency department or urgent care setting.

7. Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. As of April, 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

8. Pain from acute trauma or chronic degenerative diseases can oftentimes be managed without opioids prior to surgery. Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery.

9. Prescribing of opioids is not encouraged in patients concurrently taking benzodiazepines or other respiratory depressants. Benzodiazepines triple the already high increases in annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

10. The use of oxycodone is discouraged. There is no evidence to support that oxycodone is more effective than other oral opioids, while there are multiple studies indicating that oxycodone is more abused and has qualities that would promote addiction to a greater degree than other opioids. As a result, oxycodone should not be considered first-line and should be used only in patients who cannot tolerate other opioids and who have been evaluated for and found not to demonstrate increased risk of abuse.

11. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:

- a. Medical history and physical examination targeted to the pain condition
- b. Nature and intensity of the pain
- c. Current and past treatments, with response to each treatment
- d. Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, COPD, etc.)
- e. Effect of pain on physical and psychological functioning
- f. Personal and family history of substance abuse
- g. History of psychiatric disorders associated with opioid abuse (bipolar, ADD/ADHD, sociopathic, borderline, untreated/severe depression)
- h. Medical indication(s) for use of opioids.

12. Initiation of opioids for chronic pain should be considered on a trial basis. Prior to starting opioids, objective symptomatic and functional goals should be established with the patient. If after a reasonable trial these goals are not met, then opioids should be weaned or discontinued.

13. Practitioners should always consider the risk-benefit ratio when deciding whether to start or continue opioids. Risks and benefits should be discussed with patients prior to initiating chronic opioid therapy, and continue to be reassessed during that therapy. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be discontinued and the patient should be treated for withdrawal, if needed.

- a. Exceptions to this include patients with unstable angina and pregnant patients, especially in the 3rd trimester (withdrawal could precipitate pre-term labor).
- b. Components of ongoing assessment of risk include:
  - i. Review of the Prescription Drug Monitoring Program (PDMP) information
  - ii. Periodic urine drug testing (including chromatography)– at least yearly in low risk cases, more frequently with evidence of increased risk
  - iii. Periodic pill counts – at least yearly in low risk cases, more frequently if evidence of increased risk
  - iiii. Violations of the opioid agreement

14. All patients on chronic opioid therapy should have informed consent consisting of:

- a. Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death
- b. Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects

15. Initial dose titration for both acute and chronic pain should be with short-acting opioids. For chronic therapy, it would be appropriate once an effective dose is established to consider long-acting agents for a majority of the daily dose.

16. Opioids should be prescribed in the lowest effective dose. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely-injured patients. If daily doses for chronic pain reach 50 morphine milligram equivalents (MMEs), additional precautions should be implemented (see #13.b. above). Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is strongly discouraged, and appropriate documentation to support such dosing should be present on the chart.

17. The use of methadone is not encouraged unless the practitioner has extensive training or experience in its use. Individual responses to methadone vary widely; a given dose may have no effect on one patient while causing overdose in another. Metabolism also varies widely and is highly sensitive to multiple drug interactions, which can cause accumulation in the body and overdose. For a given analgesic effect, the respiratory depressant effect is much stronger compared to other opioids. Finally, methadone can have a potent effect on prolonging the QTc, predisposing susceptible patients to potentially fatal arrhythmias.

18. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.

19. During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

20. Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:

- a. History of overdose (a relative contraindication to chronic opioid therapy)
- b. Opioid doses over 50 MMEs/day
- c. Clinical depression
- d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.)

The recommended dose is 0.4 mg for IM or intranasal use, with a second dose available if the first is ineffective or wears off before EMS arrives. Family members can be prescribed naloxone for use with the patient.

21. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner should be able to assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an addiction treatment center which is willing to accept the patient. Simply discharging a patient from the provider's practice after prescribing the medication that led to the complication of opioid use disorder is not considered acceptable.

## 22. Discontinuing Opioid Therapy

A. If lack of efficacy of opioid therapy is determined discontinuation of therapy should be performed.

1. Opioid weaning can be performed by reducing the MED by 10% weekly until 5-10mg MED remain at which time the opioid can be fully discontinued
2. Prescription of clonidine 0.2 mg po BID or tizanidine 2mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.

B. If evidence of increased risk develops, weaning or discontinuation of opioid should be considered.

1. Opioid weaning can be performed by reducing the MED by 25% weekly until 5-10mg MED remain at which time the opioid can be fully discontinued
2. Prescription of clonidine 0.2 mg po BID or tizanidine 2mg po TID can be provided to patients complaining of opioid withdrawal related symptoms.
3. Physicians can consider weekly or bi-monthly follow-up during the weaning process

C. If evidence emerges that indicates that the opioids put a patient at the risk of imminent danger (overdose, addiction, etc.), or that they are being diverted, opioids should be immediately discontinued and the patient should be treated for withdrawal, if needed.

1. Exceptions to abrupt opioid discontinuation include patients with unstable angina and pregnant patients. These patients should be weaned from the opioid medications in a gradual manner with close follow-up

# Resources

CDC Guideline for Prescribing Opioids for Chronic Pain--United States 2016. Dowell D1, Haegerich TM1, Chou R1., JAMA. 2016 Apr 19;315(15):1624-45. doi: 10.1001/jama.2016.1464.

Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care. <https://dwd.wisconsin.gov/wc/medical/pdf/CHRONIC%20OPIOID%20CLINICAL%20MANAGEMENT%20GUIDELINES%20.pdf>

Within-subject comparison of the psychopharmacological profiles of oral oxycodone and oral morphine in non-drug-abusing volunteers. Zacny, James, & Lichtor, Stephanie. Psychopharmacology (2008) 196:105-116

Subjective, Psychomotor, and Physiological Effects Profile of Hydrocodone/Acetaminophen and Oxycodone/Acetaminophen Combination Products. Zachny, James, & Gutierrez, Sandra. Pain Medicine (2008) Vol 9, No 4: 433-443

Positive and Negative Subjective Effects of Extended-Release Oxymorphone versus Controlled-Release Oxycodone in Recreational Opioid Users. Schoedel, Kerri et. al. Journal of Opioid Management 7:3 May/June 2011. 179-192

Tapentadol Abuse Potential: A Postmarketing Evaluation Using a Sample of Individuals Evaluated for Substance Abuse Treatment. Stephen F. Butler, PhD et. al., Pain Medicine 2015; 16: 119–130

Methadone Safety: A Clinical Practice Guideline from the American Pain Society and College on Problems of Drug Dependence, in collaboration with the Heart Rhythm Society. Chou R1, et. al., J Pain. 2014 Apr;15(4):321-37

Emerging Issues in the Use of Methadone. SAMHSA Substance Abuse Treatment Advisory, Spring 2009, Volume 8, Issue 1, available at <http://store.samhsa.gov/shin/content//SMA09-4368/SMA09-4368.pdf>

Opioid Use, Misuse, and Abuse in Orthopaedic Practice. American Academy of Orthopedic Surgeons, Information Statement 1045, October, 2015, available at <http://www.aaos.org/PositionStatements/Statement1045/?ssopc=1>

Wisconsin Medical Society Opioid Prescribing Principals. <https://www.wisconsinmedicalsociety.org/advocacy/boards-councils/society-initiatives/opioid-task-force/opioid-prescribing-principles/>.

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TEXT OF RULE

SECTION 1. Med 13.02 (1g) and (1r) are created to read:

**Med 13.02 (1g)** (a) Except as provided in pars. (b) and (c), for the renewal dates of November 1, 2019 and March 1, 2020, a minimum of 2 of the 30 hours of continuing medical education required under sub. (1) shall be related to best practices in prescribing opioids, including instruction in the guidelines issued by the board under s. 440.035 (2m), Stats.

(b) For a physician who signs a statement on the application for registration certifying that between **August 1, 2016** and December 31, 2016, the physician completed the continuing medical education required under par. (a), a minimum of 2 of the 30 hours required under sub. (1) shall be related to one of the following:

1. Best practices in prescribing opioids, including instruction in the guidelines issued by the board under s. 440.035 (2m), Stats.
2. Responsible controlled substances prescribing.

(c) This subsection does not apply to a physician who, at the time of making application for a certificate of registration, does not hold a U.S. Drug Enforcement Administration number to prescribe controlled substances.

**(1r)** (a) Except as provided in pars. (b) and (c), for the renewal dates of November 1, 2021 and March 1, 2022, a minimum of 2 of the 30 hours of continuing medical education required under sub. (1) shall be related to best practices in prescribing opioids, including instruction in the guidelines issued by the board under s. 440.035 (2m), Stats.

(b) For a physician who signs a statement on the application for registration certifying that the physician meets the requirement under sub. (1g) (a) or the exception under sub. (1g) (b), a minimum of 2 of the 30 hours required under sub. (1) shall be related to one of the following:

1. Best practices in prescribing opioids, including instruction in the guidelines issued by the board under s. 440.035 (2m), Stats.
2. Responsible controlled substances prescribing.

(c) This subsection does not apply to a physician who, at the time of making application for a certificate of registration, does not hold a U.S. Drug Enforcement Administration number to prescribe controlled substances.

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(END OF TEXT OF RULE)

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## Chapter Med 1

### LICENSE TO PRACTICE MEDICINE AND SURGERY

Med 1.01	Authority and purpose.	Med 1.06	Panel review of applications; examinations required.
Med 1.015	Definitions.	Med 1.07	Conduct of examinations.
Med 1.02	Applications and credentials.	Med 1.08	Failure and reexamination.
Med 1.03	Translation of documents.	Med 1.09	Examination review by applicant.
Med 1.05	Fees.	Med 1.10	Board review of examination error claim.

**Note:** Chapter Med 1 as it existed on October 31, 1976 was repealed and a new chapter Med 1 was created effective November 1, 1976.

**Med 1.01 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 application and examination for license to practice medicine and surgery under s. 448.04 (1) (a), Stats., (hereinafter “regular license”).

**History:** Cr. Register, October, 1976, No. 250, eff. 11–1–76; correction made under s. 13.93 (2m) (b) 7., Stats., Register, May, 1989, No. 401.

**Med 1.015 Definitions.** As used in this chapter:

- (1) “FLEX” means the federated licensing examination.
- (2) “NBME” means the national board of medical examiners examination.
- (3) “USMLE” means the United States medical licensing examination.

**History:** Cr. Register, January, 1994, No. 457, eff. 2–1–94.

**Med 1.02 Applications and credentials.** Every person applying for regular license to practice medicine and surgery shall make application therefor on forms provided for this purpose by the board and shall submit to the board the following:

- (1) A completed and verified application form.
- (2) Verified documentary evidence of graduation from a medical or osteopathic school approved by the board. The board recognizes as approved those medical or osteopathic schools recognized and approved at the time of the applicant’s graduation therefrom by the American osteopathic association, or the liaison committee on medical education, or successors. If an applicant is not a graduate of a medical school approved by the board, but is a graduate of a medical school recognized and listed as such by the world health organization of the united nations, such applicant shall submit verified documentary evidence of graduation from such school and also verified documentary evidence of having passed the examinations conducted by the educational council for foreign medical graduates or successors, and shall also present for the board’s inspection the originals thereof, and if such medical school requires either social service or internship or both of its graduates, and if the applicant has not completed either such required social service or internship or both, such applicant shall also submit verified documentary evidence of having completed a 12 month supervised clinical training program under the direction of a medical school approved by the board.
- (3) (a) Verification of satisfactory completion by the applicant of 24 months of postgraduate training in one or more programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or a successor organization; or documentary evidence that the applicant is currently enrolled in a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, or the American Osteopathic Association or a successor organization and has received credit for 12 consecutive months of postgraduate training in that program and an unrestricted endorsement from the postgraduate training director that

the applicant is expected to complete at least 24 months of postgraduate training.

(b) If an applicant is a graduate of a foreign allopathic or osteopathic medical school, then the applicant must provide a verified certificate showing satisfactory completion of 24 months of postgraduate training in one or more programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or a successor organization; or documentary evidence that the applicant is currently enrolled in a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, or the American Osteopathic Association or a successor organization and has received credit for 12 consecutive months of postgraduate training in that program and an unrestricted endorsement from the postgraduate training director that the applicant is expected to complete at least 24 months of postgraduate training.

(c) If the applicant is a graduate of a foreign allopathic or osteopathic medical school and has not completed 24 months of postgraduate training approved by the board and is not currently enrolled in a postgraduate training program but the applicant has other professional experience which the applicant believes has given that applicant the education and training substantially equivalent to 24 months of postgraduate training, then the applicant may submit the documented education and training demonstrating substantially equivalent education and training. The board will review the documented education and training and may make further inquiry, including a personal interview of the applicant, as the board deems necessary to determine whether substantial equivalence in fact exists. The burden of proof of such equivalence shall lie upon the applicant. If the board finds that the documented education and training is substantially equivalent to the required training and experience the board may accept the experience in lieu of requiring the applicant to have completed 24 months of postgraduate training in a program approved by the board.

(d) The board approves of the training programs accredited by the following organizations: the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, the Liaison Committee on Medical Education, the American Association of Colleges of Osteopathic Medicine, and the National Joint Committee on Approval of Pre-Registration of Physician Training Programs of Canada, or their successor organizations.

(4) An unmounted photograph, approximately 8 by 12 cm., of the applicant taken not more than 60 days prior to the date of application and bearing on the reverse side the statement of a notary public that such photograph is a true likeness of the applicant.

(5) A verified statement that the applicant is familiar with the state health laws and the rules of the department of health services as related to communicable diseases.

(6) The required fees made payable to the Wisconsin department of safety and professional services.

**History:** Cr. Register, October, 1976, No. 250, eff. 11–1–76; cr. (6), Register, February, 1997, No. 494, eff. 3–1–97; correction in (5) made under s. 13.93 (2m) (b) 6.,

Stats., Register, December, 1999, No. 528; correction in (5), (6) made under s. 13.92 (4) (b) 6., Stats., Register November 2011 No. 671; CR 13-090: am. (2) Register April 2014 No. 700, eff. 5-1-14; EmR1505: emerg. r. and recr. (3), eff. 4-1-15; CR 15-022: r. and recr. (3) Register October 2015 No. 718, eff. 11-1-15.

**Med 1.03 Translation of documents.** If any of the documents required under this chapter are in a language other than English, the applicant shall also submit a verified English translation thereof, and the cost of such translation shall be borne by the applicant.

**History:** Cr. Register, October, 1976, No. 250, eff. 11-1-76.

**Med 1.05 Fees.** The required fees must accompany the application, and all remittances must be made payable to the Wisconsin medical examining board.

**History:** Cr. Register, October, 1976, No. 250, eff. 11-1-76.

**Med 1.06 Panel review of applications; examinations required.** (1) (a) All applicants shall complete the computer-based examination under sub. (3) (b), and an open book examination on statutes and rules governing the practice of medicine and surgery in Wisconsin. In addition, an applicant may be required to complete an oral interview if the applicant:

1. Has a medical condition which in any way impairs or limits the applicant's ability to practice medicine and surgery with reasonable skill and safety.

2. Uses chemical substances so as to impair in any way the applicant's ability to practice medicine and surgery with reasonable skill and safety.

3. Has been disciplined or had licensure denied by a licensing or regulatory authority in Wisconsin or another jurisdiction.

4. Has been found to have been negligent in the practice of medicine or has been a party in a lawsuit in which it was alleged that the applicant had been negligent in the practice of medicine.

5. Has been convicted of a crime the circumstances of which substantially relate to the practice of medicine.

6. Has lost, had reduced or had suspended his or her hospital staff privileges, or has failed to continuously maintain hospital privileges during the applicant's period of licensure following post-graduate training.

7. Has been graduated from a medical school not approved by the board.

8. Has been diagnosed as suffering from pedophilia, exhibitionism or voyeurism.

9. Has within the past 2 years engaged in the illegal use of controlled substances.

10. Has been subject to adverse formal action during the course of medical education, postgraduate training, hospital practice, or other medical employment.

11. Has not practiced medicine and surgery for a period of 3 years prior to application, unless the applicant has been graduated from a school of medicine within that period.

(b) An application filed under s. Med 1.02 shall be reviewed by an application review panel of at least 2 board members designated by the chairperson of the board. The panel shall determine whether the applicant is eligible for a regular license without completing an oral interview.

(c) All examinations shall be conducted in the English language.

(d) Written and computer-based examinations and oral interviews as required shall be scored separately and the applicant shall achieve a passing grade on all examinations to qualify for a license.

(2) The board will notify each applicant found eligible for examination of the time and place scheduled for that applicant's examinations. Failure of an applicant to appear for examinations as scheduled will void that applicant's application and require the

applicant to reapply for licensure, unless prior scheduling arrangements have been made with the board by the applicant.

(3) (a) The board accepts the FLEX examination administered on or before December 31, 1993, as its written examination and requires a score of not less than 75.0 on each component of the 2-component FLEX examination administered on or after January 1, 1985. Every applicant shall have taken the complete 2-component examination the first time the applicant was admitted to the FLEX examination.

(b) Commencing January 1, 1994, the board accepts the 3-step USMLE sequence as its written or computer-based examination and administers step 3 of the sequence. Minimum standard passing scores for each step shall be not less than 75.0. Applicants who have completed a standard M.D. training program shall complete all 3 steps of the examination sequence within 10 years from the date upon which the applicant first passes a step, either step 1 or step 2. Applicants who have completed a combined M.D. and Ph.D. medical scientist training program shall complete all 3 steps of the examination sequence within 12 years from the date upon which the applicant first passes a step, either step 1 or step 2. Applicants who have passed a step may not repeat the step unless required to do so in order to comply with the 10-year or 12-year time limit. If the applicant fails to achieve a passing grade on any step, the applicant may apply for and be reexamined on only the step failed according to the reexamination provisions of s. Med 1.08 (1).

**Note:** The 10-year or 12-year time limit applies to all applicants, regardless of the date of application, including applicants denied under the prior 7-year or 9-year time limit who submit a new application for licensure.

(c) Prior to the January 1, 2000, the board shall waive completion of steps 1 and 2 of the USMLE sequence for applicants who have passed FLEX component 1; and shall waive step 3 of the USMLE sequence for applicants who have passed FLEX component 2. Prior to January 1, 2000, the board shall waive any step of the USMLE sequence for applicants who have passed the corresponding part of the NBME examination.

**Note:** The following table represents application of s. Med 1.06 (3) (c)

USMLE STEP 1	USMLE STEP 2	USMLE STEP 3
FLEX COMPONENT 1 or NBME PART 1	FLEX COMPONENT 1 or NBME PART 2	FLEX COMPONENT 2 or NBME PART 3

(d) The board may waive the requirement for written or computer-based examinations required in this section for any applicant who has achieved a weighted average score of no less than 75.0 on all 3 components of the FLEX examination taken prior to January 1, 1985 in a single session in another licensing jurisdiction in the United States or Canada, in no more than 3 attempts. If the applicant had been examined 4 or more times before achieving a weighted average score of no less than 75.0 on all 3 components, the applicant shall meet requirements specified in s. Med 1.08 (2).

(e) The board may waive the requirement for written or computer-based examinations required in this section for any applicant who has achieved a score of no less than 75.0 on each of the 2 components of the FLEX examination administered on or after January 1, 1985 in another licensing jurisdiction in the United States or Canada, if the applicant achieved a score of no less than 75.0 on each of the 2 components in no more than 3 attempts. If the applicant has been examined 4 or more times before achieving a score of 75.0 on either or both components of the FLEX examination, the applicant shall meet requirements specified in s. Med 1.08 (2).

(f) An applicant who has passed all 3 components of any of the examinations of the following boards and councils may submit to

the board verified documentary evidence thereof, and the board will accept this in lieu of requiring further written or computer-based examination of the applicant.

1. National Board of Medical Examiners.
2. National Board of Examiners of Osteopathic Physicians and Surgeons.
3. Medical Council of Canada, if the examination is taken on or after January 1, 1978.
4. Medical Council of Canada, if the examination was taken before January 1, 1978, and the applicant is board certified at the time of application by a specialty board acceptable to the board.

(g) An applicant who has received passing grades in written or computer-based examinations for a license to practice medicine and surgery conducted by another licensing jurisdiction of the United States or Canada may submit to the board verified documentary evidence thereof. The board will review such documentary evidence to determine whether the scope and passing grades of such examinations are substantially equivalent to those of this state at the time of the applicant's examination, and if the board finds such equivalence, the board will accept this in lieu of requiring further written or computer-based examination of the candidate. The burden of proof of such equivalence shall lie upon the applicant.

(5) Any applicant who is a graduate of a medical school in which English is not the primary language of communication may be examined by the board on his or her proficiency in the English language.

**History:** Cr. Register, October, 1976, No. 250, eff. 11-1-76; am. (4), Register, August, 1979, No. 284, eff. 9-1-79; am. (3) (b), cr. (3) (b) 1. to 3., Register, October, 1980, No. 298, eff. 11-1-80; cr. (5), Register, October, 1984, No. 346, eff. 11-1-84; emerg. am. (3) (intro.), r. and recr. (3) (a), renum. (3) (b) and (c) to be (3) (c) and (d), cr. (3) (b) eff. 2-8-85; am. (3) (intro.), r. and recr. (3) (a), renum. (3) (b) and (c) to be (3) (c) and (d), cr. (3) (b), Register, September, 1985, No. 357, eff. 10-1-85; r. and recr. (1) Register, April, 1987, No. 376, eff. 5-1-87; renum. (3) (intro.), (a), (b), (c) (intro) and (d) to be (3) (a), (d), (e), (f) (intro.) and (g) and am. (a), (d), (e) and (f) (intro.), cr. (3) (b) and (c), Register, January, 1994, No. 457, eff. 2-1-94; am. (1) (a) (intro.), 3. to 6. and (d), r. and recr. (1) (a) 1. and 2., cr. (1) (a) 8. to 11., Register, February, 1997, No. 494, eff. 3-1-97; am. (1) (a) (intro.), (d), (3) (a), (b), (d), (e), (f) (intro.) and (g), Register, March, 2000, No. 531, eff. 4-1-00; CR 01-032: am. (3) (b), Register October 2001 No. 550, eff. 11-1-01; CR 03-072: am. (3) (f), cr. (3) (f) 4. Register January 2004 No. 577, eff. 2-1-04; CR 06-114: am. (3), Register April 2007 No. 616, eff. 5-1-07; CR 15-022: am. (1) (a) (intro.), (b), (d), r. (4) Register October 2015 No. 718, eff. 11-1-15.

**Med 1.07 Conduct of examinations. (1)** At the opening of the examinations each applicant shall be assigned a number which shall be used by the applicant on all examination papers, and neither the name of the applicant nor any other identifying marks shall appear on any such papers.

(2) At the beginning of the examinations a proctor shall read and distribute to the applicants the rules of conduct to be followed during the examinations and the consequences of violation of the rules. If an applicant violates the rules of conduct, the board may withhold or invalidate the applicant's examination scores, disqualify the applicant from the practice of medicine or impose other appropriate discipline.

**History:** Cr. Register, October, 1976, No. 250, eff. 11-1-76; r. and recr. (2), Register, December, 1984, No. 348, eff. 1-1-85.

**Med 1.08 Failure and reexamination. (1)** An applicant who fails to achieve a passing grade in the examinations required under this chapter may apply for reexamination on forms provided by the board and pay the appropriate fee for each reexamination as required in s. 440.05, Stats. An applicant who fails to achieve a passing grade may be reexamined twice at not less than 4-month intervals. If the applicant fails to achieve a passing grade on the second reexamination, the applicant may not be admitted to any further examination until the applicant reapplies for licensure and presents evidence satisfactory to the board of further professional training or education as the board may prescribe following its evaluation of the applicant's specific case.

(2) If an applicant has been examined 4 or more times in another licensing jurisdiction in the United States or Canada

before achieving a passing grade in written or computer-based examinations also required under this chapter, the board may require the applicant to submit evidence satisfactory to the board of further professional training or education in examination areas in which the applicant had previously demonstrated deficiencies. If the evidence provided by the applicant is not satisfactory to the board, the board may require the applicant to obtain further professional training or education as the board deems necessary to establish the applicant's fitness to practice medicine and surgery in this state. In order to determine any further professional training or education requirement, the board shall consider any information available relating to the quality of the applicant's previous practice, including the results of the applicant's performance on the oral interview required under s. 448.05 (6), Stats., and s. Med 1.06.

**Note:** Application forms are available on request to the board office, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

**History:** Cr. Register, October, 1976, No. 250, eff. 11-1-76; am. (1) and cr. (2), Register, September, 1985, No. 357, eff. 10-1-85; am. (2), Register, March, 2000, No. 531, eff. 4-1-00; CR 15-022: am. (2) Register October 2015 No. 718, eff. 11-1-15.

**Med 1.09 Examination review by applicant. (1)** An applicant who fails the statutes and rules examination may request a review of that examination by filing a written request and required fee with the board within 30 days of the date on which examination results were mailed.

(2) Examination reviews are by appointment only.

(3) An applicant may review the statutes and rules examination for not more than one hour.

(5) The applicant may not be accompanied during the review by any person other than the proctor.

(6) At the beginning of the review, the applicant shall be provided with a copy of the questions, a copy of the applicant's answer sheet and a copy of the master answer sheet.

(7) The applicant may review the examination in the presence of a proctor. The applicant shall be provided with a form on which to write comments, questions or claims of error regarding any items in the examination. Bound reference books shall be permitted. Applicants shall not remove any notes from the area. Notes shall be retained by the proctor and made available to the applicant for use at a hearing, if desired. The proctor shall not defend the examination nor attempt to refute claims of error during the review.

(8) An applicant may not review the examination more than once.

**History:** Cr. Register, February, 1997, No. 494, eff. 3-1-97; CR 15-022: am. (1), r. (4), am. (6) Register October 2015 No. 718, eff. 11-1-15.

**Med 1.10 Board review of examination error claim.**

(1) An applicant claiming examination error shall file a written request for board review in the board office within 30 days of the date the examination was reviewed. The request shall include all of the following:

(a) The applicant's name and address.

(b) The type of license for which the applicant applied.

(c) A description of the mistakes the applicant believes were made in the examination content, procedures, or scoring, including the specific questions or procedures claimed to be in error.

(d) The facts which the applicant intends to prove, including reference text citations or other supporting evidence for the applicant's claim.

(2) The board shall review the claim, make a determination of the validity of the objections and notify the applicant in writing of the board's decision and any resulting grade changes.

(3) If the decision does not result in the applicant passing the examination, a notice of denial of license shall be issued. If the board issues a notice of denial following its review, the applicant may request a hearing under s. SPS 1.05.

**Med 1.10**

WISCONSIN ADMINISTRATIVE CODE

**Note:** The board office is located at 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708.

**History:** Cr. Register, February, 1997, No. 494, eff. 3-1-97; correction in (3) made under s. 13.92 (4) (b) 7., Stats., Register November 2011 No. 671.

**CERTIFICATE**

**STATE OF WISCONSIN**

**DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES**

*I, Tom Ryan, Executive Director, Division of Policy Development in the Wisconsin Department of Safety and Professional Services and custodian of the official records of the Podiatry Affiliated Credentialing Board, do hereby certify that the annexed rules relating to the duty to obtain informed consent were duly approved and adopted by the Podiatry Affiliated Credentialing Board.*

*I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.*

*IN TESTIMONY WHEREOF, I have hereunto set my hand at 1400 East Washington Avenue, Madison, Wisconsin this 29<sup>th</sup> day of June, 2016.*

  
\_\_\_\_\_  
*Tom Ryan, Executive Director  
Division of Policy Development  
Department of Safety & Professional Services*

**CR 15-076**

STATE OF WISCONSIN  
PODIATRY AFFILIATED CREDENTIALING BOARD

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IN THE MATTER OF RULEMAKING	:	ORDER OF THE
PROCEEDINGS BEFORE THE	:	PODIATRY AFFILIATED
	:	CREDENTIALING BOARD
PODIATRY AFFILIATED	:	ADOPTING RULES
CREDENTIALING BOARD	:	(CLEARINGHOUSE RULE 15-076)

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ORDER

An order of the Podiatry Affiliated Credentialing Board to amend Pod 4.03 (2) (b) and create Pod 4.04 and Chapter 8 relating to the duty to obtain informed consent.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

Section 448.697, Stats.

**Statutory authority:**

Sections 15.085 (5) (b), 227.11 (2) (a), 448.675 (4), and 448.695 (1) (b), Stats.

**Explanation of agency authority:**

Section 15.085 (5) (b), Stats., provides that affiliated credentialing boards, such as the Podiatry Affiliated Credentialing Board, “[s]hall promulgate rules for its own guidance and for the guidance of the trade or profession to which it pertains. . .” The proposed rule will provide guidance within the profession as to how podiatrists are to inform patients about treatment options.

Section 227.11 (2) (a), Stats., provides that “[e]ach agency may promulgate rules interpreting the provisions of any statute enforced or administered by the agency, if the agency considers it necessary to effectuate the purpose of the statute, but a rule is not valid if the rule exceeds the bounds of correct interpretation.”

Section 448.675 (4), Stats., states that “[t]he affiliated credentialing board may restore a license which has been voluntarily surrendered or revoked under this subchapter on such terms and conditions as it considers appropriate.”

Section 448.695 (1) (b), Stats., provides that the Podiatry Affiliated Credentialing Board shall promulgate “rules implementing s. 448.697”. Section 448.697, Stats., requires podiatrists to inform patients of their treatment options.

**Related statute or rule:**

Sections 448.08 and 447.40, Stats.

**Plain language analysis:**

The duty of certain health care professionals, other than physicians, to obtain informed consent from their patients before conducting treatment had not been codified as a statutory duty prior to the passage of 2013 Wisconsin Act 345. Act 345 sets forth the podiatrists’ duty to obtain informed consent from their patients and institutes the reasonable podiatrist standard as the standard for informing patients regarding their treatment options. The reasonable podiatrist standard requires disclosure only of the information that a reasonable podiatrist would know and disclose under the circumstances. The rule will incorporate the new standard into the current rules governing podiatric practice and make any additional changes necessary to create consistency with the newly enacted legislation. The rule will also provide clarity to the process of renewing a license after 5 years by updating provisions regarding licensure reinstatement.

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

Although several federal agencies require investigators to obtain informed consent of human subjects participating in investigative trials, there are no specific federal regulations regarding podiatrists obtaining informed consent from their patients or the reasonable podiatrist standard.

**Comparison with rules in adjacent states:**

**Illinois:** Illinois administrative rules are silent with regards to podiatrists’ duty to inform patients of their treatment options (68 il admin 1360). A person seeking to restore a podiatric physician license after it has been expired or placed on inactive status for more than 5 years must interview before the board and submit evidence of either (1) certification of active practice in another jurisdiction and proof of 100 hours continuing education during the 2 years prior to restoration. Such evidence shall include a statement from the appropriate board or licensing authority in the other jurisdiction that the applicant was authorized to practice during the term of active practice; or (2) proof of successful completion of the PM Lexis examination within one year before applying for restoration (68 il admin 1360.60).

**Iowa:** Iowa administrative rules are silent with regards to podiatrists’ duty to inform patients of their treatment options (645 IAC 220, 222, 223, and 224). A person seeking to reactivate a podiatry license that has been on inactive status for more than five years, must provide the following: (1) verification of the license(s) from every jurisdiction in which the

applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office, and (2) verification of completion of 80 hours of continuing education within two years of application for reactivation (645 IAC 220.15 (3) (b)). A licensee whose license has been revoked, suspended, or voluntarily surrendered must reinstate their license in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the license is permanently revoked. If the order of revocation or suspension did not establish terms and conditions upon which reinstatement might occur, or if the license was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender. An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the revocation or suspension of the respondent's license no longer exists and that it will be in the public interest for the license to be reinstated. If the board determines that the license can be reinstated, then the license reactivation process is followed (645 IAC 220.16, 645 IAC 11.31)

**Michigan:** Michigan administrative rules are silent with regards to podiatrists' duty to inform patients of their treatment options (mich admin code r 338.8101 - 338.8136). "Reinstatement" is defined as the granting of a license or registration, with or without limitations or conditions, to a person whose license or registration has been revoked. "Relicensure" or "reregistration" is defined as the granting of a registration or license to a person whose license or registration has lapsed for failure to renew within 60 days after the expiration date (Michigan Statutes 339.402). An applicant for relicensure whose license has lapsed for 3 years or more and who holds a current license as a podiatrist in another state may be relicensed by completing 150 hours of continuing podiatric medical education credit within the 3 year period immediately preceding the date of application and taking and achieving a converted score of not less than 75 on the podiatric jurisprudence examination (mich admin code r 338.8111 (1)). An applicant for relicensure whose license has lapsed for 3 years or more and who does not hold a current license as a podiatrist in another state may be relicensed by taking and achieving a score of pass on part III of the examination developed and scored by the NBPME and taking and achieving a score of not less than 75 on the podiatric jurisprudence examination (mich admin code r 338.8111 (2)).

**Minnesota:** Minnesota administrative rules are silent with regards to podiatrists' duty to inform patients of their treatment options (mn r 6900.0010 – 6900.0500). To reinstate a podiatrist license, the applicant must submit: (1) verification of licensure status from each state in which the podiatrist has held an active license during the five years preceding application; (2) for each year the license has been inactive, evidence of participation in one-half the number of hours of acceptable continuing education required for biennial renewal up to five years, (3) if the license has been inactive for more than five years, the continuing education must be obtained during the five years immediately before application; and (4) other evidence as the board may reasonably require. No license that has been suspended or revoked by the board will be reinstated unless the former licensee provides evidence of full rehabilitation from the cause for which the license was suspended or revoked and complies with the other reasonable conditions imposed by the board for the purpose of establishing the extent of rehabilitation. In addition, if the disciplinary action was based in part on

failure to meet continuing education requirements, the license will not be reinstated until the former licensee has successfully completed the requirements (mn r 6900.0210).

**Summary of factual data and analytical methodologies:**

No factual data or analytical methodologies, aside from reviewing adjacent states' requirements, were used in drafting the rule due to the majority of the rule being prompted by the passage of 2013 WI Act 345.

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

The rule was posted for public comment on the economic impact of the rule, including how this 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 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 Jeffrey.Weigand@wisconsin.gov, or by calling (608) 267-2435.

**Agency contact person:**

Dale Kleven, 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 Dale2.Kleven@wisconsin.gov.

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TEXT OF RULE

SECTION 1. Pod 4.03 (2) (b) is amended to read:

**Pod 4.03 (2) (b)** If the licensee applies for renewal of the license more than 5 years after its expiration, the board shall make an inquiry to determine whether the applicant is competent to practice under the license in this state, and shall impose any reasonable conditions on ~~reinstatement~~ the renewal of the license, including oral examination, as the board deems appropriate. All applicants under this paragraph shall be required to pass the open book examination on statutes and rules, which is the same examination given to initial applicants. This section does not apply to licensees who have unmet disciplinary requirements or whose licenses have been surrendered or revoked.

SECTION 2. Pod 4.04 is created to read:

**Pod 4.04 License reinstatement.** A licensee who has unmet disciplinary requirements and failed to renew a license within 5 years of the renewal date or whose license has been surrendered or revoked may apply to have a license reinstated if the applicant provides all of the following:

(1) Evidence of completion of requirements in s. 4.03 (2) (b) if the licensee has not held an active Wisconsin license within the last 5 years.

(2) Evidence of completion of disciplinary requirements, if applicable.

(3) Evidence of rehabilitation or a change in circumstances, warranting reinstatement of the license.

SECTION 3. Chapter Pod 8 is created to read:

#### CHAPTER POD 8

#### INFORMED CONSENT

**Pod 8.01 Authority and purpose.** (1) **AUTHORITY.** The rules in this chapter adopted pursuant to the authority delegated in ss. 15.085 (5) (b), 227.11 (2) (a), and 448.695 (1) (b), Stats.

(2) **PURPOSE.** The purpose of the rules is to set forth the obligation of a podiatrist to communicate alternate modes of treatment to a patient.

**Pod 8.02 Informed consent.** Any podiatrist who treats a patient shall inform the patient about the availability of reasonable alternate modes of treatment and about the benefits and risks of these treatments. The reasonable podiatrist standard is the standard for informing a patient under this section. The reasonable podiatrist standard requires disclosure only of information that a reasonable podiatrist would know and disclose under the circumstances.

**Pod 8.03 Exceptions to communication of alternate modes of treatment.** The podiatrist's duty to inform the patient under this section does not require disclosure of any of the following:

(1) Detailed technical information that in all probability a patient would not understand.

(2) Risks apparent or known to the patient.

(3) Extremely remote possibilities that might falsely or detrimentally alarm the patient.

(4) Information in emergencies where failure to provide treatment would be more harmful to the patient than treatment.

(5) Information in cases where the patient is incapable of consenting.

(6) Information about alternate modes of treatment for any condition the podiatrist has not included in his or her diagnosis at the time the podiatrist informs the patient.

**Pod 8.04 Recordkeeping.** A podiatrist's patient record shall include documentation that alternate modes of treatment have been communicated to the patient and informed consent has been obtained from the patient as required under s. Pod 6.01.

SECTION 4. 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.

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(END OF TEXT OF RULE)  
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Dated

6/23/16

Agency



Chairperson

Podiatry Affiliated Credentialing Board

*William W. DPH*

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis

Original    Updated    Corrected

2. Administrative Rule Chapter, Title and Number

Pod 1, 4, 8

3. Subject

Duty to obtain informed Consent

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

This proposed rule is a result of recent legislation. 2013 Wisconsin Act 345 instituted a new standard regarding how podiatrists are to obtain informed consent from their patients. As a result of Act 345, podiatrists must obtain informed consent from their patients by advising them of reasonable alternate medical modes of treatment and the benefits and risks of those treatments in a manner consistent with the reasonable podiatrist standard. The reasonable podiatrist standard requires disclosure only of information that a reasonable podiatrist would know and disclose under the circumstances. The proposed rule will incorporate this new standard into the current podiatrist rules.

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 on the Department of Safety and Professional Services website and on the Wisconsin government website for 14 business days to solicit comments from the public. No businesses, business sectors, associations representing business, 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)

This proposed rule will have no economic or fiscal impact on specific businesses, business sectors, public utility rate payers, local governmental units or the state's economy as a whole.

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

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

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Podiatrists will advise their patients in a manner that is consistent with current law. There is no alternative to implementing the proposed rule due to the changes being necessitated by passage of legislation.

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### 14. Long Range Implications of Implementing the Rule

Podiatrists consistently advising patients of reasonable alternate medical modes of treatment options will result in chiropractors upholding their duty to inform patients in accordance with the statutes.

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### 15. Compare With Approaches Being Used by Federal Government

None

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

**Illinois:** Illinois administrative rules are silent with regards to podiatrists' duty to inform patients of their treatment options (68 il admin 1360). A person seeking to restore a podiatric physician license after it has been expired or placed on inactive status for more than 5 years must interview before the board and submit evidence of either (1) certification of active practice in another jurisdiction and proof of 100 hours continuing education during the 2 years prior to restoration. Such evidence shall include a statement from the appropriate board or licensing authority in the other jurisdiction that the applicant was authorized to practice during the term of active practice; or (2) proof of successful completion of the PM Lexis examination within one year before applying for restoration (68 il admin 1360.60).

**Iowa:** Iowa administrative rules are silent with regards to podiatrists' duty to inform patients of their treatment options (645 IAC 220, 222, 223, and 224). A person seeking to reactivate a podiatry license that has been on inactive status for more than five years, must provide the following: (1) verification of the license(s) from every jurisdiction in which the applicant is or has been licensed and is or has been practicing during the time period the Iowa license was inactive, sent directly from the jurisdiction(s) to the board office, and (2) verification of completion of 80 hours of continuing education within two years of application for reactivation (645 IAC 220.15 (3) (b)). A licensee whose license has been revoked, suspended, or voluntarily surrendered must reinstate their license in accordance with the terms and conditions of the order of revocation or suspension, unless the order of revocation provides that the license is permanently revoked. If the order of revocation or suspension did not establish terms and conditions upon which reinstatement might occur, or if the license was voluntarily surrendered, an initial application for reinstatement may not be made until one year has elapsed from the date of the order or the date of the voluntary surrender. An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the revocation or suspension of the respondent's license no longer exists and that it will be in the public interest for the license to be reinstated. If the board determines that the license can be reinstated, then the license reactivation process is followed (645 IAC 220.16, 645 IAC 11.31)

**Michigan:** Michigan administrative rules are silent with regards to podiatrists' duty to inform patients of their treatment options (mich admin code r 338.8101 - 338.8136). "Reinstatement" is defined as the granting of a license or registration, with or without limitations or conditions, to a person whose license or registration has been revoked. "Relicensure" or "reregistration" is defined as the granting of a registration or license to a person whose license or registration has lapsed for failure to renew within 60 days after the expiration date (Michigan Statutes 339.402). An applicant for relicensure whose license has lapsed for 3 years or more and who holds a current license as a podiatrist in another state may be relicensed by completing 150 hours of continuing podiatric medical education credit within the 3 year period immediately preceding the date of application and taking and achieving a converted score of not less than 75 on the podiatric jurisprudence examination (mich admin code r 338.8111 (1)). An applicant for relicensure whose license has lapsed for 3 years or more and who does not hold a current license as a podiatrist in another state may be relicensed by taking and achieving a score of pass on part III of the examination developed and scored by the NBPME and taking and achieving a score of not less than 75 on the podiatric jurisprudence examination (mich admin code r 338.8111 (2)).

**Minnesota:** Minnesota administrative rules are silent with regards to podiatrists' duty to inform patients of their treatment options (mn r 6900.0010 - 6900.0500). To reinstate a podiatrist license, the applicant must submit: (1) verification of licensure status from each state in which the podiatrist has held an active license during the five years preceding application; (2) for each year the license has been inactive, evidence of participation in one-half the number of hours of acceptable continuing education required for biennial renewal up to five years, (3) if the license has been inactive for more than five years, the continuing education must be obtained

## ADMINISTRATIVE RULES

### Fiscal Estimate & Economic Impact Analysis

during the five years immediately before application; and (4) other evidence as the board may reasonably require. No license that has been suspended or revoked by the board will be reinstated unless the former licensee provides evidence of full rehabilitation from the cause for which the license was suspended or revoked and complies with the other reasonable conditions imposed by the board for the purpose of establishing the extent of rehabilitation. In addition, if the disciplinary action was based in part on failure to meet continuing education requirements, the license will not be reinstated until the former licensee has successfully completed the requirements (mn r 6900.0210).

17. Contact Name Katie Vieira (Paff)	18. Contact Phone Number 608-261-4472
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This document can be made available in alternate formats to individuals with disabilities upon request.

**CERTIFICATE**

**STATE OF WISCONSIN  
DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES**

*I, Tom Ryan, Executive Director, Division of Policy Development in the Wisconsin Department of Safety and Professional Services and custodian of the official records of the Podiatry Affiliated Credentialing Board, do hereby certify that the annexed rules relating to overtreatment of patients were duly approved and adopted by the Podiatry Affiliated Credentialing Board.*

*I further certify that said copy has been compared by me with the original on file in this office and that the same is a true copy thereof, and of the whole of such original.*

*IN TESTIMONY WHEREOF, I have hereunto set my hand at 1400 East Washington Avenue, Madison, Wisconsin this 29<sup>th</sup> day of June, 2016.*



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*Tom Ryan, Executive Director  
Division of Policy Development  
Department of Safety & Professional Services*

STATE OF WISCONSIN  
PODIATRY AFFILIATED CREDENTIALING BOARD

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IN THE MATTER OF RULEMAKING	:	ORDER OF THE
PROCEEDINGS BEFORE THE	:	PODIATRY AFFILIATED
PODIATRY AFFILIATED	:	CREDENTIALING BOARD
CREDENTIALING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE 15-075)

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ORDER

An order of the Podiatry Affiliated Credentialing Board to create Pod 2.01 (24) relating to overtreatment of patients.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

Section 448.695 (1) (a), Stats.

**Statutory authority:**

Sections 15.085 (5) (b), 227.11 (2) (a), and 448.695 (1) (a), Stats.

**Explanation of agency authority:**

Pursuant to ss. 15.085 (5) (b) and 227.11 (2) (a), Stats., the Podiatry Affiliated Board is generally empowered by the legislature to promulgate rules that will provide guidance within the profession and interpret the statutes it administers. Section 448.695 (1) (a), Stats., grants express rule-writing authority to the board to promulgate rules that identify acts that constitute unprofessional conduct. This rule seeks to add a provision to the unprofessional conduct rule. Therefore, the Podiatry Affiliated Credentialing Board is generally and specifically empowered to promulgate these rules.

**Related statute or rule:**

Section 448.675, Stats.

**Plain language analysis:**

An issue that is prevalent in the health care system is overtreatment and excessive diagnostic testing of patients by health care professionals. Overtreatment and excessive use of diagnostic testing and surgical procedures result in increased costs to patients as

well as exposure to increased risk of infection, diseases, and complications. The Podiatry Affiliated Credentialing Board recognized this issue and decided to address it with these proposed rules. The proposed rule seeks to add a provision to the Unprofessional Conduct chapter Wisconsin Administrative Code Chapter Pod 2.

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

None.

**Comparison with rules in adjacent states:**

**Illinois:** Illinois does not list excessive evaluation or treatment of a patient as conduct that would be considered grounds for disciplinary action under 225 ILCS 100/4.

**Iowa:** Iowa does not list excessive evaluation or treatment as conduct that would subject a podiatrist to discipline under 645 IAC 224.2.

**Michigan:** Michigan does not list excessive evaluation or treatment as conduct that would subject a podiatrist to discipline under MCLS § 333.16221.

**Minnesota:** Minnesota does not list excessive evaluation or treatment as conduct that would subject a podiatrist to discipline under Minn. Stat. § 153.19.

**Summary of factual data and analytical methodologies:**

The methodologies used in developing the rule included reviewing statutes and administrative rules in other states and comparing them to the current unprofessional conduct provisions for podiatrists in Wisconsin.

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

The rule was 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:**

The rule does 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 [Jeffrey.Weigand@wisconsin.gov](mailto:Jeffrey.Weigand@wisconsin.gov), or by calling (608) 267-2435.

**Agency contact person:**

Dale Kleven, 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 Dale2.Kleven@wisconsin.gov.

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TEXT OF RULE

SECTION 1. Pod 2.01 (24) is created to read:

**Pod 2.01 (24)** Performing deceptive, misleading, or fraudulent treatment, evaluation, or medical or surgical services.

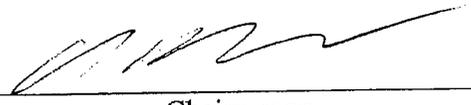
SECTION 2. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)

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Dated 6/28/16

Agency 

Chairperson  
Podiatry Affiliated Credentialing Board  
*William W. S. D. M.*

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis

Original    Updated    Corrected

2. Administrative Rule Chapter, Title and Number

Pod 2

3. Subject

Overtreatment of patients

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

An issue that is prevalent in the health care system is overtreatment and excessive diagnostic testing of patients by health care professionals. Overtreatment and excessive use of diagnostic testing and surgical procedures result in increased costs to patients as well as exposure to increased risk of infection, diseases, and complications. The Podiatry Affiliated Credentialing Board recognized this issue and decided to address it with these proposed rules. The proposed rule seeks to add a provision to the Unprofessional Conduct chapter Wisconsin Administrative Code Chapter Pod 2.

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 on the Department of Safety and Professional Services website and on the Wisconsin government website for 14 business days to solicit comments from the public. No businesses, business sectors, associations representing business, 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)

This proposed rule will not have a significant impact on specific businesses, business sectors, public utility rate payers, local governmental units or the state's economy as a whole.

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

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

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Implementing this rule will result in better patient protection from overtreatment and excessive diagnostic testing.

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14. Long Range Implications of Implementing the Rule

Implementing this rule will result in better patient protection from overtreatment and excessive diagnostic testing.

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15. Compare With Approaches Being Used by Federal Government

None

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

Illinois does not list excessive evaluation or treatment of a patient as conduct that would be considered grounds for disciplinary action under 225 ILCS 100/4.

Iowa does not list excessive evaluation or treatment as conduct that would subject a podiatrist to discipline under 645 IAC 224.2.

Michigan does not list excessive evaluation or treatment as conduct that would subject a podiatrist to discipline under MCLS § 333.16221.

Minnesota does not list excessive evaluation or treatment as conduct that would subject a podiatrist to discipline under Minn. Stat. § 153.19.

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17. Contact Name

Katie Paff

---

18. Contact Phone Number

(608) 261-4472

---

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

**ADMINISTRATIVE RULES**  
**Fiscal Estimate & Economic Impact Analysis**

**ATTACHMENT A**

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1. Summary of Rule's Economic and Fiscal Impact on Small Businesses (Separately for each Small Business Sector, Include Implementation and Compliance Costs Expected to be Incurred)

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2. Summary of the data sources used to measure the Rule's impact on Small Businesses

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3. Did the agency consider the following methods to reduce the impact of the Rule on Small Businesses?

- Less Stringent Compliance or Reporting Requirements
  - Less Stringent Schedules or Deadlines for Compliance or Reporting
  - Consolidation or Simplification of Reporting Requirements
  - Establishment of performance standards in lieu of Design or Operational Standards
  - Exemption of Small Businesses from some or all requirements
  - Other, describe:
- 

4. Describe the methods incorporated into the Rule that will reduce its impact on Small Businesses

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5. Describe the Rule's Enforcement Provisions

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6. Did the Agency prepare a Cost Benefit Analysis (if Yes, attach to form)

- Yes    No
-

**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 On behalf of Tom Ryan, Executive Director		2) Date When Request Submitted:  07/11/2016  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:  07/20/2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  <ul style="list-style-type: none"> <li>• Report from Telemedicine Rule Committee             <ul style="list-style-type: none"> <li>○ Telemedicine Article</li> </ul> </li> </ul>	
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 ( <a href="#">Fill out Board Appearance Request</a> ) <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:  Please review the linked article  <a href="http://www.wsj.com/articles/how-telemedicine-is-transforming-health-care-1466993402">http://www.wsj.com/articles/how-telemedicine-is-transforming-health-care-1466993402</a>			
11) Authorization			
<b>Nifty Lynn Dio</b>		<b>07/11/2016</b>	
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  
Department of Safety & Professional Services**

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted:  6/30/2016	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  7/20/2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  FSMB Matters – New Position Statements and Policy on Issues Impacting the Regulation of Medical Practice in the United States	
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? If yes, who is appearing?  No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  <p><i>Washington, D.C.</i> – At its recent Annual Meeting, held in San Diego April 28-30, the Federation of State Medical Boards (FSMB) House of Delegates adopted new position statements and policy on issues impacting the regulation of medical practice in the United States.</p> <p><b><i>Practice Drift</i></b> To address problems caused when physicians offer patients treatments that fall out-side of those typically recognized within their area of practice, the FSMB adopted a new position statement on “practice drift.” The policy reminds physicians of their responsibility to consider the patient's best interests in developing treatment options and to offer only treatments that they are capable of providing competently. The position statement also encourages state medical boards to take steps to prevent harm from practice drift. View the Position Statement.</p> <p><b><i>Duty to Report</i></b> The FSMB outlined several responsibilities on the parts of physicians, hospitals and health organizations, insurers and the public to provide reports to state medical boards of relevant information about medical care to en-sure they have all information needed to effectively engage in patient protection. The position statement encourages the reporting of information in categories such as patient safety, physician impairment and professional misconduct. View the Position Statement.</p> <p><b><i>Sale of Goods by Physicians and Physician Advertising</i></b> The FSMB reminded physicians that in choosing to make health-related and non-health-related goods available to patients, they must be mindful of the inherent power differential that characterizes the</p>			

physician-patient relationship and therefore guard against any possibility of exploitation of patients. Physicians should take care to avoid conflicts of interest and excessive markups in selling goods and should provide full informational disclosures and freedom of choice when offering patients goods directly. Physicians should also refrain from deceptive or misleading advertising of goods. View the Position Statement.

***Model Guidelines for the Recommendation of Marijuana in Patient Care***

The FSMB adopted guidelines that set forth standards for physicians choosing to incorporate the recommendation of marijuana in patient care and management. The guidelines address patient evaluation, informed and shared decision making, the creation of treatment plans, record-keeping, and consultation and referral. View the Model Guidelines.

In a separate action, the FSMB also addressed physician use of marijuana, formally adding marijuana to its list of substances that may impair the ability of practicing physicians.

***Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards***

The FSMB also adopted a resolution calling for advocacy against the expanded application of antitrust principles that may compromise patient safety. The resolution also called for the FSMB to assist state boards facing litigation alleging antitrust violations. The action was taken in the wake of the U.S. Supreme Court's decision in the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* case. These position statements and policy as well as all official FSMB policies are available on the FSMB website at: [www.fsmb.org/policy/advocacy-policy/policy-documents](http://www.fsmb.org/policy/advocacy-policy/policy-documents).

11) <b>Authorization</b>	
<b>Signature of person making this request</b>	<b>Date</b>
<b>Supervisor (if required)</b>	<b>Date</b>
<b>Bureau Director signature (indicates approval to add post agenda deadline item to agenda)</b>	<b>Date</b>

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Nifty Lynn Dio, Bureau Assistant On behalf of Tom Ryan, Executive Director		<b>2) Date When Request Submitted:</b>  07/11/2016  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  07/20/2016	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> <ul style="list-style-type: none"> <li>• <b>Speaking Engagements, Travel, or Public Relation Requests, and Reports</b> <ul style="list-style-type: none"> <li>○ CAC 2016 Annual Meeting, September 17-18, 2016, Portland, OR</li> </ul> </li> </ul>	
<b>7) Place Item in:</b> <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  Consider authorizing a Board member to attend			
<b>11) Authorization</b>			
<b>Nifty Lynn Dio</b>		<b>07/11/2016</b>	
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	
<b>Directions for including supporting documents:</b> 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.			

# ***Citizen Advocacy Center*** **2016 Annual Meeting**

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***Preliminary Program Announcement,  
Agenda, and Meeting Registration Form***

## **Modernizing the Regulatory Framework for Telehealth**

**Presented in conjunction with CLEAR, the Oregon Health Licensing  
Office, the Oregon Medical Board, the Oregon Board of Nursing, and  
the Oregon Physical Therapy Licensing Board**

**Saturday, September 17, 2016  
and  
Sunday, September 18, 2016**

***Portland Marriott Downtown Waterfront  
1401 SW Naito Pkwy.  
Portland, OR 97201  
(503) 226-7600***

# *Citizen Advocacy Center 2016 Annual Meeting*

On Saturday afternoon, September 17, 2016, and Sunday, September 18, 2016, immediately following the close of the CLEAR Annual Educational Conference at the Portland Marriott Downtown Waterfront, CLEAR and the Citizen Advocacy Center (CAC) will co-sponsor a national conference on Telehealth.

This conference will be CAC's 2016 meeting, and will bring stakeholders together to identify and discuss ways in which the health professional regulatory system can facilitate the use of telehealth technologies and maximize the benefits to the public, consistent with safe, quality, affordable care. Many healthcare professionals and their respective boards are taking steps to enable the appropriate, safe use of telehealth technologies. The conference will address such topics as:

- How do patients feel about telehealth?
- What are the main regulatory hurdles that need to be overcome?
- How can telehealth outcomes be evaluated?

The Citizen Advocacy Center registration form is on page 7 of this program.

We encourage you to also register for the CLEAR 2016 annual conference that is being held at the same hotel from Wednesday, September 14, 2016, through Saturday morning, September 17, 2016. CLEAR is offering Citizen Advocacy Center members the same discounted registration fee they offer their own members. CAC members should use the registration discount code, which is **clearcac**. For more information, visit the CLEAR website at <http://clearhq.org/aec16/>.

## ***ABOUT CAC***

Since 1987, CAC has been serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. We offer training, research and networking opportunities for public members and for the health care regulatory, credentialing, and governing boards on which they serve.

Created as a support program for the thousands of public members serving on health professional boards as representatives of the consumer interest, CAC soon became a resource for the health professional boards themselves.

## **Day One – Saturday, September 17, 2016**

**11:00 A.M. – REGISTRATION DESK OPENS – COFFEE AND SNACKS WILL BE AVAILABLE**

**12:00 P.M. – 12:30 P.M. – WELCOME AND INTRODUCTION REMARKS BY CAC AND CLEAR**

**12:30 P.M. – 1:30 P.M. – KEYNOTE ADDRESS: “TELEHEALTH POLICY TRENDS AND CONSIDERATIONS”**

Late in 2015 the National Conference of State Legislatures (NCSL) issued a blockbuster report entitled, *Telehealth Policy Trends and Considerations*. The report was the product of a year’s deliberation among state legislators, legislative staff, private industry, consumer organizations and others about the promise of telehealth technologies and barriers in the way of their dissemination. The report overview states: “Telehealth can increase health care access including the ability to reach care outside typical provider office hours or in different settings such as homes, long-term care facilities, schools, workplaces or prisons...(T)he possibility to improve health, along with consumer demand for convenience, is also a driving factor...For example, 74% of consumers reported they were likely to use online services.” A project committee co-chair will discuss the findings and recommendations contained in the report, including what the report has to say about licensure, safety and security, and coverage/reimbursement.

**1:30 P.M. – 2:30 P.M. – CONSUMER PERSPECTIVES**

Speakers will discuss the findings of recent surveys of consumer experiences and attitudes regarding telehealth.

**2:30 P.M. – 3:00 P.M. – BREAK**

**3:00 P.M. – 4:00 P.M. – PROVIDER PERSPECTIVES**

Speakers representing providers of telehealth services and technologies will share their opinions about how regulation and reimbursement policies can promote or inhibit the growth of safe and effective telehealth service delivery. They will also talk about the desirability of license mobility.

**BREAK UNTIL EVENING SHIMBERG EVENTS (DETAILS ON PAGE 5):**

**5:30 P.M. – 6:30 P.M. – COCKTAIL RECEPTION**

**6:30 P.M. – 7:15 P.M. – SHIMBERG LECTURE**

**7:15 P.M. – 7:30 P.M. – PRESENTATION OF SHIMBERG AWARD**

**MEETING ADJOURNS FOR THE DAY**

## **Day Two – Sunday, September 18, 2016**

**8:00 A.M. – REGISTRATION DESK OPENS – COFFEE AND BAGELS WILL BE AVAILABLE**

**8:30 A.M. – 9:30 A.M. – KEYNOTE ADDRESS: A VIEW FROM THE FEDERAL TRADE COMMISSION**

A spokesperson for the FTC will talk about ways in which the agency's antitrust enforcement activities may relate to telehealth in instances such as the Teledoc case in Texas. We will also learn whether the FTC *Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants* in the wake of the Supreme Court's *North Carolina Dental* decision has relevance to telehealth regulation.

**9:30 A.M. – 10:30 A.M. – VIEWS FROM STATE HEALTH PROFESSION REGULATORS – PART I (NURSING, PHYSICAL THERAPY AND PSYCHOLOGY)**

Regulatory representatives of these three professions will bring us up to date on the regulation of telehealth technologies in their fields. Just a few examples: nursing pioneered the interstate compact concept that facilitates practice across jurisdictional lines. Physical therapy, in the U.S. and internationally, is looking at how its regulators can avoid creating barriers to the safe and appropriate use of telehealth delivery methods. In psychology, two mental healthcare reform bills introduced in the U.S. Congress in early 2016 have telehealth provisions.

**10:30 A.M. – 11:00 A.M. – COFFEE BREAK**

**11:00 A.M. – 12:00 P.M. – VIEWS FROM STATE HEALTH PROFESSION REGULATORS – PART II (PHARMACY, OPTOMETRY AND MEDICINE)**

Regulatory representatives of these three professions will bring us up to date on the regulation of telehealth technologies in their fields. Just a few examples: Telehealth technology allows Iowa pharmacists in one location to manage pharmacies in other locations and consult with patients via teleconferencing. Several states permit teleprescribing. Teleophthalmology is gaining acceptance worldwide for both diagnosis and treatment. Among U.S. regulators, the Federation of State Medical Boards published advisory guidelines for its member boards that provide "flexibility" for doctors consistent with accepted standards of care.

**12:00 P.M. – 12:45 P.M. – FIXING MEDICARE**

Thus far, the conference has focused on licensing and regulation. Reimbursement policy can also help or hurt the expansion of telehealth delivery. Speakers representing Medicare and private insurers will comment on their approaches to telehealth reimbursement and on major legislative reform proposals introduced in Congress in 2016.

Medicare now largely limits telehealth payments through its traditional fee-for-service program to cases where people live some distance from providers, thus largely restricting this service to rural areas. Medicare Advantage programs and demonstration programs such as accountable care organizations also can provide medical consultations via computer or phone. Where telehealth is widely used, up to 70% of people's contact with their doctors is handled remotely.

**12:45 P.M. – MEETING ADJOURNS**

## ABOUT THE SHIMBERG AWARD AND LECTURE

Dr. Benjamin Shimberg, widely considered the “father” of accountability in professional and occupational licensing, was the first chair of CAC’s board of directors until his death in September 2003. The board named Ben Chairman Emeritus of CAC and created an annual Ben Shimberg public service award. Each year, the board asks the award recipient to deliver a lecture.

This year’s Shimberg Award winner is Kathleen Haley, Executive Director of the Oregon Medical Board.

Past recipients of the award were:

- 2015 Lisa McGiffert, Director, Consumers Union’s Safe Patient Project
- 2014 ProPublica, accepted by Charles Ornstein and Tracy Weber
- 2013 Kathy Apple, former Executive Director, National Council of State Boards of Nursing (NCSBN)
- 2012 Paul Grace, President and Executive Director, National Board for Certification in Occupational Therapy
- 2011 Catherine Dower, former Associate Director for Research, Center for the Health Professions, UCSF
- 2010 Art Levin, Director, Center for Medical Consumers
- 2009 Sidney Wolfe, former Director, Public Citizen’s Health Research Group
- 2008 Polly Johnson, former Executive Director of the North Carolina Board of Nursing
- 2007 Barbara Safriet, former Public Member on the Federation of State Boards of Physical Therapy
- 2006 John Rother, former Policy and Strategy Director for AARP
- 2005 Julie D’Angelo Fellmeth, Administrative Director, Center for Public Interest Law, University of San Diego School of Law, and former Enforcement Monitor for the Medical Board of California
- 2004 Mark Yessian, Former Regional Inspector General for Evaluation and Inspections, Boston Region, Office of the Inspector General, U.S. Department of Health and Human Services

## **HOTEL INFORMATION**

The annual meeting is being held in Portland Marriott, Downtown Waterfront, 1401 SW Naito Pkwy., Portland, OR 97201. CLEAR, the co-sponsor of our meeting, has arranged for preferred rates at our host hotel. These rates are good until **August 15, 2016**. Discounted reservations may be made by calling (503) 226-7600 and identifying yourself as part of the CLEAR Annual Educational Conference Group block, or by going to the online booking tool at <https://aws.passkey.com/e/14403676>. However, because of an unexpectedly large number of room registrations, there are very few rooms left at that hotel.

CLEAR has arranged for 2 overflow hotels that are located within a .8-mile radius of the Portland Marriot. These hotels are also offering discounted rates.

**If the rooms at discounted rates at the host hotel have all been taken, please contact Glenn Blind at [gblind@clearhq.org](mailto:gblind@clearhq.org). He will send you a link to register at one of the overflow hotels.**

# MEETING REGISTRATION FORM

To register for our 2016 annual meeting, please complete this form and mail, email, or fax it to:

## CAC

1400 16th Street NW • Suite 101  
 Washington, D.C. 20036  
 Voice (202) 462-1174 • FAX: (202) 354-5372  
 register@cacenter.org

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

**PAYMENT OPTIONS:**

- 1) Mail us a check payable to **CAC** for the appropriate amount,
- 2) Provide us with your email address so that we can send you an invoice, or
- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing address:	

Signature

Date

	Early Bird Rate (through August 14, 2016)	Standard Rate (beginning August 15, 2016)
<b>Registration fee:</b>	<input type="checkbox"/> \$495.00	<input type="checkbox"/> \$545.00
<b>Registration fee for individuals affiliated with CAC Member Organizations, CLEAR Member Organizations, and Oregon Health Regulatory Boards:</b>	<input type="checkbox"/> \$400.00	<input type="checkbox"/> \$475.00

**CANCELLATION POLICY: NO REFUNDS ARE POSSIBLE, BUT YOUR FULL PAYMENT MAY BE APPLIED TOWARDS A FUTURE MEETING.**

For Citizen Advocacy Center members who are interested in attending the CLEAR conference being held at the same hotel from Wednesday, September 14, 2016, through Saturday morning, September 17, 2016, register at <http://clearhq.org/aec16/> using the code **clearcac** to receive the discounted registration rate. **Note that the CLEAR early bird cutoff date is July 29, 2016, which is earlier than the CAC cutoff date.**

# MEMBERSHIP INFORMATION

**CAC** offers memberships to state health professional licensing boards and other organizations and individuals interested in our work. We invite your agency to become a **CAC** member, and request that you put this invitation on your board agenda at the earliest possible date.

**CAC** is a not-for-profit, 501(c)(3) tax-exempt service organization dedicated to supporting public members serving on healthcare regulatory and oversight boards. Over the years, it has become apparent that our programs, publications, meetings, and services are of as much value to the boards themselves as they are to the public members. Therefore, the **CAC** board decided to offer memberships to health regulatory and oversight boards in order to allow the boards to take full advantage of our offerings.

We provide the following services to boards that become members:

- 1) **Free** copies of all **CAC** publications that are available to download from our website for **all** of your board members and **all** of your staff.
- 2) A **10% discount** for **CAC** meetings, including our fall annual meeting, for **all** of your board members and **all** of your staff;
- 3) A \$20.00 discount for **CAC** webinars.
- 4) If requested, a **free** review of your board’s website in terms of its consumer-friendliness, with suggestions for improvements;
- 5) **Discounted rates** for **CAC’s on-site training** of your board on how to most effectively utilize your public members, and on how to connect with citizen and community groups to obtain their input into your board rule-making and other activities;
- 6) Assistance in **identifying qualified individuals** for service as public members.

The annual membership fees are as follows:

Individual Regulatory Board	\$275.00
“Umbrella” Governmental Agency plus regulatory boards	\$275.00 for the umbrella agency, plus \$225.00 for each participating board
Non-Governmental organization	\$375.00
Association of regulatory agencies or organizations	\$450.00
Consumer Advocates and Other Individuals (NOT associated with any state licensing board, credentialing organization, government organization, or professional organization)	\$100.00

# MEMBERSHIP ENROLLMENT FORM

**To become a CAC Member Organization for the remainder of 2016 please complete this form and mail or fax it to:**

## *CAC*

1400 16th Street NW • Suite 101  
 Washington, D.C. 20036  
 Voice (202) 462-1174 • FAX: (202) 354-5372

Name:		
Title:		
Name of Organization or Board:		
Address:		
City:	State:	Zip:
Telephone:		
Email:		

**PAYMENT OPTIONS:**

- 1) Mail us a check payable to **CAC** for the appropriate amount,
- 2) Provide us with your email address so that we can send you an invoice, or
- 3) Provide the following information to pay by credit card:

Name on credit card:	
Credit card number:	
Expiration date and security code:	
Billing Address:	

Signature

Date

Our Federal Identification Number is 52-1856543.

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

**AGENDA REQUEST FORM**

1) Name and Title of Person Submitting the Request:  Amber Cardenas & Stephanie Bloechl-Anderson		2) Date When Request Submitted:  7.8.2016	
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:  7.20.2016	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  Consideration of Credentialing Delegated Authority	
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 checked="" type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  Proposal for the Board to consider delegating authority to Department Attorneys to approve of certain violations and convictions which do not relate substantially to the practice of medicine and do not provide a legal basis for denial of a credential.			
11) <span style="float: right;">Authorization</span>  <b>s/Amber Cardenas</b> <span style="float: right;"><b>7.8.2016</b></span> <hr/> Signature of person making this request <span style="float: right;">Date</span> <hr/> Supervisor (if required) <span style="float: right;">Date</span> <hr/> Executive Director signature (indicates approval to add post agenda deadline item to agenda) <span style="float: right;">Date</span>			
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.			

# **BOARD APPEARANCE REQUEST FORM**

## **Appearance Information**

**Board Name:** Medical Examining Board

**Board Meeting Date:** 7.20.2016

**Person Submitting Agenda Request:** Amber Cardenas & Stephanie Bloechl-Anderson

**Person(s) requesting an appearance:** Stephanie Bloechl-Anderson, Credentialing Attorney, and Jamie Adams, Health Credentialing Supervisor

*(NOTE: Contact information is not required for Department staff.)*

**Reason for Appearance:** To discuss and answer any questions regarding the proposal for the Board to delegate authority regarding certain violations and convictions.

## **Appearance Contact Information**

*(NOTE: If the appearing party is represented by an attorney skip the "Appearance Contact Information" section and complete the "Attorney Contact Information" section.)*

**Mailing address:**

**Email address:**

**Telephone #:**

\*\*\*\*\*

## **Attorney Contact Information**

**Attorney Name:**

**Attorney's mailing address:**

**Attorney's e-mail address:**

**Attorney's telephone #:**

## Medical Examining Board Proposed Delegated Authority

### Credentialing Matters - Delegated Authority for Conviction Review

- To delegate authority to the DSPP Attorneys to review and approve:
  - Ordinance violations which are not substantially related to the practice of medicine, including but not limited to:
    - Littering
    - Loitering
    - Up to two (2) Underage Drinking
    - Resisting/Obstructing an Officer
    - 1 OWI
    - Public Urination
    - Disorderly Conduct
    - Trespassing
    - Disturbing the Peace
    - Operating after Suspension/Revocation
  - Up to two (2) OWIs, each five (5) or more years old, and which are not substantially related to the practice of medicine.
  - Conviction review for Medicine & Surgery (Physicians) applications which have previously been approved for a full Resident Educational License (REL) license after a criminal background check and there have been no new violations or convictions since the previous license approval.

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  <b>Janie Brischke, DLSC Program Policy Analyst Advanced</b>		<b>2) Date When Request Submitted:</b>  <b>July 7, 2016</b>  <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>	
<b>3) Name of Board, Committee, Council, Sections:</b>  <b>Medical Examining Board</b>			
<b>4) Meeting Date:</b>  <b>July 20, 2016</b>	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  <b>Medical Examining Board – Division of Legal Services and Compliance Annual Report</b>	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  <b>The Division of Legal Services and Compliance is required to provide an annual report to the Medical Examining Report. The attached report for the year 2015 fulfills the requirement.</b>			
<b>11) Authorization</b>  <b>Janie Brischke</b> <hr/> Signature of person making this request <span style="float: right;">Date</span>  <hr/> Supervisor (if required) <span style="float: right;">Date</span>  <hr/> Executive Director signature (indicates approval to add post agenda deadline item to agenda) <span style="float: right;">Date</span>			
<b>Directions for including supporting documents:</b> 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



## DIVISION OF LEGAL SERVICES AND COMPLIANCE ANNUAL REPORT

*(January 1, 2015 – December 31, 2015)*

The Wisconsin Department of Safety and Professional Services (DSPS), Division of Legal Services and Compliance (DLSC) provides legal services to professional boards, regulated industries and the Department regarding the investigation and prosecution/discipline of licensed credential holders for violations of statutes and administrative rules.

DLSC is comprised of complaint intake staff, consumer protection investigators, regulatory specialists, paralegals, attorneys/prosecutors, board counsel, and management staff. The DLSC team of professionals is responsible for the complaint intake process, monitoring compliance with disciplinary orders, administering a confidential program for impaired professionals, called the Professional Assistance Procedure (PAP), performing audits of trust accounts, and conducting business inspections for pharmacies, drug distributors and manufacturers, funeral establishments, and barber and cosmetology schools and establishments.

The Medical Examining Board (MEB) is charged with ensuring competent practice of licensed medical professionals in the state of Wisconsin. It enlists the services of DLSC in order to accomplish this purpose. The MEB relies on DLSC to provide investigation and legal services for complaints of unprofessional conduct filed against these licensees. As part of these services, DLSC provides a Medical and Affiliates Team comprised of the staff identified below. The following briefly summarizes the responsibilities of these positions:

- **Attorneys (Prosecutors)** – Legal experts that perform specialized legal services relating to one or more areas of law. Prepare pleadings, briefs, orders and all types of legal documents and memorandums. Prepare findings of fact and conclusions of law, and negotiates orders. Issues subpoenas requiring appearance of witnesses and the production of documents. Represents the MEB at formal hearings of varied complexity in connection with the administration of state laws and regulations.
- **Board Counsel** – Provide legal guidance to boards and agency staff on a wide variety of issues such as a board's authority and jurisdiction with respect to legal review of disciplinary matters, assist with legal issues related to credentialing, interpreting statutes and administrative rules affecting the Board, and prepare for and attend board meetings to present legal analysis and give advice. Board Counsel also drafts, reviews and approves a variety of documents necessary to carry out board business. Finally, Board Counsel represents the boards in hearings before administrative law judges concerning application denials.
- **Complaint Intake Staff** – Review and evaluate incoming complaints and request information; process the opening and/or closing of cases; monitor complaints in the initial review process. Also performs other administrative and program-related support to DLSC.
- **Consumer Protection Investigators and Consumer Protection Investigators Advanced** - Plan, develop and conduct comprehensive investigations involving compliance with, or violations of, a wide range of statutes, rules, regulations, and/or standards.
- **Management Staff** - Manage subordinates and programs within DLSC.
- **Paralegals and Paralegals Advanced** - Perform a wide range and combination of professional-level, law-related activities to assist DLSC staff attorneys in the delivery of legal services, conducts specialized or complex legal research and the analysis of case law, assist attorneys at hearings, draft and prepare a variety of legal documents.
- **Paralegal Advanced and Regulatory Specialists (Monitoring and PAP)** - Regulatory work in the areas of monitoring compliance with disciplinary orders and in the PAP.

In general, DLSC operates based upon a complaint-driven process, meaning the majority of compliance and disciplinary actions are the result of complaints submitted by outside sources, rather than DSPS' active search for misconduct. The complaint itself may come from a variety of sources, such as consumers and professionals who alert DSPS to the potential misconduct.

At other times, disciplinary action may be the direct result of inquiry by DSPS in conjunction with or at the request of the MEB (e.g. continuing education audits). Actions taken by the Board on such matters are the result of audits performed by DSPS.

### **Screening**

Once a complaint is received, it is reviewed by the MEB Screening Panel, which consists of Board members (medical professionals and public) as well as a DLSC prosecuting attorney. The MEB screening panel brings together the professional expertise of the Board in addition to the legal expertise of the DLSC staff.

The Screening Panel confers and determines, based on information provided, whether a violation(s) may have occurred. The panel may consider many factors, such as the seriousness of the allegations, the harm or threat of harm, whether the dispute is already resolved, and whether the matter is primarily a civil or private dispute. If a complaint does have merit, or requires further investigation, the case is opened for investigation.

If a complaint does not warrant further action, it is closed at screening and a letter is sent out to the parties. For example, the panel may close a complaint when it is determined that no violation has occurred or if there is a lack of jurisdiction over the matter.

### **Investigation**

When a case is opened for investigation, a case advisor will be assigned, along with a DLSC investigator, paralegal and attorney. At the conclusion of the investigation, DLSC staff will submit findings of the investigation to the case advisor. If the evidence is insufficient to prove a violation or there are other legal reasons not to pursue prosecution, the case advisor and the DLSC prosecuting attorney will determine the specific basis for closing the case.

### **Legal Action**

If the investigation finds that a violation has occurred, the case advisor and DLSC staff will consider options available to resolve the matter. In some circumstances, the matter may be resolved through non-disciplinary action such as an administrative warning or remedial education. However, if the licensee's misconduct cannot be corrected with a non-disciplinary option, or if the misconduct is common enough that all licensees within the profession must be alerted to its substandard nature, formal discipline may be warranted.

When formal discipline is warranted, the case advisor and DLSC legal staff will determine appropriate discipline and make specific recommendations to the MEB for case resolution. Disciplinary action may be agreed to by the licensee in a stipulation, or, if an agreement cannot be reached, discipline may be pursued through the formal hearing process.

Disciplinary options available to the MEB include:

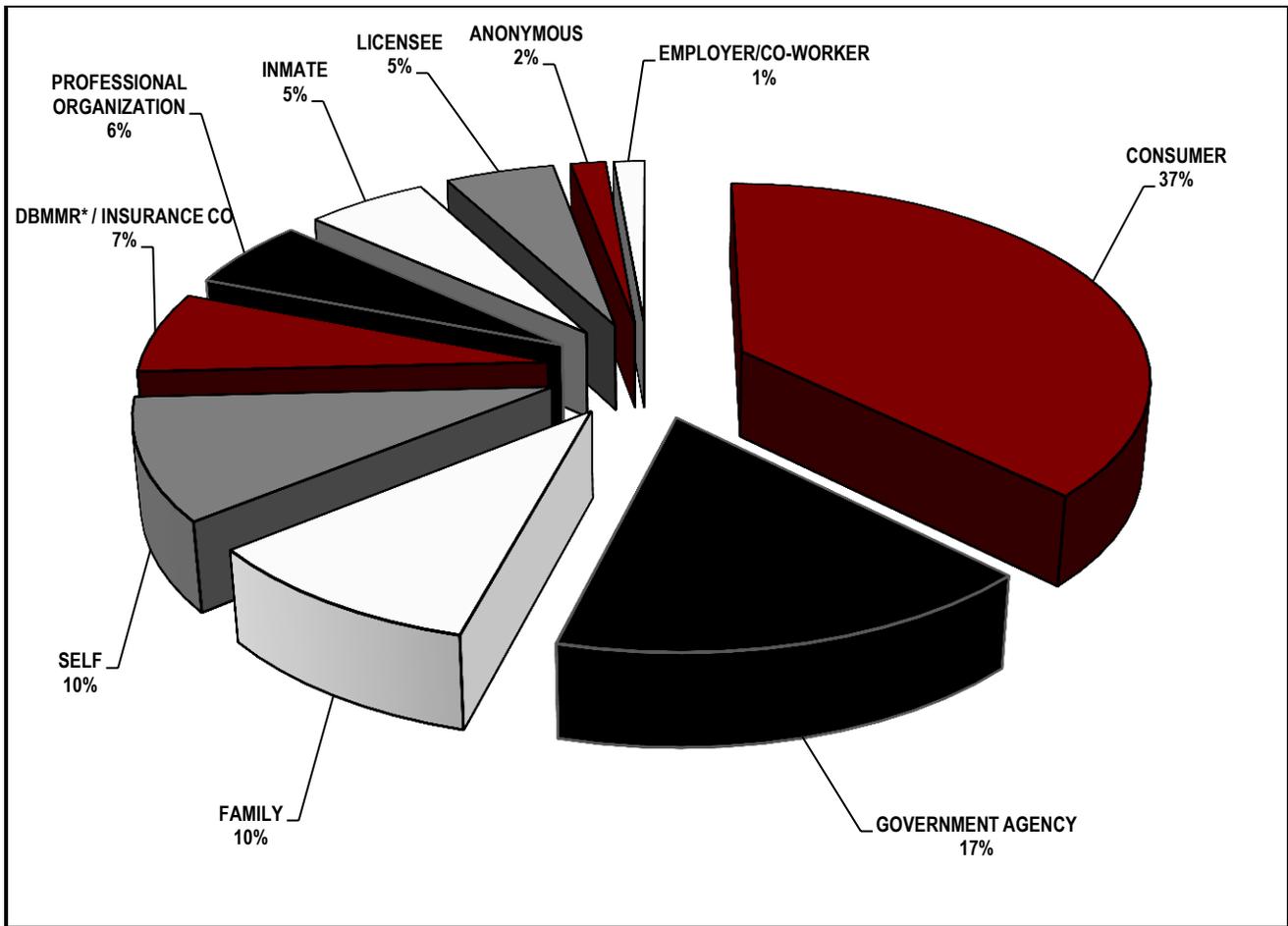
- **Reprimand** – A public warning of the licensee for a violation.
- **Limitation of License** – Imposes conditions and requirements upon the licensee and/or restrictions on the scope of the practice.
- **Suspension** – Completely and absolutely withdraws and withholds for a period of time all rights, privileges and authority previously conferred by the credential.
- **Revocation** – To completely and absolutely terminate the credential and all rights, privileges and authority previously conferred by the credential.

These types of actions are reported to the National Practitioner Databank, commonly known as the NPDB so that other states and jurisdictions may be alerted to the action taken by the Wisconsin MEB against the physician or licensee.

## SOURCES OF COMPLAINTS RECEIVED

Data from January 1, 2015 to December 31, 2015

The MEB received **484** complaints in 2015. There are multiple ways in which the MEB may receive a complaint. Below is a graphical representation of the sources of the complaints received in 2015. It is important to note that a complaint may be received in one year however, due to the nature or course of the investigation, may not be resolved until the subsequent year(s).



\* DBMMR – Data Bank Medical Malpractice Report

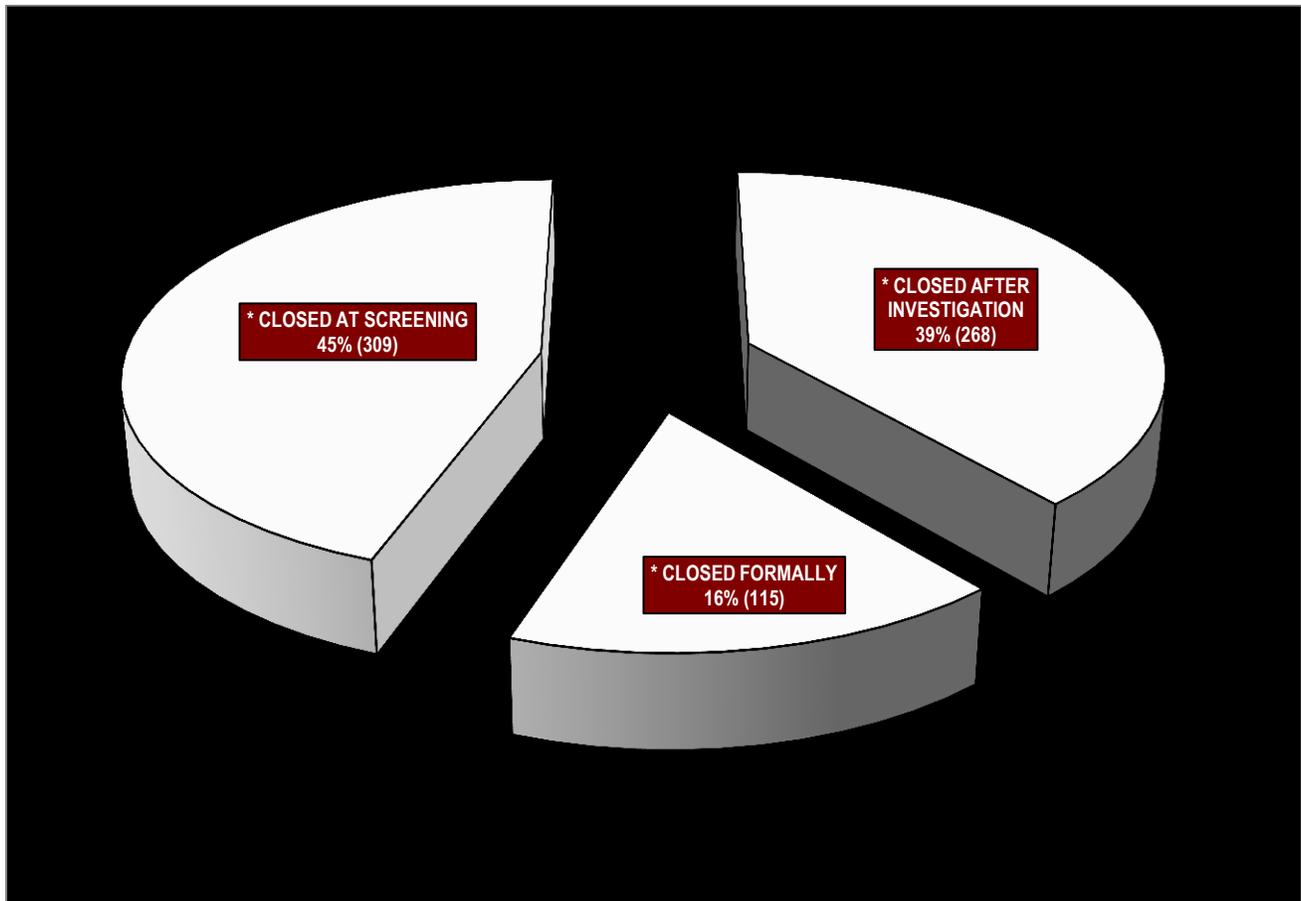
## WHEN ARE COMPLAINTS OR CASES CLOSED?

Data from January 1, 2015 to December 31, 2015

Complaints/cases may be closed in the following ways:

- If the MEB screening panel determines that an investigation is not warranted.
- After investigation if the case advisor, in conjunction with DLSC professionals, determines that the matter does not warrant professional discipline.
- After the board issues a formal disciplinary order.

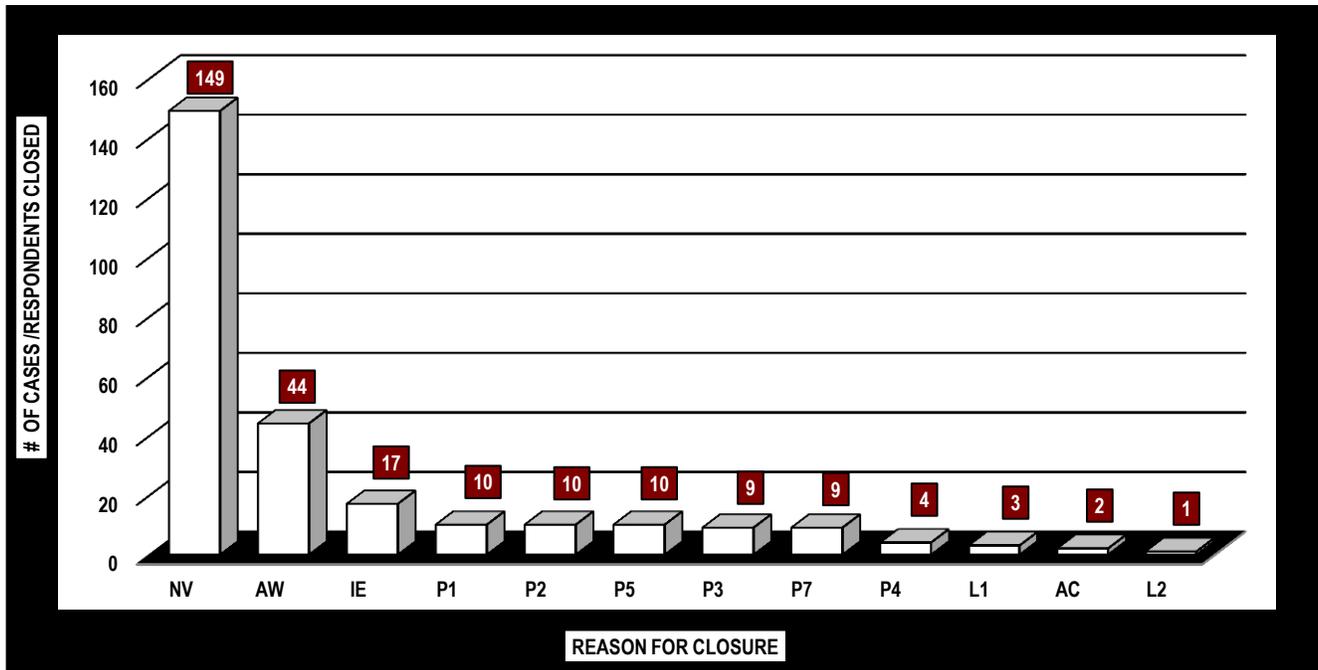
\* The following is a graphical representation of how complaints or cases/respondents were closed in 2015. It is important to note that cases closed in 2015 may have been received in previous years.



## CASES/RESPONDENTS CLOSED AFTER INVESTIGATION

Data from January 1, 2015 to December 31, 2015

**268** cases/respondents were closed after investigation (without formal discipline). There are many reasons a case may not warrant formal discipline. For example, a case may be closed after investigation due to insufficient evidence to prove a violation has occurred. Or, after careful review and deliberation, the MEB may exercise its discretion not to prosecute based on other considerations relating to the case. In order for a case to close after investigation, action must be taken by the MEB. The following summarizes the MEB cases closed after investigation, sorted by reason for closure.



- **NV - NO VIOLATION OF STATUTES OR RULES** - There is sufficient evidence to show that no violation of statutes or rules occurred.
- **AW - ADMINISTRATIVE WARNING** - There was an Administrative Warning issued to the credential holder pursuant to Wis. Stat. § 440.205. Administrative warnings do not constitute an adjudication of guilt or the imposition of discipline and may not be used as evidence that the credential holder is guilty of the alleged misconduct.
- **IE - INSUFFICIENT EVIDENCE FOR PROSECUTION** - There is insufficient evidence to meet the standard of proof required to prove that a violation occurred.
- **P1 - PROSECUTORIAL DISCRETION** - There may have been a minor or technical violation but a decision was made not to commence formal disciplinary action because the incident in question was not seriously harmful to the public.
- **P2 - PROSECUTORIAL DISCRETION** - There may have been a minor or technical violation but a decision was made not to commence formal disciplinary action on the grounds that compliance with statutes or rules has been gained.
- **P5 - PROSECUTORIAL DISCRETION** - There may have been a violation, but because the person or entity in question cannot be located, is no longer actively practicing or does not have a current credential to practice, a decision was made to close the case and place a "FLAG OR HOLD" on the credential in accordance with the Department's "Hold Status and Flagged Credentials" Policy. In the event that the person or entity is located, an application for renewal of the credential is received or the credential is renewed, the case may be re-opened and reconsidered.
- **P3 - PROSECUTORIAL DISCRETION** - There may have been a violation that is more than a minor or technical violation. However, it is not a violation which caused serious harm, and a determination has been made that the expenditure of resources required to pursue the violation would greatly exceed the value to the public of having the matter pursued.
- **P7 - PROSECUTORIAL DISCRETION** - There may have been a violation, but the regulatory authority has taken action in regard to this credential holder that addressed the conduct and further action is unnecessary.
- **P4 - PROSECUTORIAL DISCRETION** - The conduct of the credential holder may constitute negligence but does not constitute practice below the minimal standards of the professions.
- **L1 - LACK OF JURISDICTION** - There is no authority to act regarding the subject matter of the complaint.
- **AC - ADMINISTRATIVE CLOSURE** - There is a duplicate complaint; a file was opened in error; or the Respondent named in the complaint is inaccurately identified.
- **L2 - LACK OF JURISDICTION** - There is authority to act on the subject matter of the complaint, but no authority to act regarding the person or entity in question.

## SUMMARY OF DISCIPLINARY ACTION TAKEN BY THE MEB

Data from January 1, 2015 to December 31, 2015

**115** cases/respondents were resolved through formal closure (board order) in 2015. Although the number may appear small, it often represents the most serious cases that require extensive resources, time and investigation.

The MEB case advisor works with DLSC legal staff to determine the most appropriate discipline based on the violation(s). Considerations in determining discipline include the historical practices of the MEB, prior violations by the licensee, the severity of the conduct (including the risk of potential harm), and the quality of evidence. Discipline is not punitive: actions taken against a license or licensee should be limited to the purposes of public protection, rehabilitation of the licensee, deterrence of the licensee and others from engaging in similar conduct.

The following table represents the types of disciplinary actions and other orders issued in 2015. Please note: The total number of disciplines/outcomes will be higher than the number of cases closed formally as an order may involve multiple discipline/outcomes.

Orders / Disciplinary Action	Number
Reprimand	70
Limitation Requiring Education	26
Surrender – Agreement if Reapply Board May Impose Limitations (No Findings)	16
Limitation – Maintain Compliance With Each Term of Another State Order	11
Surrender – Agreement not to Renew/Permanent Relinquishment (No Findings)	9
Suspension	8
Limitation Restricting Practice	6
Remedial Education (No Findings)	6
Limitation Requiring Treatment	5
Limitation Requiring Reports	5
Limitation Requiring Screens	4
Limitation Requiring Assessment	3
Limitation Requiring Mentor/Supervision/Counselor	3
Surrender – Agreement if Reapply Board May Impose Limitations	2
Suspension (Interim Order)	2
Revocation	2
Suspension (Summary)	1
Limitation Requiring Testing	1
<b>Total</b>	<b>180</b>

**Limitation:** Per Wis. Stat. § 440.01(1)(d), means “to impose conditions and requirements upon the holder of the credential, to restrict the scope of the holder’s practice, or both.”

**Reprimand:** Per Wis. Stat. § 440.01(1)(e), means “to publicly warn the holder of a credential.”

**Revocation:** Per Wis. Stat. § 440.01(1)(f), means “to completely and absolutely terminate the credential and all rights, privileges and authority previously conferred by the credential.”

**Suspension:** Per Wis. Stat. § 440.01(h), means “to completely and absolutely withdraw and withhold for a period of time all rights, privileges and authority previously conferred by the credential.” Licensee may not engage in the practice of the profession during term of suspension.

**Suspension (Summary):** Wis. Admin. Code § SPS 6.01(3) provides that summary suspension may be used when the facts establish “that the respondent has engaged in or is likely to engage in conduct such that the public health, safety or welfare imperatively requires emergency suspension of the respondent’s license.” If summary suspension issued by Board, a formal complaint must be filed shortly thereafter and the hearing must be held promptly, so it is critical that all evidence is ready, including expert testimony if necessary. The Respondent has the right to a Hearing to Show Cause under the provisions of Wis. Admin. Code § SPS 6.09.

**Voluntary Surrender:** A voluntary relinquishment of a credential as a means of resolving the matter.

## OTHER ACTIONS TAKEN

Data from January 1, 2015 to December 31, 2015

The MEB also issues other orders/action subsequent to license application or case closure. These orders include monitoring actions, dismissals, review/rehearing denials, and credentialing actions. Below is a summary of those orders.

Other Orders / Action Issued	Number
Granting Full Licensure	24
Denying Modifications	12
Limitation Requiring Education*	11
Granting Modifications	8
Fixing Costs	4
Denying Request for Full Licensure	3
Approving Partial Modification	3
Granting Permission to Reapply for Licensure	2
Granting Stay of Suspension	2
Limitation Restricting Practice*	2
Limitation Requiring Reports*	1
Limitation Requiring Mentor/Supervision/Counselor*	1
Removing Stay of Suspension	1
Rescind Administrative Warning	1
Deny Request to Vacate Order	1
<b>Total</b>	<b>76</b>

\* Orders granting (original) limited licenses from Division of Professional Credential Processing.

## MONITORING

As part of its role in protecting the public, the MEB enlists the services of DLSC to monitor a licensee's compliance with a Final Decision and Order or Order Granting a Limited License.

Monitoring is housed within the DLSC's Administrative Unit, which consists of an advanced paralegal and two regulatory specialists. Active monitoring requires considerable resources and action by monitoring staff to ensure compliance with orders and decisions. Examples of such requirements include recovery of costs, work reports, drug screenings, and therapy and education requirements.

Below is a list of the types of disciplines/actions that are monitored:

- **Education:** The licensee is required to take continuing education in a specific topic (could be remedial or disciplinary).
- **Exam:** The licensee is required to take and pass an examination.
- **Impairment:** The licensee is suspended for a period (typically five years), with the possibility of a stay of suspension that allows the licensee to practice as long as the licensee remains in compliance with the Order. The licensee must undergo random drug screens, attend AA/NA meetings, enter into treatment, submit self-reports, and arrange for therapy reports and work reports.
- **Limitations:** conditions and requirements upon the holder of the credential, or restrict the scope of the holder's practice, or both.
- **Mentor:** The licensee is required to have a professional mentor who provides practice consultations and evaluations as specified by the Order.
- **Reports:** The licensee is required to have reports submitted by a third-party (therapists, supervisor, probation officer etc.).
- **Revocation:** (where costs are assessed): The licensee must return their license to the Department and is prohibited from practice in the state of Wisconsin. If the credential holder reapplies for licensure, the MEB may grant the license with or without conditions. [Some orders prohibit the licensee from seeking reinstatement/reapplying.]
- **Suspension:** A licensee is suspended from practice for a set period of time or indefinitely. Some suspensions may be stayed under specific conditions.
- **Voluntary Surrender:** (where costs are assessed): The licensee surrenders the registration and/or license. The licensee is prohibited from practice in the state of Wisconsin. If the person reapplies for licensure, the MEB may grant the license with or without conditions. [Some orders prohibit the licensee from seeking reinstatement/reapplying after surrendering.]

Currently (June 2016), **106** medical professionals are actively being monitored as a result of a disciplinary order.

## PROFESSIONAL ASSISTANCE PROCEDURE (PAP)

PAP can be an alternative to the formal disciplinary process for an impaired professional and encourages individuals to seek help for their impairment through a non-disciplinary contract. Currently (June 2016), there are 21 medical professionals enrolled in the PAP.

If an individual is released from PAP for failure to comply with the voluntary requirements of the program, the MEB's PAP Liaison and DLSC's PAP Coordinator may refer the individual to the Board for formal disciplinary action, if appropriate.

More information about this unique program designed to both protect the public and assist impaired professionals may be referenced at Wis. Admin. Code ch. SPS 7.

### Why does the MEB consider PAP an important tool?

- For the majority of chemically dependent professionals, this is an opportunity to seek treatment without losing their professional credentials.
- PAP promotes early identification of chemically dependent professionals and encourages their rehabilitation.
- PAP offers participants an opportunity to obtain treatment for chemical dependency while ensuring that immediate action can be taken should a participant relapse or drop out of treatment. It is important to note that participation in PAP will not exempt the professional from discipline.
- PAP does not provide treatment, but monitors participants' progress in treatment with an approved treatment provider, as well as their random drug and alcohol screens.

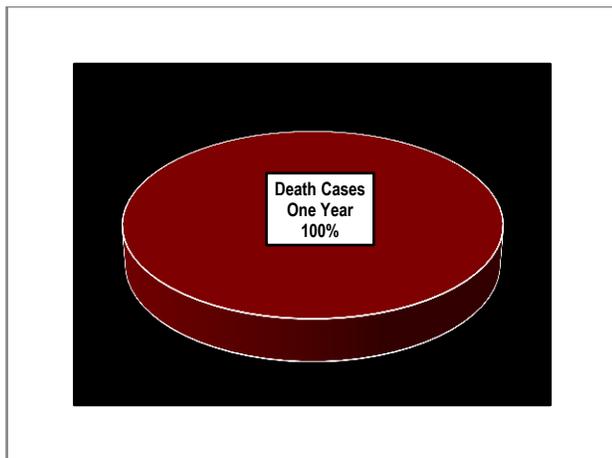
## MEETING STATUTORY DEADLINES

Data from January 1, 2015 to December 31, 2015

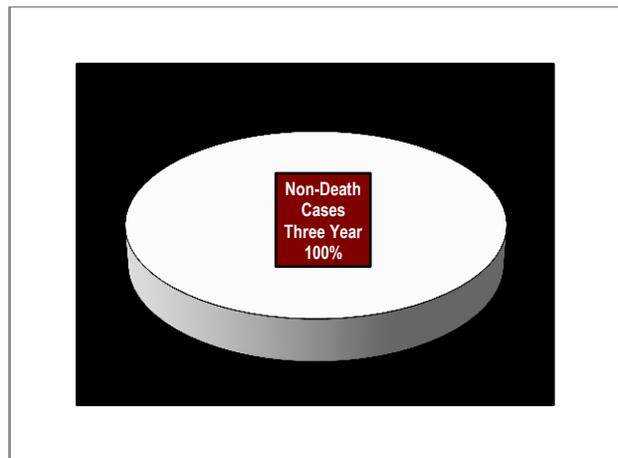
The MEB is required by Wis. Stat. § 448.02(3)(cm) to meet specific timelines for resolution of its cases.<sup>^</sup>

- In cases where the allegations involve the death of a patient, the MEB has one year to resolve the case.
- In all other cases, the MEB has three years to resolve the case.

Based on the analysis of the data, the charts below confirm the board's commitment to meeting the statutory timelines imposed. The MEB is proud of the work accomplished by both its members and DLSC staff in achieving 100% compliance.



Compliance in Cases Involving Allegations of Death



Compliance in All Other Cases

<sup>^</sup>**Wis. Stat. § 448.02(3)(cm)** – The Board may initiate disciplinary action against a physician no later than one year after initiating an investigation of an allegation involving the death of a patient and no later than three years after initiating an investigation of any other allegation, unless the Board shows to the satisfaction of the Secretary that a specified extension of time is necessary for the Board to determine whether a physician is guilty of unprofessional conduct or negligence in treatment.

Date initiating an investigation – Wis. Admin. Code § SPS 2.20(2) Computing Time Limits. In computing time limits under s. 448.02(3)(cm), the date of initiating an investigation shall be the date of the decision to commence an investigation of an informal complaint following the screening of the informal complaint under s. SPS 2.035, except that if the decision to commence an investigation of an informal complaint is made more than 45 days after the date of receipt of the informal complaint in the division, or if no screening of the informal complaint is conducted, the time for initiating an investigation shall commence 45 days after the date of receipt of the informal complaint in the division. The date that the Medical Examining Board initiates a disciplinary action is the date that a disciplinary proceeding is commenced under s. SPS 2.04.

## SUMMARY OF KEY STATISTICS

Data from January 1, 2015 to December 31, 2015

- Complaints Received: **484**
- Of the **484** MEB complaints received in 2015, **270 (56%)** were closed at screening.
- MEB Cases/Respondents Resolved (Closed) – (Cases may have been received in the year 2015 or prior years):
  - Respondents/cases closed formally: **115**
  - Respondents/cases closed after investigation (without a formal order): **268**  
[**44** of the 268 were **administrative warnings**]
  - Respondents/cases closed by the screening panel: **309**
- Most common discipline issued by the MEB: **license limitations** and **reprimands**
- Primary sources of complaints: **consumers** and **government agencies**
- Medical professionals currently monitored with disciplinary orders (active) as of June 2016: **106**
- Medical professionals currently enrolled in the Professional Assistance Procedure (PAP) as of June 2016: **21**
- Compliance with statutory deadlines (death and three year cases): **100%**