ARIZONA

MEDICAL BOARD MOVES FORWARD WITH PHYSICIAN HEALTH PROGRAM

The Arizona Medical Board approved the framework presented by board staff to implement the Physician Health Program (PHP) at its annual planning meeting on Sept. 23, 2005. The PHP evaluates, treats and monitors physicians and physician assistants with medical, psychiatric, psychological, behavioral health disorders and substance abuse that impacts a licensee's ability to safely practice medicine or perform health care tasks.

The PHP is the umbrella program including the Monitored Aftercare Program (MAP), which currently monitors licensees with substance abuse and chemical dependency problems. The PHP helps address their health issues and safe return to medical practice by ensuring appropriate education, intervention, therapeutic treatment and post-treatment monitoring and support are obtained.

The board hopes the confidential nature of the program encourages physicians with these disorders to seek assistance voluntarily, rather than continuing to practice and potentially endangering the public.

This program fulfills the board's responsibility to rehabilitate physicians and protect the public. If the physician does not voluntarily disclose a disorder, does not sufficiently self-limit or returns to practice before he or she is able, the board may issue a non-disciplinary public order limiting the physician's practice. In all cases, the board must ensure public safety is preserved.

SIX PHYSICIANS ARE NOW ARIZONA MEDICAL BOARD CONSULTANTS

The role of the medical consultant is crucial when the Arizona Medical Board investigates complaints against physicians involving quality of care issues. In the past, much of the caseload went to outside medical consultants. However, Chief Medical Consultant Mark Nanney, M.D., now says he believes the work can be better done in-house.

Shortly after joining the board as the full-time chief medical consultant in May, Dr. Nanney went to work assembling a team of in-house consultants. With the recent addition of three more board certified physicians, the board now has six medical consultants on staff. And he may add another, depending on how well the present team keeps up with the caseload.

The new medical consultants are Kelly Sems, M.D., board certified in both internal medicine and rheumatology, who has joined full-time; and two new part-time medical consultants, Gerald Moczynski, M.D., board certified in orthopedic surgery; and Ingrid Haas, M.D., board certified in obstetrics and gynecology. Until this past July, Dr. Haas was a member of the board, and now will share her expertise in investigating complaints.

The board receives a great deal of complaints regarding pain management, orthopedic surgeons, obstetricians and gynecologists. With the new medical consultants, the board can now review these cases internally. Additionally, as a former board member, Dr. Haas brings valuable insight in how to best prepare cases for presentation to the board members. Already handling cases part-time were Roderic Huber, M.D., board certified in internal medicine, and William Wolf, M.D., board certified in general surgery. By dealing with more cases internally, the board can maintain a standardized system that will result in timely and better case reviews.

"We want to bring to the board a uniform analysis," Dr. Nanney said.

The increase in and diversity of in-house consultants is expected to speed up the investigation process. The board has hundreds of physicians in private practice willing to review cases. However, it has had difficulty finding outside medical consultants in some specialties who were willing or able to review cases on a consistent basis. With the wide range of experience now possessed by the in-house consultants, Dr. Nanney says she believes "we've solved big issues in that regard."

Reprinted from the Arizona Medical Board website.

CALIFORNIA

CITATION AND FINE: AN ALTERNATIVE TO AN ACCUSATION

The Medical Board of California receives a variety of complaints of physician conduct ranging from dangerous practices to more technical violations of the law. Pursuing administrative action is very time-consuming and extremely costly, with the cost of filing an accusation averaging $10,000. Prior to 1994, the board only had the option of pursuing administrative action or criminal action for all types of violations. By not taking action for the more minor violations, the board was unable to deter physicians from certain violations such as misleading advertising, failure to sign a death certificate in a timely manner or failure to provide medical records to patients. The board believed there should be some middle ground to respond to these kinds of violations, thereby providing some measure of public protection, while also achieving a quick, less expensive resolution.

In 1994, pursuant to Business and Professions Code section 125.9, the board established a system for the issuance of a citation and fine. The process is further described by regulations under Title 16, section 1364.10. Section 1364.11 lists a table of citable offenses for which the board may issue a citation, with or without a fine.

When the board receives a complaint alleging a minor, technical violation, board staff contacts the reporting party to verify the information provided in the complaint and obtains any evidence that would establish a violation. If there is sufficient evidence, staff will contact the physician to obtain his or her written response to the complaint and ask the physician to provide any explanation or mitigation that may impact the issuance of a citation. When all the information is received, board staff, including a deputy attorney general, will review the material to determine if there is a preponderance of evidence to support a determination that a violation has occurred. At this juncture, a citation may be issued. The citation is in writing and will describe the nature of the violation including specific references to the section of law that has been violated. As appropriate, the citation may contain an order of abatement (correcting the violation), fixing a reasonable time to allow for abatement of the violation. Fines imposed may range from $100 to $2,500.

Citations are posted on the board website upon issuance and will remain there for five years from the date of resolution. A citation is not considered discipline and is not reported to the Federation of State Medical Boards or the National Practitioner Data Bank. There is an appeals process allowed under Business and Professions Code section 125.9 that allows the physician another opportunity to provide additional input to board representatives in a face-to-face forum called an informal conference. At this meeting, the citation can be withdrawn, the fine can be reduced or the citation and fine can be upheld. Another option provided to the physician is that he or she may request a hearing on the matter before an administrative law judge. This remedy is in addition to the informal conference.

At the February 2005 board meeting, a public regulatory hearing was held to discuss changes to the cite and fine program. Specifically, new sections of law will be added to the citable offense table, and the maximum fine will be raised from $2,500 to $5,000 for certain categories of violation. The ceiling was raised pursuant to SB 362 (Figueroa, Chapter 788, Statutes of 2003); however, the maximum fine would only be imposed when: 1) the cited person has received one or more citations for the same or similar violation; or 2) the citation involves multiple violations that demonstrate a willful disregard for the law. Another change to the cite and fine program would allow for a citation to be issued to a licensee for a violation of a term or condition contained in a decision that placed the licensee on probation.

The citation and fine program, as described above, was created to allow for a less onerous resolution to less serious complaints which otherwise would result in the filing of an accusation. Physicians are encouraged to respond to any correspondence from board staff, as such response may eliminate the need for a citation and fine. Typically, the board is responsible for educating physicians on various laws relating to the practice of medicine, and compliance will often negate the need for a citation. The board website (www.caldocinfo.ca.gov) "Laws & Regulations" contains the regulations governing the citation and fine process and lists the violations that are citable.

REGARDING INFORMED CONSENT: WHAT PHYSICIANS NEED TO KNOW

The October 2003 issue of the *Action Report* contained a reminder to physicians that, prior to the performance of a hysterectomy, physicians must obtain informed consent. This reminder concerns the general doctrine of obtaining and documenting informed consent prior to beginning any

medical treatment. Informed consent is a two-step process consisting of discussion with the patient and documenting that discussion. This is especially important if there is a reasonable chance a planned medical procedure may lead to additional intervention.

Physicians are reminded that, in addition to the specific laws governing informed consent for hysterectomies, numerous other California laws address informed consent. These laws place specific requirements on physicians to obtain informed consent for a variety of treatments and procedures. Failure to obtain informed consent may lead to an allegation of unprofessional conduct.

For years, the doctrine of informed consent has been a matter addressed by the courts. In 1972, the California Supreme Court set a legal standard in an opinion that there is a requirement for divulgence by the physician to the patient of all information relevant to a meaningful decisional process. Further, the court found that, "there is a duty of reasonable disclosure of the available choices with respect to proposed therapy and of the dangers inherently and potentially involved in each."[1] This doctrine of obtaining informed consent applies to many medical treatments where incisions or surgical instruments are used, or during a diagnostic procedure, or in the course of experimentation (clinical trials).[2] Informed consent implies patient participation in medical decision-making. It is a process of communication between patient and physician resulting in the patient's authorization to undergo a specific medical procedure.[3] It includes the patient being informed that the physician having the discussion may not be the physician attending to the patient during the procedure.[4] It is the physician performing the treatment who is ultimately responsible for the disclosure and obtaining informed consent. This is not to say a physician is required to obtain a patient's informed consent for every procedure that is performed.

A physician is not required to obtain informed consent for simple and common procedures, e.g., taking a common blood sample.

According to the CMA's *California Physician's Legal Handbook*, physicians have a duty to obtain the informed consent of patients prior to performing certain medical procedures. The minimum information that must be provided includes:

- the nature of the procedure and/or recommended treatment;
- the risks, complications and expected benefits; and
- the availability of alternative treatment to the treatment that is recommended (including no treatment) and the associated risks and benefits.

In addition, *Cobbs v. Grant* and the *California Physician's Legal Handbook* note it would behoove the prudent physician to inform the patient of all relevant information about a proposed treatment prior to obtaining the consent of the patient. This information would include:

- working or presumed diagnosis and differential diagnoses;
- the name of the procedure;
- a description of the procedure in layman's terms;
- purpose and risks of any planned tests;
- prognosis;
- an estimate of the current level of severity of the patient's condition; and
- all information necessary for the patient to make an informed decision.

Potential problems for physicians arise when they perform complex procedures such as a cardiac catheterization; then during the course of the cardiac catheterization, additional procedures are performed such as renal angiograms, carotid angiograms and peripheral angiograms without the required discussion and informed consent prior to the procedure. Physicians are therefore reminded that, prior to beginning procedures, they should discuss with their patients all aspects of the recommended treatment — especially any potential for additional procedures, and obtain the appropriate informed consent for each.

In addition to the general doctrine of informed consent, there are a variety of specific medical treatments, conditions and procedures for which California law addresses the issue of informed consent. These laws place specific requirements on physicians. Some of these include the following, with the respective statute for reference:

Medical condition/procedure	Statute[5]
Blood transfusions	H&S Code 1645
Blood test for HIV/AIDS	H&S Code 120990
Cancer/Breast	H&S Code 109275, 109277 B&P Code 2257
Cancer/Prostate	H&S Code 109280, 109282
Gynecological treatment	H&S Code 109278

Hysterectomy	H&S Code 1690, 1691
Silicone Implants	B&P Code 2259
Collagen Injections	B&P Code 2259.5
Sperm and Ova removal	B&P Code 2260

In addition, the board published the *Guidelines for the Treatment of Pain*,[6] which discusses the issue of informed consent: "The physician and surgeon should discuss the risks and benefits of the use of controlled substances and other treatment modalities with the patient, caregiver or guardian. Annotation: A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain."

When there is any potential for additional procedures after the initial procedure has begun, the physician should discuss this potential with the patient and document the discussion. California physicians also should consult the applicable statutes when treating patients for any of the above conditions, because California law may require that additional information be disclosed, such as with hysterectomies.

REFERENCES

1. *Cobbs v. Grant* (1972) 8 Cal.3d 229, 104 Cal. Rptr. 505
2. National Cancer Institute
3. American Medical Association
4. There have been instances where the physician having the discussion and obtaining the requisite informed consent failed to advise the patient that another physician would perform the actual procedure.
5. H&S = Health and Safety Code. B&P = Business and Professions Code
6. *Action Report*, last printing October 2003 website: http://www.caldocinfo.ca.gov.

PRESIDENT'S REPORT: MEANINGFUL PEER REVIEW

The word "discipline" has a negative connotation to the practicing physician. It strikes at the heart of a physician's self esteem and perhaps even worse, can have major economic ramifications. Yet, the board's mission of public protection centers on this issue. The highest priority of the Division of Medical Quality (the board's enforcement arm) is public protection through a disciplinary system of checks and balances. Fortunately, discipline affects less than one percent of the physicians in California each year. Most physicians practice in an exemplary manner.

Medicine, like life, is a bell-shaped curve, and so is the disciplinary group whose acts range from mistakes in judgment, to sexual offenses, to felonious acts and impairments that may affect practices. The board has a difficult job in the investigation of those varied complaints and meting out appropriate discipline. While some see the board as too harsh, others say we are too lenient.

Most do not realize the board as currently constituted was a result of the MICRA legislation which required a strong medical board as a tradeoff for economic caps on pain and suffering in malpractice awards. This 21-member board is balanced in its approach, with 13 physicians who make decisions on behalf of the medical profession they are asked to regulate.

This brings us to the basic problem facing this board and its 119,000 physicians who practice in and outside of the state's borders: how can the board partner with the physician community to do a better job of regulating the profession? The board does not micromanage the quality of medicine in California. It reacts to the problems with which it is confronted when it receives complaints, 805 (hospital peer review) reports, and malpractice reports. What is our responsibility as physicians? We all must be active in peer review, which is the cornerstone of good medical care. Peer review is not necessarily punitive, but hopefully is corrective to improve the quality of medical care. Unfortunately, the quality of peer review in this state is unknown. A law was passed in 2002 to study the quality of peer review, but due to the board's current fiscal situation, it has not been funded.

As board president, I am hopeful that peer review is conducted in hospital and office-based practices. The American Society of Plastic Surgeons has a model program in place to deal with complications in the offices for its members. Peer review is a big issue with complex problems and solutions, but is necessary for the delivery of good patient care. As physicians we must police ourselves or abdicate that right to others. This represents the challenge of the future in maintaining and improving the quality of care for all patients in California. Meaningful peer review at every practice level is essential for both patient safety and for the integrity of the medical profession.

MAJOR MILESTONE FOR THE MEDICAL BOARD OF CALIFORNIA

What is the next major milestone for the Medical Board of California? Senate Bill 231 (Figueroa) has passed through the Legislature and was signed by the Governor on Oct. 9. What is the significance of this new law?

SB 1950 (Figueroa, Chapter 1085, Statutes of 2002) created an enforcement monitor to evaluate the effectiveness of the board's Enforcement and Diversion programs and to provide two extensive, written reports to the Legislature. The initial 300-page monitor's report is the basis of SB 231, and is strongly supported by the board. Many changes already have been implemented by board staff; however, certain improvements cannot be made without the statutory changes included in this law.

What controversial issues are raised? Certainly the fee increase, which affects all California physicians, is a primary concern. The current fee was established in 1994, and there have been no fee increases since that time. However, expenses have risen significantly, including salary and benefits for employees and the cost of services from the Attorney General's office, which acts as the board's representative in legal proceedings.

Costs have outstripped revenue. The increase is $95/year. Without the increase the board would have had to make drastic cuts in all programs. Remember, a strong board was the concession the Legislature gave for MICRA protections. An insolvent medical board puts a large nail in MICRA's coffin.

The California Medical Association opposed the board's continuing ability to impose the costs of investigation and prosecution of cases on physicians who are charged with and found to have violated the Medical Practice Act (commonly known as cost recovery). Historically, those physicians who have been charged and successfully prosecuted have paid some or all of the costs of that prosecution, when that prosecution is successful.

Language in the new law eliminates the board's ability to recover such costs from individual physicians. CMA supported this change in the bill. The board will be permitted, by regulation, to raise the fee beyond the $790 biennial base to offset this lost revenue.

The new law requires the board to continue to improve the Diversion Program. While the enforcement monitor had many concerns, some of the more significant concerns already have been addressed. The law requires the program to undergo a performance audit in 2006 to ensure that it is adequately protecting the public while rehabilitating physicians with substance abuse problems. If the audit determines that the program is not meeting its mission, the program will be terminated July 1, 2008. The Diversion Program has been and is a priority of this board. We have every confidence that with the changes that have been implemented and with further improvements this valuable program will continue to serve its dual purpose well.

Finally, the new law "declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government." It further finds that using a "vertical prosecution" model for its investigations "is in the best interests of the people of California." This will involve the joint assignment of cases to board investigators and deputy attorneys general, rather than the current "hand-off" method, where evidence is collected by board investigators and then turned over to the Office of the Attorney General for review and consideration of the disposition of a case. Vertical prosecution, which is used by many other law enforcement agencies, is widely regarded as being a much more efficient way of handling the investigation and prosecution of complaints. As such, it was a key recommendation of the enforcement monitor, and the board is committed to making this new model of investigation work to the benefit of the public and physicians alike.

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COLORADO

LIMITATIONS ON PRESCRIBING FOR FAMILY AND FRIENDS

While he likely was not the first to say it, Sir William Osler is perhaps the most famous physician credited with the phrase, "A physician who treats himself has a fool for a patient." This statement could also be applied to the treatment of family members and others with whom the physician has significant emotional relationships.

Both the American Medical Association (AMA) and the American College of Physicians (ACP) have position statements against such care provision. The AMA position

states, "Physicians generally should not treat themselves or members of their immediate families," and the ACP statement reads, "Physicians should avoid treating themselves, close friends, or members of their immediate families. Physicians should also be very cautious about assuming the care of closely associated employees."

Both groups raise similar concerns about loss of objectively in medical decision-making, inadequate history taking, physical examination and possible discomfort on the part of either or both the physician and patient in sharing sensitive information or undergoing intimate exams. The AMA also raises concerns about treating conditions beyond the physician's expertise or training, loss of patient autonomy and informed consent, and impact on personal relationships that could accompany negative medical outcomes.

Finally, both groups recognize there may be emergency or isolated settings where is no other qualified physician available, but state firmly that care should be transferred to another physician as soon as practical. While there may be situations where routine care for short-term, minor problems is acceptable, physicians should not serve as a primary or regular care provider for immediate family members and should resolve requests for care from employees, family members, or friends by assisting them in obtaining appropriate care.

Despite these strong position statements, studies have found 50 to 80 percent of physicians report self-treatment, and nearly 100 percent report treatment of non-patients.

The Colorado Board of Medical Examiners has a keen interest in these issues of treatment for self, friends and family. First, prescribing Schedule II substances, except in the case of an emergency, for one's self or a family member represents grounds for disciplinary action by the board under state statute. The board also discourages self-treatment or treatment of family or others with whom significant emotional relationships exist for all controlled substances. Finally, the board feels that these practice limitations should apply to all medical and surgical care unless in the setting of minor illnesses or emergencies.

We review several cases each year where a physician has had difficulties arise due to self-treatment or treatment of family, friends or employees. Some involve controlled substances, some inappropriate or substandard care and some represent boundary violations. Probably none of the cases we review involved emergency situations where no other physician was available to provide care, and most cases involve ongoing treatment. There are even some very concerning cases involving surgical treatment. Often care is provided as a matter of convenience, but note that convenient care is not always quality care.

If care is provided to one's self, family or others with whom the physician has a significant emotional relationship, the board recommends a proper, complete written medical record documenting the care, including medications prescribed and indications, be prepared for each interaction, just as for any other patient. It is substandard to not appropriately document medical care, and too often record keeping is neglected or ignored in managing such cases.

The board believes in most cases, physicians should defer the care of themselves, their family and their friends to other qualified physicians. The board is considering adopting a policy statement regarding this issue, in order to provide licensees with specific guidance. We welcome comments and suggestions.

REGARDING MEDICAL DEVICES AND AESTHETIC PRACTICES

The Colorado Board of Medical Examiners (board) and the Office of Barbering and Cosmetology (OBC) received several inquiries about what type of medical devices are appropriate for aesthetic services and who can use such devices. The board and OBC have set some basic parameters regarding the use of medical devices for esthetic services. Medical spas and advanced aesthetic services are becoming more popular and commonplace in cosmetology salons and medical offices. There are several machines being used to improve the aesthetic appearance and health of one's skin. The most common machines are microdermabrasion, electrolysis, pulse light therapy, LED light, extreme superluminous LEDs and laser. However, depending on the machine's Food and Drug Administration (FDA) classification, all of these devices have different restrictions on who can use such device and under what circumstances.

The FDA's Center for Devices and Radiological Health (CDRH) is responsible for regulating firms who manufacture, repackage, re-label and/or import medical devices sold in the United States. In addition, CDRH regulates radiation emitting electronic products (medical and non-medical) such as lasers, X-ray systems, ultrasound equipment, microwave ovens and color televisions. Medical devices are classified into Class I, II and III. Regulatory control

increases from Class I to Class III. The device classification regulation defines the regulatory requirements for a general device type. A description of device classification and a link to the Product Classification Database can be found on the FDA's website.

The device classification is important to know in order to determine who can use the machine. In Colorado, the board and OBC deem it appropriate for licensed physicians, cosmetologists and aestheticians to use any Class I device such as electrolysis, LED and microdermabrasion. However, a Class II device can only be used under the supervision of a licensed physician in accordance with the board's delegation rule (Rule 800).

Class II devices such as pulse light and laser are more invasive than Class I, and as a result, the risk of injury is greater. Medical knowledge is needed in order to appropriately use the machine. The board and OBC have determined that Class II devices are beyond the scope of licensed cosmetologists and aestheticians and cannot be independently used unless they are using the machine under the direction and supervision of a licensed physician in accordance with Board Rule 800.

All medical device manufacturers have a FDA manufacturer number and product number. These numbers are required by federal law to be printed on all machines. Once you find either the manufacturer number or product number, you can visit the following website to determine its classification: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm

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NEW MEXICO
LEGISLATIVE UPDATE

There were a number of bills related to the practice of medicine introduced and considered during the recent session of the New Mexico State Legislature. Of particular interest, of course, were the changes made to the Medical Practice Act.

Graduates of Unapproved Medical Schools
New language allows a graduate of an international medical school that may or may not be "approved" to be licensed in New Mexico if they have also completed at least two years of an approved postgraduate training program at or affiliated with an institution located in New Mexico prior to Dec. 30, 2007. This change will allow the current students who were accepted into a New Mexico residency program to be licensed and hopefully practice in rural areas of the state.

Resident Licenses
To avoid similar problems in the future, new language will allow the board to establish by rule specific education or examination requirements for postgraduate training (otherwise known as "resident") licenses. Through the rule-making process, the board will be able to obtain public input and discussion before developing these specific requirements for a resident license.

Exam Timeframes
Existing licensing requirements prescribe a period of seven years for an applicant to complete the examination series (10 years for certain applicants). New language will allow the board to develop a rule establishing exceptions to this requirement. In the past few years, several qualified applicants were not able to be licensed in New Mexico because of the existing provision and many other states have dropped or revised their time frames for examinations given that there appears to be no direct correlation between time in which the examination series was completed and future competence of the physician.

Sexual Misconduct
Old language, that defined sexual misconduct between a physician and patient (or patient's guardian) as inappropriate only when the physician represents or infers that the sexual contact is part of the patient's treatment, was removed. This was an artificial and outdated limitation, and its removal will enhance the board's ability to carry out its statutory mandate to protect the New Mexico public. For a complete copy of the Medical Practice Act, go to the board website: www.nmmb.state.nm.us. Or, call the office to have a copy sent to you. It is the responsibility of all licensees to be familiar with the current law.

Other Bills of Interest

Pain Management
For the third year in a row, Rep. Danice Picraux introduced legislation dealing with pain management, and this year the bill finally made it into law. The bill mandates all boards licensing health professionals with prescriptive authority adopt rules establishing standards and procedures for the

application of the Pain Relief Act — approved by the board in 2003. Each board is also required to encourage those providers who have prescriptive authority and who treat patients for pain to obtain continuing education in pain management. The bill creates the Pain Management Advisory Council, which will review current pain management practices in New Mexico and nationally and provide pain management education for both consumers and health care professionals.

Domestic Abuse

A new section has been added to the Family Violence Protection Act requiring all health care providers to document cases of domestic abuse among their patients, and to provide those patients with information and referral to services for victims of abuse. The AMA Code of Medical Ethics requirements for reporting domestic and child abuse are actually more stringent than the new law, and these changes present no additional burden for physicians while at the same time serving to encourage more attention to this challenging social issue by all health care providers.

Telehealth Commission

A new law creates the Telehealth Commission, whose purpose is to coordinated a statewide effort to develop a telehealth system in New Mexico.

These and other bills can be viewed at the New Mexico State Legislature's website: www.legis.state.nm.us.

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MASSACHUSETTS
STATE BOARD OF REGISTRATION IN MEDICINE TO LEAD ON NATIONAL PRACTITIONER IDENTIFIER PLAN

In a manner unique to Massachusetts, the health care community is collaborating to implement a new Federal requirement that "covered providers" in the state obtain a National Provider Identifier (NPI). The Massachusetts Board of Registration in Medicine, which licenses approximately 30,000 physicians, is taking the lead by helping Massachusetts physicians secure their NPI as part of the relicensure process. The board also will give physicians the option of authorizing the agency to get the NPI on their behalf. This process is called "bulk enumeration." We expect bulk enumeration will be a convenient way for physicians and other health care providers to obtain their NPIs.

"We recognize the critical importance of the NPI and felt we could play an important role in the process," said board Executive Director Nancy Achin Audesse. "We want to make compliance as easy as possible for state physicians."

The Health Insurance Portability and Accountability Act of 1996, commonly known as HIPAA, required the secretary of Health and Human Services (HHS) to adopt a standard unique health identifier for health care providers. The NPI Final Rule adopted the NPI as this identifier. What is an NPI? It is a 10-position, numeric identifier designed to be used in HIPAA standard transactions. With few exceptions, it is assigned for life.

The HHS secretary delegated to the Centers for Medicare & Medicaid Services (CMS) the authority to develop the NPI enumeration process and the requirements concerning NPIs. Beginning May 23, 2005, covered providers could begin to apply for NPIs. By May 23, 2007, all HIPAA covered entities except small health plans must begin using NPIs in HIPAA standard transactions, such as claims, remittance advices and eligibility inquiries.

"Massachusetts is taking a leadership role in implementing the NPI mandate," said Audesse. "The lessons learned from these efforts should have value to other states around the country.

Reprinted from the Massachusetts Board of Registration in Medicine website.

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