Mississippi State Board of Medical Licensure Policies

3.01 Contact Lens Prescriptions

Because of the potential for eye damage in an unsupervised setting, contact lens prescriptions should be given to patients only when the physician has reason to believe that adequate follow-up evaluation will be performed by a physician or optometrist.
Adopted January 20, 1994.

3.02 Corporate Practice of Medicine

Due to increased interest in the area of managed care and integrated health care systems, the Mississippi State Board of Medical Licensure recently had an opportunity to reconsider its policy as to the corporate practice of medicine. After full consideration, it is the policy of this Board not to concern itself with the form or type of business arrangements entered into by a licensee, provided certain prerequisites are met, to-wit:

1. The physician employed or associated with the entity is licensed by the Board.
2. The method and manner of patient treatment and the means by which patients are treated are left to the sole and absolute discretion of the licensed physician. The provision of medical services and the exercise of sound medical judgment at all times shall be exercised solely in the discretion of the licensed physician and he or she shall not be subject to any influence, direct or indirect, to the contrary.
3. The manner of billing and the amount of fees and expenses charged to a patient for medical services rendered shall be left solely to the discretion of the licensed physician. It is recognized that when physicians choose to affiliate with an HMO, PPO or other managed care entity, some discretion as to fees and expenses is lost. Whenever possible, however, the manner of billing and the amount of fees and expenses charged to a patient for medical services rendered shall be left solely to the discretion of the licensed physician.
4. At no time shall a physician enter into any agreement or arrangement whereby consideration or compensation is received as an inducement for the referral of patients, referral of medical services or supplies or for admissions to any hospital.
5. The business arrangement and the actions of the physician in relation thereto, cannot be contrary to or be in violation of the Medicare or Medicaid Payment and Program Protection Act of 1987, 42 U.S.C. Section1320 (a-7)(b), commonly known as the "Medicare Anti-Kickback Statute"; the Anti-Kickback Act of 1986, 41 U.S.C. Section 5158, and related statutes, rules and regulations.
6. Free choice of physicians and hospitals is a right of every individual. One may select and change at will one's physician or hospital or may choose a medical care plan such as that provided by a closed panel or group practice or health maintenance organization (HMO) or service organization (PPO). While it is recognized that the choosing to subscribe to an HMO or PPO or accepting treatment in a particular hospital will result in the patient accepting limitations upon freedom of choice of

medical services, all physicians must recognize that situations will exist where patients will be best served by physicians or hospitals outside such contractual arrangements. If the HMO or PPO contract or other business arrangement does not permit referral to a non-contracting medical specialist, diagnostic or treatment facility or hospital, and the physician believes that the patient's best interest will be served by a specialist, facility or hospital outside of the contractual relationship, the physician has an ethical and contractual obligation to inform the patient of this fact. The physician should so inform the patient so that the patient may decide whether to accept the outside referral at his or her own expense or confine herself or himself to the services available within the HMO, PPO or other business arrangement.

7. Licensed physicians shall have the sole responsibility for approval of any and all public communications or advertisements, and these communications and/or advertisements must be in full compliance at all times with Board requirements relating to Physician Advertisements.
8. Pursuant to Miss. Code Ann. Section 79-10-31, shareholders of a professional corporation rendering medical services shall only be licensed physicians.

The above policy statement was adopted utilizing language set forth in the current opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (Sections 8.13 and 9.06).

Revised by the Board of Medical Licensure on May 16, 1996, and September 20, 2001.

3.03 Complementary and Alternative Medicine

Complementary and Alternative Medicine is those health care methods of diagnosis, treatment, or interventions that are not acknowledged to be conventional but that may be offered by some licensed physicians in addition to, or as an alternative to, conventional medicine, and that provide a reasonable potential for therapeutic gain in a patient's medical condition and that are not reasonably outweighed by the risk of such methods.

The Mississippi State Board of Medical Licensure is aware that an increasing and significant number of citizens of Mississippi are seeking complementary and alternative medicine in their health care. The Board recognizes that physicians are increasingly incorporating complementary and alternative medicine in their care of patients. The Board recognizes that innovative practices that could benefit patients and improve care should be given reasonable and responsible degrees of latitude. Abusive criticism of alternative practitioners and threats to their licensure solely because they offer their patients an integrated practice will not be tolerated. On the other hand, the Mississippi State Board of Medical Licensure is aware of the Attorney General’s findings that consumer fraud does occur in the practice of medicine. If consumer protection means anything, it should protect people weakened by illness from the dangers attendant to unsound, invalidated health practices. The Board is concerned with whether it is proper for physicians and providers to offer, agree to manage jointly or to accede to patient demands for alternative medicine that may not be particularly harmful, but for which

little or no proof of potential benefit exist. The Board feels that physicians and providers should never accede to invalidated treatments. The Board does believe that physicians may incorporate nonvalidated treatments if research results are very promising, if the physician believes that a particular patient may benefit, if the risk of harm is very low, and if the physician adheres to the conventions that govern the doctrine of informed consent for nonvalidated treatment. The Board will continue to protect the citizens of the State of Mississippi by:

1. Ensuring that licensees employ and document the medical model in their overall evaluation and treatment of the patient (i.e., history, physical, diagnosis, plan of treatment, and periodic assessment and follow up).
2. Ensuring that the licensee has the requisite training and skills to perform the particular procedure.
3. Ensuring that licensees honestly and fully explain the various procedures available for treatment of the particular condition, to include the risk and benefits of such treatment option or procedure.
4. Carefully scrutinizing any treatment which results in harm to the patient.

The Board believes this policy finds support in traditional ethical principles and is not outweighed by the competing principle of patient autonomy.

Adopted January 18, 2001.

3.04 Application Valid for One Year

It is the policy of the Mississippi State Board of Medical Licensure that an application is valid for 365 days from date of receipt. After 365 days, if applicant has not received a permanent Mississippi medical license, the application file will be considered obsolete and applicant will have to reapply for licensure, including, but not limited to, all fees, certifications, verifications and references.

Adopted January 18, 2001.

3.05 Continuing Medical Education Exemption for Physicians in a Residency or Fellowship Program

Physicians participating in an ACGME approved residency or fellowship program for at least one year of the two year CME period may be exempt from acquiring the required forty hours of CME for renewal.

Adopted April 18, 2002.

3.06 Unreferred Diagnostic Screening Tests

It is the opinion of the Mississippi State Board of Medical Licensure that any medical act that results in a written or documented medical opinion, order or recommendation that potentially affects the subsequent diagnosis or treatment of a patient constitutes the practice of medicine in this state. Further, any physician who renders such a medical opinion, order or recommendation assumes a doctor-patient relationship with that patient and is responsible for continuity of care of that patient. Failure to provide this continuity of care will be deemed to be unprofessional conduct. The obligation to insure continuity

of care does not apply in those instances where the physician rendering the medical opinion, order or recommendation has been called in by another treating physician solely for consultation purposes.

Adopted July 18, 2002. Amended January 15, 2003.

3.07 Internal Medicine/Pediatrics Combined Programs Accreditation

Information received from ACGME indicates that "combined programs" in Internal Medicine/Pediatrics are not accredited. It is the policy of the Board of Medical Licensure to accept these programs as accredited when both the internal medicine program and pediatrics program are independently accredited by the ACGME for training in each area.

Adopted September 18, 2002.

3.08 USMLE Step 3 Application and Fees

Mississippi rules and regulations require physicians making application with the Federation of State Medical Boards to sit for USMLE Step 3 in Mississippi to make application for a permanent Mississippi medical license. It is the policy of the Board of Medical Licensure that physicians requesting licensure by examination to submit an USMLE Step 3 permanent medical licensure application along with a $50 non-refundable fee. The $50 non-refundable fee will be applied to the $500 licensure fee once the application process has been completed. An applicant for USMLE Step 3 permanent medical licensure has one year from the application received date in which to pass Step 3, complete the licensure process and pay the remainder licensure fee of $450. All applicants passing Step 3 but otherwise not meeting this deadline will have to reapply for permanent Mississippi medical licensure and pay the $500 licensure fee. Physicians failing to pass USMLE Step 3 will not have to submit a new application for licensure to the Board if they reapply to sit for USMLE Step 3 within one year from the last sitting date, but will be required to pay a $25 file reactivation fee for each time file has to be reactivated. The $25 file reactivation fee will not be applied to the $500 licensure fee.

Adopted September 18, 2002.

3.09 Re-Licensure After Surrender of Medical Licensure

Upon surrender of a medical license, whether reportable or non-reportable, the physician must submit his original licensure wall certificate and current wallet card. At the time of surrender, the physician's license will become null and void.

In the event a physician, who has surrendered his/her medical license, later desires to return to the practice of medicine in Mississippi, the physician must reapply for licensure on the same basis as though he/she never held a Mississippi medical license. Stated differently, the physician is then deemed an original applicant and will be subject to all laws and regulations governing applicants for licensure, including, but not limited to, completion of an application, proof of competency where required, verification that there are no statutory grounds for licensure denial, payment of all fees, and submission of all required certifications, verifications and references. Once the physician's application

for licensure is completed the physician will be notified of his appearance date before the Board for re-licensure consideration.
Adopted March 19, 2003.

3.10 Research Fees

It is the policy of the Board of Medical Licensure to supply individuals who request information regarding their ancestors, a copy of the ancestor's medical license. There is no charge involved when there is one to five pages. If information for more than two physicians is requested, a research fee of $25 will be accessed along with the copy charge of $.50 per page.
Adopted March 19, 2003.

3.11 Final Sanctions by the Department of Health and Human Services for Default on Student Loans

Any and all final sanctions against a physician by the Department of Health and Human Services for default on a student loan will be considered unprofessional conduct, as referred to in Section 73-25-29, (8), and as such, subject to formal, disciplinary action.
Adopted June 17, 2003.

3.12 Medical Assistants

It is ethical for a physician to work in consultation with or employ allied health professionals, as long as they are appropriately trained to perform the activities being requested.

Physicians have an ethical obligation to the patients for whom they are responsible to insure that medical and surgical conditions are appropriately evaluated and treated.

Physicians may teach in recognized schools for the allied health professionals for the purpose of improving the quality of their education. The scope of teaching may embrace subjects which are within the legitimate scope of the allied health profession and which are designed to prepare students to engage in the practice of the profession within the limits prescribed by law.

It is inappropriate to substitute the services of an allied health professional for those of a physician when the allied health professional is not appropriately trained to provide the medical services being requested.

The physician is the one ultimately responsible for all care given and should adhere to the following:

1. The physician should never delegate a task beyond the education and training of the medical assistant.

2. Direct and proper supervision should be provided at all times, which means that the physician should be in the clinic at all times during which the medical assistant is providing care.
3. The physician should advise his insurance carrier of the fact that he utilizes a medical assistant.
4. The medical assistant should never hold himself or herself out as either a physician, physician assistant, or nurse. When on duty, medical assistants shall at all times wear a name tag, placard or plate identifying themselves as medical assistants.

Adopted June 17, 2004.

3.13 Exemptions From Licensure (Team Physicians)

Mississippi licensure is not required for physicians employed by a sports entity visiting Mississippi for a specific sporting event when the physician holds an active medical or osteopathic license in another state and limits the practice of medicine in Mississippi to medical treatment of the members, coaches, and staff of the sports entity that employs the physician.

Adopted November 9, 2006.

3.14 Policy of the Mississippi State Board of Medical Licensure as to the Confidentiality of Pending Disciplinary Matters

It is the policy of the Mississippi State Board of Medical Licensure to ensure the confidentiality of patient information and maintain the integrity of the investigative process. Accordingly, complaints received by the Board and any documents pertaining to pending disciplinary investigations and charges, including but not limited to summons issued by the Board, affidavits, and answers, shall be deemed confidential and shall not be released to the media or general public. The period of confidentiality shall end, however, upon the happening of any of the following events, hereinafter “public event”, to-wit:

1. Upon the accused licensee executing a written release authorizing disclosure.
2. Upon the accused licensee making any public statement or disclosure about a disciplinary proceeding then pending.
3. The disciplinary matter has been resolved by entry of a consent or agreed order, disciplinary in nature, and duly executed by licensee.
4. A public hearing has been conducted before the Board or its Executive Committee.

After a public event has occurred, the media and/or public shall be entitled to all public records as defined in the Public Records Act, codified as Miss. Code Ann. Sections 25-61-1 to 25-61-17. For the purpose of this policy, public records shall include all complaints, pleadings, exhibits, and disciplinary orders provided the identity of any patient or victim shall not be released without the express written consent of the patient/victim.

In the event an investigation is concluded without initiation of disciplinary action or charges are later dropped after initiation of disciplinary proceedings, all records of said investigation and proceedings shall remain confidential.

Unless placed into evidence at hearing, confidential investigative reports are not deemed public records.

Notwithstanding the above, orders of temporary action pending a disciplinary hearing entered pursuant to authority granted by Miss. Code Ann. Sections 73-25-63 or 73-25-89, shall be deemed public record when served on the licensee.

Nothing in this policy shall prohibit the release of information to any licensee or licensee's designated attorney pursuant to discovery as provided in Section 600 of the Board's Rules of Procedure.

Any member of the Board, its attorney, agents, employees, and staff shall have authority to share information with law enforcement officials or other administrative board or agency actively participating in an investigation concerning any alleged violation by a licensee of any federal or state law, rule or regulation.
Adopted January 19, 2006.

3.15 Administration of Botox Injections
(A Joint Policy by the Mississippi State Board of Medical Licensure and the Mississippi State Board of Nursing)
The Joint Committee of the Mississippi State Board of Medical Licensure (MSBML) and the Mississippi Board of Nursing (BON) has determined that the appropriately prepared Nurse Practitioner (NP) can administer Botox injections provided:

1. The NP is educated and competent in the use of Botox and the procedure being performed. This education and competence must be documented initially and on an ongoing basis;
2. The collaborative physician is educated in the use of Botox;
3. The NP's protocol addresses the administration of Botox;
4. The collaborative physician has examined the patient and documented the patient's chart approving the use of Botox; and
5. The NP practices according to generally accepted standards of practice.

Adopted September 20, 2007.

3.16 Policy for the Sale of Goods from Physician Offices

1. Due to the potential for patient exploitation in the sale of goods, physicians should be mindful of appropriate boundaries with patients, should avoid coercion in the sale of goods in their offices, and should not engage in exclusive distributorship and/or personal branding;

2. Physicians should make available disclosure information with the sale of any goods in order to inform patients of their financial interests;
3. Physicians may distribute goods free of charge or at cost in order to make such goods readily available; and
4. Physicians may make available for sale in their offices durable medical goods essential to the patient's care and non-health related goods associated with a charitable organization.

Adopted November 8, 2007.

3.17 Closing a Physician's Practice

When a physician ceases to practice, whether by relocation, retirement, disability, or death, certain obligations are due the patients of the physician. If relocation to another site in the same patient area, the problems are mainly logistical and making sure the patients know about the move. If leaving a partnership or group practice, the physicians remaining should not unduly hinder patient inquiries as to the location of the departing physician. Patients of the departing physician should be informed of the physician's new address and offered the opportunity to have their medical records sent to the departing physician at the new practice location. It is unethical to withhold such information upon a patient's request. If the closing is planned, as in the case of retirement, relatively few problems should be expected. However, if the closing is unexpected as in the case of disability or death, the situation is traumatic and full of problems that require quick solutions and answers.

Medical Records

One major problem that always arises when it becomes necessary to move or close a physician's office is what to do with patient records. Since these are important and confidential documents, they must be carefully preserved in some manner. If a physician is leaving the area and is in a partnership or group practice, it is customary to leave the records in the possession of the partners or group. If the physician is staying in the area, it is common practice to divide the records in some equitable manner. Most legal authorities are of the opinion that the medical records are the property of the partnership or group and not the individual physician. It is, however, the right of the patient to determine where the records or a copy of the records should go. Therefore, whether by relocation, retirement, disability or death, the patient should be advised of the right to have the medical records sent to the physician of their choice. Notification can be accomplished by a sign in the reception area, a note in the monthly billing statement, or an advertisement in a local newspaper. It is not advisable to turn the original records over to the patient. Charges to the patient are acceptable and few patients will object to a minimum charge for this service. It is considered less than professional to charge another treating physician for a copy of the patient's medical records. In any event, the records should not be unduly delayed.

Patient Notification

1. For patients under current care; i.e., taking a prescribed medication that requires refill or having a prescheduled treatment or examination, special attention must be to notifying as quickly as possible that the physician is no longer available and that immediate arrangements for care need to be made. For those scheduled in the next 14 days, a phone call works best. Others may be notified by direct mail.
2. A letter in the monthly billing statement may be used. A notice of 30 days is considered reasonable time.
3. Referral to an appropriate physician for care may be in order.
4. A notice in a newspaper of general circulation for 3 or 4 weeks will notify past and present patients and the general public of the closing of the practice and the availability of medical records.

Adopted July 10, 2008.

3.18 Ending the Physician-Patient Relationship

Once a physician-patient relationship has begun, the physician is under both an ethical and legal obligation to provide services as long as the patient needs them. There may be times, however, when a physician may no longer be able to provide care. It may be that the patient is noncompliant, unreasonably demanding, threatening, or otherwise contributing to a breakdown of the relationship. The decision to terminate the relationship must be made by the physician alone.

Regardless of the situation, to avoid a claim of "patient abandonment", a physician must follow appropriate steps to terminate the physician-patient relationship. A physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable notice and sufficient opportunity to make other arrangements for care. A physician who does not terminate the relationship properly may be charged with unprofessional conduct.

Appropriate steps to terminate the physician-patient relationship include:

1. Giving the patient or patient's representative written notice, which may be by certified mail, return receipt requested, or other reasonable proof. A copy of the letter should be included in the medical record.
2. Providing the patient with a brief and valid reason for terminating the relationship.
3. Agreeing to continue to provide care for a reasonable period of time (at least 30 days) in order to allow the patient to obtain care from another physician.
4. Providing recommendations to help the patient locate another physician of like specialty.
5. Offer to transfer records to the new physician upon signed authorization and include an authorization form with the letter.
6. A physician assistant or nurse practitioner may not independently terminate the physician-patient relationship.

Adopted July 10, 2008.

3.19 Residents and Fellows

A physician in training (resident or fellow) may not enter into a relationship (collaborate or supervise) with a mid-level provider (APRN or PA) even though they may have an unrestricted license to practice in Mississippi.

Adopted November 13, 2013.

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).

Adopted July 19, 2018.