COLORADO
PAIN MANAGEMENT

Last year, the board observed an increase in the number of cases involving the care and treatment of chronic pain patients. The board's position is that all physicians should be knowledgeable about the evaluation and treatment of acute and chronic pain. However, we are concerned that physicians who may not have the appropriate expertise are treating complex and difficult patients, resulting in care issues coming to the board's attention.

Board Policy 10-14 (found on the Internet at www.dora.state.co.us/medical/policies/10-14.pdf) explains the board's approach to reviewing cases regarding pain management, and includes guidelines for providing care based on guidance from the national model policy developed by the Federation of State Medical Boards.

Summarizing the main points of the guidelines:

1. Patient evaluation should include a history and physical with specific attention to the patient's pain complaints, current and past treatments, underlying or coexisting diseases or conditions, effect of pain on function, and history of substance abuse.
2. Treatment plans should state outcome objectives and plans for further evaluation and treatment, and drug therapy should be adjusted to meet individual patient needs. Additional treatment modalities or rehab may be necessary depending on pain etiology and extent of impairment.
3. There should be an indication of a discussion of risks and benefits of treatment and informed consent. A written agreement should be considered for patients with a history of abuse or otherwise at high risk for abuse (the board has a sample patient contract for using opioid pain medication at www.dora.state.co.us/Medical/policies/10-14SampleContract.doc), and patients should receive prescriptions from a single physician and pharmacy when possible.
4. The physician should periodically review the course of treatment and the patient's health, and continuation or medication of treatment should depend on the assessment of progress towards treatment objectives. Objective evidence of treatment outcomes and information from family members or other caregivers should be considered, and if progress is unsatisfactory, the physician should reassess the appropriateness of the current treatment plan and consider other modalities.
5. The physician should refer patients as necessary in order to achieve treatment objectives, and pay special attention to those patients who are at risk for misuse or diversion. The management of patients with co-morbid psychiatric issues or history of substance abuse may require extra care and monitoring as well as consultation with or referral to an expert in pain management.
6. The medical record for chronic pain patients should document all the relevant issues regarding evaluation and treatment as outlined above, including documentation of the presence of one or more recognized medical indications for the use of a controlled substance.
7. The physician must be aware of and maintain compliance with federal and state regulations regarding the use of controlled substances (refer to the Practitioner's Manual, 2006 of the U.S. Drug Enforcement Administration, found on the Internet at www.deadiversion.usdoj.gov/pubs/ manuals/pract/index.html).

The Colorado Pain Consortium has developed a half-day introductory workshop, Making Pain Primary, which covers basic concepts of pain management for physicians. A workshop held June 8, 2007 in Denver, provided physicians covered by COPIC with two Experience Rating System (ERS) Points. Information is available on the Internet at: www.callcopic.com/makingpain-primary-workshop.

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HAWAII
DCCA REPORTS MAJOR INCREASE IN ONLINE RENEWALS FOR PROFESSIONAL LICENSEES

The Department of Commerce and Consumer Affairs' (DCCA) Professional and Vocational Licensing Division

(PVL) announces a significant increase in the number of professional licensees who are choosing to renew their licenses online.

In the areas of electrology, mortgage, occupational therapy, physical therapy and real estate, 18,357 of 22,278, or 81 percent, of professional licensees took advantage of the department's online renewal program. This latest renewal cycle included a few of the largest groups of professional and vocational licensees. "With more than 15,000 real estate licensees and 2,200 mortgage licensees, renewing online has become the absolute preferred method for licensed professionals," said Licensing Administrator Noe Noe Tom.

"This is nearly double the rate in 2004, when 43 percent renewed online," said DCCA Director Mark Recktenwald, "The continuous increase in online renewals has been remarkable."

The development of this online service is part of the state's overall campaign to improve efficiency by implementing electronic government services. Currently ehawaii.gov has more than 30 online applications that residents, businesses and visitors may use to conduct business with the state government via the Internet. Hawaii's official Internet portal, www.ehawaii.gov, is managed by Hawaii Information Consortium, LLC (HIC). HIC works with state agencies to enable them to conduct state business online and improve public access to government information.

STATE URGES NURSES, ACUPUNCTURISTS, AND SOCIAL WORKERS TO RENEW LICENSES ONLINE

The Department of Commerce and Consumer Affairs' (DCCA) Professional and Vocational Licensing Division (PVL) is encouraging more than 24,000 Hawaii nurses, acupuncturists and social workers to renew their licenses online at http://pvl.ehawaii.gov/renewals. Professionals able to renew online include:

- Acupuncturist
- Licensed Bachelor Social Worker
- Advanced Practice Nurse Recognition
- Licensed Clinical Social Worker
- Licensed Practical Nurse
- Licensed Social Worker
- Registered Nurse

During the last renewal cycle in 2005, more than 10,000 professional license holders (about 62 percent) renewed their licenses online. "That's nearly double the number that renewed online in 2003, and it is part of an upward trend we are seeing in online filings across the board," PVL Licensing Administrator Noe Noe Tom said.

Instructions for completing the online renewal have been mailed to each current license holder. Online renewals were accepted until midnight on June 30, 2007. After that date, renewals will not be accepted online and persons wishing to renew their license must submit the forms by mail or in person to: DCCA Professional and Vocational Licensing Division 335 Merchant Street, Rm. 301 Honolulu, HI 96813.

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Reprinted from the Hawaii Department of Commerce and Consumer Affairs website.

IOWA

NEW NAME FOR IOWA BOARD

As a result of recent legislation, the Iowa Board of Medical Examiners officially became the Iowa Board of Medicine on July 1, 2007. IBM replaces the former acronym IBME. The agency remains at its current location and address.

Reprinted from the Iowa Board of Medicine website.

KANSAS

APPROVED, UNAPPROVED AND DISAPPROVED MEDICAL SCHOOLS

K.S.A. 65-2873 requires an applicant for a license to practice medicine and surgery to have graduated from a school approved by the board. If the school has not been approved by the board, an applicant may still be eligible for a license if the school has not been disapproved and

has been in operation (date instruction started) for not less than 15 years. Schools approved by the board are:

1. All schools accredited by the Liaison Committee for Medical Eduction (LCME) www.lcme.org
2. Universidad Autonoma de Guadalajara - Mexico
3. Aga Khan - Pakistan
4. American University of the Caribbean - Montserat
5. SABA University - Netherlands (For graduates who matriculated at the school from and after January 1, 2002)

No applicant from a school disapproved by the board is eligible for licensure. Schools that have been disapproved by the board are:

1. UTESA - Santa Domingo
2. UNIREMBOS - Santa Domingo
3. St. Matthews - British West Indies

Reprinted from the Kansas Board of Healing Arts website.

KENTUCKY

BOARD OVERSIGHT OF ACUPUNCTURISTS

As a result of recent legislation passed by the General Assembly, the Kentucky Board of Medical Licensure is now certifying acupuncturist practitioners in the Commonwealth. Developed in a similar format to the other allied health practitioners under the board's jurisdiction, the Acupuncture Advisory Committee was created and appointed by the board with the responsibilities of reviewing and making recommendations regarding matters relating to acupuncture. Maureen A. Flannery, M.D., of Berea, was elected chair of the committee.

By statute, the practice of acupuncture is defined as meaning the insertion of acupuncture needles, with or without accompanying electrical stimulation, at certain acupuncture points or meridians on the surface of the body for purposes of changing the flow of energy in the body and may include acupressure, cupping, moxibustion or dermal friction. The practice of acupuncture shall not include laser acupuncture, osteopathic manipulative treatment, chiropractic adjustments, physical therapy or surgery.

Currently, it is unlawful for any person not certified by the board under KRS 311.671 to 311.686 to practice acupuncture in Kentucky, or use any title, sign, card or device to indicate that he or she is an acupuncturist. It is important to note that the provisions of KRS 311.671 to 311.686 are not intended to limit, preclude or otherwise interfere with the practice of other health care practitioners, working in any setting and certified or licensed by the appropriate agencies or committees of the Commonwealth whose practices and training may include elements of the same nature as the practice of a certified acupuncturist.

Reprinted from the spring 2007 issue of the *Kentucky Board of Medical Licensure Newsletter*.

NEVADA

NEVADA STATE HEALTH DIVISION ENCOURAGES PARTICIPATION IN HEALTH ALERT NETWORK

Many physicians in Nevada have completed the four-hour course on the medical consequences of an act of bioterrorism involving the use of chemical, biological, radioactive or nuclear agents. In that course, the importance of the Nevada Health Alert Network (HAN) in public health emergencies was discussed. Urgent medical information disseminated by the Nevada HAN originates with the Centers for Disease Control and Prevention, the state health officer or a county health officer. In the event of an avian influenza pandemic or bioterrorist attack, a communication system that connects the infectious disease authorities with Nevada's physicians and physician assistants is a vital step in the completion of a comprehensive preparedness plan. Although the network was conceived for use in crisis situations, it is also used to update clinicians about emergent health issues, such as the recent E.coli 0157 outbreaks, Polonium-210 poisonings and seasonal influenza updates. At present, the system is being updated and expanded to include physicians, physician assistants and other members of the medical community. Subscription is free. An e-mail address and Internet access are required.

Reprinted from the volume 34 issue of *Newsletter*, published by the Nevada State Board of Medical Examiners.

NEW HAMPSHIRE

PITFALLS IN OXYCODONE TESTING

The Board of Medicine has become aware of a problem with immunoassays for synthetic and semi-synthetic

Opioids. This involves opiates such as Methadone, Oxycodone, Hydrocodone and Hydromorphone. Compliance testing for these drugs may result in false negative reports (absence of the drug by assay). For those patients that are tested for compliance with the prescribed medicine, a negative result may be interpreted as diversion or other opioid abuse and could result in inappropriate patient discharge.

Oxycodone is metabolized by Demethylation to Noroxycodone and Oxymorphone followed by Glucuronidation. Following use of Oxycodone, one may detect in urine Oxycodone only, or Oxycodone and Oxymorphone, or Oxymorphone only. Commercial laboratories generally rely on immunoassays for detection of Opioids, originally designed for Codeine, Heroin and Morphine. For Oxycodone (likewise other semi-synthetic drugs), urine specimens frequently do not show due to the metabolized fractions.

Instead, the opiate must be analyzed by GUMS (Gas Chromatography/mass spectrometry) or other specialized methods in order to obtain an accurate indication of Oxycodone presence. Even GUMS may have false negative results due to instability of derivatives, out dated chromatography, wrong specimen, etc. The laboratory should be informed of the specific drug, and be requested to lower the report threshold in order to pick up a low concentration. Dilution of urine can also result in false negative reports. Very low Creatinine levels indicate dilution, and request for "no threshold testing" can at least indicate presence of the drug. Finally, the urine drug concentration has no relationship to the amount of drug ingested.

The board wishes to illuminate the issue of testing for Oxycodone and other semi synthetic opiates. It is recognized that negative reports for compliance testing could indicate diversion, but may also indicate a false negative report. Please be aware of this issue, and consider further more specific testing before dismissing a patient, perhaps improperly.

Reprinted from the winter 2007 issue of *Newsletter*, published by the New Hampshire Board of Medicine.

LET US HEAR FROM YOU

Would you like for information from your board to be considered for publication in the *Journal*? If so, e-mail your articles and news releases to Edward Pittman at editor@journalonline.org or send via fax to (817) 868-4098.