Pain Management, Pain Clinics, and Prescribing Issues – 2015 Bill Summary

Research current through January 2016.

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	Bills	
Bill No.	**Description**	**Status and Date of Last Action**
US HR 953	- "Comprehensive Addiction and Recovery Act of 2015" - Creates inter-agency task force and requires that not later than 120 days after enactment, the Secretary of Health and Human Services, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, and the Administration of the DEA, shall convene a Pain Management Best Practices Inter-Agency Task Force - Task force is required to, not later than 180 days after the date on which the task force is convened, develop best practices for pain management, including chronic and acute pain, and prescribing pain medication, taking into consideration: existing pain management research, recommendations from relevant conferences, ongoing efforts at the state and local levels by medical professional organizations to develop improved pain management strategies, and the management of high-risk populations, other than populations who suffer pain, who may use or be prescribed benzodiazepines, alcohol, and diverted opioids or receive opioids in the course of medical care - The task force is further charged with the duties of soliciting and taking into consideration public comment and developing a strategy for disseminating information about the best practices developed and reporting to Congress, not later than 270 days after the date the task force is convened, the strategy for disseminating best practices, the results of a feasibility study on linking best practices developed to receiving and reviewing registrations, and recommendations on how to apply best practices developed to improve prescribing practices at medical facilities, including VA facilities	4/29/2015 – Referred to subcommittee on Higher Education and Workforce Training
US HR 1628	- "Veterans Pain Management Improvement Act" - Amends Title 38 of the United States Code to establish a pain management board in each Veterans Integrated Service Network - Creates Sec. 7309A under Subchapter I of Title 38, United States Code, which creates the Pain Management Board which shall be established in each Veterans Integrated Service Network	4/7/2015 – Referred to subcommittee on Health

Yellow highlighted text indicates the legislation has been enacted into law

	- Each Board shall provide treatment recommendations for patients with complex clinical pain who are being treated at a medical facility of the Department located in the Veterans Integrated Service Network covered by the Board, regardless of whether such treatment is on an in-patient or out-patient basis - Patient is a patient for whom a request for treatment recommendations has been made by the patient, the spouse of a patient, a family member or other individual designated by the patient to make health care decisions, a physician of the patient, or an employee of the medical facility of the Department - Based on treatment recommendations, each Board shall provide health care professionals of the Department located in the Veterans Integrated Service Network covered by the Board recommendations on the best practices regarding pain management in complex clinical pain cases - Each Board shall annually submit a report to the Secretary and Under Secretary for Health on pain management practices, which shall include the following: 1) the treatment recommendations provided, including a summary of such recommendations and an explanation of the merits of each such recommendation; 2) the recommendations for best practices, including a summary of such recommendations and an explanation of the merits of each such recommendation; and 3) any other information the Board deems appropriate - Board shall consist of a number of members determined appropriate by the Secretary who are appointed by the Secretary from among individuals who have experience as a professional in a field relating to pain management, including as a board certified pain medicine specialist, a trained and qualified primary care pain champion, a pain psychologist, a pain social worker, a pain point of contact for Veterans Integrated Service Network, a psychiatrist with addiction and psychopharmacology expertise and experience, or a health care professional or a mental health care professional; clinical patients; or family members of clinical patients	
US HR 2805	- Creates the "Heroin and Prescription Opioid Abuse Prevention, Education, and Enforcement Act of 2015"	7/9/2015 – Referred to subcommittee on

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	- Provides that not later than 120 days after enactment, the Secretary of Health and Human Services, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, and the Administrator of the DEA, shall convene a pain management best practices inter-agency task force - Requires that the task force, no later than 180 days after convened, develop best practices for pain management and prescription pain medication prescribing practices, taking into consideration existing pain management research, recommendations from relevant conferences, and ongoing efforts and state and local levels and by medical professional organizations to develop improved pain management strategies and shall submit a report to Congress not later than 270 days after the date the task force is convened that includes: 1) the strategy for disseminating best practices developed; 2) the results of a feasibility study on linking best practices to receiving and renewing controlled substances registrations; 3) recommendations on how to apply such best practices	Crime, Terrorism, Homeland Security, and Investigations
US HR 3719	- Creates the "Stop the Overdose Problem Already Becoming a Universal Substance Epidemic Act of 2015" or the "STOP ABUSE Act of 2015" - Provides that not later than 120 days after enactment of the act, the Secretary of Health and Human Services, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, the Administrator of the Drug Enforcement Administration, the Secretary of Homeland Security, and the US Attorney General, shall convene an interagency task force to address opioid abuse - Provides that the task force, not later than 180 days after the date on which the task force is convened, shall: 1) develop best practices for pain management and prescription medication prescribing practices, taking into consideration recommendations from relevant conferences, ongoing efforts at state and local levels, and medical professional organizations; 2) develop a strategy for disseminating information about the best practices; 3) conduct a study on the feasibility of implementing the best practices; and 4) submit a report to Congress not later than 270 days after being convened which includes the strategy for disseminating the best practices, the results of the feasibility study, and recommendations on how to apply	11/3/2015 – Referred to subcommittee on Crime, Terrorism, Homeland Security, and Investigations

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	such best practices to improve prescribing practices at medical facilities, including VA facilities - Amends 21 USC 823 to provide that an applicant for a controlled substance registration must comply with the required training requirements - Further provides that, in order to be registered to prescribe or otherwise dispense methadone or other opioids, a practitioner shall comply with the 12-hour training requirement at least once every three years, which training shall include training with respect to the treatment and management of opioid dependent patients, pain management treatment guidelines, and early detection of opioid addiction	
US HR 3889	Amends 21 USC 823, § 303 to provide that the Attorney General shall grant or renew the registration of a practitioner to dispense or conduct research with Schedule II – V controlled substances contingent upon a covered practitioner (defined as a practitioner that is not a hospital, pharmacy, or veterinarian) completing training that shall, at a minimum, expose practitioners to best practices for pain management, including alternatives to prescribing controlled substances or other alternative therapies to decrease the use of opioids; responsible prescribing of pain medications; methods for diagnosing, treating, and managing a substance use disorder, including the use of FDA-approved medications and evidence-based non-pharmacological therapies; linking patients to evidence-based treatment for substance use disorders; and tools to manage adherence and diversion of controlled substances, including prescription monitoring programs, drug screening, informed consent, overdose education, and the use of opioid overdose antagonists	12/4/2015 – Referred to subcommittee on Crime, Terrorism, Homeland Security, and Investigations
US HR 4063	- Creates the "Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act" or the "Jason Simcakoski PROMISE Act" - Creates section regarding guidelines on management of opioid therapy by the Department of Veterans Affairs and Department of Defense, and provides that not later than one year after enactment of this Act, the Secretary of Veterans Affairs and Secretary of Defense shall jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain which shall include the following: 1) guidelines for safely	12/3/2015 – Referred to subcommittee on Health

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	prescribing opioids for chronic, non-cancer pain in outpatient settings as compiled by the CDC; 2) enhanced guidance with respect to the following: a) the administration of two or more drugs that may result in a life-limiting drug-drug interaction, including benzodiazepines; b) treatment of patients with current acute psychiatric instability or substance use disorder or patients at risk of suicide; c) the use of opioid therapy to treat patients without any pain, including to treat mental health disorders other than opioid use disorder; 3) enhanced guidance with respect to treatment of patients with behaviors or comorbidities, such as PTSD; 4) enhanced guidance with respect to the conduct by health care providers of an effective assessment to determine whether opioid therapy is meeting the expected goals and whether opioid therapy should be continued; 5) requirements that health care providers use the Opioid Therapy Risk Report tool before initiating opioid therapy, including information from the state PMP; 6) guidelines to govern the methodologies used by health care providers to safely titrate and taper opioid therapy when adjusting or discriminating the use of opioid therapy, including with respect to: a) prescription of the lowest effective dosage; b) use of opioid only for a limited period of time; c) augmentation of opioid therapy with other pain management therapies and modalities; 7) appropriate case management; 8) use of random drug screens; 9) that health care providers discuss options for pain management therapies that don't involve the use of opioids - Creates section regarding improvement of opioid safety measures by the VA - Requires that the Secretary require all employees of the Department responsible for prescribing opioids to receive education and training on pain management and safe opioid prescribing practices - Establishes pain management teams at each medical facility responsible for coordinating and overseeing therapy for patients experiencing acute and chronic pain that is non-cancer related - Requires the director at each Veterans Integrated Service Network to establish protocols for the designation of pain management teams at each medical facility which shall include that any health care provider without expertise in	

	prescribing analgesics or who has not completed the required education and training does not prescribe opioids unless he or she consults with a provider with pain management expertise or who is on the pain management team and refers the patient to that pain management team for any subsequent prescriptions and related therapy - Requires that the Secretary shall ensure access to information on controlled substances through the PMP of each state and require health care providers to submit prescription data to state PMPs - Requires that not later than 18 months after the date of enactment, the Secretary shall allow for real-time tracking of and access to data on: 1) the key clinical indicators with respect to the totality of opioid use by veterans; 2) concurrent prescribing by providers of opioids in different health care settings; 3) mail order prescriptions of opioids - Requires that the Secretary increase the availability of opioid receptor antagonists to veterans and increase availability of opioid receptor antagonists by health care providers and, further, ensure that all veterans who are at risk of opioid overdose have access to such opioid receptor antagonists - Requires that the Secretary modify the Computerized Patient Record System to ensure that any health care provider that accesses the record of a veteran will be immediately notified whether the veteran is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose, has a history of opioid abuse, or is at risk of becoming an opioid abuser - Creates section to strengthen working group on pain management and opioid therapy - Creates section to provide that no later than 90 days after the enactment of this Act and not less frequently than once every 90 days, the Secretary shall ensure that each medical facility hosts a community meeting open to the public on improving health care furnished by the Secretary and, further, that not later than one year after enactment, and no less frequently than annually thereafter, the Secretary shall ensure that each community based outpatient clinic hosts a community meeting open to the public on improving health care furnished by the Secretary - Creates section to provide that no later than 90 days after enactment, the Secretary shall, in as many prominent	

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	locations as the Secretary determines appropriate to be seen by the largest percentage of patients and family members of patients at each medical facility: 1) display the purposes of the Patient Advocacy Program and the contact information for the patient advocate at such facility; 2) display the rights and responsibilities of patients and family members and residents and family members of residents - Creates section requiring that the Comptroller General submit a report to the Committee on Veterans' Affairs not later than two years after the date of enactment on the Patient Advocacy Program - Creates section which creates a pilot program on integration of complementary alternative medicines which requires that not later than 180 days after the Secretary receives regarding efforts to expand complementary alternative treatments, the Secretary shall commence a pilot program to assess the feasibility and advisability of using wellness-based programs to complement the provision of pain management and related health care services	
US SB 524	- "Comprehensive Addiction and Recovery Act of 2015" - Creates inter-agency task force and requires that not later than 120 days after enactment, the Secretary of Health and Human Services, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, and the Administration of the DEA, shall convene a Pain Management Best Practices Inter-Agency Task Force - Task force is required to, not later than 180 days after the date on which the task force is convened, develop best practices for pain management, including chronic and acute pain, and prescribing pain medication, taking into consideration: existing pain management research, recommendations from relevant conferences, ongoing efforts at the state and local levels by medical professional organizations to develop improved pain management strategies, and the management of high-risk populations, other than populations who suffer pain, who may use or be prescribed benzodiazepines, alcohol, and diverted opioids or receive opioids in the course of medical care - The task force is further charged with the duties of soliciting and taking into consideration public comment and developing a strategy for disseminating information	1/27/2016 – Committee on Judiciary; hearings held

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	about the best practices developed and reporting to Congress, not later than 270 days after the date the task force is convened, the strategy for disseminating best practices, the results of a feasibility study on linking best practices developed to receiving and reviewing registrations, and recommendations on how to apply best practices developed to improve prescribing practices at medical facilities, including VA facilities	
US SB 1134	- Creates the "Heroin and Prescription Opioid Abuse Prevention, Education, and Enforcement Act of 2015" - Provides that not later than 120 days after enactment, the Secretary of Health and Human Services, in cooperation with the Secretary of Veterans Affairs, the Secretary of Defense, and the Administrator of the DEA, shall convene a pain management best practices inter-agency task force - Requires that the task force, no later than 180 days after convened, develop best practices for pain management and prescription pain medication prescribing practices, taking into consideration existing pain management research, recommendations from relevant conferences, and ongoing efforts and state and local levels and by medical professional organizations to develop improved pain management strategies and shall submit a report to Congress not later than 270 days after the date the task force is convened that includes: 1) the strategy for disseminating best practices developed; 2) the results of a feasibility study on linking best practices to receiving and renewing controlled substances registrations; 3) recommendations on how to apply such best practices - Appropriates $9,000,000 for the Harold Rogers Prescription Drug Monitoring Program for years 2016 - 2020	4/29/2015 – Read twice and referred to committee on Judiciary
US SB 1392	Amends 21 USC 823, § 303 to provide that the Attorney General shall grant or renew the registration of a practitioner to dispense or conduct research with Schedule II – V controlled substances contingent upon a covered practitioner (defined as a practitioner that is not a hospital, pharmacy, or veterinarian) completing training that shall, at a minimum, expose practitioners to best practices for pain management, including alternatives to prescribing controlled substances or other alternative therapies to decrease the use of opioids; responsible prescribing of pain medications; methods for diagnosing, treating, and	5/20/2015 – Read twice and referred to committee on Health, Education, Labor, and Pensions

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	managing a substance use disorder, including the use of FDA-approved medications and evidence-based non-pharmacological therapies; linking patients to evidence-based treatment for substance use disorders; and tools to manage adherence and diversion of controlled substances, including prescription monitoring programs, drug screening, informed consent, overdose education, and the use of opioid overdose antagonists	
US SB 1641	- Creates the "Jason Simcakoski Memorial Opioid Safety Act" - Creates section regarding guidelines on management of opioid therapy by the Department of Veterans Affairs and Department of Defense, and provides that not later than one year after enactment of this Act, the Secretary of Veterans Affairs and Secretary of Defense shall jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain which shall include the following: 1) guidelines for safely prescribing opioids for chronic, non-cancer pain in outpatient settings as developed and released by the CDC; 2) enhanced guidance with respect to absolute contraindications for opioid therapy, including guidance with respect to the following: a) the coadministration of drugs that are capable of inducing a life-limiting drug-drug interaction, including benzodiazepines; b) treatment of patients with acute psychiatric instability or substance use disorder or patients at risk of suicide; c) the use of opioid therapy to treat patients without any pain, including to treat mental health disorders other than opioid use disorder; 3) enhanced guidance with respect to treatment of patients with behaviors or comorbidities, such as PTSD; 4) enhanced guidance with respect to the conduct by health care providers of an effectiveness assessment to determine whether opioid therapy is meeting the expected goals and whether opioid therapy should be continued; 5) requirements that health care providers use the Opioid Therapy Risk Report tool before initiating opioid therapy, including information from the state PMP; 6) guidelines to govern the methodologies used by health care providers to taper opioid therapy when adjusting or discontinuing their use; 7) appropriate case management; 8) use of random drug screens; 9) that health care providers discuss options	6/22/2015 – Read twice and referred to committee on Veterans' Affairs

	for pain management therapies that don't involve the use of opioids - Creates section regarding improvement of opioid safety measures by the VA - Requires that the Secretary require all employees of the Department responsible for prescribing opioids to receive education and training on pain management and safe opioid prescribing practices - Establishes pain management teams at each medical facility responsible for coordinating and overseeing therapy for patients experiencing acute and chronic pain that is non-cancer related - Requires the director at each Veterans Integrated Service Network to establish protocols for the designation of pain management teams at each medical facility which shall include that any health care provider without expertise in prescribing analgesics or who has not completed the required education and training does not prescribe opioids unless he or she consults with a provider with pain management expertise or who is on the pain management team and refers the patient to that pain management team for any subsequent prescriptions and related therapy - Requires that not later than 18 months after the date of enactment, the Secretary shall allow for real-time tracking of and access to data on: 1) the key clinical indicators with respect to the totality of opioid use by veterans; 2) concurrent prescribing by providers of opioids in different health care settings; 3) mail order prescriptions of opioids - Requires that the Secretary shall ensure access to information on controlled substances through the PMP of each state and require health care providers to submit prescription data to state PMPs - Requires that the Secretary increase the availability of opioid receptor antagonists to veterans and increase availability of opioid receptor antagonists by health care providers and, further, ensure that all veterans who are at risk of opioid overdose have access to such opioid receptor antagonists - Requires that the Secretary modify the Computerized Patient Record System to ensure that any health care provider that accesses the record of a veteran will be immediately notified whether the veteran is receiving opioid therapy and has a history of substance use disorder	

	or prior instances of overdose, has a history of opioid abuse, or is at risk of becoming an opioid abuser - Creates section to establish working group on pain management and opioid therapy - Creates section to establish pain management boards which shall consult with health care professionals, oversee compliance by health care professionals, provide oversight of pain management practices, carry out educational forums, public hearings, and other events - Creates section requiring the Secretary to conduct a study on the feasibility and advisability of carrying out a pharmacy lock-in program - Creates section requiring that the Comptroller General submit a report to the Committee on Veterans' Affairs not later than two years after the date of enactment on the Opioid Safety Initiative and opioid prescribing practices of health care providers of the Department - Creates section creating the Office of Patient Advocacy to carry out the Patient Advocacy Program whose function is to advocate on behalf of veterans with respect to health care received and sought by veterans	
US SB 2256	- Creates the "Co-Prescribing Saves Lives Act of 2015" - Requires the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense to establish health care provider training guidelines which shall address, at a minimum, best practices for appropriate and effective prescribing of pain medications, principles of pain management, the misuse potential of controlled substances, identification of potential substance use disorders and referral for further evaluation and treatment, and proper methods for disposal	11/5/2015 – Read twice and referred to committee on Health, Education, Labor, and Pensions
AL HB 133	Amends § 34-24-604 to provide that there will be no additional registration or renewal fees for additional practice locations for pain management clinics	4/28/2015 – Pending third reading on day 18; favorable from Health and Human Services
AL SB 167	Amends § 34-24-604 to provide that there will be no additional registration or renewal fees for additional practice locations for pain management clinics	5/12/2015 – Approved by Governor; effective September 1, 2015

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CO HB 1214	Directs the Colorado Consortium for Prescription Drug Abuse Prevention to study the barriers to the use of abuse-deterrent opioid analgesic drug products as a way to reduce abuse and diversion of opioid drug products and report their findings to certain committees on or before January 15, 2017	5/11/2015 – Signed by Governor; effective on signing
CT HB 5528	Seeks to amend Title 20 to require each health care provider who is authorized to prescribe narcotic drugs to complete one hour of continuing education during each license registration period on the topic of controlled substances AMENDMENT deletes provisions related to prescribing issues	4/16/2015 – Favorable report, tabled for the calendar
CT HB 6279	Seeks to amend the general statutes to require that health care providers who are authorized to prescribe controlled substances complete continuing education courses in prescription drugs and pain management	2/27/2015 – Public hearing scheduled for 3/4/2015
CT HB 6856	- Amends §§ 20-10b, 20-94d to provide that physician and advanced practice registered nurse licensees applying for renewal shall earn a minimum of 50 hours of continuing education every two years including at least one contact hour of training or education in each of six specific areas, including prescribing controlled substances and pain management - Amends § 20-126c to provide that dentist licensees applying for renewal shall earn a minimum of 25 hours of continuing education every two years, including not less than one hour of training or education in any four of ten mandatory topics for continuing education as well as one contact hour of training or education in prescribing controlled substances and pain management - Amends § 19a-88 to provide that physician assistant licensees must complete not less than one contact hour of training or education in prescribing controlled substances and pain management in the preceding two year period prior to renewal - Amends § 17a-667, provision creating Connecticut Alcohol and Drug Policy Council, to move it from the Office of Policy and Management to the Department of Mental Health and Addiction - Deletes the Secretaries of Higher Education, Motor Vehicles, and Transportation from the list of council members	6/30/2015 – Signed by Governor; effective on passage with the exception of continuing education requirements, which became effective 10/1/2015

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	- Adds Commissioner on Aging, the Chairperson of the Board of Regents for Higher Education, the president of the University of Connecticut - Provides that the chairpersons may jointly appoint up to seven individuals to the council as follows: 1) two individuals in recovery or representing an advocacy group for individuals with a substance use disorder; 2) a provider of community-based substance abuse services for adults; 3) a provider of community-based substance abuse services for adolescents; 4) an addiction medicine physician; 5) a family member of an individual in recovery; 6) an emergency medicine physician practicing in a Connecticut hospital	
FL HB 27	Amends §§ 458.3265 and 459.0137 to provide that no one may prescribe any controlled substance on the premises of a registered pain management clinic unless he or she is a physician licensed in Florida	6/19/2015 – Died in Health Policy
FL HB 281	Amends §§ 458.3265 and 459.0137 to provide that no one may prescribe any controlled substance on the premises of a registered pain management clinic unless he or she is a physician licensed in Florida	4/28/2015 – Died on calendar
2016 FL HB 423	Amends §§ 458.3265 and 459.0137 to provide that no one may prescribe any controlled substance on the premises of a registered pain management clinic unless he or she is a physician licensed in Florida	1/22/2016 – Placed on calendar
FL HB 897	Amends §§ 458.3265 and 459.0137 to provide that the department shall deny registration to any pain management clinic owned by or with any contractual or employment relationship with a physician whose DEA number has been revoked; whose application for a license to prescribe, dispense, or administer a controlled substance has been denied in any jurisdiction; or who has been convicted of or pled guilty or nolo contendere to, an offense that constitutes a felony for receipt of illicit or diverted drugs	5/14/2015 – Approved by Governor; effective on signing
FL HB 4017	Deletes sunset provisions from §§ 458.3265 and 459.0137 related to pain management clinics	4/21/2015 – Substituted by SB 450; laid on the table
2016 FL SB 210	- Amends §§ 458.3265 and 459.0137 to provide that no one may dispense medication or prescribe any controlled substance on the premises of a registered pain management clinic unless he or she is a physician licensed in Florida	1/12/2016 – Introduced

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	- Amends § 458.347 to provide that physician assistants must complete three hours of continuing education in the safe and effective prescribing of controlled substances	
FL SB 450	Deletes sunset provisions from §§ 458.3265 and 459.0137 related to pain management clinics	5/21/2015 – Approved by Governor; effective upon signing
2016 FL SB 428	- Amends §§ 458.3265 and 459.0137 to provide that no one may dispense medication or prescribe any controlled substance on the premises of a registered pain management clinic unless he or she is a physician licensed in Florida - Amends § 458.347 to provide that physician assistants must complete three hours of continuing education in the safe and effective prescribing of controlled substances	10/7/2015 – Withdrawn prior to introduction
FL SB 614	Amends §§ 458.3265 and 459.0137 to provide that no one may prescribe any controlled substance on the premises of a registered pain management clinic unless he or she is a physician licensed in Florida	5/1/2015 – Died on calendar
2016 FL SB 676	- Amends §§ 458.3265 and 459.0137 to provide that no one may dispense medication or prescribe any controlled substance on the premises of a registered pain management clinic unless he or she is a physician licensed in Florida - Amends § 458.347 to provide that physician assistants must complete three hours of continuing education in the safe and effective prescribing of controlled substances	1/27/2016 – Now in Appropriations
2016 FL SB 1182	Amends §§ 458.3265 and 459.0137 to provide that the department shall deny registration to any pain management clinic owned by or with any contractual or employment relationship with a physician whose DEA number has been revoked; whose application for a license to prescribe, dispense, or administer a controlled substance has been denied in any jurisdiction; or who has been convicted of or pled guilty or nolo contendere to, an offense that constitutes a felony for receipt of illicit or diverted drugs	1/12/2016 – Introduced
GA HB 179	Amends § 43-34-283 to add certified registered nurse anesthetists acting within the scope of their practice to the list of medical professionals who may be on site to allow a pain management clinic to provide medical treatment or services	2/3/2015 – House second readers
GA HB 212	Amends § 43-34-283 to add certified registered nurse anesthetists acting within the scope of their practice to the list of medical professionals who may be on site to allow a	3/11/2015 – Senate read and referred

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	pain management clinic to provide medical treatment or services	
GA HB 407	Creates new § 43-34-291 which provides that when a Schedule II or III substance is prescribed to a patient for a period greater than 90 consecutive days for the treatment of chronic non-malignant pain, a pain management clinic shall require the patient, or a minor patient's parent or guardian, to complete Opioid Education and Pro-Active Addiction Counseling at least once every three months during the course of such treatment	2/23/2015 – House second readers
GA HB 564	Creates § 43-34-46 which provides that on and after July 1, 2015, physicians licensed to practice medicine shall complete at least five hours of continuing education biennially in the ordering and use of controlled substances and the risks and indicators regarding development of addiction to controlled substances	4/2/2015 – House withdrawn, recommitted
HI SB 798	- Creates new section that provides that a chronic pain medication agreement shall be executed between a patient and any prescriber of a narcotic drug for use as pain medication whenever a patient is determined to have chronic pain and is prescribed a narcotic drug for three months or longer - Requires the administrator to develop a template that shall include, at a minimum, the following: 1) informed consent to treat the patient with scheduled medication on a chronic basis greater than three months, excluding hospice, that acknowledges the long term risks of the chronic use of a narcotic drug as pain medication; 2) consent to submit to random pill counts; 3) a statement that advises the patient of the risk of injury when exceeding three grams of acetaminophen on a daily basis in combination products; 4) a statement that advises the patient of the risk of injury when exceeding a morphine equivalent dose of 120 per day or combinations of the same with benzodiazepines; 5) a statement recommending a single pharmacy and identifying this pharmacy for all patients receiving pain medications - Does not apply to emergency room and urgent care providers or hospice, palliative care, or terminally ill patients and their providers	12/17/2015 – Carried over to 2016 regular session
HI SB 1229	- Creates § 329-A which provides for the establishment of a narcotics enforcement and prescription drug monitoring advisory committee whose members shall include: a	1/21/2016 – Carried over to 2016 regular

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	physician specializing in pain medicine, a physician specializing in family medicine, a physician specializing in internal medicine, a physician or psychologist specializing in substance use and addiction, and a registered pharmacist - Committee shall advise and assist the department of public safety narcotics enforcement division by: 1) monitoring and reviewing statewide statistics regarding drug prescriptions, including patient and provider information; 2) identifying the top 20% of prescribers; 3) ascertaining whether the state has met community standards of care and specialty standards of care and coordinating with the state medical board if there are any deviations from the standard of care; 4) providing recommendations regarding state-designated pain programs, opioid-use policy, continuing medical education requirements concerning drug prescriptions, and the Hawaii drug take-back and education initiative program - Creates § 329-C which provides for the establishment of a narcotics advisory committee whose members shall include four physicians licensed to prescribe prescription drugs and a pharmacist - Committee shall recommend acceptable continuing medical education program topics and curriculum to the department's narcotics enforcement division, which shall qualify for the per cycle credits required by the continuing medical education requirements - Creates § 329-D which provides for the establishment of a mandatory continuing education requirement for all prescribing practitioners who prescribe narcotic drugs, namely that prescribing practitioners shall earn four credits every two years to maintain the practitioner's DEA license, topics and curricula to be determined by the narcotics advisory committee - Creates § 329-___ which provides that a pain medication agreement shall be executed between a patient and any prescriber of a narcotic drug for use as pain medication whenever the patient is determined to have chronic pain and is prescribed a narcotic drug for use as pain medication for three months or longer, or any time the patient is prescribed a narcotic drug for use as pain medication in the patient's first encounter with the prescriber - Administrator shall develop a pain medication agreement template which shall include, at a minimum, the following:	session; re-referred to committee

	1) informed consent to treat patient with scheduled medication on a chronic basis longer than three months, excluding hospice, that acknowledges the long-term risks of the chronic use of a narcotic drug as pain medication; 2) consent to submit to random pill counts; 3) consent to drug testing a minimum of three times per year; 4) a list of insurers in the state that offer coverage for drug testing; 5) a statement that advises the patient of the risk of injury when exceeding a morphine equivalent dose of 120 per day or combinations with benzodiazepines; 6) a statement that advises the patient of the risk of injury when exceeding 3g of acetaminophen on a daily basis in combination products; 7) a statement recommending a single pharmacy and identifying the pharmacy for all patients receiving chronic pain medications; and 8) a statement that any patient violating the law shall be guilty of a felony - Amends § 329-1, definitions, to include definition for "chronic pain therapy," which means at least three months of continuous treatment for chronic pain	
IN HB 1449	Creates § 12-15-35.5-9 to provide that the office may not reimburse Medicaid for Subutex, Suboxone, or an equivalent or generic of the drug if the drug was prescribed for the treatment of pain or pain management, unless the practitioner is a physician who: 1) obtained a waiver from SAMSHA and meets the qualifying standards to treat opioid addicted patients in an office-based setting, and 2) has a valid DEA registration number and a DEA identification number that specifically authorizes treatment in an office-based setting	4/20/2015 – Senate advisors appointed
IN HB 1614	- Amends § 25-22.5-13-3 to include a definition for "practitioner" - Further amends § 25-22.5-13-3 to provide that, before November 1, 2015, the Indiana board of pharmacy or any other board, commission, or agency that controls, authorizes, or oversees controlled substance registrations shall adopt emergency rules to establish standards and protocols for practitioners who prescribe opioids for pain management - Provides that, before November 1, 2016, the board of pharmacy or other board, commission, or agency that controls, authorizes, or oversees controlled substance registrations shall adopt permanent rules to establish	1/22/2015 – First reading; referred to committee on Public Health

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	standards and protocols for practitioners who prescribe opioids for pain management - Further provides that no permanent rule adopted as required above may be amended unless the proposed amendment has been approved by the medical licensing board	
IN HR 71	Resolution urging the Centers for Medicare and Medicaid Services to revise survey measures included in the Hospital Consumer Assessment of Healthcare Providers and Systems that relate to the treatment of pain to revise the survey measures to better address the topic of pain management	4/27/2015 – First reading; adopted voice vote
2016 IN SB 214	Creates § 12-15-35.5-9 to provide that the office may not reimburse Medicaid for Subutex, Suboxone, or an equivalent or generic of the drug if the drug was prescribed for the treatment of pain or pain management, unless the practitioner is a physician who: 1) obtained a waiver from SAMSHA and meets the qualifying standards to treat opioid addicted patients in an office-based setting, and 2) has a valid DEA registration number and a DEA identification number that specifically authorizes treatment in an office-based setting AMENDMENT changes to language to indicate that the office may not reimburse Medicaid for Subutex, Suboxone, or a similar trade name or generic of the drug if the drug is only indicated for addiction treatment and was prescribed for the treatment of pain or pain management	2/1/2016 – Third reading: passed
IN SB 439	Creates § 12-15-35.5-9 to provide that the office may not reimburse Medicaid for Subutex, Suboxone, or an equivalent or generic of the drug if the drug was prescribed for the treatment of pain or pain management, unless the practitioner is a physician who: 1) obtained a waiver from SAMSHA and meets the qualifying standards to treat opioid addicted patients in an office-based setting, and 2) has a valid DEA registration number and a DEA identification number that specifically authorizes treatment in an office-based setting	3/3/2015 – First reading in House; referred to committee on Public Health
IN SB 464	- Creates new § 12-15-35.5-7.5 which provides that the office and a managed care organization may reimburse under Medicaid for methadone if the drug was prescribed for the treatment of pain or pain management only as follows: 1) if the daily dosage is not more than 60mg; 2) if the daily dosage is more than 60mg if prior authorization is	5/5/2015 – Signed by Governor; effective on signing

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	obtained and a determination of medical necessity has been shown by the provider - Creates new § 25-22.5-13-6 which provides that, if a prescriber is prescribing methadone for a patient for the treatment of pain or pain management, the prescriber shall include on the prescription or order that the prescription is for the treatment of pain - Creates new chapter § 27-8-32.4 which provides that a policy of accident and sickness insurance may provide coverage for methadone if the drug is prescribed for the treatment of pain or pain management only as follows: 1) if the daily dosage is not more than 60mg; 2) if the daily dosage is more than 60mg and prior authorization is obtained and a determination of medical necessity has been shown by the provider - Creates new § 27-13-7-20.4 which provides that an individual contract or group contract that is entered into, amended, or renewed after June 30, 2015 may provide coverage for methadone if the drug is prescribed for the treatment of pain or pain management only as follows: 1) if the daily dosage is not more than 60mg; 2) if the daily dosage is more than 60mg and prior authorization is obtained and a determination of medical necessity has been shown by the provider	
IN SB 534	Amends § 25-22.5-13-3 to provide that, before January 1, 2016, the Indiana board of pharmacy or any other board, commission, or agency that controls, authorizes, or oversees controlled substance registrations shall adopt regulations for prescribing opioid controlled substances for pain management treatment; however, if such rules are not able to be adopted by January 1, 2016, such agency shall adopt emergency rules and shall replace any such emergency rules with permanent rules by January 1, 2017 AMENDMENT – - Amends § 25-22.5-13-2 to provide that the medical licensing board shall adopt rules to establish standards and protocols for the prescribing of controlled substances, including the use of abuse deterrent formulas - Amends § 25-22.5-13-3 to provide that, before March 1, 2016, the board concerning physician assistants, the board of podiatric medicine, the state board of dentistry, and the board of nursing concerning advanced practice nurses shall adopt rules necessary to complement rules for prescribing	4/23/2015 – Signed by Governor; effective on signing

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	opioid controlled substances for pain management treatment adopted by the board under sections 1 and 2 of this chapter - Further provides that the above named boards shall provide a report in electronic format to the legislative council providing a status report on efforts to adopt the rules which includes a copy of the board's rulemaking docket and a reasonable estimate of the timetable for action required	
KY HB 329	- Amends § 218A.175 to provide that a pain management facility qualifying for an exemption whose ownership has been continuously held jointly and exclusively by practitioners having full and active licenses to practice in Kentucky since April 24, 2012 may: 1) open and operate no more than two additional facilities in locations other than those existing and operating on April 24, 2012; 2) transfer whole or partial ownership between existing practitioner owners; 3) transfer whole or partial ownership interests to new owners if the new owners are physicians having full and active licenses to practice in Kentucky and the facility notifies the cabinet of the transfer 30 days before it occurs; and 4) pass the ownership interest of a deceased former owner through that person's estate to a physician having a full and active license to practice in Kentucky without disqualifying the facility's grandfathered status	3/20/2015 – Signed by Governor
ME HP 684	Creates new section that provides that a prescriber may prescribe an extended release hydrocodone bitartrate to a patient if s/he specifies, in the prescription, the maximum daily dose and, prior to prescribing, the prescriber must query the PMP, schedule a follow-up visit with the patient, and assess the patient's pain to evaluate the likelihood that the patient's pain can be managed with a medication other than an extended release hydrocodone bitartrate	5/20/2015 – Placed in legislative files, dead
MA HB 930	- Creates 111 § 233 which creates a commission on acupuncture and wellness whose purpose is to investigate and make a comprehensive study of the potential for better integrated use of acupuncture to expand access, reduce health care costs, and provide improved quality of care to citizens - Commission is charged with, among other duties, considering strategies to evaluate and implement effective integration of acupuncture services in health care delivery	10/13/2015 – Hearing scheduled for 10/20/2015

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	with specific focus on interventions in pain management, substance abuse treatment, and wellness promotion - Creates 175 § 47HH, 176A § 8JJ, 176B § 4JJ to provide that all individual or group accident and health insurance policies and health service contracts, any contracts between a subscriber and a corporation under an individual or group hospital service plan, and any subscription certificates under an individual or group medical service agreement delivered, issued, or renewed by an insurer or nonprofit health service corporation which provides benefits to individual subscribers and members or to all group members having a principal place of employment in Massachusetts shall provide benefits for acupuncture and oriental medicine based diagnoses and treatment in the areas of pain management, PTSD, substance abuse treatment, and nausea - Creates 175 § 205A, to provide that the commissioner shall not approve a policy that does not provide benefits for acupuncture and oriental medicine based diagnoses and treatment in the areas of pain management, PTSD, substance abuse treatment, and nausea - Creates 176G § 4BB which provides that any group health maintenance contract shall provide coverage for acupuncture and oriental medicine based diagnosis and treatment in the areas of pain management, PTSD, substance abuse treatment, and nausea	
MA HB 2060	Amends 94C § 23 to provide that: - Schedule II prescriptions will become invalid 90 days after written - No Schedule II or III prescription shall be filled for more than a 90 day supply upon any single filling	7/14/2015 – Hearing scheduled for 7/14/2015
MA HB 3811	- Prohibits pharmacies and pharmacists from issuing, dispensing, or distributing medications or prescriptions containing oxycontin to any person under the age of 17 - Prohibits practitioners, registered nurses, or licensed practical nurses from prescribing any medication or prescription containing oxycontin to any person under the age of 17	10/16/2015 – Hearing scheduled for 10/22/2015
MA HB 3817	- Amends 94C § 18 to provide that practitioners who prescribe controlled substances, except veterinarians, shall be required, as a prerequisite to obtaining or renewing their professional license, to complete appropriate training relative to effective pain management, identification of	12/30/2015 – Accompanied a new draft; see HB 3926

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	patients at high risk for substance abuse, and counseling patients about the side effects, addictive nature, and proper storage and disposal of prescription medications and that the relevant boards shall require at least five hours of training relative to those topics every two years - Creates 94C § 19D which provides that a practitioner shall not issue a prescription for more than a 72-hour supply of an opiate to a patient the first time he prescribes an opiate to that patient unless, in the professional medical judgment of the practitioner, more than a 72-hour supply is required to stabilize the patient's emergency medical condition, then the practitioner may issue a prescription for the quantity needed to stabilize the patient and the condition shall be documented in the patient's medical record and the practitioner shall indicate that a non-opiate was not appropriate	
MA HB 3926	- Amends 94C § 1, definitions, to include definition for "extended-release long-acting opioid in a non-abuse deterrent form," which means a drug that is subject to the FDA Risk Evaluation and Mitigation Strategy for Extended Release and Long-Acting Opioid Analgesics and an opioid approved for medical use that does not meet the requirements for listing as a drug with abuse-deterrent properties, and which is identified as posing a heightened level of public health risk - Amends 94C § 18 to provide that practitioners who prescribe controlled substances, shall be required, as a prerequisite to obtaining or renewing a professional license, to complete appropriate training relative to: 1) effective pain management; 2) identification of patients at risk for substance use disorders; 3) counseling patients about the side effects, addictive nature, and proper storage and disposal of prescription medications; and 4) opioid antagonists, overdose prevention treatments, and instances in which a patient may be advise on both the use of and ways to access opioid antagonists and overdose prevention treatments - Creates 94C § 18A which provides that the secretary of health and human services shall establish a voluntary non-opiate directive that shall indicate to all prescribers, health care providers, and facilities that an individual shall not be administered or offered a prescription or medication order	1/13/2016 – New draft substituted; see HB 3924

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	for an opiate which can be revoked by the patient at any time - Creates 94C § 19D which provides that, when issuing an opiate prescription for an adult patient for the first time, a practitioner shall not issue such prescription for more than a 7-day supply and shall not issue an opioid prescription to a minor for more than a 7-day supply at any time - Further provides that if, in the professional medical judgment of the practitioner, more than a 7-day supply of an opiate is required to stabilize the patient's emergency medical condition, or the opiate is prescribed for chronic pain management, pain associated with a cancer diagnosis, or for palliative care, then the practitioner may issue a prescription for the quantity needed to stabilize the patient's condition and such condition shall be documented in the patient's medical record	
MA HB 3944	- Repeals 17 § 14, advisory council on alcoholism - Amends 17 § 19 to provide that, upon admission to a substance use disorder treatment program, the provider must acquire informed consent from each patient regarding the risks and benefits of all medication assisted treatment, including information on FDA approved medication assisted treatment and the availability of such treatments in each geographic region of the Commonwealth, as well as the risks and benefits of not receiving treatment - Further amends 17 § 19 to provide that substance use disorder treatment providers must provide information to the patient prior to discharge regarding the patient's option to file a voluntary non-opiate directive form - Amends 38 § 16 to provide that acute hospitals shall file a monthly report with the commissioner of public health which shall include: 1) the number of infants born in the previous month identified by the hospital as having been exposed to a Schedule I or II controlled substance or those substances in Schedule III identified as posing a heightened risk of harm to the public; and 2) the number and specific causes of hospitalizations caused by ingestion of those substances - Amends 94C § 1, definitions, to add a definition for "extended-release long-acting opioid in a non-abuse deterrent form," which means a drug that is subject to the FDA extended release and long-acting opioid analgesics risk evaluation and mitigation strategy, an opioid approved	1/13/2016 – Published as amended; see HB 3947

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	for medical use that does not meet the requirements for listing as a drug with abuse deterrent properties, and is identified as posing a heightened level of public health risk - Amends 94C § 18 to provide that prescribers who prescribe an extended-release long-acting opioid in a non-abuse deterrent form, or any immediate release opioid, shall note in the patient's record the reasons for prescribing such an opioid over other forms of pain management - Further provides that practitioners who are authorized to prescribe controlled substances, excluding veterinarians, shall be required, as a prerequisite to obtaining or renewing their professional licenses, to complete appropriate training relative to: 1) effective pain management; 2) identification of patients at risk for substance use disorders; 3) counseling patients on the side effects, addictive nature, and proper storage and disposal of prescription medications; and 4) opioid antagonists, overdose prevention treatments and instances in which a patient may be advised on both the use of and ways to access opioid antagonists and overdose prevention treatments - Creates 94C § 18A which provides for the creation of a voluntary non-opiate directive form by the department which shall indicate to all practitioners that an individual shall not be administered or offered a prescription or medication order for an opiate - Further provides that, prior to signing a voluntary non-opiate directive, a practitioner shall assess the patient's personal and family history of alcohol and drug abuse and evaluate the patient's risk for substance abuse or a practitioner believes in the practitioner's expert medical opinion that for any other reason the directive is appropriate - Further provides that the patient may revoke the directive at any time - Creates 94C § 19D which provides that, when issuing a prescription for an opiate for an adult patient for outpatient use for the first time, a practitioner shall not issue a prescription for more than a 7-day supply - Further provides that a practitioner shall not issue a prescription for more than a 7-day supply to a minor at any time - Further provides that if, in the practitioner's professional medical judgment, more than a 7-day supply of an opiate is	

	required to treat an adult or minor patient's acute medical condition, or is necessary for the treatment of chronic pain management, pain associated with a cancer diagnosis, or for palliative care, then the practitioner may issue a prescription for the quantity needed to treat said condition, which condition shall be documented in the patient's medical record and the practitioner shall indicate that a non-opiate alternative was not appropriate to address the medical condition - Section does not apply to medications designed for the treatment of substance abuse or opioid dependence - Repeals 111E § 3, drug rehabilitation advisory board	
MA HB 3947	- Repeals 17 § 14, advisory council on alcoholism - Amends 17 § 19 to provide that, upon admission to a substance use disorder treatment program, the provider must acquire informed consent from each patient regarding the risks and benefits of all medication assisted treatment, including information on FDA approved medication assisted treatment and the availability of such treatments in each geographic region of the Commonwealth, as well as the risks and benefits of not receiving treatment - Further amends 17 § 19 to provide that substance use disorder treatment providers must provide regular monitoring of patient's behavior and addressing relapse risks and provide information to the patient prior to discharge about the patient's option to file a voluntary non-opiate directive form - Amends 38 § 16 to provide that acute hospitals shall file a monthly report with the commissioner of public health which shall include: 1) the number of infants born in the previous month identified by the hospital as having been exposed to a Schedule I or II controlled substance or those substances in Schedule III identified as posing a heightened risk of harm to the public; and 2) the number and specific causes of hospitalizations caused by ingestion of those substances - Amends 94C § 1, definitions, to add a definition for "extended-release long-acting opioid in a non-abuse deterrent form," which means a drug that is subject to the FDA extended release and long-acting opioid analgesics risk evaluation and mitigation strategy, an opioid approved for medical use that does not meet the requirements for listing as a drug with abuse deterrent properties, and is	1/19/2016 – Committee on conference appointed; in concurrence

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	identified by the drug formulary commission as posing a heightened level of public health risk - Amends 94C § 18 to provide that prescribers who prescribe an extended-release long-acting opioid in a non-abuse deterrent form, or any immediate release opioid, shall note in the patient's record the reasons for prescribing such an opioid over other forms of pain management - Further provides that practitioners who are authorized to prescribe controlled substances, excluding veterinarians, shall be required, as a prerequisite to obtaining or renewing their professional licenses, to complete appropriate training relative to: 1) effective pain management; 2) identification of patients at risk for substance use disorders; 3) counseling patients on the side effects, addictive nature, and proper storage and disposal of prescription medications; and 4) opioid antagonists, overdose prevention treatments and instances in which a patient may be advised on both the use of and ways to access opioid antagonists and overdose prevention treatments - Creates 94C § 18A which provides for the creation of a voluntary non-opiate directive form by the department which shall indicate to all practitioners that an individual shall not be administered or offered a prescription or medication order for an opiate - Further provides that, prior to signing a voluntary non-opiate directive, a practitioner shall assess the patient's personal and family history of alcohol and drug abuse and evaluate the patient's risk for substance abuse or a practitioner believes in the practitioner's expert medical opinion that for any other reason the directive is appropriate - Further provides that the patient may revoke the directive at any time - Creates 94C § 19D which provides that, when issuing a prescription for an opiate for an adult patient for outpatient use for the first time, a practitioner shall not issue a prescription for more than a 7-day supply - Further provides that a practitioner shall not issue a prescription for more than a 7-day supply to a minor at any time - Further provides that if, in the practitioner's professional medical judgment, more than a 7-day supply of an opiate is required to treat an adult or minor patient's acute medical	

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	condition, or is necessary for the treatment of chronic pain management, pain associated with a cancer diagnosis, or for palliative care, then the practitioner may issue a prescription for the quantity needed to treat said condition, which condition shall be documented in the patient's medical record and the practitioner shall indicate that a non-opiate alternative was not appropriate to address the medical condition - Section does not apply to medications designed for the treatment of substance abuse or opioid dependence - Repeals 111E § 3, drug rehabilitation advisory board	
MA SB 1032	Prohibits pharmacies in Massachusetts from issuing prescriptions for medications containing opioids	9/17/2015 – Hearing scheduled for 9/24/2015
MA SB 1041	- Amends 94C § 1, definitions, to include definitions for "extended-release long-acting opioid or in an extended release form," which means a drug subject to the FDA Risk Evaluation and Mitigation Strategy for Extended-Release and Long-Acting Opioid Analgesics and "non-abuse deterrent opioid or in a non-abuse deterrent form" which means an opioid drug product that is approved for medical use but that does not meet the requirements for listing as a drug with abuse-deterrent properties - Amends 94C § 7 which provides that the department shall establish a specialty designation to registrations which shall give authorization to a practitioner to issue a prescription for an extended-release long-acting opioid in a non-abuse deterrent form; such designation may only be issued to a practitioner licensed in Massachusetts who is actively practicing and who has completed appropriate continuing medical education credits in pain management and in substance abuse prevention - Amends 94C § 18 to provide that a prescription for a narcotic substance that poses a heightened level of public health risk shall only be issued by a practitioner who has received a specialty designation and who is currently enrolled in and compliant with all the requirements of the PMP; however, no such prescription shall be issued in an emergency department setting - Creates 94C § 18A which provides that, for a prescription for a Schedule II or III substance that has not been identified as posing a heightened level of risk to the public	7/22/2015 – Hearing scheduled for 7/28/2015

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	health, a prescription issued by a practitioner in an emergency department shall not exceed a five day supply - Further provides that, for a prescription for a Schedule II or III substance that has not been identified as posing a heightened level of risk to the public health, an initial prescription – to be defined by regulation – shall be limited to a 15 day supply and a subsequent prescription issued within 60 days of the initial prescription shall not exceed an additional 15 day supply and no combination of initial and subsequent prescriptions may exceed a total 30 day supply unless the practitioner: 1) evaluates the patient's current condition, risk factors, history of substance abuse, if any, and current medications; 2) makes a determination that other pain treatments are or would be inadequate for the patient; 3) uses the PMP prior to issuing the prescription; and 4) enters into a pain management agreement - Further provides that, prior to issuing a prescription for an opioid drug identified as posing a heightened level of risk to the public health, a practitioner shall: 1) evaluate the patient's current condition, risk factors, history of substance abuse, if any, and current medications; 2) make a determination that other pain management treatments, including drugs presenting a lower risk for abuse or misuse, are or would be inadequate for the patient; 3) use the PMP; 4) enter into a pain management treatment agreement - Amends 94C § 22 to provide that a practitioner who dispenses, by issuing a written prescription, an extended-release long-acting opioid in a non-abuse deterrent form that has been identified as posing a heightened level of risk to the public health, shall prepare appropriate documentation of the medical need for said product and a statement of the practitioner's professional judgment that other treatments are not suitable for the patient which shall be placed in the patient's medical file - Amends 94C § 24A to add a requirement that the board enact regulations that include requiring participants who are duly authorized to prescribe high risk drugs to use the PMP prior to each issuance of such a prescription	
MA SB 1231	- Creates 111 § 233 which creates a commission on acupuncture and wellness whose purpose is to investigate and make a comprehensive study of the potential for better	9/29/2015 –

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	integrated use of acupuncture to expand access, reduce health care costs, and provide improved quality of care to citizens - Commission is charged with, among other duties, considering strategies to evaluate and implement effective integration of acupuncture services in health care delivery with specific focus on interventions in pain management, substance abuse treatment, and wellness promotion - Creates 175 § 47EE, 176A § 8GG, 176B § 4GG to provide that all individual or group accident and health insurance policies and health service contracts, any contracts between a subscriber and a corporation under an individual or group hospital service plan, and any subscription certificates under an individual or group medical service agreement delivered, issued, or renewed by an insurer or nonprofit health service corporation which provides benefits to individual subscribers and members or to all group members having a principal place of employment in Massachusetts shall provide benefits for acupuncture and oriental medicine based diagnoses and treatment in the areas of pain management, PTSD, substance abuse treatment, and nausea - Creates 175 § 205A to provide that the commissioner shall not approve a policy that does not provide benefits for acupuncture and oriental medicine based diagnoses and treatment in the areas of pain management, PTSD, substance abuse treatment, and nausea - Creates 176G § 4Y which provides that any group health maintenance contract shall provide coverage for acupuncture and oriental medicine based diagnosis and treatment in the areas of pain management, PTSD, substance abuse treatment, and nausea	Hearing rescheduled to 9/29/2015
MA SB 2010	- Amends 17 § 13 to provide that the commission shall identify and publish a list of non-opioid drugs that have been approved by the FDA that are effective pain management alternatives and have lesser potential for abuse that an opioid drug product and shall provide for distribution of the list and revisions to the list among prescribers and dispensers - Amends 17 § 19 to provide that a patient being discharged from a substance use disorder treatment program shall be provided information about the patient's option to voluntarily record a non-opiate directive	10/1/2015 – Substituted by SB 2020, amended

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	- Amends 94C § 1 to add definitions for "extended-release long-acting opioid," which means a drug that is subject to the FDA's Extended Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy and includes any opioid in an extended-release form, and "non-abuse deterrent opioid," which means an opioid drug product that is approved for medical use but does not meet the requirements for listing as a drug with abuse-deterrent properties, which shall include any drug in a non-abuse deterrent form - Amends 94C § 18 to provide that a prescription for a Schedule II or III narcotic substance may be filled by a pharmacist in a lesser quantity than that prescribed if the person presenting the prescription requests a lesser quantity - Creates 94C § 18A which provides that, prior to issuing a prescription for an opioid identified as posing a heightened level of public health risk, a practitioner shall: 1) evaluate the patient's condition, risk factors, history of substance abuse, if any, and current medications; 2) make a determination that other pain management treatments, including drugs presenting a lower risk for abuse or misuse, would be inadequate to treat the patient; 3) utilize the PMP prior to issuing the prescription; 4) enter into a pain management treatment agreement - Creates 94C § 18B which provides that the secretary of health and human services shall establish a voluntary non-opiate directive that shall indicate to all prescribers, health care providers, and facilities that an individual shall not be administered or offered a prescription or medication order for an opiate which can be revoked by the patient at any time - Amends 94C § 21A to provide that a pharmacist shall give notice to any person who presents for filling a prescription for a Schedule II or III narcotic substance that the person may choose to receive a lesser quantity of the prescribed substance than the quantity indicated on the prescription - Amends 94C § 22 to provide that a practitioner who dispenses, by issuing a written prescription, an extended-release long-acting opioid drug in a non-abuse deterrent form shall prepare appropriate documentation of the medical need for the drug and a statement of the	

	practitioner's professional judgment that other treatments or drugs are not suitable for the patient which documentation shall be placed in the patient's medical file - Creates 112 § 5N which provides that the board shall, by regulation, establish qualifications, standards, and criteria no less stringent than the credentialing criteria by the American Academy of Pain Management for certification as a pain management specialist - Creates 175 § 47II which provides that any policy, contract, agreement, plan, or certificate of insurance issued, delivered, or renewed within Massachusetts shall provide for: 1) a plan for the minimum coverage and adequate access to pain management services that provide alternatives to narcotic substance prescribing; 2) a plan developed based on clinical evidence and in consultation with health care practitioners for reasonable controls and safeguards on potentially addictive opiate prescription drugs - Creates 176A § 8KK, 176B § 4KK, 176G § 4CC which provide, respectively, that any contract between a subscriber and the corporation under an individual or group hospital service plan; any subscription certificate under an individual or group medical service agreement; any individual or group health maintenance contract which is delivered, issued, or renewed shall provide for: 1) a plan for the minimum coverage and adequate access to pain management services that provide alternatives to narcotic substance prescribing; 2) a plan developed based on clinical evidence and in consultation with health care providers for reasonable controls and safeguards on potentially addictive opiate prescription drugs - Creates a special commission to examine the feasibility of establishing a pain management access program, with the goal of increasing access to pain management by allowing primary care providers to arrange pain management consultations and temporary services by specialists for patients in need of comprehensive non-opiate pain management resources	
MA SB 2020	- Amends 17 § 13 to provide that the commission shall identify and publish a list of non-opioid drugs that have been approved by the FDA that are effective pain management alternatives and have lesser potential for abuse that an opioid drug product and shall provide for	10/1/2015 – Passed to be engrossed

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	distribution of the list and revisions to the list among prescribers and dispensers - Repeals 17 § 14, advisory council on alcoholism - Amends 17 § 19 to provide that a patient being discharged from a substance use disorder treatment program shall be provided information about the patient's option to voluntarily record a non-opiate directive - Amends 94C § 1 to add a definition for "extended-release long-acting opioid in a non-abuse deterrent form" which means a drug that is: 1) subject to the FDA's Extended Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy; 2) an opioid approved for medical use but does not meet the requirements for listing as a drug with abuse-deterrent properties; and 3) identified as posing a heightened level of public health risk - Amends 94C § 18 to provide that practitioners who prescribe controlled substances, except veterinarians, shall be required, as a prerequisite to obtaining or renewing a professional license, to complete appropriate training relative to: 1) effective pain management; 2) identification of at risk patients; 3) counseling patients about the side effects, addictive nature, and proper storage and disposal of prescription medications; and 4) appropriate prescription quantities for prescription medicines that have an increased risk of abuse - Creates 94C § 18A which provides that, prior to issuing an extended-release long-acting opioid in a non-abuse deterrent form, a practitioner shall: 1) evaluate the patient's condition, risk factors, history of substance abuse, if any, and current medications; 2) provide a statement that the prescription, in the prescriber's medical opinion, is an appropriate course of treatment; 3) utilize the PMP prior to issuing the prescription; 4) in the event of long term pain management, enter into a pain management treatment agreement - Creates 94C § 18B which provides that the secretary of health and human services shall establish a voluntary non-opiate directive that shall indicate to all prescribers, health care providers, and facilities that an individual shall not be administered or offered a prescription or medication order for an opiate which can be revoked by the patient at any time	

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	- Amends 94C § 21A to provide that a pharmacist shall give notice to any person who presents for filling a prescription for an opiate contained in Schedule III that the person may choose to receive a lesser quantity of the prescribed substance than the quantity indicated on the prescription - Creates 175 § 47HH which provides that any policy, contract, agreement, plan, or certificate of insurance issued, delivered, or renewed within Massachusetts shall provide for: 1) a plan for the minimum coverage and adequate access to pain management services that provide alternatives to narcotic substance prescribing; 2) a plan developed based on clinical evidence and in consultation with health care practitioners for reasonable controls and safeguards on potentially addictive opiate prescription drugs - Creates 176A § 8JJ, 176B § 4JJ, 176G § 4BB which provide, respectively, that any contract between a subscriber and the corporation under an individual or group hospital service plan; any subscription certificate under an individual or group medical service agreement; any individual or group health maintenance contract which is delivered, issued, or renewed shall provide for: 1) a plan for the minimum coverage and adequate access to pain management services that provide alternatives to narcotic substance prescribing; 2) a plan developed based on clinical evidence and in consultation with health care providers for reasonable controls and safeguards on potentially addictive opiate prescription drugs - Creates a special commission to examine the feasibility of establishing a pain management access program, with the goal of increasing access to pain management for patients in need of comprehensive pain management resources	
MA SB 2022	- Amends 17 § 13 to provide that the commission shall identify and publish a list of non-opioid drugs that have been approved by the FDA that are effective pain management alternatives and have lesser potential for abuse that an opioid drug product and shall provide for distribution of the list and revisions to the list among prescribers and dispensers - Repeals 17 § 14, advisory council on alcoholism	11/12/2015 – Committee recommended ought to pass and referred to committee on House Ways and Means

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	- Amends 17 § 19 to provide that a patient being discharged from a substance use disorder treatment program shall be provided information about the patient's option to voluntarily record a non-opiate directive - Amends 38 § 16 to provide that acute hospitals shall file a monthly report with the commissioner of public health which shall include: 1) the number of infants born in the previous month identified by the hospital as having been exposed to a Schedule I or II controlled substance or those substances in Schedule III identified as posing a heightened risk of harm to the public; and 2) the number and specific causes of hospitalizations caused by ingestion of those substances - Amends 94C § 1 to add a definition for "extended-release long-acting opioid in a non-abuse deterrent form" which means a drug that is: 1) subject to the FDA's Extended Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy; 2) an opioid approved for medical use but does not meet the requirements for listing as a drug with abuse-deterrent properties; and 3) identified as posing a heightened level of public health risk - Amends 94C § 18 to provide that a pharmacist filling a prescription for a Schedule II opioid shall dispense the prescribed substance in any quantity requested by the patient, not to exceed the quantity indicated on the prescription - Amends 94C § 18 to provide that practitioners who prescribe controlled substances, except veterinarians, shall be required, as a prerequisite to obtaining or renewing a professional license, to complete appropriate training relative to: 1) effective pain management; 2) the risks of abuse and addiction associated with opioid medication; 3) identification of at risk patients; 4) counseling patients about the side effects, addictive nature, and proper storage and disposal of prescription medications; 5) appropriate prescription quantities for prescription medicines that have an increased risk of abuse; and 6) opioid antagonists, overdose prevention treatments, and instances when a patient might be advised on both the use of and ways to access opioid antagonists and overdose prevention treatments - Creates 94C § 18A which provides that, prior to issuing an extended-release long-acting opioid in a non-abuse	

	deterrent form, a practitioner shall: 1) evaluate the patient's condition, risk factors, history of substance abuse, if any, and current medications; 2) provide a statement that the prescription, in the prescriber's medical opinion, is an appropriate course of treatment; 3) utilize the PMP prior to issuing the prescription; 4) in the event of long term pain management, enter into a pain management treatment agreement - Creates 94C § 18B which provides that the secretary of health and human services shall establish a voluntary non-opiate directive that shall indicate to all prescribers, health care providers, and facilities that an individual shall not be administered or offered a prescription or medication order for an opiate which can be revoked by the patient at any time - Creates 94C § 18C which provides that, prior to issuing a prescription for a Schedule II opioid, a practitioner shall: 1) consult with the patient regarding the quantity of the opioid and the patient's option to fill the prescription in a lesser quantity; and 2) inform the patient of the risks associated with the opioid prescribed - Amends 94C § 21A to provide that a pharmacist shall give notice to any person who presents for filling a prescription for an opiate contained in Schedule II or III that the person may choose to receive a quantity of the prescribed substance up to the quantity indicated on the prescription - Amends 94C § 22 to provide that any prescription written by a practitioner for an opioid in Schedule II shall be written by the practitioner "up to" a recommended full quantity - Creates 111 § 236 to provide that, prior to prescribing an opioid to a minor, the prescriber shall have received informed consent from the parent or guardian of the minor, except in the case of a medical emergency and shall obtain a signed consent form - Repeals 111E § 3, drug rehabilitation advisory board - Creates 175 § 47HH which provides that any policy, contract, agreement, plan, or certificate of insurance issued, delivered, or renewed within Massachusetts shall provide for: 1) a plan for the minimum coverage and adequate access to pain management services that provide alternatives to narcotic substance prescribing; 2) a plan	

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	developed based on clinical evidence and in consultation with health care practitioners for reasonable controls and safeguards on potentially addictive opiate prescription drugs - Creates 176A § 8JJ, 176B § 4JJ, 176G § 4BB which provide, respectively, that any contract between a subscriber and the corporation under an individual or group hospital service plan; any subscription certificate under an individual or group medical service agreement; any individual or group health maintenance contract which is delivered, issued, or renewed shall provide for: 1) a plan for the minimum coverage and adequate access to pain management services that provide alternatives to narcotic substance prescribing; 2) a plan developed based on clinical evidence and in consultation with health care providers for reasonable controls and safeguards on potentially addictive opiate prescription drugs - Creates a special commission to examine the feasibility of establishing a pain management access program, with the goal of increasing access to pain management for patients in need of comprehensive pain management resources	
MA SB 2103	- Amends 17 § 13 to provide that the commission shall identify and publish a list of non-opioid drug products that have been approved by the FDA that are effective pain management alternatives and have a lesser potential for abuse than an opioid drug - Further provides that the commission shall provide for distribution, including electronic distribution, of the list and shall revise the list not less frequently than annually - Repeals 17 § 14, advisory council on alcoholism - Amends 17 § 19 to provide that a patient being discharged from a substance use disorder treatment program shall be provided information about the patient's option to voluntarily record a non-opiate directive - Amends 38 § 16 to provide that acute hospitals shall file a monthly report with the commissioner of public health which shall include: 1) the number of infants born in the previous month identified by the hospital as having been exposed to a Schedule I or II controlled substance or those substances in Schedule III identified as posing a heightened risk of harm to the public; and 2) the number	1/19/2016 – See HB3947

	and specific causes of hospitalizations caused by ingestion of those substances - Amends 94C § 1 to add a definition for "extended-release long-acting opioid in a non-abuse deterrent form" which means a drug that is: 1) subject to the FDA's Extended Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy; 2) an opioid approved for medical use but does not meet the requirements for listing as a drug with abuse-deterrent properties; and 3) identified as posing a heightened level of public health risk - Amends 94C § 18 to provide that a pharmacist filling a prescription for a Schedule II opioid shall dispense the prescribed substance in any quantity requested by the patient, not to exceed the quantity indicated on the prescription - Amends 94C § 18 to provide that practitioners who prescribe controlled substances, except veterinarians, shall be required, as a prerequisite to obtaining or renewing a professional license, to complete appropriate training relative to: 1) effective pain management; 2) the risks of abuse and addiction associated with opioid medication; 3) identification of at risk patients; 4) counseling patients about the side effects, addictive nature, and proper storage and disposal of prescription medications; 5) appropriate prescription quantities for prescription medicines that have an increased risk of abuse; and 6) opioid antagonists, overdose prevention treatments, and instances when a patient might be advised on both the use of and ways to access opioid antagonists and overdose prevention treatments - Creates 94C § 18A which provides that, prior to issuing an extended-release long-acting opioid in a non-abuse deterrent form, a practitioner shall: 1) evaluate the patient's condition, risk factors, history of substance abuse, if any, and current medications; 2) provide a statement that the prescription, in the prescriber's medical opinion, is an appropriate course of treatment; 3) utilize the PMP prior to issuing the prescription; 4) in the event of long term pain management, enter into a pain management treatment agreement - Creates 94C § 18B which provides that the secretary of health and human services shall establish a voluntary non-opiate directive that shall indicate to all prescribers, health	

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	for the minimum coverage and adequate access to pain management services that provide alternatives to narcotic substance prescribing; 2) a plan developed based on clinical evidence and in consultation with health care providers for reasonable controls and safeguards on potentially addictive opiate prescription drugs - Creates a special commission to examine the feasibility of establishing a pain management access program, with the goal of increasing access to pain management for patients in need of comprehensive pain management resources	
MO HB 1077	- Creates § 334.290 which provides that a pain management clinic shall mean a privately owned clinic, facility, or office in which any licensed health care provider provides treatment for chronic non-malignant pain to a majority of its patients for 90 days or more in a 12-month period or a privately owned clinic, facility, or office that advertises in any medium for pain management services of any type - Further provides that, for purposes of determining whether a clinic, facility, or office qualifies as a pain management clinic, the entire caseload of patients who received care from any physician, osteopath, advanced practice registered nurses, and physician assistants who serve in the clinic, facility, or office shall be counted - Requires that any pain management clinic not affiliated with a hospital shall be owned by a Missouri licensed physician who is certified in pain management	5/11/2015 – Reported do pass
2016 MO HB 1608	- Creates § 197.600 which provides that a pain management clinic shall mean a privately owned clinic, facility, or office in which health care providers provide chronic non-malignant pain treatment through pharmacotherapy to a majority of patients for 90 days or more in a 12-month period or a privately owned clinic, facility, or office that advertises in any medium for pain management services through pharmacotherapy - Provides that chronic pain management services through pharmacotherapy shall not include surgical or obstetrical anesthesia services, postoperative pain control, or interventional pain management procedures and techniques - Further provides that, for purposes of determining whether a clinic, facility, or office qualifies as a pain management clinic, the entire caseload of patients who	1/19/2016 – Public hearing completed

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	received care from any physician, advanced practice registered nurses, physician assistants, and assistant physicians who serve in the clinic, facility, or office shall be counted - Prohibits any owner or employee of a pain management clinic who has previously been denied or had a restricted license to prescribe, dispense, administer, supply, or sell a controlled substance, or been subject to discipline by any licensing entity for conduct that was the result of inappropriately prescribing, dispensing, administering, supplying, or selling a controlled substance - Pain management clinics may not operate unless such clinic has been issued a pain management clinic certificate by the department of health and senior services - Requires the department of health and senior services to promulgate rules and regulations pertaining to the operation and licensure of pain management clinics, which rules and regulations shall include, but not be limited to: the certification process and any required fees; required hours of operation; required licenses and certifications of staff and staffing levels; record keeping and patient chart requirements; and a requirement to participate in any prescription drug monitoring program in Missouri	
NV SB 459	Creates new sections that provide that the various licensing boards may, by regulation, require each physician, physician assistant, dentist, advanced practice registered nurse, osteopathic physician, podiatrist, or optometrist who is registered to dispense controlled substances complete at least 1 hour of training relating specifically to the misuse and abuse of controlled substances during each period of licensure	5/5/2015 – Approved by Governor; effective May 1, 2015 and October 1, 2015
2016 NH HB 1423	- Creates new § 318-B:39 which requires that various boards submit to the joint legislative committee on administrative rules final proposed rules for prescribing controlled substances, specifically opioids, for the management or treatment of pain before September 1, 2016 - Requires that the rules contain, at a minimum, mandatory standards for the following practice components: 1) conducting and documenting a complete patient evaluation and risk assessment to determine whether a patient is an appropriate candidate for a controlled substance prescription for the management or treatment of pain;	1/12/2016 – Public hearing scheduled for 1/19/2016

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	complete patient evaluation shall include the completion of an assessment of the pain or anticipated pain in the case of prescribing opioids in advance of a surgical procedure, a physical examination, and a detailed medical and substance abuse history; a patient may be prescribed a controlled substance for the treatment or management of chronic pain only when: a) other measures have not resolved the patient's pain or, in the professional judgment of the prescriber, will not resolve the pain; b) the potential benefits outweigh the potential harm; c) there is no contraindication; 2) using the PMP when writing an initial controlled substance prescription and then periodically as circumstances dictate; 3) limiting prescriptions based on the patient evaluation, risk assessment, and review of the PMP, which limitations shall include, but not be limited to: a) allowing no more than a 5-day supply in an emergency department or urgent care setting; b) only prescribing long-acting opioids for pain after the use of short-acting opioids has been used or considered; c) prescribing the lowest possible dosage and titrating slowly; 4) documenting informed consent; 5) documenting controlled substance agreements, which shall include, at a minimum: a) the patient's agreement to provide samples for drug screening on request; b) patient's agreement to take medications at the dose and frequency prescribed; c) conduct that triggers discontinuation or tapering of opioid prescriptions; d) requirement that chronic pain management prescriptions are provided by a single practice and pharmacy; 6) periodically reviewing patients to ascertain compliance with treatment agreements; 7) providing that patients addicted to controlled substances shall be considered for referral to addiction treatment; 8) providing that medical records shall include, at a minimum, the medical history, physical examination, diagnostic, therapeutic, and laboratory results, evaluations and any consultations, treatment objectives, discussion of the risks and benefits, informed consent, treatments, medications, including type, dosage, and quantity prescribed, and details of periodic reviews; 9) creating exemptions for certain types of patients; 10) providing that failure to comply will constitute unprofessional conduct; 11) demonstrating competency in the area of pain management or opioid prescribing every 2 years through obtaining at least 4 hours	

	of continuing education or passing an approved online examination	
NH SB 45	Creates new § 281-A:23-c which provides that benefits paid under worker's compensation shall not be paid for the use of opioids for more than 90 days within any 6-month period unless the health care provider and patient enter into an opioid treatment agreement which shall include: 1) the medical basis for the use of opioids; 2) a statement of the risks and benefits; 3) the employee's agreement to seek opioids only from the health care provider with whom the agreement is made and to not share the medication with others; 4) the name of the single pharmacy at which the prescriptions will be filled; 5) the employee's agreement to forego controlled substances not included in the agreement; 6) permission for the provider to conduct random blood or urine tests; 7) a statement of the consequences of violating the agreement	5/28/2015 – House report filed
NJ AB 4760	- Amends § 24:21-15 to provide that, prior to issuing a prescription for a Schedule II controlled dangerous substance or any opioid drug which is a prescription drug, a practitioner shall discuss with a patient who is under 18 years of age and is an emancipated minor or with the patient's parent or guardian if the patient is under 18 years and unemancipated, the risks of developing a physical or psychological dependence on the substance and, if the practitioner deems it appropriate, such alternative treatments as may be available - Further provides that the practitioner must obtain written acknowledgment that such discussion took place which shall be placed in the patient's medical file - Does not apply to hospice patients	11/16/2015 – Introduced, referred to Health and Senior Services committee
NJ AB 4843	- Creates new sections that require dentists, physicians, and physician assistants to complete two hours of continuing education, as a condition of biennial registration, on programs or topics related to prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing pain, and the risks and signs of opioid abuse, addiction, and diversion - Creates new sections that require nurses and pharmacists to complete one hour of continuing education, as a condition of biennial registration, on programs or topics related to prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing	12/10/2015 – Introduced, referred to Health and Senior Services committee

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	pain, and the risks and signs of opioid abuse, addiction, and diversion	
NJ SB 2366	- Amends § 24:21-15 to provide that, prior to issuing a prescription for a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug, a practitioner shall discuss with the patient, or the patient's parent or guardian, the risks of developing a physical or psychological dependence on the substance and alternative treatments that might be available - Further provides that the practitioner shall obtain written acknowledgment of such discussion - Does not apply to prescriptions for hospice patients	1/12/2015 – Received in Assembly, referred to Health and Senior Services committee
2016 NM HB 48	Amends § 61-10-5 to provide that the board of osteopathic medicine shall adopt and promulgate rules including rules related to the management of pain based on a review of national standards for pain management	2/1/2016 – Committee recommends do pass; referred to Health
NM HB 398	Amends § 61-10-5 to provide that the board of osteopathic medicine shall adopt and promulgate rules including rules related to the management of pain based on a review of national standards for pain management	3/13/2015 – Died
NM HM 98	A memorial requesting that the Department of Health collaborate with the University of New Mexico Health Sciences Center Pain Center to design a survey of chronic pain patients to ascertain their needs in an effort to reduce overdose deaths from prescription drugs	3/18/2015 – Signed
NM SB 22	Creates new section that provides for the establishment of a program to address prescribing of controlled substances that is suspected to be excessive or otherwise in violation of established prescribing standards, which program shall include: 1) a 24-hour hotline and publicly accessible internet website for reporting suspected excessive prescribing; 2) rules and procedures for investigating reports of suspected overprescribing	12/15/2014 – Died
NM SB 24	Appropriates $1,100,000 from the general fund for expenditure in fiscal year 2016 to support the pain management center at the University of New Mexico	2/27/2015 – Died
2016 NM SB 42	Appropriates $1,100,000 from the general fund for expenditure in fiscal year 2017 to support the pain management center at the University of New Mexico	1/27/2016 – Committee recommends do pass; referred to Finance

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2016 NM SB 78	Amends § 61-10-5 to provide that the board of osteopathic medicine shall adopt and promulgate rules including rules related to the management of pain based on a review of national standards for pain management	1/28/2016 – Found germane and referred to Public Affairs
NM SB 422	- Amends § 24-1-4.1 to provide that certified nurse midwives with prescriptive authority shall consent to peer review of their opioid prescribing practices - Amends § 24-2D-2, definitions, to add definitions for "addiction," "council," "physical dependence," "prescription drug monitoring program," "review organization," "significant adverse drug event," and "tolerance" - "Addiction" means a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of a substance for its psychic effects and includes one or more of the following behaviors: impaired control over drug use, compulsive use, continued use despite harm, and craving - "Council" means the overdose prevention and pain management council - "Physical dependence" means a state of adaptation that is manifested by a drug-specific withdrawal syndrome that can be produced by one or more of the following: abrupt cessation or rapid dose reduction of the drug, decreasing blood level of the drug, or administration of an antagonist - "Review organization" means an independent peer review organization acting pursuant to the provisions of the Pain Relief Act - "Significant adverse drug event" means a drug-related incident that results in harm or injury to, or death of, a patient - "Tolerance" means a state of adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time - Creates new section to be added to the Pain Relief Act which requires the board to adopt rules to do the following: 1) implement the Pain Relief Act; 2) to determine whether the prescriptive practices of its health care licensees are consistent with appropriate treatment of pain; 3) that address pain management for patients with substance use disorders - Requires the board to evaluate health care practitioner's pain management quality of care on the following basis: 1)	2/3/2015 – Died

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	appropriate diagnosis and evaluation; 2) appropriate medical indication for the treatment prescribed; 3) documented change or persistence of recognized medical indication; 4) follow-up evaluation with appropriate continuity of care - Creates new section to be added to the Pain Relief Act which sets out health care practitioner requirements, including: 1) that the prescribing, ordering, administering, or dispensing of controlled substances for management of chronic pain is appropriate if the health care practitioner: a) completes a physical exam including an evaluation of the patient's psychological and pain status; b) is familiar with screening tools in the evaluation and management of pain; c) provides a written treatment plan; d) discusses the risks and benefits of using controlled substances with the patient; e) maintains complete and accurate records; f) monitors the management of patients needing chronic pain control when monitoring is required; 2) if the practitioner believes that a patient is seeking pain medication for reasons that are not medically justified, the practitioner is not required to prescribe controlled substances; 3) pain management for a patient with a substance use disorder shall include: a) a contractual agreement between the practitioner and patient; b) appropriate consultation; c) drug screening; d) a schedule for reevaluation at appropriate time intervals, no less than every six months; 4) practitioners with federal and state controlled substance registrations shall: a) register with the PMP; b) obtain a patient report from the PMP before prescribing, ordering, administering, or dispensing a Schedule II – IV controlled substance if the patient is a new patient of the practitioner; c) pull a PMP report no less than every six months during the continuous use of opioids by an established patient - Makes technical amendments to §§ 24-2D-3 and 24-2D-5.2 - Creates new section to be added to the Pain Relief Act which creates the Overdose Prevention and Pain Management Council and sets out the councils powers and duties - Creates new section to be added to the Pain Relief Act which provides that, as a condition of licensure, a health care practitioner authorized to prescribe opioids shall consent to peer review of the practitioner's opioid	

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	prescribing practices and provides that the council shall contract with a review organization to perform such peer reviews - Creates new section to be added to the Pain Relief Act which sets out the confidentiality, immunity, and penalty provisions related to the review organization - Amends § 61-2-10.2 to provide that optometrists shall consent to peer review of the optometrist's prescribing practices - Amends § 61-3-23.3 to provide that certified nurse anesthetists shall consent to peer review of their opioid prescribing practices - Amends § 61-3-23.4 to provide that clinical nurse specialists with prescriptive authority shall consent to peer review of their opioid prescribing practices - Amends § 61-4-9.2 to provide that certified advanced chiropractic physicians with prescriptive authority shall consent to peer review of their opioid prescribing practices - Creates new sections in the Dental Health Care Act, Medical Practice Act, Podiatry Act, Osteopaths, Pharmacy Act, and Acupuncture and Oriental Medicine Practice Act to provide that professionals licensed by those boards who hold a federal DEA registration shall consent to peer review of their opioid prescribing practices - Amends § 61-9-17.2 to provide that a prescribing psychologist who holds a federal DEA registration shall consent to peer review of their opioid prescribing practices	
NY AB 355	- Amends Public Health Law § 3309-a to require that the commissioner of education establish standards, and review and implement requirements, for the performance of continuing medical education on pain management, palliative care, and addiction - Further provides that every health care professional licensed, registered, or certified to treat humans and registered under the federal controlled substances act and in possession of a DEA registration number shall, every two years, complete three hours of coursework in pain management, palliative care, and addiction and said hours shall count toward the professional's obligation for board certification - Provides that existing curricula may be considered, including, but not limited to: I-STOP and DEA requirements; pain management; appropriate prescribing;	1/6/2016 – Referred to Health

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	managing acute pain; palliative medicine; prevention, screening, and signs of addiction; responses to abuse and addiction; and end of life care - Provides an exemption for those who request it and can show that there would be no need for such professional to complete the coursework or training because of the nature of his or her practice or that he or she has completed equivalent coursework or training	
NY AB 1671	- Creates new Article 28-F in the Public Health Law regarding chronic pain management - Creates Public Health Law § 2899-k, definitions, and includes definitions for "chronic pain," "chronic pain care certified medical school," "chronic pain care certified residency program," "council," "health care professionals," and "professional continuing education" - Creates the state chronic pain management education and training council to be an expert panel to advise the commissioner and commissioner of education on: 1) advances in the optimum treatment, management, and best practices related to mitigating or alleviating chronic pain; 2) to promote better interdisciplinary and coordinated provision of care related to chronic pain management; 3) to develop new public policies related to advancing teaching of such new treatments, management regimens, or best practices on chronic pain management and care in chronic pain management certified medical schools and chronic pain management certified residency programs; 4) develop guidelines to assist the department in establishing materials and curricula to be used in providing professional continuing education programs for health care professionals - Sets out seven policies to be considered, examined, and possibly advanced by the council - Provides that the commissioner, in consultation with the council, may designate a chronic pain treatment and management practitioner resource center or centers which shall act as a source of technical support, information, and guidance for practitioners on the latest strategies, therapies, medications, or best practices with regard to optimum treatment and management of chronic pain - Requires the council, in consultation with the department, the education department, and health care professional organizations, to develop, compile, and publish	1/6/2016 – Referred to Higher Education

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	information and course materials on the advanced treatment and mitigation of chronic pain - Amends Education Law § 6507 to provide that there shall be established standards for pre-professional and professional education for health care professionals relating to mitigation and treatment of chronic pain and shall establish standards requiring that all health care professionals applying, on or after January 1, 2018, initially or for renewal of a license, registration, or certificate, shall have completed such coursework and training - Provides an exemption for those who request it and who can show that there is no need for him or her to complete the coursework or training because of the nature of his or her practice or because he or she has completed equivalent coursework or training	
NY AB 2230	- Creates new Article 28-F in the Public Health Law regarding chronic pain management - Creates Public Health Law § 2899-b, definitions, and includes definitions for "accepted guideline," "health care practitioner," "pain-relieving medication," "professional discipline" - Creates Public Health Law § 2899-c which provides that a health care practitioner shall not be subject to professional discipline for ordering, prescribing, administering, or dispensing pain-relieving medications or other treatments for the purpose of alleviating or controlling pain when practicing within the law scope of practice and in accordance with the reasonable standard of care - Creates Public Health Law § 2899-d which provides instances when a health care practitioner is subject to professional discipline or prosecution - Creates Public Health Law § 2899-e which provides that the article shall apply to the treatment of all patients with pain, including dying patients, patients with acute or chronic pain, regardless of past or current chemical dependency or addiction	2/2/2016 – Reported referred to Codes
NY AB 2972	- Creates new Article 28-F in the Public Health Law regarding clinical education in pain management - Creates Public Health Law § 2900 which provides that every physician, physician assistant, and specialist assistant practicing in New York shall complete course work or	1/6/2016 – Referred to Health

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	training in pain management, appropriate to the professional's practice, every four years - Provides an exemption for those who request it and can show that there would be no need for such professional to complete the course work or training because of the nature of his or her practice or that he or she has completed equivalent course work or training - Existing curricula may be considered, including, but not limited to: palliative medicine, pain, neuropsychologic and other symptoms, ethics and the law, patient and family perspectives on end-of-life care, acupuncture treatment, and clinical communication skills - Creates Public Health Law § 2900-a which creates a pain management education advisory committee - Creates Education Law § 6505-d which requires that every health care practitioner licensed or certified pursuant to law who is authorized to order, prescribe, administer, or dispense pain-relieving medications or other treatment for the relief of pain in New York (other than a physician, physician assistant, and specialist assistant) shall complete course work or training regarding pain management, appropriate to the professional's practice, every four years and further provides exemptions and criteria as to existing curricula as outlined above	
NY AB 6336	- Amends Public Health Law § 3331 to provide that baseline and periodic and/or targeted drug testing shall be utilized by clinicians prescribing prescription narcotic drugs to establish a general assessment for new patients and in monitoring adherence to existing patient treatment plans, as well as detecting the use of non-prescribed drugs - Requires that testing be conducted prior to the issuance of an initial prescription and shall include confirmatory or quantitative methods - Further provides that a clinician shall not issue a prescription for a narcotic drug in excess of a 4-day supply without first obtaining confirmatory or quantitative testing results - Requires that testing be conducted at least twice annually and patients being treated for addiction shall be tested as frequently as necessary to ensure therapeutic adherence	1/6/2016 – Referred to Health
NY AB 7812	Creates Public Health Law § 3309-b to provide that, for the first opioid analgesic prescription of a calendar year that is greater than a one week's supply, the prescribing physician	1/6/2016 – Referred to Health

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	shall counsel the patient on the risks of overdose, and inform the patient of the availability of an opioid antagonist	
NY AB 8302	Amends Public Health Law § 3309-a to provide that every health care professional licensed, registered, or certified to treat humans and registered under the federal controlled substances act and in possession of a registration number from the DEA shall, prior to renewal of registration to practice, complete three hours of coursework in pain management, palliative care and addiction, and said hours shall count toward the professional's obligation for board certification or existing continuing education requirements for licensure	1/6/2016 – Referred to Health
NY AB 9066	- Creates Education Law § 6524-a which provides that each health care practitioner licensed, registered, or certified to treat humans must comply with the continuing education provisions and practitioners who fail to do so shall not be authorized to practice until they have met such requirements unless he or she has a conditional registration - Further provides that only those practitioners who fall within the top 20% of prescribers who prescribe Schedule II – IV controlled substances as determined by a semiannual review of the PMP are subject to the continuing education requirements of this section - Provides that the practitioner must complete three hours of coursework during the registration period for an applicant which shall count toward the professional's obligation for board certification - "Coursework" means curricula established by the department of health or an existing nationally recognized curricula regarding appropriate practices for pain management, palliative care, and addiction	1/21/2016 – Referred to Higher Education
NY SB 647	Creates Public Health Law § 3351-a which provides that the department shall promulgate medical guidelines and regulations for persons authorized to distribute or dispense controlled substances for the purpose of helping patients transition from pain management substances with a high risk of addiction to pain management solutions that present a low risk of addiction or do not involve controlled substances	1/6/2016 – Referred to Health
NY SB 651	- Creates Education Law §§ 6524-a and 6905-a which provide that all physicians, in order to maintain their license in good standing, must complete three hours of	1/6/216 – Referred to Higher Education

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	continuing medical education on the prescription of opiate analgesics and psychotropic drugs and the risks of addiction in their administration - Amends Education Law § 6827 to provide that pharmacists shall complete three hours of continuing education dedicated to the prevention and mitigation of opiate analgesic and psychotropic drug addiction	
NY SB 1939	- Creates new Article 28-F in the Public Health Law regarding chronic pain management - Creates Public Health Law § 2899-k, definitions, and includes definitions for "chronic pain," "chronic pain care certified medical school," "chronic pain care certified residency program," "council," "health care professionals," and "professional continuing education" - Creates the state chronic pain management education and training council to be an expert panel to advise the commissioner and commissioner of education on: 1) advances in the optimum treatment, management, and best practices related to mitigating or alleviating chronic pain; 2) to promote better interdisciplinary and coordinated provision of care related to chronic pain management; 3) to develop new public policies related to advancing teaching of such new treatments, management regimens, or best practices on chronic pain management and care in chronic pain management certified medical schools and chronic pain management certified residency programs; 4) develop guidelines to assist the department in establishing materials and curricula to be used in providing professional continuing education programs for health care professionals - Sets out seven policies to be considered, examined, and possibly advanced by the council - Provides that the commissioner, in consultation with the council, may designate a chronic pain treatment and management practitioner resource center or centers which shall act as a source of technical support, information, and guidance for practitioners on the latest strategies, therapies, medications, or best practices with regard to optimum treatment and management of chronic pain - Requires the council, in consultation with the department, the education department, and health care professional organizations, to develop, compile, and publish	1/6/2016 – Referred to Health

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	information and course materials on the advanced treatment and mitigation of chronic pain - Amends Education Law § 6507 to provide that there shall be established standards for pre-professional and professional education for health care professionals relating to mitigation and treatment of chronic pain and shall establish standards requiring that all health care professionals applying, on or after January 1, 2018, initially or for renewal of a license, registration, or certificate, shall have completed such coursework and training - Provides an exemption for those who request it and who can show that there is no need for him or her to complete the coursework or training because of the nature of his or her practice or because he or she has completed equivalent coursework or training	
NY SB 4348	- Amends Public Health Law § 3309-a to require that the commissioner of education establish standards, and review and implement requirements, for the performance of continuing medical education on pain management, palliative care, and addiction - Further provides that every health care professional licensed, registered, or certified to treat humans and registered under the federal controlled substances act and in possession of a DEA registration number shall, every two years, complete three hours of coursework in pain management, palliative care, and addiction and said hours shall count toward the professional's obligation for board certification - Provides that existing curricula may be considered, including, but not limited to: I-STOP and DEA requirements; pain management; appropriate prescribing; managing acute pain; palliative medicine; prevention, screening, and signs of addiction; responses to abuse and addiction; and end of life care - Provides an exemption for those who request it and can show that there would be no need for such professional to complete the coursework or training because of the nature of his or her practice or that he or she has completed equivalent coursework or training	2/2/2016 – Advanced to third reading
NY SB 4812	Amends Public Health Law § 3343-a to provide that the department shall annually provide all authorized prescribers of opiates notice stating the number of	1/6/2016 – Referred to Health

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	prescriptions for opiates written by such prescriber during the previous calendar year, and the prescriber's numerical ranking and percentile ranking relative to other prescribers within each county where the prescriber practices based on such number	
NY SB 5939	Amends Public Health Law § 3309-a to provide that every health care professional licensed, registered, or certified to treat humans and registered under the federal controlled substances act and in possession of a registration number from the DEA shall, prior to renewal of registration to practice, complete three hours of coursework in pain management, palliative care and addiction, and said hours shall count toward the professional's obligation for board certification or existing continuing education requirements for licensure	1/6/2016 – Referred to Health
NC HB 97	- Requires that, by July 1, 2016, certain specified health officials and health care provider licensing boards shall adopt the North Carolina Medical Board's Policy for the Use of Opiates for the Treatment of Pain - Requires that certain specified health care provider licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances, and shall require that at least one hour consists of a course designed specifically to address prescribing practices, which course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management	9/18/2015 – Signed by Governor; effective July 1, 2015
NC HB 165	- Requires that, by July 1, 2016, certain specified health officials and health care provider licensing boards shall adopt the North Carolina Medical Board's Policy for the Use of Opiates for the Treatment of Pain - Requires that certain specified health care provider licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances, and shall require that at least one hour consists of a course designed specifically to address prescribing practices, which course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management	3/9/2015 – Referred to committee on Health

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NC SB 317	- Requires that, by July 1, 2016, certain specified health officials and health care provider licensing boards shall adopt the North Carolina Medical Board's Policy for the Use of Opiates for the Treatment of Pain - Requires that certain specified health care provider licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances, and shall require that at least one hour consists of a course designed specifically to address prescribing practices, which course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management	3/24/2015 – Re-referred to Health Care
OH HCR 16	Resolution urging the Centers for Medicare and Medicaid Services to revise survey measures included in the Hospital Consumer Assessment of Healthcare Providers and Systems that relate to the treatment of pain to revise the survey measures to better address the topic of pain management	12/3/2015 – Adopted by House; reported in Senate
OH SCR 10	Resolution urging the Centers for Medicare and Medicaid Services to revise survey measures included in the Hospital Consumer Assessment of Healthcare Providers and Systems that relate to the treatment of pain to revise the survey measures to better address the topic of pain management	9/30/2015 – Referred to committee
OR HB 2913	Repeals § 413.592 requiring persons to complete pain management education program by 2008	5/14/2015 – Signed by Governor; effective May 14, 2015
PA HB 630	- Creates new section, definitions, that includes definitions for "department," "health care facility," "health care practitioner," "health care provider," "palliative care," and "task force" - Creates new section, patients' bill of rights, that sets out the rights of patients in health care facilities - Creates new sections that establish the Pain Management and Palliative Care Task Force and set outs the duties of the task force, including: 1) to develop a plan to raise public awareness of the importance of pain management and palliative care and the patients' bill of rights; 2) to facilitate coordination of and communication among state	2/26/2015 – Referred to Health

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	and local agencies and organizations to promote palliative and pain management initiatives; 3) to research and develop a plan to ensure the availability of concurrent care for pediatric patients facing life-threatening illnesses; 4) to research and develop a plan to ensure the availability of palliative care in all hospitals; 5) to research and develop a plan to ensure that all state-sponsored medical schools have affiliations with hospital palliative care programs	
SC HB 4384	- Amends § 44-53-360 to provide that a pharmacist may dispense a Schedule II substance pursuant to a faxed prescription provided: 1) the original manually signed prescription is presented to the pharmacist for review prior to dispensing; and 2) the prescription contains the name and address of the prescribing practitioner, phone number, time and date of transmission, name of the intended pharmacy - Further provides that a faxed prescription for a Schedule II substance may serve as the original prescription if such prescription is to be dispensed to: 1) a home infusion pharmacy for compounding for the direct administration to a patient by certain methods; 2) resident of a long-term care facility; 3) patient enrolled in a hospice program; or 4) resident of a community residential care facility or assisted living facility	1/12/2016 – Referred to committee on Medical, Military, Public, and Municipal Affairs
TN HB 1157	- Amends § 63-1-301 to provide definitions for "certificate holder," "medical director," and "pain management specialist" - "Certificate holder" means a medical doctor, osteopath, advanced practice nurse, or physician assistant with an unencumbered, unrestricted license to practice in Tennessee - "Medical director" means a licensed physician who provides oversight relative to the operations of a pain management clinic and is a pain management specialist - "Pain management specialist" means a licensed physician who: 1) holds a subspecialty certification in pain medicine under the boards of anesthesia, neurology, psychiatry, or physical medicine and rehabilitation; 2) has an unencumbered license; 3) has the minimum number of continuing medical education hours to satisfy retention of certification; OR 1) has American Board of Pain Medicine diplomate status by July 1, 2016; 2) has an unencumbered	5/26/2015 – Companion bill became Pub. Ch. 475

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	license; 3) has the minimum number of continuing medical education hours to satisfy retention of diplomate status - Amends § 63-1-306 to provide that each physician serving as the medical director at a pain management clinic shall either have successfully completed a residency program and board certification in anesthesiology, neurology, physical medicine, and rehabilitation and psychiatry or have status as a diplomate who is qualified to take the ABPM exam until July 1, 2016 - Further amends § 63-1-306 to provide that every pain management clinic shall submit an application to the department for certification to operate the clinic; such certificate shall be issued to a certificate holder who shall be one of the owners of the clinic - Completed form shall show proof that the clinic has a medical director who is certified as a pain management specialist or meets the requirements of the ABPM and is qualified to take the examination - Amends § 63-1-309 to delete the language "twenty percent" and substituting "fifty percent"	
TN HB 1731	- Creates new section that provides that, in the case of a pain management clinic that fails to maintain records when the records would be used to determine if a practice or facility is eligible to be licensed as a pain management clinic, the penalty for failure to maintain the records shall be assessed under Title 63, Chapter 1, Part 3 rather than any other law - Creates new section that provides penalties for operating a pain management clinic without a license and authorizes the commissioner to authorize an investigation of any person to the extent necessary to determine if the person is engaged in the unlawful operation of a pain management clinic and, further, allows the commissioner to apply for injunctive relief - Creates new section that provides that, in those cases where the conditions of any pain management clinic are, or are likely to be, detrimental to the health, safety, or welfare of the patient, the commissioner is authorized to suspend treatment of any new or existing patients to the clinic pending a reasonably prompt hearing before an administrative judge - Further provides that the commissioner may revoke the suspension at any time prior to a hearing based on	1/26/2016 – Assigned to Health subcommittee

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	information that the commissioner receives showing that such conditions have been and will continue to remain corrected - Commissioner shall notify the clinic of the suspension within ten days and shall notify the clinic what conditions are considered detrimental to the patients and an explanation of the specific time frame when, and conditions under which, the clinic can reasonably expect the suspension to be lifted - Clinic shall submit a corrective action plan within ten days of receiving notice and, if such corrective action is taken, the commissioner shall lift the suspension - Creates new section that requires the medical director of each pain clinic to report annually to the department of health the following: 1) the number of physician assistants and advanced practice nurses who are working in the clinic each month; 2) the number of pain patients seen each month; 3) the number of patients being treated at the clinic who have overdosed; 4) the number of patients who have died during the year; 5) whether the pain clinic is part of or associated with a hospital; and 6) the number of morphine milligram equivalent daily doses per patient per clinic - Creates new section that provides that, after January 1, 2017, no person shall operate a pain management clinic unless the person obtains a license from the department and is registered with the state as the certificate holder - Further provides that the department shall inspect each clinic annually to ensure compliance - Sets out application requirements and reasons for suspension or revocation of a license - Provides that, on or after July 1, 2016, an owner or operator of a pain management clinic shall not locate or participate in locating a pharmacy in which the owner or operator has an ownership interest in a location that is adjacent to the location of the clinic; doing so will result in revocation of the license - Amends § 63-1-309 to provide that medical director shall be on-site at least 50% of the time - Creates new sections to provide that the board of medical examiners and board of osteopathic physicians shall contract with the department of health to annually inspect pain management clinics, and the locations of practices of physicians in order to assess providers for compliance	

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TN HB 1982	Amends § 63-1-301 to provide that a pain management specialist is one who is board certified by the American Board of Interventional Pain Physicians and holds an unencumbered Tennessee license and maintains the minimum number of continuing education hours in pain management to satisfy retention of ABIPP diplomate status, provided that on or after July 1, 2016, new applicants shall not qualify as a pain management specialist under this subdivision	1/27/2016 – Assigned to Criminal Justice subcommittee
TN HB 2351	Requires the commissioner of health to report to the health committee of the house of representatives and the health and welfare committee of the senate annually concerning revisions to the treatment guidelines and pain clinic guidelines made as part of a required review	
TN HB 2464	Amends § 63-1-301 to provide that a pain management specialist includes one who has been certified as an addiction specialist by the American Board of Addiction Medicine, holds an unencumbered Tennessee license, and maintains the minimum number of continuing medical education hours in pain management	1/27/2016 – Assigned to Health subcommittee
TN SB 1266	- Amends § 63-1-301 to provide definitions for "certificate holder," "medical director," and "pain management specialist" - "Certificate holder" means a medical doctor, osteopath, advanced practice nurse, or physician assistant who practices in Tennessee with an unencumbered, unrestricted license; anyone with an ownership interest in a pain management clinic shall be eligible to be the certificate holder - "Medical director" means a physician who provides oversight relative to the operations of a pain management clinic and is a pain management specialist - "Pain management specialist" means a physician who holds an unencumbered Tennessee license and who: 1) has a subspecialty certification in pain management and maintains the minimum number of continuing education hours in pain management to satisfy retention of certification; OR 2) attains American Board of Pain Medicine diplomate status by July 1, 2016 and maintains the minimum number of continuing education hours in pain management to satisfy retention of diplomate status - Amends § 63-1-306 to provide that each physician serving as a medical director at a pain management clinic	5/15/2015 – Signed by Governor; effective July 1, 2015

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	shall meet at least one of the following: 1) successful completion of a residency program or ABMS or AOA board certification in anesthesiology, neurology, physical medicine, and rehabilitation and psychiatry, or 2) status as an ABPM diplomate who is qualified to take the ABPM exam until July 1, 2016 - Further amends § 63-1-306 to provide that every pain management clinic shall submit an application to the department for a certificate to operate the clinic, which shall be awarded to a certificate holder who shall be one of the owners of the clinic; further provides that the application shall show proof that the clinic has a medical director who is either a certified pain management specialist or meets the requirements of the ABPM and is qualified to take the ABPM examination - Amends § 63-1-309 to provide that a medical director shall be on-site at a pain management clinic 50% of the clinic's weekly total number of operating hours	
TN SB 1466	- Creates new section that provides that, in the case of a pain management clinic that fails to maintain records when the records would be used to determine if a practice or facility is eligible to be licensed as a pain management clinic, the penalty for failure to maintain the records shall be assessed under Title 63, Chapter 1, Part 3 rather than any other law - Creates new section that provides penalties for operating a pain management clinic without a license and authorizes the commissioner to authorize an investigation of any person to the extent necessary to determine if the person is engaged in the unlawful operation of a pain management clinic and, further, allows the commissioner to apply for injunctive relief - Creates new section that provides that, in those cases where the conditions of any pain management clinic are, or are likely to be, detrimental to the health, safety, or welfare of the patient, the commissioner is authorized to suspend treatment of any new or existing patients to the clinic pending a reasonably prompt hearing before an administrative judge - Further provides that the commissioner may revoke the suspension at any time prior to a hearing based on information that the commissioner receives showing that	1/27/2016 – Placed on Senate Health and Welfare committee calendar for 2/3/2016

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	such conditions have been and will continue to remain corrected - Commissioner shall notify the clinic of the suspension within ten days and shall notify the clinic what conditions are considered detrimental to the patients and an explanation of the specific time frame when, and conditions under which, the clinic can reasonably expect the suspension to be lifted - Clinic shall submit a corrective action plan within ten days of receiving notice and, if such corrective action is taken, the commissioner shall lift the suspension - Creates new section that requires the medical director of each pain clinic to report annually to the department of health the following: 1) the number of physician assistants and advanced practice nurses who are working in the clinic each month; 2) the number of pain patients seen each month; 3) the number of patients being treated at the clinic who have overdosed; 4) the number of patients who have died during the year; 5) whether the pain clinic is part of or associated with a hospital; and 6) the number of morphine milligram equivalent daily doses per patient per clinic - Creates new section that provides that, after January 1, 2017, no person shall operate a pain management clinic unless the person obtains a license from the department and is registered with the state as the certificate holder - Further provides that the department shall inspect each clinic annually to ensure compliance - Sets out application requirements and reasons for suspension or revocation of a license - Provides that, on or after July 1, 2016, an owner or operator of a pain management clinic shall not locate or participate in locating a pharmacy in which the owner or operator has an ownership interest in a location that is adjacent to the location of the clinic; doing so will result in revocation of the license - Amends § 63-1-309 to provide that medical director shall be on-site at least 50% of the time - Creates new sections to provide that the board of medical examiners and board of osteopathic physicians shall contract with the department of health to annually inspect pain management clinics, and the locations of practices of physicians in order to assess providers for compliance	

TN SB 1794	Amends § 63-1-301 to provide that a pain management specialist includes one who has been certified as an addiction specialist by the American Board of Addiction Medicine, holds an unencumbered Tennessee license, and maintains the minimum number of continuing medical education hours in pain management	1/21/20106 – Passed on second consideration, refer to Senate Health and Welfare committee
TN SB 2057	Amends § 63-1-301 to provide that a pain management specialist includes one who is board certified by the American Board of Interventional Pain Physicians by passing exam 1 on or before June 30, 2016, and who holds an unencumbered Tennessee license, and maintains the minimum number of continuing education hours in pain management to satisfy retention of ABIPP diplomate status; however, on or after July 1, 2016, new applicants shall not qualify under this section	1/25/2016 – Passed on second consideration, refer to Senate Health and Welfare committee
TN SB 2148	Adds new section to provide that the prescribing of oxycontin is unlawful in Tennessee except that it may be prescribed by: 1) a board-certified oncologist; 2) an anesthesiologist who has completed a fellowship in pain management; or 3) a physician treating an existing patient who is prescribed oxycontin as of the effective date of the act; however, this provision shall expire one year after the effective date of the act	1/25/2016 – Passed on second consideration, refer to Senate Health and Welfare committee
TN SB 2192	Requires the commissioner of health to report to the health committee of the house of representatives and the health and welfare committee of the senate annually concerning revisions to the treatment guidelines and pain clinic guidelines made as part of a required review	1/25/20106 – Passed on second consideration, refer to Senate Health and Welfare committee
TX HB 3200	- Amends § 481.074 to provide that a pharmacist may not dispense or deliver an opioid pain medication, or cause an opioid pain medication to be dispensed or delivered under the pharmacist's direction or supervision, more than a 10-day supply of an opioid pain medication for that patient in a 60-day period unless the pharmacist receives a form indicating that the prescribing physician intends the patient to be treated for pain for a period longer than 10 days or that the patient requires treatment with opioid medication before the expiration of the 60-day period beginning on the date the patient's previous prescription for opioid pain medication was filled	3/23/2015 – Referred to Public Health

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	- Provides that a pharmacist may partially fill a prescription for an opioid pain medication for more than a 10-day supply without the form and shall inform the physician that the remainder of the prescription is canceled - Further provides that a pharmacist may not fill a subsequent prescription for an opioid pain medication within the 60-day period without the required form	
TX SB 1235	- Amends Occupations Code § 168.001 to include a definition for "operator," which means an owner, medical director, or physician affiliated or associated with the pain management clinic in any capacity - Amends Occupations Code § 168.201 to provide that a person who owns or operates a pain management clinic is engaged in the practice of medicine and includes, but is not limited to, all supervision and delegation activities related to the clinic	6/15/2015 – Signed by Governor; effective September 1, 2015
VT HB 573	- Creates 8 § 4088k which provides that, to the extent a health insurance plan provides coverage for medically necessary diagnosis and treatment related to pain management, anxiety and PTSD, substance use disorder, and nausea, an acupuncturist licensed according to law who acts within his or her authorized scope of practice shall not be denied reimbursement by the health insurer for providing those covered services if the health insurer would reimburse another health care provider for providing the services - Further provides that the insurer may require that the services provided by the acupuncturist be provided under contract with the insurer	1/19/2016 – Read first time and referred to committee on Health Care
VT SB 243	- Amends 26 § 1400 to provide that licensees for renewal of an active license to practice medicine shall complete at least one hour of continuing medical education on the topic of hospice care, palliative care, or pain management services, or a combination of those - Further provides that licensees who prescribe controlled substances shall obtain one hour of continuing medical education on the topic of safe and effective prescribing of controlled substances, and licensees who prescribe or are likely to prescribe opioid controlled substances, as determined by the board, shall complete an additional hour of continuing education on the appropriate use of opioids, including the use of complementary and alternative therapies instead of opioids to treat chronic pain	1/5/2016 – Read first time and referred to committee on Health and Welfare

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2016 VA HB 829	- Amends § 54.1-2523 to provide that the PMP may release information to the Board of Medicine about prescribers who meet a certain threshold for prescribing covered substances for the purpose of requiring relevant continuing education, which threshold shall be determined by the board - Amends § 54.1-2912.1 to provide that the board shall require prescribers identified pursuant to § 54.1-2523 to complete two hours of continuing education in each biennium on topics related to pain management, the responsible prescribing of covered substances, and the diagnosis and management of addiction	2/2/2016 – House vote, block vote passage
VA HB 2358	Amends §§ 54.1-2709 (related to dentists), 54.1-2912.1 (related to medical board licensees) and 54.1-3219 (related to optometrists) to require those boards promulgate regulations requiring their licensees to complete continuing education on the topics of substance abuse, addiction, and related pain management and prescribing practices	2/11/2015 – Left in Health, Welfare and Institutions
VA HJR 630	Resolution directing that the Health Insurance Reform Commission study mandating health insurance coverage for abuse deterrent formulations for opioid medications and, in conducting said study, the Commission shall examine the issues of access by citizens to effective pain management medications and the need to require adoption of abuse deterrent formulation technologies for pain medicines in order to assist the continuing efforts to eliminate substance and prescription drug abuse	2/25/2015 – Bill text as passed House and Senate
WA HB 2304	Creates new section that provides the board of naturopathy shall adopt pain management rules appropriate for acute pain treatment based on the "interagency guideline on prescribing opioids for pain" published by the Washington state agency medical directors' group including, but not limited to, patient examination, screening for comorbidities and risk factors, and maximum dosage limits and treatment periods	1/15/2016 – Public hearing in the House committee on Health Care and Wellness
WA SB 5815	Creates new section that provides the board of naturopathy shall adopt pain management rules appropriate for acute pain treatment, including, but not limited to, patient examination and screening for comorbidities and risk factors	1/11/2016 – By resolution, reintroduced and retained in present status
WV SB 270	- Amends § 16-5H-2 to provide that a pain management clinic is a privately owned clinic where, in any month, more than 60% of patients are prescribed or dispensed	1/21/2015 –

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	opioids or other controlled substances for chronic pain resulting from non-malignant conditions	Referred to Health and Human Resources
WI AB 366	- Creates § 50.60 which provides definitions for "health care provider," "interventional pain medicine," "pain clinic," "pain medicine," and "pain syndrome" - "Interventional pain medicine" means the branch of medicine and surgery devoted to the diagnosis and treatment of pain syndromes through the use of invasive techniques - "Pain clinic" means: 1) a privately owned facility where a majority of the health care providers, practicing within the scope of their licenses, devotes a majority of their practices to the treatment of pain syndromes through the practice of pain medicine or interventional pain medicine or 2) a privately owned facility that advertises or holds itself out as providing pain medicine or interventional pain medicine services and that has one or more employees or contractors who prescribe opioids or opiates, benzodiazepines, barbiturates, or carisoprodol as chronic therapy for pain syndromes - "Pain medicine" means the branch of medicine devoted to the diagnosis and treatment of pain syndromes through treatments, including prescriptions of monitored prescription drugs - "Pain syndrome" means any of the following: 1) pain that is reasonably anticipated to persist, or has persisted, beyond the time frame for normal healing; 2) pain that is reasonably anticipated to persist, or has persisted, for more than three months - Creates § 50.65 which provides that 1) no pain clinic may operate unless it holds a department issued certificate to do so; 2) pain clinics must submit an application to the department for certification; business entities may submit a single application for all pain clinics it owns but must submit with the application a listing of each pain clinic site, the number of days each week each pain clinic operates, and the health care providers who are working on each day of operation at each site; 3) requires that pain clinics that undergo a change of majority ownership submit a new application for certification; 4) requires that the clinic have a medical director who is a physician practicing	1/26/2016 – Report correctly enrolled

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	in Wisconsin; 5) provides penalties for failing to notify the department if the clinic no longer meets the certification requirements - Further provides that pain clinics may only accept payments by insurance coverage, credit, credit card, check, draft, or another form of payment that is traceable (meaning capable of allowing a person to ascertain, retain, and verify personally identifiable information, including, at a minimum, the first and last name, home address, and date of birth of a payer in connection with a payment) to the person seeking treatment at the pain clinic and shall retain records of payment, except that a person seeking treatment for which a claim is submitted to an insurance company may pay to the pain clinic any insurance copayment, coinsurance, or deductible with cash or another payment method that is not traceable - Further provides that a pain clinic may not directly dispense a monitored prescription drug that is administered orally unless any of the following are true: 1) the pain clinic is licensed as a pharmacy, or 2) the pain clinic is treating an individual for a condition or complaint reasonably related to a condition for which the individual claims worker's compensation	
WI SB 272	- Creates § 50.60 which provides definitions for "advanced practice nurse prescriber," "health care provider," "pain clinic," and "physician assistant" - "Pain clinic" means a privately owned facility at which a physician, APN prescriber, PA, or other health care provider with prescribing privileges, who prescribes controlled substances, provides pain management services to patients, a majority of whom are prescribed opioids or opiates, benzodiazepines, barbiturates, or carisoprodol and provides prescriptions for more than 90 days in a 12-month period or any privately owned facility or office that advertises or otherwise holds itself out as providing pain management services and that has one or more employees or contractors who prescribe a controlled substance for pain management - Creates § 50.65 which provides that 1) no pain clinic may operate unless it holds a department issued certificate to do so; 2) pain clinics must submit an application to the department for certification and each location must be certified separately; 3) requires that pain clinics that	10/21/2015 – Fiscal estimate received

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	undergo a change of majority ownership submit a new application for certification; 4) requires that the clinic have a medical director who is a physician practicing in Wisconsin; 5) provides penalties for failing to notify the department if the clinic no longer meets the certification requirements; 6) requires that clinics annually report to the legislature a) the ratio of pain clinic staff to the number of patients receiving pain treatment; b) the number of patients receiving pain treatment who are also receiving behavioral health services; c) the clinic staff's plan for tapering individuals off of pain medications, if applicable; d) the average mileage that patients receiving pain treatment in the clinic are traveling to receive treatment at that clinic; e) ensure that all information provided does not permit identification of individual patients - Further provides that, prior to prescribing a pain medication, a physician or other health care provider at a pain clinic shall review a patient's records in the PMP for use of other pain medications - Provides that the provisions related to pain clinics do not apply to a: medical or dental school, nursing school, physician assistant training program, hospital, hospice, or nursing home	