West Virginia Board of Medicine

July 2018

Upcoming Board Meetings

September 10, 2018
November 5, 2018

Letter from the President

I write this, my final address as president of the West Virginia Board of Medicine, with satisfaction and gratitude. It has been a pleasure for me to serve the citizens of the great state of West Virginia in this most important capacity. I have been fortunate to have been given the opportunity to serve on the Board a collective 17 years through four appointments by two different governors.

As I reflect on our challenges and accomplishments throughout my presidency, I am struck by the commitment and dedication of my fellow Board members and the Board staff. I have witnessed several changes in medical regulation throughout the years, both at the national and local levels. I am pleased to know that the WVBOM has a reputation that is well deserved in prioritizing public protection.

In the midst of what has been identified as the "opioid crisis," the Board has responded by diligent investigation and the application of the West Virginia Medical Practice Act through administrative procedures. We worked closely with the WV Legislature to develop and maintain standards for a required training on drug diversion and best practice prescribing for those practitioners who prescribe controlled substances. We have added to our investigative staff, in order to respond in a timely fashion to the increased demand as a result of the crisis.

We have successfully launched the Board's participation in the Interstate Medical Licensure Compact creating an alternative pathway to medical licensure for qualifying physicians who wish to practice in multiple states. West Virginia was the fifth state to participate in this initiative that now has a membership of 25 states. To date, our Board has licensed 56 physicians in this manner and West Virginia is the state of principle licensure for 16 physicians.

During my time as president, the Board also experienced the retirement of the former executive director, Robert Knittle, and thus we found ourselves with the daunting task of searching for a replacement. Through the commitment of the search committee of the Board and the participation of senior staff members, we were able to accomplish this task and experienced a near-seamless transition. In addition, we have expanded our office space to better equip our operations and added an additional Physician Assistant member to the Board in response to the Legislature's desire.

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Letter From the President

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Importantly, the Board embarked upon a strategic planning initiative and held our first session last year. I am proud to say that the planning session was helpful in articulating our Mission, Vision and Core Values (located in box to the right).

As a result, we have a clear strategic plan and we are fulfilling it daily. It is my hope that as I vacate the office of president that this strategic plan will assist my successor in maintaining and furthering the important work of the WV Board of Medicine.

While I have completed my second term as president, I will continue to serve out my appointment as a member of the Board. Additionally, I will be serving on a national level as a member of the Nominating Committee for the Federation of State Medical Boards. It is with confidence that I leave the presidency of the Board, knowing that the excellent work that we have come to be known for will continue in the capable hands of dedicated Board members and staff. As a member of the medical community in West Virginia, I have been honored to serve in this capacity.

Bowyer, Upton to Leave Board

Rev. O. Richard Bowyer and Matthew Upton, M.D., will be leaving the West Virginia Board of Medicine when their terms expire on Sept. 30. A past president of the board, Bowyer is the only non-physician ever to hold office on the West Virginia Board of Medicine.

"Both of these members certainly will be missed," Executive Director Mark Spangler said. "Rev. Bowyer has brought a wealth of knowledge to the table with his long and distinguished service, and Dr. Upton's experience and insight has proved invaluable time and again."

As a public board member, Bowyer was first appointed to the Board of Medicine in 1981. Before his most recent tenure, he previously was appointed to the board in November 1983, October 1987, July 1998, May 2003 and December 2008. He currently serves on the board's Executive/Management Committee, Legislative Committee, Personnel Committee and Complaint Committee.

Bowyer, a native of Huntington, graduated from Marshall University with honors in philosophy, then obtained his Master of Divinity and Master of Theology degrees from Duke University in North Carolina. He has been pastor of churches in Wayne, Ohio and Marion counties, and was the campus minister for the Wesley Foundation at Fairmont State University from

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MISSION:

The West Virginia Board of Medicine is the state agency charged with protecting the health and safety of the public through licensure, regulation and oversight of medical doctors (MDs), podiatric physicians (DPMs), and collaborating physician assistants (PAs).

VISION:

We will be a national leader in innovative oversight of health professionals.

CORE VALUES:

Integrity - Our actions are congruent with our words. We question actions inconsistent with our values.

Public Protection (Compliance) - We follow the law and achieve complete compliance with the rules, policies and procedures that have been established to safeguard the public and to regulate the health care professionals we serve in a fair and just manner.

Accountability (Accuracy) - We believe we must ensure that information is exact and correct. Accurate work product, with strong attention to detail and efficiency of process, is important. We, individually and collectively, are responsible for our actions.

Trust (Reliability & Respect) - We strive to earn the confidence of others. We demonstrate consistently strong performance with respect and dignity.

Legislative Initiatives Impact Board of Medicine Operations

The West Virginia Legislature in 2018 passed several bills that directly impact the West Virginia Board of Medicine, including legislation to establish an educational permit for allopathic physician residents and fellows (HB 4027, effective June 4); a bill that establishes a minimum of two years of clinical training approved by the Accreditation Council for Graduate Medical Education (ACGME) for graduates of foreign medical schools seeking licensure in WV (SB 499, effective June 5); and legislation extending the biennial physician assessment of $125 for the Patient Injury Compensation Fund (PICF) for an additional two years (SB 576, effective June 6). *See related story on page 5.*

The educational permit bill establishes a structure like that already in place for the WV Board of Osteopathic Medicine and in 56 other licensing board jurisdictions nationwide. It was initiated at the request of two West Virginia residency sponsors, which use electronic health record (EHR) systems that are unable to accommodate requirements of the federal Centers for Medicare and Medicaid Services (CMS) regarding medical record documentation and billing. Establishing permits for allopathic residents and fellows resolves the CMS issue.

Permits, which cost $100, will be renewable for each year the resident is enrolled in GME or fellowship training. The legislation requires all residents to hold permits by July 2019. The board filed both a proposed legislative rule and an emergency rule. A 30-day public comment period is under way. If the emergency rule is approved, permits could be issued as early as this fall, upon request.

The legislative rule would be introduced as a bill and acted upon during the 2019 regular session of the Legislature.

The bill affecting foreign medical graduates changes the minimum criteria for licensure for graduates of international medical schools from three years of ACGME-accredited post-graduate training to two years. The PICF bill extends the $125 assessment of physicians through Dec. 31, 2021; it had been set to expire at the end of 2019.

Several other bills of interest to board licensees died in the waning days of the Legislature, including HB 4304 to eliminate the boards for registered nurses and licensed practical nurses in favor of a combined West Virginia Board of Nursing. A bill to reorganize the state Department of Health and Human Resources (HB 4014) failed to pass the Senate. It would have carved out a new Department of Healthcare Facilities and an Office of the Inspector General (OIG). The former would have overseen the state's seven hospitals and long-term care facilities, as well as the West Virginia Children's Home. The OIG would have included the Office of Health Facility Licensure, the Medicaid Fraud Unit and the Clearance for Access: Registry and Employment Screening Act. However, costs estimates exceeded $300,000 for each of those proposals.

Gov. Jim Justice also vetoed several health-related bills following the session, including legislation that would have altered the prior authorization process that practitioners follow in securing insurance coverage for their patients. In his veto message, Justice said he nixed SB

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This newsletter is published by the West Virginia Board of Medicine,

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Maryland Joins Interstate Medical Licensing Compact

The state of Maryland has joined the Interstate Medical Licensure Compact, effective on July 1, 2019. A bill passed Maryland's General Assembly on April 9 and signed by Gov. Larry Hogan on May 8 will make West Virginia's border state the 25th state or territory to join the IMLC.

West Virginia was the fifth state to join the compact. Among other border states, Pennsylvania has passed an IMLC law, but it is not yet fully implemented; legislation also has been introduced in Kentucky.

The compact creates a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license. The IMLC creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act.

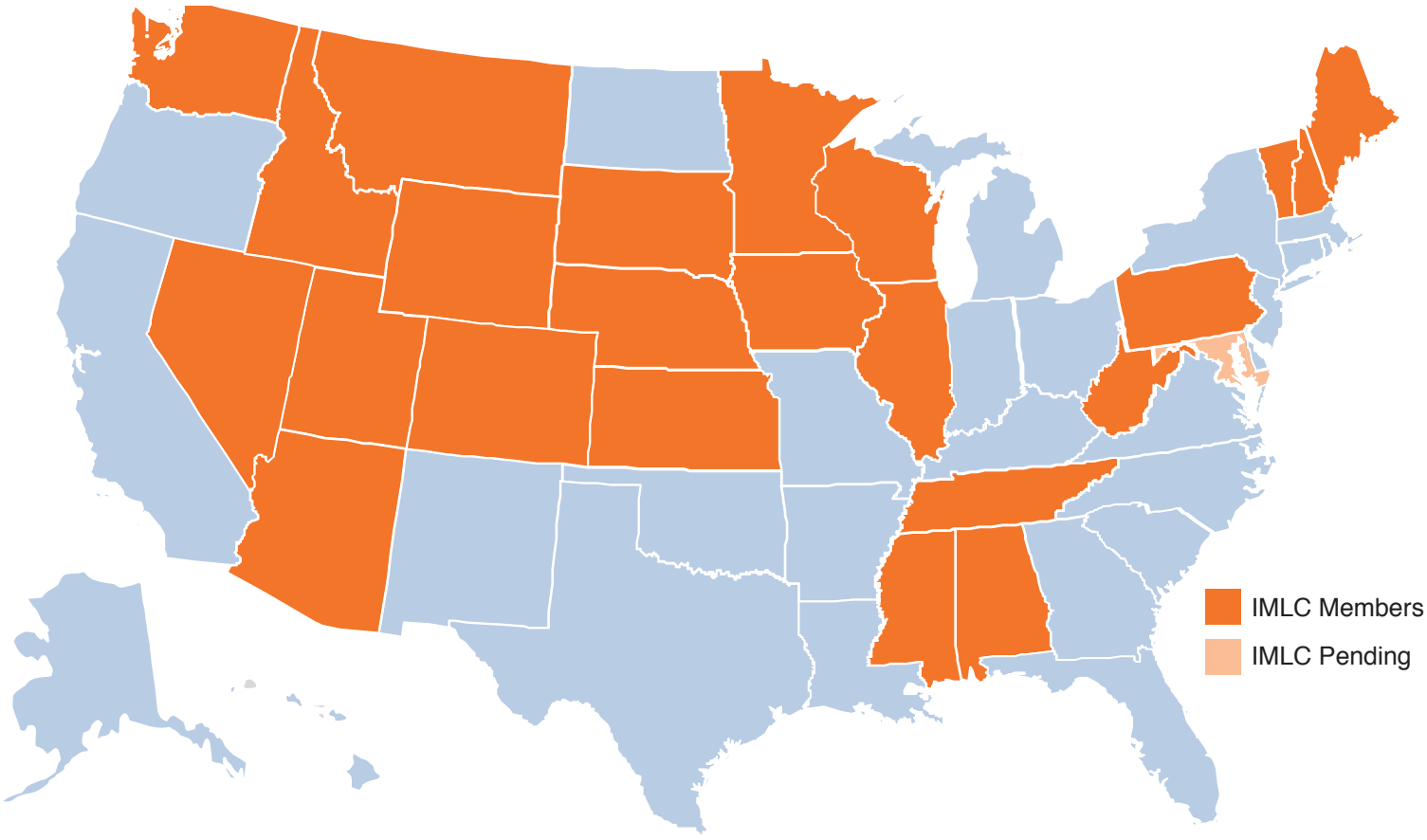
Earlier this year, the state of Vermont and the U.S. territory of Guam passed legislation to join the compact.

Participating states now include Alabama, Arizona, Colorado, Idaho, Illinois, Iowa, Kansas, Maine, Maryland, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin and Wyoming.

The initiative remains under consideration in Georgia, Indiana, Kentucky, Michigan, New York, and the District of Columbia.

The Interstate Medical Licensure Compact Commission's application process officially went live in April 2017. Through March 31, 906 physicians secured 1,301 medical licenses in compact member states, according to a commission news release.

To date, the WV Board of Medicine has issued 16 letters of qualification and 56 licenses.



New Law Changes Controlled Substance Prescribing

A bill passed during the 2018 regular session of the West Virginia Legislature, designed to help curb the opioid crisis, imposes additional conditions, limitations and requirements on physicians and podiatrists when prescribing Schedule II controlled substances. The majority of the changes in Senate Bill 273 relate to the prescribing of opioids, though certain provisions encompass the prescribing of any Schedule II controlled substance.

Gov. Jim Justice signed SB 273 into law on March 27, and it became effective on June 7.

Grandfathered Patients

The new requirements in SB 273 do not apply to prescriptions for patients currently in active treatment for cancer, receiving hospice care from a licensed hospice physician or palliative care physician, residents of a long-term care facility, or to any medications that are being prescribed for use in the treatment of substance abuse or opioid dependence. They also do not apply to existing physician-patient relationships established before Jan. 1, 2018, in which there is an established and current opioid treatment plan reflected in the patient's medical record.

All Schedule II Drugs

A physician is required to conduct a physical examination every 90 days for any patient who continues to be prescribed any Schedule II controlled substance. While this requirement does not apply to patients already receiving opioid treatment under an existing physician-patient relationship as described above, the requirement does apply to all current patients being prescribed non-opioid Schedule II controlled substances, regardless of when the physician-patient relationship was established.

Initial Prescribing

For new, non-exempt patients, prior to prescribing an opioid medication for the treatment of pain, a physician shall refer or prescribe any of the following treatment alternatives, based on the physician's clinical judgment and availability of the treatment: physical therapy, occupational therapy, acupuncture, massage therapy, osteopathic manipulation, chronic pain management program and/or chiropractic services. A physician is not required to prescribe all of the alternative treatment options prior to prescribing an opioid.

Prior to issuing a prescription

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COMMENT PERIOD UNDER WAY FOR PROPOSED RULES

The West Virginia Board of Medicine is accepting written comments on proposed amendments to 11 CSR 1A, Licensing and Disciplinary Procedures: Physicians, Podiatric Physician and Surgeons. To view the proposed amendments to this rule, please **click here**.

The board is also accepting written comments on a proposed new rule series, 11 CSR 12, Permitting and Disciplinary Procedures: Educational Permits for Graduate Medical Interns, Residents and Fellows. To view the proposed rule, please **click here**.

All comments must be received by 9 a.m. on July 23, 2018, and should be submitted to:

Mark A. Spangler, Executive Director
West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, West Virginia 25311
Mark.A.Spangler@wv.gov

Controlled Substance Prescribing

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for an opioid, a physician shall: advise the patient regarding the quantity of the opioid and a patient's option to fill the prescription in a lesser quantity; and, inform the patient of the risks associated with the opioid prescription.

Additionally, prior to issuing an initial opioid prescription, a physician shall: take and document a thorough medical history, including the patient's experience with nonopioid medication, nonpharmacological pain management approaches, and substance abuse history; conduct and document the results of a physical examination; develop a treatment plan with particular attention focused on determining the cause of the patient's pain; and, access relevant prescription monitoring information under the Controlled Substance Monitoring Program Database (CSMP).

Initial RX Limitations

A physician may not issue an initial opioid prescription for more than a seven-day supply. The prescription shall be for the lowest effective dose which in the medical judgment of the physician is the best course of treatment for this patient and his/her condition.

Subsequent Prescriptions

No fewer than six days after issuing the initial opioid prescription, the physician may issue a subsequent opioid prescription if: the subsequent prescription would not be deemed an initial prescription; the physician determines the prescription is necessary and appropriate for the patient's treatment needs and documents the rationale for the subsequent prescription; and, the physician determines the subsequent prescription does not present an undue risk of abuse, addiction, or diversion and documents that determination.

Prior to issuing the subsequent opioid prescription, the physician shall discuss with the patient, or the patient's parent or guardian, the risks associated with the prescribed drug. The discussion, which must be documented in the patient's medical record, shall include: the reasons why the prescription is necessary; alternative treatments available; and, risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines, or alcohol with opioids, can result in fatal respiratory depression.

Third Opioid Prescription

At the time of the issuance of a third prescription for an opioid, the physician shall consider referring the patient to a pain clinic or pain specialist. The physician shall discuss the benefits of seeking treatment through a pain clinic/specialist and provide the patient with an understanding of any risk associated by choosing not to pursue that option.

If the patient declines to seek treatment from a pain clinic/specialist and opts to remain a patient of the physician, and the physician continues to prescribe opioids for pain treatment, the physician shall: document in the medical record that the patient knowingly declined treatment from a pain clinic/specialist; review, at a minimum of every three months, the course of treatment, any new information regarding the etiology of the pain and the patient's progress toward treatment objectives and documents the results of the review; assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with physical and psychological dependence and document the results the assessment; and periodically make reasonable efforts, unless clinically

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Controlled Substance Prescribing

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contradicted, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence, and document with specificity the efforts undertaken.

Narcotics Contract

A prescription for a Schedule II opioid drug for a supply greater than a seven-day period shall require the patient to execute a narcotics contract with their prescribing physician. The contract shall be made a part of the patient's medical record, and is required to provide that the patient agrees:

- only to obtain scheduled medications from this particular prescribing physician;
- to fill the prescriptions at a single pharmacy, which includes a pharmacy with more than one location; and,
- to notify the prescribing physician within 72 hours of any emergency in which he or she is prescribed schedule medication.

If the patient fails to honor the narcotics contract, the physician may terminate the patient relationship or continue to treat the patient without prescribing a Schedule II opioid.

Ongoing Physical Exams

A physician is required to conduct and document the results of a physical examination every 90 days for any patient the physician continues to treat with a Schedule II controlled substance (including both opioids and non-opioid Schedule IIs).

CSMP

Physicians are still required to assess the CSMP prior to initially prescribing a Schedule II controlled substance to a patient, and at least annually thereafter should the physician continue to treat the patient with a controlled substance.

ER Prescriptions

An opioid prescription to an adult patient seeking treatment in an emergency room or urgent care facility for outpatient use may not exceed a four-day supply. An additional dosing for up to no more than a seven-day supply may be permitted, but only if the medical rational is documented in the medical record.

Minor Patients

An opioid prescription for a minor patient may not exceed a three-day supply, and the physician shall discuss with the parent or guardian the risks associated with opioid use and the reasons why the prescription is necessary.

Exceptions

A physician may prescribe an initial seven-day supply of an opioid to a patient immediately following a surgical procedure. Based upon the medical judgment of the physician, a subsequent prescription may be prescribed pursuant to the limitations, requirements and conditions above.

A physician who acquires a patient after Jan. 1, 2018, who is currently being prescribed an opioid from another physician shall be required to access the CSMP. Any prescription would not be deemed an initial prescription. The physician shall otherwise treat the patient as set forth above.

Legislative Initiatives

(continued from page 3)

442, "because it voids current contracts governing prior authorization response times (and) would be ruled unconstitutional."

The bill would have required the Public Employees Insurance Agency, managed care organizations and commercial insurers to develop prior authorization requirements and forms by Oct. 1, to be placed in easily identifiable and accessible places on their websites. Insurers would have had to accept electronic prior authorization requests and respond to those requests electronically beginning on July 1, 2019.

New Licensees: Dec. 2017 through May 2018

The West Virginia Board of Medicine issued 253 medical doctor licenses, five podiatric physician licenses and 34 physician assistant licenses for the period of December 2017 through May 2018. Congratulations to:

MEDICAL DOCTORS

A - B

Abou Mrad, Romy
Adam, Nazir Ahmed
Agarwal, Anil
Ajjarapu, Esther S. V.
Akiko, Michelle N.
AlJasmi, Mohammed Abdulaziz
Almradi, Amro
Almutairi, Heba
Alwaal, Amjad Hassan
Aly, Jasmine M.
Amin, Md. Shahrier
Amiri, Farzad
Anderson, Stuart Douglas
Argila, Jaime Sa Moreira De
Ashfaq, Sadaf
Aynampudi, Achuta Ram

Bahrami, Soon
Bakinde, Nicolas
Ballengee, Cortney Rae
Bandak, Ghassan Salim Issa
Banyas, Jeffrey Brian
Bass, Elizabeth Marianne
Beaver, Thomas Richard
Beck, Bonny Lorraine
Beckett, Katherine Marie
Benning, Ethan Michael
Bernard, Jonathan David
Berven, Michael D.
Bogan, Jennifer Kim
Boils, Christie
Bondalapati, Naveen Kumar Reddy
Boone, Brian Anthony
Boyd, Jr., Charles Edward
Bravo, Billy N.
Briningstool, Anthony Michael
Bronstein, Yulia
Brooks, Benjamin Keith

C - D

Campbell, John David
Carico, Thomas Darrell
Catausan, Michael Tinamisan
Cheyuo, Cletus
Chow, Joseph Lin-Yun
Chryssos, Antonios Emanuel
Clark, Craig Daniel
Clayton, Frederick Paul
Coca, Mircea N.
Colletti, Richard
Collins, James Ivan
Copeland, Neil Russell
Critelli, Kristen Marie
Cuda, Jonathan David

Dave, Heman Kirit
Davis,II, Cedric Emden
Deppe, Scott Allen
Didluch, Marek Tadeusz
Doyle, John Joseph

E - G

Elchico, Melanie Chang
Ellor, Susan Victoria
Ernst, Karen Darfler
Ertha, Cherie DarleneFadakar, Paul K.

Faraj, Kirmanj Muhammad
Fetty, Lora Beth
Fierro, Mark Daniel
Friehling, Linda Ann
Fromberg, David B.

Galan, Gayle Ann
Garces, Juanita
Gendi, Salwa Morcos
Gever, Deborah Lynn
Gisler, Christopher Alan
Glass, Daniel Matthew
Gonzalez, Celsio Emil
Graviss, Christopher Paul
Griffin, Peter Louis
Griffith, Mark Nutter
Griggs, Kenneth Alan
Grover, Robert
Gupta, Priyadarshan
Gupta, Shipra
Gyulai, Ferenc Emil

H - J

Ha, Tuan Xuan
Haddadi, Gita
Hammerman, Curtis Scott
Haranath, Sai Praveen
Harrington, John David
Hasenyager, Carol Ann
Hasou, Dona Tawfig
Hassan, Johara Adam
Hawthorne, Heather Dawn
Heng, Tia
Hennigar, Randolph Alexander
Hidalgo, Richard Manalo
Hinkle, David Miguel
Hoffman, Todd Mark
Horns, John Willard
Hota, Srilekha Sudha
Hough, Bruce Oliver
Houshmand, Farnaz
Huff, Mary Wood

Innerfield, Ronald Jay
Iremashvili, Viacheslav
Islam, Tina

Jackson, Linda Carol
Jahan, Ishrat
Jain, Vikas
Jariwala, Vishal Hitendrabhai
Jason, Jr., Casey John
Johnson, Ryan Edward
Jones-Fearing, Kim Bridgette

K - M

Kapoor, Mohit
Khan, Akhtar Sultan
Kim, Susanne Sugeen
Kollins, Kevin Michael
Kooshkabadi, Ali
Kosik, Russell Oliver
Krad, Omar
Krish, Sonia Nagesh
Krupkin, Richard Scott
Kuperman, Michael Benjamin

LaBahn, Jacob Keenon
LaFerla, John James
Lake, Dianah Thelma
Lasure, Benjamin Lee
Le, Andrew Toan
Lee, Allen Sanghun
Letts, Gary Saint Aubyn
Levin, Andrew David
Lewis, Diana Patricia
Lykins, Jane Eleanor

Macarthy, Toks Ebiyon
Mastores, Scott Frank
May, Elizabeth Jane
McCarthy, Paul Joseph
Meredith, Gary Stewart
Meserow, James Albert
Middleman, Edward Louis
Milburn, Jr., Bruce McNeil
Miller, Mark Daniel
Miller, Stephen Lawrence
Misiaszek, Richard Alexander
Mohan, Kinila T.
Molinar, Alddo Antonio
Moore, Melissa Ann
Morgan, Alicia Ann
Muldrow, Diana Whiteman
Munkaila, Ibrahim Abu
Musgrove, Kelsey Aleen
Musser, William Stuart

N - P

Naguib, Marco
Nandwani, Veena
Narasimhamurthy, Suman
Nazarian, Arbi
Newbold, Vivien Louise Ruth
Nicholls, Matthew David
Nitz, Matthew David

Ojha, Ajitesh
Olin, Annette Corinne
Onwochei, Francis Onwudimisho
Oppong, Cletus Kobiah
Osadsky, Rastislav

Pappas, Orestis
Patel, Rahul Nileshkumar
Patick, Casey Dawn
Patterson, James Willis
Paxton, David Matthew
Paxton, Claire Elizabeth
Payor, Lucas Benjamin

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New Licensees

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Pettrey, Colleen Megan
Potthoff, Troy Lane
Poushanchi, Behdod
Prabhu, Maitreyi Ramrao
Prasad, Apoorv
Pratt, Alan Goodale
Purnell, Phillip Ryan

R - S

Rached, Kristina Kimberley
Rawasia, Wasiq Faraz
Rearick, Travis Logan
Rehman, Azeem Abdul
Reibach, Andrew Mark
Rezai, Ali R.
Rich, Jr., David Howard
Rizvi, Syed Muhammad Azfar
Roberson, Lee Douglass
Roberts, Edmond Alan Vernon
Rodos, Adam Justin
Rose, Brian Edwin
Rosenshein, Neil Bruce
Ross, Gary Dean
Roy, Aviral
Ruyle, Matthew Scott

Salim, Jawad Ahmed
Sanders, II, Terry Gene
Sangave, Amit Arun
Saraiya, Rupali
Sarrafi, Mahdis
Schmitt, Alexis Udall
Schram, David Douglas
Scott, Grant Robert
Seachrist, Katherine Blaney
Seccurro, Sonya Colleen
Seemaladinne, Nirupama
Seidler, Molly Elizabeth
Serota, Marcjonathan
Shafiq, Asad
Shah, Rohan Vipulkumar
Sheridan, Marlana Renee
Shi, David
Shrestha, Bipin Lal
Singh, Kartik
Singh, Meenu
Smith, Robert Paul
Soltani, Sanaz Nicky
Stakic, Josif
Stavens, Gerasimos Stefanatos
Steratore, Anthony Francis
Stern, Joel Benjamin
Stevens, Levi Daniel
Stokes, Robert Fraser
Suku, Suraj

T - V

Tambakis-Odom, Constance Roseann
Tantawi, Diya Hassan
Templeton, Bonnie Heather
Thapa, Jhapat Bahadur
Thirumala, Parthasarathy Deenadayalan
Toh, Benjamin Teong
Tomlin, Brett Alan
Tran-Nguyen, Jacklyn Bichthuy
Trecha, Gregory Todd
Tubens, Sean Robert

Valdes Murua, Honorio Manuel
Vaughn, Wallisa Tejarnette
Venard, Neil Alden
Vidwans, Malavika Aniruddha

W - Z

Wagner, Lloyd David
Wang, Clifford Tau
Wanko, Sam Obi
Werchowski, Jeffrey Lawrence
Whipp, Kylen Pierce
Whyte, Authrine Chevanne
Wilson, Jon Daniel
Woodard, Jr., William Leicester

Yargosz, Philip Matthew
Yates, Paul Andrew
Younggren, Bradley Nels
Youssef, Nancy Hany

Zavaleta, Ernesto Gustavo
Zeb, Irfan
Zell, Matthew Steven
Zelman, David Julius
Zeyed, Yosaf
Zivkovic, Sasa
Zubricky, Candace Folley

PODIATRIC PHYSICIANS

Allen, Amber Marie
Hollnagel, JennaLouise
Michael, Jeffrey Addison
Wright, Daniel Robert
Yeaman, William Edward Daniel

PHYSICIAN ASSISTANTS

Abel, Danielle Marie
Andryka, Caitlin Anne
Barker, Matthew Edwar
Beckman, Amber Mae
Bewick, Jr., Ronald Winston
Brown, Allison Ann
Copeland, Morgan Leigh
D'Eramo, Rebecca Lynn
Davison, Toni Rebekah
Dillon, Randi Linn
Eccard, Cody Ann McGovern
Fancett, Lindsey Megan
Fantini, Jason R.
Garnett, Kaitlyn Arielle
Hanson, Samantha Jane
Hansroth, Jessica Chaney
Harris, Holly Marie
Kelly, Randall Doulgas
Kerr, Jordan Rhea
LaSala, Sarah Leigh
Licaj, Skerdilaid
McDonough, Maureen E.
Milligan, Christopher Wayne
O'Connor, James Carrol
Penz, Emily N.
Przybrowski, Megan Diane
Rogers, Joshua Jame
Ryan, Beth Ann
Schweid, Megan J.
Sesto, Natalie Anne
Tubens, Susan Post
Whetzel, Heather Ann
Williams, Eric Francis
Wisser, Meredith L.

Board Update

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1962 until his retirement in 2005.

Upton, who chose not to seek reappointment because of growing professional commitments, is a graduate of Washington and Lee University in Lexington, VA, and earned his Doctor of Medicine degree from West Virginia University School of Medicine. He completed residency training at WVU-Charleston Division and is board certified in Internal Medicine.

Upton was a partner of Dunbar Medical Associates from 1996 to 2015. In 2011, Upton became the chief medical information officer of Thomas Memorial Hospital, and in August 2015, he was named chief medical officer and chief medical information officer for Thomas Health System.

He serves on the board's Complaint Committee and Legislative Committee.

The Governor will appoint new board members in the fall.

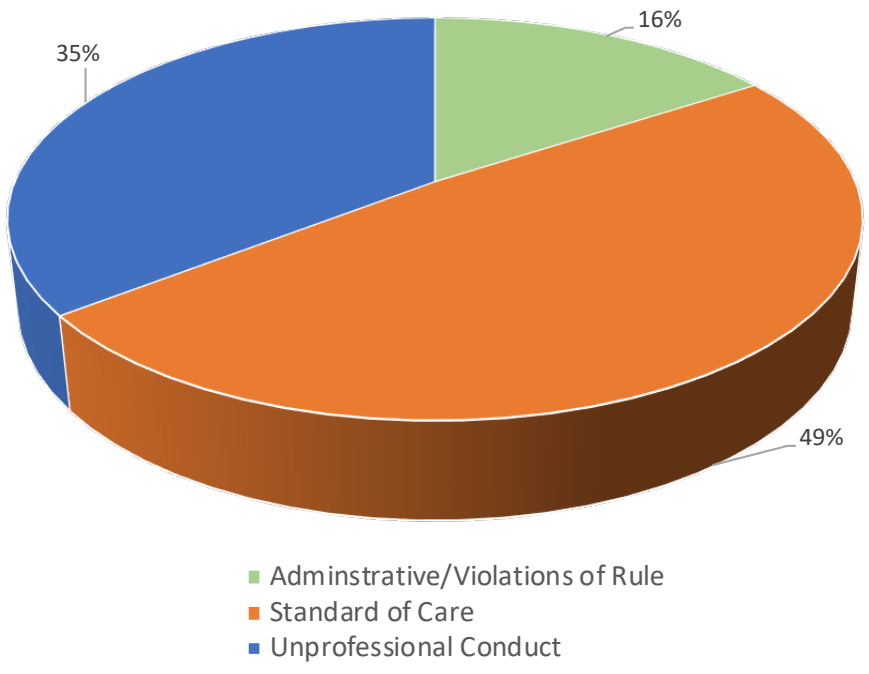
Save the Date – Addiction Conference

The sixth annual Appalachian Addiction & Prescription Drug Abuse Conference is scheduled for Oct. 18-20 at Embassy Suites in Charleston. More than 350 physicians, physician assistants, nurses, dentists, psychologists, lawyers, pharmacists, counselors, social workers and interested others attended last year's event, organized by Dr. P. Bradley Hall, executive medical director of the West Virginia Medical Professionals Health Program.

The conference is recognized by both the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine, and satisfies the licensing boards' three-hour continuing medical education requirement on Drug Diversion Training and Best Practice Prescribing of Controlled Substances Training. Continuing education credits for several other disciplines are available as well.

Topics are expected to cover a broad range of issues related to pain management, prescription drug diversion and addiction and treatment issues. Check for updates at **www.wvmphp.org**.

2017 Complaints



Contact Information

All licensees must provide the board with timely notice of all changes of address, including email addresses. A valid email address is important for licensees to receive notifications from the board regarding news releases and licensure renewal. Click on the link below to access the Licensee Change of Contact Information section of the board's website. Please be advised that your preferred contact information, although not published, may be subject to release pursuant to a public records request.

Licensee Change of Contact Information

Medical Cannabis Act Update

Implementation of the Medical Cannabis Act passed in 2017 has stalled while state officials struggle to identify a lawful banking solution to handle associated transactions. Traditional banks are reluctant to process funds from medical marijuana because it remains illegal under federal law. State Treasurer John Perdue, in a May 10 letter to Gov. Jim Justice, proposed two potential solutions, each of which would require legislative action.

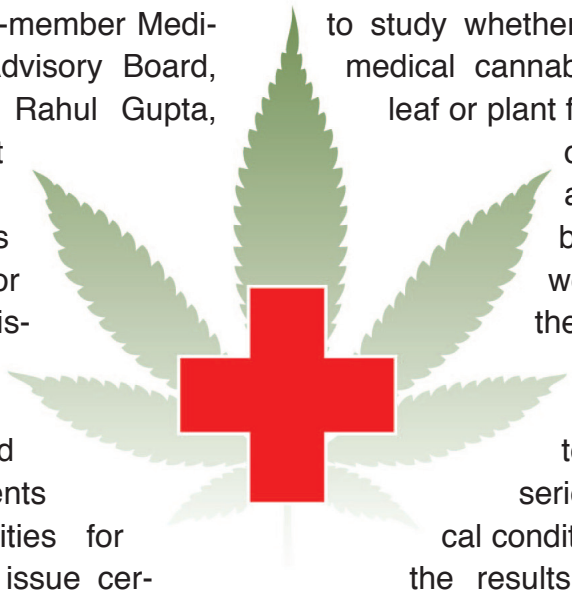
One solution would create a "closed-loop" or "open-loop" system, or a combination of both. In the closed-loop scenario, payments could only be made within a network of individuals and entities that have accounts with the system. "This system would be able to monitor and facilitate financial transactions between the state of West Virginia and authorized entities associated with medical cannabis, and would meet requirements of the banking industry," Perdue wrote. "An open-loop system would provide payment services that can also generate payments outside the network."

The second option would be to create a bank owned and operated by the state of West Virginia, specifically the Treasurer's Office.

Meanwhile, House Democrats introduced a bill during May's special session proposing a Medical Cannabis Banking Act. However, by law, legislators meeting in special session can only consider issues specifically designated for consideration by the Governor. Medical cannabis was not an issue in the Governor's "call" for the special session. The bill was triple-referenced to committees that did not meet.

Proponents are continuing to circulate a petition seeking a special session on the medical cannabis issue.

Prior to these recent developments, the 13-member Medical Cannabis Advisory Board, chaired by Dr. Rahul Gupta, on Feb. 20 sent a series of recommendations to the Governor and the Legislature. The recommendations clarified the requirements and responsibilities for physicians who issue certifications to eligible patients; altered the number of permits that the state's Bureau for Public Health's Office of Medical Cannabis could issue for growers, processors and dispensaries while allowing for "vertical integration" of those three categories; and authorized a pre-registration process for potential medical cannabis patients to more clearly ascertain the market interest in West Virginia for medical cannabis.



The House of Delegates on Feb. 28 passed a version of HB 4345 increasing the number of growers, processors and dispensaries from 10-10-30 in the original 2017 legislation to 50-50-165. The Senate scaled those numbers back to 20-20-50.

A series of other amendments were offered in the Senate and on the House floor in keeping with the Advisory Board's recommendations. One would have allowed BPH to study whether allowing medical cannabis in dry leaf or plant form to be dispensed and used by patients would further alleviate the symptoms of serious medical conditions, with the results of such study to be reported to the Joint Committee on Government and Finance.

Another proposal would have eliminated the requirement that a physician or pharmacist be on site at all times when a dispensary is open to patients and caregivers. Other revisions sought to flesh out tax implications and other financial provisions of the Medical Cannabis

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Board Actions

December 2017 through May 2018

Paul Webber Burke Jr., M.D.
12/31/2017 – Voluntary Surrender of License
Consent Order

Paul Basil Papadimitriou, M.D.
1/2/2018 – Probation of License
Consent Order

Muhammed Samer Nasher-Alneam, M.D.
1/8/2018 – Interim Limitation or Restriction on License/Practice
Consent Order

Joy Jeannine Juskowich, M.D.
3/5/2018 – Limitation or Restriction on License/Practice
Consent Order

Rodney Lee Curtis II, M.D.
3/23/2018 – Revocation of License
Board Order

Stephen J. Mallott, M.D.
4/18/2018 – Probation of License
Consent Order

Isabelita T. de Mesa, M.D.
4/18/2018 – Public Reprimand
Consent Order

Sarah Leigh LaSala, P.A.-C
4/24/2018 – Limitation or Restriction on License/Practice
Consent Order

Alberto A. Fernandez, M.D.
4/24/2018 – Suspension of License
Consent Order

Sarah Brooke Cash, M.D.
5/7/2018 – Suspension of License
Consent Order

Stephen Scott Brown, M.D.
5/7/2018 – Revocation of License
Board Order

Richard Santostefano Sr., P.A.-C
5/7/2018 – Termination of Consent Order
Board Order

Steven Scott Melek, D.P.M.
5/7/2018 – Summary Suspension of License
Board Order

CME Audit Actions

Rodhan Abass Khthir, M.D.
1/2/2018 – Administrative Fine/ Monetary Penalty
Consent Order

George Michael Dwyer, M.D.
1/8/2018 – Administrative Fine/ Monetary Penalty
Consent Order

Application Related Actions

Joseph Henry Matusic, M.D.
4/18/2018 – Administrative Fine/Monetary Penalty
Consent Order

Scott Alan Naegele, M.D.
4/18/2018 – Administrative Fine/Monetary Penalty
Consent Order

Michael Roy Spindel, M.D.
4/24/2018 – Administrative Fine/Monetary Penalty
Consent Order

Darci Nicole Barger, P.A.-C
4/30/2018 – Administrative Fine/Monetary Penalty
Consent Order

Anna Nicole Antolini, P.A.-C
4/30/2018 – Administrative Fine/ Monetary Penalty
Consent Order

Medical Cannabis *(continued from page 11)*

Act, including authorizing the State Treasurer to designate a credit union for banking functions.

In the end, however, the House refused to take up the Senate-modified version of HB 4345 in the waning hours of the 2018 regular session.

Following the session, in early April the OMC filed a series of emergency rules with the Secretary of State's office, including general rules and rules specific to growers/processors, laboratories and dispensaries, as well as a rule regarding "Safe Harbor" letters which would allow the bureau to authorize a terminally ill cancer patient to use medical cannabis purchased in another state that has entered into a reciprocity agreement with West Virginia.

Board Expands Public Outreach

Executive Director Mark Spangler traveled to West Liberty University on June 8 to make a presentation on "Medical Regulation, Licensure and Discipline in West Virginia" to students in the university's physician assistant program. The presentation outlined the board's statutory authority, rules and practices in those areas, as well as legislative changes in 2017 that modified the state's Physician Assistant Practice Act. *See related story on page 14.*

One of the Board of Medicine's long-term strategic goals, crafted during a planning session in October 2017, focused on enhanced education and outreach efforts.

According to an Association of Medical Colleges graduate questionnaire, over the past 10 years, nearly two-thirds of medical students have characterized their knowledge of state medical licensing and regulation as "inadequate." As a result, Spangler reached out to the PA programs at West Liberty, Alderson Broaddus University and the University of Charleston in late March to offer the board's services in trying to bridge the information gap.

Spangler is scheduled to make a similar presentation in July to faculty, resident physicians and rising third-year medical students during a risk management seminar at Marshall University's Joan C. Edwards School of Medicine.

Spangler, Deputy Director/General Counsel Jamie Alley and Andrew Wessels, director of intergovernmental and public relations, were joined in March by board member Dean Wright in a series of meetings with officials from Marshall Health and the School of Medicine in Huntington. The board delegation sat down with Dr. Joseph Shapiro, dean of the Medical School, Marshall Health CEO Beth Hammers and others, including faculty and local physicians.

The goal was to explain how the Board of Medicine functions, review the impact of new laws passed during the 2018 regular session of the Legislature, and outline future priorities to enhance our working relationship with MU. Board members and staff made a similar visit to West Virginia University in July 2017.

Spangler also has made presentations to the WV Association of Medical Staff Services in Martinsburg in November 2017 and to medical students at WVU-Charleston Division in February. Click here to view copies of the presentations available on the WVBOM website.

WEBSITE FACELIFT CONTINUES

Work continues on the West Virginia Board of Medicine website (www.wvbom.wv.gov), as an internal work group makes content and design adjustments to enhance its utility, transparency and navigation for licensees and the public.

The work group is examining each aspect of the website and making in-house changes in what is intended as a methodical, progressive sequence. Eventually, broader design improvements will be assigned to the board's external internet vendor.

In recent months, website visitors may have noticed that the board's Complaint Process has been added to the upper tabs for easier access. "Look up a Doctor or PA" is now a highlighted search function ton the home page.

The work group began meeting regularly in October 2017. Its goal is to refresh content, modernize website features and eliminate unnecessary redundancies. Your suggestions and observations are welcome.

PA, CME Rules Passed by Legislature

The West Virginia Legislature during the 2018 regular session approved a House of Delegates "rules bundle" (HB 4079) that included bills formally adopting legislative rules 11 CSR 1B and 11 CSR 6 on behalf of the Board of Medicine. The rules modify the Physician Assistant Practice Act, and update continuing education requirements for physicians and podiatric physicians, respectively.

Also, as part of the "rules bundle," the Legislature directed the Board of Medicine to modify 11 CSR 1A to allow for patient testimonials in physician advertising.

Changes to the PA Practice Act include: replacement of the concept of a "supervising" physician with a "collaborating" physician; enhanced prescriptive authority to achieve parity with other mid-level practitioners; expansion of signature authority; the addition of a second PA representative on the West Virginia Board of Medicine; and, parity in insurance payments.

An emergency rule to implement the changes had been in effect since Oct. 20, 2017.

New language throughout the PA Practice Act now reflects a "collaborative" relationship with a physician, rather than a "supervisory" relationship, when entering into practice agreements. "Collaboration" means a medical doctor or a podiatric physician oversees the activities of, and accepts responsibility for, the medical services rendered by a PA. Under the new standard, physicians and PAs do not have to be at the same practice location.

A collaborating physician may only delegate those medical acts which are within his or her scope of practice and customary to his or her medical practice. Likewise, a PA may not perform any services for which his or her collaborating physician is not qualified or, in a hospital setting, credentialed to perform.

PAs may now prescribe up to a 30-day, non-refillable supply of Schedule III controlled substances. Previously, they were limited to prescribing only a 72-hour supply of Schedule III medications. PAs may generally prescribe Schedule IV or V controlled substances, subject to limitations or restrictions imposed by the collaborating physician. Previously, these were limited to 90 dosage units or a 30-day supply, whichever was less.

Please note that prescribing authority may only be changed through the submission of a new practice agreement for approval by the board. Medication assisted treatment (MAT) for substance use disorder, likewise, is an advanced duty which requires the submission of a new practice agreement, supporting documentation, and the appropriate fee.

PAs may generally prescribe up to an annual supply of other prescription drugs, other than a controlled substance, for the treatment of a chronic condition other than chronic pain management. They are prohibited from prescribing Schedule I or Schedule II drugs under the Uniform Controlled Substances Act, or from prescribing Clozapine, antineoplastics, radiopharmaceuticals or general anesthetics.

Also, PAs may not prescribe, administer, order or dispense medications outside of the approved practice agreement with a collaborating physician.

Moreover, under 11 CSR 5, if a physician assistant is going to administer or dispense controlled substances in an office-based setting, he or she needs to register with the Board of Medicine as a controlled substance dispensing practitioner. When permitted under their practice agreements, and by their place of practice, physician assistants may now complete admission and/or discharge orders, medical certifications for death certificates, orders for life-sustaining treatment, orders for scope of treatment, and "Do not resuscitate" forms and/or orders.

Other such forms include: disability medical

(continued on page 15)

PA, CME Rules *(continued from page 14)*

evaluations and/or certifications in support of a hunting or fishing permit; utility company forms or certifications requiring maintenance of utilities regardless of ability to pay; governmental forms such as parking applications for mobility-impaired individuals; and forms for durable medical equipment.

All physician assistants must pass the Physician Assistant National Certifying Examination and be certified by the National Commission on the Certification of Physician Assistants (NCCPA) for initial licensure. However, NCCPA certification is no longer a requirement for licensure renewal. Under the approved rule, a licensed PA must notify the Board of Medicine of certification status. If he or she is no longer certified by NCCPA, their designation changes from "PA-C" to simply "PA."

PAs still must complete 100 hours of CME during each two-year licensing period. If a PA prescribes, administers or dispenses any controlled substance, he or she must complete a minimum of three hours in a board-approved course on drug diversion training and best practice prescribing of controlled substances.

In modernizing 11 CSR 6 for physicians and podiatric physicians, the rule identifies when an applicant may utilize post-graduate training to satisfy CME requirements; updates the requirements for drug diversion training and best practice prescribing training to incorporate a training component on prescribing and administration of an opioid antagonist; clarifies that three hours of such training must be completed each renewal cycle, unless the applicant has not prescribed, administered or dispensed controlled substances pursuant to a WV license during the reporting period; clarifies when written documentation of successful completion of CME must be submitted to the board by renewal, change of status, reinstatement and reactivation applicants; and establishes a protocol for board approval of drug diversion training and best practice prescribing of controlled substances training.

New Staff

The West Virginia Board of Medicine welcomed two new staff members in recent months, including John B. "Brad" Smith and Joshua Waine.

Smith came on board in late May as complaints coordinator, succeeding Rhonda A. Dean. We wish Dean the best of luck in her future endeavors. Waine joined the staff as a receptionist / administrative office assistant in December 2017. He replaced Diane Callison, who transitioned to a new role as physician assistant licensure analyst.

Sarah Loftus began her duties as paralegal with the Board of July 9. She suceeds Felicia A. Bryant, who left to pursue other opportunities.

See the chart on page 17 for a full list of staff and contact information.

Human Trafficking Notices

Hospital emergency departments and urgent care centers are among the specific locations required to post human trafficking assistance notices under a new law that became effective June 3. The law, which resulted from passage of HB 4169 during the 2018 regular session of the Legislature, mandates posting of 8.5 x 11 posters that provide information and a hotline for the National Human Trafficking Resource Center.

The posters can be downloaded from the state Division of Justice and Community Services website. They are to be placed in public restrooms and in a conspicuous place near the public entrances of designated businesses or establishments. The bill specifies several types of businesses for the postings, and the division director may designate other locations by legislative rule. Violations will be considered a misdemeanor offense, punishable by a fine of up to $250 on first offense, or $500 on subsequent offenses.

Ending the Patient-Physician Relationship

(Editor's note: This article also appears on the Board of Medicine website at www.wvbom.wv.gov under the "Laws & Resources tab.)

Among the calls and complaints the West Virginia Board of Medicine receives, one ongoing concern focuses on ending the patient-physician relationship. Once a patient-physician relationship has begun, a physician generally is under both an ethical and legal obligation to provide services as long as the patient needs them. There may be times, however, when you may no longer be able to provide care. It may be that the patient is noncompliant, unreasonably demanding, threatening to you and/or your staff, or otherwise contributing to a breakdown in the patient-physician relationship. Or, it may be necessary to end the relationship simply because of relocation, retirement or unanticipated termination by a managed care plan and/or employer.

More physicians than ever are being employed by a variety of medical entities rather than entering into private practice. Patient responsibility when a physician ends employment is an area which has become a more complicated and sometime unclear process. For example, a physician may have signed a non-compete clause upon hire. Patient responsibility upon the departure of a physician should be clarified in advance by contract or policy whenever possible. Consultation with an attorney in such matters is advisable.

Regardless of the situation, to avoid a claim of "patient abandonment," a physician must follow appropriate steps to terminate a patient-physician relationship. Abandonment is defined as a termination of a professional relationship between physician and patient at an unreasonable time and without giving the patient the chance to find an equally qualified replacement. To prove abandonment, the patient must show more than a simple termination of a patient-physician relationship. A patient must prove that the physician ended the relationship at a critical stage in the patient's treatment without good reason or sufficient notice to allow a patient to find another physician, and the patient was injured as a result.

A physician who does not terminate the patient-physician relationship properly may come under investigation and discipline by the board. The AMA's Code of Medical Ethics, Opinion 1.1.5 states that physicians have the option of terminating the patient-physician relationship, but they must give sufficient notice to those involved to allow another physician to be secured.

The American Medical Association, Office of the General Counsel offers the following suggestions when terminating a patient-physician relationship:

- Provide the patient with written notice, preferably by certified mail, return receipt requested;
- Provide the patient with a brief but valid explanation for terminating the relationship (for example, non-compliance, over-demanding or threatening);
- Agree to continue care or emergency care for at least 30 days, to allow a patient the opportunity to secure another physician. In some instances, it may be necessary to slowly reduce a particular medication to avoid withdrawal or negative medical consequences;
- Provide resources and/or specific recommendations to help a patient locate another physician of a like specialty (examples may include the board's website, the West Virginia State Medical Association, professional societies and nearby hospitals);
- Offer to transfer records to a newly designated physician upon signed authorization to do so.

You can do much to reduce your chances of being accused of patient abandonment by adhering to these recommendations.

Medical Malpractice Settlements and Judgments

The West Virginia Board of Medicine recently adopted Guidelines for Identifying and Reporting Practitioners on a Medical Professional Liability Claim Report. The guidelines are available on the board's website and are being provided to insurance carriers who report medical malpractice settlements and/or judgments.

Modifications to section 13 of 11 CSR 1A are included in the Board's proposed rule which is currently open for public comment.

The board also recently modified the process for which medical professional limited liability claim reports are processed. When the board receives notification from an insurance carrier that a professional medical liability payment was made on behalf of a Board of Medicine licensee, a copy of the report will be mailed to the licensee for their review.

If a licensee contends that the payment was not made on their behalf or was otherwise incorrectly reported, they will need to notify the board, in writing, within 30 days of receipt of the letter. The written submission should contain a detailed explanation of why the licensee believes the report to be erroneous and should include any documents that the licensee has that corroborate the contentions.

If the board does not receive written correspondence from the licensee contesting the payment within 30 days, the settlement/judgment will become part of the licensee's record with the board.

Please note that the board's receipt of payment notification does not affect a licensee's obligation to report malpractice settlements and judgments in association with the renewal application process.

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