Readopt with amendment Med 502.03 and Med 502.05, effective 5-3-16 (Document #11090), to read as follows:

Med 502.03 Definitions. Except where the context makes another meaning manifest, the following words have the meanings indicated when used in this chapter:

(a) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. It can be time-limited, often less than 3 months in duration;

(b) "Administer" means an act whereby a single dose of a drug is instilled into the body of, applied to the body of, or otherwise given to a person for immediate consumption or use;

(c) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include impaired control over drug use, craving, compulsive use, or continued use despite harm. The term does not include physical dependence and tolerance, which are normal physiological consequences of extended opioid therapy for pain;

(d) "Chronic pain" means a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that might or might not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. It also includes intermittent episodic pain that might require periodic treatment. For the purposes of these rules, chronic pain does not include pain from cancer or pain from terminal disease. "Chronic pain" includes but is not limited to pain commonly referred to as "chronic," "intractable," "high impact," "chronic episodic," and "chronic relapsing."

(e) "Clinical coverage" means specified and prearranged coverage that is available 24 hours a day, 7 days a week, to assist in the management of patients with chronic pain;

(f) "Dose unit" means one pill, one capsule, one patch, or one liquid dose;

(g) "Medication-assisted treatment" means any treatment of opioid addiction that includes a medication, such as methadone, buprenorphine, or naltrexone, that is approved by the FDA for opioid detoxification or maintenance treatment;

(h) "Morphine milligram equivalent (MEE)" means a conversion of various opioids to a morphine equivalent dose by the use of board-approved conversion tables;

(i) "Prescription" means a verbal, or written, or facsimile, or electronically transmitted order for medications, for self-administration by an individual patient.

(j) "Risk assessment" means a process for predicting a patient's likelihood of misusing or abusing opioids in order to develop and document a level of monitoring for that patient;

(k) "Treatment agreement" means a written agreement that outlines the joint responsibilities of licensee and patient; and

(l) "Treatment plan" means a written plan that reflects the particular benefits and risks of opioid use for each individual patient and establishes goals, expectations, methods, and time course for treatment.

Med 502.05 Chronic Pain.

(a) This section shall only apply to the treatment of "chronic pain" as defined in Med 502.03(d) and shall not apply to the treatment of pain from cancer or pain from terminal disease.

(b) If opioids are indicated and prescribed for chronic pain, prescribing licensees shall:

(1) Conduct and document a history and physical examination;

(2) Conduct and document a risk assessment, including, but not be limited to, the use of an evidence- based screening tool such as the Screener and Opioid Assessment for Patients with Pain (SOAPP);

(3) Document the prescription and rationale for all opioids according to Med 501.02(d) and (e);

(4) Prescribe opioid analgesics in a measured and monitored manner and administered in the lowest amount necessary to control pain.

(5) Comply with all federal and state controlled substances laws, rules, and regulations;

(6) Utilize a written informed consent that explains the following risks associated with opioids:

a. Addiction;

b. Overdose and death;

c. Physical dependence;

d. Physical side effects;

e. Hyperalgesia;

f. Tolerance; and

g. Crime victimization;

(7) Create and discuss a treatment plan with the patient. This shall include, but not be limited to the goals of treatment, in terms of pain management, restoration of function, safety, time course for treatment, and consideration of non-pharmacological modalities and non-opioid therapy. Informed consent documents and treatment agreements may be part of one document for the sake of convenience;

(8) Utilize a written treatment agreement that is included in the medical record, and specifies conduct that triggers the titration, discontinuation**,** or tapering of opioids based on ongoing, objective evaluation of the patient's injury or illness as required for ongoing successful treatment of chronic pain;

(9) The treatment agreement shall also address, at a minimum, the following:

a. The requirement of safe medication use and storage;

b. The requirement of obtaining opioids from only one prescriber or practice;

c. The consent to periodic and random drug testing; and

d. The prescriber's responsibility to be available or to have clinical coverage available;

(10) Document the consideration of a consultation with an appropriate specialist in the following circumstances:

a. When a patient is at high risk for abuse or addiction; or

b. When a patient has a co-morbid psychiatric disorder;

(11) Reevaluate treatment plan and use of opioids at least twice a year;

(12) Require random and periodic urine drug testing at least annually for all patients using opioids for longer than 90 days. Unanticipated findings shall be addressed in a manner that supports the health of the patient;

(13) Have clinical coverage available for 24 hours per day, 7 days per week, to assist in the management of patients;

(14) The prescriber may forego the requirements for a written treatment agreement and for periodic drug testing for patients:

a. Who are residents in a long-term, non-rehabilitative nursing home facility where medications are administered by licensed staff; or

b. Who are being treated for episodic intermittent pain and receiving no more than 50 dose units of opioids in a 3 month period; and

(15) Be allowed to continue prescribing opioid treatment, when there is no indication of misuse or diversion, for patients:

a. Who experience chronic illness or injury which results in chronic pain; and
b. Who are on a managed and monitored regimen of opioid analgesic treatment which has resulted in an increase in functionality and quality of life.

Appendix I

Rule	Statute
Med 502.03	RSA 329:9, V and XV-a; RSA 318-B:41, II(d)
Med 502.05	RSA 329:9, V and XV-a; RSA 318-B:41, II(d)