BOARD MINUTES
MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE
JULY 19, 2018

The regularly scheduled meeting of the Mississippi State Board of Medical Licensure was held on Thursday, July 19, in the Board Room of the Office of the Board located at 1867 Crane Ridge Drive, Jackson, Mississippi.

THE FOLLOWING MEMBERS WERE PRESENT:

Claude D. Brunson, M.D., Jackson, President
J. Ann Rea, M.D., Columbus, Vice President
David W. McClendon, Jr., M.D., Ocean Springs, Secretary
Charles D. Miles, M.D., West Point
Michelle Y. Owens, M.D., Jackson
C. Kenneth Lippincott, M.D., Tupelo
Kirk L. Kinard, D.O., Oxford
H. Allen Gersh, M.D., Hattiesburg

ALSO PRESENT:

Stan T. Ingram, Complaint Counsel for the Board
Heather P. Wagner, Special Assistant Attorney General
Kenneth Cleveland, Executive Director
Mike Lucius, Deputy Director
Rhonda Freeman, Director, Licensure Division
Leslie Ross, Director of Investigations
Jonathan Dalton, Investigations Supervisor
Frances Carrillo, Staff Officer
Major General (Ret.) Erik Hearon, Consumer Health Committee
Wesley Breland, Hattiesburg, Consumer Health Committee

The meeting was called to order at 9:00 a.m., by Dr. Brunson, President. The invocation was given by Dr. McClendon and the pledge was led by Maj. Gen. Hearon. Dr. Brunson welcomed Amy Key, Court Reporter.

Dr. Brunson recognized Harry Gunter, Investigator, with an award for 20 years of service with the Mississippi State Board of Medical Licensure.

Dr. Brunson recognized and thanked Board member, Dr. Charles Miles for leading and navigating the Board through extraordinary circumstances. He also personally thanked Dr. Miles for his mentorship and service to the Board as past president of the Board.

Dr Brunson advised that the Board has two new Board members starting today, he introduced Dr. Kirk Kinard of Oxford and Dr. Alan Gersh of Hattiesburg and provided a brief summary of their education and career. Dr. Kinard will be representing the 1" Supreme Court District, Dr. McClendon will be representing the 3rd Supreme Court District, and Dr. Gersh will be representing the 2nd Supreme Court District.

Special Assistant Attorney General, Ms. Heather Wagner, administered the Oath of Office to Dr. Kinard and Dr. Gersh. Dr. Brunson presented Dr. Kinard and Dr. Gersh with lapel pins.

Certificates of Board Commission were presented to Dr. Kinard and Dr. Gersh by Ms. Whitney Lipscomb, Office of Governor Phil Bryant, General Counsel. Certificates of Board Commission were belated presented to Dr. Charles Kenneth Lippincott and Dr. William David McClendon by Ms. Whitney Lipscomb, Office of Governor Phil Bryant, General Counsel.

A copy of the Oath of Office is attached hereto and incorporated by reference.

PUBLIC COMMENTS

Dr. Brunson opened the floor for public comments but there were none.

OTHER BUSINESS

Dr. Brunson asked the Board to amend the agenda to add to Item 6. Rules, Regulation & Legislative Committee, a discussion of the Policy Statement for Hospice Referral and Palliative Care. Motion was made by Dr. Miles, seconded by Dr. Rea, and carried unanimously to approve the amended agenda to add this item.

APPROVAL OF CERTIFICATIONS TO OTHER ENTITIES

369 licenses were certified to other entities.

Motion was made by Dr. McClendon, seconded by Dr. Miles, and carried unanimously to approve.

APPROVAL OF LICENSES ISSUED

237 licenses were issued.

Motion was made by Dr. Miles, seconded by Dr. Rea, and carried unanimously to approve.

EXECUTIVE DIRECTOR REPORT

The Executive Director, Dr. Cleveland introduced Mike Lucius, the newly hired Deputy Director, and provided a brief summary of his past experience with Mississippi government.

Dr. Cleveland reported the modernization of the office equipment, furnishings and other planned improvements to the office to include a new security system.

Dr Cleveland provided a summary of the Licensure Division operations in regards to new applications received and licenses issued for the fiscal year 2017-18 and for the months of May and June. He provided a summary of the Investigative Division operations in regards to Investigations for the fiscal year 2017-18.

Dr. Cleveland provided a summary of the IT Division operations in regards to renewal and reminders emailed to Licensees with a brief update in upgrading the Board's computer system.

REVIEW OF MINUTES OF THE EXECUTIVE COMMITTEE MEETING DATED MAY 9, 2018

Upon review of the minutes of the Executive Committee meeting dated May 9, 2018, 2018, Dr. McClendon moved for approval of the minutes as submitted. Dr. Rea seconded the motion and it carried unanimously.

APPROVAL OF REVISED EXECUTIVE COMMITTEE MINUTES DATED MAY 17, 2018

Dr. Brunson advised the Board received a request from Kallol Saha, M.D., to revise the minutes of his personal appearance before Executive Committee dated May 17, 2018, relating to revealing personal information. Dr. Owens moved for approval of the minutes as revised. Dr. Miles seconded the motion and it carried unanimously.

REVIEW OF MINUTES OF THE BOARD MEETING DATED MAY 10, 2018

Upon review of the minutes of the Board meeting dated May 10, 2018, Dr. Rea moved for approval of the minutes as submitted. Dr. Owens seconded the motion and it carried unanimously.

REPORT OF JULY 18, 2018, EXECUTIVE COMMITTEE MEETING

Dr. McClendon reported on the matters discussed by the Executive Committee on July 18, 2018, and recommendations made. Information pertaining to the Executive Committee's recommendations is included in the Executive Committee minutes, which are attached hereto and incorporated by reference.

Dr. Brunson called for a vote to accept the recommendations of the Executive Committee, and the Board unanimously voted to accept and ratify the recommendations of the Executive Committee.

REPORTS FROM COMMITEES

Scope of Practice - Dr. Rea (Chair), Dr. Owens, Dr. Miles, Dr. Kinard, Dr. Gersh, Dr. McClendon, Mr. Breland

Dr. Rea advised there was no new information to report.

Professionals Health Program - Dr. Lippincott (Chair), Dr. Gersh, Dr. Rea, Dr. Miles, Dr. Owens, Maj Gen (Retired) Hearon

Dr. Lippincott advised that the Physicians Health Program (PHP) celebrated its Fortieth Anniversary at their Fortieth Annual Caduceus Retreat. Dr. Lippincott reported the PHP was founded in 1978 by Drs. Ellis and Nina Moffett. Dr. Lippincott also reported that Mississippi has one of the oldest and best PHP in the nation under the direction of the current Medical Director, Dr Scott Hambleton.

Dr. Brunson recognized and thanked the Mississippi Physician Health Program and Dr. Hambleton for their great achievement.

Telemedicine & Interstate Medical Licensure Compact (IMLC) - Dr. McClendon (Chair), Dr. Miles, Dr. Kinard, Dr. Lippincott, Gen. Hearon, Ms. Freeman

Dr. McClendon advised there was no new information to report.

Licensee Education and Communication - Dr. Owens (Chair), Dr. McClendon, Dr. Gersh, Dr. Kinard, Dr. Rea, Mr. Breland, Ms. Freeman

Dr Owens advised there was no new information to report.

Physician Assistant Advisory Task Force - Dr. McClendon (Chair), Dr. Kinard, Robert Philpot, Jr., PhD, PA-C, Joanna Mason, PA-C, Lauren English, Phyllis Johnson, Board of Nursing, Ms. Freeman, PA-C Leah Calder, PA-C Gavin Nowell, Mr. Jonathan Dalton

Dr. McClendon advised there will be a presentation by the Physician Assistant Advisory Task Force member, Tristan Harris, PA-C

Tristan Harris, PA-C, addressed the Board and gave a brief summary of her education and experience as a Physician Assistant. Ms. Harris gave a presentation regarding the description, education, training and scope of practice of a Mississippi licensed Physician Assistant.

Ms. Harris introduced Dr. Lee Nichols, who was the first physician to employ a graduate of the Mississippi College PA program. Dr. Nichols addressed the Board and briefly shared his experience and insight in utilizing Physician Assistants in his practice

Rules, Regulation & Legislative - Dr. Miles (Chair), Dr. Gersh, Dr. Rea, Dr. Owens, Dr. Lippincott, Ms. Freeman, Mr. Breland, Ms. Hope Ladner

Adopt proposed Title 30, Part 2615: The Practice of Physician Assistants

Dr. Miles brought forward proposed changes to Part 2615, the Practice of Physician Assistants, and the regulation is being updated to make it comparable to the nurse practitioner collaboration rules. Changes related to unlimited mileage for primary care practices adding the definition of primary care. A motion was made by Dr. McClendon, seconded by Dr. Rea, to adopt the proposed changes to the regulation and it carried unanimously. A copy of the regulation is attached hereto and incorporated by reference. The amended regulation will be filed with the Occupational Licensing Review Commission

3.20 Hospice Referral and Palliative Care Policy

Dr. Miles brought forward a new policy for hospice referral and palliative care. This policy is to ensure appropriate referrals of terminal patients to hospice care. Dr. Brunson called for a vote to accept the changes recommended to the policy, and the matter carried unanimously. This policy will be in effect immediately. A copy of the Policy is attached hereto and incorporated by reference.

Final Adopt proposed Title 30, Part 2630: Collaboration with Nurse Practitioners

Dr. Miles brought forward proposed changes to Part 2630, Collaboration with Nurse Practitioners that had been approved at the March 22, 2018, and submitted to the Occupational Licensing Review Commission (OLRC) who has issued a resolution and approval with minor changes for the Board's Final Adoption. Changes are in the Definition of primary care practices and extended mileage. Dr. Brunson called for a vote to accept the minor changes recommended by the OLRC and upon a vote, the Board unanimously approved. A copy of the regulation is attached hereto and incorporated by reference.

Final Adopt proposed Title 30, Part 2640: Prescribing, Administering and Dispensing

Dr. Miles brought forward the reformatted proposed changes to Part 2640: Prescribing, Administering and Dispensing for final adoption. Part 2640 had previously been submitted to the Occupational Licensing Review Commission (OLRC) for approval and the OLCR requested the regulation be submitted as separate parts, not as one comprehensive submission, a request with which the Board staff complied. Dr. Brunsoncalled for a vote to approve the re-formatting of the submissoni to the OLRC, and upon a vote, the Board unanimously approved. A copy of the regulation is attached hereto and incorporated by reference.

REQUEST APPROVAL OF PROPOSED CONSENT ORDERS FOR

a. Horrell Townsend D.O., Medical License No. 11143
b. Don A. Gibson M.D., Medical License No. 07980
c. Eric J Zoog M.D., Medical License No. 16418

Following a brief discussion, motion was made by Dr. Miles, seconded by Dr. Rea, and carried to approve the proposed Consent Orders and carried to approve the proposed Consent Orders as submitted by the above listed physicians.

A copy of each Consent Order is attached hereto and incorporated by reference.

REQUEST TO LIFT CONSENT ORDER OF RONNIE ALI D.O., OCEAN SPRINGS, MS, MEDICAL LICENSE NUMBER 16596

Mr. Ingram introduced Dr. Ali. Mr. Ingram advised that this is a petition to remove restrictions imposed on Dr. Ali by virtue of a May 2016, Consent Order.

Mr. Ingram entered numerous exhibits into the record and provided the Board with a brief background. Mr. Ingram summarized the Consent Order that Dr Ali is currently under and advised that he has met all of the Board's requirements.

Following questions from Board members, motion was made by Dr. Miles, seconded by Dr. Owens and carried unanimously to remove all restrictions currently on Dr. Ali's medical license.

A copy of the Order lifting restrictions is attached hereto and incorporated by reference.

REQUEST TO LIFT RESTRICTIONS OF MEISAM H. MOGHBELLI, M.D., CLEVELAND, OH, MEDICAL LICENSE NUMBER: 20853

DR. GERSH RECUSED HIMSELF AND EXITED THE MEETING

Mr. Ingram advised that Dr. Moghbelli is not present today but has submitted a Request for Removal of Restrictions in absentia.

Mr. Ingram summarized the circumstances of the request. The May 18, 2017, Consent Order of the board that Dr. Moghbelli is currently under was based on allegations that he violated HIPAA by accessing medical records of a patient. Mr. Ingram entered numerous exhibits into the record and provided the Board with a brief background. Mr. Ingram summarized the Consent Order that Dr. Moghbelli is currently under and advised that he has met all of the Board's requirements.

Motion was made by Dr. Rea, seconded by Dr. Miles and carried unanimously to remove all restrictions currently on Dr. Moghbelli medical license.

A copy of the Order removing restrictions is attached hereto and incorporated by reference.

THE BOARD RECESSES AT 10:09 A.M. AND RETURNED AT 10:28 A.M.

APPROVAL OF REVISED EXECUTIVE COMMITTEE MINUTES DATED MAY 17, 2017 **CORRECTION**

Dr. Brunson advised the Board had approved a request from Kallol Saha, M.D., to revise the minutes of his personal appearance before Executive Committee dated May 17, 2017, but the date that was listed as 2018 should be corrected to 2017. Dr. Brunson asked for a motion to correct the date of the minutes from May 17, 2018, to May 17, 2017. Dr Owens moved for approval of the minutes as revised. Dr. Rea seconded the motion and it carried unanimously.

HEARING IN THE CASE OF JAMES L. HOLZHAUER, M.D., COLUMBUS, MS MISSISSIPPI MEDICAL LICENSE NUMBER: 11477

Mr. Ingram advised a request was received from attorney, William B. Johnson, III, for a continuance until the September Board meeting. Motion was made by Dr. Miles, seconded by Dr. McClendon, and carried unanimously to grant the Continuance until the September Board meeting.

A copy of the Order of Continuance is attached hereto and incorporated by reference.

HEARING IN THE CASE OF TIMOTHY SUMMERS, M.D., MERIDIAN, MS MISSISSIPPI MEDICAL LICENSE NUMBER: 07197

Mr. Ingram advised a request was received from attorney, Edward Blackmon, Jr , for a continuance until the September Board meeting. Motion was made by Dr Owens, seconded by Dr. Rea, and carried unanimously to grant the Continuance until the September Board meeting.

A copy of the Order of Continuance is attached hereto and incorporated by reference.

HEARING IN THE CASE OF CHARLES S. FILLINGANE, D.O., MILTON, FL MEDICAL LICENSE NUMBER: 11114

Mr. Ingram briefly summarized that Dr. Fillingane executed a Consent Order as a result of his prior appearance before the Executive Committee. Dr. Fillingane refused to comply with said Order and as a result he was charged with violation of an agreed Order and was prohibited from practicing medicine pending a hearing.

Mr. Ingram advised that Licensee has since that time agreed to comply with the original Consent Order and follow all recommendations and is now in compliance. Mr. Ingram recommended for this matter to be continued and maintain prohibition of practice until such time as the Board is in receipt from the Mississippi Physician Health Program that he is able to practice medicine with reasonable skill and safety to patients.

Motion was made by Dr. Rea, seconded by Dr. Owens, and carried unanimously to grant the Continuance until the September Board meeting.

A copy of the Order of Continuance is attached hereto and incorporated by reference.

ORDER OF PROHIBITION SERVED, ROBERT M. LEVY, M.D., FAYETTEVILLE, AR
MISSISSIPPI MEDICAL LICENSE NUMBER 15663
FOR INFORMATIONAL PURPOSES

Dr. Cleveland advised that the Board the Board received a letter from Dr. Hambleton, Medical Director of the Mississippi Physician Health Program withdrawing advocacy of Dr. Levy based on his termination from the VA Hospital in Arkansas based on findings that he was not able to practice medicine with reasonable skill and safety to patients. This is in violation of his Contract Agreement and he was issued an Order of Prohibition on June 25, 2018, immediately prohibiting Licensee from practicing medicine.

A copy of the Order of Prohibition is attached hereto and incorporated by reference.

HEARING IN THE CASE OF OTIS ANDERSON, III, M.D., HOLLY SPRINGS, MS
MISSISSIPPI MEDICAL LICENSE NUMBER: 21754

Mr. Ingram advised this matter will be complicated and lengthy hearing requiring additional documents to be obtained to adequately address the charges. Also Mr. Ingram advised that a key witness out of the country and in Europe for the entire month of August. Mr. Ingram has recommended the Board consider to continue this matter until such time as the key witness is available and documents have been reviewed before scheduling a special session / setting

Recommendations will be made to the Board of proposed dates after documents have been obtained and reviewed to schedule a specially called two day hearing.

OTHER BUSINESS

The next meeting is scheduled for Wednesday, September 19, 2018, Board Meeting, Thursday, September 20, 2018.

THE BOARD RECESSED AT 10:45 A.M. AND RETURNED AT 10:55 A.M.

HEARING IN THE CASE OF ROBERT BLAIR LEE, M.D., OCEAN SPRINGS, MS MISSISSIPPI MEDICAL LICENSE NUMBER: 10711

Dr. Brunson advised that Heather P. Wagner, Special Assistant Attorney General, will serve as the Hearing Officer for this hearing.

Mr. Ingram introduced Dr. Lee's attorneys, Mark Garriga and Ann Lundy. Mr. Ingram briefly summarized Dr. Lee's licensure status having been charged with violating the medical practice act by virtue of being disciplined and surrendering his medical license in the State of Kentucky. Mr. Ingram provided the Board with a brief background and history surrounding Dr. Lee's case.

Both Mr. Ingram and Mr. Garriga stipulated to and entered numerous exhibits into the record.

Mr. Ingram provided the Board with an opening statement.

Mr. Garriga provided the Board with an opening statement.

Edward Manning, Ph.D., was called to the witness stand and sworn in by the court reporter. Dr. Manning provided a brief summary of his education and career licensed as a Psychologist. Dr. Manning provided testimony in regards to Dr. Lee's evaluation. Dr. Manning answered numerous questions by the Board members before he exited the witness stand

THE BOARD RECESSED AT 12:02 P.M. FOR LUNCH AND RETURNED AT 12:48 A.M.

Dr. Lee was called to the witness stand and sworn in by the court reporter Dr. Lee provided his personal background and education. Mr. Garriga questioned Dr. Lee concerning his practice in Tennessee and Kentucky. Dr. Lee answered Mr. Garriga's questions regarding the action by the Kentucky Hospital. Dr. Lee answered questions by the Board members and Mr. Ingram before he exited the witness stand.

THE BOARD RECESSED AT 2:46 P.M. AND RETURNED AT 3:02 P.M.

Dr. Robert G. Johnson was called by telephone to testify and was sworn in by the court reporter. Dr. Johnson provided his personal background and education. Ms. Lundy questioned Dr. Johnson regarding his practice with Dr. Lee in Ocean Springs, MS Dr. Johnson answered questions by the Board members and Mr. Ingram and completed his telephonic testimony.

A motion was made by Dr. Rea, seconded by Dr. McClendon and carried to close the meeting to consider whether to enter into executive session on this matter.

A motion was made by Dr. Miles, seconded by Dr. Rea and carried that the Executive Committee enter into executive session to discuss investigative proceedings regarding allegations of misconduct or violations of law by Licensee. The Board entered into Executive Session.

Upon a motion by Dr. McClendon, seconded by Dr Owens and carried, the Board came out of executive session at which time Dr. Brunson asked Dr. McClendon to report on its decision. Dr. McClendon reported that the Board will continue its September 7, 2017, Order of Summary Suspension of License. Licensee's request to have his Mississippi medical license reinstated is not granted at this time He may request reinstatement of his Mississippi medical license upon resolution of his medical licensing issues in Kentucky. All members voted in favor of this action with the exception of Dr. Gersh, who voted against.

A copy of the Determination and Order is attached hereto and incorporated by reference.

The official account of this proceeding was recorded by Amy Key, Court Reporter.

ADJOURNMENT

There being no further business, the meeting adjourned at 4:46 p.m.

Claude D. Brunson III

Claude Brunson, M.D.
President

Minutes taken and transcribed
By Frances Carrillo
Staff Officer
July 19, 2018

OATH OF OFFICE

I, H. Allen Gersh, M.D. do solemnly swear (or affirm) that I will faithfully support the Constitution of the United States and the Constitution of the State of Mississippi, and obey the laws thereof; that I am not disqualified from holding the office of Mississippi State Board of Medical Licensure that I will faithfully discharge the duties of the office upon which I am about to enter. So help me God.

Subscribed and sworn to before me at Jackson Mississippi, this 19th day of July, 2018

H. Allen Gersh

By Frances E. Carrillo

FRANCES E CARRILLO
NOTARY PUBLIC
ID No. 034329
Commission Expires
Apr 24, 2021
STATE OF MISSISSIPPI
RANKIN COUNTY

OATH OF OFFICE

I, Kirk L. Kinard, D.O. do solemnly swear (or affirm) that I will faithfully support the Constitution of the United States and the Constitution of the State of Mississippi, and obey the laws thereof; that I am not disqualified from holding the office of Mississippi State Board of Medical Licensure that I will faithfully discharge the duties of the office upon which I am about to enter. So help me God.

Subscribed and sworn to before me at Jackson Mississippi, this 19th day of July, 2018

By Frances E. Carrillo

FRANCES E CARRILLO
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Part 2615 Physician Assistants

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.2 Definitions. For the purpose of Part 2615, Chapter 1 only, the following terms have the meanings indicated:

A. "Board" means the Mississippi State Board of Medical Licensure.

B. "Physician Assistant" means a person who meets the Board's criteria for licensure as a physician assistant and is licensed as a physician assistant by the Board.

C. "Supervising Physician" means a doctor of medicine or a doctor of osteopathic medicine who holds an unrestricted license from the Board, who is in the practice of medicine, and who has been approved by the Board to supervise physician assistants.

D. "Supervise" or "Supervision" means overseeing and accepting responsibility for the medical services rendered by a physician assistant.

E. "Primary Office" means the usual practice location of a physician and being the same location reported by that physician to the Mississippi State Board of Medical Licensure and the United States Drug Enforcement Administration.

F. "NCCPA" means the National Commission on Certification of Physician Assistants.

G. "PANCE" means the Physician Assistant National Certifying Examination.

H. "ARC-PA" means the Accreditation Review Commission on Education for the Physician Assistant.

I. "Predecessor or Successor Agency" refers to the agency responsible for accreditation of educational programs for physician assistants that preceded ARC-PA or the agency responsible for accreditation of educational programs for physician assistants that succeeded ARC-PA.

J. "Primary Care" means specialty practice that is limited to, or defined as, Family Practice, General Internal Medicine, Mental Health, Women's Health, and/or General Pediatrics.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

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C. "Supervising Physician" means a doctor of medicine or a doctor of osteopathic medicine who holds an unrestricted license from the Board, who is in the ~~full-time~~ practice of medicine, and who has been approved by the Board to supervise physician assistants.

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Source: Miss. Code Ann. §73-26-5 (1972, as amended).

Part 2615 Physician Assistants

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.5 Requirement of Protocol - Prescribing/Dispensing. Physician assistants shall practice according to a Board-approved protocol which has been mutually agreed upon by the physician assistant and the supervising physician. Each protocol shall be prepared taking into consideration the specialty of the supervising physician, and must outline diagnostic and therapeutic procedures and categories of pharmacologic agents which may be ordered, administered, dispensed and/or prescribed for patients with diagnoses identified by the physician assistant.

Each protocol shall contain a detailed description of back-up coverage if the supervising physician is away from the primary office. Although licensed, no physician assistant shall practice until a duly executed protocol has been approved by the Board.

Except as hereinafter provided in below, physician assistants may not write prescriptions for or dispense controlled substances or any other drug having addiction-forming or addiction-sustaining liability. A physician assistant may, however, administer such medications pursuant to an order by the supervising physician if in the protocol.

Prescribing Controlled Substances and Medications by Physician Assistants

A. Scope

Pursuant to these rules, authorized physician assistants may prescribe controlled substances in Schedules II through V.

B. Application for Authority to Prescribe Controlled Substances

1. Physician assistant applicants applying for controlled substance prescriptive authority must complete a Board approved educational program prior to making application.
2. In order to obtain the authority to prescribe controlled substances in any schedule, the physician assistant shall submit an application approved by the Board.

C. Incorporation of Physician Rules Pertaining to Prescribing, Administering and Dispensing of Medication

For the purpose of directing the manner in which physician assistants may prescribe controlled substances, the Board incorporates Administrative Code Part 2640, Chapter 1 Pertaining to Prescribing, Administering and Dispensing of Medication as applied to physicians, including but not limited to all Definitions, Maintenance of Records and Inventories, Use of Diet Medication, Use of Controlled Substances for Chronic (Non-Terminal) Pain, and Prescription Guidelines. All physician assistants authorized to prescribe controlled substances shall fully comply with these rules. As stated herein, it is understood Physician Assistants may not dispense medications.

D. Registration for Controlled Substances Certificate Prescriptive Authority

1. Every physician assistant authorized to practice in Mississippi who prescribes any controlled substance must be registered with the U. S. Drug Enforcement Administration in compliance with Title 21 CFR, Part 1301 Food and Drugs.
2. Pursuant to authority granted in Mississippi Code, Section 41-29-125, the Board hereby adopts, in lieu of a separate registration with the Board, the registration

with the U.S. Drug Enforcement Administration as required in Part 2615, Rule 1.5.D.1, provided, however, where a physician assistant already possesses a controlled substances registration certificate for a practice location in another state or jurisdiction, the physician assistant may not transfer or otherwise use the same registration until he or she meets the training requirements set forth in Part 2615, Rule 1.5.B.1. In the event, however, a physician assistant has had limitations or other restrictions placed upon his or her license wherein he or she is prohibited from handling controlled substances in any or all schedules, said physician assistant shall be prohibited from registering with the U. S. Drug Enforcement Administration for a Uniform Controlled Substances Registration Certificate without first being expressly authorized to do so by order of the Board.

3. The registration requirement set forth in these rules does not apply to the distribution and manufacture of controlled substances. Any physician assistant who engages in the manufacture or distribution of controlled substances or legend drugs shall register with the Mississippi State Board of Pharmacy pursuant to Mississippi Code, Section 73-21-105. For the purposes herein, "distribute" shall mean the delivery of a drug other than by administering, prescribing, or dispensing. The word "manufacture" shall have the same meaning as set forth in Mississippi Code, Section 73-21-105(q).

E. Drug Maintenance, Labeling and Distribution Requirements

Persons registered to prescribe controlled substances may order, possess, prescribe, administer, distribute or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of these rules and in conformity with provisions of the Mississippi Uniform Controlled Substances Law, Mississippi Code, Sections 41-29-101 et. seq., except physician assistants may not receive samples of controlled substances. A physician assistant may receive and distribute pre-packaged medications or samples of non-controlled substances for which the physician assistant has prescriptive authority.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

Part 2615 Physician Assistants

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.5 Requirement of Protocol - Prescribing/Dispensing. Physician assistants shall practice according to a Board-approved protocol which has been mutually agreed upon by the physician assistant and the supervising physician. Each protocol shall be prepared taking into consideration the specialty of the supervising physician, and must outline diagnostic and therapeutic procedures and categories of pharmacologic agents which may be ordered, administered, dispensed and/or prescribed for patients with diagnoses identified by the physician assistant.

Each protocol shall contain a detailed description of back-up coverage if the supervising physician is away from the primary office. Although licensed, no physician assistant shall practice until a duly executed protocol has been approved by the Board.

Except as hereinafter provided in below, physician assistants may not write prescriptions for or dispense controlled substances or any other drug having addiction-forming or addiction-sustaining liability. A physician assistant may, however, administer such medications pursuant to an order by the supervising physician if in the protocol.

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2. Pursuant to authority granted in Mississippi Code, Section 41-29-125, the Board hereby adopts, in lieu of a separate registration with the Board, the registration

with the U.S. Drug Enforcement Administration as required in Part 2615, Rule 1.5.D.1, provided, however, where a physician assistant already possesses a controlled substances registration certificate for a practice location in another state or jurisdiction, the physician assistant may not transfer or otherwise use the same registration until he or she meets the training requirements set forth in Part 2615, Rule 1.5.B.1. In the event, however, a physician assistant has had limitations or other restrictions placed upon his or her license wherein he or she is prohibited from handling controlled substances in any or all schedules, said physician assistant shall be prohibited from registering with the U. S. Drug Enforcement Administration for a Uniform Controlled Substances Registration Certificate without first being expressly authorized to do so by order of the Board.

3. The registration requirement set forth in these rules does not apply to the distribution and manufacture of controlled substances. Any physician assistant who engages in the manufacture or distribution of controlled substances or legend drugs shall register with the Mississippi State Board of Pharmacy pursuant to Mississippi Code, Section 73-21-105. For the purposes herein, "distribute" shall mean the delivery of a drug other than by administering, prescribing, or dispensing. The word "manufacture" shall have the same meaning as set forth in Mississippi Code, Section 73-21-105(q).

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Persons registered to prescribe controlled substances may order, possess, prescribe, administer, distribute or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of these rules and in conformity with provisions of the Mississippi Uniform Controlled Substances Law, Mississippi Code, Sections 41-29-101 et. seq., except physician assistants may not receive samples of controlled substances. A physician assistant may receive and distribute pre-packaged medications or samples of non-controlled substances for which the physician assistant has prescriptive authority.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

Part 2615 Physician Assistants

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.6 Supervision. Before any physician shall supervise a physician assistant, the physician and physician assistant must present to the Board a duly executed protocol and obtain written approval to practice in a supervisory arrangement. Protocols will be forwarded to the Board's Physician Assistant Advisory Committee for their review and recommendation prior to disapproval. The facts and matters to be considered by the Committee when reviewing a protocol or supervision arrangement shall include, but are not limited to, how the supervising physician and physician assistant plan to implement the protocol, the method and manner of supervision, consultation, referral, compatibility of practice, and liability.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.6 Supervision. Before any physician shall supervise a physician assistant, the physician and physician assistant must present to the Board~~'s Executive Director~~ a duly executed protocol and obtain written approval to practice in a supervisory arrangement. Protocols will be forwarded to the Board's Physician Assistant Advisory Committee for their review and recommendation prior to disapproval. The facts and matters to be considered by the Committee when reviewing a protocol or supervision arrangement shall include, but are not limited to, how the supervising physician and physician assistant plan to implement the protocol, the method and manner of supervision, consultation, referral, compatibility of practice, and liability.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

Part 2615 Physician Assistants

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.7 Supervising Physician Limited. No physician shall be authorized to supervise a physician assistant unless that physician holds an unrestricted license to practice medicine in the state of Mississippi.

Supervision means overseeing activities of, and accepting responsibility for, all medical services rendered by the physician assistant. Except as described in the following paragraph, supervision must be continuous, but shall not be construed as necessarily requiring the physical presence of the supervising physician.

New graduate physician assistants and all physician assistants whose Mississippi license is their initial license require the on-site presence of a supervising physician for one hundred twenty (120) days or its equivalent of 960 hours. If physician assistant's clerkship was completed with their supervising physician, the 120 days or 960 hours may be reduced.

The physician assistant's practice shall be confined to the primary office or clinic of the supervising physician, or any hospital(s), clinic(s) or other health care facilities within 75 miles of where the primary office is located, wherein the supervising physician holds medical staff privileges or that otherwise serves as an extension of the physician and physician assistant(s) practice. Exceptions to this requirement may be granted, on an individual basis, provided the location(s) of practice are set forth in the protocol.

Physician Assistants practicing in primary care shall have no mileage restrictions placed on the relationship between the supervisory physician and the physician assistant if the following conditions are met:

1. The protocol is between a primary care physician and a primary care physician assistant.
2. The physician is in a compatible practice (e.g., same specialty, treat the same patient population) with the physician assistant.
3. The physician and physician assistant utilize electronic medical records (EMR) in their practice and also utilize EMR in the formal quality improvement program.
4. The physician practices within the State of Mississippi for a minimum of twenty (20) hours per week or eighty (80) hours per month (does not include telemedicine).

The supervising physician must provide adequate means for communication with the physician assistant. Communication may occur through the use of technology which may include, but is not limited to, radio, telephone, fax, modem, or other telecommunication device.

Each primary supervisory relationship shall include and implement a formal quality improvement program which must be maintained on site and must be available for inspection by representatives of the Mississippi State Board of Medical Licensure. The quality assurance/quality improvement program shall consist of:

A. Review by a supervisory physician of a random sample of charts that represent 10% or 20 charts, whichever is less, of patients seen by the physician assistant every month. Charts should represent the variety of patient types seen by the physician assistant. Patients that the physician assistant and a supervising physician have consulted on during the month will count as one chart review.
B. The physician assistant shall maintain a log of charts reviewed which include the identifier for the patient's charts, reviewers' names, and dates of review.
C. Each physician assistant shall meet face to face with a supervisory physician once per quarter for the purpose of quality assurance, and this meeting should be documented.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.7 Supervising Physician Limited. No physician shall be authorized to supervise a physician assistant unless that physician holds an unrestricted license to practice medicine in the state of Mississippi.

Supervision means overseeing activities of, and accepting responsibility for, all medical services rendered by the physician assistant. Except as described in the following paragraph, supervision must be continuous, but shall not be construed as necessarily requiring the physical presence of the supervising physician.

New graduate physician assistants and all physician assistants whose Mississippi license is their initial license require the on-site presence of a supervising physician for one hundred twenty (120) days or its equivalent of 960 hours. If physician assistant's clerkship was completed with their supervising physician, the 120 days or 960 hours may be reduced.

The physician assistant's practice shall be confined to the primary office or clinic of the supervising physician, or any hospital(s), ~~or~~ clinic(s) or other health care facilities~~y~~ within ~~30~~75 miles of where the primary office is located, wherein the supervising physician holds medical staff privileges or that otherwise serves as an extension of the physician and physician assistant(s) practice. Exceptions to this requirement may be granted, on an individual basis, provided the location(s) of practice are set forth in the protocol.

Physician Assistants practicing in primary care shall have no mileage restrictions placed on the relationship between the supervisory physician and the physician assistant if the following conditions are met:

5. The protocol is between a primary care physician and a primary care physician assistant.
6. The physician is in a compatible practice (e.g., same specialty, treat the same patient population) with the physician assistant.
7. The physician and physician assistant utilize electronic medical records (EMR) in their practice and also utilize EMR in the formal quality improvement program.
8. The physician practices within the State of Mississippi for a minimum of twenty (20) hours per week or eighty (80) hours per month (does not include telemedicine).

The supervising physician must provide adequate means for communication with the physician assistant. Communication may occur through the use of technology which may include, but is not limited to~~,~~ radio, telephone, fax, modem, or other telecommunication device.

~~The supervising physician shall, on at least a monthly basis, conduct a review of the records/charts of at least ten percent (10%) of the patients treated by the physician assistant, with~~

Part 2615 Physician Assistants

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.11 Identification. The supervising physician shall be responsible to ensure that any physician assistant under his or her supervision does not advertise or otherwise hold himself or herself out in any manner which would tend to mislead the general public or patients. Physician assistants shall, at all times when on duty, wear a name tag, placard or plate identifying themselves as physician assistants.

Physician assistants may not advertise in any manner which implies that the physician assistant is an independent practitioner. In accordance with Miss. Code Ann., §41-121-1 et. seq., and in an effort maintain transparency in healthcare, physician assistants practicing in an off-site or satellite office, wherein a supervisory physician is not physically located, are required to post in their office waiting room, in a conspicuous location, the name, credentials and office contact information of their supervisory physician.

A person not licensed as a physician assistant by the Board who holds himself or herself out as a physician assistant is subject to the penalties applicable to the unlicensed practice of medicine.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

Part 2615 Chapter 1: The Practice of Physician Assistants

Rule 1.11 Identification. The supervising physician shall be responsible to ensure that any physician assistant under his or her supervision does not advertise or otherwise hold himself or herself out in any manner which would tend to mislead the general public or patients. Physician assistants shall, at all times when on duty, wear a name tag, placard or plate identifying themselves as physician assistants.

Physician assistants may not advertise in any manner which implies that the physician assistant is an independent practitioner. In accordance with Miss. Code Ann., §41-121-1 et. seq., and in an effort maintain transparency in healthcare, physician assistants practicing in an off-site or satellite office, wherein a supervisory physician is not physically located, are required to post in their office waiting room, in a conspicuous location, the name, credentials and office contact information of their supervisory physician.

A person not licensed as a physician assistant by the Board who holds himself or herself out as a physician assistant is subject to the penalties applicable to the unlicensed practice of medicine.

Source: Miss. Code Ann. §73-26-5 (1972, as amended).

3.20 Hospice Referral and Palliative Care

The purpose of this policy is to provide the expectations of the Board when licensees refer patients for hospice care. The Board recognizes the importance of providing appropriate care for terminal patients, encourages appropriate referrals of terminal patients to hospice care, and stresses the importance of referring physicians to provide an adequate supply of medications for patients transitioning into hospice care.

Therefore, it is the policy of the Board that a licensee referring a patient to hospice should provide that patient with a final prescription for all necessary medications to transition to hospice care. While any prescription(s) issued by the referring physician for this purpose should be limited to no greater than a thirty (30) day supply, the prescription(s) should be of sufficient duration and effect as to allow the Hospice Medical Director, or other hospice collaborative provider, a reasonable period of time to see and evaluate the patient.

When providing prescriptions to terminally ill patients who will be transitioning into hospice care, the Board would remind licensees that:

- Prescriptions for patients who are treated for pain resulting from a terminal illness do not count against a licensee's prescription percentage threshold (Part 2640, Rule 1.2).

- A licensee is not required to check the MPMP when an opioid is prescribed for treatment of terminal-illness pain (Part 2640, Rule 1.3).

- A licensee is not required to administer a point of service drug test to terminally ill patients prior to prescribing controlled substances (Part 2640, Rule 1.7).

Part 2630 *Collaboration*

Part 2630 Chapter 1: Collaboration with Nurse Practitioners

Rule 1.1 Scope. These rules apply to all individuals licensed to practice medicine or osteopathic medicine in the state of Mississippi.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.2 Definitions. For the purpose of Part 2630, Chapter 1 only, the following terms have the meanings indicated:

A. "Physician" means any person licensed to practice medicine or osteopathic medicine in the state of Mississippi who holds an unrestricted license or whose practice or prescriptive authority is not limited as a result of voluntary surrender or legal/regulatory order.
B. "Primary Care Physician" means a physician whose practice is limited to, or defined as, Family Practice, General Internal Medicine, Mental Health, Women's Health, and/or General Pediatrics.
C. "Free Standing Clinic" means a clinic or other facility wherein patients are treated by a nurse practitioner, which is more than seventy-five (75) miles away from the primary office of the collaborative/consultative physician. Excluded from this definition are all licensed hospitals, state health department facilities, federally qualified community health clinics and volunteer clinics.
D. "Primary Office" means the usual practice location of a physician and being the same location reported by that physician to the Mississippi State Board of Medical Licensure and the United States Drug Enforcement Administration.
E. "Collaborating/Consulting Physician" means a physician who, pursuant to a duly executed protocol, has agreed to collaborate/consult with a nurse practitioner.
F. "Nurse Practitioner" means any person licensed to practice nursing in the state of Mississippi and certified by the Mississippi Board of Nursing to practice in an expanded role as a nurse practitioner.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.3 Board Review. Physicians who wish to collaborate/consult with a nurse practitioner who plans or anticipates practicing in a free standing clinic, must first (a) appear personally or by telephone before the Mississippi State Board of Medical Licensure and/or the Joint Committee of the Board of Medical Licensure and the Board of Nursing if the Board of Medical Licensure determines that the collaborative/consultative relationship may not be approved absent action from the Joint Committee, (b) present and discuss the protocol, and (c) obtain approval from the Board to act as a collaborating/consulting physician. The facts and matters to be considered by the Board shall include, but are not limited to, how the collaborating/consulting physician and

nurse practitioner plan to implement the protocol, the method and manner of collaboration, consultation, and referral.

The requirement for Board appearance and approval set forth in the preceding paragraph also applies to any physician collaborating/consulting with a nurse practitioner who later moves to a free standing clinic under an existing protocol.

Where a nurse practitioner is practicing in a free standing clinic pursuant to an existing protocol as of the effective date of this regulation, the requirements of personal appearance or telephone interview and Board approval set forth in the paragraph above shall not be required until the next succeeding renewal date for said certificate as required by the Mississippi State Board of Nursing.

Where two or more physicians anticipate executing a protocol to collaborate/consult with a nurse practitioner practicing in a free standing clinic, it shall not be necessary that all of the physicians personally appear before the Mississippi State Board of Medical Licensure as required in the preceding paragraph. In this situation, the physician who will bear the primary responsibility for the collaboration/consultation with the nurse practitioner shall make the required personal appearance or telephone interview.

Each collaborative/consultative relationship shall include and implement a formal quality improvement program which shall be maintained on site and shall be available for inspection by representatives of the Mississippi State Board of Medical Licensure. The quality assurance/quality improvement program shall consist of:

A. Review by collaborative physician of a random sample of charts that represent 10% or 20 charts, whichever is less, of patients seen by the nurse practitioner every month. Charts should represent the variety of patient types seen by the nurse practitioner. Patients that the nurse practitioner and collaborating physician have consulted on during the month will count as one chart review.
B. The nurse practitioner shall maintain a log of charts reviewed which include the identifier for the patient's charts, reviewers' names, and dates of review.
C. Each nurse practitioner shall meet face to face with a collaborating physician once per quarter for the purpose of quality assurance and this meeting should be documented.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.4 Collaborative/Consultative Relationships. Physicians with collaborative relationships with APRN must ensure backup physician coverage when the primary collaborative physician is unavailable. The backup physician must be on APRN protocol. In the event of death, disability (physical/mental), or relocation, which would result in the APRN not having a collaborative physician, the APRN has the duty to immediately notify the Mississippi Board of Nursing as jointly agreed by the Mississippi Board of Nursing and the Mississippi Board of Medical

Licensure. The Nursing Board will then immediately notify the Mississippi State Board of Medical Licensure.

In order that patients may continue to be treated without interruption of care, the APRN may be allowed to continue to practice for a 90-day grace period while the APRN attempts to secure a collaborative physician without such practice being considered the practice of medicine. The Mississippi State Board of Medical Licensure, or its designee, will serve as the APRN's collaborative physician with the agreement of the Mississippi Board of Nursing. The Mississippi State Board of Medical Licensure and the Mississippi State Board of Nursing will assist the APRN in their attempt to secure a collaborative physician. If a collaborative physician has not been secured at the end of the 90-day grace period, an additional 90-day extension may be granted by mutual agreement of the Executive Committee of the Mississippi Board of Nursing and the Executive Committee of the Mississippi State Board of Medical Licensure. During this additional 90-day extension, the above described collaborative agreement will continue. The APRN will not be allowed to practice until the previously described collaborative arrangement with the Mississippi State Board of Medical Licensure is agreed upon.

Source: *Miss. Code Ann. §73-43-11 (1972, as amended).*

Rule 1.5 Primary Care Extended Mileage. Primary care physicians, as defined in Rule 1.2, shall have no mileage restrictions placed on the collaborative agreement between the physician and the nurse practitioner if the following conditions are met:

1. The collaborative agreement is between a primary care physician and a primary care nurse practitioner.
2. The physician is in a compatible practice (e.g., same specialty, treat the same patient population) with the nurse practitioner.
3. The physician utilizes electronic medical records (EMR) in their practice, and also utilizes EMR in the formal quality improvement program.
4. The physician practices within the State of Mississippi for a minimum of twenty (20) hours per week or eighty (80) hours per month (does not include telemedicine).

All other requirements stated herein regarding collaborative agreements/relationships with nurse practitioners shall apply.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.6 Violation of Rules. Any violation of the rules as enumerated above shall constitute unprofessional conduct in violation of Mississippi Code, Section 73-25-29(8).

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.7 Effective Date of Regulation. The above rules pertaining to collaborating/consulting physicians shall become effective September 21, 1991.

Amended May 19, 2005; Amended March 13, 2009; Amended November 19, 2009; Amended July 14, 2011; Amended May 4, 2016; Amended July 19, 2018

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2630 *Collaboration*

Part 2630 Chapter 1: Collaboration with Nurse Practitioners

Rule 1.1 Scope. These rules apply to all individuals licensed to practice medicine or osteopathic medicine in the state of Mississippi.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.2 Definitions. For the purpose of Part 2630, Chapter 1 only, the following terms have the meanings indicated:

A. "Physician" means any person licensed to practice medicine or osteopathic medicine in the state of Mississippi who holds an unrestricted license or whose practice or prescriptive authority is not limited as a result of voluntary surrender or legal/regulatory order.
B. "Primary Care Physician" means a physician whose practice is limited to, or defined as, Family Practice, General Internal Medicine, Mental Health, Women's Health, and/or General Pediatrics.
C. "Free Standing Clinic" means a clinic or other facility wherein patients are treated by a nurse practitioner, which is more than seventy-five (75) miles away from the primary office of the collaborative/consultative physician. Excluded from this definition are all licensed hospitals, state health department facilities, federally qualified community health clinics and volunteer clinics.
D. "Primary Office" means the usual practice location of a physician and being the same location reported by that physician to the Mississippi State Board of Medical Licensure and the United States Drug Enforcement Administration.
E. "Collaborating/Consulting Physician" means a physician who, pursuant to a duly executed protocol, has agreed to collaborate/consult with a nurse practitioner.
F. "Nurse Practitioner" means any person licensed to practice nursing in the state of Mississippi and certified by the Mississippi Board of Nursing to practice in an expanded role as a nurse practitioner.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.3 Board Review. Physicians who wish to collaborate/consult with a nurse practitioner who plans or anticipates practicing in a free standing clinic, must first (a) appear personally or by telephone before the Mississippi State Board of Medical Licensure and/or the Joint Committee of the Board of Medical Licensure and the Board of Nursing if the Board of Medical Licensure determines that the collaborative/consultative relationship may not be approved absent action from the Joint Committee, (b) present and discuss the protocol, and (c) obtain approval from the Board to act as a collaborating/consulting physician. The facts and matters to be considered by the Board shall include, but are not limited to, how the collaborating/consulting physician and

nurse practitioner plan to implement the protocol, the method and manner of collaboration, consultation, and referral.

The requirement for Board appearance and approval set forth in the preceding paragraph also applies to any physician collaborating/consulting with a nurse practitioner who later moves to a free standing clinic under an existing protocol.

Where a nurse practitioner is practicing in a free standing clinic pursuant to an existing protocol as of the effective date of this regulation, the requirements of personal appearance or telephone interview and Board approval set forth in the paragraph above shall not be required until the next succeeding renewal date for said certificate as required by the Mississippi State Board of Nursing.

Where two or more physicians anticipate executing a protocol to collaborate/consult with a nurse practitioner practicing in a free standing clinic, it shall not be necessary that all of the physicians personally appear before the Mississippi State Board of Medical Licensure as required in the preceding paragraph. In this situation, the physician who will bear the primary responsibility for the collaboration/consultation with the nurse practitioner shall make the required personal appearance or telephone interview.

Each collaborative/consultative relationship shall include and implement a formal quality improvement program which shall be maintained on site and shall be available for inspection by representatives of the Mississippi State Board of Medical Licensure. The quality assurance/quality improvement program shall consist of:

A. Review by collaborative physician of a random sample of charts that represent 10% or 20 charts, whichever is less, of patients seen by the nurse practitioner every month. Charts should represent the variety of patient types seen by the nurse practitioner. Patients that the nurse practitioner and collaborating physician have consulted on during the month will count as one chart review.
B. The nurse practitioner shall maintain a log of charts reviewed which include the identifier for the patient's charts, reviewers' names, and dates of review.
C. Each nurse practitioner shall meet face to face with a collaborating physician once per quarter for the purpose of quality assurance and this meeting should be documented.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.4 Collaborative/Consultative Relationships. Physicians with collaborative relationships with APRN must ensure backup physician coverage when the primary collaborative physician is unavailable. The backup physician must be on APRN protocol. In the event of death, disability (physical/mental), or relocation, which would result in the APRN not having a collaborative physician, the APRN has the duty to immediately notify the Mississippi Board of Nursing as jointly agreed by the Mississippi Board of Nursing and the Mississippi Board of Medical

Licensure. The Nursing Board will then immediately notify the Mississippi State Board of Medical Licensure.

In order that patients may continue to be treated without interruption of care, the APRN may be allowed to continue to practice for a 90-day grace period while the APRN attempts to secure a collaborative physician without such practice being considered the practice of medicine. The Mississippi State Board of Medical Licensure, or its designee, will serve as the APRN's collaborative physician with the agreement of the Mississippi Board of Nursing. The Mississippi State Board of Medical Licensure and the Mississippi State Board of Nursing will assist the APRN in their attempt to secure a collaborative physician. If a collaborative physician has not been secured at the end of the 90-day grace period, an additional 90-day extension may be granted by mutual agreement of the Executive Committee of the Mississippi Board of Nursing and the Executive Committee of the Mississippi State Board of Medical Licensure. During this additional 90-day extension, the above described collaborative agreement will continue. The APRN will not be allowed to practice until the previously described collaborative arrangement with the Mississippi State Board of Medical Licensure is agreed upon.

Source: *Miss. Code Ann. §73-43-11 (1972, as amended).*

Rule 1.5 Primary Care Extended Mileage. Primary care physicians, as defined in Rule 1.2, shall have no mileage restrictions placed on the collaborative agreement between the physician and the nurse practitioner if the following conditions are met:

1. The collaborative agreement is between a primary care physician and a primary care nurse practitioner.
2. The physician is in a compatible practice (e.g., same specialty, treat the same patient population) with the nurse practitioner.
3. The physician utilizes electronic medical records (EMR) in their practice, and also utilizes EMR in the formal quality improvement program.
4. The physician practices within the State of Mississippi for a minimum of twenty (20) hours per week or eighty (80) hours per month (does not include telemedicine).

All other requirements stated herein regarding collaborative agreements/relationships with nurse practitioners shall apply.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.6 Violation of Rules. Any violation of the rules as enumerated above shall constitute unprofessional conduct in violation of Mississippi Code, Section 73-25-29(8).

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Rule 1.7 Effective Date of Regulation. The above rules pertaining to collaborating/consulting physicians shall become effective September 21, 1991.

Amended May 19, 2005; Amended March 13, 2009; Amended November 19, 2009; Amended July 14, 2011; Amended May 4, 2016; Amended July 19, 2018

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.1 Scope. These rules apply to all individuals who have prescriptive authority and are licensed by the Mississippi State Board of Medical Licensure.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.1 Scope. These rules apply to all individuals who have prescriptive authority and are licensed ~~to practice medicine, osteopathic medicine or podiatric medicine in the state of Mississippi~~ by the Mississippi State Board of Medical Licensure.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.2 Definitions. For the purpose of Part 2640, Chapter 1 only, the following terms have the meanings indicated:

A. "Administer", "Controlled Substances", and "Ultimate User" shall have the same meaning as set forth in Mississippi Code, Section 41-29-105, unless the context otherwise requires.
B. "Board" means the Mississippi State Board of Medical Licensure.
C. "Physician" means any person licensed to practice medicine, osteopathic medicine or podiatric medicine in the state of Mississippi.
D. "Physician Assistant" means any person meeting the requirements of licensure in the state of Mississippi as required by Part 2617, Chapter 1.
E. "Licensee" means any person licensed by this Board who has prescriptive authority.
F. "Prescriptive Authority" means the legal authority of a professional licensed to practice in the state of Mississippi who prescribes controlled substances and is registered with the U. S. Drug Enforcement Administration in compliance with Title 21 CFR, Part 1301 Food and Drugs.
G. "Prescribe" means to designate or order by means of either a written or oral prescription the delivery of a controlled substance or legend drug to an ultimate user.
H. "Dispense" means to deliver a controlled substance or legend drug other than by administering or prescribing to an ultimate user or research subject including the packaging, labeling, or compounding necessary to prepare the substance for that delivery.
I. For the purpose of enforcement of the labeling requirements set forth in this chapter, Part 2640, Rule 1.7.B, "Dispensing Physician" means any physician who dispenses to a patient for the patient's use any controlled substance, legend drug or other medication where such medication is purchased by the physician for resale to a patient whether or not a separate charge is made. As stated in Part 2617, it is understood that Physician Assistants may not dispense medications.
J. "Prescription Drug" or "Legend Drug" means a drug required under federal law to be labeled with the following statement prior to being dispensed or delivered; "Caution: Federal law prohibits dispensing without prescription," or a drug which is required by any applicable federal or state law or regulation to be dispensed on prescription only or is restricted to use by licensees only.
K. "Pain Management Practice" means a public or privately owned practice for which 50% or more of the patients are issued, on a regular or recurring basis, a prescription for opioids, barbiturates, benzodiazepines, carisoprodol, butalbital compounds, or tramadol for the treatment of chronic non-cancerous/non-terminal pain. Included in this definition is any practice that advertises and/or holds itself out to provide pain management services. Patients who are treated for pain resulting from a terminal illness do not count against the percentage stated herein.
L. "Inpatient" means a patient in a hospital, nursing home, long term care facility, inpatient (not home-bound) hospice, or any other facility wherein medications are dispensed to a patient by a third party who is duly licensed and/or certified to dispense medications in a healthcare or related facility.

M. "Bariatric Medicine, Medical Weight Loss, or Weight Management Practice" means a public or privately owned practice

1. for which 30% or more of the patients are provided a comprehensive weight management treatment program or;
2. 30% or more of the patients receive any controlled substance approved by the FDA for the pharmacologic management of weight loss or;
3. which advertises weight loss by any means.

Excluded from this definition is any practice in which a licensee advertises the use of nonpharmacological products as part of the licensee's overall practice of medicine. In order to be excluded from this definition, the licensee's practice must have nonpharmacological weight loss and/or weight loss management as a component of the overall management of the patient's total health care. If the use of nonpharmacological products for weight loss and/or weight management exceeds 30% of the total outpatient clinic visits for any single 90-day consecutive period, the practice will be considered a bariatric medicine/medical weight loss practice and will be subject to all the rules and regulations pertaining to bariatric medicine/medical weight loss practice.

Bariatric surgeons whose primary practice is surgical weight loss and not long-term management of weight loss through medical, pharmaceutical, and/or behavioral management are also excluded from this definition.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.2 Definitions. For the purpose of Part 2640, Chapter 1 only, the following terms have the meanings indicated:

A. "Administer", "Controlled Substances", and "Ultimate User" shall have the same meaning as set forth in Mississippi Code, Section 41-29-105, unless the context otherwise requires.
B. "Board" means the Mississippi State Board of Medical Licensure.
C. "Physician" means any person licensed to practice medicine, osteopathic medicine or podiatric medicine in the state of Mississippi.
D. "Physician Assistant" means any person meeting the requirements of licensure in the state of Mississippi as required by Part 2617, Chapter 1.
E. "Licensee" means any person licensed by this Board who has prescriptive authority.
F. "Prescriptive Authority" means the legal authority of a professional licensed to practice in the state of Mississippi who prescribes controlled substances and is registered with the U. S. Drug Enforcement Administration in compliance with Title 21 CFR, Part 1301 Food and Drugs.
G. "Prescribe" means to designate or order by means of either a written or oral prescription the delivery of a controlled substance or legend drug to an ultimate user.
H. "Dispense" means to deliver a controlled substance or legend drug other than by administering or prescribing to an ultimate user or research subject including the packaging, labeling, or compounding necessary to prepare the substance for that delivery.
I. For the purpose of enforcement of the labeling requirements set forth in this chapter, Part 2640, Rule 1.7.B, "Dispensing Physician" means any physician who ~~shall~~ dispenses to a patient for the patient's use any controlled substance, legend drug or other medication where such medication is purchased by the physician for resale to a patient whether or not a separate charge is made. As stated in Part 2617, it is understood that Physician Assistants may not dispense medications.
J. "Prescription Drug" or "Legend Drug" means a drug required under federal law to be labeled with the following statement prior to being dispensed or delivered; "Caution: Federal law prohibits dispensing without prescription," or a drug which is required by any applicable federal or state law or regulation to be dispensed on prescription only or is restricted to use by ~~physicians~~ licensees only.
K. "Pain Management ~~Clinic~~ Practice" means a public or privately owned ~~facility~~ practice for which ~~the majority (~~50% or more~~)~~ of the patients are issued, on a ~~monthly~~ regular or recurring basis, a prescription for opioids, barbiturates, benzodiazepines, carisoprodol, butalbital compounds, or tramadol for the treatment of chronic non-cancerous/non-terminal pain. Included in this definition ~~shall be~~ is any practice that advertises and/or holds itself out to provide pain management services. ~~Physicians or practices that treat patients for pain resulting from a terminal illness are excluded from this definition.~~ Patients who are treated for pain resulting from a terminal illness do not count against the percentage stated herein.
L. "Inpatient" means a patient in a hospital, nursing home, long term care facility, inpatient (not home-bound) hospice, or any other facility wherein medications are dispensed to a

patient by a third party who is duly licensed and/or certified to dispense medications in a healthcare or related facility.

M. "Bariatric Medicine, Medical Weight Loss, or Weight Management ~~Clinic~~ Practice" means a public or privately owned ~~facility~~ practice.

1. for which 30% or more of the patients are provided a comprehensive weight management treatment program or;
2. 30% or more of the patients receive any controlled substance approved by the FDA for the pharmacologic management of weight loss or;
3. ~~any clinic operated by, staffed by, or affiliated with through affiliation, employment, or collaboration agreement with a Mississippi licensee or;~~ which advertises weight loss by any means.

Excluded from this definition is any practice in which a licensee advertises the use of nonpharmacological products as part of the licensee's overall practice of medicine. In order to be excluded from this definition, the licensee's practice ~~shall~~ must have nonpharmacological weight loss and/or weight loss management as a component of the overall management of the patient's total health care. If the use of nonpharmacological products for weight loss and/or weight management exceeds 30% of the total outpatient clinic visits for any single 90-day consecutive period, the practice ~~shall~~ will be considered a bariatric medicine/medical weight loss practice and shall will be subject to all the rules and regulations pertaining to bariatric medicine/medical weight loss practice.

Bariatric surgeons whose primary practice is surgical weight loss and not long-term management of weight loss through medical, pharmaceutical, and/or behavioral management are also excluded from this definition.

~~N. Advertised medical weight loss must include behavior modification, comprehensive nutritional education, exercise or physical therapy intervention, long-term maintenance programs, dispensing and/or prescribing FDA-approved medications as indicated for weight loss on a monthly basis as part of the patient's treatment plan.~~

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.3 Registration for Controlled Substances Certificate. Every licensee who prescribes, administers or dispenses any controlled substance within Mississippi or who proposes to engage in the prescribing, administering or dispensing of any controlled substance within Mississippi must be registered with the U.S. Drug Enforcement Administration in compliance with Title 21 CFR Part 1301 Food and Drugs.

Each individual who is licensed by the Mississippi State Board of Medical Licensure and has prescriptive authority must be registered with the Mississippi Prescription Monitoring Program (MPMP). Every licensee who provides medical care in a pain management practice as defined in Rule 1.2 (K) must review the MPMP at each patient encounter in which a prescription for a controlled substance is issued. Every licensee, regardless of practice specialty, must review the MPMP at each patient encounter in which an opioid is prescribed for acute and/or chronic non-cancerous/non-terminal pain. Those licensees whose practice is not a pain management practice as defined previously must actively utilize the MPMP upon initial contact with new patients and at least every three (3) months thereafter on any and all patients who are prescribed, administered, or dispensed controlled substances other than opioids. Licensees who issue a prescription for Lomotil, Lyrica, Testosterone, Pseudoephedrine, or Amphetamines prescribed to pediatric patients under the age of sixteen (16) for the treatment of ADHD, are not required in that instance to utilize the MPMP as stated herein.

Reports generated on such patients should span the length of time from the previous review of the MPMP so that adequate information is obtained to determine patient compliance with treatment. Documentation, such as a copy of the report itself and/or reflection in the chart dictation and/or notes, must be kept within the patient's record and made available for inspection upon request. As allowed by the Mississippi Board of Pharmacy and the MPMP, properly registered designees of the licensee may run/obtain the report for the licensee's review as required herein.

Utilization of the MPMP as stated herein is not required when treating inpatient; however, upon discharge from said inpatient setting with a prescription for a controlled substance, the MPMP must be reviewed as required herein.

Pursuant to authority granted in Mississippi Code, Section 41-29-125, the Mississippi State Board of Medical Licensure hereby adopts, in lieu of a separate registration with the Board, the registration with the U.S. Drug Enforcement Administration as required in the above paragraph. In the event, however, a licensee has had limitations or other restrictions placed upon his or her license wherein he or she is prohibited from ordering, dispensing, or prescribing controlled substances in any schedule, said licensee shall be prohibited from registering with the U.S. Drug Enforcement Administration for a Uniform Controlled Substances Registration Certificate without first being expressly authorized to do so by order of the Mississippi State Board of Medical Licensure.

Persons registered to prescribe, administer, dispense or conduct research with controlled substances may order, possess, prescribe, administer, dispense or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of these rules and in conformity with provisions of the Mississippi Uniform Controlled Substances Law, Mississippi Code Section 41-29-101 et seq.

The registration requirement set forth in these rules does not apply to the distribution and manufacture of controlled substances. Any licensee who engages in the manufacture or distribution of controlled substances or legend drugs must register with the Mississippi State Board of Pharmacy pursuant to Mississippi Code, Section 73-21-105 and will be subject to all applicable federal statutes and regulations controlling such practices. For the purposes herein, "distribute" means the delivery of a drug other than by administering, prescribing or dispensing. The word "manufacture" has the same meaning as set forth in Mississippi Code, Section 41-29-105(q).

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.3 Registration for Controlled Substances Certificate. Every ~~physician~~ licensee ~~licensed to practice in Mississippi~~ who prescribes, administers or dispenses any controlled substance within Mississippi or who proposes to engage in the prescribing, administering or dispensing of any controlled substance within Mississippi must be registered with the U.S. Drug Enforcement Administration in compliance with Title 21 CFR Part 1301 Food and Drugs.

~~In addition, that physician must be registered with the Mississippi Prescription Monitoring Program (MPMP) by December 31, 2013.~~Each individual who is licensed by the Mississippi State Board of Medical Licensure and has prescriptive authority must be registered with the Mississippi Prescription Monitoring Program (MPMP). Every licensee who provides medical care in a pain management practice as defined in Rule 1.2 (~~G~~K) ~~shall~~ must review the MPMP at each patient encounter in which a prescription for a controlled substance is issued. Every licensee, regardless of practice specialty, ~~shall~~ must review the MPMP at each patient encounter in which an opioid is prescribed for acute and/or chronic non-cancerous/non-terminal pain. Those licensees whose practice is not a pain management practice as defined previously ~~shall~~must actively utilize the MPMP upon initial contact with new patients and at least every three (3) months thereafter on any and all patients who are prescribed, administered, or dispensed controlled substances other than opioids. Licensees who issue a prescription for Lomotil, Lyrica, Testosterone, Pseudoephedrine, or Amphetamines prescribed to pediatric patients under the age of sixteen (16) for the treatment of ADHD, are not required in that instance to utilize the MPMP as stated herein.

Reports generated on such patients should span the length of time from the previous review of the MPMP so that adequate information is obtained to determine patient compliance with treatment. Documentation, such as a copy of the report itself and/or reflection in the chart dictation and/or notes, ~~shall~~must be kept within the patient's record and made available for inspection upon request. As allowed by the Mississippi Board of Pharmacy and the MPMP, properly registered designees of the licensee may run/obtain the report for the licensee's review as required herein.

~~In addition, licensees required to register under this section shall also utilize the MPMP to generate a global report to review their entire practice as a whole at least yearly. Documentation of the global report shall be kept in a separate file to be available for inspection upon request.~~

Utilization of the MPMP as stated herein is not required when treating inpatient; however, upon discharge from said inpatient setting with a prescription for a controlled substance, the MPMP must be reviewed as required herein.

Pursuant to authority granted in Mississippi Code, Section 41-29-125, the Mississippi State Board of Medical Licensure hereby adopts, in lieu of a separate registration with the Board, the registration with the U.S. Drug Enforcement Administration as required in the above paragraph.

In the event, however, a ~~physician~~ licensee has had limitations or other restrictions placed upon his or her license wherein he or she is prohibited from ~~handling~~ ordering, dispensing, or prescribing controlled substances in any ~~or all~~ schedule, said ~~physician~~ licensee shall be prohibited from registering with the U.S. Drug Enforcement Administration for a Uniform Controlled Substances Registration Certificate without first being expressly authorized to do so by order of the Mississippi State Board of Medical Licensure.

Persons registered to prescribe, administer, dispense or conduct research with controlled substances may order, possess, prescribe, administer, dispense or conduct research with those substances to the extent authorized by their registration and in conformity with the other provisions of these rules and in conformity with provisions of the Mississippi Uniform Controlled Substances Law, Mississippi Code, Section~~s~~ 41-29-101 et seq.

The registration requirement set forth in these rules does not apply to the distribution and manufacture of controlled substances. Any ~~physician~~ licensee who engages in the manufacture or distribution of controlled substances or legend drugs ~~shall~~must register with the Mississippi State Board of Pharmacy pursuant to Mississippi Code, Section 73-21-105 and ~~shall~~will be subject to all applicable federal statutes and regulations controlling such practices. For the purposes herein, "distribute" ~~shall~~ mean~~s~~ the delivery of a drug other than by administering, prescribing or dispensing. The word "manufacture" ~~shall~~ has~~ve~~ the same meaning as set forth in Mississippi Code, Section 41-29-105(q).

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.4 Maintenance of Records and Inventories. Every licensee shall maintain inventories, logs, and records prescribed in this rule.

A. Controlled substances inventory record. All controlled substances classified under Schedules II, IIN, III, IIIN, IV and V which are purchased by the licensee must be inventoried at least every two (2) years. All inventory records for controlled substances in Schedules II and IIN must be maintained separately from the inventory records for Schedules III, IIIN, IV and V controlled substances. To insure the reliability of an inventory, the physician must maintain a readily retrievable record of controlled substances purchased, including a copy of all purchase invoices identifying the name, quantity and strength/dose of the controlled substance purchased, the supplier and the date purchased. Controlled substances inventory must also meet all applicable federal statutes and regulations.
B. Controlled substances dispensation/administration record. Every licensee who dispenses or administers, Schedules II, IIN, III, IIIN, IV and V controlled substances must maintain a separate readily retrievable record of all such substances dispensed or administered. This requirement does not apply to Schedules III, IIIN, IV and V prepackaged samples and starter packs. All dispensation/administration records for controlled substances in Schedules II and IIN must be maintained separately from the dispensation/administration records for Schedules III, IIIN, IV and V controlled substances. The record must contain the following information:
    1. The date the controlled substance was dispensed or administered.
    2. The name, quantity and strength/dose of the controlled substance dispensed or administered.
    3. The method of administration of the controlled substance, i.e. oral, IV or subcutaneous.
    4. The name and address of the patient to whom the controlled substance was dispensed or administered.
    5. For all Schedules II and III amphetamines, amphetamine-like anorectic drugs, or sympathomimetic amine drugs dispensed in the treatment of narcolepsy, hyperkinesis, brain dysfunction, epilepsy, or depression, the dispensing or administration records must include the diagnosis and the reason for use of the Schedules II and III controlled substances.

Controlled substances dispensation/administration records must also meet all applicable federal statutes and regulations.

Patient Record - A licensee who prescribes, dispenses or administers a legend drug or controlled substance must maintain a complete record of his or her examination, evaluation and treatment of the patient which must include documentation of the diagnosis and reason for prescribing, dispensing or administering any legend drug or controlled substance; the name, dose, strength, quantity of the legend drug or controlled substance and the date that the legend drug or controlled substance was prescribed, dispensed or administered. The record required by this rule

must be maintained in the patient's medical records. If medical records are maintained at the office of the licensee, the records must be available for inspection by the representatives of the Mississippi State Board of Medical Licensure.

Licensees must not prescribe, administer or dispense any legend drug; any controlled substance; or any drug having addiction-forming or addiction-sustaining liability without a good faith prior examination and medical indication. A determination as to whether a "good faith prior examination and medical indication" exists depends upon the facts and circumstances in each case. One of the primary roles of a physician is to elicit detailed information about the signs and symptoms which a patient presents in order that he or she may recommend a course of treatment to relieve the symptoms and cure the patient of his or her ailment or maintain him or her in an apparent state of good health. In order for a licensee to achieve a reasonable diagnosis and treatment plan, a history and physical examination consistent with the nature of the complaint are necessary. The importance of these aspects of proper medical practice cannot be over emphasized. The paramount importance of a complete medical history in establishing a correct diagnosis is well established. Standards of proper medical practice require that, upon any encounter with a patient, in order to establish proper diagnosis and regimen of treatment, a licensee must take three steps: (a) take and record an appropriate medical history, (b) carry out an appropriate physical examination, and (c) record the results. The observance of these principles is an integral component of the "course of legitimate professional practice."

Some of the factors used in determining the presence or absence of "good faith" may include, but are not limited to:

1. the quality and extent of the documented history and physical exam;
2. the extent to which the prescribed therapy is supported by documented history and physical exam;
3. the licensee's permitting the patient to name the drug desired;
4. a licensee dispensing or prescribing drugs to patients having no medical need, when the licensee knew or should have known that the patients were addicts or abusing/misusing substances;
5. repeated refills over relatively short periods of time or the issuance of prescriptions at a time when the patient should not have been finished taking the same medication from a prior prescription had the prescription directions been properly followed or the correct dosage taken;
6. general remarks of the licensee indicating his or her experience with non-therapeutic uses of the drug;
7. a licensee prescribing contraindicated medication such as amphetamines and depressants in a manner which results in therapeutic conflicts.

The aforementioned is of particular importance in cases in which controlled substances are to play a part in the course of treatment. It is the responsibility of the licensee to dispense, prescribe or administer all therapies with proper regard for the actual and potential dangers. This fact has been established in a number of closely related administrative and criminal cases, **United States v. Bartee**, 479 F.2d 484 (10th Cir. 1973) (No physical examination prior to issuance of prescriptions for controlled substances); **United States v. Greene**, 511 F.2d 1062 (7th Cir. 1975); **Arthurs v. Board of Registration of Medicine**, 418 N.E. 2d 1236 (MA 1981) (failure to record in patient file prescriptions for controlled substances issued or failure to record patient

visit); **Brainard v. State Board of Medical Examiners**, 157 P2d 7 (Ca. 1945); **Dannerberg v. Board of Regents**, 430 N.Y.2d 700 (1980) (issuance of three prescriptions for sleeping pills to an undercover agent without a physical examination; **Widlitz v. Board of Regents of New York,** 429 N.Y. 2d 794 (1980) (issuance of Desoxyn to patients whom physician knew were drug addicts without conducting physical examination); **United States v. Rosenberg**, 515 F.2d 190 (9th Cir. 1975) (no physical examination, evidences that prescriptions were not in course of professional practice); and **United States v. Hooker**, 541 F.2d 300 (1st Cir. 1976), (little more than cursory physical examination, frequent neglect to inquire as to past medical history, little or no exploration of the type of problem the patient allegedly had "indicates that the minimal professional procedures followed were designed only to give an appearance of propriety to appellant's unlawful distributions").

A determination of proper "medical indication" requires examination of the nature of the therapy and all circumstances surrounding its implementation. Use of any therapy should be supported by standards of medical practice, reasonable scientific evidence or consensus and documented in the medical record. Case law developed by the courts in connection with controlled substances criminal violations and administrative decisions further illustrates several indications of lack of good faith. See **United States v. Greene**, 511 F.2d 1062 (7th Cir. 1975) and **United States v. Rosenburg**, 515 F.2d 190 (9th Cir. 1975). One of primary importance is the failure to follow at least the minimal professional procedures. Some of the factors used in determining the existence of "good faith" may include, but are not limited to: (a) the physician's permitting the patient to name the drug desired; (b) a physician dispensing drugs to patients having no medical need, when the physician knew or should have known that the patients were addicts; (c) repeated refills over relatively short periods of time or the issuance of prescriptions at a time when the patient should not have been finished taking the same medication from a prior prescription had the prescription directions been properly followed or the correct dosage taken; (d) general remarks of the physician indicating his or her experience with non-therapeutic uses of the drug; (e) a physician prescribing contraindicated medication such as amphetamines and depressants in a manner which results in therapeutic conflicts

A licensee must not sell or trade any medication which he or she receives as prepackaged samples or starter packs, whether or not said samples are controlled substances, legend drugs or other medication.

The Controlled Substances Inventory, Controlled Substance Dispensation/Administration Record, and Patient Record required by these rules must be maintained in the office of the licensee for a period of seven (7) years from the date that the record is completed or the controlled substances, legend drugs or other medications are prescribed, administered or dispensed and must be made available for inspection by representatives of the Mississippi State Board of Medical Licensure pursuant to authority granted in Mississippi Code, Section 41-29-125. Record retention for Controlled Substances Inventory, Controlled Substance Dispensation/Administration Record, and Patient Record must also meet all applicable federal statutes and regulations.

A licensee may use a data processing system or a manual record keeping system for the storage and retrieval of Controlled Substances Dispensation/Administration Records. If a licensee

utilizes a data processing system, it must provide immediate retrieval of all dispensation/administration records of controlled substances.

Whether maintained manually or in a data processing system, all records of dispensation/administration of controlled substances must be readily retrievable. If a data processing system is utilized, a hard-copy printout of the records of dispensation/administration must be made at regular intervals, not to exceed seven (7) days. Such hard-copy printouts must be maintained for a period of five (5) years and must be made available for inspection and copying by investigators of the Mississippi State Board of Medical Licensure.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.4 Maintenance of Records and Inventories. Every ~~physician licensed to practice medicine, osteopathic medicine or podiatric medicine in the state of Mississippi~~licensee shall maintain inventories, logs, and records prescribed in this rule.

A. Controlled substances inventory record. All controlled substances classified under Schedules II, IIN, III, IIIN, IV and V which are purchased by the ~~physician~~ licensee must be inventoried at least every two (2) years. All inventory records for controlled substances in Schedules II and IIN must be maintained separately from the inventory records for Schedules III, IIIN, IV and V controlled substances. To insure the reliability of an inventory, the physician ~~shall~~must maintain a readily retrievable record of controlled substances purchased, including a copy of all purchase invoices identifying the name, quantity and strength/dose of the controlled substance purchased, the supplier and the date purchased. Controlled substances inventory must also meet all applicable federal statutes and regulations.
B. Controlled substances dispensation/administration record. Every ~~physician~~licensee who ~~shall~~ dispense<u>s</u> or administer<u>s</u>, Schedules II, IIN, III, IIIN, IV and V controlled substances ~~shall~~must maintain a separate readily retrievable record of all such substances dispensed or administered. This requirement ~~shall~~does not apply to Schedules III, IIIN, IV and V prepackaged samples and starter packs. All dispensation/administration records for controlled substances in Schedules II and IIN must be maintained separately from the dispensation/administration records for Schedules III, IIIN, IV and V controlled substances. The record ~~shall~~must contain the following information:
    1. The date the controlled substance was dispensed or administered.
    2. The name, quantity and strength/dose of the controlled substance dispensed or administered.
    3. The method of administration of the controlled substance, i.e. oral, IV or subcutaneous.
    4. The name and address of the patient to whom the controlled substance was dispensed or administered.
    5. For all Schedules II and III amphetamines, amphetamine-like anorectic drugs, or sympathomimetic amine drugs dispensed in the treatment of narcolepsy, hyperkinesis, brain dysfunction, epilepsy, or depression, the dispensing or administration records ~~shall~~must include the diagnosis and the reason for use of the Schedules II and III controlled substances.

Controlled substances dispensation/administration records must also meet all applicable federal statutes and regulations.

~~Within thirty (30) days after the effective date of this rule the Mississippi State Board of Medical Licensure shall cause a notice to be mailed to every physician whose practice location is in the state of Mississippi notifying them of the Controlled Substance Inventory and separate~~

~~Dispensation/Administration Record. Every physician shall within ninety (90) days of the effective date of this rule, prepare an initial inventory of controlled substances. An example combination Controlled Substances Inventory Record and Controlled Substances Dispensation/Administration Record are hereby incorporated as Appendixes "C" and "D" to these rules.~~

Patient Record - A ~~physician~~licensee who prescribes, dispenses or administers a legend drug or controlled substance ~~shall~~must maintain a complete record of his or her examination, evaluation and treatment of the patient which must include documentation of the diagnosis and reason for prescribing, dispensing or administering any legend drug or controlled substance; the name, dose, strength, quantity of the legend drug or controlled substance and the date that the legend drug or controlled substance was prescribed, dispensed or administered. The record required by this rule ~~shall~~must be maintained in the patient's medical records.~~, provided that such~~ If medical records are maintained at the office of the ~~physician~~ licensee, the records must be ~~and are~~ available for inspection by the representatives of the Mississippi State Board of Medical Licensure~~ pursuant to authority granted in Mississippi Code, Section 41-29-125~~.

~~No physician~~ Licensees ~~shall~~must not prescribe, administer or dispense any legend drug; any controlled substance; or ~~other~~ any drug having addiction-forming or addiction-sustaining liability without a good faith prior examination and medical indication ~~therefore~~. A determination as to whether a "good faith prior examination and medical indication ~~therefore~~" exists depends upon the facts and circumstances in each case. One of the primary roles of a physician is to elicit detailed information about the signs and symptoms which a patient presents in order that he or she may recommend a course of treatment to relieve the symptoms and cure the patient of his or her ailment or maintain him or her in an apparent state of good health. In order for a ~~physician~~licensee to achieve a ~~proper~~ reasonable diagnosis and treatment plan, a history and physical examination consistent with the nature ~~and~~ of the complaint are necessary. The importance of these aspects of proper medical practice cannot be over emphasized. The paramount importance of a complete medical history in establishing a correct diagnosis is well established. Standards of proper medical practice require that, upon any encounter with a patient, in order to establish proper diagnosis and regimen of treatment, a ~~physician~~licensee must take three steps: (a) take and record an appropriate medical history, (b) carry out an appropriate physical examination, and (c) record the results. The observance of these principles ~~as~~ is an integral component ~~function~~ of the "course of legitimate professional practice."

Some of the factors used in determining the ~~existence~~ presence or absence of "good faith" may include, but are not limited to:

1. the quality and extent of the documented history and physical exam;
2. the extent to which the prescribed therapy is supported by documented history and physical exam;
3. the ~~physician~~licensee's permitting the patient to name the drug desired;
4. a ~~physician~~licensee dispensing or prescribing drugs to patients having no medical need, when the ~~physician~~licensee knew or should have known that the patients were addicts or abusing/misusing substances;
5. repeated refills over relatively short periods of time or the issuance of prescriptions at a time when the patient should not have been finished taking the same medication from a

prior prescription had the prescription directions been properly followed or the correct dosage taken;

6. general remarks of the ~~physician~~licensee indicating his or her experience with non-therapeutic uses of the drug;
7. a licensee prescribing contraindicated medication such as amphetamines and depressants in a manner which results in therapeutic conflicts.

The aforementioned is of particular~~ly of~~ importance in cases in which controlled substances are to play a part in the course of treatment. It is the responsibility of the ~~physician~~licensee to dispense, prescribe or administer ~~such drugs~~all therapies with proper regard for the actual and potential dangers. This fact has been established in a number of closely related administrative and criminal cases, **United States v. Bartee**, 479 F.2d 484 (10th Cir. 1973) (No physical examination prior to issuance of prescriptions for controlled substances); **United States v. Greene**, 511 F.2d 1062 (7th Cir. 1975); **Arthurs v. Board of Registration of Medicine**, 418 N.E. 2d 1236 (MA 1981) (failure to record in patient file prescriptions for controlled substances issued or failure to record patient visit); **Brainard v. State Board of Medical Examiners**, 157 P2d 7 (Ca. 1945); **Dannerberg v. Board of Regents**, 430 N.Y.2d 700 (1980) (issuance of three prescriptions for sleeping pills to an undercover agent without a physical examination; **Widlitz v. Board of Regents of New York,** 429 N.Y. 2d 794 (1980) (issuance of Desoxyn to patients whom physician knew were drug addicts without conducting physical examination); **United States v. Rosenberg**, 515 F.2d 190 (9th Cir. 1975) (no physical examination, evidences that prescriptions were not in course of professional practice); and **United States v. Hooker**, 541 F.2d 300 (1st Cir. 1976), (little more than cursory physical examination, frequent neglect to inquire as to past medical history, little or no exploration of the type of problem the patient allegedly had "indicates that the minimal professional procedures followed were designed only to give an appearance of propriety to appellant's unlawful distributions").

A determination of proper "medical indication"~~: also~~ requires ~~a careful~~ examination of the nature of the ~~drug~~ therapy and all circumstances surrounding ~~dispensation~~ its implementation. Use of any therapy should be supported by standards of medical practice, reasonable scientific evidence or consensus and documented in the medical record. Case law developed by the courts in connection with controlled substances criminal violations and administrative decisions further illustrates several indications of lack of good faith. See **United States v. Greene**, 511 F.2d 1062 (7th Cir. 1975) and **United States v. Rosenburg**, 515 F.2d 190 (9th Cir. 1975). One of primary importance is the failure to follow at least the minimal professional procedures. Some of the factors used in determining the existence of "good faith" may include, but are not limited to: (a) the physician's permitting the patient to name the drug desired; (b) a physician dispensing drugs to patients having no medical need, when the physician knew or should have known that the patients were addicts; (c) repeated refills over relatively short periods of time or the issuance of prescriptions at a time when the patient should not have been finished taking the same medication from a prior prescription had the prescription directions been properly followed or the correct dosage taken; (d) general remarks of the physician indicating his or her experience with non-therapeutic uses of the drug; (e) a physician prescribing contraindicated medication such as amphetamines and depressants in a manner which results in therapeutic conflicts

A ~~physician~~licensee ~~shall~~must not sell or trade any medication which he or she receives as prepackaged samples or starter packs, whether or not said samples are controlled substances, legend drugs or other medication.

The Controlled Substances Inventory, Controlled Substance Dispensation/Administration Record, and Patient Record required by these rules ~~shall~~must be maintained in the office of the ~~physician~~licensee for a period of seven (7) years from the date that the record is completed or the controlled substances, legend drugs or other medications are prescribed, administered or dispensed and ~~shall~~must be made available for inspection by representatives of the Mississippi State Board of Medical Licensure pursuant to authority granted in Mississippi Code, Section 41-29-125. Record retention for Controlled Substances Inventory, Controlled Substance Dispensation/Administration Record, and Patient Record must also meet all applicable federal statutes and regulations. ~~In cases where Mississippi and federal requirements conflict, the latter shall control.~~

A ~~physician~~licensee may use a data processing system or a manual record keeping system for the storage and retrieval of Controlled Substances Dispensation/Administration Records. If a ~~physician~~licensee utilizes a data processing system, it must provide immediate retrieval of all dispensation/administration records of controlled substances.

Whether maintained manually or in a data processing system, all records of dispensation/administration of controlled substances must be readily retrievable. If a data processing system is utilized, a hard-copy printout of the records of dispensation/administration ~~shall~~must be made at regular intervals, not to exceed seven (7) days. Such hard-copy printouts ~~shall~~must be maintained for a period of five (5) years and ~~shall~~must be made available for inspection and copying by investigators of the Mississippi State Board of Medical Licensure.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.5 Use of Diet Medication. Pursuant to Mississippi Code, Section 41-29-139(e), it is unlawful for any licensee to prescribe, dispense or administer any medication classified as Schedule II, pursuant to Section 41-29-115, for the exclusive treatment of obesity, weight control, or weight loss.

Prescribing or dispensing a controlled substance for weight reduction or the treatment of obesity should be based on accepted scientific knowledge and sound clinical grounds. All such prescribing and dispensing must be in compliance with applicable state and federal laws.

The licensee providing comprehensive treatment of obesity must be present at the facility when he or she prescribes or dispenses[1] controlled substances for the purpose of weight reduction or the treatment of obesity. A licensee may administer, order, dispense or prescribe controlled substances for the purpose of weight loss or the treatment of obesity only as an adjunct to a clearly documented comprehensive program of behavior modification, comprehensive nutritional education, and exercise or physical therapy intervention. The licensee must comply with all of the following conditions:

A. An initial comprehensive evaluation is to be conducted by and thoroughly recorded by the prescribing licensee prior to the prescribing, ordering, dispensing or administering of any drug. Such evaluation should include a thorough history and thorough physical exam of the patient to include at a minimum:
    1. Past medical history, past surgical history, social history, family history, weight history, dietary history, gynecological history, review of systems, allergies and medications.
    2. A physical exam to include height; weight; blood pressure; pulse; % body fat or waist circumference/weight hip ratio; lungs; heart; abdomen; and extremities.
    3. Appropriate testing related to medical weight loss (CBC, comprehensive metabolic profile, lipid panel, thyroid panel, EKG, if prior or present history of cardiac disease, hypertension, diabetes, dyslipidemia, or strong family history of cardiac disease age >60
    4. The licensee must determine and record the patient's Body Mass Index ("BMI"). No patient should receive anorexic medications unless the patient has (i) a BMI of ≥ 30.0 in a normal otherwise healthy patient, or (ii) a BMI ≥ 27.0 in an individual with at least one associated co-morbidity, or (iii) current body weight ≥ 120 percent of a well-documented, long standing healthy weight that the patient maintained after the age of 18, or (iv) body fat $\geq 30\%$ in females, or body fat $\geq 25\%$ in males, or (v) waist-hip circumference such that the individual is known to be at increased cardiovascular and/or co-morbidity risk because of abdominal visceral fat, or presence of a co-morbidity condition or conditions aggravated by the patients

[1] Part 2640, Rule 1.9, controls in all cases. Physician assistants are not permitted to dispense medication.

excessive adiposity. The indication for anorexic therapy must be documented in the record and re-evaluated at each visit or with each prescription refill.

5. Absolute contraindications of Schedule III or IV anorectic drugs for purposes of weight loss management are pregnancy, breast feeding, or severe allergic reactions to these medications. Relative contraindications of Schedule III and IV anorectics for the purpose of weight loss management are uncontrolled bipolar, uncontrolled epilepsy, uncontrolled hypertension, episodic tachyarrhythmia, excessive stimulation, history of substance abuse, severe anticholinergic effects, such as, extreme dryness of mouth or unmanageable constipation should be addressed with licensee prior to starting weight loss medications. Schedule III and IV anorectics can be used in conjunction with any other medications deemed safe by the licensee.

B. The licensee must not utilize any Schedules III, IV or V controlled substance when he or she knows or has reason to believe an absolute contraindication exists or relative contraindication exists that would be harmful to the patient.
C. A licensee is not permitted to prescribe, order, or dispense controlled substances for the purpose of weight reduction or treatment of obesity greater than a 30 day supply. Exempted from this requirement are those licensees defined in Rule 1.2(M) and those licensees treating patients resulting from a referral to those licensees defined in Rule 1.2(M).
D. A patient continued on a controlled substance for the purpose of weight reduction or the treatment of obesity must undergo an in-person re-evaluation once every 30 days; however, those licensees defined in Rule 1.2(M) may re-evaluate patients once every 90 days. A recording of weight, BMI, blood pressure, pulse, and/or any other test which may be necessary for monitoring potential adverse effects of drug therapy should be completed at each visit. Once medically established goals have been met for an individual patient, the need for ongoing medication should be re-evaluated and documented in the record.
E. Continuation of the prescribing, ordering, dispensing, or administering of controlled substances should occur only if the patient has continued progress toward achieving or maintaining medically established goals and has no significant adverse effects from the medication.
F. A licensee must not utilize a schedule III, IV or V controlled substance or legend drug for purposes of weight loss unless it has an FDA approved indication for this purpose and then only in accordance with all of the above enumerated conditions. The purpose of this rule is to prohibit the use of such drugs as diuretics and thyroid medications for the sole purpose of weight loss.

Off-label use of any medication that does not have Food and Drug Administration approval for use in the treatment of weight loss is prohibited if administered solely for the purpose of weight loss. Thyroid hormone, diuretics, vitamin B12, B1, B2, B6, methionine, choline, inositol, chromium picolate and human chorionic gonadotropin are examples of medications that may not be used in this manner. This prohibition does not apply to FDA categories of nutritional supplements sold without prescription.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.5 Use of Diet Medication. Pursuant to Mississippi Code, Section 41-29-139(e), it is unlawful for any ~~physician~~ licensee~~in this state~~ to prescribe, dispense or administer any ~~amphetamine or amphetamine-like anorectic and/or central nervous system stimulant~~medication classified as Schedule II, pursuant to Section 41-29-115, for the exclusive treatment of obesity, weight control, or weight loss.

~~The Board of Medical Licensure is obligated under the laws of the state of Mississippi to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including those used for the purpose of weight reduction, may lead to drug diversion and abuse by individuals who seek drugs for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.~~

Prescribing or dispensing a controlled substance for weight reduction or the treatment of obesity should be based on accepted scientific knowledge and sound clinical grounds. All such prescribing and dispensing ~~should~~ must be in compliance with applicable state and federal laws.

The ~~physician~~licensee ~~and/or nurse practitioner/physician assistant being overseen/collaborating to~~ provide~~e~~ing comprehensive treatment of obesity ~~shall~~must be present at the facility when he or she prescribes or dispenses[1] controlled substances for the purpose of weight reduction or the treatment of obesity. ~~As to the administration, dispensation or prescription of controlled substance anorectics in Schedules III, IV and V, use of said medications in the treatment of obesity or weight loss should be done with caution.~~ A ~~physician~~licensee may administer, order, dispense or prescribe ~~said medications~~controlled substances for the purpose of weight loss ~~in~~ or the treatment of obesity only as an adjunct ~~to a regimen~~to a clearly documented comprehensive program of behavior modification, comprehensive nutritional education, and exercise or physical therapy intervention. ~~weight reduction based on caloric restriction, provided~~ The ~~physician~~licensee must ~~complies~~ comply with ~~the following and that all~~ of the following conditions ~~are met~~:

A. An initial comprehensive evaluation is to be conducted by and thoroughly recorded by the prescribing ~~physician~~licensee ~~and/or mid-level provider~~ prior to the prescribing, ordering, dispensing or administering of any drug. Such evaluation should include a thorough history and thorough physical exam of the patient to include at a minimum:

1. Past medical history, past surgical history, social history, family history, weight history, dietary history, gynecological ~~(GYN)~~ history ~~if female~~, review of systems, allergies and medications.

[1] Part 2640, Rule 1.9, controls in all cases. Physician assistants are not permitted to dispense medication.

2. A physical exam to include ~~H~~height~~,~~; weight~~,~~; ~~Body Mass Index (BMI),~~ blood pressure~~,~~; pulse~~,~~; % body fat or waist circumference/weight hip ratio~~,~~; ~~HEENT, chest~~lungs~~,~~; heart~~,~~; abdomen~~,~~; and extremities.
3. Appropriate testing related to medical weight loss (CBC, comprehensive metabolic profile, lipid panel, thyroid panel, EKG, if prior or present history of cardiac disease, hypertension, diabetes, dyslipidemia, or strong family history of cardiac disease age >60
4. The ~~physician~~licensee must determine and record the patient's Body Mass Index ("BMI"). No patient should receive anorexic medications unless ~~T~~the patient ~~should have~~has (i) a BMI of ≥ 30.0 in a normal otherwise healthy patient, or (ii) a BMI ≥ 27.0 in an individual with at least one associated co-morbidity, or (iii) current body weight ≥ 120 percent of a well-documented, long standing healthy weight that the patient maintained after the age of 18, or (iv) body fat ≥ 30% in females, or body fat ≥ 25% in males, or (v) waist-hip circumference such that the individual is known to be at increased cardiovascular and/or co-morbidity risk because of abdominal visceral fat, or presence of a co-morbidity condition or conditions aggravated by the patients excessive adiposity. The indication for anorexic therapy must be documented in the record and re-evaluated at each visit or with each prescription refill.
5. Absolute contraindications of Schedule III or IV anorectic drugs for purposes of weight loss management are pregnancy, breast feeding, or severe allergic reactions to these medications. Relative contraindications of Schedule III and IV anorectics for the purpose of weight loss management are uncontrolled bipolar, uncontrolled epilepsy, uncontrolled hypertension, episodic tachyarrhythmia, excessive stimulation, history of substance abuse, severe anticholinergic effects, such as, extreme dryness of mouth or unmanageable constipation should be addressed with ~~physician~~licensee prior to starting weight loss medications. Schedule III and IV anorectics can be used in conjunction with any other medications deemed safe by the ~~physician~~licensee.

B. The ~~physician~~ licensee ~~shall~~must not utilize any Schedules III, IV or V controlled substance when he or she knows or has reason to believe an absolute contraindication exists or relative contraindication exists that would be harmful to the patient.

C. ~~The physician shall not initiate or discontinueor continue prescribing utilizing controlled scheduled medications for weight loss medication if the patient is in active detoxification and/or withdrawal from an addictive substance/ alcoholany program for alcohol or substance abuse recovery or detoxification.~~

D. A ~~physician~~licensee ~~cannot~~ is not permitted to prescribe, order, or dispense controlled substances for the purpose of weight reduction or treatment of obesity greater than a 30 day supply. Exempted from this requirement are those licensees defined in Rule 1.2(M) and those licensees treating patients resulting from a referral to those licensees defined in Rule 1.2(M).

E. A patient continued on a controlled substance ~~in schedule III, IV, V~~ for the purpose of weight reduction or the treatment of obesity should must undergo an in-person re-evaluation once every 30 days; however, those licensees defined in Rule 1.2(M) may re-evaluate patients once every 90 days. A recording of weight, BMI, blood pressure, pulse, and/or any other test which may be necessary for monitoring potential adverse effects of drug therapy should be completed at each visit. Once medically established goals have been met for an individual patient, the need for ongoing medication should be re-

evaluated and documented in the record.~~it is strongly recommended that reduced dosing and drug holidays be implemented for those patients who need maintenance medication.~~

F. Continuation of the prescribing, ordering, dispensing, or administering of controlled substances ~~in schedule III, IV or V~~ should occur only if the patient has continued progress toward achieving or maintaining medically established goals and has no significant adverse effects from the medication.

G. A ~~physician~~licensee ~~shall~~must not utilize a schedule III, IV or V controlled substance or legend drug for purposes of weight loss unless it has an FDA approved indication for this purpose and then only in accordance with all of the above enumerated conditions. The purpose of this rule is to prohibit the use of such drugs as diuretics and thyroid medications for the sole purpose of weight loss.

~~Any o~~Off-label use of any medication that does not have Food and Drug Administration approval for use in the treatment of weight loss is prohibited if administered solely for the purpose of weight loss. Thyroid hormone, diuretics, vitamin B12, B1, B2, B6, methionine, choline, inositol, chromium picolate and human chorionic gonadotropin are examples of medications that may not be used in this~~e sole treatment of weight loss and are not inclusive examples~~ manner. ~~Off-label use of medication that does not have Food and Drug Administration approval for the sole use and treatment of weight loss is prohibited in individual practice or allowing off-label use by midlevel providers will result in discipline by the Board. (Non FDA approved supplements may be used in the overall treatment of weight loss.)~~This prohibition does not apply to FDA categories of nutritional supplements sold without prescription.

~~Record keeping guidelines for medical weight loss: Every physician who prescribes, orders, dispenses, or administers a controlled substance to a patient for the purpose of weight reduction or treatment of obesity is required to maintain medical records in compliance to the above required guidelines. The treatment should be based on evidence based medicine. Adequate medical documentation should be kept so that progress as well as the success or failure of any modality is easily ascertained. The medical record should also contain the information demonstrating the patient's continued efforts to lose weight, the patient's dedication to the treatment program and response to treatment, and the presence or absence of contraindications, adverse effects and indicators of the need to discontinue treatment utilizing controlled substances.~~

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.6 Bariatric Medicine, Medical Weight Loss, or Weight Management Practice

A. No bariatric medicine, medical weight loss, or weight management practice shall operate in Mississippi unless the owner or operator of the facility is a Mississippi licensed physician. This licensee must meet all requirements below at all times while the facility is in operation. For the purposes of this rule, physicians who collaborate with mid-level providers will be considered an operator of the practice in the context of that collaborative arrangement.

B. The physician owner/operator of the bariatric medicine, medical weight loss, weight management practice must register with the MSBML using a form prescribed by the board. Certificates of registration once issued are not transferable or assignable. Only the primary physician is required to register with the Board. All licensees associated with the practice, whether in the capacity as the owner or as a practitioner, must be listed on the application and must also meet all regulations governing the treatment of obesity/medical weight loss. Physicians who are added to the registration once a certificate is issued must be reported to the MSBML for approval prior to beginning practice. Physicians who are removed from the registration must be reported to the board within 30 days of removal. Each practice location requires a separate registration certificate.

C. A bariatric medicine, medical weight loss, or weight management practice may not operate in the state of Mississippi without obtaining a registration certificate from the Mississippi State Board of Medical Licensure.

D. Certificates are valid for one year and must be renewed annually along with practitioner's license to practice medicine in the state of Mississippi. There is a 30-day grace period for renewal after which the owner/operator must reapply for an original certificate. The clinic may not continue to operate while the certificate is expired.

   If a physician's practice is a bariatric medicine, medical weight loss, or weight management practice as defined above or the physician collaborates, manages, oversees, or employs any licensed professional providing comprehensive treatment of obesity, the licensee must have 100 AMA or AOA Category 1 CME in the core-content of bariatric medicine or be currently certified by a board in bariatric medicine. A licensee currently practicing bariatric medicine, medical weight loss or weight management has 24 months from effective date of this regulation to comply with the initial CME requirement. All CME must be obtained within the 24 month period. Reference is made to exclusions noted in Rule 1.2, H.

   Licensee must biennially obtain 60 AMA or AOA Category 1 CME in core-content of bariatric medicine before certification can be renewed with the MSBML.

E. A Medical Spa practice, Wellness practice, or other practice that meets the definition of Bariatric Medicine, Medical Weight Loss, or Weight Management Practice will be subject to all rules pertaining to Bariatric Medicine, Medical Weight Loss, or Weight Management Practice if the facility has a Mississippi licensee affiliated in any manner.

   Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.6 Bariatric Medicine,/Medical Weight Loss, or Weight Management ~~Clinics~~Practice

~~A. A Bariatric Medicine,/ Medical Weight Loss, or Weight Management Clinic Practice is defined as a public or privately owned facility for which 30% or more of the patients are provided a comprehensive weight management treatment programabove. Advertised medical weight loss must include behavior modification, comprehensive nutritional education, exercise or physical therapy intervention, and long-term maintenance programs. , Advertised medical weight loss may include ordering, administering, dispensing and/or prescribing medication with FDA-approved medications as indicated indications for weight loss on a monthly basis as part of the patient's treatment plan.~~

A. No bariatric medicine, medical weight loss, or weight management ~~clinic~~practice shall operate in Mississippi unless the owner or operator of the facility is a Mississippi licensed physician. This licensee must meet all requirements below at all times while the facility is in operation. For the purposes of this rule, physicians who collaborate with mid-level providers will be considered an operator of the practice in the context of that collaborative arrangement.

B. The physician owner/operator of the bariatric medicine, medical weight loss, weight management ~~clinic~~practice ~~shall~~must register with the MSBML using a form prescribed by the board. ~~The form to register is attached hereto (Appendix F).~~ Certificates of registration once issued are not transferable or assignable. Only the primary physician ~~and/or clinic are~~is required to register with the Board. All ~~physicians~~ licensees associated with the ~~clinic~~practice, whether in the capacity as the owner or as a practitioner, ~~should~~ must be listed on the application and must also ~~be required to~~ meet all regulations governing the treatment of obesity/medical weight loss. ~~All~~ Physicians who are added ~~or removed from the clinic~~ to the registration once a certificate is issued must be reported to the MSBML for approval prior to beginning practice. Physicians who are removed from the registration must be reported to the board within 30 days of removal. Each ~~clinic~~ practice location requires a separate registration certificate.

C. A bariatric medicine, medical weight loss, or weight management ~~clinic~~practice may not operate in the state of Mississippi without obtaining a registration certificate from the Mississippi State Board of Medical Licensure.

D. Certificates are valid for one year and must be renewed annually along with practitioner's license to practice medicine in the state of Mississippi. There is a 30-day grace period for renewal after which the owner/operator must reapply for an original certificate. The clinic may not continue to operate while the certificate is expired.

~~E. If a physician's practice is 30% or greater in bariatric medicine, advertising medical weight lossa Bariatric Medicine/Medical Weight Loss Clinic as defined above, or the physician collaborates, manages, oversee, or employs any licensed professional providing overseeing/collaborating with a nurse practitioner or physician assistant to provide comprehensive treatment of obesity, the physician must have expertise in the field of bariatric medicine with no less thanas demonstrated by:~~

~~1. 100 AMA or AOA Category 1 CME hours in the core content of bariatric medicine prior to practicing in the specialized field of bariatric medicine/medical weight loss.~~

~~For any physician who is currently practicing 30% or greater in bariatric medicine or advertising medical weight loss, the physician has 24 months from effective date of this regulation to comply with the initial CME requirement or be board certified in bariatric medicine in order to continue practicing bariatric medicine/medical weight loss in the state of Mississippi. All Category 1 CME in core-content of bariatric medicine should be obtained within a 24 month period.~~

~~Following the initial 0100 Category 1 CME, a physician is required to obtain 30 AMA or AOA Category 1 CME in core-content of bariatric medicine annually in order to continue practicing bariatric medicine and to renew certification with the MSBML~~. If a physician's practice is a bariatric medicine, medical weight loss, or weight management practice as defined above or the physician collaborates, manages, oversees, or employs any licensed professional providing comprehensive treatment of obesity, the licensee must have 100 AMA or AOA Category 1 CME in the core-content of bariatric medicine or be currently certified by a board in bariatric medicine. A licensee currently practicing bariatric medicine, medical weight loss or weight management has 24 months from effective date of this regulation to comply with the initial CME requirement. All CME must be obtained within the 24 month period. Reference is made to exclusions noted in Rule 1.2, H.

Licensee must biennially obtain 60 AMA or AOA Category 1 CME in core-content of bariatric medicine before certification can be renewed with the MSBML.

F. A Medical Spa ~~facility~~practice, Wellness ~~Center~~practice, or other ~~facility~~practice that meets the definition of Bariatric Medicine, Medical Weight Loss, or Weight Management ~~Clinic~~Practice ~~shall~~ will be subject to all rules pertaining to Bariatric Medicine, Medical Weight Loss, or Weight Management ~~Clinics~~Practice if the facility has a Mississippi ~~licensed physician~~licensee affiliated in any manner.

~~for which 30% or more of the patients are provided a comprehensive weight management treatment program or advertises medical weight loss to the public must include behavior modification, comprehensive nutritional education, exercise or physical therapy intervention, long-term maintenance programs, the dispensation and/or prescribing of FDA-approved medications as indicated for weight loss on a monthly basis by a physician and/or nurse practitioner/physician assistant being overseen/collaborating to provide comprehensive treatment of obesity~~ ~~is prohibited unless all criteria above are met.~~

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.7 Use of Controlled Substances for Chronic (Non-Cancer/Non-Terminal) Pain.
The following rules are not intended to supersede or exempt licensees from the requirements heretofore stated in Rule 1.4 *Maintenance of Records and Inventories.*

A. Definitions
   For the purpose of Part 2640, Rule 1.7 only, the following terms have the meanings indicated:
   1. "Chronic Pain" is a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending licensee and one or more licensee specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than three months), then they will be considered for the purposes of this regulation to have "de facto" chronic pain and subject to the same requirements of this regulation. "Terminal Disease Pain" should not be confused with "Chronic Pain."
   2. "Terminal Disease Pain" is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.
   3. "Acute Pain" is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. Acute pain is generally self-limited and is responsive to therapies, including controlled substances.
   4. "Addiction" is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm.
   5. "Physical Dependence" is a physiological state of neuroadaptation to substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. .
   6. "Substance Abuse" is the use of any substance for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.
   7. "Tolerance" is a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia.

B. A licensee may order, prescribe, administer, or dispense controlled substances, or other drugs having addiction-forming and addiction-sustaining liability to a person for the treatment of chronic pain.

C. The ordering, prescribing, administration, or dispensation of controlled substances, or other drugs having addiction-forming or addiction-sustaining liability for the treatment of chronic pain should be done with caution. A licensee may order, administer, dispense or

prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:

1. Before initiating treatment with a controlled substance, or any other drug having addiction-forming or addiction-sustaining liability, the licensee must conduct a risk/benefit analysis by reviewing records of prior treatment. The risk/benefit analysis should weigh in favor of treatment and indicate the need for controlled substance therapy. Such a determination must take into account the specifics of each patient's diagnosis, past treatments, suitability for long-term controlled substance, with the need for other treatment modalities. The results of this analysis must be clearly entered into the patient medical record and must include supporting documentation such as consultation or referral reports and efforts to determine the underlying etiology of the chronic pain.
2. Documentation in the patient record must include a complete medical history and physical examination and supporting studies and reports of consultation.
3. The diagnosis must demonstrate the presence of one or more recognized medical indications for the use of controlled substances.
4. Documentation of a written treatment plan which must contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan must contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. The consent must also include specific requirements of the patient, such as using one licensee and pharmacy, urine/serum medication level monitoring when requested, pill counts, and the grounds for which the treatment may be terminated (e.g., 'doctor shopping' behavior, adverse urine/serum screens, etc.).
5. Periodic review and documentation of the treatment course is conducted no less frequently than every 3 months. The licensee's evaluation of progress toward the stated treatment objectives must support all changes in therapy. This should include referrals and consultations as necessary to achieve those objectives.

D. No licensee shall order, administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.

E. No licensee shall order, administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating licensee's directions. These circumstances include those patients obtaining controlled substances or other drugs having addiction-forming and addiction-sustaining liability from more than one licensee or healthcare provider and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other drug having addiction-forming and addiction-sustaining liability before a prior prescription should have been consumed according to the treating licensee's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose due to an acute exacerbation if the treating licensee documents that the escalation was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or continuing escalations

should be a reason for concern and a re-evaluation of the present treatment plan must be undertaken by the licensee.

F. No licensee shall order, prescribe, administer, or dispense any controlled substance or other drug having addiction-forming or addiction-sustaining liability for the purpose of "detoxification treatment" or "maintenance treatment" and no licensee shall order, prescribe, administer, or dispense any narcotic controlled substance for the purpose of "detoxification treatment" or "maintenance treatment" unless the licensee is registered in accordance with Section 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a licensee from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Nothing in this paragraph shall prohibit a licensee from ordering, prescribing, administering, or dispensing controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

G. When initiating opioid therapy for chronic pain, the licensee must first run a MPMP on the patient. The licensee must prescribe the lowest effective dosage. While there is no single dosage threshold identified below which the risk of overdose is eliminated, licensees must strive to keep daily opioid doses less than or equal to 50 mg of morphine equivalence (mEq), as dosages larger than 50 mEq per day increases risk without adding benefits for pain control or function. Licensees must avoid dosages greater than or equal to 90 mg of morphine equivalence per day and must provide significant justification for exceeding the 90 mg ceiling stated herein. If the licensee determines that a patient requires greater than 100 mg of morphine equivalence per day, the licensee must refer the patient to a pain specialist for further treatment.

H. When opioids are prescribed for acute pain, the licensee must prescribe the lowest effective dose of immediate release opioids, as the use of long acting opioids for acute non-cancer/non-terminal pain is prohibited. Licensees must prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Licensees are discouraged from prescribing or dispensing more than a three (3) day supply of opioids for acute non-cancer/non-terminal pain, and must not provide greater than a ten (10) day supply for acute non-cancer/non-terminal pain. Licensees may issue an additional ten (10) day supply if clinically necessary, but said supply must be issued in accordance with Title 21 CFR § 1306.12 *Refilling prescriptions; issuance of multiple prescriptions* (i.e., the prescription must be dated on the date of issuance with 'do not fill until' noting the date the prescription may be filled), and such need for an additional ten (10) day supply must be documented in the chart to evidence that no other alternative was appropriate or sufficient to abate the acute pain associated with that medical condition. Additional ten (10) day supplies, with one (1) refill, may be issued if deemed medically necessary and only if supported by additional clinical evaluation.

I. As stated in Rule 1.3, every licensee must review an MPMP report at each patient encounter in which a Schedule II medication is prescribed for acute pain or chronic non-cancer/non-terminal pain. MPMP reports may be obtained by designees of the licensee as allowed by the MPMP program.

J. When prescribing opioids for either chronic or acute pain, it is a relative contraindication (black box warning) to prescribe opioids concurrently with Benzodiazepines and/or Soma. However, opioids and benzodiazepines may be prescribed concurrently on a very

short term basis, and in accordance with section H of this rule, when an acute injury requiring opioids occurs. The need for such concurrent prescribing must be documented appropriately in the chart. Patients who are currently on an established regimen of concomitant opioids and benzodiazepines may be allotted a reasonable period of time to withdraw from one or both substances. Caution and care should be taken to prescribe the lowest effective dose of each medication if unable to discontinue one or the other completely. Clinicians involved in managing a patient's care should document communication regarding the patient's needs, goals, risks and coordination of care. Prescribing of opioids concurrently with benzodiazepines and/or Soma may be allowed only under very limited circumstances in which the combination is used to treat very specific chronic medical conditions for which there is no other treatment modality available.

K. When a licensee treats chronic non-cancerous/non-terminal pain and/or psychiatric conditions outside the definition of a pain management practice (Rule 1.2) (K) the licensee must actively utilize the MPMP upon initial contact with a new patient and every 3 months thereafter on any and all patients who are prescribed, administered, or dispensed controlled substances. Reports generated on patients must span the length of time from the previous review of the MPMP so that adequate information is obtained to determine the patient's compliance for and with treatment. Documentation, such as a copy of the report itself and/or reflections in the charts dictation and/or notes must be kept within the patient's record and made available for inspection upon request.

L. Point of service drug testing must be done at least three (3) times per calendar year when Schedule II medication is written for the treatment of chronic non-cancer/non-terminal pain. Point of service drug testing and MPMP review, as described in Rule 1.7 (K), must be done at least three (3) times per calendar year for patients prescribed benzodiazepines for chronic medical and/or psychiatric conditions which are non-cancer/non-terminal. Point of service drug testing must test, at a minimum, for opioids, benzodiazepines, amphetamines, cocaine, and cannabis. Inpatient treatment, as defined in Rule 1.2(L), is exempt from this requirement. Further, all hospice treatment is exempt from point of service drug testing requirements stated herein.

M. The use of Methadone to treat acute non-cancer/non-terminal pain is prohibited. The use of Methadone for the treatment of chronic non-cancer/non-terminal pain is permissible within a registered Pain Management Practice, as defined in Rule 1.2(K), or when resulting from a referral to a certified pain specialist. If Methadone is prescribed to treat chronic non-cancer/non-terminal pain, it must be prescribed only by a physician.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.7 Use of Controlled Substances for Chronic (Non-Terminal) Pain.
The following rules are not intended to supersede or exempt licensees from the requirements heretofore stated in Rule 1.4 *Maintenance of Records and Inventories.*

A. Definitions

For the purpose of Part 2640, Rule 1.7 only, the following terms have the meanings indicated:

1. "Chronic Pain" is a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending ~~physician~~licensee and one or more ~~physicians~~licensee specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than ~~six~~three months), then they will be considered for the purposes of this regulation to have "de facto" chronic pain and subject to the same requirements of this regulation. "Terminal Disease Pain" should not be confused with "Chronic Pain." ~~For the purpose of this rule, "Terminal Disease Pain" is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.~~
2. "Terminal Disease Pain" is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.
3. "Acute Pain" is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. ~~It~~Acute pain is generally ~~time limited~~self-limited and is responsive to therapies, including controlled substances ~~as defined by the U.S. Drug Enforcement Administration. Title 21 CFR Part 1301 Food and Drugs.~~
4. "Addiction" is a ~~neurobehavorial~~neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. ~~Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.~~
5. "Physical Dependence" is a physiological state of neuroadaptation to a ~~opioid therapy substance~~substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. ~~Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.~~
6. "Substance Abuse" is the use of any substance for non-therapeutic purposes; or use of medication for purposes other than those for which it is prescribed.
7. "Tolerance" is a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects,

including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. ~~Such tolerance may or may not be evident during treatment and does not equate with addiction.~~

B. ~~Notwithstanding any other provisions of these rules, a~~A ~~physician~~licensee may order, prescribe, administer, or dispense controlled substances ~~in Schedules II, IIN, III, IIIN, IV and V~~, or other drugs having addiction-forming and addiction-sustaining liability to a person ~~in the usual course of treatment of that person for a diagnosed condition causing~~ for the treatment of chronic pain.

C. ~~Notwithstanding any other provisions of these rules, as to t~~The ordering, prescribing, administration, or dispensation of controlled substances ~~in Schedules II, IIN, III, IIIN, IV and V,~~ or other drugs having addiction-forming ~~and~~ or addiction-sustaining liability~~, use of said medications in~~ for the treatment of chronic pain should be done with caution. A ~~physician~~licensee may order, administer, dispense or prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:

1. Before initiating treatment ~~utilizing a Schedules II, IIN, III, IIIN, IV or V~~with a controlled substance, or any other drug having addiction-forming ~~and~~ or addiction-sustaining liability, the ~~physician~~licensee ~~shall~~must conduct ~~an appropriate~~ risk/benefit analysis by reviewing ~~his or her own~~ records of prior treatment. ~~or review the records of prior treatment which another treating physician has provided to the physician,~~The risk/benefit analysis should weigh in favor of treatment and indicate ~~that there is an indicated~~the need for ~~long-term~~ controlled substance therapy. Such a determination ~~shall~~must take into account the specifics of each patient's diagnosis, past treatments, ~~and~~ suitability for long-term controlled substance, ~~use either alone or in combination with~~with the need for other ~~indicated~~ treatment modalities ~~for the treatment of chronic pain.~~ ~~This shall~~The results of this analysis must be clearly entered into the patient medical record and ~~shall~~must include supporting documentation such as consultation or referral reports and efforts to determine the underlying ~~pathology or cause~~etiology of the chronic pain.
2. Documentation in the patient record ~~shall~~must include a complete medical history and physical examination and supporting studies and reports of consultation.
3. The diagnosis must ~~that indicates~~demonstrate the presence of one or more recognized medical indications for the use of controlled substances.
4. Documentation of a written treatment plan which ~~shall~~must contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan ~~should also~~must contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. The ~~is should also~~ consent must also include specific requirements of the patient, such as using one ~~physician~~licensee and pharmacy, if possible~~, and~~ urine/serum medication level monitoring when requested, pill counts, and the grounds for which the treatment ~~shall~~may be terminated (e.g., 'doctor shopping' behavior, adverse urine/serum screens, etc.).
5. Periodic review and documentation of the treatment course is conducted ~~at reasonable intervals (no more than every six months)~~no less frequently than every 3 months. ~~with modification of therapy dependent on t~~The ~~physician~~licensee's evaluation of progress toward the stated treatment objectives must support all changes in therapy.

This should include referrals and consultations as necessary to achieve those objectives.

D. No ~~physician~~licensee shall order, administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.

E. No ~~physician~~licensee shall order, administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating ~~physician~~licensee's directions. These circumstances include those patients obtaining controlled substances or other drugs having addiction-forming and addiction-sustaining liability~~other abusable drugs~~ from more than one ~~physician~~licensee or healthcare provider and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other drug having addiction-forming and addiction-sustaining liability~~other abusable drugs~~ before a prior prescription should have been consumed according to the treating ~~physician~~licensee's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose ~~of their pain medication~~ due to an acute exacerbation ~~of their condition but have maintained a therapeutic dose level; however, it will be required of~~if the treating ~~physician~~licensee ~~to document in the patient record that such increase in dose level~~ documents that the escalation was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan ~~shall~~must be undertaken by the ~~physician~~licensee.

F. No ~~physician~~licensee shall order, prescribe, administer, or dispense any controlled substance or other drug having addiction-forming or addiction-sustaining liability ~~to a patient who is a drug addict~~ for the purpose of "detoxification treatment" or "maintenance treatment" and no ~~physician~~licensee shall order, prescribe, administer, or dispense~~administer or dispense~~ any narcotic controlled substance for the purpose of "detoxification treatment" or "maintenance treatment" unless ~~they~~ the ~~physician~~licensee is~~are properly~~ registered in accordance with Section ~~303(g)~~ 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a ~~physician~~licensee from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. ~~Not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days.~~ Nothing in this paragraph shall prohibit a ~~physician~~licensee from ordering, prescribing, administering, or dispensing ~~administering or dispensing narcotic~~ controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

G. When initiating opioid therapy for chronic pain, the licensee ~~shall~~must first run a MPMP on the patient. The licensee ~~shall~~must prescribe the lowest effective dosage. While there is no single dosage threshold identified below which the risk of overdose is eliminated, licensees ~~should~~ must strive to keep daily opioid doses less than or equal to 50 mg of morphine equivalence (mEq), as dosages larger than 50 mEq per day increases risk without adding benefits for pain control or function. Licensees ~~should~~must avoid dosages

greater than or equal to 90 mg of morphine equivalence per day and must provide significant justification for exceeding the 90 mg ceiling stated herein. If the licensee determines that a patient requires greater than 100 mg of morphine equivalence per day, the licensee must refer the patient to a pain specialist for further treatment.

H. When opioids are prescribed for acute pain, the licensee ~~should~~must prescribe the lowest effective dose of immediate release opioids, as the use of long acting opioids for acute non-cancer/non-terminal pain is prohibited. ~~and should~~Licensees must prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. ~~Three days or less should be sufficient and more than 7 days should be avoided in absence of significant justification (Example: Postsurgical pain stemming from a significant procedure).~~ Licensees are discouraged from prescribing or dispensing more than a three (3) day supply of opioids for acute non-cancer/non-terminal pain, and must not provide greater than a ten (10) day supply for acute non-cancer/non-terminal pain. Licensees may issue an additional ten (10) day supply if clinically necessary, but said supply must be issued in accordance with Title 21 CFR § 1306.12 *Refilling prescriptions; issuance of multiple prescriptions* (i.e., the prescription must be dated on the date of issuance with 'do not fill until' noting the date the prescription may be filled), and such need for an additional ten (10) day supply must be documented in the chart to evidence that no other alternative was appropriate or sufficient to abate the acute pain associated with that medical condition. Additional ten (10) day supplies may be issued, beyond the aforementioned but pursuant to those same requirements, if deemed medically necessary and only if supported by additional clinical evaluation which evidences no other alternative was appropriate or sufficient to abate the acute pain associated with that medical condition.

I. As stated in Rule 1.3, every licensee must review an MPMP report at each patient encounter in which a Schedule II medication is prescribed for acute pain or chronic non-cancer/non-terminal pain. MPMP reports may be obtained by designees of the licensee as allowed by the MPMP program.

J. When prescribing opioids for either chronic or acute pain, it ~~shall be~~is ~~considered~~ a relative contraindication (black box warning) to prescribe opioids concurrently with Benzodiazepines and/or Soma. However, opioids and benzodiazepines may be prescribed concurrently on a very short term basis, and in accordance with section H of this rule, when an acute injury requiring opioids occurs. The need for such concurrent prescribing must be documented appropriately in the chart. Patients who are currently on an established regimen of concomitant opioids and benzodiazepines may be allotted a reasonable period of time to withdraw from one or both substances. Caution and care should be taken to prescribe the lowest effective dose of each medication if unable to discontinue one or the other completely. Clinicians involved in managing a patient's care should document communication regarding the patient's needs, goals, risks and coordination of care. Prescribing of opioids concurrently with benzodiazepines and/or Soma may be allowed only under very limited circumstances in which the combination is used to treat very specific chronic medical conditions for which there is no other treatment modality available.

K. When a licensee treats chronic non-cancerous/non-terminal pain and/or psychiatric conditions outside the definition of a pain management practice (Rule 1.2) (~~G~~K) the licensee ~~shall~~must actively utilize the MPMP upon initial contact with a new patient and

every 3 months thereafter on any and all patients who are prescribed, administered, or dispensed controlled substances. Reports generated on patients ~~shall~~must span the length of time from the previous review of the MPMP so that adequate information is obtained to determine the patient's compliance for and with treatment. Documentation, such as a copy of the report itself and/or reflections in the charts dictation and/or notes ~~shall~~must be kept within the patient's record and made available for inspection upon request. ~~In addition, licensees required to register under this section shall also utilize the MPMP to generate a global report to review the entire practice as a whole at least yearly. Documentation of the global report shall be kept in a separate file to be available for inspection upon request.~~

L. Point of service drug testing must be done at least three (3) times per calendar year when a Schedule II medication is written for the treatment of chronic non-cancer/non-terminal pain. Point of service drug testing and MPMP review, as described in Rule 1.7 (K), must be done at least three (3) times per calendar year for patients prescribed benzodiazepines for chronic medical and/or psychiatric conditions which are non-cancer/non-terminal. Point of service drug testing must test, at a minimum, for opioids, benzodiazepines, amphetamines, cocaine, and cannabis. Inpatient treatment, as defined in Rule 1.2(L), is exempt from this requirement. Further, all hospice treatment is exempt from point of service drug testing requirements stated herein.

M. The use of Methadone to treat acute non-cancer/non-terminal pain is prohibited. The use of Methadone for the treatment of chronic non-cancer/non-terminal pain is permissible within a registered Pain Management Practice, as defined in Rule 1.2(K), or when resulting from a referral to a certified pain specialist. If Methadone is prescribed to treat chronic non-cancer/non-terminal pain, it must be prescribed only by a physician.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.8 Drug Maintenance Requirements. All medications maintained or stored in licensee's office must be maintained or stored in the manufacturer's or re-packager's original container. The label of any container in which drugs are maintained must bear the drug name, strength, the manufacturer's control lot number and the expiration date. Drugs that are pre-counted and prepackaged for purposes of dispensing must be identifiable as to expiration date and manufacturer's control lot number. The containers in which drug products are maintained must not be labeled in any false or misleading manner. The labeling requirements of this rule are in addition to all other applicable state and federal statutes and regulations.

A physician must not dispense out-of-date medications. Out-of-date medications must be promptly removed from current stock and stored separately until proper disposal. A physician, when dispensing a product in a manufacturer's original package or container must dispense the product with this information intact.

The medication storage and dispensing areas must be maintained in a sanitary fashion. All medications must be maintained, stored and dispensed in such a manner as to maintain the integrity of the product.

A licensee must not accept the return for subsequent resale or exchange any drugs after such items have been taken from the premises where sold, distributed or dispensed and from the control of the licensee.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.8 Drug Maintenance Requirements. All ~~drug products~~medications ~~which are~~ maintained~~/~~ or stored in the ~~office of a physician~~physician licensee's office ~~shall~~must be maintained or ~~/~~stored in the manufacturer's or re-packager's original container. The label of any container in which drugs are maintained must bear the drug name, strength, the manufacturer's control lot number and the expiration date. Drugs ~~which~~ that are pre-counted and prepackaged for purposes of dispensing ~~shall~~must be identifiable as to expiration date and manufacturer's control lot number. The containers in which drug products are maintained ~~shall~~must not be labeled in any false or misleading manner. The labeling requirements of this rule are in addition to~~, and not in lieu of, other labeling requirements of the Laws of the state of Mississippi, Rules of the Mississippi State Board of Medical Licensure, and Laws of the United States or Federal Regulations~~ all other applicable state and federal statutes and regulations. ~~In the event of conflict, federal statutes and regulations shall control.~~

A physician ~~shall~~must not dispense out-of-date ~~drugs~~ medications.~~ or store out-of-date drugs intermixed with the stock of current drugs.~~ Out-of-date ~~drugs~~ medications ~~shall~~must be promptly removed from current stock and stored separately until proper disposal ~~shall be made~~. A physician, when dispensing a product in a manufacturer's original package or container~~, the labeling of which bears an expiration date, a manufacturer's control lot number or other information which may be of value to the patient, shall~~must dispense the product with this information intact.

The ~~drug~~ medication storage and dispensing areas ~~shall~~must be maintained in a sanitary fashion. All drug ~~products~~medications ~~shall~~must be maintained, stored and dispensed in such a manner as to maintain the integrity of the product.

A ~~physician~~licensee ~~shall~~must not accept the return for subsequent resale or exchange any drugs after such items have been taken from the premises where sold, distributed or dispensed and from the control of the ~~physician~~licensee.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.9 Labeling Requirements for Dispensing Physicians. For the purposes of this rule, a "dispensing physician" means any physician who dispenses to a patient for the patient's use any controlled substance, legend drug or other medication where such medication is purchased by the physician for resale to a patient whether or not a separate charge is made.

Every dispensing physician, as defined above, who dispenses a controlled substance, legend drug or any other medication must insure that all such substances dispensed be labeled containing the following information:

A. The name of the patient to whom the medication was dispensed.
B. The date that the medication was dispensed.
C. The name, strength and quantity of the medication.
D. Direction for taking or administering the medication.
E. The name and address of the physician dispensing the medication.

The label required by this rule must be written in legible handwriting or typed and must be permanently affixed to the package or container in which the medication is dispensed. Prepackaged samples or starter packs in their original packages or containers need only have the patient name, date distributed, and physician's name if the manufacturer's packaging meets other requirements.

No physician may delegate dispensing authority to another person. A physician must personally dispense the medication. For the purpose of this regulation, "personally dispense" means the physician must actually obtain the medication, prepare, count, place the same into the appropriate container and affix the appropriate label to the container.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.9 Labeling Requirements for Dispensing Physicians. For the purposes of this rule, a "dispensing physician" ~~shall~~ means any physician who ~~shall~~ dispenses to a patient for the patient's use any controlled substance, legend drug or other medication where such medication is purchased by the physician for resale to a patient whether or not a separate charge is made.

Every dispensing physician, as defined above, who ~~shall~~ dispenses a controlled substance, legend drug or any other medication ~~shall~~must insure that all such substances dispensed be labeled containing the following information:

A. The name of the patient to whom the medication was dispensed.
B. The date that the medication was dispensed.
C. The name, strength and quantity of the medication.
D. Direction for taking or administering the medication.
E. The name and address of the physician dispensing the medication.

The label required by this rule ~~shall~~must be written in legible handwriting or typed and ~~shall~~must be permanently affixed to the package or container in which the medication is dispensed. ~~This labeling requirement shall not apply to p~~Prepackaged samples or starter packs in their original packages or containers need only have the patient name, date ~~dispensed~~distributed, and physician's name if the manufacturer's packaging meets other requirements.

No physician may delegate dispensing authority to another person. A physician must personally dispense the medication. For the purpose of this regulation, "personally dispense" ~~shall~~ means the physician must actually obtain the medication, prepare, count, place the same into the appropriate container and affix the appropriate label to the container.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.10 Prescription Guidelines–Controlled Substances. It is the responsibility of the licensee to determine the type, dosage, form, frequency of application and number of refills of any controlled substances prescribed to a patient. The following requirements apply to all prescriptions for controlled substances written by a licensee with controlled substance prescriptive authority:

A. All prescriptions for controlled substances must be written in strict compliance with Mississippi Code, Sections 41-29-101 through 41-29-311 and Title 21 of U.S. Code of Federal Regulations, Part 1306.
B. On all prescriptions of controlled substances wherein refills are permitted, licensees must indicate the appropriate refills, not to exceed five (5), or mark "none."
C. Each licensee must insure that the complete name and address of the patient to whom the licensee is prescribing the controlled substance appears on the prescription.
D. A licensee must not permit any prescription for controlled substances to be signed by anyone in the place of or on behalf of the licensee.
E. A licensee must not pre-sign prescription pads or order forms.
F. A licensee must not utilize prescription pads or order forms upon which the signature of the licensee has been affixed by any means other than manual signature. This prohibition includes the e-mailing of any controlled substance prescription. A hard copy prescription generated from an electronic prescription system must contain a manual signature unless: (i) the prescription is printed on security paper that ensures it is not subject to copying or alteration, and (ii) an electronic or digital signature is affixed. Electronic transmission of Schedule III-V controlled substance prescription information is limited to computer to facsimile (fax) transmissions or traditional fax to fax transmissions. Electronic transmission of Schedule II controlled substance prescription information is permitted under limited circumstances. Requirements for fax prescription orders and systems utilized for faxing prescriptions are as follows:
    1. The prescription order must contain the date, time, telephone number and location of the transmitting device. Prescription blanks utilized in this manner must bear a pre-printed heading that indicates the blank is a "Fax Prescription Form." Fax prescription orders must contain a manual or authenticated electronic/digital signature of the prescriber. Only Schedule II narcotic substances that are to be prepared or compounded for the direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or intra spinal infusion may be transmitted by the licensee or the licensee's agent to a pharmacy of the patient's choice by facsimile. All original hardcopy faxed prescriptions must immediately be voided after successfully completing the fax transmission by writing across the face of the prescription from corner to corner the notation "faxed." The original prescription (or copy) must be retained in the licensee's patient file with additional information included on the back of the prescription as to the date it was faxed, the name or initials of the person faxing the prescription and the name/location of the pharmacy receiving the fax transmission.

In addition to filing the original prescription (or copy) in the patient file, a perpetual, chronological logbook of fax transactions must be established and maintained. Such a logbook would serve to protect the prescribing licensee in the event the original prescription is somehow lost or misfiled. The information contained in such a logbook must include the patient's name and address, date of issuance, name, strength and quantity of the drug prescribed and the name and fax number of the receiving pharmacy and a personal identifier of the person faxing the prescription. Such logs must be maintained in the licensee's clinic in a readily retrievable manner, and kept for at least seven (7) years after the original record is established. The requirements set forth in this rule are in addition to documentation required in Part 2640, Rule 1.4.

2. When prescribing any controlled substance for a resident of a Long-term Care Facility (LTCF)(as defined in Section 1301.01(25), Code of Federal Regulations), such prescription may be transmitted by the licensee or the licensee's agent to the dispensing pharmacy by facsimile. The licensee or the licensee's agent must note on the prescription that the patient is a resident of a LTCF. The original prescription (or copy) and fax transaction log will be prepared and maintained in the same manner as described in Part 2640, Rule 1.10.F.1.
3. When prescribing any controlled substance for a patient residing in a hospice certified by Medicare under Title XVIII or licensed by the state, such prescription may be transmitted by the licensee or the licensee's agent to the dispensing pharmacy by facsimile. The licensee or the licensee's agent must note on the prescription that the patient is a hospice patient. The original prescription (or copy) and fax transmission log will be maintained in the same manner as described in Part 2640, Rule 1.10.F.1.

G. No more than one (1) controlled substance shall be issued on a single prescription blank.
H. Prescriptions for Benzodiazepines must be limited to a one (1) month supply, with no more than two (2) refills, or a ninety (90) day supply with no refills. The MPMP must be checked each time a prescription for benzodiazepines is authorized and evidence of such check must be noted within the patient file.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.10 Prescription Guidelines–Controlled Substances. It is the responsibility of the ~~physician or physician assistant~~licensee to determine the type, dosage, form, frequency of application and number of refills of any controlled substances prescribed to a patient. ~~It is recognized that other healthcare providers may prescribe controlled substances.~~ The following requirements apply to all prescriptions for controlled substances written by a ~~healthcare professionals~~licensee with controlled substance prescriptive authority ~~regulated by the Mississippi State Board of Medical Licensure~~:

A. All prescriptions for controlled substances must be written in strict compliance with Mississippi Code, Sections 41-29-101 through 41-29-311 and Title 21 of U.S. Code of Federal Regulations, Part 1306.

B. On all prescriptions of controlled substances wherein refills are permitted, ~~physician~~licensees ~~shall~~must indicate the appropriate refills, not to exceed five (5), or mark "none."

C. Each ~~physician~~ licensee ~~shall~~must insure that the complete name and address of the patient to whom the ~~physician~~ licensee is prescribing the controlled substance appears on the prescription.

D. A ~~physician~~ licensee ~~shall~~must not permit any prescription for controlled substances to be signed by anyone ~~non-physician~~ in the place of or on behalf of the ~~physician~~licensee.

E. A ~~physician~~ licensee ~~shall~~must not pre-sign ~~blank~~ prescription pads or order forms. ~~under any circumstances.~~

F. A ~~physician~~ licensee ~~shall~~must not utilize ~~blank~~ prescription pads or order forms upon which the signature of the ~~physician~~ licensee has been ~~electronically, mechanically or photo statically reproduced~~affixed by any means other than manual signature. This prohibition includes the e-mailing of any controlled substance prescription. A hard copy prescription generated from an electronic prescription system must contain a manual signature unless:~~; however, if it is~~ (i) the prescription is printed on security paper that ensures it is not subject to copying or alteration, and (ii) an electronic or digital signature ~~may be substituted~~is affixed. Electronic transmission of Schedule III-V controlled substance prescription information is ~~generally allowed (except Schedule II which is addressed below); however, for the purposes of this regulation, electronic transmission of controlled substance prescription data is~~ limited to computer to facsimile (fax) transmissions or traditional fax to fax transmissions. Electronic transmission of Schedule II controlled substance prescription information is permitted under limited circumstances. Requirements for fax prescription orders and systems utilized for faxing prescriptions are as follows:

1. The prescription order ~~shall~~must contain the date, time, telephone number and location of the transmitting device. Prescription blanks utilized in this manner ~~shall~~must bear a pre-printed heading that indicates the blank is a "Fax Prescription Form." Fax prescription orders must contain a manual or authenticated electronic/digital signature of the prescriber. ~~As to Schedule II drugs, o~~Only Schedule II narcotic substances that are to be prepared or compounded for the direct administration to a patient by parenteral, intravenous, intramuscular, subcutaneous or

intra spinal infusion may be transmitted by the ~~physician~~licensee or the ~~physician~~licensee's agent to a pharmacy of the patient's choice by facsimile. All original hardcopy faxed prescriptions ~~shall~~must immediately be voided after successfully completing the fax transmission by writing across the face of the prescription from corner to corner the notation "faxed." The original prescription (or copy) ~~shall~~must be retained in the ~~physician~~licensee's patient file with additional information included on the back of the prescription as to the date it was faxed, the name or initials of the person faxing the prescription and the name/location of the pharmacy receiving the fax transmission.

~~It is also required, that i~~In addition to filing the original prescription (or copy) in the patient file, a perpetual, chronological logbook of fax transactions ~~be shall~~must be established and maintained. Such a logbook would serve to protect the prescribing ~~physician~~ licensee in the event the original prescription is somehow lost or misfiled. The information contained in such a logbook ~~shall~~must include the patient's name and address, date of issuance, name, strength and quantity of the drug prescribed and the name and fax number of the receiving pharmacy and ~~the initials or name~~a personal identifier of the person faxing the prescription. Such logs ~~shall~~must be maintained in the ~~physician~~licensee's clinic in a readily retrievable manner, and kept for at least seven (7) years after the original record is established. The requirements set forth in this rule are in addition to~~, and not in lieu of~~ documentation required in Part 2640, Rule 1.4.

2. When ~~a prescription is prepared and written for~~ prescribing any controlled substance for a resident of a Long-term Care Facility (LTCF)(as defined in Section 1301.01(25), Code of Federal Regulations), such prescription may be transmitted by the ~~practitioner~~ licensee or the ~~practitioner's~~ licensee's agent to the dispensing pharmacy by facsimile. The licensee or the licensee's ~~physician or the physician's~~ agent ~~will~~ must note on the prescription that the patient is a resident of a LTCF. The original prescription (or copy) and fax transaction log will be prepared and maintained in the same manner as described in Part 2640, Rule 1.10.F.1.
3. When ~~a prescription is written for~~prescribing any controlled substance for a patient residing in a hospice certified by Medicare under Title XVIII or licensed by the state, such prescription may be transmitted by the licensee or the licensee's ~~practitioner or the practitioner's~~ agent to the dispensing pharmacy by facsimile. The licensee or the licensee's~~physician or the physician's~~ agent ~~will~~ must note on the prescription that the patient is a hospice patient. The original prescription (or copy) and fax transmission log will be maintained in the same manner as described in Part 2640, Rule 1.10.F.1.

~~4. Each system shall have policies and procedures that address the following:~~

~~i. The patient shall not be restricted from access to the pharmacy of their choice.~~

~~ii. The system shall have security and system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of prescription information, as well as physical safeguards to protect computer systems and other pertinent equipment from intrusion.~~

~~iii. Processes to protect, control and audit access to confidential patient information, including the prevention of unauthorized access to data when transmitted over communication networks or when data physically moves from one location to~~

~~another using media such as magnetic tape, removable drives or other media used to store downloaded information.~~

G. No more than one (1) controlled substance shall be issued on a single prescription blank.

H. Prescriptions for Benzodiazepines must be limited to a one (1) month supply, with no more than two (2) refills, or a ninety (90) day supply with no refills. The MPMP must be checked each time a prescription for benzodiazepines is authorized and evidence of such check must be noted within the patient file.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.11 Prescription Guidelines - All Medications. In addition to any other requirements set forth in these rules pertaining to the issuance of prescriptions of controlled substances, the following additional requirements apply to all prescriptions, whether or not said prescriptions are for controlled substances, legend drugs or any other medication:

A. Prescriptions may not be written outside of a valid licensee-patient relationship. While not all of the elements in subsection A are necessary each time a prescription is authorized (e.g., via appropriate telemedicine as defined in Rule 5.5 of Part 2635, calling in refills, taking call for a practice partner for short term care, etc.), all initial encounters, and at reasonable intervals thereafter, should conform to this rule and be done pursuant to a valid licensee-patient relationship. The elements of this valid relationship are:
   1. verify that the person requesting the medical treatment is in fact who they claim to be;
   2. conducting an appropriate history and physical examination of the patient that meets the applicable standard of care;
   3. establishing a diagnosis through the use of accepted medical practices, i.e., a patient history, mental status exam, physical exam and appropriate diagnostic and laboratory testing;
   4. discussing with the patient the diagnosis, risks and benefits of various treatment options to obtain informed consent;
   5. insuring the availability of appropriate follow-up care; and
   6. maintaining a complete medical record available to patient and other treating health care providers.

B. Electronic prescription transmission is permitted provided the transmission meets applicable state and federal standards for transmission. E-prescribing is the electronic entry of a prescription by a licensee, the secure electronic transmission of the prescription to a pharmacy, the receipt of an electronic message by the pharmacy and E-prescription renewal requests sent electronically by the pharmacy to the practitioner.

C. Every written prescription delivered to a patient, or delivered to any other person on behalf of a patient, must be manually signed on the date of issuance by the licensee. This does not prohibit the transmission of electronic prescriptions and telefaxed prescriptions (but not e-mail) for non-controlled drugs to the pharmacy of the patient's choice. Such telefaxed or electronic prescriptions must be authorized by a written or electronic signature and must be issued in accordance with all other provisions of this rule. No prescriptions for any form or compound containing nalbuphine HCl, carisoprodol, butalbital compounds, or tramadol HCl shall be telefaxed.

D. Electronic prescriptions for controlled substances are permitted if a practitioner has complied with the DEA requirements and is using a certified electronic prescribing system for the transmission of control substances prescriptions.

E. All written prescriptions must be on forms containing two lines for the licensee's signature. There must be a signature line in the lower right-hand corner of the prescription form beneath which must be clearly imprinted the words "substitution permissible." There must be a signature line in the lower left corner of the prescription form beneath which must be clearly imprinted with the words "dispense as written." The

licensee's signature on either signature line must validate the prescription and designate approval or disapproval of product selection. Each prescription form must bear the pre-printed name of the licensee or the licensee must clearly print his or her name on the prescription form, in addition to the licensee's original signature. In the event that the prescription form bears the pre-printed name of more than one licensee, the licensee must clearly indicate the name of the licensee writing the prescription. In the case of a prescription that is electronically generated and transmitted, the licensee must make an overt act when transmitting the prescription to indicate either "dispense as written" or "substitution permissible". When done in conjunction with the electronic transmission of the prescription, the prescriber's overt act indicates to the pharmacist that the brand name drug prescribed is medically necessary.

F. If a prescription form which does not contain two signature lines required in Part 2640, Chapter 1, Rule 1.11.D is utilized by the licensee, he or she must write in his or her own handwriting the words "dispense as written" thereupon to prevent product selection.

Every written prescription issued by a licensee for a legend drug should clearly state whether or not the prescription should be refilled, and if so, the number of authorized refills and/or the duration of therapy. Licensee s should avoid issuing prescriptions refillable on "prn" basis. If a licensee chooses to issue a prescription refillable "prn", the life of the prescription or time limitation must clearly be set forth on the prescription. In no case shall a prescription which is refillable on a "prn" basis be refilled after the expiration of one (1) year. Regardless of whether a prescription is refillable on a "prn" basis or the prescription expressly states the number of authorized refills, the use of said medication should be re-evaluated on at least an annual basis. Upon the expiration of one (1) year, a prescription becomes invalid, regardless of the number of refills indicated or "prn" designation.

G. Every written prescription issued by a licensee, bearing more than one non-controlled medication, must clearly indicate the intended refill instructions for each medication. Lack of clearly indicated refill instructions prohibit the refilling of the medications. All unused lines on a multi-line prescription blank must be clearly voided by the issuing licensee.

H. A prescription will no longer be valid after the occurrence of any one of the following events:
   1. Thirty (30) days after the death of the issuing licensee.
   2. Thirty (30) days after the issuing licensee has moved or otherwise changed practice location resulting in termination of the licensee patient relationship. Termination of the licensee patient relationship results when a patient is no longer able to seek personal consultation or treatment from the issuing licensee.
   3. Immediately after loss of DEA Controlled Substances Privilege by the issuing licensee if the prescription is for controlled substances.
   4. Immediately upon revocation, suspension or surrender of the licensee's license.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.11 Prescription Guidelines - All Medications. In addition to any other requirements set forth in these rules pertaining to the issuance of prescriptions of controlled substances, the following additional requirements apply to all prescriptions, whether or not said prescriptions are for controlled substances, legend drugs or any other medication:

A. Prescriptions may not be written outside of a valid ~~physician~~licensee-patient relationship. While not all of the elements in subsection A are necessary each time a prescription is authorized (e.g., via appropriate telemedicine as defined in Rule 5.5 of Part 2635, calling in refills, taking call for a practice partner for short term care, etc.), all initial encounters, and at reasonable intervals thereafter, should conform to this rule and be done pursuant to a valid licensee-patient relationship. The elements of this valid relationship are:
   1. verify that the person requesting the medical treatment is in fact who they claim to be;
   2. conducting an appropriate history and physical examination of the patient that meets the applicable standard of care;
   3. establishing a diagnosis through the use of accepted medical practices, i.e., a patient history, mental status exam, physical exam and appropriate diagnostic and laboratory testing;
   4. discussing with the patient the diagnosis, risks and benefits of various treatment options to obtain informed consent;
   5. insuring the availability of appropriate follow-up care; and
   6. maintaining a complete medical record available to patient and other treating health care providers.

B. Electronic prescription transmissions ~~are allowed~~ is permitted ~~using standards established and approved by the United States Department of Health and Human Services - Agency for Healthcare Research and Quality (HHS-AHRQ)~~ provided the transmission meets applicable state and federal standards for transmission. E-prescribing is the electronic entry of a prescription by a ~~practitioner~~licensee, the secure electronic transmission of the prescription to a pharmacy, the receipt of an electronic message by the pharmacy and E-prescription renewal requests sent electronically by the pharmacy to the practitioner. ~~Electronic transmissions may be computer to computer or computer to facsimile.~~

C. Every written prescription delivered to a patient, or delivered to any other person on behalf of a patient, must be manually signed on the date of issuance by the ~~physician~~licensee. This does not prohibit~~, however,~~ the transmission of electronic prescriptions and telefaxed prescriptions (but not e-mail) for non-controlled drugs to the pharmacy of the patient's choice. Such telefaxed or electronic prescriptions ~~shall~~must be authorized by a written or electronic signature and ~~shall~~must be issued in accordance with all other provisions of this rule. No prescriptions for ~~brand name or generic equivalents of~~any form or compound containing n~~N~~albuphine HC~~e~~l, c~~C~~arisoprodol, b~~B~~utalbital compounds, or t~~T~~ramadol HCl shall be telefaxed.

D. Electronic prescriptions for controlled substances ~~(schedules II, III, IV, and V)~~ are permitted if ~~(or when)~~ a practitioner has complied with the DEA requirements and is using a certified electronic prescribing system for the transmission of control substances

prescriptions. ~~The Board of Medical Licensure considers Nalbuphine Hcl, Carisoprodol, Butalbital compounds and Tramadol to be controlled substances.~~

E. All written prescriptions ~~shall~~must be on forms containing two lines for the ~~physician's~~ licensee's signature. There ~~shall~~must be a signature line in the lower right-hand corner of the prescription form beneath which ~~shall~~must be clearly imprinted the words "substitution permissible." There ~~shall~~must be a signature line in the lower left corner of the prescription form beneath which ~~shall~~must be clearly imprinted with the words "dispense as written." The ~~physician's~~ licensee's signature on either signature line ~~shall~~must validate the prescription and designate approval or disapproval of product selection. Each prescription form ~~shall~~must bear the pre-printed name of the ~~physician~~licensee or the ~~physician~~ licensee ~~shall~~must clearly print his or her name on the prescription form, in addition to the licensee's~~physician's~~ original signature. In the event that the prescription form bears the pre-printed name of more than one licensee~~physician~~, the licensee ~~physician~~ ~~shall~~must clearly indicate the name of the ~~phy~~ licensee ~~sician~~ writing the prescription. In the case of a prescription that is electronically generated and transmitted, the licensee ~~physician~~ must make an overt act when transmitting the prescription to indicate either "dispense as written" or "substitution permissible". When done in conjunction with the electronic transmission of the prescription, the prescriber's overt act indicates to the pharmacist that the brand name drug prescribed is medically necessary.

F. If a prescription form which does not contain two signature lines required in Part 2640, Chapter 1, Rule 1.11.D is utilized by the licensee~~physician~~, he or she ~~shall~~must write in his or her own handwriting the words "dispense as written" thereupon to prevent product selection.

Every written prescription issued by a licensee ~~physician~~ for a legend drug should clearly state whether or not the prescription should be refilled, and if so, the number of authorized refills and/or the duration of therapy. ~~I~~Licensee ~~Physicians~~ should avoid issuing prescriptions refillable on "prn" basis. If a licensee ~~physician~~ chooses to issue a prescription refillable "prn", the life of the prescription or time limitation must clearly be set forth on the prescription. In no case shall a prescription which is refillable on a "prn" basis be refilled after the expiration of one (1) year. Regardless of whether a prescription is refillable on a "prn" basis or the prescription expressly states the number of authorized refills, the use of said medication should be re-evaluated on at least an annual basis. Upon the expiration of one (1) year, a prescription becomes invalid, regardless of the number of refills indicated or "prn" designation. ~~Thereafter, a new prescription, if indicated, must be issued.~~

G. Every written prescription issued by a licensee~~physician~~, bearing more than one non-controlled medication, ~~shall~~must clearly indicate the intended refill instructions for each medication. Lack of clearly indicated refill instructions prohibit the refilling of the medications. All unused lines on a multi-line prescription blank ~~shall~~must be clearly voided by the issuing licensee~~physician~~.

H. A prescription ~~shall~~will no longer be valid after the occurrence of any one of the following events:

1. Thirty (30) days after the death of the issuing licensee~~physician~~.

2. Thirty (30) days after the issuing licensee ~~physician~~ has moved or otherwise changed ~~the~~ practice location ~~of his or her practice so as to~~ resulting in terminat~~e~~ion of the ~~doctor/~~licensee patient relationship. Termination of the ~~doctor/~~licensee patient relationship results when a patient is no longer able to seek personal consultation or treatment from the issuing licensee~~physician~~.
3. ~~Insofar as controlled substances are concerned, i~~Immediately after loss of DEA Controlled Substances Privilege by the issuing licensee~~physician~~ if the prescription is for controlled substances.
4. Immediately ~~after~~ upon revocation, suspension or surrender of the licensee~~physician's~~ license.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.12 Freedom of Choice. A licensee must not be influenced in the prescribing of drugs, devices or appliances by a direct or indirect financial interest in a pharmaceutical firm, pharmacy or other supplier.

A licensee may own or operate a pharmacy if there is no resulting exploitation of patients. A licensee must not give patients prescriptions in code or enter into agreements with pharmacies or other suppliers regarding the filling of prescriptions by code. Patients are entitled to the same freedom of choice in selecting who will fill their prescription needs as they are in the choice of a provider. The prescription is a written direction for a therapeutic or corrective agent. A patient is entitled to a copy of the licensee's prescription for drugs or other devices as required by the principles of medical ethics. The patient has a right to have the prescription filled by any legal means. Where medication is to be dispensed or a prescription, excluding refills, called in to a pharmacist for medication, a licensee must inform each patient of that patient's right to a written prescription and the right to have the prescription filled wherever the patient wishes.

Patients have an ethically and legally recognized right to prompt access to the information contained in their individual medical records. The prescription is an essential part of the patient's medical record. If a patient requests a written prescription in lieu of an oral prescription, this request must be honored. Licensees must not discourage patients from requesting a written prescription or urge, suggest or direct in any manner that a patient fill a prescription at an establishment which has a direct telephone line or which has entered into a business or other preferential arrangement with the licensee with respect to the filling of the licensee's prescriptions.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.12 Freedom of Choice. A licensee ~~physician~~ ~~shall~~must not be influenced in the prescribing of drugs, devices or appliances by a direct or indirect financial interest in a pharmaceutical firm, pharmacy or other supplier. ~~Whether the firm is a manufacturer, distributor, wholesaler, or repackager of the product involved is immaterial. Reputable firms rely on the quality and the efficacy to sell their products under competitive circumstances and do not appeal to physicians to have financial involvements with the firm in order to influence their prescribing, administering or dispensing.~~

A licensee ~~physician~~ may own or operate a pharmacy if there is no resulting exploitation of patients. A licensee ~~physician~~ ~~shall~~must not give ~~a~~ patients prescriptions in code or enter into agreements with pharmacies or other suppliers regarding the filling of prescriptions by code. Patients are entitled to the same freedom of choice in selecting who will fill their prescription needs as they are in the choice of a ~~physician~~provider. The prescription is a written direction for a therapeutic or corrective agent. A patient is entitled to a copy of the licensee ~~physician's~~ prescription for drugs or other devices as required by the principles of medical ethics. The patient has a right to have the prescription filled ~~wherever the patient wishes~~by any legal means. Where medication is to be dispensed or a prescription, excluding refills, called in to a pharmacist for medication, a licensee ~~physician~~ ~~shall~~must inform each patient of that patient's right to a written prescription and the right to have the prescription filled wherever the patient wishes.

Patients have an ethically and legally recognized right to prompt access to the information contained in their individual medical records. The prescription is an essential part of the patient's medical record. If a patient requests a written prescription in lieu of an oral prescription, this request ~~shall~~must be honored. Licensees ~~Physicians~~ ~~shall~~must not discourage patients from requesting a written prescription or urge, suggest or direct in any manner that a patient fill a prescription at an establishment which has a direct telephone line or which has entered into a business or other preferential arrangement with the ~~physician~~licensee with respect to the filling of the licensee ~~physician's~~ prescriptions.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.13 Security of Controlled Substances. In all clinics or offices within the control of a licensee, all controlled substances and other drugs having addiction-forming or addiction-sustaining liability must be maintained in such a manner as to deter loss by theft or burglary. All controlled substances must be stored in a securely locked, substantially constructed container or area. Only the physician or persons authorized by the physician shall have access to this storage area. When a licensee detects a loss of controlled substances, the Board may issue an order requiring that person to appear before the Board and present a plan designed to prevent further loss of controlled substances. The Board has the authority to order implementation measures to improve security over controlled substances.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

~~*Rule 1.13 Other Drugs Having Addiction-forming Liability*. All physicians shall maintain inventory, dispensation/administration and patient records in the same format as that required by Part 2640, Rule 1.4 when administering or dispensing the drug Nalbuphine Hydrochloride (Nubain) or its generic equivalent. The inventory and dispensation/administration records for said drug may be maintained separately or included as a part of the physician's controlled substance records.~~

*Rule 1.14*3 *Security of Controlled Substances*. In all clinics or offices ~~wherein~~ within the control of a licensee, all controlled substances ~~or~~ and other drugs having addiction-forming or addiction-sustaining liability ~~are maintained, said medication shall~~must be maintained in such a manner as to deter loss by theft or burglary. A~~a~~ll controlled substances ~~shall~~must be stored in a securely locked, substantially constructed container or area. Only the physician or persons authorized by the physician shall have access to this storage area. When a licensee ~~physician who is registered with the U.S. Drug Enforcement Administration has experienced~~ detects a loss of controlled substances, the Board may issue an order requiring that person to appear before the Board and present a plan designed to prevent further loss of controlled substances. ~~or he or she may be ordered by t~~The Board has the authority to order implementation ~~any other reasonable~~ measures to improve security over controlled substances ~~deemed necessary by the Board to prevent further loss of the controlled substances~~.

~~In all clinics or offices of a physician registered to handle controlled substances with the U.S. Drug Enforcement Administration,~~

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.14 Pain Management Medical Practice.

A. A pain management medical practice must have, at all times, a majority ownership (more than 50%) by a physician or group of physicians licensed by the Board, and/or a hospital or health care entity registered with the Secretary of State to do business in the state of Mississippi. The physician or physician owners must practice an annual average of at least 20 hours per week within the state of Mississippi.
B. A pain management medical practice must register with the Board.
C. Each physician owner of a pain management medical practice must meet the requirements set forth below.
D. Each licensee who serves as medical director, manager, or employee or who provides care in a pain management medical practice must meet the requirements set forth below.

Application for Initial Registration and Renewal - A physician owner of a pain management medical practice must:

1. submit the documents demonstrating proof of ownership or provide alternative documents with a written request for special consideration;
2. report ownership or investment interest in any other pain management facility operating within the state of Mississippi and provide the name and address of the other pain management facility(ies) in which the physician has ownership or vested interest;
3. identify all individuals with prescriptive authority who are employed or contracted in any capacity at each facility; and
4. report any changes of information provided in the application for registration or renewal within 30 days of the effective date of the change.

E. Physician owners or operators may not operate a pain management practice in the state of Mississippi without obtaining a certificate from the Mississippi State Board of Medical Licensure. Certificates, once issued, are not transferable or assignable. Only the primary physician owner is required to register with the Board if there is more than one physician owner of the practice. Additional physician owners must register if they also provide patient care. Each practice requires a separate certificate.
F. Physician owners or operators may not operate a pain management practice in Mississippi unless the practice is owned or operated by a hospital or healthcare entity registered with the Secretary of State to do business in the state of Mississippi, or by a physician who:
    1. practices at least 20 hours per week providing direct patient care;
    2. holds an active unrestricted medical license ; and
    3. holds a certificate of registration for that pain management practice.
G. No physician owners or operators of a pain management practice, nor any physician, nor any physician assistant, nor any medical director, manager, or employee or any physician or physician assistant who provides care may:

1. have been denied, by any jurisdiction, a certificate permitting the licensee to order, prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions;
2. have been issued, by any jurisdiction, a limited certificate to order, prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions;
3. have been denied a certificate issued by the Drug Enforcement Administration (DEA) permitting the licensee to order, prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions;
4. have been issued a limited certificate by the Drug Enforcement Administration (DEA) permitting the licensee to order, prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions;
5. have been subject to a disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, administering, supplying or selling a controlled substance or the other listed medications under definitions; or
6. have been terminated from Mississippi's Medicaid Program, the Medicaid program of any other state, or the federal Medicare program, unless eligibility has been restored.

H. No physician or physician assistant may own, operate, or practice in a pain management medical practice who has been convicted of, pled nolo contendere to or received deferred adjudication for:
1. an offense that constitutes a felony; or
2. an offense that constitutes a misdemeanor, the facts of which relates to the illegal distribution or sale of drugs or controlled substances.

I. Training requirements for all physicians practicing in pain management medical practices. Effective July 1, 2014, all physician owners or operators or any physician who serves as medical director, manager, or employee or who provides care in pain management medical practice must meet the qualifications set forth in subsections (1) through (5) below. All physicians prescribing or dispensing controlled substance medications in pain management practices registered by the Board must meet one (1) of the following qualifications:
1. board certification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Board of Addiction Medicine (ABAM) and hold a subspecialty certification in pain medicine;
2. board certification by a specialty board recognized by the American Osteopathic Association Bureau of Osteopathic Specialists (BOS) in pain management;
3. board certification in pain medicine by the American Board of Pain Medicine (ABPM);
4. successful completion of a residency program in physical medicine and rehabilitation, anesthesiology, neurology, or neurosurgery and approved by the ACGME or the AOA; or
5. successful completion of 100 hours of inter-active live participatory AMA or AOA Category 1 CME courses in pain management.

Upon qualifying under any of the 5 subsections above, physicians must also document completion of 30 hours of Category 1 CME for renewal of a pain management medical practice certificate.

a. CME must have emphasis in the specific areas of pain management, addiction, or prescribing of opiates.
b. CME may be included with the forty hour requirement for licensure renewal.
c. Excess hours may not be carried over to another two year cycle. For the purpose of this regulation, the two year period begins with the fiscal year July 1, 2014, and every two years thereafter to be concurrent with the licensure requirement.

J. Physicians and physician assistants practicing in a registered pain management medical practice must be registered with the Mississippi Prescription Monitoring Program (MPMP). A report from the MPMP must be obtained on the initial visit for each patient. Subsequent reports must be obtained for each patient at every visit.

K. Requirements for physician assistants practicing in pain management medical practices. Physician assistants must meet the following qualifications prior to practicing in a registered pain management practice:
1. A Board approved protocol in the practice of pain management as required by Part 2615, Chapter 1, Rules 5 and 6, with a physician who holds a license that is not designated as limited, restricted, retired, temporary, or in-training;
2. Physician assistants with approved prescriptive authority must obtain 10 hours as required by the licensure requirement plus 5 hours of Category 1 CME related to prescribing and pain management for every year the physician assistant is practicing in a pain management medical practice;
3. Physician assistants with prescriptive authority must be familiar with and adhere to the Administrative Rule Pertaining to Prescribing, Administering and Dispensing of Medication, Part 2640, Chapter 1; and
4. Physician assistants with prescriptive authority must be registered with the Mississippi Prescription Monitoring Program (MPMP).

L. A physician who is a current participant in the Mississippi Professionals Health Program (MPHP) may not be the primary physician owner of a pain practice. This does not prohibit a MPHP participant from working in a pain practice.

M. Prior to the initial issuance of an opioid and/or benzodiazepine for the treatment of chronic non-cancer/non-terminal pain, each patient in a pain management practice must have an in-person evaluation by a registered pain management physician.

N. Certificates are valid for one year and must be renewed annually. There is a thirty-day grace period for renewal after which the owner or operator must reapply for an original certificate. The physician owner or operator of the practice must post the certificate in a conspicuous location so as to be clearly visible to patients. The practice may not continue to operate while the certificate has expired.

O. The Board has the authority to inspect a pain management medical practice. During such inspections, authorized representatives of the Board, who may be accompanied by investigators from state or federal law enforcement agencies, may inspect documents and medical records to ensure compliance with any applicable laws and rules.

P. If the Board finds that a registered pain management practice no longer meets any of the requirements to operate as a pain practice, the Board may immediately revoke or suspend the physician's certificate to operate a pain management medical practice. The physician owner or operator shall have the right to an administrative hearing before the Board at the next available and scheduled meeting of the Board. Further, the Board has the discretion to lift the suspension of a certificate when the pain management medical practice demonstrates compliance with applicable rules and regulations.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.15~~5~~4 Pain Management Medical Practice.

~~A. Definitions. For the purpose of Part 2640, Rule 1.15 only, the following terms have the meanings indicated:~~

~~1. "Board" means the Mississippi State Board of Medical Licensure.~~

~~"Physician" means any person licensed to practice medicine or osteopathic medicine in the state of Mississippi as required by Part 2601, Chapter 02."Physician Assistant" means any person meeting the requirements of licensure in the state of Mississippi as required by Part 2617, Chapter 1.~~

~~"Licensee" means any person licensed and/or regulated by the Mississippi State Board of Medical Licensure to practice in the state of Mississippi.~~

~~2. "Prescriptive Authority" means the legal authority of a professional licensed to practice in the state of Mississippi who prescribes controlled substances and is registered with the U. S. Drug Enforcement Administration in compliance with Title 21 CFR, Part 1301 Food and Drugs.~~

~~3. "Pain Management Medical Practice" is defined as means a public or privately owned medical practice for which that provides pain management services to patients, a majority (more than 530%) of the patients are issued on a regular or recurring basis which are issued a prescription for, or are dispensed, opioids, barbiturates, benzodiazepines, carisoprodol, butalbital compounds, or tramadol for the treatment of chronic noncancerous pain. Included in this definition shall be any practice that advertises and/or otherwise holds itself out to provide pain management services. more than one hundred eighty days (180) days in a twelve month period. Excluded from this definition are all licensed hospitals, state health department facilities, federally qualified community health clinics, volunteer clinics, hospice services, and out-patient surgical clinics. Physicians or practices or physician/clinic practice(s) at which the majority of the patients are treated for pain as a result of a terminal illness are also excluded from the definition of pain management practice.~~

A. A ~~physician owner(s)/operator(s) of the~~ pain management medical practice must ~~possess and maintain~~have, at all times, a majority ownership (more than 50%) by a physician or group of physicians licensed by the Board, and/or a hospital or health care entity registered with the Secretary of State to do business in the state of Mississippi. The physician or physician owners must practice an annual average of at least 20 hours per week within the state of Mississippi.

B. A pain management medical practice ~~and shall~~must register with the Board. ~~the practice with the Board. No physician may practice in a pain management medical practice unless that practice is majority owned (over 50 %) by a physician or physicians, unless exempted under A.5 above. A hospital or hospital system owned pain management practice is exempt from the majority ownership requirement.~~

C. Each ~~A~~physician owner of a pain management medical practice ~~or medical director who owns, operates or is employed in any pain management medical practice~~ must meet the requirements set forth below.

D. Each ~~physician~~licensee who serves as medical director, manager, or employee or who provides care in a pain management medical practice must meet the requirements set forth below.

Application for Initial Registration and Renewal - A physician owner~~(s)/operator(s)~~ of ~~the~~ a pain management medical practice must:

1. submit the documents ~~required by the application process for~~demonstrating proof of ownership or provide alternative documents with a written request for special consideration;
2. report ownership or investment interest ~~of~~ in any other pain management facility operating within the state of Mississippi and provide the name and address of the other pain management facility(ies) in which ~~there~~ the physician has~~is an~~ ownership or vested interest;
3. identify all individuals with prescriptive authority who are employed or contracted in any capacity ~~and will be prescribing or dispensing controlled substances to patients of~~ at each ~~the~~ facility; and
4. report any changes of information provided in the application for registration or renewal within 30 days of the effective date of the change.

E. Physician owner~~(~~s or ~~)~~/operator~~(s)~~ may not operate a pain management practice in the state of Mississippi without obtaining a certificate from the Mississippi State Board of Medical Licensure. Certificates, once issued, are not transferable or assignable. Only the primary physician owner is required to register with the Board if there is more than one physician owner of the practice. Additional physician owners must register if they also provide patient care. Each practice requires a separate certificate.

F. Physician owners or operators~~owner(s)/operator(s) or employees~~ may not operate a pain management practice in Mississippi unless the practice is owned or operated by a hospital or healthcare entity registered with the Secretary of State to do business in the state of Mississippi, or by a ~~medical director~~physician who:

1. ~~is a physician who~~ practices ~~full time in Mississippi; (Full time is defined as~~ at least 20 hours per week ~~of~~ providing direct patient care~~.);~~;
2. holds an active unrestricted medical license ~~that is not designated as limited, retired, temporary, or in-training~~; and
3. holds a certificate of registration for that pain management practice.

G. No~~In addition, the~~ physician owners or operators~~owner(s)/operator(s)~~ of a pain management practice, nor any physician, nor any physician assistant, ~~employee, of the practice~~ nor any medical director, manager, or employee or any physician or physician assistant who provides care~~a physician or physician assistant with whom the physician owner(s)/operator(s) of a practice contracts for services may not~~:

1. have been denied, by any jurisdiction, a certificate permitting the licensee to order, prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions;
2. have been issued, by any jurisdiction, a limited certificate to order, prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions;
3. have been denied a certificate issued by the Drug Enforcement Administration (DEA) permitting the licensee to order, prescribe, dispense, administer, supply or sell a

controlled substance or the other listed medications under definitions~~under which the person may prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions~~;

4. have been issued a limited certificate by the Drug Enforcement Administration (DEA) permitting the licensee to order, prescribe, dispense, administer, supply or sell a controlled substance or the other listed medications under definitions;
5. ~~have held a certificate issued by the Drug Enforcement Administration under which the person may prescribe, dispense, administer, or supply, or sell a controlled substance that has been restricted;~~
5. have been subject to a disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, administering, supplying or selling a controlled substance or the other listed medications under definitions; or
6. have been terminated from Mississippi's Medicaid Program, the Medicaid program of any other state, or the federal Medicare program, unless eligibility has been restored.

H. No physician or physician assistant may own, operate, or practice in a pain management medical practice who has been convicted of, pled nolo contendere to or received deferred adjudication for:

1. an offense that constitutes a felony; or
2. an offense that constitutes a misdemeanor, the facts of which relates to the illegal distribution or sale of drugs or controlled substances.

I. Training r~~R~~equirements for all physicians practicing in pain management medical practices. Effective July 1, 2014, all physician owners or operators or any physician who serves as medical director, manager, or employee or who provides care in a pain management medical practice must meet~~s who have not met~~ the qualifications set forth in subsections (1) through (5) below.~~, shall have successfully completed a pain residency fellowship or a pain medicine residency that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).~~ All physicians prescribing or dispensing controlled substance medications in pain management practices registered by the Board must meet one (1) of the following qualifications:

1. board certification by a specialty board recognized by the American Board of Medical Specialties (ABMS) or the American Board of Addiction Medicine (ABAM) and hold a subspecialty certification in pain medicine;
2. board certification by a specialty board recognized by the American Osteopathic Association Bureau of Osteopathic Specialists (BOS) in pain management;
3. board certification in pain medicine by the American Board of Pain Medicine (ABPM);
4. successful completion of a residency program in physical medicine and rehabilitation, anesthesiology, neurology, or neurosurgery and approved by the ACGME or the AOA; or
5. successful completion of 100 hours of ~~in person, face to fact,~~ inter-active live participatory AMA or AOA Category 1 CME courses in pain management.

Upon qualifying under any of the 5 subsections above, physicians must also document completion of 30 hours of ~~live lecture format,~~ Category 1 CME for renewal of a pain management medical practice~~pain practice~~ certificate.

~~a. Live lecture format participation may be in person; or remotely as is the case of teleconference;s or live iInternet webinars.~~

a. CME must have emphasis in the specific areas of pain management, addiction, ~~and/~~or prescribing of opiates.

b. CME ~~is to~~may be included with the forty hour requirement for licensure renewal.

c. Excess hours may not be carried over to another two year cycle. For the purpose of this regulation, the two year period begins with the fiscal year July 1, 2014, and every two years thereafter to be concurrent with the licensure requirement.

J. Physicians and physician assistants practicing in a registered pain management medical practice~~pain practice~~ must be registered with the Mississippi Prescription Monitoring Program (MPMP). A report from the MPMP ~~shall~~must be obtained on the initial visit for each patient. Subsequent reports must be obtained for each patient at every visit. ~~and at intervals deemed appropriate forconsistent with good patient care from the MPMPbut no less frequently than every three months. for every patient receiving controlled substances in a registered pain management practice.~~

K. Requirements for physician assistants practicing in pain management medical practices. Physician assistants must meet the following qualifications prior to practicing in a registered pain management practice:

1. A Board approved protocol in the practice of pain management as required by Part 2615, Chapter 1, Rules 5 and 6, with a physician who holds a license that is not designated as limited, restricted, retired, temporary, or in-training;
2. Physician assistants with approved prescriptive authority must obtain 10 hours as required by the licensure requirement plus 5 hours of Category 1 CME related to prescribing and pain management for every year the physician assistant is practicing in a pain management medical practice~~Board registered pain practice~~;
3. Physician assistants with prescriptive authority must be familiar with and adhere to the Administrative Rule Pertaining to Prescribing, Administering and Dispensing of Medication, Part 2640, Chapter 1; and
4. Physician assistants with prescriptive authority must be registered with the Mississippi Prescription Monitoring Program (MPMP).

L. A physician who is a current participant in the Mississippi Professionals Health Program (MPHP) may not be the primary physician owner of a pain practice. ~~Notwithstanding, t~~This does not prohibit an MPHP participant from working in a pain practice.

M. ~~The initial visit for each patient in a pain management practice must include an in person evaluation and plan of care by a registered pain management physician p~~rior to the ~~issuance of an opioid and/or benzodiazepine for the treatment of chronic non-cancer/non-terminal pain.~~ Prior to the initial issuance of an opioid and/or benzodiazepine for the treatment of chronic non-cancer/non-terminal pain, each patient in a pain management practice must have an in-person evaluation by a registered pain management physician.

N. Certificates are valid for one year and must be renewed annually ~~along with the practitioner's license to practice medicine in the state of Mississippi~~. There is a thirty-day grace period for renewal after which the owner~~(s)/~~ or operator~~(s)~~ must reapply for an original certificate. The physician owner~~(s)/~~ or operator~~(s)~~ of the practice ~~shall~~must post the certificate in a conspicuous location so as to be clearly visible to patients. The practice may not continue to operate while the certificate has expired.

O. The Board ~~shall have~~has the authority to inspect a pain management medical practice~~pain management practice~~. During such inspections, authorized representatives of the Board, who may be accompanied by ~~agents of the Mississippi Bureau of Narcotics~~investigators from state or federal law enforcement agencies, may inspect ~~all necessary~~ documents and medical records to ensure compliance with ~~all~~ any applicable laws and rules.

P. If the Board finds that a registered pain management practice no longer meets any of the requirements to operate as a pain practice, the Board may immediately revoke or suspend the physician's certificate to operate a pain management medical practice~~pain management practice~~. The physician owner~~(s)~~/ or operator~~(s)~~ shall have the right to an administrative hearing before the Board at the next available and scheduled meeting of the Board. Further, the Board has the discretion to lift the suspension of a certificate when the pain management medical practice demonstrates compliance with ~~the Board's~~applicable rules and regulations.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.15 Violation of Rules.

The prescribing, administering or dispensing of any controlled substance in violation of the above rules shall constitute the administering, dispensing or prescribing of any narcotic drug or other drug having addiction-forming or addiction-sustaining liability otherwise than in the course of legitimate professional practice, in violation of Mississippi Code, Section 73-25-29(3).

The prescribing, administering or dispensing of any legend drug or other medication in violation of the above rules constitutes unprofessional conduct, dishonorable or unethical conduct likely to deceive, defraud or harm the public, in violation of Miss. Code Ann., § 73-25-29(8)(d).

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

*Rule 1.16*5 *Violation of Rules.*

The prescribing, administering or dispensing of any controlled substance in violation of the above rules shall constitute the administering, dispensing or prescribing of any narcotic drug or other drug having addiction-forming or addiction-sustaining liability otherwise than in the course of legitimate professional practice, in violation of ~~Mississippi Code~~Miss. Code Ann., ~~Section~~ § 73-25-29(3).

The prescribing, administering or dispensing of any legend drug or other medication in violation of the above rules ~~shall~~ constitute<u>s</u> unprofessional conduct, dishonorable or unethical conduct likely to deceive, defraud or harm the public, in violation of ~~Mississippi Code~~Miss. Code Ann., ~~Section~~§ 73-25-29(8)(d).

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.16 Effective Date of Rules. The above rules pertaining to prescribing, administering and dispensing of medication shall become effective October 31, 1987; as amended November 1, 1990; as amended January 3, 1994; as amended September 10, 1995; as amended June 30, 1996; as amended March 18, 1999; as amended May 20, 1999; as amended February 17, 2001; as amended March 22, 2001; as amended July 15, 2004; as amended October 14, 2004; as amended November 8, 2007; as amended May 15, 2008; as amended March 13, 2009; as amended March 24, 2011; as amended September 17, 2012; as amended September 19, 2013; as amended May 22, 2014; as amended November 13, 2015; and as amended March 22, 2018.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

Part 2640: Prescribing, Administering and Dispensing

Part 2640 Chapter 1: Rules Pertaining to Prescribing, Administering and Dispensing of Medication

Rule 1.1~~7~~6 Effective Date of Rules. The above rules pertaining to prescribing, administering and dispensing of medication shall become effective October 31, 1987; as amended November 1, 1990; as amended January 3, 1994; as amended September 10, 1995; as amended June 30, 1996; as amended March 18, 1999; as amended May 20, 1999; as amended February 17, 2001; as amended March 22, 2001; as amended July 15, 2004; as amended October 14, 2004; as amended November 8, 2007; as amended May 15, 2008; as amended March 13, 2009; as amended March 24, 2011; as amended September 17, 2012; as amended September 19, 2013; as amended May 22, 2014; ~~and~~ as amended November 13, 2015; and as amended March 22, 2018.

Source: Miss. Code Ann. §73-43-11 (1972, as amended).

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE

OF

HORRELL H. TOWNSEND, D.O.

CONSENT ORDER

WHEREAS, HORRELL H. TOWNSEND, D.O., hereinafter referred to as "Licensee," is the current holder of Mississippi Medical License Number 11143 and said license is current until June 30, 2019;

WHEREAS, the Investigative Staff of the Mississippi State Board of Medical Licensure, hereinafter referred to as the "Board," has conducted an investigation of Licensee and has in its possession evidence which, if produced during the course of an evidentiary hearing, would substantiate grounds upon which the Board may discipline Licensee pursuant to the Mississippi Medical Practice Act;

WHEREAS, on June 21, 2018, Licensee met with the Board's Executive Director to discuss the aforementioned investigation. After a detailed discussion of the matter, it is the desire of the Licensee to resolve the pending matter by entry of a Consent Order;

WHEREAS, the conduct discussed represents violation(s) of the Mississippi Medical Practice Act, specifically Miss. Code Ann., §§73-25-29(3), (8)(d) and (13), and §73-25-83(a), as amended, for which the Mississippi State Board of Medical Licensure may place Licensee's medical license on probation, the terms of which may be set by the Board,

suspend his right to practice medicine for a time deemed proper by the Board, revoke said license, or take any other action the Board may deem proper under the circumstances;

WHEREAS, Licensee wishes to avoid an evidentiary hearing before the Mississippi State Board of Medical Licensure and, in lieu thereof, has consented to certain conditions being placed on his license to practice medicine in the State of Mississippi;

NOW, THEREFORE, the Mississippi State Board of Medical Licensure, with the consent of Licensee as signified by his joinder herein, enters into this Consent Order and places the following terms, conditions, and restrictions on Licensee's Mississippi medical license, to wit:

1. Licensee shall submit, as soon as possible, to a clinical competency assessment program at a Board approved facility/program, specifically assessing his ability to practice Family Medicine. Licensee shall bear all costs associated with said evaluation. Licensee shall sign any and all releases with the facility/program permitting the Board full and complete access to any findings, and to facilitate any needed communication between the facility/program and the Board.

2. Upon receipt of the assessment report, the Board reserves the right to request Licensee to informally appear before the Board, its Executive Committee, or the Executive Director, to discuss the findings, recommendations, and determine the ultimate duration of this Consent Order. Licensee agrees to implement any and all recommendations made by the aforementioned assessment and, further, understands and agrees that the Board in its sole discretion may impose additional practice restriction(s) which may be deemed necessary based upon the results of said assessment.

3. Licensee shall immediately cease treating, and appropriately refer out, any and all patients receiving Testosterone therapy.

4. Licensee must immediately cease taking on any new Chronic Pain patients, as that term is defined by Board rules and regulations, and has six (6) months from the date of Board approval of this Order to appropriately transfer care, or otherwise reduce his Chronic Pain patient base to no more than thirty percent (30%) of his total patient load.

5. Licensee shall obey all federal, state and local laws, as well as comply with all rules and regulations of the Board governing the practice of medicine. Any further acts of misconduct will result in further action.

6. Licensee shall notify the Board within ten (10) days of any change in his practice location and/or change in employment, including initiation or termination of any practice location within the State of Mississippi.

7. Licensee expressly agrees he will not seek an appearance before the Board prior to the completion of the terms of this Order and, further, agrees the terms and conditions of this Order, once executed, may not be appealed.

8. Licensee shall reimburse the Board for all costs incurred in relation to the pending matter pursuant to Miss. Code Ann., § 73-25-30. Licensee shall be advised of the total assessment by separate written notification, and shall tender to the Board a certified check or money order made payable to the Mississippi State Board of Medical Licensure, on or before forty (40) days from the date the assessment is mailed to Licensee via U.S. Mail to Licensee's current mailing address.

This Consent Order shall be subject to approval by the Board. If the Board fails to approve this Consent Order, in whole or in part, it shall have no force or effect on the

parties. It is further understood and agreed that the purpose of this Consent Order is to avoid a hearing before the Board. In this regard, Licensee authorizes the Board to review and examine any documentary evidence or material concerning the Licensee prior to or in conjunction with its consideration of this Consent Order. Should this Consent Order not be accepted by the Board, it is agreed that presentation to and consideration of the Consent Order and other documents and matters pertaining thereto by the Board shall not unfairly or illegally prejudice the Board or any of its members from further participation in any hearing or other resolution of the proceeding.

Should the Board hereafter receive documented evidence of Licensee violating any of the terms and conditions of this Consent Order, the Board shall have the right, pursuant to a full evidentiary hearing, to revoke the medical license of Licensee, suspend it for a time deemed proper by the Board, or take any other action determined as necessary by the Board.

Further, it is not the intent or purpose of this Order to encourage malpractice liability as a result of Board action. Therefore, by execution and entry of this Consent Order, Licensee is not admitting to or acknowledging any conduct or act(s) of malpractice.

Licensee understands and expressly acknowledges that this Consent Order, if approved and executed by the Mississippi State Board of Medical Licensure, shall constitute a public record of the State of Mississippi. Licensee further acknowledges that the Board shall provide a copy of this Order to, among others, the National Practitioner Data Bank and the U.S. Drug Enforcement Administration, and the Board makes no representation as to actions, if any, which any other agency or jurisdiction may take in response to this Order.

Recognizing his right to notice of charges specified against him, to have such charges adjudicated pursuant to Miss. Code Ann., §§ 73-25-27, to be represented therein

by legal counsel of his choice, and to a final decision rendered upon written findings of fact and conclusions of law, **HORRELL H. TOWNSEND, D.O.**, nonetheless, hereby waives his right to notice and a formal adjudication of charges and authorizes the Board to enter an order accepting this Consent Order, thereby imposing the above terms and conditions on his license to practice medicine in the state of Mississippi.

EXECUTED, this the 5th day of July, 2018.

HORRELL H. TOWNSEND, D.O.

ACCEPTED AND APPROVED this the 19th day of July, 2018 by the Mississippi State Board of Medical Licensure.

Kenneth E. Cleveland, M.D.
Executive Director

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE

OF

DON ALBERT GIBSON, M.D.

CONSENT ORDER

WHEREAS, DON ALBERT GIBSON, M.D., hereinafter referred to as "Licensee," is the current holder of Mississippi Medical License No. 07980, said license number expires on June 30, 2019;

WHEREAS, the Investigative Staff of the Mississippi State Board of Medical Licensure, hereinafter referred to as the "Board," has conducted an investigation of Licensee and has in its possession evidence which, if produced during the course of an evidentiary hearing, would substantiate that Licensee has violated certain provisions of the Mississippi Medical Practice Law, specifically, Subsections (8)(d) and (13) of §73-25-29 and §73-25-83(a), Miss. Code Ann., as amended, including but not limited to provisions of the Board's Administrative Code pertaining to collaboration with Nurse Practitioners (APRNs), and failure to maintain a complete record documenting the evaluation and treatment of a patient, for which the Board may revoke the medical license of Licensee, suspend it for a time deemed proper by the Board, or take any other action as the Board may deem proper under the circumstances;

WHEREAS, on June 28, 2018, Licensee presented before the Board's Executive Director to discuss the aforementioned investigation. During his appearance, Licensee represented to the Executive Director that he was collaborating with or responsible for an APRN practicing at a particular practice site, but Licensee had little to no understanding of what the APRN was doing, as Licensee had not visited the facility or had an in-person meeting with the APRN. Furthermore, Licensee failed to maintain a complete record of controlled substances prescribed, all of which are in violation of the rules and regulations set by the Board;

WHEREAS, it is the desire of Licensee to avoid an evidentiary hearing before the Board and, in lieu thereof, has agreed to enter into this Consent Order;

NOW, THEREFORE, the Mississippi State Board of Medical Licensure, with consent of Licensee as signified by his joinder herein, does hereby agree to the following:

1. Licensee shall, within one (1) year of the acceptance and approval of this Order, successfully complete Board approved Continuing Medical Education (CME) in the areas of (i) Practice Boundaries and (ii) Prescribing Controlled Substances, said courses to be selected from the list of Board approved courses attached hereto as Exhibit "A". Licensee shall provide proof of attendance and participation in each aspect of the courses required herein. Any credit received for such CME shall be in addition to the usual forty (40) hours of Category I credits required by Board regulation. Licensee will be required to be on-site while taking the CME course(s), as the course(s) cannot be taken on-line or by other means. Licensee shall submit proof of successful completion to the Board.
2. Licensee is hereby prohibited from supervising or collaborating with Physician Assistants (PAs) and/or Advanced Practice Registered Nurses (APRNs) at any and all locations.
3. Licensee shall obey all federal, state and local laws, and all rules and regulations governing the practice of medicine. Any further acts of misconduct will result in further action.
4. Licensee shall reimburse the Board for all costs incurred in relation to the pending matter pursuant to Miss. Code Ann., § 73-25-30. Licensee shall be advised of the total assessment by separate written notification, and shall tender to the Board a certified check or money order made payable to the Mississippi State Board of Medical Licensure, on or before forty (40) days from the date the assessment is mailed to Licensee via U.S. Mail to Licensee's current mailing address.

Licensee shall have the right, but not the obligation, to appear before the Board after the expiration of one (1) year from the date of this Order to request the removal of any or all of the

aforementioned restrictions. Licensee expressly agrees he will not seek an appearance before the Board prior to the completion of the terms of this Order.

This Consent Order shall be subject to approval by the Board. If the Board fails to approve this Consent Order, in whole or in part, it shall have no force or effect on the parties. It is further understood and agreed that the purpose of this Consent Order is to avoid a hearing before the Board. In this regard, Licensee authorizes the Board to review and examine any documentary evidence or material concerning the Licensee prior to or in conjunction with its consideration of this Consent Order. Should this Consent Order not be accepted by the Board, it is agreed that presentation to and consideration of this Consent Order and other documents and matters pertaining thereto by the Board shall not unfairly or illegally prejudice the Board or any of its members from participation in any further proceedings.

Should the Board hereafter receive documented evidence of Licensee violating any of the terms and conditions of this Consent Order, the Board shall have the right, pursuant to a full evidentiary hearing, to revoke the medical license of Licensee, suspend it for a time deemed proper by the Board, or take any other action determined as necessary by the Board.

Further, it is not the intent or purpose of this Order to encourage malpractice liability as a result of Board action. Therefore, by execution of this Consent Order, Licensee is not admitting to or acknowledging any conduct or act of malpractice.

Licensee understands and expressly acknowledges that this Consent Order shall constitute a public record of the State of Mississippi. Licensee further acknowledges that the Board shall provide a copy of this Order to, among others, the U.S. Drug Enforcement Administration, and the Board makes no representation as to action, if any, which any other agency or jurisdiction may take in response to this Order.

Recognizing his right to notice of charges specified against him, to have such charges adjudicated pursuant to Miss. Code Ann., § 73-25-27 (1972), to be represented therein by legal counsel of his choice, and to a final decision rendered upon written findings of fact and conclusions of law, **DON ALBERT GIBSON, M.D.**, nevertheless, hereby waives his right to notice and a formal adjudication of

charges, thereby placing his medical license on probation, subject to those terms and conditions listed above.

EXECUTED AND EFFECTIVE, this the _____, day of July, 2018.

DON ALBERT GIBSON, M.D.

ACCEPTED AND APPROVED, this the 9th, day of July, 2018, by the Mississippi State Board of Medical Licensure.

KENNETH E. CLEVELAND, M.D.
Executive Director

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE

OF

ERIC JAMES ZOOG, M.D.

CONSENT ORDER

WHEREAS, ERIC JAMES ZOOG, M.D., hereinafter referred to as "Licensee," is the current holder of Mississippi Medical License No. 16418, said license number expires on June 30, 2019;

WHEREAS, the Investigative Staff of the Mississippi State Board of Medical Licensure, hereinafter referred to as the "Board," has conducted an investigation of Licensee and has in its possession evidence which, if produced during the course of an evidentiary hearing, would substantiate that Licensee has violated certain provisions of the Mississippi Medical Practice Law, specifically, Subsections (8)(d) and (13) of §73-25-29 and §73-25-83(a), Miss. Code Ann., as amended, including but not limited to provisions of the Board's Administrative Code pertaining to collaboration with Nurse Practitioners (APRNs); for which the Board may revoke the medical license of Licensee, suspend it for a time deemed proper by the Board, or take any other action as the Board may deem proper under the circumstances;

WHEREAS, on September 20, 2017, Licensee presented before the Executive Committee of the Board to discuss the aforementioned investigation. During his appearance, Licensee made certain statements and representations to the Board regarding his not collaborating with, or being responsible for, APRNs practicing at a particular practice site both pertinent and subject to the aforementioned investigation. Pursuant to this appearance, the Investigative Division of the Board was instructed to continue investigation of Licensee's current and past activities at the now defunct clinic location heretofore mentioned;

WHEREAS, information obtained via the investigative process has revealed the aforementioned violations stemming from Licensee's collaborative practice with APRNs outside his primary, hospital based practice;

WHEREAS, it is the desire of Licensee to avoid an evidentiary hearing before the Board and, in lieu thereof, has agreed to enter into this Consent Order;

NOW, THEREFORE, the Mississippi State Board of Medical Licensure, with consent of Licensee as signified by his joinder herein, does hereby place Licensee's certificate to practice medicine in the state of Mississippi on **probation**, subject to the following terms and conditions:

1. Licensee shall, within one (1) year of the acceptance and approval of this Order, successfully complete Board approved Continuing Medical Education (CME) in the areas of (i) Medical Ethics, (ii) Practice Boundaries, and (iii) Collaboration with Mid-Level Providers, said courses to be selected from the list of Board approved courses attached hereto as Exhibit "A". Licensee shall provide proof of attendance and participation in each aspect of the courses required herein. Any credit received for such CME shall be in addition to the usual forty (40) hours of Category I credits required by Board regulation. Licensee will be required to be on-site while taking the CME course(s), as the course(s) cannot be taken on-line or by other means. Licensee shall submit proof of successful completion to the Board.
2. Licensee is hereby prohibited from supervising or collaborating with Physician Assistants (PAs) and/or Advanced Practice Registered Nurses (APRNs) at any locations other than Licensee's primary, hospital based practice.
3. Licensee shall obey all federal, state and local laws, and all rules and regulations governing the practice of medicine. Any further acts of misconduct will result in further action.
4. Licensee expressly agrees he will not seek an appearance before the Board prior to the completion of the terms of this Order and, further, agrees the terms and conditions of this Order, once executed, may not be appealed.

5. Licensee shall reimburse the Board for all costs incurred in relation to the pending matter pursuant to Miss. Code Ann., § 73-25-30. Licensee shall be advised of the total assessment by separate written notification, and shall tender to the Board a certified check or money order made payable to the Mississippi State Board of Medical Licensure, on or before forty (40) days from the date the assessment is mailed to Licensee via U.S. Mail to Licensee's current mailing address.

This Consent Order shall be subject to approval by the Board. If the Board fails to approve this Consent Order, in whole or in part, it shall have no force or effect on the parties. It is further understood and agreed that the purpose of this Consent Order is to avoid a hearing before the Board. In this regard, Licensee authorizes the Board to review and examine any documentary evidence or material concerning the Licensee prior to or in conjunction with its consideration of this Consent Order. Should this Consent Order not be accepted by the Board, it is agreed that presentation to and consideration of this Consent Order and other documents and matters pertaining thereto by the Board shall not unfairly or illegally prejudice the Board or any of its members from participation in any further proceedings.

Should the Board hereafter receive documented evidence of Licensee violating any of the terms and conditions of this Consent Order, the Board shall have the right, pursuant to a full evidentiary hearing, to revoke the medical license of Licensee, suspend it for a time deemed proper by the Board, or take any other action determined as necessary by the Board

Further, it is not the intent or purpose of this Order to encourage malpractice liability as a result of Board action. Therefore, by execution of this Consent Order, Licensee is not admitting to or acknowledging any conduct or act of malpractice.

Licensee shall have the right, but not the obligation, to appear before the Board after the expiration of one (1) year from the date of this Order to request the removal of any or all of the aforementioned restrictions.

Licensee understands and expressly acknowledges that this Consent Order shall constitute a public record of the State of Mississippi. Licensee further acknowledges that the Board shall provide a

copy of this Order to, among others, the U.S Drug Enforcement Administration, and the Board makes no representation as to action, if any, which any other agency or jurisdiction may take in response to this Order

Recognizing his right to notice of charges specified against him, to have such charges adjudicated pursuant to Miss. Code Ann., § 73-25-27 (1972), to be represented therein by legal counsel of his choice, and to a final decision rendered upon written findings of fact and conclusions of law, **ERIC JAMES ZOOG, M.D.**, nevertheless, hereby waives his right to notice and a formal adjudication of charges, thereby placing his medical license on probation, subject to those terms and conditions listed above.

EXECUTED AND EFFECTIVE, this the 19, day of July, 2018.

ERIC JAMES ZOOG, M.D.

ACCEPTED AND APPROVED, this the 19th, day of July, 2018, by the Mississippi State Board of Medical Licensure

KENNETH E. CLEVELAND, M.D.
Executive Director

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE OF

RONNIE ALI, D.O.

ORDER REMOVING RESTRICTIONS

THIS MATTER came on regularly for hearing on July 19, 2018, before the Mississippi State Board of Medical Licensure, in response to a request Ronnie Ali, D.O, (hereinafter "Licensee") for removal of all restrictions on his license by virtue of that certain Consent Order which he entered into with the Board on May 19, 2016. After consideration of the matter, the Board finds Licensee's request to be well taken. Licensee has complied with all of the terms and conditions set forth in the aforesaid Consent Order.

THEREFORE, IT IS HEREBY ORDERED that Licensee's request for removal of all restrictions on his license to practice medicine is hereby granted. Licensee now holds an unrestricted license to practice medicine in the State of Mississippi.

IT IS FURTHER ORDERED, that pursuant to Miss. Code Ann. Sections 73-25-27, a copy of this Order shall be sent by registered mail or personally served upon Ronnie Ali, D.O

SO ORDERED, this the 19th day of July, 2018.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

BY: _____

CLAUDE D. BRUNSON, M.D.
PRESIDENT

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE OF

MEISAM H. MOGHBELLI, M.D.

ORDER REMOVING RESTRICTIONS

THIS MATTER came on regularly for hearing on July 19, 2018, before the Mississippi State Board of Medical Licensure, in response to a request Meisam H. Moghbelli, M.D. (hereinafter "Licensee") for removal of all restrictions on his license by virtue of that certain Determination and Order rendered by this Board on May 18, 2017. After consideration of the matter, the Board finds Licensee's request to be well taken. Licensee has complied with all of the terms and conditions set forth in the aforesaid Determination and Order.

THEREFORE, IT IS HEREBY ORDERED that Licensee's request for removal of all restrictions on his license to practice medicine is hereby granted. Licensee now holds an unrestricted license to practice medicine in the State of Mississippi.

IT **IS FURTHER ORDERED**, that pursuant to Miss. Code Ann. Sections 73-25-27, a copy of this Order shall be sent by registered mail or personally served upon Meisam H. Moghbelli, M.D

SO ORDERED, this the 19th day of July, 2018.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

BY: _____

CLAUDE D. BRUNSON, M.D.
PRESIDENT

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE OF

JAMES LEONARD HOLZHAUER, M.D.

ORDER OF CONTINUANCE

THIS MATTER came on regularly for hearing on July 19, 2018, before the Mississippi State Board of Medical Licensure, in response to a request for continuance of the hearing set for this date, made by James Leonard Holzhauer, M.D. (hereinafter "Licensee") through his attorney Whitman B. Johnson, III. After consideration of the matter, the Committee finds Licensee's request to be well taken

IT IS, THEREFORE, ORDERED that this matter is continued until September 20, 2018 at 9:00 a.m.

IT IS FURTHER ORDERED that pursuant to the Order of Temporary Suspension previously entered in this matter, Licensee is hereby prohibited from practicing obstetrics pending the outcome of the hearing as now scheduled. Pending the scheduled hearing, Licensee is prohibited from treating, counseling or otherwise offering any medical advice or services to patients in the area of obstetrics, whether directly or indirectly and whether in a private clinic or hospital.

SO ORDERED, this the 19th day of July, 2018.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

BY: _____

CLAUDE D. BRUNSON, M.D.
PRESIDENT

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE OF

TIMOTHY SUMMERS, M.D.

ORDER OF CONTINUANCE

THIS MATTER came on regularly for hearing on July 19, 2018, before the Mississippi State Board of Medical Licensure, in response to a request for continuance of the hearing set for this date, made by Timothy Summers, M.D. (hereinafter "Licensee") through his attorney Edward Blackmon, Jr. After consideration of the matter, the Committee finds Licensee's request to be well taken.

IT IS, THEREFORE, ORDERED that this matter is continued until September 20, 2018 at 9:00 a.m.

SO ORDERED, this the 19th day of July, 2018.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

BY: _____

CLAUDE D. BRUNSON, M.D.
PRESIDENT

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE OF

CHARLES SAMUEL FILLINGANE, D.O.

ORDER OF CONTINUANCE

THIS MATTER came on regularly for hearing on July 19, 2018, before the Mississippi State Board of Medical Licensure, in response to a request for continuance of the hearing set for this date, made by Charles Samuel Fillingane, D.O. (hereinafter "Licensee") through his attorney Philip J. Chapman. After consideration of the matter, the Committee finds Licensee's request to be well taken.

IT IS, THEREFORE, ORDERED that this matter is continued until September 20, 2018 at 9:00 a.m.

IT IS FURTHER ORDERED that pursuant to the Order of Temporary Suspension previously entered in this matter, pending the scheduled hearing or other resolution, Licensee is prohibited from treating, counseling or otherwise offering any medical advice or services to patients.

SO ORDERED, this the 19th day of July, 2018.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

BY: _____

CLAUDE D. BRUNSON, M.D.
PRESIDENT

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE

OF

ROBERT M. LEVY, M.D.

ORDER OF PROHIBITION

WHEREAS, Robert M. Levy, M.D., hereinafter referred to as "Licensee," currently holds Mississippi Medical License Number 15663, and said license is valid until June 30, 2018;

WHEREAS, due to a diagnosis and treatment for chemical dependency, on September 8, 2016, Licensee entered into a Recovery Contract Agreement with the Mississippi Physician Health Program, hereinafter "MPHP", and the Mississippi State Board of Medical Licensure, hereinafter referred to as the "Board," thereby imposing certain conditions and restrictions on Licensee in order to maintain his sobriety and insure his ability to practice with reasonable skill and safety to patients. A copy of the Recovery Contract Agreement is attached hereto as Exhibit "A";

WHEREAS, on June 12, 2018, the Board, received a letter, attached hereto as Exhibit "B", from the Department of the Veterans Affairs Medical Center, Fayetteville, Arkansas, advising the Board that there is substantial evidence that Licensee *"significantly failed to meet generally-accepted standards of clinical practice that constituted an imminent threat to patient welfare.";*

WHEREAS, on June 20, 2018, the Board received a letter, attached hereto as Exhibit "C", from the MPHP advising the Board that the MPHP could no longer provide advocacy for Licensee's continued practice of medicine, effective June 9, 2018;

is hereby **prohibited from practicing medicine** until such time as the Board and MPHP determine that Licensee is able to return to the practice of medicine. During any period of prohibition as provided herein, Licensee shall not seek renewal of his license.

IT IS FURTHER ORDERED, that a copy of this Order shall be sent by registered mail or personally served upon Robert M. Levy, M.D., and shall be effective immediately upon receipt thereof.

ORDERED this the 21st day of June, 2018.

Mississippi State Board of Medical Licensure

Kenneth E. Cleveland, M.D.
Executive Director

I, Leslie Ross, CMBI, CPM
personally served this
subpoena/summons on
Robert M. Levy, M.D.
This the 25th day of June, 2018.

evidence that Licensee *"significantly failed to meet generally-accepted standards of clinical practice that constituted an imminent threat to patient welfare."*

4. That on June 20, 2018, the Board received a letter from the MPHP advising the Board that the MPHP could no longer provide advocacy for Licensee's continued practice of medicine, effective June 9, 2018. The letter dated June 20, 2018, from Scott Hambleton, M.D., Medical Director of MPHP, stated in part;

> *"It is the opinion of the MPHC that Dr. Levy is not fit to practice medicine with reasonable skill and safety to the public, and that if he were to practice medicine at this time that it would represent an imminent threat to the public health".*

5. That Item No. 19 of the Recovery Contract Agreement with MPHP states, in part:

> **Breach of Contract and/or Relapse.** *The withdrawal of MPHP's advocacy may, in the MPHC's discretion, include the express authority of the MPHC and the MPHP to notify any entity or individual before whom there has been (or would have been) support on my behalf, including without limitation, the following concerned parties: any employer, my referent, appropriate insurers with whom the MPHP has established agreements, or with whom the MPHP has communicated or offered support on my behalf, credentialing entities, and possibly, the MSBML (or other relevant licensing boards). This agreement constitutes my irrevocable authorization to the MPHP and the MPHC to make such communications about the withdrawal of support.*

6. That by his signature and consent to the Recovery Contract Agreement, Licensee understands and recognizes the Board's authority to immediately prohibit Licensee from the practice of medicine. Specifically, Item No. 19 states, in part:

> **Breach of Contract and/or Relapse**. *In the event I should relapse or fail to comply with any of the conditions of this agreement, the MSBML shall have the authority, with recommendation from the MPHP/MPHC, to immediately prohibit me from practicing medicine until such time as the*

Mississippi Physician Health Program

Recovery Contract Agreement

Effective Date: 9.8.11

Name: Robert Wiley MPHP No. 0460

Practice Name: Veterans Healthcare of the Ozarks

Practice Address: 1100 N College Ave
Fayetteville, AR 72703

Specialty: pathology

Current Hospital Privileges: suspended

Exhibit "A"

408 West Parkway Place • Ridgeland, Mississippi 39157-6010 • Ph: 601-420-0240 • Fax: 601-707-3792
www.msphp.com

Required by MPHP | Initials

✓ RmL I shall provide to the MSBML a monthly work itinerary at the beginning of each month for the purpose of compliance with urine screen monitoring.

X RmL I agree to submit to polygraph testing, or provide hair or fingernail samples for analysis, if further verification of recovery and/or compliance is required, as directed by MPHP or MSBML, in addition to any other screens which may be obtained by other agencies. I understand the MSBML may receive a copy of any screens collected by the MPHP and reciprocally MPHP may receive a copy of screens from the Board.

X RmL I understand that I am responsible for all costs related to drug screening, whether at the request of the MSBML or MPHP and that failure to pay for screens is a violation of my contract.

X RmL 4. **Term.** I agree to the terms of this contract for the life of my medical practice, (hereinafter "Term"). I will abide by all stipulations in this contract and any subsequent recommendations of the Mississippi Physician Health Committee (MPHC)/MPHP during my continuing care/monitoring phase. Upon expiration of the Term, all requirements and conditions imposed by this contract will remain in full force and effect until such time as I personally appear before the MPHC for the purpose of discussing the status of my compliance and/or recovery, including extension, renewal or discharge from this contract.

X RmL Satisfaction of MPHP "Compliance" is determined at the sole discretion of MPHP/MPHC and my continued practice of medicine is contingent upon maintaining MPHP advocacy.

X RmL 5. **Providers.** I agree to notify MPHP in writing of the name and contact information of the following providers with-in 30 days of the date of this contract.

- X Primary Care Physician
- X Psychiatrist
- X Therapist
- X Physician Medication Monitor
- X Workplace Monitor, Immediate Supervisor, and/or Chief of Staff

X RmL I understand it is my responsibility to clear any and all medication prescribed by any provider through an approved Physician Medication Monitor.

X RmL I agree to a work site monitor as a condition of continuing advocacy. Said Monitor will send quarterly reports to the Medical Director regarding my ongoing progress. Examples of information reported include the following: appearance at work, any perceived problems, incident reports or other concerns. Said Monitor should have frequent contact with me, preferably be in

Required by MPHP Initials

X AnL 7. **Annual Retreat.** I agree to attend the Annual Caduceus Club Retreat and other special functions of the MPHP.

X AnL 8. **Reporting Requirements.** I agree to contact the office of the MPHP by phone at least once a month.

AnL 9. **Medical Release and Authorization.** I agree to provide appropriate release forms for urine drug screen results, treatment center records, therapist reports, and other written and verbal information required by MPHP to document my compliance with this contract.

X AnL I hereby authorize the treatment center wherein I received treatment for chemical dependency, its administrator, medical staff and personnel, or any other treatment center or hospital to release to the MPHP/MSBML all records of any treatment. Additionally, I shall provide the MPHP/ MSBML with authorization to obtain medical information for the purpose of monitoring or reviewing treatment or therapy that I have received from the treatment center. I agree and understand there must be a free flow of information to and from the MPHP and MSBML, necessary to ensure my compliance with this Agreement, but most importantly, to ensure my continued recovery. In this regard, I hereby agree to execute any other medical releases necessary to accomplish this goal. At anytime, the MPHP and MSBML may freely communicate with, via telephone, facsimile, or personal interview, any individual or entity involved in my treatment and/or recovery, including but not limited to, any employee and/or representative of MPHP/MSBML, any hospital or healthcare facility in which I have received treatment, any physician or other healthcare entity from which I have received medical and/or dental care, business associates, partners, friends and family. In so doing, I waive all privileges and rights to confidentiality, which I would otherwise possess with respect thereto. This release and authorization is specifically granted in compliance with 42 U.S.C. §290(dd-2) (Confidentiality of Record of the Identity, Diagnosis, Prognosis and Treatment of Substance Abuse Patients) and 42 C.F.R. Part 2 (Regulations for Confidentiality of Alcohol and Drug Abuse Patient Records).

AnL Any refusal on my part to execute a medical release deemed necessary to accomplish the above exchange of information or any act on my part, which may be interpreted by MPHP or MSBML as a revocation of a previously executed release shall be deemed a violation of this Agreement and shall be immediately reported to the MSBML.

X AnL 10. **Honest Disclosure.** I understand my ethical and contractual obligation to honestly and to completely answer all application questions regarding my recovery and participation with MPHP. Such questions may appear on

Required by MPHP Initials

X Am 17. **Financial Responsibility.** I agree to be responsible regarding my financial obligations. I understand MPHC considers financial responsibility, in general, an important element of recovery. Specifically, I accept my financial responsibility to MPHP, my licensure board, laboratory screening services, therapist, psychiatrists, etc. Further, treatment facilities often extend treatment to program participants on credit in an effort to assist them with their recovery and the opportunity to resume work. MPHP fully expects that any outstanding debt to treatment providers/organizations be satisfied in a responsible and timely manner.

X Am 18. **Subpoena for Records.** Unless directed otherwise by the Program Participant, MPHP/MPHC resists the release of subpoenaed participant records to the fullest extent of the law. I understand that I am financially liable for all MPHP/MPHC costs and attorney fees in such matters.

X Am 19. **Breach of Contract and/or Relapse.** I understand that any breach of this contract will be grounds for re-evaluation by the MPHP with an immediate report to the MSBML.

X Am I understand that if I experience a relapse, this fact shall be immediately reported by the MPHP to the Executive Director of the MSBML. Such report will include, or be followed by MPHP's response to the relapse and its recommendations regarding the relapse. I understand that MPHP's practice related recommendations regarding licensure/DEA issues are non-binding to the MSBML.

X Am In the event I should relapse or fail to comply with any of the conditions of this agreement, the MSBML shall have the authority, with recommendation from the MPHP/MPHC, to immediately prohibit me from practicing medicine until such time as the MSBML and MPHP determines that I am able to return to the practice of medicine. In so doing, the MSBML and MPHP may require me to undergo further evaluation.

X Am In the event of a relapse or violation of this agreement, any action by the MSBML may be deemed disciplinary action, and all documents relating thereto, including this agreement, shall thereafter be deemed public record and reportable to the Federation of State Medical Boards, the National Practitioner Data Bank and other entities requiring MSBML reporting.

X Am The withdrawal of MPHP's advocacy may, in the MPHC's discretion, include the express authority of the MPHC and the MPHP to notify any entity or individual before whom there has been (or would have been) support on my behalf, including without limitation, the following concerned parties: any employer, my referent, appropriate insurers with whom the MPHP has established agreements, or with whom the MPHP has communicated or offered support on my behalf, credentialing entities, and possibly, the MSBML (or

Required
by MPHP Initials

NOTE: Alterations of this contract cannot be made without prior written approval from the MPHP Medical Director and/or the MPHC.

Program Participant Date

MPHC Chairman 1/26/16 Date

Medical Director, MPHP 9/20/16 Date

Executive Director, MSBML 10/21/15 Date

TM\Contracts\StandardContAgmt
Rev. 12/13

Exhibit "A"

Mississippi Physician Health Program

June 20, 2018

Kenneth E. Cleveland, M.D.
Executive Director
MS State Board of Medical Licensure
1867 Crane Ridge Drive
Jackson, MS 39216

Dear Dr. Cleveland:

Re: Robert Levy, M.D.

I regret to inform you that Mississippi Physician Health Program (MPHP) will no longer provide advocacy for Dr. Levy's continued practice of medicine effective June 9, 2018.

As you recall, Dr. Levy is a 51-year-old pathologist living in Fayetteville, Arkansas. He had previously practiced at the Veterans Healthcare System of the Ozarks (Virginia Hospital) in Fayetteville, Arkansas, utilizing his Mississippi medical license. On March 22, 2016, he was suspected of being impaired in the workplace secondary to alcohol use and was referred to Pine Grove Behavioral Health by the Louisiana State Board of Medical Examiners (LSBME). He completed a comprehensive three-day evaluation at Pine Grove Behavioral Health on May 25, 2016, and was diagnosed with alcohol-use disorder, moderate severity, and determined to be not fit to practice. He was admitted to Pine Grove Behavioral Health for residential treatment on July 11, 2016, and discharged appropriately on October 8, 2016. At the time of his discharge, his diagnosis changed to alcohol-use disorder, severe. He was instructed to obtain advocacy from the Arkansas Medical Foundation Physician Health Program (Arkansas PHP) and MPHP. Dr. Levy executed a life-of-practice Recovery Contract Agreement with MPHP on September 19, 2016 and he executed a 5-year monitoring agreement with the Arkansas PHP on October 27, 2016. He appeared before the Mississippi Physician Health Committee on November 2, 2016 and was cleared to return to work.

The current status of Dr. Levy at the VA Hospital is unclear. His Louisiana medical license is inactive, and he does not have an Arkansas medical license. He previously utilized his Mississippi medical license to practice pathology at the VA Hospital. He reported that he was placed on administrative leave sometime last year and had not practiced pathology since that time.

Exhibit "C"

408 West Parkway Place • Ridgeland, Mississippi 39157-6010 • Ph: 601-420-0240 • Fax: 601-707-3792
www.msphp.com

BEFORE THE MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

IN THE MATTER OF THE PHYSICIAN'S LICENSE

OF

ROBERT BLAIR LEE, M.D.

DETERMINATION AND ORDER

THIS MATTER came on regularly for hearing on July 19, 2018, before the Mississippi State Board of Medical Licensure (hereinafter "Board"), pursuant to Title 73, Chapter 25 of Mississippi Code (1972) Annotated The Board initiated these proceedings on September 7, 2017, by issuance of a Summons and Affidavit against Robert Blair Lee, M.D., (hereinafter "Licensee") setting forth four (4) counts of violation of the Mississippi Medical Practice Act, namely, Count 1 - the suspension or other restriction posed on his license issued by the licensing authority of another state of jurisdiction; Count 2 - surrendering his license or authorization to practice medicine in another state or jurisdiction; Count 3 - being disciplined by a licensed hospital or medical staff said hospital; and Count 4 - unprofessional conduct likely to harm the public; in violation of Subsections (9), (10) and (8)(d) of Miss. Code Ann., § 73-25-29 and §73-25-83(c). Simultaneous with the issuance of the aforementioned Summons and Affidavit, the Board issued an Order of Temporary Suspension of Licensee pending the outcome of the hearing, then scheduled for September 21, 2017. Through a series of continuances, the matter was set for hearing this date.

Licensee was present at the July 19, 2018, hearing, represented by Honorable Mark Garriga and Ann Lundy. Complaint counsel for the Board was Honorable Stan T. Ingram. Sitting as legal advisor to the Board was Honorable Heather Wagner, Special Assistant Attorney General. Board members present for all proceedings were Claude D. Brunson, M.D., Charles D. Miles, M.D., Charles K. Lippincott, M.D., William D. McClendon, Jr., M.D., Michelle Y Owens, M.D., Jeanne Ann Rea, M.D., Allen Gersh, M.D and Kirk L. Kinard, D.O During the hearing, the Board considered evidence and testimony presented by Complaint Counsel and Licensee

Based upon the evidence and testimony presented, the Board renders the following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

1. Licensee was issued Mississippi Medical License Number 10711 on July 1, 1985, and is a physician duly licensed to practice medicine in the State of Mississippi, with said license (as currently suspended) current until June 30, 2019.

2. Licensee's primary specialty is Thoracic Cardiovascular Surgery and he lists his primary practice address as 3603 Bienville Blvd., Ste. 103, Ocean Springs, Mississippi.

3. On August 7, 2017, the Board received certified copies of disciplinary action taken against Licensee by the Kentucky Board of Medical Licensure. The records show that on April 4, 2017, the Kentucky Board of Medical Licensure, acting by and through its Inquiry Panel B, and after having considered this matter at its March 16, 2017, meeting issued a Complaint and an Emergency Order of

Restriction against Licensee. The Complaint charged Licensee with violation of Kentucky Revised Statutes (hereinafter "KRS") 311.595(21), that is, having been disciplined by a licensed hospital or medical staff of said hospital, including removal, suspension or limitation of hospital privileges.

4. The actions by the Kentucky Board were taken after Lourdes Hospital, Paducah, Kentucky, suspended Licensee's clinical privileges and medical staff appointment on April 14, 2016, pursuant to a recommendation from the Medical Executive Committee (MEC). Specifically, Licensee's suspension was "due to several issues including techniques used in surgeries and patient selection for surgeries (too complicated for resources available at Lourdes). The suspension was initiated after a culmination of the issues, including a death of a patient on the operating table."

5. Licensee requested and was granted a hearing pursuant to Lourdes Hospital's Credentials Policy. The Hearing Panel affirmed the recommendation by the MEC. As a result, Licensee's clinical privileges and medical staff appointment were terminated on November 28, 2016.

6. Pursuant to KRS 311.592 and 13B.125 (1) and based upon the information available to it, Inquiry Panel B of the Kentucky Medical Board found probable cause and legal basis to support the issuance of an Emergency Order of Restriction in that the Panel concluded that Licensee's practice constituted "a danger to the health, welfare and safety of his patients or the general public." Said

Order prohibited Licensee from performing or participating in any act which would constitute the "practice of surgery" until the resolution of the Complaint setting forth the allegations or until such further Order of the Kentucky Medical Board.

7. While the aforementioned Complaint by the Kentucky Board was pending, Licensee entered into an Agreed Order of Surrender on May 24, 2017, with the Kentucky Board, wherein Licensee voluntarily surrendered his Kentucky Medical License (No. 46919). By virtue of the Agreed Order of Surrender, Licensee stipulated and agreed that he had engaged in conduct which violated the provisions of KRS 311.595(21) and that there were legal grounds for the parties to enter into the Surrender. Pursuant to the terms of the Surrender, Licensee agreed not to engage in any act which would constitute the practice of medicine in the Commonwealth of Kentucky, subject to the right to petition for reinstatement after expiration of two (2) years, provided certain conditions are met, including but not limited to, a clinical skills assessment at the Center for Personalized Education for Physicians (CPEP). Licensee further agreed that any violation of the Agreed Order of Surrender would "constitute an immediate danger to the public health, safety or welfare".

8. On January 3, 2017, being prior to the Kentucky actions as set forth above, Licensee left the state of Kentucky and moved to Ocean Springs, Mississippi. For period of nine months, licensee practiced in Ocean Springs performing surgery at the Singing River Medical Center.

9. Following the summary suspension of licensure by the Mississippi Board on September 7, 2017, Licensee attempted to reinstate his Kentucky licensee through completion of the assessment at CPEP. Further, licensee submitted to multiple neuropsychological evaluations and multiple MRI's, all done in an effort to address Licensee's competency and ability to practice medicine with reasonable skill and safety to patients. Despite such efforts, the Kentucky Board declined reconsideration of his Kentucky license, citing the fact that the May 24, 2017, Agreed Order of Surrender extended him no such right until after expiration two (2) years (or May 24, 2019). During the hearing, the Board considered each and every assessment, but noted the fact that Licensee's certificate to practice medicine in Kentucky remained surrendered.

CONCLUSIONS OF LAW

Based upon the foregoing, the Board concludes that Licensee is guilty of Counts 1, 2, 3 and 4 of the September 7, 2017, Affidavit of Leslie Ross, and that the Board is authorized by Miss. Code Ann. Section 73-25-29 to suspend, revoke, restrict or refuse to reinstate Licensee's license to practice medicine in Mississippi, as a result of any one (1) of those violations.

IT IS THEREFORE, ORDERED that based upon the Findings of Fact and Conclusions of Law enumerated above, and after consideration of the evidence presented by way of oral testimony and documentation, that Licensee's certificate to practice medicine in the state of Mississippi shall remain suspended. At such time as Licensee secures reinstatement of his license in Kentucky, he shall have the right to petition the Board for reinstatement of his Mississippi medical license.

IT IS FURTHER ORDERED that Licensee shall reimburse the Board for all costs incurred in relation to this matter pursuant to Miss. Code Ann. Section 73-25-30. Licensee shall be advised of the total assessment by separate notification, and shall tender to the Board a certified check or money order on or before forty (40) days from the date the assessment is mailed to Licensee via U.S. mail at the address shown on file at the Board.

IT IS FURTHER ORDERED that pursuant to Miss. Code Ann. Section 73-25-27, a copy of this Determination and Order shall be sent by registered mail or personally served upon Licensee or his counsel.

SO ORDERED, this the 19th day of July, 2018.

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

BY: 

CLAUDE D. BRUNSON, M.D., PRESIDENT

Executive Session
Mississippi State Board of Medical Licensure
July 20, 2018

AGENDA ITEM: Hearing in the Case of Robert B. Lee, M.D., Ocean Springs, MS

Medical License Number: 10711

In a motion by Dr. McClendon, seconded by Dr. Owens, and carried, the Board elected to deny Dr. Lee's request to reinstate his Mississippi medical license upon resolution of his medical licensing issues in Kentucky. Dr. Lee may request reinstatement of his Mississippi medical license at that time.

	FOR	AGAINST	ABSTAIN	ABSENT
Claude D. Brunson, M.D.	X			
Ann Rea, M.D.	X			
W. David McClendon, M.D.	X			
Charles D. Miles, M.D.	X			
C. Ken Lippincott, M.D.	X			
Michelle Y. Owens, M.D.	X			
Kirk L. Kinard, D.O.	X			
Allen Gersh, M.D.		X		

Claude D. Brunson, M.D., President