

Tennessee Pain Clinic Guidelines

The Pain Clinic Guidelines are to define the indicators of good practice and the roles and responsibilities of the medical directors/providers of a pain clinic. Standards for pain clinics will foster quality pain care for the citizens of Tennessee suffering from chronic pain. The nature of chronic pain requires a biopsychosocial approach to care for this complex patient population. As there are multiple care models to deliver biopsychosocial treatment for chronic pain patients, these guidelines will focus on indicators of good practice instead of specific aspects of any one model of care.

Pain clinics should use opioids when other treatments have been found to be inadequate and should use opioids sparingly. Pain clinics should utilize all reasonable and available chronic pain options and provide opioid alternative options for chronic, nonmalignant pain patients. Opioids should be considered as a last resort option for chronic, nonmalignant pain. Reevaluation of treatment and updates to treatment plans should be ongoing. Patients in end of life situations (palliative care or terminal illness) and cancer pain patients may be offered opioids as clinically indicated.

Clinics that prescribe opioids and benzodiazepines to over 50% of their patients must be licensed as a pain management clinic with the state of Tennessee. A pain clinic that routinely treats chronic pain patients with opioids without investigating other treatments fails to meet basic standards for a pain medicine clinic.

Medical Directors, Pain Specialists, Owners of a Pain Clinic

“Medical Director” as define by T.C.A. § 63-1-301 means an individual who:

- (A) Is licensed as a physician under chapter 6 or 9 of this title, and who practices in this state with an unrestricted, unencumbered license;
- (B) Provides oversight relative to the operations of a pain management clinic; and
- (C) Is a pain management specialist on or after July 1, 2016;
- (D) Medical Director holds the license of the pain management clinic.

“Pain management specialist” as define by T.C.A., § 63-1-301 means a physician licensed under chapter 6 or 9 of this title who: (A)(i) Has a subspecialty certification in pain medicine as accredited by the Accreditation Council for Graduate Medical Education (ACGME) through either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA), or is eligible to sit for the board examination offered by ABMS or AOA;

- (ii) Holds an unencumbered Tennessee license; and
 - (iii) Maintains the minimum number of continuing medical education (CME) hours in pain management to satisfy retention of ABMS or AOA certification. Any exceptions to this requirement shall be approved by the respective regulatory board;
- (B)(i) Attains American Board of Pain Medicine (ABPM) diplomate status;
- (ii) Holds an unencumbered Tennessee license; and
 - (iii) Maintains the minimum number of CME hours in pain management to satisfy retention of ABPM diplomate status. Any exceptions to this requirement shall be approved by the respective regulatory board;
- (C) Is board certified by the American Board of Interventional Pain Physicians(ABIPP) by passing exams 1& 2 and holds an unencumbered Tennessee license and maintains the minimum number of CME hours in pain management to satisfy retention of ABIPP diplomate status; or

(D) Has an active pain management practice in a clinic accredited in outpatient interdisciplinary pain rehabilitation by the commission on accreditation of rehabilitation facilities or any successor organization and holds an unencumbered Tennessee license.

An Owner or License Holder is defined by T.C. A § 63-1-301 which states that a medical doctor licensed under chapter 6 of this title; an osteopathic physician licensed under chapter 9 of this title; an advanced practice nurse licensed under chapter 7 of this title, who meets the requirements contained in T.C.A. § 63-7-126; or a physician assistant licensed under chapter 19 of this title, who practices in this state with an unrestricted, unencumbered license.

Medical directors should uphold the standards of the Tennessee Chronic Pain Guidelines, Tennessee Chronic Pain Clinic Guidelines, and all subsequent updates to these guidelines for all pain clinics he or she supervises.

Medical directors and pain specialists should have a direct and supervisory role in the care of their pain patients. Direct involvement in care includes:

1. If the plan of care is initiated by a nurse practitioner or physician assistant the medical director or the pain specialist should see the new patient within 30 days of the initial evaluation when opioids are a part of the plan of care. The medical director must be actively involved in ongoing patient care. Low risk patients who receive less than 50 MMED may be followed by non-pain specialists.
2. Medical directors are responsible for establishing and documenting a system of medical oversight that ensures at least an annual face to face visit with the medical director and/or pain specialist for opioid management.

Rule 1200-34-01-.07 states: Medical directors are required to be onsite in the pain clinic at least 20% of the clinic's weekly total number of operating hours. The days and hours the medical director attends the clinic should be documented with signature readily available for inspection by the Department of Health. The medical directors should document their personal evaluation of the patient in the medical record.

Medical directors and/or pain specialists should be readily available for direct consultation and communication with their supervised nurse practitioners, physician assistants, or residents during regular clinic hours. On-site inspections by TDH should review documentation that nurse practitioners and physician assistants have a reliable and timely manner of communication with supervising physicians.

Pain Medicine Clinic Effective Practices

The following practices are considered important areas for pain medicine clinic quality of care. These practices may be used in evaluations of pain clinics, either in routine reviews or in evaluation of a complaint.

Individualized interdisciplinary care is provided with clinically appropriate and timely adjustments.

Examples of effective interdisciplinary care include (1) Medical charts show changes based on prudent interpretation of urine drug screen information; (2) Clinical assessments are well documented; (3) Rationale for decision making in treatment planning is clear in medical records; (3) Protocols that

maximize use of opioid sparing strategies are used; (4) Co-prescription of benzodiazepines is minimized and the rationale for use clear when chosen.

There is evidence of effective care coordination.

Evidence of effective care coordination includes: (1) Appropriate referral to other specialists in a timely manner; (2) Appropriate follow up of referrals; (3) Absence of referral to a pharmacy in which the clinic has a financial interest; (4) Medical directors have a direct supervisory role in the care of their patients; and (5) The patient assessment and plan of care is documented and kept current; and (6) The clinic accepts referrals from the community.

There is evidence of timely screening for substance use disorder and referral as clinically appropriate.

Evidence of timely screening includes: (1) Use of a validated screening tool; (2) Documented results of the screening; (3) Documented referral as appropriate for substance use disorder treatment that includes wrap-around services; (4) Absence of pain medicine clinic staff providing substance abuse services.

Functional outcomes are used as the primary measure of success of treatment. Note: other outcomes are important in wise management of patients. Using functional outcomes as the primary measure of success does not minimize the value of other outcomes, including pain control.

Evidence of meaningful improvements in functional outcomes include: (1) Assessment of patient function; and (2) Evaluation of changes in patient function over time with appropriate changes in treatment plans to achieve better functional outcomes.

There is ongoing emphasis on patient education. Note: setting patient expectations prudently is part of wise management of patients. Failure to meet expectations for pain control often leads to increasing patient demands for dose escalation, which leads to increased risk of substance use disorders.

Emphasis on patient education includes: (1) Patient education of the diagnosis and treatment options, including patient risks using controlled substances; (2) Individual treatment goals and treatment plan documented; (3) Explanation of when and how evaluation of treatment effectiveness will be performed; and (4) Assure that women of childbearing age are appropriately screened and educated about voluntary reversible long action contraceptives (VRLAC) and have access to family planning services.

Naloxone is prescribed for patients at higher risk for overdose or overdose death.

Evidence of appropriate naloxone co-prescription includes: (1) A systematic way of evaluating patients for risk of overdose and overdose death; and (2) Evidence of appropriate patient education and prescription of naloxone for higher risk patients.

There is evidence of compliance with legal requirements for licensed pain medicine clinics.

Compliance with relevant statutes includes, but is not limited to: (1) The medical director meets the requirements of T.C.A. § 63-1-301; (2) The clinic is appropriately licensed (or, in the transition period, appropriately certified); (3) Cash payments are not accepted; (4) Controlled substances are not dispensed; (5) The medical director is on site 20% of the time and is conducting appropriate chart reviews; (6)

Evidence of time the medical director spends in the clinic is available; and (7) All licensed personnel hold licenses that are in good standing.

Resource Links:

Public Chapter 1033 - <http://tn.gov/assets/entities/health/attachments/pc1033.pdf>

Tennessee Chronic Pain Guidelines - <https://www.tn.gov/content/dam/tn/health/healthprofboards/pain-management-clinic/ChronicPainGuidelines.pdf>