ALABAMA

USE OF LASERS

On Aug. 15, 2007, the Alabama State Board of Medical Examiners approved for final adoption Administrative Rules Chapter 540-X-11, Guidelines for the Use of Lasers and Other Modalities Affecting Living Tissue. No changes were made from the proposed rules published on June 29, 2007. The effective date of the rules is Sept. 20, 2007. The deadline for compliance with the provisions of the rules was Aug. 15, 2008.

The rules and associated forms were mailed to all physicians in Alabama with active licenses in September 2007.

A .pdf file of the rules as approved for final adoption can be found at: http://www.albme.org/Documents/540-X-11%20Final%20.pdf

BOARD AND COMMISSION RULE CHANGES DUE TO ACT 07-402

The Board and Commission promulgated emergency rules effective Sept. 4, 2007, pursuant to Act 07-402, which had an effective date of Sept. 1, 2007. The rule amendments were published for public comment in the Sept. 28, 2007, *Alabama Administrative Monthly*.

The rule amendments can be accessed at: http://www.albme.org/Default.aspx?Page=Rules.

Reprinted from the Alabama State Board of Medical Examiners website.

ARKANSAS

INTERNET PRESCRIPTION CONSUMER PROTECTION ACT

Act 128 of 2007 amends the Arkansas Internet Prescription Consumer Protection Act. This Act prohibits Internet sales into Arkansas of prescription drugs if the patient has not actually consulted a prescribing practitioner.

TRAMADOL IS NOW A SCHEDULE IV MEDICATION

The 86th General Assembly amended Arkansas law to list the drug, Tramadol, as a Schedule IV controlled substance by passing Act 558 of the 2007 Regular Session.

RADIOLOGY ASSISTANTS AND PRACTITIONER ASSISTANTS

Act 655 of 2007 transfers regulatory authority of radiology assistants and radiology practitioner assistants to the Arkansas State Medical Board.

DISCIPLINING PHYSICIANS WITH MULTIPLE STATE LICENSES

Act 123 permits the board to discipline a physician licensed in Arkansas if the licensee is found in violation of a statute or regulation governing the practice of medicine by a medical licensing authority or agency of another state.

PHYSICIAN REIMBURSEMENT FOR SERVICES PERFORMED BY A PHYSICIAN ASSISTANT

Act 458 of 2007 ensures physicians receive full reimbursement for health care services performed by a physician assistant under the physician's supervision. For more details regarding the above acts, visit www.arkleg.state.ar.us.

RURAL MEDICAL PRACTICE STUDENT LOANS AND SCHOLARSHIPS LAW

During the 2007 session, legislation was passed amending the mechanism the board uses to deal with physicians who default on their loan from the Arkansas State Rural Medical Practice Student Loan and Scholarship Board. Section 10 of Act 1058 states "Upon receipt of a final order from another state agency of the State of Arkansas or a final order from a court of this state after all appeal rights have been exhausted, that finds a physician licensed to

practice medicine in this state has breached the loan contract entered into by the physician under § § 6-81-701 et seq., the board may suspend the license of that physician." This means that once the board has received documentation that these conditions have been met, a disciplinary hearing would be scheduled. For a complete copy of Act 1058 of 2007, visit www.arkleg.state.ar.us.

Reprinted from issue 34 of *NEWSLETTER*, published by the Arkansas State Medical Board.

CALIFORNIA

BOARD TO SPONSOR SUMMIT ON PHYSICIAN DIVERSION

Following its unanimous vote July 26, 2007 to abolish its current Diversion Program for physicians with substance abuse problems, the Medical Board of California will sponsor a summit early in 2008 to discuss in a comprehensive manner the complex issues involved and how the public can best be protected. At present, the program is scheduled by law to be sunsetted on June 30, 2008.

At the upcoming summit, the board will invite the input of interested parties, including the general public, the California Medical Association, the California Society of Addiction Medicine, the California Psychiatric Association, the Center for Public Interest Law and patient advocacy groups. It will re-examine whether – and under what conditions – confidential "diversion" from discipline is possible within a public protection mandate, and whether such a program should be operated by a state agency or a private entity. It also will consider the possibility that there be a statewide program for all health care professionals and possibly all professionals within California that administers policies directed at this issue.

For further information, please see the article linked on the home page of the board's website (www.mbc.ca.gov) under "What's New" titled "Diversion Program Information".

Reprinted from the Medical Board of California website.

COLORADO

RULE 800

Once again, the board is considering revising Rule 800. Several articles have appeared in the *Examiner* regarding this rule, but the board finds itself continuing to deal with physicians regarding misapplication of the rule.

The original intent was to allow a physician to extend his or her ability to provide care through delegation to non-physicians with the appropriate training and supervision. As an example, in my own practice, this permits me to delegate to medical assistants protocol driven management of urinary retention monitored with post void residual ultrasound. It also allows me to have these assistants instill BCG into the bladder for treatment of bladder cancer, again using strict protocols. The patient is treated in our office, has had initial evaluation and treatment by me, and has a current medical record. There is no doubt in anyone's mind that a distinct doctor-patient relationship exists. Rule 800 allows for offsite management of similar non-judgmental care provided the physician is no more than 30 minutes away.

Now it seems Rule 800 is being inappropriately used to provide medical services which are not in the context of an established doctor-patient relationship. The most common situation of concern is in physicians extending their practices into commercial areas, such as medical spas and advanced esthetic services where lasers and pulse light devices are in wide use. This is usually in the context of a physician being designated as a "medical director." In many instances, not only does the physician have little knowledge of the treatment device, but also has scant information as to the training and experience of those providing the treatment. There is usually no relationship between the medical director and the person receiving treatment. Similar oversight relationships are becoming more popular in such fields as vein and hemorrhoid treatment, tattoo removal, and lipo dissolve therapies.

In the interest of public protection, the board plans to more closely regulate the relationship between medical directors and spa owners. Written agreements will be developed to codify this. Other states are obviously dealing with this problem and we are in the process of reviewing their policies. We will be scheduling a rulemaking hearing in the near future and welcome your comments.

BOARD SUPPORTS REVISIONS TO DEA RULE CHANGE

The board recently reviewed the proposed revisions to part 1306 of Title 21 of the Code of Federal Regulations and

voted to respond to the Drug Enforcement Administration (DEA) in unanimous support of these changes. If adopted, these proposed revisions would allow duly authorized providers, under certain conditions, to issue multiple prescriptions authorizing a patient to receive a total of up to a 90-day supply of a Schedule II controlled substance.

In conjunction with the Colorado Boards of Nursing and Pharmacy, the Board of Medical Examiners felt such changes will not adversely affect the health, safety and welfare of Colorado residents and will have a positive impact on licensed health care providers who prescribe Schedule II controlled substances to their patients. The boards further felt such changes to the law would benefit pharmacists and pharmacies by reducing problems with the timely refilling of such prescriptions.

Further information on the DEA may be obtained by visiting this link: www.usdoj.gov/dea/

Reprinted from the Volume 15, Number 1 issue of the *Examiner*, published by the Colorado Board of Medical Examiners.

KENTUCKY

BOARD POLICY ON REPORTING OF IMPAIRED PHYSICIANS BY OTHER PHYSICIANS AND HOSPITALS

A complete version of the Kentucky Board of Medical Licensure policy on reporting of impaired physicians is available on the board website, www.kbml.ky.gov, under the policy statement and guideline section.

In summary, the policy states if a licensed physician or hospital staff suspects that a physician is impaired – due to chronic alcoholism, chemical dependency or physical/mental disability (ies) – such fact must be reported directly to the Kentucky Board of Medical Licensure within 10 days of obtaining direct knowledge of the impairment. The report to the board must be in writing and contain the name of the physician suspected of being impaired, and an account of the facts giving rise to that suspicion.

Upon receipt of this information, if it appears that the physician may be impaired, but has not violated other specific sections of the Medical Practice Act, the board shall contact the physician suspected of being impaired, by certified mail – return receipt requested. The board will advise the physician that they have been granted a 30-day grace period in which to contact the Kentucky Physicians Health Foundation and submit to an appropriate evaluation. Once the notice is issued, the board will communicate with the Foundation to determine whether the physician has complied with the board's directive.

Questions and additional assistance regarding this matter should be addressed to board staff.

APPLICATION PROCESS CHANGE

In 2006 the board began requiring all applicants applying for initial medical or osteopathic license to utilize the Federation Credentials Verification Service (FCVS). Renewal applications are not affected by the change.

The FCVS provides a centralized, uniform process for state medical boards to obtain a verified, primary source record of a physician's core medical credentials. Once verified, the physician can use the FCVS to obtain licensure across the nation at any time during the physician's career. Currently, 13 state medical boards require licensure applicants to register with the FCVS for credentials verification and 62 boards accept their credentialing.

The FCVS provides a lifetime repository for verified information relating to medical training and once completed, greatly enhances the portability of a medical license.

Reprinted from the online version of the winter 2007 issue of the *Kentucky Board of Medical Licensure Newsletter*.

MASSACHUSETTS

HEALTH CARE REFORM LAW SIGNED

The signing of the Massachusetts Health Care Reform law did more than expand health care opportunities for the residents of the Commonwealth.

Within the bill was a provision that allows the board to retain unexpended balances in its Trust Fund from year to year. By law, approximately 68 percent of physician license fees are deposited in the Trust Fund, with the remainder directed to the General Fund. The additional resources made available by this statutory change will permit the board to implement its ambitious technology improvement agenda — and guarantee that a larger por-

tion of physician license fees are retained by the board to improve services to physicians and the public.

Until the Health Care Reform law, each June 30 unexpended balances in the board's Trust Fund reverted to the state's General Fund. Furthermore, such balances were commonplace because cash flow issues caused by the uneven two-year re-licensure cycle that sees 22,000 physicians re-licensed in odd-numbered years, and only 8,000 re-licensed in even numbered years. This made planning for major projects, particularly technology improvements, nearly impossible.

First up among the innovations planned is online license renewal. Physicians will be able to use the board's website to complete and submit the renewal application as a single electronic transaction, and check online for updates to their application status. It will save time for physicians, save the board money, boost efficiency and data quality and advance the goal of making it easier for agencies, hospitals and health plans to share information as they seek to be more efficient in protecting the public.

Other long-planned technology projects include The Joint Commission compliant wallet license cards with physician's photos and creating a central physician data repository to eliminate administrative burdens on physicians and providers, improve accuracy and support better decision-making by the board, hospitals and health plans.

"We are so grateful to the administration and the legislature for recognizing our needs," said board Executive Director Nancy Achin Audesse. "The Trust Fund provision included in Health Care Reform law is the key to all of the board's foreseeable technology improvement plans."

In Massachusetts the licensing period for physicians is two years, with licenses expiring on a physician's birthday. Because of how the system was put in place in 1987, the license cycle is quite uneven. In even-numbered years, approximately 8,000 of the state's physician's will renew their licenses. In odd numbered years the figure is more than 20,000. It is a challenge to the board's licensing division, to say the least.

Rose Foss, director of licensing, said, "It's challenging, but we have a great staff who really pull together, for the whole team it's a point of honor to provide efficient service, even in the crunch years." In addition to the renewing physicians, the licensing staff is concerned about the normal volume of applications for initial licensure, and for new residents at teaching hospitals.

The board is considering legislation that would "even out" the licensing cycle. One proposal would be to grant three-year licenses to certain physicians born in odd numbered years, so that their next renewal would occur in the slower, even numbered years. This would balance out the license cycle more closely 50-50, while keeping license renewal on the easy-to-remember birthday.

The legislative process is a long one, however, and plenty of time will be available for public comment and consideration of other proposals. Ultimately, however, the board would like to rationalize the licensing cycle for the benefit of all.

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MICHIGAN
WEBSITE DEVELOPMENTS

The Bureau of Health Professions has three, soon to be four, websites other than the website most people visit www.michigan.gov/healthlicense. In fall 2006, the bureau launched two websites that pertain to areas other than licensing and regulation of health professionals.

One site, the Michigan Healthcare Workforce Center website www.michigan.gov/mhwc, contains information about health care workforce initiatives, licensee survey results, workforce retention and activities of the Workforce Development, Research and Evaluation Section. The site also has links to career and employment resources, state and national news, articles and publications pertaining to workforce related issues and a section for international health care professionals.

The Health Careers website www.michigan.gov/healthcareers contains information about health careers, including professions not regulated by the state at this time, such as medical assistants, massage therapists, genetic counselors and phlebotomists. It includes information about various occupations, pay scales, career profiles and videos, and where to get training for these occupations. It also includes a link to community colleges that are offering accelerated training programs throughout Michigan.

The bureau also expanded upon, and improved the look of, the information that was already available about pain and symptom management www.michigan.gov/painmanagement. This website is for the general public and health professionals alike. The website has a public section with information regarding diseases and conditions that cause pain, medications for treating pain and tools to search for local doctors or psychologists who specialize in pain management. This consumer portion of the website provides information on a wide array pain management issues, including chronic disease pain management, palliative and end of life care, advanced directives and living wills. Numerous links to other websites, articles and current news regarding pain management also are provided.

This part of the site can provide family members with information about pain management at the end of life, hospice and palliative care, forms for advanced directives, which are directions for your physician and loved ones about how you wish to be medically treated at the end of your life when you may not be able to express your wishes, living wills, and links to other interesting articles and publications. Health professionals can find information about Michigan's pain management laws, state and national guidelines and pain management information for the care of patients throughout the life span. Professionals can also access numerous links to other important articles and publications.

Finally, the bureau is now completing a new website about patient safety. This site, like the pain management site, is for both the general public and health professionals. The public can learn about what a person can do to protect themselves and their family from medical and nursing errors in various health care settings. Information and tools are also available regarding how to avoid medication errors and how you can check on the status and history of your health care providers, nursing homes and home health agencies. We believe this site will greatly assist and educate the public about this important issue. Health professionals will also find helpful information about what they can do to improve patient safety in their place of work, how to improve patient literacy, the importance of reporting errors, and the advantages of maintaining electronic medical records. We will also be posting patient safety success stories, shared with us by individual health professionals, office practices and other facilities.

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MISSOURI

NEW LEGISLATION AFFECTS SUPERVISING PHYSICIANS AND PHYSICIAN ASSISTANTS

On April 30, 2007, the Missouri General Assembly passed House Bill No. 497, which amends the physician assistant statute to require the supervising physician to work within the same facility 66 percent of the time a physician assistant provides patient care, except a physician assistant may make follow-up patient examinations in hospitals, nursing homes, patient homes and correctional facilities, each such examination being reviewed, approved and signed by the supervising physician. The legislation also states:

- The supervising physician must be readily available in person or via telecommunication during the time the physician assistant is providing patient care;
- The physician assistant shall be limited to practice at locations where the supervising physician is no further than 30 miles by road using the most direct route available, or in any other fashion so distanced as to create an impediment to effective intervention and supervision of patient care or adequate review of services;
- The board shall promulgate rules to direct the advisory commission on physician assistants to establish a formal waiver mechanism by which an individual physician-physician assistant team may apply for alternate minimum amounts of on-site supervision and maximum distance from the supervising physician. After review of an application for a waiver, the advisory commission on physician assistants shall present its recommendation to the board for its advice and consent on the approval or denial of the application. The rule shall establish a process by which the public is invited to comment on the application for a waiver, and shall specify that a waiver may only be granted if a supervising physician and physician assistant demonstrate to the board's satisfaction in accordance with its uniformly applied criteria that:
  a) Adequate supervision will be provided by the physician for the physician assistant, given the physician assistant's training and experience and the acuity of patient conditions normally treated in the clinical setting;
  b) The physician assistant shall be limited to practice at locations where the supervising physician is no further than fifty miles by road using the most direct route available, or in any other fashion so distanced as to create an impediment to effective

intervention and supervision of patient care or adequate review of services;

c) The community or communities served by the supervising physician and physician assistant would experience reduced access to health care services in the absence of a waiver; and

d) The applicant will practice in an area designated at the time of application as a health professional shortage area.

Any other provisions of Chapter 334 notwithstanding, for up to 90 days following the effective dates of rules promulgated by the board to establish the waiver process, any physician assistant practicing in a health professional shortage area as of April 1, 2007, shall be allowed to practice under the onsite requirements stipulated by the supervising physician on the supervising physician form that was in effect on April 1, 2007:

- All applicants for physician assistant licensure who complete a physician assistant training program after Jan. 1, 2008, shall have a master's degree from a physician assistant program;
- It is the responsibility of the supervising physician to determine and document the completion of at least a one-month period of time during which the licensed physician assistant shall practice with a supervising physician continuously present before practicing in a setting where a supervising physician is not continuously present;
- No contract or other agreement shall require a physician to act as a supervising physician for a physician assistant against the physician's will. A physician shall have the right to refuse to act as a supervising physician, without penalty, for a particular physician assistant. No contract or other agreement shall limit the supervising physician's ultimate authority over any protocols or standing orders or in the delegation of the physician's authority to any physician assistant, but this requirement shall not authorize a physician in implementing such protocols, standing orders, or delegation to violate applicable standards for safe medical practice established by hospital's medical staff;
- Physician assistants shall file with the board a copy of their supervising physician form;
- No physician shall be designated to serve as supervising physician for more than three fulltime equivalent licensed physician assistants.

This limitation shall not apply to physician assistant agreements of hospital employees providing inpatient care service in hospitals as defined in chapter 197, RSMo.

The board encourages reading the legislation in its entirety to fully understand the current scope of practice of a physician assistant. Once the legislation has been approved by the governor, the board's Advisory Commission for physician assistants will begin drafting rules for the waiver process. When the rules are finalized the board will notify its licensees.

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LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail your articles and news releases to Edward Pittman at editor@journalonline.org or send via fax to (817) 868-4098.