



SPS NEWS

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February 2006

The Importance of Labor Costs in a Pain Practice

Benjamin Johnson, MD, MBA

In this era of continuing decreases in healthcare reimbursements, paying attention to the costs of running a practice is a crucial reality. Put simply, reducing the costs by 10% is equal to earning 20% in profit. Aside from the physical plant, labor costs constitute the largest portion of the cost profile of most practices. If this be true, selecting the right number and quality of clinical and administrative personnel is a practice-saving strategy. Choosing personnel, whether they are front-office, LPNs, RNs, NPs, or others, is a difficult and time-consuming task; and must not be entirely left up to administrators external to the practice. Although the skill set of each person is important, the group “chemistry” is at least as important; and allows each person to optimize and maximize the skills and attitudes that they bring to the practice.

One scenario that was destined for difficulty involved a hospital that sought out a pain specialist to start a new pain center in their hospital. The hospital administrator assured the specialist a satisfactory clinic space with shared access to interventional facilities. Also promised was a ready supply of credentialed personnel from the hospital labor pool. The beauty of this arrangement was coverage during periods of staff vacations, illness, etc. However, the specialist did not have any input into the selection of these personnel. As you might guess, the personnel that the specialist received were the cast-offs from each of the respective departments. The front office and nursing personnel, the two most important groups of any clinic staff, were not of sufficient maturity or experience to facilitate a startup venture. The result of these poor personnel choices was a great increase in the cost of practice, due to operational inefficiencies. The front office personnel took too long to register patients, and the nursing personnel took too long to ready patients for the provider’s encounters. Due to the patient’s prolonged stay in the clinic, patient throughput suffered, thus increasing personnel overtime pay and simultaneously decreasing potential profits. When these costs are viewed in the environment of a less-than-optimal payor mix, it can be readily seen that practice costs can begin to approach, if not surpass, revenue production.

In this scenario, the practitioner **MUST** negotiate the right to interview and monitor personnel on a probationary status before accepting them as permanent staff. During the probationary period, the personnel must have objective performance measures to meet, with careful documentation of their performance.

In summary, labor cost is typically the most important issue in controlling the cost of any medical practice; and the practitioner must secure and retain the ability to monitor and control this important factor. Failure to do so jeopardizes the viability of the practice, and the ability of the practitioner to continue to help patients in need of their services.

Mission Statement

The Southern Pain Society is a regional section of the American Pain Society and endorses and supports the mission and goals of the American Pain Society. The Southern Pain Society's missions are to serve people with pain by advancing research and treatment and to increase the knowledge and skill of the regional professional community.

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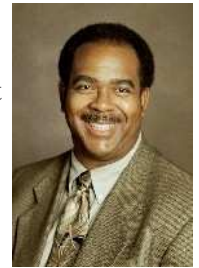
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President's Column

Benjamin Johnson, MD, MBA

The 2005 Southern Pain Society Annual Meeting was held last October in Lexington, Kentucky. It was an excellent meeting, due principally to the efforts of the program chairman, Jonathan Cole, and the president of the Kentucky Pain Society, Dr. Ballard Wright. In spite of the Gulf Coast hurricane disaster, the meeting was well-attended, and we received excellent reviews on the quality of the meeting. I am grateful to our executive director Lori Postal, as well as all of the speakers and attendees for dedicating their time, attention, and expertise to the success of this meeting. One of the most talked-about presentations was a lunch presentation by Dr. William Witt from the University of Kentucky Pain Center, regarding some recent developments in the usage of ultra-low-dose opioid analgesics in intrathecal drug delivery systems. Another highlight of the meeting was an excellent presentation by Dr. Joe Chen regarding his experiences of delivering medical care to gulf coast pain patients in the midst of the Hurricane Katrina disaster.



In this issue of the Southern Pain Society newsletter, we present articles from Jennifer Bolen and Ike Eriator, experts in their respective fields. As many of you know, attorney Jennifer Bolen is the current recipient of the SPS President's Award for her distinguished service to the pain community at large. She has been instrumental in educating pain specialists and other healthcare providers in the regulatory and medicolegal implications of both the usage of controlled substances, as well as the issue of compliance with billing and coding of healthcare delivery. Dr. Ike Eriator, MD, MPH is a pain specialist in Jackson, MS with special expertise in the epidemiology and the critical reading of medical literature. Dr. Eriator is an anesthesiologist and fellowship-trained, board-certified pain specialist at the University of Mississippi, who also teaches epidemiology at Jackson State University. He has created a series of articles regarding the accurate interpretation of scientific literature as it relates to pain medicine.

Also in this newsletter is the beginning of a series of editorials on practice-related issues. The first article addresses some basic issues of labor costs in a medical practice. It is my hope that these editorials will encourage some correspondence and questions from our readership.

Is Your Practice Evidence-Based?

Ike Eriator, MD, MPH

Who you see determines what you get;

How often do we ask “Does the evidence support what I am doing?” Or “Is there a better way of doing this?” There is still a significant variability in the approach to care by different practitioners when facing the same clinical pain problem. In fact, for back pain, the practitioner you see often determines the tests and interventions you get (Cherkin et al., 1994). Surgery for sick-listed patients with back pain in the United States is five times the rate in Sweden, with no more positive effect on work, pain or back function in the United States compared to Sweden (Hansson and Hansson, 2000). Even in the United States, surgery rates for back pain in the southern states was about 60 percent higher than in the western states (Taylor et al., 1994).

What is Evidence-Based Medicine?

Evidence Based Medicine (EBM) is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. It is an integration of the individual clinical expertise with the best available external clinical evidence from systematic research and the patient’s values and expectations. EBM involves seeing a patient with a problem, asking a question, seeking out the best evidence (or guideline) that answers the question, appraising the evidence, applying it and monitoring the change. Our clinical skills and judgment are important in determining how the evidence or guideline applies to the individual patient’s unique biology and values.

Why Evidence-Based Practice?

Apart from acting as a milieu through which we can inject the current best external evidence into our practice, EBM can improve the way we keep up to date. In the traditional model, in order to keep up to date in our profession, we need to read several articles daily. The problem is that many of us do not. Our professional and personal lives leave us with too little time to read as much as we should. Even then, there are so many journals to choose from, and we tend to read what is familiar to us, and avoid the difficult issues. While many practitioners self report that they get their knowledge from the printed sources, research show that many of us really get our knowledge from human sources (Gorman, P. et al., 1994). The usual educational strategies involve didactic sessions by experts on subjects chosen by others, usually in a large lecture format and with very little follow up. This format does not really improve our practice pattern (Davis et al., 1999). EBM has been advocated as a way to apply current scientific and rational decision making in the care of our patients (Strauss et al, 2005).

Best Evidence;

EBM requires the use of best evidence. As discussed in the September 2005 edition of SPS Newsletter (Pages 4 -5), systematic reviews and meta-analysis provide the best evidence (level 1a) of the effectiveness of an intervention. Randomized

controlled trials (RCTs) are next in the hierarchy (Level 1b). Non randomized controlled studies are next, followed by concurrent cohort studies, retrospective cohort studies and case controlled studies. In evidence based guidelines, the lowest grade is reserved for respected authorities, descriptive studies, case reports and report of expert committees (Riegelman, 2005a). Unfortunately, the absence of the best grades of evidence has often resulted in the use of information from case series and nonrandomized retrospective reports in clinical decision making. Fortunately, interest in EBM has been growing exponentially. In 1992, there were only a few MEDLINE citations, while in 2004, there were over 13,000 EBM citations. There are also several useful resources that have done the evidence based reviews and generated summaries for us. In the absence of such summaries, an evaluation of the available relevant studies can be done using the MAARIE framework (Method, Assignment, Assessment, Results, Interpretation and Extrapolation). See Riegelman (2005b) for more details. Pain is one of the few areas where an evidenced based textbook (McQuay and Moore, 1998) was published in the early part of the recent resurgence of EBM

Approach;

To apply EBM to our pain practice, there are different approaches that can be used to obtain the best external evidence. The method chosen will depend on the clinical question you are trying to answer. One way is to search and appraise the evidence yourself. This provides evidence based care, but it takes time and resources. Another approach is to search the evidence based resources for the answer to your question. This is a good approach for the non-experts in EBM. And with such a wealth of available EBM resources today, most practitioners can find solutions to their questions by searching through such appraised and summarized evidence. Searching through such resources is much quicker, but unfortunately, not all questions can be answered by the currently available EB reviews and summaries. A third approach to getting the best external evidence is to replicate the practice of experts. If you use this method, you have to be careful to separate evidence based from ego-based recommendations.

Some Examples;

Have you wondered about the evidence supporting the continuation of normal activities instead of enforced bed-rest in patients with back pain for less than 4 weeks? There is level 1 evidence (RCT) and this evidence supports a clinically beneficial effect on return to work. However, there is no demonstrated significant benefit on pain (Philadelphia Panel, 2001). The same evidence based clinical guideline indicate that for back pain greater than 12 weeks in duration, therapeutic exercise has clinically important benefits on pain and function, but no clinically demonstrable benefits on return to work. Spinal manipulative therapy for acute or chronic low back pain is more effective than placebo in reducing pain and improving activities of daily living, but it is no more or less effective than pain medications, physical therapy, back school or the care of a general practitioner (Assendelft et al., 2005)

Here is another short example involving primary literature review. Just the other day, we had a patient with back pain with radiculopathy referred for epidural steroid injection. The MRI of the lumbar spine showed epidural lipomatosis. The question was whether to proceed with the epidural injection as requested or not. Epidural injections may be complicated by epidural lipomatosis (McCullen et al., 1999, Sandberg and Lavyne, 1999). A search through many of the evidence based resources was negative. A search through MEDLINE showed 10 relevant articles directly related to this topic. Many were case reports or case series. Three included detailed literature review. One included a meta-analysis. A recent case report described two patients with beneficial effects of epidural steroid injections (Botwin and Sakalkale, 1999). The weight of evidence after combining the studies suggested that weight loss and surgical decompression would be most effective for patients similar to ours. We counseled the patient using information from our review and respected his decision.

Is Your Practice evidence-Based?

Our patients and payers expect us to provide the best possible care on the basis of the currently available high quality evidence. This is especially true when we are dealing with the highly variable and subjective sensation of pain. The traditional approach of providing pain care is neither very efficient nor effective. Our payers are realizing this, and demanding more proof of the effectiveness of our interventions. Is your practice evidence based?

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From the Executive Director

Lori H. Postal, RNC, MS

We are very pleased to begin our 18th year as the Southern Pain Society! We were incorporated in the State of Texas in 1988 and have grown and matured during the years. We currently have 236 members, many of whom joined us during our last annual meeting in Lexington. We are delighted to have them as part of our organization.

A reminder to those of you who still need to pay your dues for 2006. We hope that you get what you need from our organization, and would welcome hearing from you if you have suggestions for improvement or enhancements.

We are especially looking forward to the 2006 Annual Meeting in Birmingham on October 27-29th. As co-chair of this year's meeting, Dr. Daniel Doleys is putting together an outstanding agenda on Clinical Pain Medicine and Management. We hope you will join us at the Ross Bridge Resort for a stimulating meeting.

Later this year we will have elections for the following positions: President Elect, Treasurer, Secretary and 2 at-large Directors. We are open to receiving nominations at any time. If you would like to nominate yourself, or an SPS colleague for one of these positions, please send a short letter indicating why you are nominating the person. Please ensure that they are willing to accept if elected!. Please mail your nomination to

Nominating Committee
Southern Pain Society
2474-302 Walnut Street
Cary, NC 27511

A Summary of Current DEA Positions and Resulting Federal Legal/Regulatory “Standards”

Jennifer Bolin, JD

This article contains a quick summary of the DEA’s current position on using controlled substances to treat pain. My discussion covers three key sources:

1. The Code of Federal Regulations, Section 1306.04, pertaining to valid prescriptions.
2. The *Interim Policy Statement on Dispensing Controlled Substances for the Treatment of Pain*, published by the DEA in the Federal Register on November 16, 2004; and
3. The *Clarification Statement on the Controlled Substances Act and the Use of Schedule II Controlled Substances for the Treatment of Pain*, published by the DEA in the Federal Register on August 23, 2005.

In a “back to school” sense, I recommend you cut out **Table 1**, laminate it, and keep it as a quick reference card. It is important for you to understand that DEA is in the process of drafting a final policy statement on dispensing controlled substances for the treatment of pain. DEA has not said when it will publish this final policy statement. Use our website, www.legalsideofpain.com to stay current on DEA releases. As you read this article, realize that I share your frustration about the lack of clear boundaries and inconsistency between federal, state, and health plan approaches to prescribing controlled substances to treat pain. I, and many others, continue to work for balance and clarity on your behalf.

21 CFR § 1306.04 – Purpose of Issue of Prescription

When you receive a federal drug registration number, DEA expects you to follow federal controlled substances laws, regulations, and policies. Citing federal law, DEA expects its registrants to administer, dispense, and prescribe controlled substances for a **legitimate medical purpose while acting in the usual course of professional practice**. These two concepts, often viewed formally as a single standard, have been part of the federal law since at least 1970. The Code of Federal Regulations (CFR), which explains most of the Controlled Substances Act of 1970, contains the “legitimate medical purpose” standard.

In relevant part, 21 CFR § 1306.04, entitled *Purpose of Issue of Prescription*, states:

(a) A prescription for a controlled substance to be effective **must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice**. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. An order pur-

porting to be a prescription issued not in the usual course of professional treatment or in legitimate and authorized research is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.

A related CFR provision is 21 CFR § 1306.05, entitled *Manner of Issuance of Prescriptions*, which states:

(a) All prescriptions for controlled substances **shall be dated as of, and signed on, the day when issued and shall bear the full name and address of the patient, the drug name, strength, dosage form, quantity prescribed, directions for use and the name, address and registration number of the practitioner**. A practitioner may sign a prescription in the same manner as he would sign a check or legal document (e.g., J.H. Smith or John H. Smith). Where an oral order is not permitted, prescriptions shall be written with ink or indelible pencil or typewriter and shall be manually signed by the practitioner. The prescriptions may be prepared by the secretary or agent for the signature of a practitioner, but the prescribing practitioner is responsible in case the prescription does not conform in all essential respects to the law and regulations. **A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by these regulations.**

DEA does not have the authority to tell clinicians how to practice medicine. However, many states adopt the federal “legitimate medical purpose” standard, thereby tying it with state licensing board expectations and accepted clinical standards of care. Make sure you know your state’s position on what constitutes “legitimate medical purpose within the usual course of professional practice,” and read all applicable state laws, regulations, and guidelines on controlled substance prescribing and pain management. If you need help locating these materials, try www.legalsideofpain.com. In a future article, I will discuss state definitions of this standard.

Interim Policy Statement

In November 2004, DEA used its authority to publish its position on the federal law relating to the use of controlled substances to treat pain in the *Interim Policy Statement on Dispensing Controlled Substances for the Treatment of Pain*. DEA discussed several issues in the *Interim Policy Statement*, one of which I discuss below. DEA states clearly in the *Interim Policy Statement* that it expects its registrants to **minimize the potential for the abuse and diversion of controlled substances** by adhering to applicable legal/regulatory boundaries and by following current, accepted clinical care standards.

In a few recent criminal cases, lawyers and law enforcement investigators continue to blur the lines between civil and criminal standards thereby causing many pain professionals to lose faith in our justice system and question whether it is

“safe” to use controlled substances to treat pain. Obviously, this is a significant issue but one that is beyond the scope of this article. Nonetheless, I believe it is important for you to understand the “legitimate medical purpose” and “minimization” standards and use them to support your controlled substance prescribing and underlying documentation. When you incorporate legal/regulatory concepts and language into your medical records and daily practice, you will improve your ability to withstand a compliance audit.

Clarification Statement

In August 2005, DEA used its authority to *clarify* its position on the Controlled Substances Act in a document called *Clarification of Existing Requirements under the Controlled Substances Act for Prescribing Schedule II Controlled Substances*. In this document, DEA pronounced that it believes the Controlled Substances Act of 1970 and federal regulations on controlled substances prohibit the use of “Do Not Fill” prescriptions. Since its release in November 2004, many people interpreted the *Interim Policy Statement* as a federal law requiring clinicians to see patients using Schedule II medications every thirty days. DEA has said this is an incorrect interpretation of the *Interim Policy Statement* and the federal law.

Because of the confusion, and the many letters sent to DEA following the *Interim Policy Statement*, DEA chose to address this point in the *Clarification Statement*, stating the *Interim Policy Statement* [and federal law] does not require patients to see their physicians every thirty days to get their prescriptions for Schedule II controlled substances. Instead, DEA expects its registrants to **“consider whether a patient should be seen more or less frequently depending on their individual circumstances.”** This comment by DEA implies that registrants have a burden to balance what they know about a patient and his/her history (medical, substance abuse, and behavioral during the course of the physician/patient relationship) when deciding how frequently to see a patient who requires Schedule II medications. The more risks a patient presents, the more frequently you should see them personally and the more monitoring measures you should consider to demonstrate, as objectively as possible, that you are complying with federal and state standards on this matter.

DEA also points out in the *Clarification Statement*:

“in each instance where a physician issues a prescription for any controlled substance, is that the physician properly determine there is a legitimate medical purpose for the patient to be prescribed that controlled substance and that the physician be acting in the usual course of professional practice.”

DEA recognizes that “schedule II controlled substances, by definition, have the highest potential for abuse, and are the most likely to cause dependence, of all the controlled substances that have an approved medical use.” Thus, DEA expects physicians to:

“use the utmost care in determining whether their patients for whom they are prescribing schedule II controlled substances should be seen in person each time a prescription is issued or whether seeing the patient in person at somewhat less frequent intervals is consistent with sound medical practice and appropriate safeguards against diversion and misuse.”

DEA also expects physicians to “abide by any requirements im-

posed by their state medical boards with respect to proper prescribing practices and what constitutes a bona fide physician-patient relationship.”

Assuming DEA is correct when it says “Do Not Fill” prescriptions are illegal under federal law, what other options do you have for getting patients their schedule II medications? DEA uses the *Clarification Statement* to point out that a clinician who regularly sees a patient and issues him/her a prescription for a schedule II controlled substance (for a legitimate medical purpose and without seeing the patient in person), may **“mail the prescription to the patient or pharmacy.”** Of course, your ability to mail prescriptions is further subject to state law and some states disallow mailing while others impose a “patient permission” requirement. In addition, mailing has its own problems – like will the patient get the prescription or the added cost of certified or registered mail.

DEA uses the *Clarification Statement* to confirm yet another alternative – faxing:

“A prescription for a schedule II controlled substance may be transmitted by the practitioner or the practitioner's agent to a pharmacy via facsimile equipment, provided that the original written, signed prescription is presented to the pharmacist for review prior to the actual dispensing of the controlled substance, except as noted [elsewhere in this section of the regulations].”

Remember, however, your ability to fax schedule II prescriptions is further subject to state law. Make sure you understand your state’s position on this matter before you use the faxing alternative.

As a final point, DEA uses the *Clarification Statement* to explain that the federal law does not contain dosage limits for schedule II prescriptions. However, some states do impose dosage limits on the amount of a schedule II controlled substance that clinicians may prescribe. Find out your state’s position and factor that into your daily prescribing practices. Remember too that many states require clinicians to “control the drug supply,” especially to patients with a substance abuse history or other indications of abuse potential. Thus, increasing the number of dosage units may not be the right answer and may actually encourage abuse and diversion in certain patient populations.

DEA expects its registrants to issue controlled substance prescriptions **for a legitimate medical purpose in the usual course of professional practice.** “Physicians and pharmacies have a duty as DEA registrants to ensure that their prescribing and dispensing of controlled substances occur in a manner consistent with effective controls against diversion and misuse, taking into account the nature of the drug being prescribed.”

DEA and a Final Policy Statement

DEA will issue a final policy statement on the use of con-

trolled substances for the treatment of pain and every physician who prescribes controlled substances should find a good source to help them stay current on these matters. In all cases, physicians and physician extenders must become familiar with existing federal and state legal/regulatory materials and be prepared to reevaluate their practices for compliance purposes.

INSERT DISCLAIMER— I intend this article to serve as an educational tool for pain management practitioners, and I do not intend for it to serve as specific legal advice. If you need help on legal questions, contact an attorney who is qualified to advise you on these matters. You can reach me at 865-560-1945 of jbolen@legalsideofpain.com.

About the Author

Ms. Bolen is an attorney from Knoxville, TN. She served for nearly fourteen years as an Assistant U.S. Attorney with the U.S. Department of Justice, and she handled health care fraud and drug diversion investigations involving pain management issues. Ms. Bolen left public service in 2003, and started to educational effort known as “The Legal Side of Pain®”. Ms. Bolen serves on the editorial board for *Pain Medicine News*, *Forensic Pain Medicine*, and *The Journal of Opioid Management*. She teaches nationwide and is dedicated to helping the pain management physician and supporting health care providers understand legal/regulatory concepts and use these concepts to provide quality health care to patients in pain. If you have more examples of system disconnects – between pain management and health plans and/or WC programs, email Ms. Bolen at jbolen@legalsideofpain.com. You may reach her website at www.legalsideofpain.com

1. 21 CFR 1306.04 – Prescriptions.

2. 21 CFR 1306.04.

3. 21 CFR 1306.05.

4. U.S. Drug Enforcement Administration, *Interim Policy Statement on Dispensing Controlled Substances for the Treatment of Pain*, November 16, 2004, as published in the Federal Register: Volume 60, Number 220, Pages 67170-67172. Available at <http://waisaccess.gpo.gov> (DOCID:fr16no04-82). Accessed January 10, 2006. A full discussion of the *Interim Policy Statement* is beyond the scope of this article. You should obtain and read a copy of this statement and consider how it affects your practice.

5. To read about all of DEA’s comments in the *Interim Policy Statement*, visit us on-line at www.legalsideofpain.com and see the tab called “DEA Issues.”

6. *Interim Policy Statement*, see note 4 above.

7. I, and others, continue to research and write about this issue in medical journals and other publications. It is im-

portant for you to understand the distinctions between civil and criminal standards by which various entities will judge your prescribing habits. Thus, you should seek out and read materials on this topic periodically to stay current about DEA’s administrative and criminal roles. See also Bolen, J., Commentary, DEA and Schedule II “Do Not Fill Prescriptions” – Disappointing Enforcement Activity, accepted for publication in *Pain Medicine*, Vol. 7, No. 1, pages 80-85 (2006).

8. U.S. Drug Enforcement Administration, *Clarification of Existing Requirements Under the Controlled Substances Act for Prescribing Schedule II Controlled Substances*, August 26, 2005, as published in the Federal Register: Volume 70, Number 165, Pages 50408-50409. Available at <http://wais.access.gpo.gov> (DOCID:fr26au05-139). Accessed January 10, 2006.

9. For a complete discussion of the DEA’s position on “Do Not Fill” prescriptions and case law surrounding this issue, see Bolen, J., Commentary, DEA and Schedule II “Do Not Fill Prescriptions” – Disappointing Enforcement Activity, accepted for publication in *Pain Medicine*, Vol. 7, No. 1, pages 80-85 (2006).

10. The exact language from the *Clarification Statement* is as follows: **“the IPS did not state that patients must visit their physician’s office every month to pick up a new prescription. There is no such requirement in the CSA or DEA regulations.”** *Clarification Statement*, see note 8 above.

11. *Clarification Statement*, see note 8 above.

12. *Clarification Statement*, see note 8 above.

13. *Clarification Statement*, see note 8 above.

14. *Clarification Statement*, see note 8 above.

15. *Clarification Statement*, see note 8 above.

16. I am not convinced the DEA is correct in its claim that “Do Not Fill” prescriptions are improper under federal law. For more information on this topic, see Bolen, J., Commentary, DEA and Schedule II “Do Not Fill Prescriptions” – Disappointing Enforcement Activity, accepted for publication in *Pain Medicine*, Vol. 7, No. 1, pages 80-85 (2006).

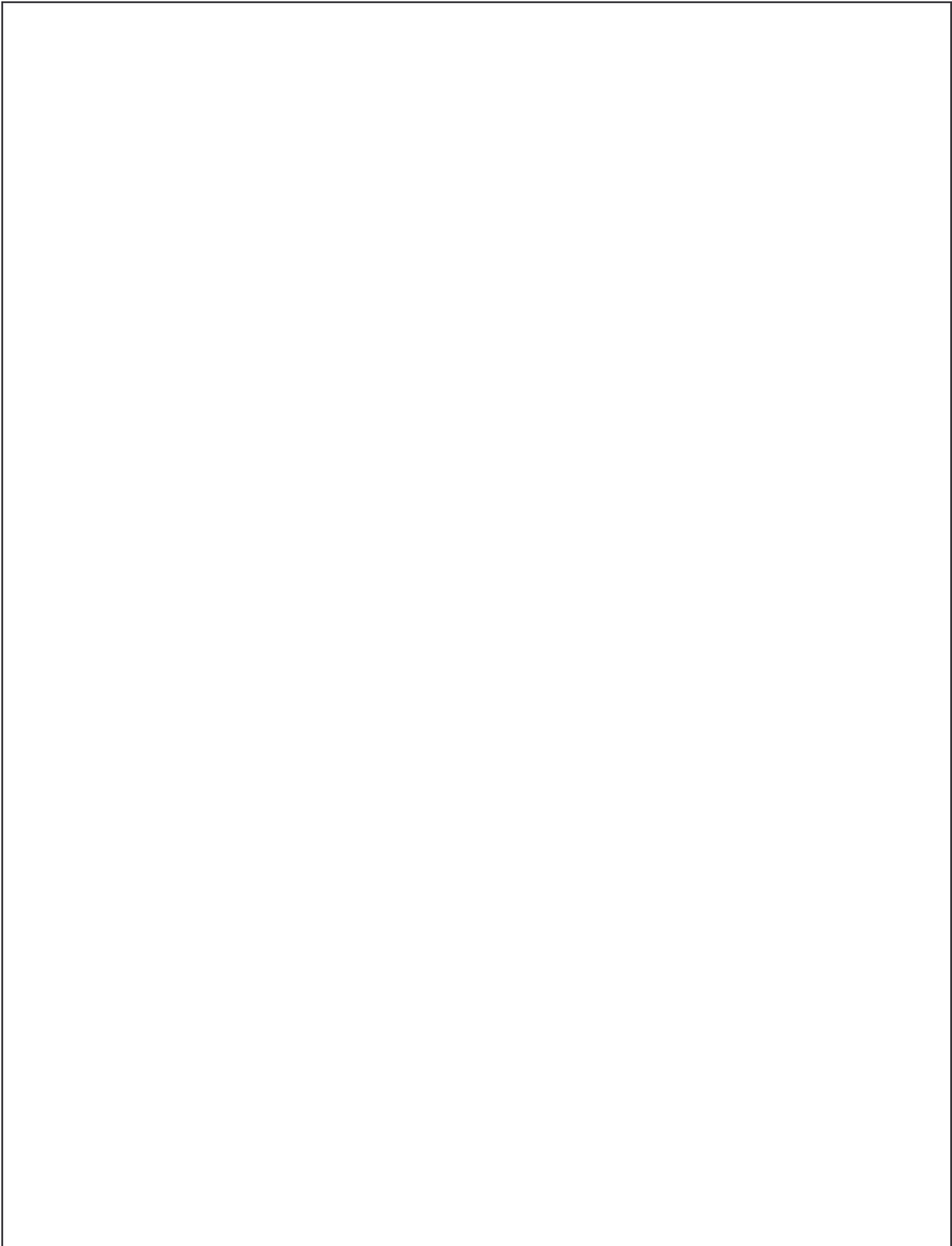
17. *Clarification Statement*, see note 8 above.

18. *Clarification Statement*, see note 8 above.

19. *Clarification Statement*, see note 8 above.

20. *Clarification Statement*, see note 8 above.

21. *Clarification Statement*, see note 8 above.



New Chronic Pain Network Offers Comprehensive, Integrated Education Program for Pain Management Professionals

Sydney, Australia, August 22, 2005 — The Chronic Pain Network™ (CPN) was launched today at the International Association for the Study of Pain's 11th World Congress on Pain by cosponsors Organon Pharmaceuticals USA Inc., and Ligand Pharmaceuticals Inc. CPN is the only comprehensive, integrated and aligned national pain management education program developed by clinicians for clinicians that provides a singular resource for practitioners and patients to support appropriate patient pain assessment, treatment, and balanced risk management of chronic pain. According to the American Pain Foundation, more than 50 million Americans live with chronic pain. While pain is the number one reason that people seek medical care, many general practitioners currently do not have the resources to effectively treat patients in this arena. The Chronic Pain Network provides healthcare professionals an array of tools and resources to address their patients' individual needs. One of the key components of the CPN is the Chronic Pain Management Resource System which includes a Clinical Resource Kit and a Regulatory Resource Kit. Clinicians can also access www.chronicpainnetwork.com to register for the program, and learn about CME programs on chronic pain and its management. All materials are developed and reviewed by a Chronic Pain Network Education Board of leaders in the pain management community. The Clinical Resource Kit is a comprehensive, customizable patient assessment and pain management resource. This resource includes assessment and documentation forms and patient education forms. The Regulatory Resource Kit provides an overview of regulatory requirements relevant to healthcare professionals who prescribe pain medication. The Regulatory Resource Kit is CME-accredited and works in tandem with the Clinical Resource Kit to support clinicians by providing easy access to information on the legal and regulatory guidelines surrounding pain management. "Every person in pain has a unique background, history and set of circumstances that have led them to seek out help in managing their pain. The Chronic Pain Network enables healthcare providers to properly assess people in pain and help them work together as a team to provide the most appropriate regimen of care," said Richard Payne, MD, Chair of the CPN Education Board Past President, American Pain Society, Duke University Divinity School, Durham, NC. CPN features additional tools, including a centralized and comprehensive home on the Web where members can easily access the latest information and resources on pain management. Patient education materials including a pain diary, frequently asked questions about sustained-release

opioids and information on managing insomnia and side effects are also available. The network also offers CME accredited and non-CME educational events for continuous learning opportunities. "The ultimate beneficiaries of the Chronic Pain Network are people who need help managing their pain, as they become active participants in their Pain Management Plan," said Bill McCarberg, MD,

FABPM, Kaiser Permanente, member of the CPN Education Board. "The Network is a resource that helps all of the crucial elements come together in working toward helping healthcare providers help their patients – one unique case at a time." The CPN Education Board is comprised of esteemed physicians, allied healthcare professionals and advocacy leaders in the pain management community:

- Richard Payne, MD, Duke University Divinity School, Durham
- Jennifer Bolen, JD, J. Bolen Group, LLC, Knoxville, TN
- David Brushwood, JD, RPh, University of Florida, Gainesville
- Penny Cowan, American Chronic Pain Association, Rocklin
- June L. Dahl, PhD, University of Wisconsin Medical School, Madison, WI
- LD Buck Hartford, PA, Peninsula Pain Clinic, PLLC, Bremerton, WA
- Howard A. Heit, MD, FACP, FASAM, Georgetown University Medical Center, Washington, DC
- Bill McCarberg, MD, FABPM, Kaiser Permanente, San Diego, CA
- Mary L. McPherson, PharmD, BCPS, CDE, University of Maryland, Baltimore, MD
- Christine Miaskowski, RN, PhD, FAAN, UCSF School of Nursing, San Francisco, CA
- Seddon R. Savage, MS, MD, Dartmouth Medical School, Hanover, NH

For more information, please visit the CPN website, www.chronicpainnetwork.com.

Newsletter Submissions

All submissions to SPS News should be typewritten and double spaced with title and name of author(s). The article should be copy-ready. Please include biographical information. Send to lpostal@southernpainsociety.org

Submission Deadlines

Winter edition-November 1; Spring edition-February 1; Summer edition-May 1; Fall edition-August 1.



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Address Correction Requested

We're on the web!
www.Southernpainsociety.org

Save the Date!

**2006 Annual Meeting
in conjunction with
The Pain and
Rehabilitation Institute**

**October 27-29, 2006
Ross Bridge Resort
Birmingham, Alabama**

Visit SPS's Website!

Stan Chapman, PhD
Chair, E communications

You might really be surprised to find all of the helpful resources available on SPS's website, southernpainsociety.org. You may not know that SPS is the only regional section of the American Pain Society that has its own independent website in addition to being a link within the APS website. Going to the website is a great way to stay in touch with SPS. It contains many features, and links, including copies of recent newsletters, a description and brochure of upcoming meetings, and a listing of officers and Board members, districts and their Presidents, and committees and their chairs. If you want to become more involved with SPS through participation in a district and/or with a committee, going to the website will help you get in touch with the right person. Furthermore, you might know of someone interested in membership. An application can be downloaded directly from the website.

The website not only includes information about SPS, but also lists literally hundreds of online resources related to health care, including major organizations, journals, search engines, grant opportunities and providers, medical dictionaries, a medical encyclopedia, and comprehensive information about medications. You owe it to yourself to explore and see what's there!