STATUTES

- **Controlled Substances Act** (No provisions found)
  Title 53. Food, Drugs, and Cosmetics; Chapter 11. Narcotic Drugs and Drug Control

- **Professional Practice Act**
  Chapter 61. Professional and Occupational Licenses; Article 1. Uniform Licensing

- **Medical Practice Act**
  Title 63. Professions and the Healing Arts; Chapter 6. Medicine and Surgery

- **Intractable Pain Treatment Act** (Part of Medical Practice Act)
  Title 63. Professions and the Healing Arts; Chapter 6. Medicine and Surgery; Part 11. Intractable Pain Treatment

- **Osteopathic Practice Act**
  Title 63. Professions and the Healing Arts; Chapter 9. Osteopathic Physicians

- **Pharmacy Practice Act** (No provisions found)
  Title 63. Professions and the Healing Arts; Chapter 10. Pharmacy

REGULATIONS

- **Controlled Substances Regulations**
  No policy found

- **Medical Board Regulations**
  Rules of the Tennessee State Board of Medical Examiners; Division of Health Related Boards

- **Osteopathic Board Regulations**
  Rules of the Tennessee State Board of Osteopathic Examination

- **Pharmacy Board Regulations** (No provisions found)
  Rules of the Tennessee Board of Pharmacy

OTHER GOVERNMENTAL POLICIES

- **Medical Board Policy Statement**
RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- **Criminal Offenses**
  Title 39. Criminal Offenses; Chapter 13. Offenses Against Person; Part 2. Criminal Homicide

- **Standards for Hospitals**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-1. Standards for Hospitals

- **Standards for Nursing Homes**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-6. Standards for Nursing Homes

- **Standards for Residential Hospices**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-15. Standards for Residential Hospices

- **Standards for Home Care Organizations Providing Hospice Services**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-26. Standards for Home Care Organizations Providing Hospice Services

- **Standards for Home Care Organizations Providing Home Health Services**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-26. Standards for Home Care Organizations Providing Home Health Services

- **Standards for HIV Supportive Living Facilities**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-28. Standards for HIV Supportive Living Facilities

- **Standards for Home Care Organizations Providing Professional Support Services**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-34. Standards for Home Care Organizations Providing Professional Support Services

- **Standards for Outpatient Diagnostic Centers**
  Rules of the Tennessee Department of Health and Tennessee Department of Environment and Conservation; Bureau of Manpower and Facilities; Division of Health Care Facilities; Chapter 1200-8-35. Standards for Outpatient Diagnostic Centers
## Provisions that may ENHANCE pain management

<table>
<thead>
<tr>
<th>Criteria</th>
<th>1</th>
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<td>Controlled substances are necessary for public health</td>
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<td>Other provisions that may enhance pain management</td>
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### STATUTES

- Controlled Substances Act¹
- Professional Practice Act
- Medical Practice Act²
- Intractable Pain Treatment Act
- Osteopathic Practice Act²
- Pharmacy Practice Act²

### REGULATIONS

- Controlled Substances Act²
- Medical Board
- Osteopathic Board
- Pharmacy Board¹

### OTHER GOVERNMENTAL POLICIES

- Medical Board Policy Statement

### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- Criminal Offenses
- Standards/Hospitals
- Standards/Nursing Homes
- Standards/Hospices
- Standards/Home Care Orgs - Hospice Services
- Standards/Home Care Orgs - Home Health Services
- Standards/HIV Supportive Living Facilities
- Standards/Home Care Orgs - Prof. Support Services
- Standards/Outpt Diagnostic Ctrs

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Note: A dot indicates that one or more provisions were identified
¹ No provisions were found in this policy, ² No policy found
## Provisions that may IMPEDE pain management

<table>
<thead>
<tr>
<th>Criteria</th>
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<td><strong>Opioids are a last resort</strong></td>
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<td><strong>Medical decisions are restricted</strong></td>
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<td><strong>Length of prescription validity is restricted</strong></td>
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<td><strong>Provisions that are ambiguous</strong></td>
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- Medical Practice Act
- Intractable Pain Treatment Act
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- Pharmacy Practice Act¹

### REGULATIONS
- Controlled Substances²
- Medical Board
- Osteopathic Board
- Pharmacy Board¹

### OTHER GOVERNMENTAL POLICIES
- Medical Board Policy Statement

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- Standards/Hospitals¹
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- Standards/Hospices¹
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- Standards/Home Care Orgs - Prof. Support Services¹
- Standards/Outpt Diagnostic Cts¹

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¹ No provisions were found in this policy, ² No policy found
**TENNESSEE STATUTES**

**Professional Practice Act**

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

**Tenn. Code Ann. § 63-1-102**

63-1-102. Chapter definitions

(2) "Practice of the healing arts" means offering or undertaking to diagnose, treat, operate on, or prescribe for any human pain, injury, disease, deformity, or physical or mental condition. The practice of acupuncture is hereby declared to be included within the definition of "practice of the healing arts" as defined by this section; and

**Tenn. Code Ann. § 63-6-214**

63-6-214. Grounds for license denial, suspension or revocation -- Reporting misconduct

(b) The grounds upon which the board shall exercise such power include, but are not limited to:

(12) Dispensing, prescribing or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical infirmity or disease, or in amounts and/or for durations not medically necessary, advisable or justified for a diagnosed condition;

(13) Dispensing, prescribing or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the habit of using controlled substances without making a bona fide effort to cure the habit of such patient;

**CRITERION 2:**

Pain management is part of medical practice

**CRITERION 12:**

Medical decisions are restricted

**CRITERION 16:**

Provisions that are ambiguous

**CATEGORY A:**

Arbitrary standards for legitimate prescribing

**COMMENT:** Implies that there is a limit on the amount of controlled substances that can be prescribed or dispensed, but that limit is not specified.

**COMMENT:** Tennessee law does not seem to create an exemption for patients with pain and a history of addiction.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
63-6-1103. Legislative declarations

The general assembly finds and declares all of the following:

1. The state has a right and duty to control the illegal use of opiate drugs.
2. Inadequate treatment of acute and chronic pain originating from cancer or noncancerous conditions is a significant health problem.
3. For some patients, pain management is the single most important treatment a physician can provide.
4. A patient suffering from severe chronic intractable pain has the option to request that the goals of pain treatment should extend beyond pain scores, to include improvements in patient functioning and quality of life.
5. To the complexity of their problems, many patients suffering from severe chronic intractable pain may require referral to a physician with expertise in the treatment of severe chronic intractable pain. In some cases, severe chronic intractable pain is best treated by a team of clinicians in order to address the associated physical, psychological, social, and vocational issues.
6. In the hands of knowledgeable, ethical, and experienced pain management practitioners, opiates administered for severe acute and severe chronic intractable pain can be safe.
7. Opiates can be an accepted treatment for patients in severe chronic intractable pain who have not obtained relief from any other means of treatment.
8. A patient suffering from severe chronic intractable pain has the option to request or reject the use of any or all modalities to relieve such patient's severe chronic intractable pain.
9. A physician treating a patient who suffers from severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve severe chronic intractable pain as long as the prescribing physician is in conformance with the provisions of this part.
10. A patient who suffers from severe chronic intractable pain has the option to choose opioid medication for the treatment of the severe chronic intractable pain as long as the prescribing physician in conformance with the provisions of this part.
11. The patient's physician may refuse to prescribe opioid medication for a patient who requests the treatment for severe chronic intractable pain. However, that physician shall inform the patient that there are physicians whose primary practices are the treatment of severe chronic intractable pain with methods that include the use of opiates.

[CONTINUED ON NEXT PAGE]
**Intractable Pain Treatment Act**

63-6-1104. Pain patient's bill of rights

a) This section may be known and cited as the "Pain Patient's Bill of Rights."

b) A patient suffering from severe chronic intractable pain has the option to request or refuse the use of any or all modalities in order to relieve such patient's severe chronic intractable pain.

c) A patient who suffers from severe chronic intractable pain has the option to choose opioid medications to relieve severe chronic intractable pain without first having to submit to an invasive medical procedure, which is defined as surgery, destruction of a nerve or other body tissue by manipulation, or the implantation of a drug delivery system or device, as long as the prescribing physician acts in conformance with the provisions of this part.

d) The patient's physician may refuse to prescribe opioid medication for the patient who requests a treatment for severe chronic intractable pain. However, that physician shall inform the patient that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opioids.

e) A physician who uses opioid therapy to relieve severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve severe chronic intractable pain, as long as that prescribing physician is in conformance with this part.

f) A patient may voluntarily request that such patient's physician provide an identifying notice of the prescription for purposes of emergency treatment or law enforcement identification.

g) Nothing in this section shall do either of the following:

1) Limit any reporting or disciplinary provisions applicable to licensed physicians and surgeons who violate prescribing practices or other provisions set forth in this chapter or the regulations adopted thereunder; or

2) Limit the applicability of any federal statute or federal regulation or any of the other statutes or regulations of this state that regulate dangerous drugs or controlled substances.

[CONTINUED ON NEXT PAGE]
63-6-1105. Physician authorized to write prescriptions

Notwithstanding any other provision of law, a physician may prescribe or administer dangerous drugs or controlled substances to a person in the course of the physician’s treatment of a person for intractable pain to provide adequate pain treatment.

63-6-1106. Disciplinary action against physicians

a) No physician may be subject to disciplinary action by the board for prescribing or administering appropriate amounts, combinations, or durations of dangerous drugs or controlled substances in the course of treatment of a person for intractable pain.

b) The board is authorized to set by rule guidelines to govern treatment under this part. Such guidelines may include requirements for documented medical history, written treatment plans, discussion of benefits and risks of the treatment, periodic review, and the keeping of appropriate records. Such guidelines may be in addition to specific requirements for persons with substance abuse issues governed by § 63-6-1107.

63-6-1107. Treatment of chemically dependent individuals

a) Notwithstanding any other provision of this part, subsections c and d shall govern the treatment of persons for chemical dependency by a physician because of their use of dangerous drugs or controlled substances.

b) The provisions of this part provide no authority to a physician to prescribe or administer dangerous drugs or controlled substances to a person for other than legitimate medical purposes as defined by the board and who the physician knows or should know to be using drugs for nontherapeutic purposes.

c) The provisions of this part authorize a physician to treat a patient who develops an acute or chronic painful medical condition with a dangerous drug or a controlled substance to relieve the patient’s pain using appropriate doses, for an appropriate length of time, and for as long as the pain persists. A patient under this subsection includes a person who:

1) Is a current drug abuser;
2) Is not currently abusing drugs but has a history of drug abuse; or
3) Lives in an environment that poses a risk for drug misuse or diversion of the drug to illegitimate use.

d) A physician who treats a patient under subsection c shall monitor the patient to ensure the prescribed dangerous drug or controlled substance is used only for the treatment of the patient’s painful medical condition. To ensure that the prescribed dangerous drug or controlled substance is not being diverted to another use and the appropriateness of the treatment of the patient’s targeted symptoms, the physician shall:

1) Specifically document the:
   A) Understanding between the physician and patient about the patient’s prescribed treatment;
   B) Name of the drug prescribed;
   C) Dosage and method of taking the prescribed drug;
   D) Number of dose units prescribed; and
   E) Frequency of prescribing and dispensing the drug; and
2) Consult with a psychologist, psychiatrist, expert in the treatment of addictions, or other health care professional, as appropriate.

[CONTINUED ON NEXT PAGE]
63-6-1109. Use of physician’s assistants or other personnel – Licensing – Continued

a) Any physician who practices pain management shall also be able to hire physician assistants to assist such physician’s in such physician’s practice. Any of these assistants shall be a licensed physician assistant according to the requirements in § 63-19-105(a) except for any person who meets the following requirements:

(1) Is sixty-five (65) years of age or older;
(2) Was granted a degree in pre-medical studies in 1960;
(3) Was granted a master of science degree from the University of Tennessee in 1991;
(4) Was an instructor and assistant professor during the time period 1977-97 at East Tennessee State University in Surgical Technology;
(5) Was an instructor in surgical techniques and instruments to medical students and surgical residents at the Quillen College of Medicine at East Tennessee State University;
(6) Met the standards and qualifications of the American Association of Physician Assistants in March of 1976 and was rated as “physicians assistant – SP-2”;
(7) Satisfactorily completed the postgraduate course “clinical skills for physicians’ assistants V” in September 1977 from the Hahnemann Medical College and Hospital in Philadelphia, Pennsylvania:
(8) Held an “assistants renewal certificate” issued by the Virginia Board of Medicine from July 1, 1977, to June 30, 1978; and
(9) Was recognized as a “certified surgical assistant” by the National Surgical Assistant Association in May of 1987.

b) Such person shall be issued a license within sixty (60) days upon submission of evidence to the board of medical examiners that such person met all of the above criteria; provided, however, that such person shall only work under the supervision of one (1) physician who is in the sole practice of pain management and rehabilitation medicine. Such person’s duties shall only include helping the physician examine the patients in the physician’s office, doing diagnostic EMGs, ordering appropriate lab x-ray studies, seeing the physician’s hospital patients on hospital rounds and writing orders to be countersigned by such physician, but, at no time shall this person be allowed to prescribe medicine. Such person shall also have the ability to work under a physician, who is in the sole practice of pain management and rehabilitation medicine, while performing extensive medical missionary trips in underprivileged countries. Any continuing education requirements for a person meeting the above criteria shall not be waived.
TENNESSEE STATUTES

Osteopathic Practice Act

63-9-111. Denial, suspension and revocation of licenses or certificates -- Enjoining violations -- Enforcement -- Investigations

(a) The board has the power to:

(1) Deny an application for a license to any applicant who applies for the same through reciprocity or otherwise;
(2) Permanently or temporarily withhold issuance of a license;
(3) Suspend or limit or restrict a previously issued license for such time and in such manner as the board may determine;
(4) Reprimand or take such action in relation to disciplining an applicant or licensee as the board in its discretion may deem proper; or
(5) Permanently revoke a license.

(b) The grounds upon which the board shall exercise the powers set forth in subsection (a) include, but are not limited to:

(12) Dispensing, prescribing or otherwise distributing to any person a controlled substance or other drug if such person is addicted to the habit of using controlled substances without making a bona fide effort to cure the habit of such patient.

(-) CRITERION 12: Medical decisions are restricted

CATEGORY A: Restrictions based on patient characteristics
TENNESSEE

REGULATIONS

Medical Board Regulations
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

Tenn. Comp. R. & Regs. R. 0880-2-14

0880-2-14 SCOPE OF PRACTICE

(1) Policy Statement - The scope of practice of physicians in Tennessee is broadly defined and includes many aspects which if not particularly regulated could lead to serious ramifications for the consuming public. This rule is to designate specific areas in the practice of medicine for regulation the violation of which may result in disciplinary action pursuant to either T.C.A. §§ 63-6-214(b)(1) or 63-6-214(b)(4) or 63-6-214(b)(12).

(2) Pharmaceutical Dispensing - Physicians who elect to dispense medication for remuneration must comply with the following:

(d) Dispensing or prescribing controlled substances in amounts or for durations not medically necessary, advisable or justified is considered to be practicing beyond the scope of the professional practice.

(6) Authority of Physician to Prescribe for the Treatment of Pain - Purpose - The purpose of this chapter is to recognize that some dangerous drugs and controlled substances are indispensable for the treatment of pain, and are useful for relieving and controlling many other related symptoms that patients may suffer. It is the position of the board that these drugs may be prescribed for the treatment of pain and other related symptoms after a reasonably based medical diagnosis has been made, in adequate doses and for appropriate lengths of time, which in some cases may be as long as the pain or related symptoms persist. The board recognizes that pain, including intractable pain, and many other related symptoms are subjective complaints and that the appropriateness and the adequacy of drug and dose will vary from individual to individual. The practitioner is expected to exercise sound medical judgment in treating pain and related symptoms with dangerous drugs and controlled substances.

(a) Definitions. The following words and terms, as used in this rule shall have the following meanings in the context of providing medications for pain and related symptoms.

1. Abuser of narcotic drugs, controlled substances and dangerous drugs - A person who takes a drug or drugs for other than legitimate medical purposes.

2. Intractable pain - 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.

3. Non-therapeutic in nature or manner - A medical use or purpose that is not legitimate.

4. Prescribing pharmaceuticals or practicing consistent with the public health and welfare - Prescribing pharmaceuticals and practicing medicine for a legitimate medical purpose in the usual course of professional practice.

(b) Guidelines - The Tennessee Board of Medical Examiners will use the following guidelines to determine whether a physician’s conduct violates T.C.A. § 63-6-214 (b)(12) through (14) in regard to the prescribing, administering, ordering, or dispensing of pain medications and other drugs necessary to address their side effects.

[CONTINUED ON NEXT PAGE]
1. The treatment of pain, including intractable pain, with dangerous drugs and controlled substances is a legitimate medical purpose when done in the usual course of professional practice.

2. A physician or surgeon duly authorized to practice medicine in Tennessee and to prescribe controlled substances and dangerous drugs in this state shall not be subject to disciplinary action by the board for prescribing, ordering, administering, or dispensing dangerous drugs or controlled substances for the treatment and relief of pain, including intractable pain, in the usual course of professional practice for a legitimate medical purpose in compliance with applicable state and federal law.

3. Prescribing, ordering, administering, or dispensing dangerous drugs or controlled substances for pain will be considered to be for a legitimate medical purpose if based upon accepted scientific knowledge of the treatment of pain, including intractable pain, not in contravention of applicable state or federal law, and if prescribed, ordered, administered, or dispensed in compliance with the following guidelines where appropriate and as necessary to meet the individual needs of the patient:

(i) After a documented medical history, which may be provided orally or in writing by the patient, and physical examination by the physician providing the medication including an assessment and consideration of the pain, physical and psychological function, any history and potential for substance abuse, coexisting diseases and conditions, and the presence of a recognized medical indication for the use of a dangerous drug or controlled substance;

(ii) Pursuant to a written treatment plan tailored for the individual needs of the patient by which treatment progress and success can be evaluated with stated objectives such as pain relief and/or improved physical and psychological function. Such a written treatment plan shall consider pertinent medical history and physical examination as well as the need for further testing, consultations, referrals, or use of other treatment modalities;

(iii) The physician should discuss the risks and benefits of the use of controlled substances with the patient or guardian;

(iv) Subject to documented periodic review of the care by the physician at reasonable intervals in view of the individual circumstances of the patient in regard to progress toward reaching treatment objectives which takes into consideration the course of medications prescribed, ordered, administered, or dispensed as well as any new information about the etiology of the pain;

(v) Complete and accurate records of the care provided as set forth in parts (i)-(iv) of this paragraph should be kept. When controlled substances are prescribed, names, quantities prescribed, dosages, and number of authorized refills of the drugs should be recorded, keeping in mind that pain patients with a history of substance abuse or who live in an environment posing a risk for medication misuse or diversion require special consideration. Management of these patients may require closer monitoring by the physician managing the pain and consultation with appropriate health care professionals.

4. A decision by a physician not to strictly adhere to the provisions of paragraph 3 of this section will, for good cause shown, be grounds for the board to take no disciplinary action in regard to the physician. Each case of prescribing for pain will be evaluated on an individual basis. The physician’s conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmaceutically recognized to be appropriate for the diagnosis, the patient’s individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
5. If the provisions as set out in subparagraphs (1)-(4) of this section are met, and if all drug treatment is properly documented, the board will consider such practices as prescribing in a therapeutic manner, and prescribing and practicing medicine in a manner consistent with public health and welfare.

6. Quantity of pharmaceutical and chronicity of prescribing will be evaluated on the basis of the documented appropriate diagnosis and treatment of the recognized medical indication, documented persistence of the recognized medical indication, and properly documented follow-up evaluation with appropriate continuing care as set out in this rule.

7. A physician may use any number of treatment modalities for the treatment of pain, including intractable pain, which are consistent with legitimate medical purposes.

8. These rules shall not be construed so as to apply to the treatment of acute pain with dangerous drugs or controlled substances for purposes of short-term care.

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Tenn. Comp. R. & Regs. R. 1050-2-.13

1050-2-.13 SPECIFICALLY REGULATED AREAS AND ASPECTS OF MEDICAL PRACTICE

(1) The scope of practice of osteopathic physicians in Tennessee is broadly defined in the Osteopathic Medical Act and promulgated rules and includes many aspects which if not particularly regulated could lead to serious ramifications for the consuming public. This rule is to designate specific areas in the practice of osteopathic medicine for regulation the violation of which may result in disciplinary action pursuant to T.C.A. § 63-9-111.

(2) Pharmaceutical Dispensing - Osteopathic physicians who elect to dispense medication for remuneration must comply with the following:

(d) Dispensing or prescribing controlled substances in amounts or for durations not medically necessary, advisable or justified is considered to be practicing beyond the scope of the professional practice.

[CONTINUED ON NEXT PAGE]
[CONTINUED]

(c) Purposes and Intent

1. The Board recognizes that principles of quality medical practice dictate that the people of the State of Tennessee have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances.

2. Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed pursuant to the Tennessee Intractable Pain Treatment Act to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

3. The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. Physicians are referred to the U.S. Agency for Health Care and Research Clinical Practice Guidelines for a sound approach to the management of acute and cancer-related pain. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

4. The Board is obligated under the laws of the State of Tennessee to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

5. Physicians should not fear disciplinary action from the Board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain therapy for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with applicable state and federal law.

6. Each case of prescribing for pain will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning-and recognizing that some types of pain cannot be completely relieved.

[CONTINUED ON NEXT PAGE]
TENNESSEE REGULATIONS

Osteopathic Board Regulations

[CONTINUED]

7. The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing. The goals is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

(b) Guidelines - The Board adopts the following guidelines when evaluating the use of controlled substances for pain control:

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

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

3. Informed Consent and Agreement for Treatment - The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible.

4. Periodic Review - At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. Consultation - The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. The management of pain in patients with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. Medical Records - The physician should keep accurate and complete records to include the medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; treatment objectives; discussion of risks and benefits; treatments; medications (including date, type, dosage and quantity prescribed); instructions and agreements; and periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

[CONTINUED ON NEXT PAGE]
(c) No physician is required to provide treatment to patients with intractable pain with opiate medications but when refusing to do so shall inform the patient that there are physicians whose primary practice is in the treatment of severe, chronic, intractable pain with methods including the use of opiates. If the patient requests a referral to such a physician, and the physician makes such a referral that referral shall be noted in the patient's medical records.

(d) If a physician provides medical care for persons with intractable pain, with or without the use of opiate medications, to the extent that those patients become the focus of the physician's practice the physician must be prepared to document specialized medical education in pain management sufficient to bring the physician within the current standard of care in that field which shall include education on the causes, different and recommended modalities for treatment, chemical dependency and the psycho/social aspects of severe, chronic intractable pain.

(e) The treatment of persons with an acute or chronic painful medical condition who also require treatment for chemical dependency by a physician shall be governed by subsections T.C.A. § 63-6-1107 (c) and (d).
TENNESSEE

OTHER GOVERNMENTAL POLICY

Medical Board Policy Statement
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

MANAGEMENT OF PRESCRIBING WITH EMPHASIS ON ADDICTIVE OR DEPENDENCE-PRODUCING DRUGS

The Tennessee Board of Medical Examiners is charged by the General Assembly to protect the citizens of the State from harmful physician management. A significant number of physicians who are asked to appear before the Board are required to do so because of their lack of information about the management and responsibilities involved in prescribing controlled substances. Frequently, the inadvertent offender is a physician with a warm heart and a desire to relieve pain and misery, who is always pressed for time and finds himself or herself prescribing controlled drugs on demand over prolonged periods without adequate documentation. These are often for chronic ailments such as headache, arthritis, old injuries, chronic orthopedic problems, backache and anxiety. (Terminal cancer pain management is not a consideration here.) The purpose of the Board of Medical Examiners in presenting the following information is to help licensed physicians in Tennessee consider and reevaluate their prescribing practice of controlled substances. Practicing physicians have often mentioned the abrupt education they received in their own prescribing patterns. Moreover, there have been many request to the Board from physicians requesting detailed information on prescribing in certain specific situations.

It is not what you prescribe, but how well you manage the patient’s care, and document that care in legible form, that is important.

The prescribing matters that come before the Board are almost always related to the prescription of controlled substances. We feel that a majority of instances where physicians have been disciplined by the Board for prescribing practices could have been avoided completely if they had followed the steps that are being outlined here.

To prevent any misunderstanding, it is necessary to state what the Board does not have.

- It does not have a list of “bad” or “disallowed” drugs, except in certain circumstances, amphetamines, amphetamine-like substances and central nervous system stimulants. (See, Board of Medical Examiner Rule 0880-2-.14, a copy of which is available to you by contacting the Board’s administrative office at (615) 367-6231.) All formulary drugs, except as previously noted, are good if prescribed and administered when properly indicated. Conversely, all drugs are ineffective, dangerous, or even lethal when used inappropriately.

- It does not have some magic formula for determining the dosage and duration of administration for any drug. These are aspects of prescribing that must be determined within the confines of the individual clinical case, and continued under proper monitoring. What is good for one patient may be insufficient or fatal for another.

What the Board does have is the expectation that physicians will create a record that shows:
- Proper indication for the use of drug or other therapy;
- Monitoring of the patient where necessary;
- The patient’s response to therapy based on follow-up visits; and
- All rationale for continuing or modifying the therapy.

[CONTINUED ON NEXT PAGE]
**OTHER GOVERNMENTAL POLICY**

**Medical Board Policy Statement**

[For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -]

**STEP ONE**

First and foremost, before you prescribe anything, start with a diagnosis which is supported by history and physical findings, and by the results of any appropriate tests. Too many times a doctor is asked why he or she prescribed a particular drug, and the response is, “Because the patient has arthritis.” Then the doctor is asked, “How did you determine that?” and the answer is, “Because that’s what the patient complained of.” Nothing in the record or in the doctor’s recollection supports the diagnosis except the patient’s assertion. **Do a workup sufficient to support a diagnosis including all necessary tests.**

**STEP TWO**

Create a treatment plan which includes the use of appropriate non-addictive modalities, and make referrals to appropriate specialists, such as neurologists, orthopedists, psychiatrists, etc. The result of the referral should be included in the patient’s chart.

**STEP THREE**

Before beginning a regimen of controlled drugs, make a determination through trial or through a documented history that **non-addictive modalities are not appropriate or they do not work.** A finding of intolerance or allergy to NSAIDs is one thing, but the assertion of the patient that, “Gosh, Doc, nothing seems to work like that Percodan stuff!” is quite another. Too many of the doctors the Board has seen have started a treatment program with powerful controlled substances without ever considering other forms of treatment.

**STEP FOUR**

Make sure you are not dealing with a drug-seeking patient. If you know the patient, review the prescription records in the patient’s chart and discuss the patient’s chemical history before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum obtain an oral drug history, and discuss chemical use and family chemical history with the patient.

**STEP FIVE**

It is a good idea to obtain the informed consent of the patient before using a drug that has the potential to cause dependency problems. **Take the time to explain the relative risks and benefits of the drug and record in the chart the fact that this was done.** When embarking on what appears to be the long term use of a potentially addictive substance, it may be wise to hold a family conference and explain the relative risks of dependency or addiction and what that may mean to the patient and to the patient’s family. Refusal of the patient to permit a family conference may be significant information.

**STEP SIX**

Maintain regular monitoring of the patient, including frequent physical monitoring. If the regimen is for a prolonged drug use, it is very important to monitor the patient for the root condition which necessitates the drug and for the side effects of the drug itself. **This is true no matter what type of controlled substance is used or what schedule it belongs to. Also, remember that with certain conditions, drug holidays are appropriate.** This allows you to check to see whether the original symptoms recur when the drug is not given - indicating a continuing legitimate need for the drug or whether withdrawal symptoms occur - indicating dependence.

[CONTINUED ON NEXT PAGE]
OTHER GOVERNMENTAL POLICY

Medical Board Policy Statement

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

[CONTINUED]

STEP SEVEN
Make sure YOU are in control of the supply of the drug. To do this, at a minimum you must keep detailed records of the type, dose, and amount of the drug prescribed. You must also monitor, record and personally control all refills. Do not authorize your office personnel to refill prescriptions without consulting you. **One good way to accomplish this is to require the patient to return to obtain refill authorization, at least part of the time.**

Records of the cumulative dosage and average daily dosage are especially valuable. A thumbnail sketch of three hypothetical cases will illustrate our point here. In the first case, a physician prescribes Tussionex to a patient for approximately five years for a cumulative dosage of nineteen and one half gallons. In the second case, a physician prescribes Tylenol 3’s to a patient for slightly more than a year at the average daily rate of 30 per day. The third case is very similar, except that it was Tylenol 4’s at the rate of 20 per day. Some quick observations:
- No physician who was aware of that kind of prescribing would have continued with it.
- Few, if any, patients could have been consuming that much Tylenol with codeine. In all likelihood, they were reselling it.

Another important part of controlling the supply of drugs is to check on whether the patient is obtaining drugs from other physicians. Checking with pharmacies and pharmacy chains and other health care providers may tell you whether a patient is obtaining extra drugs or the patient is doctor shopping. If you are aware it is occurring, contact other physicians and health professionals in your area.

STEP EIGHT
Maintaining regular contact with the patient’s family is a valuable source of information on the patient’s response to the therapy regimen, and may be much more accurate and objective than feedback from the patient alone. The family is a much better source of information on behavioral changes, especially dysfunctional behavior, than is the patient. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be a symptom of dependency or addiction. The family is also a good source of information on whether the patient is obtaining drugs from other sources, or is self-medicating with other drugs or alcohol.

STEP NINE
To reiterate, one of the most frequent problems faced by a physician when he or she comes before the Board or other outside review bodies is **inadequate records.** It is entirely possible that the doctor did everything correctly in managing a case, but without records which reflect all the steps that went into the process, the job of demonstrating it to any outside reviewer becomes many times more difficult. Luckily, this is a problem which is solvable.
**STATUTES**

**Criminal Offenses**

-TENNESSEE STATUTES

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile


  39-13-216. Assisted suicide

  (a) The board has the power to:

  .

  (b) It is not an offense under this section to:

  (1) Withhold or withdraw medical care as defined by § 32-11-103;

  (2) Prescribe, dispense, or administer medications or perform medical
  procedures calculated or intended to relieve another person's pain or discomfort (but
  not calculated or intended to cause death), even if the medications or medical
  procedures may hasten or increase the risk of death;

  .

- Tenn. Code Ann. § 39-17-402

  39-17-402. Definitions.

  As used in this part and title 53, chapter 11, parts 3 and 4, unless the context otherwise requires:

  .

  (23) "Practitioner" means:

  (A) A physician, dentist, optometrist, veterinarian, scientific investigator or
  other person licensed, registered or otherwise permitted to distribute, dispense, conduct
  research with respect to or to administer a controlled substance in the course of
  professional practice or research in this state;

  .

Note: *Underlining* and/or *shading* was added to identify policy language meeting the corresponding criterion.
TENNESSEE REGULATIONS
Standards for Hospitals
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

Tenn. Comp. R. & Regs. R. 1200-8-1-04

1200-8-1-04 ADMINISTRATION

(8) The hospital shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

Tenn. Comp. R. & Regs. R. 1200-8-1-12

1200-8-1-12 PATIENT RIGHTS.

(1) Each patient has at least the following rights:

(g) To have appropriate assessment and management of pain;

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
TENNESSEE
REGULATIONS
Standards for Nursing Homes
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

Tenn. Comp. R. & Regs. R. 1200-8-6-.04

1200-8-6-.04 ADMINISTRATION

... (18) The nursing home shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

... (19) The nursing home shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

Tenn. Comp. R. & Regs. R. 1200-8-6-.12

1200-8-6-.12 RESIDENT RIGHTS.

(1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights:

... (x) To have appropriate assessment and management of pain:

... (x) To have appropriate assessment and management of pain:

REGULATIONS
Standards for Residential Hospices
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

Tenn. Comp. R. & Regs. R. 1200-8-15-.04

1200-8-15-.04 ADMINISTRATION

... (4) The residential hospice shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

... (4) The residential hospice shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.

**REGULATIONS**

Standards for Home Care Organizations Providing Hospice Services
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

1200-8-26-.04 ADMINISTRATION

(3) The home health agency shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

Tenn. Comp. R. & Regs. R. 1200-8-26-.12

1200-8-26-.12 PATIENT RIGHTS

(1) Each patient has at least the following rights:

(a) To privacy in treatment and personal care;
(b) To have appropriate assessment and management of pain;

**REGULATIONS**

Standards for Home Care Organizations Providing Home Health Services
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

1200-8-26-.12 PATIENT RIGHTS

(1) Each patient has at least the following rights:

(a) To privacy in treatment and personal care;
(b) To have appropriate assessment and management of pain;

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
TENNESSEE

REGULATIONS

Standards for HIV Supportive Living Facilities
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

Tenn. Comp. R. & Regs. R. 1200-8-28-.04
1200-8-28-.04 ADMINISTRATION

(4) The HIV supportive living facility shall provide a process that assesses pain in all patients. There shall be an appropriate and effective pain management program.

Tenn. Comp. R. & Regs. R. 1200-8-28-.12
1200-8-28-.12 RESIDENT RIGHTS

(1) The HIV supportive living facility shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity and individuality. Each resident has at least the following rights:

(m) To have appropriate assessment and management of pain;

REGULATIONS

Standards for Home Care Organizations Providing Professional Support Services
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

Tenn. Comp. R. & Regs. R. 1200-8-34-.12
1200-8-34-.12 CONSUMER RIGHTS

(1) Each consumer has at least the following rights:

(a) To privacy in treatment and personal care;
(b) To have appropriate assessment and management of pain;

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.

TENNESSEE

Tenn. Comp. R. & Regs. R. 1200-8-35-.12

1200-8-35-.12 PATIENT RIGHTS.

(1) Each patient has at least the following rights:

(f) To have appropriate assessment and management of pain;

REGULATIONS

Standards for Outpatient Diagnostic Centers

For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile.

COMMENT: Establishes a responsibility for outpatient diagnostic centers to ensure that pain management is an essential part of patient care.

CRITERION B: Other provisions that may enhance pain management

CATEGORY C: Regulatory or policy issues

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
STATUTES

- **Controlled Substances Act**
  Health and Safety Code; Title 6. Food, Drugs, Alcohol, and Hazardous Substances; Subtitle C. Substance Abuse Regulation and Crimes; Chapter 481. Texas Controlled Substances Act

- **Professional Practice Act (No provisions found)**
  Occupations Code; Title 3. Health Professions; Subtitle A. Provisions Applying to Health Professions Generally

- **Intractable Pain Treatment Act (Part of Professional Practice Act)**
  Occupations Code; Title 3. Health Professions; Subtitle A. Provisions Applying to Health Professions Generally; Chapter 107. Intractable Pain Treatment

- **Medical Practice Act**
  Occupations Code; Title 3. Health Professions; Subtitle B. Physicians

- **Pharmacy Practice Act**
  Occupations Code; Title 3. Health Professions; Subtitle J. Pharmacy and Pharmacists

REGULATIONS

- **Controlled Substances Regulations**
  Title 37. Public Safety and Corrections; Part I. Texas Department of Public Safety; Chapter 13. Controlled Substances

- **Medical Board Regulations**
  Title 22. Examining Boards; Part 9. Texas Medical Board

- **Pharmacy Board Regulations**
  Title 22. Examining Boards; Part 15. Texas State Board of Pharmacy

OTHER GOVERNMENTAL POLICIES

- **Medical Board Policy Statement**

- **Pharmacy Board Policy Statement**
RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- **Texas Cancer Council**
  Health and Safety Code; Title 2. Health; Subtitle E. Health Care Councils and Resource Centers; Chapter 102. Texas Cancer Council

- **Licensing of Hospitals**
  Title 25. Health Services; Part 1. Department of State Health Services; Chapter 133. Hospital Licensing; Subchapter C. Operational Requirements

- **Licensing of Home and Community Support Services Agencies**
  Title 40. Social Services and Assistance; Part 1. Department of Aging and Disability Services; Chapter 97. Licensing Standards for Home and Community Support Services Agencies; Subchapter D. Additional Standards Specific to License Category and Specific to Special Services

*Note:* Texas’s Controlled Substances Act continues to reference the triplicate prescription program that was repealed in 2002; although not considered a barrier to practice, efforts should be made to remove from state law all references to this vestigial policy.
## Provisions that may ENHANCE pain management

<table>
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<th>Criteria</th>
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<td>Controlled substances are necessary for public health</td>
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### STATUTES

| Controlled Substances Act                                               |   |   |   |   |   |   |   | ● |
| Professional Practice Act\(^1\)                                         |   |   |   |   |   |   |   |   |
| Intractable Pain Treatment Act \(^2\)                                   | ● | ● | ● |   |   | ● |   |   |
| Medical Practice Act                                                     | ● |   |   |   |   |   |   |   |
| Pharmacy Practice Act                                                    |   | ● |   |   |   |   |   |   |

### REGULATIONS

| Controlled Substances Act                                               |   |   |   |   |   |   |   | ● |
| Medical Board                                                            | ● | ● |   |   |   |   |● |   |
| Pharmacy Board                                                           |   | ● |   |   |   |   |   |   |

### OTHER GOVERNMENTAL POLICIES

| Medical Board Policy Statement                                          | ● | ● | ● |   |   | ● |   |   |
| Pharmacy Board Policy Statement                                        | ● | ● | ● | ● |   |   |   |   |

### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

| Texas Cancer Council                                                     |   |   |   |   |   |   |   | ● |
| Licensing of Hospitals                                                   |   |   |   |   |   |   | ● |   |
| Licensing of Home and Community Support Services Agencies               |   |   |   |   |   |   | ● |   |

Note: A dot indicates that one or more provisions were identified
\(^1\) No provisions were found in this policy, \(^2\) No policy found
### Provisions that may IMPEDE pain management

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#### STATUTES

| Controlled Substances Act                                               |    |     |     |     |     |     |     |     |
| Intractable Pain Treatment Act                                          |    |     |     |     |     |     |     |     |
| Medical Practice Act                                                    |    |     |     |     |     |     |     |     |
| Pharmacy Practice Act                                                   |    |     |     |     |     |     |     |     |

#### REGULATIONS

| Controlled Substances                                                   |    |     |     |     |     |     |     |     |
| Medical Board                                                           |    |     |     |     |     |     |     |     |
| Pharmacy Board                                                          |    |     |     |     |     |     |     |     |

#### OTHER GOVERNMENTAL POLICIES

| Medical Board Policy Statement                                          |    |     |     |     |     |     |     |     |
| Pharmacy Board Policy Statement                                         |    |     |     |     |     |     |     |     |

#### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

| Texas Cancer Council                                                   |    |     |     |     |     |     |     |     |
| Licensing of Hospitals                                                 |    |     |     |     |     |     |     |     |
| Licensing of Home and Community Support Services Agencies              |    |     |     |     |     |     |     |     |

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Note: A dot indicates that one or more provisions were identified

1 No provisions were found in this policy.

2 No policy found.
STATUTES

Controlled Substances Act

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -


§ 481.002. Definitions

In this chapter:

(39) "Practitioner" means:

(A) a physician, dentist, veterinarian, podiatrist, scientific investigator, or other person licensed, registered, or otherwise permitted to distribute, dispense, analyze, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state;


Tex. Health & Safety Code § 481.074 - 481.075

§ 481.074. Prescriptions

(d) Except as specified in Subsections (e) and (f) of this section, a person may not fill a prescription for a controlled substance listed in Schedule II after the end of the seventh day after the date on which the prescription is issued. A person may not refill a prescription for a substance listed in Schedule II.

§ 481.075. Official Prescription Program

(b) Each official prescription form must be sequentially numbered.

(c) The director shall issue official prescription forms to practitioners for a fee covering the actual cost of printing, processing, and mailing the forms at 100 a package. Before mailing or otherwise delivering prescription forms to a practitioner, the director shall print on each form the number of the form and any other information the director determines is necessary.

(d) A person may not obtain an official prescription form unless the person is a practitioner as defined by Section 481.002 (39) (A) or an institutional practitioner.

(e) Each official prescription form used to prescribe a Schedule II controlled substance must contain:

(1) information provided by the prescribing practitioner, including:

(A) the date the prescription is written;

(B) the controlled substance prescribed;

(C) the quantity of controlled substance prescribed, shown numerically followed by the number written as a word;

(D) the intended use of the controlled substance or the diagnosis for which it is prescribed and the instructions for use of the substance;

(E) the practitioner’s name, address, and Federal Drug Enforcement Administration number; and

(F) the name, address, and date of birth or age of the person for whom the controlled substance is prescribed;

(2) information provided by the dispensing pharmacist, including the date the prescription is filled; and

(3) the signatures of the prescribing practitioner and the dispensing pharmacist.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.

CRITERION 3: Opioids are part of professional practice

CRITERION 14: Undue prescription requirements

CRITERION 13: Length of prescription validity is restricted

§ 107.001. Short Title
This chapter may be cited as the Intractable Pain Treatment Act.

§ 107.002. Definitions
In this chapter:
(1) “Board” means the Texas State Board of Medical Examiners.

(2) “Intractable pain” means a state of pain for which:
   (A) the cause of the pain cannot be removed or otherwise treated; and
   (B) in the generally accepted course of medical practice, relief or cure of the cause of the pain:
      (i) is not possible; or
      (ii) has not been found after reasonable efforts.

(3) “Physician” means a physician licensed by the board.

§ 107.003. Nonapplicability of Chapter to Certain Chemically Dependent Persons
Except as provided by Subchapter C, this chapter does not apply to a person being treated by a physician for chemical dependency because of the person’s use of a dangerous drug or controlled substance.

§ 107.051. Authority to Prescribe or Administer Dangerous Drug or Controlled Substance
Notwithstanding any other law, a physician may prescribe or administer a dangerous drug or controlled substance to a person in the course of the physician’s treatment of the person for intractable pain.

§ 107.052. Limitations on Prescription or Administration of Dangerous Drug or Controlled Substance
This chapter does not authorize a physician to prescribe or administer to a person a dangerous drug or controlled substance:
(1) for a purpose that is not a legitimate medical purpose as defined by the board; and
(2) if the physician knows or should know the person is using drugs for a nontherapeutic purpose.

§ 107.053. Limitation on Authority of Hospital or Other Health Care Facility Regarding Use of Dangerous Drug or Controlled Substance
A hospital or other health care facility may not prohibit or restrict the use of a dangerous drug or controlled substance prescribed or administered by a physician who holds staff privileges at the hospital or facility for a person diagnosed and treated by a physician for intractable pain.

[CONTINUED ON NEXT PAGE]
[CONTINUED]

§ 107.101. Patient

In this subchapter, “patient” includes a person who:

(1) is currently abusing a dangerous drug or controlled substance;
(2) is not currently abusing such a drug or substance but has a history of such abuse; or
(3) lives in an environment that poses a risk for misuse or diversion to illegitimate use of such a drug or substance.

§ 107.102. Authority To Treat

This chapter authorizes a physician to treat a patient with an acute or chronic painful medical condition with a dangerous drug or controlled substance to relieve the patient’s pain using appropriate doses, for an appropriate length of time, and for as long as the pain persists.

§ 107.103. Duty to Monitor Patient

A physician who treats a patient under this subchapter shall monitor the patient to ensure that a prescribed dangerous drug or controlled substance is used only for the treatment of the patient’s painful medical condition.

§ 107.104. Documentation and Consultation Required

To ensure that a prescribed dangerous drug or controlled substance is not diverted to another use and to ensure the appropriateness of the treatment of the patient’s targeted symptoms, the physician shall:

(1) specifically document:
   (A) the understanding between the physician and patient about the patient’s prescribed treatment;
   (B) the name of the drug or substance prescribed;
   (C) the dosage and method of taking the prescribed drug or substance;
   (D) the number of dose units prescribed; and
   (E) the frequency of prescribing and dispensing the drug or substance; and

(2) consult with a psychologist, psychiatrist, expert in the treatment of addictions, or other health care professional, as appropriate.

[CONTINUED ON NEXT PAGE]
(+) CRITERION 5: Addresses fear of regulatory scrutiny

STATUTES

Intractable Pain Treatment Act

For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

[CONTINUED]

§ 107.151. Disciplinary Action Prohibited

A physician is not subject to disciplinary action by the board for prescribing or administering a dangerous drug or controlled substance in the course of treatment of a person for intractable pain.

§ 107.152. Authority of Board to Revoke or Suspend License

(a) This chapter does not affect the authority of the board to revoke or suspend the license of a physician who:

(1) prescribes, administers, or dispenses a drug or treatment:

(A) for a purpose that is not a legitimate medical purpose as defined by the board; and

(B) that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed;

(2) fails to keep a complete and accurate record of the purchase and disposal of:

(A) a drug listed in Chapter 481, Health and Safety Code; or

(B) a controlled substance scheduled in the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Section 801 et seq.);

(3) writes a false or fictitious prescription for:

(A) a dangerous drug as defined by Chapter 483, Health and Safety Code;

(B) a controlled substance listed in a schedule under Chapter 481, Health and Safety Code; or

(C) a controlled substance scheduled in the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Section 801 et seq.); or

(4) prescribes, administers, or dispenses in a manner inconsistent with public health and welfare:

(A) a dangerous drug as defined by Chapter 483, Health and Safety Code;

(B) a controlled substance listed in a schedule under Chapter 481, Health and Safety Code; or

(C) a controlled substance scheduled in the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Section 801 et seq.).

(b) For purposes of Subsection (a)(2), the physician's records must include a record of:

(1) the date of purchase;

(2) the sale or disposal of the drug or substance by the physician;

(3) the name and address of the person receiving the drug or substance; and

(4) the reason for the disposal or dispensing of the drug or substance to the person.
**Medical Practice Act**

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

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**Statutes**

**Medical Practice Act**

For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

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**Tex. Occ. Code § 153.014**

§ 153.014. Information Provided to License Holders

At least once each biennium, the board shall provide to license holders information on:

1. Prescribing and dispensing pain medications, with particular emphasis on Schedule II and Schedule III controlled substances;
2. Abusive and addictive behavior of certain persons who use prescription pain medications;
3. Common diversion strategies employed by certain persons who use prescription pain medications, including fraudulent prescription patterns; and
4. The appropriate use of pain medications and the differences between addiction, pseudo-addiction, tolerance, and physical dependence.

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**Tex. Occ. Code § 156.055**

§ 156.055. Continuing Education in Pain Treatment

A physician licensed under this subtitle who submits an application for renewal of a license that designates a direct patient care practice and whose practice includes treating patients for pain is encouraged to include continuing medical education in pain treatment among the hours of continuing medical education completed to comply with Section 156.051(a)(2).

---

**Tex. Occ. Code § 164.053**

§ 164.053. Unprofessional or Dishonorable Conduct

(a) For purposes of Section 164.052(a)(5), unprofessional or dishonorable conduct likely to deceive or defraud the public includes conduct in which a physician:

1. 
2. 
3. Writes prescriptions for or dispenses to a person who:
   A. Is known to be an abuser of narcotic drugs, controlled substances, or dangerous drugs; or
   B. The physician should have known was an abuser of narcotic drugs, controlled substances, or dangerous drugs;

(c) Subsection (a)(3) does not apply to a person the physician is treating for:

1. The person's use of narcotics after the physician notifies the board in writing of the name and address of the person being treated; or
2. Intractable pain under the Intractable Pain Treatment Act (Article 4495c, Revised Statutes).

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**Comment**

Establishes a mechanism (board responsibility) to provide practitioners information/education about pain management.

---

**Comment**

Establishes a mechanism (encouraging continuing education) to provide practitioners information/education about pain management.

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**Comment**

Exemption of these patients nevertheless continues the prescribing restriction for all other patients with an addictive disease or history of addiction.

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Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
**STATUTES**

**Pharmacy Practice Act**

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

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Tex Occ. Code § 551.003

§ 551.003. Definitions

In Chapters 551-566:

(34) "Practitioner" means:

(A) a person licensed or registered to prescribe, distribute, administer, or dispense a prescription drug or device in the course of professional practice in this state, including a physician, dentist, podiatrist, or veterinarian but excluding a person licensed under this subtitle;

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Tex Occ. Code § 554.014

§ 554.014. Information Provided to License Holders

At least once each biennium, the board shall provide to license holders information on:

1. prescribing and dispensing pain medications, with particular emphasis on Schedule II and Schedule III controlled substances;

2. abusive and addictive behavior of certain persons who use prescription pain medications;

3. common diversion strategies employed by certain persons who use prescription pain medications, including fraudulent prescription patterns; and

4. the appropriate use of pain medications and the differences between addiction, pseudo-addiction, tolerance, and physical dependence.

---

**COMMENT**: Establishes a mechanism (board responsibility) to provide practitioners information/education about pain management.

---

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
§ 170.1. Purpose
The purpose of this chapter is to recognize that some dangerous drugs and controlled substances listed in Chapter 481 and 483 of the Texas Health and Safety Code are indispensable for the treatment of pain, and are useful for relieving and controlling many other related symptoms that patients may suffer. It is the position of the board that these drugs may be prescribed for the treatment of pain and other related symptoms after a reasonably based medical diagnosis has been made, in adequate doses, and for appropriate lengths of time, which in some cases may be as long as the pain or related symptoms persist. The board recognizes that pain, including intractable pain, and many other related symptoms are subjective complaints and that the appropriateness and the adequacy of drug and dose will vary from individual to individual. The practitioner is expected to exercise sound medical judgment in treating pain and related symptoms with dangerous drugs and controlled substances.

§ 170.2. Definitions
The following words and terms, as used in the Medical Practice Act, Article 4495b, § 3.08, shall have the following meanings in the context of providing medications for pain and related symptoms.

Abuser of narcotic drugs, controlled substances and dangerous drugs--A person who takes a drug or drugs for other than legitimate medical purposes.

Intractable pain--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.

Non-therapeutic in nature or manner--A medical use or purpose that is not legitimate.

Prescribing pharmaceuticals or practicing consistent with the public health and welfare--Prescribing pharmaceuticals and practicing medicine for a legitimate medical purpose in the usual course of professional practice.

§ 170.3. Guidelines
The Texas State Board of Medical Examiners will use the following guidelines to determine whether a physician’s conduct violates the Medical Practice Act, §§ 3.08(4)(E), 3.08(4)(F), and 3.08(18), in regard to the prescribing, administering, ordering, or dispensing of pain medications and other drugs necessary to address their side effects.

1. The treatment of pain, including intractable pain, with dangerous drugs and controlled substances is a legitimate medical purpose when done in the usual course of professional practice.
(2) A physician or surgeon duly authorized to practice medicine in Texas and to prescribe controlled substances and dangerous drugs in this state shall not be subject to disciplinary action by the board for prescribing, ordering, administering, or dispensing dangerous drugs or controlled substances for the treatment and relief of pain, including intractable pain, in the usual course of professional practice for a legitimate medical purpose in compliance with applicable state and federal law:

(A) After a documented medical history, which may be provided orally or in writing by the patient, and physical examination by the physician providing the medication including an assessment and consideration of the pain, physical and psychological function, any history and potential for substance abuse, coexisting diseases and conditions, and the presence of a recognized medical indication for the use of a dangerous drug or controlled substance;

(B) Pursuant to a written treatment plan tailored for the individual needs of the patient by which treatment progress and success can be evaluated with stated objectives such as pain relief and/or improved physical and psychological function. Such a written treatment plan shall consider pertinent medical history and physical examination as well as the need for further testing, consultations, referrals, or use of other treatment modalities;

(C) The physician should discuss the risks and benefits of the use of controlled substances with the patient or guardian;

(D) Subject to documented periodic review of the care by the physician at reasonable intervals in view of the individual circumstances of the patient in regard to progress toward reaching treatment objectives which takes into consideration the course of medications prescribed, ordered, administered, or dispensed as well as any new information about the etiology of the pain;

(E) Complete and accurate records of the care provided as set forth in subparagraphs (A)-(D) of this paragraph should be kept. When controlled substances are prescribed, names, quantities prescribed, dosages, and number of authorized refills of the drugs should be recorded, keeping in mind that pain patients with a history of substance abuse or who live in an environment posing a risk for medication misuse or diversion require special consideration. Management of these patients may require closer monitoring by the physician managing the pain and consultation with appropriate health care professionals.

(4) A decision by a physician not to strictly adhere to the provisions of paragraph (3) of this section will, for good cause shown, be grounds for the board to take no disciplinary action. Each case of prescribing for pain will be evaluated on an individual basis. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning, and recognizing that some types of pain cannot be completely relieved.

(5) If the provisions as set out in paragraphs (1)-(4) of this section are met, and if all drug treatment is properly documented, the board will consider such practices as prescribing in a therapeutic manner, and prescribing and practicing medicine in a manner consistent with public health and welfare.

(6) Quantity of pharmaceutical and chronicity of prescribing will be evaluated on the basis of the documented appropriate diagnosis and treatment of the recognized medical indication, documented persistence of the recognized medical indication, and properly documented follow-up evaluation with appropriate continuing care as set out in this chapter.

(7) A physician may use any number of treatment modalities for the treatment of pain, including intractable pain, which are consistent with legitimate medical purposes.

(8) These rules shall not be construed so as to apply to the treatment of acute pain with dangerous drugs or controlled substances for purposes of short term care.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
REGULATIONS
Pharmacy Board Regulations

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

22 TAC § 281.7
§ 281.7. Grounds for Discipline for a Pharmacist License

(a) For the purposes of the Act, § 565.001(a)(2), “unprofessional conduct” shall include, but not be limited to:

(1) dispensing a prescription drug pursuant to a forged, altered, or fraudulent prescription;

(2) dispensing a prescription drug order pursuant to a prescription from a practitioner as follows:

(A) the dispensing of a prescription drug order not issued for a legitimate medical purpose or in the usual course of professional practice shall include the following:

(i) dispensing controlled substances or dangerous drugs to an individual or individuals in quantities, dosages, or for periods of time which grossly exceed standards of practice, approved labeling of the federal Food and Drug Administration, or the guidelines published in professional literature; or

(ii) dispensing controlled substances or dangerous drugs when the pharmacist knows or reasonably should have known that the controlled substances or dangerous drugs are not necessary or required for the patient’s valid medical needs or for a valid therapeutic purpose;

(B) the provisions of subparagraph (A)(i) and (ii) of this paragraph are not applicable for prescriptions dispensed to persons with intractable pain or to a narcotic drug dependent person in accordance with the requirements of Title 21, Code of Federal Regulations, § 1306.07;

22 TAC § 291.31
§ 291.31. Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(34) Practitioner--
(A) a person licensed or registered to prescribe, distribute, administer, or dispense a prescription drug or device in the course of professional practice in this state, including a physician, dentist, podiatrist, or veterinarian but excluding a person licensed under this subtitle;

22 TAC § 291.34. Records

(ii) Prescription drug orders for Schedule II controlled substances shall be issued on an official prescription form as required by the Texas Controlled Substances Act, § 481.075, and be manually signed by the practitioner.
Pain Control and the Texas State Board of Medical Examiners


text goes here

(+) CRITERION 2: Pain management is part of medical practice
(+) CRITERION 3: Opioids are part of professional practice
(+) CRITERION 6: Prescription amount alone does not determine legitimacy
(+) CRITERION 4: Encourages pain management
(+) CRITERION 7: Physical dependence or analgesic tolerance are not confused with "addiction"

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
**OTHER GOVERNMENTAL POLICIES**

**Pharmacy Board Policy Statement**

*For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile.*

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**Texas State Board of Pharmacy**

**Position Statement on the Treatment of Pain**

The Texas State Board of Pharmacy recognizes that quality care dictates that the people of the State of Texas have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages pharmacists to view effective pain management as a part of quality care for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All pharmacists should become knowledgeable about effective methods of pain treatment as well as statutory requirements for dispensing controlled substances.

Inadequate pain control may result from physicians' and pharmacists' lack of knowledge about pain management or an inadequate understanding of addiction. The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins.

The Board also recognizes that controlled substances are subject to abuse by individuals who seek them for mood altering and other psychological effects rather than their legitimate medical uses. When dispensing controlled substances, the pharmacist should be diligent in preventing them from being diverted from legitimate to illegitimate use. Tolerance and physical dependence are normal consequences of sustained use of these drugs and are not synonymous with psychological dependency (addiction). Psychological dependency is characterized by the compulsion to take the drug despite its harmful and destructive effect on the individual.

Pharmacists should not fear disciplinary action from the Board for dispensing controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain and sound clinical grounds. All such dispensing must be based on clear documentation of the patient’s medical condition and pertinent discussions with the prescribing physician.

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**CRITERION 2:** Pain management is part of medical practice

**CRITERION 3:** Opioids are part of professional practice

**CRITERION 4:** Encourages pain management

**CRITERION 5:** Addresses fear of regulatory scrutiny

**CRITERION 7:** Physical dependence or analgesic tolerance are not confused with “addiction”

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*Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.*
**REGULATIONS**

**Licensing of Hospitals**

For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

25 TAC § 133.42

§ 133.42. Patient Rights

(a) Patient rights requirements for all hospitals.

(1) A hospital shall adopt, implement, and enforce a policy to ensure patients' rights. The written policy shall include:

(A) the right of the patient to the hospital’s reasonable response to his or her requests and needs for treatment or service, within the hospital’s capacity, its stated mission, and applicable law and regulation;

(B) the right of the patient to considerate and respectful care:

(i) the care of the patient includes consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness;

(ii) the care of the dying patient optimizes the comfort and dignity of the patient through:

(I) treating primary and secondary symptoms that respond to treatment as desired by the patient or surrogate decision maker;

(II) effectively managing pain;

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
40 TAC § 97.403

§ 97.403. Standards Specific to Agencies Licensed to Provide Hospice Services

(h) The hospice must perform and make available to each client admitted for hospice services a client-specific comprehensive health assessment that identifies the client's need for hospice care and the client's need for medical, nursing, social, emotional, and spiritual care which includes, but is not limited to, the palliation and management of the terminal illness and related conditions and support services for clients and their families.

1. The hospice must complete the comprehensive health assessment in a timely manner consistent with the client's immediate needs, but no later than seven calendar days after the start of hospice care.

2. The comprehensive health assessment must include:

   A. input from the appropriate interdisciplinary team member(s) and an assessment of:

   i. each client's physical condition, including functional ability and nutritional status;

   ii. each client's pain and other symptoms and the management of discomfort and symptom relief;

3. A written plan of care must be established and maintained for each client admitted to the hospice program, and the care provided to a client must be in accordance with the plan. The plan of care must specify the care and services necessary to meet the client-specific needs identified in the comprehensive health assessment described in subsection (h) of this section, include all client care orders, reflect planned interventions for problems identified, and ensure that care and services are appropriate to the severity level of each client's and the client's family's specific needs.

3. The plan must include:

   A. a comprehensive health assessment of the client's needs and identification of the services including the management of pain and symptom relief. The plan must state in detail the scope and frequency of services that are needed to meet the client's and family's needs;

   B. interventions to facilitate the management of pain and symptoms;

   C. a system of measures that captures significant outcomes that are essential to optimal hospice care, that are used in the care planning and coordination of services, and that are an essential part of the hospice's quality assessment and performance improvement program. The measures include, but are not limited to:

   i. pain;

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
STATUTES

- Controlled Substances Act
  Title 58. Occupations and Professions; Chapter 37. Controlled Substances

- Medical Practice Act
  Title 58. Occupations and Professions; Chapter 67. Utah Medical Practice Act

- Osteopathic Practice Act
  Title 58. Occupations and Professions; Chapter 68. Utah Osteopathic Medical Practice Act

- Pharmacy Practice Act
  Title 58. Occupations and Professions; Chapter 17b. Pharmacy Practice Act

- Intractable Pain Treatment Act
  No policy found

REGULATIONS

- Controlled Substances Regulations (No provisions found)

- Professional Board Regulations

- Medical Board Regulations (No provisions found)

- Osteopathic Board Regulations (No provisions found)

- Pharmacy Board Regulations (No provisions found)

OTHER GOVERNMENTAL POLICIES

No policies found

RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

No policies found
# Provisions that may ENHANCE pain management

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## STATUTES

- Controlled Substances Act
- Medical Practice Act
- Osteopathic Practice Act
- Pharmacy Practice Act
- Intractable Pain Treatment Act

## REGULATIONS

- Controlled Substances Act
  - Professional Board
  - Medical Board
  - Osteopathic Board
  - Pharmacy Board

## OTHER GOVERNMENTAL POLICIES

## RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

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Note: A dot indicates that one or more provisions were identified

1 No provisions were found in this policy.

2 No policy found.
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**STATUTES**

- Controlled Substances Act
- Medical Practice Act
- Osteopathic Practice Act
- Pharmacy Practice Act
- Intractable Pain Treatment Act

**REGULATIONS**

- Controlled Substances Act
- Professional Board
- Medical Board
- Osteopathic Board
- Pharmacy Board

**OTHER GOVERNMENTAL POLICIES**

**RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES**

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Note: A dot indicates that one or more provisions were identified

*1 No provisions were found in this policy, 2 No policy found*
**U T A H**

<table>
<thead>
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<th>CRITERION 16: Provisions that are ambiguous</th>
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<td>CATEGORY B: Unclear intent leading to possible misinterpretation</td>
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<tr>
<td><strong>COMMENT:</strong> “Excess” implies there is a limit, but the limit is not specified</td>
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**STATUTES**

**Controlled Substances Act**
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -


§ 58-37-2. Definitions

(1) As used in this chapter:

(gg) “Practitioner” means a physician, dentist, veterinarian, pharmacist, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis a controlled substance in the course of professional practice or research in this state.

Utah Code Ann. § 58-37-6

§ 58-37-6. License to manufacture, produce, distribute, dispense, administer, or conduct research — Issuance by department — Denial, suspension, or revocation — Records required — Prescriptions

(i) A practitioner licensed under this chapter may not prescribe or administer dosages of a controlled substance in excess of medically recognized quantities necessary to treat the ailment, malady, or condition of the ultimate user.

**STATUTES**

**Medical Practice Act**
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

Utah Code Ann. § 58-67-102

§ 58-67-102. Definitions

In addition to the definitions in Section 58-1-102, as used in this chapter:

(B) “Practice of medicine” means:

(a) to diagnose, treat, correct, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, or to attempt to do so, by any means or instrumentality, and by an individual in Utah or outside the state upon or for any human within the state;

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
CRITERION 3: Opioids are part of professional practice

Pharmacy Practice Act

Utah Code Ann. § 58-17b-102
§ 58-17b-102. Definitions

In addition to the definitions in Section 58-1-102, as used in this chapter:

(59) "Practitioner" means an individual currently licensed, registered, or otherwise authorized by the appropriate jurisdiction to prescribe and administer drugs in the course of professional practice.

CRITERION 2: Pain management is part of medical practice

Osteopathic Practice Act

Utah Code Ann. § 58-68-102
§ 58-68-102. Definitions

In addition to the definitions in Section 58-1-102, as used in this chapter:

(8) "Practice of osteopathic medicine" means:

(a) to diagnose, treat, correct, administer anesthetics, or prescribe for any human disease, ailment, injury, infirmity, deformity, pain, or other condition, physical or mental, real or imaginary, or to attempt to do so, by any means or instrumentality, which in whole or in part is based upon emphasis of the importance of the musculoskeletal system and manipulative therapy in the maintenance and restoration of health, by an individual in Utah or outside of the state upon or for any human within the state, except that conduct described in this Subsection (8)(a) that is performed by a person legally and in accordance with a license issued under another chapter of this title does not constitute the practice of medicine.

CRITERION 1:

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
REGULATIONS

Professional Board Regulations

For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile.

U.A.C. R156-1-502


Unprofessional conduct includes:

(6) failing, as a prescribing practitioner, to follow the "Model Policy for the Use of Controlled Substances for the Treatment of Pain", 2004, established by the Federation of State Medical Boards, which is hereby adopted and incorporated by reference.

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Section 1: Preamble

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

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

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

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

(continued on next page)
REGULATIONS
Professional Board Regulations
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

(continued)

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

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

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

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

Section II: Guidelines

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

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

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

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

   a. urine/serum medication levels screening when requested;
   b. number and frequency of all prescription refills and
   c. reasons for which drug therapy may be discontinued (e.g., violation of agreement).

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

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

6. Medical Records—The physician should keep accurate and complete records to include:

   a. the medical history and physical examination,
   b. diagnostic, therapeutic and laboratory results,
   c. evaluations and consultations,
   d. treatment objectives,
   e. discussion of risks and benefits,
   f. informed consent,
   g. treatments,
   h. medications (including date, type, dosage and quantity prescribed),
   i. instructions and agreements and
   j. periodic reviews.

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

   (CONTINUED ON NEXT PAGE)
7. Compliance With Controlled Substances Laws and Regulations—To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

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

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

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

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

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

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

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

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

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

- **CONTROLLED SUBSTANCES ACT**
  
  Title 18. Health; Part 5. Foods and Drugs; Chapter 84. Possession and Control of Regulated Drugs

- **MEDICAL PRACTICE ACT (No provisions found)**
  
  Title 26. Professions and Occupations; Chapter 23. Medicine and Surgery

- **OSTEOPATHIC PRACTICE ACT**
  
  Title 26. Professions and Occupations; Chapter 33. Osteopathy

- **PHARMACY PRACTICE ACT**
  
  Title 26. Professions and Occupations; Chapter 36. Pharmacy

- **INTRACTABLE PAIN TREATMENT ACT**
  
  No policy found

REGULATIONS

- **CONTROLLED SUBSTANCES REGULATIONS**
  
  Agency 13. Agency of Human Services; Sub-Agency 140. Department of Health; Chapter 011. Regulated Drug Rule

- **MEDICAL BOARD REGULATIONS (No provisions found)**
  
  Agency 04. Secretary of State; Sub-Agency 030. Office of Professional Regulation; Chapter 150. Rules of the Vermont Board of Medical Practice

- **OSTEOPATHIC BOARD REGULATIONS (No provisions found)**
  
  Agency 04. Secretary of State; Sub-Agency 030. Office of Professional Regulation; Chapter 220. Rules of the Board of Osteopathic Physicians and Surgeons

- **PHARMACY BOARD REGULATIONS**
  
  Agency 04. Secretary of State; Sub-Agency 030. Office of Professional Regulation; Chapter 230. Board of Pharmacy Administrative Rules

OTHER GOVERNMENTAL POLICIES

- **MEDICAL BOARD GUIDELINE**
  
RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- **Bill of Rights for Hospital Patients**
  Title 18. Health; Part 3. Hospitals, Health Centers, Nursing Homes; Chapter 42. Bill of Rights for Hospital Patients

- **Nursing Home Resident Bill of Rights**
  Title 33. Human Services; Part 5. Programs and Services for Vulnerable Adults; Chapter 73. Nursing Home Residents’ Bill of Rights

- **Opiate Addiction Treatment**
  Agency 13. Agency of Human Services; Sub-Agency 140. Department of Health; Chapter 062. Opiate Addiction Treatment Rules
### Provisions that may ENHANCE pain management

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#### STATUTES
- **Controlled Substances Act**
- **Medical Practice Act**
- **Osteopathic Practice Act**
- **Pharmacy Practice Act**
- **Intractable Pain Treatment Act**

#### REGULATIONS
- **Controlled Substances**
- **Medical Board**
- **Osteopathic Board**
- **Pharmacy Board**

#### OTHER GOVERNMENTAL POLICIES
- **Medical Board Guideline**

#### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES
- **Bill of Rights for Hospital Patients**
- **Nursing Home Resident Bill of Rights**
- **Opiate Addiction Treatment**

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Note: A dot indicates that one or more provisions were identified

¹ No provisions were found in this policy, ² No policy found
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<td>Physical dependence or analgesic tolerance confused with “addiction”</td>
<td>Medical decisions are restricted</td>
<td>Length of prescription validity is restricted</td>
<td>Undue prescription requirements</td>
<td>Other provisions that may impede pain management</td>
<td>Provisions that are ambiguous</td>
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### STATUTES

- Controlled Substances Act
- Medical Practice Act
- Osteopathic Practice Act
- Pharmacy Practice Act
- Intractable Pain Treatment Act

### REGULATIONS

- Controlled Substances
- Medical Board
- Osteopathic Board
- Pharmacy Board

### OTHER GOVERNMENTAL POLICIES

- Medical Board Guideline

### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- Bill of Rights for Hospital Patients
- Nursing Home Resident Bill of Rights
- Opiate Addiction Treatment

Note: A dot indicates that one or more provisions were identified.

1 No provisions were found in this policy.
2 No policy found.
18 V.S.A. § 4201

§ 4201. Definitions
As used in this chapter, unless the context otherwise requires:

(24) "Practitioner" includes a physician, dentist, veterinarian, surgeon or any other person who may be lawfully entitled under this chapter to distribute, dispense, prescribe, or administer regulated drugs to patients.

(**CRITERION 3:** Opioids are part of professional practice)

26 V.S.A. § 1750

§ 1750. Definitions
As used in this chapter:

(10) "Practice of osteopathic medicine" means the diagnosis, treatment, operation or prescription for any human disease, pain, injury, deformity or other physical or mental condition, which practice is based in part upon educational standards and requirements which emphasize the importance of the neuromusculoskeletal structure and manipulative treatment in the maintenance and restoration of health.

(**CRITERION 2:** Pain management is part of medical practice)
STATUTES

Pharmacy Practice Act

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

26 V.S.A. § 2022

§ 2022. Definitions

As used in this chapter:

(15) “Practitioner” shall mean a physician, dentist, nurse, veterinarian, scientific investigator, or other person (other than pharmacists) licensed by this state or adjoining states or the province of Quebec and permitted by such license to dispense, conduct research with respect to or administer drugs in the course of professional practice or research in their respective state or province.

(+) CRITERION 3: Opioids are part of professional practice
CVR 13-140-011

VIII. Dosages and Doses

(a) Preface

18 V.S.A., § 4234 directs the Board of Health to establish a Recommended Individual Therapeutic Dosage for selected stimulants, depressants, and narcotic drugs. The Board of Health has done so, but wishes to formally preface this submission with an explanation of these dosages.

The Recommended Individual Therapeutic Dosage is not a medical or pharmacologic concept with any implication for medical practice. Instead, it is a legal concept established only for this statute.

In clinical practice, there is no one recommended dose and no predetermined maximum dose for most drugs. Most drugs have more than one legitimate use, and doses vary accordingly. The Board of Health does not intend to guide or restrict medical practice in any way. These doses do not represent a standard of practice.

REGULATIONS

Pharmacy Board Regulations

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

CVR 04-030-230

Section 8. Abbreviations And Definitions

8.23 “Practitioner” means an individual currently licensed, registered, or otherwise authorized by the appropriate jurisdiction to prescribe and administer Drugs in the course of professional practice.

19.3.2. No prescription for a Schedule II controlled drug shall be filled more than 10 days after issuance of the prescription.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
OTHER GOVERNMENTAL POLICY

Medical Board Guideline
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Federation of State Medical Boards of the United States, Inc.

The recommendations contained herein were adopted as policy by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., May 2004.

Introduction

The Federation of State Medical Boards (the Federation) is committed to assisting state medical boards in protecting the public and improving the quality and integrity of health care in the United States. In 1997, the Federation undertook an initiative to develop model guidelines and to encourage state medical boards and other health care regulatory agencies to adopt policy encouraging adequate treatment, including use of opioids when appropriate for patients with pain. The Federation thanks the Robert Wood Johnson Foundation for awarding a grant in support of the original project, and the American Academy of Pain Medicine, the American Pain Society, the American Society of Law, Medicine, & Ethics, and the University of Wisconsin Pain & Policy Studies Group for their contributions.

Since adoption in April 1998, the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain have been widely distributed to state medical boards, medical professional organizations, other health care regulatory boards, patient advocacy groups, pharmaceutical companies, state and federal regulatory agencies, and practicing physicians and other health care providers. The Model Guidelines have been endorsed by the American Academy of Pain Medicine, the Drug Enforcement Administration, the American Pain Society, and the National Association of State Controlled Substances Authorities. Many states have adopted pain policy using all or part of the Model Guidelines. Despite increasing concern in recent years regarding the abuse and diversion of controlled substances, pain policies have improved due to the efforts of medical, pharmacy, and nursing regulatory boards committed to improving the quality of and access to appropriate pain care.

Notwithstanding progress to date in establishing state pain policies recognizing the legitimate uses of opioid analgesics, there is a significant body of evidence suggesting that both acute and chronic pain continue to be undertreated. Many terminally ill patients unnecessarily experience moderate to severe pain in the last weeks of life. The undertreatment of pain is recognized as a serious public health problem that results in a decrease in patients' functional status and quality of life and may be attributed to a myriad of social, economic, political, legal and educational factors, including inconsistencies and restrictions in state pain policies. Circumstances that contribute to the prevalence of undertreated pain include: (1) lack of knowledge of medical standards, current research, and clinical guidelines for appropriate pain treatment; (2) the perception that prescribing adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities; (3) misunderstanding of addiction and dependence; and (4) lack of understanding of regulatory policies and processes. Adding to this problem is the reality that the successful implementation of state medical board pain policy varies among jurisdictions.

(CONTINUED ON NEXT PAGE)
In April 2003, the Federation membership called for an update to its Model Guidelines to assure currency and adequate attention to the undertreatment of pain. The goal of the revised model policy is to provide state medical boards with an updated template regarding the appropriate management of pain in compliance with applicable state and federal laws and regulations. The revised policy notes that the state medical board will consider inappropriate treatment, including the undertreatment of pain, a departure from an acceptable standard of practice. The title of the policy has been changed from Model Guidelines to Model Policy to better reflect the practical use of the document.

The Model Policy is designed to communicate certain messages to licensees that the state medical board views pain management to be important and integral to the practice of medicine; that opioid analgesics may be necessary for the relief of pain; that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society; that physicians have a responsibility to minimize the potential for the abuse and diversion of controlled substances; and that physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes. This policy is not meant to constrain or dictate medical decision-making.

Through this initiative, the Federation aims to achieve more consistent policy in promotion of adequate pain management and education of the medical community about treating pain within the bounds of professional practice and without fear of regulatory scrutiny. In promulgating this Model Policy, the Federation strives to encourage the legitimate medical uses of controlled substances for the treatment of pain while stressing the need to safeguard against abuse and diversion.

State medical boards are encouraged, in cooperation with their state's attorney general, to evaluate their state pain policies, rules, and regulations to identify any regulatory restrictions or barriers that may impede the effective use of opioids to relieve pain. Accordingly, this Model Policy has been revised to emphasize the professional and ethical responsibility of the physician to assess patients' pain as well as to update references and definitions of key terms used in pain management.

The Model Policy is not intended to establish clinical practice guidelines nor is it intended to be inconsistent with controlled substance laws and regulations.

1. As of January 2004, 22 of 70 state medical boards have policy, rules, regulations or statutes reflecting the Federation's Model Guidelines for the Use of Controlled Substances for the Treatment of Pain and two (2) states have formally endorsed the Model Guidelines.


(continued on next page)
OTHER GOVERNMENTAL POLICY

Medical Board Guideline

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

(+) CRITERION 8: Other provisions that may enhance pain management

CATEGORY A: Issues related to healthcare professionals

COMMENT: Recognizes that inadequate treatment of pain is subject to disciplinary action just as other substandard practices might be.

(+) CRITERION 2: Pain management is part of medical practice

(+) CRITERION 4: Encourages pain management

(+) CRITERION 7: Physical dependence or analgesic tolerance are not confused with “addiction”

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

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

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

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

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

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

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

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

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

Section II: Guidelines

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

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

**Treatment Plan—** The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or treatments are planned.

**Informed Consent and Agreement for Treatment—** The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient’s surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including urine/serum medication levels screening when requested; number and frequency of all prescription refills; and reasons for which drug therapy may be discontinued (e.g., violation of agreement).

(continues on next page)
Periodic Review—The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient’s state of health. Continuation or modification of controlled substances for pain management therapy depend on the physician’s evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient’s decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient’s response to treatment. If the patient’s progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

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

Medical Records—The physician should keep accurate and complete records to include
1. the medical history and physical examination,
2. diagnostic, therapeutic and laboratory results,
3. evaluations and consultations,
4. treatment objectives,
5. discussion of risks and benefits,
6. informed consent,
7. treatments,
8. medications (including date, type, dosage and quantity prescribed),
9. instructions and agreements and
10. periodic reviews.

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

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

(CONTINUED ON NEXT PAGE)
### OTHER GOVERNMENTAL POLICY

#### Medical Board Guideline

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

(Continued)

**Section III: Definitions**

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

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

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

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

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

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

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

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

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

**Bill of Rights for Hospital Patients**

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

(+) **CRITERION B:** Other provisions that may enhance pain management

**CATEGORY C:** Regulatory or policy issues

**COMMENT:** Establishes a responsibility for hospitals to ensure that pain management is an essential part of patient care.

18 V.S.A. § 1852

§ 1852. Patients' bill of rights; adoption

(a) The general assembly hereby adopts the 'Bill of Rights for Hospital Patients' as follows:

- The patient has the right to receive professional assessment of pain and professional pain management.

(+) **CRITERION B:** Other provisions that may enhance pain management

**CATEGORY C:** Regulatory or policy issues

**COMMENT:** Establishes a responsibility for nursing homes to ensure that pain management is an essential part of patient care.

**STATUTES**

**Nursing Home Resident Bill of Rights**

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

33 V.S.A. § 7301

§ 7301. Nursing home residents' bill of rights

The general assembly hereby adopts the Nursing Home Residents' Bill of Rights as follows:

(1) The governing body of the facility shall establish written policies regarding the rights and responsibilities of residents and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures shall be made available to residents, to any guardians, next of kin, reciprocal beneficiaries, sponsoring agency, or representative payees selected pursuant to subsection 205(j) of the Social Security Act, and Subpart Q of 20 CFR Part 404, and to the public.

(2) The staff of the facility shall ensure that, at least, each individual admitted to the facility:

- is provided with professional assessment of pain and its management.

(+) **CRITERION B:** Other provisions that may enhance pain management

**CATEGORY C:** Regulatory or policy issues

**COMMENT:** Establishes a responsibility for nursing homes to ensure that pain management is an essential part of patient care.
CVR 13-140-062

13 140 062. Opiate Addiction Treatment Rules

D. Pain Management in Maintenance Patients

1. Management of chronic pain in the methadone-maintained patient includes consultation with a specialist in pain medicine when possible and appropriate.

D. Patients with Chronic Pain

1. Programs shall make careful diagnostic distinctions between the physical dependence associated with chronic administration of opiates for relief of pain and the disease of opiate addiction. Apparent drug-seeking behaviors, typically associated with the disease of chronic opiate addiction, may occur as a response to inadequately treated or prolonged pain (“pseudo-addiction”). The physical dependence and tolerance to opiates seen in some chronic pain patients is an expected physiological response to pharmacological therapy and does not support a diagnosis of active opiate addiction.

CRITERION 8:
Other provisions that may enhance pain management

CATEGORY C: Regulatory or policy issues

COMMENT: Establishes a responsibility for OTP staff to refer methadone-maintained patients who have chronic pain for treatment of their pain.

CRITERION 8:
Other provisions that may enhance pain management

CATEGORY A: Issues related to healthcare professionals

COMMENT: Identifies pseudoaddiction as an important barrier to the appropriate use of opioid analgesics.

CRITERION 7:
Physical dependence or analgesic tolerance are not confused with “addiction”

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
STATUTES

- **CONTROLLED SUBSTANCES ACT**
  Title 54.1. Professions and Occupations; Subtitle III. Professions and Occupations Regulated by Boards Within the Department of Health Professions; Chapter 34. Drug Control Act

- **PROFESSIONAL PRACTICE ACT (No provisions found)**
  Title 54.1. Professions and Occupations; Subtitle III. Professions and Occupations Regulated by Boards Within the Department of Health Professions; Chapter 24. General Provisions

- **MEDICAL PRACTICE ACT**
  Title 54.1. Professions and Occupations; Subtitle III. Professions and Occupations Regulated by Boards Within the Department of Health Professions; Chapter 29. Medicine and Other Healing Arts

- **PHARMACY PRACTICE ACT**
  Title 54.1. Professions and Occupations; Subtitle III. Professions and Occupations Regulated by Boards Within the Department of Health Professions; Chapter 33. Pharmacy

- **INTRACTABLE PAIN TREATMENT ACT**
  No policy found

REGULATIONS

- **CONTROLLED SUBSTANCES REGULATIONS (Part of Pharmacy Board Regulations) (No provisions found)**
  Title 18. Professional Occupational Licensing; Agency Number 110. Board of Pharmacy

- **MEDICAL BOARD REGULATIONS**
  Title 18. Professional Occupational Licensing; Agency Number 85. Board of Medicine

- **PHARMACY BOARD REGULATIONS (No provisions found)**
  Title 18. Professional Occupational Licensing; Agency Number 110. Board of Pharmacy

OTHER GOVERNMENTAL POLICIES

- **MEDICAL BOARD GUIDELINE**
RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- **INJUNCTION AGAINST ASSISTED SUICIDE**
  Title 8.01. Civil Remedies and Procedures; Chapter 24. Injunctions

- **REGULATIONS FOR THE LICENSURE OF HOSPICE**
  Title 12. Health; Agency Number 5. Department of Health; Hospitals, Nursing Homes, and Related Institutions and Services; Chapter 391. Regulations for the Licensure of Hospice; Part II. Administrative Services
## Provisions that may ENHANCE pain management

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### STATUTES

- Controlled Substances Act
- Professional Practice Act
- Medical Practice Act
- Pharmacy Practice Act
- Intractable Pain Treatment Act

### REGULATIONS

- Controlled Substances
- Medical Board
- Pharmacy Board

### OTHER GOVERNMENTAL POLICIES

- Medical Board Guideline

### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- Injunction Against Assisted Suicide
- Regulations for the Licensure of Hospice

Note: A dot indicates that one or more provisions were identified

1 No provisions were found in this policy, 2 No policy found

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\textbf{STATUTES}

\textbf{Controlled Substances Act}

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

\begin{itemize}
\item \textbf{§ 54.1-3401. Definitions}
\end{itemize}

As used in this chapter, unless the context requires a different meaning:

\begin{itemize}
\item "Practitioner" means a physician, dentist, licensed nurse practitioner pursuant to § 54.1-2957.01, licensed physician assistant pursuant to § 54.1-2952.1, pharmacist pursuant to § 54.1-3300, TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32, veterinarian, scientific investigator, or other person licensed, registered or otherwise permitted to distribute, dispense, prescribe and administer, or conduct research with respect to, a controlled substance in the course of professional practice or research in the Commonwealth.
\end{itemize}

\begin{itemize}
\item \textbf{§ 54.1-3408.1. Prescription in excess of recommended dosage in certain cases}
\end{itemize}

In the case of a patient with intractable pain, a physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes.

Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this title.

\textbf{CRITERION 3:}

Opioids are part of professional practice

\textbf{CRITERION 6:}

Prescription amount alone does not determine legitimacy

Note: \textit{Underlining} and/or \textit{shading} was added to identify policy language meeting the corresponding criterion.
Virginia

STATUTES

Medical Practice Act

Va. Code Ann. § 54.1-2900

§ 54.1-2900. Definitions

As used in this chapter, unless the context requires a different meaning:

... “Practice of medicine or osteopathic medicine” means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method.

... Va. Code Ann. § 54.1-2912.2

§ 54.1-2912.2. Board may endorse certain document

In the furtherance of its responsibility to ensure continued practitioner competency, the Board of Medicine may endorse the Medical Society of Virginia’s Guidelines for the Use of Opioids in the Management of Chronic, Non-Cancer Pain, developed and adopted in 1997.

For the purpose of this section, “endorse” means to publicize and distribute such guidelines as providing an appropriate standard of care; however, the Board’s endorsement shall not be construed to mean that the guidelines must be followed or are regulations or are in any way intended to be enforceable law.

Va. Code Ann. § 54.1-2971.01

§ 54.1-2971.01. Prescription in excess of recommended dosage in certain cases

A. Consistent with § 54.1-3408.1, a physician may prescribe a dosage of a pain-relieving agent in excess of the recommended dosage upon certifying the medical necessity for the excess dosage in the patient’s medical record. Any practitioner who prescribes, dispenses or administers an excess dosage in accordance with this section and § 54.1-3408.1 shall not be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for recognized medicinal or therapeutic purposes.

B. The Board of Medicine shall advise physicians of the provisions of this section and § 54.1-3408.1.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
§ 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or therapeutic purposes only

A. A prescription for a controlled substance may be issued only by a practitioner of medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of this title. The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons or animals with whom the practitioner has a bona fide practitioner-patient relationship.

(+) CRITERION 3: Opioids are part of professional practice

A. The following words and terms when used in this chapter shall have the meanings ascribed to them in § 54.1-2900 of the Code of Virginia:

Practice of medicine or osteopathic medicine (by reference means the prevention, diagnosis and treatment of human physical or mental ailments, conditions, diseases, pain or infirmities by any means or method)
OTHER GOVERNMENTAL POLICY

Medical Board Guideline

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Federation of State Medical Boards of the United States, Inc.

The recommendations contained herein were adopted as policy by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., May 2004.

--------------------------------------------------------------------------------

Introduction

The Federation of State Medical Boards (the Federation) is committed to assisting state medical boards in protecting the public and improving the quality and integrity of health care in the United States. In 1997, the Federation undertook an initiative to develop model guidelines and to encourage state medical boards and other health care regulatory agencies to adopt policy encouraging adequate treatment, including use of opioids when appropriate for patients with pain. The Federation thanks the Robert Wood Johnson Foundation for awarding a grant in support of the original project, and the American Academy of Pain Medicine, the American Pain Society, the American Society of Law, Medicine, & Ethics, and the University of Wisconsin Pain & Policy Studies Group for their contributions.

Since adoption in April 1998, the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain have been widely distributed to state medical boards, medical professional organizations, other health care regulatory boards, patient advocacy groups, pharmaceutical companies, state and federal regulatory agencies, and practicing physicians and other health care providers. The Model Guidelines have been endorsed by the American Academy of Pain Medicine, the Drug Enforcement Administration, the American Pain Society, and the National Association of State Controlled Substances Authorities. Many states have adopted pain policy using all or part of the Model Guidelines. Despite increasing concern in recent years regarding the abuse and diversion of controlled substances, pain policies have improved due to the efforts of medical, pharmacy, and nursing regulatory boards committed to improving the quality of and access to appropriate pain care.

Notwithstanding progress to date in establishing state pain policies recognizing the legitimate uses of opioid analgesics, there is a significant body of evidence suggesting that both acute and chronic pain continue to be undertreated. Many terminally ill patients unnecessarily experience moderate to severe pain in the last weeks of life.2 The undertreatment of pain is recognized as a serious public health problem that results in a decrease in patients' functional status and quality of life and may be attributed to a myriad of social, economic, political, legal and educational factors, including inconsistencies and restrictions in state pain policies.3 Circumstances that contribute to the prevalence of undertreated pain include: (1) lack of knowledge of medical standards, current research, and clinical guidelines for appropriate pain treatment; (2) the perception that prescribing adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities; (3) misunderstanding of addiction and dependence; and (4) lack of understanding of regulatory policies and processes. Adding to this problem is the reality that the successful implementation of state medical board pain policy varies among jurisdictions.

(Continued on next page)
In April 2003, the Federation membership called for an update to its Model Guidelines to assure currency and adequate attention to the undertreatment of pain. The goal of the revised model policy is to provide state medical boards with an updated template regarding the appropriate management of pain in compliance with applicable state and federal laws and regulations. The revised policy notes that the state medical board will consider inappropriate treatment, including the undertreatment of pain, a departure from an acceptable standard of practice. The title of the policy has been changed from Model Guidelines to Model Policy to better reflect the practical use of the document.

The Model Policy is designed to communicate certain messages to licensees that the state medical board views pain management to be important and integral to the practice of medicine; that opioid analgesics may be necessary for the relief of pain; that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society; that physicians have a responsibility to minimize the potential for the abuse and diversion of controlled substances; and that physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes. This policy is not meant to constrain or dictate medical decision-making.

Through this initiative, the Federation aims to achieve more consistent policy in promotion of adequate pain management and education of the medical community about treating pain within the bounds of professional practice and without fear of regulatory scrutiny. In promulgating this Model Policy, the Federation strives to encourage the legitimate medical uses of controlled substances for the treatment of pain while stressing the need to safeguard against abuse and diversion.

State medical boards are encouraged, in cooperation with their state’s attorney general, to evaluate their state pain policies, rules, and regulations to identify any regulatory restrictions or barriers that may impede the effective use of opioids to relieve pain. Accordingly, this Model Policy has been revised to emphasize the professional and ethical responsibility of the physician to assess patients’ pain as well as to update references and definitions of key terms used in pain management.

The Model Policy is not intended to establish clinical practice guidelines nor is it intended to be inconsistent with controlled substance laws and regulations.

1. As of January 2004, 22 of 70 state medical boards have policy, rules, regulations or statutes reflecting the Federation’s Model Guidelines for the Use of Controlled Substances for the Treatment of Pain and two (2) states have formally endorsed the Model Guidelines.


(CONTINUED ON NEXT PAGE)
OTHER GOVERNMENTAL POLICY

Medical Board Guideline

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

(+) CRITERION 8:
Other provisions that may enhance pain management

CATEGOR A:
Issues related to healthcare professionals

COMMENT: Recognizes that inadequate treatment of pain is subject to disciplinary action just as other substandard practices might be.

(+) CRITERION 2:
Pain management is part of medical practice

(+) CRITERION 4:
Encourages pain management

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The (name of board) recognizes that principles of quality medical practice dictate that the people of the State of (name of state) have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes non-treatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

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

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

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

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

(CONTINUED ON NEXT PAGE)
OTHER GOVERNMENTAL POLICY

Medical Board Guideline

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

(continued)

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

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

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

Section II: Guidelines

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

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

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

Informed Consent and Agreement for Treatment—The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient’s surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including urine/serum medication levels screening when requested; number and frequency of all prescription refills; and reasons for which drug therapy may be discontinued (e.g., violation of agreement).

(continued on next page)
OTHER GOVERNMENTAL POLICY

Medical Board Guideline

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

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

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

1. the medical history and physical examination,
2. diagnostic, therapeutic and laboratory results,
3. evaluations and consultations,
4. treatment objectives,
5. discussion of risks and benefits,
6. informed consent,
7. treatments,
8. medications (including date, type, dosage and quantity prescribed),
9. instructions and agreements and
10. periodic reviews.

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

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

(Continued on next page)
OTHER GOVERNMENTAL POLICY

Medical Board Guideline

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

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

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

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

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

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

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

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

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

**Tolerance**—Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.
CRITERION 8: Other provisions that may enhance pain management

CATEGORY A: Issues related to healthcare professionals

COMMENT: Clarifies for physicians that there is an important distinction between physician-assisted suicide and prescribing controlled substances for pain relief; this language identifies a clinical misperception that is pervasive in end-of-life care and attempts to lessen its impact on patient treatment.

STATUTES

Injunction Against Assisted Suicide

For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

Va. Code Ann. § 8.01-622.1

§ 8.01-622.1. Injunction against assisted suicide; damages; professional sanctions

E. Nothing in this section shall be construed to limit or conflict with § 54.1-2971.01 or the Health Care Decisions Act (§ 54.1-2981 et seq.). This section shall not apply to a licensed health care provider who (i) administers, prescribes or dispenses medications or procedures to relieve another person’s pain or discomfort and without intent to cause death, even if the medication or procedure may hasten or increase the risk of death, or (ii) withholds or withdraws life-prolonging procedures as defined in § 54.1-2982. This section shall not apply to any person who properly administers a legally prescribed medication without intent to cause death, even if the medication may hasten or increase the risk of death.
12 VAC 5-391-240. Patient rights.

A. The hospice program shall establish and implement written policies and procedures regarding the rights of patients. A copy of the patient's rights shall be displayed in the hospice office for public review.

B. Written procedures to implement the policies shall ensure that each patient is:

5. Assured the right to participate in the planning of his care, including appropriate assessment and management of pain and the right to refuse services.


A. At the time of a patient's admission to the hospice program, the IDG shall develop and maintain a plan of care, including but not limited to:

4. A comprehensive assessment of pain, as warranted by the patient's condition and the scope of services provided by the hospice program.

12 VAC 5-391-330. Medical direction.

A. There shall be a medical director, who shall be a physician licensed by the Virginia Board of Medicine, responsible for the overall direction and management of the medical component of care. The individual shall have training and experience in the psychological and medical needs of the terminally ill.

B. The medical director shall have admitting privileges at one or more hospitals and nursing facilities that provide inpatient service to the hospice program's patients.

C. The duties and responsibilities of the medical director shall include at least the following:

1. Consulting with attending physicians regarding pain and symptom management.
STATUTES

- **CONTROLLED SUBSTANCES ACT**  
  Title 69. Food, Drugs, Cosmetics, and Poisons; Chapter 69.50. Uniform Controlled Substances Act

- **PROFESSIONAL PRACTICE ACT**  
  Title 18. Businesses and Professions; Chapter 18.130. Regulation of Health Professions – Uniform Disciplinary Act

- **MEDICAL PRACTICE ACT**  
  Title 18. Businesses and Professions;  
  Chapter 18.71. Physicians  
  Chapter 18.72. Medical Disciplinary Board

- **OSTEOPATHIC PRACTICE ACT (No provisions found)**  
  Title 18. Businesses and Professions; Chapter 18.57. Osteopathy – Osteopathic Medicine and Surgery

- **PHARMACY PRACTICE ACT (No provisions found)**  
  Title 18. Businesses and Professions;  
  Chapter 18.64. Pharmacists  
  Chapter 18.130. Regulation of Health Professions – Uniform Disciplinary Act

- **INTRACTABLE PAIN TREATMENT ACT**  
  No policy found

REGULATIONS

- **CONTROLLED SUBSTANCES REGULATIONS (No provisions found)**  
  Title 246. Department of Health; Chapter 887. Pharmacy; Regulations Implementing the Uniform Controlled Substances Act

- **PROFESSIONAL BOARD REGULATIONS (No provisions found)**  
  Title 246. Department of Health; Chapter 12. Administrative Procedures and Requirements for Credentialed Health Care Providers

- **MEDICAL BOARD REGULATIONS**  
  Title 246. Department of Health; Chapter 919. Medical Quality Assurance Commission

- **OSTEOPATHIC BOARD REGULATIONS (No provisions found)**  
  Title 246. Department of Health; Chapter 853. Osteopathic Physicians and Surgeons

- **PHARMACY BOARD REGULATIONS (No provisions found)**  
  Title 246. Department of Health; Chapters 856-905
OTHER GOVERNMENTAL POLICIES

Department of Health Guideline

RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

No policies found
## Provisions that may ENHANCE pain management

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### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

Note: A dot indicates that one or more provisions were identified

1 No provisions were found in this policy
2 No policy found
### Provisions that may IMPEDE pain management

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### STATUTES

- Controlled Substances Act
- Professional Practice Act
- Medical Practice Act
- Osteopathic Practice Act
- Pharmacy Practice Act
- Intractable Pain Treatment Act

### REGULATIONS

- Controlled Substances
- Professional Board
- Medical Board
- Osteopathic Board
- Pharmacy Board

### OTHER GOVERNMENTAL POLICIES

- Dept. of Health Guideline •

**RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES**

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Note: A dot indicates that one or more provisions were identified.

1. No provisions were found in this policy.
2. No policy found.
**WASHINGTON**

### STATUTES

**Controlled Substances Act**

For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

**Rev. Code Wash. (ARCW) § 69.50.101**

§ 69.50.101. Definitions

Unless the context clearly requires otherwise, definitions of terms shall be as indicated where used in this chapter:

- 

(w) "Practitioner" means:

1. A physician under chapter 18.71 RCW, a physician assistant under chapter 18.71A RCW, an osteopathic physician and surgeon under chapter 18.57 RCW, an optometrist licensed under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010 subject to any limitations in RCW 18.53.010, a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a registered nurse, advanced registered nurse practitioner, or licensed practical nurse under chapter 18.79 RCW, a pharmacist under chapter 18.64 RCW or a scientific investigator under this chapter, licensed, registered or otherwise permitted inssofar as is consistent with those licensing laws to distribute, dispense, conduct research with respect to or administer a controlled substance in the course of their professional practice or research in this state.

### STATUTES

**Professional Practice Act**

For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

**Rev. Code Wash. (ARCW) § 18.130.340**

§ 18.130.340. Opiate therapy guidelines

The secretary of health shall coordinate and assist the regulatory boards and commissions of the health professions with prescriptive authority in the development of uniform guidelines for addressing opiate therapy for acute pain, and chronic pain associated with cancer and other terminal diseases, or other chronic or intractable pain conditions. The purpose of the guidelines is to assure the provision of effective medical treatment in accordance with recognized national standards and consistent with requirements of the public health and safety.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
WASHINGTON

STATUTES

Medical Practice Act
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

Rev. Code Wash. (ARCW) § 18.71.011

§ 18.71.011. Definition of practice of medicine — Engaging in practice of chiropractic prohibited, when

A person is practicing medicine if he does one or more of the following:

1. Offers or undertakes to diagnose, cure, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality;

2. Administers or prescribes drugs or medicinal preparations to be used by any other person;

3. Severs or penetrates the tissues of human beings;

4. Uses on cards, books, papers, signs or other written or printed means of giving information to the public, in the conduct of any occupation or profession pertaining to the diagnosis or treatment of human disease or conditions the designation "doctor of medicine", "physician", "surgeon", "m.d." or any combination thereof unless such designation additionally contains the description of another branch of the healing arts for which a person has a license: PROVIDED HOWEVER, That a person licensed under this chapter shall not engage in the practice of chiropractic as defined in RCW 18.25.005.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
WASHINGTON

REGULATIONS

Medical Board Regulations

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

WAC § 246-919-800

WAC 246-919-800. Purpose.

(1) The medical quality assurance commission recognizes that effective pain management is an essential component of quality medical care and that no single approach to the treatment of pain is exclusively correct.

(2) The commission wishes to reassure practitioners that they need not fear disciplinary action from the commission for prescribing, dispensing, or administering opioids when treating pain so long as the care provided is consistent with currently acceptable medical practices. This includes acute, chronic and intractable pain (RCW 69.50.308(g)).

(3) While many other medications may be appropriate in the treatment of pain, these regulations specifically address the use of opioids. As used in these regulations, the term opioid means any natural or synthetic medication that has morphine like activity.

WAC § 246-919-810

WAC 246-919-810. What specific guidance should a practitioner follow?

(1) The commission has adopted guidelines for the management of pain in order to acquaint practitioners with recognized national standards in the field of pain treatment.

(2) These guidelines specifically address the patient evaluation and treatment plan, informed consent, periodic reviews, use of consultations, and the necessity for maintaining accurate and complete medical records.

(3) These guidelines may be revised from time to time to reflect changes in the practice of pain management.

(4) Practitioners who cannot or choose not to treat patients who have complex or chronic pain conditions should offer appropriate referrals for those patients.

WAC § 246-919-820

WAC 246-919-820. What knowledge should a practitioner possess to treat pain patients?

Practitioners treating pain should be:

(1) Knowledgeable about the complex nature of pain;

(2) Familiar with the pain treatment terms used in the commission's pain treatment guidelines; and

(3) Knowledgeable about acceptable pain treatment modalities.

WAC § 246-919-830

WAC 246-919-830. How will the commission evaluate prescribing for pain?

(1) The practitioner's treatment will be evaluated by a review of the provided care to see if it is clinically sound and in accordance with currently acceptable medical practice regarding the treatment of pain.

(2) No disciplinary action will be taken against a practitioner based solely on the quantity and/or frequency of opioids prescribed.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.

BACKGROUND

Substitute Senate Bill 5365 Uniform Disciplinary Act Amendments directed the Secretary of the Department of Health to "...coordinate and assist the regulatory boards and commissions of the health professions with prescribing authority in the development of uniform guidelines for addressing opiate therapy for acute pain and chronic pain associated with cancer and terminal diseases, or other chronic or intractable pain conditions. The purpose of the guidelines is to assure the provision of effective medical treatment in accordance with recognized national standards and consistent with requirement of public health safety".

The Department of Health convened a group entitled Task Force on Policies for Management of Pain. This task force included representation from the medical, pharmacy, and nurses’ associations and commissions; physicians from pain management clinics and private practice; a Washington state Representative; and patients with chronic intractable pain.

INTRODUCTION

There are widespread concerns among patients throughout the state about access to appropriate medical treatment, including opioid therapy, for addressing chronic intractable pain. Similarly, providers express apprehensions about challenges by state disciplinary authorities when prescribing opioid analgesics for indicated medical treatment when serving the legitimate medical needs of pain patients. The under treatment of chronic pain due to concerns about addiction and drug diversion affect the public health, safety and welfare. There is a need for guidance which would: a) encourage appropriate treatment for pain management; b) reduce providers’ fear of injudicious discipline; and, c) protect the public from inappropriate prescribing practices and diversion.

PURPOSE STATEMENT

The Secretary of the Department of Health recommends the uniform adoption, by appropriate state regulatory authorities, of the following guidelines when managing pain. It is not the intent of these guidelines to define complete standards of acceptable medical care in the treatment of pain patients. These guidelines are not intended to direct clinical practice parameters. It is the intent that providers will have confidence that these guidelines are the standard by which opioid usage is evaluated.

POLICY STATEMENT

Under generally accepted standards of medical practice, opioids may be prescribed for the treatment of acute or chronic pain including chronic pain associated with cancer and other non-cancer pain conditions. Prescribing opioids requires special consideration. It is the position of the Department of Health that opioids may be prescribed, dispensed, or administered when there is an indicated medical need without fear of injudicious discipline.

(CONTINUED ON NEXT PAGE)
OTHER GOVERNMENTAL POLICY

Department of Health Guideline

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

GUIDELINES FOR OPIOID USAGE

Acute Pain

Opioids are useful for patients with acute pain such as surgery, burn, or trauma. The goal of such treatment is to provide adequate and timely pain management to the patient. Side effects of opioids that are difficult to treat may occur and must be balanced against the benefits of pain relief. The provider should, for any patient who has a history of alcoholism or other drug addictions, carefully monitor medications and when available seek appropriate consultation.

Chronic Pain Associated With Cancer

Chronic pain associated with cancer may often be successfully managed with opioids. If use of opioids is the primary analgesic strategy, adequate doses should be given frequently enough to keep the patient continuously comfortable. Addiction is rare in patients with cancer pain; tolerance and physical dependency are often unavoidable and should not interfere with opioid prescribing. Not all pain in patients with cancer is responsive to opioids; alternative strategies for managing the pain should also be made available.

Other Chronic Pain Conditions

Opioid analgesics can be useful in the treatment of patients with intractable non-cancer pain especially, where efforts to remove the cause of pain or to treat it with other modalities have failed or were not fully successful. The pain of such patients may have a number of different etiologies and may require several modalities. In addition, the extent to which pain is associated with psychological, physical, and social impairment varies greatly. Therefore, the selection for a trial of opioid therapy should be based on a careful assessment of the pain as well as the impairment experienced by the patient.

Continuation of opioid therapy should be based on the provider's evaluation of the results of treatment, including the degree of pain relief, changes in psychological, physical, and social functioning, and appropriate utilization of health services. Providers are encouraged to obtain consultation from providers who are knowledgeable in pain management, particularly when managing patients with a history of alcohol abuse or previous chronic opioid use.

DEFINITIONS

1. Addiction - A disease process involving use of psychoactive substances wherein there is loss of control, compulsive use, and continued use despite adverse social, physical, psychological, or spiritual consequences.

2. Physical Dependence - A physiologic state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence is not necessarily associated with full blown addiction, and condition does not always equate with addiction.

3. Psychological Dependence - A subjective sense of need for a specific substance, either for its positive effects or to avoid negative effects associated with its abstinence.

4. Tolerance - State in which an increased dosage of a psychoactive substance is needed to produce a desired effect.

5. Withdrawal Syndrome - The onset of a predictable constellation of signs and symptoms following the abrupt discontinuation of, or rapid decrease in, dosage of a psychoactive substance.

(Continued on next page)
6. Acute Pain - An essential biologic signal of the potential for or the extent of injury. It is usually short-lived and is associated with hyperactivity of the sympathetic nervous system; e.g. tachycardia, increased respiratory rate and blood pressure, diaphoresis, and papillary dilation. The concurrent affect is anxiety.

7. Chronic Pain - Pain persistent beyond expected healing time and often cannot be ascribed to a specific injury. Chronic pain may not have a well-defined onset and by definition does not respond to treatment directed at its causes.

8. Intractable Pain in a Non-Cancer Patient - Pain in which the cause cannot be removed or otherwise treated and no relief or cure has been found after reasonable efforts.

GUIDELINES FOR ASSESSMENT AND DOCUMENTATION IN NON-CANCER PAIN

Alternative strategies for managing pain must be explored. If alternative strategies for managing the pain are unsuccessful, long term opioid therapy can be added. The goal is not merely to treat the symptoms of pain, but to devise pain management strategies which deal effectively with all aspects of the patient’s pain syndrome, including psychological, physical, social, and work-related factors. Documentation in the patient’s medical record should include:

1. History and medical examination - A complete physical examination and comprehensive medical history should be part of the active treatment record including, but not limited to, a review of past pain treatment outcomes and any history of addiction risks to establish a diagnosis and treatment plan.

2. Diagnosis and medical indication - A working diagnosis must be delineated, which includes the presence of a recognized medical indication for the use of any treatment or medication.

3. Written treatment plan with recorded measurable objectives - The plan should have clearly stated, measurable objectives, indication of further planned diagnostic evaluation, and alternative treatments.

4. Informed consent - Discussions of risks and benefits should be noted in some format in the patient’s record.

5. Periodic reviews and modifications indicated - At these periodic reviews, the provider should reassess the treatment plan, the patient’s clinical course, and outcome goals with particular attention paid to disease progression, side effect and emergence of new conditions.

6. Consultation - The treating provider should be knowledgeable and competent in referring patients to the appropriate specialist if needed and noting in the patient’s record the treating provider’s interpretation of the consultation reports. Additionally, a new patient with evidence of at-risk patterns of opioid usage should be evaluated by a knowledgeable specialist.

7. Records - The provider should keep accurate and complete records documenting the dates and clinical findings for all evaluations, consultations, treatments, medications and patient instructions.

(CONTINUED ON NEXT PAGE)
8. Assessment and monitoring - Some patients with chronic pain not associated with cancer may be at risk of developing increasing opioid consumption without objective improvement in functional status. Subjective reports by the patient should be supported by objective observations. Objective measures in the patient’s condition are determined by an ongoing assessment of the patient’s functional status, including the ability to engage in work or other gainful activities, patient consumption of health care resources, positive answers to specific questions about the pain intensity and its interference with activities of daily living, quality of family life and social activities, and physical activity of the patient as observed by the physician.

Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a disease with behavior characterized by psychological dependence and aberrant drug related behaviors. Addicts compulsively use drugs for non-medical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts, merely because they are being treated with opioids.

The physician is responsible for monitoring the dosage of the opioid. Monitoring includes ongoing assessment of patient compliance with drug prescriptions and related treatment plans. Communication between health care providers is essential. The patient should receive long term analgesic medications from one physician and where possible one pharmacy. All providers should be particularly cautious with patients with a history of alcoholism or other drug addiction when prescribing long term opioids. Consults with addiction specialists are recommended.

PATIENT RESPONSIBILITIES

1. It is the patient’s responsibility to candidly provide the treatment provider with a complete and accurate treatment history, including past medical records, past pain treatment and alcohol and other drug addiction history.

2. The patient should participate as fully as possible in all treatment decisions.

3. The patient and family members, if available, should inform the prescriber of all drug side effects and concerns regarding prescription drugs.

4. The patient should not use other psychoactive agents, including alcohol, naturopathic products or over-the-counter drugs without agreement of the prescriber.

5. The patient should use the same name when receiving medical care to assure completeness of the medical record.

6. The patient should demand respect and expect to be believed.

7. The patient should keep an open mind and be willing to work with the treatment provider, including:

   a. negotiate with the provider to arrive at an acceptable plan of treatment;

   b. be open in trying alternative treatment strategies; and

   c. follow the treatment provider’s instructions precisely.

8. The patient should, where possible, get all central nervous system medications from one provider. If this is not possible, the patient should inform each provider of all medication he/she is receiving.

9. The patient should, where possible, have all prescriptions filled at a single pharmacy.

10. The patient should not horde, share, or sell medications.

11. The patient should be aware that providers may, by law, share information with other providers about the patient’s care.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
WEST VIRGINIA

Citations for Policies Evaluated

STATUTES

- **CONTROLLED SUBSTANCES ACT**
  Chapter 60A. Uniform Controlled Substances Act

- **PROFESSIONAL PRACTICE ACT**
  Chapter 30. Professions and Occupations; Article 1. General Provisions Applicable to All State Boards of Examination or Registration Referred to in Chapter

- **MEDICAL PRACTICE ACT**
  Chapter 30. Professions and Occupations; Article 3. West Virginia Medical Practice Act

- **INTRACTABLE PAIN TREATMENT ACT (Part of Medical Practice Act)**
  Chapter 30. Professions and Occupations; Article 3A. Management of Intractable Pain

- **OSTEOPATHIC PRACTICE ACT (No provisions found)**
  Chapter 30. Professions and Occupations; Article 14. Osteopathic Physicians and Surgeons

- **PHARMACY PRACTICE ACT**
  Chapter 30. Professions and Occupations; Article 5. Pharmacists, Pharmacy Technician, Pharmacy Interns and Pharmacies

REGULATIONS

- **CONTROLLED SUBSTANCES REGULATIONS (Part of Pharmacy Board Regulations) (No provisions found)**
  Title 15. Legislative Rule; West Virginia Board of Pharmacy; Series 2. Rules of the Board of Pharmacy for the Uniform Controlled Substances Act

- **MEDICAL BOARD REGULATIONS**
  Title 11. Legislative Rule; West Virginia Board of Medicine

- **OSTEOPATHIC BOARD REGULATIONS**
  Title 24. Legislative Rule; West Virginia Board of Osteopathy

- **PHARMACY BOARD REGULATIONS**
  Title 15. Legislative Rule; West Virginia Board of Pharmacy
OTHER GOVERNMENTAL POLICIES

- **MEDICAL BOARD GUIDELINE**

- **JOINT BOARD POLICY STATEMENT**

RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

No policies found
### Provisions that may ENHANCE pain management

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<td>Controlled substances are necessary for public health</td>
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#### STATUTES
- Controlled Substances Act
- Professional Practice Act
- Medical Practice Act
- Intractable Pain Treatment Act
- Osteopathic Practice Act
- Pharmacy Practice Act

#### REGULATIONS
- Controlled Substances
- Medical Board
- Osteopathic Board
- Pharmacy Board

#### OTHER GOVERNMENTAL POLICIES
- Medical Board Guideline
- Joint Board Policy Statement

#### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

Note: A dot indicates that one or more provisions were identified

1 No provisions were found in this policy, 2 No policy found

### Provisions that may IMPEDE pain management

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<td>Length of prescription validity is restricted</td>
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### STATUTES

- Controlled Substances Act
- Professional Practice Act
- Medical Practice Act
- Intractable Pain Treatment Act
- Osteopathic Practice Act
- Pharmacy Practice Act

### REGULATIONS

- Controlled Substances Act
- Medical Board
- Osteopathic Board
- Pharmacy Board

### OTHER GOVERNMENTAL POLICIES

- Medical Board Guideline
- Joint Board Policy Statement

### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

Note: A dot indicates that one or more provisions were identified
1 No provisions were found in this policy.
2 No policy found

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### STATE STATUTES

**Controlled Substances Act**
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

W. Va. Code § 60A-1-101

<table>
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<th>Definitions</th>
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<td>As used in this act:</td>
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<tr>
<td>(v) &quot;Practitioner&quot; means:</td>
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<tr>
<td>(1) A physician, dentist, veterinarian, scientific investigator or other person licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer a controlled substance in the course of professional practice or research in this state.</td>
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### STATUTES

**Professional Practice Act**
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

W. Va. Code § 30-1-7a

<table>
<thead>
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<th>Continuing education</th>
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<tr>
<td>(1) Notwithstanding any other provision of this code or the provision of any rule to the contrary, each person issued a license to practice medicine and surgery or a license to practice podiatry or a license as a physician assistant by the West Virginia Board of Medicine, each person licensed as a pharmacist by the West Virginia Board of Pharmacy, each person licensed to practice registered professional nursing or licensed as an advanced nurse practitioner by the West Virginia Board of Examiners for Registered Professional Nurses, each person licensed as a licensed practical nurse by the West Virginia State Board of Examiners for Licensed Practical Nurses and each person licensed to practice medicine and surgery as an osteopathic physician and surgeon or certified as an osteopathic physician assistant by the West Virginia Board of Osteopathy shall complete two hours of continuing education coursework in the subject of end-of-life care including pain management during each continuing education reporting period through the reporting period ending the thirtieth day of June, two thousand five. The two hours shall be part of the total hours of continuing education required by each board by rule and not two additional hours.</td>
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Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
WEST VIRGINIA

CRITERION 2: Pain management is part of medical practice

W. Va. Code § 30-3-4

§ 30-3-4. Definitions

As used in this article:

(3) "Practice of medicine and surgery" means the diagnosis or treatment of, or operation or prescription for, any human disease, pain, injury, deformity or other physical or mental condition.

W. Va. Code § 30-3-14

§ 30-3-14. Professional discipline of physicians and podiatrists; reporting of information to board pertaining to professional malpractice and professional incompetence required; penalties; grounds for license denial and discipline of physicians and podiatrists; investigations; physical and mental examinations; hearings; sanctions; summary sanctions; reporting by the board; reapplication; civil and criminal immunity; voluntary limitation of license; probable cause determinations.

(c) The board may deny an application for license or other authorization to practice medicine and surgery or podiatry in this state and may discipline a physician or podiatrist licensed or otherwise lawfully practicing in this state who, after a hearing, has been adjudged by the board as unqualified due to any of the following reasons:

(13) Prescribing, dispensing, administering, mixing or otherwise preparing a prescription drug, including any controlled substance under state or federal law, other than in good faith and in a therapeutic manner in accordance with accepted medical standards and in the course of the physician’s or podiatrist’s professional practice: Provided, that a physician who discharges his or her professional obligation to relieve the pain and suffering and promote the dignity and autonomy of dying patients in his or her care, and in so doing, exceeds the average dosage of a pain relieving controlled substance, in Schedule II and III of the Uniform Control Substance Act, does not violate this article.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
WEST VIRGINIA

CRITERION 16:
Provisions that are ambiguous

CATEGORY B:
Unclear intent leading to possible misinterpretation

COMMENT: Suggests that physicians would not qualify for immunity and relief from concerns about regulatory scrutiny if they prescribe opioids as a treatment of first choice for patients who present initially with severe pain, such as those with sickle-cell anemia.

STATUTES

Intractable Pain Treatment Act

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

W. Va. Code § 30-3A-1 - 30-3A-4

§ 30-3A-1. Definitions

For the purposes of this article, the words or terms defined in this section have the meanings ascribed to them. These definitions are applicable unless a different meaning clearly appears from the context.

(1) An "accepted guideline" is a care or practice guideline for pain management developed by a nationally recognized clinical or professional association, or a specialty society or government-sponsored agency that has developed practice or care guidelines based on original research or on review of existing research and expert opinion. Guidelines established primarily for purposes of coverage, payment or reimbursement do not qualify as accepted practice or care guidelines when offered to limit treatment options otherwise covered by the provisions of this article.

(2) "Board" or "licensing board" means the West Virginia board of medicine, the West Virginia board of osteopathy, the West Virginia board of registered nurses or the West Virginia board of pharmacy.

(3) "Intractable pain" means a state of pain having a cause that cannot be removed. Intractable pain exists if an effective relief or cure of the cause of the pain: (1) is not possible; or (2) has not been found after reasonable efforts. Intractable pain may be temporary or chronic.

(4) "Nurse" means a registered nurse licensed in the state of West Virginia pursuant to the provisions of article seven [§ 30-7-1 et seq.] of this chapter.

(5) "Pharmacist" means a registered pharmacist licensed in the state of West Virginia pursuant to the provisions of article five [§ 30-5-1 et seq.] of this chapter.

(6) "Physician" means a physician licensed in the state of West Virginia pursuant to the provisions of article three or article fourteen [§§ 30-3-1 et seq. or 30-14-1 et seq.] of this chapter.

(Continued on next page)
§ 30-3A-2. Limitation on disciplinary sanctions or criminal punishment related to management of intractable pain

(a) A physician shall not be subject to disciplinary sanctions by a licensing board or criminal punishment by the state for prescribing, administering or dispensing pain-relieving controlled substances for the purpose of alleviating or controlling intractable pain when:

(1) In a case of intractable pain involving a dying patient, the physician discharges his or her professional obligation to relieve the dying patient's intractable pain and promote the dignity and autonomy of the dying patient, even though the dosage exceeds the average dosage of a pain-relieving controlled substance;

or

(2) In the case of intractable pain involving a patient who is not dying, the physician discharges his or her professional obligation to relieve the patient's intractable pain, even though the dosage exceeds the average dosage of a pain-relieving controlled substance, if the physician can demonstrate by reference to an accepted guideline that his or her practice substantially complied with that accepted guideline. Evidence of substantial compliance with an accepted guideline may be rebutted only by the testimony of a clinical expert. Evidence of noncompliance with an accepted guideline is not sufficient alone to support disciplinary or criminal action.

(b) A registered nurse shall not be subject to disciplinary sanctions by a licensing board or criminal punishment by the state for administering pain-relieving controlled substances to alleviate or control intractable pain, if administered in accordance with the orders of a licensed physician.

(c) A registered pharmacist shall not be subject to disciplinary sanctions by a licensing board or criminal punishment by the state for dispensing a prescription for a pain-relieving controlled substance to alleviate or control intractable pain, if dispensed in accordance with the orders of a licensed physician.

(d) For purposes of this section, the term "disciplinary sanctions" includes both remedial and punitive sanctions imposed on a licensee by a licensing board, arising from either formal or informal proceedings.

(e) The provisions of this section shall apply to the treatment of all patients for intractable pain, regardless of the patient's prior or current chemical dependency or addiction. The board may develop and issue policies or guidelines establishing standards and procedures for the application of this article to the care and treatment of persons who are chemically dependent or addicted.

(Continued on next page)
WEST VIRGINIA

CRITERION 3:
Opioids are part of professional practice

STATUTES

Intractable Pain Treatment Act
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

(continued)

§ 30-3A-3. Acts subject to discipline or prosecution

(a) Nothing in this article shall prohibit disciplinary action or criminal prosecution of a physician for:

(1) Failing to maintain complete, accurate, and current records documenting the physical examination and medical history of the patient, the basis for the clinical diagnosis of the patient, and the treatment plan for the patient;

(2) Writing a false or fictitious prescription for a controlled substance scheduled in article two (§ 60A-2-201 et seq.), chapter sixty-a of this code; or

(3) Prescribing, administering, or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801, et seq., chapter sixty-a of this code (§ 60A-1-101 et seq.); or

(4) Diverting controlled substances prescribed for a patient to the physician's own personal use.

(b) Nothing in this article shall prohibit disciplinary action or criminal prosecution of a nurse or pharmacist for:

(1) Administering or dispensing a controlled substance in violation of the provisions of the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. §§ 801, et seq., chapter sixty-a of this code (§ 60A-1-101 et seq.); or

(2) Diverting controlled substances prescribed for a patient to the nurse's or pharmacist's own personal use.

§ 30-3A-4. Construction of article

This article may not be construed to legalize, condone, authorize or approve mercy killing or assisted suicide.

STATUTES

Pharmacy Practice Act
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

W. Va. Code § 30-5-1b

§ 30-5-1b. Definitions

The following words and phrases, as used in this article, have the following meanings, unless the context otherwise requires:

(29) “Practitioner” means an individual currently licensed, registered or otherwise authorized by any state, territory or district of the United States to prescribe and administer drugs in the course of professional practice, including allopathic and osteopathic physicians, dentists, physician assistants, optometrists, veterinarians, podiatrists and nurse practitioners as allowed by law.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
REGULATIONS

Medical Board Regulations
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

W. Va. Admin. Code § 11-1A-12

§ 11-1A-12, 12.1
Causes For Denial, Probation, Limitation, Discipline, Suspension, or Revocation of Licenses of Physicians and Podiatrists.

12.1 The Board may deny an application for a licensee on probation, suspend a license, limit or restrict or revoke any license heretofore or hereafter issued by the Board, upon satisfactory proof that the licensee has:

v. Exercised influence on the patient or client in such a manner as to exploit the patient or client for the financial gain of the licensee or of a third party, which shall include, but not be limited to, the promoting or selling of services, goods, appliances or drugs and the promoting or advertising on any prescription form of a community pharmacy. For the purposes of this subdivision, it is legally presumed that prescribing, dispensing, administering, mixing or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities, is not in the best interests of the patient and is not in the course of the physician's or podiatrist's professional practice, without regard to his or her intent.

REGULATIONS

Osteopathic Board Regulations
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

W. Va. CSR § 24-1-18

§ 24-1-18. Causes For Denial, Probation, Limitation, Discipline, Suspension Or Revocation of Licenses of Osteopathic Physicians.

18.1. The Board may deny an application for a license, place a licensee on probation, suspend a license, limit or restrict a license or revoke any license issued by the Board, upon satisfactory proof that the licensee has:

18.1.22. Exercised influence on the patient or client in such a manner as to exploit the patient or client for the financial gain of the licensee or of a third party, which shall include, but not be limited to, the promoting or selling of services, goods, appliances or drugs and the promoting or advertising on any prescription form of a community pharmacy. For the purposes of this subdivision, it is legally presumed that prescribing, dispensing, administering, mixing or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities, is not in the best interests of the patient and is not in the course of the physician's professional practice, without regard to his or her intent.
W. Va. CSR § 15-1-2


2.1. The following words and phrases as used in this Rule have the following meanings, unless the context otherwise requires:

2.1.42. "Practitioner" means an individual currently licensed, registered or otherwise authorized by the jurisdiction in which he or she practices to prescribe and administer drugs in the course of professional practices, as allowed by law.
Medical Board Guideline

Policy for the Use of Controlled Substances for the Treatment of Pain

Section I: Preamble

The West Virginia Board of Medicine recognizes that principles of quality medical practice dictate that the people of the State of West Virginia have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inadequately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes non-treatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

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

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

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

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

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

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

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

Section II: Guidelines

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

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

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

Informed Consent and Agreement for Treatment—The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient’s surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including urine/serum medication levels screening when requested; number and frequency of all prescription refills; and reasons for which drug therapy may be discontinued (e.g., violation of agreement).

(continued on next page)

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
OTHER GOVERNMENTAL POLICY

Medical Board Guideline
- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

(CONTINUED)

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

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

Medical Records—The physician should keep accurate and complete records to include the medical history and physical examination, diagnostic, therapeutic and laboratory results, evaluations and consultations, treatment objectives, discussion of risks and benefits, informed consent, treatments, medications (including date, type, dosage and quantity prescribed), instructions and agreements and periodic reviews. Records should remain current and be maintained in an accessible manner and readily available for review.

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

Section III: Definitions

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

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

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

(CONTINUED ON NEXT PAGE)
OTHER GOVERNMENTAL POLICY

Medical Board Guideline
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

(CONTINUED)

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

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

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

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

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

Tolerance—Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose overtime. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.
WEST VIRGINIA BOARDS OF EXAMINERS FOR REGISTERED NURSES, MEDICINE, OSTEOPATHY, AND PHARMACY

JOINT POLICY STATEMENT ON PAIN MANAGEMENT AT THE END OF LIFE

Rationale

The West Virginia Boards of Examiners for Registered Professional Nurses, Medicine, Osteopathy, and Pharmacy (hereinafter the Boards) recognize that:

• inadequate treatment of pain for patients at end-of-life is a serious health problem affecting thousands of patients every year;

• fear about dying in pain is the number one concern of West Virginians and all Americans facing the end of life;¹

• principles of quality healthcare practice dictate that the people of the State of West Virginia have access to appropriate and effective pain relief; and

• the appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain at the end of life as well as reduce the morbidity associated with untreated or undertreated pain.

Insufficient pain control may result from health care professionals' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state, and local regulatory agencies may also result in inadequate treatment of pain. Therefore, this statement has been developed to clarify the Boards' position on adequate pain control and to address misperceptions health care professionals may have, specifically as related to the use of controlled substances for patients with terminal illness, to alleviate health care professional uncertainty and to ensure better pain management. This statement is not intended to define complete or best practice, but rather to communicate what the Boards consider to be within the boundaries of professional practice.

It is the position of the Boards that nurses, physicians, and pharmacists (hereinafter healthcare professionals) under their respective jurisdictions shall provide adequate pain control as a part of quality practice for all patients who experience pain as a result of terminal illness. Accordingly, all health care professionals who are engaged in treating terminally ill patients are obligated to become knowledgeable about effective methods of pain assessment and treatment as well as statutory requirements for prescribing, administering, and dispensing controlled substances.

This statement applies explicitly and solely to pain management at the end of life. It creates no presumption regarding appropriate or inappropriate pain management in other circumstances.

Definitions

"Adequate pain control" means pain management that reduces a patient's moderate or severe pain to a level of mild pain or no pain at all, as reported by the patient.

"Terminal illness" means the medical condition of a patient who is dying from an incurable, inevitable disease as diagnosed by a treating physician.

(Continued on next page)
West Virginia

OTHER GOVERNMENTAL POLICY

Joint Board Policy Statement

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

(Continued)

**Collaboration Among the Healthcare Team**

Communication and collaboration among members of the healthcare team and with the patient and family are essential to achieve adequate pain control in end-of-life care. Within this interdisciplinary framework for end-of-life care, effective pain management should include at a minimum:

- thorough documentation of all aspects of the patient's assessment and care;
- a working diagnosis and therapeutic treatment plan including pharmacologic and non-pharmacologic interventions;
- regular and documented evaluation of response to the interventions and, as appropriate, revisions to the treatment plan;
- evidence of communication among care providers;
- education of the patient and family; and,
- a clear understanding by the patient, the family and healthcare team of the treatment goals.

**Management of Pain**

The management of pain should be based upon current knowledge and research and may include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly and the quantity and frequency of pain medication doses should be adjusted according to the intensity and duration of the pain. Health care professionals should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Boards are obligated under the laws of the State of West Virginia to protect the public health and safety. The Boards recognize that inappropriate prescribing, administering, and dispensing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Health care professionals should be diligent in preventing the diversion of drugs for illegitimate purposes. While not in any way minimizing the severity of this problem, the Boards recognize that governmental policies to prevent the misuse of controlled substances should not interfere with their appropriate use for the legitimate medical purpose of providing effective relief of pain at the end of life.

Health care professionals should not fear disciplinary action from the Boards for prescribing, administering, or dispensing controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. All such prescribing must be established with clear documentation of unrelieved pain and in compliance with applicable state or federal law.

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OTHER GOVERNMENTAL POLICY

Joint Board Policy Statement

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

(continued)

Physicians

The West Virginia Boards of Medicine and Osteopathy judge the validity of prescribing based on the physician’s treatment of the patient and on available documentation, rather than on the quantity and frequency of prescribing. To facilitate communication between health care professionals, physicians should write on the prescription for a controlled substance for a terminally ill patient the diagnosis “terminal illness.” The goal is to control the patient’s pain for its duration while effectively addressing other aspects of the patient’s functioning, including physical, psychological, social, and spiritual dimensions. The West Virginia Management of Intractable Pain Act sets forth the conditions under which physicians may prescribe opioids without fear of discipline. This act states that in a case of intractable pain involving a dying patient, the physician discharges his or her professional obligation to relieve the dying patient’s intractable pain and promote the dignity and autonomy of the dying patient, even though the dosage exceeds the average dosage of a pain-relieving controlled substance. (West Virginia Code §30-3A-1 et seq). This entire act is attached to this statement. Because, by law, West Virginia physicians have a professional and ethical obligation to control the pain of dying patients, the West Virginia Board of Medicine regards inadequate control of pain as a possible basis for professional discipline. The West Virginia Board of Osteopathy acknowledges and accepts that osteopathic physicians have the professional and ethical obligation to control the pain of dying patients.

Nurses

The nurse is often the healthcare professional most involved in the on-going pain assessment, implementation of the prescribed pain management plan, evaluation of the patient’s response to pain medications, and adjustment of the amount of medication administered based on patient status. To accomplish adequate pain control, the physician’s prescription must provide dosage ranges and frequency parameters within which the nurse may titrate medication to achieve adequate pain control. Consistent with the scope of professional nursing practice (Title 19, Series 10), which includes prime consideration of comfort and safety for all patients, the registered professional nurse is accountable for implementing the pain management plan utilizing his or her knowledge and documented assessment of the patient’s needs. The nurse has the authority to adjust the amount of medication administered within the dosage and frequency ranges stipulated by the treating physician and according to established protocols of the healthcare institution or agency. However, the nurse does not have the authority to change the medical pain management plan. When adequate pain control is not being achieved under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the treating physician and documenting this communication. The West Virginia Management of Intractable Pain Act sets forth the conditions under which nurses may administer opioids without fear of discipline.

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**OTHER GOVERNMENTAL POLICY**

**Joint Board Policy Statement**
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

(Continued)

**Pharmacists**

With regard to pharmacy practice, West Virginia has no quantity restrictions on dispensing controlled substances including those in Schedule II. This fact is significant when utilizing the federal rule and state law that allow the partial filling of Schedule II prescriptions for up to 60 days for patients who are terminally ill or in a long-term care facility. In these situations it would minimize expenses and unnecessary waste of drugs if the physician would note on the prescription that the patient is terminally ill and specify partial filling may be appropriate. The pharmacist may then dispense smaller quantities of the prescription to meet the patient's needs up to the total quantity authorized.

Government-approved labeling for dosage level and frequency can be useful as guidance for patient care. Health professionals may, on occasion, determine that higher levels are justified in specific cases. Federal and state rules also allow the facsimile transmittal of an original prescription for Schedule II drugs for hospice patients. As an exception to the general rule that prescriptions for Schedule II drugs must be in writing and signed by the physician, in an emergency, a pharmacist may dispense a Schedule II pain-relieving controlled substance upon an oral prescription, provided that the quantity dispensed is limited to the amount adequate to treat the patient during the emergency, and a written prescription is supplied to the pharmacy within 7 days following the oral prescription. Pharmacy rules also allow the emergency refilling of prescriptions in Schedules III, IV, and V. The West Virginia Management of Intractable Pain Act sets forth the conditions under which pharmacists may dispense opioids without fear of discipline.


2 American Medical Association Code of Medical Ethics. Opinions 2.20, 2.21 and 2.211.
STATUTES

- **CONTROLLED SUBSTANCES ACT**
  Controlled Substances; Chapter 961. Uniform Controlled Substances Act

- **MEDICAL PRACTICE ACT** (No provisions found)
  Regulation and Licensing; Chapter 448. Medical Practices

- **PHARMACY PRACTICE ACT** (No provisions found)
  Regulation and Licensing; Chapter 450. Pharmacy Examining Board

- **INTRACTABLE PAIN TREATMENT ACT**
  No policy found

REGULATIONS

- **CONTROLLED SUBSTANCES REGULATIONS** (No provisions found)
  Controlled Substances Board

- **MEDICAL BOARD REGULATIONS** (No provisions found)
  Medical Examining Board

- **PHARMACY BOARD REGULATIONS** (No provisions found)
  Pharmacy Examining Board

OTHER GOVERNMENTAL POLICIES

- **PHARMACY BOARD POLICY STATEMENT**

RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

- **NURSING HOMES**
  Department of Health and Family Services; Chapter HFS 132. Nursing Homes; Subchapter VI. Services
### Provisions that may ENHANCE pain management

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<td>Controlled substances are necessary for public health</td>
<td>Pain management is part of medical practice</td>
<td>Opioids are part of professional practice</td>
<td>Encourages pain management</td>
<td>Addresses fear of regulatory scrutiny</td>
<td>Prescription amount alone does not determine legitimacy</td>
<td>Physical dependence or analgesic tolerance are not confused with &quot;addiction&quot;</td>
<td>Other provisions that may enhance pain management</td>
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Note: A dot indicates that one or more provisions were identified
¹ No provisions were found in this policy.
² No policy found.
### Provisions that may IMPEDE pain management

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Note: A dot indicates that one or more provisions were identified.
¹ No provisions were found in this policy.
² No policy found.
Wis. Stat. § 961.001

Declaration of intent.

The legislature finds that the abuse of controlled substances constitutes a serious problem for society. As a partial solution, these laws regulating controlled substances have been enacted with penalties. The legislature, recognizing a need for differentiation among those who would violate these laws makes this declaration of legislative intent:

(1g) Many of the controlled substances included in this chapter have useful and legitimate medical and scientific purposes and are necessary to maintain the health and general welfare of the people of this state.

Wis. Stat. § 961.01

Definitions.

As used in this chapter:

(19) "Practitioner" means:

(a) A physician, advanced practice nurse, dentist, veterinarian, podiatrist, optometrist, scientific investigator or, subject to s. 448.21 (3), a physician assistant, or other person licensed, registered, certified or otherwise permitted to distribute, dispense, conduct research with respect to, administer or use in teaching or chemical analysis a controlled substance in the course of professional practice or research in this state.

Wis. Stat. § 961.38

Prescriptions.

(1g) In this section, "medical treatment" includes dispensing or administering a narcotic drug for pain, including intractable pain.
OTHER GOVERNMENTAL POLICY

Pharmacy Board Policy Statement

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

The Wisconsin Pharmacy Examining Board encourages patient pain control by optimizing the Patient - Pharmacy - Medical care management triad.

BACKGROUND

The Wisconsin Pharmacy Examining Board has been approached by June L. Dahl, PhD, Director of the Wisconsin Pain Initiative and Matt Bromley, Communications and Policy Director for the American Alliance of Cancer Pain Initiatives, to expand its position statement of Pain & Policy Studies Group on Wisconsin Pharmacists and Schedule II Medications as published in the Board’s Wisconsin Regulatory Digest article Volume 13, No. 2 October, 2001 [http://drl.wi.gov/boards/phm/digest/20011000.pdf]

A survey of Wisconsin pharmacists’ knowledge and attitudes about dispensing opioid analgesics for chronic cancer and non-cancer pain was published in the March/April 2001 issue of the Journal of the American Pharmaceutical Association. [http://www.medsch.wisc.edu/painpolicy/publicat/01japhak/01japhak.htm] The study found that not all pharmacists knew what constituted legitimate dispensing practices for controlled substances under federal or state policy in emergencies or for patients with terminal illness. Also many pharmacists were unaware of the distinction between addiction, physical dependence, and tolerance. The Board encourages pharmacists to re-educate themselves with current literature on pain management. Appropriate pain control can improve or at least maintain a patient’s quality of life. It is the pharmacist’s duty to provide medications along with proper counseling to ensure pain control. The PEB considers refusal to fill a Schedule II prescription based on speculation or ignorance unacceptable.

Specifically, this expanded Position Board Statement clearly articulates to pharmacists that the Board;
1) encourages pain management;
2) recognizes that pain management, and the use of opioids for pain management, are a part of medical pharmacy practice; and,
3) recognizes confusion exists around the terms addiction, physical dependence and tolerance.

While developing this statement, the Board surveyed multiple other state’s Position Statements for completeness and consistency. The Board acknowledges utilization of the position statements of The Iowa and Texas Boards of Pharmacy.

As with all professional and practice questions, should they require clarification, the Board encourages Pharmacist contact. Written correspondence is preferred either via the Department of Regulation and Licensing URLs or by US Postal Service.

(continued on next page)
OTHER GOVERNEMENTAL POLICY

Pharmacy Board Policy Statement

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

CONTINUED

The Wisconsin Pharmacy Examining Board
Position Statement on the Treatment of Pain

The mission of The Wisconsin Pharmacy Examining Board is to promote, preserve and protect the public health, safety and welfare by fostering provision of quality pharmaceutical care to all Wisconsinites. The Board recognizes quality care dictates the citizens of the State of Wisconsin have access to appropriate and effective pain relief. The appropriate application of current knowledge, practice standards and treatment modalities can serve to improve the quality of life for those patients who suffer from pain. This in turn will reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages pharmacists to view effective pain management as a part of quality care for ALL patients with pain, acute or chronic. It is especially important for patients who experience pain as a result of terminal illness. All pharmacists should become knowledgeable about effective methods of pain treatment, as well as, statutory requirements for dispensing controlled substances.

Inadequate pain control may result from physicians’ and pharmacists’ lack of knowledge about pain management or an inadequate understanding of addiction. The Board recognizes controlled substances, including opioid analgesics, may be essential in the treatment of pain, whether acute due to trauma or surgery or chronic due to cancer or non-cancer origins.

The Board recognizes controlled substances are subject to abuse by individuals who seek them for mood altering and other psychological effects rather than their legitimate medical uses. When dispensing controlled substances, the pharmacist should be diligent in preventing them from being diverted from legitimate to illegitimate use.

Tolerance and physical dependence are normal consequences of sustained use of these drugs and are NOT synonymous with psychological dependency (addiction). Psychological dependency is characterized by the compulsion to take a drug despite its harmful and destructive effect on the individual. Tolerance represents a secondary medical condition requiring pharmacy and medical assistance to resolve and continue patient pain control. Psychological dependency requires social (regulatory), plus pharmacy and medical assistance to maximize patient care while controlling the harmful and destructive patient behavior.

As with all medication therapies, the Board affirms the pharmacist’s duty to provide medications along with proper counseling to ensure pain control. Failure to:

a) counsel, monitor and assist the patient in receiving optimal care of any condition or, b) knowingly facilitating care, continuing care or providing medications known to be inappropriate to the patient is unprofessional practice with the possibility of discipline under various Board rules plus Wisconsin and Federal Regulations. IE, controlled substances shall only be dispensed for legitimate medical purposes.

By participating as a member of the health care team, Pharmacists should NOT fear disciplinary action from the Board for dispensing controlled substances, including opioid analgesics, for a legitimate medical purpose in the usual course of professional practice. The Board will initially consider dispensing controlled substances for pain to be for a legitimate medical purpose based on accepted scientific knowledge of the treatment of pain, patient clinical presentation and sound clinical judgment. All such dispensing must be based on clear documentation in the patient’s pharmacy records of the patient’s medical condition plus pertinent discussions with the prescribing practitioner. Using proper written documentation, the patient’s medical condition and clinical response to treatment provide a strong foundation for verifying optimal patient care, if review of the patient record is necessitated at some future time.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
Wis. Adm. Code HFS 132.60

HFS 132.60 Resident care.

(1) INDIVIDUAL CARE. Unless it is in conflict with the plan of care, each resident shall receive care based upon individual needs.

(c) Basic nursing care. 1. Nursing care initiated in the hospital shall be continued immediately upon admission to the nursing home unless ordered otherwise by the admitting physician.

5. The nursing home shall provide appropriate assessment and treatment of pain for each resident suspected of or experiencing pain based on accepted standards of practice that includes all of the following:

a. An initial assessment of pain intensity that shall include: the resident's self-report of pain, unless the resident is unable to communicate; quality and characteristics of the pain, including the onset, duration and location of pain; what measures increase or decrease the pain; the resident's pain relief goal; and the effect of the pain on the resident's daily life and functioning.

b. Regular and periodic reassessment of the pain after the initial assessment, including quarterly reviews, whenever the resident's medical condition changes, and at any time pain is suspected, including prompt reassessment when a change in pain is self-reported, suspected or observed.

c. The delivery and evaluation of pain treatment interventions to assist the resident to be as free of pain as possible.

d. Consideration and implementation, as appropriate, of non-pharmacological interventions to control pain.

(+)

CRITERION 8: Other provisions that may enhance pain management

CATEGORY C: Regulatory or policy issues

COMMENT: Establishes a responsibility for nursing homes to ensure that pain management is an essential part of patient care.
STATUTES

- **CONTROLLED SUBSTANCES ACT**
  Title 35. Public Health and Safety; Chapter 7. Food and Drugs; Article 10. Controlled Substances

- **MEDICAL PRACTICE ACT**
  Title 33. Professions and Occupations; Chapter 26. Physicians and Surgeons

- **PHARMACY PRACTICE ACT** (No provisions found)
  Title 33. Professions and Occupations; Chapter 24. Pharmacy

- **INTRACTABLE PAIN TREATMENT ACT**
  No policy found

REGULATIONS

- **CONTROLLED SUBSTANCES REGULATIONS**
  Agency 024. Commerce Department; Sub-Agency 060. Board of Pharmacy - Commissioner of Drugs and Substances Control; Commissioner of Drugs and Substances Control Rules and Regulations

- **MEDICAL BOARD REGULATIONS**
  Agency 024. Commerce Department; Sub-Agency 052. Board of Medicine Rules and Regulations

- **PHARMACY BOARD REGULATIONS**
  Agency 024. Commerce Department; Sub-Agency 059. Board of Pharmacy

OTHER GOVERNMENTAL POLICIES

- **MEDICAL BOARD POLICY STATEMENT**

RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

No policies found
## Provisions that may ENHANCE pain management

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<td>Prescription amount alone does not determine legitimacy</td>
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### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

Note: A dot indicates that one or more provisions were identified

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<td>Opioids are a last resort</td>
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<td>Length of prescription validity is restricted</td>
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### STATUTES
- Controlled Substances Act
- Medical Practice Act
- Pharmacy Practice Act
- Intractable Pain Treatment Act

### REGULATIONS
- Controlled Substances Act
- Medical Board
- Pharmacy Board

### OTHER GOVERNMENTAL POLICIES
- Medical Board Policy Statement

### RELEVANT POLICIES OR PROVISIONS IDENTIFIED BY BOOLEAN (KEY WORD) SEARCHES

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Note: A dot indicates that one or more provisions were identified.  
1 No provisions were found in this policy, 2 No policy found
WYOMING

STATUTES

Controlled Substances Act

- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

Wyo. Stat. § 35-7-1002

§ 35-7-1002 Definitions

(a) As used in this act:

(xx) "Practitioner" means:

(A) A physician, dentist, veterinarian, podiatrist, scientific investigator, or other person licensed, registered or otherwise permitted to distribute, dispense, conduct research with respect to or administer a controlled substance in the course of professional practice or research in this state;

§ 35-7-1060 Controlled substances prescription tracking program

(a) In addition to other duties and responsibilities as provided by this act, the board shall maintain a computerized program to track prescriptions for controlled substances for the purposes of assisting patients, practitioners and pharmacists to avoid inappropriate use of controlled substances and of assisting with the identification of illegal activity related to the dispensing of controlled substances. The tracking program and any data created thereby shall be administered by the board, and the board may charge reasonable fees to help defray the costs of operating the program. Any fee shall be included with and in addition to other registration fees established by the board as authorized in W.S. 35-7-1023.

(b) All prescriptions for schedule II, III and IV controlled substances dispensed by any retail pharmacy licensed by the board shall be filed with the board electronically or by other means required by the board. The board may require the filing of other prescriptions and may specify the manner in which the prescriptions are filed.

(c) The tracking program shall not be used to infringe on the legal use of a controlled substance. Information obtained through the controlled substance prescription tracking program is confidential and may not be released and is not admissible in any judicial or administrative proceeding, except as follows:

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.

WYOMING STATUTES

Medical Practice Act

- For complete reference to this policy, see “Citations for Policies Evaluated” at the beginning of this State Profile -

§ 33-26-102 Definitions

(a) As used in this chapter:

(x) “Practicing medicine” means any person who in any manner:

(A) Advertises, holds out, or represents to the public that he is authorized to practice medicine in this state; or

(B) Offers or undertakes to prevent, diagnose, correct or treat, in any manner, by any means, method or device, any human disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition, injury, deformity or ailment, including the management of pregnancy and parturition;

§ 33-26-402 Grounds for suspension; revocation; restriction; imposition of conditions; refusal to renew or other disciplinary action

(a) The board may refuse to renew, and may revoke, suspend or restrict a license or take other disciplinary action, including the imposition of conditions or restrictions upon a license on one (1) or more of the following grounds:

(x) Except as permitted by law, repeatedly prescribing or administering, selling or supplying any drug legally classified as a narcotic, addicting or scheduled drug to a known abuser;
REGULATIONS

Controlled Substances Regulations

WC WR 024-060-001

Section 1.01. Definitions.

As used herein, the following terms shall have the meanings specified:

(f) The term "Drug Dependent Person" means a person who is using a controlled substance and who is in a state of psychic or physical dependence, or both arising from the use of that substance on a continuous basis. Drug dependence is characterized by behavioral and other responses which include a strong compulsion to take the substance on a continuous basis in order to experience its psychic effects or to avoid the discomfort caused by its absence.

REGULATIONS

Medical Board Regulations

WC WR 024-052-001

Chapter 1 LICENSE ELIGIBILITY, APPLICATION AND INTERVIEWS

Section 3. Definitions.

The definitions contained in W.S. 33-26-102 and those contained in the APA are incorporated herein by this reference. In addition, the following definitions apply to this chapter:

(k) "Practicing medicine" means any person who in any manner:

(i) Advertises, holds out or represents to the public that he is authorized to practice medicine in this state; or

(ii) Offers or undertakes to prevent, diagnose, correct or treat, in any manner, by any means, method or device any human disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition, injury, deformity or ailment, including the management of pregnancy and parturition.
REGULATIONS

Pharmacy Board Regulations
- For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile -

WC WR 024-059-002

CHAPTER 002. GENERAL PRACTICE OF PHARMACY REGULATIONS

Section 4. Definitions.

(w) "Practitioner" means an individual currently licensed, registered or otherwise authorized by the jurisdiction in which he/she practices to prescribe drugs in the course of professional practice.

Note: Underlining and/or shading was added to identify policy language meeting the corresponding criterion.
MEMO TO: ALL WYOMING PHYSICIANS AND PHYSICIAN ASSISTANTS

From: John H. Babson, President
Wyoming Board of Medicine
Re: Medical charts for patients
Using Schedule II-IV controlled drugs
Date: December 15, 2005

Many physicians worry about how to care for patients with intractable pain: Should addiction be feared more than pain relief? Will adequate pain relief lead to trouble with the Board of Medicine? What resources are available to help me with patients taking medicine for chronic pain: have I consulted the Wyoming Board of Pharmacy’s Prescription Drug Monitoring Program (PDMP)?

Though the first question will remain a matter of professional judgment, the second can be easily answered: The Board of Medicine has NEVER SANCTIONED A PHYSICIAN FOR PAIN MANAGEMENT THAT IS APPROPRIATE AND WELL DOCUMENTED.

The Board has investigated cases involving extraordinary amounts of controlled substances. In most instances, the physicians involved presented an adequate diagnostic basis for the therapy and produced extensive, detailed documentation in support of the decisions. The investigations in those matters were closed without disciplinary action. In a few situations, however, physicians were unable to produce sufficient documentation and they faced different results, generally Board mandated courses in pain management and/or record maintenance.

To assure yourself that your documentation is appropriate, please consider the following:

1. Be sure that your medical records contain evidence of an ADEQUATE HISTORY AND PHYSICAL, including an assessment of pain and physical and psychological function. Always include a notation indicating inquiry into substance abuse history, and assessment of underlying and coexisting disease and a review of any recognized medical indication for controlled substances. Document attempts to maintain the patient on the lowest dose necessary to achieve relief and improve function;

2. YOUR TREATMENT PLAN SHOULD DISCLOSE CLEAR CUT, OBJECTIVE CRITERIA by which the patient’s progress can be measured. Though physicians should tailor pain relief to each patient’s individual needs, goals such as pain relief and improved physical and psychosocial function should be included and progress carefully monitored and noted;

3. Make certain that your records indicate that you DISCUSSED THE RISKS AND BENEFITS WITH THE PATIENT, reviewed other, available treatment options and noted the patient’s understanding and consent in the chart;

4. Your records must reflect PERIODIC REVIEW OF THE TREATMENT COURSE. New information should be added to the records along with appropriate assessment of continued treatment and the trial of other modalities;

(Continued on next page)
OTHER GOVERNMENTAL POLICY

Medical Board Policy Statement

For complete reference to this policy, see "Citations for Policies Evaluated" at the beginning of this State Profile.

(CONTINUED)

5. DOCUMENT CONSULTATIONS WITH OTHER PHYSICIANS AND HEALTH CARE PROVIDERS. Consult with colleagues knowledgeable and experienced in handling prolonged treatment with controlled substances. The chart should also reflect your willingness to refer the patient for evaluation and treatment to achieve the goals of the treatment plan. If you or the patient has any qualms about a proposed treatment plan, suggest a second opinion. Physicians should pay special attention and document any indication that their patient is at risk of misuse, diversion and/or past or potential substance abuse disorder;

6. To the extent possible, assure yourself that the RECORDS INDICATE ALL MEDICATIONS THE PATIENT IS TAKING, the purpose for each medication, the duration, dose and frequency and identification of the physician, PA or APN writing the prescriptions;

7. Ask the patient and document inquiries about obtaining CONTROLLED SUBSTANCES FROM OTHER SOURCES, including physicians, the internet and any other provider;

8. Be certain that your ACTIONS ARE IN COMPLIANCE WITH FEDERAL AND STATE SUBSTANCE ABUSE LAWS AND REGULATIONS. Call the Wyoming Board of Pharmacy if you have any questions about prescribing: 307-234-0294

9. Please be sure the entire chart, including hospital records, is LEGIBLE. Documentation, no matter how complete, is of little value if it cannot be read.

PRESCRIPTION DRUG MONITORING PROGRAM

In addition to careful planning and adequate chart notation, the Wyoming Board of Pharmacy has developed a tool to assist you in patient care. THE PRESCRIPTION DRUG MONITORING PROGRAM (PDMP), IS A DATA BASE COLLECTING MONTHLY REPORTS OF PATIENT SPECIFIC DATA FROM ALL WYOMING PHARMACIES FOR ALL SCHEDULE II, III AND IV CONTROLLED SUBSTANCE PRESCRIPTIONS DISPENSED TO WYOMING RESIDENTS.

Accessible to all licensed providers holding a valid unrestricted DEA number, you can request a specific patient profile for all or selected scheduled drugs over a defined time period. Upon a faxed request from a physician the Pharmacy Board will generate the requested report within one hour. Additionally, the Pharmacy Board frequently generates unsolicited patient profiles and mails them to practitioners who prescribed, and the pharmacies that dispensed the drugs in question.

If interested in using this valuable service, please utilize a personalized profile request (PPR) sent to you with your DEA number. You can obtain PPR forms by contacting Denise Embury, Records Analyst at the Board of Pharmacy, 307-234-0294.
Purpose of this section:

Policy affecting pain management can be improved by repealing or amending negative provisions and by adopting new positive provisions. This section presents examples of provisions from pain policies, including from federal law, expert bodies, and the states. Model or uniform acts are referenced where applicable; they are the product of careful consideration and drafting by expert bodies. Although not an exhaustive compilation, this section provides language that can be adopted or adapted as alternatives to existing statutes, regulations, or guidelines according to the policy needs of individual states.

Using this section:

The need to consider using provisions in this section will become apparent after reviewing how the policies of a particular state have been evaluated and presented in the State Profiles section (see Section VIII). Improving balance means increasing the provisions with potential to enhance pain management, and decreasing those that may impede it. If a state has few positive provisions, Part A can be used to identify provisions to consider adopting. If a state has a number of negative provisions, Part B can provide guidance for repealing the language or adopting alternatives. Example language is not given for Criterion #8, Criterion #15, or Criterion #16 because these criteria can be applied to a number of diverse issues; the policy language associated with these criteria can be found for each state in the State Profiles section (Section VIII).

It is important to note that this is not a comprehensive overview of the ways that states can improve patient access to adequate pain management through policy adoption or change. The criteria used to evaluate state pain policies directly relate to the Central Principle of Balance, and affect the availability and medical use of opioid analgesics. Some states, however, have initiated legislative or regulatory activity that has the potential to impact pain management, but fall outside of evaluation criteria. Although such policy may ultimately have beneficial consequences for patients' pain relief, they contain no language associated with any of the evaluation criteria; therefore, neither positive nor negative provisions are identified. Consequently, a policy can contribute to pain management but fail to contain language that meets the evaluation criteria.

Pointers:

Model Policy. Evaluation of the Federation’s Model Policy, using the criteria in this publication, shows that it satisfies most positive criteria and contains no negative provisions. Adoption of the Model Policy by state professional licensing boards will enhance the evaluation of a state’s pain policies. Consequently, state healthcare regulatory boards are encouraged to adopt new policies, or amend their existing guidelines, according to the recent national standard created by the Federation. To date, 28 states have adopted the Model Policy, or the previous Model Guidelines, either all or in part.

Legislation. In general, legislation involving the use of controlled substances in pain management and medical practice should be avoided because of the unpredictability of the legislative process and the risk of undue regulation of medical practice and decisions about patient care. However, if impediments exist in statute, only the legislative process can remove...
them. Depending on their significance, specific legislation may be needed, or may be delayed until there is an opportunity to rectify the problem as an amendment to other legislation.

Cautions. The purpose of this document is to promote positive policy change, ultimately leading to more balanced policy regarding the use of controlled substances for pain management. Positive policy change, however, is not enough. To be effective, policy adoption must be followed by consistent implementation and efforts to communicate the policy widely and repeatedly to healthcare professionals to encourage positive practice change.

The model provisions are presented in the same order as the evaluation criteria. Many of the specific provisions are taken from models, which can be adopted in their entirety.

PART A. Provisions That May Enhance Pain Management

The following provisions may be considered for inclusion in policies that currently lack language to enhance pain management.

CRITERION #1. CONTROLLED SUBSTANCES ARE RECOGNIZED AS NECESSARY FOR THE PUBLIC HEALTH

The following are examples of provisions expressing that controlled substances are necessary for the public health. Without such a provision, a state’s controlled substances law would focus disproportionately on the abuse potential of opioids, thereby creating an unbalanced policy. Such a provision is present in international narcotics control treaties, and the federal CSA, and should be present in a state’s Uniform Controlled Substances Act.

**Federal Controlled Substances Act**

“Many of the drugs included within this title have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.” (21 USCS § 801(1))

**Uniform Controlled Substances Act**

“Legitimate use of controlled substances is essential for public health and safety, and the availability of these substances must be assured.” (National Conference of Commissioners on Uniform State Laws, 1994)

**Wisconsin - Statute - Uniform Controlled Substances Act**

“Many of the controlled substances included in this chapter have useful and legitimate medical and scientific purposes and are necessary to maintain the health and general welfare of the people of this state.” (Wis. Stat. § 961.001 (1g))

Note: Adopted from the Federal Controlled Substances Act (21 USCS § 801(1)).
CRITERION #2. PAIN MANAGEMENT IS RECOGNIZED AS PART OF GENERAL MEDICAL PRACTICE

The following language clearly recognizes that pain management is a part of medical practice. This language follows the Federation’s well-established model Modern Medical Practice Act (MMPA) and should appear in a state’s Medical Practice Act or regulations, and also has been adopted into the practice acts of other healthcare professions.

**MODERN MEDICAL PRACTICE ACT**

Definitions.
“The definition of the practice of medicine should include...offering or undertaking to prevent or to diagnose, correct and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect or abnormal physical or mental condition of any person, including the management of pregnancy and parturition.” (Federation of State Medical Boards of the U.S., 2000)

**RHODE ISLAND - STATUTE - Medical Practice Act**

Definitions.
“The practice of medicine’ shall include the practice of allopathic and osteopathic medicine. Any person shall be regarded as practicing medicine within the meaning of this chapter who holds himself or herself out as being able to diagnose, treat, operate, or prescribe for any person ill or alleged to be ill with disease, pain, injury, deformity or abnormal physical or mental condition, or who shall either profess to heal, offer or undertake, by any means or method to diagnose, treat, operate, or prescribe for any person for disease, pain, injury, deformity or physical or mental condition.” (R.I. Gen. Laws 5-37-1 (13))

*Note: Adopted from the Modern Medical Practice Act (Federation of State Medical Boards, 1988)*

**COLORADO - STATUTE - Controlled Substances Act**

“(1) As used in this section, ‘medical treatment’ includes dispensing or administering a narcotic drug for pain, including intractable pain.” (CO Rev. Stat. CSA 18-18-308)

**NEW JERSEY - STATUTE - Osteopathic Practice Act**

“...the practice of osteopathy shall include the diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity, mental or physical condition.” (N.J. Stat. §45:9-14.3)

*Note: Adopted from the Modern Medical Practice Act (Federation of State Medical Boards, 1988)*
**IOWA – REGULATION – Medical Board Regulations**

Definitions.
“'The practice of medicine and surgery' shall mean holding one's self out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition and who shall either offer or undertake, by any means or methods, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical or mental condition.” (653 IAC 10.1(17A,147))

Note: Adopted from the Modern Medical Practice Act (Federation of State Medical Boards, 1988)

**TENNESSEE – REGULATION – Osteopathic Board Regulations**

“The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness.” (1050-2-.13)

Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**FLORIDA – REGULATION – Pharmacy Board Regulations**

“The Board encourages pharmacies to view pain management as a part of quality pharmacy practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness.” (64B16-27.831, F.A.C.)

Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**CONNECTICUT – Medical Board Guideline**

“...the Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness.” (“Statement of the Connecticut Medical Examining Board on the Use of Controlled Substances for the Treatment of Pain.” Pennsylvania State Board of Medicine Bulletin. pp. 4-5. Winter 1998-1999. Effective: October 20, 1998)

Note: Adopted from the Model Policy for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 2004)
CRITERION #3. MEDICAL USE OF OPIOIDS IS RECOGNIZED AS LEGITIMATE PROFESSIONAL PRACTICE

This language recognizes that the use of opioids as controlled substances is a legitimate, and therefore legal, medical practice. Sometimes the medical use of opioids has been relegated to the periphery of practice or even outside practice. Such recognition is an important contribution to a balanced regulatory environment for physicians, osteopaths, pharmacists, and nurses.

WEST VIRGINIA - Joint Board Policy Statement

“The West Virginia Boards of Examiners for Registered Professional Nurses, Medicine, Osteopathy, and Pharmacy (hereinafter the Boards) recognize that...principles of quality healthcare practice dictate that the people of the state of West Virginia have access to appropriate and effective pain relief.” (West Virginia Examiners for Registered Professional Nurses, Medicine, Osteopathy, and Pharmacy Boards. “Joint Policy Statement on Pain Management at the End of Life.” Adopted March 12, 2001)

Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

NEW YORK - STATUTE - Controlled Substances Act

“Practitioner’ means: A physician, dentist, podiatrist, veterinarian, scientific investigator, or other person licensed, or otherwise permitted to dispense, administer or conduct research with respect to a controlled substance in the course of a licensed professional practice...” (NY CLS Pub Health §3302)

MICHIGAN - STATUTE - Medical Practice Act

“(1) The legislature finds that the use of controlled substances is appropriate in the medical treatment of certain forms of intractable pain, and that the efforts to control diversion or improper administration of controlled substances should not interfere with the legitimate, medically recognized use of those controlled substances to relieve pain and suffering.” (MPA 14.15 (16204c))

NEW JERSEY - STATUTE - Pharmacy Practice Act

“Practitioner’ means an individual currently licensed, registered or otherwise authorized by the jurisdiction in which the individual practices to administer or prescribe drugs in the course of professional practice.” (N.J. Stat. §45:14-41)
**ARKANSAS - REGULATION - Controlled Substances Regulations**

“A physician, podiatric physician, osteopathic physician, dentist, veterinarian, optometrist, scientific investigator, researcher, mid-level practitioner, or other persons licensed, registered, or otherwise permitted to prescribe, dispense, distribute, administer or conduct research with respect to controlled substances in the course of professional practice.” (007 07 CARR 009)

**UTAH - REGULATION - Professional Practice Regulations**

“The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment.” (R156-1-502)

*Note: Adopted from the Model Policy for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 2004)*

**ALABAMA - REGULATION - Medical Board Regulations**

“The Board will consider prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds.” (540-X-4-.08 AAC)

*Note: Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*

**TENNESSEE - REGULATION - Osteopathic Board Regulations**

“The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds.” (1050-2-.13)

*Note: Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*

**IDAHO - REGULATION - Pharmacy Board Regulations**

“ 02. Individual Practitioner. The term ‘individual practitioner’ means a physician, dentist, veterinarian, or other individual licensed, registered, or otherwise permitted, by the state in which he practices, to dispense a controlled substance in the course of professional practice, but does not include a pharmacist, a pharmacy, or an institutional practitioner.” (IDAPA 27.01.01.433)
**SOUTH DAKOTA - Medical Board Guideline**

“The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment...” (South Dakota State Board of Medical and Osteopathic Examiners. "The Federation of State Medical Boards of the United States, Inc. Model Guidelines for the Use of Controlled Substances for the Treatment of Pain." Effective: January, 1999)

*Note: Adopted from the Model Policy for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 2004)*

**ARIZONA - Osteopathic Board Guideline**

“The Board will consider prescribing, ordering, administering, or dispensing controlled substances for pain to be for a legitimate medical purpose if based on accepted scientific knowledge of the treatment of pain or if based on sound clinical grounds.” (Arizona Board of Osteopathic Examiners in Medicine and Surgery Guidelines. “The Prescribing of Controlled Substances for the Treatment of Pain Management.” Effective: January 22, 2000)

*Note: Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*

**IOWA - Pharmacy Board Policy Statement**

“The Board recognizes that the use of controlled substances, including opioid analgesics, is often essential for adequate pain control.” (Iowa Board of Pharmacy Examiners. “The Treatment of Pain.” Effective: February 12, 2002)

**KANSAS - Joint Board Policy Statement**

“Prescribing, administering or dispensing controlled substances, including opioid analgesics, to treat pain is considered a legitimate medical purpose if based upon sound clinical grounds. (Kansas State Boards of Healing Arts, Nursing, and Pharmacy.” “Joint Policy Statement by the Boards of Healing Arts, Nursing, and Pharmacy on the Use of Controlled Substances for the Treatment of Pain.” Approved: July 17, 2002)

*Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*
CRITERION #4. PAIN MANAGEMENT IS ENCOURAGED

Is it the policy of the state to encourage pain management? Although some states have taken steps to improve pain management, the answer to this important question can be made explicitly clear by including specific language in state policy. Several states have adopted policies that encourage pain management. Such language can occur in statutes, regulations, or guidelines – an appropriate place to add such language would be in state board policies that regulate the health professions and establish standards of practice.

**OKLAHOMA - STATUTE - Uniform Controlled Substances Act**

“The State of Oklahoma encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic. It is especially important for patients who experience pain as a result of terminal illness.” (63 Okl. St. § 2-551)

**ARKANSAS - STATUTE - Medical Practice Act**

“The General Assembly finds that: (1) Pain management plays an important role in good medical practice.” (ACA § 17-95-701-707)

**NEBRASKA - STATUTE - Public Health and Welfare**

“The Legislature therefore encourages physicians to view effective pain management as part of quality medical practice for all patients with pain, acute or chronic, including those patients who experience pain as a result of terminal illness.” (Pub Health and Welfare 71-2418)

**UTAH - REGULATIONS - Professional Practice Regulations**

“Accordingly, this policy has been developed to clarify the Board’s position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.” (R156-1-502)

*Note: Adopted from the Model Policy for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 2004)*

**IOWA - REGULATIONS - Medical Board Regulations**

“The purpose of the rule is to assist physicians who prescribe and administer drugs to provide relief and eliminate suffering in patients with chronic, nonmalignant pain as defined in this rule.” (635 IAC 10.1(17A,147))
**FLORIDA - REGULATIONS - Pharmacy Board Regulations**

“Accordingly, these guidelines have been developed to... encourage better pain management.” (64B16-27.831, F.A.C.)

*Note:* Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**FLORIDA - REGULATIONS - Pharmacy Board Regulations**

“Accordingly, these guidelines have been developed to... encourage better pain management.” (64B16-27.831, F.A.C.)

*Note:* Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**CALIFORNIA - Medical Board Guideline**

“These Guidelines are intended to promote improved pain management for all forms of pain and for all patients in pain.” (California Medical Board. “Guideline for Prescribing Controlled Substances for Intractable Pain.” Action Report. Vol. 87, pp. 1, 4-6. October 2003. Adopted: August 2, 2003)

**ARIZONA - Osteopathic Board Guideline**

“The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of a terminal illness.” (Arizona Board of Osteopathic Examiners in Medicine and Surgery Guidelines. “The Prescribing of Controlled Substances for the Treatment of Pain Management.” Effective: January 22, 2000)

*Note:* Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**MICHIGAN - Pharmacy Board Guideline**

“The Board encourages pharmacists to view effective pain management as a part of quality health care for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness.” (Michigan Board of Pharmacy. “Michigan Board of Pharmacy Guidelines for the Use of Controlled Substances for the Treatment of Pain.”)

*Note:* Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**KANSAS - Joint Board Policy Statement**

“The boards adopt this statement to help assure health care providers and patients and their families that it is the policy of this state to encourage competent comprehensive care for the treatment of pain.” (Kansas Boards of Healing Arts, Nursing, and Pharmacy “Joint Policy Statement of the Boards of Healing Arts, Nursing, and Pharmacy on the Use of Controlled Substances for the Treatment of Pain.” Effective: 7/17/2002)
**Criterion #5. Practitioners’ Concerns about Regulatory Scrutiny Are Addressed**

Fear of regulatory scrutiny, real or perceived, is an important impediment to the adequate management of pain and should be addressed to achieve a balanced regulatory environment. A number of states have adopted provisions in statutes, regulations, and guidelines to allay these fears. It should be noted that adoption of policy alone may have little effect until it is implemented and observed by government agencies, as well as understood and accepted by practitioners. Adoption of such a policy should be preceded by a review of enforcement, regulatory, or disciplinary actions and media coverage so that the agency adopting the policy is prepared to address the reasons for concerns in any meetings or materials that accompany the policy.

**New Mexico - Statute - Pain Relief Act**

“No health care provider who prescribes, dispenses or administers medical treatment for the purpose of relieving intractable pain and who can demonstrate by reference to an accepted guideline that his practice substantially complies with that guideline and with the standards of practice identified in Section 4 of the Pain Relief Act shall be subject to disciplinary action or criminal prosecution, unless the showing of substantial compliance with an accepted guideline is rebutted by clinical expert testimony. If no currently accepted guidelines are available, then rules issued by the board may serve the function of such guidelines for purposes of the Pain Relief Act. The board rules must conform to the intent of that act. Guidelines established primarily for purposes of coverage, payment or reimbursement do not qualify as an “accepted guideline” when offered to limit treatment options otherwise covered within the Pain Relief Act.”

(N.M. Stat. Ann § 24-2D-3)

*Note: Adopted from the Pain Relief Act (Project on Legal Constraints on Access to Effective Pain Relief, 1996).*

**Arkansas - Medical Practice Act**

“(a) (1) A physician shall not be subject to disciplinary action by the Arkansas State Medical Board solely for prescribing dangerous or controlled drugs for the relief of chronic intractable pain.”

(A.C.A. § 17-95-701-707)

**Oklahoma - Controlled Substances Act**

“D. The Oklahoma State Board of Medical Licensure and Supervision and the Oklahoma State Board of Osteopathic Examiners shall issue policies, guidelines or rules that ensure that physicians who are engaged in the appropriate treatment of pain are not subject to disciplinary action, and the Boards shall consider policies and guidelines developed by national organizations with expertise in pain medicine or in a medical discipline for this purpose.”

(UCSA 63 Okl St 2-551)
ALABAMA – REGULATION – Medical Board Regulations

“Physicians should not fear disciplinary action from the Board, or other state regulatory or enforcement agency for prescribing, dispensing, or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice.” (540-X-4-.08)

Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

NEVADA – Osteopathic Practice Act

“An osteopathic physician is not subject to disciplinary action solely for: 1. Prescribing or administering to a patient under his care…(c)A controlled substance which is listed in schedule II, III, IV or V by the State Board of Pharmacy pursuant to NRS 453.146, if the controlled substance is lawfully prescribed or administered for the treatment of intractable pain in accordance with accepted standards for the practice of osteopathic medicine.” (Nev. Rev. Stat. Ann § 633.521)

NEBRASKA – Public Health and Welfare Act

“The Board of Examiners in Medicine and Surgery shall adopt policies and guidelines for the treatment of pain to ensure that physicians who are engaged in the appropriate treatment of pain are not subject to disciplinary action, and the board shall consider policies and guidelines developed by national organizations with expertise in pain management for this purpose.” (Public Health and Welfare 71-2420)

UTAH – REGULATION – Professional Practice Regulations

“Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice.” (R156-1-502. Unprofessional Conduct)

Note: Adapted from the Model Policy for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 2004)

TENNESSEE – REGULATION – Osteopathic Board Regulations

“Physicians should not fear disciplinary action from the Board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice.” (1050-2-.13 Specifically Regulated Areas and Aspects of Medical Practice)

Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)
**FLORIDA - REGULATION - Pharmacy Board Regulations**

“Pharmacists should not fear disciplinary action from the Board or other state regulatory or enforcement agencies for dispensing controlled substances for a legitimate medical purpose.” (64B16-27.831, F.A.C. “Standards of Practice for the Dispensing of Controlled Substances for Treatment of Pain”)

**NORTH CAROLINA - Medical Board Policy Statement**

“No physician need fear reprisals from the Board for appropriately prescribing, as described above, even large amounts of controlled substances indefinitely for chronic non-malignant pain.” (“Management of Chronic Non-Malignant Pain,” issued by the North Carolina Board of Medical Examiners, September 13, 1996)

**ARIZONA - Osteopathic Board Guideline**

“Physicians should not fear disciplinary action from the Board, or other state regulatory or enforcement agency for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice.” (Arizona Board of Osteopathic Examiners in Medicine and Surgery Guidelines. “The Prescribing of Controlled Substances for the Treatment of Pain Management.” Effective: January 22, 2000)

*Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*

**TEXAS - Pharmacy Board Policy Statement**

“Pharmacists should not fear disciplinary action from the Board for dispensing controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice.” (“Texas State Board of Pharmacy Position Statement on the Treatment of Pain,” Adopted August 29, 2001)

*Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*

**WEST VIRGINIA - Joint Board Policy Statement**

“Health care professionals should not fear disciplinary action from the Board for prescribing, administering, or dispensing controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. All such prescribing must be established with clear documentation of unrelieved pain and in compliance with applicable state of federal law.” (West Virginia Examiners for Registered Professional Nurses, Medicine, Osteopathy, and Pharmacy Boards. “Joint Policy Statement on Pain Management at the End of Life.” Adopted March 12, 2001)

*Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*
**CRITERION #6. PRESCRIPTION AMOUNT ALONE IS RECOGNIZED AS INSUFFICIENT TO DETERMINE LEGITIMACY OF PRESCRIBING**

In the past there has been a tendency to judge the legitimacy of a practice on the basis of the amount or duration of prescribing. However, a judgment based on such limited information is likely to yield “false positives” (i.e., identification of acceptable treatment as inappropriate). A decision about professional conduct should be made according to the adequacy of care in relation to professional standards. Some states have adopted standards of care that replace quantity and duration with an evaluation of the physician’s treatment of the patient. This is in keeping with the Central Principle of Balance because it replaces an arbitrary standard with one that focuses on the physician’s overall treatment of the patient.

**VIRGINIA – STATUTE – Controlled Substances Act**

“In the case of a patient with intractable pain, a physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient’s medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be in violation of the provisions of this title because of such dosage, if such excess dosage, is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes.” (CSA 54.1-3408.1)

**NEBRASKA – STATUTE – Public Health and Welfare Act**

“(3) The Legislature finds that physicians should be able to prescribe, dispense, or administer a controlled substance in excess of the recommended dosage.” (Public Health and Welfare 71-2418 Legislative Findings)

**NEW MEXICO – STATUTE – Pain Relief Act**

“D. In an action brought by a board against a health care provider based on treatment of a patient for pain, the board shall consider the totality of the circumstances and shall not use as the sole basis of the action…(6) the quantity of medication prescribed or dispensed.” (Pain Relief Act 24-2D-3 Disciplinary Action;)

**TENNESSEE – REGULATION – Medical Board Regulations**

“It is the position of the board that these drugs may be prescribed for the treatment of pain and other related symptoms after a reasonably based medical diagnosis has been made, in adequate doses, and for appropriate lengths of time, which in some cases may be as long as the pain or related symptoms persist.” (0880-2-.14, TAC)

**FLORIDA – REGULATION – Osteopathic Board Regulations**

“The Board will judge the validity of prescribing based on the osteopathic physician’s treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing.” (64B15-14.005, F.A.C. Standards for the Use of Controlled Substances for Treatment of Pain)

*Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*
**Utah - Regulation - Professional Practice Regulations**

“The Board will judge the validity of the physician’s treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration.” (R156-1-502. Unprofessional Conduct)

*Note:* Adapted from the Model Policy for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 2004)

**Nebraska - Medical Board Guidelines**

“The Board will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and chronicity of prescribing.” (“Guidelines for the Use of Controlled Substances for the Treatment of Pain” issued by the Kansas State Board of Healing Arts, October 17, 1998)

*Note:* Adopted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**Arizona - Osteopathic Board Guideline**


*Note:* Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**Texas - Medical Board Policy Statement**

Quantity and chronicity of prescribing will be judged on the basis of the diagnosis and treatment of the targeted symptoms and neither of these factors are prima facie evidence of inappropriate or excessive prescribing. (“Pain Control and the Texas State Board of Medical Examiners,” Newsletter, Vol. 15, no. 1, Spring/Summer 1993, p. 1)

**California - Pharmacy Board Policy Statement**

“The Board understands that the ongoing use of opioids for cancer, post-surgical, and chronic pain is not what causes addiction or a patient’s desire for higher doses of pain medication. Patients suffering from extreme pain or progression of disease may require increased doses of medication; the appropriate dose is that which is required to adequately treat the pain, even if the dose is higher than usually expected.” (California State Board of Pharmacy. “Dispensing Controlled Substances for Pain: A Statement of the California State Board of Pharmacy,” Health Notes, p. 4-5, 1996)
**CRITERION #7. PHYSICAL DEPENDENCE OR ANALGESIC TOLERANCE ARE NOT CONFUSED WITH “ADDICTION”**

It may be preferable not to include medical terminology in statutes or regulations because medical terminology evolves in a dynamic field such as pain management. Incorrect, archaic or ambiguous terminology such as “controlled dangerous drugs” can be confusing and can inappropriately narrow allowable medical treatment by stigmatizing opioid analgesics. Thus, policymakers should consider carefully the necessity and appropriateness of using and defining medical terms in statutes or regulations.

Considerable misunderstanding exists about what “addiction” is and is not. Medical and scientific knowledge about pain physiology and opioid pharmacology have clarified the difference between “addiction,” and physical dependence and analgesic tolerance. Policy language, however, often does not reflect this distinction. When policies contain inaccurate definitions of addiction-related terms, repeal is the first choice. If this is not possible, definitions can be modified to clarify the critical distinction and prevent further confusion.

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**UNIFORM CONTROLLED SUBSTANCES ACT**

“If a State chooses to use [a definition for such terms as “addict,” “drug dependent person,” or “habitual user”], the State should assure that the definition can not be construed to include a patient using a controlled substance pursuant to the lawful order of a practitioner.” (National Conference of Commissioners on Uniform State Laws, 1994)

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**LOUISIANA – STATUTE – Controlled Substances Act**

“(38) ‘Substance abuse’ or ‘addiction’ means a compulsive disorder in which an individual becomes preoccupied with obtaining and using a substance, despite adverse social, psychological, or physical consequences, the continued use of which results in a decreased quality of life. The development of controlled dangerous substance tolerance or physical dependence does not equate with substance abuse or addiction.” (La. R.S. 40:961 Definitions)

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**FLORIDA – REGULATION – Medical Board Regulations**

“Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.” (64B8-9.013, FAC)

*Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*

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**TENNESSEE – REGULATION – Osteopathic Board Regulations**

“Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.” (1050-2-.13 Specifically Regulated Areas and Aspects of Medical Practice)

*Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)*
**Utah - Regulation - Professional Practice Regulations**

“Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.” (R156-1-502. Unprofessional Conduct)

Note: Adapted from the Model Policy for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 2004)

**Arizona - Osteopathic Board Guideline**


Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)

**Texas - Medical Board Policy Statement**

“Tolerance and physical dependence are normal consequences of sustained use of these drugs and are not synonymous with psychological dependency (addiction) on them. Psychological dependency is characterized by the compulsion to take the drug despite its harmful and destructive effect on the individual.” (Texas State Board of Medical Examiners Newsletter, Volume 15, no. 1, Spring/Summer 1993)

**California - Pharmacy Board Policy Statement**

“In addition, with long-term treatment of pain with opioids, patients may develop a tolerance to the drug or a dependence on the drug. These occurrences are considered ‘normal’ and ‘to be expected’ - they should not be confused by the licensed healthcare professional with drug addiction or be mislabeled as “drug seeking.” (California State Board of Pharmacy “Health Notes: Pain Management,” 1996, pp. 4-5)

**West Virginia - Joint Policy Statement**

“Health care professionals should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.” (West Virginia Boards of Examiners for Registered Nurses, Medicine, Osteopathy, and Pharmacy. “Joint Policy Statement on Pain Management at the End of Life.” Effective: March 12, 2001)

Note: Adapted from the Model Guidelines for the Use of Controlled Substances for the Treatment of Pain (Federation of State Medical Boards of the United States, Inc., May 1998)
PART B. Provisions That May Impede Pain Management

It is advisable to repeal provisions that, if implemented, could impede effective pain management; this section indicates the extent that some states have removed potential barriers from controlled substances or professional practice policies.

**CRITERION #9. OPIOIDS ARE CONSIDERED A TREATMENT OF LAST RESORT**

Most policies are appropriately silent on specific medical and pharmacologic matters. A number of states have language that directly states that the medical use of opioids is or should be, as a matter of policy, a treatment of last resort. These should be repealed as they are inconsistent with medical knowledge and clinical practice. In general, it is preferable for government to avoid characterizing the role of medicine and drugs in the treatment of pain; law should permit rather than direct the course of medicine so that it can follow science and clinical experience. Restrictive language in the context of policies that determine the legality of the use of controlled substances in professional practice for all patients could have unintended consequences.

To date, Ohio, Virginia, and West Virginia have repealed provisions that define the use of controlled substances as a treatment of last resort.

**CRITERION #10. MEDICAL USE OF OPIOIDS IS IMPLIED TO BE OUTSIDE LEGITIMATE PROFESSIONAL PRACTICE**

Some states have language that implies that the medical use of opioids for chronic pain is questionable, and therefore at the periphery or even outside of ordinary professional practice, and consequently illegal. For example, some state policies have definitions of “intractable pain” that carry this implication. Such provisions should be repealed. The appropriate recognition of opioids, pain and medical practice can be achieved by adopting provisions from Part A of this section relating to Criterion #1, Criterion #2, and Criterion #3.

**Examples**: In 2002, the states of Iowa and Michigan eliminated all use of the word “intractable” when they revised pain-related policy. North Dakota and Rhode Island made similar changes to their state statutes in 2005.

**CRITERION #11. PHYSICAL DEPENDENCE OR ANALGESIC TOLERANCE ARE CONFUSED WITH “ADDICTION”**

If policies contain drug abuse-related terms that confuse addiction with the physical dependence or tolerance that may occur during opioid treatment of persistent pain, they should be repealed or defined more accurately. This action, if communicated to the public, health professionals, and regulators, may help to rectify the long-standing suspicion that chronic pain patients using opioids are addicted or drug dependent. Such provisions can be found in Part A of this section relating to Criterion #7.

Rhode Island was the first state to repeal an inaccurate addiction-related definition from state law; a number of states have recently adopted board policies that have correct definitions, including Kansas, Kentucky, Louisiana, Missouri, Nevada, Texas, and West Virginia.

**CRITERION #12. MEDICAL DECISIONS ARE RESTRICTED**

Decisions about patient care should be made by the treating practitioner based on examination of the individual patient and the application of medical expertise, rather than being outlined by the government. Practitioners need to have flexibility to respond to the
treatment needs of individual patients, which can vary greatly even among patients with the same disease or condition. If the evaluation of state policies identifies any of the four types of provisions that have the potential to interfere with medical decisions outlined in Criterion #12, these should be amended or repealed.

**Examples:**

**Category A – Patient Characteristics:** In 1997, Texas amended its policy to allow prescribing to patients who are currently abusing or who have a history of substance abuse. North Dakota repealed the same provision in 2005.

**Category B – Mandatory Consultation:** To date, California, Colorado, Idaho, Iowa, Kentucky, Massachusetts, Michigan, New Mexico, North Dakota, Oregon, Rhode Island, Vermont, Virginia, and West Virginia have repealed policy language that requires physicians to obtain consultations when using opioids to treat pain.

**Category C – Quantity Prescribed or Dispensed:** In 2001, Wisconsin repealed overly restrictive dosage unit limitations (a 34-day supply), while Utah repealed a similar provision by 2006.

**Category D – Undue Prescription Limitations:** In 2003, Kentucky eliminated a medical regulatory recommendation for drug holidays when using opioids to treat pain.

**Criterion #13. Length of Prescription Validity is Restricted**

In a balanced drug control policy, efforts to reduce drug diversion should not interfere with providing medications to the patient. Unrealistically short prescription validity periods can interfere with a physician’s ability to provide medications, as well as a patient’s ability to obtain them without having to make extraordinary and sometimes expensive arrangements. Neither the federal Controlled Substances Act nor federal regulations limit the period of time that a prescription may be dispensed after it has been issued. Similarly, most states do not impose a validity period. Validity periods should be repealed or amended to be realistic.

**Examples:** The following states have repealed overly restrictive prescription validity periods: and Hawaii (3 days), Idaho (7 days), Michigan (5 days), Rhode Island (7 days), Texas (7 days), and Wisconsin (7 days).

**Criterion #14. Practitioners Are Subject to Additional Prescription Requirements**

Some states have enacted laws that require the physician to use a special government-supplied prescription form to prescribe certain controlled substances (typically only those in Schedule II). Increasingly, states are adopting policy to electronically monitor prescribing and dispensing without using a government-supplied prescription form for Schedule II medications.

**Examples:** In 1994, Indiana became the first state to switch from a special prescription form (triplicate) to an EDT system without requiring a government-issued prescription form. Since then, a number of states have likewise transitioned to a system without a government-issued prescription form for Schedule II controlled substances: California (2005), Hawaii (2002), Idaho (2001), Illinois (1999), Michigan (2002), New York (2005), and Rhode Island (1997).
Section I: Preamble

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

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

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

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

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

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

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

APPENDIX A:
FEDERATION OF STATE MEDICAL BOARD'S
MODEL POLICY FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN

(Adopted May, 2004)

Section I: Preamble

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

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

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

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

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

The Board will judge the validity of the physician’s treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient’s pain while effectively addressing other aspects of the patient’s functioning, including physical, psychological, social and work-related factors.
Allegations of inappropriate pain management will be evaluated on an individual basis. The board will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician’s conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section II: Guidelines

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

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

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

3. Informed Consent and Agreement for Treatment—The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient’s surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including:
   a. urine/serum medication levels screening when requested;
   b. number and frequency of all prescription refills; and
   c. reasons for which drug therapy may be discontinued (e.g., violation of agreement).

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

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

6. Medical Records—The physician should keep accurate and complete records to include:
   a. the medical history and physical examination,
   b. diagnostic, therapeutic and laboratory results,
   c. evaluations and consultations,
   d. treatment objectives,
   e. discussion of risks and benefits,
   f. informed consent,
   g. treatments,
   h. medications (including date, type, dosage and quantity prescribed),
   i. instructions and agreements and
   j. periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.
7. Compliance With Controlled Substances Laws and Regulations—To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

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

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

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

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

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

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

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

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

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

The following material provides background information on pain, controlled substances, and professional practice:


http://www3.interscience.wiley.com/cgi-bin/jissue/85510548?CRETRY=1&SRTRY=0

http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B6T8R-4HDPX61-1-1&cdi=5093&_user=443835&_orig=browse&_coverDate=10%2F31%2F2005&_sk=999699995&view=c&wchp=dGLbVzb-zSkWz&md5=7d061305721e33d820faadb2e58fa4ce8&ie=/sdarticle.pdf


http://www.painpolicy.wisc.edu/publicat/94ppcs.htm

http://www.painpolicy.wisc.edu/publicat/02fsmb/jmld02.pdf

http://www.painpolicy.wisc.edu/publicat/02jpsm1/jpsm02.pdf


http://www.painpolicy.wisc.edu/matrix.htm

http://www.painpolicy.wisc.edu/domestic/diversion.htm


http://www.doctordeluca.com/Library/Pain/RiskActionAgainstDocsPrescribingOpioids05.pdf

The initial, crucial step legislatures and state agencies can take to improve pain management is to study the problem. Although the problems and solutions differ from state to state, one state can often benefit from the efforts and experiences of others, so reviewing what other states have done is recommended.

The most common and probably the most valuable method is to create a multidisciplinary task force, commission, or advisory committee to study carefully the legal, fiscal, and other barriers to pain management for all types of pain patients in the state (chronic cancer and non-cancer, post-surgical, sickle-cell, AIDS, etc.). For this process it is important to review relevant state policies outlined below, and then make and implement recommendations in legislation (policy, budget), regulations, guidelines, public information, education, training, program development, etc. States with sunrise/sunset review criteria should consider subjecting those statutes and regulations that affect pain management to those criteria (in addition to the criteria set out in this Evaluation Guide).

1. Controlled substances policy

Does the state Controlled Substances Act recognize the essential medical uses of controlled substances as in federal law and as recommended by the National Conference of Commissioners on Uniform State Laws?

Does state statute or regulation unduly restrict prescribing of controlled substances, such as:

- requiring government prescription forms for Schedule II controlled substances only;
- restricting treatment of addicts, even if they have pain;
- requiring second opinion or consultation before prescribing for pain;
- including legal terminology that confuses pain patients with addicts;
- limiting number of dosage units of controlled substances (e.g., opioids) that can be prescribed at one time; or
- unduly limiting the period of validity of a prescription for a scheduled substance?

2. Healthcare policy

Do the relevant practice acts or board regulations contain any provisions that are unduly restrictive or confusing when applied to the prescribing of controlled substances for the treatment of pain (i.e., no prescribing to addicts, even if they have pain)? Are the boards’ statutes, regulations, and guidelines adequately disseminated or available to licensees and others?

Have the boards of medicine, osteopathy, pharmacy, and nursing adopted guidelines or policies clarifying that the board recognizes that the use of controlled substances for the treatment of pain is accepted professional practice and setting forth the principles that a practitioner can follow to confidently avoid the risk of disciplinary sanctions by a regulatory agency in the state?

Do the state’s professional schools for medicine, pharmacy, and nursing provide adequate instruction about pain and palliative care?

3. Facility regulation (hospital, hospice, nursing home, home care, etc.)

What is the attitude of the state regulators of health care facilities? Is pain a priority or is the...
priority to reduce the use of controlled drugs? Do licensing, certification, or inspection criteria include assessment and treatment of pain and training of patient care staff? Is technical assistance on pain and symptom management available?

Are there inappropriate restrictions, requirements, formularies, or financial constraints on the delivery of pain management?

4. State health policy

Are there inappropriate financial constraints on the delivery of pain management? Do managed care organizations have policies addressing pain assessment, treatment, reimbursement, and appropriate access to specialists?

Does state Medicaid policy adequately reimburse the controlled drugs used in pain and symptom management? Does it unduly restrict which drugs are covered and in what amounts?

Does Workers Compensation adequately address the needs of people with chronic severe pain?

Does the state cancer control plan emphasize pain management and palliative care for cancer patients in the state? Does the plan include actions that should be taken to improve state policy and access to quality pain and palliative care?

Is there a State Pain Initiative or other pain and palliative care organization that advocates for improved pain management and policy? Is there adequate communication between government agencies and state pain initiatives or leading pain practitioners? Do state regulators participate in the initiative’s activities?

Does the public have access to information about pain and symptom management including cancer and chronic non-cancer pain, and where to go for help? Are any organizations undertaking proactive efforts to provide information?

Does the toll-free number for cancer information also include information about pain management?

5. Law enforcement and regulatory policy

Do the state agencies that are involved in drug law enforcement and monitoring of controlled substances prescribing, dispensing, and patient use have adequate safeguards against the inappropriate scrutiny of practitioners who legitimately prescribe and dispense controlled substances and the maintenance of confidentiality of patient information (i.e., what standards do they use for initiating or continuing investigations, or what input do they get in establishing standards and from whom)? Have state legal officials (such as the Attorney General) reviewed state policies relevant to pain management, and end-of-life matters such as advance directives and durable power of attorney as recommended by the National Association of Attorneys General?
The purpose of this section is to describe briefly the regulatory systems and recent trends that affect pain management. References are provided for more extensive information.

There are several regulatory systems that influence access to and delivery of pain management. These include the regulation of patient care facilities, reimbursement, drug regulation, and the licensing of health professionals. This section discusses the latter two.

**Drug regulation**

There are three tiers of drug regulation: international, federal, and state. The latter two will be discussed here; publications about international regulation are available on the PPSG website at [www.painpolicy.wisc.edu](http://www.painpolicy.wisc.edu).

Federal and state law provide for three general levels of drug control, including “over-the-counter” drugs, “prescription” drugs, and “controlled substances.” Under federal and state laws, over-the-counter drugs, such as aspirin, are the least controlled and are available directly to the consumer at a wide variety of retail establishments without a physician’s order. Prescription drugs, such as antibiotics, which have greater potency and risks, must be approved as safe and effective for human use by the FDA according to authority under the Federal Food, Drug and Cosmetic Act. Their availability for medical use is pursuant to a prescription from a physician, dentist, podiatrist, or other professional licensed to prescribe. Prescription drugs are also regulated at the state level by food and drug laws, and by pharmacy laws that typically are administered by state pharmacy boards. Manufacturers and wholesalers are subject to provisions regarding the production, marketing, advertising, and distribution of prescription drugs. Federal and state laws provide penalties for obtaining prescription drugs without a prescription. As a class, prescription drugs may be prescribed for other than their specifically labeled indications if there is a medical rationale.

Controlled substances laws provide an additional layer of control over the distribution of prescription drugs that have a potential for producing psychological or physical dependence as a means of preventing abuse, trafficking, and diversion. The federal Controlled Substances Act (CSA) contains numerous provisions regarding the possession, manufacture and trafficking in illicit controlled substances, for which criminal penalties are established; at the same time, the CSA recognizes that controlled substances are necessary for public health and that their availability for medical and scientific purposes must be assured. Therefore, despite increased control measures, the requirements of the CSA are not intended to interfere with the medical uses of prescription drugs. The CSA specifies five classification schedules that carry different penalties for unlawful uses; requirements for prescriptions also vary depending on the schedule. Schedule I contains all drugs that have no approved medical use, such as the opioid heroin. Schedules II–IV contain drugs that have been approved by the FDA for medical use, including the opioids (Schedule II also contains non-opioids such as amphetamines and certain barbiturates); opioids with the highest potential for abuse are in Schedule II and include drugs such as morphine, hydromorphone, oxycodone, fentanyl. Opioids such as hydrocodone combinations and codeine combinations are in Schedule III, while Schedule IV also contains codeine in smaller dosages. Schedule V contains some opioids in smaller amounts, which may be over-the-counter cough preparations; these schedules also include non-opioids.

Under the CSA, it is not lawful to prescribe narcotic drugs for the purpose of maintenance or detoxification of narcotic addiction; this activity requires separate registration by the federal government and in some states. The use of drugs approved for this purpose, such as
methadone and buprenorphine, must be in compliance with federal and state regulations. Methadone, however, may be prescribed as an analgesic according to the same rules for prescribing any other Schedule II opioid analgesic.

All persons or business entities must be registered with the Drug Enforcement Administration (and with state agencies in some states) to manufacture, distribute, handle, dispense or prescribe controlled substances. Registrants' purchases of Schedule II controlled substances and Schedule III narcotics are made using a special order form to monitor all transfers of controlled substances within a “closed system.” Prescriptions for Schedule II drugs must be written and may not be refilled, while five refills are permitted for drugs in Schedules III and IV. Federal law allows oral or faxed (but not electronic transmission) of prescriptions of controlled substances in Schedule II in medical emergencies under specific circumstances. Federal law also allows for the partial dispensing and faxing (but not oral or electronic data transmission) of prescriptions under certain circumstances. Federal laws do not limit the amount of the prescription or the duration of prescribing. There are penalties, both criminal and civil, for violation of federal requirements. The federal requirements are available at [http://www.access.gpo.gov/nara/cfr/waisidx_03/21cfrv9_03.html](http://www.access.gpo.gov/nara/cfr/waisidx_03/21cfrv9_03.html).

The states have adopted versions of the CSA that use the same classification system, generally using a model Uniform Controlled Substances Act (UCSA) prepared by the National Conference of Commissioners on Uniform State Laws in 1970. All of the state Acts permit prescribing of controlled substances in Schedules II - V, although most do not specifically reflect the recognition by federal law of the medical uses of controlled substances. A 1994 revision of the model UCSA has been prepared to correct these deficiencies, but only a few states have adopted the changes. The criminal provisions of the state Acts are enforced by state and local police agencies, while the drug regulatory aspects of state controlled substances laws are administered by a variety of state agencies, including departments of regulation and licensing and medical or pharmacy boards. These agencies often have regulations that govern the prescribing and dispensing of controlled substances more so than under federal law. Penalties for violation of prescribing requirements vary greatly. Some states also limit the amount that can be prescribed at one time, and limit the validity of a controlled substance prescription to a few days or weeks. Some have overly broad definitions of “addict” that could include physically dependent pain patients; some states prohibit prescribing to persons with an addictive disease, or require they be reported to a state agency.

A number of years ago, some states began enacting “Prescription Monitoring Programs” (PMPs) that require the physician to use government-issued prescription forms when prescribing controlled substances in certain schedules (see Table 3). The purpose of PMPs is to provide law enforcement, prescribers and dispensers with information on “doctor shoppers,” “scammers,” and dishonest physicians. Although representatives of PMPs indicate that such programs are not intended to interfere with medical practice, and that precautions are taken to avoid interference, some in the medical field continue to express concern that PMPs, especially those that require a government-issued prescription form for Schedule II controlled substances only, have a “chilling effect” on physician prescribing due to physician fear of being investigated for excessive prescribing. Indeed, several studies have shown that, after implementation of such programs, the prescribing of those drugs being monitored declined substantially, and may have caused an increase in the prescribing of drugs in lower (less restricted) schedules that may have been less appropriate clinically for the patient’s condition. This decline in prescribing has been interpreted by law enforcement authorities to indicate a reduction in inappropriate prescribing.

Since the mid 1990s, states began to adopt PMPs that use electronic data transmission (EDT) systems. The EDT system requires the pharmacist to send prescription information electronically.
to the state agency that administers the program, which can obviate the need for a government-issued prescription form. Many of these EDT programs monitor all drug classes (not just Schedule II) and do not require a government-issued prescription form. (However, one state continues to use a government-issued form for Schedule II controlled substances in conjunction with an EDT program.) See Table 3 for a description of current prescription monitoring programs.

**Regulation of healthcare professionals**

The regulation of professional practice in medicine, osteopathy, pharmacy, nursing, and other professions occurs at the state, not federal level (although federal agencies substantially affect professional practice by denying or revoking controlled substances registration). State legislatures have adopted statutes to protect the public; these provide authority for a state agency to license and discipline members of the profession. Typically, the law creates a board, such as a medical board, that is responsible for licensing the members of the profession, as well as disciplining licensees for violating standards of professional conduct (these are usually expressed in the board’s statute or in regulations). Boards have the power to adopt regulations to implement their statutory authority. The enactment of statutes and adoption of regulations are both subject to public scrutiny and, generally, public comment. A fixed number of board members with staggered terms typically is appointed by the Governor, sometimes in consultation with the profession’s state society and sometimes with several appointments by the Legislature. Typically, there will be at least some members who are not licensees of the board, called “public members.”

Board investigation of a licensee is usually initiated by a complaint or by referral from another agency. Boards differ greatly as to the procedures used for inquiry and investigation into complaints; some boards are required by law to investigate each complaint received; others can exercise discretion. Investigations may or may not be prompt, and may be dropped due to insufficient evidence or may proceed to disciplinary action, which can range from a warning, to education, to a limitation or removal of prescribing privilege or of the professional license. Board disciplinary actions are conducted pursuant to the state’s Administrative Procedure Act; the licensee may appeal the decision to state courts. Boards also manage non-disciplinary programs to assist in the identification, treatment, and recovery of impaired professionals.

Each category of professional licensing board has a national organization that serves all the state boards; for medical boards it is the Federation of State Medical Boards; for pharmacy boards it is the National Association of Boards of Pharmacy; for nursing boards it is the National Council of Boards of Nursing. The national organizations can be involved in a number of activities, such as: (1) the sponsorship of annual meetings, (2) the appointment of study task forces to address specific issues relevant to the regulation of that profession, and (3) a range of other technical assistance and information activities, including newsletters, statistics about licenses and discipline, and preparation of model statutes, regulations, and professional practice guidelines.
Figure 1.
Recent Trends in State Pain-Specific Policy
1985 - 2005

By: University of Wisconsin Pain & Policy Studies Group, 2006
| Table 1: International Authoritative Sources |


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<thead>
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<th>Table 2: National Authoritative Sources</th>
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<td>Federal Food Drug and Cosmetic Act. Title 21 USCS Chapter 9, 1938.</td>
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**Notes:**
(1) Current as of 8/07/2006; prescription monitoring programs are subject to change.
(2) Does not include Washington State’s triplicate program that is used for disciplinary purposes only.
* Indicates physicians are required to obtain state-issued prescription forms.
* The West Virginia program was discontinued in 1998, but re-authorized in 2002.

**Sources:** U.S. General Accounting Office, “Prescription Drugs: State Monitoring Programs Provide Useful Tool to Reduce Diversion” May 2002; Drug Enforcement Administration, “Prescription Accountability Resource Guide,” September 1998; and updated information obtained from states.


Controlled Substances Act. Title 21 USC §801(1).


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http://www.painpolicy.wisc.edu/dea01.htm


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Federation of State Medical Boards of the United States Inc.  Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. Euless, TX: Federation of State Medical Boards of the United States Inc; 1998. [http://www.fsmb.org](http://www.fsmb.org)


Federation of State Medical Boards of the United States Inc. Model Policy for the Use of Controlled Substances for the Treatment of Pain. Dallas, TX: Federation of State Medical Boards of the United States Inc.; 2004. [http://www.fsmb.org](http://www.fsmb.org)


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Relief and Preventing Abuse of Pain Medications. Adopted at the National Association of Attorneys General Spring Meeting; Washington, DC; March 17-20, 2003b.

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