



The Comprehensive Addiction and Recovery Act of 2016: The Potential Impact on Physicians and Combating the Opioid Epidemic

By Rachel V. Rose, JD, MBA

Overview

When an individual thinks of opioids, typically two items come to mind – prescription drugs (e.g., oxycodone, oxycontin, percocet, and morphine) and heroin. The National Institute on Drug Abuse defined opioids as, “medications that relieve pain. They reduce the intensity of pain signals reaching the brain and affect those brain areas controlling emotion, which diminishes the effects of a painful stimulus.”¹ All Food and Drug Administration (FDA) approved pharmaceuticals are required to have a legitimate medical basis in order to be approved. Pain medications are appropriate in a variety of medical situations, including palliative care and post-operative pain relief.

Unfortunately, problems arise when these medications are prescribed without a legitimate medical basis or medical necessity. As Nevada Governor Brian Sandoval articulated, “[a]t least one person in Nevada dies every day from an opioid overdose.”² According to the United States Drug Enforcement Agency (DEA), the two main catalysts for prescription drug abuse are indiscriminate prescribing and criminal activity.³ The United States Attorney’s Office in Minnesota provides a compelling example – “in 2015, we have filed eight indictments representing 58 defendants charged with trafficking heroin and other illicit drugs.”⁴ Of the “illicit drugs,” prescription painkillers rank at the top of the list. There are two main problems associated with prescription painkillers: (1) addiction by the patient; and (2) prescription diversion, which “occurs when people steal or fraudulently obtain otherwise legal prescription drugs.”⁵ Examples of the improper management of a patient’s care in relation to pain management and prescription diversion are rampant.

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MISSION STATEMENT

The Nevada State Board of Medical Examiners serves the state of Nevada by ensuring that only well-qualified, competent physicians, physician assistants, respiratory therapists and perfusionists receive licenses to practice in Nevada. The Board responds with expediency to complaints against our licensees by conducting fair, complete investigations that result in appropriate action. In all Board activities, the Board will place the interests of the public before the interests of the medical profession and encourage public input and involvement to help educate the public as we improve the quality of medical practice in Nevada.

BOARD NEWS

Aurangzeb "Aury" Nagy, MD, FAANS, Joins Board of Medical Examiners

The Board welcomes Dr. Aurangzeb "Aury" Nagy, appointed by Governor Sandoval to the Board of Medical Examiners effective August 31, 2016. He replaces outgoing member, Dr. Beverly A. Neyland, who served two terms on the Board from September 1, 2008 to August 31, 2012, and October 16, 2012 to August 30, 2016. The Board wishes to thank Dr. Neyland for her service to the citizens of the state of Nevada.

Aurangzeb "Aury" Nagy, MD, FAANS, is a neurosurgeon and currently a partner in Nevada Brain & Spine Care. A Las Vegas native, Dr. Nagy graduated from Bishop Gorman High School, Yale University and Baylor College of Medicine. He is board certified through the American Board of Neurological Surgery and received his fellowship training at Louisiana State University and the University of Pennsylvania.

Dr. Nagy served as Spine Committee Chair and Neurosurgery Section Chief for Spring Valley Hospital as well as an adjunct clinical faculty member for Touro University. He was a product development consultant, Speakers Bureau clinical lecturer and educator for Integra NeuroSciences, Inc. He currently is a speaker for LDR regarding their artificial cervical disc and Medtronic for their Deep Brain Stimulator technology.

Dr. Nagy is a frequent author on the subject of back pain and has participated in several research programs about spine and brain injuries. He was the first neurosurgeon in Nevada to place an artificial cervical disc in a patient and his deep brain stimulation procedures for Parkinson's patients are well-regarded. He has served in the White House Medical Corps as a neurosurgeon and is a member of the Southern Nevada Medical Reserve Corps, as well as the Clark County Medical Society.

Dr. Nagy is also an active member of the southern Nevada business community. From 2011 through 2014, he was named a "Top Doctor" in southern Nevada with the highest ranking possible among neurosurgeons. In 2009, he was named one of the top "40 Under 40" business people under the age of 40 by *In Business Las Vegas*. In 2010, *Nevada Business Magazine* named him among the state's "Top Business Leaders Under 40."

Dr. Nagy is a founding Board member for the Yale Club of Nevada. He has served as the organization's Secretary from 2009 to 2012 and as President in 2013. He also served on the Board of Directors for First Security Bank of Nevada from 2007 to 2011 and has been involved in numerous medical and community organizations.

Dr. Nagy has most recently served on the Governor's Workforce Health Sector Committee, as well as the Federal Advisory Committee to U.S. Congress, Health Information Advisory Committee.

The Board welcomes Dr. Nagy as a physician member.

BOARD MEMBERS

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NOTIFICATION OF ADDRESS CHANGE, PRACTICE CLOSURE AND LOCATION OF RECORDS

Pursuant to NRS 630.254, all licensees of the Board are required to "maintain a permanent mailing address with the Board to which all communications from the Board to the licensee must be sent." A licensee must notify the Board in writing of a change of permanent mailing address within 30 days after the change. Failure to do so may result in the imposition of a fine or initiation of disciplinary proceedings against the licensee.

Please keep in mind the address you provide will be viewable by the public on the Board's website.

Additionally, if you close your practice in Nevada, you are required to notify the Board in writing within 14 days after the closure, and for a period of 5 years thereafter, keep the Board apprised of the location of the medical records of your patients.

The four examples below provide insight into the legal ramifications of prescribing issues:

1. On April 9, 2015, Nanci Mae Dusso pleaded guilty to the fraudulent obtaining of prescription painkillers and Social Security fraud. Utilizing out-of-state identification, she convinced a plethora of health care providers to prescribe pain killers through complaining of everything from shoulder pain to misrepresenting that she was in from out of town visiting a family member with cancer.⁶
2. In March 2016, Dr. Moshe Mirilashvili was convicted in the United States Southern District Court of New York of conspiracy to distribute oxycodone. "In total, between October 2012 and December 2014, Mirilashvili wrote more than 13,000 medically unnecessary prescriptions for oxycodone, comprising nearly 1.2 million oxycodone tablets with a street value of \$36,000,000 or more. Mirilashvili collected more than \$2.4 million in fees for 'doctor visits' during this time period."⁷
3. In July 2016, the United States Attorney's Office for the Southern District of Texas announced that a Houston area physician, Richard A. Evans, and a co-conspirator, David Devido, were convicted of 19 counts of distributing hydrocodone and oxycodone. "Some of the patients testified as to lax procedures at the clinic and the ease with which they were able to obtain prescriptions. Evans charged patients \$200-\$240 cash for an initial office visit, at which time they would obtain a first prescription. Refills are not permitted for narcotics. However, the jury heard that patients were told they could obtain a new prescription in 30 days without an office visit as long as the patient sent a money order to Evans for \$200-\$240. Patients were also told they could obtain a third prescription without an office visit as long as they again sent the payment to Evans."⁸
4. In July 2016, in the Eastern District of Louisiana, Dr. Shannon Ceasar was arrested for the illegal dispensing of controlled substances and threatening both law enforcement officials and the state medical board. "As alleged, rather than doing no harm as a physician, Shannon Ceasar illegally dispensed oxycodone into a community struggling with an epidemic of opioid addiction," stated United States Attorney Kenneth Polite. "Then, when the governing medical board and law enforcement dared to challenge his criminality, Ceasar threatened to kill them. This level of disregard for human life, particularly from a physician, is absolutely despicable."⁹

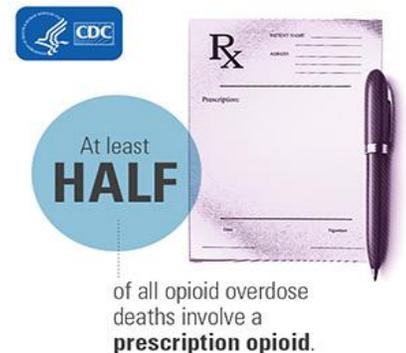
These actions underscore the crucial role physicians play both in contributing to and in combating this national prescription opioid issue.

In order to assist in combating this epidemic, The United States Congress passed the Comprehensive Addiction and Recovery Act of 2016 ("CARA") (Pub. L. 114-198 (Jul 22, 2016)). The law contains nine main sections, or "Titles", that comprise the crux of this article. Overall, the goal is to make providers aware that opioid abuse is being addressed in a multifaceted way – from prosecuting "rogue" prescribers to helping physicians and patients with addiction and treatment options.

Analysis

Prescription drug abuse has been on the rise; yet, the statistics continue to be eye-opening. The Centers for Disease Control (CDC) set forth the following fatal consequence statistics of this epidemic:

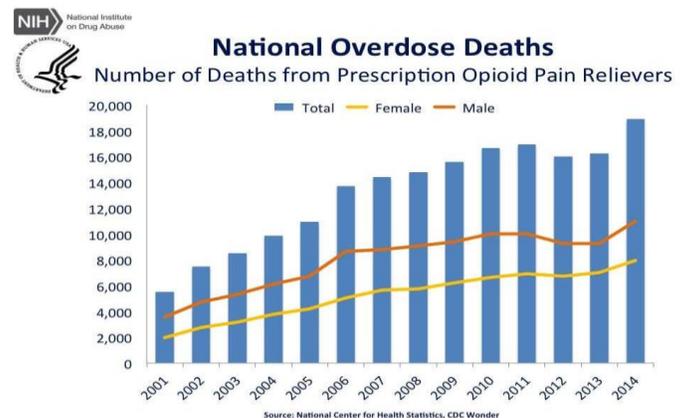
- In 2011, nearly 41,340 unintentional drug overdose deaths occurred in the United States – equating to one death every 12.45 minutes;
- 22,810 deaths out of the 41,340 unintentional drug overdose deaths were attributed to prescription drugs, with 16,917 of those deaths being linked to opioid overdoses; and
- Prescription drug abuse is the fastest growing segment of drug utilization.¹⁰



Continued on page 4

In 2014, almost two million Americans abused or were dependent on prescription opioids. These statistics led Congress to pass CARA, which became effective on July 22, 2016.¹¹ Notably Section 303(2) of CARA amended Section 102(18) of the Controlled Substance Act by inserting “or ‘opioid’” after “The term ‘opiate’”¹² and, collateral consequences for patients are highlighted in Title IV; however, the report to Congress will not be available until next summer. The legislation is broken down into the following areas:

- Title I – Prevention and Education
- Title II – Law Enforcement and Treatment
- Title III – Treatment and Recovery
- Title IV – Addressing Collateral Consequences
- Title V – Addiction and Treatment for Women, Families, and Veterans
- Title VI – Incentivizing State Comprehensive Initiatives to Address Prescription Opioid Abuse
- Title VII – Miscellaneous
- Title VIII – Kingpin Designation Improvement
- Title IX – Department of Veterans Affairs



Needless to say, the law is rather comprehensive. Although Title VI expressly relates to “States” in the title, one important take away in reading this law is to read it in its entirety. For example, Section 301 provides grants by amending Subpart 1 of part B of Title V of the Public Health Service Act¹³ and adding Section 514B - EVIDENCE-BASED PRESCRIPTION OPIOID AND HEROIN TREATMENT AND INTERVENTIONS DEMONSTRATION.

“(a) Grants To Expand Access.—

(1) **AUTHORITY TO AWARD GRANTS.**—The Secretary shall award grants, contracts, or cooperative agreements to State substance abuse agencies, units of local government, nonprofit organizations, and Indian tribes and tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) that have a high rate, or have had a rapid increase, in the use of heroin or other opioids, in order to permit such entities to expand activities, including an expansion in the availability of evidence-based medication-assisted treatment and other clinically appropriate services, with respect to the treatment of addiction in the specific geographical areas of such entities where there is a high rate or rapid increase in the use of heroin or other opioids, such as in rural areas.

(2) **NATURE OF ACTIVITIES.**—Funds awarded under paragraph (1) shall be used for activities that are based on reliable scientific evidence of efficacy in the treatment of problems related to heroin or other opioids.

(b) **Application.**—To be eligible for a grant, contract, or cooperative agreement under subsection (a), an entity shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

(c) **Evaluation.**—An entity that receives a grant, contract, or cooperative agreement under subsection (a) shall submit, in the application for such grant, contract, or agreement, a plan for the evaluation of any project undertaken with funds provided under this section. Such entity shall provide the Secretary with periodic evaluations of the progress of such project and an evaluation at the completion of such project as the Secretary determines to be appropriate.

(d) **Geographic Distribution.**—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall ensure that not less than 15 percent of funds are awarded to eligible entities that are not located in metropolitan statistical areas (as defined by the Office of Management and Budget). The Secretary shall take into account the unique needs of rural communities, including communities with an incidence of individuals with opioid use disorder that is above the national average and communities with a shortage of prevention and treatment services.

(e) **Additional Activities.**—In administering grants, contracts, and cooperative agreements under subsection (a), the Secretary shall—

(1) evaluate the activities supported under such subsection;

(2) disseminate information, as appropriate, derived from evaluations as the Secretary considers appropriate;

(3) provide States, Indian tribes and tribal organizations, and providers with technical assistance in connection with the provision of treatment of problems related to heroin and other opioids; and

(4) fund only those applications that specifically support recovery services as a critical component of the program involved.

(f) Authorization Of Appropriations.—To carry out this section, there are authorized to be appropriated \$25,000,000 for each of fiscal years 2017 through 2021.”

Section 301 should be read in relation to Section 303, which requires providers to undergo a minimum of eight (8) hours of training from specific entities, including the American Medical Association and other medical specialty organizations. Furthermore, certain populations, including women, families and Veterans are emphasized. And, Section 502(C) includes provisions for Veterans Treatment Court. In sum, this is a complex law, which involves a variety of government agencies and will take time to implement.

Conclusion

Opioid abuse is epidemic and impacts individuals, physicians and society as a whole. Physicians have a responsibility to manage care responsibly and transition to alternative forms of pain management. The enactment of CARA shows the Government’s commitment to assisting various populations (e.g., veterans), patients and providers to address these issues. In sum, it is incumbent upon everyone to appreciate the options and do their part to combat this widespread problem.

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¹ National Institute on Drug Abuse, *What Are Opioids*, <https://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids> (last accessed Aug. 1, 2016).

² Jason Hildago, *Nevada and the Pain Killer Epidemic* (Jun. 22, 2016), available at <http://www.rgj.com/story/news/nevada/2016/06/21/nevada-sandoval-seeks-answers-not-excuses-opioid-painkiller-epidemic/86186372/>.

³ U.S. Drug Enforcement Agency, February 2015 Presentation, available at http://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2015/feb_2015/rannazzisi.pdf.

⁴ United States Attorney’s Office, District of Minnesota, *Heroin Trafficking and Opioid Abuse*, available at <https://www.justice.gov/usao-mn/heroin-trafficking-and-opioid-abuse>.

⁵ *Ibid.*

⁶ United States Department of Justice, *Nanci Mae Dusso Pleads Guilty to Using Stolen Identities To Obtain Opioid Prescriptions* (Apr. 9, 2015), available at <https://www.justice.gov/usao-mn/pr/nanci-mae-dusso-pleads-guilty-using-stolen-identities-obtain-prescription-opiates>.

⁷ United States Attorney’s Office, Southern District of New York, *Manhattan U.S. Attorney Announces Conviction Of Local Doctor For Unlawfully Dispensing More Than 1.2 Million Oxycodone Pills* (March 17, 2016), available at <https://www.justice.gov/usao-sdny/pr/manhattan-us-attorney-announces-conviction-local-doctor-unlawfully-dispensing-more-12>.

⁸ United States Attorney’s Office, Southern District of Texas, *Houston Doctor Convicted for Distributing Prescription Narcotics* (Jul 26, 2016), available at <https://www.justice.gov/usao-sdtx/pr/houston-doctor-convicted-distributing-prescription-narcotics>.

⁹ United State’s Attorney’s Office, Eastern District of Louisiana, *Local Doctor Arrested for Illegally Dispensing Controlled Substances and Threatening to Kill Law Enforcement* (Jul 25, 2016), available at <https://www.justice.gov/usao-edla/pr/local-doctor-arrested-illegally-dispensing-controlled-substances-and-threatening-kill>.

¹⁰ Centers for Disease Control, *National Center for Health Statistics/National Vital Statistics Report; June 2014 CDC Vital Signs: Opioid Painkiller Prescribing* (Jul. 2014).

¹¹ Comprehensive Addiction and Recovery Act of 2016 (“CARA”) (Pub. L. 114-198 (Jul 22, 2016), <https://www.congress.gov/bill/114th-congress/senate-bill/524/text> (last accessed Aug. 1, 2016).

¹² Controlled Substances Act ([21 U.S.C. 802\(18\)](#)).

¹³ Public Health Service Act ([42 U.S.C. 290bb et seq.](#)).

Disclaimer: The opinions expressed in the article are those of the author, and do not necessarily reflect the opinions of the Board members or staff of the Nevada State Board of Medical Examiners.

FDA Requires Strong Warnings: Opioid Analgesics, Prescription Opioid Cough Products and Benzodiazepine Labeling Related to Serious Risks and Death from Combined Use

Action to better inform prescribers and protect patients as part of FDA 'Opioids Action Plan'

After an extensive review of the latest scientific evidence, the U.S. Food and Drug Administration (FDA) announced it is requiring class-wide changes to drug labeling, including patient information, to help inform health care providers and patients of the serious risks associated with the combined use of certain opioid medications and a class of central nervous system (CNS) depressant drugs called benzodiazepines.



Among the changes, the FDA is requiring boxed warnings – the FDA’s strongest warning – and patient-focused Medication Guides for prescription opioid analgesics, opioid-containing cough products, and benzodiazepines – nearly 400 products in total – with information about the serious risks associated with using these medications at the same time. Risks include extreme sleepiness, respiratory depression, coma and death. Today’s actions are one of a number of steps the FDA is taking as part of the agency’s [Opioids Action Plan](#), which focuses on policies aimed at reversing the prescription opioid abuse epidemic, while still providing patients in pain access to effective and appropriate pain management.

“It is nothing short of a public health crisis when you see a substantial increase of avoidable overdose and death related to two widely used drug classes being taken together,” said FDA Commissioner Robert Califf, M.D. “We implore health care professionals to heed these new warnings and more carefully and thoroughly evaluate, on a patient-by-patient basis, whether the benefits of using opioids and benzodiazepines – or CNS depressants more generally – together outweigh these serious risks.”

Given the importance of reaching health care professionals and the public with information about the risks of using these products together, the FDA also issued a Drug Safety Communication. Through the Drug Safety Communication and by requiring patient [Medication Guides](#), the agency also provides information for anyone who is taking, or who knows someone taking, either of these types of medications and encourages them to better understand the risks of taking them together; and, when it is medically necessary, for health care providers to be careful to prescribe them as directed, without increasing the dose or dosing frequency for either drug.

Opioid analgesics are powerful pain-reducing medications that include prescription oxycodone, hydrocodone, and morphine, among other drugs, under both brand and generic names. Certain other opioid medications are also approved to treat cough. Opioid analgesic misuse and abuse have increased significantly in the United States over the past two decades, and represent major public health concerns due to the risk of coma and fatal respiratory depression associated with opioid analgesic overdose. Benzodiazepines are drugs typically prescribed for the treatment of neurological and/or psychological conditions, including anxiety, insomnia and seizure disorders. Both classes of drugs depress the central nervous system (“CNS depressants”); however, each has unique pharmacology, safety risks, and labeling information related to its use. Therefore, the FDA is requiring opioid analgesics, prescription opioid cough products, and benzodiazepines to have slightly different labeling. Additionally, due to the unique medical needs and benefit/risk considerations for patients undergoing medication-assisted therapy treatment (MAT) to treat opioid addiction and dependence, the FDA is continuing to examine available evidence regarding the use of benzodiazepines and opioids used as part of MAT.

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The FDA's data review showed that physicians have been increasingly prescribing them together, and this has been associated with adverse outcomes. Among the data reviewed by the FDA, the agency concluded that from 2004 to 2011, the rate of emergency department visits involving non-medical use of both drug classes increased significantly, with overdose deaths (from taking prescribed or greater than prescribed doses) involving both drug classes nearly tripling during that period. Additionally, the number of patients who were prescribed both an opioid analgesic and benzodiazepine increased by 41 percent between 2002 and 2014, which translates to an increase of more than 2.5 million opioid analgesic patients receiving benzodiazepines.

Clinical guidelines from the U.S. Centers for Disease Control and Prevention (CDC) and existing labeling warnings regarding combined use caution prescribers about co-prescribing opioids and benzodiazepines to avoid potential serious health outcomes. The actions of the FDA today are consistent with the CDC.

In February 2016, the FDA received a citizen petition from numerous local and state public health officials and other stakeholders asking the agency to make certain changes to the existing labeling for benzodiazepines and opioid analgesics. The FDA had already initiated a review of the scientific information on concomitant use of these two drug classes when the agency received the petition, and was encouraged that these public health officials shared the agency's concerns. The FDA also responded to the citizen petition.

Working with the health care community and federal and state partners to help reduce opioid misuse and abuse and improve appropriate opioid prescribing, while ensuring that patients in pain continue to have appropriate access to opioid analgesics, is a top priority for the FDA and part of Health and Human Services' targeted approach focused on prevention, treatment, and intervention. The agency is committed to continuing to monitor these products and take further actions as needed.

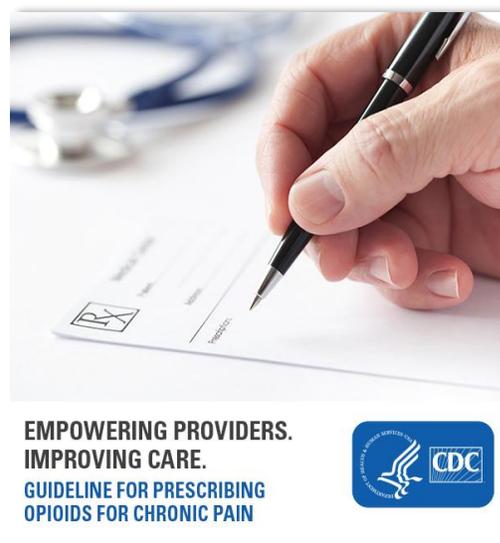
The FDA, an Agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices. The Agency also is responsible for the safety and security of our nation's food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products.

Media Contact: [Sarah Peddicord](#) 301-796-2805

Consumers: 888-INFO-FDA

Related Information:

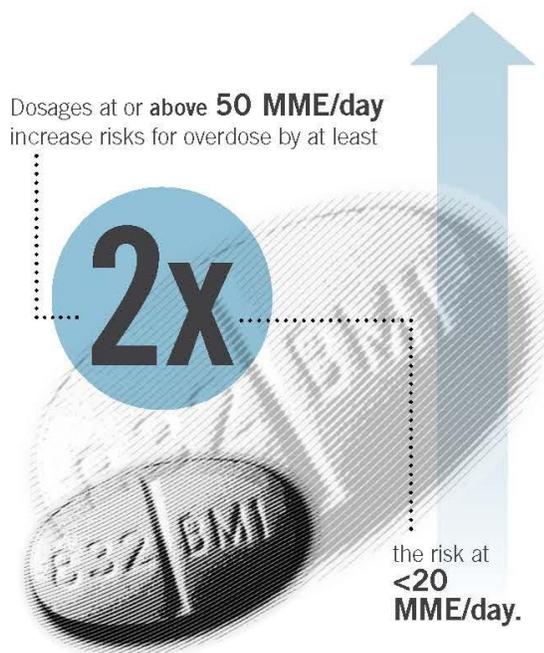
- [New Safety Measures Announced for Opioids and Benzodiazepines](#)
- [FDA Opioids Action Plan](#)
- [HHS Action Plan](#)
- [CDC: Prescription Painkiller Overdoses in the U.S.](#)
- [CDC Guideline for Prescribing Opioids for Chronic Pain](#)
- [CDC Common Elements in Guidelines for Prescribing Opioids for Chronic Pain](#)
- [CDC 'Turn the Tide' Pocket Guide](#)
- [CDC Clinical and Patient/Partner Tools](#)



CALCULATING TOTAL DAILY DOSE OF OPIOIDS FOR SAFER DOSAGE

Higher Dosage, Higher Risk.

Higher dosages of opioids are associated with higher risk of overdose and death—even relatively low dosages (20-50 morphine milligram equivalents (MME) per day) increase risk. Higher dosages haven't been shown to reduce pain over the long term. One randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy (with average final dosage 52 MME) and maintenance of current dosage (average final dosage 40 MME).



WHY IS IT IMPORTANT TO CALCULATE THE TOTAL DAILY DOSAGE OF OPIOIDS?

Patients prescribed higher opioid dosages are at higher risk of overdose death.

In a national sample of Veterans Health Administration (VHA) patients with chronic pain receiving opioids from 2004–2009, **patients who died** of opioid overdose were prescribed an average of **98 MME/day**, while **other patients** were prescribed an average of **48 MME/day**.

Calculating the total daily dose of opioids helps identify patients who may benefit from closer monitoring, reduction or tapering of opioids, prescribing of naloxone, or other measures to reduce risk of overdose.

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

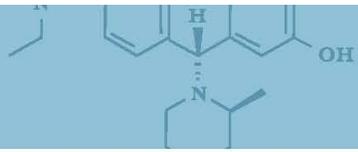
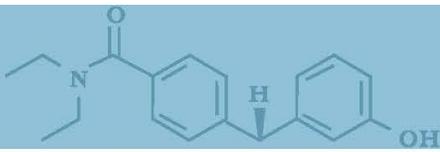
90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

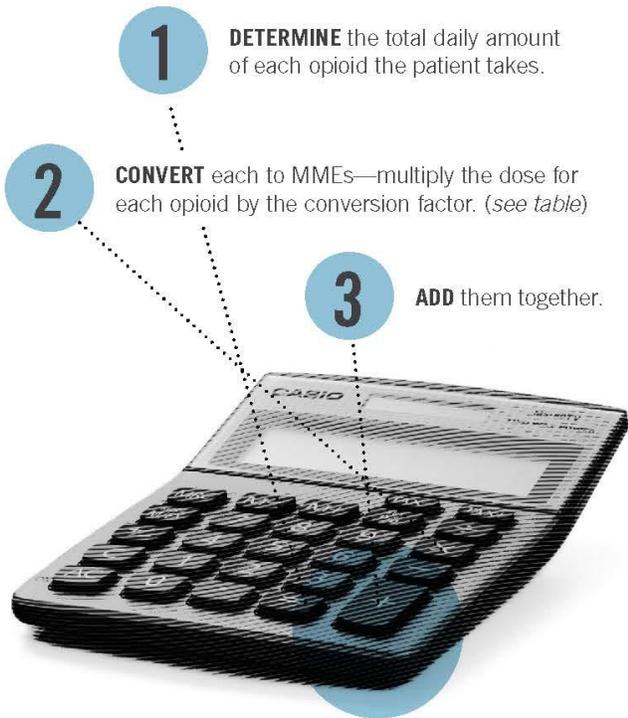


U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html



HOW SHOULD THE TOTAL DAILY DOSE OF OPIOIDS BE CALCULATED?



Calculating morphine milligram equivalents (MME)

| OPIOID (doses in mg/day except where noted) | CONVERSION FACTOR |
|---|-------------------|
| Codeine | 0.15 |
| Fentanyl transdermal (in mcg/hr) | 2.4 |
| Hydrocodone | 1 |
| Hydromorphone | 4 |
| Methadone | |
| 1-20 mg/day | 4 |
| 21-40 mg/day | 8 |
| 41-60 mg/day | 10 |
| ≥ 61-80 mg/day | 12 |
| Morphine | 1 |
| Oxycodone | 1.5 |
| Oxymorphone | 3 |

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CAUTION:

- Do not use the calculated dose in MMEs to determine dosage for converting one opioid to another—the new opioid should be lower to avoid unintentional overdose caused by incomplete cross-tolerance and individual differences in opioid pharmacokinetics. Consult the medication label.

USE EXTRA CAUTION:

- Methadone:** the conversion factor increases at higher doses
- Fentanyl:** dosed in mcg/hr instead of mg/day, and absorption is affected by heat and other factors

HOW SHOULD PROVIDERS USE THE TOTAL DAILY OPIOID DOSE IN CLINICAL PRACTICE?

- Use caution when prescribing opioids at any dosage and prescribe the lowest effective dose.
- Use extra precautions when increasing to ≥50 MME per day such as:
 - Monitor and assess pain and function more frequently.
 - Discuss reducing dose or tapering and discontinuing opioids if benefits do not outweigh harms.
 - Consider offering naloxone.
- Avoid or carefully justify increasing dosage to ≥90 MME/day.



LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

DEA Report: Counterfeit Pills Fueling U.S. Fentanyl and Opioid Crisis



Problems resulting from abuse of opioid drugs continue to grow

Hundreds of thousands of counterfeit prescription pills, many containing deadly amounts of [fentanyl](#) and fentanyl-related compounds, have made their way into the U.S. drug market, according to a [DEA intelligence report](#). Law enforcement nationwide is reporting higher fentanyl availability, seizures and known overdose deaths than at any other time since the drug's creation in 1959.

Fentanyl is a synthetically produced opioid that, when produced and administered legitimately, is used to treat severe pain. Overseas labs in China are mass-producing fentanyl and fentanyl-related compounds and marketing them to drug trafficking groups in Mexico, Canada and the United States.

In addition to being deadly to users, fentanyl poses a grave threat to law enforcement officials and first responders, as a lethal dose of fentanyl can be accidentally inhaled or absorbed through the skin. DEA recently released a [Police Roll Call video](#) nationwide to warn law enforcement about this danger. The video can be accessed at: www.DEA.gov.

Other findings from the report:

- Fentanyl and fentanyl-related compounds are traditionally mixed into or sold as heroin, or on its own, oftentimes without the customer's knowledge. Since 2014, U.S. law enforcement agencies have been seizing a new form of fentanyl—counterfeit prescription opioid pills containing fentanyl or fentanyl-related compounds. The counterfeit pills often closely resemble the authentic medications they were designed to mimic, and the presence of fentanyl is only detected upon laboratory analysis.
- Fentanyl traffickers have been successful at expanding the fentanyl market and introducing new fentanyl-laced drug products to the U.S. drug market. The DEA National Forensic Laboratory Information System (NFLIS) reported that there were 13,002 fentanyl exhibits tested by forensic laboratories across the country in 2015 (the latest year for which data is available), which is a 65 percent increase from the 7,864 fentanyl exhibits in 2014. There were approximately eight times as many fentanyl exhibits in 2015 as there were during the 2006 fentanyl crisis, clearly demonstrating the unprecedented threat and expansion of the fentanyl market.
- The rise of counterfeit pills that contain fentanyl in the illicit drug market will likely result in more opioid-dependent individuals, overdoses and deaths. There were over 700 fentanyl-related deaths reported in the United States between late 2013 and 2014. During 2013-2014, the Centers for Disease Control (CDC) reported that deaths from synthetic opioids increased 79 percent, from 3,097 to 5,544. Although the synthetic opioid category does contain other opioids, this sharp increase coincides with a sharp increase in fentanyl availability, and the CDC reports that a substantial portion of the increase appears to be related to illicit fentanyl.
- In March 2016, law enforcement officers in Lorain County, Ohio, seized 500 pills that visually appeared to be oxycodone. The pills were blue and had "A 215" markings, consistent with 30 milligram oxycodone pills. Laboratory analysis indicated that the pills did not contain oxycodone, but were instead the research chemical U-47700. U-47700 is an unscheduled synthetic opioid not studied for human use that has caused at least 17 overdoses and several deaths in the United States.
- Many Chinese laboratories illicitly manufacturing synthetic drugs, such as fentanyl and their precursors, also manufacture legitimate chemicals for purchase by U.S. companies. This means that laboratories responsible for supplying fentanyl in counterfeit pills can also run legitimate businesses. Although Chinese clandestine laboratories may be contributing to the fentanyl supply, legitimate laboratories may also be sources of supply.
- Traffickers can typically purchase a kilogram of fentanyl powder for a few thousand dollars from a Chinese supplier, transform it into hundreds of thousands of pills, and sell the counterfeit pills for millions of dollars in profit. If a particular batch has 1.5 milligrams of fentanyl per pill, approximately 666,666 counterfeit pills can be manufactured from 1 kilogram of pure fentanyl.

The entire intelligence brief, "[Counterfeit Prescription Pills Containing Fentanyls: A Global Threat](#)" can be accessed at www.DEA.gov.

VA Highlights Initiatives to Prevent Veteran and Service Member Suicide

The Department of Veterans Affairs (VA) is asking for the entire nation's help in reducing Veteran suicide during [Suicide Prevention Month](#). VA is calling on community leaders, supervisors, colleagues, friends, and family members to **BeThere** for veterans and service members starting with a simple act, which can play a pivotal role in preventing suicide.



"You don't have to be a trained professional to support someone who may be going through a difficult time," said Dr. Caitlin Thompson, Director of the VA Office of Suicide Prevention. "We want to let people know that things they do every day, like calling an old friend or checking in with a neighbor, are strong preventive factors for suicide because they help people feel less alone. That's what this campaign is about - encouraging people to be there for each other."

The campaign also highlights VA resources that are available to support veterans and service members who are coping with mental health challenges or are at risk for suicide, and it encourages everyone to share these resources with someone in their life.

"We hope our Suicide Prevention Month efforts help educate people about the VA and community resources available nationwide," said VA Under Secretary for Health David J. Shulkin, M.D. "We're committed to working with experts and organizations across the country to identify ways we can help veterans and service members get the care they deserve and to expand the network of mental health support."

[Veteran suicide data](#) released by the VA Office of Suicide Prevention in early August 2016 serves as a foundation for informing and evaluating suicide prevention efforts inside the VA health care system and for developing lifesaving collaborations with community-based health care partners.

VA plans to host a series of roundtable discussions with key stakeholder groups in the coming months as part of its plan to develop a public health strategy for preventing veteran suicide. In August, VA hosted its first roundtable discussion, "Suicide Prevention is Everyone's Business," with corporate sector partners. In September, VA hosted the [Veterans Affairs Suicide Prevention Innovations](#) event, which brought together a community of experts from business, industry, academia and government agencies to collaboratively identify solutions for reducing suicide rates among veterans and service members. In addition, new programs such as REACH VET were launched nationwide in September to identify veterans in VHA care who may be vulnerable, in order to provide the care they need before a crisis occurs.

For more information about VA's suicide prevention efforts:

- Suicide Prevention Month website: VeteransCrisisLine.net/BeThere
- Suicide Prevention Month toolkit: VeteransCrisisLine.net/SpreadTheWord
- [Suicide Prevention Fact Sheet](#)
- VA's Veterans Crisis Line: Call **1-800-273-8255 and Press 1**; chat online at VeteransCrisisLine.net/Chat or text to **838255** — even if a veteran is not registered with VA or enrolled in VA health care.
- Make the Connection website: <http://maketheconnection.net>
- VA Mental Health website: <http://www.mentalhealth.va.gov>

9.8 Million American Adults Had Serious Thoughts of Suicide in 2015

2.7 million adults made suicide plans and 1.4 million made nonfatal suicide attempts



A new report by the Substance Abuse and Mental Health Services Administration (SAMHSA) reveals that in 2015, 4 percent of American adults aged 18 and older thought seriously about killing themselves during the past 12 months from when they were surveyed. During this same period, 1.1 percent of adults made suicide plans, and 0.6 percent of adults made non-fatal attempts at suicide.

More than 42,000 people in the United States die from suicide annually, according to the U.S. Centers for Disease Control and Prevention – making suicide the tenth leading cause of death overall. The rates for completed suicide remain at historically high levels, with a 27 percent increase since 2000.

The Administration is seeking \$88 million in fiscal year 2017 funding for SAMHSA efforts to prevent suicide in all segments of the community.

The SAMHSA report shows that the overall percentage of adults who had serious thoughts of attempting suicide has remained stable in most years since SAMHSA started tracking this in 2008. However, the report shows from 2014 to 2015, an increase in serious thoughts of suicide among young adults (aged 18 to 25) from 7.5 percent in 2014 to 8.3 percent in 2015.

The report also shows a significant increase from 2014 to 2015 in the rate of nonfatal suicide attempts among young adult females – up from 1.5 percent in 2014 to 2 percent in 2015.

About one fourth of adults who had serious thoughts of suicide in the past year made suicide plans. One in seven adults who had serious thoughts of suicide in the past year made a nonfatal suicide attempt, according to the report. All of these levels have also remained roughly consistent since SAMHSA started monitoring these demographics in 2008.

“We must continue to raise awareness that suicide is preventable, and provide effective, science-based services to everyone who needs it,” said SAMHSA Principal Deputy Administrator Kana Enomoto. “SAMHSA and others have programs in place to save lives and lead people toward a brighter future. Everyone – family, friends, teachers, faith community leaders, co-workers, healthcare providers – can save a life by reaching out to someone in crisis and assisting them in getting the help they need.”

The report shows some differences in the levels of suicidal thoughts and behaviors among certain groups. Young adults had significantly higher levels of serious suicidal thoughts compared to any other age group – twice as high, for example, as people aged 40 to 54 (8.3 percent versus 3.5 percent respectively). Those aged 65 and older had a significantly lower level of suicidal thoughts in the past year of 1.8 percent.

People who drank alcohol and used illicit drugs in the past year had significantly higher levels of suicidal thoughts, making suicidal plans, and making nonfatal suicide attempts than the general adult population. For example, 9.8 percent of past-year alcohol and illicit drug users had serious suicidal thoughts compared to 4 percent of all adults.

Users of certain types of illicit drugs in the past year were more likely to have suicidal thoughts and behavior. For example, people using methamphetamines in the past year were much more likely to have serious suicidal thoughts (21.6 percent versus 4 percent); to have made suicide plans (7.2 percent versus 1.1 percent); and to have made nonfatal suicide attempts (4.3 percent versus 0.6 percent) than the general adult population.

Continued on page 13

Similarly, rates of suicidal thoughts and behaviors were higher among adults who experienced a major depressive episode in the past 12 months. Nearly one third of these adults (28.6 percent) had serious thoughts of suicide, 9.9 percent made suicide plans, and 4.2 percent made nonfatal suicide attempts.

The report also shows that only about half (49 percent) of adults who had serious thoughts of suicide in the past 12 months received mental health services. People who made nonfatal suicide attempts had a higher rate of mental health treatment at 60.4 percent.

The following warning signs can be used to determine if you or someone you know may be at risk for suicide:

- **Talking about wanting to die or to kill oneself.**
- **Looking for a way to kill oneself, such as searching online or buying a gun.**
- **Talking about feeling hopeless or having no reason to live.**
- **Talking about feeling trapped or in unbearable pain.**
- **Talking about being a burden to others.**
- **Increasing the use of alcohol or drugs.**
- **Acting anxious or agitated or behaving recklessly.**
- **Sleeping too little or too much.**
- **Withdrawing or feeling isolated.**
- **Showing rage or talking about seeking revenge.**
- **Displaying extreme mood swings.**

September is recognized as National Suicide Prevention Awareness Month to help promote awareness and resources around the issues of suicide prevention. SAMHSA developed the National Suicide Prevention Lifeline 1-800-273-TALK (Lifeline) to provide immediate help to people in crisis. The Lifeline is a nationwide network of crisis centers that provides help 24 hours a day, seven days a week for individuals in emotional distress or suicidal crisis.

People who are in crisis or are concerned about someone else in crisis can call the Lifeline and get connected to the nearest crisis center to receive help. Individuals can also get help online by clicking the “Click to Chat” button at <http://www.suicidepreventionlifeline.org/>. The Lifeline can also be contacted via TTY for the deaf and hearing impaired by dialing (800)-799-4889.

There are many other resources available to people in need of suicide prevention and other mental health services and to those who want to help. For more information about suicide and what you can do to prevent suicide, go to SAMHSA’s [Suicide Prevention Resource Center \(www.sprc.org\)](http://www.sprc.org) and click on Suicide Prevention Basics. SAMHSA’s [Behavioral Health Treatment Locator \(findtreatment.samhsa.gov\)](http://findtreatment.samhsa.gov) is a ready source of information on a wide array of mental health programs throughout the nation.

SAMHSA also works with other agencies and mental health groups to promote specialized mental health and suicide prevention services geared to community, college, tribal, workplace and other settings.

Please find the report, ***Suicidal Thoughts and Behaviors among Adults, Results from the 2015 National Survey on Drug Use and Health***, available at: <http://www.samhsa.gov/data/sites/default/files/NSDUH-DR-FFR3-2015/NSDUH-DR-FFR3-2015.pdf>.

For more information, contact the SAMHSA Press Office at 240-276-2130.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (DHHS) that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Robotics Symposium of Las Vegas



4.00 AMA PRA
Category 1 Credit(s)TM

October 15, 2016

8:00 AM - 12:00 PM

Vegas PBS - Technology Campus

3050 E Flamingo Rd
Las Vegas, NV 89121

CCMS/NSMA Members: \$80
Non-Member and/or Guest: \$130

Why you should attend... The purpose of this CME is to increase the physician's knowledge of the robotic procedures across all specialties. The program will highlight advancements in robotics. Attendees will learn advantages/disadvantages compared to open surgery. This multi-specialty event will emphasize evidence based best practices and physicians will gain knowledge/confidence when referring patients to specialist performing robotics. This program is intended to introduce and encourage physicians who are not using Robotics, to use in the future as a non-invasive surgery option for patients.

PROGRAM FORMAT

WELCOME
Souzan El-Eid, MD
President, Clark County Medical Society

7:30 am | Registration & Breakfast
8:00-9:00 am | History & Evolution of Robotic
9:00-10:00 am | Multi-Specialty Presentations
10:00-10:15 am | Networking Break
10:15-11:15 am | Multi-Specialty Presentations
11:15 - 12:00 pm | Multi-Specialty Stations

*Lunch Served during Group/Roundtable
Open Forum Discussion*

PRESENTING PHYSICIANS

Jayram Krishnan, DO
History & Evolution | Cleveland Clinic Urology

Nadia Gomez, MD
General Gynecology Surgery | UNSOM/UNRSOM

Richard Baynosa, MD
Plastic Surgery | UNSOM/UNRSOM

Melissa Gutierrez, MD
URO Surgery | Women's Health Specialty Care

Ovunc Bardakcioglu, MD
Colorectal Surgery | UNSOM/UNRSOM

Lynn Kowalski, MD
Gynecology Oncology Surgery | Nevada Surgery & Cancer Care

Leslie Browder, MD
Colorectal Surgery | Womens Cancer Centers of Nevada

Matthew Johnson, MD
Critical Care Surgery | Desert Surgical Associates

Norton Roitman, MD
Advances Neuro Psychiatry Surgery | Norton A. Roitman, MD

Scott Slavis, MD
Kidney Surgery | Cleveland Clinic Urology

Omid Lesani, MD
Prostatectomy | Las Vegas Urology

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renee.hinostrosa@clarkcountymedical.org

REGISTRATION FORM



**4.00 AMA PRA
Category 1 Credit(s)TM**

October 15, 2016

8:00 AM - 12:00 PM

Vegas PBS - Technology Campus

3050 E Flamingo Rd
Las Vegas, NV 89121

CCMS/NSMA Members: \$80
Non-Member and/or Guest: \$130

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Physicians

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint providership of the University of Nevada, Reno School of Medicine and Clark County Medical Society. The University of Nevada School of Medicine is accredited by the ACCME to provide continuing medical education to physicians.

The University of Nevada School of Medicine designates this live activity for a maximum of 4.00 AMA PRA Category 1 Credit(s)TM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurses

The University of Nevada Reno School of Medicine approves this program for 4.00 hours of nursing continuing education credit.



Reserve Your Seat Today!

| | | | | | |
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| CCMS/NSMA Member | \$80 | x | _____ | = | \$_____ |
| Non-Member and/or Guest | \$130 | x | _____ | = | \$_____ |

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| Make checks payable to: Clark County Medical Society or CCMS | | | | |
| Mail to: | Clark County Medical Society 2590 E. Russell Road Las Vegas, Nevada 89120 | | | |
| Fax: | 702.739.6345 | Phone: | 702.739.9989 | |
| Email: | Janice.Poblete@clarkcountymedical.org | | | |

**WHOM TO CALL IF YOU
HAVE QUESTIONS**

Management: Edward O. Cousineau, JD
Executive Director
Todd C. Rich
Deputy Executive Director
Donya Jenkins
Finance Manager
Administration: Laurie L. Munson, Chief
Legal: Robert Kilroy, JD
General Counsel
Licensing: Lynnette L. Daniels, Chief
Investigations: Pamela J. Castagnola, CMBI, Chief

**2016 BME MEETING &
HOLIDAY SCHEDULE**

January 1 – New Year’s Day holiday
January 18 – Martin Luther King, Jr. Day holiday
February 15 – Presidents’ Day holiday
March 4-5 – Board meeting
May 30 – Memorial Day holiday
June 3-4 – Board meeting
July 4 – Independence Day holiday
September 5 – Labor Day holiday
September 9-10 – Board meeting
October 28 – Nevada Day holiday
November 11 – Veterans’ Day holiday
November 24 & 25 – Thanksgiving/Family Day holiday
December 2-3 – Board meeting (Las Vegas)
December 26 – Christmas holiday (observed)

Nevada State Medical Association

3700 Barron Way
Reno, NV 89511
775-825-6788
<https://www.nvdoctors.org> website

Clark County Medical Society

2590 East Russell Road
Las Vegas, NV 89120
702-739-9989 phone
702-739-6345 fax
<http://www.clarkcountymedical.org> website

Washoe County Medical Society

3700 Barron Way
Reno, NV 89511
775-825-0278 phone
775-825-0785 fax
<http://wcmsnv.org> website

Nevada State Board of Pharmacy

431 W. Plumb Lane
Reno, NV 89509
775-850-1440 phone
775-850-1444 fax
<http://bop.nv.gov> website
pharmacy@pharmacy.nv.gov email

Nevada State Board of Osteopathic Medicine

2275 Corporate Circle, Ste. 210
Henderson, NV 89074
702-732-2147 phone
702-732-2079 fax
<http://bom.nv.gov> website

Nevada State Board of Nursing

Las Vegas Office
4220 S. Maryland Pkwy, Bldg. B, Suite 300
Las Vegas, NV 89119
702-486-5800 phone
702-486-5803 fax
Reno Office
5011 Meadowood Mall Way, Suite 300,
Reno, NV 89502
775-687-7700 phone
775-687-7707 fax
<http://nevadanursingboard.org> website

Unless otherwise noted, Board meetings are held at the Reno office of the Nevada State Board of Medical Examiners and videoconferenced to the conference room at the offices of the Nevada State Board of Medical Examiners/Nevada State Board of Dental Examiners, 6010 S. Rainbow Blvd., Building A, Suite 1, in Las Vegas.

Hours of operation of the Board are 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding legal holidays.

DISCIPLINARY ACTION REPORT

COHEN, Lisa M., M.D. (12977)

Lexington, Massachusetts

Summary: Disciplinary action taken against Dr. Cohen's medical license in Massachusetts.

Charges: One violation of NRS 630.301(3) [disciplinary action taken against her medical license in another state].

Disposition: On September 9, 2016, the Board accepted a Settlement Agreement by which it found Dr. Cohen violated NRS 630.301(3), as set forth in the First Amended Complaint, and imposed the following discipline against her: (1) public reprimand; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

GLYMAN, Mark L., M.D. (6502)

Las Vegas, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records related to Dr. Glyman's treatment of two patients.

Charges: Two violations of NRS 630.301(4) [malpractice]; two violations of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient].

Disposition: On September 9, 2016, the Board accepted a Settlement Agreement by which it found Dr. Glyman violated NRS 630.3062(1) (2 counts), as set forth in Counts III and IV of the Complaint, and imposed the following discipline against him: (1) 3 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Counts I and II of the Complaint were dismissed with prejudice.

MALL, Michael S., M.D. (6074)

Las Vegas, Nevada

Summary: Alleged malpractice, failure to maintain appropriate medical records related to Dr. Mall's treatment of a patient, unlawful prescribing of controlled substances, practicing beyond the scope permitted by law or performing services beyond the scope of his training, continual failure to exercise the skill or diligence or use methods ordinarily exercised under the same circumstances by physicians in the

same specialty or field, and engaging in conduct that violates standards of practice.

Charges: One violation of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.301(4) [malpractice]; one violation of NRS 630.306(3) [administering, dispensing or prescribing any controlled substance to others except as authorized by law]; one violation of NRS 630.306(5) [practicing beyond the scope permitted by law or performing services which the licensee knows he is not competent to perform or which are beyond the scope of his training]; one violation of NRS 630.306(7) [continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field]; one violation of NRS 630.306(2)(b) [engaging in any conduct which the Board has determined is a violation of the standards of practice established by regulation of the Board].

Disposition: On September 9, 2016, the Board accepted a Settlement Agreement by which it found Dr. Mall violated NRS 630.3062(1), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 3 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. All remaining counts of the Complaint were dismissed.

PHILLIPS, Maryanne D., M.D. (7635)

Henderson, Nevada

Summary: Case No. 12-10032-1: disciplinary action taken against Dr. Phillips' medical license in New Mexico and alleged failure to report said disciplinary action to the Nevada State Board of Medical Examiners. Case No. 14-10032-1: alleged malpractice, failure to maintain appropriate medical records related to Dr. Phillips' treatment of 11 patients, and writing prescriptions for controlled substances to treat acute or chronic pain in a manner that deviates from the policies set forth in the Model Guidelines.

Charges: Case No. 12-10032-1: one violation of NRS 630.301(3) [disciplinary action taken against her medical license in another state]; one violation of NRS 630.306(11) [failure to report in writing, within 30 days, disciplinary action taken against her by another state]; one violation of NRS 630.306(2)(a) [engaging in any conduct which is intended to deceive]. Case No. 14-10032-1: one violation of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.301(4) [malpractice]; one violation of NRS 630.306(2)(b) [engaging in any conduct which the Board has determined is a violation of the standards of practice established by regulation of the Board].

Disposition: On September 9, 2016, the Board accepted a Settlement Agreement by which it found Dr. Phillips violated NRS 630.301(3), as set forth in Count I of the Complaint in Case No. 12-10032-1, and NRS 630.301(4), as set forth in Count II of the Complaint in Case No. 14-10032-1, and imposed the following discipline against her: (1) Dr. Phillips' license to practice medicine in the state of Nevada shall be placed on probation for 36 months subject to various terms and conditions; (2) a \$500.00 fine for Case No. 12-10032-1 and a \$500.00 fine for Case No. 14-10032-1; (3) public reprimand; (4) 6 hours of CME, in addition to any CME requirements regularly imposed upon her as a condition of licensure in Nevada; (5) reimbursement of the Board's fees and costs associated with investigation and prosecution of the two matters. Counts II and III of the Complaint in Case No. 12-10032-1 and Counts I and III of the Complaint in Case No. 14-10032-1 were dismissed.

STOUGHTON, Ned S., M.D. (10960)

Las Vegas, Nevada

Summary: Dr. Stoughton voluntarily surrendered his license to practice medicine in Nevada.

Statutory Authority: NRS 630.240 [voluntary surrender of license].

Disposition: On September 9, 2016, the Board accepted Dr. Stoughton's voluntary surrender of his license to practice medicine in Nevada while under investigation.

WILCOX, Simmon L., M.D. (11588)**Pahrump, Nevada**

Summary: Conviction of criminal offenses.

Charges: Two violations of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute]; two violations of NRS 630.301(11)(g) [conviction of any offense involving moral turpitude].

Disposition: On August 19, 2016, the Board revoked Dr. Wilcox' license to practice medicine in the state of Nevada based upon the terms of the Settlement Agreement filed in the matter on June 7, 2016. The Board further ordered that Dr. Wilcox be issued a public reprimand.

WILSON, Jennifer McKim, M.D.**(10019)****Reno, Nevada**

Summary: Alleged malpractice and failure to maintain appropriate medical records related to Dr. Wilson's treatment of a patient.

Charges: One violation of NRS 630.3062(1) [failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient]; one violation of NRS 630.301(4) [malpractice].

Disposition: On September 9, 2016, the Board accepted a Settlement Agreement by which it found Dr. Wilson violated NRS 630.3062(1), as set forth in Count I of the Complaint, and imposed the following discipline against her: (1) 5 hours of CME, in addition to any CME requirements regularly imposed upon her as a condition of licensure in Nevada; (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter. Count II of the Complaint was dismissed with prejudice.

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Public Reprimands Ordered by the Board

September 15, 2016

Lisa M. Cohen, M.D.
c/o David Mortensen, Esq.
Alverson, Taylor, Mortensen & Sanders
7401 West Charleston Blvd.
Las Vegas, NV 89117-1401

Dr. Cohen:

On September 9, 2016, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the First Amended Complaint filed against you in Case Number 15-33456-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(3), disciplinary action taken against your medical license in Massachusetts. For the same, you shall receive a public reprimand and pay the fees and costs related to the investigation and prosecution of this matter.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

September 15, 2016

Michael Mall, M.D.
c/o John H. Cotton, Esq.
John H. Cotton & Associates
7900 West Sahara, Suite 200
Las Vegas, NV 89117

Dr. Mall:

On September 9, 2016, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement (Agreement) between you and the Board's Investigative Committee in relation to the formal Complaint filed against you in Case Number 15-8666-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1), medical records. For the same, you shall receive a public reprimand, take three (3) hours of continuing medical education, the aforementioned hours of CME shall be in addition to any CME requirements that are regularly imposed upon you as a condition of licensure in the State of Nevada, and pay the fees and costs related to the investigation and prosecution of this matter.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought professional disrespect upon you and which reflects unfavorably upon the medical profession as a whole.

Sincerely,

Michael J. Fischer, M.D., President
Nevada State Board of Medical Examiners

★ ★ ★

NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144