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## Proposed Regulation Agency Background Document

<b>Agency name</b>	Boards of Nursing and Medicine, Department of Health Professions
<b>Virginia Administrative Code (VAC) citation(s)</b>	18VAC90-30 18VAC90-40
<b>Regulation title(s)</b>	Regulations Governing the Licensure of Nurse Practitioners Regulations for Prescriptive Authority for Nurse Practitioners
<b>Action title</b>	Replacement of emergency regulations
<b>Date this document prepared</b>	7/21/17

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 17 (2014) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual*.

### Brief summary

*Please provide a brief summary (preferably no more than 2 or 3 paragraphs) of the proposed new regulation, proposed amendments to the existing regulation, or the regulation proposed to be repealed. Alert the reader to all substantive matters or changes. If applicable, generally describe the existing regulation.*

Regulations Governing Opioid Prescribing for Pain and Prescribing of Buprenorphine were promulgated as emergency regulations to address the opioid abuse crisis in Virginia; this proposed action is to replace the emergency regulation with permanent regulations.

The regulations establish the practitioners to whom the rules apply and the exceptions or non-applicability. Regulations for the management of acute pain include requirements for the evaluation of the patient, limitations on quantity and dosage, and medical record-keeping. Regulations for management of chronic pain include requirements for evaluation and treatment, including a treatment plan, informed consent and agreement, consultation with other providers,

and medical record-keeping. Regulations for prescribing of buprenorphine include requirements for patient assessment and treatment planning, limitations on prescribing the buprenorphine mono-product (without naloxone), dosages, co-prescribing of other drugs, consultation and medical records for opioid addiction treatment.

Proposed regulations are identical to the re-adopted emergency regulations.

## Acronyms and Definitions

*Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.*

FDA = Food and Drug Administration  
PMP = Prescription Monitoring Program

## Legal basis

*Please identify the state and/or federal legal authority to promulgate this proposed regulation, including: 1) the most relevant citations to the Code of Virginia or General Assembly chapter number(s), if applicable; and 2) promulgating entity, i.e., agency, board, or person. Your citation should include a specific provision authorizing the promulgating entity to regulate this specific subject or program, as well as a reference to the agency/board/person's overall regulatory authority.*

Regulations are promulgated under the general authority of Chapter 24 of Title 54.1 of the Code of Virginia. Section 54.1-2400, which provides the Boards of Nursing and Medicine the authority to promulgate regulations to administer the regulatory system:

***§ 54.1-2400 -General powers and duties of health regulatory boards***

*The general powers and duties of health regulatory boards shall be:*

...

*6. To promulgate regulations in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ [54.1-100](#) et seq.) and Chapter 25 (§ [54.1-2500](#) et seq.) of this title. ...*

In addition, the Board of Medicine has been mandated to adopt regulations by passage of HB2167 and SB1180 in the 2017 General Assembly:

***§ [54.1-2928.2](#). Board to adopt regulations related to prescribing of opioids and buprenorphine.***

*The Board shall adopt regulations for the prescribing of opioids and products containing buprenorphine. Such regulations shall include guidelines for:*

*1. The treatment of acute pain, which shall include (i) requirements for an appropriate patient history and evaluation, (ii) limitations on dosages or day supply of drugs prescribed, (iii)*

requirements for appropriate documentation in the patient's health record, and (iv) a requirement that the prescriber request and review information contained in the Prescription Monitoring Program in accordance with § [54.1-2522.1](#);

2. The treatment of chronic pain, which shall include, in addition to the requirements for treatment of acute pain set forth in subdivision 1, requirements for (i) development of a treatment plan for the patient, (ii) an agreement for treatment signed by the provider and the patient that includes permission to obtain urine drug screens, and (iii) periodic review of the treatment provided at specific intervals to determine the continued appropriateness of such treatment; and

3. The use of buprenorphine in the treatment of addiction, including a requirement for referral to or consultation with a provider of substance abuse counseling in conjunction with treatment of opioid dependency with products containing buprenorphine.

### Purpose

Please explain the need for the new or amended regulation. Describe the rationale or justification of the proposed regulatory action. Describe the specific reasons the regulation is essential to protect the health, safety or welfare of citizens. Discuss the goals of the proposal and the problems the proposal is intended to solve.

The purpose of the regulatory action is the establishment of requirements for prescribing of controlled substances containing opioids or buprenorphine to address the overdose and addiction crisis in the Commonwealth. The goal is to provide prescribers with definitive rules to follow so they may feel more assured of their ability to treat pain in an appropriate manner to avoid under-prescribing or over-prescribing.

### Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of changes" section below.

The regulations establish the practitioners to whom the rules apply and the exceptions or non-applicability. Regulations for the management of acute pain include requirements for the evaluation of the patient, limitations on quantity and dosage, and medical record-keeping. Regulations for management of chronic pain include requirements for evaluation and treatment, including a treatment plan, informed consent and agreement, consultation with other providers, and medical record-keeping. Regulations for prescribing of buprenorphine include requirements for patient assessment and treatment planning, limitations on prescribing the buprenorphine mono-product (without naloxone), dosages, co-prescribing of other drugs, consultation and medical records for opioid addiction treatment.

### Issues

Please identify the issues associated with the proposed regulatory action, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, please indicate.

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- 1) The primary advantage to the public is a reduction in the amount of opioid medication that is available in our communities. A limitation on the quantity of opioids that may be prescribed should result in fewer people becoming addicted to pain medication, which sometimes leads them to turn to heroin and other illicit drugs. Persons who are receiving opioids for chronic pain should be more closely monitored to ensure that the prescribing is appropriate and necessary. A limitation on prescribing the buprenorphine mono-product should result in a reduction in the number of tablets that are sold on the street. The primary disadvantage to the public may be that more explicit rules for prescribing may result in some physicians and nurse practitioners choosing not to manage chronic pain patients in their practice.
- 2) The primary advantage to the Commonwealth is the potential reduction in the number of persons addicted to opioids and deaths from overdoses. There are no disadvantages.
- 3) The Director of the Department of Health Professions has reviewed the proposal and performed a competitive impact analysis. The Board is authorized under § 54.1-2400 to “*To promulgate regulations in accordance with the Administrative Process Act (§ 2.2-4000 et seq.) which are reasonable and necessary to administer effectively the regulatory system. Such regulations shall not conflict with the purposes and intent of this chapter or of Chapter 1 (§ 54.1-100 et seq.) and Chapter 25 (§ 54.1-2500 et seq.) of this title.*” There is no restraint on competition as a result of promulgating this regulation; all prescribers must follow the same rules for prescribing of opioids or buprenorphine.

**Requirements more restrictive than federal**

Please identify and describe any requirement of the proposal which is more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

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There regulations for prescribing of buprenorphine are consistent with the rules of the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

**Localities particularly affected**

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

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There are no localities particularly affected.

## Public participation

*Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.*

In addition to any other comments, the Boards of Nursing and Medicine are seeking comments on the costs and benefits of the proposal and the potential impacts of this regulatory proposal. Also, the agency/board is seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting, recordkeeping and other administrative costs, 2) probable effect of the regulation on affected small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation.

Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to Elaine Yeatts at [elaine.yeatts@dhp.virginia.gov](mailto:elaine.yeatts@dhp.virginia.gov) or at 9960 Mayland Drive, Henrico, VA 23233 or by fax at (804) 527-4434.. Comments may also be submitted through the Public Forum feature of the Virginia Regulatory Town Hall web site at: <http://www.townhall.virginia.gov>. Written comments must include the name and address of the commenter. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of this stage and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (<http://www.townhall.virginia.gov>) and on the Commonwealth Calendar website (<https://www.virginia.gov/connect/commonwealth-calendar>). Both oral and written comments may be submitted at that time.

## Economic impact

*Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.*

<p><b>Projected cost to the state to implement and enforce the proposed regulation, including:</b>  <b>a) fund source / fund detail; and</b>  <b>b) a delineation of one-time versus on-going expenditures</b></p>	<p>As a special fund agency, the Board must generate sufficient revenue to cover its expenditures from non-general funds, specifically the renewal and application fees it charges to practitioners or entities for necessary functions of regulation. All notifications will be done electronically. There are no on-going expenditures.</p>
<p><b>Projected cost of the new regulations or changes to existing regulations on localities.</b></p>	<p>None</p>
<p><b>Description of the individuals, businesses, or other entities likely to be affected by the new regulations or changes to existing regulations.</b></p>	<p>Nurse practitioners with prescriptive authority</p>

<p><b>Agency’s best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected.</b> Small business means a business entity, including its affiliates, that:</p> <p>a) is independently owned and operated and;</p> <p>b) employs fewer than 500 full-time employees or has gross annual sales of less than \$6 million.</p>	<p>There are 6, 647 nurse practitioners with prescriptive authority. It is likely that many would be employed by large entities.</p>
<p><b>All projected costs of the new regulations or changes to existing regulations for affected individuals, businesses, or other entities. Please be specific and include all costs including:</b></p> <p>a) the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; and</p> <p>b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.</p>	<p>There are no additional costs to the regulants. If a prescriber is not currently following standard of care for management of chronic pain with opioid, a patient will incur additional cost for urine drug screens – required by the emergency regulations. Additionally, patients who are being switched from the buprenorphine mono-product to the combination product will experience an increase in cost for that drug.</p>
<p><b>Beneficial impact the regulation is designed to produce.</b></p>	<p>The primary benefit is a reduction in the amount of opioid medication that is available in our communities. Persons who are receiving opioids for chronic pain should be more closely monitored to ensure that the prescribing is appropriate and necessary. A limitation on prescribing the buprenorphine mono-product should result in a reduction in the number of tablets that are sold on the street.</p>

**Alternatives**

*Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.*

In 2004, the Virginia Board of Medicine adopted the Federation of State Medical Boards’ *Model Policy on the Use of Controlled Substances in the Treatment of Pain* as Board Guidance Document 85-24. It served as a guide to licensees who accepted the challenge of treating chronic pain, informed the Board members of the essential aspects of good pain management, and also provided the public with perspective on this sometimes controversial field of medicine.

As the thinking about chronic pain management evolved, the Federation of State Medical Boards revisited the issue in 2012-2013 and produced a subsequent version of the Model Policy. At its October 24, 2013 meeting, the Board voted to replace the 2004 version with the 2013 *Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain* to serve as its guidance in this matter.

While guidance is helpful to practitioners licensed by the Board of Medicine, Guidance Document 85-24 is not enforceable and does not offer specific limitations on prescribing or rules for management of acute and chronic pain. Likewise, it did not address issues relating to prescribing of buprenorphine.

To ensure that regulations were adopted in accordance with the standard of care and acceptable practices for management of pain and buprenorphine for addiction, the Board of Medicine convened a Regulatory Advisory Panel (RAP), which met on January 6, 2017 to draft regulations, which were then discussed and recommended by the Legislative Committee of the Board on January 27, 2017. The draft regulations were posted on the Board’s website prior to its meeting on February 16, 2017 in order to allow interested parties an opportunity to address the Board in public comment in advance of the regulatory action.

To address several specific concerns about the regulations, a second RAP was convened on May 15, 2017 to recommend amendments for re-adoption as emergency regulations. Those recommendations were reviewed by the Legislative Committee of the Board of Medicine on May 19, 2017. The recommendations of the Legislative Committee were reviewed by the Committee of the Joint Boards of Nursing and Medicine on June 7, 2017 and then adopted by the Board of Medicine on June 22, 2017 and the Board of Nursing on July 18, 2017. The restriction on prescribing the buprenorphine mono-product was identified as the most pressing issue, so the Boards readopted emergency regulations to modify that restriction in acknowledgement that there is a very small percentage of patients who have a demonstrated intolerance to naloxone. Other changes were included in the re-adoption of emergency regulations as described in the Details section below.

### Regulatory flexibility analysis

*Pursuant to § 2.2-4007.1B of the Code of Virginia, please describe the agency’s analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.*

There are no alternative regulatory methods consistent with public health and safety, as demonstrated by the adoption of this regulation as an emergency action.

### Public comment

*Please summarize all comments received during the public comment period following the publication of the NOIRA, and provide the agency response.*

There were no comments on the emergency regulations adopted by the Joint Boards for nurse practitioners. However, since the regulations are substantially identical to those for doctors and physician assistants, the comments on those regulations are summarized below.

Commenter	Comment	Agency response
Medical Society of Virginia	Supports work of Board to promote appropriate prescribing while maintaining physician discretion to offer treatment that meets patient needs; supports multi-stakeholder approach that incorporated best practices & practical application in clinical settings	The Board appreciates the comment.
Va. Hospital & Healthcare Association	Supports efforts of the Board with input from stakeholders; appropriate balance in establishing clear guidelines without impeding the delivery of effective patient-centered care.	The Board appreciates the comment.
Va. Academy of Family Physicians	Sent a summary of comments received from members. Many commenters sought clarification; others requested more flexibility in required visits and documentation based on patient age or clinical criteria.	To address some of the questions posed by physicians and others, the Board has posted a Q & A on opioid prescribing on its website. A number of the comments from VAFP members are addressed in that document. The Board did not amend its proposed regulation to allow variances based on age or other criteria in the management of chronic pain. Physicians are allowed to use their clinical judgment in the quantity and dosage of opioid drugs, if extenuating circumstances are documented in the patient record.
83 persons	Opposed to restrictions on prescribing of the buprenorphine mono-product because: 1) some patients have a hypersensitivity, allergy or intolerance to naloxone; 2) the combination drug is more expensive & some patients (especially self-pay patients) cannot afford the drug; and 3) both forms of buprenorphine can be and are being abused.	In recognition of the intolerance to naloxone reported by patients and physicians, the Board re-adopted emergency regulations to allow up to 3% of a prescriber's patients to receive prescriptions for the mono-product if they have a demonstrated intolerance as documented in the patient record. Prescribers at substance abuse treatment centers are encouraged to advise patients about possible sources for assistance with the cost of the combination product, but the Board declined to base prescribing decisions on cost.
Dr. Rod Rogge	Drug wholesalers know where large shipments of opioids are going & should take responsibility for tracking & reporting. Intent of the regulation is good.	The Board appreciates the comment but it does not have any authority over tracking and reporting by drug wholesalers.
Sandra & Richard Wood	Should define appropriate "extenuating circumstances" related to use of opioids & benzodiazepines	The Board declined to amend regulations for further definition. It prefers to allow physicians to use their professional judgment to determine extenuating circumstances on a case-by-case basis.
Center for	1) Should delete restriction on	1) Testimony at the RAP indicated that the



<p>Lawful Access and Abuse Deterrence</p>	<p>prescribing buprenorphine for chronic pain except as approved by FDA for that purpose to allow such prescribing; 2) buprenorphine mono-product with different delivery systems are in the pipeline; regulations prohibit professional judgment in determining medical necessity; practitioner-administered mono-product should be allowed.</p>	<p>FDA does not approve prescribing of buprenorphine for chronic pain, so the regulation was amended to prohibit such prescribing; 2) Section 150 does allow use of the buprenorphine mono-product <i>in formulations other than tablet form for indications approved by the FDA</i>, so different delivery systems will be acceptable. Section 150 also allows for practitioner administration: <i>Buprenorphine mono-product tablets may be administered directly to patients in federally licensed opioid treatment programs.</i></p>
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### Family impact

*Please assess the impact of this regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one’s spouse, and one’s children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.*

The institution of the family and family stability is being severely impacted by the opioid addiction crisis in the Commonwealth. The impact of this action is intended to empower and instruct practitioners in the appropriate prescribing of opioids to manage pain in such a manner as to prevent addiction and diversion.

### Detail of changes

*Please list all changes that are being proposed and the consequences of the proposed changes; explain the new requirements and what they mean rather than merely quoting the proposed text of the regulation. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact. Please describe the difference between existing regulation(s) and/or agency practice(s) and what is being proposed in this regulatory action. If the proposed regulation is intended to replace an emergency regulation, please follow the instructions in the text following the three chart templates below.*

The proposed language replaces emergency regulations, as re-adopted by the Board of Medicine on June 22, 2017 and the Board of Nursing on July 18, 2017. In the re-adopted emergency regulation and the proposed regulations, the term substance “abuse” is amended to the term substance “misuse.”

Current section number	Current requirement	Proposed change, intent, rationale, and likely impact of proposed requirements
18VAC90-30-220	Sets out the grounds for disciplinary action against the license of a nurse practitioner	There are two grounds for unprofessional conduct currently found in Medicine regulations that are applicable to nurse practitioners, but are not found in

		<p>18VAC90-30-220. Since those grounds are relevant to prescribing of controlled substances and are referenced in the Medicine regulations for opioid prescribing, the Board concurred that they should be added to Chapter 30 for nurse practitioners. The additional grounds are:</p> <ul style="list-style-type: none"> <li>• Has willfully or negligently breached the confidentiality between a practitioner and a patient. A breach of confidentiality that is required or permitted by applicable law or beyond the control of the practitioner shall not be considered negligent or willful; or</li> <li>• Has engaged in unauthorized use or disclosure of confidential information received from the Prescription Monitoring Program.</li> </ul>
18VAC90-40-10	Section 10 sets out definitions for words and terms used in this chapter.	<p>Amendments include a definition for acute pain to mean pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months. The definition for chronic pain means non-malignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months. Other amendments are included to define acronyms or terms used in the regulation.</p> <p><i>There are various definitions for acute and chronic pain. The Federation of State Medical Boards guidance defines "acute" pain as generally lasting six weeks or less. Since requirements for the management of chronic pain are more burdensome on prescribers and patients, the Boards adopted a more generous definition for acute pain, as no more than three months.</i></p>

**New sections of regulation for 18VAC90-40-10 et seq.**

Section number	Proposed requirements	Other regulations and law that apply	Intent and likely impact of proposed requirements
150	<p>Section 150 sets out the rules for evaluation of a patient.</p> <p>Subsection A specifies that the chapter does not apply to: 1) The treatment of acute or chronic pain related to cancer, a patient in hospice care or a patient in palliative care; 2) The treatment of acute or chronic pain during an inpatient hospital admission, in a nursing home or an assisted living facility that uses a sole source pharmacy; or 3) A patient enrolled in a clinical trial as</p>	§§ 54.1-100, 54.1-3303 and 54.1-2522.1	<p>Exclusions specified in subsection A were requested by physician groups and are reasonable exceptions to requirements for managing pain.</p> <p>The intent of this section is to ensure that nurse practitioners prescribe opioids only when absolutely necessary, rather than as a routine treatment and that the prescription be limited in quantity and dosage.</p>

	<p>authorized by state or federal law.</p> <p>Subsection B requires that non-pharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids. If an opioid is considered necessary for the treatment of acute pain, the practitioner shall give a short-acting opioid in the lowest effective dose for the fewest possible days.</p> <p>Subsection C requires that prior to initiating treatment with a controlled substance for a complaint of acute pain, the prescriber must perform a history and physical examination appropriate to the complaint, query the Prescription Monitoring Program as set forth in the Code of Virginia and conduct an assessment of the patient’s history and risk of substance abuse.</p>		<p>Prior to prescribing a controlled substance for pain, the nurse practitioner has legal obligations in the establishment of a practitioner/patient relationship and in checking the PMP and also a professional obligation to assess the patient’s risk.</p>
<p>160</p>	<p>Section 170 establishes the requirements for treatment of acute pain with opioids.</p> <p>Subsection A specifies that initiation of opioid treatment for patients with acute pain shall be with short-acting opioids. When prescribing a controlled substance containing an opioid, a practitioner is limited to a quantity that do not exceed a <b>seven-day</b> supply as determined by the manufacturer’s directions for use, unless extenuating circumstances are clearly documented in the medical record. The 7-day limit also applies to prescriptions of a controlled substance containing an opioid upon discharge from an emergency department.</p> <p>When an opioid is prescribed as part of treatment for a surgical procedure shall be for no more than 14 consecutive days in accordance with manufacturer’s direction and within the immediate perioperative period, unless extenuating circumstances are clearly documented in the medical record.</p> <p>Subsection B sets the following limits on dosages:</p> <ol style="list-style-type: none"> <li>1. The practitioner must carefully consider and document in the medical record the reasons to exceed 50 MME/day.</li> <li>2. Prior to exceeding 120 MME/day, the practitioner must document in the medical record the reasonable justification for such doses or refer to or consult with a pain management specialist.</li> <li>3. Naloxone shall be prescribed for any</li> </ol>	<p>§§ 54.1-2915 (13) and 54.1-3408</p>	<p>Legislation introduced in the General Assembly would have limited prescribing for acute pain to 7 days and for emergency room discharge to 3 days. The medical community requested that the Board make the decision about prescribing limitation through regulation, and the Board determined that a consistent 7-day limit was advisable. If post-surgical pain is being treated, the limitation is 14 days. In each case, the prescriber can document circumstances that would warrant prescribing outside the limits. A specified limitation on days of prescribing will reduce the amount of unused or unnecessary opioids available for abuse or diversion. It will also encourage practitioners to prescribe non-opioid controlled substances that may be just as effective but not addictive.</p> <p>Since there are many controlled substances containing opioids, the acceptable limitation on dosage is translated into morphine milligram equivalency (MME). Typically, a patient should not be prescribed a dosage in excess of 50 MME per day. If a prescriber exceeds 120 MME per day for a patient, there</p>

	<p>patient when risk factors of prior overdose, substance abuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present.</p> <p>Subsection C limits co-prescribing of certain substances. Due to a higher risk of fatal overdose when opioids are prescribed with benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.</p> <p>Subsection D provides that buprenorphine is not indicated for acute pain in the outpatient setting, except when a waived buprenorphine prescriber is treating pain in a patient whose primary diagnosis is the disease of addiction.</p>		<p>must be a clear justification or consultation with or referral to a pain specialist. Naloxone, an overdose antidote, should always be prescribed under the conditions listed in subsection B. A specified standard in regulation should assist practitioners in determining dosages that are consistent with the standard of care in prescribing for pain.</p> <p>Subsection C lists drugs, for which there is a high risk of overdose if co-prescribed with an opioid. Regulations require documentation of the circumstances necessitating co-prescribing and the tapering plan in place.</p> <p>Buprenorphine is not allowed for treatment of pain outside of the practice of a waived prescriber because of a high risk of abuse.</p>
<p>170</p>	<p>Section 170 requires that the medical record include a description of the pain, a presumptive diagnosis for the origin of the pain, an examination appropriate to the complaint, a treatment plan and the medication prescribed or administered to include the date, type, dosage, and quantity prescribed or administered.</p>	<p>§§ 54.1-3303 and 32.1-127.1:03 18VAC85-20-26</p>	<p>Requirements for the medical record in the treatment of a patient with are consistent with the establishment of a bona fide practitioner-patient relationship and regulations for complete records.</p>
<p>180</p>	<p>Section 180 sets out the requirements for evaluation of the chronic pain patient.</p> <p>Subsection A provides that, prior to initiating management of chronic pain with a controlled substance containing an opioid, a medical history and physical examination, to include a mental status examination, must be performed and documented in the medical record, including:</p> <ol style="list-style-type: none"> <li>1. The nature and intensity of the pain;</li> <li>2. Current and past treatments for pain;</li> <li>3. Underlying or coexisting diseases or conditions;</li> <li>4. The effect of the pain on physical and psychological function, quality of life and activities of daily living;</li> <li>5. Psychiatric, addiction and substance abuse history of the patient and any family history of addiction or substance abuse;</li> <li>6. A urine drug screen or serum medication level;</li> <li>7. A query the Prescription Monitoring Program as set forth in § 54.1-2522 of the</li> </ol>	<p>§§ 54.1-3303 and 54.1-2522.1</p>	<p>Prescribing for chronic pain with a substance containing an opioid (longer than 30 days) requires a more in-depth evaluation of the patient because of the high risk of addiction. In addition to a thorough evaluation of the patient’s physical and mental status, the prescribed must obtain a urine drug screen or serum medication level to determine what drugs (illicit or prescribed) are in the patient’s system and must check with PMP to determine what other drugs may have been prescribed. A urine drug screen may cost as little as \$50, but it is an essential test to determine the risk of abuse or addiction if a practitioner is going to initiate prescribing of opioids for chronic pain.</p> <p>Subsection B requires the</p>

	<p>Code of Virginia;              8. An assessment of the patient’s history and risk of substance abuse; and              9. A request for prior applicable records.</p> <p>Subsection B specifies that prior to initiating opioid treatment for chronic pain, the practitioner shall discuss with the patient the known risks and benefits of opioid therapy and the responsibilities of the patient during treatment. The practitioner shall also discuss with the patient an exit strategy for the discontinuation of opioids in the event they are not effective</p>		<p>practitioner to discuss risks and benefits, the responsibilities of the patient, and an exit strategy for discontinuation if necessary. Those patient responsibilities should include securely the drug and properly disposing of any unwanted or unused drug to prevent affecting our people or the environment.</p>
<p>190</p>	<p>A. Non-pharmacologic and non-opioid treatment for pain shall be given consideration prior to treatment with opioids.</p> <p>B. In initiating and treating with opioids, the practitioner shall:</p> <ol style="list-style-type: none"> <li>1. Carefully consider and document in the medical record the reasons to exceed 50 MME/day;</li> <li>2. Prior to exceeding 120 MME/day, the practitioner shall document in the medical record the reasonable justification for such doses and refer to or consult with a pain management specialist.</li> <li>3. Prescribe naloxone for any patient when risk factors of prior overdose, substance abuse, doses in excess of 120 MME/day, or concomitant benzodiazepine is present; and</li> <li>4. Document the rationale to continue opioid therapy every three months.</li> </ol> <p>C. Buprenorphine mono-product in tablet form shall not be prescribed for chronic pain.</p> <p>D. Due to a higher risk of fatal overdose when opioids, including buprenorphine, are given with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective</p>	<p>§§ 54.1-2915 (3) (13) and 54.1-3408</p>	<p>Board members carefully considered guidelines for treating with opioids from the Center for Disease Control and other sources familiar with pain management to determine that the equivalent of 50 MME/day was a reasonable dosage for chronic pain. However, the practitioner may still exercise his/her professional judgment based on factors unique to a patient and may exceed the dosage if documented and justified in the medical record. Board members discussed simply referencing CDC guidelines but determined that prescribers need the Board regulation as a standard by which to base prescribing decisions.</p> <p>Likewise, any decision to exceed 120 MME/day should be documented and justified and the prescriber should refer to or consult with a pain management specialist. The Board recognizes that most chronic pain is going to be managed by primary care physicians, so they are not required to refer patients for chronic pain but are required to consult with practitioners who have expertise in managing pain with opioids.</p> <p>Any prescribing of doses in excess of 120 MME/day or concomitant benzos heightens the risk of overdose, so the rules require prescribing of naloxone in addition to the opioid.</p>

	<p>doses of these medications if prescribed.</p> <p>E. The practitioner shall regularly screen for opioid use disorder and shall initiate specific treatment for opioid use disorder or refer the patient for evaluation and treatment if indicated</p>		<p>Subsection C specifies that buprenorphine must be prescribed for chronic pain in formulations and dosages consistent with FDA approval, which calls for a delivery method that is effective but not at high risk for diversion – such as a transdermal patch. Subsection C recommended that the buprenorphine mono-product (without naloxone) cannot be used for chronic pain. FDA does not approve such usage, but there seemed to be some confusion in that regulation, so specificity was recommended in the re-adopted emergency and proposed regulations.</p> <p>Subsection D notes the higher risk of fatal overdose when an opioid is co-prescribed with certain other drugs and requires the prescriber to document the extenuating circumstances for such co-prescribing and a tapering plan for achieving the lowest possible effective doses.</p> <p>Subsection E requires evaluating for opioid use disorder and for initiation or referral for treatment if indicated.</p>
200	<p>Section 210 sets out the requirements for a treatment plan as documented in the medical record to include: 1) measures to be used to determine progress in treatment, including but not limited to pain relief and improved physical and psychosocial function, quality of life, and daily activities; 2) further diagnostic evaluations and other treatment modalities or rehabilitation that may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment; and 3) the presence or absence of any indicators for medication misuse, abuse or diversion and the action taken by the prescriber.</p>	<p>§ 54.1-3408 18VAC85-20-28</p>	<p>This section details what a practitioner should include in a treatment plan and what should be documented in the patient record, included the presence or absence of indicators for medication abuse, misuse, abuse or diversion. The intent is to have documentation that the practitioner has a plan for monitoring the effectiveness of his prescribing and for being alert to signs of abuse, diversion, misuse, or addiction. A patient who is compliant with the plan should not have to be concerned about being denied his/her pain medication, and a prescriber who is fully documenting and monitoring should not have to be concerned about compliance with law and regulation.</p>
210	<p>Section 210 sets out the requirements for informed consent and the treatment</p>	<p>§ 54.1-3408 18VAC85-20-28</p>	<p>The intent of section 210 is</p>

	<p>agreement.</p> <p>Subsection A requires the prescriber to document in the medical record informed consent, to include risks, benefits and alternative approaches, prior to the initiation of opioids for chronic pain.</p> <p>Subsection B requires there to be a written treatment agreement, signed by the patient, in the medical record that addresses the parameters of treatment, including those behaviors which will result in referral to a higher level of care, cessation of treatment, or dismissal from care.</p> <p>C. The treatment agreement shall include, but not be limited to permission for the practitioner to: 1) Obtain urine drug screens or serum medication levels, when requested; 2) Query and receive reports from the Prescription Monitoring Program; and 3) Consult with other prescribers or dispensing pharmacists for the patient.</p> <p>D. Expected outcomes shall be documented in the medical record including improvement in pain relief and function or simply in pain relief. Limitations and side effects of chronic opioid therapy shall be documented in the medical record.</p>		<p>protection for both the patient and the practitioner. With a clearly documented treatment plan and informed consent, the patient should know the expectation for continued treatment with opioids and the practitioner has a roadmap to follow in the management of chronic pain.</p>
<p>220</p>	<p>Section 220 establishes requirements for opioid therapy for chronic pain.</p> <p>Subsection A requires the prescriber to review the course of pain treatment and any new information about the etiology of the pain and the patient’s state of health at least every three months.</p> <p>Subsection B specifies that continuation of treatment with opioids shall be supported by documentation of continued benefit from such prescribing. If the patient’s progress is unsatisfactory, the prescriber shall assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.</p> <p>C. Practitioners shall check the Prescription Monitoring Program at least every three months after the initiation of treatment.</p> <p>D. Practitioner shall order and review a urine</p>	<p>§§ 54.1-2915 (3) (13) and 54.1-3408</p>	<p>Requirements in section 220 for opioid therapy for chronic pain are intended to ensure that the practitioner is carefully considering the effects of the prescribing, evaluating the patient’s progress, considering other modalities for pain control, monitoring the patient’s prescribing history to check for evidence of drugs from other sources, and evaluating for opioid use disorder.</p> <p>The evaluation needs to occur at least every 3 months so problems can be detected before addiction or diversion is evidenced. The only method of assurance that the drug is being taken by the patient as prescribed and that there are no other drugs in the patient’s system is by the use of a urine drug screen or serum medication level. The</p>

	<p>drug screen or serum medication levels at the initiation of chronic pain management and at least every three months for the first year of treatment and at least every six months thereafter.</p> <p>E. The practitioner shall regularly screen for opioid use disorder and shall initiate specific treatment for opioid use disorder or refer the patient for evaluation for treatment if indicated.</p>		<p>type of screen will be determined by the prescriber, but the regulation requires testing every three months for the first year and every six months thereafter.</p>
230	<p>A. When necessary to achieve treatment goals, the prescriber shall refer the patient for additional evaluation and treatment.</p> <p>B. When a prescriber makes the diagnosis of opioid use disorder, treatment for opioid use disorder shall be initiated or the patient shall be referred for evaluation and treatment.</p>	§ 54.1-2915 (3)	<p>Section 230 has the regulation for achieving the treatment goals as set in the treatment plan, which may include referral or, if there is a diagnosis of opioid use disorder, refers initiation of treatment or referral to address the condition.</p>
240	<p>Section 240 specifies the content of a medical record when a nurse practitioner is prescribing opioids for chronic pain, including the requirement that records be accurate and complete and in an accessible manner readily available for review. The content shall include:</p> <ol style="list-style-type: none"> <li>1. The medical history and physical examination;</li> <li>2. Past medical history;</li> <li>3. Applicable records from prior treatment providers and/or any documentation of attempts to obtain;</li> <li>4. Diagnostic, therapeutic and laboratory results;</li> <li>5. Evaluations and consultations;</li> <li>6. Treatment goals;</li> <li>7. Discussion of risks and benefits;</li> <li>8. Informed consent and agreement for treatment;</li> <li>9. Treatments;</li> <li>10. Medications (including date, type, dosage and quantity prescribed and refills).</li> <li>11. Patient instructions; and</li> <li>12. Periodic reviews.</li> </ol>	§§ 54.1-3303 and 32.1-127.1:03 18VAC85-20-26	<p>Requirements for the medical record in the treatment of a patient with are consistent with the establishment of a bona fide practitioner-patient relationship and requirements for a complete record of the treatment plan and goals, informed consent, evaluations and consultations and periodic reviews as specified in other sections of this chapter.</p>
250	<p>Section 250 sets out the general provisions for the prescribing of buprenorphine for addiction treatment.</p> <p>Subsection A. Prescribers engaged in office-based opioid addiction treatment with buprenorphine shall have obtained a waiver from the Substance Abuse Mental Health Services Administration and the appropriate Drug Enforcement Administration registration.</p> <p>B. Prescribers shall abide by all federal and</p>	§ 54.1-3408	<p>The general provisions set out the required qualifications for practitioners who are authorized to engage in office-based opioid addiction treatment with buprenorphine. They must have training and a SAMHSA waiver, and they are required to either provide counseling in their practice or refer for counseling as</p>



	<p>state laws and regulations governing the prescribing of buprenorphine for the treatment of opioid use disorder.</p> <p>C. Nurse practitioners, who have obtained a waiver from the Substance Abuse Mental Health Services Administration, shall only prescribe buprenorphine for opioid addiction pursuant to a practice agreement with a waived doctor of medicine or doctor of osteopathic medicine.</p> <p>D. Practitioners engaged in medication-assisted treatment must refer the patient to a mental health provider for counseling or provide counseling in their practice and document such in the medical record.</p>		<p>documented in the patient record. The intent is to ensure that these programs are truly treating the disease of addiction and not just prescribing buprenorphine.</p>
260	<p>Patient assessment and treatment planning.</p> <p>A. A practitioner shall perform and document an assessment that includes a comprehensive medical and psychiatric history, substance abuse history, family history and psychosocial supports, appropriate physical examination, urine drug screen, pregnancy test for women of childbearing age and ability, a check of the Prescription Monitoring Program, and, when clinically indicated, infectious disease testing for HIV, Hepatitis B, Hepatitis C and TB.</p> <p>B. The treatment plan shall include the practitioner’s rationale for selecting medication assisted treatment, patient education, written informed consent, how counseling will be accomplished, and a signed treatment agreement that outlines the responsibilities of the patient and the prescriber.</p>	<p>§§ 54.1-3303 and 54.1-3408</p>	<p>The intent of section 260 is to require an appropriate and comprehensive assessment and a plan for treating the patient with medication. There must be a signed agreement that outlines the responsibilities of the two parties and written informed consent so the patient understands the expectations and limitations.</p>
270	<p>Section 270 sets out the requirements for treatment with buprenorphine.</p> <p>A. Buprenorphine without naloxone (buprenorphine mono-product) shall not be prescribed except: 1) When a patient is pregnant; 2) When converting a patient from methadone to buprenorphine containing naloxone for a period not to exceed seven days; or 3) In formulations other than tablet form for indications approved by the FDA; or 4) For patients who have a demonstrated intolerance to naloxone; such prescriptions for the mono-product shall not exceed 3% of the total prescriptions for buprenorphine written by the prescriber, and the exception shall be clearly documented in the patient’s medical record.</p> <p>B. Buprenorphine mono-product tablets may</p>	<p>§§ 54.1-2915 (3) (13) and 54.1-3408</p>	<p>Buprenorphine mono-product has become a frequently abused drug in Southwest Virginia. Legislation introduced in the 2017 General Assembly would have limited the use of the mono-product for pregnant women only. Legislators were convinced to amend those bills to allow the Medical Board to determine appropriate use for the mono-product, and rules adopted are a compromise between those who wanted very restricted availability and those who want access to the mono-product for general prescribing for addiction treatment. The Board believes that</p>

<p>be administered directly to patients in federally licensed opiate treatment programs (OTPs). With the exceptions, listed in subsection A, only the buprenorphine product containing naloxone shall be prescribed or dispensed for use offsite from the program.</p> <p>C. The evidence for the decision to use buprenorphine mono-product shall be fully documented in the medical record.</p> <p>D. Due to a higher risk of fatal overdose when buprenorphine is prescribed with other opioids, benzodiazepines, sedative hypnotics, carisoprodol, and tramadol, the prescriber shall only co-prescribe these substances when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses if these medications are prescribed.</p> <p>E. Prior to starting medication-assisted treatment, the practitioner shall perform a check of the Prescription Monitoring Program.</p> <p>F. During the induction phase, except for medically indicated circumstances as documented in the medical record, patients should be started on no more than 8 mg. of buprenorphine. The patient shall be seen by the prescriber at least once a week.</p> <p>G. During the stabilization phase, the prescriber shall increase the daily dosage of buprenorphine in safe and effective increments to achieve the lowest dose that avoids intoxication, withdrawal, or significant drug craving.</p> <p>H. Practitioners shall take steps to reduce the chances of buprenorphine diversion by using the lowest effective dose, appropriate frequency of office visits, pill counts, and checks of the Prescription Monitoring Program. The practitioner shall also require urine drug screens or serum medication levels at least every three months for the first year of treatment and at least every six months thereafter.</p> <p>I. Documentation of the rationale for prescribed doses exceeding 16 mg. of buprenorphine per day shall be placed in the medical record. Dosages exceeding 24 mg. of buprenorphine per day shall not be prescribed.</p> <p>J. The practitioner shall incorporate relapse prevention strategies into counseling or assure that they are addressed by a licensed</p>		<p>the rules set forth in subsection A will allow appropriate access with minimal risk of diversion and abuse. The additional formulations (other than tablets) are available as transdermal patches, mucosal adhesives and implantable devices; the FDA is in the process of also approving an injectable formulation. The mono-product tablet may still be administered in an opioid treatment program but not dispensed or prescribed for use offsite.</p> <p>According to numerous comments and testimony from patients and physicians, the restriction on prescribing the mono-product was highly problematic to a small number of patients who have demonstrated an intolerance to naloxone. While the literature does not validate the existence of allergies to naloxone, physicians on the RAP and others have observed the physical manifestations of intolerance, estimated to be within 3% of their patients. To provide these patients with access to buprenorphine in the treatment of substance abuse as soon as possible, it was determined that the Board should readopt the emergency regulations to include this allowance for prescribing.</p> <p>Additional requirements in this section specify a check of the PMP and the appropriate dosage for initiating and maintaining a patient on buprenorphine. While 4 mg. of buprenorphine is usually adequate for induction, regulations allow a prescriber to start a patient on 8 mg. During induction, the patient has to be seen at the program at least once a week. As with management of chronic pain, a urine drug screen or serum medication level must be obtained every 3 months for the first year and every 6 months thereafter.</p> <p>While a practitioner is allowed to prescribe dosages of 16 mg. per</p>
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	mental health professional.		<p>day, any prescribing above that level must be documented and justified. Dosages exceeding 24 mg. per day are not FDA-approved and are prohibited.</p> <p>Requirements in this section also include steps to reduce the chance of diversion and relapse strategies that must be employed.</p>
280	<p>Establishes requirements for prescribing of buprenorphine to special populations.</p> <p>A. Pregnant women may be treated with the buprenorphine mono-product, usually 16 mg. per day or less.</p> <p>B. Patients under the age of 16 years shall not be prescribed buprenorphine for addiction treatment unless such treatment is approved by the FDA.</p> <p>C. The progress of patients with chronic pain shall be assessed by reduction of pain and functional objectives which can be identified, quantified and independently verified.</p> <p>D. Practitioners shall evaluate patients with medical comorbidities by history, physical exam, appropriate laboratory studies, and be aware of interactions of buprenorphine with other prescribed medications.</p> <p>E. Practitioners shall not undertake buprenorphine treatment with a patient who has psychiatric comorbidities and that is not stable. A patient who is determined by the prescriber to be psychiatrically unstable shall be referred for psychiatric evaluation and treatment prior to initiating medication-assisted treatment.</p>	<p>§§ 54.1-2915 (3) (13) and 54.1-3408</p>	<p>Because of the risk associated with addiction treatment with buprenorphine, this section has specific rules for special populations of patients, including pregnant women, children under age 16, patients with a diagnosis of chronic pain in addition to addiction, and other medical or psychiatric comorbidities.</p> <p>The second RAP noted that a small number of pregnant women who have a history of substance misuse may need to have buprenorphine with naloxone. Therefore, in subsection A, the word “shall” was changed to “may” to allow such prescribing based on the medical history of the patient and the professional judgment of the prescriber</p>
290	<p>A. Records shall be timely, accurate, legible, complete and readily accessible for review.</p> <p>B. The treatment agreement and informed consent shall be maintained in the medical record.</p> <p>C. Confidentiality requirements of 42 CFR, Part 2 which prohibits release of medical records, re-disclosure or other information without the patient’s consent or a court order, or in cases of a bona fide medical emergency, or in the mandatory reporting of</p>	<p>42 CFR, Part 2 § 32.1-127.1:03. 18VAC85-20-27</p>	<p>In addition to the requirements for complete patient records, this section specifies confidentiality relating to substance abuse treatment in federal rules and the confidentiality provisions of regulations in Chapter 30, Regulations Governing the Practice of Nurse Practitioners.</p>

	child abuse, shall be followed.		
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