



MEDICAL EXAMINING BOARD
Room 121A, 1400 East Washington Avenue, Madison
Contact: Tom Ryan (608) 266-2112
July 15, 2015

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 17, 2015 – Review and Approval (5-11)**
- C) Legislative/Administrative Rule Matters**
 - 1) OT 1, 3, 4 Relating to Self-Referral and Occupational Therapy Services
 - a) **8:00 A.M. - APPEARANCE – Brian Holmquist, Chair of Occupational Therapists Affiliated Credentialing Board (12-29)**
 - 2) Review of Pod 1, 4, and 8 Relating to the Duty to Obtain Informed Consent and Pod 2 Relating to the Overtreatment of Patients **(30-39)**
 - 3) Iowa Telemedicine Rules **(40-45)**
 - 4) Legislative Review for CR15-021 Relating to Entrance Exams **(46-53)**
 - 5) Review of Scope Statement Relating to General Update and Cleanup of Rules **(54-56)**
 - 6) Update on Pending and Possible Rule Projects
- D) Appointments, Reappointments, Confirmations, and Committee Panel and Liaison Appointments**
- E) Administrative Updates**
 - 1) Department and Staff Updates
 - 2) Wis. Stat. s 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
 - 3) Case Status Report on SharePoint **(57)**
 - 4) Informational Items
- F) APPEARANCE – DSPP Prescription Drug Monitoring Program (PDMP) Staff – PDMP Update – Discussion and Consideration (58-63)**
- G) Federation of State Medical Boards (FSMB) Matters**

- H) **Speaking Engagement(s), Travel, or Public Relation Request(s)**
 - 1) **Speaking Request - Wisconsin Association of Osteopathic Physicians and Surgeons (WAOPS) Fall Meeting – September 25-26, 2015 (64)**
- I) Screening Panel Report
- J) Informational Items
- K) Items Added After Preparation of Agenda
 - 1) Introductions, Announcements and Recognition
 - 2) Administrative Updates
 - 3) Education and Examination Matters
 - 4) Credentialing Matters
 - 5) Practice Matters
 - 6) Legislation/Administrative Rule Matters
 - 7) Liaison Report(s)
 - 8) Informational Item(s)
 - 9) Disciplinary Matters
 - 10) Presentations of Petition(s) for Summary Suspension
 - 11) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
 - 12) Presentation of Proposed Decisions
 - 13) Presentation of Interim Order(s)
 - 14) Petitions for Re-Hearing
 - 15) Petitions for Assessments
 - 16) Petitions to Vacate Order(s)
 - 17) Petitions for Designation of Hearing Examiner
 - 18) Requests for Disciplinary Proceeding Presentations
 - 19) Motions
 - 20) Petitions
 - 21) Appearances from Requests Received or Renewed
 - 22) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports
- L) Public Comments
- M) **APPEARANCE – Al Rohmeyer, Administrator and Sarah Norberg, Supervising Attorney, Division of Legal Services and Compliance – Introductions and Q & A (65)**

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.).

- N) **9:45 A.M. - APPEARANCE – Full Board Oral Interview – My-My Huynh, M.D. (66-150)**
- O) **10:00 A.M. - APPEARANCE - Review of Administrative Warning – T.J.O. (WARN00000318) (DLSC case number 14 MED 077) (151-153)**

- P) Complaint(s) for Determination of Probable Cause**
- 1) 13 MED 355 – Rajesh Malhotra, M.D. **(154-156)**
- Q) Deliberation on Administrative Warnings**
- 1) 12 MED 410 and 13 MED 071 – L.C.E. **(157-158)**
 - 2) 14 MED 413 – M.J.E. **(159-160)**
- R) Deliberation on Proposed Stipulations, Final Decisions and Orders by the Division of Legal Services and Compliance (DLSC)**
- 1) 14 MED 012 – Michelle M. Miller, M.D. **(161-166)**
 - 2) 14 MED 297 – Chady Abboud Leon, M.D. **(167-173)**
 - 3) 14 MED 477 – Saad Sabbagh, M.D. **(174-179)**
 - 4) 15 MED 097 – Craig S. Michelsen, M.D. **(180-185)**
- S) Waiver of the 24 Months of ACGME Approved Post-Graduate Training Based on Education and Training**
- 1) Marwan Abdulaal, M.D. **(186-223)**
- T) Case Closing(s)**
- 1) 12 MED 288 **(224-226)**
 - 2) 12 MED 337 **(227-233)**
 - 3) 13 MED 152 **(234-237)**
 - 4) 13 MED 155 **(238-241)**
 - 5) 13 MED 350 **(242-262)**
 - 6) 13 MED 416 **(263-268)**
 - 7) 13 MED 481 **(269-272)**
 - 8) 14 MED 052 **(273-277)**
 - 9) 14 MED 213 **(278-284)**
 - 10) 14 MED 322 **(285-293)**
 - 11) 14 MED 359 **(294-310)**
 - 12) 14 MED 417 **(311-312)**
 - 13) 14 MED 571 **(313-316)**
 - 14) 15 MED 004 **(317-319)**
 - 15) 15 MED 006 **(320-336)**
 - 16) 15 MED 056 **(337-340)**
 - 17) 15 MED 061 **(341-345)**
 - 18) 15 MED 103 **(346-348)**
- U) 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

V) Consulting with Legal Counsel

RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION

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

ADJOURNMENT

**ORAL INTERVIEW OF CANDIDATES FOR LICENSURE
ROOM 124D/E**

11:30 A.M., OR IMMEDIATELY FOLLOWING FULL BOARD MEETING

CLOSED SESSION – Reviewing Applications and Conducting Oral Interviews of Six (6) Candidates for Licensure – Drs. Simons, Ogland Vukich, Vasudevan, Yale.

**MEDICAL EXAMINING BOARD
MEETING MINUTES
June 17, 2015**

PRESENT: Mary Jo Capodice, D.O; Greg Collins; Rodney Erickson, M.D.; Suresh Misra, M.D.; Carolyn Ogland Vukich, M.D.; Michael Phillips, M.D. (*via GoToMeeting; disconnected from the meeting from 9:10a.m.-9:40a.m., 10:31a.m-11:54a.m., and was excused at 11:56 a.m.*); Kenneth Simons, M.D.; Sridhar Vasudevan, M.D.; Timothy Westlake, M.D.; Robert Zondag

EXCUSED: Russell Yale, M.D.

STAFF: Tom Ryan, Executive Director; Nilajah Madison-Head, Bureau Assistant; and other Department staff

CALL TO ORDER

Kenneth Simons, Chair, called the meeting to order at 8:00 a.m. A quorum of ten (10) members was confirmed.

ADOPTION OF AGENDA

MOTION: Suresh Misra moved, seconded by Greg Collins, to adopt the agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES

Amendments to the Minutes:

- *Remove "Excused: James Barr"*

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, to approve the minutes of May 20, 2015 as amended. Motion carried unanimously.

RECOGNITION OF BOARD MEMBERS

APPEARANCE - Dr. Timothy Swan

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, that the Wisconsin Medical Examining Board acknowledges the outstanding service of Dr. Timothy Swan as Vice Chair and member of the Wisconsin Medical Examining Board and in addition wishes him much success in his role as Vice Speaker of the American College of Radiology. Motion carried unanimously.

James Barr

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, that the Wisconsin Medical Examining Board wishes to extend its sincere condolences to the family of the late James Barr and makes known to them that James Barr was held in high regard for his many contributions to the Wisconsin Medical Examining Board during his tenure. Motion carried unanimously.

FEDERATION OF STATE MEDICAL BOARDS (FSMB) MATTERS

Non-Clinical Board Members Workgroup

MOTION: Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to authorize Robert Zondag's participation in the FSMB's Non-Clinical Board Members Workgroup. Motion carried unanimously.

LEGISLATIVE/ADMINISTRATIVE RULE MATTERS

Review and Approval of Med 3, 4, 23 (CR15-022) Relating to Physician Licensure

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, to authorize the Chair to approve the Legislative Report and Draft for Clearinghouse Rule 15-022 as amended, revising Med, 3, 5, 23 relating to physician licensure for submission to the Governor's Office and Legislature. Motion carried unanimously.

Discuss Scope Statement for General Clean-Up of Administrative Rules

MOTION: Sridhar Vasudevan moved, seconded by Rodney Erickson, to request DSPS staff draft a Scope Statement to modernize, update, and clarify rules affecting the Medical Examining Board. Motion carried unanimously.

MOTION: Timothy Westlake moved, seconded by Robert Zondag, to designate Kenneth Simons as the Administrative Rule Coordinator's contact for all matters relating to drafting the Scope statement and rule(s) that follow(s). Motion carried unanimously.

SPEAKING ENGAGEMENT(S), TRAVEL, OR PUBLIC RELATION REQUEST(S)

MOTION: Sridhar Vasudevan moved, seconded by Robert Zondag, to authorize Mary Jo Capodice to attend the AOA and AAOE Annual Conference in Orlando, FL in October 2015 and to appoint her as the Board's delegate. Motion carried unanimously.

(Michael Phillips disconnected and left the meeting at 9:10a.m.)

CLOSED SESSION

MOTION: Sridhar Vasudevan moved, seconded by Greg Collins, 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; Kenneth Simons – yes; Sridhar Vasudevan – yes; Timothy Westlake – yes; and Robert Zondag – yes. Motion carried unanimously.

The Board convened into Closed Session at 9:13 a.m.

RECONVENE TO OPEN SESSION

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to reconvene in Open Session at 11:51 a.m. Motion carried unanimously.

(Michael Phillips rejoined the meeting at 11:54 a.m.)

VOTE ON ITEMS CONSIDERED OR DELIBERATED UPON IN CLOSED SESSION, IF VOTING IS APPROPRIATE

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

COMPLAINT(S) FOR DETERMINATION OF PROBABLE CAUSE

12 MED 289 – Levi C. Leong, M.D.

MOTION: Carolyn Ogland Vukich moved, seconded by Robert Zondag, to find probable cause to believe that Levi C. Leong, M.D., DLSC case number 12 MED 289, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried. Recused: Mary Jo Capodice.

(Mary Jo Capodice recused herself and left the room for deliberation, and voting in the matter concerning Levi C. Leong, M.D., Respondent – DLSC case number 12 MED 289.)

13 MED 187 – Vance Masci, M.D.

MOTION: Suresh Misra moved, seconded by Timothy Westlake, to find probable cause to believe that Vance Masci, M.D., DLSC case number 13 MED 187, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried. Recused: Mary Jo Capodice, Sridhar Vasudevan, and Rodney Erickson.

(Mary Jo Capodice, Sridhar Vasudevan and Rodney Erickson recused themselves and left the room for deliberation, and voting in the matter concerning Vance Masci, M.D., Respondent – DLSC case number 13 MED 187.)

15 MED 025 – Roger Pellmann, M.D.

MOTION: Mary Jo Capodice moved, seconded by Suresh Misra, to find probable cause to believe that Roger Pellmann, M.D., DLSC case number 15 MED 025, has committed unprofessional conduct, and therefore to issue the Complaint and hold a hearing on such conduct pursuant to Wis. Stat. § 448.02(3)(b). Motion carried. Recused: Kenneth Simons.

(Kenneth Simons recused himself and left the room for deliberation, and voting in the matter concerning Roger Pellmann, M.D., Respondent – DLSC case number 15 MED 025.)

REVIEW OF ADMINISTRATIVE WARNING(S)

APPEARANCE – D.G.(WARN00000320)(DLSC case number 14 MED 368)

MOTION: Rodney Erickson moved, seconded by Robert Zondag, to affirm the Administrative Warning in the matter of DLSC case number 14 MED 368 (D.G.). Motion carried. Sridhar Vasudevan opposed.

FULL BOARD ORAL INTERVIEW

(Michael Phillips rejoined the meeting at 9:40 a.m.)

APPEARANCE - Kevin Clark, M.D.

MOTION: Carolyn Ogland Vukich moved, seconded by Robert Zondag, to grant the application of Kevin Clark, M.D., for license to practice medicine and surgery, once all requirements are met. Motion carried unanimously.

REQUEST FOR EQUIVALENCY REVIEW OF 24 MONTHS OF ACGME APPROVED POST-GRADUATE TRAINING BASED ON EDUCATION AND TRAINING

Marwan Abdulaal, M.D.

MOTION: Sridhar Vasudevan moved, seconded by Carolyn Ogland Vukich, to defer the matter of Marwan Abdulaal, M.D. to gather further information. Motion carried unanimously.

(Michael Phillips disconnected and left the meeting at 10:31a.m.)

DELIBERATION ON ADMINISTRATIVE WARNINGS

13 MED 525 – S.L.F.

MOTION: Carolyn Ogland Vukich moved, seconded by Suresh Misra, to issue an Administrative Warning in the matter of DLSC case number 13 MED 525 (S.L.F.). Motion carried unanimously.

14 MED 365 – W.G.D.

MOTION: Suresh Misra moved, seconded by Rodney Erickson, to issue an Administrative Warning in the matter of DLSC case number 14 MED 365 (W.G.D.). Motion carried unanimously.

15 MED 001 – N.W.

MOTION: Carolyn Ogland Vukich moved, seconded by Suresh Misra, to issue an Administrative Warning in the matter of DLSC case number 15 MED 001 (N.W.). Motion carried unanimously.

15 MED 007 – S.M.K.

MOTION: Mary Jo Capodice moved, seconded by Rodney Erickson, to issue an Administrative Warning in the matter of DLSC case number 15 MED 007 (S.M.K.). Motion carried unanimously.

15 MED 031 – P.L.V.

MOTION: Rodney Erickson moved, seconded by Carolyn Ogland Vukich, to issue an Administrative Warning in the matter of DLSC case number 15 MED 031 (P.L.V.). Motion carried unanimously.

15 MED 096 – R.P.M.

MOTION: Sridhar Vasudevan moved, seconded by Suresh Misra, to issue an Administrative Warning in the matter of DLSC case number 15 MED 096 (R.P.M.). Motion carried unanimously.

**DELIBERATION ON PROPOSED STIPULATIONS, FINAL DECISIONS AND ORDERS BY THE
DIVISION OF LEGAL SERVICES AND COMPLIANCE (DLSC)**

12 MED 381 – David J. Drake, M.D.

MOTION: Timothy Westlake moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against David J. Drake, M.D., DLSC case number 12 MED 381. Motion carried unanimously.

13 MED 145 – Lorne P. Schlecht, M.D.

MOTION: Greg Collins moved, seconded by Timothy Westlake, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Lorne P. Schlecht, M.D., DLSC case number 13 MED 145. Motion carried unanimously.

13 MED 510 – Eileen S. Gavin, M.D.

MOTION: Timothy Westlake moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Eileen S. Gavin, M.D., DLSC case number 13 MED 510. Motion carried unanimously.

14 MED 041 – Carl R. Sunby, M.D.

MOTION: Greg Collins moved, seconded by Timothy Westlake, to reject the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Carl R. Sunby, M.D., DLSC case number 14 MED 041. Motion carried. Recused: Carolyn Ogland Vukich.

(Carolyn Ogland Vukich recused herself and left the room for deliberation, and voting in the matter concerning Carl R. Sunby, M.D., Respondent – DLSC case number 14 MED 041.)

14 MED 131 – Steven D. Nichols, M.D.

MOTION: Suresh Misra moved, seconded by Robert Zondag, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Steven D. Nichols, M.D., DLSC case number 14 MED 131. Motion carried unanimously.

14 MED 266 – Jon A. Cafaro, M.D.

MOTION: Timothy Westlake moved, seconded by Greg Collins, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Jon A. Cafaro, M.D., DLSC case number 14 MED 266. Motion carried unanimously.

14 MED 468 – Norman C. Reynolds, Jr., M.D.

MOTION: Timothy Westlake moved, seconded by Suresh Misra, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Norman C. Reynolds, Jr., M.D., DLSC case number 14 MED 468. Motion carried unanimously.

14 MED 496 – Vikram Gunnala, M.D.

MOTION: Timothy Westlake moved, seconded by Robert Zondag, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Vikram Gunnala, M.D., DLSC case number 14 MED 496. Motion carried unanimously.

MONITORING MATTERS

Ronald Rubin, M.D. – Requesting to be Allowed to Provide Patient Care

MOTION: Robert Zondag moved, seconded by Suresh Misra, to deny the request of Ronald Rubin, M.D. to be allowed to provide patient care. **Reason for Denial:** Respondent did not obtain an AODA assessment by a pre-approved AODA assessor at a facility acceptable to the Board. Motion carried unanimously.

Farid Ahmad, M. D. – Requesting Full Unlimited License

MOTION: Robert Zondag moved, seconded by Timothy Westlake, to deny the request of Farid Ahmad, M.D. for full licensure. **Reason for Denial:** Respondent's request is denied because he did not comply with Page 2, paragraph 2(a-d) of the Order. The Respondent did not demonstrate successful completion of all CPEP recommendations. Motion carried unanimously.

CASE CLOSING(S)

MOTION: Robert Zondag moved, seconded by Sridhar Vasudevan, to close the following cases according to the recommendations by the Division of Legal Services and Compliance:

1. 13 MED 316 (S.J.W.) – No Violation (NV)
2. 13 MED 353 (S.S.D.) – No Violation (NV)
3. 13 MED 536 (T.E.) – Insufficient Evidence (IE)
4. 14 MED 046 (K.F.Q.) – No Violation (NV)
5. 14 MED 190 (M.D.P.) – Insufficient Evidence (IE)
6. 14 MED 197 (R.B.) – No Violation (NV)
7. 14 MED 262 (A.E.U.) – No Violation (NV)
8. 14 MED 283 (R.L.A.) – Prosecutorial Discretion (P1)
9. 14 MED 357 (J.A.) – Prosecutorial Discretion (P1)
10. 14 MED 445 (H.K.L.) – No Violation (NV)
11. 14 MED 598 (G.F.B.) – No Violation (NV)
12. 15 MED 016 (L.A.H.) – No Violation (NV)
13. 15 MED 048 (E.N.W.) – Prosecutorial Discretion (P3)
14. 15 MED 054 (A.R.D.) – Prosecutorial Discretion (P3)
15. 15 MED 063 (M.L.A.) – No Violation (NV)
16. 15 MED 070 (P.G.C.) – No Violation (NV)

Motion carried unanimously.

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

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

(Michael Phillips was excused from the meeting 11:56 a.m.)

2014 MEDICAL EXAMINING BOARD ANNUAL REPORT

MOTION: Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to designate Robert Zondag to advise DSPS Staff regarding changes to the 2014 Medical examining Board Annual Report and to approve the final report. Motion carried unanimously.

ADJOURNMENT

MOTION: Suresh Misra moved, seconded by Mary Jo Capodice, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 12:09 p.m.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Taylor Thompson, Bureau Assistant on behalf of Tom Ryan, Executive Director		2) Date When Request Submitted: 4/23/15 Items will be considered late if submitted after 12:00 p.m. on the deadline date: ▪ 8 business days before the meeting	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 6/17/15	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? OT 1, 3, 4 Relating to Self-Referral of Occupational Therapy Services 8:00 AM - APPEARANCE - Brian Holmquist, Chair of Occupational Therapists Affiliated Credentialing Board	
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 checked="" type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:			
11) Authorization			
Taylor Thompson		4/23/15	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN
OCCUPATIONAL THERAPISTS
AFFILIATED CREDENTIALING BOARD

IN THE MATTER OF RULE-MAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	OCCUPATIONAL THERAPISTS
OCCUPATIONAL THERAPISTS	:	AFFILIATED CREDENTIALING
AFFILIATED CREDENTIALING	:	BOARD
BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE)

PROPOSED ORDER

An order of the Occupational Therapists Affiliated Credentialing Board to repeal OT 1.02 (17), 4.03 (2) (a), and 4.03 (2) (c) and (d); to amend OT 3.05 (title) and (intro.), 3.05 (2), 4.02 (2) (f), 4.03 (2) (title), 4.03 (2) (b), 4.03 (3) (a), and 4.03 (3) (f); to create OT 3.05 (1) (title) and 3.05 (3) relating to self-referral of occupational therapy services.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Section 448.965, Stats.

Statutory authority:

Sections 15.085 (5) (b), 227.11 (2) (a), 440.08 (3) (b), 448.965 (1) (c), Wisconsin Statutes.

Explanation of agency authority:

Section 15.085 (5) (b), Stats., provides that affiliated credentialing boards such as the Occupational Therapists 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 to occupational therapists regarding the topic of who may refer occupational therapy services.

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 440.08 (3) (b), Stats., provides that affiliated credentialing boards such as the Occupational Therapists Affiliated Credentialing Board, “[...] may promulgate rules

requiring the holder of a credential who fails to renew the credential within 5 years after its renewal date to complete requirements in order to restore the credential, in addition to the applicable requirements for renewal established under chs. 440 to 480, that the [...] affiliated credentialing board determines are necessary to protect the public health, safety, or welfare.”

Section 448.965 (1) (c), Stats., provides that the affiliated credentialing board shall promulgate rules that establish, “[s]tandards of practice for occupational therapy, including a code of ethics and criteria for referral.”

Related statute or rule:

None.

Plain language analysis:

Under the current administrative rules, an occupational therapist may receive an order or a referral to perform occupational therapy services for a patient. Orders identify the need for occupational therapy evaluation and intervention while a referral is the act of requesting occupational therapy services. Currently, physicians, dentists, or podiatrists may order occupational therapy evaluation. However, occupational therapists may accept referrals from a variety of health care professionals including advanced practice nurses, chiropractors, optometrists, physical therapists, and physician assistants (Wisconsin Administrative Code OT 4.03 (2) (b)). Furthermore, there are some services that occupational therapists can perform without the need of a referral such as consultation, habilitation, screening, client education, wellness, prevention, environmental assessments, and work-related ergonomic services. According to Wisconsin Administrative Code OT 4.03 (2) (e), neither an order nor a referral from a physician is required for evaluation or intervention if the occupational therapy services are provided in an educational environment, including in a child’s home if the child has disabilities.

The proposed rule seeks to clarify that occupational therapists are able to self-refer occupational therapy services along with the host of other health care professionals that are listed above. Currently, the rule allows other health care professionals to refer occupational therapy services. However, the current rule does not specifically state that occupational therapists are allowed to self-refer. The self-referral of occupational therapy services would allow patients greater access to health care and would alleviate the burden on occupational therapists of relying on receiving orders and referrals from other health care professionals in order to provide health care services. The proposed rule will also remove all references to orders received by health care professionals as this is outdated terminology that no longer reflects current practices.

The proposed rule will also provide clarity to the process of renewing a license after 5 years by updating provisions regarding late renewal and reinstatement. The term reinstatement will be defined as the process by which a licensee whose license has been

surrendered or revoked or who holds a license with unmet disciplinary requirements that has not been renewed within five years of the renewal date may apply to have that license reinstated with or without conditions.

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

None.

Comparison with rules in adjacent states:

Illinois: Illinois state statute provides that the implementation of direct occupational therapy treatment shall be based upon a referral from a licensed physician, dentist, podiatric physician, advanced practice nurse (who has a written collaborative agreement with a collaborating physician to provide or accept referrals from licensed occupational therapists), physician assistant (who has been delegated authority to provide or accept referrals from or to licensed occupational therapists), or optometrist (225 ILCS 75/3.1). An occupational therapist may consult with, educate, evaluate, and monitor services for individuals groups, and populations concerning occupational therapy needs without referral. A referral is not required for providing consultation, habilitation, screening, education, wellness, prevention, environmental assessments, and work-related ergonomic services to individuals, groups, or populations. Referral from a physician or other health care provider is not required for evaluation or intervention for children and youths if an occupational therapist or occupational therapy assistant provides services in a school-based or educational environment, including the child's home (225 ILCS 75/3.1).

Illinois administrative code provides that an occupational therapist seeking to restore a license that has expired or been placed on inactive status for 5 years must demonstrate completion of 24 hours of continuing education within 24 months prior to the restoration and one of the following: (1) Sworn evidence of active practice in another jurisdiction; (2) An affidavit attesting to military service; (3) Verification of successful completion of the Certification Examination of the NBCOT for licensure as a registered occupational therapist or certified occupational therapy assistant within the last 5 years prior to applying for restoration; or (4) Evidence of successful completion of 48 hours of continuing education in occupational therapy, including attendance at college level courses, professionally oriented continuing education classes, special seminars, or any other similar program completed within 2 years prior to application for restoration (68 Ill. Admin. Code pt. 1315.160).

Iowa: Iowa statutes provide that occupational therapy may be provided by an occupational therapist without referral from a physician, podiatric physician, dentist, or chiropractor, except that a hospital may require that occupational therapy services provided in the hospital be performed only following prior review by and authorization of the performance of the occupational therapy services by a member of the hospital medical staff (Iowa Code s. 148B.3A).

Iowa administrative code provides that an occupational therapist seeking to reactivate a license that has been inactive for 5 years or less must provide verification of the license(s) from every jurisdiction in which the applicant is or has been practicing during the time period the Iowa license was inactive and verification of 15 hours of continuing education for an occupational therapy assistant and 30 hours of continuing education for an occupational therapist within two years of application for reactivation. If the license has been on inactive status for more than five years, an applicant must provide verification of the license(s) from every jurisdiction in which the applicant is or has been practicing during the time period the Iowa license was inactive and verification of completion of 30 hours of continuing education for an occupational therapy assistant and 60 hours of continuing education for an occupational therapist within two years of application for reactivation; or evidence of successful completion of the professional examination required for initial licensure completed within one year prior to the submission of an application for reactivation (Iowa Admin. Code r. 645 – 206.11). 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 (Iowa Admin. Code r. 645 – 206.11 and Iowa Admin. Code r. 645 – 11.31).

Michigan: Michigan statutes and administrative code are silent with regards to required orders or referrals from other healthcare providers. An applicant whose license has lapsed for 3 years or more may be relicensed by meeting the following: (1) Passing the examination on state laws and rules related to the practice of occupational therapy; (2) Completing supervised practice experience requirements; (3) Verifying any license or registration from another state that was held while the license was lapsed; and (4) Either completing the NBCOT's certification examination for occupational therapists or presenting evidence that he or she was registered or licensed as an occupational therapist in another state during the 3-year period immediately preceding the application for relicensure (Mich. Admin. Code R. 338.1227).

Minnesota: Minnesota statutes do not require referral from a healthcare provider, however, in the absence of a physician referral or prior authorization, an occupational therapist must provide the following written notification: "Your health care provider, insurer, or plan may require a physician referral or prior authorization and you may be obligated for partial or full payment for occupational therapy services rendered." (Minn. Stat. s. 148.6438).

Summary of factual data and analytical methodologies:

The Board received input from the Wisconsin Occupational Therapy Association. Adjacent states’ administrative rules were reviewed. No other factual data or analytical methodologies were used.

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 are attached.

Effect on small business:

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

Agency contact person:

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

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

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

TEXT OF RULE

SECTION 1. OT 1.02 (17) is repealed.

SECTION 2. OT 3.05 (title) and (intro.) are amended to read:

~~OT 3.05 Failure to be registered~~ Late renewal and reinstatement. Failure to be registered. Failure to renew a license by June 1 of an odd numbered year shall cause the license to ~~lapse~~ expire. A licensee who allows the license to ~~lapse~~ expire may apply to the board for late renewal or reinstatement of the license as follows by completing one of the following:

SECTION 3. OT 3.05 (1) (title) is created to read:

OT 3.05 (1) LATE RENEWAL BEFORE 5 YEARS.

SECTION 4. OT 3.05 (2) is amended to read:

OT 3.05 (2) LATE RENEWAL AFTER 5 YEARS. If the licensee applies for renewal of the license more than 5 years after its expiration, the board shall make such inquiry as it finds necessary 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 section 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 5. OT 3.05 (3) is created to read:

OT 3.05 (3) REINSTATEMENT. A licensee who has unmet disciplinary requirements and failed to renew within 5 years of the renewal date or whose license has been surrendered or revoked, may apply to have the license reinstated in accordance with all of the following:

- (a) Evidence of the completion of the requirements under sub. (2).
- (b) Evidence of completion of disciplinary requirements, if applicable.
- (c) Evidence of rehabilitation or change in circumstances warranting reinstatement of the license.

SECTION 6. OT 4.02 (2) (f) is amended to read:

OT 4.02 (2) (f) Application of physical agent modalities ~~based on a physician order as an adjunct to or in preparation for engagement in treatment.~~ Application is performed by an experienced therapist with demonstrated and documented evidence of theoretical background, technical skill and competence

SECTION 7. OT 4.03 (2) (title) is amended to read:

OT 4.03 (2) REFERRALS AND ORDERS.

SECTION 8. OT 4.03 (2) (a) is repealed.

SECTION 9. OT 4.03 (2) (b) is amended to read:

OT 4.03 (2) (b) Referrals may be accepted from advanced practice nurses, chiropractors, dentists, optometrists, physical therapists, physicians, physician assistants, podiatrists, psychologists, or other health care professionals.

SECTION 10. OT 4.03 (2) (c) and (d) are repealed.

SECTION 11. OT 4.03 (3) (a) is amended to read:

OT 4.03 (3) (a) The occupational therapist directs the evaluation process upon receiving ~~an order or~~ a referral from another health care professional. An occupational therapist alone or in collaboration with the occupational therapy assistant shall prepare an occupational therapy evaluation for each individual ordered for occupational therapy services. The occupational therapist interprets the information gathered in the evaluation process.

SECTION 12. OT 4.03 (3) (f) is amended to read:

OT 4.03 (3) (f) Evaluation results shall be communicated to the ~~ordering~~ referring health care professional and to the appropriate persons in the facility and community

SECTION 13. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Occupational Therapists
Affiliated Credentialing Board

Chapter OT 4

PRACTICE AND SUPERVISION

OT 4.01 Authority and purpose.
 OT 4.02 Scope of practice.
 OT 4.03 Standards of practice.

OT 4.04 Supervision and practice of occupational therapy assistants.
 OT 4.05 Supervision of non-licensed personnel and therapy aides.

OT 4.01 Authority and purpose. The rules in this chapter are adopted by the board under the authority of ss. 15.085 (5) (b), 227.11 (2) and 448.965, Stats., to govern the standards of practice and supervision requirements for occupational therapists and occupational therapy assistants.

History: CR 02-026: cr. Register December 2002 No. 564, eff. 1-1-03.

OT 4.02 Scope of practice. (1) “Occupational therapy,” as defined at s. 448.96 (5), Stats., may include the following interventions:

(a) Remediation or restitution of performance abilities that are limited due to impairment in biological, physiological, psychological or neurological processes.

(b) Adaptation of task, process or environment, or the teaching of compensatory techniques, in order to enhance performance.

(c) Disability prevention methods and techniques which facilitate the development or safe application of performance skills.

(d) Health promotion strategies and practices which enhance performance abilities.

(2) Occupational therapy interventions include the following:

Note: A comprehensive list of occupational therapy interventions can be found in the Model Practice Act of the American Occupational Therapy Association (AOTA). The AOTA may be contacted on the web at www.aota.org or by mail at American occupational therapy association, P.O. Box 31220, Bethesda, MD 20824-1220.

(a) Screening, evaluating, developing, improving, sustaining, or restoring skills in activities of daily living, work or productive activities, instrumental activities of daily living, play, leisure activities, rest and sleep, education and social participation.

(b) Evaluating, developing, remediating, or restoring sensorimotor, sensoriperceptual neuromusculoskeletal, emotional regulation, cognition, communication, social skills, or psychosocial components of performance.

(c) Designing, fabricating or training in the use of assistive technology, upper extremity orthotic devices and lower extremity positioning orthotic devices.

(d) Training in the use of prosthetic devices, excluding gait training.

(e) Adaptation of environments and processes, including the application of ergonomic principles, to enhance performance and safety in daily life roles.

(f) Application of physical agent modalities based on a physician order as an adjunct to or in preparation for engagement in treatment. Application is performed by an experienced therapist with demonstrated and documented evidence of theoretical background, technical skill and competence.

Note: An example of standards for evaluating theoretical background, technical skill and competence is the position paper on physical agent modalities issued by the American occupational therapy association (AOTA). AOTA may be contacted on the web at www.aota.org, and by mail at American Occupational Therapy Association, P.O. Box 31220, Bethesda, MD 20824-1220.

(g) Evaluating and providing intervention and case management in collaboration with the client, family, caregiver or other involved individuals or professionals.

(h) Educating the client, family, caregiver, or others in carrying out appropriate nonskilled interventions.

(i) Consulting with groups, programs, organizations, or communities to provide population-based services.

(j) Therapeutic use of occupations, exercises, and activities.

(k) Training in self-care, self-management, health management and maintenance, home management, community work reintegration, and school activities and work performance.

(L) Therapeutic use of self, including one’s personality, insights, perceptions and judgments, as part of the therapeutic process.

(m) Assessment, recommendation, and training in techniques to enhance functional mobility, including management of wheelchair and other mobility devices.

(n) Vision and low vision rehabilitation.

(o) Driver rehabilitation and community mobility.

(p) Management of feeding, eating, and swallowing to enable eating and feeding performance.

(q) Facilitating the occupational performance of groups, populations, or organizations through the modification of environments and adaptation processes.

(r) Use of a range of specific therapeutic procedures, including wound care management; techniques to enhance sensory, perceptual, and cognitive processing; and pain management, lymphedema management, and manual therapy techniques, to enhance performance skills.

History: CR 02-026: cr. Register December 2002 No. 564, eff. 1-1-03; CR 13-109: am. (2) (intro.), (a), (b), cr. (2) (j) to (r) Register September 2014 No. 705 eff. 10-1-14.

OT 4.03 Standards of practice. Occupational therapists and occupational therapy assistants shall adhere to the minimum standards of practice of occupational therapy that have become established in the profession, including but not limited to the following areas:

(1) SCREENING. (a) An occupational therapist, alone or in collaboration with an occupational therapy assistant, when practicing either independently or as a member of a treatment team, shall identify individuals who present deficits or declines in performance of their occupations including occupational performance skills and performance patterns.

(b) Screening methods shall take into consideration the occupational performance contexts relevant to the individual.

(c) Screening methods may include interviews, observations, testing and records review to determine the need for further evaluation and intervention.

(d) The occupational therapist or occupational therapy assistant shall transmit screening results and recommendations to all appropriate persons.

(2) REFERRALS AND ORDERS. (a) Evaluation, rehabilitation treatment, and implementation of treatment with individuals with specific medical conditions shall be based on an order from a physician, dentist, podiatrist, or any other qualified health care professional.

(b) Referrals may be accepted from advanced practice nurses, chiropractors, optometrists, physical therapists, physician assistants, psychologists, or other health care professionals.

(c) Although an order is not required, an occupational therapist or occupational therapy assistant may accept a referral for the purpose of providing services which include consultation, habilita-

tion, screening, client education, wellness, prevention, environmental assessments, and work-related ergonomic services.

(d) Orders shall be in writing. However, verbal orders may be accepted if they are followed by a written and signed order by the ordering professional within 3 days from the date on which the client consults with the occupational therapist or occupational therapy assistant.

(e) Orders or referrals from another health care professional are not required for evaluation or intervention if an occupational therapist or occupational therapy assistant provides services in an educational environment, including the child's home, for children and youth with disabilities pursuant to rules promulgated by the federal individuals with disabilities education act, the department of public instruction and the department of health services, or provides services in an educational environment for children and youth with disabilities pursuant to the code of federal regulations.

(3) EVALUATION. (a) The occupational therapist directs the evaluation process upon receiving an order or referral from another health care professional. An occupational therapist alone or in collaboration with the occupational therapy assistant shall prepare an occupational therapy evaluation for each individual ordered for occupational therapy services. The occupational therapist interprets the information gathered in the evaluation process.

(b) The evaluation shall consider the individual's medical, vocational, social, educational, family status, and personal and family goals, and shall include an assessment of how performance skills, and performance patterns and their contexts and environments influence the individual's functional abilities and deficits in the performance of their occupations.

(c) Evaluation methods may include observation, interviews, records review, and the use of structured or standardized evaluative tools or techniques.

(d) When standardized evaluation tools are used, the tests shall have normative data for the individual's characteristics. If normative data are not available, the results shall be expressed in a descriptive report. Collected evaluation data shall be analyzed and summarized to indicate the individual's current status.

(e) Evaluation results shall be documented in the individual's record and shall indicate the specific evaluation tools and methods used.

(f) Evaluation results shall be communicated to the ordering professional and to the appropriate persons in the facility and community.

(g) If the results of the evaluation indicate areas that require intervention by other health care professionals, the individual shall be appropriately referred or an appropriate consultation shall be requested.

(h) Initial evaluation shall be completed and results documented within the time frames established by the applicable facility, community, regulatory, or funding body.

(4) PROGRAM PLANNING. (a) The occupational therapist is responsible for the development of the occupational therapy intervention plan. The occupational therapist develops the plan collaboratively with the client, and may include the occupational therapy assistant and team working with the client, including the physician — as indicated.

(b) The program shall be stated in measurable and reasonable terms appropriate to the individual's needs, functional goals and prognosis and shall identify short and long term goals.

(c) The program shall be consistent with current principles and concepts of occupational therapy theory and practice.

(d) In developing the program, the occupational therapist alone or in collaboration with the occupational therapy assistant shall also collaborate, as appropriate, with the individual, family, other health care professionals and community resources; shall select the media, methods, environment, and personnel needed to

accomplish the goals; and shall determine the frequency and duration of occupational therapy interventions provided.

(e) The program shall be prepared and documented within the time frames established by the applicable facility, community, regulatory, or funding body.

(5) PROGRAM IMPLEMENTATION. (a) The occupational therapy program shall be implemented according to the program plan previously developed. The occupational therapist may delegate aspects of intervention to the occupational therapy assistant dependent on the occupational therapy assistant's demonstrated and documented service competency.

(b) The individual's occupations, occupational performance, skills, occupational performance patterns, and occupational performance contexts and environments shall be routinely and systematically evaluated and documented.

(c) Program modifications shall be formulated and implemented consistent with the changes in the individual's occupational performance skills, occupational performance patterns and occupational performance contexts and environments.

(d) All aspects of the occupational therapy program shall be routinely and systematically reviewed for effectiveness and efficacy.

(6) DISCONTINUATION OF SERVICES. (a) Occupational therapy services shall be discontinued when the individual has achieved the program goals or has achieved maximum benefit from occupational therapy.

(b) A comparison of the initial and current state of functional abilities and deficits in occupational performance skills, and occupational performance patterns, affecting performance in the individual's occupations shall be made and documented.

(c) A discharge plan shall be prepared, consistent with the interventions provided, the individual's goals, and the expected prognosis. Consideration shall be given to the individual's occupational performance contexts and environments including appropriate community resources for referral, and environmental factors or barriers that may need modification.

(d) Sufficient time shall be allowed for the coordination and effective implementation of the discharge plan.

(e) Recommendations for follow-up or reevaluation shall be documented.

History: CR 02-026: cr. Register December 2002 No. 564, eff. 1-1-03; correction in (2) (e) made under s. 13.92 (4) (b) 6., Stats., Register November 2011 No. 671; CR 13-109: am. (1) (a), (2) (title), (a), (c) to (e), (3) (a), (b), (f), (4) (d), (5) (b), (c), (6) (b), (c) Register September 2014 No. 705, eff. 10-1-14.

OT 4.04 Supervision and practice of occupational therapy assistants.

(1) An occupational therapy assistant must practice under the supervision of an occupational therapist. Supervision is an interactive process that requires both the occupational therapist and the occupational therapy assistant to share responsibility for communication between the supervisor and the supervisee. The occupational therapist is responsible for the overall delivery of occupational therapy services and shall determine which occupational therapy services to delegate to the occupational therapy assistant or non-licensed personnel based on the establishment of service competence between supervisor and supervisee, and is accountable for the safety and effectiveness of the services provided.

(2) Supervision of an occupational therapy assistant by an occupational therapist shall be either close or general. The supervising occupational therapist shall have responsibility for the outcome of the performed service.

(3) When close supervision is required, the supervising occupational therapist shall have daily contact on the premises with the occupational therapy assistant. The occupational therapist shall provide direction in developing the plan of treatment and shall periodically inspect the actual implementation of the plan. The occupational therapist shall cosign evaluation contributions and

intervention documents prepared by the occupational therapy assistant.

(4) (a) When general supervision is allowed, the supervising occupational therapist shall have direct contact with the occupational therapy assistant and face-to-face contact with the client by every tenth session of occupational therapy and no less than one time per calendar month. Direct contact with the occupational therapy assistant is for the purpose of reviewing the progress and effectiveness of treatment and may occur simultaneously or separately from the face-to-face contact with the client.

(b) The occupational therapist shall record in writing a specific description of the supervisory activities undertaken for each occupational therapy assistant. The written record shall include client name, status and plan for each client discussed.

(c) "Direct contact" means face-to-face communication or communication by means of telephone, electronic communication, or group conference.

(5) Close supervision is required for all rehabilitation, neonate, early intervention, and school system services provided by an entry level occupational therapy assistant. All other occupational therapy services provided by an occupational therapy assistant may be performed under general supervision, if the supervising occupational therapist determines, under the facts of the individual situation, that general supervision is appropriate using established professional guidelines.

History: CR 02-026: cr. Register December 2002 No. 564, eff. 1-1-03; CR 08-050: am. (3), renum. (4) to be (4) (a) and am., cr. (4) (b) and (c) Register January 2009 No. 637, eff. 2-1-09.

OT 4.05 Supervision of non-licensed personnel and therapy aides. (1) An occupational therapist or occupational therapy assistant must provide direct supervision of non-licensed personnel at all times. Direct supervision requires that the supervising occupational therapist or occupational therapy assistant be on premises and available to assist.

(2) When an occupational therapist or occupational therapy assistant delegates to non-licensed personnel maintenance or restorative services to clients, the occupational therapist or occupational therapy assistant must be in the immediate area and within audible and visual range of the client and the non-licensed personnel.

(3) An occupational therapist or occupational therapy assistant may delegate to non-licensed personnel only non-skilled, specific tasks which are neither evaluative, assessive, task selective nor recommending in nature, and only after ensuring that the non-licensed person has been appropriately trained for the performance of the task.

(4) Occupational therapists and occupational therapy assistants must exercise their professional judgment when determining the number of non-licensed persons they can safely and effectively supervise to ensure that quality care is provided at all times. A limit of 2 is recommended.

(5) Any duties assigned to non-licensed personnel must be determined and appropriately supervised by an occupational therapist or occupational therapy assistant and must not exceed the level of training, knowledge, skill and competence of the individual being supervised. The licensed occupational therapist or occupational therapy assistant is responsible for the acts or actions performed by any non-licensed person functioning in the occupational therapy setting.

(6) An occupational therapist or occupational therapy assistant may delegate to non-licensed personnel duties or functions, including the following services:

- (a) Transportation of clients.
- (b) Preparation or setting up of treatment equipment and work area.
- (c) Attending to clients' personal needs during treatment.
- (d) Clerical, secretarial or administrative duties.

(7) Duties or functions that an occupational therapist or occupational therapy assistant may not delegate to non-licensed personnel include, but are not limited to, the following:

- (a) Interpretation of referrals or orders for occupational therapy services.
- (b) Evaluative procedures.
- (c) Development, planning, adjusting or modification of treatment procedures.
- (d) Acting on behalf of the occupational therapist or occupational therapy assistant in any matter related to direct client care which requires judgment or decision making.

History: CR 02-026: cr. Register December 2002 No. 564, eff. 1-1-03; CR 13-109: am. (6) (intro.), (7) (a) Register September 2014 No. 705, eff. 10-1-14.



Governor Scott Walker
Wisconsin State Capitol
115 East Capitol
Madison, WI 53702

The Occupational Therapist Affiliated Credentialing Board (OTACB) in the Department of Safety and Professional Services reviewed its rules Wis. Admin. Code chs. 1, 2, 3 and 4 and determined that the rules were outdated. The Board identified several key areas in the rules that were not typical of practice within the profession. The Board was also prompted by the American Occupational Therapy Association (AOTA), who changed the definition of Occupational Therapy Practice for the AOTA Model Practice Act in April of 2011. The OT Board sought to incorporate some of the language from the AOTA Model Practice Act and to institute changes that will update the current code language with current practices within the profession.

The Wisconsin Occupational Therapy Association (representing over 5,000 OT professionals) has monitored the rules update process for a year, offered suggestions and appreciate the updated rules which more accurately represent practice. There was an issue that was not changed because the Board felt they did not have authority to make substantive content changes. Before the changed rules are signed into effect WOTA is asking that Governor Walker consider requesting that the OTACB remove the requirement of a Physician referral for the reasons outlined.

1. Occupational Therapists welcome Physician referral in medical model OT. We want the partnership with a physician and want the diagnosis of client problems to be initiated by the physician. In general OTs majorly practice under physician referral. In order to provide OT services a physician initiates the process of asking for OT services in medical model OT. The process is already in place by reimbursement systems to require Physician referral so it does not need to be written into the administrative rules for OT.
2. There are only 10 states nationwide that do require referral for OT in their licensure language. These are the 10 states: Alabama, Illinois, Indiana, Kansas, Minnesota, New York, Pennsylvania, Texas, Washington, and Wisconsin. So not requiring physician referral in OT regulatory language is a national standard that is followed by a majority of states (40).
3. OT Practice is so broad and inclusive of many services that would not require a physician to request them such as: prevention and wellness, consultation to industry and work environments, ergonomics, home modification, falls prevention, energy conservation joint protection, habilitation (teaching skills not yet learned) social skills training, behavior management, sensory strategies for children with autism and technology. Many of these are already covered in our rules as "*may have a referral but are not required to*", OTs want this to be continued.
4. Another reason that has been given is the requirement to have a physician referral/order may negatively impact small businesses who offer a range of services from OT to alternative health practices and pediatric practices that include services for children with autism and other developmental disabilities who may have a medical condition that they are not being seen by the OT for but requires that the OT get a referral/order for evaluation and rehabilitation treatment for individuals with medical conditions currently.

The OTACB is currently reviewing the administrative rules to determine if they create barriers to small businesses as the Governor has requested.

Currently the revised language says this:

Definitions in Chapter 1

(19) "Order" means the practice of identifying the need for occupational therapy evaluation and intervention and delegating the responsibility to perform the evaluation and intervention to an occupational therapist.

(22) "Referral" means the practice of requesting occupational therapy services.

OT 4.03 (2) REFERRAL AND ORDERS. (a) Evaluation, rehabilitation treatment, and implementation of treatment with individuals with specific medical conditions shall be based on an order from a physician, dentist or podiatrist, or any other qualified health care professional.

SECTION 13. OT 4.03 (2) (c), (d), and (e) are amended to read:

OT 4.03 (2) (c) Although an order is not required, an occupational therapist or occupational therapy assistant may accept a referral for the purpose of providing services which include consultation, habilitation, screening, client education, wellness, prevention, environmental assessments, and work-related ergonomic services.

OT 4.03 (2) (d) Orders shall be in writing. However, verbal orders may be accepted if they are followed by a written and signed order by the ordering professional within 3 days from the date on which the client consults with the occupational therapist or occupational therapy assistant.

OT 4.03 (2) (e) Orders or referral from another health care provider professional is not required for evaluation or intervention if an occupational therapist or occupational therapy assistant provides services in an educational environment, including the child's home, for children and youth with disabilities pursuant to rules promulgated by the federal individuals with disabilities education act, the department of public instruction and the department of health services, or provides services in an educational environment for children and youth with disabilities pursuant to the code of federal regulations.

WOTA wants to see this whole 4.03 section on Orders removed.

If Physicians feel that it needs to be defined in our language then we could accept the inclusion of this requirement if one or both of the following **bolded** changes were made.

remove

OT 4.03 (2) REFERRAL AND ORDERS. (a) **Evaluation,** (If evaluation was removed as a requirement the OT could evaluate if there was a need for OT before the need to get a Dr's order) rehabilitation treatment, and implementation of treatment with individuals with specific medical conditions shall (**remove shall and replace with may**) be based on an order from a physician, dentist or podiatrist, or any other qualified health care professional.

Thank you for considering asking the OTACB to make this simple change that would then facilitate the rules being put into effect after a year of review and updating. They are good rules we want them in place this year.

Teri Black COTA ROH

Teri Black

WOTA Legislative Chair

Gov. Scott Walker,

First I want to thank you for your initiatives to help small business! As I am in the process of opening a private practice, I am quickly learning how daunting the barriers to small business can be.

I am an Occupational Therapist who wishes to provide comprehensive holistic rehabilitation and wellness services, operating independently from the insurance systems. My goal is to provide affordable cash-based care to clients who may have limited insurance coverage, no insurance coverage, maxed out their benefits for the year already, or simply wish to seek care without the limits that insurance carriers place on the type and amount of care I am able to provide as a therapist. By doing this I will also be able to provide patient care near 100% of the time I am working, thus making me a more experienced and knowledgeable therapist.

As you may know, Occupational Therapy licensing requires that I have earned a masters degree in occupational therapy, passed at least two credentialing and license exams, and participate in on going clinical education.

Working closely with physicians and receiving their referrals can be very helpful to me as a therapist with a complicated case. For example, working in a hospital with someone with a spinal cord injury, a stroke, or a severe traumatic injury. However, working in an outpatient clinic - I mainly see sports injuries, torn muscles, chronic pain conditions, or posture related deficits. My clinical training has prepared me adequately to treat these types of injuries without a referral.

Obtaining referrals can be an active barrier to my practice, especially as someone working outside the insurance system. If a client comes to me with a shoulder injury, with no insurance, it will be very difficult for them to afford not only to come to me but also to go to a doctors visit to establish a medical necessity for therapy. It may take them weeks to get into the physician, and then weeks for the physician to get the referral to me. All in that time, the client's shoulder continues to cause them pain, limit their function, and the original injury becomes worse. Also from a business stand point - I am missing out on weeks of payments, they are potentially missing weeks of work, and weeks of money that is not stimulating the local economy. All from a simple requirement for a referral.

Please consider following the forward moving vision of many other states by waiving the need for referrals, or at least limiting the types of conditions that require a referral for Occupational Therapy service.

Thank you so much for your service, Gov. Walker - please help Occupational Therapists do our service!

Sincerely,
Rita Burlingame, MS, OTR/L

I am writing this letter in regard to the up coming licensure changes for practice in Occupational Therapy. I am an OTR who lives in rural Wisconsin. I wish to start an independent business servicing clients for therapy. Having each client required to have a physician referral limits my small business. I am hopeful that the Occupational Therapy techniques I have learned in combination with the Myofascial Techniques I have pursued with my continuing education will help improve peoples quality of life physically and mentally in my hometown. The requirement of the physician order limits my ability to make a living where I am. Many states allow a person to self refer for therapy.

Many people are living with chronic conditions or even recent injuries and are well aware of their problems, diagnosis, and limitations. Requiring them to go and get a doctors permission delays treatment and incurs extra expense. OTRs are trained at looking for limitations we are not there to diagnose but we do evaluate before treatment. The greatest asset we have is the persons self-report and examination of the limitations not the doctors orders. Most orders read evaluate and treat anyway. My point is an OT is liable to the licenses they hold so why no self referral? Hold us to our continued growth and educational requirements but let us have a chance making it in a small rural setting.

Jennifer Flanigan OTR

Amend Wisconsin Statutes to Permit Direct Access to Outpatient Occupational Therapy Services

In Wisconsin, the practice of occupational therapy by licensed and highly trained health care professionals is contingent upon a physician referral. This requirement does not serve the needs of patients who require occupational therapy and who must first be seen by a physician to receive a referral for needed therapy. This practice results in costly treatment delays, restricted access to needed services, patient frustration, and a loss of business revenue while patients wait unnecessarily for needed services.

The physician referral requirement is particularly burdensome for private outpatient therapy clinics and private practice therapists. In outpatient settings, the referral requirement causes unnecessary delays in care, creates additional work for outpatient providers, and serves as a deterrent for private pay clientele. All of which results in higher operating costs and lost revenues for small outpatient clinics.

Legislating direct access to outpatient occupational therapy services in Wisconsin will benefit small business owners and patients. How? By expanding access to care, by increasing patient choice in selecting their health care professional, and by providing private outpatient clinics with the opportunity to provide patients with less expensive and more timely care.

At the clinic I run for children with behavioral issues I frequently work with children on the autism spectrum, or children with mental illness and/or developmental disabilities. I am not providing typical OT it is behavior management often for sensory issues. Because they have a medical condition I have to send them to get a referral from their Doctor for me to evaluate them or provide any interventions. Removing the requirement for a physician referral would allow children to access the services I provide without incurring the cost of a doctor visit.

Thank you for your consideration, An Occupational Therapist in Appleton WI.

I am writing this letter in regard to the up coming licensure changes for practice in Occupational Therapy. I am an OTR who lives in rural Wisconsin. I wish to start an independent business servicing clients for therapy. Having each client required to have a physician referral limits my small business. I am hopeful that the Occupational Therapy techniques I have learned in combination with the Myofascial Techniques I have pursued with my continuing education will help improve peoples quality of life physically and mentally in my hometown. The requirement of the physician order limits my ability to make a living where I am. Many states allow a person to self refer for therapy.

Many people are living with chronic conditions or even recent injuries and are well aware of their problems, diagnosis, and limitations. Requiring them to go and get a doctors permission delays treatment and incurs extra expense. OTRs are trained at looking for limitations we are not there to diagnose but we do evaluate before treatment. The greatest asset we have is the persons self-report and examination of the limitations not the doctors orders. Most orders read evaluate and treat anyway. My point is an OT is liable to the licenses they hold so why no self referral? Hold us to our continued growth and educational requirements but let us have a chance making it in a small rural setting.

Jennifer Flanigan OTR

5-13-2013

To: Brett Davis
% Department of Health Services

Regarding: How current Licensure requirements for physician referral restrict patient access to health care services, i.e., Occupational Therapy Services while also increasing health care costs.

The current licensure requirement for physician referral to access OCCUPATIONAL THERAPY EVALUATION & TREATMENT results in the following:

- Limitation of patient access to independent health care organizations secondary to the large HMO's refusing to allow physician's within their HMO to refer patient's 'out of system', even for services not provided in house.
- Large HMO's limit patient access by refusing to allow outside providers to be a part of their system, thus again limiting competition.
- Health care cost increase secondary to lack of competition, for example, SaluCare Rehab charges \$60.00 for occupational therapy evaluation and \$160.00/hour for occupational treatment whereas the same service(s) within the local HMO(s) are billed at a much higher hourly rate.
- Patient's are unable to access services that are less costly while at the same time more effective than those provided 'in-house'. In essence, quality of care & lower costs fail to increase referrals due to blockage of those referrals by the large systems.
- The ability of the small health care business to survive is compromised secondary to the large system's demand that their physician's keep referrals 'in house'.
- If direct access without physician referral was allowed, it would be a first step in "opening up the market place" to 'access by all'.

Sincerely yours,

Judith Schabert

Judith A. Schabert, President

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Katie Paff Administrative Rules Coordinator		2) Date When Request Submitted: 6/30/2015 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: 7/15/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Review of Pod 1, 4, and 8 relating to the duty to obtain informed consent and Pod 2 relating to the overtreatment of patients	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: The Medical Examining Board has the authority under s. 15.085 (5) (b) 1. to review and comment on rules promulgated by the affiliated credentialing boards prior to submittal to the Legislative Clearinghouse. The Med Board will review Pod 1, 4, and 8 relating to the duty to obtain informed consent and Pod 2 relating to the overtreatment of patients.			
11) Authorization			
Katie Vieira (Paff)		6/30/2015	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN
PODIATRY AFFILIATED CREDENTIALING BOARD

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

PROPOSED ORDER

An order of the Podiatry Affiliated Credentialing Board to amend Pod 4.03 (2) (b) and create Pod 1.02 (9), 4.04, and Chapter 8 relating to the duty to obtain informed consent.

Analysis prepared by the Department of Safety and Professional Services.

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 proposed 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 proposed 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 proposed rule due to the majority of the proposed 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 will be 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.

Fiscal Estimate and Economic Impact Analysis:

~~The Fiscal Estimate and Economic Impact Analysis is attached.~~

Effect on small business:

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

Agency contact person:

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

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

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

TEXT OF RULE

SECTION 1. Pod 1.02 (9) is created to read:

Pod 1.02 (9) “Reinstatement” means the process by which 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, shall apply to have the license reinstated.

SECTION 2. 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 3. 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 their license reinstated in accordance with 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 4. 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 define 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 in keeping with s. Pod 6.01.

SECTION 5. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, pursuant to s. 227.22 (2) (intro.), Stats.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Podiatry Affiliated Credentialing Board

STATE OF WISCONSIN
PODIATRY AFFILIATED CREDENTIALING BOARD

IN THE MATTER OF RULEMAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	PODIATRY AFFILIATED
PODIATRY AFFILIATED	:	CREDENTIALING BOARD
CREDENTIALING BOARD	:	ADOPTING RULES
	:	CLEARINGHOUSE RULE

PROPOSED 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.

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 proposed 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 proposed 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 proposed 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 will be 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.

Fiscal Estimate and Economic Impact Analysis:

~~The Fiscal Estimate and Economic Impact Analysis document is attached.~~

Effect on small business:

The proposed 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 Eric.Esser@wisconsin.gov, or by calling (608) 267-2435.

Agency contact person:

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

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

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

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.

(END OF TEXT OF RULE)

Dated _____

Agency _____

Chairperson
Podiatry Affiliated Credentialing Board

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Kenneth Simons		2) Date When Request Submitted: 6/17/2015	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 7/15/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Iowa Telemedicine Rules	
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: Board Discussion.			
11) Authorization			
Signature of person making this request			Date
Supervisor (if required)			Date
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)			Date



FOR IMMEDIATE RELEASE: June 3, 2015
CONTACT: Mark Bowden, (515) 242-3268 or
mark.bowden@iowa.gov

New rule sets standards of practice for physicians who use telemedicine

DES MOINES, IA – A new administrative rule taking effect today (June 3, 2015) establishes the standards of practice for physicians who use telemedicine.

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

The rule recognizes that telemedicine can provide important benefits for patients, including increased access to health care, expanded use of medical specialty expertise, and prompt access to medical records.

Hamed Tewfik, M.D., chair of the Iowa Board of Medicine, said there are many stakeholders in the rule, but the primary focus is patient safety. He emphasized that physicians using telemedicine will be held to the same standards of care and professional ethics as physicians who provide traditional in-person medical care.

The rule-making process started in October 2014 after a Board subcommittee spent several months reviewing national policies, laws and rules and meeting with representatives of Iowa physician and hospital organizations, medical educators, and regulatory officials to identify precepts for a rule.

The rule is the first time the Board has broadly addressed the application of telemedicine. In 1996, the Board issued a policy statement that embraced a nationally recognized standard that the practice of medicine is where the patient is located, not where the physician is located.

The following is the new rule:

653—13.11(147,148,272C) Standards of practice—telemedicine. This rule establishes standards of practice for the practice of medicine using telemedicine.

1. The board recognizes that technological advances have made it possible for licensees in one location to provide medical care to patients in another location with or without an intervening health care provider.

2. Telemedicine is a useful tool that, if applied appropriately, can provide important benefits to patients, including increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and potential cost savings.

3. The board advises that licensees using telemedicine will be held to the same standards of care and professional ethics as licensees using traditional in-person medical care.

4. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may subject the licensee to potential discipline by the board.

13.11(1) Definitions. As used in this rule:

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

“Board” means the Iowa board of medicine.

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

“Licensee” means a medical physician or osteopathic physician licensed by the board.

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

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

13.11(2) Practice guidelines. A licensee who uses telemedicine shall utilize evidence-based telemedicine practice guidelines and standards of practice, to the degree they are available, to ensure patient safety, quality of care, and positive outcomes. The board acknowledges that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine for many medical specialties.

13.11(3) Iowa medical license required. A physician who uses telemedicine in the diagnosis and treatment of a patient located in Iowa shall hold an active Iowa medical license consistent with state and federal laws. Nothing in this rule shall be construed to supersede the exceptions to licensure contained in 653—subrule 9.2(2).

13.11(4) Standards of care and professional ethics. A licensee who uses telemedicine shall be held to the same standards of care and professional ethics as a licensee using traditional in-person encounters with patients. Failure to conform to the appropriate standards of care or professional ethics while using telemedicine may be a violation of the laws and rules governing the practice of medicine and may subject the licensee to potential discipline by the board.

13.11(5) Scope of practice. A licensee who uses telemedicine shall ensure that the services provided are consistent with the licensee’s scope of practice, including the licensee’s education, training, experience, ability, licensure, and certification.

13.11(6) Identification of patient and physician. A licensee who uses telemedicine shall verify the identity of the patient and ensure that the patient has the ability to verify the identity, licensure status, certification, and credentials of all health care providers who provide telemedicine services prior to the provision of care.

13.11(7) Physician-patient relationship.

a. A licensee who uses telemedicine shall establish a valid physician-patient relationship with the person who receives telemedicine services. The physician-patient relationship begins when:

- (1) The person with a health-related matter seeks assistance from a licensee;
- (2) The licensee agrees to undertake diagnosis and treatment of the person; and
- (3) The person agrees to be treated by the licensee whether or not there has been an in-person encounter between the physician and the person.

b. A valid physician-patient relationship may be established by:

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

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

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

13.11(8) Medical history and physical examination. Generally, a licensee shall perform an in-person medical interview and physical examination for each patient. However, the medical interview and physical examination may not be in-person if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis as though the medical interview and physical examination had been performed in-person. Prior to providing treatment, including issuing prescriptions, electronically or otherwise, a licensee who uses telemedicine shall interview the patient to collect the relevant medical history and perform a physical examination, when medically necessary, sufficient for the diagnosis and treatment of the patient. An Internet questionnaire that is a static set of questions provided to the patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview, does not constitute an acceptable medical interview and physical examination for the provision of treatment, including issuance of prescriptions, electronically or otherwise, by a licensee.

13.11(9) Nonphysician health care providers. If a licensee who uses telemedicine relies upon or delegates the provision of telemedicine services to a nonphysician health care provider, the licensee shall:

a. Ensure that systems are in place to ensure that the nonphysician health care provider is qualified and trained to provide that service within the scope of the nonphysician health care provider's practice;

b. Ensure that the licensee is available in person or electronically to consult with the nonphysician health care provider, particularly in the case of injury or an emergency.

13.11(10) Informed consent. A licensee who uses telemedicine shall ensure that the patient provides appropriate informed consent for the medical services provided, including consent for the use of telemedicine to diagnose and treat the patient, and that such informed consent is timely documented in the patient's medical record.

13.11(11) Coordination of care. A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating physician(s) for the patient, when available, where in-person services can be delivered in coordination with the telemedicine services. The licensee shall provide a copy of the medical record to the patient's medical home or treating physician(s).

13.11(12) Follow-up care. A licensee who uses telemedicine shall have access to, or adequate knowledge of, the nature and availability of local medical resources to provide appropriate follow-up care to the patient following a telemedicine encounter.

13.11(13) Emergency services. A licensee who uses telemedicine shall refer a patient to an acute care facility or an emergency department when referral is necessary for the safety of the patient or in the case of an emergency.

13.11(14) Medical records. A licensee who uses telemedicine shall ensure that complete, accurate and timely medical records are maintained for the patient when appropriate, including all patient-related electronic communications, records of past care, physician-patient communications, laboratory and test results, evaluations and consultations, prescriptions, and instructions obtained or produced in connection with the use of telemedicine technologies. The licensee shall note in the patient's record when telemedicine is used to provide diagnosis and treatment. The licensee shall ensure that the patient or another licensee designated by the patient has timely access to all information obtained during the telemedicine encounter. The licensee shall ensure that the patient receives, upon request, a summary of each telemedicine encounter in a timely manner.

13.11(15) Privacy and security. A licensee who uses telemedicine shall ensure that all telemedicine encounters comply with the privacy and security measures of the Health Insurance Portability and Accountability Act to ensure that all patient communications and records are secure and remain confidential.

a. Written protocols shall be established that address the following:

(1) Privacy;

(2) Health care personnel who will process messages;

(3) Hours of operation;

(4) Types of transactions that will be permitted electronically;

(5) Required patient information to be included in the communication, including patient name, identification number and type of transaction;

(6) Archiving and retrieval; and

(7) Quality oversight mechanisms.

b. The written protocols should be periodically evaluated for currency and should be maintained in an accessible and readily available manner for review. The written protocols shall include sufficient privacy and

security measures to ensure the confidentiality and integrity of patient-identifiable information, including password protection, encryption or other reliable authentication techniques.

13.11(16) *Technology and equipment.* The board recognizes that three broad categories of telemedicine technologies currently exist, including asynchronous store-and-forward technologies, remote monitoring, and real-time interactive services. While some telemedicine programs are multispecialty in nature, others are tailored to specific diseases and medical specialties. The technology and equipment utilized for telemedicine shall comply with the following requirements:

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

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

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

13.11(17) *Disclosure and functionality of telemedicine services.* A licensee who uses telemedicine shall ensure that the following information is clearly disclosed to the patient:

a. Types of services provided;

b. Contact information for the licensee;

c. Identity, licensure, certification, credentials, and qualifications of all health care providers who are providing the telemedicine services;

d. Limitations in the drugs and services that can be provided via telemedicine;

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

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

g. Appropriate uses and limitations of the technologies, including in emergency situations;

h. Uses of and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;

i. To whom patient health information may be disclosed and for what purpose;

j. Rights of patients with respect to patient health information; and

k. Information collected and passive tracking mechanisms utilized.

13.11(18) *Patient access and feedback.* A licensee who uses telemedicine shall ensure that the patient has easy access to a mechanism for the following purposes:

a. To access, supplement and amend patient-provided personal health information;

b. To provide feedback regarding the quality of the telemedicine services provided; and

c. To register complaints. The mechanism shall include information regarding the filing of complaints with the board.

13.11(19) *Financial interests.* Advertising or promotion of goods or products from which the licensee(s) receives direct remuneration, benefit or incentives (other than the fees for the medical services) is prohibited to the extent that such activities are prohibited by state or federal law. Notwithstanding such prohibition, Internet services may provide links to general health information sites to enhance education; however, the licensee(s) should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, licensees should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of a preferred relationship with any pharmacy is prohibited. Licensees shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from the pharmacy.

13.11(20) *Circumstances where the standard of care may not require a licensee to personally interview or examine a patient.* Under the following circumstances, whether or not such circumstances involve the use of telemedicine, a licensee may treat a patient who has not been personally interviewed, examined and diagnosed by the licensee:

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

b. For institutional settings, including writing initial admission orders for a newly hospitalized patient;

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

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

e. Situations in which the patient has been examined in person by an advanced registered nurse.

practitioner or a physician assistant or other licensed practitioner with whom the licensee has a supervisory or collaborative relationship;

f. Emergency situations in which the life or health of the patient is in imminent danger;

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

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

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

13.11(21) *Prescribing based solely on an Internet request, Internet questionnaire or a telephonic evaluation—prohibited.* Prescribing to a patient based solely on an Internet request or Internet questionnaire (i.e., a static questionnaire provided to a patient, to which the patient responds with a static set of answers, in contrast to an adaptive, interactive and responsive online interview) is prohibited. Absent a valid physician-patient relationship, a licensee's prescribing to a patient based solely on a telephonic evaluation is prohibited, with the exception of the circumstances described in subrule 13.11(20).

13.11(22) *Medical abortion.* Nothing in this rule shall be interpreted to contradict or supersede the requirements established in rule 653—13.10(147,148,272C).

This rule is intended to implement Iowa Code chapters 147, 148 and 272C.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Katie Paff Administrative Rules Coordinator		2) Date When Request Submitted: 6/30/2015 <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 7/15/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Legislative Review for CR15-021 relating to entrance to exams	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required: N/A	
10) Describe the issue and action that should be addressed: The Board will receive an update on the legislative review of CR 15-021 and consider authorizing the Chair to approve the Adoption Order.			
11) Authorization			
Katie Vieira (Paff)		6/30/2015	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**STATE OF WISCONSIN
MEDICAL EXAMINING BOARD**

IN THE MATTER OF RULEMAKING :
PROCEEDINGS BEFORE THE : **REPORT TO THE LEGISLATURE**
: **CR 15-021**
MEDICAL EXAMINING BOARD :
:

I. THE PROPOSED RULE:

The proposed rule, including the analysis and text, is attached.

II. REFERENCE TO APPLICABLE FORMS:

None.

III. FISCAL ESTIMATE AND EIA:

The Fiscal Estimate and EIA are attached.

IV. DETAILED STATEMENT EXPLAINING THE BASIS AND PURPOSE OF THE PROPOSED RULE, INCLUDING HOW THE PROPOSED RULE ADVANCES RELEVANT STATUTORY GOALS OR PURPOSES:

This proposed rule addresses a change in policy instituted by 2013 Wisconsin Act 114. The new legislation requires the Department of Safety and Professional Services and its attached boards refrain from requiring applicants complete their postsecondary education before being eligible to take an examination for licensure. This change prompted a review of Wis. Admin. Code ch. Med 1. The pertinent section affected is s. Med 1.04, which requires applicants to submit a completed application including all required documents to the board no less than three weeks prior to the date of an administration of the United States Medical Licensing Examination (USMLE). The required documents which must be submitted includes evidence of graduation from medical school; thereby requiring, that applicants graduate medical school before submitting a completed application. However, Act 114 states that no such requirement may be imposed on applicants seeking licensure. The proposed rule repeals s. Med 1.04 in order to bring current rules into conformity with Act 114.

V. SUMMARY OF PUBLIC COMMENTS AND THE BOARD'S RESPONSES, EXPLANATION OF MODIFICATIONS TO PROPOSED RULES PROMPTED BY PUBLIC COMMENTS:

The Medical Examining Board held a public hearing on April 15, 2015. No testimony was received at the hearing, nor did the Board receive any written comments.

VI. RESPONSE TO LEGISLATIVE COUNCIL STAFF RECOMMENDATIONS:

Clearinghouse Report did not contain any comments.

VII. REPORT FROM THE SBRRB AND FINAL REGULATORY FLEXIBILITY ANALYSIS:

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF RULEMAKING	:	PROPOSED ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING BOARD
MEDICAL EXAMINING BOARD	:	ADOPTING RULES
	:	CLEARINGHOUSE RULE 15-021

PROPOSED ORDER

An order of the Medical Examining Board to repeal Med 1.04 relating to entrance to exams.

Analysis prepared by the Department of Safety and Professional Services.

ANALYSIS

Statutes interpreted:

Section 440.071 (1), Stats.

Statutory authority:

Sections 15.08 (5) (b), 227.11 (2) (a), Stats., and 2013 Wisconsin Act 114

Explanation of agency authority:

Pursuant to ss. 15.08 (5) (b) and 227.11 (2) (a), Stats., the Medical Examining Board is generally empowered by the legislature to promulgate rules that will provide guidance within the profession and interpret the statutes it administers. 2013 Wisconsin Act 114 created s. 440.071 (1) Stats, which provides that neither the Department nor a credentialing board may require a person to complete any postsecondary education or training before the person is eligible to take an examination for a credential. This legislative change prompted the Medical Examining Board to exercise its rule-making authority to draft the proposed rule which seeks to bring current administrative code into compliance with the new legislation.

Related statute or rule:

None.

Plain language analysis:

This proposed rule addresses a change in policy instituted by 2013 Wisconsin Act 114. The new legislation requires the Department of Safety and Professional Services and its attached boards refrain from requiring applicants complete their postsecondary education

before being eligible to take an examination for licensure. This change prompted a review of Wis. Admin. Code ch. Med 1. The pertinent section affected is s. Med 1.04, which requires applicants to submit a completed application including all required documents to the board no less than three weeks prior to the date of an administration of the United States Medical Licensing Examination (USMLE). The required documents which must be submitted includes evidence of graduation from medical school; thereby requiring, that applicants graduate medical school before submitting a completed application. However, Act 114 states that no such requirement may be imposed on applicants seeking licensure. The proposed rule repeals s. Med 1.04 in order to bring current rules into conformity with Act 114.

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

None.

Comparison with rules in adjacent states:

Illinois: Illinois requires submission of an official transcript and diploma or an official transcript and certification of graduation from the medical education program granting the degree as a requirement for licensure. 68 Ill. Admin. Code tit.68 § 1285.70 a) 5).

Iowa: Iowa requires evidence of a diploma issued by a medical college or college of osteopathic medicine and surgery approved by the board. Iowa Code §148.3. However, this requirement is not a prerequisite for taking an examination for a credential.

Michigan: For licensure by examination, Michigan requires applicants to establish that he or she is a graduate of a medical school approved by the board. Mich. Admin. Code r. 338.2317 (2). However, Michigan does not require applicants to complete any postsecondary education as a prerequisite to taking an examination for a credential.

Minnesota: Minnesota does not require applicants to complete any postsecondary education as a prerequisite to taking an examination for a credential.

Summary of factual data and analytical methodologies:

No factual data or analytical methodologies were used in drafting the proposed rule due to the proposed rule being prompted by recent legislation.

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

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

Fiscal Estimate and Economic Impact Analysis:

The Fiscal Estimate and Economic Impact Analysis are attached.

Effect on small business:

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

Agency contact person:

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

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

Comments may be submitted to Kathleen Paff, Administrative Rule Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, WI 53708-8935, or by email to Kathleen.Paff@wisconsin.gov. Comments must be received on or before April 15, 2015 to be included in the record of rule-making proceedings.

TEXT OF RULE

SECTION 1. Med 1.04 is repealed.

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

(END OF TEXT OF RULE)

This Proposed Order of the Medical Examining Board is approved for submission to the Governor and Legislature.

Dated

April 15, 2015

Agency

Kenneth B. Smith MD

Board Chairperson
Medical Examining Board

ADMINISTRATIVE RULES

Fiscal Estimate & Economic Impact Analysis

1. Type of Estimate and Analysis
 Original Updated Corrected

2. Administrative Rule Chapter, Title and Number
Med 1

3. Subject
Entrance to Exams

4. Fund Sources Affected <input type="checkbox"/> GPR <input type="checkbox"/> FED <input checked="" type="checkbox"/> PRO <input type="checkbox"/> PRS <input type="checkbox"/> SEG <input type="checkbox"/> SEG-S	5. Chapter 20, Stats. Appropriations Affected 20.165(1)
--	--

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 addresses a policy change due to the passage of 2013 Wisconsin Act 114. The Act requires the Department of Safety and Professional Services and its attached boards to allow applicants to take their credentialing examination before completing any postsecondary education. This statute seeks to remove barriers to licensure and allow applicants to become credentialed as soon as they are prepared to enter their chosen profession. The proposed rule implements the legislative intent of 2013 Wisconsin Act 114 by eliminating the application deadline requirement found in Wis. Admin. Code s Med. 1.04. The application deadline requirement is no longer necessary.

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.
The proposed rule was posted on the Department of Safety and Professional Services' website for 14 days in order to solicit comments from businesses associations representing businesses, local governmental units and individuals that may be affected by the rule. No comments were received.

11. Identify the local governmental units that participated in the development of this EIA.
No local governmental units participated in developing this EIA.

12. Summary of Rule's Economic and Fiscal Impact on Specific Businesses, Business Sectors, Public Utility Rate Payers, Local Governmental Units and the State's Economy as a Whole (Include Implementation and Compliance Costs Expected to be Incurred)
The proposed rule will have minimal or no economic or fiscal impact on specific businesses, business sectors, and 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
This proposed rule will implement the legislative intent of 2013 Wisconsin Act 114 and bring greater consistency between Wis. Admin. Code ch. Med 1 and Wisconsin statutes.

14. Long Range Implications of Implementing the Rule
The long range implication of implementing the proposed rule includes eliminating barriers that prevent applicants from taking their credentialing exams as soon as they are prepared to enter their chosen profession.

15. Compare With Approaches Being Used by Federal Government

ADMINISTRATIVE RULES
Fiscal Estimate & Economic Impact Analysis

None.

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

Illinois: Illinois requires submission of an official transcript and diploma or an official transcript and certification of graduation from the medical education program granting the degree as a requirement for licensure. 68 Ill. Admin. Code tit.68 § 1285.70 a) 5).

Iowa: Iowa requires evidence of a diploma issued by a medical college or college of osteopathic medicine and surgery approved by the board. Iowa Code §148.3. However, this requirement is not a prerequisite for taking an examination for a credential.

Michigan: For licensure by examination, Michigan requires applicants to establish that he or she is a graduate of a medical school approved by the board. Mich. Admin. Code r. 338.2317 (2). However, Michigan does not require applicants to complete any postsecondary education as a prerequisite to taking an examination for a credential.

Minnesota: Minnesota does not require applicants to complete any postsecondary education as a prerequisite to taking an examination for a credential.

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.

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Katie Vieira Administrative Rules Coordinator		2) Date When Request Submitted: 7/3/2015 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: 7/15/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Review of Scope Statement relating to general update and cleanup of rules	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required N/A	
10) Describe the issue and action that should be addressed: The Board will review and discuss the Scope Statement relating to general update and cleanup of rules regarding licenses to practice medicine and surgery and biennial registration.			
11) Authorization			
Katie Vieira (Paff)		7/3/2015	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATEMENT OF SCOPE

Medical Examining Board

Rule No.: Med 1, Med 14

Relating to: General update and cleanup of rules

Rule Type: Permanent

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

None.

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

The objective of the proposed rule is to modernize and cleanup the administrative rules in Chapters Med 1 and Med 14 relating to licenses to practice medicine and surgery and biennial registration. The proposed rules will better align with statute, reflect current practices, and provide a clearer regulatory landscape for applicants.

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

Current administrative rules contain provisions relating to the Department administered statute and rules examination. 2013 WI Act 240 limited examinations for licensure to practice medicine and surgery to those administered by national organizations. The proposed rule would remove all references to the statutes and rules examination.

Current administrative code does not address the "COMLEX-USA" Comprehensive Osteopathic Medical Licensing Examination. The proposed rule would add the COMLEX exam under the definitions section of Med 1 and detail the Board requirements and procedures for the COMLEX examination.

The proposed rule would update the list of board recognized accrediting agencies to include prominent accrediting agencies that are not listed in the current code.

The proposed rule would also more explicitly refer to section 448.05 (2) (c) of the Wisconsin Statutes as the Board's authority to grant waivers from the required 24 months of postgraduate training in programs accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for applicants who demonstrate substantially equivalent education and training as provided in section Med 1.02 (3) (c).

Current administrative code contains provisions in which the Board administers and determines eligibility for the USMLE Step 3 which do not reflect current practices. The proposed rule would modify or repeal these sections to reflect current practices.

The renewal date in Chapter Med 14 for doctor of osteopathy does not match the renewal date in statute. The proposed rule would align the renewal date in administrative code with the statute. Additionally, the biennial registration requirements in Chapter Med 14 have not been updated for at least 10 years. The proposed rule would update Chapter Med 14 to reflect common, contemporary renewal requirements in the field.

Throughout Med 1 and Med 14, many provisions do not specify the type of exam to which the provision applies. The proposed rule would clarify references to all exams.

The proposed rule package may also include other non-substantive rule changes.

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

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

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

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

Section 448.05 (2) (c), Stats. “The board may promulgate rules specifying circumstances in which the board, in cases of hardship or in cases in which the applicant possesses a medical license issued by another jurisdiction, may grant a waiver from any requirement under par. (a) or (b). The board may grant such a waiver only in accordance with those rules.”

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

State employees will spend approximately 80 hours developing the proposed rule.

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

The proposed rule will impact initial and renewal applicants for licensure to practice medicine and surgery.

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

None.

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

The proposed rule is likely to have minimal to no economic impact on small businesses.

Contact Person: Katie Vieira (Paff), Kathleen.Vieira@wisconsin.gov, (608) 261-4472

Approved for publication:

Approved for implementation:

Authorized Signature

Authorized Signature

Date Submitted

Date Submitted

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

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:		2) Date When Request Submitted: 6/17/2015	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 7/15/2015	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? Administrative Report <ul style="list-style-type: none"> • Case Status Report on Sharepoint 	
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: Advise the Board of the case status report now being available on Sharepoint.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	



2015 SENATE BILL 21

February 3, 2015 – Introduced by JOINT COMMITTEE ON FINANCE, by request of Governor Scott Walker. Referred to Joint Committee on Finance.

1 **AN ACT relating to:** state finances and appropriations, constituting the
2 executive budget act of the 2015 legislature.

Analysis by the Legislative Reference Bureau

INTRODUCTION

This bill is the “executive budget bill” under section 16.47 (1) of the statutes. It contains the governor’s recommendations for appropriations for the 2015–2017 fiscal biennium.

The bill repeals and recreates the appropriation schedule in chapter 20 of the statutes, thereby setting the appropriation levels for the 2015–2017 fiscal biennium. The descriptions that follow relate to the most significant changes in the law that are proposed in the bill. In most cases, changes in the amounts of existing spending authority and changes in the amounts of bonding authority under existing bonding programs are not discussed.

For additional information concerning this bill, see the Department of Administration’s publication *Budget in Brief* and the executive budget books, the Legislative Fiscal Bureau’s summary document, and the Legislative Reference Bureau’s drafting files, which contain separate drafts on each policy item. In most cases, the policy item drafts contain a more detailed analysis than is printed with this bill.

GUIDE TO THE BILL

As is the case for all other bills, the sections of the budget bill that affect statutes are organized in ascending numerical order of the statutes affected.

SENATE BILL 21

12. A program to award grants to a nonprofit organization to provide education on hunting, fishing, and trapping and to establish programs to recruit persons to engage in those activities.

13. A program to award grants to promote the safe operation of all-terrain vehicles.

RETIREMENT AND GROUP INSURANCE

Currently, state employees may receive health care coverage under Group Insurance Board plans and qualify for employer contributions toward the payment of their health insurance premiums depending on the number of hours they are employed during the year. This bill permits state employees to be paid an annual stipend of \$2,000 in lieu of health insurance coverage.

This bill increases the terms of appointed members of the Group Insurance Board from two years to four years, expiring on May 1 of the odd-numbered years.

SAFETY AND PROFESSIONAL SERVICES**ELIMINATION OF DSPTS**

Under current law, DSPTS and the various boards and councils attached to DSPTS regulate professional licensure and buildings and safety in Wisconsin. Effective January 1, 2016, this bill eliminates DSPTS and transfers all of its functions to DFIPS. The bill attaches to DFIPS the various boards and councils attached to DSPTS under current law.

PROFESSIONAL LICENSURE

Under current law, the licensure period for most credentials issued by DSPTS or a credentialing board under DSPTS is two years, with renewal dates in either the odd-numbered or even-numbered year.

This bill instead provides that the licensure period for most credentials is four years, staggered so that the actual renewal dates for credential holders who have even-numbered birth years are two years apart from the renewal dates for credential holders who have odd-numbered birth years. The bill also provides that the change from two-year to four-year credential periods may be phased in over time.

Under current law, the Veterinary Examining Board (board) regulates the practice of veterinarians and veterinary technicians in Wisconsin. Currently, the board is under the umbrella of DSPTS. This bill transfers the board to the DATCP.

Current law requires the Pharmacy Examining Board (PEB) to establish by rule and administer a prescription drug monitoring program (PDMP). The PDMP requires pharmacies and physicians or other practitioners to generate a record documenting each dispensing of a prescription drug by the pharmacy or practitioner that is covered by the PDMP, generally a controlled substance or other drug the PEB identifies as having a substantial potential for abuse. Among other requirements, the pharmacy or practitioner must deliver records generated under the PDMP to the PEB. This bill transfers the PDMP to the Controlled Substances Board (CSB), which, like the PEB, is attached to DSPTS.

The bill also adds all of the following members to the current membership of the CSB:

SENATE BILL 21

1. The chairperson of the Medical Examining Board or his or her designee.
2. The chairperson of the Dentistry Examining Board or his or her designee.
3. The chairperson of the Board of Nursing or his or her designee.

The bill also specifies that the PEB may disclose a record generated under the PDMP to law enforcement agencies, including under circumstances indicating suspicious or critically dangerous conduct or practices of a pharmacy, pharmacist, practitioner, or patient.

Current law further requires the PEB to specify by rule the discipline for failure to comply with the PDMP. Under the bill, those rules must permit the board to refer to the appropriate board for discipline, or the appropriate law enforcement agency for investigation and possible prosecution, a pharmacist, pharmacy, or practitioner that fails to comply with the PDMP.

BUILDINGS AND SAFETY

This bill transfers DSPS's responsibilities with respect to administration of the laws regulating private on-site wastewater treatment systems (POWTS) to DNR and eliminates a program to provide grants to individuals and businesses who are served by failing POWTS.

This bill further transfers \$21,000,000 from the petroleum inspection fund to the transportation fund in each year of the fiscal biennium.

STATE GOVERNMENT**STATE FINANCE**

This bill increases the amount of state public debt to refund any unpaid indebtedness used to finance tax-supported or self-amortizing facilities from \$3,785,000,000 to \$5,285,000,000.

The bill extends into the 2016-17 fiscal year a lapse requirement imposed for most state agencies during the 2013-15 fiscal biennium. Under the bill, the secretary of administration must lapse moneys to the general fund from executive branch state agency general purpose revenue and program revenue appropriations.

The bill requires the cochairpersons of the Joint Committee on Legislative Organization, during the 2015-17 fiscal biennium, to ensure that \$9,232,200 is lapsed from sum certain general purpose revenue appropriation accounts or is subtracted from the expenditure estimates for any other types of appropriations, or both.

Currently, in any fiscal year, the secretary of administration may temporarily reallocate moneys to the general fund from other funds in an amount not to exceed 5 percent of the total general purpose revenue appropriations for that fiscal year. In 2013 Wisconsin Act 20, this amount was increased to 9 percent for the 2013-15 fiscal biennium. This bill makes the increase to 9 percent permanent.

Current statutes provide that no bill directly or indirectly affecting general purpose revenues may be adopted if the bill would cause the estimated general fund balance on June 30 of any fiscal year to be less than a certain amount of the total general purpose revenue appropriations for that fiscal year. For fiscal years 2017-18 and 2018-19, and for each fiscal year thereafter, the amount is 2 percent of total general purpose revenue appropriations for that fiscal year.

SENATE BILL 21**SECTION 4474**

1 **SECTION 4474.** 450.11 (1b) (bm) of the statutes is amended to read:

2 450.11 **(1b)** (bm) A pharmacist or other person dispensing or delivering a drug
3 shall legibly record the name on each identification card presented under par. (b) to
4 the pharmacist or other person, and the name of each person to whom a drug is
5 dispensed or delivered subject to par. (e) 2., and shall maintain that record for a time
6 established by the board by rule or, for a record that is subject to s. ~~450.19~~ 961.385,
7 until the name is delivered to the controlled substances board under s. ~~450.19~~
8 961.385, whichever is sooner.

9 **SECTION 4475.** 450.11 (1m) of the statutes is amended to read:

10 450.11 **(1m)** ELECTRONIC TRANSMISSION. Except as provided in s. ~~453.068~~ 89.068
11 (1) (c) 4., a practitioner may transmit a prescription order electronically only if the
12 patient approves the transmission and the prescription order is transmitted to a
13 pharmacy designated by the patient.

14 **SECTION 4476.** 450.125 of the statutes is amended to read:

15 **450.125 Drugs for animal use.** In addition to complying with the other
16 requirements in this chapter for distributing and dispensing, a pharmacist who
17 distributes or dispenses a drug for animal use shall comply with s. ~~453.068~~ 89.068.

18 **SECTION 4477.** 450.19 of the statutes is renumbered 961.385, and 961.385 (1)
19 (ar), (2) (a) 3., (c) and (f) and (2m) (b), as renumbered, are amended to read:

20 **961.385 (1) (ar)** "Practitioner" has the meaning given in s. 450.01 (17) but does
21 not include a veterinarian licensed under ch. ~~453~~ 89.

22 **(2) (a) 3.** The prescription order is for a monitored prescription drug that is a
23 substance listed in the schedule in s. 961.22 and is not a narcotic drug, as defined in
24 s. ~~961.01 (15)~~, and the prescription order is for a number of doses that is intended to
25 last the patient 7 days or less.

SENATE BILL 21**SECTION 4477**

1 (c) Specify the persons to whom a record may be disclosed and the
2 circumstances under which the disclosure may occur. The rule promulgated under
3 this paragraph shall permit the board to share disclose a record generated by the
4 program with to relevant state and local boards and agencies, including law
5 enforcement, and relevant agencies of other states, including under circumstances
6 indicating suspicious or critically dangerous conduct or practices of a pharmacy,
7 pharmacist, practitioner, or patient. The board shall define what constitutes
8 suspicious or critically dangerous conduct or practices for purposes of the rule
9 promulgated under this paragraph.

10 (f) Specify Permit the board to refer to the appropriate board for discipline for
11 failure, or the appropriate law enforcement agency for investigation and possible
12 prosecution, a pharmacist, pharmacy, or practitioner that fails to comply with rules
13 promulgated under this subsection, including by failure to generate a record that is
14 required by the program.

15 (2m) (b) After consultation with representatives of licensed pharmacists and
16 pharmacies, and subject to the approval of the secretary of safety and professional
17 services, the board may delay the requirement that a record delivered to the board
18 contain the name recorded under s. 450.11 (1b) (bm) for an additional period beyond
19 the date specified in par. (a).

20 **SECTION 4478.** 451.04 (4) of the statutes is amended to read:

21 451.04 (4) EXPIRATION AND RENEWAL. Renewal applications shall be submitted
22 to the department on a form provided by the department on or before the applicable
23 renewal date specified determined under s. 440.08 (2) (a) and (ag) and shall include
24 the applicable renewal fee determined by the department under s. 440.03 (9) (a).

25 **SECTION 4479.** 452.025 (5) (a) of the statutes is amended to read:

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Dr. Mary Jo Capodice		2) Date When Request Submitted: 7/7/2015 <small>Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting</small>	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 7/15/2015	5) Attachments: <input type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page? Speaking Request - Wisconsin Association of Osteopathic Physicians and Surgeons (WAOPS) Fall Meeting – September 25-26, 2015	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled? <input type="checkbox"/> Yes (Fill out Board Appearance Request) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: WAOPS has invited Dr. Capodice to speak again at its Fall meeting September 25-26 (Friday-Saturday) at the Radisson Hotel in Madison, on any topic of expertise or interest. Travel & lodging and conference registration will be covered.			
11) Authorization			
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: Al Rohmeyer, Administrator, Division of Legal Services and Compliance		2) Date When Request Submitted: 6/4/2015 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others 	
3) Name of Board, Committee, Council, Sections: Medical Examining Board			
4) Meeting Date: 7/15/2015	5) Attachments: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6) How should the item be titled on the agenda page? APPEARANCE – Al Rohmeyer, Administrator, and Sarah Norberg, Supervising Attorney, Division of Legal Services and Compliance – Introductions and Q & A	
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? Yes, Al Rohmeyer and Sarah Norberg	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: Introductions of new staff and Q & A.			
11) Authorization			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Bureau Director signature (indicates approval to add post agenda deadline item to agenda)		Date	