PRESCRIPTION DRUG ABUSE, ADDICTION AND DIVERSION: OVERVIEW OF STATE LEGISLATIVE AND POLICY INITIATIVES

A THREE PART SERIES

PART 3: PRESCRIBING OF CONTROLLED SUBSTANCES FOR NON-CANCER PAIN

PREPARED BY

THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS

AND

THE NATIONAL SAFETY COUNCIL

For comprehensive information about the series, please see Part 1: State Prescription Drug Monitoring Programs (PMPs) and Part 2: State Regulation of Pain Clinics.

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PURPOSE OF OVERVIEW

The National Alliance for Model State Drug Laws (NAMSDL) and the National Safety Council (NSC) present a three-part overview to assist federal, state and local policymakers, criminal justice and health care professionals, drug and alcohol specialists, and other stakeholders with the development of legislative and policy options to address prescription drug abuse, addiction, and diversion. The overview outlines the status of state laws, regulations and, where possible, policies on three key initiatives undertaken by state officials to tackle the spectrum of prescription drug issues. These initiatives are (1) implementation and improvement of state prescription drug monitoring programs (PMPs), (2) regulation of pain clinics, and (3) establishment and enhancement of policies and guidelines for the prescribing of controlled substances for non-cancer pain. Additionally, the overview summarizes practices for these initiatives that various organizations and institutions recommend and identifies which states are following those practices.

The three-part overview uses the phrase "recommended practices" rather than the phrase "best practices." Many of the practices discussed find support in the anecdotal evidence drawn from the knowledge, experiences, and wisdom of people responsible for the practical application and enforcement of efforts on PMPs, pain clinics, and the prescribing of controlled substances. However, numerous suggested practices have not yet been subjected to the scientific rigor and outcome evaluation traditionally associated with a "best practice." In the absence of complementary scientific information, what is deemed "best" may depend in part on the approach and perspective of those making the determinations. Staff of each organization and institution promoting certain practices necessarily use their acquired information, combined experiences, and beliefs to shape their proposals. Consequently, the overview focuses on "recommended practices" that are common among the organizations and institutions referenced herein.

The status information reflects only that information publicly available through laws, regulations, or official policy. Such formalization of a practice or principle often comes after months of preparation involving multiple stages of drafting, review and input, modification, and trial and error experimentation. A state not listed in the overview as following a particular practice may indeed be in the midst of preparatory work designed to help write language that will ultimately pass in the form of a statute, rule, or written policy or guideline.

Finally, the ultimate choice to adopt a "recommended practice" and the timing of the adoption lies with state and local decision-makers. State and local policymakers must carefully weigh the benefits of a specific practice against the costs of implementation, current state priorities, and other factors. The balancing process may result in a variance among states regarding the emphasis on certain practices over others. Some state officials may proceed with a more gradual implementation than neighboring states because of differences in available funds. Others may find it necessary to delay initiation of a particular practice. Despite their differences, all state and local leaders strive to improve their states' ability to address prescription drug abuse, addiction, and diversion with increasingly scarce public funds. The three-part overview is intended to add value to the decision-making process of those leaders so they can make the most effective judgments possible for their respective jurisdictions.

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PRESCRIPTION DRUG ABUSE, ADDICTION AND DIVERSION: A NATIONAL PROBLEM

Prescription drug abuse is the fastest growing drug problem in the Nation proclaimed federal officials in the 2011 strategy entitled *Epidemic: Responding to America's Prescription Drug Abuse Crisis.* Statistic after statistic confirmed reports that the problem had reached significant proportions.

- In 2010, about 12 million Americans (age 12 or older) reported nonmedical use of prescription pain relievers in the past year. (Centers for Disease Control, Vital Signs, November 2011)

- Among new abusers of pain relievers, 68 percent of new users (those who began misuse of pain relievers in the past year) obtained their abused pills from a friend or relative for free or took them without asking, 17 percent received prescriptions from one or more doctors, and 9 percent purchased pills from a friend, dealer, or the Internet. (Office of National Drug Control Policy Press Release identifying key findings using data from 2009 and 2010 National Survey on Drug Use and Health, April 25, 2012)

- Among occasional abusers of pain relievers (less than once a week on average in the past year), 66 percent obtained the pills for free from a friend or relative or took them without asking, 17 percent received prescriptions from one or more doctors, and 13 percent purchased pills from a friend or relative, dealer, or the Internet. (Office of National Drug Control Policy Press Release identifying key findings using data from 2009 and 2010 National Survey on Drug Use and Health, April 25, 2012)

- Among chronic abusers of pain relievers, only 41 percent obtained the pills for free or without asking from a friend or relative, 26 percent received prescriptions from one or more doctors, and 28 percent purchased pills from a friend or relative, dealer, or the Internet. (Office of National Drug Control Policy Press Release identifying key findings using data from 2009 and 2010 National Survey on Drug Use and Health, April 25, 2012)

- Chronic nonmedical use (use 200 days or more in the past year) of opioid pain relievers has increased 75% since 2002-2003. (Letter identifying key findings of CDC research using data from National Survey on Drug Use and Health, July 3, 2012, Grant Baldwin, Director, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention)

- The largest increase in chronic nonmedical use of opioid pain relievers was seen among people aged 26-34 (81%) and 35-49 (135%). (Letter identifying key findings of CDC research using data from National Survey on Drug Use and Health, July 3, 2012, Grant Baldwin, Director, Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention)

- Treatment admissions for abuse of prescription pain relievers rose 430% from 1999-2009. (Substance Abuse and Mental Health Services Administration News Release, December 8, 2011)

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- Estimated number of emergency department visits for misuse or abuse of pharmaceuticals nearly doubled from 2004 to 2009. Nearly 630,000 emergency department visits in 2004 were related to the misuse or abuse of pharmaceuticals, compared to more than 1.2 million in 2009. (Center for Substance Abuse Research, University of Maryland, College Park, CESAR Fax, February 7, 2011, Vol. 20, Issue 5)

- Nearly half a million of the emergency department visits in 2009 were due to people misusing or abusing prescription pain relievers. (Centers for Disease Control, Vital Signs, November 2011)

- Overdose deaths from prescription pain relievers is now greater than those of deaths from heroin and cocaine combined. (Centers for Disease Control, Vital Signs, November 2011)

Recent data from the 2011 National Survey on Drug Use and Health (NSDUH) showed a slight decline from the prior year in first time use for persons aged 12 or older, a decrease of 100,000 people. Regular nonmedical users of prescription-type psychotherapeutic drugs also dropped by about 900,000 people. Despite this welcome news, prescription drug abuse, addiction, and diversion remains a challenge for federal, state, and local leaders. The number of citizens in 2011 using psychotherapeutic drugs for nonmedical purposes is significant, 6.1 million people according to NSDUH. Of these, 4.5 million users abused pain relievers. Confronted by the devastating social and economic consequences of the abuse, policymakers search for solutions to the prescription drug problem. In so doing, they must reflect a balance with their words and actions that they have never before had to create. Twenty years ago, policymakers drafted and implemented laws and policies to address concerns with cocaine, methamphetamine, and heroin. Leaders did not have to consider aspects of legitimate use because these substances generally have no legitimate use among the public. The drug problems that leaders face today flow from a very different environment. Prescription drugs have many legal uses and many legal users. Laws and policies of today must simultaneously prevent abuse, addiction, and diversion while allowing and supporting the legal use of prescription drugs by those who need the medications to maintain quality of life. To create this delicate yet necessary balance, policymakers can draw upon the skills and expertise of criminal justice officials, health care professionals, prevention experts, and drug and alcohol addiction treatment specialists. As policymakers implement effective prescription drug abuse laws and policies, they must also be prepared to address the substantial number of current prescription drug addicts who will be cut off from their drug supply. If left untreated, these addicts may turn to heroin, a transition that will bring about increased hepatitis, HIV, and crime.

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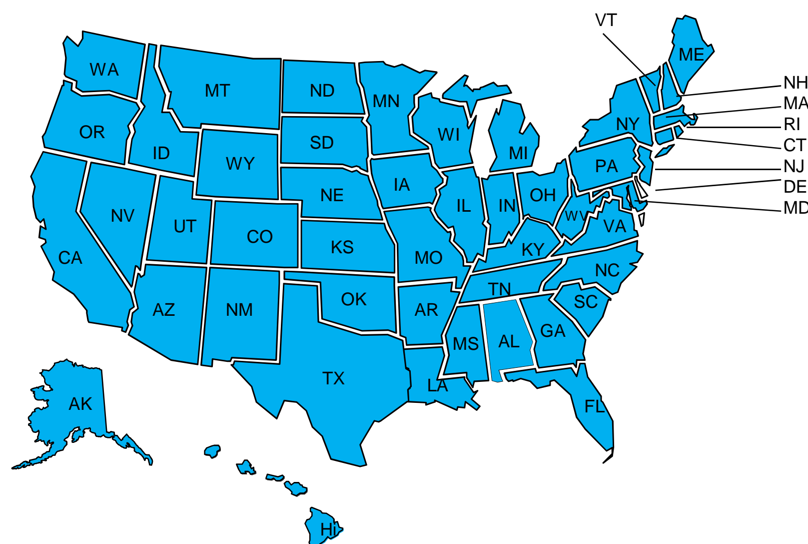
PART 3:

PRESCRIBING OF CONTROLLED SUBSTANCES FOR NON-CANCER PAIN



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A CLOSER LOOK AT PRESCRIBING PRACTICES

As state officials gained experience with the enforcement of pain clinic regulation acts, "pill mill" operators re-labeled their facilities. What was once called a "pain clinic" became a wellness clinic or a weight loss center. Some operators tried to open up detox centers on the same premises where they handed out pills to claim that the location was a treatment clinic. Others reduced the percentage of individuals receiving controlled substances below a majority of patients so their activities would no longer be defined as a pain clinic under state law.

The shifting nature of "pill mill" operations is a sign that state officials are succeeding to some degree in reducing "pill mills" as they first surfaced. Florida, long considered a hot spot for "pill mills," has been the center of concerted enforcement efforts to rid the state of these criminal operations. Available information from state leaders indicates that "pill mills" are not as plentiful in Florida as they were before initiation of the enforcement activities. However, the initiatives may have sometimes resulted in unintended consequences. An online survey of Florida patients conducted in January 2012 by the American Academy of Pain Management (Academy) suggests that legitimate patients are experiencing difficulties in accessing appropriate pain medications. Robert Twillman, Ph.D., FAPM, Director of Policy and Advocacy for the Academy, notes that additional reactions to pain clinic legislation include sharply reduced prescribing by primary care doctors and closure of some pain clinics.

The struggle to address the indiscriminate doling out of pills characteristic of "pill mills" while protecting access to proper pain care has focused attention on the prescribing of controlled substances and other drugs to treat non-cancer pain. The attempted metamorphosis by "pill mill" operators has reinforced that the problem associated with their activities is not unique to a particular type of facility. The underlying problem is with the practices by which prescription drugs are received and distributed to people.

Federal, state, and local policy makers, criminal justice and regulatory representatives, and health care professionals have begun to scrutinize prescribing behaviors. In their respective roles, they have started to review the statutes, regulations, and policies that guide the prescribing of controlled substances for non-cancer pain. Their common goal is to identify and effect necessary modifications to ensure that prescribing practices support proper patient care without contributing to the widespread problem of prescription drug abuse, addiction, and diversion.

WORKING GROUP ON PRESCRIPTION DRUG ABUSE, ADDICTION AND DIVERSION – STATUTORY OR REGULATORY TOOLS TO ADDRESS "PILL MILLS" AND SAFEGUARDS FOR PRACTITIONERS

On September 25, 2012, the National Alliance for Model State Drug Laws (NAMSDL) convened nineteen people to identify legislative and policy options for addressing "pill mills" and safeguarding the legitimate practice of pain management (Working

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Group). The participants included doctors, pain management experts, law enforcement representatives, a district attorney, a pharmacist, regulatory officials, and prevention and addiction treatment specialists. This initial meeting was the beginning of a multi-step, multi-disciplinary approach to provide policymakers with practical solutions to preventing prescription drug abuse, addiction, and diversion while safeguarding legitimate access to prescription drugs. NAMSDL will distribute in early 2013 the Working Group's proposals to a wide variety of stakeholders for review and comment.

The meeting process was designed to facilitate an exchange of ideas and to gather the information necessary for drafting model language for statutes, regulations, policies, and guidelines. The participants were divided into three subgroups based on professional background. During the morning, each subgroup, with the help of a facilitator, brainstormed the relevant issues and identified options for effectively responding to the designated interests, needs, and concerns. In the afternoon, each subgroup shared its ideas and related comments. All Working Group members then had the opportunity to discuss the recommendations.

STANDARDS OF PRACTICE

NAMSDL's Working Group members emphasized that standards to guide pain management practices need to reflect a consensus definition of appropriate medical care for the treatment of pain. The standards should support an integrative, interdisciplinary approach, and should promote referrals to addictionologists, psychiatrists and other specialists and the use of alternatives and adjuncts to controlled substances.

Patient satisfaction is an important consideration in the development and implementation of a treatment plan. However, it cannot be the overriding factor used to measure the success of the plan. Patients have a right to pain management but not an automatic right to controlled substances. Treatment services must be based on the informed judgment of the prescriber working in consultation with other health professionals.

Working Group members proposed that objective and subjective therapeutic outcomes be translated into standards. Functional improvement, decreased health care utilization, and reductions in the rate of deterioration of a patient's condition are examples of the type of outcomes that standards should encompass.

These guiding principles will have meaning only when practitioners incorporate them into the daily workflow of their respective practices. Working Group members suggested that the professional associations of prescribers and licensing boards craft the new or modified standards. Collaboration on the standards among various prescribers' oversight and professional entities will assure consistency across classes of prescribers. Additionally, third party payers, educational institutions, and others who influence the behaviors of practitioners should encourage the use of evidence based standards and an interdisciplinary approach. Examples of supportive measures by third party payers include the provision of incentives to access state prescription drug monitoring programs (PMPs) and reimbursement for psychological or psychiatric evaluations for pain patients.

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EDUCATION

Improved education for prescribers on proper pain management was a priority for Working Group members. Too many practitioners lack the necessary knowledge and awareness to treat pain in a holistic manner, defaulting instead to the prescribing of controlled substances as the sole or primary option. Some practitioners may, therefore, unwittingly contribute to or demonstrate "pill mill" behaviors. Other important subjects of learning include appropriate prescribing of medications, critical thinking skills, use of state prescription drug monitoring programs (PMPs), and addiction identification and referral to treatment.

These topics need to be incorporated into the existing educational requirements at all stages of a prescriber's career according to Working Group members. Schools for the medical and health professions must introduce these subjects to students. Accrediting agencies must provide oversight assessment of curricula provided by institutions for residents and interns to insure that adequate attention is placed on providing instruction and experience in proper pain assessment and management. Licensing authorities should include relevant questions and content on board exams to reinforce the need for such education.

Mandatory continuing medical education on these topics for current practitioners with a license to prescribe will serve to maintain, develop, or increase the knowledge, skills, and professional judgment a prescriber uses to provide quality pain management services.

Working Group members see a critical role for The Drug Enforcement Administration (DEA) and state officials in shaping the learning process. Regulatory bodies can help ensure the quality and continuity of educational programs through the establishment of minimal requirements to obtain a state license or DEA registration to prescribe controlled substances.

RECOMMENDED PRESCRIBING PRACTICES

NAMSDL's legal team, comprised of staff attorneys and a legal consultant, conducted a review of eight core documents widely used by physicians, their professional associations, and regulatory bodies to inform and shape the prescribing of controlled substances to treat non-cancer pain. The selected policies, guidelines, rules, strategies, and guides are:

1. "Model Policy for the Use of Controlled Substances for the Treatment of Pain" – Federation of State Medical Boards, May 2004

2. "Utah Clinical Guidelines on Prescribing Opioids" – Utah Department of Health, 2008

3. "Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-cancer Pain" – The Journal of Pain, February 2009

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4. "Washington State Interagency Guidelines on Opioid Dosing for Chronic Non-cancer Pain" – Agency Medical Directors Group, 2010 Update

5. Washington State Rules for Managing Chronic Non-cancer Pain, Medical Quality Assurance Commission, March 2011

6. "Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 2 – Guidance" – American Society of Interventional Pain Physicians (ASIPP), 2012

7. "Extended-Release (ER) and Long-Acting (LA) Opioid Analgesics Risk Evaluation and Mitigation Strategy (REMS)" – U.S. Food and Drug Administration, Modified August 2012

8. "Responsible Opioid Prescribing: A Physician's Guide" – Scott Fishman, M.D., 2012

A comparison of these materials revealed the following seven commonly recommended prescribing practices:

1. Required or recommended education related to the prescribing of controlled substances to treat pain that includes, but is not necessarily limited to, the following topics: pain management, prescribing controlled substances for pain, addiction and addiction treatment, and use of the state's prescription drug monitoring program (PMP).

2. Conducting a comprehensive patient examination, including a physical examination, and screening for signs of abuse and addiction.

3. Devising and implementing a treatment plan that includes informed consent/agreement to treatment and a process for periodic review of that treatment plan.

4. Required or recommended use of the state's Prescription Drug Monitoring Program (PMP).

5. Referral of high-risk patients that require additional evaluation and treatment as well as recommended steps to take if a physician or doctor suspects or has reason to believe that a patient is abusing or diverting prescription drugs.

6. Limiting or recommending limits on the number of days' supply and/or number of refills permitted for Schedule II opioid prescriptions.

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7. Maintaining complete and accurate medical records, including records related to prescriptions issued and physician-dispensed controlled substances.

NAMSDL's legal team researched and analyzed pertinent laws, regulations, and medical board policies in all 50 states to determine which jurisdictions incorporate one or more of the seven recommended practices. The results of the analysis have been translated into tables, one per recommended prescribing practice, that can be found in the following pages. The legal provisions cited in these charts are limited to physicians and do not include references for other prescribing professionals such as registered nurses or physician assistants. Also, the referenced legal sections are limited to **the prescribing of controlled substances to treat non-cancer pain** and do not include references for other circumstances that result in the prescribing of controlled substances. Finally, these tables do not include information on worker's compensation statutes and regulations that address insurance coverage for the prescribing of controlled substances to treat pain.

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STATE STATUTES AND REGULATIONS REQUIRING OR RECOMMENDING THAT PHYSICIANS WHO PRESCRIBE CONTROLLED SUBSTANCES TO TREAT PAIN RECEIVE EDUCATION RELATED TO PRESCRIBING FOR PAIN THAT MAY INCLUDE, BUT IS NOT NECESSARILY LIMITED TO, THE FOLLOWING TOPICS: PAIN MANAGEMENT, PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN, ADDICTION AND ADDICTION TREATMENT, AND USE OF THE STATE'S PRESCRIPTION DRUG MONITORING PROGRAM.

*** DENOTES A STATE THAT HAS IMPLEMENTED PAIN MANAGEMENT CLINIC STATUTES AND/OR REGULATIONS.**

State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
AL				
AK				
AZ				
AR	X		§ 060.00.1-19	
CA	X	Business and Professions § 2190.5 and § 2191		
CO				
CT				
DE				
DC				
FL*	X		§ 64B8-9.0131[1]	
GA	X		§ 360-3-.06[2]	
HI				
ID				
IL				
IN				
IA				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
KS				
KY*	X		201 § 9:310E[3]	
LA*				
ME				
MD				
MA	X	94C § 518[4]		
MI	X	§ 333.16204, § 333.17033[5]		X[6]
MN				X[7]
MS*				
MO				
MT				X
NE				
NV				
NH				
NJ				
NM	X	§ 24-2D-5.1	§ 16.10.14.11	
NY				
NC				
ND				
OH*	X	§ 4731.283	§ 4731-21-03, § 4731-29-01[8]	
OK				
OR	X	§ 413.590	§ 409-050-0130, § 847-008-0075	
PA				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
RI				
SC				
SD				
TN*	X		§ 0880-02-.14, § 1200-34-01-.09[9]	
TX*	X	Occupations § 156.055	22 § 195.4[10]	
UT	X	§ 26-1-36		
VT				
VA				X[11]
WA	X		§ 246-919-863	
WV*				
WI				
WY				

[1] The provision is limited to pain clinics.
[2] The provision applies only to practitioners that lack certain professional certifications.
[3] The provision applies to all prescribers.
[4] The provision applies to all prescribers.
[5] The provision applies to all licensees and registrants.
[6] The recommendation was issued by the Pain and Symptom Management Advisory Committee.
[7] The Joint Statement on Pain Management by the Minnesota Boards of Medical Practice, Nursing, and Pharmacy lists the ways that healthcare professionals can assist patients in managing their pain, including becoming and remaining knowledgeable regarding effective pain management.
[8] The provision is limited to pain clinics.
[9] The provision is limited to pain clinics.
[10] The provision is limited to pain clinics.
[11] The Virginia Board of Medicine offers an online pain management course for which physicians can receive up to 6.5 hours of CME credits.

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STATE STATUTES AND REGULATIONS REQUIRING PHYSICIANS WHO PRESCRIBE CONTROLLED SUBSTANCES TO TREAT PAIN TO CONDUCT A PATIENT EXAMINATION THAT INCLUDES A PHYSICAL EXAM AND/OR SCREENING FOR SIGNS OF SUBSTANCE ABUSE AND ADDICTION.

*** DENOTES A STATE THAT HAS IMPLEMENTED PAIN MANAGEMENT CLINIC STATUTES AND/OR REGULATIONS.**

State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
AL	X		§ 540-X-4-.08	X – Policy Is Codified
AK				
AZ				X
AR	X		§ 060.00.1-19, § 060.00.1-2.8	
CA				X
CO				X
CT				X
DE	X		24 § 1700-31.0	X – Policy Is Codified
DC	X		Business, Occupations and Professions § 4616	
FL*	X	§ 456.44, § 458.3265[P]	§ 64B8-9.013	X
GA	X		§ 360-3-.06	X
HI				X
ID				X
IL				
IN				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
IA	X		§ 653-13.2, § 653-13.9	X
KS				X
KY*	X	§ 218A.172	201 § 9:260E	X
LA*	X		46 § 6921	
ME	X		02-373 Chapter 21 § 111	X – Policy Is Codified
MD				X
MA				X
MI				X
MN	X	§ 152.125		X
MS*	X		§ 30-17-2640:1.7	X
MO				X
MT				X
NE				X
NV	X		§ 630.187	X
NH	X		Board of Medicine § 501.02	X
NJ	X		§ 13:35-7.6	
NM	X	§ 24-2D-4	§ 16.10.14.8	X
NY				
NC				X
ND				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
OH*	X	§ 4731.052	§ 4731-21-02, § 4731-29-01[P]	X – Policy Is Codified
OK	X		§ 435:10-7-11, § 510:5-9-2	X – Policy Is Codified
OR	X		§ 847-015-0030	X
PA				X
RI	X		§ 31-1-13:2.0	X
SC				X
SD				X
TN*	X	§ 63-6-1107	§ 0880-02-.14, § 1200-34-01-.07[P]	
TX*	X		22 § 170.3	
UT	X		§ 156-1-501	X
VT				
VA	X (Adopted by 1998 Senate Joint Resolution 165)			X
WA	X		§ 246-919-853	X
WV*	X	§ 16-5H-4[P]		X
WI				X
WY				X

[P] The provision is limited to pain clinics.

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STATE STATUTES AND REGULATIONS REQUIRING PHYSICIANS WHO PRESCRIBE CONTROLLED SUBSTANCES TO TREAT PAIN TO DEVISE AND IMPLEMENT A TREATMENT PLAN THAT INCLUDES INFORMED CONSENT/AGREEMENT TO TREATMENT AND A PROCESS FOR PERIODIC REVIEW OF THAT TREATMENT PLAN.

*** DENOTES A STATE THAT HAS IMPLEMENTED PAIN MANAGEMENT CLINIC STATUTES AND/OR REGULATIONS.**

State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
AL	X		§ 540-X-4-.08	X – Policy Is Codified
AK				
AZ				X
AR	X		§ 060.00.1-2 (2.8), § 060.00.1-19	X
CA				X
CO				X
CT				X
DE	X		24 § 1700-31.0	X – Policy Is Codified
DC	X		Business, Professions and Occupations § 4616	
FL*	X	§ 456.44	§ 64B-9.013	X
GA	X		§ 360-3-.06	X
HI				X
ID				X
IL				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
IN				
IA	X		§ 653-13.2, § 653-13.9	X
KS				X
KY*	X	§ 218A.172	201 § 9:260E	X
LA*	X		46 § 6921	
ME	X		02-373 Chapter 21 § 111	X – Policy Is Codified
MD				X
MA				X
MI				X
MN	X	§ 152.125		X
MS*	X		§ 30-17-2640:1.7	X
MO				X
MT				X
NE				X
NV	X		§ 630.187, § 630.620	X
NH	X	§ 318-B:9	Board of Medicine § 501.02	X
NJ	X		§ 13:35-7.6	
NM	X	§ 24-2D-4	§ 16.10.14.8	X
NY				X
NC				X

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
ND				
OH*	X	§ 4731.052	§ 4731-21-02 § 4731-29-01[P]	X – Policy Is Codified
OK	X		§ 435:10-7-11, § 510:5-9-2	X – Policy Is Codified
OR	X		§ 847-015-0030	X
PA				X
RI	X		§ 31-1-13:2.0	X
SC				X
SD				X
TN*	X	§ 63-6-1107	§ 0880-02-.14, § 1200.34-01-.07[P]	
TX*	X	Occupations § 107.104	22 § 170.01, 22 § 170.03	
UT	X		§ 156-1-501	X
VT				
VA	Adopted by 1998 Senate Joint Resolution 165			X
WA	X		§ 246-919-854, 855, 856, 857	X
WV*	X	§ 16-5H-4[P]		X
WI				X
WY				X

[P] The provision is limited to pain clinics.

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STATE STATUTES AND REGULATIONS THAT REQUIRE OR RECOMMEND USE OF THE STATE'S PRESCRIPTION DRUG MONITORING PROGRAM PRIOR TO PRESCRIBING CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN – PLEASE NOTE THAT THERE ARE ADDITIONAL MORE GENERAL PROVISIONS IN SEVERAL STATES RELATED TO MANDATORY PMP USE.

*** DENOTES A STATE THAT HAS IMPLEMENTED PAIN MANAGEMENT CLINIC STATUTES AND/OR REGULATIONS.**

State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
AL				
AK				
AZ				
AR				
CA				
CO				
CT				
DE[1]				
DC				
FL*				
GA				
HI				
ID				
IL				
IN				
IA				
KS				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
KY*[1]	X	§ 218A.172	201 § 9:260E	
LA*	X		48 Part I § 7831[2]	
ME				
MD				
MA[1]				
MI				
MN				
MS*				
MO	As of December 2012, Missouri does not have a PMP Program	As of December 2012, Missouri does not have a PMP Program	As of December 2012, Missouri does not have a PMP Program	As of December 2012, Missouri does not have a PMP Program
MT				
NE				
NV[1]				
NH				
NJ				
NM	X		§ 16.10.14.10	
NY[1]				
NC				X[3]
ND				
OH*[1]				
OK				
OR				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
PA				
RI				
SC				
SD				
TN*[1]	X		§ 1200.34-01-.07[4]	
TX*				
UT				
VT				
VA				
WA				X[5]
WV*	X	§ 60A-9-5a, § 16-5H-4[6]		
WI				
WY				

[1] For requirements to access the state's PMP under broader prescribing circumstances, see Part 1: State Prescription Drug Monitoring Programs (PMPs).
[2] The provision applies to the medical director of a pain management clinic.
[3] The North Carolina Medical Board issued a Position Statement on Prescribing Controlled Substances Responsibly, which advises all physicians who prescribe controlled substances for chronic pain to use the state's Controlled Substance Reporting System.
[4] The provision is limited to pain clinics and requires a notation in a patient record indicating whether the state's PMP was accessed.
[5] The state Department of Health website FAQ section includes an answer that encourages checking the state PMP as part of proper management of patients who are prescribed opioids for chronic pain.
[6] The provision is limited to pain clinics.

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STATE STATUTES AND REGULATIONS THAT (1) REQUIRE PHYSICIANS WHO PRESCRIBE CONTROLLED SUBSTANCES TO TREAT PAIN TO REFER HIGH-RISK PATIENTS WHO REQUIRE ADDITIONAL EVALUATION AND TREATMENT AND (2) OUTLINE RECOMMENDED STEPS THOSE PHYSICIANS CAN TAKE IF THEY SUSPECT OR HAVE REASON TO BELIEVE THAT A PATIENT IS ABUSING OR DIVERTING PRESCRIPTION DRUGS.

*** DENOTES A STATE THAT HAS IMPLEMENTED PAIN MANAGEMENT CLINIC STATUTES AND/OR REGULATIONS.**

State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
AL	X		§ 540-X-4-.08	X – Policy Is Codified
AK				
AZ				X
AR				
CA	X	Business and Professions § 2241.5, Health and Safety § 124960		X
CO				X
CT				X
DE	X		24 § 1700-31.0	X – Policy Is Codified
DC	X		Business, Professions and Occupations § 4616	
FL*	X	§ 456.44	§ 64B-9.013	X
GA	X		§ 360-3-.06	
HI				X
ID				X
IL				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
IN				
IA	X		§ 653-13.2, § 653-13.9	X
KS				X
KY*	X	§ 218A.172	201 § 9:260E, 902 § 20:420E	X
LA*	X		46 § 6921	
ME	X		02-373 Chapter 21 § 111	X – Policy Is Codified
MD				X
MA				X
MI				X
MN				X
MS*	X		§ 30-17-2640:1.7	X
MO				X
MT				X
NE	X		§ 630.138	X
NV				X
NH	X		Board of Medicine § 501.02	X
NJ	X		§ 13:35-7.6	
NM	X		§ 16.10.14.8	X
NY				
NC				X
ND				
OH*	X	§ 4731.052	§ 4731-21-02	X – Policy Is Codified

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
OK	X		§ 435:10-7-11, § 510:5-9-2	X – Policy Is Codified
OR	X		§ 847-015-0030	X
PA				X
RI				X
SC				X
SD				X
TN*	X	§ 63-6-1107	§ 0880-02-.14	
TX*	X	Occupations § 107.104	22 § 170.3	
UT	X		§ 156-1-501	X
VT				
VA	Adopted by Senate Joint 1998 Resolution 165			X
WA	X	§ 18.71.450	§ 246-919-860, 861, 862	X
WV*				X
WI				X
WY				X

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STATE STATUTES AND REGULATIONS THAT LIMIT OR RECOMMEND LIMITS ON THE NUMBER OF DAYS' SUPPLY AND/OR NUMBER OF REFILLS PERMITTED FOR SCHEDULE II OPIOID PRESCRIPTIONS – THE PROVISIONS CITED IN THIS CHART APPLY TO ALL SCHEDULE II PRESCRIPTIONS.

* DENOTES A STATE THAT HAS IMPLEMENTED PAIN MANAGEMENT CLINIC STATUTES AND/OR REGULATIONS.

State Abbreviation	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	Restriction(s)	State Medical Board Policy Identified
AL	X		§ 580-2-17-.09	No Refills Permitted	
AK					
AZ	X	§ 36-2525		No Refills Permitted	
AR	X	§ 5-64-308		No Refills Permitted	
CA	X	Health and Safety § 11200		No Refills Permitted	
CO					
CT					
DE	X	16 § 4739	24 § Controlled Substances Act 4.0	No Refills Permitted; 100 Dosage Units Or Up To A 31-Day Supply Maximum	
DC	X	§ 48-903.08	Health § 1306	No Refills Permitted; Multiple Prescriptions May Be Issued For Up To A 90-Day Supply	
FL*	X	§ 893.04	§ 64B16-27.211	No Refills Permitted	
GA	X	§ 16-13-41	§ 480-22-.05	No Refills Permitted	

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State Abbreviation	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	Restriction(s)	State Medical Board Policy Identified
ID	X	§ 37-2722	Agency 27 Chapter 01 § 113	No Refills Permitted; Multiple Prescription Orders For Up To A 90-Day Supply Are Permitted	
IL	X	720 § 570/309, 570/312		No Refills Permitted; 30-Day Maximum Supply Per Prescription; 3 Sequential 30-Day Prescriptions Permitted	
IN	X	§ 35-48-3-9	856 § 2-6-8	No Refills Permitted	
IA	X	§ 124.308	§ 657-10.21, § 657-10.25	No Refills Permitted; Multiple Prescriptions For Up To A 90-Day Supply Are Permitted	
KS	X	§ 65-4123		No Refills Permitted	
KY*	X	§ 218A.180, § 218A.205		No Refills Permitted	
LA*	X	40 § 978	46 § 2745 and 2747, 46 § 2519, 48 § 3923, 48 Part I§ 7833[1]	No Refills Permitted; Multiple Prescriptions For Up To A 90-Day Supply Are Permitted	
ME					
MD	X	Criminal Law § 5-501		No Refills Permitted	
MA	X	94C § 23		No Refills Permitted; 30-Day Maximum Supply Per Prescription	
MI	X		§ 338.3168		

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State Abbreviation	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	Restriction(s)	State Medical Board Policy Identified
MN	X	§ 152.11		No Refills Permitted	
MS*	X	§ 41-29-137		No Refills Permitted	
MO	X	§ 195.080		30-Day Supply Maximum; May Be Increased At Physician's Instruction	
MT	X	§ 37-7-401, § 50-32-208	§ 24.174.510	No Refills Permitted	
NE	X	§ 28-414		No Refills Permitted	
NV	X	§ 453.256, § 453.257		No Refills Permitted	
NH	X	§ 318-B:9		No Refills Permitted; 34-Day Supply Maximum; 60-Day Supply Maximum For Certain Drugs	
NJ	X	§ 24:21-15, § 45:9-22.19	§ 13:45H-7.9, §13:35-7.6, § 13:45H-7.5	No Refills Permitted; 30-Day or 120 Dosage Unit Supply Maximum; Multiple Prescriptions May Be Issued For Up To A 90-Day Supply	
NM	X	§ 30-31-18	§ 16.19.20.43	No Refills Permitted	
NY	X	Public Health § 3332, § 3339	10 § 80.67	No Refills Permitted; 30-Day Maximum Supply; Up To A 3-Month Supply For Relief Of Pain Resulting From Chronic Conditions	
NC	X	§ 90-106		No Refills Permitted	
ND	X	§ 19-03.1-22		No Refills Permitted	
OH*	X	§ 3719.05	§ 4729-5-30	No Refills Permitted	

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State Abbreviation	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	Restriction(s)	State Medical Board Policy Identified
OK	X	63 § 2-309	§ 535:15-3-21	No Refills Permitted	
OR	X	§ 475.185		No Refills Permitted	
PA	X	35 § 780-111		No Refills Permitted	
RI	X	§ 21-28-3.18		No Refills Permitted; 30-Day Maximum Supply; 3 Separate Prescriptions, Each With A 1-Month Supply Can Be Issued At Once	
SC	X	§ 44-53-360	§ 61-4-508.1	No Refills Permitted; 31-Day Maximum Supply	
SD	X	§ 24-42-2.1	§ 20:51:05:16, § 44:58:08:17.01	No Refills Permitted	
TN*	X	§ 53-11-308		No Refills Permitted	
TX*	X	Health and Safety § 481.074		No Refills Permitted; Multiple Prescriptions May Be Issued For Up To a 90-Day Supply	
UT	X	§ 58-37-6		No Refills Permitted; One-Month Supply Maximum; 3 30-Day Prescriptions May be Issued At Once	X[2]

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State Abbreviation	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	Restriction(s)	State Medical Board Policy Identified
VT	X		§ 20-4-1400:9.16	Multiple Prescription For Up To A 90-Day Supply Are Permitted	
VA	X	§ 54.1-3411	§ 18/110-20-290	No Refills Permitted	
WA	X	§ 18.71.450, § 69.50.308		No Refills Permitted	X[3]
WV*	X	§ 60A-3-308	§ 15-2-7, § 16-5H-4[4]	No Refills Permitted; Multiple Prescriptions For Up To A 90-Day Supply Are Permitted	
WI	X	§ 961.38	Pharmacy Examining Board § 8.06	No Refills Permitted	
WY	X	§ 35-7-1030	Board of Pharmacy Chapter 6 § 10	No Refills Permitted	

[1] The provision is limited to pain clinics.

[2] The Utah Department of Health Clinical Guidelines on Prescribing Opioids information on choosing the proper medication for a certain condition, dosing criteria, length of therapy, etc.

[3] The Washington State Interagency Guideline on Opioid Dosing for Chronic Non-Cancer Pain includes information on prescribing opioids for chronic pain including safe prescribing practices, dosing thresholds, tapering, and discontinuing opioid use, etc.

[4] The provision is limited to pain clinics.

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STATE STATUTES AND REGULATIONS REQUIRING THE MAINTENANCE OF COMPLETE AND ACCURATE MEDICAL RECORDS ABOUT PRESCRIPTIONS ISSUED AND PHYSICIAN-DISPENSED CONTROLLED SUBSTANCES AS RELATED TO PRESCRIBING FOR PAIN.

*** DENOTES A STATE THAT HAS IMPLEMENTED PAIN MANAGEMENT CLINIC STATUTES AND/OR REGULATIONS.**

State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
AL	X		§ 540-X-4-.08	X – Policy Is Codified
AK				
AZ				X
AR	X		§ 060.00.1-2 (2.8)	X
CA	X	Business and Professions § 2241.5		X
CO				X
CT				X
DE	X		24 § 1700-31.0	X – Policy is Codified
DC	X		Business, Professions and Occupations § 4616	
FL*	X	§ 456.44, § 458.3265[P]	§ 64B-9.013	X
GA	X		§ 360-3-.06	X
HI				X
ID				X
IL				
IN				

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
IA	X		§ 653-13.2	X
KS				X
KY*	X	§ 218A.172	§ 2019:260E	X
LA*	X		46 § 6921, 48 Part I § 7861[P]	
ME	X		02-373 Chapter 21 § 111	X – Policy Is Codified
MD				X
MA				X
MI				X
MN				X
MS*	X		§ 30-17-2640:1.7	X
MO	X	§ 334.106		X
MT				X
NE				X
NV	X		§ 630.187	X
NH	X		Board of Medicine § 501.02	X
NJ	X		§ 13:35-7.6	
NM	X	§ 24-2D-4	§ 16.10.14.8	X
NY				X
NC				X
ND	X	§ 19-03.3-02		
OH*	X	§ 4731.052	§ 4731-21-02, § 4731-29-01[P]	X – Policy Is Codified

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State Name	Statute or Regulation Identified	Statutory Citation(s)	Regulatory Citation(s)	State Medical Board Policy Identified
OK	X		§ 435:10-7-11, § 510:5-9-2	X – Policy Is Codified
OR	X		§ 847-015-0030	X
PA				X
RI	X		§ 31-1-13:2.0	X
SC				X
SD				X
TN*	X	§ 63-6-1107	§ 0880-02-.14	
TX*	X	Occupations § 107.104	22 § 170.01, 22 § 170.3	
UT	X		§ 156-1-501	X
VT				
VA	Adopted by 1998 Senate Joint Resolution 165			X
WA	X		§ 246-919-853	X
WV*	X	§ 16-5H-4[P]		X
WI				X
WY				X

[P] The provision is limited to pain clinics.

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