NEVADA STATE BOARD OF MEDICAL EXAMINERS

NEWSLETTER

VOLUME 50 ★★★ March 2014

What Physicians Should Consider When Retaining or Disposing of Medical Records

Part One of a Two-Part Series

By: Rachel V. Rose, JD, MBA[A]

Physicians, like patients, are seeing many changes in the practice of medicine. These changes include: Accountable Care Organizations ("ACOs") and other joint venture arrangements and mergers; physicians switching practices; and changes in insurance providers. In light of these macro-considerations, physicians are faced with a multitude of "housekeeping" measures – one of which is the retention and disposal of medical records.

Different laws, regulations and guidelines impact the retention of medical records. For example, the Health Insurance Portability and Accountability Act ("HIPAA")[1] and related regulations, the American Medical Association ("AMA") Guidelines,[2] and state laws[3] all need to be considered. Part one of this series focuses on Federal HIPAA requirements and the AMA Guidelines. The specifics of Nevada's retention laws will be addressed in the next newsletter.

HIPAA

The U.S. Department of Health and Human Services – Office for Civil Rights (HHS-OCR) provided interpretive guidance[4] to the HIPAA Privacy Rule[5] and Security Rule[6] in relation to the disposal and retention of protected health information ("PHI"). The Privacy Rule requires appropriate physical, administrative and technical safeguards to ensure that a patient's privacy is protected. The Privacy rule applies to all forms of PHI; whereas the Security Rule only applies to electronic protected health information ("ePHI"). The purpose behind the Privacy rule is to ensure the integrity of the patient's health record and avoid inappropriate disclosure of such information. This includes both the retention of PHI and the disposal of PHI. For example, paper charts would need to be shredded in a manner that the information cannot be reconstructed (i.e., confetti shredding). If paper charts are being moved from one location to another, then care should be taken to seal the documents so that they cannot be easily viewed (i.e., file cabinets should be locked and the movement of the information should be monitored). Hence, while the Privacy Rule and Security Rule do not require a particular method of disposal, it is impermissible for covered entities (or their business associates for that matter) to "simply abandon PHI or dispose of it in dumpsters or other containers that are accessible by the public or other unauthorized persons."[7]

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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.

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The Security Rule, which was enhanced in the Health Information Technology for Economic and Clinical Health Act ("HITECH Act")[8], requires policies and procedures to address the creation, receipt, transmission or maintenance of ePHI.[9] Some of the compliance items are standard, while others are required or addressable. Even if an item is noted as "addressable," care should be taken because not implementing the standard can lead to increased fines and liability in the event of a breach. Sanitization standards for electronic items, ranging from hard drives to photocopiers, need to be implemented in order to ensure that the ePHI is purged or destroyed.

Finally, regarding a federal standard related to medical record retention requirements under HIPAA, HHS presented the following guidance:

> *No, the HIPAA Privacy Rule does not include medical record retention requirements. Rather, state laws generally govern how long medical records are to be retained. However, the HIPAA Privacy Rule does require that covered entities apply appropriate administrative, technical, and physical safeguards to protect the privacy of medical records and other protected health information (PHI) for whatever period such information is maintained by a covered entity, including through disposal. See 45 CFR 164.530(c).* [10]

In sum, it is important to protect a patient's health records and also appreciate that an audit trail stemming back six years is required under HIPAA, the HITECH Act and subsequent regulations. In this area, the federal laws defer to the respective state laws.

AMA Guidance

Another resource physicians should consider is the AMA. Oftentimes, the AMA provides guidance on areas of practice and practice management, and medical record retention is not an exception. Opinion 7.05 specifically addresses the retention of medical records and emphasizes the ethical and legal obligations physicians have in relation to their practices. Issued in June 1994, before the passage of HIPAA and the HITECH Act, this Opinion's guidelines are still relevant. In particular, of the nine items listed, notions of checking state laws, medical malpractice statutes, the five-year retention period for Medicare and Medicaid patients and providing patients the opportunity to obtain their records before disposal are all prudent pieces of advice.[11] These guidelines comport with and compliment HIPAA and the HITECH Act.

Conclusion

In sum, the changing dynamics of physicians' practices, along with mergers, joint-venture structures and ACOs provide a challenging environment for a physician's custodial duties of a patient's health records. Part two of this series builds upon federal law and addresses Nevada's statute and common scenarios physicians face.

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[1] Pub. L. 104-191 (1996).

[2] American Medical Association, *Opinion 7.05 – Retention of Medical Records*, *available at*, www.ama-assn.org/.

[3] *See* NRS, Chapter 629 – Healing Arts Generally (defining "health care records" as "any reports, notes, orders, photographs, X rays or other recorded data or information whether maintained in written, electronic or other form which is received or produced by a provider of health care, or any person employed by a provider of health care, and contains information relating to the medical history, examination, diagnosis or treatment of the patient" in NRS 629.021).

[4] U.S. Department of Health and Human Services – Office for Civil Rights, *Frequently Asked Questions About the Disposal of Protected Health Information*, p. 1.

[5] 45 CFR 164.530(c).

[6] 45 CFR 164.310(d)(2)(i) and (ii).

[7] *Supra*, n. 4 at 1.

[8] Pub. L. 111-5.

[9] *See* 45 CFR 164.306(a)(4), 164.308(a)(5), and 164.530(b) and (i).

[10] *Supra*, n. 4 at 4.

[11] *Supra*, n. 2.

***Disclaimer:** The opinions expressed in the Guest Author's 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.*

BOARD MEMBER NEWS

Board Adopts FSMB Opioid Model Policy

At its December 6, 2013 quarterly meeting, the Nevada State Board of Medical Examiners adopted by reference the Federation of State Medical Boards' *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*, July 2013. (NAC 630.187)

The Board is currently in the process of updating its regulations to reflect the current title of the publication.

The link to the *Model Policy* on the Federation of State Medical Boards' website follows:
http://www.fsmb.org/pdf/pain_policy_july2013.pdf

Board Passes Department of Public Safety Audit

The Department of Public Safety (DPS) conducted a Criminal History/Fingerprinting Performance Audit of the Board's fingerprinting and Criminal History Record Information (CHRI) process, and FBI and state regulatory compliance in regards to civil applicant (licensing) fingerprint results. The audit consisted of on-site and written inquiry components. New policy and procedure was introduced to the Board through the audit process. The purpose of the audit was for the DPS to determine if the Board is in compliance with requirements relating to CHRI storage, electronic storage, security, dissemination, training, and outsourcing.

The audit commenced in late 2013 and was completed January 21, 2014. The Board was found to be in compliance, and the special category of "electronic storage" will be subject to a Technical Security Audit by the DPS Criminal Justice Information System Security Office later in 2014.

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COMMUNITY OUTREACH PROGRAM

If you are interested in discussing the community outreach program or scheduling a presentation, please contact: Douglas C. Cooper, CMBI, Executive Director of the Nevada State Board of Medical Examiners, at dccnsbme@medboard.nv.gov or by calling 775-688-2559.

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.

New Edition of Electronic Health Record Technology Certification Criteria Issued

Progress by HHS increases interoperability and supports clinical and delivery reforms

The HHS Office of the National Coordinator for Health Information Technology (ONC) has issued proposals for the next edition (the "2015 Edition") of electronic health record (EHR) technology certification criteria.

This proposed rule marks the first time ONC has proposed an edition of certification criteria separate from the Centers for Medicare & Medicaid Services' "meaningful use" regulations. The proposals represent ONC's new regulatory approach that includes more incremental and frequent rulemaking. This approach allows ONC to update certification criteria more often to reference improved standards, continually improve regulatory clarity, and solicit comments on potential proposals as a way to signal ONC's interest in a particular topic area.

"The proposed 2015 Edition EHR certification criteria reflect ONC's commitment to incrementally improving interoperability and efficiently responding to stakeholder feedback," said Karen DeSalvo, M.D., M.P.H., National Coordinator for health IT. "We will continue to focus on setting policy and adopting standards that make it possible for health care providers to safely and securely exchange electronic health information and for patients to become an integral part of their care team."

Compliance with the 2015 Edition would be voluntary – EHR developers that have certified EHR technology to the 2014 Edition would not need to recertify to the 2015 Edition for customers to participate in the Medicare and Medicaid EHR Incentive Programs. Similarly, health care providers eligible to participate in the Medicare and Medicaid EHR Incentive Programs would not need to "upgrade" to EHR technology certified to the 2015 Edition to have EHR technology that meets the Certified EHR Technology definition. "This provides the opportunity for developers and health care providers to move to the 2015 Edition on their own terms and at their own pace," said Dr. DeSalvo.

The proposed rule will be published in the Federal Register on Feb. 26, 2014. ONC will accept comments on the proposed rule through April 28, 2014. The final rule is expected to be issued in summer 2014.

Contact: HHS Press Office (202) 260-6342 ***Note:*** All HHS press releases, fact sheets and other materials available at *http://www.hhs.gov/news*.

Quality Data Added to Physician Compare Website

The Centers for Medicare & Medicaid Services (CMS) announced that for the first time, quality measures have been added to Physician Compare, a website that helps consumers search for information about hundreds of thousands of physicians and other health care professionals. The site helps consumers make informed choices about their care.

"Patients and their families need facts to help them in making important decisions about health care, and choosing the right physician is one of the most important decisions they face," said CMS Administrator Marilyn Tavenner.

In the first year, 66 group practices and 141 Accountable Care Organizations (ACO) now have quality data publicly reported on Physician Compare. The data are reported at the group practice and ACO level.

The quality measures being added today include:

- Controlling blood sugar levels in patients with diabetes.
- Controlling blood pressure in patients with diabetes.
- Prescribing aspirin to patients with diabetes and heart disease.
- Patients with diabetes who do not use tobacco.
- Prescribing medicine to improve the pumping action of the heart in patients who have both heart disease and certain other conditions.

The provider ratings are displayed using stars, which are a graphical representation of performance on a measure. The actual percentage score is also listed to the right of the star display. CMS chose this system to make the information more usable and easy to scan for consumers.

Physician Compare, created by the Affordable Care Act, already includes information about specialties offered by doctors and group practices; board certification; and affiliation with hospitals and other health care professionals.

"This is an important first step in publicly reporting quality measures on Physician Compare," said Patrick Conway, M.D., CMS's Chief Medical Officer and Deputy Administrator for Innovation and Quality. "Offering a strong set of meaningful quality measures on the site will ultimately help consumers make decisions and it will encourage quality improvement among the clinician community, who shares CMS's strong commitment to the best possible patient care."

Physician Compare is available at http://www.medicare.gov/physiciancompare and also can be accessed through www.medicare.gov and by clicking on "Find doctors & other health professionals."

New FSMB Resource Provides Tools for Improving Physician-Patient Communications

Many of the complaints state medical boards receive from patients can be linked at some level to a breakdown in communications between physicians and patients – even when the complainant is unaware communication is at the root of the problem. To help address this issue, the FSMB has developed a new **"**Physician-Patient Communications Resource Center" for boards to use in educating physicians about the kinds of communication issues that can lead to complaints from their patients.

The Resource Center includes articles and studies from state medical board newsletters, health care publications, medical societies, academic studies and blogs.

"While the Board does see examples of inappropriate and substandard care, most often the mistakes we see have to do with dysfunctional communication," according to one of the articles in the Resource Center. "When the physician-patient relationship breaks down, the result is often a patient complaint to the Medical Board and, frequently, a medical malpractice claim. Too often, the breakdown deals with some aspect of poor communication. I believe that more than 80 percent of the complaints the Board sees begin with dissatisfaction sown with the seed of miscommunication."

According to resources available on the website, examples of poor communication that can lead to complaints to medical boards include:

- A patient may find his or her physician's tone insulting or dismissive
- Inappropriate comments about a patient's appearance or anatomical features unrelated to the patient's health
- Incomplete communication about possible clinical outcomes and side effects of care, which can set up unrealistic expectations for the outcome of treatment

"Patients expect to receive ever-expanding clarity when communicating with their physician and physicians feel the pressure to see patients in an expediently-efficient timeframe; herein lies the problem that generates an expanding log of complaints to the Medical Board," according to an article available in the Resource Center.

A few of the topics covered in the Resource Center include:

- "Communication is Often Key to Patient Complaints"
- "Helping Licensees Stay Out of Trouble: Yes, We Do That Too"
- "Patient Engagement: Are You Thinking About Your Patients in the Right Way?"
- "Use of Electronic Health Records Can Improve Patient-Physician Communication"

For More Information:

The "Physician-Patient Communications Resource Center" can be accessed at: www.fsmb.org/physician_patient_communications_resource_center.html .

Contact: *Drew Carlson, Communications Director, 817.868.4043 Email: dcarlson@fsmb.org*

Five Ways Health Care Reform Could Increase Your Malpractice Risks

This article was originally published by Physicians Practice at www.physicianspractice.com.

Guest Author: Aubrey Westgate

As health care reform initiatives pick up in 2014, the risk of a malpractice lawsuit may increase for many physicians. Here's why:

1. More patients. As more patients gain insurance and patient demand increases, your practice may become busier. "In some regards it's going to be better but currently with the volume of patients that we anticipate will hit primary-care physician practices they don't have the time or staff to manage the volume of patients that are coming their way," Laura Martinez, Vice President of Risk Management at medical malpractice insurer MagMutual, recently told *Physicians Practice.* "My concern is that it's going to create some potential crises for them."

2. New patients. Patients who like their doctors are less likely to sue them, so a strong relationship with patients is critical. As your practice begins accepting new patients (some of whom may have been forced to select you as their new physician after being dropped from their previous insurance plans), it must focus on building strong relationships. "Physicians are going to be starting from square one with people, the patient may even be going to a physician he or she did not want to go to but was forced to go to," Mike Atchison, an attorney at Burr & Forman LLP based in Birmingham, Ala., recently told *Physicians Practice*. "That's always a bad situation."

3. Payment problems. Many of the health insurance plans offered through health insurance exchanges include high deductibles, meaning patients are going to be shouldering more of their healthcare costs, Susan Shepard, a nurse and Director of Patient Safety Education at medical malpractice insurer The Doctors Company recently told *Physicians Practice*. As your practice steps up its patient payment collection efforts, patient relations could become strained. That, of course, could increase the likelihood that a patient will file a malpractice lawsuit.

4. Nonphysician providers. As more patients gain insurance and as the physician shortage increases, more practices are likely to hire non-physician providers, such as nurse practitioners and physician assistants, Jeff Brunken, President of physician insurer MGIS, recently told *Physicians Practice.* Make sure your practice is complying with scope of practice regulations and supervising these individuals appropriately.

5. New partners. Many health reform initiatives, such as accountable care organizations, require physicians to form new partnerships with other healthcare systems and physicians. This could raise communication and care handoff problems — at least at the outset. "Usually all the discussion and the focus before they get [involved in these initiatives] is all about the business side of it, and how do the numbers work and so forth," said Brunken. "We always remind our clients to make sure that they understand how the communication side of it works."

Aubrey Westgate is an Associate Editor at Physicians Practice, where she writes and edits for the journal and covers news for the blog. Aubrey has worked in television news, public relations, and newspaper reporting and freelancing. In her spare time she enjoys reading and spending time with her family. For additional information go to: www.physicianspractice.com.

***Disclaimer:* The opinions expressed in the Guest Author's 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.**

Acetaminophen Prescription Combination Drug Products with more than 325 mg:

FDA Statement - Recommendation to Discontinue Prescribing and Dispensing

ISSUE: FDA is recommending health care professionals discontinue prescribing and dispensing prescription combination drug products that contain more than 325 milligrams (mg) of acetaminophen per tablet, capsule or other dosage unit. There are no available data to show that taking more than 325 mg of acetaminophen per dosage unit provides additional benefit that outweighs the added risks for liver injury. Further, limiting the amount of acetaminophen per dosage unit will reduce the risk of severe liver injury from inadvertent acetaminophen overdose, which can lead to liver failure, liver transplant, and death.

Cases of severe liver injury with acetaminophen have occurred in patients who:

- Took more than the prescribed dose of an acetaminophen-containing product in a 24-hour period.
- Took more than one acetaminophen-containing product at the same time.
- Drank alcohol while taking acetaminophen products.

BACKGROUND: In January 2011, the FDA asked manufacturers of prescription combination drug products containing acetaminophen to limit the amount of acetaminophen to no more than 325 mg in each tablet or capsule by January 14, 2014. The FDA requested this action to protect consumers from the risk of severe liver damage which can result from taking too much acetaminophen. This category of prescription drugs combines acetaminophen with another ingredient intended to treat pain (most often an opioid), and these products are commonly prescribed to consumers for pain, such as pain from acute injuries, post-operative pain, or pain following dental procedures.

Acetaminophen is also widely used as an over-the-counter (OTC) pain and fever medication, and is often combined with other ingredients, such as cough and cold ingredients. The FDA will address OTC acetaminophen products in another regulatory action. Many consumers are often unaware that many products (both prescription and OTC) contain acetaminophen, making it easy to accidentally take too much.

More than half of manufacturers have voluntarily complied with the FDA request. However, some prescription combination drug products containing more than 325 mg of acetaminophen per dosage unit remain available. In the near future the FDA intends to institute proceedings to withdraw approval of prescription combination drug products containing more than 325 mg of acetaminophen per dosage unit that remain on the market.

RECOMMENDATION: The FDA recommends that health care providers consider prescribing combination drug products that contain 325 mg or less of acetaminophen. The FDA also recommends that when a pharmacist receives a prescription for a combination product with more than 325 mg of acetaminophen per dosage unit, he or she contacts the prescriber to discuss a product with a lower dose of acetaminophen. A two-tablet or two-capsule dose may still be prescribed, if appropriate. In that case, the total dose of acetaminophen would be 650 mg (the amount in two 325 mg dosage units). When making individual dosing determinations, health care providers should always consider the amounts of both the acetaminophen and the opioid components in the prescription combination drug product.

Health care providers and pharmacists who have further questions are encouraged to contact the Division of Drug Information at 888.INFO.FDA (888-463-6332) or druginfo@fda.hhs.gov.

Healthcare professionals and patients are encouraged to report adverse events or side effects related to the use of these products to the FDA's MedWatch Safety Information and Adverse Event Reporting Program:

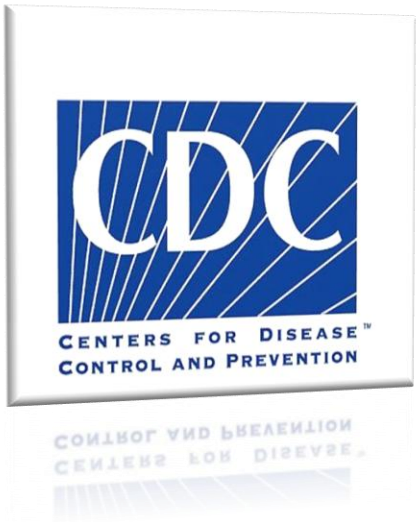
- Complete and submit the report online: www.fda.gov/MedWatch/report.htm
- Download form, or call 1-800-332-1088 to request a reporting form, then complete and return to the address on the pre-addressed form, or submit by fax to 1-800-FDA-0178.

For more information:
- 1/14/2014 - FDA Statement
- Previous MedWatch Alert: 01/13/2011 - Acetaminophen Prescription Products Limited to 325 mg Per Dosage Unit
- Acetaminophen Information

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.
Read the FDA Blog: FDA Voice RSS Feed for FDA News Releases

Physicians are a Leading Source of Prescription Opioids for the Highest-Risk Users

Finding highlights important role physicians can play in reducing prescription drug overdoses



Most people who abuse prescription opioid drugs get them for free from a friend or relative – but those at highest risk of overdose are as likely to get them from a doctor's prescription, CDC researchers reported in a research letter, "Sources of Prescription Opioid Pain Relievers by Frequency of Past-Year Nonmedical Use: United States, 2008-2011," in the *Journal of the American Medical Association Internal Medicine* (*JAMA Internal Medicine*).

This finding underscores the need for prevention efforts that focus on physicians' prescribing behaviors and patients at highest risk for overdose.

"Many abusers of opioid pain relievers are going directly to doctors for their drugs," said CDC Director Tom Frieden, M.D., M.P.H. "Health care providers need to screen for abuse risk and prescribe judiciously by checking past records in state prescription drug monitoring programs. It's time we stop the source and treat the troubled."

Data have shown that the majority of all people who use opioids for nonmedical reasons (using drugs without a prescription, or using drugs just for the "high" they cause) get the drugs from friends or family for free. Prevention efforts have focused on this group, emphasizing methods such as collecting unused medications through take-back events that are aimed at providing a safe and convenient way of disposing of prescription drugs responsibly.

But these efforts fail to target those at highest risk of overdose: people who use prescription opioids nonmedically 200 or more days a year. CDC's new analysis shows that these highest risk users get opioids through their own prescriptions 27 percent of the time, as often as they get the drugs from friends or family for free or buy them from friends. And they are about four times more likely than the average user to buy the drugs from a dealer or other stranger.

Researchers analyzed data for the years 2008 through 2011 from the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). Other major sources of opioids for frequent nonmedical users include obtaining drugs from friends or relatives for free (26 percent), buying from friends or relatives (23 percent), or buying from a drug dealer (15 percent).

Also in today's issue of *JAMA Internal Medicine* is an in-depth investigation of the opioid overdose death problem in Tennessee. The Tennessee Department of Health, Vanderbilt University School of Medicine, and CDC found that high-risk opioid use is frequent in the state, is increasing, and is connected to an increase in overdose deaths. The article, "High-Risk Use by Patients Prescribed Opioids for Pain and Its Role in Overdose Deaths," covers a 5-year period (2007-2011) during which opioid prescribing rates increased 32 percent (from 108 to 143 prescriptions per 100 population). The authors found that one third of the population of Tennessee filled a prescription for an opioid each year. Opioid analgesic-related overdose deaths were strongly associated with being prescribed high dosages of opioids (>100 morphine milligram equivalents a day) and with obtaining opioids from multiple prescribers and pharmacies.

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Physicians are a Leading Source of Prescription Opioids for the Highest-Risk Users

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This article calls attention to the need for federal and state agencies to work together to prevent prescription drug overdose and abuse.

Steps the federal government is taking include:

- Tracking drug overdose trends to better understand the epidemic.
- Encouraging the development of abuse-deterrent opioid formulations and products that treat abuse and overdose.
- Educating health care providers and the public about prescription drug abuse and overdose.
- Requiring that manufacturers of extended-release and long-acting opioids make available to prescribers educational programs about the risks and benefits of opioid therapy, choosing patients appropriately, managing and monitoring patients, and counseling patients on the safe use of these drugs.
- Developing, evaluating and promoting programs and policies shown to prevent prescription drug abuse and overdose, while making sure patients have access to safe, effective pain treatment.
- Supporting states' efforts by providing the science and resources to help states address the key drivers of the epidemic: high-risk prescribing and high-risk prescription drug use.

Promising steps that many states are taking include:

- Enhancing and integrating prescription drug monitoring programs: electronic databases that track all prescriptions for opioids in the state and identify high-risk use of opioids. Half of individuals who were prescribed opioids, and overdosed, in the Tennessee study could have been identified through such a database in advance of their deaths.
- Using medical claims data to identify improper prescribing of opioids.
- Setting up programs for public insurance programs, workers' compensation programs, and state-run health plans that identify and address improper patient use of opioids.
- Passing, enforcing and evaluating pain clinic and other state laws to reduce prescription opioid abuse.
- Encouraging state licensing boards to take action against inappropriate prescribing.
- Increasing access to substance abuse treatment.

For more information about U.S. prescription drug overdoses:
www.cdc.gov/homeandrecreationalsafety/overdose

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Contact: CDC Media Relations (404) 639-3286

National Registry of Certified Medical Examiners

The Federal Motor Carrier Safety Administration (FMCSA) is establishing a National Registry of Certified Medical Examiners to perform physical examinations for persons who wish to obtain a license to drive a commercial motor vehicle (CMV) interstate.

Beginning May 21, 2014, **all medical certificates issued on or after this date must be issued only by examiners listed on the National Registry of Certified Medical Examiners.**

Healthcare professionals who wish to conduct medical examinations for interstate CMV drivers must complete training on FMCSA's physical qualifications regulations and advisory criteria, and pass a certification test to be listed on the National Registry.

Healthcare professionals are eligible to apply for medical examiner certification if their scope of practice authorizes them to perform physical examinations as defined by the state in which they practice. Professionals authorized to perform physical examinations for commercial motor vehicle drivers must have one of the following degrees:

Advanced Practice Nurse (APN) *	**Doctor of Chiropractic (DC)**
Medical Doctor (MD)	**Doctor of Osteopathy (DO)**
Physician Assistant (PA)	**Other health care professionals authorized by his/her state to perform physical examinations**

All medical examiners who conduct physical examinations for interstate CMV drivers must meet the following criteria:

- Complete certain training concerning FMCSA's physical qualification standards.
- Pass a test to verify an understanding of those standards.
- Maintain and demonstrate competence through periodic training and testing.

**As of July 1, 2013, now known as Advanced Practice Registered Nurse (APRN) in Nevada, but still titled as above within the National Registry of Certified Medical Examiners.*

Further information may be found at http://nrcme.fmcsa.dot.gov/.

Nevada Dept. of Motor Vehicles – National Registry

Journal of Medical Regulation Examines Impact of Health Care Workforce Issues in Special Edition

Research and analysis explores the impact of changing demographic trends and delivery models on the work of state medical boards

As U.S. demographics continue to shift and the health care system experiences rapid change in patient-care models, state medical boards will increasingly need to examine their policies in areas such as medical workforce capacity, scope of practice, and assessment of competency, according to the latest issue of the *Journal of Medical Regulation* (JMR).

In a special themed-edition titled "Health Care Workforce in Transition: The Impact of Changing Demographic Trends and Delivery Models on Medical Regulation," a diverse range of articles explore various aspects of the impact of workforce issues on state medical regulators, including:

- **"A State Medical Board's Assessment of its Physician Workforce Capacity: Purpose, Process, Perspective and Lessons Learned."** The District of Columbia Board of Medicine offers advice on the gathering of workforce data about health care professionals and how it can help shape a medical board's policy making.

- **"Board Certification Status: Considerations for Maintenance of Licensure and the Specialty of Pediatrics."** A team from the American Academy of Pediatrics compares practice patterns of board-certified and non-board-certified pediatricians, raising questions about how professional competency measures such as Maintenance of Certification and Maintenance of Licensure might impact future patient access.

- **"From Health Care to Population Health: Retooling Legal Structures for a New Paradigm."** Policy analyst Jackson Williams, JD, explores a new paradigm for U.S. health care that places greater emphasis on managing population health and proposes extending great responsibility for health care services to non-physicians.

- **"Special Report: The Minimum Data Set."** In a special report, physician workforce experts Edward Salsberg and Christina Hosenfeld comment on the critical role state medical boards can play in helping assess workforce needs, and a research team from the FSMB offers data on state medical board information-gathering practices and opinions.

In her introduction to the special issue, JMR Editor-in-Chief Ruth Horowitz, PhD, notes:

"While state medical boards are critical in ensuring that physicians have necessary skills to practice safely, they increasingly face the reality that non-physicians have underutilized skills that may contribute more to our health care system. The number of physicians we currently have and will need in the future – and how we regulate them – is a key concern. Thus, we must count how many physicians are in active practice, in which places, and in what specialties; determine how many physicians we need and who else can use their learned skills; and evaluate how board policies may contribute to or fill gaps in service."

The article, "A State Medical Board's Assessment of its Physician Workforce Capacity: Purpose, Process, Perspective and Lessons Learned," is the free featured article in the current issue of JMR.

The *Journal of Medical Regulation* is a quarterly publication of the Federation of State Medical Boards (FSMB). To learn more about the JMR or to subscribe, please visit http://jmr.fsmb.org. The JMR website includes an archive of articles dating to 1967, available free of charge to researchers and individuals interested in medical regulation. Remaining volumes covering the years 1913-1966 will be added to the JMR archive in the near future.

About the FSMB

The 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. It assists these state and territorial medical boards as they go about their mandate of protecting the public's health, safety and welfare. The FSMB leads by promoting excellence in medical practice, licensure, and regulation.

Contact: *Drew Carlson, Communications Director, 817.868.4043 Email: dcarlson@fsmb.org*

BOARD REGULATION UPDATE

On February 26, 2014, two amendments to the Nevada Administrative Code advanced by the Nevada State Board of Medical Examiners (Board), became effective. The first, R035-13, provides that practitioners of respiratory care and perfusionists who are licensed by the Board may now receive continuing education units when the licensee performs a medical review for the Board. The regulation makes this alternative consistent with that of medical doctor and physician assistant licensees, who currently can receive continuing medical education credits when they perform medical reviews for the Board. The second, R036-13, requires that physician assistant, practitioner of respiratory care and perfusionist applicants for licensure provide to the Board proof that they are either a citizen of the United States or lawfully entitled to remain and work in the United States. Although the Board has always required this proof from all applicants for licensure, previously this requirement only existed in statute for medical doctor applicants.

The full text of the new regulations, found below, can also be obtained via the Board's website. Questions regarding the new regulations can be directed to Edward O. Cousineau, J.D., Deputy Executive Director, or Douglas C. Cooper, CMBI, Executive Director.

New language in blue.
Redacted language in red.

LCB File No. R035-13

Effective February 26, 2014

Section 1. NAC 630.530 is hereby amended to read as follows:

630.530 1. The license of a practitioner of respiratory care may be renewed biennially upon dates set by the Board. The license will not be renewed unless the practitioner of respiratory care provides satisfactory proof:

(a) Of current certification by the National Board for Respiratory Care or its successor organization; and

(b) That he or she has completed the number of contact hours of continuing professional education required by subsections 2 and 3.

2. To renew a license for the practice of respiratory care, a licensee must complete the number of contact hours of continuing education required by subsection 3, of which:

(a) Sixty percent must be from an approved educational source directly related to the practice of respiratory care. Two hours of this 60 percent must be in medical ethics.

(b) Forty percent must be in any program approved by the American Association for Respiratory Care for Continuing Respiratory Care Education or any program of another organization approved by the Board.

3. The following contact hours for continuing education are required for a licensee to renew a license for the practice of respiratory care:

(a) If licensed during the first 6 months of the biennial period of registration, 20 hours.

(b) If licensed during the second 6 months of the biennial period of registration, 15 hours.

(c) If licensed during the third 6 months of the biennial period of registration, 10 hours.

(d) If licensed during the fourth 6 months of the biennial period of registration, 5 hours.

4. A practitioner of respiratory care shall notify the Board within 10 days if his or her certification by the National Board for Respiratory Care or its successor organization is withdrawn.

5. To allow for the renewal of a license to practice respiratory care by each person to whom a license was issued or renewed in the preceding renewal period, the Board will make such reasonable attempts as are practicable to:

(a) Mail a renewal notice at least 60 days before the expiration of a license to practice respiratory care; and

(b) Send a renewal application to a licensee at the last known address of the licensee on record with the Board.

6. If a licensee fails to pay the fee for biennial registration required by NAC 630.525 on or before July 1 of each odd-numbered year, or fails to submit proof that the licensee completed the number of contact hours of continuing education required by subsections 2 and 3, his or her license to practice respiratory therapy in this State expires. Within 2 years after the date on which the license expires, the holder may be reinstated to practice respiratory care if he or she:

(a) Pays twice the amount of the current fee for biennial registration to the Secretary-Treasurer of the Board;

(b) Submits proof that he or she completed the number of contact hours of continuing education required by subsections 2 and 3; and

(c) Is found to be in good standing and qualified pursuant to the provisions of this chapter and NRS 630.277.

7. The Board may issue not more than 10 contact hours of continuing education during a biennial licensing period to a licensee if the licensee performs a medical review for the Board. The hours issued by the Board:

(a) May be credited against the hours required for a biennial licensing period pursuant to subsections 2 and 3; and

(b) Must be equal to the actual time involved in performing the medical review, not to exceed 10 hours.

Sec. 2. NAC 630.740 is hereby amended to read as follows:

630.740 1. The license of a perfusionist may be renewed biennially. Except as otherwise provided in subsection 2, each person licensed as a perfusionist shall, at the time of the renewal of his or her license, provide satisfactory proof to the Board that he or she has completed during the biennial licensing period at least 30 hours of continuing education units that have been approved for credit by the American Board of Cardiovascular Perfusion. The continuing education units must be completed in the various categories of continuing education recognized by the American Board of Cardiovascular Perfusion, as follows:

(a) At least 15 hours, not less than 2 hours of which must be related to medical ethics, must be completed in Category I approved continuing education, which may include, without limitation, such activities as:

(1) Attendance at an international, national, regional or state meeting relating to perfusion.

(2) Publication of a book, chapter or article relating to perfusion.

(3) Presenting or addressing at an international, national, regional or state meeting relating to perfusion.

(4) Completion of a self-directed continuing education course relating to perfusion.

(b) Not more than 15 hours may be completed in Category II or Category III approved continuing education, which may include, without limitation, such activities as:

(1) Attendance at an international, national, regional, state or local meeting relating to perfusion that has not been approved for Category I credit.

(2) Attendance at a manufacturer-specific or company-sponsored educational activity that was not equally accessible to all perfusionists.

(3) Attendance at a medically-related international, national, regional, state or local meeting that has not been approved for Category I credit.

(4) Attendance at advanced cardiac life-support training that has not been approved for Category I credit.

(5) Individual education and other self-study activities that have not been approved for Category I credit.

2. If the perfusionist was licensed only during the second year of a biennial licensing period, he or she must attain and prove upon his or her renewal application the completion during the biennial licensing period of at least 16 hours of continuing education units that have been approved for credit by the American Board of Cardiovascular Perfusion, as follows:

(a) At least 8 hours, not less than 2 hours of which must be related to medical ethics, must be completed in Category I approved continuing education activities; and

(b) Not more than 8 hours must be completed in Category II and Category III approved continuing education activities.

3. The notice of renewal that the Board is required to send to a licensed perfusionist pursuant to NRS 630.2695 will be sent to the last known address of the perfusionist on record with the Board.

4. The Board may issue not more than 15 hours of continuing education units during a biennial licensing period to a licensed perfusionist if the perfusionist performs a medical review for the Board. The hours issued by the Board:

(a) May be credited against the hours required for a biennial licensing period pursuant to subsection 1 or 2; and

(b) Must be equal to the actual time involved in performing the medical review, not to exceed 15 hours.

LCB File No. R036-13

Effective February 26, 2014

Section 1. NAC 630.280 is hereby amended to read as follows:

630.280 An applicant for licensure as a physician assistant must have the following qualifications:

1. If the applicant has not practiced as a physician assistant for 12 months or more before applying for licensure in this State, he or she must, at the order of the Board, have taken and passed the same examination to test medical competency as that given to applicants for initial licensure.

2. ***Be a citizen of the United States or be lawfully entitled to remain and work in the United States.***

3. Be able to communicate adequately orally and in writing in the English language.

[3.**]** ***4.*** Be of good moral character and reputation.

[4.**]** ***5.*** Have attended and completed a course of training in residence as a physician assistant approved by **[**the**]** ***one of the following entities affiliated with the American Medical Association or its successor organization:***

(a) The Committee on Allied Health Education and Accreditation **[**, the**]** ***or its successor organization;***

(b) The Commission on Accreditation of Allied Health Education Programs ***or its successor organization;*** or **[**the**]**

(c) The Accreditation Review Committee on Education for the Physician Assistant **[**, which are affiliated with the American Medical Association.

5. **]** ***or its successor organization.***

6. Be certified by the National Commission on Certification of Physician Assistants **[**.

6.**]** ***or its successor organization.***

7. Possess a high school diploma, general equivalency diploma or postsecondary degree.

Sec. 2. NAC 630.500 is hereby amended to read as follows:

630.500 An applicant for licensure as a practitioner of respiratory care must have the following qualifications:

1. If he or she has not practiced as a practitioner of respiratory care for 12 months or more immediately preceding his or her

Continued on page 14

application for licensure in this State, the applicant must, except as otherwise provided in subsections 2 and 3, at the order of the Board, take and pass any examination that the Board deems appropriate to test the professional competency of the practitioner.

2. If he or she has not practiced as a practitioner of respiratory care for 12 months or more but less than 5 years immediately preceding his or her application for licensure in this State, the applicant may provide proof that he or she has successfully completed 10 units of continuing education for each year or portion thereof he or she has not practiced respiratory care. If he or she provides proof of successfully completing at least 10 units of continuing education for each year or portion thereof he or she has not practiced respiratory care, the applicant is exempt from the examination required pursuant to subsection 1.

3. If he or she has not practiced as a practitioner of respiratory care for 5 years or more immediately preceding his or her application for licensure in this State, the applicant must retake and pass the examination required to be certified as a practitioner of respiratory care administered by the National Board for Respiratory Care or its successor organization.

4. ***Be a citizen of the United States or be lawfully entitled to remain and work in the United States.***

5. Be able to communicate adequately orally and in writing in the English language.

[5.] ***6.*** Be of good moral character and reputation.

[6.] ***7.*** Be in compliance with the provisions of NRS 630.277.

Sec. 3. NAC 630.700 is hereby amended to read as follows:

630.700 1. An application for licensure as a perfusionist must be made on a form provided by the Board. The application must set forth:

(a) The date and place of birth of the applicant;

(b) The gender of the applicant;

(c) The education of the applicant, including, without limitation, each high school and postsecondary institution attended by the applicant, the dates of attendance and whether the applicant is a graduate of those schools and institutions;

(d) If the applicant has ever applied for a license or certificate to practice perfusion in another state or jurisdiction, the date and disposition of the application;

(e) The training and experience of the applicant in the practice of perfusion;

(f) If the applicant has ever been investigated for misconduct in the practice of perfusion, had a license or certificate to practice perfusion revoked, modified, limited or suspended or had any disciplinary action or proceeding instituted against the applicant by a licensing body in another state or jurisdiction, the dates, circumstances and disposition of each such occurrence;

(g) If the applicant has ever been convicted of a felony or any offense involving moral turpitude, the dates, circumstances and disposition of each such occurrence;

((h) If the applicant has ever been investigated for, charged with or convicted of the use or illegal sale or dispensing of a controlled substance, the dates, circumstances and disposition of each such occurrence; and

(i) Each place of residence of the applicant after the date of graduation of the applicant from high school or the receipt by the applicant of a high school general equivalency diploma, whichever occurred most recently.

2. An applicant must submit to the Board:

(a) ***Proof that the applicant is a citizen of the United States or that the applicant is lawfully entitled to remain and work in the United States.***

(b) Proof of completion of a perfusion education program that satisfies the requirements of NRS 630.2691. For the purpose of that section, the following perfusion education programs shall be deemed approved by the Board:

(1) Any perfusion education program completed by the applicant on or before June 1,
1994, which was approved by the Committee on Allied Health Education and Accreditation of the American Medical Association;

(2) Any perfusion education program completed by the applicant after June 1, 1994, which was accredited by the Accreditation Committee-Perfusion Education and approved by the Commission on Accreditation of Allied Health Education Programs of the American Medical Association, or its successor; or

(3) Any other perfusion education program completed by the applicant, the educational standards of which the Board determines are at least as stringent as those established by the Accreditation Committee-Perfusion Education and approved by the Commission on Accreditation of Allied Health Education Programs of the American Medical Association, or its successor.

[(b)] ***(c)*** Except as otherwise provided in NRS 630.2693, proof of passage of the certification examination given by the American Board of Cardiovascular Perfusion or its successor, as required by NRS 630.2692.

[(c)] ***(d)*** Such further evidence and other documents or proof of qualifications as are required by the Board.

3. Each application must be signed by the applicant and sworn to before a notary public or other officer authorized to administer oaths.

4. The application must be accompanied by the applicable fee.

5. An applicant shall pay the reasonable costs of any examination required for licensure.

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WHOM TO CALL IF YOU HAVE QUESTIONS

Management:	Douglas C. Cooper, CMBI Executive Director
	Edward O. Cousineau, J.D. Deputy Executive Director/Legal
	Donya Jenkins Finance Manager
Administration:	Laurie L. Munson, Chief
Legal:	Bradley O. Van Ry, J.D. General Counsel
	Erin L. Albright, J.D. General Counsel
Licensing:	Lynnette L. Daniels, Chief
Investigations:	Pamela J. Castagnola, CMBI, Chief

2014 BME MEETING & HOLIDAY SCHEDULE

January 1 – New Year's Day holiday
January 20 – Martin Luther King, Jr. Day holiday
February 17– Presidents' Day holiday
March 7-8 – Board meeting
May 26 – Memorial Day holiday
June 6-7 – Board meeting
July 4 – Independence Day holiday
September 1 – Labor Day holiday
September 5-6 – Board meeting
October 31 – Nevada Day holiday
November 11 – Veterans' Day holiday
November 27 & 28 – Thanksgiving/family day holiday
December 5-6 – Board meeting
December 25 – Christmas holiday

Nevada State Medical Association
3660 Baker Lane #101
Reno, NV 89509
775-825-6788
http://www.nsmadocs.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
3660 Baker Lane #202
Reno, NV 89509
775-825-0278 phone
775-825-0785 fax
http://www.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
901 American Pacific Dr., Unit 180
Henderson, NV 89014
702-732-2147 phone
702-732-2079 fax
www.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
www.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

AHMED, Syed, M.D. (5158)
Las Vegas, Nevada

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On January 17, 2014, the Investigative Committee summarily suspended Dr. Ahmed's license until further order of the Investigative Committee of the Board of Medical Examiners.

FAZEKAS, Karl, M.D. (3298)
Las Vegas, Nevada

Summary: Alleged sexual activity with two patients under his care.

Charges: Two violations of NRS 630.301(5) [engaging in sexual activity with a patient who is currently being treated by the practitioner]; two violations of NRS 630.301(6) [disruptive behavior with patients if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient]; one violation of NRS 630.301(9) [engaging in conduct that brings the medical profession into disrepute].

Disposition: On December 6, 2013, the Board accepted a Settlement Agreement by which it found Dr. Fazekas violated NRS 630.301(9) (two counts) and imposed the following discipline against him: (1) public reprimand; (2) $5,000 fine; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Moreover, Dr. Fazekas is not currently licensed to practice medicine in Nevada and agrees he will never attempt to apply for licensure in the future.

FRICKE, Fred, Jr., M.D. (3167)
Elko, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records related to Dr. Fricke'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 December 6, 2013, the Board accepted a Settlement Agreement by which it found Dr. Fricke violated NRS 630.3062(1), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) $2,500 fine; (2) 10 hours continuing medical education regarding the subject of septic shock and/or acute renal failure; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Count II of the Complaint was dismissed.

GREGORY, Maurice, Jr., M.D. (4894)
Las Vegas, Nevada

Summary: Alleged malpractice, continual failure to exercise the skill or diligence or use the methods ordinarily exercised in the same circumstances by other physicians practicing in the same specialty or field, and failure to maintain appropriate medical records related to Dr. Gregory's treatment of five patients.

Charges: Five violations of NRS 630.301(4) [malpractice]; 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]; 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].

Disposition: On December 6, 2013, the Board accepted a Settlement Agreement and a plea of no contest by which it found Dr. Gregory violated NRS 630.3062(1), as set forth in Count IV of the First Amended Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 10 hours continuing medical education regarding the subject of opioid prescribing and/or pain management; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter; (4) all other terms and conditions of settlement. Counts I, II and III of the First Amended Complaint were dismissed.

LEVISEUR, Carl, M.D. (5386)
Pahrump, Nevada

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

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

Disposition: On December 6, 2013, the Board accepted a Settlement Agreement by which it found Dr. Leviseur violated NRS 630.3062(1), as set forth in Count II of the Complaint, and imposed the following discipline against him: (1) $1,000 donation to charity; (2) 15 hours continuing medical education, at least 3 to 5 hours of which must address the subject of anticoagulation therapy, and the remaining hours to be on the subject of family practice; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Count I of the Complaint was dismissed.

LORENZO, Angela, PA-C (PA816)
Las Vegas, Nevada

Summary: Alleged malpractice, continual failure to exercise the skill or diligence or use methods ordinarily excercised in the same circumstances by other physicians practicing in the same specialty or field, and failure to maintain appropriate medical records related to Ms. Lorenzo's treatment of four patients.

Charges: Two violations of NAC 630.380(1)(f) [malpractice]; one violation of NAC 630.380(1)(m), referencing NRS 630.306(7) [continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physician assistants in good standing practicing in the same specialty or field]; one violation of NAC 630.380(1)(m), referencing 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 December 6, 2013, the Board accepted a Settlement Agreement and a plea of no contest by which it found Ms. Lorenzo violated NAC 630.380(1)(f), as set forth in Counts I and II of the Complaint, and NRS 630.3062(1), as set forth in Count IV of the Complaint, and imposed the following discipline against her: (1) 24 months' probation, subject to various terms and conditions; (2) public repri-

Continued from page 16

mand; (3) 20 hours continuing medical education regarding the subject of diagnosis/treatment of hypothyroidism, hyperthyroidism, hormonal imbalances in men/women, uses of testosterone, and/or medical ethics; (4) 20 hours community service in a medically-related field; (5) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter; (6) all other terms and conditions of settlement. Count III of the Complaint was dismissed with prejudice.

MAXWELL, Richard, M.D. (13894)
Sandy, Utah

Summary: Disciplinary action taken against Dr. Maxwell's medical license in Idaho, and alleged failure to report said disciplinary action to the Nevada State Board of Medical Examiners.

Charges: Two violations of NRS 630.301(3) [disciplinary action taken against his medical license in another state]; two violations of NRS 630.306(11) [failure to report in writing, within 30 days, disciplinary action taken against him by another state].

Disposition: On December 6, 2013, the Board accepted a Settlement Agreement by which it found Dr. Maxwell violated NRS 630.306(11) and imposed the following discipline against him: (1) $200 fine; (2) reimbursement of the Board's fees and costs of investigation and prosecution. Count I and one of the two counts in Count II, of the Complaint were dismissed.

PATIN, Christopher, M.D. (9873)
Reno, Nevada

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

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

Disposition: On December 6, 2013, the Board accepted a Settlement Agreement by which it found Dr. Patin violated NRS 630.301(4), as set forth in Count I of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) $1,500 fine; (3) 10 hours continuing medical education regarding the subject of diagnosing and treating renal insufficiency; (4) reimbursement of the Board's fees and costs of investigation and prosecution. Count II of the Complaint was dismissed.

SARFO, Kofi, M.D. (11205)
Las Vegas, Nevada

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

Charges: Six violations of NRS 630.301(4) [malpractice]; 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].

Disposition: On December 6, 2013, the Board accepted a Settlement Agreement and a plea of no contest by which it found Dr. Sarfo violated NRS 630.3062(1), as set forth in Count II of the Complaint, and imposed the following discipline against him: (1) public reprimand; (2) 10 hours continuing medical education regarding the subject of electronic health records; (3) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter; (4) all other terms and conditions of settlement. Count I of the Complaint was dismissed with prejudice.

SEIP, Douglas, M.D. (4420)
Las Vegas, Nevada

Summary: Alleged malpractice and failure to maintain appropriate medical records related to Dr. Seip'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 December 6, 2013, the Board accepted a Settlement Agreement by which it found Dr. Seip 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) $1,500 fine; (3) 15 hours continuing medical education regarding the subject of trauma and orthopedics; (4) 25 hours community service; (5) reimbursement of the Board's costs and fees associated with investigation and prosecution of the matter. Count II of the Complaint was dismissed.

SWAINE, Kent, M.D. (13917)
Las Vegas, Nevada

Summary: Reasonable belief that the health, safety and welfare of the public was at imminent risk of harm.

Statutory Authority: NRS 630.326(1) [risk of imminent harm to the health, safety or welfare of the public or any patient served by the physician].

Action Taken: On January 31, 2014, the Investigative Committee summarily suspended Dr. Swaine's license until further order of the Investigative Committee or the Board of Medical Examiners.

TAFEL, John, M.D. (14116)
Wilmington, North Carolina

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

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

Disposition: On December 6, 2013, the Board accepted Dr. Tafel's voluntary surrender of his license to practice medicine in Nevada while under investigation.

YEE, Larry, M.D. (4655)
North Las Vegas, Nevada

Summary: Alleged unlawful prescribing of controlled substances and willful failure to comply with an order of the Board.

Charges: 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 630.3065(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 December 6, 2013, the Board found Dr. Yee violated NRS 630.306(3), NRS 630.3065(2)(a) and NRS 630.301(9), as set forth in the Complaint, and imposed the following discipline against him: (1) revocation of license; (2) public reprimand; (3) reimbursement of the Board's fees and costs of investigation and prosecution.

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Public Reprimands Ordered by the Board

Karl Fazekas, M.D.

December 17, 2013

Karl Fazekas, M.D.
c/o Harold Gewerter, Esq.
5536 S. Fort Apache Road, Suite 102
Las Vegas, NV 89148

Dr. Fazekas:

On December 6, 2013, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement proposed between you and the Board's Investigative Committee in relation to the formal Complaint filed against you regarding Case Number 10-4909-1.

In accordance with its acceptance, the Board has entered an Order which indicates that you engaged in conduct that is grounds for discipline pursuant to Nevada's Medical Practice Act, to wit: in the course of treating the two patients named in the underlying Complaint, you willfully and unlawfully used physical force, or the immediate threat of such force, against the two patients, with the intent to compel them to do, or abstain from doing, an act which they had a right to do, or abstain from doing, by preventing the two patients from leaving the medical examination room, and/or by performing unnecessary examinations on the breasts and/or genital opening of the two patients; for which you have been found guilty of two counts of engaging in conduct which brings the medical profession into disrepute, violations of Nevada Revised Statute 630.301(9).

For these violations, you are to be publicly reprimanded, fined in the amount of $5,000.00, pay to the Board $10,948.77, the costs and expenses attendant to the investigation and prosecution of the matter, and although you are no longer licensed to practice medicine in the state of Nevada, you are precluded from ever attempting to apply for such licensure in the future.

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

Sincerely,

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

Maurice Gregory, Jr., M.D.

December 17, 2013

Maurice Gregory, Jr., M.D.
c/o Jacob L. Hafter, Esq.
Hafter Law
911 N. Buffalo Dr., Ste. 209
Las Vegas, NV 89128

Dr. Gregory:

On December 6, 2013, based upon your plea of no contest, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement between you and the Board in Case No. 12-7067-1 and found that you committed a violation of the Medical Practice Act (MPA) of the state of Nevada, more specifically:

That you pled no contest to a violation of Nevada Revised Statute 630.3062(1).

As a result of its finding that you violated the MPA, the Board entered its **Order** as follows:

That you shall be issued a public reprimand; that you shall pay the costs of investigation and prosecution of this matter in the amount of $5,000 within 30 days of the Board's acceptance of the Settlement Agreement; that you shall complete 10 hours of CME; and that you shall comply with all other terms and conditions contained in the Settlement Agreement and Order.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought personal and 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

Angela Lorenzo, PA-C

December 17, 2013

Angela Lorenzo, PA-C
c/o Jacob L. Hafter, Esq.
Hafter Law
911 N. Buffalo Dr., Ste. 209
Las Vegas, NV 89128

Ms. Lorenzo:

On December 6, 2013, based upon your plea of no contest, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement between you and the Board in Case No. 12-28540-2 and found that you committed multiple violations of the Medical Practice Act (MPA) of the state of Nevada, more specifically:

That you pled no contest to two (2) violations of Nevada Administrative Code 630.380(1)(f) and to a violation of Nevada Revised Statute 630.3062(1).

As a result of its finding that you violated the MPA, the Board entered its **Order** as follows:

That you shall be placed on probation for a period of twenty-four (24) months, subject to all related terms and conditions, beginning upon the date of acceptance of the Settlement Agreement by the Board; that you shall be issued a public reprimand; that you shall pay the costs of investigation and prosecution of this matter in the amount of $15,000 within 18 months; that you shall complete 20 hours of CME and perform 20 hours of community service; and that you shall comply with all other terms and conditions contained in the Settlement Agreement and Order.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought personal and 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

Christopher Patin, M.D.

December 17, 2013

Christopher Patin, M.D.
HAWC Medical Clinic
1055 S. Wells Ave.
Reno, NV 89502

Dr. Patin:

On December 6, 2013, 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 13-12350-1.

In accordance with its acceptance of the Agreement, the Board entered an Order

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finding you violated Nevada Revised Statute 630.301(4), malpractice as defined by Nevada Administrative Code 630.040. For the same, you shall pay a $1,500 fine within one hundred twenty (120) days of the Board's acceptance of the Agreement; complete 10 hours of Continuing Medical Education regarding the subject of diagnosing and treating renal insufficiency within one (1) year of the Board's acceptance of the Agreement; receive a public reprimand; and pay the costs related to the investigation and prosecution of this matter within one hundred and twenty (120) days of the Board's acceptance of the Agreement.

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

Kofi Sarfo, M.D.

December 17, 2013

Kofi Sarfo, M.D.
c/o Jacob L. Hafter, Esq.
Hafter Law
911 N. Buffalo Dr., Ste. 209
Las Vegas, NV 89128

Dr. Sarfo:

On December 6, 2013, based upon your plea of no contest, the Nevada State Board of Medical Examiners (Board) accepted the Settlement Agreement between you and the Board in Case No. 12-29257-1 and found that you committed a violation of the Medical Practice Act (MPA) of the state of Nevada, more specifically:

That you pled no contest to a violation of Nevada Revised Statute 630.3062(1).

As a result of its finding that you violated the MPA, the Board entered its **Order** as follows:

That you shall be issued a public reprimand; that you shall pay the costs of investigation and prosecution of this matter in the amount of $4,900 within 180 days of the Board's acceptance of the Settlement Agreement; that you shall complete 10 hours of CME; and that you shall comply with all other terms and conditions contained in the Settlement Agreement and Order.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought personal and 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

Douglas J. Seip, M.D.

December 17, 2013

Douglas J. Seip, M.D.
c/o L. Kristopher Rath, Esq.
Hutchison & Steffan
10080 West Alta Dr., Ste. 200
Las Vegas, NV 89145

Dr. Seip:

On December 6, 2013, 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 13-6513-1.

In accordance with its acceptance of the Agreement, the Board entered an Order finding you violated Nevada Revised Statute 630.3062(1), failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient. For the same, you shall pay a $1,500 fine within twelve (12) months of the Board's acceptance of the Agreement; complete 15 hours of Continuing Medical Education regarding the subject of trauma and orthopedics within one (1) year of the Board's acceptance of the Agreement; receive a public reprimand; perform twenty-five (25) hours of community service with Dr. Florence Jameson at Volunteers in Medicine in Southern Nevada within twelve (12) months of the Board's acceptance of the Agreement and pay the costs related to the investigation and prosecution of this matter within twelve (12) months of the Board's acceptance of the Agreement.

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

Larry Yee, M.D.

December 17, 2013

Larry Yee, M.D.
1075 Olive Drive, House 8
Davis, CA 95616-4734

Dr. Yee:

On December 6, 2013, the Nevada State Board of Medical Examiners (Board) found that you committed multiple violations of the Medical Practice Act (MPA) of the state of Nevada and revoked your license to practice medicine in the state of Nevada, more specifically:

That you committed a violation of Nevada Revised Statute (NRS) 630.306(3) by prescribing controlled substances without holding the required DEA registration from September 29, 2011 up through August 31, 2012; that you committed a violation of NRS 630.3065(2)(a) by willfully failing to undergo outpatient psychiatric treatment/counseling as required by the previous Settlement Agreement and Order of the Board; and that you committed a violation of NRS 630.301(9) by engaging in conduct that brought the medical profession into disrepute.

As a result of its finding that you violated the MPA, the Board entered its **Order** as follows:

That your license to practice medicine in the state of Nevada shall be revoked; that you shall be issued a public reprimand, and that you shall pay the costs of investigation and prosecution of this matter in the amount of $5,023.23 within one year of the Order.

Accordingly, it is my unpleasant duty as President of the Board to formally and publicly reprimand you for your conduct which has brought personal and 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