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The 2019 Florida Statutes

Title XXXII
REGULATION OF PROFESSIONS AND OCCUPATIONS

Chapter 456
HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

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456.44 Controlled substance prescribing.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Acute pain" means the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness. The term does not include pain related to:

1. Cancer.

2. A terminal condition. For purposes of this subparagraph, the term "terminal condition" means a progressive disease or medical or surgical condition that causes significant functional impairment, is not considered by a treating physician to be reversible without the administration of life-sustaining procedures, and will result in death within 1 year after diagnosis if the condition runs its normal course.

3. Palliative care to provide relief of symptoms related to an incurable, progressive illness or injury.

4. A traumatic injury with an Injury Severity Score of 9 or greater.

(b) "Addiction medicine specialist" means a board-certified psychiatrist with a subspecialty certification in addiction medicine or who is eligible for such subspecialty certification in addiction medicine, an addiction medicine physician certified or eligible for certification by the American Society of Addiction Medicine, or an osteopathic physician who holds a certificate of added qualification in addiction medicine through the American Osteopathic Association.

(c) "Adverse incident" means any incident set forth in s. 458.351(4)(a)-(e) or s. 459.026(4)(a)-(e).

(d) "Board-certified pain management physician" means a physician who possesses board certification in pain medicine by the American Board of Pain Medicine, board certification by the American Board of Interventional Pain Physicians, or board certification or subcertification in pain management or pain medicine by a specialty board recognized by the American Association of Physician Specialists or the American Board of Medical Specialties or an osteopathic physician who holds a certificate in Pain Management by the American Osteopathic Association.

(e) "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

(f) "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

(g) "Mental health addiction facility" means a facility licensed under chapter 394 or chapter 397.

(h) "Registrant" means a physician, a physician assistant, or an advanced practice registered nurse who meets the requirements of subsection (2).

(2) REGISTRATION.—A physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under part I of chapter 464 who prescribes any controlled substance, listed in Schedule II, Schedule III, or Schedule IV as defined in s. 893.03, for the treatment of chronic nonmalignant pain, must:

(a) Designate himself or herself as a controlled substance prescribing practitioner on his or her practitioner profile.

(b) Comply with the requirements of this section and applicable board rules.

(3) STANDARDS OF PRACTICE FOR TREATMENT OF CHRONIC NONMALIGNANT PAIN.—The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient is incompetent. The registrant shall use a written controlled substance agreement between the registrant and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant unless otherwise authorized by the treating registrant and documented in the medical record.

(d) The patient shall be seen by the registrant at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant shall reevaluate the appropriateness of continued treatment. The registrant shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or a psychiatrist.

(f) A registrant must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.
2. Diagnostic, therapeutic, and laboratory results.
3. Evaluations and consultations.
4. Treatment objectives.
5. Discussion of risks and benefits.
6. Treatments.
7. Medications, including date, type, dosage, and quantity prescribed.
8. Instructions and agreements.
9. Periodic reviews.
10. Results of any drug testing.
11. A photocopy of the patient's government-issued photo identification.
12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.
13. The registrant's full name presented in a legible manner.

(g) A registrant shall immediately refer patients with signs or symptoms of substance abuse to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

(4) STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The applicable boards shall adopt rules establishing guidelines for prescribing controlled substances for acute pain, including evaluation of the patient, creation and maintenance of a treatment plan, obtaining informed consent and agreement for treatment, periodic review of the treatment plan, consultation, medical record review, and compliance with controlled substance laws and regulations. Failure of a prescriber to follow such guidelines constitutes grounds for disciplinary action pursuant to s. 456.072(1)(gg), punishable as provided in s. 456.072(2).

(5) PRESCRIPTION SUPPLY.—

(a) For the treatment of acute pain, a prescription for an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812 may not exceed a 3-day supply, except that up to a 7-day supply may be prescribed if:

1. The prescriber, in his or her professional judgment, believes that more than a 3-day supply of such an opioid is medically necessary to treat the patient's pain as an acute medical condition;

2. The prescriber indicates "ACUTE PAIN EXCEPTION" on the prescription; and

3. The prescriber adequately documents in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3-day supply limit established in this subsection.

(b) For the treatment of pain other than acute pain, a prescriber must indicate "NONACUTE PAIN" on a prescription for an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812.

(6) EMERGENCY OPIOID ANTAGONIST.—For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II controlled substance listed in s. 893.03 or 21 U.S.C. s. 812 must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1).

(7) NONOPIOID ALTERNATIVES.—

(a) The Legislature finds that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to refuse an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812.

(b) The department shall develop and publish on its website an educational pamphlet regarding the use of nonopioid alternatives for the treatment of pain. The pamphlet shall, at a minimum, include:

1. Information on available nonopioid alternatives for the treatment of pain, including nonopioid medicinal drugs or drug products and nonpharmacological therapies.

2. The advantages and disadvantages of the use of nonopioid alternatives.

(c) Except in the provision of emergency services and care, as defined in s. 395.002, before providing anesthesia or prescribing, ordering, dispensing, or administering an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812 for the treatment of pain, a health care practitioner, excluding those licensed under chapter 465, must:

1. Inform the patient of available nonopioid alternatives for the treatment of pain, which may include nonopioid medicinal drugs or drug products, interventional procedures or treatments, acupuncture, chiropractic treatments, massage therapy, physical therapy, occupational therapy, or any other appropriate therapy as determined by the health care practitioner.

2. Discuss the advantages and disadvantages of the use of nonopioid alternatives, including whether the patient is at a high risk of, or has a history of, controlled substance abuse or misuse and the patient's personal preferences.

3. Provide the patient with the educational pamphlet described in paragraph (b).

4. Document the nonopioid alternatives considered in the patient's record.

History.—s. 3, ch. 2011-141; s. 31, ch. 2012-160; s. 16, ch. 2016-105; s. 6, ch. 2016-224; s. 4, ch. 2016-231; s. 3, ch. 2018-13; s. 48, ch. 2018-106; s. 1, ch. 2019-123.