

Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain

Background and Introduction

The Vermont Board of Medical Practice (the Board) is committed to protecting the public and to assisting its licensees to meet their professional obligations by providing quality health care. To those ends, in January 2006 the Board published its first Policy for the Use of Controlled Substances for the Treatment of Pain. That policy was largely based on a model policy published by the Federation of State Medical Boards (FSMB) in 2004. In 2013, FSMB published a revised model policy that incorporates the latest best practices and new developments in the healthcare profession regarding the safe and effective use of controlled substances to treat chronic pain. The Board has carefully reviewed that new policy and adapted it to reflect Vermont laws, regulations, and Board expectations.

The Board acknowledges the hard work performed by FSMB and the great value to the Board and the profession of having a set of common core expectations in place as so many physicians across the nation strive to provide quality pain treatment. The usefulness of the past and current model policies is confirmed through the many endorsements they have received.

The FSMB model policies 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, and along with Vermont many other states have adopted all or part of the Model Policies.

The 2013 FSMB Model Policy reflects the considerable body of research and experience accrued since the 2004 revision was adopted [2]. Significantly, in the introduction to the Model Policy, FSMB recognized that there is a lack of evidence as to the effectiveness and safety of long-term opioid therapy. Despite that lack of evidence, opioids are widely used to treat chronic pain, and FSMB's intent in creating a Model Policy was to promote the public health by encouraging state medical boards to adopt consistent policy regarding the treatment of pain, particularly chronic pain, and to promote patient access to appropriate pain management and, if indicated, substance abuse and addiction treatment. The Model Policy emphasizes the professional and ethical responsibility of physicians to appropriately assess and manage patients' pain, assess the relative level of risk for misuse and addiction, monitor for aberrant behaviors and intervene as appropriate. It also includes references and the definitions of key terms used in pain management. Much of FSMB's work has been incorporated into our Vermont Policy.

In its introduction to the 2013 Model Policy, FSMB included an overview of the issues addressed in the policy. While the Board acknowledges that the practice environment in Vermont may not be identical to the national environment considered by FSMB, the issues addressed in the Model Policy are all relevant to Vermont practice and were considered by the Board when promulgating this Vermont policy. Accordingly, the Board incorporates the following discussion directly from the introduction to the FSMB as a useful statement of the context and the problem set targeted by this Policy.

FSMB Statement of Issues Addressed in the New Model Policy

There is a significant body of evidence suggesting that many Americans suffer from chronic pain and much of that pain is inadequately or ineffectively treated [8-10]. Since the 2004 revision, evidence for risk associated with opioids has surged, while evidence for benefits has remained controversial and insufficient. Over the last decade, there has been a parallel increase in opioid sales and an increase in morbidity and mortality associated with these drugs. At the same time, approximately one in four patients seen in primary care settings suffers from pain so intense as to interfere with the activities of daily living [4]. Pain arises from multiple causes and often is categorized as either acute pain (such as that from traumatic injury and surgery) or chronic pain (such as the pain associated with terminal conditions such as cancer or severe vascular disease or with non-terminal conditions such as arthritis or neuropathy) [4,8]. This model policy applies most directly to the treatment of chronic pain and the use of opioid analgesics but many of the strategies to improve appropriate prescribing and mitigate risks can be applied to the use of other controlled medications and to the treatment of acute pain.

Undertreatment of pain is recognized as a serious public health problem that compromises patients' functional status and quality of life [4,9]. A myriad of psychological, social, economic, political, legal and educational factors—including inconsistencies and restrictions in state pain policies—can either facilitate or impede the ability and willingness of physicians to manage patients with pain [6,10-11].

While acknowledging that undertreatment of pain exists, it must be understood that chronic pain often is intractable, that the current state of medical knowledge and medical therapies, including opioid analgesics, does not provide for complete elimination of chronic pain in most cases, and that the existence of persistent and disabling pain does not in and of itself constitute evidence of undertreatment [4,8,12]. Indeed, some cases of intractable pain actually result from overtreatment in terms of procedures and medications.

Complicating the picture, adverse outcomes associated with the misuse, abuse and diversion of prescription opioids have increased dramatically since the FSMB's last review [3]. Physicians and other health care professionals have contributed—often inadvertently—to these increases.

Circumstances that contribute to both the inadequate treatment of pain and the inappropriate prescribing of opioids by physicians may include: (1) physician uncertainty or lack of knowledge as to prevailing best clinical practices; (2) inadequate research into the sources of and treatments for pain; (3) sometimes conflicting clinical guidelines for appropriate treatment of pain; (4) physician concerns that prescribing needed amounts of opioid analgesics will result in added scrutiny by regulatory authorities; (5) physician misunderstanding of causes and manifestations of opioid dependence and addiction; (6) fear on the part of physicians of causing addiction or being deceived by a patient who seeks drugs for purposes of misuse; (7) physicians practicing outside the bounds of professional conduct by prescribing opioid analgesics without a legitimate medical purpose; and (8) inadequate physician education about regulatory policies and processes [3-4,12,14-20]. Inappropriate treatment also can result from a mistaken belief on the part of patients and their physicians that complete eradication of pain is an attainable goal, and one that can be achieved without disabling adverse effects. Additionally, treatment options may be limited based on availability and/or health plan policies on covered benefits or drug formularies.

Patients share with physicians a responsibility for appropriate use of opioid analgesics [21-22]. This responsibility encompasses providing the physician with complete and accurate information and adhering to the treatment plan. While many patients take their medication safely as prescribed and do not use opioids problematically, some patients—intentionally or unintentionally—are less than forthcoming or have unrealistic expectations regarding the need for opioid therapy or the amount of medication required. Other patients may begin to use medications as prescribed, then slowly deviate from the therapeutic regimen. Still others may not comply with the treatment plan because they misunderstood the physician’s instructions. Some patients share their drugs with others without intending harm (a pattern of misuse that is seen quite often among older adults [15]). Then there are patients who deliberately misuse or are addicted to opioids, and who mislead, deceive or fail to disclose information to their physicians in order to obtain opioids to sustain their addiction and avoid withdrawal [19-23].

Patients often leave medications unsecured where they can be stolen by visitors, workers and family members, which is another important source of diversion. Thus a prescription that is quite appropriate for an elderly patient may ultimately contribute to the death of a young person who visits or lives in the patient’s home. Therefore, the physician’s duty includes not only appropriate prescribing of opioid analgesics, but also appropriate education of patients regarding the secure storage of medications and their appropriate disposal once the course of treatment is completed [18,23].

A more problematic individual is the criminal patient, whose primary purpose is to obtain drugs for resale. Whereas many addicted patients seek a long-term relationship with a prescriber, criminal patients sometimes move rapidly from one prescriber (or dispenser) to another. Such individuals often visit multiple practitioners (a practice sometimes characterized as “doctor shopping”) and travel from one geographic area to another not for the purposes of relief of legitimate pain but in search of unsuspecting targets [19-21]. Physicians’ attention to patient assessment and the routine use of state prescription drug monitoring programs (PDMPs), where available, have been cited as effective ways to identify individuals who engage in such criminal activities [20-23,45].

Conclusion: The goal of this Model Policy is to provide state medical boards with an updated guideline for assessing physicians’ management of pain, so as to determine whether opioid analgesics are used in a manner that is both medically appropriate and in compliance with applicable state and federal laws and regulations. The revised Model Policy makes it clear that the state medical board will consider inappropriate management of pain, particularly chronic pain, to be a departure from accepted best clinical practices, including, but not limited to the following:

- Inadequate attention to initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain: Not unlike many drugs used in medicine today, there are significant risks associated with opioids and therefore benefits must outweigh the risks.*
- Inadequate monitoring during the use of potentially abusable medications: Opioids may be associated with addiction, drug abuse, aberrant behaviors, chemical coping and other dysfunctional behavioral problems, and some patients may benefit from opioid dose reductions or tapering or weaning off the opioid.*

- *Inadequate attention to patient education and informed consent: The decision to begin opioid therapy for chronic pain should be a shared decision of the physician and patient after a discussion of the risks and a clear understanding that the clinical basis for the use of these medications for chronic pain is limited, that some pain may worsen with opioids, and taking opioids with other substances or certain condition (i.e. sleep apnea, mental illness, pre-existing substance use disorder) may increase risk.*
- *Unjustified dose escalation without adequate attention to risks or alternative treatments: Risks associated with opioids increase with escalating doses as well as in the setting of other comorbidities (i.e. mental illness, respiratory disorders, pre-existing substance use disorder and sleep apnea) and with concurrent use with respiratory depressants such as benzodiazepines or alcohol.*
- *Excessive reliance on opioids, particularly high dose opioids for chronic pain management: Prescribers should be prepared for risk management with opioids in advance of prescribing and should use opioid therapy for chronic non-cancer pain only when safer and reasonably effective options have failed. Maintain opioid dosage as low as possible and continue only if clear and objective outcomes are being met.*
- *Not making use of available tools for risk mitigations: When available, the state prescription drug monitoring program should be checked in advance of prescribing opioids and should be available for ongoing monitoring. In addition, the Model Policy is designed to communicate to licensees that the state medical board views pain management as an important area of patient care that is integral to the practice of medicine; that opioid analgesics may be necessary for the relief of certain pain conditions; and that physicians will not be sanctioned solely for prescribing opioid analgesics or the dose (mg./mcg.) prescribed for legitimate medical purposes. However, prescribers must be held to a safe and best clinical practice. The federal Controlled Substances Act [25] defines a “lawful prescription” as one that is issued for a legitimate medical purpose by a practitioner acting in the usual course of professional practice. The use of opioids for other than legitimate medical purposes poses a threat to the individual and to the public health, thus imposing on physicians a responsibility to minimize the potential for misuse, abuse and diversion of opioids and all other controlled substances.*

Finally, the Board stresses three points about this policy.

1. This is a policy that provides guidelines. On its own, the policy will not be the basis for an allegation of unprofessional conduct. It is offered to assist providers. However, parts of the policy reflect Vermont and federal laws and regulations that must be followed. Failure to follow those requirements may result in action by another regulatory or law enforcement agency, such as the D.E.A., or an allegation from the Board of unprofessional conduct under 26 V.S.A. § 1254(a)(27) (failure to comply with provisions of federal or state statutes or rules governing the practice of medicine or surgery). In addition, the policy reflects the Board’s understanding of the standard of care at the time the policy is adopted. Thus, failure to follow the guidance may put a provider at risk of failing to meet the standard of care, which could lead to an allegation of unprofessional conduct under 26 V.S.A. § 1354(a)(22) or 26 V.S.A. § 1354(b).
2. By its terms, this policy pertains only to treatment of chronic pain. Many of the expectations that apply to treatment for chronic pain do not apply strictly to treatment of acute pain, or to use of controlled substances other than opioids. Also, as a policy targeting use of opioids for chronic pain, it is not directed at palliative, end-of-life care. However, some of the statutory and regulatory requirements noted in the guidelines do apply more broadly and physicians need to be

mindful of that. For instance, any provider who writes a prescription for any DEA Schedule II, III, or IV substance must be registered for VPMS. Furthermore, all controlled substances carry some risk of misuse, abuse, and diversion. Thus, you are encouraged to consider whether some of the practices set forth here may be of benefit in prescribing situations that are not specifically covered by this policy.

3. Statutes and regulations change, and the standard of care evolves. The Board will endeavor to update this policy as needed, but the existence of this policy does not reduce the obligation of all prescribers to keep up with changes to law, regulations, or the standard of care.

In closing, we hope that you find this Policy of help in this challenging area of practice and encourage your comments and suggestions as to how it could be improved.

Adopted by Board motion passed at the meeting held on April 2, 2014.

Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain

SECTION I: PREAMBLE

The Vermont Board of Medical Practice is obligated under the laws of the State of Vermont to protect the public health and safety. The Board recognizes that principles of high-quality medical practice dictate that the people of the State of Vermont have access to appropriate, safe and effective pain management. The application of up-to-date knowledge and treatment modalities can help to restore function and thus improve the quality of life of patients who suffer from pain, particularly chronic pain [4,8,26].

This policy has been developed to articulate the Board's position on the use of controlled substances for pain, particularly the use of opioid analgesics and with special attention to the management of chronic pain. The policy thus is intended to encourage physicians to be knowledgeable about best clinical practices as regards the prescribing of opioids and be aware of associated risks. For the purposes of this policy, inappropriate treatment of pain includes non-treatment, inadequate treatment, overtreatment, and continued use of ineffective treatments.

The Board recognizes that opioid analgesics are useful and can be essential in the treatment of acute pain that results from trauma or surgery, as well as in the management of certain types of chronic pain, whether due to cancer or non-cancer causes [20,26,28]. The Board will refer to current clinical practice guidelines and expert reviews in approaching allegations of possible mismanagement of pain [8,10,12,14,26-41, 80].

A. Responsibility for Appropriate Pain Management:

All physicians and other providers of healthcare should be knowledgeable about assessing patients' pain and function, and familiar with methods of managing pain [4,16]. Unless indicated otherwise expressly or by context, all references in this document to "physician" should be read to include other licensees of the Board who may prescribe DEA scheduled controlled substances, which includes podiatrists, physician assistants, and residents who hold a limited training license. Physicians also need to understand and comply with federal and state requirements for prescribing opioid analgesics [3,12,19]. Whenever federal laws and regulations differ from those of Vermont, the more stringent rule is the one that should be followed [42].

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, when current best clinical practices are met.

The Board considers the use of opioids for pain management to be for a legitimate medical purpose when based on sound clinical judgment and current best clinical practices, appropriately documented, and of demonstrable benefit to the patient. To be within the usual course of professional practice, a legitimate physician-patient relationship must exist and the prescribing or administration of medications should be appropriate to the identified diagnosis, should be accompanied by careful follow-up monitoring of the

patient's response to treatment as well as his or her safe use of the prescribed medication, and should demonstrate that the therapy has been adjusted as needed [7,38,43]. There should be documentation of appropriate referrals as necessary [36-37].

The medical management of pain should reflect current knowledge of evidence-based or best clinical practices for the use of pharmacologic and nonpharmacologic modalities, including the use of opioid analgesics and non-opioid therapies [14,16,27]. Such prescribing must be based on careful assessment of the patient and his or her pain (see the discussion on risk stratification, below) [33].

Pain should be assessed and treated promptly, and the selection of therapeutic modalities (including the quantity and frequency of medication doses) should be adjusted according to the nature of the pain, the patient's response to treatment, and the patient's risk level relative to the use of medications with abuse potential [8,10,12,14,26-38].

B. Preventing Opioid Diversion and Abuse:

The Board also recognizes that individuals' use of opioid analgesics for other than legitimate medical purposes poses a significant threat to the health and safety of the individual as well as to the public health [3]. The Board further recognizes that inappropriate prescribing of controlled substances by physicians may contribute to drug misuse and diversion by individuals who seek opioids for other than legitimate medical purposes [5,19,44]. Accordingly, the Board expects physicians to incorporate safeguards into their practices to minimize the risk of misuse and diversion of opioid analgesics and other controlled substances [19-23,38,45-46].

Allegations of inappropriate pain management will be evaluated on an individual basis. The Board may use a variety of sources to determine the appropriateness of treatment including prescribing information obtained from the Vermont Prescription Monitoring System (VPMS).¹ The Board will judge the validity of the physician's treatment of a patient on the basis of available documentation, rather than solely on the quantity and duration of medication administered. The goal is safe management of the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors, and mitigating risk of misuse, abuse, diversion and overdose. [4,29].

The Board will consider the unsafe or otherwise inappropriate treatment of pain to be a departure from best clinical practice, taking into account whether the treatment is appropriate to the diagnosis and the patient's level of risk.

¹ It is a recognized goal for the future that states cooperate on interstate and regional basis to share Prescription Monitoring Program information. If and when that occurs, the expectation for use of VPMS will be expanded to include use of available information from other states.

SECTION II: GUIDELINES

The Board has adopted the following criteria for use in evaluating a physician's management of a patient with pain, including the physician's prescribing of opioid analgesics:

A. Understanding Pain:

The diagnosis and treatment of pain is integral to the practice of medicine [4,34-37]. In order to cautiously prescribe opioids, physicians must understand the relevant pharmacologic and clinical issues in the use of such analgesics, and carefully structure a treatment plan that reflects the particular benefits and risks of opioid use for each individual patient. Such an approach should be employed in the care of every patient who receives chronic opioid therapy [4,8].

B. Patient Evaluation and Risk Stratification:

The medical record should document the presence of one or more recognized medical indications for prescribing an opioid analgesic [7] and reflect an appropriately detailed patient evaluation [38]. Such an evaluation should be completed before a decision is made as to whether to prescribe an opioid analgesic.

The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. For example, meaningful assessment of chronic pain, including pain related to cancer or non-cancer origins, usually demands a more detailed evaluation than an assessment of acute pain. Assessment of the patient's pain typically would include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions, and the effect of the pain on the patient's physical and psychological functioning [31].

For every patient, the initial work-up should include a systems review and relevant physical examination, as well as laboratory investigations as indicated [33,36,48-53]. Such investigations help the physician address not only the nature and intensity of the pain, but also its secondary manifestations, such as its effects on the patient's sleep, mood, work, relationships, valued recreational activities, and alcohol and drug use.

Social and vocational assessment is useful in identifying supports and obstacles to treatment and rehabilitation; for example: Does the patient have good social supports, housing, and meaningful work? Is the home environment stressful or nurturing? [14].

Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse also should be part of the initial evaluation [11,14,21-23,45], and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics [56-58]. This can be done through a careful clinical interview, which also should inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance misuse [31]. Use of a validated screening tool (such as the Screener and Opioid Assessment for Patients with Pain [SOAPP-R; 48] or the Opioid Risk Tool [ORT; 49]), or other validated screening tools, can save time in collecting and evaluating the information and determining the patient's level of risk.

All patients should be screened for depression and other mental health disorders, as part of risk evaluation. Patients with untreated depression and other mental health problems are at increased risk for misuse or abuse of controlled medications, including addiction, as well as overdose. Patients who have a history of substance use disorder (including alcohol) are at elevated risk for failure of opioid analgesic therapy to achieve the goals of improved comfort and function, and also are at high risk for experiencing harm from this therapy, since exposure to addictive substances often is a powerful trigger of relapse [11,31,45]. Therefore, patients with a history of substance use disorders should have a thorough evaluation of their risk for relapse and opiate misuse. Patients considered to be at a higher risk should not be prescribed opioids or should receive consultation from an addiction specialist, if possible, before starting opioids. Patients who have an active substance use disorder should not receive opioid therapy until they are established in a treatment/recovery program [31] or alternatives are established such as co-management with an addiction professional. Physicians who treat patients with chronic pain should be aware of addiction treatment options, including the role of replacement agonists such as methadone and buprenorphine. Physicians who are interested in treating addiction in the office need to be aware that they must have a special DEA license, known as an x-license, to do so. Information on how to qualify to prescribe buprenorphine may be found on the U.S. Substance Abuse and Mental Health Services website: http://buprenorphine.samhsa.gov/waiver_qualifications.html

Information provided by the patient is necessary for the evaluation process, but often is not adequate on its own to allow for proper evaluation of a patient. Reports of previous evaluations and treatments should be confirmed by obtaining records from other providers, if possible. Patients occasionally provide fraudulent records, so if there is any reason to question the truthfulness of a patient's report, it is best to request records directly from the other providers [54-55].

If possible, the patient evaluation should include information from family members and/or significant others [22-23,49-50]. VPMS should be consulted to determine whether the patient is receiving prescriptions from any other physicians, and the results obtained from VPMS should be documented in the patient record [34].

In dealing with a patient who is taking opioids prescribed by another physician—particularly a patient on high doses—the evaluation and risk stratification assume even greater importance [21-23]. With all patients, the physician's decision as to whether to prescribe opioid analgesics should reflect the totality of the information collected, as well as the physician's own knowledge and comfort level in prescribing such medications and the resources for patient support that are available in the community [21-23].

C. Development of a Treatment Plan and Goals:

The goals of pain treatment include reasonably attainable improvement in pain and function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; and avoidance of unnecessary or excessive use of medications [4,8]. Effective means of achieving these goals vary widely, depending on the type and causes of the patient's pain, other concurrent issues, and the preferences of the physician and the patient.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies [38]. The treatment plan should contain information supporting the selection of therapies, both pharmacologic (including medications other than opioids) and nonpharmacologic. It also should specify the objectives that will be used to evaluate treatment progress, such as relief of pain and improved physical and psychosocial function [14,36,47]. Ongoing documentation of treatment should reference the treatment plan, as appropriate.

The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered [21-23,45].

D. Informed Consent and Treatment Agreement:

The decision to initiate opioid therapy should be a shared decision between the physician and the patient. The physician should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient, with persons designated by the patient, or with the patient's surrogate or guardian if the patient is without medical decision-making capacity [32,35]. If opioids are prescribed, the patient (and possibly family members) should be counseled on safe ways to store and dispose of medications [3,37].

Use of a written informed consent and treatment agreement (sometimes referred to as a "treatment contract") is highly recommended [21-23,35,38]. The failure to use a treatment contract in a given case does not per se constitute unprofessional conduct, but in the absence of a treatment agreement contract, documentation in the patient's chart should meet the same goals and support a conclusion that the standard of care was met.

Informed consent documents typically address:

- The potential risks and anticipated benefits of chronic opioid therapy.
- Potential side effects (both short- and long-term) of the medication, such as constipation and cognitive impairment.
- The likelihood that tolerance to and physical dependence on the medication will develop.
- The risk of drug interactions and over-sedation.

- The risk of impaired motor skills (affecting driving and other tasks).
- The risk of opioid misuse, dependence, addiction, and overdose.
- The limited evidence as to the benefit of long-term opioid therapy.
- The physician's prescribing policies and expectations, including the number and frequency of prescription refills, as well as the physician's policy on early refills and replacement of lost or stolen medications.
- Specific reasons for which drug therapy may be changed or discontinued (including violation of the policies and agreements spelled out in the treatment agreement).

Treatment agreements outline the joint responsibilities of physician and patient [35-37] and are indicated for opioid or other medications that may be abused. They typically discuss:

- The goals of treatment, in terms of pain management, restoration of function, and safety.
- The patient's responsibility for safe medication use (e.g., by not using more medication than prescribed or using the opioid in combination with alcohol or other substances; storing medications in a secure location; and safe disposal of any unused medication).
- The patient's responsibility to obtain his or her prescribed opioids from only one physician or practice.
- The patient's agreement to periodic drug testing (as of blood, urine, hair, or saliva).
- The physician's responsibility to be available or to have a covering physician available to care for unforeseen problems and to prescribe scheduled refills.

Informed consent documents and treatment agreements can be part of one document for the sake of convenience.

E. Initiating an Opioid Trial:

Safer alternative treatments should be considered before initiating opioid therapy for chronic, non-malignant pain. Opioid therapy should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) and with specified evaluation points. The physician should explain that progress will be carefully monitored for both benefit and harm in terms of the effects of opioids on the patient's level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety [51]. When initiating opioid therapy, the lowest dose possible should be given to an opioid naïve patient and titrated to effect. It is generally suggested to begin opioid therapy with a short acting opioid and consider rotating to a long-acting/extended release opioid only if indicated. Vermont law now requires checking VPMS in certain circumstances before a prescription for controlled substances is written, including when initiating treatment of chronic pain with opioids, as further discussed in the following section.

A decision to continue opioid therapy beyond the trial period should reflect a careful evaluation of benefits versus adverse events [29] and/or potential risks.

F. Monitoring and Adapting the Treatment Plan:

The physician should regularly review the patient's progress, including any new information about the etiology of the pain or the patient's overall health and level of function [35,49-50]. When possible, collateral information about the patient's response to opioid therapy should be obtained from family members or other close contacts.

In addition to the need to consider information from the patient and close contacts, physicians must make use of the state prescription monitoring system. Vermont law now requires all providers who prescribe or dispense any Schedule II, III, or IV drugs to register to use VPMS. It also requires consultation of VPMS in specified circumstances²:

- At least annually for ongoing opioid chronic pain treatment;
- When first prescribing opioids for long-term, chronic pain treatment expected to last for 90 days or more;
- The first time prescribing a Schedule II, III, or IV opioid for chronic pain; and
- Before writing a replacement prescription for any Schedule II, III, or IV controlled substance. Replacement refers to the issuance of a prescription to replace medication reported by the patient as lost or stolen. (The Board notes that Vermont law also requires that a replacement prescription be marked "REPLACEMENT" and documented in the chart as a replacement prescription.)

The law also tasks the Commissioner of Health with creating rules relating to those requirements, including consideration of additional situations that trigger a required check of VPMS; the rules are not published as of the date of this policy, but will be posted on the Board webpage. If a provider fails to follow the requirements of the statute and any applicable rules, there may be both a violation of Vermont law relating to the practice of medicine, which is one form of unprofessional conduct, and such failure may be a factor in evaluating whether the standard of care was met.

The patient should be seen more frequently while the treatment plan is being initiated and the opioid dose adjusted [44-51]. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled less frequently. (However, if the patient is seen less than monthly and an opioid is prescribed, arrangements must be made for the patient to obtain a refill or new prescription when needed.)

At each visit, the results of chronic opioid therapy should be monitored by assessing what have been called the "5As" of chronic pain management; these involve a determination of whether the patient is experiencing a reduction in pain (Analgesia), has demonstrated an improvement in level of function

² The full text of the law enacting the statutory requirements is in Act 75 of the 2013 session of the General Assembly, available online at: <http://www.leg.state.vt.us/DO2014CS//ACTS/ACT075.PDF>.

(Activity), whether there are significant Adverse effects, whether there is evidence of Aberrant substance-related behaviors, and mood of the individual (Affect) [38,52]. Validated brief assessment tools that measure pain and function, such as the three-question “Pain, Enjoyment and General Activity” (PEG) scale [47] or other validated assessment tools, may be helpful and time effective.

Continuation, modification or termination of opioid therapy for pain should be contingent on the physician’s evaluation of (1) evidence of the patient’s progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as overdose or diversion [21-23,45]. A satisfactory response to treatment would be indicated by a reduced level of pain, increased level of function, and/or improved quality of life [29]. Information from family members or other caregivers should be considered in evaluating the patient’s response to treatment [14,35-36]. Use of measurement tools to assess the patient’s level of pain, function, and quality of life (such as a visual analog or numerical scale) can be helpful in documenting therapeutic outcomes [14,49].

G. Periodic Drug Testing and Response to Evidence of Aberrant Behavior:

Periodic drug testing may be useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs [53-54]. Drug testing is an important monitoring tool because self-reports of medication use are not always reliable and behavioral observations may detect some problems but not others [55-59]. Patients being treated for addiction should be tested as frequently as necessary to ensure therapeutic adherence. Use of testing should not be limited to instances in which the provider perceives a problem; the regular use of testing as a universal precaution will avoid having the request for a test become a confrontation that affects the physician-patient relationship.

Urine may be the preferred biologic specimen for testing because of its ease of collection and storage and the cost-effectiveness of such testing [53]. When such testing is conducted as part of pain treatment, forensic standards are generally not necessary and not in place, but physicians should use their judgment as to steps needed to ensure reliability of results for individual patients. Initial testing may be done using class-specific immunoassay drug panels (point-of-care or laboratory-based), which typically do not identify particular drugs within a class unless the immunoassay is specific for that drug. If necessary, this can be followed up with a more specific technique, such as gas chromatography/mass spectrometry (GC/MS) or other chromatographic tests to confirm the presence or absence of a specific drug or its metabolites [53]. In drug testing in a pain practice, it is important to identify the specific drug not just the class of the drug.

Physicians need to be aware of the limitations of available tests (such as their limited sensitivity for many opioids) and take care to order tests appropriately [54]. For example, when a drug test is ordered, it is important to specify that it include the opioid being prescribed [53]. Because of the complexities involved in interpreting drug test results, it is advisable to confirm significant or unexpected results with the laboratory toxicologist or a clinical pathologist [59-60].

While immunoassay, point of care (POC) testing has its utility in the making of temporary and “on the spot” changes in clinical management, its limitations with regard to accuracy have recently been the subject of study. These limitations are such that the use of point of care testing for the making of more long term and permanent changes in management of people with the disease of addiction and other

clinical situations may not be justified until the results of confirmatory testing with more accurate methods such as LC-MS/MS are obtained. A recent study on LC-MS/MS results following immunoassay POC testing in addiction treatment settings and found very high rates of “false negatives and positives” [53,81].

Test results that suggest opioid misuse should be discussed with the patient. It may be helpful to approach such a discussion in a positive, supportive fashion, so as to strengthen the physician-patient relationship and encourage healthy behaviors (as well as behavioral change where that is needed). Both the test results and subsequent discussion with the patient should be documented in the medical record [53].

Periodic pill counting is also a useful strategy to confirm medication adherence and to minimize diversion (e.g., selling, sharing or giving away medications). The Board acknowledges the limitations of pill counts, but believes that there may be benefit and notes that there are means to limit the ability of patients to find “work arounds” to pill counts, such as serialized blister pack packaging.

As noted earlier, consulting VPMS before prescribing opioids for chronic pain and during ongoing use is highly recommended and required in some circumstances by Vermont law, as discussed above at Section F, Monitoring and Adapting the Treatment Plan. VPMS is useful for monitoring compliance with the treatment agreement as well as identifying individuals obtaining controlled substances from multiple prescribers [21-23,55,62].

If the patient’s progress is unsatisfactory, the physician must decide whether to revise or augment the treatment plan, whether other treatment modalities should be added to or substituted for the opioid therapy, or whether a different approach—possibly involving referral to a pain specialist or other health professional—should be employed [35-37,62-63]. Prescriptions of shorter duration and more frequent appointments are additional steps that may be taken by a physician who is concerned about the risk of misuse, abuse, or diversion presented by a patient. Evidence of misuse of prescribed opioids demands prompt intervention by the physician [19,21-23,32,35]. Patient behaviors that require such intervention typically involve recurrent early requests for refills, multiple reports of lost or stolen prescriptions, obtaining controlled medications from multiple sources without the physician’s knowledge, intoxication or impairment (either observed or reported), and pressuring or threatening behaviors [23].

The presence of illicit drugs or drugs not legitimately prescribed in drug tests similarly requires action on the part of the prescriber. Some aberrant behaviors are more closely associated with medication misuse than others [62-63]. Most worrisome is a pattern of behavior that suggests recurring misuse, such as unsanctioned dose escalations, deteriorating function, and failure to comply with the treatment plan [64].

Documented drug diversion or prescription forgery, obvious impairment, and abusive or assaultive behaviors require a firm, immediate response³ [22-23,38,46]. Indeed, failure to respond can place the

³ 18 V.S.A. 4223 addresses criminal fraud or deceit in obtaining or attempting to obtain a regulated drug and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R. § 164.512(f)(5) permits disclosure of health information when a crime has occurred at a medical facility. Licensees should check with their organizations or legal counsel for guidance as to what constitutes a good faith belief that there is evidence of criminal conduct.

patient and others at significant risk of adverse consequences, including accidental overdose, suicide attempts, arrests and incarceration, or even death [23,65-67]. For this reason, physicians who prescribe chronic opioid therapy should be knowledgeable in the diagnosis of substance use disorders and able to distinguish such disorders from physical dependence—which is expected in chronic therapy with opioids and many sedatives.

H. Consultation and Referral:

The treating physician should seek a consultation with, or refer the patient to, a pain, psychiatry, addiction or mental health specialist as needed [37-38]. For example, a patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment, if available [31,66].

Physicians who prescribe chronic opioid therapy should be familiar with treatment options for opioid addiction (including those available in licensed opioid treatment programs [OTPs]) and those offered by an appropriately credentialed and experienced physician through office-based opioid treatment [OBOT]), so as to make appropriate referrals when needed [23,31,37,39].

I. Discontinuing Opioid Therapy:

Throughout the course of opioid therapy, the physician and patient should regularly weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate [46].

If opioid therapy is continued, the treatment plan may need to be adjusted to reflect the patient's changing physical status and needs, as well as to support safe and appropriate medication use [22-23].

Reasons for discontinuing opioid therapy include resolution of the underlying painful condition, emergence of intolerable side effects, inadequate analgesic effect, failure to improve the patient's quality of life despite reasonable titration, deteriorating function, or significant aberrant medication use [38, 45].

If opioid therapy is discontinued, the patient who has become physically dependent should be provided with a safely structured tapering and withdrawal regimen. Withdrawal can be managed either by the prescribing physician (who may want to consult with an addiction specialist) or by referring the patient to an addiction specialist [63]. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate [21-23].

Additionally, providers should not continue opioid treatment unless the patient has received a benefit, including demonstrated functional improvement.

J. Medical Records:

Every physician who treats patients for chronic pain must maintain accurate, complete, and legible medical records. Information that should appear in the medical record includes the following [22-23,38,43-44]:

- Copies of the signed informed consent and treatment agreement.
- The patient's medical history.
- Results of the physical examination and all laboratory tests.
- Results of the risk assessment, including results of any screening instruments used.
- A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity).
- Instructions to the patient, including discussions of risks and benefits with the patient and any significant others.
- Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement.
- Notes on evaluations by and consultations with specialists or other providers, and notation by the receiving provider of response to the information and recommendations.
- Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors [21-23,30,38,45,68].

These may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers.

- Authorization for release of information to other treatment providers.

The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record [25]. The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed [23]. Records should be up-to-date and maintained in an accessible manner so as to be readily available for review [25].

Good records demonstrate that a service was provided to the patient and establish that the service provided was medically necessary. Even if the outcome is less than optimal, thorough records protect the physician as well as the patient [23,38,45,68].

K. Compliance with Controlled Substance Laws and Regulations:

To prescribe, dispense or administer controlled substances, the physician must be registered with the DEA, licensed by Vermont, and comply with applicable federal and Vermont laws and regulations [25]. Physicians licensed by the Board who have a DEA registration number must include at least 1 hour AMA PRA Category 1 Credit™ CME on safe prescribing in every two-year licensing period, as required by Vermont law and the Board's Rules for CME.

Physicians are referred to the Physicians' Manual of the U.S. Drug Enforcement Administration for specific rules and regulations governing the use of controlled substances. Additional resources are available on the DEA's website at www.deadiversion.usdoj.gov. This policy, other Board of Medical Practice communications regarding prescribing, and any other relevant Vermont policies or regulations are made available on the Board's website, http://healthvermont.gov/hc/med_board/bmp.aspx.

L. Practice Systems:

The Board recommends that physicians ensure that their practices establish systems and processes to help practice effectively, safely, and in accordance with this policy. Consistent processes and training of staff will allow for better care, deter misuse and diversion, and protect the patient and the physician. Examples of systems follow:

- The law and regulations surrounding VPMS allow for use of delegates to perform checks. It is not necessary for the physician to check the system, so the Board encourages establishment of a process that provides for office staff to get the needed information from VPMS for the provider.
- Another recommendation is to issue prescriptions for controlled substances for a duration that is a multiple of 7, up to 28 days (and adjusted for holidays) to reduce the incidents of prescriptions running out on weekends, and thereby reduce the need for a physician who does not know the patient as well, but who is on call, to write a prescription.

SECTION III: DEFINITIONS

For the purposes of this Policy, the following terms are defined as shown.

Aberrant Substance Use Behaviors: Behaviors that are outside the boundaries of the agreed-upon treatment plan may constitute aberrant substance use behaviors [22-23]. For example, obtaining prescriptions for the same or similar drugs from more than one physician or other health care provider without the treating physician's knowledge is aberrant behavior, as is use of illicit drugs.

Abuse: Abuse has been described as a maladaptive pattern of drug use that results in harm or places the individual at risk of harm [29]. Abuse of a prescription medication involves its use in a manner that deviates from approved medical, legal, and social standards, generally to achieve a euphoric state ("high") or to sustain opioid dependence that is opioid addiction, or use that is for any purpose other than that for which the medication was prescribed[28].

Addiction: A longstanding definition of addiction is: “a primary, chronic, neurobiologic disease, whose development and manifestations are influenced by genetic, psychosocial, and environmental factors. [28] Addiction often is said to be characterized by behaviors that include impaired control over drug use, craving, compulsive use, and continued use despite harm [28].

A newer definition, adopted by the American Society of Addiction Medicine in 2011, describes addiction as “a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death” [40].

(As discussed below, physical dependence and tolerance are expected physiological consequences of extended opioid therapy for pain and in this context do not indicate the presence of addiction.)

Controlled Substance: A controlled substance is a drug that is subject to special requirements under the federal Controlled Substances Act of 1970 (CSA) [25], which is designed to ensure both the availability and control of regulated substances. Under the CSA, availability of regulated drugs for medical purposes is accomplished through a system that establishes quotas for drug production and a distribution system that closely monitors the importation, manufacture, distribution, prescribing, dispensing, administering, and possession of controlled drugs. Civil and criminal sanctions for serious violations of the statute are part of the government’s control apparatus. The Code of Federal Regulations (Title 21, Chapter 2) implements the CSA. The CSA provides that responsibility for scheduling controlled substances is shared between the Food and Drug Administration (FDA) and the DEA. In granting regulatory authority to these agencies, the Congress noted that both public health and public safety needs are important and that neither takes primacy over the other. To accomplish this, the Congress provided guidance in the form of factors that must be considered by the FDA and DEA when assessing public health and safety issues related to a new drug or one that is being considered for rescheduling or removal from control.

The CSA does not limit the amount of drug prescribed, the duration for which it is prescribed, or the period for which a prescription is valid (although some states do impose such limits).

Most potent opioid analgesics are classified in Schedules II or III under the CSA, indicating that they have a significant potential for abuse and a currently accepted medical use in treatment in the U.S. (with certain restrictions), and that abuse of the drug may lead to severe psychological or physical dependence. Although the scheduling system provides a rough guide to abuse potential, it should be recognized that all controlled medications have some potential for abuse.

Dependence: Physical dependence is a state of biologic adaptation that is evidenced by a class-specific withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist [28]. It is important to distinguish addiction from the type of physical dependence that can and does occur within the context of good medical care, as when a patient on long-

term opioid analgesics for pain becomes physically dependent on the analgesic. This distinction is reflected in the two primary diagnostic classification systems used by health care professionals: the International Classification of Mental and Behavioural Disorders, 10th Edition (ICD-10) of the World Health Organization [70], and the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association [71]. In the DSM-IV-TR, a diagnosis of “substance dependence” meant addiction. In the upcoming DSM V, the term dependence is reestablished in its original meaning of physiological dependence. When symptoms are sufficient to meet criteria for substance misuse or addiction, the term “substance use disorder” is used, accompanied by severity ratings [69].

It may be important to clarify this distinction during the informed consent process, so that the patient (and family) understands that physical dependence and tolerance are likely to occur if opioids are taken regularly over a period of time, but that the risk of addiction is relatively low, although estimates do vary. Discontinuing chronic opioid therapy may be difficult, even in the absence of addiction. According to the World Health Organization, “The development of tolerance and physical dependence denote normal physiologic adaptations of the body to the presence of an opioid” [70]. Consequently, physical dependence alone is neither necessary nor sufficient to diagnose addiction [71,72].

Diversion: Drug diversion is defined as the intentional transfer of a controlled substance from authorized to unauthorized possession or channels of distribution [73-74]. The federal Controlled Substances Act (21 U.S.C. §§ 801 et seq.) establishes a closed system of distribution for drugs that are classified as controlled substances. Records must be kept from the time a drug is manufactured to the time it is dispensed. Health care professionals who are authorized to prescribe, dispense, and otherwise control access to such drugs are required to register with the DEA [25,75].

Pharmaceuticals that make their way outside this closed distribution system are said to have been “diverted” [75], and the individuals responsible for the diversion (including patients) are in violation of federal and Vermont law.

Experience shows that the degree to which a prescribed medication is misused depends in large part on how easily it is redirected (diverted) from the legitimate distribution system [17,19,74].

Misuse: The term misuse (also called nonmedical use) encompasses all uses of a prescription medication other than those that are directed by a physician and used by a patient within the law and the requirements of good medical practice [28].

Opioid: An opioid is any compound that binds to an opioid receptor in the central nervous system (CNS) [4]. The class includes both naturally occurring and synthetic or semi-synthetic opioid drugs or medications, as well as endogenous opioid peptides [35].

Most physicians use the terms “opiate” and “opioid” interchangeably, but toxicologists (who perform and interpret drug tests) make a clear distinction between them. “Opioid” is the broader term because it includes the entire class of agents that act at opioid receptors in the CNS, whereas “opiates” refers to natural compounds derived from the opium plant but not semisynthetic opioid derivatives of opiates or completely synthetic agents. Thus, drug tests that are “positive for opiates” have detected one of these compounds or a metabolite of heroin, 6-monoacetyl morphine (MAM). Drug tests that are “negative for

opiates” have found no detectable levels of opiates in the sample, even though other opioids that were not tested for—including the most common currently used and misused prescription opioids—may be present in the sample that was analyzed [53,59-260].

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

Acute pain is the normal, predictable physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Acute pain generally is time-limited, lasting six weeks or less [4].

Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury (e.g., more than three months). It may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over a period of months or years.

Chronic non-cancer related pain is chronic pain that is not associated with active cancer and does not occur at the end of life [4,76].

Opioid-induced hyperalgesia may develop as a result of long-term opioid use in the treatment of chronic pain. Primary hyperalgesia is pain sensitivity that occurs directly in the damaged tissues, while secondary hyperalgesia occurs in surrounding undamaged tissues. Human and animal studies have demonstrated that primary or secondary hyperalgesia can develop in response to both chronic and acute exposure to opioids. Hyperalgesia can be severe enough to warrant discontinuation of opioid treatment [77].

Tolerance: Tolerance is a state of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug’s effects over time. Tolerance is common in opioid treatment, has been demonstrated following a single dose of opioids, and is not the same as addiction [28].

Trial Period: A period of time during which the efficacy of an opioid for treatment of an individual’s pain is tested to determine whether the treatment goals can be met in terms of reduction of pain and restoration of function. If the goals are not met, the opioid dose may be adjusted, a different opioid substituted, an adjunctive therapy added, or use of opioids discontinued and an alternative approach to pain management selected [36].

Universal Precautions: The concept of universal precautions is borrowed from an infectious disease model of the same name to underscore its comparability to practices in other areas of medicine. The concept recognizes that all patients have a level of risk that can only be estimated initially, with the estimate modified over time as more information is obtained. The 10 essential steps of universal precautions can be summarized as follows [38]:

1. Make a diagnosis with an appropriate differential.
2. Conduct a patient assessment, including risk for substance use disorders.
3. Discuss the proposed treatment plan with the patient and obtain informed consent.

4. Have a written treatment agreement that sets forth the expectations and obligations of both the patient and the treating physician.
5. Initiate an appropriate trial of opioid therapy, with or without adjunctive medications.
6. Perform regular assessments of pain and function.
7. Reassess the patient's pain score and level of function.
8. Regularly evaluate the patient in terms of the "5 A's": Analgesia, Activity, Adverse effects, Aberrant behaviors, and Affect.
9. Periodically review the pain diagnosis and any comorbid conditions, including substance use disorders, and adjust the treatment regimen accordingly.
10. Keep careful and complete records of the initial evaluation and each follow-up visit.

By acknowledging the fact that there are no signs that invariably point to substance use disorder [41], the universal precautions encourage a consistent and respectful approach to the assessment and management of pain patients, thereby minimizing stigma, improving patient care, and reducing overall risk [38].

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References

1. Federation of State Medical Boards (FSMB). *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*. Washington, DC: The Federation, 1998.
2. Federation of State Medical Boards (FSMB). *Model Policy for the Use of Controlled Substances for the Treatment of Pain*. Washington, DC: The Federation, 2004.
3. Office of National Drug Control Policy (ONDCP). *Epidemic: Responding to America's Prescription Drug Abuse Crisis*. Washington, DC: Executive Office of the President, The White House, 2011.
4. Institute of Medicine (IOM) of the National Academy of Sciences (NAS). *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*. Washington, DC: National Academies Press, 2011.
5. Bohnert ASB, Valenstein M, Bair MJ et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *Journal of the American Medical Association*. 2011 Apr 6;305(13):1315-1321.
6. Fishbain D, Johnson S, Webster L et al. Review of regulatory programs and new opioid technologies in chronic pain management: Balancing the risk of medication abuse with medical need. *Journal of Managed Care Pharmacy*. 2010;16(4):276-278.

7. Bloodworth D. Opioids in the treatment of chronic pain: Legal framework and therapeutic indications and limitations. *Physical Medicine and Rehabilitation Clinics of North America*. 2006;17:355-379.
8. Noble M, Treadwell JR, Tregear SJ et al. *Cochrane Database of Systematic Reviews, Issue 1. Long-term Opioid Management for Chronic Noncancer Pain*. New York, NY: The Cochrane Collaborative, John Wiley & Sons, Ltd., 2010. Review.
9. Rosenblum A, Marsch LA, Joseph H et al. Opioids and the treatment of chronic pain: Controversies, current status, and future directions. *Experimental and Clinical Psychopharmacology*. 2008 Oct; 16(5):405-416.
10. Passik SD & Weinreb HJ. Managing chronic nonmalignant pain: Overcoming obstacles to the use of opioids. *Advances in Therapy*. 2000;17(2):70-83.
11. Passik SD & Kirsch KL. The interface between pain and drug abuse and the evolution of strategies to optimize pain management while minimizing drug abuse. *European Clinical Psychopharmacology*. 2008 Oct; 16(5):400-404.
12. American Academy of Pain Medicine (AAPM), American Pain Society (APS), and American Society of Addiction Medicine (ASAM). *Public Policy Statement on the Rights and Responsibilities of Healthcare Professionals in the Use of Opioids for the Treatment of Pain*. Chevy Chase, MD: American Society of Addiction Medicine, 2004.
13. Gomes T, Mamdani MM, Dhalla IA et al. Opioid dose and drug-related mortality in patients with nonmalignant pain. *Archives of Internal Medicine*. 2011 Apr 11;171(7):686-691.
14. Chou R, Fanciullo GJ, Fine PG et al., for the American Pain Society and American Academy of Pain Medicine Opioid Guidelines Panel. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *Journal of Pain*. 2009 Feb;10(2):113-130.
15. Cicero TJ, Surratt HL, Kurtz S et al. Patterns of prescription opioid abuse and comorbidity in an aging treatment population. *Journal of Substance Abuse Treatment*. 2012 Jan;42(1):87-94.
16. American College of Physicians (ACP). *Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians*. Philadelphia, PA: The College, 2008.
17. Parran TV Jr. Prescription drug abuse: A question of balance. *Alcohol and Substance Abuse*. 1997;81(4):253-278.
18. Wilford BB, Finch J, Czechowicz D et al. An overview of prescription drug misuse and abuse: Defining the problem and seeking solutions. *Journal of Law, Medicine and Ethics*. 1994 Fall;22(3):197-203.
19. American Medical Association (AMA), Council on Scientific Affairs. Drug abuse related to prescribing practices (CSA Rep. C, A-81; Reaffirmed 1991, 2001, 2011). *Proceedings of the House of Delegates of the American Medical Association*. Chicago, IL: The Association, 1981.

20. American Medical Association (AMA), Council on Scientific Affairs. Education regarding prescribing controlled substances (Sub. Res. 76; Reaffirmed: 1998, 2008). *Proceedings of the House of Delegates of the American Medical Association*. Chicago, IL: The Association, 1988.
21. Ling W, Wesson DR & Smith DE. Abuse of prescription opioids. In AW Graham, TK Schultz, M Mayo-Smith, RK Ries & BB Wilford (eds.) *Principles of Addiction Medicine, Third Edition*. Chevy Chase, MD: American Society of Addiction Medicine, 2003.
22. Wesson DR & Smith DE. Prescription drug abuse: Patient, physician, and cultural responsibilities. *Western Journal of Medicine*. 1990;152(5):613-616.
23. Parran TV Jr., Wilford BB & DuPont RL. Prescription drug abuse and addiction, Part II: Patient management. *Up-to-Date online medical education website* [www.uptodate.com]. Philadelphia, PA: Lippincott, Williams & Wilkins, 2012.
24. Blumenschein K, Fink JL, Freeman PR et al., for the Kentucky All Schedule Prescription Electronic Reporting Program (KASPER) Evaluation Team. *Review of Prescription Drug Monitoring Programs in the United States*. Lexington, KY: University of Kentucky College of Pharmacy, June 2010.
25. Controlled Substances Act of 1970 (CSA). *Federal Register (CFR)*. Public Law No. 91-513, 84 Stat. 1242.
26. Dasgupta N, Kramer ED, Zalman MA et al. Association between nonmedical and prescriptive usage of opioids. *Drug and Alcohol Dependence*. 2006 Apr 28;82(2):135-142.
27. American Academy of Addiction Psychiatry (AAAP). *Policy Statement: Use of Opioids in the Treatment of Chronic, Non-malignant Pain*. East Providence, RI: The Academy, 2007 (revised 2009).
28. American Academy of Pain Medicine (AAPM), American Pain Society (APS), and American Society of Addiction Medicine (ASAM). *Definitions Related to the Use of Opioids in the Treatment of Chronic Pain*. Glenview, IL: American Pain Society, 2001.
29. American Pain Society (APS) and American Academy of Pain Medicine (AAPM). Clinical guideline for the use of chronic opioid therapy in chronic noncancer pain. *Journal of Pain* 2009 Feb; 10(2):113-130.
30. American Society of Anesthesiologists (ASA) and American Society of Regional Anesthesia and Pain Medicine (ASRAPM). *Practice Guidelines for Chronic Pain Management: An Updated Report by the ASA Task Force on Chronic Pain Management and ASRAPM*. Washington, DC: ASA & ASRAPM, 2010.
31. Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment Improvement Protocol (TIP) 54: *Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*. DHHS Pub. No. (SMA) 12-4671. Rockville, MD: CSAT, SAMHSA, 2012.

32. Department of Veterans Affairs (VA) and Department of Defense (DoD). *Clinical Practice Guideline: Management of Opioid Therapy for Chronic Pain* (Version 2.0). Washington, DC: VA/DoD, 2010.
33. Institute for Clinical Systems Improvement (ICSI). *Health Care Guideline: Assessment and Management of Chronic Pain, Fifth Edition*. Bloomington, MN: The Institute, 2011.
34. Maine Primary Care Association (MPCA). *Health Care Safety Net Series: Opiate Use for Chronic, Non-Cancer Pain (CNCP), First Edition*. Augusta, ME: The Association, October 2011.
35. National Opioid Use Guideline Group (NOUGG). *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, Version 5.6*. Ottawa, Canada: National Pain Centre, April 30, 2010.
36. Utah Department of Health (UDOH). *Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain*. Salt Lake City, UT: The Department, February 2009.
37. Washington State Agency Medical Directors' Group (WSAMDG). *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An Educational Aid to Improve Care and Safety With Opioid Treatment*. Corvallis, WA: Washington Department of Health, 2010.
38. Gourlay DL & Heit HA. Universal precautions in pain medicine: A rational approach to the treatment of chronic pain. *Pain Medicine*. 2005;6:107-112.
39. Zacny J, Bigelow G, Compton P et al. College on Problems of Drug Dependence task force on prescription opioid nonmedical use and abuse: Position statement. *Drug and Alcohol Dependence*. 2003; 69:215-232.
40. American Society of Addiction Medicine (ASAM). *The Definition of Addiction*. Chevy Chase, MD: The Society, 2011.
41. Heit HA & Gourlay DL. The treatment of chronic pain in patients with a history of substance abuse. In JC Ballantyne & JP Rathmell (eds.) *Bonica's Management of Pain, Fourth Edition*. Philadelphia, PA: Lippincott, Williams & Wilkins, 2010.
42. Angarola R. The effect of national and international drug control laws on patient care. In BB Wilford (ed.) *Balancing the Response to Prescription Drug Abuse: Report of a National Symposium on Medicine and Public Policy*. Chicago, IL: American Medical Association, 1990.
43. Drug Enforcement Administration (DEA), Office of Diversion Control. *Physician's Manual: An Informational Outline of the Controlled Substances Act of 1970*. Washington, DC: DEA, U.S. Department of Justice, 1990.
44. Wilford BB & DuPont RL. Prescription drug abuse. In A Wertheimer & T Fulda (eds.). *A Textbook on Pharmaceutical Policy*. Binghamton, NY: The Haworth Press, 2007.

45. Isaacson JH, Hopper JA, Alford DP et al. Prescription drug use and abuse: Risk factors, red flags, and prevention strategies. *Postgraduate Medicine*. 2005;118:19.
46. Smith MY & Woody G. Nonmedical use and abuse of scheduled medications prescribed for pain, pain-related symptoms, and psychiatric disorders: Patterns, user characteristics, and management options. *Current Psychiatry Reports*. 2005 Oct;7(5):337-343.
47. Krebs EE, Lorenz KA, Bair MJ et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. *Journal of General Internal Medicine*. 2009 Jun; 24(6):733-738.
48. Butler SF, Budman SH, Fernandez K et al. Validation of a screener and opioid assessment measure for patients with chronic pain. *Pain*. 2004 Nov;112(1-2):65-75.
49. Webster LR & Webster RM. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the Opioid Risk Tool. *Pain Medicine*. 2005 Nov-Dec;6(6):432-442.
50. White AG, Birnbaum HG, Schiller M et al. Analytic models to identify patients at risk for prescription opioid abuse. *American Journal of Managed Care*. 2009 Dec;15(12):897-906.
51. Nicolaidis C, Chianello T & Gerrity M. Development and preliminary psychometric testing of the Centrality of Pain Scale. *Pain Medicine*. 2011 Apr;12(4):612-617.
52. Becker WC, Tobin DG & Fiellin DA. Nonmedical use of opioid analgesics obtained directly from physicians: Prevalence and correlates. *Archives of Internal Medicine*. 2011;171(11):1034-1036.
53. Gourlay D, Heit HA & Caplan YH. *Urine Drug Testing in Clinical Practice; The Art & Science of Patient Care*. John Hopkins University School of Medicine; 5th Edition, June 2012. Available: (<http://www.udtmonograph.com>).
54. Starrels JL, Fox AD, Kunins HV et al. They don't know what they don't know: Internal medicine residents' knowledge and confidence in urine drug test interpretation for patients with chronic pain. *Journal of General Internal Medicine*. 2012 Nov;27(11):1521-1527.
55. Edlund M, Martin BC, Fan M-Y et al. Risks for opioid abuse and dependence among recipients of chronic opioid therapy: Results from the TROUP Study. *Drug and Alcohol Dependence*. 2010;112:90-98.
56. Fleming MF, Balousek SL, Klessig CL et al. Substance use disorders in a primary care sample receiving daily opioid therapy. *Journal of Pain*. 2007 Jul;8(7):573-582.
57. Fishbain DA, Cole B, Lewis J et al. What percentage of chronic nonmalignant pain patients exposed to chronic opioid analgesic therapy develop abuse/addiction and/or aberrant drug-related behaviors? A structured evidence-based review. *Pain Medicine*. 2008 May-Jun;9(4):444-459.
58. Berndt S, Maier C & Schütz HW. Polymedication and medication compliance in patients with chronic non-malignant pain. *Pain*. 1993 Mar;52(3):331-339.

59. Wasan AD, Michna E, Janfaza D et al. Interpreting urine drug tests: Prevalence of morphine metabolism to hydromorphone in chronic pain patients treated with morphine. *Pain Medicine*. 2008 Oct; 9(7):918-923.
60. Starrels JL, Becker WC, Alford DP et al. Systematic review: Treatment agreements and urine drug testing to reduce opioid misuse in patients with chronic pain. *Annals of Internal Medicine*. 2010 Jun 1; 152(11):712-720.
61. Meltzer EC, Rybin D, Saitz R et al. Identifying prescription opioid use disorder in primary care: Diagnostic characteristics of the Current Opioid Misuse Measure (COMM). *Pain*. 2011 Feb;152(2):397-402.
62. Passik SD & Kirsh KL. Assessing aberrant drug-taking behaviors in the patient with chronic pain. *Current Pain Headache Reports*. 2004;8(4):289–294.
63. Passik SD & Kirsch KL. Managing pain in patients with aberrant drug-taking behaviors. *Journal of Supportive Oncology*. 2005;3(1):83–86.
64. Schnoll SH & Finch J. Medical education for pain and addiction: Making progress toward answering a need. *Journal of Law, Medicine & Ethics*. 1994 Fall;22(3):252-256.
65. Chou R, Fanciullo GJ, Fine PG et al. Opioids for chronic noncancer pain: Prediction and identification of aberrant drug-related behaviors: A review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. *Journal of Pain* 2009 Feb; 10(2):131-146.
66. Walwyn WM, Miotto KA & Evans CJ. Opioid pharmaceuticals and addiction: The issues, and research directions seeking solutions. *Drug and Alcohol Dependence*. 2010 May 1;108(3):156-165.
67. Turk DC, Swanson KS & Gatchel RJ. Predicting opioid misuse by chronic pain patients: A systematic review and literature synthesis. *Clinical Journal of Pain*. 2008 Jul-Aug;24(6):497-508.
68. Community Care Behavioral Health (CCBH) & Institutes for Research Education and Training in Addictions (IRETA). *Buprenorphine Treatment for Opioid Dependence*. Pittsburgh, PA: The Institute, May 2011.
69. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)*. Washington, DC: American Psychiatric Publishing, Inc., 2013.
70. World Health Organization (WHO). *International Classification of Diseases, 10th Edition (ICD-10)*. Geneva, Switzerland: World Health Organization, 1996.
71. American Psychiatric Association (APA). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM-IV-TR)*. Washington, DC: American Psychiatric Publishing, Inc., 2000.

72. Heit HA. Addiction, physical dependence, and tolerance: Precise definitions to help clinicians evaluate and treat chronic pain patients. *Journal of Pain Palliative Care Pharmacotherapy* 2003; 17(1):15-29.
73. Johnson CE, Arfken CL, DiMenza S et al. Diversion and abuse of buprenorphine: Findings from national surveys of treatment patients and physicians. *Drug and Alcohol Dependence*. 2012 Jan 1;120 (1-3):190-195.
74. Cicero TJ, Kurtz SP, Surratt HL et al. Multiple determinants of specific modes of prescription opioid diversion. *Journal of Drug Issues*. 2011 Spring;41(2):283-304.
75. McNicholas LF, chair, for the CSAT Expert Panel. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol [TIP] Series Number 40. DHHS Publication No. [SMA] 04-3939. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2004.
76. Covington EC. Pain and addictive disorder: Challenge and opportunity. In P Prithvi Raj (ed.) *Practical Management of Pain, 4th Edition*. New York, NY: Elsevier/Mosby, 2007.
77. Chu LF, Angst MS & Clark D. Opioid-induced hyperalgesia in humans: Molecular mechanisms and clinical considerations. *Clinical Journal of Pain*. 2008;24(6):479–496.
78. World Health Organization (WHO). *Ensuring Balance in National Policies on Controlled Substances: Guidance for Availability and Accessibility of Controlled Medicines, Second Edition*. Geneva, Switzerland: World Health Organization, 2011.
79. General Accounting Office (GAO). *Prescription Drugs: State Monitoring Programs May Help to Reduce Illegal Diversion*. Washington, DC: Government Printing Office, 2004.
80. National Summit for Opioid Safety: Project ROAM and Physicians for Responsible Opioid Prescribing; October 31 and November 1, 2012; Seattle, WA.
81. Passik S, Heit H, Rzetelny A, Pesce A, Mikel C, and Kirsh K (2013). Trends in Drug and Illicit Use from Urine Drug Testing from Addiction Treatment Clients. Proceedings of the International Conference on Opioids. Boston, MA.

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