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**MEDICAL EXAMINING BOARD**  
**Room 121A, 1400 East Washington Avenue, Madison**  
**Contact: Tom Ryan (608) 266-2112**  
**October 21, 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 (1-5)**
- B) Minutes of September 16, 2015 – Review and Approval (6-13)**
- C) 8:00 A.M. – APPEARANCE – DSPTS Attorney Joost Kap – Presentation on Petition for Summary Suspension and Designation of Hearing Official**
  - 1) **15 MED 261 – Charles R. Szyman, D.O. (14-33)**
- D) Administrative Updates**
  - 1) Department and Staff Updates
  - 2) Introductions, Announcements and Recognition
  - 3) Wis. Stat. s 15.085 (3)(b) – Affiliated Credentialing Boards’ Biannual Meeting with the Medical Examining Board to Consider Matters of Joint Interest
  - 4) Informational Items
- E) Elections, Appointments, Reappointments, Confirmations, and Committee Panel and Liaison Appointments**
- F) Legislative Report (34)**
  - 1) Assembly Bill 253/Senate Bill 196 (Interstate Medical Licensure Compact)
  - 2) Senate Bill 185 (Creation of a Clinical Exercise Physiology Affiliated Credentialing Board)
  - 3) Senate Bill 268/Assembly Bill 364 (PDMP)
  - 4) Senate Bill 269/Assembly Bill 365 (PDMP)
  - 5) Senate Bill 271 (Methadone)
  - 6) Senate Bill 272 (Pain Clinics)
  - 7) Senate Bill 307 (Complementary and Alternative Health Medicine Exemptions)
- G) Legislative/Administrative Rule Matters (35-116)**
  - 1) Med 24 – Telemedicine – Preliminary Rule Draft (35-96)

- 2) Med 3, 5 – Physician Licensure – Adoption Order **(97-112)**
  - 3) Med 13 – CME for Prescribing Opioids – Scope Statement **(113-114)**
  - 4) Med 1, 14 – General Update and Cleanup of Rules **(115-116)**
  - 5) Update on Pending and Possible Rule Projects
- H) **Council Member Appointment Matters (117-119)**
- 1) Respiratory Care Practitioners Examining Council
    - a) Consider Appointment
      - 1) Ann Bonner
    - b) Reappointments
      - 1) William Rosandick
      - 2) Lynn Waldera
- I) **Federation of State Medical Boards (FSMB) Matters (120-121)**
- 1) Interstate Medical Licensure Compact –Inaugural Meeting, held on October 27-28 2015 in Room N505 of the Michael A. Bilandic Building, Chicago Illinois – Consider Attendance
- J) Speaking Engagement(s), Travel, or Public Relation Request(s)
- K) Screening Panel Report
- L) **Newsletter Matters**
- 1) Fall Newsletter Review **(122-129)**
- M) **Informational Items**
- 1) Physician Re-Entry **(130-132)**
- N) Items Added After Preparation of Agenda
- 1) Introductions, Announcements and Recognition
  - 2) Administrative Updates
  - 3) Elections, Appointments, Reappointments, Confirmations, and Committee, Panel and Liaison Appointments
  - 4) Education and Examination Matters
  - 5) Credentialing Matters
  - 6) Practice Matters
  - 7) Future Agenda Items
  - 8) Legislation/Administrative Rule Matters
  - 9) Liaison Report(s)
  - 10) Newsletter Matters
  - 11) Annual Report Matters
  - 12) Informational Item(s)
  - 13) Disciplinary Matters
  - 14) Presentations of Petition(s) for Summary Suspension
  - 15) Presentation of Proposed Stipulation(s), Final Decision(s) and Order(s)
  - 16) Presentation of Proposed Decisions
  - 17) Presentation of Interim Order(s)
  - 18) Petitions for Re-Hearing
  - 19) Petitions for Assessments
  - 20) Petitions to Vacate Order(s)

- 21) Petitions for Designation of Hearing Examiner
- 22) Requests for Disciplinary Proceeding Presentations
- 23) Motions
- 24) Petitions
- 25) Appearances from Requests Received or Renewed
- 26) Speaking Engagement(s), Travel, or Public Relation Request(s), and Reports

O) Future Agenda Items

P) Public Comments

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

**Q) Full Board Oral Interview of Candidate for Licensure**

- 1) **9:30 A.M. APPEARANCE – Asma Aouthmany, M.D. (133-178)**

**R) Deliberation on Petition for Summary Suspension and Designation of Hearing Official**

- 1) 15 MED 261 – Charles R. Szyman, D.O. **(179-198)**

**S) Complaint for Determination of Probable Cause**

- 1) 15 MED 261 – Charles R. Szyman, D.O. **(199-201)**

**T) Deliberation on Monitoring Matters**

- 1) Roman Berezovski, M.D. – Requesting Reduction of Drug Screens **(202-229)**
- 2) Chady Abboud Leon, M.D. – Requesting to have Order Set Aside and Case Reopened **(230-)**
- 3) Roger Pellmann, M.D. – Requesting Conditional License to Participate in CPEP Program **(242-)**

**U) Deliberation on Administrative Warning(s)**

- 1) 13 MED 308 – K.E.B. **(256-257)**
- 2) 13 MED 353 – G.P.C. **(258-259)**
- 3) 13 MED 437 – D.G. **(260-264)**
- 4) 14 MED 170 – D.S.H. **(265-266)**
- 5) 14 MED 355 – R.D.L. **(267-268)**
- 6) 15 MED 224 – P.B. **(269-271)**
- 7) 15 MED 225 – C.L.U. **(272-273)**

**V) Deliberation on Proposed Stipulations, Final Decisions and Orders by the Division of Legal Services and Compliance (DLSC)**

- 1) 13 MED 149 – Dayna P. Schwarz, M.D. **(274-279)**
- 2) 13 MED 224 – Scott D. Jenkins, M.D. **(280-284)**
- 3) 14 MED 150 – Timothy J. Thompson, M.D. **(285-290)**
- 4) 14 MED 212 – Scott A. Schlidt, M.D. **(291-296)**
- 5) 14 MED 260 – Robert N. Hetz, M.D. **(297-303)**
- 6) 14 MED 549 – Juan Preciado-Riestra, M.D. **(304-315)**

7) 15 MED 142 – Ravi Murali, M.D. **(316-322)**

**W) Deliberation on Proposed Stipulations and Interim Orders by the Division of Legal Services and Compliance (DLSC)**

1) 15 MED 262 – Wilton C. Calderon, D.O. **(323-327)**

**X) Deliberation on Credentialing Matters**

1) Proposed Limited License – My-My Huynh, M.D. **(328-336)**

2) Proposed Limited License – Sohail Imran Mohammad, M.D. **(337-345)**

**Y) Request for Waiver of C.E. Requirements**

1) W.D.J. Request for Waiver of CE Requirements for 2011-2013 Biennium **(346-373)**

**Z) Case Closing(s)**

1) 13 MED 461 **(374-378)**

2) 14 MED 023 **(379-382)**

3) 14 MED 027 **(383-388)**

4) 14 MED 135 **(389-392)**

5) 14 MED 172 **(393-398)**

6) 14 MED 173 **(399-408)**

7) 14 MED 174 **(409-416)**

8) 14 MED 212 **(417-421)**

9) 14 MED 216 **(422-439)**

10) 14 MED 345 **(440-446)**

11) 14 MED 363 **(447-454)**

12) 14 MED 596 **(455-459)**

13) 14 MED 599 **(460-464)**

14) 14 MED 612 **(465-469)**

15) 15 MED 115 **(470-475)**

16) 15 MED 149 **(476-481)**

17) 15 MED 175 **(482-484)**

18) 15 MED 188 **(485-487)**

19) 15 MED 196 **(488-496)**

20) 15 MED 217 **(497-502)**

21) 15 MED 226 **(503-507)**

22) 15 MED 270 **(508-510)**

23) 15 MED 302 **(511-515)**

**AA) 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

**BB) Consulting with Legal Counsel**

**RECONVENE TO OPEN SESSION IMMEDIATELY FOLLOWING CLOSED SESSION**

**CC) APPEARANCE – Jamie Adams, DSPS Division of Credentialing Processing – Discussion of Unrestricted MN License Application (516)**

**DD) Board Training Needs – Discussion**

**EE) Open Session Items Noticed Above not Completed in the Initial Open Session**

**FF) Vote on Items Considered or Deliberated Upon in Closed Session, if Voting is Appropriate**

**GG) 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 Five (5) Candidates for Licensure – Dr. Capodice, Erickson, Yale, and Vasudevan**

**MEDICAL EXAMINING BOARD  
MEETING MINUTES  
September 16, 2015**

**PRESENT:** Mary Jo Capodice, D.O.; Greg Collins; Rodney Erickson, M.D.; Suresh Misra, M.D. (*via phone – arrived at 9:08 a.m./excused at 9:19 a.m.*); Carolyn Ogland Vukich, M.D.; Michael Phillips, M.D.; David Roelke, M.D.; Kenneth Simons, M.D.; John Tripoli; Sridhar Vasudevan, M.D.; Timothy Westlake, M.D.; Russell Yale, M.D. (*excused at 11:27 a.m.*); Robert Zondag

**STAFF:** Tom Ryan, Executive Director; Kimberly Wood, 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 twelve (12) members was confirmed.

**ADOPTION OF AGENDA**

**Amendments to the Agenda:**

- After Item K. (Open Session) **ADD:** Annual Report Matters – DLSC Annual Report 1/1/14-12/31/14
- Item V.1. (Closed Session) **CORRECT:** case closing number from 13 MED 103 to 13 MED 417

**MOTION:** Robert Zondag moved, seconded by Sridhar Vasudevan, to adopt the agenda as amended. Motion carried unanimously.

**APPROVAL OF MINUTES**

**Amendments to the Minutes:**

- **Page 1 of the Minutes:** Change date on Minutes to ‘August 19, 2015’
- **Page 5 of the Minutes:** Under the sub-header ‘Review for Visiting Physician Licensure – Raphael Sacho, M.D.’, correct the recusal language as follows:
  - ‘(Kenneth Simons recused himself and left them...’
- **Page 5 of the Minutes:** Under the sub-header ‘Sarika Pamarthy, M.D.’, correct the recusal language as follows:
  - ‘(Kenneth Simons recused himself and left them...’

**MOTION:** Greg Collins moved, seconded by Robert Zondag, to approve the minutes of August 19, 2015 as amended. Motion carried unanimously.

**ORAL INTERVIEW DELEGATION MOTION**

**MOTION:** Sridhar Vasudevan moved, seconded by Michael Phillips, to delegate to two professional Board Members the ability to conduct oral interviews and, if necessary, recommend a full Board oral interview. Motion carried unanimously.

**LEGISLATIVE/ADMINISTRATIVE RULE MATTERS**

## **Opioid Prescribing – Board Discussion**

**MOTION:** Timothy Westlake moved, seconded by Sridhar Vasudevan, to request DSPS staff draft a Scope Statement relating to Opioid Prescribing CME and to authorize the Chair to approve the scope statement for submission to the Governor’s Office and for implementation. Motion carried unanimously.

**MOTION:** Rodney Erickson moved, seconded by Russell Yale, to create a controlled substances committee to address prescription usage. Motion carried unanimously.

**MOTION:** Robert Zondag moved, seconded by Greg Collins, to affirm the appointment of Mary Jo Capodice, Rodney Erickson, Carolyn Ogland, Timothy Westlake, and Sridhar Vasudevan to the Controlled Substances Committee. Motion carried unanimously.

## **Update**

### **Med 23 – Telemedicine**

**MOTION:** Michael Phillips moved, seconded by Greg Collins, to designate Kenneth Simons to serve as liaison to DSPS staff for drafting Med 23, relating to Telemedicine. Motion carried unanimously.

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

### **Consider MEB Recommendations for Nominations for 2016 FSMB Board of Directors and Nominating Committee Elections, and for the Following Appointments by the Incoming FSMB Chair: Audit, Bylaws, Editorial, Education, Ethics and Professionalism, Finance, and Potentially to FSMB Special Committees and Workgroups**

**MOTION:** Sridhar Vasudevan moved, seconded by Mary Jo Capodice, to recommend Robert Zondag for consideration as a member of the FSMB Ethics and Professionalism Committee. Motion carried unanimously.

*(Suresh Misra connected at 9:08 a.m.)*

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

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to grant Timothy Westlake the ability to speak on behalf of the Board regarding issues pertaining to opioids. Motion carried unanimously.

### **Consider Attendance at the Citizen Advocacy Center 2015 Annual Meeting – Washington, D.C. – November 12-13, 2015**

**MOTION:** Sridhar Vasudevan moved, seconded by Robert Zondag, to designate John Tripoli to attend the Citizen Advocacy Center 2015 Annual Meeting on November 12-13, 2015 in Washington, D.C. and to authorize travel. Motion carried unanimously.

## **ANNUAL REPORT MATTERS**

### **DLSC Annual Report 1/1/14-12/31/14**

**MOTION:** Sridhar Vasudevan moved, seconded by Timothy Westlake, to approve the 2014 Medical Examining Board Annual Report as amended. Motion carried unanimously.

*(Suresh Misra disconnected at 9:19 a.m.)*

### **CLOSED SESSION**

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

The Board convened into Closed Session at 9:20 a.m.

### **RECONVENE TO OPEN SESSION**

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to reconvene to Open Session. Motion carried unanimously.

The Board reconvened in Open Session at 11:53 a.m.

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

**MOTION:** Timothy Westlake moved, seconded by Mary Jo Capodice, to affirm all motions made and votes taken in Closed Session. Motion carried unanimously.

### **REVIEW OF ADMINISTRATIVE WARNING(S)**

#### **9:30 A.M. APPEARANCE – R.P.M. (WARN00000364) (DLSC case number 15 MED 096)**

**MOTION:** Sridhar Vasudevan moved, to rescind the Administrative Warning in the matter of DLSC case number 15 MED 096 (R.P.M.). Motion failed for lack of a second.

**MOTION:** Russell Yale moved, seconded by Mary Jo Capodice, to affirm the Administrative Warning in the matter of DLSC case number 15 MED 096 (R.P.M.). Motion carried. Opposed: Sridhar Vasudevan

*(Drs. Roelke, Simons, and Phillips recused themselves and left the room for deliberation, and voting in the matter concerning, R.P.M. (WARN00000364) (DLSC case number 15 MED 096).)*

### **DELIBERATION ON COMPLAINTS FOR DETERMINATION OF PROBABLE CAUSE**

**13 MED 224 – Scott D. Jenkins, M.D.**

**MOTION:** Mary Jo Capodice moved, seconded by Carolyn Ogland, to find probable cause to believe that Scott D. Jenkins, M.D., DLSC case number 13 MED 224, 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.

*(Rodney Erickson recused himself and left the room for deliberation, and voting in the matter concerning, Scott D. Jenkins, M.D.; Respondent – DLSC case number 13 MED 224.)*

**13 MED 501 – Ricardo R. Sinense, M.D.**

**MOTION:** Carolyn Ogland moved, seconded by Greg Collins, to find probable cause to believe that Ricardo R. Sinense, M.D., DLSC case number 13 MED 501, 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.

*(Kenneth Simons recused himself and left the room for deliberation, and voting in the matter concerning, Ricardo R. Sinense, M.D.; Respondent – DLSC case number 13 MED 501.)*

**14 MED 104 – Robert J. Defatta, M.D.**

**MOTION:** Robert Zondag moved, seconded by Mary Jo Capodice, to find probable cause to believe that Robert J. Defatta, M.D., DLSC case number 14 MED 104, 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.

*(Russell Yale recused himself and left the room for deliberation, and voting in the matter concerning, Robert J. Defatta; Respondent – DLSC case number 14 MED 104.)*

**15 MED 308 – Ricardo R. Sinense, M.D.**

**MOTION:** Mary Jo Capodice moved, seconded by Michael Phillips, to find probable cause to believe that Ricardo R. Sinense, M.D., DLSC case number 15 MED 308, 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.

*(Kenneth Simons and Rodney Erickson recused themselves and left the room for deliberation, and voting in the matter concerning, Ricardo R. Sinense, M.D.; Respondent – DLSC case number 15 MED 308.)*

**DELIBERATION ON ADMINISTRATIVE WARNINGS**

**13 MED 265 – J.A.S.**

**MOTION:** Michael Phillips moved, seconded by Timothy Westlake, to issue an Administrative Warning in the matter of DLSC case number 13 MED 265 (J.A.S.). Motion carried unanimously.

**14 MED 005 – S.K.M.**

**MOTION:** Michael Phillips moved, seconded by Sridhar Vasudevan, to issue an Administrative Warning in the matter of DLSC case number 14 MED 005 (S.K.M.). Motion carried.

*(Kenneth Simons recused himself and left the room for deliberation, and voting in the matter concerning, S.K.M. – DLCS case number 14 MED 005.)*

**14 MED 022 – J.E.D.**

**MOTION:** Greg Collins moved, seconded by Robert Zondag, to issue an Administrative Warning in the matter of DLSC case number 14 MED 022 (J.E.D.). Motion carried unanimously.

**14 MED 038 – A.D.**

**MOTION:** Timothy Westlake moved, seconded by Mary Jo Capodice, to issue an Administrative Warning in the matter of DLSC case number 14 MED 038 (A.D.). Motion carried unanimously.

**14 MED 186 – C.R.C.**

**MOTION:** Timothy Westlake moved, seconded by Michael Phillips, to issue an Administrative Warning in the matter of DLSC case number 14 MED 186 (C.R.C.). Motion carried.

*(Rodney Erickson recused himself and left the room for deliberation, and voting in the matter concerning, C.R.C. – DLCS case number 14 MED 186.)*

**15 MED 226 – J.R.K.**

**MOTION:** Mary Jo Capodice moved, seconded by Michael Phillips, not to issue an Administrative Warning in the matter of DLSC case number 15 MED 226 (J.R.K.). Motion carried unanimously.

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

**13 MED 385 – Barbara J. O’Connell, M.D.**

**MOTION:** Greg Collins moved, seconded by Michael Phillips, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Barbara J. O’Connell, M.D., DLSC case numbers 13 MED 385. Motion carried unanimously.

**14 MED 449 – Farzaneh Masool Tondkar, M.D.**

**MOTION:** Timothy Westlake moved, seconded by Mary Jo Capodice, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Farzaneh Masool Tondkar, M.D., DLSC case number 14 MED 449. Motion carried unanimously.

**14 MED 513 – William D. Wacker, M.D.**

**MOTION:** Mary Jo Capodice moved, seconded by Russell Yale, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against William D. Wacker, M.D., DLSC case number 14 MED 513. Motion carried unanimously.

**14 MED 578 – John H. Braxton, M.D.**

**MOTION:** Rodney Erickson moved, seconded by Mary Jo Capodice, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against John H. Braxton, M.D., DLSC case number 14 MED 578. Motion carried unanimously.

**15 MED 142 – Ravi Murali, M.D.**

**MOTION:** Timothy Westlake moved, seconded by David Roelke, to reject the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Ravi Murali, M.D., DLSC case number 15 MED 142. Motion carried. Opposed: Sridhar Vasudevan

**15 MED 170 – Phillip S. Yee, M.D.**

**MOTION:** Mary Jo Capodice moved, seconded by David Roelke, to adopt the Findings of Fact, Conclusions of Law and Order in the matter of disciplinary proceedings against Phillip S. Yee, M.D., DLSC case number 15 MED 170. Motion carried unanimously.

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

**15 MED 150 and 15 MED 151 – Troy D. Schrock, D.O.**

**MOTION:** Mary Jo Capodice moved, seconded by Robert Zondag, to adopt the Interim Order in the matter of disciplinary proceedings against Troy D. Schrock, D.O., DLSC case numbers 15 MED 150 and 15 MED 151. Motion carried unanimously.

**DELIBERATION ON CREDENTIALING MATTERS**

**Full Board Review – Sohail Imran Mohammad**

**MOTION:** Sridhar Vasudevan moved, seconded by David Roelke, to table the application of Sohail Imran Mohammad, to a future meeting. Motion carried unanimously.

*(Russell Yale was excused at 11:27 a.m.)*

**Application of My-My Huynh, M.D.**

**MOTION:** Timothy Westlake moved, seconded by Robert Zondag, to table the application of My-My Huynh, M.D., to a future meeting. Motion carried unanimously.

**WAIVER OF THE 24 MONTHS OF ACGME APPROVED POST-GRADUATE TRAINING  
BASED ON EDUCATION AND TRAINING**

**10:00 A.M. APPEARANCE: Attorney Dan Icenogle and William Blanchard, M.D.**

**MOTION:** Timothy Westlake moved, seconded by Russell Yale, to deny a waiver to the 24-month post-graduate training program accredited by the ACGME, to William Blanchard, M.D., per Wis. Stat. § 448.05(2)(c). Motion carried unanimously.

**MOTION:** Russell Yale moved, seconded by Sridhar Vasudevan, to find that the training and education of William Blanchard, M.D., is not substantially equivalent to the requirements set forth in Wis. Stat. § 448.05(2). Motion carried unanimously.

**CASE CLOSING(S)**

**MOTION:** Greg Collins 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 417 – (F.X.D.) for No Violation
2. 13 MED 265 – (P.J.R.) for No Violation
3. 13 MED 304 – (J.E.R.) for No Violation
4. 14 MED 007 – (S.N.K.) for Prosecutorial Discretion (P5)
5. 14 MED 057 – (N.A.P.) for No Violation
6. 14 MED 182 – (R.M.B.) for Prosecutorial Discretion (P1)
7. 14 MED 199 – (A.U.) for No Violation
8. 14 MED 273 – (A.P.A.) for Prosecutorial Discretion (P3)
9. 14 MED 382 – (J.P.P.) for No Violation
10. 14 MED 539 – (J.G.H.) for No Violation
11. 14 MED 596 – (D.C.G.) for Prosecutorial Discretion (P4)
12. 14 MED 613 – (W.T., V.B. and V.N.) for No Violation
13. 15 MED 062 – (T.A.S.) for No Violation
14. 15 MED 080 – (G.N.W.) for No Violation
15. 15 MED 099 – (D.J.R.) for Insufficient Evidence
16. 15 MED 191 – (M.P.L. and A.J.C.) for No Violation
17. 15 MED 202 – (A.M.M.) for No Violation

Motion carried unanimously.

**14 MED 371 – J.E.G.**

**MOTION:** Mary Jo Capodice moved, seconded by Robert Zondag, to close DLSC case number 14 MED 371, against J.E.G., for Insufficient Evidence. Motion carried.

*(Carolyn Ogland recused herself and left the room for deliberation, and voting in the matter concerning, J.E.G. – DLCS case number 14 MED 371.)*

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

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

**ADJOURNMENT**

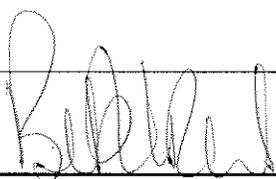
**MOTION:** Sridhar Vasudevan moved, seconded by Robert Zondag, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 11:55 a.m.

DRAFT

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Beth Cramton on behalf of Attorney Joost Kap Division of Legal Services and Compliance		<b>2) Date When Request Submitted:</b>  October 14, 2015  Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 8 work days before the meeting for Medical Board ▪ 8 work days before the meeting for all others	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  October 21, 2015	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Presentation of Petition for Designation of Hearing Official in Case Number 15 MED 261, Charles R. Szyman, D.O.	
<b>7) Place Item in:</b> <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input checked="" type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  Timothy Westlake, M.D.	
<b>10) Describe the issue and action that should be addressed:</b>  If the Board Orders the Summary Suspension for Respondent, then the Board, or its appointed delegates, must designate a member of the Board, an employee of the Department or an administrative law judge employed by the Department of Administration to preside over a hearing to show cause and issue the Order for Designation of Hearing Official.			
<b>11)</b>		Authorization	Date  10-14-15
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	
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**BOARD APPEARANCE REQUEST FORM**

**Board Name:** Medical Examining Board

**Board Meeting Date:** October 21, 2015

**Person Submitting Agenda Request:** Beth Cramton, Paralegal for DLSC

**Person requesting an appearance:** Joost Kap, Attorney for DLSC

**Mailing address:** 1400 E. Washington Avenue, Madison, WI 53703

**Email address:** Joost.Kap@wisconsin.gov

**Telephone #:** (608) 261-4464

**Reason for Appearance:** Consideration of Petition for Designation of Hearing Official in case number 15 MED 261, Charles R. Szyman, D.O.

\*\*\*\*\*

**Is the person represented by an attorney? If so, who?**

**Attorney's mailing address:**

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

**Phone Attorney:**

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

---

IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
 : DLSC CASE NO. 15 MED 261  
CHARLES R. SZYMAN, D.O., :  
RESPONDENT. :

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PETITION FOR DESIGNATION OF HEARING OFFICIAL

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Joost Kap, the attorney assigned to this matter, on behalf of the Department of Safety and Professional Services, Division of Legal Services and Compliance, requests the Wisconsin Medical Examining Board designate under Wis. Stat. § 227.46(1), a member of the Board, an employee of the Department or an administrative law judge employed by the Department of Administration to preside over a hearing to show cause provided for in Wis. Admin. Code § SPS 6.09. This request is made pursuant to Wis. Admin. Code §§ SPS 6.09 and 6.11(1)(a) and is based on the following:

1. The Petition for Summary Suspension, with accompanying attachments, in this matter was filed with the Medical Examining Board on October 14, 2015.

2. On October 14, 2015, Respondent was provided notice of the time and place of the presentation of the Petition for Summary Suspension by certified mail with a return receipt requested in an envelope properly stamped and addressed to Respondent at his address of record at 515 N. 4th Street, Manitowoc, Wisconsin 54220, by regular mail in an envelope properly stamped and addressed to Respondent at his address of record at 515 N. 4th Street, Manitowoc, Wisconsin 54220, and by email to Respondent at his email address of record at [dadszyman@yahoo.com](mailto:dadszyman@yahoo.com).

3. The Petition for Summary Suspension will be presented to the Medical Examining Board on October 21, 2015, at which time Respondent and the prosecuting attorney may be present and will have the opportunity to be heard during the determination of probable cause by the Medical Examining Board.

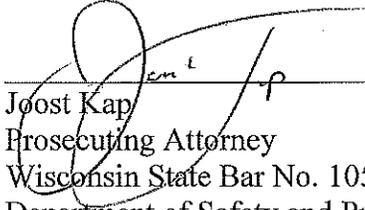
4. On October 21, 2015, the Order of Summary Suspension may be issued by the Medical Examining Board.

5. Pursuant to Wis. Stat. § 448.02(4)(b), Respondent is entitled to a hearing to show cause why an Order of Summary Suspension should not be continued.

6. Petitioner requests the Board designate, under Wis. Stat. § 227.46(1), an administrative law judge employed by the Department of Administration to preside over a

hearing to show cause provided for in Wis. Admin. Code § SPS 6.09, in the event such hearing is requested.

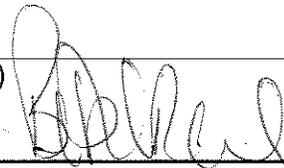
Dated in Madison, Wisconsin, this 14<sup>th</sup> day of October, 2015.



Joost Kap  
Prosecuting Attorney  
Wisconsin State Bar No. 1055878  
Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 7190  
Madison, WI 53707-7190  
Tel. (608) 261-4464

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Beth Cramton on behalf of Attorney Joost Kap Division of Legal Services and Compliance		<b>2) Date When Request Submitted:</b>  October 14, 2015  Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 8 work days before the meeting for Medical Board ▪ 8 work days before the meeting for all others	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medial Examining Board			
<b>4) Meeting Date:</b>  October 21, 2015	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Presentation of Petition for Summary Suspension in Case Number 15 MED 261, Charles R. Szyman, D.O.	
<b>7) Place Item in:</b> <input type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input checked="" type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled?</b>  <input checked="" type="checkbox"/> Yes (Fill out Board Appearance Request) <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  Timothy Westlake, M.D.	
<b>10) Describe the issue and action that should be addressed:</b>  The Board must decide whether to grant the Petition for Summary Suspension. Respondent has the right to appear during open session presentation to be heard [Wis. Stat. § 448.02(4)].  The Board must decide whether there is probable cause to believe that: 1. Respondent has violated the Board's statutes and rules; 2. It is necessary to suspend Respondent's license immediately to protect the public health, safety or welfare.			
<b>11) Authorization</b>  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">  </div> <div style="width: 35%; text-align: right;">                 10.14.15             </div> </div> <hr/> Signature of person making this request <span style="float: right;">Date</span>  <hr/> Supervisor (if required) <span style="float: right;">Date</span>  <hr/> Executive Director signature (indicates approval to add post agenda deadline item to agenda) <span style="float: right;">Date</span>			
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**BOARD APPEARANCE REQUEST FORM**

**Board Name:** Medical Examining Board

**Board Meeting Date:** October 21, 2015

**Person Submitting Agenda Request:** Beth Cramton, Paralegal for DLSC

**Person requesting an appearance:** Joost Kap, Attorney for DLSC

**Mailing address:** 1400 E. Washington Avenue, Madison, WI 53703

**Email address:** Joost.Kap@wisconsin.gov

**Telephone #:** (608) 261-4464

**Reason for Appearance:** Presentation of Notice and Petition for Summary Suspension in case number 15 MED 261, Charles R. Szyman, D.O.

\*\*\*\*\*

**Is the person represented by an attorney? If so, who?**

**Attorney's mailing address:**

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

**Phone Attorney:**

STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
: DLSC CASE NO. 15 MED 261  
CHARLES R. SZYMAN, D.O., :  
RESPONDENT. :

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PETITION FOR SUMMARY SUSPENSION  
[Wis. Stat. § 448.02(4) and Wis. Admin. Code ch. SPS 6]

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Joost Kap, being duly sworn on oath, upon information and belief, deposes and states as follows:

1. I am an attorney employed by the Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance (Department) and in the course of my job duties have been assigned to the investigation and prosecution of 15 MED 261 against Respondent Charles R. Szyman, D.O., for the Wisconsin Medical Examining Board (Board).

2. My business address is 1400 East Washington Avenue, Madison, Wisconsin 53703, and my business mailing address is Post Office Box 7190, Madison, Wisconsin 53707-7190.

3. Respondent Charles R. Szyman, D.O. (DOB February 27, 1951), is licensed in the state of Wisconsin to practice medicine and surgery, having license number 29228-21, first issued on April 22, 1988, with registration current through February 29, 2016. Respondent's most recent address on file with the Department is 515 N. 4th Street, Manitowoc, Wisconsin 54220.

4. At all times relevant to this matter, Respondent has been and continues to be employed as a pain management physician by a pain clinic associated with Holy Family Memorial Hospital in Manitowoc, Wisconsin.

5. Respondent's profile on the website maintained by his employer identifies his practice specialties as pain management and sleep medicine. It also claims Respondent is a board certified anesthesiologist, but a certification query on the American Board of Anesthesiology website does not confirm that.

6. Respondent is the subject of an ongoing investigation by the United States Drug Enforcement Administration (DEA) which began in June 2013 and has involved, among other things, investigative interviews with Respondent, his current and former patients, and undercover law enforcement agents posing as Respondent's patients.

7. The DEA has provided the Department with 515 pages of reports and other evidence gathered in the course of its investigation of Respondent. This information was provided by the DEA to initiate and assist the Department in its investigation and prosecution of 15 MED 261.

8. I have personally reviewed the DEA materials and base this Petition largely thereon. In the interest of limiting disclosure of the DEA materials, I will only make them available to the Board upon request during the closed session of the Board's October 21, 2015 meeting.

9. The Department has also gathered Respondent's treatment records for 47 patients, including those referenced in the DEA materials. I have reviewed patient records to confirm the information referenced in the DEA materials for Patients A and B below, and will make them available to the Board upon request during the closed session of the Board's October 21, 2015 meeting.

10. On October 7, 2015, I spoke with Lieutenant David Remiker, the law enforcement officer in charge of investigations for the Manitowoc County Sheriff's Department Metro Drug Unit. At my request, Lt. Remiker authored a narrative report detailing his experience investigating drug activity in Manitowoc County, where Respondent practices. Lt. Remiker's report was then converted to the sworn affidavit attached to this petition as Exhibit A.

11. The DEA materials, Respondent's treatment records and Exhibit A establish that Respondent has prescribed and continues to prescribe unusually large amounts of controlled substances, opioids in particular, without adequate or any medical support, without adequate or any physical examinations or medical testing, while allowing patients to request specific drugs and dosages, and when he knows or should know the prescriptions he writes are being diverted, abused, and are causing the accidental and intentional deaths of his patients and others in the community where he practices.

### **Undercover Investigation**

12. Between November 2013 and February 2015, the DEA and local law enforcement agencies used undercover agents who posed as patients presenting to Respondent.

13. In November 2013, an undercover local law enforcement agent (Agent) presented to Respondent as a new patient. The report of the encounter states as follows:

- a. Agent completed forms and answered questions from a nurse inquiring about pain. Agent repeatedly denied any pain and the nurse began asking questions in the past tense. Agent was photographed and told it was common practice because Respondent's clinic sees approximately 70 patients a day.
- b. When Respondent entered the exam room, he inquired why Agent was there if reporting no pain. Agent indicated the desire to establish care in case of future pain. Respondent asked more questions about pain, which Agent denied, and Respondent then asked Agent what he wanted for pills. Agent

suggested Percocet and Respondent gave Agent a prescription for Percocet 5mg #60.

14. In February 2014, Agent presented to Respondent as a returning patient. The report of the encounter states as follows:

- a. Agent completed forms and answered questions from a nurse inquiring about pain. Agent repeatedly denied any pain. The nurse took Agent's blood pressure and vitals, and again asked about pain. Agent again denied any pain.
- b. When Respondent entered the exam room, he asked Agent if there were any changes. Agent replied that the Percocet 5mg was not working well, and Respondent suggested Agent increase to Percocet 10mg. Respondent also indicated he would increase the amount from #60 to #120.
- c. Respondent gave Agent two prescriptions for Percocet 10mg #120, one for the date of the visit, and one which was postdated. Respondent instructed Agent to fill the second one within 60 days even if not needed because otherwise it would expire.

15. In April 2014, Agent presented to Respondent as a returning patient. The report of the encounter states as follows:

- a. Agent completed forms and answered questions from a nurse inquiring about pain. Agent repeatedly denied any pain. The nurse took Agent's blood pressure and vitals, and again asked about pain. Agent again denied any pain and the nurse asked Agent to "give her something" as most people have some pain when they present, but that she would let Respondent figure it out.
- b. When Respondent entered the exam room, he asked Agent if there were any changes. Agent replied that the Percocet 10mg was not working well, but Agent had recently tried a "30" and liked it. Respondent chuckled and stated "everybody likes those."
- c. Respondent stated the only issue with "30s" is Agent would be subject to pill counts. Respondent advised Agent that if called for a pill count, saying there were too many is good, but having too few is not good. Respondent gave Agent three prescriptions for Oxycodone 30mg, one for each of the next three months.

16. In June 2014, Agent presented to Respondent as a returning patient, and this time with another local law enforcement agent posing as a friend ("Agent 2"). The report of the encounter states as follows:

- a. Agent completed forms and answered questions from a nurse inquiring about pain. Agent repeatedly denied any pain. The nurse took Agent's

blood pressure and heart rate, and again asked about pain. Agent again denied any pain.

- b. When Respondent entered the exam room, he greeted Agent who introduced Agent 2. Respondent asked Agent if there were any changes, which Agent denied. Respondent asked if Agent had “picked up” today and Agent indicated Agent had dropped off, but not yet picked up. Respondent appeared to be calculating dates in his head and stated “I will get you your scripts and get you the heck out-of-here.”
- c. Agent asked Respondent how Agent 2 could establish care. Respondent indicated Agent 2 should check in with the front desk. Respondent left the exam room and returned several minutes later with three Oxycodone 30mg prescriptions for Agent. Respondent asked Agent 2 “so, what ails you?” to which Agent 2 responded “nothing.” Agent 2 was directed to front desk staff who instructed Agent 2 on how to get a referral to Respondent.

17. In September 2014, Agent and Agent 2 presented to Respondent. The report of the encounter states as follows:

- a. Agent was asked by front desk staff to confirm a phone number and prescription for Oxycodone 30mg. No forms were offered although a nurse asked Agent questions about pain, to which Agent indicated no pain for the last two years.
- b. When Respondent entered the room, he engaged Agent in casual conversation, after which Respondent indicated Agent would receive three prescriptions for Oxycodone 30mg.
- c. Agent indicated Agent 2 could not get referred to Respondent despite having completed all the requirements, apparently because Agent 2 did not have chronic pain. Respondent stated he could not do it right now and that it would have to be done with “political sensitivity.” Respondent gave Agent 2 a piece of paper and asked Agent 2 to provide a name, date of birth, phone number and a short description of pain or problem. Respondent stated that “when the stars are aligned just right,” Agent 2 will get a spot.

18. In November 2014, Agent 2 presented to Respondent as a new patient. The report of the encounter states as follows:

- a. Agent 2 completed new patient registration forms and paid \$75 in cash. Agent 2 was shown to an exam room and was asked questions by a nurse about reported shoulder pain. Agent 2 denied any pain at the time, but rated past pain as 3-5/10, and stated Motrin does not help. The nurse took blood pressure and vital signs.
- b. When Respondent entered the exam room, he asked Agent 2 “how’s the shoulder doing?” Agent 2 reported no pain at the moment, confirmed that

Motrin does not work, and stated Agent 2 “takes Oxy 30’s from other people.”

- c. Respondent briefly manipulated Agent 2’s shoulder and asked about frequency of pain, to which Agent 2 responded 2-4 times every 1-2 months. Respondent diagnosed a shoulder problem although Agent 2 has never in fact suffered from any shoulder problem. Respondent stated “so, Oxy 30’s?” Agent 2 responded yes and Respondent prescribed Oxycodone 30mg #90.

19. In February 2015, Agent 2 presented to Respondent as a returning patient. The report of the encounter states as follows:

- a. Agent 2 paid \$75 cash and filled out forms on which Agent 2 circled no pain to all questions, except for “pain will occasionally wake me up at night.” A nurse took Agent 2’s blood pressure and asked more questions about pain, which Agent 2 all denied and indicated a pain level of 0 out of 10.
- b. When Respondent entered the exam room, he asked Agent 2 “what’s going on with you?” to which Agent 2 replied “nothing today, feeling fine today.” Respondent made small talk and asked “so, did that last you?” to which Agent 2 replied “well I had to use the free refills, so maybe if we could up it, so I won’t have to come back.”
- c. Respondent and Agent 2 engaged in a discussion about how many pills Agent 2 was using per month and Respondent stated “you’re going to have to think about getting insurance because if the police come look at me and see that I’m giving you a free pass, it won’t be good for me. That’s like if I’m doing a regular patient and my impression of this was that it was for the occasional shoulder pain, but that’s not what’s happening. And if you’re taking that much they should be doing drug testing on you and pill counts.”
- d. Respondent and Agent 2 engaged in a discussion about how Agent 2 could receive more Oxycodone and Respondent indicated “we’ll just do it a different way. Just slow down cowboy. . . so if you call ten days before April 16<sup>th</sup> and ten days before May 16<sup>th</sup> you can just come in and get your scrips and then I won’t see you until June. You’re all set.” Agent 2 was then given two prescriptions for Oxycodone IR 30mg #90, one written for the date of the visit and one for a month later.

#### **Patient A**

20. Patient A, a female born in 1956, was treated by Respondent for chronic back pain for thirteen years between August 2001 and the time of her death in December 2014, at which point Respondent was prescribing the following medications on a monthly basis:

- a. Morphine Sulfate ER 200mg #600

- b. Morphine Sulfate IR 30mg #1080
- c. Hydrocodone-Acetaminophin 10-325 #270
- d. Clonazepam 2mg #30
- e. Adderall 20mg #60

21. The Manitowoc County Coroner's report states that Patient A had a known history of chronic drug abuse and identifies the cause of Patient A's death as Mixed Drug Intoxication.

### **Patient B**

22. Patient B, a female of unknown age, was interviewed by DEA on June 18, 2013. Patient B reports treating with Respondent for "degenerative back pain." Patient B states she first treated with Respondent after her prior provider discharged her for non-compliance with prescriptions for hydromorphone and morphine.

23. Patient B stated the discharge from her prior provider caused her to attempt suicide by morphine overdose. Patient B states she has on other occasions attempted suicide by overdose with the medications prescribed to her by Respondent.

24. Patient B reported multiple psychiatric hospitalizations, and stated Respondent is aware of her overdose attempts and hospitalizations, but has never attempted an "intervention" of any type.

25. Patient B stated that Respondent prescribes her "28 Oxy 30's a day" and used to prescribe her "40 Oxy 30's a day, 1200 a month." Patient B stated she only follows her prescriptions when she anticipates a urine screen, and is "half passed out" when she does so.

26. Patient B stated that before Oxycontin was reformulated, Respondent prescribed it for her as follows: "6 Oxy 80's, 4 Oxy 60's, 4 Oxy 40's, and 8 Oxy 30's a day."

27. Patient B stated that Respondent allows her to request specific drugs and dosages.

28. Patient B stated her appointments with Respondent last approximately five minutes and that Respondent no longer asks about her pain level. Instead, Respondent asks if "everything is OK." When Patient B answers "yes," Respondent will refill her prescription and post-date another prescription for the following month.

29. Patient B stated that Respondent does not perform any physical exam or order any imaging or testing, and often forgets who Patient B is.

30. Patient B stated she used to see Respondent every four months, and in the interim would call a prescription "hotline" to request her prescriptions for pick up a week later.

## **Patient Deaths**

31. The DEA materials contain a January 22, 2015 report from the Manitowoc County Coroner's Office which reflects that between February 22, 2013 and December 5, 2014, seven of Respondent's patients died of the following causes: (1) accident: morphine toxicity, oral ingestion of morphine, chronic substance abuse; (2) acute methadone intoxication; (3) suicide; (4) mixed drug toxicity; (5) accidental overdose of prescription medications; (6) mixed drug toxicity; and (7) mixed drug toxicity.

## **Affidavit of David E. Remiker**

32. The sworn Affidavit of David E. Remiker is attached hereto as Exhibit A. It speaks for itself and highlights the significant concern with Respondent's prescribing.

## **Respondent's Recorded Interview Testimony**

33. On March 19, 2015, Respondent was interviewed by agents from the DEA and the Manitowoc County Sheriff's Department Metro Drug Unit regarding Respondent's treatment of pain management patients, and his prescribing of controlled substances, specifically opioids. The report summarizing the interview states as follows:

- a. Respondent's specialty is anesthesia and he is board certified in anesthesia.
- b. Respondent graduated from medical school in 1984, completed his residency in Olympia Fields, Illinois, and worked in a hospital anesthesia department for approximately one year before moving to his current practice in Manitowoc, Wisconsin.
- c. Respondent practices in a pain clinic affiliated with his employer, Holy Family Memorial Hospital. Clinic hours are typically 7:30 a.m. to 5:15 p.m., Monday – Friday.
- d. Respondent performs examinations on all patients, but not at every visit. Respondent states that all patients "get examined" by coming into an exam room where Respondent "can see them" although he does not "necessarily push and pull on everyone." All patients have vitals taken by a nurse.
- e. A new patient examination consists of Respondent examining the eyes, ears, nose and throat, and a check for hair infestation. Respondent will ensure the trachea is in the middle and the chest wall is symmetrical, and he performs a manual examination of the spine on "spots that are injured or hurt." Respondent will "push or pull where [he] needs to" and will "usually" review any prior charts and studies. New patients without medical records will be seen and Respondent just "starts from scratch" with them.
- f. Respondent sees approximately 20-25 patients per day.<sup>1</sup>

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<sup>1</sup> This is inconsistent with the nurse's statement of 70 patients per day, reflected in paragraph 13(a) above.

- g. Respondent does not see patients in pairs.<sup>2</sup>
- h. If a patient is “good to go”—meaning Respondent sees no reason to distrust the patient—he allows those patients to pick up prescriptions without seeing them. Respondent maintains a prescription “hotline” whereby patients who are “good to go” may leave a message requesting their prescriptions, which a nurse then processes for the patient or their designated representative to pick up.
- i. Respondent typically checks state court records for any “legal issues” and checks with “people in the community” in order to determine if a patient is “good to go.”
- j. Respondent does not request prescription profiles from local pharmacies, and will review the Wisconsin Prescription Drug Monitoring Program only if he becomes suspicious about something.
- k. About 4-5 months prior to the interview, Respondent began calling patients in for pill counts, which were previously done only for cause. Respondent was unsure whether his office has a “set policy” for how pill counts are conducted. Respondent has always wanted to conduct regular pill counts, but has lacked the manpower for what he describes as a “full time job.”
- l. Respondent primarily prescribes oxycodone, morphine, fentanyl, buprenorphine, hydromorphone and hydrocodone.
- m. Respondent recognizes there are “a bunch of people coming through here whose full time job it is to scam [him]” and he “doesn’t believe what people tell [him] for the most part.”
- n. Respondent requires new patients to complete an “Opioid Risk Assessment” form, but acknowledges the “whole joke” is that it relies on the patient providing truthful answers. Respondent “would never turn anyone away” based on their responses on the risk assessment form.
- o. Respondent believes his patients are dependent on the medications he prescribes, and that some are addicted to them. Respondent does not, however, know who his addicted patients are because he wouldn’t necessarily be treating them the way he is if he knew they were addicted to their medications.
- p. Respondent stated that if the medication dose is too high, the patient becomes “stupid,” but if the dose is too low, Respondent “hasn’t achieved anything.”
- q. Respondent previously had no ceiling on the dosages he would prescribe because he received advice from an expert in the field who advised Respondent the dose is high enough “when they feel OK.” However, Respondent has since learned “it’s not a good thing” to prescribe an unlimited quantity of pain medication.

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<sup>2</sup> This is inconsistent with the undercover activities described in paragraphs 12-19 above.

- r. Many of Respondent's patients on large amounts of narcotics are "very insecure" about their need for medication. Respondent does not believe these patients are addicted, but rather afraid they will get "abandoned."
- s. Respondent tells patients they have two bad choices: deal with their pain or deal with the effects of pain medication.
- t. Respondent has discharged patients upon learning they diverted the medications he prescribed to them. However, Respondent stated that local law enforcement intelligence about diversion does not always result in a patient being discharged. If Respondent believes the intelligence is unconfirmed, he will increase his surveillance of the patient, including increased urine tests.
- u. As an example of such surveillance, Respondent identified a patient who local law enforcement believed was diverting.<sup>3</sup> Respondent called the patient in to his office, watched her take the high dosage of opioids he prescribed for her, and then "watched her all day." When the patient did not "tip over," Respondent was satisfied she was taking her medication as prescribed.
- v. Respondent stated "it's not as easy as you'd think" regarding how to deal with a patient who tests negative on a urine drug screen because urinalysis is not black and white.
- w. Respondent would like a liaison with local law enforcement so he can "know exactly what's going on and have a better understanding."
- x. Respondent is aware that pills he prescribes are routinely found when local law enforcement executes search warrants. Respondent states it is "kind of scientific fact" that 30% of his patients are not going to follow his prescriptions and are either "using it up themselves or diverting it."
- y. Respondent is aware of overdose deaths associated with the medications he prescribes.
- z. Some of Respondent's "high dose opioid" patients travel long distances to see him and they are "very legitimate," but cannot be referred to providers near them because those providers would not prescribe "that kind of medication."
- aa. Respondent is willing to prescribe higher amounts of pain medication than other providers because he believes "there are people outside of the bell curve and those people deserve to be treated as well."
- bb. Respondent acknowledges his prescribing is "out of the norm," but believes it is for a legitimate medical purpose for "a different patient population."

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<sup>3</sup> A report regarding this patient is found in the DEA materials.

- cc. Respondent believes pain and addiction “are very integrated” and not in conflict with each other. Respondent states “it’s all suffering” and believes he is alleviating suffering.
- dd. Respondent states he welcomes contacts from pharmacists who call to verify or express concern about Respondent’s prescribing, but will not alter or decrease his prescribing based on such concerns.
- ee. Respondent does not become upset when people question his prescribing because he knows he is “off the beaten path” and that some who express concern “speak out of ignorance.”

34. Respondent Charles R. Szyman, D.O., by engaging in prescribing of controlled substances, as set out in paragraphs 12-33 above, has committed unprofessional conduct, as defined by Wis. Admin. Code § Med 10.02(2)(h) (Nov. 2002)<sup>4</sup> and Wis. Admin. Code §§ Med 10.03(2)(b) and (c) (Oct. 2013)<sup>5</sup> and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

35. Based on this Petition and the Affidavit of David E. Remiker, there is probable cause to believe it is necessary to suspend Respondent’s Wisconsin medical license (no. 29228-21) immediately to protect the public health, safety or welfare.

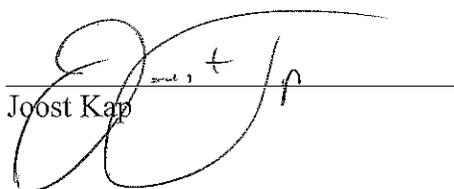
36. A formal Complaint to be filed with the Wisconsin Department of Administration, Division of Hearings and Appeals, alleging that Respondent has committed unprofessional conduct, is attached.

WHEREFORE, the Division of Legal Services and Compliance hereby requests that the Wisconsin Medical Examining Board:

1. Find that notice has been given to Respondent Charles R. Szyman, D.O., under Wis. Admin. Code § SPS 6.05.

2. Find probable cause to believe that Respondent Charles R. Szyman, D.O., has engaged in or is likely to engage in conduct such that the public health, safety or welfare imperatively requires emergency suspension of Respondent’s license and registration to practice medicine and surgery.

3. Issue an order summarily suspending the license and registration of Respondent Charles R. Szyman, D.O. (no. 29228-21), to practice medicine and surgery in the state of Wisconsin and order that such suspension continue until the effective date of a final decision and order issued in the disciplinary proceeding against Respondent, unless otherwise ordered by the Board.

  
 \_\_\_\_\_  
 Joost Kap

<sup>4</sup> For conduct occurring before October 1, 2013.

<sup>5</sup> For conduct occurring on or after October 1, 2013.



STATE OF WISCONSIN  
BEFORE THE MEDICAL EXAMINING BOARD

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IN THE MATTER OF THE DISCIPLINARY :  
PROCEEDINGS AGAINST :  
: DLSC CASE NO. 15 MED 261  
CHARLES R. SZYMAN, D.O., :  
RESPONDENT. :

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AFFIDAVIT OF DAVID E. REMIKER

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STATE OF WISCONSIN )  
 ) ss  
COUNTY OF MANITOWOC )

David E. Remiker, being duly under oath, deposes and states as follows:

1. I am an adult resident of the state of Wisconsin. I make this affidavit based upon my personal knowledge of the things set forth below, and in support of the Petition for Summary Suspension filed by the Wisconsin Department of Safety and Professional Services, Division of Legal Services and Compliance, as to Charles R. Szyman, D.O.

2. I am currently employed as the Lieutenant of Investigations for the Manitowoc County Sheriff's Office Detective Division, and am also the Supervisor of the Manitowoc County Metro Drug Unit. I was hired by the Manitowoc County Sheriff's Office in January of 1993, and in January 1999 was assigned as the Narcotics Investigator in the Manitowoc County Metro Drug Unit, a multi-jurisdictional/agency drug task force consisting of law enforcement officers from the Manitowoc County Sheriff's Office, the Manitowoc Police Department, the Two Rivers Police Department, and the Kiel Police Department.

3. In December of 2008, I was promoted to my current position as Lieutenant of Investigations with a primary assignment within the agency to supervise the Manitowoc County Metro Drug Unit. In the course of my work, I have conducted hundreds of investigations related to diversion, abuse and trafficking of prescription medications. I have testified in numerous capacities and venues, and have undergone specialized training related to controlled substances diversion, abuse and trafficking.

4. My primary responsibility is to supervise, manage and coordinate personnel and investigations related to controlled substance offenses. I currently supervise six individuals assigned to the drug task force in addition to overseeing the operations of the Manitowoc County Sheriff's Office Detective Division, which consists of four Investigators and one Lieutenant Supervisor.

5. During the course of my work since 1999, I have consistently received information that Charles R. Szyman, D.O., is prescribing mass quantities of narcotics, specifically opioid pain medications. A majority of the individuals who provide us with information or intelligence about prescription drug diversion, abuse and trafficking have identified Dr. Szyman as their prescribing physician or the source of their narcotics.

6. During the course of my work since 1999, I have conducted investigations related to individuals abusing, diverting or overdosing on prescription medication, and have consistently found that the prescription pain medication involved were received through the course of health care appointments between Dr. Szyman and the patient, victim or suspect. During the course of investigative interviews and observations at the scenes of criminal investigations, I have consistently encountered mass quantities of prescription medication bottles, prescribing records, and narcotic pain medications indicating the prescribing physician as Dr. Szyman.

7. During the course of my work since 1999, I have conducted investigative interviews of individuals who describe short-term and long-term patient/physician relationships with Dr. Szyman, and the ease in obtaining mass quantities and numerous combinations of medications from Dr. Szyman through the course of health care appointments.

8. During the course of my work since 1999, I have conducted investigative interviews of individuals who describe and identify the beginning of their addiction to prescription pain medication, and eventual abuse and addiction to other narcotics including heroin and methamphetamine, as resulting from their doctor-patient relationship with Dr. Szyman.

9. During the course of my work since 1999, I have conducted investigative interviews of individuals who independently describe their interactions with Dr. Szyman to include consistent appointments and statements made by Dr. Szyman, and state their appointments with him would involve little to no physical examination, little to no complaints of pain, and little to no complaint of injury or source of pain.

10. During the course of my work since 1999, I have conducted investigative interviews of individuals who independently identify Dr. Szyman as the physician that "everybody goes to" for very easily obtained narcotic pain medications. Local law enforcement officers have repeatedly described the "reputation" that Dr. Szyman has in their communities, based on their contacts with individuals involved with diversion, abuse and trafficking of prescription pain medication in mass quantities.

11. For example, investigators from the Manitowoc County Metro Drug Unit pursued an investigation related to a female subject that investigators identified as a patient of Dr. Szyman. Investigators conducted several controlled purchases of prescription pain medication from the subject, which eventually led to a search warrant at her residence and an interview. During the course of the interview, the subject revealed she is a long-term and ongoing patient of Dr. Szyman, reportedly for various physical and mental issues. The subject indicated she receives numerous monthly prescription medications from Dr. Szyman, including thousands of prescription pain medications. The subject admitted to diverting the medications prescribed to her by Dr. Szyman, and stated the proceeds of these activities exceeded approximately \$10,000.00 per month. In the subject's opinion, the medications she is prescribed by Dr. Szyman

have caused and/or exacerbated her physical and mental health problems, including a hospital admission for major stomach and constipation problems. The subject described mental health issues, including bipolar disorder and suicidal tendencies occurring during the course of her doctor-patient relationship with Dr. Szyman. The subject's testimony was substantiated by information obtained from the U.S. Drug Enforcement Administration (DEA) Diversion Unit and the Wisconsin Prescription Drug Monitoring Program.

12. I have identified five individuals who were patients of Dr. Szyman and died from either overdose death or suicide. I have spoken with a deputy coroner in Manitowoc County who is also a licensed physician. He believes Dr. Szyman's prescribing has caused the deaths of numerous individuals in Manitowoc County, and that on some occasions, the medication amounts being prescribed by Dr. Szyman would be physically impossible to consume by a normal person without resulting in complete incapacitation or death.

13. I have reviewed the Department's Petition for Summary Suspension which this affidavit is offered in support of. I am aware of the DEA investigation on which the petition also relies, and in many instances was directly involved in the law enforcement activities described in the petition. I believe the petition accurately reflects the significant concerns about Dr. Szyman's prescribing of controlled substances, and believe that his ongoing practice continues to present an immediate danger to his patients and the general public of the community I serve.

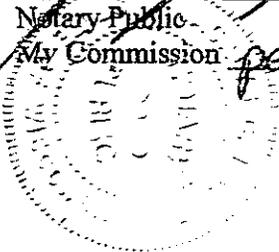


Lt. David E. Remiker

Subscribed and sworn to before me  
this 13 day of October 2015.



Notary Public  
My Commission permanent



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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>		<b>2) Date When Request Submitted:</b> 9/29/2015 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  10/21/2015	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Legislative Report	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b>  No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  Insert Bill number under 'Find a Proposal' at <a href="http://legis.wisconsin.gov/">http://legis.wisconsin.gov/</a> :  Assembly Bill 253/Senate Bill 196 (Interstate Medical Licensure Compact) Senate Bill 185 (Creation of a Clinical Exercise Physiology Affiliated Credentialing Board) Senate Bill 268/Assembly Bill 364 (PDMP) Senate Bill 269/Assembly Bill 365 (PDMP) Senate Bill 271 (Methadone) Senate Bill 272 (Pain Clinics) Senate Bill 307 (Complementary and Alternative Health Medicine Exemptions)			
<b>11) Authorization</b>			
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	

## AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:  Katie Vieira Administrative Rules Coordinator		2) Date When Request Submitted:  10/8/2015  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:  10/21/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  Med 24 – Telemedicine – Preliminary Rule Draft	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  N/A	
10) Describe the issue and action that should be addressed:  The Board will review the preliminary rule draft of the proposed rule relating to telemedicine.			
11) Authorization			
<b>Katie Vieira</b>		<b>10/8/2015</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD

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

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PROPOSED ORDER

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

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**Statutes interpreted:**

None.

**Statutory authority:**

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

**Related statute or rule:**

None.

**Explanation of agency authority:**

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

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

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

**Plain language analysis:**

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

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

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

**Comparison with rules in adjacent states:**

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

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

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

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

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

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

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

The rule 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:**

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

**Agency contact person:**

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

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

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

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TEXT OF RULE

SECTION 1. Chapter Med 24 is created to read:

CHAPTER MED 24

TELEMEDICINE

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

**Med 24.02 Definitions.** For the purposes of this chapter:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Med 24.12 Coordination of care.** A licensee who uses telemedicine shall, when medically appropriate, identify the medical home or treating 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).

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

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

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

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

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

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

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

**Med 24.17 Technology and equipment.** The board recognizes that three broad categories of telemedicine technologies 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:

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

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

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

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

(1) Types of services provided.

(2) Contact information for the licensee.

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

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

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

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

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

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

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

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

(11) Information collected and passive tracking mechanisms utilized.

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

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

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

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

**Med 24.20 Financial interests.** Advertising or promotion of goods or products from which the licensee(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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(END OF TEXT OF RULE)  
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Dated \_\_\_\_\_

Agency \_\_\_\_\_

Chairperson  
Medical Examining Board

**MEDICINE BOARD[653]**

**Adopted and Filed**

Pursuant to the authority of Iowa Code section 147.76, the Board of Medicine hereby amends Chapter 13, “Standards of Practice and Principles of Medical Ethics,” Iowa Administrative Code.

This rule establishes the standards of practice for physicians who use telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board approved the Notice of Intended Action for this rule making during a regularly scheduled meeting on October 3, 2014. The Notice was published in the Iowa Administrative Bulletin on December 10, 2014, as **ARC 1769C**. A public hearing on **ARC 1769C** was held on January 15, 2015.

Five comments were received at the hearing, and 18 written comments were received. The Board received written comments from Rebecca J. Hafner-Fogarty, M.D., Zipnosis; Timothy G. Abrahamson, M.D., Greater Des Moines Dermatology; Susan Koehler, Iowa Board of Physician Assistants; Sara Allen, Iowa Hospital Association; David Erickson, M.D., Avera Health; Thomas G. Seaman, Teladoc; Karla Fultz McHenry, Fultz McHenry Consulting; Clare M. Kelly, Iowa Medical Society; Jonathan D. Linkous, American Telemedicine Association; Laurie Clair, Iowa Physician Assistant Society; Dale F. Andres, D.O., Mercy Health Network; Andrew Zinkel, M.D., HealthPartners; Kate Walton, UnityPoint Health; Gretchen Borchelt, National Women’s Law Center; Ted Stopulos, Iowa Health Care Association and Iowa Center for Assisted Living; Craig Sieverding, Davis Brown Law Firm; Leah J. McWilliams, Iowa Osteopathic Medical Association; and Planned Parenthood of the Heartland. Comments were made at the hearing by Ken Croken, Genesis Health System; Dennis Tibben, Iowa Medical Society; Mike Falkstrom, Planned Parenthood of the Heartland; Dale Andres, D.O., Mercy Health Network; and Stephanie Cooper, Mercy Physician Services.

The Board continued a public discussion of **ARC 1769C** at a regularly scheduled meeting on February 6, 2015, at which time it was determined to accept public comments until March 20, 2015.

Several revisions were made to proposed rule 653—13.11(147,148,272C) based on comments received between October 3, 2014, and March 20, 2015:

In subrule 13.11(1), the definition of “asynchronous store-and-forward transmission” was added and, in the definition of “telemedicine,” the adjective “asynchronous” was added to the phrase “store-and-forward transmission.” The definition of “telemedicine” was enhanced to recognize that telemedicine includes store-and-forward technologies, remote monitoring, and real-time interactive services, including teleradiology and telepathology.

In subrule 13.11(2), language was changed to acknowledge that some nationally recognized medical specialty organizations have established comprehensive telemedicine practice guidelines that address the clinical and technological aspects of telemedicine.

In subrule 13.11(3), a citation to 653—subrule 9.2(2) was added to identify the exceptions to Iowa licensure.

In subrule 13.11(7), changes were made to clarify that a physician-patient relationship can be established under some circumstances involving a telemedicine encounter with a patient.

Subrule 13.11(8) notes that generally a licensee shall perform an in-person medical interview and physical examination for each patient but also recognizes that the in-person interview and in-person physical examination may not be necessary if the technology utilized in a telemedicine encounter is sufficient to establish an informed diagnosis. This subrule was revised to define characteristics of an appropriate Internet questionnaire to collect information on a patient’s medical history and current health issues.

In subrule 13.11(9) as revised, the licensee will not be required to personally assess the qualifications of each nonphysician health care provider, but the licensee must ensure that systems are in place to make certain that a nonphysician health care provider is qualified and appropriately trained.

In subrule 13.11(16), the adjective “asynchronous” was added to the phrase “store-and-forward technologies.”

In subrule 13.11(17), the phrase “if these differ from an in-person encounter” was added in paragraph “e” pertaining to the requirement to disclose fees for medical services provided via telemedicine.

In subrule 13.11(19), language was added to acknowledge that there may be state and federal laws that govern the financial interests of licensees who practice medicine by using telemedicine.

In subrule 13.11(20), language was revised to reflect that the standard of care may not require a licensee to personally interview and examine a patient prior to the provision of care in certain circumstances, including both in the use of telemedicine and in in-person encounters with a patient.

In subrule 13.11(21) as revised, it is recognized that without a valid physician-patient relationship, or outside of circumstances described in subrule 13.11(20), the prescribing of any prescription medications, not limited to controlled substances, based solely on an Internet request, an Internet questionnaire or a telephonic evaluation is prohibited.

Subrule 13.11(22) clarifies that nothing in rule 653—13.11(147,148,272C) shall be interpreted to contradict or supersede the requirements established in rule 653—13.10(147,148,272C).

At a regularly scheduled meeting on April 3, 2015, the Board voted to adopt this rule with the above-listed changes.

After analysis and review of this rule making, it has been determined that this rule could have a positive impact on jobs in Iowa. The new rule will facilitate the practice of medicine at more locations within the state.

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

This rule will become effective on June 3, 2015.

The following amendment is adopted.

Adopt the following **new** rule 653—13.11(147,148,272C):

**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.

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## MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

### *Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup*

#### INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)<sup>1</sup> and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients<sup>2</sup> via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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<sup>1</sup> The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).

<sup>2</sup> The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.

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## Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

### Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.<sup>3</sup> However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.<sup>4</sup>

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.<sup>5</sup>

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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<sup>3</sup> See Center for Telehealth and eHealth Law (Ctel), <http://ctel.org/> (last visited Dec. 17, 2013).

<sup>4</sup> *Id.*

<sup>5</sup> See Cal. Bus. & Prof. Code § 2290.5(d).

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- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

## Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.<sup>6</sup> The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

## Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.<sup>7</sup>

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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<sup>6</sup> American Medical Association, Council on Ethical and Judicial Affairs, *Fundamental Elements of the Patient-Physician Relationship* (1990), available at <http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf>.

<sup>7</sup> See Ctel.

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## Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

### Licensure:

A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.<sup>8</sup>

### Establishment of a Physician-Patient Relationship:

Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

### Evaluation and Treatment of the Patient:

A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

### Informed Consent:

Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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<sup>8</sup> Federation of State Medical Boards, *A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996)*, available at [http://www.fsmb.org/pdf/1996\\_grpol\\_telemedicine.pdf](http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf).

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## Continuity of Care:

Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

## Referrals for Emergency Services:

An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

## Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

## Privacy and Security of Patient Records & Exchange of Information:

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).<sup>9</sup> Guidance documents are available on the HHS Office for Civil Rights Web site at: [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa).

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) 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, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

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<sup>9</sup> 45 C.F.R. § 160, 164 (2000).

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results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

### Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:

Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit from that pharmacy.

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### Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

### **Section Five. Parity of Professional and Ethical Standards**

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice. A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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1 State of Arkansas *As Engrossed: S3/3/15 S3/12/15*

2 90th General Assembly

# A Bill

3 Regular Session, 2015

SENATE BILL 133

4

5 By: Senator Bledsoe

6 By: Representative D. Ferguson

7

8

## For An Act To Be Entitled

9 AN ACT TO ENCOURAGE THE USE OF TELEMEDICINE; TO  
10 REDUCE HEALTHCARE DISPARITIES; TO IMPROVE ACCESS TO  
11 CARE; TO ADDRESS GEOGRAPHIC MALDISTRIBUTION OF  
12 PRIMARY CARE AND SPECIALTY CARE; TO AUTHORIZE  
13 REIMBURSEMENT AND REGULATION OF SERVICES PROVIDED  
14 THROUGH TELEMEDICINE; TO DECLARE AN EMERGENCY; AND  
15 FOR OTHER PURPOSES.

16

17

18

## Subtitle

19

TO ENCOURAGE THE USE OF TELEMEDICINE; AND  
20 TO DECLARE AN EMERGENCY.

21

22

23

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

24

25 SECTION 1. DO NOT CODIFY. Title.

26 This act shall be known and may be cited as the "Telemedicine Act".

27

28 SECTION 2. DO NOT CODIFY. Legislative findings.

29 The General Assembly finds and declares that:

30

31

32

33

(1) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine;

34

35

36

(2) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, and a way to provide, ensure, or enhance access to



1 health care, given these barriers, is through the appropriate use of  
2 technology to allow healthcare consumers access to qualified healthcare  
3 professionals; and

4 (3) There is a need in this state to embrace efforts that will  
5 encourage:

6 (A) Health insurers and healthcare professionals to  
7 support the use of telemedicine; and

8 (B) All state agencies to evaluate and amend their  
9 policies and rules to remove regulatory barriers prohibiting the use of  
10 telemedicine.

11  
12 SECTION 3. Arkansas Code Title 17, Chapter 80, Subchapter 1, is  
13 amended to add an additional section to read as follows:

14 17-80-117. Telemedicine.

15 (a) As used in this section:

16 (1) "Distant site" means the location of the healthcare  
17 professional delivering services through telemedicine at the time the  
18 services are provided;

19 (2) "Healthcare professional" means a person who is licensed,  
20 certified, or otherwise authorized by the laws of this state to administer  
21 health care in the ordinary course of the practice of his or her profession;

22 (3) "Originating site" means:

23 (A) The offices of a healthcare professional or a licensed  
24 healthcare entity where the patient is located at the time services are  
25 provided by a healthcare professional through telemedicine; and

26 (B) The home of a patient in connection with treatment for  
27 end-stage renal disease;

28 (4) "Professional relationship" means at minimum a relationship  
29 established between a healthcare professional and a patient when:

30 (A) The healthcare professional has previously conducted  
31 an in-person examination and is available to provide appropriate follow-up  
32 care, when necessary, at medically necessary intervals;

33 (B) The healthcare professional personally knows the  
34 patient and the patient's relevant health status through an ongoing personal  
35 or professional relationship, and is available to provide appropriate follow-  
36 up care, when necessary, at medically necessary intervals;

1                   (C) The treatment is provided by a healthcare professional  
2 in consultation with, or upon referral by, another healthcare professional  
3 who has an ongoing relationship with the patient and who has agreed to  
4 supervise the patient's treatment, including follow-up care;

5                   (D) An on-call or cross-coverage arrangement exists with  
6 the patient's regular treating healthcare professional;

7                   (E) A relationship exists in other circumstances as  
8 defined by rule of the Arkansas State Medical Board for healthcare  
9 professionals under its jurisdiction and their patients; or

10                   (F) A relationship exists in other circumstances as  
11 defined by rule of a licensing or certification board for other healthcare  
12 professionals under the jurisdiction of the appropriate board and their  
13 patients if the rules are no less restrictive than the rules of the Arkansas  
14 State Medical Board;

15                   (5) "Store and forward technology" means the transmission of a  
16 patient's medical information from an originating site to the provider at the  
17 distant site without the patient being present; and

18                   (6) "Telemedicine" means the medium of delivering clinical  
19 healthcare services by means of real-time two-way electronic audio-visual  
20 communications, including without limitation the application of secure video  
21 conferencing, to provide or support healthcare delivery that facilitates the  
22 assessment, diagnosis, consultation, or treatment of a patient's health care  
23 while the patient is at an originating site and the healthcare professional  
24 is at a distant site.

25                   (b)(1) The standards of appropriate practice in traditional healthcare  
26 professional-patient settings shall govern the licensed healthcare  
27 professional's treatment recommendations made via electronic means, including  
28 issuing a prescription via telemedicine.

29                   (2) This section does not alter existing state law or rules  
30 governing a healthcare professional's scope of practice.

31                   (3) This section does not authorize drug-induced, chemical, or  
32 surgical abortions performed through telemedicine.

33                   (4)(A) Store and forward technology shall not be considered  
34 telemedicine.

35                   (B) This subchapter does not restrict the use of store and  
36 forward technology.

1 (c) A healthcare professional shall follow applicable state and  
2 federal law, rules, and regulations for:

3 (1) Informed consent;

4 (2) Privacy of individually identifiable health information;

5 (3) Medical recordkeeping and confidentiality; and

6 (4) Fraud and abuse.

7 (d)(1) A healthcare professional who is treating patients in Arkansas  
8 through telemedicine shall be fully *licensed or certified* to practice in  
9 Arkansas and is subject to the rules of the appropriate state *licensing or*  
10 *certification* board.

11 (2) The requirement in subdivision (d)(1) of this section does  
12 not apply to the acts of a healthcare professional located in another  
13 jurisdiction who provides only episodic consultation services.

14 (e)(1) A healthcare professional at a distant site shall not utilize  
15 telemedicine with respect to a patient located in Arkansas unless a  
16 professional relationship exists between the healthcare professional and the  
17 patient or the healthcare professional otherwise meets the requirements of  
18 professional relationship as defined in § 17-80-117(a)(4).

19 (2) The existence of a professional relationship is not required  
20 in the following circumstances:

21 (A) Emergency situations where the life or health of the  
22 patient is in danger or imminent danger; or

23 (B) Simply providing information of a generic nature, not  
24 meant to be specific to an individual patient.

25 (f) State licensing and certification boards for a healthcare  
26 professional shall amend their rules where necessary to comply with this  
27 section.

28  
29 SECTION 4. Arkansas Code Title 23, Chapter 79, is amended to add an  
30 additional subchapter to read as follows:

31  
32 Subchapter 16 – Coverage for Services Provided Through Telemedicine

33  
34 23-79-1601. Definitions.

35 As used in this subchapter:

36 (1) "Distant site" means the location of the healthcare

1 professional delivering healthcare services through telemedicine at the time  
2 the services are provided;

3 (2)(A) "Health benefit plan" means:

4 (i) An individual, blanket, or group plan, policy,  
5 or contract for healthcare services issued or delivered by an insurer, health  
6 maintenance organization, hospital medical service corporation, or self-  
7 insured governmental or church plan in this state; and

8 (ii) Any health benefit program receiving state or  
9 federal appropriations from the State of Arkansas, including the Arkansas  
10 Medicaid Program and the Health Care Independence Program, commonly referred  
11 to as the "Private Option", or any successor program.

12 (B) "Health benefit plan" includes:

13 (i) Indemnity and managed care plans; and

14 (ii) Non-federal governmental plans as defined in 29  
15 U.S.C. § 1002(32), as it existed on January 1, 2015.

16 (C) "Health benefit plan" does not include:

17 (i) Disability income plans;

18 (ii) Credit insurance plans;

19 (iii) Insurance coverage issued as a supplement to  
20 liability insurance;

21 (iv) Medical payments under automobile or homeowners  
22 insurance plans;

23 (v) Health benefit plans provided under Arkansas  
24 Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et  
25 seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

26 (vi) Plans that provide only indemnity for hospital  
27 confinement;

28 (vii) Accident only plans;

29 (viii) Specified disease plans; or

30 (ix) Long-term care only plans;

31 (3) "Healthcare professional" means a person who is licensed,  
32 certified, or otherwise authorized by the laws of this state to administer  
33 health care in the ordinary course of the practice of his or her profession;

34 (4) "Originating site" means:

35 (A) The offices of a healthcare professional or a licensed  
36 healthcare entity where the patient is located at the time services are

1 provided by a healthcare professional through telemedicine; and

2 (B) The home of a patient in connection with treatment for  
3 end-stage renal disease; and

4 (5) "Telemedicine" means the medium of delivering clinical  
5 healthcare services by means of real-time two-way electronic audio-visual  
6 communications, including without limitation the application of secure video  
7 conferencing, to provide or support healthcare delivery that facilitates the  
8 assessment, diagnosis, consultation, or treatment of a patient's health care  
9 while the patient is at an originating site and the healthcare professional  
10 is at a distant site.

11  
12 23-79-1602. Coverage for telemedicine.

13 (a)(1) This subchapter shall apply to all health benefit plans  
14 delivered, issued for delivery, reissued, or extended in Arkansas on or after  
15 January 1, 2016, or at any time when any term of the health benefit plan is  
16 changed or any premium adjustment is made thereafter.

17 (2) Notwithstanding subdivision (a)(1) of this section, this  
18 subchapter shall apply to the Arkansas Medicaid Program on and after July 1,  
19 2016.

20 (b) A healthcare service provided through telemedicine shall comply  
21 with the requirements of § 17-80-117.

22 (c)(1) A health benefit plan shall cover the services of a physician  
23 who is licensed by the Arkansas State Medical Board for healthcare services  
24 through telemedicine on the same basis as the health benefit plan provides  
25 coverage for the same healthcare services provided by the physician in  
26 person.

27 (2) Subject to subdivision (d)(1) of this section, a health  
28 benefit plan shall reimburse a physician licensed by the board for healthcare  
29 services provided through telemedicine on the same basis as the health  
30 benefit plan reimburses a physician for the same healthcare services provided  
31 in person.

32 (d)(1) The combined amount of reimbursement that a health benefit plan  
33 allows for the compensation to the distant site physician and the originating  
34 site shall not be less than the total amount allowed for healthcare services  
35 provided in person.

36 (2) Payment for healthcare services provided through

1 telemedicine shall be provided to the distant site physician and the  
2 originating site upon submission of the appropriate procedure codes.

3 (3) This section does not:

4 (A) Prohibit:

5 (i) A health benefit plan from reimbursing other  
6 healthcare professionals; or

7 (ii) A health benefit plan from paying a facility  
8 fee to a provider at the distant site in addition to a fee paid to the  
9 healthcare professional; or

10 (B) Require an insurer to pay more for a healthcare  
11 service provided through telemedicine than would have been paid if the  
12 healthcare service was delivered in person.

13 (e) A health benefit plan shall not impose on coverage for healthcare  
14 services provided through telemedicine:

15 (1) An annual or lifetime dollar maximum on coverage for  
16 services provided through telemedicine other than an annual or lifetime  
17 dollar maximum that applies to the aggregate of all items and services  
18 covered;

19 (2) A deductible, copayment, coinsurance, benefit limitation, or  
20 maximum benefit that is not equally imposed upon all healthcare services  
21 covered under the health benefit plan; or

22 (3) A prior authorization requirement for services provided  
23 through telemedicine that exceeds the prior authorization requirement for in-  
24 person healthcare services under the health benefit plan.

25 (f) This subchapter does not prohibit a health benefit plan from:

26 (1) Limiting coverage of healthcare services provided through  
27 telemedicine to medically necessary services, subject to the same terms and  
28 conditions of the covered person's health benefit plan that apply to services  
29 provided in person; or

30 (2)(A) Undertaking utilization review, including prior  
31 authorization, to determine the appropriateness of healthcare services  
32 provided through telemedicine, provided that:

33 (i) The determination of appropriateness is made in  
34 the same manner as determinations are made for the treatment of any illness,  
35 condition, or disorder covered by the health benefit plan whether the service  
36 was provided in-person or through telemedicine; and

1 (ii) All adverse determinations are made by a  
2 physician who possesses a current and valid unrestricted license to practice  
3 medicine in Arkansas.

4 (B) Utilization review shall not require prior  
5 authorization of emergent telemedicine services.

6 (g)(1) A health benefit plan may adopt policies to ensure that  
7 healthcare services provided through telemedicine submitted for payment  
8 comply with the same coding, documentation, and other requirements necessary  
9 for payment an in-person service other than the in-person requirement.

10 (2) If deemed necessary, the State Insurance Department may  
11 promulgate rules containing additional standards and procedures for the  
12 utilization of telemedicine to provide healthcare service through health  
13 benefit plans if the additional standards and procedures do not conflict with  
14 this subchapter or § 17-80-117, and are applied uniformly by all health  
15 benefit plans.

16  
17 *SECTION 5. Arkansas Code Title 23, Chapter 86, Subchapter 1, is*  
18 *amended to add an additional section to read as follows:*

19 23-86-123. Prior authorization by physician.

20 (a) As used in this section:

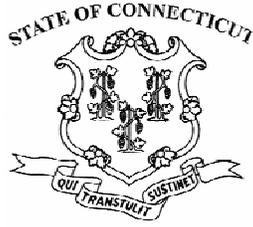
21 (1) "Prior authorization" means the process by which a health  
22 carrier determines the medical necessity or eligibility for coverage of a  
23 healthcare service before a covered person receives the healthcare service in  
24 order to provide coverage and reimbursement for the healthcare service; and

25 (2) "Telemedicine" means the medium of delivering clinical  
26 healthcare services by means of real-time two-way electronic audiovisual  
27 communications, including without limitation the application of secure video  
28 conferencing, to provide or support healthcare delivery that facilitates the  
29 assessment, diagnosis, consultation, treatment, education, care management,  
30 or self-management of a patient's health care while the patient is at an  
31 originating site and the healthcare professional is at a distant site.

32 (b) When conducting prior authorization, whether for healthcare  
33 services provided through telemedicine or provided in person, a physician who  
34 possess a current and unrestricted license to practice medicine in the State  
35 of Arkansas shall make all adverse determinations.

36





**Substitute Senate Bill No. 467**

**Public Act No. 15-88**

**AN ACT CONCERNING THE FACILITATION OF TELEHEALTH.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2015*) (a) As used in this section:

(1) "Asynchronous" means any transmission to another site for review at a later time that uses a camera or other technology to capture images or data to be recorded.

(2) "Health record" means the record of individual, health-related information that may include, but need not be limited to, continuity of care documents, discharge summaries and other information or data relating to a patient's demographics, medical history, medication, allergies, immunizations, laboratory test results, radiology or other diagnostic images, vital signs and statistics.

(3) "Facility fee" has the same meaning as in section 19a-508c of the general statutes.

(4) "Medical history" means information, including, but not limited to, a patient's past illnesses, medications, hospitalizations, family history of illness if known, the name and address of the patient's primary care provider if known and other matters relating to the

**Substitute Senate Bill No. 467**

health condition of the patient at the time of a telehealth interaction.

(5) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth.

(6) "Peripheral devices" means the instruments a telehealth provider uses to perform a patient exam, including, but not limited to, stethoscope, otoscope, ophthalmoscope, sphygmomanometer, thermometer, tongue depressor and reflex hammer.

(7) "Remote patient monitoring" means the personal health and medical data collection from a patient in one location via electronic communication technologies that is then transmitted to a telehealth provider located at a distant site for the purpose of health care monitoring to assist the effective management of the patient's treatment, care and related support.

(8) "Store and forward transfer" means the asynchronous transmission of a patient's medical information from an originating site to the telehealth provider at a distant site.

(9) "Synchronous" means real-time interactive technology.

(10) "Telehealth" means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health, and includes (A) interaction between the patient at the originating site and the telehealth provider at a distant site, and (B) synchronous interactions, asynchronous store and forward transfers or remote patient monitoring. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail.

(11) "Telehealth provider" means any physician licensed under

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chapter 370 of the general statutes, physical therapist licensed under chapter 376 of the general statutes, chiropractor licensed under chapter 372 of the general statutes, naturopath licensed under chapter 373 of the general statutes, podiatrist licensed under chapter 375 of the general statutes, occupational therapist licensed under chapter 376a of the general statutes, optometrist licensed under chapter 380 of the general statutes, advanced practice registered nurse licensed under chapter 378 of the general statutes, physician assistant licensed under chapter 370 of the general statutes, psychologist licensed under chapter 383 of the general statutes, marital and family therapist licensed under chapter 383a of the general statutes, clinical social worker or master social worker licensed under chapter 383b of the general statutes, alcohol and drug counselor licensed under chapter 376b of the general statutes, professional counselor licensed under chapter 383c of the general statutes or dietitian-nutritionist certified under chapter 384b of the general statutes, who is providing health care or other health services through the use of telehealth within such person's scope of practice and in accordance with the standard of care applicable to the profession.

(b) (1) A telehealth provider shall only provide telehealth services to a patient when the telehealth provider: (A) Is communicating through real-time, interactive, two-way communication technology or store and forward technologies; (B) has access to, or knowledge of, the patient's medical history, as provided by the patient, and the patient's health record, including the name and address of the patient's primary care provider, if any; (C) conforms to the standard of care applicable to the telehealth provider's profession and expected for in-person care as appropriate to the patient's age and presenting condition, except when the standard of care requires the use of diagnostic testing and performance of a physical examination, such testing or examination may be carried out through the use of peripheral devices appropriate to the patient's condition; and (D) provides the patient with the

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telehealth's provider license number and contact information.

(2) At the time of the telehealth provider's first telehealth interaction with a patient, the telehealth provider shall inform the patient concerning the treatment methods and limitations of treatment using a telehealth platform and, after providing the patient with such information, obtain the patient's consent to provide telehealth services. The telehealth provider shall document such notice and consent in the patient's health record.

(c) Notwithstanding the provisions of this section or title 20 of the general statutes, no telehealth provider shall prescribe schedule I, II or III controlled substances through the use of telehealth.

(d) Each telehealth provider shall, at the time of each telehealth interaction, ask the patient whether the patient consents to the telehealth's provider disclosure of records concerning the telehealth interaction to the patient's primary care provider. If the patient consents to such disclosure, the telehealth provider shall provide such records to the patient's primary care provider, in a timely manner, in accordance with the provisions of sections 20-7b to 20-7e, inclusive, of the general statutes.

(e) The provision of telehealth services and health records maintained and disclosed as part of a telehealth interaction shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 P.L. 104-191, as amended from time to time.

(f) Nothing in this section shall prohibit: (1) A health care provider from providing on-call coverage pursuant to an agreement with another health care provider or such health care provider's professional entity or employer; (2) a health care provider from consulting with another health care provider concerning a patient's care; or (3) orders of health care providers for hospital outpatients or

**Substitute Senate Bill No. 467**

inpatients. For purposes of this subsection, "health care provider" means a person or entity licensed or certified pursuant to chapter 370, 372, 373, 375, 378 or 379 of the general statutes or licensed or certified pursuant to chapter 368d or 384d of the general statutes.

(g) No telehealth provider shall charge a facility fee for telehealth services.

Sec. 2. (NEW) (*Effective January 1, 2016*) (a) As used in this section, "telehealth" has the same meaning provided in section 1 of this act.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider. Such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.

(c) No such policy shall: (1) Exclude a service for coverage solely because such service is provided only through telehealth and not through in-person consultation between the insured and a health care provider, provided telehealth is appropriate for the provision of such service; or (2) be required to reimburse a treating or consulting health care provider for the technical fees or technical costs for the provision of telehealth services.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in

***Substitute Senate Bill No. 467***

the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

Sec. 3. (NEW) (*Effective January 1, 2016*) (a) As used in this section, "telehealth" has the same meaning provided in section 1 of this act.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall provide coverage for medical advice, diagnosis, care or treatment provided through telehealth, to the extent coverage is provided for such advice, diagnosis, care or treatment when provided through in-person consultation between the insured and a health care provider. Such coverage shall be subject to the same terms and conditions applicable to all other benefits under such policy.

(c) No such policy shall: (1) Exclude a service for coverage solely because such service is provided only through telehealth and not through in-person consultation between the insured and a health care provider, provided telehealth is appropriate for the provision of such service; or (2) be required to reimburse a treating or consulting health care provider for the technical fees or technical costs for the provision of telehealth services.

(d) Nothing in this section shall prohibit or limit a health insurer, health care center, hospital service corporation, medical service corporation or other entity from conducting utilization review for telehealth services, provided such utilization review is conducted in the same manner and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

Approved June 22, 2015

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 189

BY HEALTH AND WELFARE COMMITTEE

AN ACT

1 RELATING TO TELEHEALTH SERVICES; AMENDING TITLE 54, IDAHO CODE, BY THE ADDI-  
2 TION OF A NEW CHAPTER 56, TITLE 54, IDAHO CODE, TO PROVIDE A SHORT TITLE,  
3 TO PROVIDE LEGISLATIVE FINDINGS, TO DEFINE TERMS, TO DEFINE THE SCOPE  
4 OF PRACTICE FOR TELEHEALTH SERVICES, TO PROVIDE THAT A PATIENT-PROVIDER  
5 RELATIONSHIP SHALL BE ESTABLISHED UNDER CERTAIN CIRCUMSTANCES, TO  
6 CLARIFY REQUIREMENTS FOR PATIENT EVALUATION AND TREATMENT, TO PROVIDE  
7 REQUIREMENTS RELATING TO PRESCRIPTION DRUG ORDERS, TO PROVIDE THAT PA-  
8 TIENTS USING TELEHEALTH SERVICES MUST GIVE INFORMED CONSENT, TO PROVIDE  
9 THAT CONTINUING CARE SHALL BE MADE AVAILABLE TO PATIENTS, TO REQUIRE  
10 THAT PROVIDERS OF TELEHEALTH SERVICES SHALL HAVE ACCESS TO CERTAIN MED-  
11 ICAL RESOURCES, TO REQUIRE THAT PROVIDERS KEEP CERTAIN RECORDS AND MAKE  
12 THEM AVAILABLE TO CERTAIN PERSONS, TO PROVIDE THAT CERTAIN BOARDS MAY  
13 SUBJECT PROVIDERS OF TELEHEALTH SERVICES TO PROFESSIONAL DISCIPLINE  
14 AND TO GRANT RULEMAKING AUTHORITY TO CERTAIN BOARDS.  
15

16 Be It Enacted by the Legislature of the State of Idaho:

17 SECTION 1. That Title 54, Idaho Code, be, and the same is hereby amended  
18 by the addition thereto of a NEW CHAPTER, to be known and designated as Chap-  
19 ter 56, Title 54, Idaho Code, and to read as follows:

20 CHAPTER 56  
21 IDAHO TELEHEALTH ACCESS ACT

22 54-5601. SHORT TITLE. This chapter shall be known and may be cited as  
23 the "Idaho Telehealth Access Act."

24 54-5602. LEGISLATIVE FINDINGS. The legislature hereby finds the fol-  
25 lowing:

26 (1) Telehealth services enhance access to health care, make delivery of  
27 health care more cost-effective and distribute limited health care provider  
28 resources more efficiently.

29 (2) Citizens with limited access to traditional health care may be di-  
30 agnosed and treated sooner through telehealth services than they would be  
31 otherwise, resulting in improved health outcomes and less costly treatments  
32 due to early detection and prevention.

33 (3) Telehealth services address an unmet need for health care by per-  
34 sons who have limited access to such care due to provider shortages or geo-  
35 graphic barriers.

36 (4) Telehealth services provide increased capacity for appropriate  
37 care in the appropriate location at the appropriate time to better serve  
38 patients, providers and communities.

39 (5) When practiced safely, telehealth services result in improvement  
40 in health outcomes by expanding health care access for the people of Idaho.

1 54-5603. DEFINITIONS. As used in this chapter:

2 (1) "Asynchronous store and forward transfer" means the transmission  
3 of a patient's health care information from an originating site to a provider  
4 at a distant site over a secure connection that complies with state and fed-  
5 eral security and privacy laws.

6 (2) "Distant site" means the site at which a provider delivering tele-  
7 health services is located at the time the service is provided.

8 (3) "Originating site" means the location of a patient at the time tele-  
9 health services are provided.

10 (4) "Provider" means a person who is licensed, required to be licensed,  
11 or, if located outside of Idaho, would be required to be licensed if located  
12 in Idaho, pursuant to title 54, Idaho Code, to deliver health care consistent  
13 with his or her license.

14 (5) "Synchronous interaction" means real-time communication through  
15 interactive technology that enables a provider and a patient at two (2) lo-  
16 cations separated by distance to interact simultaneously through two-way  
17 video and audio or audio transmission.

18 (6) "Telehealth services" means health care services provided by a  
19 provider to a person through the use of electronic communications, infor-  
20 mation technology, asynchronous store and forward transfer or synchronous  
21 interaction between a provider at a distant site and a patient at an origi-  
22 nating site. Such services include, but are not limited to, clinical care,  
23 health education, home health and facilitation of self-managed care and  
24 caregiver support.

25 54-5604. SCOPE OF PRACTICE. A provider offering telehealth services  
26 must at all times act within the scope of the provider's license and accord-  
27 ing to all applicable laws and rules, including, but not limited to, this  
28 chapter and the community standard of care.

29 54-5605. PROVIDER-PATIENT RELATIONSHIP. (1) If a provider offering  
30 telehealth services in his or her practice does not have an established  
31 provider-patient relationship with a person seeking such services, the  
32 provider shall take appropriate steps to establish a provider-patient rela-  
33 tionship by use of two-way audio and visual interaction; provided however,  
34 that the applicable Idaho community standard of care must be satisfied.  
35 Nothing in this section shall prohibit electronic communications:

36 (a) Between a provider and a patient with a preexisting provider-pa-  
37 tient relationship;

38 (b) Between a provider and another provider concerning a patient with  
39 whom the other provider has a provider-patient relationship;

40 (c) Between a provider and a patient where the provider is taking call  
41 on behalf of another provider in the same community who has a provider-  
42 patient relationship with the patient; or

43 (d) In an emergency.

44 (2) As used in this section, "emergency" means a situation in which  
45 there is an occurrence that poses an imminent threat of a life-threatening  
46 condition or severe bodily harm.

1           54-5606. EVALUATION AND TREATMENT. Prior to providing treatment, in-  
2 cluding a prescription drug order, a provider shall obtain and document a  
3 patient's relevant clinical history and current symptoms to establish the  
4 diagnosis and identify underlying conditions and contraindications to the  
5 treatment recommended. Treatment recommendations provided through tele-  
6 health services shall be held to the applicable Idaho community standard  
7 of care that applies in an in-person setting. Treatment based solely on an  
8 online questionnaire does not constitute an acceptable standard of care.

9           54-5607. PRESCRIPTIONS. (1) A provider with an established provider-  
10 patient relationship, including a relationship established pursuant to  
11 section 54-5605, Idaho Code, may issue prescription drug orders using tele-  
12 health services within the scope of the provider's license and according to  
13 any applicable laws, rules and regulations, including the Idaho community  
14 standard of care; provided however, that the prescription drug shall not be a  
15 controlled substance unless prescribed in compliance with 21 U.S.C. section  
16 802(54) (A) .

17           (2) Nothing in this chapter shall be construed to expand the prescrip-  
18 tive authority of any provider beyond what is authorized by the provider's  
19 licensing board.

20           (3) No drug may be prescribed through telehealth services for the pur-  
21 pose of causing an abortion.

22           54-5608. INFORMED CONSENT. A patient's informed consent for the use of  
23 telehealth services shall be obtained as required by any applicable law.

24           54-5609. CONTINUITY OF CARE. A provider of telehealth services shall  
25 be available for follow-up care or to provide information to patients who  
26 make use of such services.

27           54-5610. REFERRAL TO OTHER SERVICES. A provider shall be familiar  
28 with and have access to available medical resources, including emergency  
29 resources near the patient's location, in order to make appropriate patient  
30 referrals when medically indicated.

31           54-5611. MEDICAL RECORDS. Any provider offering telehealth services  
32 as part of his or her practice shall generate and maintain medical records  
33 for each patient using such telehealth services in compliance with any ap-  
34 plicable state and federal laws, rules and regulations, including the health  
35 insurance portability and accountability act (HIPAA), P.L. 104-191 (1996),  
36 and the health information technology for economic and clinical health act  
37 (HITECH), P.L. 111-115 (2009). Such records shall be accessible to other  
38 providers and to the patient in accordance with applicable laws, rules and  
39 regulations.

40           54-5612. ENFORCEMENT AND DISCIPLINE. A provider is prohibited from  
41 offering telehealth services in his or her practice if the provider is not  
42 in full compliance with applicable laws, rules and regulations, including  
43 this act and the Idaho community standard of care. State licensing boards  
44 shall be authorized to enforce the provisions of this chapter relating to the

1 practice of individuals they license. A provider who fails to comply with  
2 applicable laws, rules and regulations is subject to discipline by his or her  
3 licensing board.

4 54-5613. RULEMAKING. Any board authorized by title 54, Idaho Code, to  
5 license providers may promulgate rules relating to telehealth services pur-  
6 suant to this chapter and consistent with the provisions contained herein.

STATE OF MAINE

IN THE YEAR OF OUR LORD  
TWO THOUSAND AND FIFTEEN

H.P. 443 - L.D. 662

**An Act To Increase Access to Health Care through Telemedicine**

Be it enacted by the People of the State of Maine as follows:

**Sec. 1. 32 MRSA §3300-D** is enacted to read:

**§3300-D. Interstate practice of telemedicine**

**1. Definition.** For the purposes of this section, "telemedicine" has the same meaning as in Title 24-A, section 4316, subsection 1.

**2. Requirements.** A physician not licensed to practice medicine in this State may provide consultative services through interstate telemedicine to a patient located in this State if the physician is registered in accordance with subsection 3. A physician intending to provide consultative services in this State through interstate telemedicine shall provide any information requested by the board and complete information on:

- A. All states and jurisdictions in which the physician is currently licensed;
- B. All states and jurisdictions in which the physician was previously licensed; and
- C. All negative licensing actions taken previously against the physician in any state or jurisdiction.

**3. Registration.** The board may register a physician to practice medicine in this State through interstate telemedicine if the following conditions are met:

- A. The physician is fully licensed without restriction to practice medicine in the state from which the physician provides telemedicine services;
- B. The physician has not had a license to practice medicine revoked or restricted in any state or jurisdiction;
- C. The physician does not open an office in this State, does not meet with patients in this State, does not receive calls in this State from patients and agrees to provide only consultative services as requested by a physician, advanced practice registered nurse or physician assistant licensed in this State and the physician, advanced practice

registered nurse or physician assistant licensed in this State retains ultimate authority over the diagnosis, care and treatment of the patient;

D. The physician registers with the board every 2 years, on a form provided by the board; and

E. The physician pays a registration fee not to exceed \$500.

**4. Notification of restrictions.** A physician registered to provide interstate telemedicine services under this section shall immediately notify the board of restrictions placed on the physician's license to practice medicine in any state or jurisdiction.

**5. Jurisdiction.** In registering to provide interstate telemedicine services to residents of this State under this section, a physician agrees to be subject to the laws and judicial system of this State and board rules with respect to providing medical services to residents of this State.

**6. Notification to other states.** The board shall obtain confirmation of licensure from all states and jurisdictions in which a physician applying for registration has ever been licensed prior to registering the physician pursuant to subsection 3. The board shall request notification from a state or jurisdiction if future adverse action is taken against the physician's license in that state or jurisdiction.



AN ACT REVISING LICENSURE AND OTHER REGULATIONS BY THE BOARD OF MEDICAL EXAMINERS FOR PHYSICIANS AND PHYSICIAN ASSISTANTS; CREATING A RESIDENT PHYSICIAN LICENSE; REPEALING SPECIALIZED, TELEMEDICINE, AND TEMPORARY PHYSICIAN LICENSES; PROVIDING THE BOARD WITH RULEMAKING AUTHORITY FOR TELEMEDICINE GUIDELINES AND SHORT-TERM LICENSES; REVISING AND UPDATING ACCREDITATION ENTITIES; AMENDING SECTIONS 27-6-103, 37-3-102, 37-3-103, 37-3-201, 37-3-203, 37-3-204, 37-3-211, 37-3-301, 37-3-303, 37-3-305, 37-3-307, 37-3-308, 37-3-312, 37-3-321, 37-3-323, 37-3-403, AND 37-20-402, MCA; REPEALING SECTIONS 37-3-304, 37-3-306, 37-3-311, 37-3-315, 37-3-327, 37-3-328, 37-3-341, 37-3-342, 37-3-343, 37-3-344, 37-3-345, 37-3-347, 37-3-348, 37-3-349, AND 37-6-304, MCA; AND PROVIDING AN EFFECTIVE DATE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

**Section 1.** Section 27-6-103, MCA, is amended to read:

**"27-6-103. Definitions.** As used in this chapter, the following definitions apply:

(1) "Dentist" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice dentistry under the provisions of Title 37, chapter 4, who at the time of the assessment:

(i) has as the individual's principal residence or place of dental practice the state of Montana;

(ii) is not employed full-time by any federal governmental agency or entity; and

(iii) is not fully retired from the practice of dentistry; or

(b) for all other purposes, a person licensed to practice dentistry under the provisions of Title 37, chapter 4, who at the time of the occurrence of the incident giving rise to the claim:

(i) was an individual who had as the principal residence or place of dental practice the state of Montana and was not employed full-time by any federal governmental agency or entity; or

(ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render dental services and whose shareholders, partners, or owners were individual dentists

licensed to practice dentistry under the provisions of Title 37, chapter 4.

(2) (a) "Health care facility" means a facility licensed as a health care facility under Title 50, chapter 5.

(b) For the purposes of this chapter, a health care facility does not include:

- (i) an end-stage renal dialysis facility;
- (ii) a home infusion therapy agency;
- (iii) a residential care facility; or
- (iv) a governmental infirmary, except a university or college infirmary.

(3) "Health care provider" means a physician, a dentist, a podiatrist, or a health care facility.

(4) "Hospital" means a hospital as defined in 50-5-101.

(5) "Malpractice claim" means a claim or potential claim of a claimant against a health care provider for medical or dental treatment, lack of medical or dental treatment, or other alleged departure from accepted standards of health care that proximately results in damage to the claimant, whether the claimant's claim or potential claim sounds in tort or contract, and includes but is not limited to allegations of battery or wrongful death.

(6) "Panel" means the Montana medical legal panel provided for in 27-6-104.

(7) "Physician" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice medicine under the provisions of Title 37, chapter 3, who at the time of the assessment:

~~(i) has as the individual's principal residence or place of medical practice the state of Montana or practices telemedicine as defined in 37-3-342;~~

(i) has as the individual's principal residence or place of medical practice the state of Montana or practices telemedicine as defined in 37-3-102;

~~(ii)~~(ii) is not employed full-time by any federal governmental agency or entity; and

~~(iii)~~(iii) is not fully retired from the practice of medicine; or

(b) for all other purposes, a person licensed to practice medicine under the provisions of Title 37, chapter 3, who at the time of the occurrence of the incident giving rise to the claim:

~~(i) was an individual who had as the principal residence or place of medical practice the state of Montana or practiced telemedicine as defined in 37-3-342 and~~ had as the principal residence or place of medical practice the state of Montana or practiced telemedicine as defined in 37-3-102 and was not employed full-time by any federal governmental agency or entity; or

(ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render medical services and whose shareholders, partners, or owners were individual physicians licensed to practice medicine under the provisions of Title 37, chapter 3.

(8) "Podiatrist" means:

(a) for purposes of the assessment of the annual surcharge, an individual licensed to practice podiatry under the provisions of Title 37, chapter 6, who at the time of the assessment:

- (i) has as the individual's principal residence or place of podiatric practice the state of Montana;
- (ii) is not employed full-time by any federal governmental agency or entity; and
- (iii) is not fully retired from the practice of podiatry; or

(b) for all other purposes, a person licensed to practice podiatry under the provisions of Title 37, chapter 6, who at the time of the occurrence of the incident giving rise to the claim:

- (i) was an individual who had as the principal residence or place of podiatric practice the state of Montana and was not employed full-time by any federal governmental agency or entity; or
- (ii) was a professional service corporation, partnership, or other business entity organized under the laws of any state to render podiatric services and whose shareholders, partners, or owners were individual podiatrists licensed to practice podiatry under the provisions of Title 37, chapter 6."

**Section 2.** Section 37-3-102, MCA, is amended to read:

**"37-3-102. Definitions.** Unless the context requires otherwise, in this chapter, the following definitions apply:

(1) "ACGME" means the accreditation council for graduate medical education.

(2) "AOA" means the American osteopathic association.

~~(1)~~(3) "Approved internship" means an internship training program of at least 1 year in a hospital program that is either is approved for intern training by the ~~American osteopathic association~~ AOA or conforms to the minimum standards for intern training established by the ~~council on medical education of the American medical association~~ ACGME or successors. However, the board may, upon investigation, approve any other internship.

~~(2)~~(4) "Approved medical school" means a school that either is accredited by the ~~American osteopathic association~~ AOA or conforms to the minimum education standards established by the ~~council on medical education of the American medical association~~ LCME or the world health organization or successors for medical

~~schools that meet standards established by the board by rule or is equivalent in the sound discretion of the board. The board may, on investigation of the education standards and facilities, approve any medical school, including foreign medical schools.~~

~~(3)(5) "Approved residency" means a residency training program in a hospital conforming to the minimum standards for residency training established by the council on medical education of the American medical association ACGME or successors or approved for residency training by the American osteopathic association AOA.~~

~~(4)(6) "Board" means the Montana state board of medical examiners provided for in 2-15-1731.~~

~~(5)(7) "Department" means the department of labor and industry provided for in Title 2, chapter 15, part 17.~~

(8) "ECP" means an emergency care provider licensed by the board, including but not limited to an emergency medical responder, an emergency medical technician, an advanced emergency medical technician, or a paramedic.

(9) "LCME" means the liaison committee on medical education.

~~(6)(10) "Medical assistant" means an unlicensed allied health care worker who functions under the supervision of a physician or podiatrist in a physician's or podiatrist's office and who performs administrative and clinical tasks.~~

~~(7)(11) "Physician" means a person who holds a degree as a doctor of medicine or doctor of osteopathy and who has a valid license to practice medicine or osteopathic medicine in this state.~~

~~(8)(12) "Practice of medicine" means the diagnosis, treatment, or correction of or the attempt to or the holding of oneself out as being able to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities, whether physical or mental, by any means, methods, devices, or instrumentalities, including electronic and technological means such as telemedicine. If a person who does not possess a license to practice medicine in this state under this chapter and who is not exempt from the licensing requirements of this chapter performs acts constituting the practice of medicine, the person is practicing medicine in violation of this chapter.~~

(13) (a) "Telemedicine" means the practice of medicine using interactive electronic communications, information technology, or other means between a licensee in one location and a patient in another location with or without an intervening health care provider. Telemedicine typically involves the application of secure videoconferencing or store-and-forward technology, as defined in 33-22-138.

(b) The term does not mean an audio-only telephone conversation, an e-mail or instant messaging conversation, or a message sent by facsimile transmission."

**Section 3.** Section 37-3-103, MCA, is amended to read:

**"37-3-103. Exemptions from licensing requirements.** (1) This chapter does not prohibit or require a license with respect to any of the following acts:

- (a) the gratuitous rendering of services in cases of emergency or catastrophe;
- (b) the rendering of services in this state by a physician lawfully practicing medicine in another state or territory. However, if the physician does not limit the services to an occasional case or if the physician has any established or regularly used hospital connections in this state or maintains or is provided with, for the physician's regular use, an office or other place for rendering the services, the physician must possess a license to practice medicine in this state.
- (c) the practice of dentistry under the conditions and limitations defined by the laws of this state;
- (d) the practice of podiatry under the conditions and limitations defined by the laws of this state;
- (e) the practice of optometry under the conditions and limitations defined by the laws of this state;
- (f) the practice of chiropractic under the conditions and limitations defined by the laws of this state;
- (g) the practice of Christian Science, with or without compensation, and ritual circumcisions by rabbis;
- (h) the practice of medicine by a physician licensed in another state and employed by the federal government;
- (i) the rendering of nursing services by registered or other nurses in the lawful discharge of their duties as nurses or of midwife services by registered nurse-midwives under the conditions and limitations defined by law;
- (j) the rendering of services by interns or resident physicians in a hospital or clinic in which they are training, subject to the conditions and limitations of this chapter. ~~The board may require a resident physician to be licensed if the physician otherwise engages in the practice of medicine in the state of Montana;~~
- (k) the rendering of services by a physical therapist, surgical or medical technician, or medical assistant, as provided in 37-3-104, ~~or other paramedical specialist~~ under the appropriate amount and type of supervision of a person licensed under the laws of this state to practice medicine, but this exemption does not extend the scope of ~~a paramedical specialist~~ the individuals listed in this subsection (1)(k);

- (l) the rendering of services by a physician assistant in accordance with Title 37, chapter 20;
  - (m) the practice by persons licensed under the laws of this state to practice a limited field of the healing arts, ~~and including physical therapists and other licensees~~ not specifically designated, under the conditions and limitations defined by law;
  - (n) the execution of a death sentence pursuant to 46-19-103;
  - (o) the practice of direct-entry midwifery. For the purpose of this section, the practice of direct-entry midwifery means the advising, attending, or assisting of a woman during pregnancy, labor, natural childbirth, or the postpartum period. Except as authorized in 37-27-302, a direct-entry midwife may not dispense or administer a prescription drug, as those terms are defined in 37-7-101.
  - (p) the use of an automated external defibrillator pursuant to Title 50, chapter 6, part 5.
- (2) Licensees referred to in subsection (1) who are licensed to practice a limited field of healing arts shall confine themselves to the field for which they are licensed or registered and to the scope of their respective licenses and, with the exception of those licensees who hold a medical degree, may not use the title "M.D.", "D.O.", or any word or abbreviation to indicate or to induce others to believe that they are engaged in the diagnosis or treatment of persons afflicted with disease, injury, or defect of body or mind except to the extent and under the conditions expressly provided by the law under which they are licensed."

**Section 4.** Section 37-3-201, MCA, is amended to read:

- "37-3-201. Organization.** (1) (a) The board shall, ~~at the first meeting each year,~~ elect from among its members a president, vice-president, and secretary.
- (b) The board shall adopt a seal on which appear the words "The Board of Medical Examiners of Montana" and "Official Seal". ~~The board shall authenticate acts, rules, orders, and licenses by applying the seal.~~
- (2) The board shall establish a screening panel for disciplinary matters as provided for in 37-1-307 ~~and shall authorize the screening panel to oversee any rehabilitation program established pursuant to 37-3-203."~~

**Section 5.** Section 37-3-203, MCA, is amended to read:

- "37-3-203. Powers and duties.** (1) The board may:
- (a) adopt rules necessary or proper to carry out the requirements in Title 37, chapter 3, parts 1 through 3 of this chapter 4, as well as chapters covering podiatry, acupuncture, physician assistants, nutritionists, and

emergency care providers as set forth in Title 37, chapters 6, 13, 20, and 25, and 50-6-203, respectively. The rules must be fair, impartial, and nondiscriminatory.

(b) hold hearings and take evidence in matters relating to the exercise and performance of the powers and duties vested in the board;

(c) aid the county attorneys of this state in the enforcement of parts 1 through ~~3~~ 4 and 8 of this chapter as well as Title 37, chapters 6, 13, 20, and 25, and Title 50, chapter 6, regarding emergency care providers licensed by the board. The board also may assist the county attorneys of this state in ~~and~~ the prosecution of persons, firms, associations, or corporations charged with violations of ~~parts 1 through 3 of this chapter; the provisions listed in this subsection (1)(c).~~

(d) review certifications of disability and determinations of eligibility for a permit to hunt from a vehicle as provided in 87-2-803(11); and

(e) fund additional staff, hired by the department, to administer the provisions of this chapter, by increasing license fees as necessary.

(2) (a) The board shall establish a medical assistance program to assist and rehabilitate licensees who are subject to the jurisdiction of the board and who are found to be physically or mentally impaired by habitual intemperance or the excessive use of addictive drugs, alcohol, or any other drug or substance or by mental illness or chronic physical illness.

(b) The board shall ensure that a licensee who is required or volunteers to participate in the medical assistance program as a condition of continued licensure or reinstatement of licensure must be allowed to enroll in a qualified medical assistance program within this state and may not require a licensee to enroll in a qualified treatment program outside the state unless the board finds that there is no qualified treatment program in this state.

(3) (a) The board shall report annually on the number and types of complaints it has received involving physician practices in providing written certification, as defined in 50-46-302, for the use of marijuana for a debilitating medical condition provided for in Title 50, chapter 46. The report must contain:

- (i) the number of complaints received by the board pursuant to 37-1-308;
- (ii) the number of complaints for which a reasonable cause determination was made pursuant to 37-1-307;
- (iii) the general nature of the complaints;

(iv) the number of investigations conducted into physician practices in providing written certification; and  
 (v) the number of physicians disciplined by the board for their practices in providing written certification for the use of marijuana for a debilitating medical condition.

(b) Except as provided in subsection (3)(c), the report may not contain individual identifying information regarding the physicians about whom the board received complaints.

(c) For each physician against whom the board takes disciplinary action related to the physician's practices in providing written certification for the use of marijuana for a debilitating medical condition, the report must include:

- (i) the name of the physician;
- (ii) the general results of the investigation of the physician's practices; and
- (iii) the disciplinary action taken against the physician.

(d) The board shall provide the report to the children, families, health, and human services interim committee by August 1 of each year and shall make a copy of the report available on the board's website.

(4) The board may enter into agreements with other states for the purposes of mutual recognition of licensing standards and licensing of physicians and ECPs from other states under the terms of a mutual recognition agreement."

**Section 6.** Section 37-3-204, MCA, is amended to read:

**"37-3-204. Meetings.** The board shall hold meetings for ~~examinations and for other~~ business properly before the board at least twice annually at times and places set by the board. The president of the board may call special meetings that the president considers advisable or necessary."

**Section 7.** Section 37-3-211, MCA, is amended to read:

**"37-3-211. Executive secretary officer.** To perform services to the board in connection with the board's duties under this chapter, assist in prosecution and matters of license discipline, and administer the board's affairs, the department shall hire an executive ~~secretary~~ officer."

**Section 8.** Section 37-3-301, MCA, is amended to read:

**"37-3-301. License required -- kinds of licenses.** (1) Before being issued a license, an applicant may

not engage in the practice of medicine in this state.

(2) The department may issue ~~four~~ two kinds of licenses under the board's seal, ~~which include a physician's license, a specialized license, a temporary license, and a telemedicine license issued in accordance with 37-3-341 through 37-3-345 and 37-3-347 through 37-3-349~~ and a resident license. ~~The physician's license and the specialized license must be signed by the president, but the temporary license may be signed by any board member. The board shall decide which kind of license to issue.~~

(3) The board shall provide guidelines by administrative rule for the practice of telemedicine by physicians.

(4) A license issued by the board that has not expired prior to [the effective date of this act] remains valid until renewal unless the licensee is otherwise subject to disciplinary proceedings."

**Section 9.** Section 37-3-303, MCA, is amended to read:

**"37-3-303. Practice authorized by physician's license.** A physician's license authorizes the holder to perform one or more of the acts embraced in ~~37-3-102(8)~~ 37-3-102(12) in a manner ~~reasonably~~ consistent with the holder's training, skill, and experience."

**Section 10.** Section 37-3-305, MCA, is amended to read:

**"37-3-305. Qualifications for licensure.** (1) Except as provided in ~~subsections (4) and (5), a person may not be granted~~ subsection (2), the board shall grant a physician's license to practice medicine in this state ~~unless the person~~ to an applicant who:

- (a) is of good moral character as determined by the board;
- (b) is a graduate of an approved medical school as defined in 37-3-102;
- (c) has ~~successfully~~ completed an approved residency program ~~of at least 2 years~~ or, for an applicant who graduated from medical school prior to 2000, has had experience or training that ~~in the opinion of the board~~ has determined is at least the equivalent of ~~a 2-year~~ an approved residency program;
- (d) has passed all of the steps of the United States medical licensing examination, the federation of state medical boards' federation licensing examination, or an examination offered by any of the following entities:

- (i) the national board of medical examiners or its successors;
- (ii) the national board of osteopathic medical examiners or its successors;

(iii) the medical council of Canada or its successors if the applicant is a graduate of a Canadian medical school approved by the medical council of Canada or its successor; or

(iv) the educational commission for foreign medical graduates or its successors if the applicant is a graduate of a foreign medical school outside of the United States and Canada;

~~(d)~~(e) has submitted a completed application with the required nonrefundable fee; and

~~(e)~~(f) is able to communicate, ~~in the opinion of the board,~~ in the English language as determined by the board.

(2) The board may authorize the department to issue the license subject to terms of probation or other conditions or limitations set by the board or may refuse a license if the applicant has committed unprofessional conduct or is otherwise unqualified;

(3) The board may by rule impose additional requirements for licensure to protect the health and safety of the public or to enter into a mutual recognition licensing agreement with another state.

(4) The board may adopt rules that provide conditions for short-term nondisciplinary licenses.

~~(3) A person may not be granted a temporary license to practice medicine in this state unless the person:~~

~~—— (a) is of good moral character as determined by the board;~~

~~—— (b) is a graduate of an approved medical school as defined in 37-3-102;~~

~~—— (c) has successfully completed an approved residency program of at least 2 years or, for an applicant who graduated from medical school prior to 2000, has had experience or training that in the opinion of the board is at least the equivalent of a 2-year approved residency program; and~~

~~—— (d) is able, in the opinion of the board, to communicate in the English language.~~

~~—— (4) The 2-year minimum requirements in subsections (1)(c) and (3)(c) do not apply to a person who:~~

~~—— (a) has completed an approved internship of at least 1 year or in the opinion of the board has had experience or training that is at least the equivalent of a 1-year internship;~~

~~—— (b) is a resident in good standing with the Montana family practice residency program; and~~

~~—— (c) is seeing patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in this state.~~

~~—— (5) The 2-year minimum requirements in subsections (1)(c) and (3)(c) do not apply to a person who:~~

~~—— (a) has completed an approved internship of at least 1 year or, in the opinion of the board, has had experience or training that is at least the equivalent of a 1-year internship;~~

- ~~———— (b) is a resident in good standing with a program accredited by the accreditation council for graduate medical education or the American osteopathic association;~~
- ~~———— (c) in the course of an approved rotation of the person's residency program, is seeing patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in this state;~~
- ~~———— (d) makes application to the department on an approved form; and~~
- ~~———— (e) pays a fee set by the board, as provided in 37-3-308."~~

**Section 11.** Section 37-3-307, MCA, is amended to read:

**"37-3-307. Qualifications for licensure -- temporary resident license.** (1) The board may authorize the department to issue ~~to an applicant~~ a temporary resident license to practice medicine ~~on the basis of to an applicant who:~~

- ~~———— (a) passing an examination prescribed by the board;~~
- ~~———— (b) certification of record or other certificate of examination issued to or for the applicant by the national board of medical examiners or successors, by the federation licensing examination committee or successors, by the national board of osteopathic medical examiners or successors, or by the medical council of Canada or successors if the applicant is a graduate of a Canadian medical school that has been approved by the medical council of Canada or successors, certifying that the applicant has passed an examination given by the board; or~~
- ~~———— (c) a valid, unsuspended, and unrevoked license or certificate issued to the applicant on the basis of an examination by an examining board under the laws of another state or territory of the United States or of the District of Columbia or of a foreign country whose licensing standards at the time the license or certificate was issued were essentially equivalent, in the judgment of the board, to those of this state at the time for granting a license to practice medicine; and~~
- ~~———— (d) being a graduate of an approved medical school who has completed 1 year of internship or the equivalent and being of good moral character and good conduct.~~

~~———— (2) The board may require that graduates of foreign medical schools pass the examination given by the education council for foreign medical graduates or successors:~~

~~———— (3) A temporary license may be issued to a physician employed by a public institution who is practicing under the direction of a licensed physician. The board may authorize the department to issue a temporary license subject to terms of probation or other conditions or limitations set by the board or may refuse a temporary license~~

~~to a person who has committed unprofessional conduct. The issuance of a temporary license does not impose any future obligation or duty on the part of the board to grant full licensure or to renew or extend the temporary license. The board may, in the case of an applicant for a temporary license, require a written, oral, or practical examination of the applicant.~~

(a) is in good standing:

(i) in a Montana residency program and is seeing patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in this state; or

(ii) with an approved residency and who, in the course of an approved rotation of the applicant's residency program, is seeing patients under the supervision of a physician who possesses a current, unrestricted license to practice medicine in this state; and

(b) submits an application to the department on an approved form and submits the fee set by the board, as provided in 37-3-308.

(2) A resident license may not be issued for a period that exceeds 1 year. A resident license may be renewed, at the board's discretion, for additional 1-year periods as long as the resident is in good standing in an approved residency program."

**Section 12.** Section 37-3-308, MCA, is amended to read:

**"37-3-308. Application fee -- further tax forbidden.** (1) ~~An~~ Each applicant for a license to practice medicine to be issued on the basis of an examination by the board shall pay an examination fee as set by the board. The board shall set the fee, and it shall be reasonable and commensurate with the costs of the examination and related costs. Such examination fee shall be in addition to the application fee. All applicants, including applicants for a temporary license, shall pay an initial application fee as prescribed by the board.

(2) A license tax may not be imposed upon physicians by a municipality or any other subdivision of the state."

**Section 13.** Section 37-3-312, MCA, is amended to read:

**"37-3-312. Issuance of license.** If the board determines that an applicant possesses the qualifications required by this chapter, the department shall issue a license to practice medicine, ~~which shall be signed by the president or vice-president, attested by the secretary, and sealed with the seal of the board.~~

**Section 14.** Section 37-3-321, MCA, is amended to read:

**"37-3-321. Refusal of license.** If the board determines that an applicant for a license to practice medicine does not possess the qualifications or character required by this chapter or that the applicant has committed unprofessional conduct, ~~it shall refrain from authorizing the department to issue a~~ the board may deny ~~the~~ license. ~~The department shall mail to the applicant, at the applicant's last address of record with the department, written notification of the board's decision, together with notice of a time and place of a hearing before the board. If the applicant without cause fails to appear at the hearing or if after the hearing the board determines that the applicant is not entitled to a license, the board shall refuse to grant the license."~~

**Section 15.** Section 37-3-323, MCA, is amended to read:

**"37-3-323. Suspension of license -- investigation.** (1) The department may investigate whenever the department learns of a reason to suspect that a license applicant or a person having a license to practice medicine in this state:

(a) is mentally or physically unable to safely engage in the practice of medicine, has procured a license to practice medicine by fraud or misrepresentation or through mistake, has been declared incompetent by a court of competent jurisdiction and has not later been lawfully declared competent, or has a condition that impairs the person's intellect or judgment to the extent that the condition incapacitates the person for the safe performance of professional duties;

(b) ~~has been guilty of~~ has engaged in unprofessional conduct;

(c) has practiced medicine with a suspended or revoked license;

(d) has had a license to practice medicine suspended or revoked by any licensing authority for reasons other than nonpayment of fees; or

(e) while under probation has violated the terms of probation.

(2) The investigation must be for the purpose of determining the probability of the existence of these conditions or the commission of these offenses and may, upon order of the board, include requiring the person to submit to a physical examination or a mental examination, or both, by a physician or physicians selected by the board or the board's representative if it appears to be in the board considers that the evaluation is in the best interests of the public ~~that this evaluation be secured~~. The board may examine and scrutinize the hospital records

and reports of a licensee or license applicant as part of the examination, and copies must be released to the board on written request.

(3) If a person holding a license to practice medicine under this chapter is by a final order or adjudication of a court of competent jurisdiction adjudged to be mentally incompetent, to be addicted to the use of addictive substances, or to have been committed pursuant to 53-21-127, the person's license may be suspended by the board. The suspension continues until the licensee is found or adjudged by the court to be restored to reason or cured or until the person is discharged as restored to reason or cured and the person's professional competence has been proved to the satisfaction of the board."

**Section 16.** Section 37-3-403, MCA, is amended to read:

**"37-3-403. Report of prohibition or limitation on practice by hospital.** ~~Each~~ With the exception of the first two violations of hospital policies related to charts, medical records, or other policies not directly associated with the clinical care of a patient, each hospital or health care facility that prohibits or limits the privilege of a physician to practice medicine within that facility shall report the action to the state board of medical examiners within 30 days after the action is taken. The report must include ~~the~~ each reason ~~or reasons~~ for the prohibition or limitation."

**Section 17.** Section 37-20-402, MCA, is amended to read:

**"37-20-402. Criteria for licensing physician assistant.** A person may not be licensed as a physician assistant in this state unless the person:

- (1) is of good moral character;
- (2) is a graduate of a physician assistant training program accredited by the accreditation review commission on education for the physician assistant or, if accreditation was granted before 2001, accredited by the American medical association's committee on allied health education and accreditation or the commission on accreditation of allied health education programs; and
- (3) has taken and passed an examination administered by the national commission on the certification of physician assistants; ~~and~~
- ~~(4) holds a current certificate from the national commission on the certification of physician assistants."~~

**Section 18. Repealer.** The following sections of the Montana Code Annotated are repealed:

- 37-3-304. Practice authorized by temporary license.
- 37-3-306. Physician's license -- examination -- reciprocity and endorsement.
- 37-3-311. Foreign medical graduate examination.
- 37-3-315. Qualifications for licensure -- specialized license -- suspension -- practice authorized.
- 37-3-327. Subpoena -- fees.
- 37-3-328. Failure to appear or testify.
- 37-3-341. Legislative findings.
- 37-3-342. Definition -- scope of practice allowed by telemedicine license.
- 37-3-343. Practice of telemedicine prohibited without license -- scope of practice limitations -- violations and penalty.
- 37-3-344. Application for telemedicine license.
- 37-3-345. Qualifications for telemedicine license -- basis for denial.
- 37-3-347. Reasons for denial of license -- alternative route to licensed practice.
- 37-3-348. Discipline of physician with telemedicine license.
- 37-3-349. Consent to jurisdiction.
- 37-6-304. Designations on license -- recording.

**Section 19. Effective date.** [This act] is effective July 1, 2015.

- END -

## AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request:  Katie Vieira Administrative Rules Coordinator		2) Date When Request Submitted:  10/8/2015  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:  10/21/2015	5) Attachments: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  <b>Med 3, 5 – Physician Licensure – Adoption Order</b> <b>Med 13 – CME for Prescribing Opioids – Scope</b> <b>Med 1, 14 – General update and cleanup of rules</b>	
7) Place Item in: <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	8) Is an appearance before the Board being scheduled?  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	9) Name of Case Advisor(s), if required:  N/A	
10) Describe the issue and action that should be addressed:  The Legislative Review period for CR15-022 relating to physician licensure ended on September 1 <sup>st</sup> , 2015 and was adopted on October 8 <sup>th</sup> , 2015. The anticipated effective date of this rule is November 1 <sup>st</sup> , 2015.  The Scope Statement for Med 13 relating to continuing medical education for prescribing opioids was submitted to the Governor’s Office on September 29 <sup>th</sup> , 2015. We are still waiting for approval to implement the rule.  Med 1 and 14 relating to the general update and cleanup of rules – wait to draft preliminary rule.			
11) Authorization			
<b>Katie Vieira</b>		<b>10/8/2015</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			

**CERTIFICATE**

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

*I, Tom Ryan, Executive Director, Division of Policy Development in the Wisconsin Department of Safety and Professional Services and custodian of the official records of the Medical Examining Board, do hereby certify that the annexed rules relating to physician licensure were duly approved and adopted by the Medical Examining Board on the 8<sup>th</sup> day of October, 2015.*

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

*IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed the official seal of the board at 1400 East Washington Avenue, Madison, Wisconsin this 8<sup>th</sup> day of October, 2015.*



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

STATE OF WISCONSIN  
MEDICAL EXAMINING BOARD

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IN THE MATTER OF RULEMAKING	:	ORDER OF THE
PROCEEDINGS BEFORE THE	:	MEDICAL EXAMINING BOARD
MEDICAL EXAMINING BOARD	:	ADOPTING RULES
	:	(CLEARINGHOUSE RULE 15-022)
	:	

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ORDER

The Medical Examining Board proposes an order to repeal Med 1.06 (4), 1.09 (4), and 3.06; to amend Med 1.06 (1) (a) (intro.), (b), and (c), 1.08 (2), 1.09 (1), 1.09 (6), Chapter 3 (title), 3.01, 3.02, 3.04, Chapter 5 (title), 5.01, 5.02, 5.04, and 5.05; to repeal and recreate Med 1.02 (3), 3.05, and 5.06; and to create Med 23, relating to physician licensure.

Analysis prepared by the Department of Safety and Professional Services.

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ANALYSIS

**S Statutes interpreted:**

448.04 (1) and 448.05 (2), Stats.

**Statutory authority:**

Sections 15.08 (5) (b), 227.11 (2) (a), 448.40 (1), Stats., and 2013 Wisconsin Act 240

**Explanation of agency authority:**

Sections 15.08 (5) (b) and 227.11 (2) (a), Stats., provide general authority from the legislature to the Medical Examining Board (Board) to promulgate rules that will provide guidance within the profession and interpret the statutes it administers. Section 448.40 (1), Stats., allows the Board to draft rules that will carry out the purposes of ch. 448, Stats. With the passage of 2013 Wisconsin Act 240, the legislature granted specific rule-making authority to the Board to draft rules to address the new physician licensure classifications created by the Act.

**Related statute or rule:**

Wis. Admin. Code ch. Med 1, 3, and 5

**Plain language analysis:**

These rules address the changes instituted by the passage of 2013 Wisconsin Act 240 regarding physician licensure. The Act changed the postgraduate training requirement for all applicants seeking physician licensure from 12 months to 24 months. Both U.S. and foreign trained medical school graduates must complete 24 months of postgraduate training or must be currently enrolled and have successfully completed 12 months of a postgraduate training program, and have an unrestricted endorsement from the postgraduate training director that the applicant is expected to complete at least 24 months of postgraduate training.

Act 240 repealed the visiting professor license and created the restricted license to practice medicine and surgery as a visiting physician. The visiting physician license is open to any physician licensed outside of Wisconsin who is invited to serve on the academic staff of a medical school in this state. The holder of a visiting physician license may only practice in the education facility, research facility or medical school where the license holder is teaching, researching, or practicing medicine and surgery. The license is valid for one year and remains valid as long as the license holder is actively engaged in teaching, researching, or practicing medicine and surgery and is lawfully entitled to work in the U.S.

The temporary educational permit to practice medicine and surgery was also repealed and replaced with the resident educational license to practice medicine and surgery (REL). The REL allows the license holder to pursue postgraduate training under the direction of a Wisconsin licensed physician. The holder of a REL may practice online in the postgraduate training program in which the person is being trained. The REL is valid for one year and may be renewed for additional one year terms as long as the license holder is enrolled in a postgraduate training program.

The Act created the administrative physician license. The administrative physician license allows the license holder to pursue administrative or professional managerial functions but does not allow the license holder to treat patients. The administrative physician license holder must comply with all of the same application requirements as a regular license to practice medicine and surgery.

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

None.

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

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

**Fiscal Estimate and Economic Impact Analysis:**

The Fiscal Estimate and Economic Impact Analysis document is attached.

**Effect on small business:**

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

**Agency contact person:**

Katie Vieira, Administrative Rules Coordinator, Department of Safety and Professional Services, Division of Policy Development, 1400 East Washington Avenue, Room 151, P.O. Box 8366, Madison, Wisconsin 53708; telephone (608) 261-4472; email at Kathleen.Vieira@wisconsin.gov.

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TEXT OF RULE

SECTION 1. Med 1.02 (3) is repealed and recreated to read:

**Med 1.02 (3) (a)** Verification of satisfactory completion by the applicant of 24 months of postgraduate training in one or more programs accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or a successor organization; or documentary evidence that the applicant is currently enrolled in a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, or the American Osteopathic Association or a successor organization and has received credit for 12 consecutive months of postgraduate training in that program and an unrestricted endorsement from the postgraduate training director that the applicant is expected to complete at least 24 months of postgraduate training.

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

(c) If the applicant is a graduate of a foreign allopathic or osteopathic medical school and has not completed 24 months of postgraduate training approved by the board and is not currently enrolled in a postgraduate training program but the applicant has other professional experience which the applicant believes has given that applicant the

education and training substantially equivalent to 24 months of postgraduate training, then the applicant may submit the documented education and training demonstrating substantially equivalent education and training. The board will review the documented education and training and may make further inquiry, including a personal interview of the applicant, as the board deems necessary to determine whether substantial equivalence in fact exists. The burden of proof of such equivalence shall lie upon the applicant. If the board finds that the documented education and training is substantially equivalent to the required training and experience the board may accept the experience in lieu of requiring the applicant to have completed 24 months of postgraduate training in a program approved by the board.

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

SECTION 2. Med 1.06 (1) (a) (intro.), (b), and (c) are amended to read:

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

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

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

SECTION 3. Med 1.06 (4) is repealed.

SECTION 4. Med 1.08 (2) is amended to read:

**Med 1.08 (2)** If an applicant has been examined 4 or more times in another licensing jurisdiction in the United States or Canada before achieving a passing grade in written or computer-based examinations also required under this chapter, the board may require the applicant to submit evidence satisfactory to the board of further professional training or education in examination areas in which the applicant had previously demonstrated deficiencies. If the evidence provided by the applicant is not satisfactory to the board, the board may require the applicant to obtain further professional training or education as the board deems necessary to establish the applicant's fitness to practice

medicine and surgery in this state. In order to determine any further professional training or education requirement, the board shall consider any information available relating to the quality of the applicant's previous practice, including the results of the applicant's performance on the oral ~~examination~~ interview required under s. 448.05 (6), Stats., and s. Med 1.06.

SECTION 5. Med 1.09 (1) is amended to read:

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

SECTION 6. Med 1.09 (4) is repealed.

SECTION 7. Med 1.09 (6) is amended to read:

**Med 1.09 (6)** At the beginning of the review, the applicant shall be provided with a copy of the questions, a copy of the applicant's answer sheet ~~or oral-practical tape~~ and a copy of the master answer sheet.

SECTION 8. Med 3 (title) is amended to read:

### CHAPTER MED 3

#### VISITING ~~PROFESSOR~~ PHYSICIAN LICENSE

SECTION 9. Med 3.01 and 3.02 are amended to read:

**Med 3.01 Authority and purpose.** The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11 (2) (a) and 448.40, Stats., and govern application for ~~a temporary license to practice medicine and surgery under s. 448.04 (1) (b) 2., Stats.,~~ restricted license to practice medicine and surgery as a visiting physician under 448.04 (1) (bg), Stats., (hereinafter "visiting ~~professor~~ physician license"), and also govern practice thereunder.

**Med 3.02 Applications, credentials, and eligibility.** An applicant who is a graduate of a ~~foreign~~ an allopathic medical school located outside of the United States or Canada or an osteopathic medical school that is approved by the board and who is invited to ~~serve on the academic staff of a teach, conduct research, or practice medicine and surgery at a medical education facility, medical research facility, or medical school in this state as a visiting professor physician~~ may apply to the board for a ~~temporary-visiting professor license~~ visiting physician license and shall submit to the board all of the following:

(1) A completed and verified application for this purpose as required in s. Med 1.02 (1), which includes proof that the applicant has graduated from and possesses a diploma from an allopathic medical or osteopathic medical school that is approved by the board.

(1m) Documentary evidence of licensure to practice medicine and surgery.

(2) A signed letter from the appointing authority president or dean or delegate of the president or dean of a medical school, or facility in this state indicating that the applicant has been invited to serve on the academic staff of such medical school as a visiting professor intends to teach, conduct research, or practice medicine and surgery at a medical education facility, medical research facility, or medical school in this state.

(3) A curriculum vitae setting out the applicant's education and qualifications ~~and a verified photographic copy of the diploma (with translation) conferring the degree of doctor of medicine granted to the applicant by such college.~~

~~(4) A photograph of the applicant as required in s. Med 1.02 (4).~~

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

~~(6) Documentary evidence of noteworthy attainment in a specialized field of medicine.~~

(7) Documentary evidence of ~~post-graduate~~ postgraduate training completed in the United States ~~and/or~~ or foreign countries.

(8) Oral interview conducted by at the discretion of the board.

(9) Documentary evidence that the applicant teaches medicine, engages in medical research, or practices medicine and surgery outside of Wisconsin.

(10) The required fees determined under s. 440.03 (9) (a), Stats.

SECTION 10. Med 3.04 is amended to read:

**Med 3.04 Practice limitations.** The holder of a ~~temporary~~ visiting professor physician license may practice medicine and surgery as defined in s. 448.01 (9), Stats., providing such practice is ~~full-time and is entirely limited to the medical education facility, medical research facility, or medical school where the license holder is teaching, conducting research, or practicing medicine and surgery, and is limited to the terms and restrictions established by the board.~~ the duties of the academic position to which the holder of such license is appointed.

SECTION 11. Med 3.05 is repealed and recreated to read:

**Med 3.05 Expiration and renewal.** A visiting physician license is valid for one year and remains valid only while the license holder is actively engaged in teaching, conducting research, or practicing medicine and surgery and is lawfully entitled to work in the United States. The visiting physician license may be renewed at the discretion of the board.

SECTION 12. Med 3.06 is repealed.

SECTION 13. Med 5 (title) is amended to read:

#### CHAPTER MED 5

#### TEMPORARY EDUCATIONAL PERMIT RESIDENT EDUCATIONAL LICENSE TO PRACTICE MEDICINE AND SURGERY

SECTION 14. Med 5.01 and 5.02 are amended to read:

**Med 5.01 Authority and purpose.** The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11 and 448.40, Stats., and govern application for ~~temporary educational permit~~ the resident educational license to practice medicine and surgery under ~~s. 448.04 (1) (e), Stats., s. 448.04 (1) (bm), Stats.,~~ (hereinafter "temporary resident educational permit license"), and also govern practice thereunder.

**Med 5.02 Applications, credentials, and eligibility.** An applicant who has been ~~appointed to accepted into~~ a postgraduate training program in a facility in this state approved by the board under the provisions of s. Med 1.02 (3) and accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization may apply to the board for a ~~temporary educational permit~~ resident educational license to practice medicine and surgery ~~and~~. The applicant shall submit to the board all of the following:

(1) ~~A completed and verified application form supplied by the board for this purpose. These application forms are furnished by the board to the directors of training programs in approved facilities in this state and are available to the applicant from such directors.~~

(1m) Documentary evidence that the applicant is a graduate of and possesses a diploma from an allopathic or osteopathic medical school approved by the board.

~~(2) The documentary~~ Documentary evidence that and credentials required under s. Med 1.02 (2), (4) and (5) the applicant has been accepted into a postgraduate training program accredited by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, or a successor organization.

(3) A signed letter from the president or dean or the delegate of the president or dean of the institution sponsoring the postgraduate training program into which the applicant has been accepted confirming that the applicant has been or will be accepted into a postgraduate training program.

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

SECTION 15. Med 5.04 and 5.05 are amended to read:

**Med 5.04 Practice limitations.** The holder of a ~~temporary educational permit to practice medicine and surgery~~ resident educational license may, under the direction of a person licensed to practice medicine and surgery in this state, perform services requisite to the postgraduate training program in which ~~that holder~~ the licensee is serving. Acting under such direction, ~~the holder of such temporary educational permit~~ the resident educational licensee shall also have the right to prescribe drugs ~~other than narcotics and controlled substances~~ and to sign any certificates, reports or other papers for the use of public authorities which are required of or permitted to persons licensed to practice medicine and surgery. The ~~holder of such temporary educational permit~~ resident educational licensee shall confine ~~his or her~~ the training and entire practice to the facility postgraduate training program in which ~~the permit holder~~ the resident educational licensee is taking the training ~~and to the duties of such training.~~

**Med 5.05 Revocation.** Violation by ~~the holder of a temporary educational permit~~ a resident educational licensee to practice medicine and surgery of any of the provisions of this chapter or of any of the provisions of the Wisconsin Administrative Code or of ch. 448, Stats., which apply to persons licensed to practice medicine and surgery shall be cause for the revocation of such ~~temporary educational permit~~ resident educational license.

SECTION 16. Med 5.06 is repealed and recreated to read:

**Med 5.06 Expiration and renewal.** A resident educational license to practice medicine and surgery granted under this chapter is valid for one year from the date of issuance and may be renewed for additional one-year terms as long as the license holder is enrolled in the postgraduate training program.

SECTION 17. Ch. Med 23 is created to read:

## CHAPTER MED 23

### ADMINISTRATIVE PHYSICIAN LICENSE

**Med 23.01 Authority and purpose.** The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.11, and

448.40, Stats., and govern application for licensure as an administrative physician under s. 448.04 (1) (ac), Stats., and also govern practice thereunder.

**Med 23.02 Application, credentials and eligibility.** An applicant for an administrative physician license must provide a completed and verified application which includes proof that the applicant has graduated from and possesses a diploma from an allopathic or osteopathic medical school approved by the board; and documentary evidence of completion of a postgraduate training program approved by the board. Applicants for an administrative physician license must also meet the same qualifications for licensure as applicants applying under s. 448.05 (2) (a) or (b), Stats.

**Med 23.03 Fees.** The required fees must accompany the application, and must be made payable to the Wisconsin department of safety and professional services.

**Med 23.04 Practice limitations.** The Board may issue an administrative physician license to an applicant whose primary responsibilities are those of an administrative or academic nature, such as professional managerial, administrative, or supervisory activities. The holder of an administrative physician license may not examine, care for, or treat patients. An administrative physician license does not include the authority to prescribe drugs or controlled substances, delegate medical acts, issue opinions regarding medical necessity, or conduct clinical trials on humans.

**Med 23.05 Registration and renewal.** Each administrative physician licensee shall register biennially with the board. Administrative physicians who possess the degree of doctor of osteopathy must register by March 1<sup>st</sup> of each even-numbered year. Administrative physicians who possess the degree of doctor of medicine must register on or before November 1 of each odd-numbered year. The department shall mail to each licensee at his or her last known address as it appears in the records of the board a notice of renewal for registration. The board shall notify the licensee within 30 business days of receipt of a completed registration form as to whether the application for registration is approved or denied. The administrative physician licensee must comply with all other provisions of s. 448.13, Stats. and of ch. Med 13.

**Med 23.06 Interview.** Applicants may be required to complete an oral interview at the discretion of the board.

SECTION 18. EFFECTIVE DATE. The rules adopted in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, pursuant to s. 227.22 (2) (intro.), Stats.

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(END OF TEXT OF RULE)

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Dated 2015 October 27

Agency Summit B. [Signature]  
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 and 5

3. Subject

Physician licensure

4. Fund Sources Affected

GPR  FED  PRO  PRS  SEG  SEG-S

5. Chapter 20, Stats. Appropriations Affected

20.165 (1) (hg)

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 instituted by recent legislation, specifically 2013 Wisconsin Act 240. This legislation transformed physician licensure in Wisconsin by discontinuing the visiting professor license and the temporary educational license and creating three new licensure classes. One of the new licensure classes is the visiting physician license. The visiting physician license is open to candidates from outside of Wisconsin who have been invited to serve on the academic staff of a medical school in this state. The visiting physician license holder must limit their teaching, researching, and practice of medicine to the education facility, research facility or college where the visiting physician licensee has been invited to teach, research, or practicing medicine. The resident education license allows new medical school graduates to become licensed in order to complete their postgraduate training. The resident educational license holder must practice medicine and surgery only in connection with his or her duties under their postgraduate training program. Lastly, the administrative physician license allows the license holder to pursue professional managerial functions but does not allow treating patients. The Act also increased the required graduate medical educational training from one year to two years. The proposed rule seeks to amend Wis. Admin. Code s. Med 1, 3, and 5 to reflect these changes.

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 government units participated in the development of 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)

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

## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

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

The benefit of implementing this proposed rule includes carrying out the statutory goals of 2013 Wisconsin Act 240 and giving clear guidance on the requirements for licensure to those applying for a license to practice medicine and surgery in Wisconsin.

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14. Long Range Implications of Implementing the Rule

Long range implications of implementing the rule include greater consistency in the licensure process for applicants seeking to practice medicine and surgery in Wisconsin.

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15. Compare With Approaches Being Used by Federal Government

None.

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

**Illinois:** Illinois requires 1 year of postgraduate clinical training for both US and Foreign graduates. 225 ILCS 60/11.

Visiting Professor Permit This permit holder maintains a license to practice medicine in his or her native licensing jurisdiction during the period of the visiting professor permit and receives a faculty appointment to teach in a medical, osteopathic or chiropractic school in Illinois. A visiting professor permit is valid for 2 years from the date of its issuance or until the faculty appointment is terminated, whichever occurs first. 225 ILCS 60/18 (A.)

Visiting physician permit This permit is granted to persons who have received an invitation or appointment to study, demonstrate or perform a specific medical, osteopathic, chiropractic or clinical subject or technique in a medical, osteopathic, or chiropractic school, a state or national medical, osteopathic, or chiropractic professional association or society conference or meeting, or a hospital licensed under the Hospital Licensing Act, a hospital organized under the University of Illinois Hospital Act, or a facility operated pursuant to the Ambulatory Surgical Treatment Center Act. The permit is valid for 180 days from the date of issuance or until the completion of the clinical studies or conference has concluded, whichever occurs first. 225 ILCS 60/18 (B)

Visiting resident permit is a credential that is issued to candidates who maintain an equivalent credential in his or her native licensing jurisdiction during the period of the temporary visiting resident permit. The permit holder must be enrolled in a postgraduate clinical training program outside the state of Illinois and must have been invited or appointed for a specific time period to perform a portion of that postgraduate clinical training program under the supervision of an Illinois licensed physician in an Illinois patient care clinic or facility that is affiliated with the out-of-state post graduate training program. 225 ILCS 60/18 (C).

**Iowa:** Iowa requires one year of residency training in a hospital-affiliated program approved by the board, graduates of international medical schools must complete 24 months of graduate training. 653 IAC 9.3.

Resident physician license allows the resident physician to practice under the supervision of a licensed practitioner in a board-approved resident training program in Iowa. The resident physician licensure is required of any resident physician enrolled in a resident training program and practicing in Iowa and can only remain active as long as the resident physician practices in the program designated in his or her application. If the resident physician leaves that program, the license immediately becomes inactive. 653 IAC 10.03 (1).

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## ADMINISTRATIVE RULES Fiscal Estimate & Economic Impact Analysis

Special licensure is granted to physicians who are academic staff members of a college of medicine or osteopathic medicine if that physician does not meet the qualifications for permanent licensure but is held in high esteem for unique contributions that have been made to medicine. This class of licensure is renewed by the board on a case-by-case basis, and specifically limits the license to practice at the medical college and at any health care facility affiliated with the medical college. 653 IAC 10.4.

The Iowa Board did not have a comparable administrative physician license.

**Michigan:** Michigan requires graduates of schools located in the U.S. and its territories to complete 2 years of postgraduate clinical training. Mich. Admin. Code R. 338.2317. Foreign medical school graduates are required to complete 2 years of postgraduate clinical training in a program approved by the board, or in a board approved hospital or institution. Mich. Admin. Code R. 338.2316 (4) (a).

Clinical academic limited license is a class of licensure which is granted to candidates who have graduated from medical school and have been appointed to a teaching or research position in an academic institution. Mich. Admin. Code R. 338.2327a. This license holder must practice only for an academic institution and under the supervision of one or more physicians fully licensed in Michigan. This class of license is renewable on an annual basis but not past 5 years. MCLS §333.17030.

Educational limited license This class of licensure authorizes the license holder to engage in the practice of medicine as part of a postgraduate educational training program. This license is granted to applicants who have graduated or who expect to graduate within the following 3 months from a medical school approved by the board and that the applicant has been admitted to a training program approved by the board. Foreign trained applicants must verify that they have completed a degree in medicine, have been admitted to a board approved training program and have passed an examination in the basic and clinical medical sciences conducted by the educational commission for foreign medical graduates. Mich. Admin. Code R. 338.2329a.

Michigan does not have a comparable administrative physician license.

**Minnesota:** Minnesota requires U.S. or Canadian medical school graduates to complete 1 year of graduate clinical medical training. Minn. Stat. § 147.02 (d). Foreign medical school graduates must complete 2 years of graduate clinical medical training. Minn. Stat §147.037 (d).

Residency permit A person must have a residency permit to participate in residency program in Minnesota. If a resident permit holder changes their residency program, that person must notify the board in writing no later than 30 days after termination of participation in the residency program. A separate residency permit is required for each residency program until a license is obtained. Minn. Stat. §147.0391.

Minnesota exempts from licensure physicians that are employed in a scientific, sanitary, or teaching capacity by the state university, the Department of Education, a public or private school, college, or other bona fide educational institution, or nonprofit organizations operated primarily for the purpose of conducting scientific research directed towards discovering the causes of and cures for human diseases. Minn. Stat. §147.09 (6).

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

Minnesota does not have a comparable administrative physician license.

17. Contact Name Shawn Leatherwood	18. Contact Phone Number 608-261-4438
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This document can be made available in alternate formats to individuals with disabilities upon request.

# STATEMENT OF SCOPE

## Medical Examining Board

Rule No.: Med 13

Relating to: Continuing Medical Education for Prescribing Opioids

Rule Type: Permanent

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

N/A

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

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

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

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

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

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

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

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

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

40 hours

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

Wisconsin licensed physicians

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

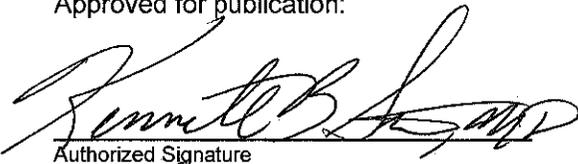
None.

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

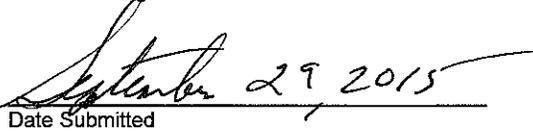
The proposed rule will have minimal to no economic impact on small businesses and the state's economy as a whole.

**Contact Person:** Katie Vieira, Administrative Rule Coordinator, Kathleen.Vieira@wisconsin.gov, (608) 261-4472

Approved for publication:



Authorized Signature



Date Submitted

Approved for implementation:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date Submitted

# 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:**

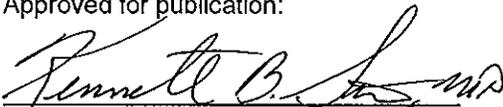
None.

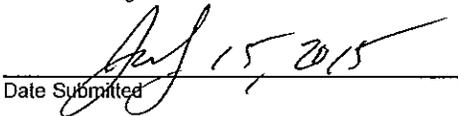
**8. Anticipated economic impact of implementing the rule (note if the rule is likely to have a significant economic impact on small businesses):**

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:

  
Authorized Signature

  
Date Submitted

Approved for implementation:

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date Submitted

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Kimberly Wood, Program Assistant Supervisor-Advanced		<b>2) Date When Request Submitted:</b>  9/21/2015  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  10/21/2015	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Medical Examining Board – Council Member Appointment Matters 1) Respiratory Care Practitioners Examining Council a. Consider Appointment i. Ann Bonner b. Reappointments i. William Rosandick ii. Lynn Waldera	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A	
<b>10) Describe the issue and action that should be addressed:</b>  The Board should determine how best to proceed with appointments or reappointments to the Respiratory Care Practitioners Examining Council.  a. Consider Appointment iii. Ann Bonner – Recent application (Replace Ann Meicher) Expiration: 7/1/2017 – RESUME ATTACHED 1. Motion Language: to appoint Ann Bonner to the Respiratory Care Practitioners Examining Council as a Respiratory Care Practitioner Member for a term to expire on July 1, 2017.  b. Reappointments iv. William Rosandick – Reappointment until 7/1/2016 1. Motion Language: to reappoint William Rosandick to the Respiratory Care Practitioners Examining Council as a Respiratory Care Practitioner Member for a term to expire on July 1, 2016.  v. Lynn Waldera – Reappointment until 7/1/2017 1. Motion Language: to reappoint Lynn Waldera to the Respiratory Care Practitioners Examining Council as a Respiratory Care Practitioner Member for a term to expire on July 1, 2017.			
<b>11) Authorization</b>			
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)		Date	

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

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.

Ann Bonner  
121 Pine Grove Platteville, WI 53818  
608-642-3200  
acmbonner@centurytel.net

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#### OBJECTIVE

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A position in a managerial or supervisory capacity for respiratory, sleep and cardiology areas in a growing and nurturing health care facility.

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#### SKILLS PROFILE

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- Proficient and competent in all areas of respiratory care and cardiology diagnostics.
  - Excellent patient care and customer service skills.
  - Over 30 years in the field of respiratory care in a variety of patient care settings and roles.
  - Knowledge of and experience with multiple electronic medical records.
- 

#### EMPLOYMENT HISTORY

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**Supervisor Cardiopulmonary Services** 2005-current  
*Southwest Health Center Platteville, WI*

- Provide department oversight for all Respiratory and Sleep personnel
- Provide respiratory care services including but not limited to aerosol and oxygen therapy, ventilator care, ABG collection, BIPAP setup and monitoring.
- Perform stress testing, holter monitoring, pulmonary function testing.
- Perform in lab sleep testing on Sandman sleep platform including scoring of records.
- Serve on multiple committees including disaster preparedness, patient safety, information steering, forms and scanning.

**Respiratory Therapist** 2008- 2013  
*Monroe Clinic Monroe, WI*

- Provide respiratory care services including but not limited to aerosol and oxygen therapy, ventilator care, ABG collection and analysis, BIPAP setup and monitoring.
- Serve as a clinical/managerial resource for policy development and clinical advancement.

**Director Respiratory and EKG Services** 1999-2005  
*Lawnwood Regional Medical Center, Ft. Pierce, FL*

- Provided direction and leadership to respiratory and EKG departments at a 330 bed acute care health facility.

**Director Cardiopulmonary Services** 1991-1999  
*JFK Medical Center Atlantis, FL*

- Provided direction and leadership to respiratory, EKG, ECHO, cardiac rehab, EEG and sleep lab departments at a 379 bed acute care health facility.
- 

#### EDUCATION/ CERTIFICATIONS

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**Associate Degree in Respiratory Care** 1984  
*Lansing Community College Lansing, MI*

**Registered Respiratory Therapist** 1984  
*NBRC*

**Registered Polysomnography Technologist** 2010  
*Board of Polysomnograph Technologist*

**American Board of Sleep Medicine Sleep Certificate** 2011  
*American Academy of Sleep Medicine*

**Advanced Cardiopulmonary Life Support/Basic Life Support/  
Neonatal Resuscitation** current  
current

**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:  9/29/2015	
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
3) Name of Board, Committee, Council, Sections:  Medical Examining Board			
4) Meeting Date:  10/21/2015	5) Attachments: x Yes <input type="checkbox"/> No	6) How should the item be titled on the agenda page?  FSMB Matters: Interstate Medical Licensure Compact	
7) Place Item in: x Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	8) Is an appearance before the Board being scheduled? If yes, who is appearing?  No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed:  The State of Illinois and the Department of Financial and Professional Regulation are honored to host the inaugural meeting of the Interstate Medical Licensure Compact Commission. The meeting will be held October 27, 2015 from 8:00 a.m. to 5:00 p.m. and October 28, 2015 from 8:00 a.m. to Noon in Room N505 of the Michael A. Bilandic Building, 160 North LaSalle, Chicago, Illinois 60601.  For a copy of the Senate bill, go here:  <a href="http://docs.legis.wisconsin.gov/2015/related/proposals/sb196">http://docs.legis.wisconsin.gov/2015/related/proposals/sb196</a>  For more information on the Compact go to: <a href="http://www.licenseportability.org/">http://www.licenseportability.org/</a> .			
11) <b>Authorization</b>			
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



**Illinois Department of Financial and Professional Regulation**  
**Division of Professional Regulation**

**BRUCE RAUNER**  
Governor

**BRYAN A. SCHNEIDER**  
Secretary

**JAY STEWART**  
Director  
Division of Professional Regulation

September 28, 2015

Tom H. Ryan, JD, MPA, Executive Director  
Wisconsin Medical Examining Board  
1400 E. Washington Avenue, Room 178  
Madison, WI 53703-3041

Dear Director Ryan:

The State of Illinois and the Department of Financial and Professional Regulation are honored to host the inaugural meeting of the Interstate Medical Licensure Compact Commission. The meeting will be held October 27<sup>th</sup> and 28<sup>th</sup> in Room N505 of the Michael A. Bilandic Building, 160 North LaSalle Street, Chicago, Illinois 60601.

The Interstate Medical Licensure Compact is an important step in improving physician licensure portability and in increasing access to healthcare for the citizens of your state. For more information on the Compact please go to: <http://www.licenseportability.org/>.

While your state is not yet a member of the Compact, we encourage you to send a non-voting representative to this historic meeting.

There are several hotels within walking distance of the Bilandic Building. Commissioners will be staying at the Fairmont Chicago, 200 North Columbus Drive, Chicago, Illinois 60601. Other attendees may want to contact the Fairmont or one of the other nearby hotels to reserve a room soon as possible as hotels in downtown Chicago often fill up far in advance.

For further information please contact:

Brian S. Zachariah, MD, MBA  
Chief Medical Coordinator, IDFPR  
100 W. Randolph Street  
Suite 9-300  
Chicago, IL 60601  
812-814-4580  
[brian.zachariah@illinois.gov](mailto:brian.zachariah@illinois.gov)

cc: Executive Director, State Medical Board

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Kimberly Wood, Program Assistant Supervisor-Advanced		<b>2) Date When Request Submitted:</b>  10/13/2015  Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  10/21/2015	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Review and Approval of the Medical Examining Board Fall 2015 Newsletter Draft	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session	<b>8) Is an appearance before the Board being scheduled?</b>  <input type="checkbox"/> Yes ( <a href="#">Fill out Board Appearance Request</a> ) <input checked="" type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>  N/A	
<b>10) Describe the issue and action that should be addressed:</b>  The Board should review the Newsletter Draft, identify any revisions and ultimately approve the newsletter for distribution. If revisions are necessary the Board should identify a member to approve the draft once changes have been made  Suggested Motion Language: to approve the Medical Examining Board Fall 2015 Newsletter Draft, as published in the 10/21/2015 meeting agenda, and to request distribution by <b>&lt;Insert Date&gt;</b> .  Or  Suggested Motion Language: to designate <b>&lt;Insert Name&gt;</b> to approve changes to the Medical Examining Board Fall 2015 Newsletter Draft and to authorize distribution once approved.			
<b>11) Authorization</b>			
<b>Kimberly Wood</b>		<b>10/13/2015</b>	
Signature of person making this request		Date	
Supervisor (if required)		Date	
Executive Director signature (indicates approval to add post agenda deadline item to agenda)    Date			
<b>Directions for including supporting documents:</b> 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.			



A Publication of the Wisconsin Medical Examining Board

November 2015

### Update 2013 Wisconsin ACT 240

With the implementation of [2013 WI Act 240](#), the WI DSPS Credentialing Process for Physician licensure has changed in the following ways:

- The WI Statutes and Rules examination is no longer required;
- Because the Statutes and Rules Exam is not a requirement, the initial licensing fees have changed from \$150 (\$75 Initial Credential Fee (ICF)/\$75 Exam Fee) to \$75 (ICF);
- Applicants are now required to have 24 months of ACGME/AOA approved post-graduate training in order to meet the licensure requirements. If an applicant has completed at least 12 months of training and is continuing in the same program, the facility can provide verification of the 12 months of training along with an unrestricted endorsement that the applicant is expected to fully complete an additional 12 months. This will satisfy the 24 month post-graduate training requirement;
- The Visiting Professor permit has changed to a Visiting Physician license. The Visiting Professor credential is now limited to foreign educated physicians only; the Visiting Physician credential does not have that restriction;
- An Administrative Physician credential was created to allow Physicians to hold a medical license in a non-clinical capacity if their primary responsibilities are of an administrative or academic nature;
- The Temporary Educational Permit (TEP) has been replaced by the Resident Educational License (REL). With this change, the REL is now required for first year residents. Residents are eligible to continue with an REL until they complete 24 months of ACGME training and beyond at the discretion of their training program. The TEP previously did not allow first year residents to hold a TEP credential.

### Chair's Corner

*By Dr. Kenneth Simons*

The noted philosopher Santayana said, "Those who forget the past are doomed to repeat it."

All of us who have been fortunate to practice the science and art of medicine for longer than just the past 15 years, are probably struck by the 'new' emphasis on medicine as a team sport as well as on significant efforts involving patient safety. Not that any of this is bad (it is actually quite good), but for those of us who trained in that earlier time, it does fail to represent to our current trainees our earlier pioneering efforts with teamwork and patient safety.

I dare say that all of our older colleagues (yes, I include myself) considered ourselves part of a team. I vividly recall receiving a call in my first month of internship in the Emergency Department about a seventeen year old on her way in who was about to deliver a baby. There was no time to get her to Labor and Delivery as she was crowning. Thank goodness for me that there was an experienced nurse with me who put her hands around my trembling ones, thereby allowing us to deliver a healthy baby boy. Clearly, this brand new intern was unprepared and could never have done it alone.

During my residency, I was always fortunate to consider myself a member of an interdisciplinary team caring for patients. The team was always there in the clinic or the OR and there was always respect between the disciplines: medicine, nursing, pharmacy, technicians, etc. Yes, things occasionally got testy (we are all human after all) but when the tense situation had resolved, we debriefed and apologized for any hurt we had caused.



*Kenneth Simons*

*See Chair's Corner Page 3*

## **Wisconsin Prescription Drug Monitoring Program: Important Changes on the Horizon**

The Wisconsin Prescription Drug Monitoring Program (PDMP) continues to provide physicians with a valuable tool to help combat prescription drug abuse. Through the PDMP, registered prescribers and their delegates can access their patients' controlled substance prescription histories, which can help guide clinical decision making about the prescribing of opiates and other controlled substances. Currently, over 12,000 prescribers, pharmacists, and their delegates have registered to access the PDMP database. Prescribers account for approximately 49% of registered users and have performed about 25% of the patient queries to date. While the number of patient queries performed each month continues to increase, the PDMP remains underutilized.

In order to optimize use of the PDMP, important changes are on the horizon. With the support of funding from a Centers for Disease Control Prescription Drug Overdose Prevention Grant through the Department of Health Services, enhancements will be made to the PDMP system. The enhanced PDMP system will emphasize usability in an effort to better integrate PDMP data into clinical workflow. Ease-of-use could become vitally important with forthcoming legislation ([Assembly Bill 364](#)) that would make use of the PDMP mandatory for prescribers before issuing controlled substance prescriptions. The legislation would also improve the quality of the data by requiring pharmacies to submit data to the PDMP within 24 hours of dispensing a controlled substance. Current law requires submission within seven days of dispensing.

To register for access to the PDMP database, visit: <http://dsps.wi.gov/pdmp/access/prescriber>. When prompted, enter "newacct" as your username and "welcome" as your password. Complete and submit the online registration form. If you have any questions while registering, please contact DSPS staff at [PDMP@wisconsin.gov](mailto:PDMP@wisconsin.gov).

A wealth of useful information is available on the Department of Safety and Professional Services Website at: <http://dsps.wi.gov>

### **Do you have a change of name or address?**

Licensees can update name or address information on the Department website at:

<https://online.drl.wi.gov/UserLogin.aspx>

Please note that confirmation of change is not automatically provided. Legal notices will be sent to a licensee's address of record with the Department.

### **Telephone Directory:**

Call the Department of Safety and Professional Services toll-free (877) 617-1565, or (608) 266-2112 in the Madison area to connect to the service you need.



## **Medical Examining Board Membership and Staff Assignments**

*The Medical Examining Board consists of 13 members. The members are appointed by the Governor and confirmed by the Senate.*

### **Board Members:**

Kenneth Simons, M.D., Chairperson (Milwaukee)  
Timothy Westlake, M.D., Vice Chairperson (Hartland)  
Mary Jo Capodice, D.O., Secretary (Sheboygan)  
Greg Collins, Public Member (Ashwaubenon)  
Rodney Erickson, M.D., Physician Member (Tomah)  
Suresh Misra, M.D., Physician Member (Milwaukee)  
Carolyn Ogland Vukich, M.D., Physician Member (Madison)  
Michael Phillips, M.D., Physician Member (Oconomowoc)  
David Roelke, M.D., Physician Member (Hartland)  
John Tripoli, Public Member (Elm Grove)  
Sridhar Vasudevan, M.D., Physician Member (Belgium)  
Russell Yale, M.D., Physician Member (Fox Point)  
Robert Zondag, Public Member (Delafield)

*Information on how to apply for appointment to the Wisconsin Medical Examining Board can be found through the Office of the Governor:*

<http://walker.wi.gov/governor-office/apply-to-serve/boards-commissions>

### **Department of Safety and Professional Services**

#### **Administrative Staff:**

Thomas Ryan, Executive Director  
Amber Cardenas, Legal Counsel  
Nifty Lynn Dio, Bureau Assistant

#### **Executive Staff:**

Dave Ross, Secretary  
Jonathan Barry, Deputy Secretary  
Eric Esser, Assistant Deputy Secretary

*The dates and times of the Medical Examining Board meetings are announced on the DSPS website at <http://dsps.wi.gov>.*

*Meeting agendas are posted approximately one week prior to the meeting.*

### *From Chair's Corner Page 1*

I recently had the good fortune to hear Dr. Leonard Marcus speak about swarm intelligence and how a colony of ants (who have been around longer than humans) are able to accomplish tasks for which a solitary ant is absolutely inept. The message was clear, working in teams we can accomplish so much more than any single individual. As for patient safety, long before there were timeouts in the operating room, we did site marking in my residency to prevent removal of the wrong eye. In addition, we apologized to families for an outcome or error and did not need a law to simply express our innate humanity to our patients and their families for an unanticipated or less than desirable outcome. My faculty instructed us to do the right thing and I don't for a minute believe that this was unique to my training facility. Rather, I'm willing to bet that those of you who trained in that time period have similar

stories to tell. So, let's embrace and champion these new efforts at inter-professional education and patient safety but let us not think for a moment that this is all brand new. In this case, repetition is a good thing, but we should not forget, and more importantly, should respect the earlier endeavors upon which the current efforts are building.

As David in 2005, "There are these two young fish swimming along and they happen to meet an older fish swimming the other way who nods at them and says, "Morning boys. How's the water?" And the two young fish swim on for a bit, and then eventually one of them looks over at the other and goes "What the h\*\*\* is water?" Like the two young fish, we can go our whole lives being completely oblivious to the world around us and that which came before us. But it doesn't mean we should.

### **Current Name and Address Required**

All applicants and recipients of a credential are required by Wisconsin Statute to notify the Department of Safety and Professional Services (Department) when they change their name or address from that most recently provided to the Department. The applicant or credential holder has 30 days to notify the Department from the date the change is made.

Failure to comply in a timely manner may result in a \$50 forfeiture. Please keep in mind that if you do not provide the Department with name and address changes, you may not receive important information such as complaint and investigation notices concerning your credential. The Department is only legally required to try to contact you at your last known address as indicated in Department records.

Finally, it is considered "unprofessional conduct" and subject to discipline on your credential if you fail to cooperate in a timely manner with a Board investigation. So if you fail to update your name and address, you take the chance of not receiving important correspondence from the Department, triggering the "unprofessional conduct" provisions. See Wis. Stat. §§ [440.035](#), [440.11](#) and Wis. Admin. Code § [Med 10.03\(3\)\(g\)](#). You can update your name or address via the Department website at <http://dsps.wi.gov>.

## **Enforcement Actions of the Medical Examining Board**

The Medical Examining Board, with help from staff at the Department of Safety and Professional Services, can take action against licensed professionals around the state to help protect the profession and the citizens of Wisconsin. You may search for any of the Board Orders listed below on the Department's website by using this link:

*Board Order Search:* <http://dsps.wi.gov/Other-Services/Lookup-Orders-Disciplinary>

*Disciplinary actions are reported to the National Practitioners Data Bank. Available options to the Board are:*

**Reprimand** - A public warning of the licensee for a violation.

**Limitation of License** - Imposes conditions and requirements upon the licensee, imposes restrictions on the scope of practice, or both.

**Suspension** - Completely and absolutely withdraws and withholds for a period of time all rights, privileges and authority previously conferred by the credential.

**Revocation** - To completely and absolutely terminate the credential and all rights, privileges and authority previously conferred by the credential.

*Non-disciplinary actions are not reported to the National Practitioners Data Bank. Available options to the Board are:*

**Administrative Warning** - Issued if violation is of a minor nature, a first occurrence and the warning will adequately protect the public. The issuance of an Administrative Warning is public information, however the reason for issuance is not.

**Remedial Education Order** - Issued when there is reason to believe that the deficiency can be corrected with remedial education, while sufficiently protecting the public.

# Board Orders

March 2015 - October 2015

Profession	Order No	Order Date	Respondent	City	State
Medicine and Surgery, MD	<a href="#">ORDER0002435</a>	3/3/2015	Werwath, David L	Virginia Beach	VA
Physician Assistant	<a href="#">LS0708153MED</a>	3/9/2015	Nolden, Jennifer L	Verona	WI
Medicine and Surgery, MD	<a href="#">ORDER0004245</a>	3/18/2015	Braxton, John H	Marshfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0004246</a>	3/18/2015	O'connell, Barbara J	Verona	WI
Medicine and Surgery, DO	<a href="#">ORDER0004247</a>	3/18/2015	Schrock, Troy D	Unity	WI
Medicine and Surgery, MD	<a href="#">ORDER0004248</a>	3/18/2015	Masool Tondkar, Farzaneh	Milwaukee	WI
Medicine and Surgery, MD	<a href="#">ORDER0004249</a>	3/18/2015	Wacker, William D	Menomonee Falls	WI
Medicine and Surgery, MD	<a href="#">ORDER0004250</a>	3/18/2015	Yee, Phillip S	Decorah	IA
Medicine and Surgery, MD	<a href="#">ORDER0004207</a>	3/18/2015	Safavi, Yasmin Nakhat Yusuf	Oregon	WI
Medicine and Surgery, MD	<a href="#">ORDER0003925</a>	3/18/2015	Poe, Susan L	Barneveld	WI
Medicine and Surgery, MD	<a href="#">ORDER0002361</a>	3/18/2015	Sidhu, Devinder Kaur	Pleasant Prairie	WI
Medicine and Surgery, DO	<a href="#">ORDER0003636</a>	3/18/2015	Wentzel, Andrew R	Madison	MN
Medicine and Surgery, MD	<a href="#">ORDER0004001</a>	3/18/2015	Kelly, John Edward	Oconomowoc	WI
Medicine and Surgery, MD	<a href="#">ORDER0000861</a>	3/18/2015	Berezovski, Roman	Greenfield	WI
Medicine and Surgery, DO	<a href="#">ORDER0003280</a>	3/23/2015	Spiegel, Barry	Waukesha	WI
Medicine and Surgery, MD	<a href="#">ORDER0004213</a>	4/6/2015	Stine, Stephen B	Wausau	WI
Medicine and Surgery, MD	<a href="#">ORDER0004202</a>	4/6/2015	Arassi, Siamak B	Brookfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0004203</a>	4/6/2015	Keeling, Gregory S	Baraboo	WI
Medicine and Surgery, MD	<a href="#">ORDER0004204</a>	4/7/2015	Malhotra, Rajesh	Independence	MO
Medicine and Surgery, MD	<a href="#">ORDER0004205</a>	4/15/2015	Pratt, Charles D	Bayside	WI
Medicine and Surgery, MD	<a href="#">ORDER0004206</a>	4/15/2015	Ruttum, Mark Stuart	Elm Grove	WI
Medicine and Surgery, MD	<a href="#">ORDER0004207</a>	4/15/2015	Safavi, Yasmin Nakhat Yusuf	Oregon	WI
Medicine and Surgery, MD	<a href="#">ORDER0004208</a>	4/15/2015	Sunby, Carl R	Middleton	WI
Medicine and Surgery, MD	<a href="#">ORDER0004209</a>	4/15/2015	Williams, Thomas Hugh	Pewaukee	WI
Medicine and Surgery, MD	<a href="#">ORDER0004210</a>	4/15/2015	Yee, Mon L	Fitchburg	WI
Medicine and Surgery, MD	<a href="#">ORDER0003914</a>	4/15/2015	Stanger, Ann E	Fitchburg	WI
Medicine and Surgery, MD	<a href="#">ORDER0003563</a>	4/15/2015	Klingbeil, Jeffrey K	Appleton	WI
Medicine and Surgery, MD	<a href="#">ORDER0004007</a>	4/15/2015	Nahin, David R	Brookfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0003283</a>	4/15/2015	Kaprelian, Vallie M	Appleton	WI
Medicine and Surgery, MD	<a href="#">ORDER0004001</a>	4/15/2015	Kelly, John Edward	Oconomowoc	WI
Medicine and Surgery, MD	<a href="#">ORDER0004147</a>	4/15/2015	Abboud Leon, Chady	Marshfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0004148</a>	4/15/2015	Michelsen, Craig S	Janesville	WI
Medicine and Surgery, MD	<a href="#">ORDER0004149</a>	4/15/2015	Miller, Michelle M	Cedarburg	WI
Medicine and Surgery, MD	<a href="#">ORDER0004150</a>	4/15/2015	Sabbagh, Saad E	Commerce Twp	MI
Medicine and Surgery, MD	<a href="#">ORDER0004072</a>	4/15/2015	Gavin, Eileen S	Merrill	WI
Medicine and Surgery, MD	<a href="#">ORDER0003815</a>	4/15/2015	Koeller, Arlyn A	Iron River	WI
Medicine and Surgery, MD	<a href="#">ORDER0004014</a>	4/15/2015	Shapiro, David Eliot	Highland Park	IL
Occupational Therapist	<a href="#">ORDER0003773</a>	4/15/2015	Kurtz, Jamie A	Milwaukee	WI
Medicine and Surgery, MD	<a href="#">ORDER0004013</a>	4/15/2015	Richards, Marcia J	Elm Grove	WI

Search for any of the Board Orders listed above on the Department's website by using the link below:

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# Board Orders

March 2015 - October 2015

Profession	Order No	Order Date	Respondent	City	State
Medicine and Surgery, MD	<a href="#">ORDER0003029</a>	4/27/2015	Rubin, Ronald G	Mequon	WI
Medicine and Surgery, MD	<a href="#">ORDER0002832</a>	5/15/2015	Ahmad, Farid A	Greenfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0004070</a>	5/15/2015	Cafaro, John A	Milwaukee	WI
Medicine and Surgery, MD	<a href="#">ORDER0004071</a>	5/20/2015	Drake, David J	Racine	WI
Medicine and Surgery, MD	<a href="#">ORDER0004072</a>	5/20/2015	Gavin, Eileen S	Merrill	WI
Medicine and Surgery, DO	<a href="#">ORDER0004073</a>	5/20/2015	Gunnala, Vikram	Chicago	IL
Medicine and Surgery, MD	<a href="#">ORDER0004074</a>	5/20/2015	Reynolds, Norman Clark	Shorewood	WI
Medicine and Surgery, MD	<a href="#">ORDER0004075</a>	5/20/2015	Schlecht, Lorne P	Sheboygan Falls	WI
Medicine and Surgery, MD	<a href="#">ORDER0004076</a>	5/20/2015	Nichols, Steven D	Wausau	WI
Podiatric Medicine and Surgery	<a href="#">ORDER0004049</a>	5/20/2015	Balkansky, Alan L	Milwaukee	WI
Podiatric Medicine and Surgery	<a href="#">ORDER0004050</a>	5/20/2015	Vanbeek, Edward P	Green Bay	WI
Medicine and Surgery, MD	<a href="#">ORDER0003928</a>	5/20/2015	Rilling, Richard G	Stoughton	WI
Medicine and Surgery, MD	<a href="#">ORDER0002303</a>	5/20/2015	Haughey, Stephen A	Whitefish Bay	WI
Medicine and Surgery, MD	<a href="#">ORDER0003029</a>	5/20/2015	Rubin, Ronald G	Mequon	WI
Medicine and Surgery, MD	<a href="#">ORDER0003562</a>	5/20/2015	Cates, Robert C	Brodhead	WI
Medicine and Surgery, MD	<a href="#">ORDER0003813</a>	5/20/2015	Ali, Zulfiqar	Milwaukee	WI
Medicine and Surgery, MD	<a href="#">ORDER0003604</a>	5/20/2015	Liegeois, Nanette J	Oak Brook	IL
Medicine and Surgery, MD	<a href="#">ORDER0002139</a>	5/20/2015	Montemurro, Angelina M	Kenosha	WI
Medicine and Surgery, MD	<a href="#">ORDER0003411</a>	5/20/2015	Rogow, Linda R	Glendale	WI
Medicine and Surgery, MD	<a href="#">ORDER0003991</a>	5/20/2015	Agarwal, Amit	Niles	IL
Medicine and Surgery, MD	<a href="#">ORDER0003992</a>	5/20/2015	Ahrens, Sarah E	Madison	WI
Medicine and Surgery, MD	<a href="#">ORDER0003993</a>	5/20/2015	Ali, Malik S	Franklin	WI
Medicine and Surgery, MD	<a href="#">ORDER0003994</a>	5/20/2015	Bommakanti, Chandralekha	Oshkosh	WI
Medicine and Surgery, MD	<a href="#">ORDER0003995</a>	5/20/2015	Coron, Alfred J	Lac Du Flambeau	WI
Medicine and Surgery, MD	<a href="#">ORDER0003996</a>	5/20/2015	Douglas, Robert F	Neenah	WI
Medicine and Surgery, MD	<a href="#">ORDER0003997</a>	5/20/2015	Harris, John S	Appleton	WI
Medicine and Surgery, MD	<a href="#">ORDER0003998</a>	5/20/2015	Hernandez, Graciela	Elm Grove	WI
Medicine and Surgery, MD	<a href="#">ORDER0003999</a>	5/20/2015	Huiras, Christopher M	La Crosse	WI
Medicine and Surgery, MD	<a href="#">ORDER0004000</a>	5/20/2015	Johnson, Timothy A	Cadillac	MI
Medicine and Surgery, MD	<a href="#">ORDER0004001</a>	5/20/2015	Kelly, John Edward	Oconomowoc	WI
Medicine and Surgery, MD	<a href="#">ORDER0004002</a>	5/20/2015	Kohler, Sidney H	Mequon	WI
Medicine and Surgery, DO	<a href="#">ORDER0004003</a>	5/20/2015	Kolb, Robert	Ham Lake	MN
Medicine and Surgery, MD	<a href="#">ORDER0004004</a>	5/20/2015	McDaniels, Edison P	Janesboro	AR
Medicine and Surgery, MD	<a href="#">ORDER0004005</a>	5/20/2015	Moreno, Luz Stella	Milwaukee	WI
Medicine and Surgery, MD	<a href="#">ORDER0004006</a>	5/20/2015	Munkwitz, George A	Mequon	WI
Medicine and Surgery, MD	<a href="#">ORDER0004007</a>	5/27/2015	Nahin, David R	Brookfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0004008</a>	5/27/2015	Ortwein, Robert K	Racine	WI
Medicine and Surgery, MD	<a href="#">ORDER0004009</a>	6/3/2015	Owskiak, Andrew Mark	Kenosha	WI
Medicine and Surgery, MD	<a href="#">ORDER0004010</a>	6/5/2015	Price, Steven J	Neenah	WI

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# Board Orders

March 2015 - October 2015

Profession	Order No	Order Date	Respondent	City	State
Medicine and Surgery, MD	<a href="#">ORDER0004011</a>	6/5/2015	Prohaska, Gary T	Palm Desert	CA
Medicine and Surgery, MD	<a href="#">ORDER0004012</a>	6/17/2015	Reichmuth, Tracy S	Lincoln	NE
Medicine and Surgery, MD	<a href="#">ORDER0004013</a>	6/17/2015	Richards, Marcia J Js	Elm Grove	WI
Medicine and Surgery, MD	<a href="#">ORDER0004014</a>	6/17/2015	Shapiro, David Eliot	Highland Park	IL
Medicine and Surgery, MD	<a href="#">ORDER0004015</a>	6/17/2015	Tombuloglu, Bedriye Y	Greenfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0004016</a>	6/17/2015	Weisberg, Mitchell Ross	Skokie	IL
Medicine and Surgery, MD	<a href="#">ORDER0004017</a>	6/17/2015	Wilson, Jeffrey W	Rochester	MN
Medicine and Surgery, MD	<a href="#">ORDER0003821</a>	6/17/2015	Dryer, Deborah A	Iron River	WI
Medicine and Surgery, MD	<a href="#">ORDER0004024</a>	6/19/2015	Bishop, Mark P	Colorado Springs	CO
Medicine and Surgery, MD	<a href="#">LS0112061MED</a>	6/19/2015	Kadile, Eleazar M	Green Bay	WI
Medicine and Surgery, MD	<a href="#">ORDER0003910</a>	6/23/2015	Perkins, Rick L	Tomah	WI
Medicine and Surgery, MD	<a href="#">ORDER0003911</a>	6/25/2015	Tannan, Dilip Kumar	Oshkosh	WI
Medicine and Surgery, MD	<a href="#">ORDER0003912</a>	6/30/2015	Seno, Louis Steve	Mequon	WI
Medicine and Surgery, MD	<a href="#">ORDER0003913</a>	7/8/2015	Burgesser-howard, Mary F	Brookfield	WI
Medicine and Surgery, MD	<a href="#">ORDER0003914</a>	7/14/2015	Stanger, Ann E	Fitchburg	WI
Medicine and Surgery, MD	<a href="#">ORDER0003915</a>	7/15/2015	Strauss, Richard H	La Crosse	WI
Medicine and Surgery, MD	<a href="#">ORDER0003916</a>	7/15/2015	Zereik, Jamal A	Farmington	MO
Medicine and Surgery, MD	<a href="#">ORDER0003917</a>	7/15/2015	Hunt, Jill M	Dubuque	IA
Medicine and Surgery, MD	<a href="#">ORDER0003918</a>	7/15/2015	Garces, Christopher A	Sheboygan	WI
Medicine and Surgery, MD	<a href="#">ORDER0003919</a>	7/16/2015	Stow, Glenn C	Shawnee	OK
Medicine and Surgery, MD	<a href="#">ORDER0003920</a>	8/5/2015	Fergus, Peter Andrew	Marinette	WI
Medicine and Surgery, MD	<a href="#">ORDER0003921</a>	8/12/2015	Hendricks, Richard J	Madison	WI
Medicine and Surgery, MD	<a href="#">ORDER0003922</a>	8/12/2015	Hert, Robert C	Greendale	WI
Medicine and Surgery, MD	<a href="#">ORDER0003923</a>	8/18/2015	Hudzinski, Janeen M	Manitowoc	WI
Medicine and Surgery, MD	<a href="#">ORDER0003924</a>	8/19/2015	Plzak, George J	Madison	WI
Medicine and Surgery, MD	<a href="#">ORDER0003925</a>	8/19/2015	Poe, Susan L	Barneveld	WI
Medicine and Surgery, MD	<a href="#">ORDER0003926</a>	8/19/2015	Schaper, Dale S	Franklin	WI
Medicine and Surgery, MD	<a href="#">ORDER0003927</a>	8/19/2015	Smollen, William J	Racine	WI
Medicine and Surgery, MD	<a href="#">ORDER0003928</a>	8/19/2015	Rilling, Richard G	Stoughton	WI
Medicine and Surgery, MD	<a href="#">ORDER0003934</a>	8/19/2015	Jweied, Eias Elias	Oak Lawn	IL
Medicine and Surgery, MD	<a href="#">ORDER0003755</a>	8/19/2015	Lloyd, James Robert	Elm Grove	WI
Medicine and Surgery, MD	<a href="#">ORDER0002143</a>	8/19/2015	Hale, John Michael	Green Bay	WI
Medicine and Surgery, MD	<a href="#">ORDER0003635</a>	8/19/2015	Grelle, Amy Rongstad	Cross Plains	WI
Medicine and Surgery, MD	<a href="#">ORDER0002303</a>	8/24/2015	Haughey, Stephen A	Whitefish Bay	WI
Medicine and Surgery, MD	<a href="#">ORDER0003604</a>	8/27/2015	Liegeois, Nanette J	Oak Brook	IL
Medicine and Surgery, MD	<a href="#">ORDER0002139</a>	8/27/2015	Montemurro, Angelina M	Kenosha	WI
Medicine and Surgery, MD	<a href="#">ORDER0003411</a>	8/27/2015	Rogow, Linda R	Glendale	WI
Medicine and Surgery, MD	<a href="#">ORDER0003813</a>	8/27/2015	Ali, Zulfiqar	Milwaukee	WI
Medicine and Surgery, MD	<a href="#">ORDER0003604</a>	8/27/2015	Liegeois, Nanette J	Oak Brook	IL

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# Board Orders

March 2015 - October 2015

Profession	Order No	Order Date	Respondent	City	State
Medicine and Surgery, DO	<a href="#">ORDER0003814</a>	9/3/2015	Frankwitz, Alicia A	Wayzata	MN
Medicine and Surgery, MD	<a href="#">ORDER0003815</a>	9/9/2015	Koeller, Arlyn A	Iron River	WI
Medicine and Surgery, MD	<a href="#">ORDER0003816</a>	9/16/2015	Eiche, Jocelyn K	Wauwatosa	WI
Medicine and Surgery, MD	<a href="#">ORDER0003817</a>	9/16/2015	Krieger, Westscot G	Appleton	WI
Medicine and Surgery, MD	<a href="#">ORDER0003818</a>	9/16/2015	Archinihu, Johnspencer C	Orlando	FL
Medicine and Surgery, MD	<a href="#">ORDER0003819</a>	9/16/2015	Welch, Stephen F	Freeport	IL
Medicine and Surgery, MD	<a href="#">ORDER0003820</a>	9/16/2015	Zambrano, Isidoro V	Fort Atkinson	WI
Medicine and Surgery, MD	<a href="#">ORDER0003821</a>	9/16/2015	Dryer, Deborah A	Iron River	WI
Medicine and Surgery, MD	<a href="#">LS0112061MED</a>	9/23/2015	Kadile, Eleazar M	Green Bay	WI
Occupational Therapist	<a href="#">ORDER0003773</a>	9/24/2015	Kurtz, Jamie A	Milwaukee	WI

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Board Order Search: <http://dsps.wi.gov/Other-Services/Lookup-Orders-Disciplinary>

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  FSMB		<b>2) Date When Request Submitted:</b>  10/8/2015 Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>	
<b>3) Name of Board, Committee, Council, Sections:</b>  Medical Examining Board			
<b>4) Meeting Date:</b>  10/21/2015	<b>5) Attachments:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b>  Informational Item – Physician Re-Entry	
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b>  No	<b>9) Name of Case Advisor(s), if required:</b>	
<b>10) Describe the issue and action that should be addressed:</b>  Item is informational only. If the Board would like to discuss it, it could be added as a separately listed item on a future agenda.			
<b>11) Authorization</b>			
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	

## Physician Re-entry

The AMA defines physician re-entry as "a return to clinical practice in the discipline in which one has been trained or certified following an extended period of clinical inactivity not resulting from discipline or impairment." (See more [facts on physician re-entry](#).)

The issue of physician re-entry into the workforce is growing in importance. Anecdotal evidence indicates that re-entry into the workforce will affect women more often than men (and the numbers of women entering medical school continue to grow), but this is an issue that cuts across genders and specialties.

To address this concern, a number of organizations and individuals are collaborating to examine re-entry and create guidelines, recommendations, and strategies to assist physicians and ensure access to care for patients. The AMA, through its [Council on Medical Education](#) (CME), continues to play an active role in this regard.

- The AMA held a conference on physician re-entry in May 2010, in collaboration with the Federation of State Medical Boards (FSMB) and the American Academy of Pediatrics (AAP), to develop recommendations for a coordinated national approach to re-entry.
- The AMA's annual book *State Medical Licensure Requirements and Statistics* includes a table on [re-entry regulations of state medical boards](#).
- An educational seminar, "Physician Re-entry to Clinical Practice: What You Need To Know," was held at the 2010 Interim Meeting of the AMA House of Delegates meeting in San Diego, Nov. 6. The [presentation by Claudette Dalton, MD](#), is now available
- [AMA Bibliography on Physician Re-entry and Re-entry-Related Resources](#)
- [AMA Physician Re-entry Program Questionnaire and Results](#)
- [Physician Re-entry to Practice: Data to Guide Program Development](#) - AMA CME Report, November 2009
- [AMA CME report on physician re-entry](#), June 2008
- [AMA seeks clear path for doctors' re-entry into medicine](#) (*American Medical News*)
- [A national survey of 'inactive' physicians in the United States of America: enticements to reentry](#) (co-authored by AMA-staff), *Human Resources for Health*, February 2011

Also, check out a [glossary](#) of reentry terms and the [toolkit](#) from the AAP for physicians seeking re-entry into medicine; the [Roadmap to Reentry](#), a resource developed by the AAP and the Center for Personalized Education for Physicians that provides guidelines for physicians and physician assistants seeking to navigate the re-entry process; and the website of the [Physician Reentry into the Workforce Project](#)

The Federation of State Medical Boards (FSMB) published in 2012 its 12 guidelines on reentry for state member boards, created by the [Special Committee on Reentry to Practice](#). The guidelines highlight some key reentry issues, such as data needs, mentors for reentry physicians, and medical liability insurance.

### Re-entry Programs

**Note:** This list is for informational purposes only. A listing here does not indicate endorsement by the AMA.

- [The Cedars-Sinai Medical Center Physician Re-entry Program](#)  (Los Angeles, California)
- [Center for Personalized Education for Physicians](#)  (Denver, Colorado)
- [Coalition for Physician Enhancement](#)  (national consortium)
- [Drexel Medicine Physician Refresher/Re-Entry Course](#)  (Philadelphia, Pennsylvania)
- [University of California San Diego School of Medicine Physician Assessment and Clinical Education Program \(PACE\)](#)  (San Diego, California)
- [Upstate New York Clinical Competency Center at Albany Medical College](#)  (Albany, New York)
- [Texas A & M Health Science Center KSTAR Program](#)  (Fort Worth, Texas)

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

**AGENDA REQUEST FORM**

<b>1) Name and Title of Person Submitting the Request:</b>  Jamie Adams Records Management Supervisor		<b>2) Date When Request Submitted:</b> 10/2/15											
		Items will be considered late if submitted after 4:30 p.m. and less than: <ul style="list-style-type: none"> <li>▪ 10 work days before the meeting for Medical Board</li> <li>▪ 14 work days before the meeting for all others</li> </ul>											
<b>3) Name of Board, Committee, Council, Sections:</b> Medical Examining Board													
<b>4) Meeting Date:</b> 10/21/15	<b>5) Attachments:</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>6) How should the item be titled on the agenda page?</b> Discussion of unrestricted MN License application											
<b>7) Place Item in:</b> <input checked="" type="checkbox"/> Open Session <input type="checkbox"/> Closed Session <input type="checkbox"/> Both	<b>8) Is an appearance before the Board being scheduled? If yes, who is appearing?</b> <input checked="" type="checkbox"/> Yes by Jamie Adams  <input type="checkbox"/> No	<b>9) Name of Case Advisor(s), if required:</b>											
<b>10) Describe the issue and action that should be addressed:</b>  The Board will discuss the Application for License to Practice Medicine and Surgery for Individuals with a Current Unrestricted Minnesota License and how the law change effective 4/1/15 in regards to post-graduate training affects that application method.													
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;"><b>11)</b></td> <td style="width: 50%; text-align: right;"><b>Authorization:</b></td> </tr> <tr> <td>s/Jamie Adams</td> <td style="text-align: right;">10/2/15</td> </tr> <tr> <td style="border-top: 1px solid black;">Signature of person making this request</td> <td style="text-align: right; border-top: 1px solid black;">Date</td> </tr> <tr> <td style="border-top: 1px solid black;">Supervisor (if required)</td> <td style="text-align: right; border-top: 1px solid black;">Date</td> </tr> <tr> <td style="border-top: 1px solid black;">Bureau Director signature (indicates approval to add item to agenda post agenda deadline)</td> <td style="text-align: right; border-top: 1px solid black;">Date</td> </tr> </table>				<b>11)</b>	<b>Authorization:</b>	s/Jamie Adams	10/2/15	Signature of person making this request	Date	Supervisor (if required)	Date	Bureau Director signature (indicates approval to add item to agenda post agenda deadline)	Date
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<b>Directions for including supporting documents:</b> <ol style="list-style-type: none"> <li>1. This form should be attached to any documents submitted to the agenda.</li> <li>2. Post Agenda Deadline items must be authorized by a Supervisor and the Board Services Bureau Director.</li> <li>3. If necessary, Provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.</li> </ol>													