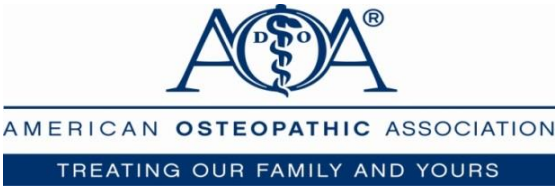

January 23, 2018

Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive, Suite 200-B
Jackson, Mississippi 39216

RE: MSBML's Proposed Changes to the Rules Pertaining to Prescribing, Administering and Dispensing of Medication

The American Osteopathic Association (AOA) and the Mississippi Osteopathic Medical Association (MOMA) would like to thank you for the opportunity to provide comments on the Mississippi State Board of Medical Licensure's (MSBML) Proposed Changes to the Rules Pertaining to Prescribing, Administering and Dispensing of Medication (Proposed Changes). The AOA and MOMA appreciate the MSBML taking steps to address prescription drug abuse, misuse and diversion in the state of Mississippi. We agree that the problem is widespread and continues to worsen, and we support a multi-pronged, evidence-based approach to this issue that ensures that patients with legitimate medical needs are able to access to timely, high-quality care.

The AOA represents 137,000 osteopathic physicians (DOs) and medical students, promotes public health, encourages scientific research, serves as the primary certifying body for DOs and is the accrediting agency for osteopathic medical schools. More information on DOs/osteopathic medicine can be found at www.osteopathic.org. MOMA is a professional medical organization that represents more than 500 DOs providing patient care in Mississippi.

We strongly agree that clinical practices surrounding the use of controlled substances, especially long-term opioid use for chronic pain, need to be re-examined and reconsidered, and therefore support a number of aspects of the MSBML's Proposed Changes. In addition, we urge you to consider nonpharmacologic treatment strategies, such as osteopathic manipulative treatment, as another approach to pharmacotherapy for chronic pain. The osteopathic approach uses physical examination as well as patient history to identify causes of chronic pain, and can include screening for depression or other significant nonphysical contributors to pain. This offers a framework for patient education to encourage adherence to treatment based on an understanding of the associated inter-related factors.

We offer the following specific comments on the Proposed Changes:

- **Rule 1.2 K.** increases the number of medical practices that fall under the category of a "pain management practice" subject to the more stringent requirements of **Rule 1.14**. Previously,

"pain management practice" regulations only applied to practices for which 50% of the patients receive opioids and other controlled substances for chronic pain on a regular basis; the Proposed Changes lower this percentage to 30%. State laws vary in their definitions of "pain management clinic," and many set the percentage at 50%.[1] Since the administrative requirements placed upon pain management practices are significantly more burdensome than other types of medical practices, we urge an evidence-based approach when identifying an appropriate percentage.

- **Rule 1.3** requires MSBML licensees who prescribe controlled substances in a pain management practice, or who prescribe opioids outside of such a practice, to query the Mississippi Prescription Monitoring Program (MPMP) **every time** such a prescription is issued. Licensees who practice outside of a pain management practice are only required to query the MPMP **upon initial contact** with a new patient, and **every three months thereafter** for patients who are prescribed controlled substances other than opioids. We are concerned with the specific recommendation on the frequency of MPMP review and recommend that it be modified for *all licensees*, to require them to query the program once upon initial contact with a new patient who is starting treatment with a controlled substance (including opioid therapy for chronic pain) and periodically during treatment, and any time there is aberrant behavior, or abnormal urine/serum toxicology results.

- **Rule 1.6(D)** requires an initial 100 hours of content-specific Continuing Medical Education (CME), and 60 hours biennially thereafter for physicians practicing bariatric medicine. There is an exception to the initial requirement, but not the biennial requirements, for physicians who are board certified in bariatric medicine. **Rule 1.14(I)** requires an initial 100 hours of content-specific CME, and 30 hours annually thereafter for physicians practicing pain management. There is an exception to the initial requirement, but not the biennial requirements, for physicians who possess pain-related board certifications, or who complete certain residency programs. In addition to a request that the language regarding the initial-versus-ongoing requirements be clarified, we have several concerns with these Rules.

  First, we oppose any attempts to impose any specific CME course requirements that do not count toward current state CME totals (Mississippi currently requires physicians to complete 40 hours of CME biennially).

  Second, **Rule 1.6(D)** and **Rule 1.14(N)** state that bariatric medicine and pain management medical practice registration certificates, respectively, are valid for one year and must be renewed annually along with the physician's license to practice medicine; however, medical licensure periods are biennial. In addition, the ongoing CME requirements for bariatric medicine contained in **Rule 1.6(D)** are biennial, but those for physicians practicing pain management in **Rule 1.14(I), referring to (N),** are annual, though **Rule 1.14(I)(b)** states that the 30 annual pain-related CME hours may be included in the 40 hour biennial licensure renewal requirement. We urge the MSBML to clarify and streamline these certificate renewal requirements and the attendant CME in order to ameliorate the onerous administrative burdens placed upon physicians which impede their ability to provide timely care to patients in need.

  Third, **Rule 1.14(I)** fails to recognize all appropriate pain-related certifications offered by the AOA. As written, the Rule recognizes AOA subspecialty certification in pain management for

[1] *See* Fla. Stat. § 458.3265(1)(a)(1)(c); O.C.G.A. § 43-34-282(7); ORC Ann. 4731.054(A)(5)(a); TN Code § 63-1-301 (8)(A); Tex. Occ. Code § 168.001(1); W. Va. Code § 16-5H-2(d).

osteopathic anesthesiologists, but it fails to recognize AOA subspecialty certification in pain medicine offered for DOs practicing in other specialties. The AOA recognizes both as equivalent for purposes of controlled substance prescribing and pain clinic ownership and operation, and respectfully request the following amendment:

> Rule 1.14(I)(2) "board certification by a specialty board recognized by the [AOA] Bureau of Osteopathic Specialists (BOS) in pain management **or pain medicine**;"

- **Rule 1.7(C)(4).** We oppose terminating patients from care based on a urine/serum drug test result since this could have adverse consequences for patient safety, potentially including the patient obtaining opioids from other sources, and the provider missing opportunities to facilitate treatment for substance use disorder.

- **Rule 1.7(G).** While we agree that all medications and especially opioids should be prescribed at the lowest effective dose, the dosage limitations/cautions appear arbitrary and unsupported by evidence. For example, depending on a number of factors (genetics, past history of recreational drug use, overall tolerance, etc.), some patients may require over 90 milligrams of morphine equivalence (mEq) per day. We are concerned that the Proposed Changes calling for prescribers to avoid this dosage could result in blanket policies being adopted by some health care settings that would leave such patients with inadequate pain management. We therefore recommend revising this section to:

  "Licensees **should~~must~~** avoid dosages greater than or equal to 90 [mEq] per day and must provide significant justification for exceeding the 90 mg ceiling state herein."

- **Rule 1.7(H).** We agree that the lowest effective dose of immediate-release opioids should be prescribed for acute pain, and that three or fewer days can usually be sufficient for most nontraumatic pain not related to major surgery. Studies disagree on a specific duration of opioid use for treatment of acute pain, however; therefore, we believe that this Rule should be reworded to allow physicians flexibility in determining the most appropriate course of treatment for an individual patient, using the aforementioned as guidance.[2]

We appreciate the MSBML's efforts to address prescription drug abuse in the state of Mississippi, and thank you for considering our comments. Should you need any additional information, please feel free to contact Raine Richards, JD, Director, State Government Affairs at rrichards@osteopathic.org or (800) 621-1773, ext. 8199.

Sincerely,

Mark A. Baker, DO
President, AOA

DeGail J. Hadley, DO
President, MOMA

[2] Deborah Dowell, MD; Tamara M. Haegerich, PhD; Roger Chou, MD. "CDC Guideline for Prescribing Opioids for Chronic Pain." Recommendation 6. *Centers for Disease Control and Prevention*, Mar. 18, 2016.

CC: William S. Mayo, DO, President-elect, AOA
Joseph M. Yasso, Jr., DO, Chair, Department of Governmental Affairs, AOA
Thomas L. Ely, DO, Chair, Bureau of State Government Affairs, AOA
Adrienne White-Faines, MPA, Chief Executive Officer, AOA
David Pugach, JD, Senior Vice President, Public Policy, AOA
Raine Richards, JD, Director, State Government Affairs, AOA
Ed Williams, PhD, Executive Director, MOMA