FORUM
NORTH CAROLINA MEDICAL BOARD
FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA
SUMMER 2013

Q&A on HIPAA: Pg. 8

Doing our part to encourage responsible prescribing of controlled substances

William Walker, MD
NCMB President

Safe and appropriate prescribing of controlled substances remains a top concern of the North Carolina Medical Board. In each of the past five years, about 30 percent of all public actions taken against licensees related to prescribing problems. The vast majority of these involved controlled substances. As the number of prescriptions for controlled substances prescribed in North Carolina continues to rise, it seems likely that the number of Board actions will also increase.

Sometimes the prescribing we review is clearly excessive and inappropriate. Last year, for example, the Board indefinitely suspended the license of a physician whose prescribing led multiple pharmacists and other professionals to report the physician to the Board.

The Board's investigation found that the physician wrote prescriptions for Diazepam, Hydrocodone, Oxycodone, Oxycodone ER, Temazepam, Alprazolam and Tussionex liquid over a period of 16 months to a single patient. The patient used multiple pharmacies to obtain these drugs. A NC Controlled Substances Reporting System (NCCSRS) query of the patient's prescription history found 117 separate entries (each entry representing a prescription for controlled substances dispensed) for the 16-month period reviewed. In a second instance, the physician prescribed 360 Oxycodone HCL 15mg tablets to a patient and then, just two days later, prescribed 720 Oxycodone HCL 30mg tablets to the same person. A third example of the physician's excessive prescribing involved a high school student who was being prescribed Xanex and Vynase. A school social worker reported the student often slurred his words and would sometimes fall asleep in the middle of a conversation. The same student allegedly sold some of the medications prescribed by the physician. When the school refused to continue to administer the student's medications, the physician sent the school a letter stating there was "no risk" in giving the student the prescribed drugs.

Cases like this one, where prescribing is clearly substandard (as confirmed by independent expert medical reviewers) and the physician appears not to recognize or acknowledge problems with care are rare. Far more often, issues with prescribing are more subtle and the licensees in question are well meaning medical professionals who have ventured into the treatment of chronic pain out of a genuine desire to help patients. Problems arise when these licensees don't know appropriate standards of care and then engage in potentially unsafe prescribing.

The Board's duty to protect the public obligates it to not only to stop unsafe prescribing practices, but also to promote safe and appropriate prescribing. Some of our efforts to encourage proper prescribing include publishing informational articles in this newsletter. We post information about obtaining free or low-cost CME in the area of prescribing controlled substances for chronic pain on the Board's website. The Board also frequently recommends "Responsible Opioid Prescribing: A Clinician's Guide" by M. Scott Fishman, MD, which is considered the national gold standard publication for prescribing opioids. In NC, however, the foundation for safely prescribing controlled substances is the Board's position statement, "Policy for the use of controlled

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substances for the treatment of pain."

The Board adopted this position statement in July 1996 and completely revised it in July 2005 based on the "model policy" on the treatment of chronic pain developed by the Federation of State Medical Boards (FSMB). Given the rapid changes occurring in controlled substance use and prescribing, the Board is currently reviewing and revising the position statement again.

Over the past few years, the Board has sought opinions from its licensees and others when revising position statements and rules. To continue this outreach, the NCMB will host a public forum on the subject of prescribing controlled substances for the treatment of pain at its offices in Raleigh on August 21st, between 4 and 6 p.m. The Board will consider these comments and suggestions as it develops the latest revision of its position statement. If you are unable to attend, you may submit comments by August 30 to *forum@ncmedboard.org*

To help licensees understand this important policy discussion, we have dedicated most of this issue of the *Forum* to the subject of controlled substances. We have published the full text of the Board's existing position statement. We've also published a draft of the FSMB's new "Model Policy on the Appropriate Use of Opioid Analgesics in the Treatment of Chronic Pain," which will be an important resource for the Board during the review and revision process. A distinguished panel of physicians and recognized experts in the field developed the draft FSMB policy after a months-long study of current issues as well as trends and standards of care in the treatment of chronic pain I'm proud to say that two North Carolina physicians—Janelle Rhyne, MD, a past president of this Board and past chair of the FSMB, and the NCMB's Associate Medical Director C. Michael Sheppa, MD,—participated in this workgroup. State medical boards often use FSMB's model policies as starting points when tackling complex issues such as the use of opioids in the treatment of pain.

Finally, I am happy to report that this summer's legislative session improved the NC Controlled Substances Reporting System law (NCCSRS). The NCCSRS allows licensees to appropriately review their patients' controlled substances prescription histories. Prior to the revision, the law required the prescriber to personally conduct all queries. In June, Governor McCrory signed Senate Bill 222 into law. As adopted, the law authorizes physicians and other registered users of the NCCSRS to delegate queries to designated persons in the practice, provided those persons register for access to the database. Although the change will take several months to implement, when completed, obtaining reports from the NCCSRS will be much easier and faster.

To promote responsible prescribing, the NCMB encourages licensees to register with the NCCSRS and use it regularly. The NCCSRS helps physicians and PAs avoid prescribing controlled substances to patients who may have received multiple prescriptions from other providers. Please read the article on the pending changes to the NCCSRS on P. 7.

I urge you to take the time to learn more about controlled substance prescribing. Participating in the Board's policy discussion around appropriate prescribing of controlled substances for pain allows you to have a voice in creating Board policy. If you are treating pain in your practice, make sure you have current and complete information about controlled substance prescribing. Don't be a well-meaning but uninformed prescriber who unintentionally adds to the epidemic of prescription drug misuse and abuse.

Send comments to *forum@ncmedboard.org*

Public forum

Where: NCMB offices, 1203 Front Street, Raleigh, NC 27609

When: Wednesday, August 21, 4-6 p.m.

Why: NCMB is reviewing and revising its position statement on treating chronic pain

Who should attend: Licensees and other interested parties

Please scan the code with your smartphone to complete a one-question survey, or visit us online to provide your answer.

How often do you prescribe controlled substances to treat chronic pain?

North Carolina Medical Board Forum Credits

Volume XVI | Summer 2013

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We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

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Have something for the editor?
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Primum Non Nocere

Get engaged: Board seeks licensee input as part of chronic pain position statement review

The Federation of State Medical Boards (FSMB) recently adopted a completely revised "Model Policy on the Appropriate Use of Opioid Analgesics in the Treatment of Chronic Pain". State medical boards are not obligated to accept an FSMB model policy as their own policy, but they are invited and encouraged to use the policy as a basic framework that may be customized to the particular needs of the individual regulatory boards and their licensees. The NCMB used the Federation's 2004 policy on the treatment of chronic pain as a guide when revising its own position statement on the use of controlled substances for the treatment of chronic pain in 2005. The NCMB is beginning the process of reviewing and revising the 2005 version of its policy soon and expects to use the Federation's new model policy as a blueprint once again.

The Board also wants to know what you, its licensees, think. If you prescribe controlled substances to treat chronic pain in your practice, or if there is a chance you might start doing so in the future, please take the time to look over the Board's existing position statement. There have been important developments related to the treatment of chronic pain in the last several years and the Board expects to make significant changes to the position statement.

The Board will hold a public forum to receive comments from interested parties, orally and/or in writing on August 21 from 4-6 p.m. at the Board's administrative offices in Raleigh (see notice announcing the forum on P.2).

To help licensees get up to speed on this important issue, we are publishing the full text of the Board's existing "Policy for the use of controlled substances for the treatment of pain," as well as an excerpt from the FSMB's proposed model policy that provides a summary of topics covered. We hope you will take advantage of this opportunity to communicate your thoughts and concerns to the Board. What subjects should be addressed in the Board's new position? What specific areas related to the use of controlled substances for the treatment of chronic pain would you like Board guidance on?

Licensees may submit comments in writing in advance of the public hearing by emailing them to *forum@ncmedboard.org*

BOARD POSITION STATEMENT

Policy for the use of controlled substances for the treatment of pain

- Appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities. The Board realizes that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen.
- All prescribing of controlled substances must comply with applicable state and federal law.
- Guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.
- Deviation from these guidelines will be considered on an individual basis for appropriateness.

Section I: Preamble

The North Carolina Medical Board recognizes that principles of quality medical practice dictate that the people of the State of North Carolina have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes nontreatment, undertreatment,

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FEDERATION OF STATE MEDICAL BOARDS MODEL POLICY

EXCERPT – PROPOSED Model Policy on the Appropriate Use of Opioid Analgesics in the Treatment of Chronic Pain (adopted July 2013)

Introduction

The Federation of State Medical Boards (the FSMB) is committed to assisting state Medical Boards in protecting the public and improving the quality and integrity of health care in the United States. In 1997, the Federation undertook an initiative to develop model guidelines and to encourage state Medical Boards and other health care regulatory agencies to adopt policies encouraging safe and effective treatment of patients with pain, including the use of opioid analgesics as indicated [1]. The Federation updated its guidelines in 2003 [2] so that its Model Policy would reflect the best available evidence on management of chronic pain and give adequate attention to both the undertreatment and overtreatment of pain and the inappropriate use of opioid analgesics.

Through this initiative, the Federation has sought to achieve the dual goals of promoting safe and effective pain management within the bounds

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BOARD POSITION STATEMENT

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overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this policy has been developed to clarify the Board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from physicians' lack of knowledge about pain management. Fears of investigation or sanction by federal, state and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the Board will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The Board recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Board will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The North Carolina Medical Board is obligated under the laws of the State of North Carolina to protect the public health and safety. The Board recognizes that the use of opioid analgesics for other than legitimate medical purposes pose a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Board expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The Board will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section II: Guidelines

The Board has adopted the following criteria when evaluating the physician's treatment of pain, including the use of controlled substances:

Evaluation of the Patient- A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Treatment Plan- The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment- The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (e.g., violation of agreement); and
- the North Carolina Controlled Substance Reporting Service can be accessed and its results used to make treatment decisions.

Periodic Review- The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. Reviewing the North Carolina Controlled Substance Reporting Service should be considered if

inappropriate medication usage is suspected and intermittently on all patients.

Consultation- The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Medical Records- The physician should keep accurate and complete records to include

- the medical history and physical examination,
- diagnostic, therapeutic and laboratory results,
- evaluations and consultations,
- treatment objectives,
- discussion of risks and benefits,
- informed consent,
- treatments,
- medications (including date, type, dosage and quantity prescribed),
- instructions and agreements and
- periodic reviews including potential review of the North Carolina Controlled Substance Reporting Service.

Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance With Controlled Substances Laws and Regulations- To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and any relevant documents issued by the state of North Carolina for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain- Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.

Addiction- Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

Chronic Pain- Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain- An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence- Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction- The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Substance Abuse- Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance- Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Created September 26, 1996; redone July 2005 based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain," as amended by the FSMB in 2004; amended September 2008

FSMB MODEL POLICY

Continued from page 3.

the bounds of professional practice by educating physicians about methods that promote appropriate prescribing, without inducing fear of regulations. The Federation recognizes that inappropriate prescribing can contribute to adverse outcomes such as reduced function, opioid addiction, overdose, and death [3-5]. By promulgating its Model Policies, the Federation has sought to encourage the legitimate medical use of opioid analgesics for the treatment of pain while emphasizing the need to safeguard against their misuse and diversion.

Since their publication, the 1998 and 2004 Model Policies have been widely distributed to state medical boards, medical professional organizations, other health care regulatory boards, patient advocacy groups, pharmaceutical companies, state and federal regulatory agencies, and practicing physicians and other health care providers. The policies have been endorsed by the American Academy of Pain Medicine, the Drug Enforcement Administration, the American Pain Society, and the National Association of State Controlled Substances Authorities. Many states have adopted all or part of the Model Policies.[1]

The updated Model Policy presented here reflects the considerable body of research and experience accrued since the 2004 revision was adopted [2]. While recognizing that adequate evidence is currently lacking as to the effectiveness and safety of long-term opioid therapy, this Model Policy is designed to promote the public health by encouraging state medical boards to adopt consistent policy regarding the treatment of pain, particularly chronic pain, and to promote patient access to appropriate pain management and, if indicated, substance abuse and addiction treatment.

The Model Policy emphasizes the professional and ethical responsibility of physicians to appropriately assess and manage patients' pain, assess the relative level of risk for misuse and addiction, monitor for aberrant behaviors and intervene as appropriate. It also includes references and the definitions of key terms used in pain management.

The Federation encourages every state Medical Board to work with the state Attorney General to evaluate the state's policies, regulations and laws in an effort to identify any barriers to the effective use of opioids to relieve pain, while ensuring that adequate safeguards are in place to deter and rapidly detect those who would obtain opioid analgesics for nonmedical purposes [6-7].

The Federation acknowledges with gratitude the efforts of the state Board members and directors who collaborated to prepare this updated Model Policy, as well as the contributions of the independent experts and medical organizations that advised the drafting committee and reviewed its work. The Federation also thanks SAMHSA for its support of this important project.

Issues Addressed in the New Model Policy

There is a significant body of evidence suggesting that both acute and chronic pain continue to be undertreated [8-10]. Approximately one in four patients seen in primary care settings suffer from pain as intense as to interfere with the activities of daily living [4]. Pain arises from multiple causes and often is categorized as either acute pain (such as that from traumatic injury and surgery) or chronic pain (such as the pain associated with terminal conditions such as cancer or severe vascular disease or with non-terminal conditions such as arthritis or neuropathy) [4,8]. This model policy applies most directly—although not exclusively—to the treatment of chronic pain.

Undertreatment of pain is recognized as a serious public health problem that compromises patients' functional status and quality of life [4,9]. A myriad of psychological, social, economic, political, legal and educational factors—including inconsistencies and restrictions in state pain policies—can either facilitate or impede the ability and willingness of physicians to manage patients with pain [6,10-11].

While acknowledging that undertreatment exists, it must be understood that chronic pain often is intractable, that the current state of medical knowledge does not provide for complete elimination of chronic pain in most cases, and that the fact of persistent and disabling pain does not in and of itself constitute evidence of undertreatment [4,8,12]. Indeed, some cases of intractable pain actually result from overtreatment in terms of procedures and medications.

Complicating the picture, adverse outcomes associated with the misuse, abuse and diversion of prescription opioids have increased dramatically since the Federation's last review [3]. Physicians and other health care professionals have contributed—often inadvertently—to these alarming but inadequately understood statistics [5-6,13].

Circumstances that contribute to both the undertreatment of pain and the inappropriate prescribing of opioids by physicians include: (1) physician uncertainty as to prevailing standards of care; (2) inadequate research into the sources of and treatments for pain; (3) sometimes conflicting clinical guidelines for appropriate treatment of pain; (4) physician concerns that prescribing adequate amounts of opioid analgesics will result in unnecessary scrutiny by regulatory authorities; (5) physician misunderstanding of causes and manifestations of opioid dependence and addiction; (6) fear on the part of physicians of causing addiction or being deceived by a patient who seeks drugs for purposes of misuse; (7) physician behaviors that have been described as "confrontation phobia" and "hypertropied enabling"; and (8) inadequate physician education about regulatory policies and processes [3-4,12,14-20]. Inappropriate treatment also can result from a mistaken belief on the part of patients and their physicians that complete eradication of pain is an attainable goal, and one that can be achieved without disabling adverse effects.

Patients share with physicians a responsibility for appropriate use of opioid analgesics [21-22]. This responsibility encompasses providing the physician with complete and accurate information and adhering to the treatment plan. Some patients—intentionally or unintentionally—are less than forthcoming or have unrealistic expectations regarding the need for opioid therapy or the amount of medication required. Other patients may begin to use medications as prescribed, then slowly deviate from the therapeutic regimen. Still others may not comply with the treatment plan because they misunderstood the physician's instructions. Some patients share their drugs with others without intending harm (a pattern of misuse that is seen quite often among older adults [15]). Then there are patients who deliberately misuse or are addicted to opioids, and who mislead, deceive or fail to disclose information to their physicians in order to obtain opioids to sustain their addiction and avoid withdrawal [19-23].

Patients' carelessness in leaving drugs where they can be stolen by visitors, workers and family members is another important source of diversion. Thus a prescription that is quite appropriate for an elderly patient may ultimately contribute to the death of a young person who visits or lives in the patient's home. Therefore, the physician's duty includes not only appropriate prescribing of opioid analgesics, but also appropriate education of patients regarding the secure storage of medications and their appropriate disposal once the course of treatment is completed [18,23].

A more problematic individual is the criminal patient, whose primary purpose is to obtain drugs for resale. Whereas most addicted patients seek a long-term relationship with a prescriber, criminal patients sometimes move rapidly from one prescriber (or dispenser) to another. Such individuals often visit multiple practitioners in a day (a practice known as "doctor shopping") and travel from one geographic area to another in search of unsuspecting targets [19-21]. Physicians' attention to patient assessment and the routine use of state prescription drug monitoring programs (PDMPs), where available, have been cited as effective ways to identify individuals who engage in such criminal activities [20-23,45].

Summary

The goal of this Model Policy is to provide state medical Boards with an updated template for assessing physicians' management of pain, so as to determine whether opioid analgesics are used in a manner that is both medically appropriate and in compliance with applicable state and federal laws and regulations. The revised Model Policy makes it clear that the state Medical Board will consider inappropriate management of pain, particularly chronic pain, to be a departure from accepted standards of practice.

In addition, the Model Policy is designed to communicate to licensees that the state Medical Board views pain management as an important area of patient care that is integral to the practice of medicine; that opioid analgesics may be necessary for the relief of pain; and that physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes. However, prescribers must be held to a safe and appropriate standard of care. The federal Controlled Substances Act [25] defines a "lawful prescription" as one that is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. The use of opioids for other than legitimate medical purposes poses a threat to the individual and to the public health, thus imposing on physicians a responsibility to minimize the potential for misuse, abuse and diversion of opioids and all other controlled substances.

Citations and the full version of the "Model Policy" are available on the home page of the Board's website at www.ncmedboard.org

Changes to the NCCSRS

New law makes improvements, eases access

William D. Bronson, Program Manager, Drug Control Unit, NCDHHS

Governor Pat McCrory signed legislation on June 19 that will strengthen and improve the North Carolina Controlled Substances Reporting System (CSRS) and make it a more easily accessible and useful tool for health care providers. Provider input led to one of the most significant changes in Senate Bill 222 (Session Law 2013-152), a provision to allow prescribers and dispensers to delegate the task of querying the system to approved delegates. Additional changes allow for more complete and timely information going into the CSRS and increased communication from DHHS to prescribers, dispensers and licensing boards.

The CSRS was established in 2007 as an important tool for prescribers and dispensers of controlled substances, allowing them to provide safer care for their patients. The CSRS helps to combat the deaths, emergency department visits and diversion of controlled substances occurring as we experience an epidemic of prescription drug misuse. The CSRS provides a database that allows DHHS registered prescribers and dispensers of controlled substances to have Web access to review the controlled substance prescriptions their patients have received in an effort to provide safer care.

Portions of the law go into effect immediately while other portions become effective January 1, 2014. Provisions that have already become law will take time to implement and will be phased in.

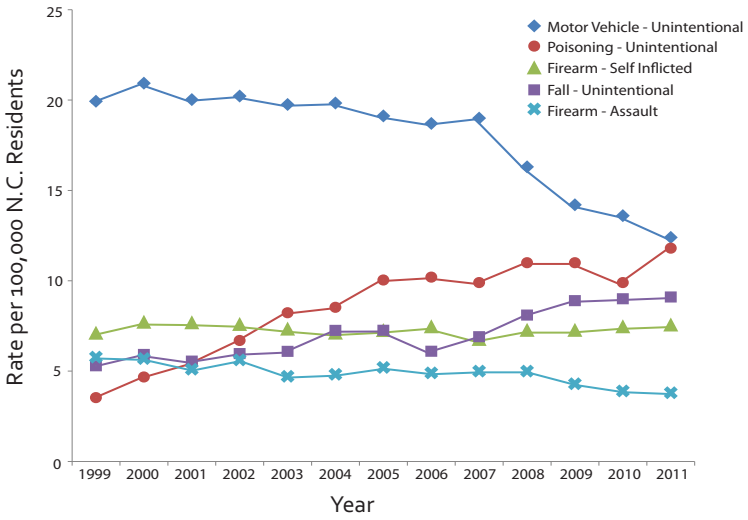
Specific provisions enacted

The following provides a brief summary of the provisions. Further details will be posted on the CSRS website (*www.nccsrs.org*) as they become available.

- Prescribers and Dispensers may delegate the task of querying to others under their supervision provided DHHS registers and approves the delegates. The delegator must be registered with the CSRS and the delegates will be linked to the prescriber or dispenser who will be responsible for their activities and the handling of confidential information. Fines for misuse of the CSRS or information from the CSRS are increased to up to $10,000 per instance. It is important to note that the delegation is only for querying and obtaining the information. Interpreting the information continues to be the responsibility of the prescriber or dispenser.
- Physician dispensed medication in excess of a 48 hour supply must be reported to the CSRS starting January 1, 2014. This closes an information gap that currently exists. Further information on how this requirement may be met will be disseminated in the near future to Board of Pharmacy permitted dispensaries.
- Effective January 1, 2014, all required prescriptions dispensed by pharmacies and required dispensed medication must be reported to the CSRS not later than the close of business three business days after the delivery of the medication to the patient. In addition, dispensers are encouraged to report the information no later than 24 hours after the prescription is delivered. Dispensers will also be required to report the method of payment to the CSRS.

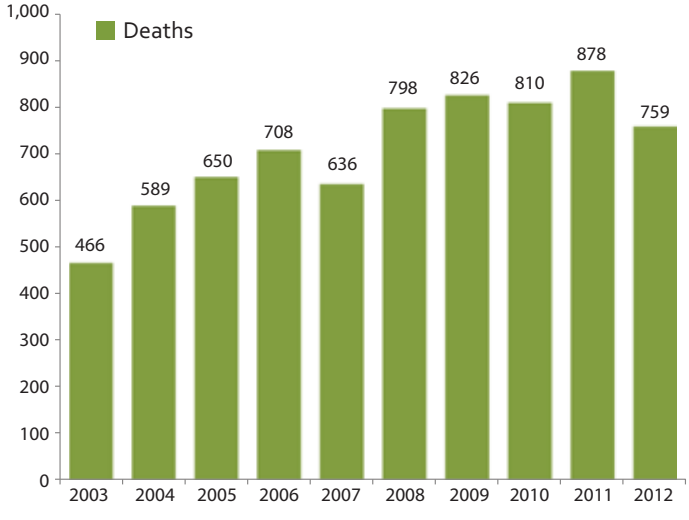
See CSRS on page 11.

LEADING CAUSE OF INJURY DEATH RATES PER 100,000, N.C. 1999-2011



Source: N.C. State Center for Health Statistics, Vital Statistics Deaths, 1999-2011
Analysis by the Injury Epidemiology and Surveillance Unit

UNINTENTIONAL DEATHS IN N.C. DUE TO CONTROLLED SUBSTANCES 2003-2012



OCME reports 2012 deaths may be underreported due to delays
Source: N.C. State Medical Examiner's Office

Complying with the HIPAA final Omnibus Rule

Many aspects of the law have changed since its initial enactment

Margie Satinsky, MBA, President, Satinsky Consulting, LLC

HIPAA has been with us for more than a decade, but the federal agencies responsible for writing and enforcing this complex law have only recently published final rules that reflect the current, official government position on how various aspects of the law should be interpreted and implemented. The Omnibus Final Rule was published in the Federal Register in January 2013 and took effect March 23rd. "Covered entities"—including medical providers/practices, health plans and healthcare clearinghouses that transmit protected health information electronically, Business Associates, and subcontractors of Business Associates (i.e. Agents) are required to be in full compliance by September 23.

The Omnibus Final Rule modifies HIPAA Privacy, Security and Enforcement Rules, Breach Notification Rules under the HITECH Act of 2009, and the Genetic Information Nondiscrimination Act. It implements statutory amendments under the HITECH Act of 2009, strengthens privacy and security protection for individuals' health information, modifies the definition of a "breach," and strengthens privacy protections for genetic information, among other changes.

Durham practice management consultant Marjorie Satinsky tells *Forum* readers what they need to know.

Ms. Satinsky

What is HIPAA?

In 1996, the federal government passed the Health Insurance Portability and Accountability Act (HIPAA). Its purpose was to provide assurances that the healthcare system would keep personal health information private. The Administrative Simplification portion of the law had five parts: the Privacy Rule, Transactions and Code Sets Standards, the Security Rule, the Employer Identifier Standard, and the National Provider Identifier Standards. The HITECH Act of 2009, part of the American Recovery and Reinvestment Act (ARRA), both modified some of the provisions of the Privacy and Security Rules and added requirements. Other relevant statutes are the Interim Final Regulations on implementation of Breach Notification; Federal Trade Commission (FTC) Final Regulations on implementation of Breach Notification; the Interim Final Rule addressing Breach Notification and monetary penalties; the 2010 Notice of Proposed Rule Making; and the Genetic Information Nondiscrimination Act of 2008. The intent of the Final Omnibus Rule is to eliminate inconsistencies among some of these statutes and bring everything together.

We're a small medical practice. Do we really have to bother with all the steps needed to comply with the Privacy and Security Rules?

Yes! When HIPAA first passed, the Department of Health and Human Services (DHHS), and its enforcement arm, the Office of Civil Rights (OCR), focused on education and voluntary compliance rather than on enforcement. That situation has changed, and an active enforcement audit program is now in effect. If you are a covered entity or Business Associate, small size does not mean you are under the radar screen. When I give presentations on HIPAA, the question I hear most often (usually from smaller practices) is whether or not practices really have to take HIPAA compliance seriously. Now that the federal government's HIPAA enforcement audit program has begun in earnest, many small entities have already faced stiff fines for incidents that meet the definition of a Breach. Here's an example: On January 2, 2013, DHHS announced its first HIPAA breach settlement involving fewer than 500 patients. The Hospice of North Idaho agreed to a settlement of $50,000. The agency had reported a theft of a laptop computer containing electronic personal health information (PHI) for 441 patients, and during the course of its investigation, OCR discovered that the Hospice had not conducted a risk analysis to safeguard PHI. Practices should understand that ignorance is not a valid defense and know that, if "willful neglect" is demonstrated, the financial penalties are even stiffer.

How has enforcement changed since HIPAA went into effect?

DHHS now does a preliminary investigation of every complaint. If the preliminary review indicates a possible violation of HIPAA rules due to willful neglect, the investigation automatically proceeds. If the preliminary review does not show willful neglect, DHHS has the option of trying to achieve voluntary corrective action.

A 30-day cure period factors into the determination of the size of the penalty. The clock starts running at the time the entity (i.e., Covered Entity, Business Associate, or Subcon-

tractor) learns of, or should reasonably know of, the problem. DHHS has a formal and proactive audit program in place in order to identify noncompliance with HIPAA. Practices and other covered entities should take heed and act now to ensure that they are meeting the requirements of the law. I am aware of several medical practices that attested to being HIPAA compliant when they applied for financial incentives under Meaningful Use and are now targets for audit. Questionable HIPAA compliance may jeopardize their receipt of the federal subsidy.

How does the Omnibus Final Rule enhance the rights of individuals with respect to PHI?

The Omnibus Final Rule strengthens limitations on the use and disclosure of PHI for marketing and fundraising purposes. Individuals can now request electronic copies of PHI, and Covered Entities must provide it in the form requested by the individual if readily producible, or in a readable form and format agreed to by the Covered Entity. Individuals can request transmission of a copy of PHI directly to a designated person. In such cases, the Covered Entity must verify the identity of the individual making the request and take reasonable steps to ensure that the email address of the recipient is correct. Individuals who pay out of pocket in full for a service can restrict disclosure of that information to a health plan. To help parents and guardians, Covered Entities now have an easier process for disclosing proof of immunization to schools in those states that have school entry and other similar laws. There's more clarity in the procedures for notifying individuals of a Breach. When individuals request PHI, Covered Entities must provide the requested information within 30 days, with a one-time 30-day extension.

How has the definition of a Breach changed, and what are the guidelines for determining and reporting a Breach?

The manner of determining whether or not a Breach has occurred remains more subjective than many in the health industry would like it to be. Still, the Omnibus Rule modifies and clarifies the definition of Breach and the risk assessment approach. Under the Omnibus Final Rule, a Breach is defined as: an impermissible use or disclosure of PHI unless the Covered Entity or Business Associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Rather than focusing on potential harm to the individual, as in the HITECH Act of 2009, the new language speaks to the responsibility of a risk assessment, performed by the Covered Entity or Business Associate, to assess the nature and extent of the PHI, the unauthorized person who used the PHI or to whom it was disclosed, whether or not the PHI was actually acquired or viewed, and the extent to which the risk has been mitigated. A common example of a possible Breach is a lost or stolen laptop

The price of noncompliance: a HIPAA penalties primer

Violations of the HIPAA Privacy and Security Rules have three types of associated penalties – civil monetary penalties, criminal penalties, and penalties for violation of the breach notification provision. It is possible to be "double dinged" – i.e., to receive both a civil penalty and a penalty related to Breach notification.

Improper use or disclosure of PHI can result in four categories of civil monetary penalties reflecting increasing levels of culpability by individuals, employees, and/or organizations. State attorneys general (AG) are authorized to pursue civil actions for HIPAA privacy and security violations that have threatened or adversely affected a resident of that AG's respective state. The state must notify DHHS of a suit before or as soon as feasible after filing.

Civil Penalties

The following apply to covered entities, Business Associates, and to subcontractors (i.e., agents) of Business Associates.

- $100-$50,000 per violation for an unknowing privacy violation by a covered entity or Business Associate, with a $1.5 million maximum/calendar year penalty for violations of an identical provision.
- $1,000 - $50,000 per violation for a violation for which it is established that the violation was due to reasonable cause and not to willful neglect, with a $1.5 million maximum/calendar year penalty for violations of an identical provision.
- $10,000 - $50,000 per violation for which it is established that the violation was due to willful neglect and was corrected in a timely manner, with a $1.5 million maximum/calendar year penalty for violations of an identical provision.
- $50,000 per violation for a violation in which it is established that the violation was due to willful neglect and was not timely corrected, with a $1.5 million maximum/calendar year penalty for violations of an identical provision.

Criminal Penalties

For the violation to be criminal, the individual who committed the violation must have done so willingly, knowing the implications of divulging the PHI. As with the civil penalties, there are different levels of severity for criminal violations.

- $50,000 per violation and up to one year in jail.
- For violations committed under false pretenses, $100,000 per violation and up to five years in jail.
- For violations where there was intent to sell, transfer, or use PHI for commercial advantage, personal gain, or malicious harm, up to $250,000 per violation and up to 10 years in jail.

computer. The loss or theft itself does not necessarily mean a Breach. If the owner can retrieve the laptop and forensically show that there was no Breach, then there's nothing to report. But if the laptop can't be retrieved, there is a Breach that must be reported to the individuals affected and possibly to the media and to the Centers for Medicare and Medicaid Services (CMS).

How does the Omnibus Rule modify the HIPAA Privacy Rule to protect genetic information as required by the Genetic Information Nondiscrimination Act (GINA) of 2008?

GINA prohibits discrimination based on an individual's genetic information in health coverage and employment contexts. Genetic information is defined as the genetic tests of an individual or an individual's family members and about diseases or disorders manifested in an individual's family members. A distinction is made between genetic tests and medical tests such as HIV tests, complete blood work, cholesterol testing, and liver function tests. This particular provision applies primarily to health plans.

Should my practice revise its (NPP) and redistribute it to patients?

The Notice of Privacy Practices (NPP) must be revised. There have been many changes since the initial passage of the HIPAA Privacy and Security Rules. For example, the NPP now must have language regarding patient authorization for most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures regarding the sale of PHI. There must also be a statement regarding patient authorization for uses and disclosures not specifically described in the NPP. New language must mention an individual's right to opt out of fundraising communications. Healthcare providers must clearly acknowledge their obligation to restrict use and disclosure to a health plan upon request by an individual who has paid out-of-pocket in full for a specific service.

Healthcare providers are not required to print and distribute a hard copy of the revised NPP to every patient. However, within a year after the new NPP goes into effect, they must make the revised NPP available for patients to read. They can use a summary version, provided that the full NPP is readily available. As has been the case from the outset, providers must document the patient's acknowledgment of the right to review the NPP or refusal to exercise it. Providers should also post the new NPP in a clear and prominent location. Again, they can post a summary, provided that the full version is available. Providers should also post the new NPP on their websites. If patients have granted permission to receive practice information by email, the practice can send the revised NPP electronically.

What are good resources for additional information?

- The Final Omnibus Rule was published in the Federal Register on January 25, 2013. The link is *www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf*. The material identifies modifications and additions, citing both public comment and rationale for DHHS' final decisions.
- The North Carolina Healthcare Information and Communications Alliance (NCHICA) has already revised the sample Business Associate Agreement and is working to revise other sample tools. Go to *www.nchica.org* for additional information.
- The website of the Office of Civil Rights contains instructions for submitting a Breach form: *www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html*.

Has a Breach occurred?

One of the major changes in the 2013 Omnibus Final Rule applies to the definition of a "Breach" – i.e., the unauthorized use or disclosure of PHI. We're talking about "unsecured" PHI – PHI that is not secured through a technology or methodology specified by DHHS that renders the PHI unusable, unreadable, or indecipherable to unauthorized individuals (e.g., encryption). An impermissible use or disclosure of unsecured PHI is now considered to be a reportable breach unless the covered entity, Business Associate, or subcontractor (i.e. Agent) of a Business Associate, as applicable, demonstrates that there is a low probability that the PHI has been compromised.

The burden of proof regarding a Breach requires a four-part risk analysis. For example, a lost or stolen laptop computer isn't always a breach. The conclusion depends on answers to the following questions:

1. The nature and extent of the PHI, including the types of identification and the likelihood of re-identification
2. The unauthorized person who used the PHI or to whom a disclosure was made
3. Whether or not the PHI was acquired or viewed
4. The extent to which the risk to the PHI has been mitigated

CSRS continued from page 7.

- DHHS may alert prescribers and dispensers of patients who have obtained prescriptions in a manner that may represent abuse, diversion of controlled substances, or an increased risk of harm to the patient. These "unsolicited alerts" will usually come via email and direct the practitioner to consult a specific query number in the CSRS. Although all prescribers may receive an alert, only registered prescribers will be able to view the query prepared for them in their account. Non-registered prescribers will be encouraged to register and will be provided a link to obtain an application.
- DHHS may alert licensing boards of prescribing or dispensing practices in accordance with rules established by the respective board.
- DHHS must provide information to sheriffs, designated deputy sheriff's, police chiefs or their designated investigators assigned to investigate diversion and illegal use of prescription medications or pharmaceutical products identified as controlled substances who are engaged in a bona fide investigation and pursuant to a court order.

Independent of the recent statutory changes, the CSRS is working with the Medical Board to make it easier to register for access to the reporting system while enabling the CSRS to maintain more complete information. These improvements are currently in the developmental stages. Among them are:

- A streamlined registration process whereby a prescriber could register for Web access to the CSRS via a portal on the NCMB's website. A notarized signature would not be required for this avenue of registration. The prescriber would sign into a secure Medical Board portal. A link would be provided for them to register for the CSRS. The plan is to ask licensees of the Medical Board for information not currently stored by the Board (such as DEA number and proposed password) but required to access the reporting system. This additional information will be combined with the information on record with the NCMB and sent electronically to the CSRS office for registration. Prior to transmitting the data the prescriber will sign the privacy statement and give consent for the transmission.
- An upgrade to the language format that pharmacies report into the CSRS is planned. (changing from ASAP 1995 to ASAP 4.2). This change will allow CSRS to capture more information including the ID of the person picking up a prescription for a Schedule II and/or Schedule III opioid analgesic.

We are hopeful that these changes and improvements will enable more prescribers to begin using this valuable tool. Routine use of the CSRS is quickly becoming the standard of care when providing treatment that includes prescribing controlled substances.

Contact Devon Scott or William Bronson with the Department of Health and Human Services at 919-733-1765 if you have any questions.

Position Statement Update

The NCMB regularly adopts new position statements and reviews and, where appropriate, revises the existing official position statements of the Board to ensure that they remain relevant. We periodically publish a summary of recent revisions to position statements to help licensees stay abreast of changes. Full positions statements may be found online in the Professional Resources section of the Board's website.

Statement: **Treatment of obesity**
Date revised: May 2013
Changes: The statement is revised to add a cautionary note regarding the use of HCG in the treatment of obesity. The following has been added to the full version of the position statement:
Treatment modalities and prescription medications that have not been proven to have beneficial effects should not be used. For example, it is the Board's position that the use of HCG for the treatment of obesity is not appropriate.

Statement: **Contact with patients before prescribing**
Date revised: May 2013
Changes: Revisions include the addition of consistent references to opiate vs. opioid as well as the insertion of language that included, as an exception, the prescribing of an opioid antagonist. The following selection from the position statement has been revised to include the underlined portion:
Prescribing for a patient whom the licensee has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, prescribing for a patient of another licensee for whom the prescriber is taking call, continuing medication on a short-term basis for a new patient prior to the patient's first appointment, <u>or prescribing an opioid antagonist to someone in a position to assist a person at risk of an opiate-related overdose.</u>

Statement: **Medical Record Documentation**
Date revised: May 2013
Changes: This statement was reviewed and no changes were necessary.

North Carolina Medical Board

Quarterly Board Actions Report | February - April 2013

The Board actions listed below are published in an abbreviated format. The report does not include non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. Recent Board actions are also available at *www.ncmedboard.org*. Go to "Professional Resources" to view current disciplinary data or to sign up to receive notification when new actions are posted via the RSS Feed subscription service.

Name/license#/location	Date of action	Cause of action	Board action
ANNULMENTS			
None			
SUMMARY SUSPENSIONS			
None			
REVOCATIONS			
None			
SUSPENSIONS			
BISSELL, Karen Romaine, MD (000026314) Mooresville, NC	03/05/2013	MD failed to complete delinquent medical records, on one occasion building up a backlog of approximately 1,000 patient records. MD told a board investigator that she "has better things to do, that records are laborious and that she didn't appreciate being treated like a criminal." She told the investigator she would complete the current backlog of records, which numbered at least 92. MD made no attempt to complete any delinquent records.	Indefinite suspension
HAYNES, Gregory Delano, MD (200800455) Lenoir, NC	02/21/2013	Concerns about the quality of care MD provided to a patient with Hepatitis C.	MD's license is suspended for one year, stayed; Must submit himself for a professional assessment.
KING, David James, MD (000033388) Louisburg, NC	02/28/2013	MD presigned prescription blanks for controlled substances and left them for office staff to complete when MD was away. This practice resulted in patients receiving prescriptions for controlled substances without ever seeing a physician.	MD is suspended for 60 days, immediately stayed all but a period of two days to be served on March 4 and March 5, 2013; $3,000 fine.
LILJEBERG, Robert Louis, MD (009400564) Hickory, NC	02/21/2013	MDs privileges to practice at Viewmont Surgery Center had been indefinitely suspended due to MD's conduct toward an employee. The surgery center referred to MD's attempt to vandalize the car of an employee. The attempt was recorded on video surveillance.	MD is suspended for a period of 90 days, to begin on 03/01/2013 and end on May 31, 2013.
SCOTTI, Stephen Douglas, MD (200900302) Charlottesville, VA	02/21/2013	History of substance abuse. On 2/24/12, MD had a relapse and abused LSD. On the same date, MD was involved in an automobile accident and arrested and charged with Driving While Under the Influence of Drugs (DUID).	MD's license is indefinitely suspended, immediately stayed; MD has completed inpatient treatment and signed a monitoring contract with NCPHP.
SVEDBERG, Kelly Gene, PA (001000631) Waxhaw, NC	02/21/2013	PA pleaded guilty to one felony count of conspiracy to commit health care fraud; he was sentenced to probation, home confinement, community service and restitution in the amount of $81,356.59.	PA is suspended for a period of 13 months, to run 03/01/2013 to 04/01/2014.
WILSON, Vincent Paul, MD (201201585) New Bern, NC	04/04/2013	History of alcohol abuse; history of substance abuse, specifically Ambien.	Indefinite suspension
ZIOMEK, Paul Henry, MD (000036083) Rutherfordton, NC	02/27/2013	MD failed to enter into a reentry agreement or obtain written approval from the Board before resuming the practice of medicine.	Indefinite suspension
PROBATIONS			
None			

Name/license#/location	Date of action	Cause of action	Board action
REPRIMANDS			
CARUSO, James Anthony, PA (000102678) Chicago, IL	03/06/2013	PA was charged with unlawfully parking in a handicapped parking space and consuming alcohol on the premises of a gas station, which has only an off-premesis alcohol permit. PA was also charged with driving under the influence. PA failed to inform the Board of the misdemeanor charges on his annual renewal, despite a direct question asking licensees to list all occurences within the past 10 years.	Reprimand; $1,000 fine
GOAD, Bradley Jackson, DO (200701414) Woodlawn, VA	02/21/2013	DO entered into a consent order with the Virginia Board related to findings that DO presigned prescription blanks intending that the blanks be used for patients at a long-term care facility for which his practice provided patient care.	Reprimand
GRAHAM, Cecil Curtis, MD (200200535) Peoria, AZ	04/02/2013	MD entered into a consent order with the West Virginia Board based on failure to properly supervise a physician extender and other matters related to quality of care.	Reprimand
IRONS, Robert Neal, PA-C (000103399) Hurdle Mills, NC	03/12/2013	PA treated and prescribed controlled substances to a family member with acute Leukemia. The family member had been under the care of PA's supervising physician. PA took over the care until he became the principal care provider. PA wrote increasing doses of narcotics for his family member. Not all of the prescriptions were documented in the patient record. Prescribing controlled susbtances to a close family member is prohibited by administrative rule.	PA is reprimanded; PA is also suspended for six months, immediately stayed.
KIM, Jong Whan, MD (200101455) Elizabeth Town, NC	03/31/2013	The Board received a complaint that MD had an inappropriate relationship with Patient A. MD denies this. Patient A contacted MD and told him she had a burn she would like him to look at. MD met Patient A at a hotel in Wilmington, NC, and treated her in her hotel room. MD failed to make any record of this treatment.	MD is reprimanded; within six months of the date of this order, MD must complete the "Maintaining Proper Boundaries" course at Vanderbilt.
STONE, James Walter, MD (200600851) Richmond, VA	02/06/2013	MD administered the drug phenylephrine instead of Decadron as intended. The patient experienced complications and had to be hospitalized for four days. MD entered into a consent order with the Virginia Board and accepted a reprimand.	Reprimand
STURGILL FANT, Vanessa Jean, MD (200701834) Woodlawn, VA	02/20/2013	MD entered into a consent order with the Virginia Board. MD presigned prescription blanks with the intent that the prescriptions be kept on-site. The blanks were not dated and signed by MD on the date issued as required by VA code.	Reprimand
TAUB, Neal Stephen, MD (000035767) Charlotte, NC	03/25/2013	The Board perceives a need for continued improvement in MD's monitoring of patients' medication use, handling of unexpected urine drug screen results and other areas of patient care.	Reprimand
DENIALS OF LICENSE/APPROVAL			
BARINHOLTZ, David Bruce, MD Chicago, IL	04/03/2013	MD made multiple false statements on his NC license application.	Denial of application for NC medical license.
SHIMKUS, Jeanette Frances, DO, Chesapeake, VA	04/03/2013	DO failed to satisfy the Board of her qualifications for a license because she has been convicted of a felony.	Denial of application for NC medical license.
SURRENDERS			
NEWSOME, George Edward, MD (0000016439) Wilson, NC	03/08/2013		Voluntary surrender of medical license
SANCHEZ-BRUGAL, Fernando A., MD (009900128) Asheville, NC	02/25/2013		Voluntary surrender of medical license

Name/license#/location	Date of action	Cause of action	Board action
PUBLIC LETTERS OF CONCERN			
BRAASCH, Ernest Russell, MD (000018391) Raleigh, NC	02/22/2013	MD treated three family members on repeated occasions, including prescribing controlled substances/other medications; MD did not keep any records and used some of the prescribed medications, including a controlled substance, himself.	Public letter of concern; MD has completed CME in prescribing practices.
CHANDLER, Charles Edward, III, MD (201300853) Atlanta, GA	04/29/2013	MD failed to disclose material information on his NC license application. MD failed to appropriately disclose a 3-month academic probation during residency training and two prior misdemeanor charges, neither of which resulted in a conviction.	NC license issued, with a public letter of concern.
DUNN, Ernest Clinton, Jr., MD (000024967) Bayboro, NC	02/22/2013	MD's prescribing of controlled substances failed to meet acceptable and prevailing standards.	Public letter of concern; must complete CME in prescribing controlled substances and chronic pain management.
GILLIAM, Linda Harris, MD (200300982) Jonesboro, AR	01/30/2013	MD violated her previous order with Arkansas Board dated 10/27/10. MD failed to participate in drug screening, failed to provide quarterly reports from a treating psychiatrist and failed to provide quarterly reports from a counselor.	Public letter of concern.
JONES, Thomas McIntosh, MD (000025334) Fayetteville, NC	03/25/2013	Quality of care; poor documentation.	Public letter of concern.
LUPIA, Raul Humberto, MD (009400906) Oxford, NC	04/08/2013	MD prescribed controlled and non-controlled substances to family members, in violation of the Board's position statement on treating self/family and related administrative rules.	Public letter of concern.
LUTNER, Lawrence, MD (201300681) Mt. Pleasant, SC	04/16/2013	MD omitted material information from his application for a NC medical license.	NC medical license issued, with a public letter of concern.
MANION, Kernan Thomas, MD (200200407) Wilmington, NC	02/21/2013	MD failed to comply with a prior Board order and obtain an assessment in a timely manner.	Public letter of concern.
ROSIER, Margaret Bridgid, MD (200700993) Raleigh, NC	04/23/2013	MD was arrested and charged with DUI following a minor rear-end collision. MD was cautioned previously by the Board after an alcohol related incident in 2009 that similar behavior could result in public action. MD was evaluated by NCPHP and subsequently entered a residential treatment program.	Public letter of concern.
MISCELLANEOUS ACTIONS			
ARCEO-FREDERICK, Liza Antoinette, MD (200201038) Huntington, WV	04/23/2013	Prior history of substance abuse.	MD's license is reinstated.; must provide 60 days notice prior to returning to practice in NC. Before resuming practice in NC, MD must obtain an assessment by the NCPHP. MD is restricted and may not practice anesthesiology in NC.
CLARK, Bendik Larson, MD (201300724) Bristol, TN	04/23/2013	Prior history of substance abuse.	MD is issued a license via consent order; must maintain NCPHP contract.
DAVIS, John Edward, MD (000020255) Columbus, NC	04/01/2013	MD's staff privileges at Rutherford Regional Medical Center were summarily suspended related to concerns regarding MD's physical ability to perform complex surgical procedures; a CPEP assessment determined that MD is capable of practicing in many medical environments, including office-based practice.	Non-disciplinary consent order; MD's medical practice must be approved in advance by the Board president; MD may only perform surgery in the OR as a first assistant with 100 percent supervision by a surgeon licensed in NC.
MCDONALD, Janice Adelaide, MD (200101474) Virginia Beach, VA	04/15/2013	Prior history of substance abuse.	License issued via consent order; must maintain NCPHP contract.

Name/license#/location	Date of action	Cause of action	Board action
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
GERANCHER, John Charles, III, MD (009500077) Winston-Salem, NC	02/06/2013	MD was arrested and charged with indecent exposure in two unrelated incidents. MD has successfully completed several weeks of intensive residential treatment and continues to receive outpatient therapy. He has signed a five year monitoring contract with NCPHP.	MD is issued a temporary medical license; Expires 09/30/2013.
SMITH, Bryan Dorsey, MD (200201531) Pinehurst, NC	03/21/2013		Temporary physician license made full and unrestricted.
COURT APPEALS/STAYS			
None			
CONSENT ORDERS AMENDED			
None			
DISMISSALS			
None			

FINES

The NCMB issues non-disciplinary administrative fines in certain cases where incorrect and/or incomplete information on a medical licensing application causes Board staff to spend an inordinate amount of time resolving the issue(s),

Date	Reason	Amount
3/15/2012	Error/omission on license application or annual renewal	$500.00
3/27/2013	Error/omission on license application or annual renewal	$1,000.00
3/28/2013	Error/omission on license application or annual renewal	$1,000.00
4/16/2013	Error/omission on license application or annual renewal	$1,000.00

CCNC's Project Lazarus initiative provides additional CME opportunities in the area of chronic pain

Community Care of North Carolina (CCNC) is expanding the Project Lazarus approach to the management of chronic pain statewide through multiple initiatives, including community-based trainings for clinicians. The program's goals include decreasing mortality due to unintentional poisonings; to decrease inappropriate utilization of ED for pain management; and to decrease inappropriate ED utilization of imaging with diagnosis of chronic pain. Additional goals include increasing use of CCNC's Provider Portal and the North Carolina Controlled Substances Reporting System.

CCNC will conduct trainings on the medical assessment and treatment of chronic pain in 40 sites across the state, including the following.

- Wilmington, NC - August 29th
- Hickory, NC - September 10th
- Boone, NC - October 30th
- Raleigh, NC - October 8th
- Reidsville, NC - November 19th

Program

All trainings will be held from 5:30 PM to 9:00 PM.
5:30-6:00: Registration and Dinner
6:00-6:10: Introduction to Seminar Objectives
6:10-6:30: Nature of Pain/Role of Opioids
6:30-7:00: Risk Stratification and Initiating Treatment
7:00-7:30: Case discussion 1: Getting started (involving local pain management experts)
7:30-7:45: Break
7:45-8:15: Monitoring, Intervening and When to Stop
8:15-8:45: Case discussion 2: Monitoring and adapting the treatment plan
8:45-9:00: Wrap up/Next steps

*All dates are subject to change. Visit *http://projectlazarustrainings.eventbrite.com/* for more information and to register for trainings.

Additional resources

CCNC has also developed chronic pain toolkits to guide treating providers in Emergency Room, primary care providers and care managers. The kits provide decision support and other tools for providers identifying and addressing each patient's specific care needs. Toolkits can be accessed online at *https://www.communitycarenc.org/population-management/chronic-pain-project/*

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EXAMINATIONS

Residents Please Note USMLE Information

United States Medical Licensing Examination
Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at *www.fsmb.org*.

Special Purpose Examination (SPEX)
The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

BOARD MEETING DATES

August 22-23 (Hearings)
September 18-20, 2013 (Full Board)
October 17-18, 2013 (Hearings)
November 20-22, 2013 (Full Board)

Meeting agendas, minutes and a full list of meeting dates can be found on the Board's website
ncmedboard.org

Visit the Board's website at *www.ncmedboard.org* to change your address online. The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 30 days of a move.

Controlled substances CME event set for Raleigh: October 25

The NCMB has partnered with the North Carolina Medical Society and other health care organizations to give licensees the opportunity to participate in high quality continuing medical education on the subject of appropriate opioid prescribing.

Register now to complete SCOPE (Safe and Competent Opioid Prescribing Education) of Pain training, held Friday, October 25, in conjunction with the NCMS Annual Meeting at the Raleigh Marriott City Center. SCOPE of Pain, developed by the Boston University School of Medicine and funded by an unrestricted educational grant from the manufacturers of ER/LA opioid analgesics, is designed to help physicians and other practitioners safely and competently manage patients with chronic pain. The FDA has mandated that manufacturers of extended release/long acting (ER/LA) opioid analgesics make available comprehensive prescriber education in the safe use of these medications, as part of a comprehensive Risk Evaluation and Mitigation Strategy (REMS).

During the afternoon-long program, attendees will learn how to:

- Decide on appropriateness of opioid analgesics
- Assess for opioid misuse risk
- Counsel patients about opioid safety, risks and benefits
- Competently monitor patients prescribed opioids for benefit and harm
- Make decisions on continuing or discontinuing opioid analgesics, and
- Safely discontinue opioids when there is too little benefit or too much risk and harm.

WHAT: SCOPE of Pain CME in opioid prescribing
WHEN: Friday, October 25, 12pm-4:15pm
WHERE: Raleigh Marriott City Center, 500 Fayetteville St., Raleigh
CME: qualifies for 4 AMA PRA Category 1 Credits
Tuition: $25
TO REGISTER: *www.scopeofpain.com/in-person-training/meeting-locations.php?event=12*

The program will also include a panel discussion among national and North Carolina experts on the subject of controlled substances and the treatment of pain.