

PAIN info



NEWS FROM THE FLORIDA ACADEMY OF PAIN MEDICINE ♦ VOL III, NO. 2 ♦ FALL, 2009

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July 16-18, 2010 The Breakers, Palm Beach

FAPM Annual Meeting and Tradeshow

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President's Message ***By Raul A. Monzon, M.D.***



Change is Coming! And the Florida Academy of Pain Medicine Board of Directors has been working diligently to protect your practices. Help us continue to fight for you! While FAPM is in total agreement with the need to shut down the "pill mills," the proposed rules and regulations to implement the Prescription Drug Monitoring Program are draconian in part, and potentially excessively burdensome to most practicing Florida pain medicine physicians.

Keep reading...then please contribute to the FAPM Legal Defense Fund.

In our last Message, <http://fapmmed.net/FAPMFall09NL.pdf>, we alerted you to the developing rules and regulations for implementation of Florida's new Prescription Drug Monitoring Program. Under Florida's Department of Health, a Joint Committee of the Board of Medicine and Board of Osteopathic Medicine has been tasked with the rulemaking process.

Since the last Message, Marla Golden, DO, a Member-at-Large on the FAPM Board, has been appointed Chair of FAPM's Legislative Committee. Dr Sanford Pollak, DO, an FAPM Past President, and Stanley Dennison MD, were tapped to serve on that Committee with Dr Golden. The FAPM Board of Directors has retained the services of Attorney Christopher Nuland, former FMA Counsel, who has made a practice of helping physicians and physician organizations. He is well respected in the medical community, as well as in the legislative and regulatory communities. Mr Nuland, the Board and Legislative Committee hammered out FAPM's position and prepared comments for the November 21 Joint Committee meeting.

FAPM Board Members, Drs Eduardo Dieguez Jr, Marla Golden, and I attended that meeting, as did Mr Nuland and FAPM Legislative Committee members Drs Sanford Pollak and Stanley Dennison. The next meeting is December 19, and again, FAPM will be represented with Board and Legislative Committee Members as well as Attorney Nuland. Following is what was just submitted by FAPM to the Joint Committee, for consideration prior to the December 19 meeting.

While the FAPM agrees that increased regulation of pain management is warranted, it respectfully reminds the Board that increased vigilance must be balanced with the rights of the patient to reasonable access to pain management. With that as a preamble, the FAPM specifically suggests the following changes to the proposed rule:

(2)(a) While FAPM supports the need for a complete medical history and physical examination, requiring that this be performed outside of the clinic by a disinterested physician only serves to unnecessarily delay the treatment, to the detriment of the patient. Moreover, the authorizing statute does not appear to grant the Boards rulemaking authority to impose the proposed requirement of an outside evaluation. Therefore, the FAPM recommends that the proposed "Option for Discussion" not be adopted.

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of an causal evaluation. Therefore, the FAPM recommends that the proposed "Option for Discussion" not be adopted.

Moreover, consistent with the testimony provided by numerous parties and the logistical reality that documentation of a medical history often occurs immediately after the office visit, the FAPM suggests that the first sentence of this section be amended to read, "A medical history and physical examination must be conducted prior to commencement of any treatment."

2(c)1. The FAPM supports drug screening at the initial visit and subsequent periodic drug testing at the discretion of the treating physician. However, third party payors may not cover such services, and this would place an undue financial burden on the patient and the health care system. The FAPM respectfully reminds the Boards that artificial standards such as those currently proposed may not be seen as "medically necessary" by payors and could create a financial barrier to treatment. Nevertheless, the FAPM does support initial testing and periodic testing at the discretion of the treating physician and suggests that lines 1-3 on page 3 be amended to read, "1. Drug screening to be conducted prior to the issuance of a controlled substance prescription, and thereafter, on a periodic basis as determined by the treating physician."

2(f) The FAPM agrees that steps must be taken to ensure valid specimens. However, the proposed DOT process is beyond what is needed for most practices. These types of measures should be reserved for high-risk patient populations. Most practices do well with CLIA-waived Point of Service tests or specimens collected and sent out for analysis using technology for low limits of detection and screening for adulterants and tampering. Requiring revision of the physical plant of an office by altering plumbing and requiring the taping of toilet seats and faucets is unreasonable. Removing soap and water from the bathroom will render that room ill-equipped to handle its normal function and create an unsanitary condition. Although patients should be required to enter the bathroom without bags and the contents of their pockets, the State should be careful not to create artificial and unnecessary barriers to patient care.

In lieu of these proposed, draconian security measures, the FAPM recommends that a monitored drug test be required only in accordance with subsection (c), or when the patient exhibits signs of abuse, misuse or addiction.

Therefore, the FAPM recommends that subsection (f) be amended to read, "Patient drug screenings conducted in pain-management clinics as set forth in subsection (2)(c) of this rule shall be the responsibility of the physician, with security measures consistent with the patient's history or abuse, misuse, or addiction."

(2)(g)14. The creation of a separate document is an unnecessary administrative burden. Should the Boards require the maintenance of such information, it could routinely be kept within the normal medical record, with the actual security measures left to the discretion of the treating physician. Moreover, the recently enacted Prescription Monitoring Program will include this information in its database. The FAPM therefore recommends that this proposed section not be adopted.

(2)(h)1. According to the Board of Medicine's own Rule (64B8-11.001), other than physician certified by an ABMS board with a subcertification in pain management, only those who have received board certification from the American Board of Pain Medicine may represent themselves as board certified pain management physicians. Patients exhibiting signs of abuse, misuse or addiction should be referred to addiction medicine physicians; the reference to "psychiatrist" should be deleted, as referral to general psychiatrists would be inappropriate.

Moreover, immediately ceasing all medication often is contraindicated from a medical perspective. Abuse and addiction are medical problems, with addiction being an inherent risk of prescribing and taking controlled substances. Patients who develop such problems should not be punished—they should be treated. It is our responsibility as medical professionals to ensure that they receive the care they need for any and all medical problems. Therefore, in lieu of the proposed language, the FAPM suggests that a patient who fails a urine screening be evaluated for substance abuse and, if necessary, referred to an independent addiction specialist for further evaluation and coordinated treatment with the addictionologist, patient, and pain doctor.

The FAPM therefore recommends that this section be amended to read, "1. If a patient's drug screenings reflect the presence of controlled or illicit substances, other than medications reflected in the patient medical record as being prescribed, the treating physician shall immediately evaluate the patient's risk for substance abuse and, if deemed necessary by the physician, refer the patient to an appropriate substance abuse professional for further evaluation and coordinated treatment."

in the patient medical record as being prescribed, the treating physician shall immediately evaluate the patient's risk for substance abuse and, if deemed necessary by the physician, refer the patient to an appropriate substance abuse professional for further evaluation and coordinated treatment with the addictionologist, patient, and pain physician."

(2)(j) Additional regulations regarding infection control appear to be inappropriate for a facility providing basic non-invasive pain management services. The FAPM therefore recommends that this section be deleted.

(2)(k)5. The requirement of ACLS for Level II invasive procedures may well be appropriate, but is excessive for a local anesthetic, even if injected and therefore "invasive." The Office Surgery Rule at 64B8-9.009 adequately addresses this issue, and this subsection should therefore be deleted.

(2)(l) Given the paucity of adverse incidents that occur within pain management clinics, these regulations appear excessive. The FAPM therefore recommends that page 10/line 12 through page 11/line 1 be deleted.

(2)(m) (3) Fifty hours of Pain CME per year is clearly excessive, especially when considering that the American Board of Pain Medicine requires only 50 hours every two years. The FAPM recommends that physicians practicing Pain Management meet this high standard by January 31, 2012, allowing a full biennium to meet the standard. Moreover, in order to allow longstanding, reputable physicians to continue their careers, but to eliminate poorly trained physicians who have only recently entered the field, the FAPM recommends that those qualifying under this section also be able to demonstrate no less than three years of relevant clinical experience (this is the same eligibility requirement used by the American Board of Pain Medicine, which has previously been approved by the Florida Board of Medicine). Moreover, in order to strengthen the proposed CME requirements, the FAPM recommends that the 50 hours incorporate the following specific areas of pain management, to wit:

- a. The goals of treating both short term and ongoing pain treatment
- b. Controlled substance prescribing rules, including Controlled Substance Agreements
- c. Urine testing, including usefulness and limitations
- d. The use of controlled substances in treating short term and ongoing pain syndromes, including usefulness, drug-drug interactions, side effects and their appropriate treatment
- e. Evidenced-based non-controlled pharmacological pain treatments
- f. Evidenced-based non-pharmacological pain treatments
- g. A pain medicine history and physical examination
- h. Appropriate progress note keeping
- i. Comorbidities with pain disorders, including psychiatric and addictive disorders
- j. Drug abuse and diversion, and prevention of same

Therefore, the FAPM recommends that this subsection be amended to read, "Three (3) years of relevant clinical experience and fifty (50) hours per biennium of Category I American Medical Association/American Osteopathic Association continuing medical education in Pain Medicine/Management, which must include the following:

- a. The goals of treating both short term and ongoing pain treatment
- b. Controlled substance prescribing rules, including Controlled Substance Agreements
- c. Urine testing, including usefulness and limitations
- d. The use of controlled substances in treating short term and ongoing pain syndromes, including usefulness, drug-drug interactions, side effects and their appropriate treatment
- e. Evidenced-based non-controlled pharmacological pain treatments
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or...”

(2)(m) *Having examined the positions of the various stakeholders, it has become evident to the FAPM that there is substantive agreement on virtually all aspects of the proposed rule, with the possible exception of the training requirements. While the FAPM recognizes the value of outstanding training and wishes to promote the same, the Academy is concerned that prolonged debate on this single issue may unnecessarily delay the rest of the rule. Therefore, the FAPM suggests that the Committee may want to separate training into its own rule so that the entire rulemaking process is not delayed pending the resolution of this one area of substantial disagreement.*

64B8-9.0132(20(b)) *Unannounced inspections are disruptive to both the physicians and the patients. One week notice is sufficient to make alternative arrangements for patients, but not so long as to allow a non-compliance facility to suddenly come into compliance.*

Thank you in advance for your consideration of these important issues, and the FAPM looks forward to continuing its involvement in the development of these crucial rules.

As a point of interest, the American Academy of Pain Medicine recently published its [Position Paper on Pain Medicine](#). This paper is totally congruent with the FAPM position. This is a good description of what we are aiming for and why it is necessary. This document will be provided to the Joint Committee, and can be found by clicking link above or on [FAPM's website](#).

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FAPM NEWSLETTER

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