NEVADA STATE BOARD OF MEDICAL EXAMINERS

NEWSLETTER

VOLUME 59 ★★★ June 2016

7 Ways to Prepare for 2016 HIPAA Audits

By Rachel V. Rose, JD, MBA

Phase two of audits for the Health Insurance Portability and Accountability Act (HIPAA) are coming this year as the Office of Civil Rights looks to crack down on violations.

HIPAA was signed into law in August of 1996, and the Privacy and Security Rules were both implemented over a decade ago. Moreover, the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which made significant changes to a variety of facets of HIPAA, passed in 2009. Section 13411 of the HITECH Act requires the Office of Civil Rights (OCR) - which is part of the U.S. Department of Health and Human Services (HHS) - to conduct periodic HIPAA audits.

Why is there so much emphasis on meeting standards that have been required for two decades in some instances? It's due mainly to the increased use of technology in healthcare and accompanying cybersecurity risks. The purpose of this article is to provide an overview of the OCR audit program (Phase 2), identify key areas of risk and provide suggestions on how to mitigate adverse findings.

OCR audit program

In 2011, OCR launched the requisite OCR Pilot Privacy, Security, and Breach Notification Audit Program. For the first phase, only covered entities were audited. This second phase includes business associates of covered entities.

Regardless of the type of entity, the time frames for the audit are the same. From the time the audit notification letter is sent from OCR, organizations should plan on a 30-day to 90-day process. Analogous to a Recovery Audit Contractor (RAC) audit, an entity has a certain period of time to produce the requested information. The information may be requested either on-site or as a desk audit, which is described below.

Next, OCR reviews the information provided and drafts a report. The entity then has the opportunity to review and respond to the draft report, after which OCR finalizes the report. The scope of the Phase 1 audits was limited to the federal Privacy, Security, and Breach Notification Rules. This does not mean that a state law or international law provision may have been violated - it just was not addressed in the Phase 1 audits.

Phase 2 audits will be more robust, in part due to a $4 million increase in OCR's 2016 budget. Another area of difference will be the number of on-site versus desk audits. During the Phase 1 audits, covered entities were evaluated by a third party, who visited them on-site. Phase 2 audits will include a greater number of desk audits - entities responding to the audits from their desks by providing policies and documentation of privacy policies and procedures to HHS.

Article continued on page 3

FEATURED IN THIS ISSUE:

ALSO IN THIS ISSUE:

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.

Federal Grant Awarded to Support State Medical Boards in Implementing Interstate Medical Licensure Compact

WASHINGTON, D.C. (June 17, 2016) – The U.S. Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, has announced that it will provide funding to support state medical and osteopathic boards as they implement the administrative and technical infrastructure of the new Interstate Medical Licensure Compact.

The grant from HRSA of $250,000 annually for three years will help the Compact become operational and will support educational outreach to expand participation in the Compact by other states. Grant funding will begin on July 1, 2016.

The Compact, which has been enacted by 17 states since 2015, offers a voluntary, expedited licensing process for physicians interested in practicing medicine in multiple states. The Compact is expected to expand access to health care, especially to those in rural and underserved areas of the country, and facilitate the use of telemedicine technologies in the delivery of health care.

"This is good and very welcome news that comes as the Commission prepares to undertake significant tasks and make important decisions," said Ian Marquand, Chairperson of the Interstate Medical Licensure Compact Commission. "As Commission Chairperson and as an individual Commissioner whose state is keenly interested in the success of the Compact, I look forward to learning more about how the grant will support that work."

"The continuing support of HRSA has been very beneficial to state medical boards in their ongoing effort to increase access to quality health care and support the expanded use of telemedicine for patients by streamlining the medical licensure process," said Art Hengerer, MD, Chair of the Federation of State Medical Boards (FSMB).

The FSMB has been a strong proponent of the Compact and a variety of other initiatives to facilitate medical license portability and to reduce administrative and regulatory redundancies associated with multi-state practice and telemedicine.

States that have enacted the Compact include Alabama, Arizona, Colorado, Idaho, Illinois, Iowa, Kansas, Minnesota, Mississippi, Montana, Nevada, New Hampshire, South Dakota, Utah, West Virginia, Wisconsin and Wyoming.

For more information about the Interstate Medical Licensure Compact, please visit http://licenseportability.org/.

To read the Interstate Medical Licensure Compact legislation, click here.

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About the Federation of State Medical Boards: The Federation of State Medical Boards is a national non-profit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. FSMB leads by promoting excellence in medical practice, licensure and regulation as the national resource and voice on behalf of state medical boards in their protection of the public. To learn more about FSMB, visit: www.fsmb.org/
You can also follow FSMB on Twitter (@theFSMB and @FSMBPolicy).

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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.

 Continued from front page

This serves as a signal - a key administrative area that will be looked at during the audits is the adequacy of policies and procedures. Therefore, the number of administrative and security violations could increase significantly.

Key areas of risk

A good place for practices to start is to look at the findings from Phase 1, as well as recent penalties that were assessed by HHS for HIPAA violations. Violations occurred in the administrative, technical and physical realms. Primarily, policies and procedures were found to be inadequate; encryption of USB drives, laptops and email was found to be lacking; and inadequate employee security awareness and training were some of the major areas of vulnerability.

Suggestions to mitigate adverse findings

The most prudent approach is to be prepared ahead of time, much like an IRS or Joint Commission audit. Whatever aspect of HIPAA compliance an organization is addressing, a good vantage point from which to start is the patient information. Every action should take into account the confidentiality, integrity and availability of the information. The way to make employees and contractors aware is through training, while the required way to hold business associates and subcontractors accountable is through the contractual obligations in a business associate agreement (BAA). Moreover, an annual risk assessment is a must. And, the HHS website is the ideal place to find explanations of what is set out in the laws and regulations.

Here are some tips to make sure that the practice is HIPAA compliant and avoid an adverse audit outcome:

1. Begin compliance efforts from the vantage point of the government, who may "review pertinent policies, procedures, or practices of the covered entity or business associate and of the circumstances regarding any alleged violation";

2. Read Section 164.316 for what is required in relation to policies and procedures from an administrative, technical and physical aspect;

3. Curtail policies and procedures to your individual practice;

4. Know where the external and internal sources of protected health information are located;

5. Encrypt everything both at rest and in transit and make sure that the level of encryption utilized is adequate;

6. Train employees - Trustwave is a reputable vendor that has online training or various organizations offer live courses;

7. Perform due diligence on various third-party risk assessors for expertise, price and quality. OCR audits and HIPAA compliance should not be taken lightly. RAC audits also started with a pilot program more than a decade ago and now generate a substantial amount of revenue for the government, as well as serving as a check on providers' claims submissions. Those submissions, by the way, are also required to be HIPAA-compliant.

Conclusion

The overall goal of the Phase 2 audits is to raise awareness and provide the opportunity for entities to correct their practices surrounding the creation, receipt, transmission and maintenance of protected health information.

'Article originally appeared in February 25, 2016 edition of medicaleconomics.modernmedicine.com and reprinted with permission of author'

US Department of Health and Human Services - HIPAA Audit Protocol
http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/protocol/

Rachel V. Rose, JD, MBA is the founder of Rachel V. Rose – Attorney at Law, PLLC, Houston, TX (rvrose@rvrose.com). She advises on a variety of health care and securities law issues including HIPAA/The HITECH Act, Dodd-Frank and compliance. She is the Policy Liaison for the American Bar Association's Fraud and Compliance IG and the Chair of the Federal Bar Association's Corporate and Association's Counsel Division. Ms. Rose is an affiliated member of Baylor College of Medicine's Center for Medical Ethics and Health Policy, where she teaches bioethics. She has also co-authored two books, including '*What Are International HIPAA Considerations?*'

Physician Suicide – Words Matter
'Let's Tell the Truth'

Guest Author: Pamela Wible, MD

A euphemism is a vague and indirect expression substituted for a fact to avoid something unpleasant or embarrassing.

Each year more than one million Americans lose their doctors to suicide. Across the country, our doctors are jumping from hospital rooftops, overdosing in call rooms, found hanging in hospital chapels. It's medicine's dirty secret. And it's covered up by our hospitals, clinics, and medical schools—often with euphemisms.

That's not science. It's deception.

Though suicides may be investigated, we rarely learn the truth. No follow-up articles. Autopsy reports never revealed. So how can we solve a medical condition that's actively hidden by our own medical institutions? We can't.

To date, I've compiled 265 cases of physician and medical student suicides. Here's how some suicides are actually reported by medicine and the media to the public:

Euphemisms to cover up doctor suicides

- Doctor passed away unexpectedly in his sleep.
- Doctor found dead in hospital. Declared non-suspicious.
- Doctor's death an inconvenience for patients.
- His light went out too soon.
- Medical student passed into eternity.
- Doctor found dead on interstate. No foul play.
- Doctor died by "accidental overdose." (unlikely - doctors dose drugs for a living.)
- Doctor died suddenly.
- She passed away peacefully at home.
- He went to be with the Lord.

Words matter. When we hide the truth, we prevent the collection of data and the implementation of strategies to prevent suicides. Hiding behind misleading phrases that obscure diagnoses will never prevent suicide. So what can we all do now?

Here's an idea – Let's tell the truth

December 9, 2015
Dear Pamela,

I am an anesthesiologist in the U.K. I have struggled with my own mental health issues, including suicidal thoughts ten years ago. I have been greatly helped by the London-based practitioners health programme.

My hospital has once again had a trainee suicide last week, and of course there were "no signs" that he was struggling. Nice guy, worked Monday anesthetising gynae patients. Found dead at home Wednesday. Only in his early thirties. The work email used euphemisms like "sadly found dead at home." Who do these euphemisms protect?

Sylvia

September 18, 2015
Dear Pamela,

I just lost another colleague today. He is the second one in two months. He didn't show up to work and was found dead on his couch. It was obvious he was sickly for months, but he just kept going. I don't know if the autopsy will find suicide or cancer or something else. Either way if it was suicide by drugs or suicide by self-neglect, I'm tired of losing people and scared of being the next victim of this epidemic. What is there to do?

Mary

September 18, 2015
Dear Mary,
What do you think would help you?

Pamela

September 18, 2015
Dear Pamela,
I do not know what would help. Taking care of the sick is hard enough without all the administration and profit-motive pressures from the outside world. I've seen people harden themselves, but lose empathy for the humans we care for. The only thing that I can think of to help myself is to pay off my loans, my mortgage, and create a decent college fund for my kid – then *get out of* the world of medicine.

Mary

February 23, 2015
Dear Pamela,
I just lost another colleague and friend to suicide two weeks ago. As he was an anesthesiologist and I am an obstetrician, I saw him every day and no clue that he was in such a state of despair. How can we recognize others in trouble?

Thanks!
Elizabeth

February 23, 2015
Dear Elizabeth,
Suicide among physicians and medical students is unique when compared to the general population. I spoke recently with two retired police officers, parents of a physician friend. They've walked into numerous suicide scenes. They tell me that most people in the general population do not leave suicide notes and usually have behavior changes that worry friends and family in the time leading up to their suicides.

Physicians are typically high-functioning until their last breath. They're performing complex surgeries just hours before dying by suicide. Physicians also are very good at documenting and leaving notes. These suicide notes should be studied for common themes. Who is doing this? I'm analyzing every letter I receive and I strongly believe that nearly all of these suicides are preventable if we simply start taking appropriate action to remove the threats to doctors' lives. **The instructions are in their letters!**

If you encounter a suspicious death or suicide by a colleague, please don't sweep it under the rug. Hold a morbidity and mortality conference (as you would for a suspicious death in a patient) to investigate what it is that you and your medical institution can do to prevent the next tragedy. Suicide is preventable.

So how can we recognize those in trouble? Pay attention to even minor behavior changes and any and all complaints from physicians. A doctor who says, "I had a rough day" may actually be crying out for help. Befriend one another – especially male physicians. My informal collection of hundreds of completed suicide cases reveals that for every suicided female med student/physician, we lose seven males. Men do not generally ask for help. Anesthesiologists are high risk. Hug all male anesthesiologists!

We need a medical culture that supports our emotional health, that normalizes our need for comfort and non-punitive help when we're in pain. Until then, please reach out to each other. Maybe a buddy system. Don't allow doctors to isolate.

Pamela

What you can do now:

1) Read *Physician Suicide Letters—Answered*. Share with your colleagues.
2) View and share TEDMED talk - *Why Doctors Kill Themselves*.
3) DO NO HARM Documentary film by Robyn Symon — Kickstarter.
4) Make physician wellness a priority in your organization. Need help? Contact me.

Pamela Wible, MD, is the founder of the Ideal Medical Care Movement and was named one of the 2015 Women Leaders in Medicine by the American Medical Student Association for her pioneering contributions to medical student and physician suicide prevention. She has been interviewed by CNN, ABC, CBS, and is a frequent guest on NPR. Dr. Wible lives in Eugene, Oregon, where she loves caring for patients as a solo family physician in a clinic designed entirely by her community. Contact Dr. Wible: http://www.idealmedicalcare.org/contact.php Website: www.idealmedicalcare.org

Rates of Nonmedical Prescription Opioid Use and Opioid Use Disorder Double in 10 Years

Almost 10 million U.S. adults report misusing prescription opioids in 2012-2013.

Nonmedical use of prescription opioids more than doubled among adults in the United States from 2001-2002 to 2012-2013, based on a study from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), part of the National Institutes of Health. Nearly 10 million Americans, or 4.1 percent of the adult population, used opioid medications in 2012-2013, a class of drugs that includes OxyContin and Vicodin, without a prescription or not as prescribed (in greater amounts, more often, or longer than prescribed) in the past year. This is up from 1.8 percent of the adult population in 2001-2002.

More than 11 percent of Americans report nonmedical use of prescription opioids at some point in their lives, a considerable increase from 4.7 percent ten years prior.

The number of people who meet the criteria for prescription opioid addiction has substantially increased during this time frame as well, with 2.1 million adults (0.9 percent of the U.S. adult population) reporting symptoms of "nonmedical prescription opioid use disorder (NMPOUD)," according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

"The increasing misuse of prescription opioid pain relievers poses a myriad of serious public health consequences," said Nora D. Volkow, MD, director of the National Institute on Drug Abuse (NIDA), which contributed funding for the study. "These include increases in opioid use disorders and related fatalities from overdoses, as well as the rising incidence of newborns who experience neonatal abstinence syndrome. In some instances, prescription opioid misuse can progress to intravenous heroin use with consequent increases in risk for HIV, hepatitis C and other infections among individuals sharing needles."

Scientists analyzed data from NIAAA's National Epidemiologic Survey on Alcohol and Related Conditions-III (NESARC-III), ongoing research that examines alcohol and drug use disorders among the U.S. population, as well as associated mental health conditions.

The study appears online in the Journal of Clinical Psychiatry.

Prescription opioid misuse is an urgent public health problem, with drug poisoning deaths involving opioid analgesics, which includes both prescription and illicit opioids, quadrupling between 1999 and 2014, according to the Centers for Disease Control and Prevention. Emergency department visits increased by 153 percent from 2004 to 2011, based on data from the Substance Abuse and Mental Health Services Administration's Drug Abuse Warning Network.

"Given the dramatic increase in nonmedical use of prescription opioids, it is important that clinicians and patients also recognize the potent interaction of opioids with alcohol and other sedative-hypnotic drugs – an interaction that can be lethal," said NIAAA Director George F. Koob, PhD.

People who develop alcohol use disorder at some point in their lives are nearly twice as likely to also develop opioid use disorder, based on NESARC-III data.

Similar to other substance use disorders, prescription opioid use disorder includes symptoms such as:

- taking the drug in larger amounts or over a longer period than was intended
- the persistent desire to cut down or control use/unsuccessful efforts to do so
- failure to fulfill major role obligations at work, school or home as a result of prescription opioid use
- symptoms of tolerance and/or withdrawal

 Continued from page 6

Rates of nonmedical prescription opioid use were greatest among men, those with annual incomes less than $70,000, those previously married, and with a high school-level education or less. Use was greater among whites and Native Americans and those living in the Midwest and West.

Study results also show that few people misusing prescription opioids receive treatment. Based on NESARC-III data, only about 5 percent of people misusing prescription opioids in the past year and 17 percent of those with prescription opioid use disorder ever receive help. Evidence-based treatment options for addiction to prescription opioids include medications and behavioral counseling approaches.

"The national data from NESARC-III substantially advances what we know about prevalence, co-occurring disorders and treatment rates," said Senior Author Bridget Grant, PhD, Chief of the NIAAA Laboratory of Epidemiology and Biometry. "Prior to this analysis, there was a lack of current epidemiologic data on nonmedical prescription opioid use and prescription opioid use disorder using DSM-5 criteria."

Based on the 2012-2013 NESARC-III data, 2.1 percent of U.S. adults (4.8 million) have [ever] had prescription opioid use disorder in their lifetime and 0.9 percent had this disorder in the past year, according to DSM-5 criteria. This compares to 1.4 percent lifetime and 0.4 percent past year rates in 2001-2002, with slightly different criteria under the DSM-IV. Rates for 2012-2013, NESARC-III using DSM-IV criteria were 2.9 percent and 0.8 percent, respectively.

Overall, the study found that nonmedical prescription opioid use among U.S. adults has increased by 161 percent from 2001-2002 to 2012-2013 while prescription opioid use disorder has increased by 125 percent. The authors suggest that this may be due in part to anincrease in opioid prescribing and dosage, lessened perception of risk because of its legality, and lack of understanding of addictive potential.

"The increasing misuse of prescription opioid pain relievers poses a myriad of serious public health consequences."
- Nora D. Volkow, MD, Director, NIDA

The researchers found that nonmedical prescription opioid use and prescription opioid use disorder are linked to other drug use disorders and a variety of mental health disorders, including posttraumatic stress disorder, and borderline, schizotypal, and antisocial personality disorders. Persistent depression and major depressive disorder are linked to nonmedical prescription opioid use, while bipolar I disorder is linked to prescription opioid use disorder.

The National Institute on Alcohol Abuse and Alcoholism, part of the National Institutes of Health, is the primary U.S. agency for conducting and supporting research on the causes, consequences, prevention and treatment of alcohol abuse, alcoholism, and alcohol problems. NIAAA also disseminates research findings to general, professional and academic audiences. Additional alcohol research information and publications are available at: http://www.niaaa.nih.gov.

The National Institute on Drug Abuse is a component of the National Institutes of Health, U.S. Department of Health and Human Services. NIDA supports most of the world's research on the health aspects of drug use and addiction. The Institute carries out a large variety of programs to inform policy, improve practice, and advance addiction science. Fact sheets on the health effects of drugs and information on NIDA research and other activities can be found at www.drugabuse.gov, which is now compatible with your smartphone, iPad or tablet. To order publications in English or Spanish, call NIDA's DrugPubs Research Dissemination Center at 1-877-NIDA-NIH or 240-645-0228 (TDD) or email requests to drugpubs@nida.nih.gov (link sends e-mail)*. Online ordering is available at drugpubs.drugabuse.gov. NIDA's media guide can be found at www.drugabuse.gov/publications/media-guide/dear-journalist, and its easy-to-read website can be found at www.easyread.drugabuse.gov. You can follow NIDA on Twitter (link is external) and Facebook (link is external).*

About the National Institutes of Health (NIH): NIH, the nation's medical research agency, includes 27 institutes and centers and is a component of the U.S. Department of Health and Human Services. NIH is the primary federal agency conducting and supporting basic, clinical and translational medical research, and is investigating the causes, treatments and cures for both common and rare diseases. For more information about NIH and its programs, visit www.nih.gov.

SB459 and the Impact on Nevada Prescribers

By: Yenh Long, Program Administrator for the Nevada PMP

The United States contains 4.6% of the world's population, yet it consumes 80% of the world's supply of opioids and 99% of the world's supply of hydrocodone.[1] According to the CDC, the quantity of prescription pain medications sold nationally quadrupled from 1999 to 2010.[2] This steep increase in controlled substance use has been accompanied by an increase in overdose deaths. In 2013, Nevada had the fourth highest rate of drug overdose deaths in the U.S. with 20.7 deaths per 100,000 people, an increase of 80% from 1999.[3] Faced with this epidemic of prescription drug abuse; Nevada policymakers have taken steps to decrease controlled substance misuse, abuse and overdoses/deaths.

The Nevada Prescription Monitoring Program (PMP) is one of the first tools to provide prescribers and dispensers with insight into their patients' prescription controlled substance use history. Use of the PMP is now mandatory under Senate Bill (SB) 459, which was signed into law by Governor Brian Sandoval in May 2015, with the goal of reducing controlled substance misuse, abuse, and overdoses/deaths. Effective October 1, 2015, this bill addresses three primary topics: (1) the mandatory use of the Nevada PMP by prescribers, (2) the Good Samaritan Drug Overdose Act (GSDOA), and (3) next-day reporting to the PMP database.

Firstly, SB 459 requires prescribers to obtain and review a patient's controlled substance history report (from the PMP) to assess whether a controlled substance is medically necessary before prescribing it to a new patient, or to an existing patient if the prescription is for more than seven days and is part of a new course of treatment. This bill does not affect ongoing courses of treatments for established patients, nor does it apply to in-patient chart orders. Prescribers who fail to comply may be subject to professional discipline if their licensing board determines the violation is intentional. SB459 also states that individual licensing boards may require all of their respective prescribers to complete at least 1 hour of training relating to the misuse and abuse of controlled substances during each biennial controlled substance licensing period.

The second area of emphasis is the Good Samaritan Drug Overdose Act. This statute allows for licensed prescribers to prescribe and dispense an opioid antagonist to a patient's friend, family member, or to a person that could assist another person at risk for an opioid drug overdose, although this is not mandatory. Prescribers are immune from criminal and civil proceedings directly related to writing or declining to write the prescription. This law also allows persons with a standing order from a prescriber to possess and dispense opioid antagonists without a license from the Board of Pharmacy as long as that person does not receive compensation for their services. Pharmacists may also dispense opioid antagonists without a prescription following standardized procedures, which are currently being written by the Board of Pharmacy.

Lastly, this new law requires pharmacies and dispensing practitioners to report their dispensing to the PMP "not later than the end of the next business day after dispensing a controlled substance." Next-day reporting to the PMP will provide users with more up-to-date patient information. It is crucial that the data submitted to the PMP is as accurate as possible and the Board of Pharmacy will establish administrative penalties for dispensers who fail to report this required information.[4]

These regulatory changes will hopefully help combat the epidemic of controlled substance abuse, overdoses and deaths. We can expect to see changes in the prescribing process of controlled substances, as well as changes regarding our duties as pharmacists in educating and providing the public with opioid antagonists.

References:
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2. Paulozzi L, Jones CM, Mack K, Rudd, RA. Vital signs: overdoses of prescription opioid pain relievers-United States, 1999-2008. MMWR. November 2011;60(43):1487-92.
3. Prescription drug abuse: strategies to stop the epidemic [Internet]. Trust for America's Health; 2013 October [cited 2015 November 22]. Available at: http://healthyamericans.org/reports/drugabuse2013/release.php?stateid=NV
4. SB459 (As Enrolled). Reg. Sess. 2015. Available at: https://www.leg.state.nv.us/App/NELIS/REL/78th2015/Bill/2161/Text

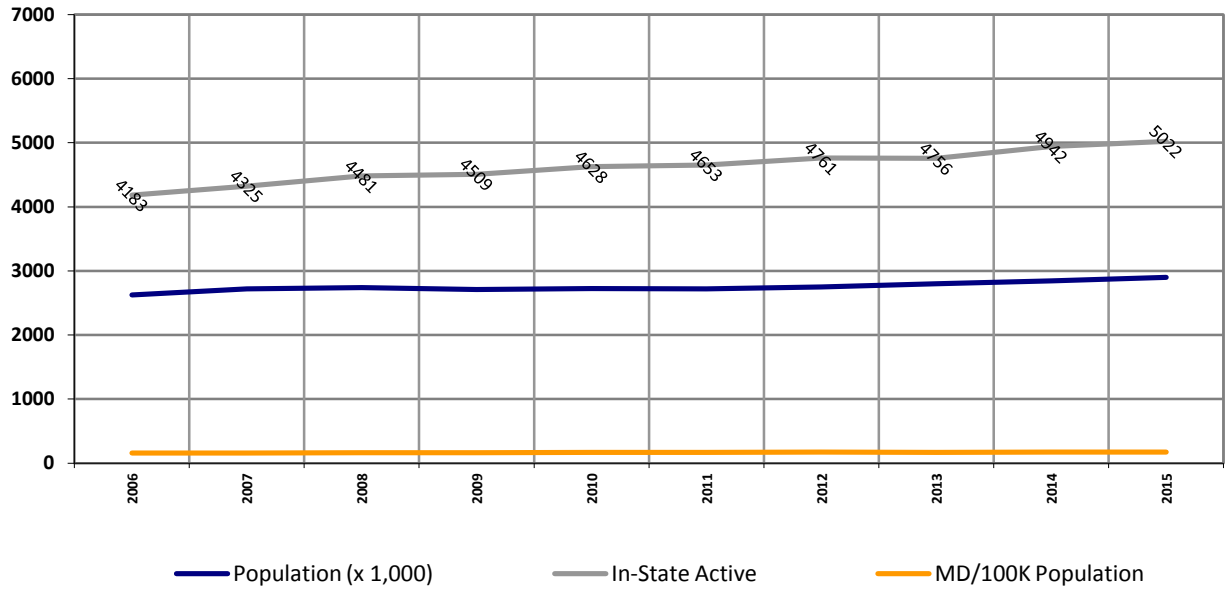
2015 ANNUAL REPORT HIGHLIGHTS

The Board licenses physicians, physician assistants, respiratory therapists and perfusionists. In 2015, the Board issued the following new licenses:

Practice	
Physicians	593
Physician Assistants	112
Respiratory Therapists	149
Perfusionists	10

In 2015, the ratio of physicians to 100,000 population* decreased slightly over the previous year. The following graph shows the growth of the state's population (measured in thousands so that the trend line will fit on the graph, and last reported at 2,897,584), the state's active, in-state physician population (in absolute numbers), and the ratio of physicians to population (measured as physicians per 100,000 population). From 2005 through 2007, the ratio averaged between 159 and 161 physicians per 100,000. From 2008 through 2012, the ratio increased, averaging between 164 and 173. In 2013, the ratio was 170; in 2014, the ratio increased to 174; and in 2015, the ratio decreased to 173.

Comparison of Population With In-State, Active Physicians



*Population statistics provided by the Nevada State Demographer, Nevada Department of Taxation.

The physician licensure for active, in-state physicians increased by 1.6% in 2015. The following table is a county-by-county breakdown of physician licenses for the last ten years. In 2015, Carson City, Clark, Elko, Lander, Mineral, Pershing and Washoe Counties showed growth in their physician populations; Churchill, Douglas, Lyon and Nye Counties showed decreases; and the remaining six counties remained static in their physician populations.

Physician Licensure Counts (2006-2015)

County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Carson City	144	140	142	143	151	158	152	164	168	171
Churchill	22	21	23	22	20	22	23	27	29	24
Clark	2850	2949	3060	3086	3186	3207	3305	3277	3403	3460
Douglas	82	93	97	85	84	87	89	80	86	79
Elko	41	41	46	45	46	48	41	40	40	43
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	1	1	1	1	0	0	1	0	0	0
Humboldt	7	9	9	10	9	10	11	12	11	11
Lander	2	2	2	3	3	2	2	2	2	3
Lincoln	1	1	2	2	2	2	2	2	2	2
Lyon	13	13	11	14	13	15	16	15	16	12
Mineral	5	6	5	6	6	5	6	5	5	6
Nye	18	19	17	16	15	16	14	13	16	15
Pershing	3	2	2	2	3	2	1	0	0	1
Storey	1	0	0	0	0	0	0	0	0	0
Washoe	981	1017	1056	1064	1081	1069	1088	1110	1155	1186
White Pine	12	11	8	10	9	10	10	9	9	9
In-State Active Status	**4183**	**4325**	**4481**	**4509**	**4628**	**4653**	**4761**	**4756**	**4942**	**5022**
Out-of-State Active Status	1388	1309	1655	1577	1888	1757	2084	1868	2251	2116
TOTAL ACTIVE STATUS	**5571**	**5634**	**6136**	**6086**	**6516**	**6410**	**6845**	**6624**	**7193**	**7138**
Inactive & Retired Statuses	834	776	760	781	770	758	748	818	801	806
TOTAL LICENSED (Active, Inactive & Retired Statuses)	**6405**	**6410**	**6896**	**6867**	**7286**	**7168**	**7593**	**7442**	**7994**	**7944**

The number of physician assistants increased by 7.6% in 2015. The locale of physician assistants trends similarly to the locale of physicians statewide, as is shown on the following table. In 2015, there was growth in Clark, Elko, Eureka, Humboldt, Lyon, Nye and Washoe Counties; Carson City, Douglas and Storey Counties showed decreases; and the remaining seven counties remained static.

Physician Assistant Licensure Counts (2006-2015)

County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Carson City	14	15	15	14	13	16	17	14	18	17
Churchill	3	6	7	6	4	6	9	10	9	9
Clark	262	271	307	310	332	342	386	398	452	479
Douglas	10	15	15	10	11	9	12	16	17	15
Elko	7	7	6	5	5	5	7	9	10	13
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	1	1	1	1	1	1	1	1	0	1
Humboldt	1	1	1	0	0	0	0	0	0	1
Lander	1	1	1	1	0	1	2	1	1	1
Lincoln	2	3	2	3	3	3	3	3	3	3
Lyon	4	2	4	5	6	6	4	5	6	7
Mineral	1	1	1	1	1	2	2	3	3	3
Nye	10	6	10	6	7	4	4	2	2	5
Pershing	0	0	0	0	0	0	0	0	0	0
Storey	1	1	1	1	1	1	1	2	2	1
Washoe	71	76	83	82	91	91	104	109	121	138
White Pine	1	1	1	1	1	1	1	1	1	1
TOTAL ACTIVE STATUS	**389**	**407**	**455**	**446**	**476**	**488**	**553**	**574**	**645**	**694**

The number of respiratory therapists decreased slightly by 0.6% in 2015. In 2015, there was growth in Churchill, Clark, Elko and Eureka Counties; Carson City, Douglas, Humboldt, Lyon, Nye and Washoe Counties showed decreases; and the remaining seven counties remained static.

Respiratory Therapist Licensure Counts (2006-2015)

County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Carson City	10	9	10	12	12	12	13	12	13	11
Churchill	9	8	8	5	5	4	5	4	4	5
Clark	640	655	743	798	880	920	1006	982	1069	1079
Douglas	14	16	18	20	20	18	15	16	16	13
Elko	10	7	7	5	6	8	9	7	8	9
Esmeralda	0	0	0	0	0	0	0	0	0	0
Eureka	0	0	0	0	0	0	0	0	0	1
Humboldt	3	5	5	4	4	5	5	4	4	2
Lander	2	2	3	1	1	1	1	2	2	2
Lincoln	2	2	2	0	0	0	0	0	0	0
Lyon	19	19	20	16	18	15	16	15	16	15
Mineral	2	2	3	3	3	2	2	2	2	2
Nye	10	11	8	10	11	13	12	13	15	13
Pershing	0	0	0	0	0	0	0	0	0	0
Storey	1	0	1	0	0	0	0	0	0	0
Washoe	153	154	163	160	176	192	197	186	202	191
White Pine	3	2	2	3	4	3	3	3	3	3
TOTAL ACTIVE STATUS	**878**	**892**	**993**	**1037**	**1140**	**1193**	**1284**	**1246**	**1354**	**1346**

The number of perfusionists decreased significantly by 17.2% in 2015 – those decreases being in Carson City, Clark and Washoe Counties, with all other counties remaining static.

Perfusionist Licensure Counts (2010-2015)*

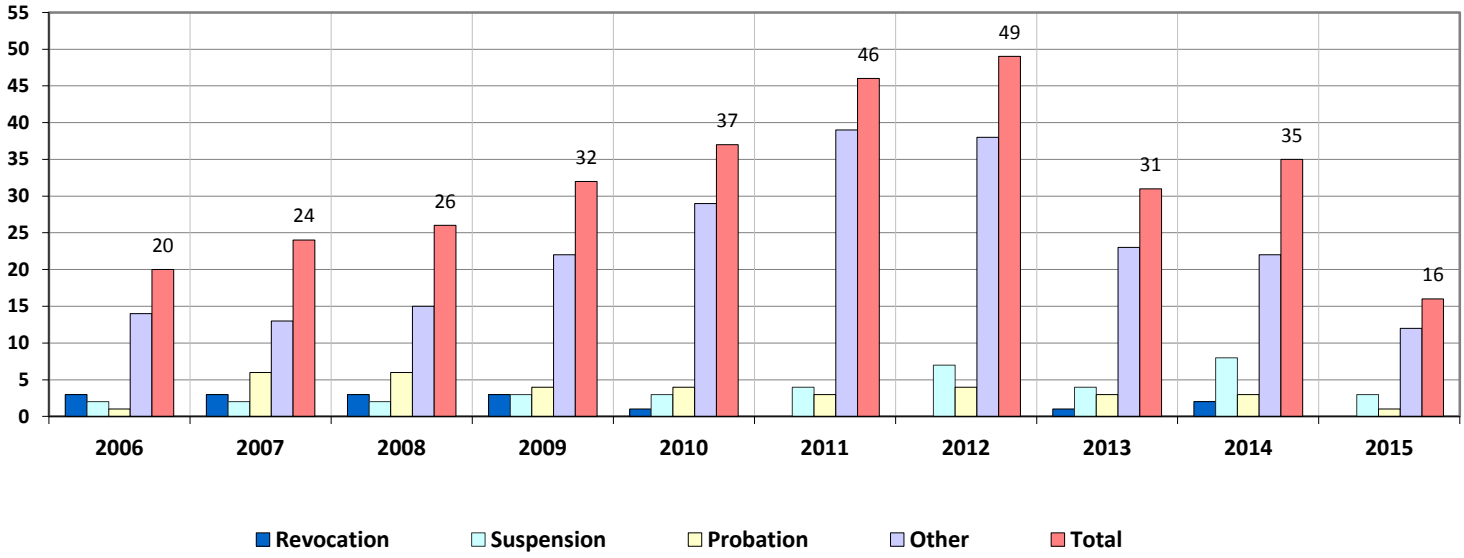
County	2010	2011	2012	2013	2014	2015
Carson City	1	1	1	1	1	0
Churchill	0	0	0	0	0	0
Clark	20	19	25	20	23	20
Douglas	0	0	0	0	0	0
Elko	0	0	0	0	0	0
Esmeralda	0	0	0	0	0	0
Eureka	0	0	0	0	0	0
Humboldt	0	0	0	0	0	0
Lander	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0
Lyon	0	0	0	0	0	0
Mineral	0	0	0	0	0	0
Nye	0	0	0	0	0	0
Pershing	0	0	0	0	0	0
Storey	0	0	0	0	0	0
Washoe	5	5	5	4	5	4
White Pine	0	0	0	0	0	0
TOTAL ACTIVE STATUS	**26**	**25**	**31**	**25**	**29**	**24**

*In 2009, the Nevada State Legislature passed legislation requiring that all perfusionists must be licensed. No perfusionists were licensed by the Board prior to 2010.

COMPLAINTS, INVESTIGATIONS AND DISCIPLINE

In 2015, the Board opened 689 investigations, closed 304 investigations (many of which, of course, originated in preceding years) and imposed 16 disciplinary actions against physicians. The graph below shows the number and types of discipline imposed by the Board regarding physicians for the last ten years.

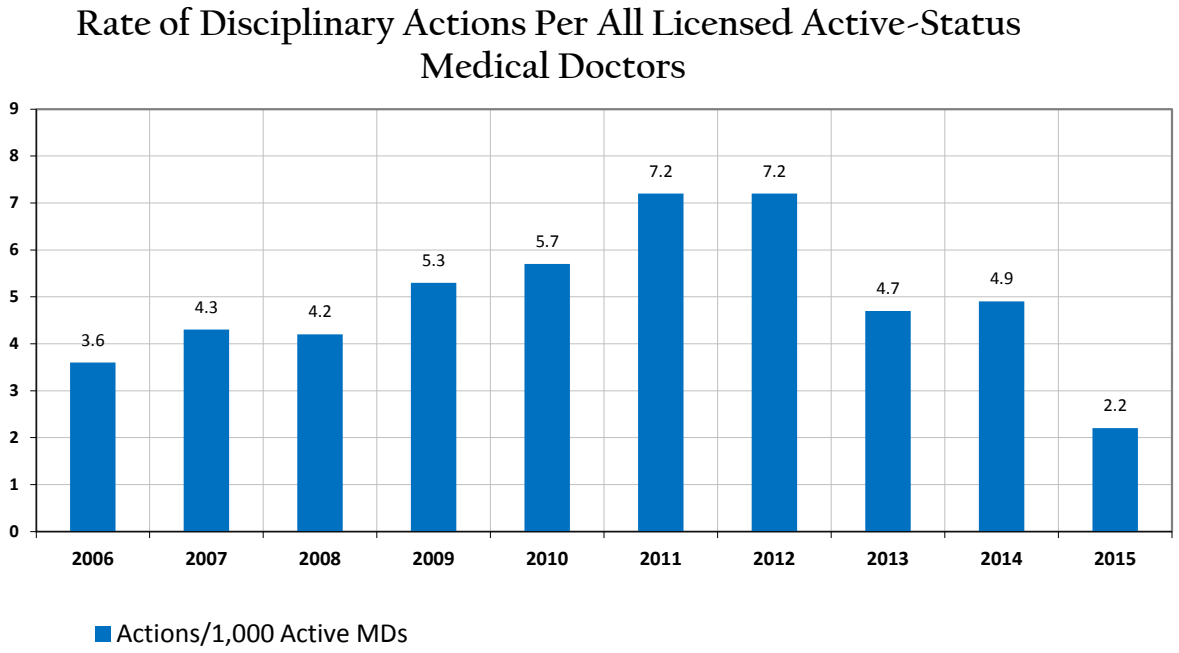
Disciplinary Actions Taken Against Medical Doctors*



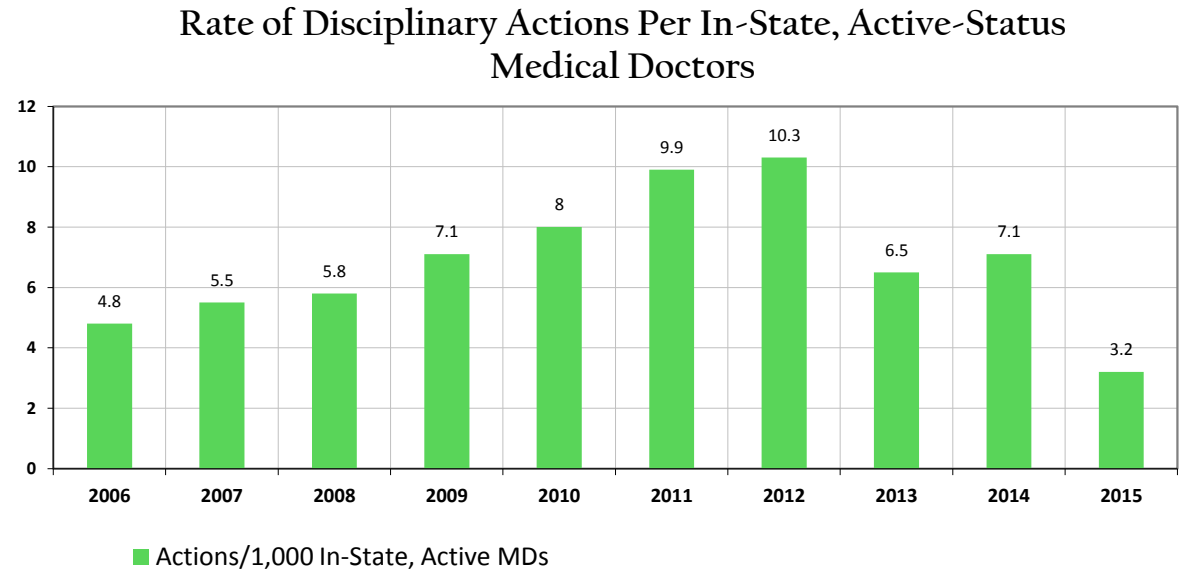
Note: "Other" actions include: Voluntary Surrender of License While Under Investigation, License Restriction, Public Reprimand, Licensure Denial, CME Ordered, Fine, Drug or Alcohol Treatment Program Ordered, and Competency Exam Ordered.

*Any discrepancy in these numbers from a report published by any other source is due to: (1) differences in verbiage or categorization; or (2) differences in the number of actions taken per practitioner.

The graph below shows the rate of disciplinary actions taken by the Board per 1,000 active-status licensed physicians for the last ten years.



The graph below shows the rate of disciplinary actions taken by the Board per 1,000 in-state, active-status licensed physicians for the last ten years.



FSMB House of Delegates Approves New Policy Guidelines for State Medical Regulators

Washington, D.C. – At its recent Annual Meeting, held in San Diego April 28-30, the Federation of State Medical Boards (FSMB) House of Delegates adopted new position statements and policy on issues impacting the regulation of medical practice in the United States.

Practice Drift

To address problems caused when physicians offer patients treatments that fall outside of those typically recognized within their area of practice, the FSMB adopted a new position statement on "practice drift." The policy reminds physicians of their responsibility to consider the patient's best interests in developing treatment options and to offer only treatments that they are capable of providing competently. The position statement also encourages state medical boards to take steps to prevent harm from practice drift. View the Position Statement.

Duty to Report

The FSMB outlined several responsibilities on the parts of physicians, hospitals and health organizations, insurers and the public to provide reports to state medical boards of relevant information about medical care to ensure they have all information needed to effectively engage in patient protection. The position statement encourages the reporting of information in categories such as patient safety, physician impairment and professional misconduct. View the Position Statement.

Sale of Goods by Physicians and Physician Advertising

The FSMB reminded physicians that in choosing to make health-related and non-health-related goods available to patients, they must be mindful of the inherent power differential that characterizes the physician-patient relationship and therefore guard against any possibility of exploitation of patients. Physicians should take care to avoid conflicts of interest and excessive markups in selling goods and should provide full informational disclosures and freedom of choice when offering patients goods directly. Physicians should also refrain from deceptive or misleading advertising of goods. View the Position Statement.

Model Guidelines for the Recommendation of Marijuana in Patient Care

The FSMB adopted guidelines that set forth standards for physicians choosing to incorporate the recommendation of marijuana in patient care and management. The guidelines address patient evaluation, informed and shared decision making, the creation of treatment plans, record-keeping, and consultation and referral. View the Model Guidelines.

In a separate action, the FSMB also addressed physician use of marijuana, formally adding marijuana to its list of substances that may impair the ability of practicing physicians.

Advocacy Efforts in Response to Antitrust Concerns of State Medical Boards

The FSMB also adopted a resolution calling for advocacy against the expanded application of antitrust principles that may compromise patient safety. The resolution also called for the FSMB to assist state boards facing litigation alleging antitrust violations. The action was taken in the wake of the U.S. Supreme Court's decision in the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* case.

These position statements and policy as well as all official FSMB policies are available on the FSMB website at: www.fsmb.org/policy/advocacy-policy/policy-documents.

Contact: Drew Carlson, (817) 868-4043 dcarlson@fsmb.org www.fsmb.org

The Federation of State Medical Boards (FSMB) is a national non-profit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. The FSMB serves as the voice for state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices. To learn more about FSMB, visit www.fsmb.org. You can also follow FSMB on Twitter (@theFSMB and @FSMBPolicy).

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
http://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

FOOTE, Ronald H., M.D. (9240)
Las Vegas, Nevada

Summary: Alleged willful failure to comply with an order of the Board.

Charges: One violation of NRS 630.3065(2)(a) [willful failure to comply with an order of the Board]; one violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute].

Disposition: On June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Foote violated NRS 630.3065(2)(a), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) suspension of license for 2 years, effective May 30, 2014, with credit for serving 2 years of the suspension pursuant to the Stipulation for Indefinite Summary Suspension which was ordered on May 30, 2014, and therefore this 2-year suspension shall conclude and be lifted effective 5 p.m., PDT, on June 3, 2016; (2) public reprimand; (3) continuation of all recovery and monitoring activities with the Nevada Professionals Assistance Program for at least the next 5 years; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter; (5) upon the lifting of the summary suspension, Dr. Foote agrees to the following limitations on his practice: (a) he will only be permitted to treat female patients when he has a verifiable chaperone present to observe his treatment and interactions with female patients and the chaperone's name is to be documented within each medical record; (b) he will obtain therapy with a certified sex addiction therapist, or equivalent, on at least a monthly basis; and (c) the Board may monitor Limitation No. 2 for at least 1 year. After 1 year, Dr. Foote may petition the Board to lift the foregoing 3 limitations on his license.

HALL, Wesley W., M.D. (2416)
Reno, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records related to Dr. Hall'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 June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Hall violated NRS 630.301(4), as set forth in Count II of the Complaint, and imposed the following discipline against him: (1) 6 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. Count I of the Complaint was dismissed with prejudice.

HOEPFNER, Mark T., M.D. (5680)
Las Vegas, Nevada

Summary: Alleged malpractice related to Dr. Hoepfner's treatment of a patient.

Charges: One violation of NRS 630.301(4) [malpractice].

Disposition: On June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Hoepfner violated NRS 630.301(4), as set forth in the Complaint, and imposed the following discipline against him: (1) 6 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.

KUTHURU, Mahesh R., M.D. (12101)
Las Vegas, Nevada

Summary/Charges: On March 25, 2014, the Board's Investigative Committee summarily suspended Dr. Kuthuru's license based upon actions taken against Dr. Kuthuru by other entities and pursuant to NRS 630.326(1). On July 9, 2014, the Board's Investigative Committee filed a Complaint against Dr. Kuthuru alleging 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] and one violation of NRS 630.306(16) [engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by Board].

Disposition: On June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Kuthuru violated NRS 630.301(1) [conviction of a felony relating to the practice of medicine or the ability to practice medicine], and imposed the following discipline against him: (1) revocation of license, effective June 3, 2016, pursuant to various terms and conditions; (2) Dr. Kuthuru waives any right to seek judicial review (state or federal) to reinstate his revoked license pending his release from imprisonment; (3) public reprimand; (4) following his release from imprisonment, Dr. Kuthuru may petition the Board to reinstate his license, pursuant to various terms and conditions, including reimbursement of the Board's fees and costs of investigation and prosecution of the matter prior to petitioning the Board for reinstatement of his license. In the event the Board reinstates Dr. Kuthuru's license, Dr. Kuthuru shall be placed on probation for a period of 3 years with an obligation to comply with the terms and conditions of his parole and probation related to the case of *United States of America v. Mahesh Kuthuru, MD*, United States District Court, Northern District of New York, Case Nos. 5:14-cr-00018-002 and 5:15-cr-00015-001. Upon receipt of written notice of Dr. Kuthuru's completion of his federal probation and upon Dr. Kuthuru's completion of 3 years of probation with the Board, the Board shall reinstate Dr. Kuthuru's licensure status to active.

LONG, Deanne, M.D. (14790)
Salt Lake City, Utah

Summary: Disciplinary action taken against Dr. Long's medical license in Utah.

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

Disposition: On June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Long violated 630.301(3), as set forth in the Complaint, and imposed the following discipline against her: (1) revocation of license, with the revocation stayed and Dr. Long being placed on probation for a period of 46 months, subject to various terms and conditions; (2) Dr. Long may petition the Board before the probationary period has expired to request that the terms of the Agreement be modified or that the probationary period be terminated before the probationary period expires; (3) public reprimand; (4) 6 hours of CME, in addition to any CME requirements regularly

Continued from page 16

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 matter.

REGALADO, Maria Corazon O., M.D. (8966)
Las Vegas, Nevada

Summary: Alleged leaving signed blank prescription forms for her APRNs to use while she was away from the office.

Charges: One violation of NRS 630.304(4) [signing a blank prescription form].

Disposition: On June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Regalado violated NRS 630.304(4), as set forth in the Complaint, and imposed the following discipline against her: (1) public reprimand; (2) 6 hours of CME, in addition to any CME requirements regularly imposed upon her as a condition of licensure in Nevada; (3) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

VAN HORN, John W., M.D. (6295)
Wadsworth, Nevada

Summary: Conviction of criminal offense.

Charges: One violation of NRS 630.301(11)(d) [conviction of sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime]; one violation of NRS 630.301(11)(g) [conviction of any offense involving moral turpitude].

Disposition: On June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Van Horn violated NRS 630.301(11)(d) and NRS 630.301(11)(g), as set forth in the Amended Complaint, and imposed the following discipline against him: (1) revocation of license, with the revocation stayed and Dr. Van Horn being placed on probation for an indeterminate period of time not to exceed 48 months, subject to various terms and conditions; (2) public reprimand; (3) 6 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; (4) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

WELCH, Andrew J., M.D. (3713)
Las Vegas, Nevada

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

Charges: 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 June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Welch violated NRS 630.3062(1) (2 counts), as set forth in the Complaint, and imposed the following discipline against him: (1) 6 hours of CME, in addition to any CME requirements regularly imposed upon him as a condition of licensure in Nevada; and (2) reimbursement of the Board's fees and costs associated with investigation and prosecution of the matter.

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 June 3, 2016, the Board accepted a Settlement Agreement by which it found Dr. Wilcox violated NRS 630.301(9) (2 counts), as set forth in Counts I and II of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) If Dr. Wilcox is sentenced to probation and/or supervised release in the matter of *United States of America v. Simmon Lee Wilcox*, United States District Court, District of Utah, Central Division, Case No. 2:13-cr-00717-TS-PMW, Dr. Wilcox's license to practice medicine shall be suspended for 6 months, with the suspension stayed. Dr. Wilcox will be placed on probation pursuant to the terms and conditions issued by the United States District Court in the foregoing federal court matter. Upon receipt of written notice of Dr. Wilcox's completion of his federal probation and/or supervised release, the Board shall reinstate Dr. Wilcox's licensure status to "active" without restriction. Dr. Wilcox shall reimburse the Board's fees and costs incurred in the investigation and prosecution of its case against him within 90 days of the sentencing in the foregoing federal court matter; (3) If Dr. Wilcox is sentenced to incarceration/custody in the foregoing federal court matter, Dr. Wilcox's license to practice medicine shall be revoked, effective the date he presents to begin his incarceration/custody sentence. Following his release from incarceration/custody, Dr. Wilcox may petition the Board to reinstate his license to practice medicine pursuant to the following terms and conditions: (a) that he reimburse the Board's fees and costs of the investigation and prosecution of its case against him prior to petitioning the Board for reinstatement of his license; (b) that he submit proof of compliance with CME requirements; and (c) that in addition to any additional terms the Board deems appropriate in the event the Board reinstates his license, Dr. Wilcox shall be placed on probation for a period of 1 year and Dr. Wilcox shall comply with the terms and conditions of his parole and probation and/or supervised release which may follow his incarceration/custody period, if any. Upon receipt of written notice of Dr. Wilcox's completion of his federal probation and/or supervised release following his incarceration/custody and upon Dr. Wilcox's completion of 1 year of probation with the Board, the Board shall reinstate Dr. Wilcox's licensure status to "active" without restriction. Dr. Wilcox has 90 days to file an appeal and request a stay of his pending sentence as ordered by the United States District Court. The Board has been informed by Dr. Wilcox's legal counsel for Board-related matters that Dr. Wilcox has, in fact, hired an attorney who specializes in federal appeals. It is anticipated that Dr. Wilcox will file his appeal and request a stay of the pending sentence by mid-August of 2016.

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Public Reprimands Ordered by the Board

June 7, 2016

Ronald Foote, M.D.
c/o L. Kristopher Rath, Esq.
Hutchison & Steffen
10080 West Alta Dr., Ste. 200
Las Vegas, NV 89145

Dr. Foote:

On June 3, 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 14-12899-1 and the allegations in Case Number 15074.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you engaged in conduct that is grounds for discipline pursuant to the MPA, to wit: one (1) count of willful failure to comply with an Order of the Board Pursuant to Nevada Revised Statute 630.3065(2)(a). For this violation, you will have your license to practice medicine suspended for two (2) years, effective May 30, 2014, receiving credit for serving two (2) years of the suspension pursuant to the Stipulation for Indefinite Summary Suspension, which was ordered on May 30, 2014. Accordingly, upon approval of this Agreement by the Board on June 3, 2016, this two (2) year suspension was lifted effective five (5) p.m., Pacific Daylight Time, on June 3, 2016. You shall: 1) be publicly reprimanded; 2) reimburse the fees and costs related to the investigation and prosecution of this matter; and, 3) continue all recovery and monitoring activities with the Nevada Physician Health Program and Dr. Peter Mansky for at least the next five (5) years. After five (5) years, you may petition the Board to lift this requirement.

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

June 7, 2016

Mahesh Kuthuru, M.D.
c/o John Savage, Esq.
John H. Cotton & Associates
7900 W. Sahara, Ste. 200
Las Vegas, NV 89117

Dr. Kuthuru:

On June 3, 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 14-32161-1 and the Order for Summary Suspension.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you en-gaged in conduct that violated the Medical Practice Act, to wit: a conviction of a felony relating to the practice of medicine or the ability to practice medicine which is a violation of Nevada Revised Statute (NRS) 630.301(1), as set forth in the Judgment and as alleged in the Indictment and pursuant to NRS 630.352(4)(e), your license to practice medicine in the state of Nevada shall be revoked, effective June 3, 2016. You shall be publicly reprimanded, which will include language that is synonymous with the terms of the Agreement. Following your release from imprisonment pursuant to the Judgment, you may petition the Board to reinstate your license to practice medicine in the state of Nevada pursuant to the following terms and conditions: (1) Pursuant to NRS 622.400, you shall reimburse the fees and costs related to the investigation and prosecution of this matter and you must pay the reimbursement of fees and costs prior to petitioning the Board for reinstatement of your license to practice medicine in the state of Nevada; (2) you must submit proof that you have complied with the required continuing medical education (CME) requirements while imprisoned; and, you must submit proof that you attended and completed a twenty four (24) hour ethics course entitled "The PBI Professional Boundaries Course" and completion of this course may not be used to fulfill the normal CME requirements regarding ethics.

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

June 7, 2016

Deanne Long, M.D.
c/o Nathan A. Crane, Esq.
10 Exchange Place, 11th Floor
Salt Lake City, UT 84111

Dr. Long:

On June 3, 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 15-40633-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.301(3), by having being disciplined by the Division of Occupational and Professional Licensing of the Department of Commerce of the state of Utah on January 22, 2015.

For this violation, you shall be publicly reprimanded; you shall pay the fees and costs related to the investigation and prosecution of this matter; you shall complete six (6) hours of continuing medical education (CME) and 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.

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

Continued from page 18

June 7, 2016

Maria Regalado, M.D.
3750 S. Jones Blvd., Ste. 110
Las Vegas, NV 89103

Dr. Regalado:

On June 3, 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 15-12597-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.304(4) by leaving signed blank prescription forms when you were out of the country.

For this violation, you shall be publicly reprimanded; you shall pay the fees and costs related to the investigation and prosecution of this matter; and you shall complete six (6) hours of continuing medical education (CME) and 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.

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

June 7, 2016

John Wert Van Horn, M.D.
PO Box 447
Wadsworth, NV 89442

Dr. Van Horn:

On June 3, 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 Amended Complaint filed against you in Case Number 15-9568-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statutes (NRS) 630.301(11)(d) and NRS 630.301(11)(g).

For this violation, you shall by publicly reprimanded; you shall pay the fees and costs related to the investigation and prosecution of this matter; and you shall take six (6) hours of continuing medical education (CME) and the aforementioned hours of CME shall be in addition to any CME requirements that are regularly imposed you upon as a condition of licensure in the state of Nevada.

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

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NEVADA STATE BOARD OF MEDICAL EXAMINERS

1105 Terminal Way, Ste. 301

Reno, NV 89502-2144