



Alabama Board of Medical Examiners Newsletter and Report

www.albme.org

January – March 2008

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Board offers recommendations for weight loss programs

by Edward C. Facundus, MD*

Concomitant with the dramatic rise of obesity in Alabama is an increase in obesity-related comorbidities that require medical treatment. Our experience as well as documentation in the literature shows that maintaining a healthy weight reduces and/or eliminates these comorbidities. Many physicians have implemented weight loss programs within their practices for this reason. Additionally, free standing weight loss clinics have emerged as a popular method for weight management. Because the Board has encountered problems related to the medical supervision and management of weight control, the following recommendations are suggested to ensure the standard of care is met.

Good medical practice requires that all new patients have a complete history and physical examination. In addition to the usual medical history, the record would include and document previous and current weight loss programs, diet medications, exercise regimens, previous weight loss surgery and any changes in dietary requirements. Prior to prescribing diet medications, a work history should be obtained to verify
(continued on page 3)

*Dr. Facundus is a board certified general surgeon, with an emphasis in bariatric surgery, practicing in Huntsville, Alabama. He has been a member of the Board of Medical Examiners since 2004.



Edward C. Facundus, MD

Matters to consider when using online communication with patients

by J. Allen Meadows, MD*

The advent of almost limitless medical information available on the Internet and the opportunity for online communication with patients presents both opportunities and challenges. Patients may spend hours of research on the Internet, reading information that,



J. Allen Meadows, MD

in many cases, is incorrect or unsuitable for their disease. By appropriate means physicians can turn this wealth of information into a positive force for their patients.

Many physicians have developed a Web site for their patients' access. Correctly used, these sites can provide accurate information, either written by their physician or through reference to sources that their physician trusts. In several national surveys, patients overwhelmingly prefer to receive their medical information from
(continued on page 4)

*Dr. Meadows is a board certified allergist with a practice in Montgomery, Alabama. He served on the Board of Medical Examiners from 2002 to 2004 and currently serves on the Board of Directors of Medem.

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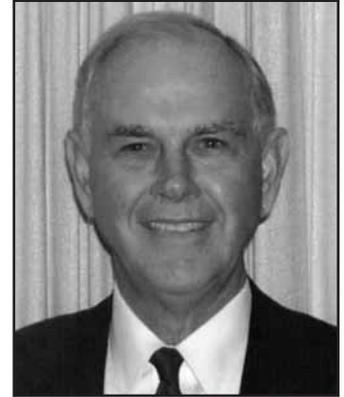
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**A Message from the Executive Director
Annual report of the Alabama BME**

by Larry Dixon

The 2007 Annual Report of the Alabama Board of Medical Examiners indicates a modest decrease in the number of physicians newly licensed in Alabama. There were 616 approved applicants by endorsement and 157 approved applicants by examination, 29 fewer approved applicants than in 2006. For your information, the following annual report has been compiled by the Board and its staff:



Larry Dixon

**Alabama Board of Medical Examiners
Annual Report – 2007**

Applicants Certified To Medical Licensure Commission

- 1. Applicants by endorsement616
- 2. Non-disciplinary Citation with Administrative Charge4
- 3. Applicants by examination157

Applicants Certified For Limited License95

Applicants Taking SPEX Examinations

- 1. Applicants passing examinations15
- 2. Applicants failing examinations5

Advanced Practice Nurses (CRNP/CNM)

- 1. Certified Registered Nurse Practitioner Collaborations Approved.....799
- 2. Certified Nurse Midwife Collaborations Approved.....6

Physician Assistants

- 1. Physician Assistants Licensed47
- 2. Physician Assistants Registered to Physicians (new applications)181
- 3. Physician Assistants Granted Temporary Licensure19
- 4. Temporary Licensure Converted to Full Licensure (after passing exam) .14
- 5. Temporary Licensees Granted Registration18
- 6. Anesthesiologist Assistants Licensed3
- 7. Anesthesiologist Assistants Granted Temporary License.....0
- 8. Anesthesia Assistants Registered to Physicians (new applications)3

ACSC Issued/Renewed11,233

Disciplinary/Confidential Actions

- 1. ACSC Surrender / Revocation / Restriction / Reinstatement0
- 2. Certificates of Qualification Denied / Surrendered.....7
- 3. Certificates of Qualification with Agreements / Restrictions2
- Certificate of Qualification Restrictions Terminated1
- 4. Letters of Concern113
- 5. Patient Complaints Received597
- 6. Patient Complaints Investigated.....416

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Weight loss clinics

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no contraindications to the selected drug. In addition, no controlled medications

may be prescribed before the physician has performed a physical exam. Further, the patient's psychiatric history must be reviewed, including drug or alcohol dependency. The patient's body mass index (BMI) is included in the physical exam. **As with all medical practice encounters, appropriate medical records must be kept.**

Once this information has been gathered in the history and the documentation of obesity verified by the physical examination, the physician can review weight management recommendations. The plan should be more than just the prescription of pharmaceutical agents; it should

include diet, activity and exercise within the patient's limitations. Discussing the diet plan is not simply handing out a fact sheet; it requires educating the patient about why the diet is important and encouragement to follow the plan.

When appropriate, the physician may need to obtain a nutritionist referral. If physical limitations preventing a self-monitored exercise regimen exist, consider a consultation with a physical therapist. If there is a suggestion of an eating disorder, a psychiatric evaluation is appropriate.

Do not prescribe amphetamines or other weight loss medications for patients who do not qualify according to the published

manufacturer's indication and usage guidelines. If the physician considers diet medications necessary to treat the patient, consider the interaction of these medications with other prescribed and OTC drugs. Further, follow the indications and contraindications for the medications according

to published FDA guidelines. Individualize dosing and length of treatment. **If medications are considered for a patient with addictive potential, obtain appropriate initial and follow-up**

No controlled medications may be prescribed before the prescribing physician has performed a physical exam.

drug screens.

The chart notation on every follow-up visit must include a brief review of the patient's diet, activity and exercise. A brief exam, with BMI, is performed. New recommendations can be made based on the success or failure of these findings. Adverse events due to medications must be charted.

Free standing weight loss clinics should work within the medical community. **If medications are prescribed, the prescribing physician must assume primary care of the patient or formally collaborate with the patient's primary care physician.**

Refer to the Prescription Drug Monitoring Database when prescribing controlled substance diet medications. This reference may aid in identifying patients who are abusing or diverting drugs.

See the Newsletter Links section of www.albme.org for links to the following resources:

- [FDA – links to amphetamine prescribing information](#)
- [Obesity drug information](#)
- [Prescription Drug Monitoring Program](#)

Annual Report

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7. Other Complaints Investigated.....	110
8. Investigations Completed.....	431
9. Collaborative Practice Inspections.....	89
10. Collaborative Practice Compliance Seminars.....	10
11. Office Based Surgery Site Inspections.....	0
12. Interviews Conducted.....	62
13. Complaints filed with Medical Licensure Commission.....	24
14. Evaluations Ordered.....	6
15. Voluntary Agreements Entered Into.....	5
Voluntary Agreements Removed.....	3
16. Voluntary Restrictions Entered Into.....	1
Voluntary Restrictions Removed.....	1
17. Flag file for Reinstatement.....	5
18. Impaired Physician Coordinator Monitoring.....	63
Number monitored since 1990.....	797
19. Requested CME Course Attendance.....	20
20. Sent for Expert Review.....	10
21. Administrative Fines Assessed (MLC).....	11
22. Summary Suspensions.....	2
23. Summary Suspensions – Revocation.....	0
24. Summary Suspensions – Pending a Hearing before the MLC.....	2
25. Summary Suspensions – Dismissed.....	0
26. Voluntary Surrender of Alabama Medical License.....	2

Online communication continued from page 1

one source: their own doctor. Providing these resources satisfies the patient's need to search and reduces the chance that the patient will obtain information from alternative Internet sources that may give erroneous or misinterpreted data.

In addition to Internet references, facts about medical conditions, written by the physician or Web links to reliable references, can be placed on the site. The printed educational handouts given to patients in the office can be available on the Web site. Some physicians have even recorded videos of their important patient education talks; patients can review the discussion after they leave the office and at any time in the future.

Providing helpful, up-to-date information online can assist patients with other types of information, such as office or clinic hours, holidays, how to access care after hours, unexpected closures for the facility, etc. It is also a venue for sending data to patients about health concerns in the community, the availability or lack of flu vaccine, etc. If there is a drug recall, the physician can post information about the recall.

For this Web site to be effective, it cannot become stagnant; it must be frequently updated. The physician must be familiar with what is posted on the site. Although an employee or a contract company may maintain and update it, the physician is ultimately responsible for the content.

Many patients express an interest in having a physician with whom they can communicate online. Giving patients a physician's personal e-mail address is fraught with potential unintended consequences, including violations of liability carrier guidelines ("[eRisk Guidelines](#)") and violations of HIPPA regulations, both of which require certain security measures when communicating health information by electronic means. When it became evident that online communication with patients

was increasing, the AMA, in cooperation with state medical boards and liability carriers, created the eRisk Guidelines for online communications with patients ([AMA Guidelines for Physician-Patient Electronic Communications](#)). A number of commercially available entities facilitate online communication with patients and follow these national guidelines.

If a physician utilizes electronic communication with patients, it is important to know that:

- (1) The rules of the Alabama Board of Medical Examiners ([Contact with Patients before Prescribing](#)) emphasize that online communication is a supplement to, not a substitute for, personal visits;
- (2) This service should be offered only to existing patients within a state in which the physician has an active medical license; and

- (3) Physicians who choose to have online communications with their patients must have systems in place to ensure that this communication supplements existing in-person relationships. A suggestion for verifying communication with an existing patient is to require registration for the Web site; an employee in the physician's office confirms that the registration is from a current patient before online communication is initiated.

As mentioned above, the Web site must have security measures that conform, at a minimum, to the eRisk Guidelines and the HIPPA requirements.

Becoming popular with patients is the development of a personal health record (PHR) to facilitate connecting patients with their doctors. PHRs are different from electronic medical records: the PHR is owned and maintained by the patient, and the patient can grant or deny PHR access to any physician deemed necessary. PHRs have value in that they can provide the physician with a complete review of the patient's history and medications list, decreasing the likelihood of missed communication through forgetfulness and, if the PHR is on the physician's computer, targeted information can be sent to patients with specific diseases.

See the Newsletter Links section of www.albme.org for resources about online communication with patients.

- [eRisk Guidelines](#)
- [AMA Guidelines for Physician-Patient Electronic Communications](#)
- [Alabama BME Rules](#) (scroll down to section.11)

Physicians can turn this wealth of information into a positive force for their patients.

For this Web site to be effective, it cannot become stagnant.

Your Medical License

As a physician, your license to practice medicine in the State of Alabama is one of your most important assets. It allows you to apply what you learned during years of school and post-graduate training to earn a livelihood to support your family.

Exercise care to protect this asset.

Rules you should know concerning medical records

One brief article cannot cover all of the requirements for good medical records. But, familiarity with the rules of the Board of Medical Examiners and Medical Licensure Commission that concern medical records is important for every physician licensed by the state of Alabama.

Joint Guidelines for Medical Records Management

In 1998, the Board and Commission adopted rules for medical records management. ([Board of Medical Examiners Administrative Rule 540-X-9-.10](#); [Medical Licensure Commission](#)

[Administrative Rules, 545-X-4-.08](#)). The first, and obvious, rule is that physicians shall maintain legible, well documented records reflecting the history, findings, diagnosis and course of treatment in the care of a patient.

Although this is an understandable requirement, the Board sees many patient records that are missing some or all of these provisions.

The legibility and completeness of the record are especially important when transferring records to another physician or when providing requested copies to the Board or to your liability insurance carrier. There have been instances where a physician's handwriting was so illegible that even he had difficulty reading it.

The joint guidelines state that medical records should be maintained *for such period as may be necessary to treat the patient and for such additional time as may be required for medical-legal purposes.*

The Medical Association of the State of Alabama (MASA) recommends retaining records for a minimum of 10 years. Also, it is prudent to confer with your liability insurance carrier and abide by its recommendations.

In the joint guidelines, the Board and Commission mandate that *upon a patient's request and authorization, the physician should provide a copy or summary of the medical record to the patient or to another physician, attorney or other person designated by the patient.*

Alabama state law allows the physician to require that the requester pay reasonable copying charges before releasing the copies except in an emergency. A physician must not refuse to release copies of records based on unpaid bills for medical services.

The applicable law sets the reasonable cost for copying

as not exceeding \$1 per page for the first 25 pages and 50 cents per page for each page in excess of 25, a search fee of \$5, and the actual cost of mailing. In addition, the actual cost of reproducing x-rays or other special records may be included. **Physicians charging for the cost of reproducing medical records should give primary consideration to the ethical and professional duties owed to other physicians and to their patients, and should waive copying charges when appropriate.**

When a physician retires, terminates employment or

otherwise leaves a medical practice, he or she is responsible for ensuring that active patients receive reasonable notification and are given the opportunity to arrange for the transfer of their medical records. The departing physician is not required to prepare the notification but is responsible for seeing that it is properly done. Most physicians accomplish the notification by mailing letters to active patients and by entering announcements in public places, such as local newspapers. A physician partner or physician group may not withhold from a departing physician information necessary for the notification. Upon the death of a physician, the estate should notify active

patients and provide enough information for the patient to obtain a copy of the medical record or have it transferred to another physician.

Minimum Standards for Medical Records

In 2004, the Medical Licensure Commission adopted a rule concluding that the maintenance of adequate medical records is an integral part of good medical care. ([Medical Licensure Commission Administrative Rules, 545-X-4-.06](#)) Adequate records are necessary to ensure continuity of care, not only by the physician who maintains a particular

record, but by other medical professionals. The rule states that every physician licensed to practice medicine in Alabama shall maintain for each patient a record which, in order to meet the mini-

mum standard for medical records, shall:

- Be legible and written in English;
- Contain only those terms and abbreviations that are or should be comprehensible to other medical professionals;
- Contain adequate identification of the patient;

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Medical records should be maintained for such period as may be necessary to treat the patient and for such additional time as may be required for medical-legal purposes.

A physician must not refuse to release copies of records based on unpaid bills for medical services.

Medical records

continued from page 5

- Indicate the date any professional service was provided;
- Contain pertinent information concerning the patient's condition;
- Reflect examinations, vital signs, and tests obtained, performed or ordered and the findings or results of each;
- Indicate the initial diagnosis and the patient's initial reason for seeking the physician's service;
- Indicate the medications prescribed, dispensed or administered and the quantity and strength of each;
- Reflect the treatment performed or recommended;
- Document the patient's progress during the course of treatment; and
- Include all patient records received from other health care providers, if those records formed the basis for a treatment decision by the physician.

Physicians should comply, within a reasonable time, with a proper request for medical records.

Failure to competently manage medical records

In its rule defining "unprofessional conduct," the Commission sets out four examples that concern medical records ([Medical Licensure Commission Administrative Rules, 545-X-4-.09](#)):

- Refusing to comply, within a reasonable time, with a request from another physician for medical records or information when the request is accompanied by a properly executed patient authorization;
- Intentionally, knowingly or willfully causing or permitting a false or misleading representation of a material fact to be entered on any medical record of a patient;
- Intentionally, knowingly or willfully preparing, executing or permitting the preparation by another person of a false or misleading report or statement concerning the medical condition or extent of a disability of a patient; and
- Failing or refusing to maintain adequate records on a patient or patients.

Other considerations

MASA's [Medical Records Policy](#) contains valuable information concerning medical records issues and is a good resource for physicians. For example, there is frequently a question about how to handle the transfer of records from other health care providers, hospital admissions and discharge summaries, and other medical information not generated by the transferring physician: should these records be included in a copy provided to a patient or transferred to another physician? According to MASA's

Medical Records Policy there is no clear cut precedent to provide guidance in this area, and there is a difference of opinion among knowledgeable experts. The general view is that a physician should transfer, with the patient's authorization, any **medical** information in the patient's record that is pertinent to the patient's medical history and/or to any ongoing course of treatment. Records that should not be forwarded include confidential financial information, treatment records from drug or alcohol programs, and records concerning sexually transmitted or other notifiable diseases.

Another good source of information on medical records issues is the AMA's [Code of Medical Ethics](#). It covers such topics as access by non-treating medical staff, sale of a medical practice and retention of medical records.

[HIPAA](#), (the Health Insurance Portability and Accountability Act) sets national standards for the privacy of healthcare records. For more information concerning HIPAA, a good place to start is the [AMA's HIPAA resource page](#). Also see [DHHS Office for Civil Rights](#) – the official central governmental hub for all HIPAA issues.

See the Newsletter Links section of www.albme.org for links to the following resources:

- [Board of Medical Examiners Administrative Rules, 540-X-9-.10](#) (scroll down to section .10).
- [Medical Licensure Commission Administrative Rules, 545-X-4-.08](#) (scroll down to section .08), *Joint Guidelines of the State Board of Medical Examiners and Medical Licensure Commission for Medical Records Management*.
- [Medical Licensure Commission Administrative Rules, 545-X-4-.06](#) (scroll down to section .06), *Unprofessional Conduct*.
- [Medical Licensure Commission Administrative Rules, 545-X-4-.09](#) (scroll down to section .09), *Minimum Standards for Medical Records*.
- [The Medical Association of the State of Alabama's Medical Records Policy](#).
- [The American Medical Association Council on Ethical and Judicial Affairs' Code of Medical Ethics](#).
- [AMA's HIPAA resource page](#).
- [DHHS Office for Civil Rights](#).

Utilization of mid-level practitioners

In January 2008, the Board adopted an amendment to its administrative rule 540-X-7-.26, "Limitations Upon Utilization of Physician Assistants." This rule allows a physician, whether in a surgical or a non-surgical specialty, to supervise a cumulative total of 120 hours per week. The cumulative total includes the services of **all** mid-level practitioners, i.e., certified registered nurse practitioners (CRNPs), certified nurse midwives (CNMs) and physician assistants (PAs). The supervising/collaborating physician has the responsibility to be aware of and to maintain the documentation for each

registered/collaborating mid-level practitioner. Even when the CRNP, CNM or PA is employed by a third party, the supervising/collaborating physician is responsible for the quality of care provided by the mid-level practitioner. Documentation of the registration agreement(s)/collaborative practice agreement(s) must be maintained at every practice site for reference and to document how many hours the mid-level practitioner and the physician are eligible to work together. Also, this document will contain information about the scope of practice and any additional duties

requested and approved.

The registration and collaborative practice agreements authorize supervision/collaboration between the mid-level practitioner and covering physicians under specific circumstances. For physician assistants, a covering physician must be in the same partnership, group, medical professional corporation or physician practice foundation as the primary physician or be an individual with whom the primary physician regularly shares call. The covering physician must practice in the same medical specialty as the primary supervising physician.

Medicare requires use of National Provider Identifiers

On March 1, 2008, doctors electronically billing Medicare were required to include their National Provider Identifier (NPI) on all claims in addition to any older identification numbers they may have been using. The program has allowed physicians to use their older identifiers alone while they obtained new NPIs. After May 23, 2008, physicians are required to use only NPIs on all electronic claims submitted to Medicare and all other health care payers. The deadlines don't apply to physicians who file only paper claims, but those who send their claims to a clearinghouse that files electronically on their behalf must comply. For more information see the Centers for Medicare and Medicaid Services Web page on [Medicare NPI Implementation](#). (Print readers see the Newsletter Links section of [www.albme.org](#).)

Office-based surgical procedures

In 2003, the Board adopted rules governing surgical procedures performed in a physician's office or clinic (outside a hospital or outpatient facility licensed by the Department of Public Health). In this rule, "surgery" is defined as "the revision, destruction, incision or structural alteration of human tissue performed using a variety of methods and instruments." If you perform such procedures in your office or clinic, you should thoroughly read and comply with these administrative rules. See the Board's web page concerning [office-based surgery](#). (Print readers see Newsletter Links section at [www.albme.org](#).)

Physicians performing office-based surgery using moderate or deep sedation/analgesia (as defined in the rules) must meet the requirements of the rules, including registration with the Board and maintaining certain equipment and supplies. Physicians must be able to document satisfactory completion of training, such as being Board certified or being an active candidate for certification by a Board approved by the American Board of Medical Specialties or having comparable formal training. **Alternative credentialing for procedures outside the physician's core curriculum must be approved by the Alabama Board of Medical Examiners after application to the Board.** The physician and at least one assistant must be trained in and current in Advanced Cardiac Life Support.

www.albme.org

The following forms are available on the BME's Web site:

- Retired Senior Volunteer license application
- CME worksheet
- Request for waiver from CME due to retirement
- Address change form
- Application for replacement of lost or destroyed license
- Malpractice payment report form for insurance companies
- Dispensing physician registration form
- Office based surgery registration form
- Office based surgery adverse event reporting form
- Laser/pulsed light device procedures registration form
- Laser/pulsed light device procedure adverse event reporting form
- Notification of commencement or termination of collaborative practice
- Collaborative practice QA forms, chart review audits

Signature requirements for prescriptions

by Ed Munson, Jr., Senior Investigator

Recent inquiries to the Board indicate that there is a great deal of confusion among physicians about what is considered to be an appropriate and legally produced prescription. The confusion has not been confined to controlled substance prescriptions. This article, compiled from Board of Medical Examiners and Board of Pharmacy rules and regulations, deals with prescriptions that originate from hand written (hard copy) prescriptions, e-scripts, computer generated and faxed prescriptions, as well as verbally ordered (phone in) prescriptions.

Written prescriptions include any physician-authorized prescriptions that are not transmitted from computer to computer (“e-scripts”) or verbally issued. A prescription originating from a computer and manually hand faxed (not electronically e-faxed) to the pharmacy is considered

a written prescription. Among other requirements, written prescriptions must contain the two lines, “Dispense as written” and “Product selection permitted,” with a signature above one of them. Pharmacists may refuse to fill prescriptions that do not meet Pharmacy Board and Board of Medical Examiners guidelines ([Board of Medical Examiners Rule 540-X-4-.05](#)).

A written prescription with manual signature that conforms with the guidelines and is handed to the patient is acceptable for any prescription, whether for controlled or non-controlled drugs.

A written prescription with a manual signature that conforms with the guidelines and is manually hand faxed to a pharmacy is acceptable for all prescriptions except those for Schedule II drugs. Only a written prescription with original signature is acceptable for prescriptions for

Schedule II medications. Prescriptions for hospice and long term care facility patients (so noted as HOSPICE or LTC on the prescription) shall have the manually hand faxed prescription signature serve as the original.

A computer-generated prescription with a manual signature that conforms with the guidelines and is printed at the office and manually hand faxed to a pharmacy is acceptable for all prescriptions except those for Schedule II drugs.

A computer-generated prescription with an electronic or stamped signature that conforms with the guidelines and is electronically transmitted (e-faxed) directly from the physician’s office computer to the pharmacy fax machine is acceptable only for non-controlled drugs. Acceptable prescriptions for Schedules III through V must be printed in the office, manually signed and given to the patient or

(continued on page 9)

	Sched II	Sched III	Sched IV	Sched V	Legend
Written Rx, Original Signature, Handed to Patient					
Written Rx, Original Signature, Manually faxed to pharmacy	❖				
Written Rx, Stamped signature, Manually faxed to pharmacy					
Computer generated Rx, Printed in office, Original signature, Manually faxed to pharmacy	❖				
Computer generated Rx, Printed in office, Original signature, Handed to Patient					
Computer generated Rx, Printed in office, Electronic signature, Manually faxed to pharmacy					
Computer generated Rx, Electronic signature, Electronically faxed (E-faxed) to pharmacy					
Verbal order for Rx	◆				
E-prescription (physician’s computer to pharmacist’s computer) ●					

Shaded boxes = meets requirements

❖ HOSPICE labeled Schedule II prescriptions allow for a faxed signature to serve as the original signature

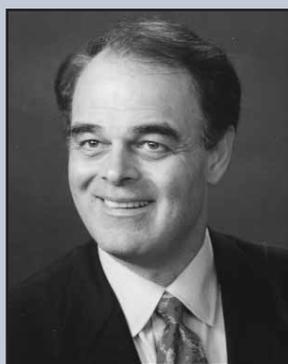
◆ Emergency 72-hour verbal rule for HOSPICE Schedule II prescriptions

● No exceptions for controlled, scheduled drugs

Meet the Board

James G. Chambers, III, MD, is a family practice physician with a private practice in Huntsville since 1975, and he holds active privileges at Huntsville Hospital. After he earned his bachelor's degree at the University of Alabama, Tuscaloosa, and his medical degree from the University of Alabama School of Medicine, he completed his residency training at Baptist Medical Center in Birmingham.

Dr. Chambers has been a member of the Madison County Medical Society since 1975, the American Academy of Family Practice, and the Alabama Academy of Family Practice since 1978. Between the years of 1998-2008 his list of medical activities grew to include the State Committee of Public Health and the Board of Medical Examiners. Dr. Chambers currently serves as Chairman of the Board of the Medical Scholarship Program and a member of the UAB Medical Alumni



James G. Chambers, III, MD



James G. Davis, MD

Association Board of Trustees. At the 2007 MASA Annual Session in Birmingham, Dr. Chambers was privileged to be sworn into the position of President of MASA by his son, Jimmy, currently enrolled at the UAB School of Medicine.

James G. Davis, MD, an orthopedic surgeon in private practice in Birmingham, has been a member of the Board of Medical Examiners since 2006. He received his bachelor's degree from the University of Alabama, Tuscaloosa, and his medical degree from the University of

Alabama School of Medicine. After finishing his internship at Carraway Methodist Hospital in Birmingham, he completed a four year orthopedic surgery residency at the University of Alabama at Birmingham. Before entering private practice in 1981, he served as Chief of the Department of Orthopedic Surgery at Cooper Green Hospital. He is certified by the American Board of

Orthopaedic Surgery and holds active privileges at St. Vincent's Hospital, Cooper Green Hospital and Birmingham VA Hospital. Dr. Davis is also a Fellow of the American Academy of Orthopaedic Surgeons and served on the Board of Directors and as Alabama's Councilor to the AAOS. He is a past president of the Alabama Orthopaedic Society and served as the Executive Director of the AOS from 1992-2007. For the year 2005, he was the President of the Jefferson County Medical Society.

Signature requirements

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physically faxed from the physician's office fax machine. Again, Schedule II prescriptions are acceptable only with an original signature.

Any prescription refill authorizations or communication for prescriptions must contain all the appropriate legal requirements of a prescription, including the prescribing physician's signature.

Verbal orders are physician-authorized telephone communications with a pharmacy for prescriptions or pharmacy-generated refill authorizations. Verbal orders are acceptable for all medication prescriptions except those for Schedule II drugs. (If there is an emergency Schedule II prescription

verbal order needed for a HOSPICE or LTC patient, the amount prescribed can only be for a 72-hour emergency period of time. The emergency Schedule II prescription must follow with a handwritten prescription for only the emergency prescribed amount within seven days of the request to the pharmacy.) It is important to make a note in the patient's medical record that the prescription or refill was authorized verbally and by whom.

E-scripts, where a computer-generated prescription is transmitted directly from the physician's computer to a pharmacy's computer, must conform with Board of Pharmacy requirements (*Board of Pharmacy Rule 680-X-2-.32*) and is acceptable for non-controlled drug prescriptions only. The e-script must include certain information and

must be transmitted over an e-script network **approved by the Pharmacy Board** and include security and authenticity measures. Physicians desiring to use e-prescribing methods must submit certain information to the Pharmacy Board and obtain prior approval by contacting Ms. Joyce C. Altsman, RPh, at jaltsman@albop.com or (205) 981-2280.

See the Newsletter Links section of www.albme.org for links to the following resources:

- [Board of Medical Examiners Rule 540-X-4-.05, Prescription Guidelines](#)
- [Board of Pharmacy Rule 680-X-3-.10, Facsimile Prescription Drug Orders for Controlled Substances](#)
- [Board of Pharmacy Rule 680-X-2-.32, Prescriptions by Electronic Means](#)

Meet the Staff – Board Investigators

In the most recent *Board Newsletter and Report*, you met Jim Nichols, the Board's Chief Investigator, and Ed Munson, Jr., Senior Investigator. The Board employs five additional investigators:

Mr. Randy Dixon joined the Board as an investigator in 2004, following his retirement from the City of Montgomery where he worked for 25 years. He began his career with the city in 1979 as a police officer in the patrol division and subsequently spent time in the traffic and administrative divisions. In 1997, Mr. Dixon achieved the rank of police major. In 1998, he was transferred to the Mayor's office where he was promoted to the position of Executive Assistant to the Mayor.

Mr. Jeff Grimsley became an investigator with the Board in May 1999. Prior to his employment with the Board, Mr. Grimsley worked for the Montgomery Police Department for 21 years, beginning in the patrol division, moving to the detective division, and then, after being shot on duty by an escaped prisoner, as lieutenant over the Community Service Bureau.

Mr. Stan Ingram has been employed as an investigator with the Board since July 1999. He began his career as a police officer with the Montgomery Police Department, work-

ing in various divisions, including a number of years in the investigative division. After 20 years of service, Mr. Ingram retired from the police department and became a probation officer with the Alabama Pardons and Paroles Board before joining the Board of Medical Examiners. He received a bachelor's degree in criminal justice from Auburn University and is a graduate of the F.B.I. National Academy.

In March 2004, the Board employed **Mr. David McGilvray** as an investigator after he retired from the Montgomery Police Department following 21 years of service. Mr. McGilvray attained his bachelor's and masters degrees in criminal justice from Auburn University, is a graduate of the F.B.I. National Academy and was an Adjunct Professor at Troy University for seven years. He is also a veteran of the Marine Corps.

Mr. Edwin Rogers is the Board's most recently employed investigator, being hired in November 2007. He was previously an investigator with a national insurance company where he worked after retiring with 20 years of service from the Montgomery Police Department. Mr. Rogers is a graduate of Huntington College in Montgomery where he received a bachelor's degree in business.

Tact, sympathy and understanding are expected of the physician, for the patient is no mere collection of symptoms, signs, dis-ordered functions, damaged organs and disturbed emotions. He is human, fearful and hopeful, seeking relief, help, and reassurance. To the physician, as to the anthropologist, nothing human is strange or repulsive. The misanthrope may become a smart diagnostician of organic disease but he can scarcely hope to succeed as a physician. The true physician has a Shakespearian breath of interest in the wise and the foolish, the proud and the humble, the stoic hero and the whining rogue. He cares for people.

– Tinsley R. Harrison, MD

Do you collaborate with a certified nurse practitioner?

If you have a collaborative practice agreement with a Certified Registered Nurse Practitioner, be aware that it is under your medical license that the CRNP practices. Even if the CRNP works in a group setting, with only one physician as the primary collaborator, it is that physician's license that authorizes the CRNP to practice.

If the collaborating physician leaves the group or otherwise changes jobs but the CRNP does not go to the new practice, the collaborative agreement remains active until the physician notifies the Board of its dissolution.

Thus, even though the physician is no longer in the same practice with the CRNP, if the agreement has not been terminated, then that physician remains responsible for any unauthorized performance by the CRNP and the actions and decisions of the CRNP, and risks a Board action for non-compliance with Board rules concerning collaborative practices.

Actions taken against physicians for improper Internet prescribing

According to the Federation of State Medical Boards' *Rx Beat*, the newsletter for the National Clearinghouse on Internet Prescribing, the Drug Enforcement Agency revoked the DEA certificates for Richard Carino, MD, (not an Alabama licensee) for approving controlled substance prescriptions over the Internet while working for iPharmacy.MD.

A decision was recently handed down by the 8th U.S. Circuit Court of Appeals sentencing retired surgeon Thomas Hanny, MD, (not an Alabama licensee), to 33 months in prison for authorizing Internet drug sales without any examination of patients.

From September through November 2007, the medical boards of California, Florida, Indiana, Rhode Island, Texas and Virginia took actions against physicians for prescribing medicine via the Internet, including probation, suspension, reprimands, fines and a voluntary surrender in lieu of further investigation.

New York physician Ana Maria Santi, MD, (not an Alabama licensee), received a two-year jail sentence plus one year of house confinement and two additional years of supervised probation for issuing thousands of prescriptions for HGH and steroids to clients she never met.

Report of Public Actions of the Medical Licensure Commission and Board of Medical Examiners

Medical Licensure Commission January 2008

◆ On Jan. 23, the Commission entered an Order temporarily suspending the license to practice medicine of **James C. O'Brien, MD**, license number MD.7085, Killen, AL, until such time as the Board's Administrative Complaint shall be heard and a decision rendered thereon.

◆ On Jan. 30, the Commission entered an Order terminating all conditions previously imposed on the license to practice medicine in Alabama of **Joel C. Bolen, MD**, license number MD.20157, Montgomery, AL.

◆ On Jan. 30, the Commission entered an Order reinstating the license to practice medicine in Alabama of **Richard D. Price, MD**, license number MD.23525, Birmingham, AL.

Board of Medical Examiners January 2008

None.

Medical Licensure Commission February 2008

◆ On Feb. 19, upon the Stipulation of

the parties, the Commission reprimanded the license to practice medicine in Alabama of **Edward I. Lammons, MD**, license number MD.5532, Phenix City, AL, and assessed an administrative fine.

Board of Medical Examiners February 2008

None.

Medical Licensure Commission March 2008

◆ On March 3, the Board entered an Order reprimanding the license to practice medicine or osteopathy in Alabama of **Lisa A. Florence, DO**, license number DO.920, Southside, AL, and assessing an administrative fine.

◆ On March 3, the Commission entered an Order revoking the license to practice medicine in Alabama of **Lawrence R. Jellinek, MD**, license number MD.23229, Santa Barbara, CA.

◆ On March 26, upon the stipulation of the parties, the Commission entered a Consent Order reprimanding the license to practice medicine in Alabama of **Muhammad W.S. Ali, MD**,

license number MD.22219, Jasper, AL, assessing an administrative fine, and prohibiting the performance of echocardiograms and specifying to what facilities patients may be referred.

◆ On March 26, upon the stipulation of the parties, the Commission entered a Consent Order reprimanding the license to practice medicine in Alabama of **Russell Dean Ulrich, DO**, license number DO.47, Piedmont, AL, assessing an administrative fine, placing the license on probation and limiting his prescribing authority.

◆ On March 26, the Commission found that the voluntary surrender of the certificate of qualification and license to practice medicine in Alabama of **James C. O'Brien, MD**, license number MD.7085, Florence, AL, signed on Feb. 28, 2008, satisfactorily resolved all pending issues in the Administrative Complaint and therefore ordered that the Administrative Complaint be dismissed.

Board of Medical Examiners March 2008

None.



Alabama State Board of Medical Examiners

Newsletter and Report

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Change of Address

Alabama law requires that every licensed physician notify the Board of Medical Examiners in writing within **15 days** of a change of the physician's practice location address and/or mailing address.