AGENCY RECEIPT

NOTICE OF SUBSTANTIVE POLICY STATEMENT

1. Agency Name: State of Arizona Board of Podiatry Examiners

2. Substantive Policy Statement No: 07-01

3. Subject Matter of Substantive Policy Statement:

The Guidelines for Treatment of Chronic Pain and Model Policy for the Use of Controlled Substances for the Treatment of Pain from adopted from the Federation of State Medical Boards of the United States, Inc.

ARIZONA STATE BOARD OF PODIATRY EXAMINERS

SUBSTANTIVE POLICE STATEMENT REGARDING BOARD POLICY PROCEDURES NOTIFYING ALL LICENSEES THAT THE BOARD IS ADOPTING AS A MODEL POLICY FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN AND THE GUIDELINES FOR TREATMENT OF CHRONIC PAIN SETFORTH BY THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.

SPS 07-01

This substantive policy statement is advisory only. A substantive policy statement does not include internal procedural documents that only affect the internal procedures of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona administrative procedure act. If you believe that this substantive policy statement does impose additional requirements or penalties on regulated parties you may petition the agency under Arizona Revised Statues §41-1033 for a review of the document.

Whereas in A.R.S § 32-871. (A)- (F) Dispensing ofDrugs and Devices; Conditions; Definition, it states that a podiatrist may dispense drugs. R4-25-603 (A) 1-10. Prescribing and Dispensing Requirements. It outlines and states the requirements on how to prescribe and dispense.

Whereas, the Board in the interest of ensuring a podiatrist to prescribe controlled substance and correctly treat chronic pain has adopted the Federation of State Medical Boards of the United States, Inc. Model Policy for the Use of Controlled Substances for the Treatment of Pain and The Guidelines for Treatment of Chronic Pain. Whereas, in the interest of meeting the Board's statutory mandates elaborated in A.R.S. #32-871 (A)- (F) and R4-25-603 (A) 1-10 and ensuring additional protection to the health and safety ofthe public the Board shall implement a

procedure whereby the Board shall have guidelines and a model policy for the use of controlled substances for the treatment of chronic pain.

(Adopted at the Board meeting ofNovember 14, 2007)

NOTICE OF AGENCY SUBSTANTIVE POLICY STATEMENT

STATE OF ARIZONA BOARD OF PODIATRY EXAMINERS

1. Subject of the substantive policy statement and the substantive policy statement number by which the policy statement is referred:

   Notification to existing active licensee's and applicants applying for a Podiatry license that as part of the policy governing the practice of podiatry the Board Policy has adopted Model Policy for the Use of Controlled Substances for the Treatment of Pain and The Guidelines for Treatment of Chronic Pain as set forth by the Federation of State Medical Boards of the United States, Inc. Board Policy No. SPS 07-01

2. Date the substantive policy statement was issued and the effective date of the policty statement if different from the issuance date.

   The substantive policy statement was adopted by the board November 14, 2007 and was effective that date.

3. Summary of the contents of the substantive policy statement.

   The statement provides notice to new applicants and exsisting licensee's as a Podiatrist physician that the Board has adopted the Model Policy for the Use of Controlled Substances for the Treatment of Pain and The Guidelines for Treatment of Chronic Pain as set forth by the Federation of State Medical Boards of the United States, Inc.

4. A statement as to whether the substantive policy statement is a new statement or a revision.

   This is a new statement.

5. The name, address, and telephone number of the person to who questions and comments about the substantive policy statement may be directed:

   Name: Sarah Penttinen, Executive Director

   Address: 1400 West Washington, Room 230, Phoenix, Arizona 85007

Telephone: 602-542-3095

Fax: 602-542-3093

e-mail: sarah.penttinen@podiatty.az.gov

6. **Information about where a person may obtain a copy of the substantive policy statement and the costs of obtaining a policy statement.**

A request may be directed to the address or phone number above. The cost is charged at $0.25 per page.

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Federation of State Medical Boards of the United States, Inc.

The recommendations contained herein were adopted as policy by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., May 2004.

Introduction

The Federation of State Medical Boards (the Federation) is committed to assisting state medical boards in protecting the public and improving the quality and integrity of health care in the United States. In 1997, the Federation undertook an initiative to develop model guidelines and to encourage state medical boards and other health care regulatory agencies to adopt policy encouraging adequate treatment, including use of opioids when appropriate for patients with pain. The Federation thanks the Robert Wood Johnson Foundation for awarding a grant in support of the original project, and the American Academy of Pain Medicine, the American Pain Society, the American Society of Law, Medicine, & Ethics, and the University of Wisconsin Pain & Policy Studies Group for their contributions.

Since adoption in April1998, the *Model Guidelinesfor the Use ofControlled Substances for the Treatment of Pain* have been widely distributed to state medical boards, medical professional organizations, other health care regulatory boards, patient advocacy groups, pharmaceutical companies, state and federal regulatory agencies, and practicing physicians and other health care providers. The *Model Guidelines* have been endorsed by the American Academy of Pain Medicine, the Drug Enforcement Administration, the American Pain Society, and the National Association of State Controlled Substances Authorities. Many states have adopted pain policy using all or part of the *Model Guidelines*. :_Despite increasing concern in recent years regarding the abuse and diversion of controlled substances, pain policies have improved due to the efforts of medical, pharmacy, and nursing regulatory boards committed to improving the quality of and access to appropriate pain care.

Notwithstanding progress to date in establishing state pain policies recognizing the legitimate uses of opioid analgesics, there is a significant body of evidence suggesting that both acute and chronic pain continue to be undertreated. Many terminally ill patients unnecessarily experience moderate to severe pain in the last weeks of life The undertreatment of pain is recognized as a serious public health problem that results in a decrease in patients' functional status and quality of life and may be attributed to a myriad of social, economic, political, legal and educational factors, including inconsistencies and restrictions in state pain policies.[1]Circumstances that contribute to the prevalence ofundertreated pain include: (1) lack of knowledge of medical standards, current research, and clinical guidelines for appropriate pain treatment; (2) the perception that prescribing adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities; (3) misunderstanding of addiction and dependence; and (4) lack of understanding of regulatory policies and processes. Adding to this problem is the reality that the successful implementation of state medical board pain policy varies among jurisdictions.

In April2003, the Federation membership called for an update to its *Model Guidelines* to assure currency and adequate attention to the undertreatrnent of pain. The goal of the revised model policy is to provide state medical boards with an updated template regarding the appropriate management of pain in compliance with applicable state and federal laws and regulations. The revised policy notes that the state medical board will consider inappropriate treatment, including the undertreatment of pain, a departure from an acceptable standard of practice. The title of the policy has been changed from *Model Guidelines* to *Model Policy* to better reflect the practical use of the document.

The *Model Policy* is designed to communicate certain messages to licensees: that the state medical board views pain management to be important and integral to the practice of medicine; that opioid analgesics may be necessary for the relief of pain; that the use of opioids for other than legitimate medical purposes poses a threat to the individual and society; that physicians have a responsibility to minimize the potential for the abuse and diversion of controlled substances; and that physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes. This policy is not meant to constrain or dictate medical decision-making.

Through this initiative, the Federation aims to achieve more consistent policy in promotion of adequate pain management and education of the medical community about treating pain within the bounds of professional practice and without fear of regulatory scrutiny. In promulgating this *Model Policy,* the Federation strives to encourage the legitimate medical uses of controlled substances for the treatment of pain while stressing the need to safeguard against abuse and diversion.

State medical boards are encouraged, in cooperation with their state's attorney general, to evaluate their state pain policies, rules, and regulations to identify any regulatory restrictions or barriers that may impede the effective use of opioids to relieve pain. Accordingly, this *Model Policy* has been revised to emphasize the professional and ethical responsibility of the physician to assess patients' pain as well as to update references and definitions of key terms used in pain management.

The *Model Policy* is not intended to establish clinical practice guidelines nor is it intended to be inconsistent with controlled substance laws and regulations.

1. As of January 2004, 22 of70 state medical boards have policy, rules, regulations or statutes reflecting the Federation's *Model Guidelinesfor the Use of Controlled Substances for the Treatment of Pain* and two (2) states have formally endorsed the *Model Guidelines*.
2. SUPPORT Study Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: *JAMA,* 274(20) (1995): p. 1591-1598.
3. A.M. Gilson, D.E. Joranson, and M.A. Mauer, Improving Medical Board Policies: Influence of a Model, *J of Law, Medicine, and Ethics,* 31 (2003): p. 128.

Model Policy for the Use of Controlled Substances for the Treatment of Pain

Section 1: Preamble

The (name of board) recognizes that principles of quality medical practice dictate that the people of the State of (name of state) have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this policy have been developed to clarify the Board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from physicians' lack of knowledge about pain management. Fears of investigation or sanction by federal, state and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the Board will consider the inappropriate treatment of pain to be a departure from standards of practice and will

investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The Board recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Board will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The (name ofboard) is obligated under the laws of the State of(name of state) to protect the public health and safety. The Board recognizes that the use of opioid analgesics for other than legitimate medical purposes pose a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Board expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The Board will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The board will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section II: Guidelines

The Board has adopted the following criteria when evaluating the physician's treatment of pain, including the use of controlled substances:

Evaluation of the Patient-A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Treatment Plan-The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment-The physician should discuss the risks and benefits ofthe use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (e.g., violation of agreement).

Periodic Review-The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state ofhealth. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Consultation-The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Medical Records-The physician should keep accurate and complete records to include

1. the medical history and physical examination,
2. diagnostic, therapeutic and laboratory results,
3. evaluations and consultations,
4. treatment objectives,
5. discussion of risks and benefits,
6. informed consent,
7. treatments,
8. medications (including date, type, dosage and quantity prescribed),
9. instructions and agreements and
10. periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance With Controlled Substances Laws and Regulations-To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and

state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and (any relevant documents issued by the state medical board) for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain-Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.

Addiction-Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

Chronic Pain-Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain-An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence-Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction- The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Substance Abuse-Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance-Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

The Guidelines for Treatment of Chronic Pain

Introduction

The diagnosis and treatment of pain is integral to the practice of medicine. The Arizona Medical Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic , and it is especially urgent for patients who experience pain because of terminal illness.

The Board recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery, and in the treatment of chronic pain, whether due to cancer or non-cancer origins.

The following guidelines demonstrate the Board's desire to encourage physicians to administer controlled substances in the course of treating pain without fear of disciplinary action from this Board when such treatment is provided with the accepted community standard of care.

Policy for the Treatment of Chronic Pain[1]

Section 1: Preamble

The Board recognizes that access to the highest quality medical care includes access to effective and appropriate pain relief . Appropriate up-to-date treatment modalities improve the quality of life for patients who suffer from chronic pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain.

When investigating allegations of inappropriate pain management, the Board gathers all relevant medical records, statements from the complainant and physician and has the information reviewed by a physician(s) experienced in pain management. The Board refers to current clinical practice guidelines and expert analysis when reviewing cases involving pain management. The Board judges the validity of the physician's treatment of the patient based on all the information, not just quantity and duration of the medication administration.

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The Board will consider prescribing, ordering, dispensing or administering controlled substances for chronic pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must document chronic pain associated with an objective pain generator and/or a recognized chronic pain syndrome. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of chronic pain.

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[1] These guidelines are based in part on the Federation of State Medical Boards' Model Policy for the Use of Controlled Substances for the Treatment of Pain, and the Consensus Statement on the Use of Opioids for the Treatment of Chronic Pain by the American Pain Society and the American Academy of Pain Medicine.

The Laws of the State of Arizona mandate that the Board protect the public health and safety. The Board recognizes that the use of opioid analgesics for other than legitimate medical purposes poses a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Diversion of controlled substances should be a concern of every health professional, but efforts to stop diversion should not interfere with prescribing opioids when appropriate for chronic pain management. Attention to patterns of prescription requests and inappropriate drug seeking behavior can decrease the risk of diversion and abuse. Accordingly, the Board expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

The chronic pain management goal is to address the patient's pain along with other aspects of the patient's functioning, including physical, psychological, social and work-related factors. When managing chronic pain, the physician should consider current clinical knowledge, evidence-based clinical practice, medical research and the use of pharmacologic and multidisciplinary non-pharmacologic modalities. The physician should adjust the quantity and frequency of doses according to the intensity and duration of the pain. Physicians must recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

Section II: Guidelines

The following guidelines apply to the physician's treatment of chronic pain, including the long-term use of controlled substances:

Evaluation of the Chronic Pain Patient – Evaluation should initially include a pain history and assessment of the impact of pain on the patient, a directed physical examination, a review of previous diagnostic studies, a review of previous interventions, a drug history, and an assessment of coexisting diseases or conditions.

Treatment Plan – Treatment planning should be tailored to both the individual and the presenting problem. Consideration should be given to different treatment modalities, such as formal pain rehabilitation program, the use of behavioral strategies, the use of non-invasive techniques, or the use of medications, depending upon the physical and psychosocial impairment related to the pain. An opioid trial should not be initiated in the absence of a complete assessment of the chronic pain complaint.

Informed Consent – The physician must discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. This discussion should include the risks of addiction/abuse, not alleviating all pain, and treatment alternatives including the effects of no treatment.

Agreement for Treatment- There are circumstances in which the use of a documented verbal or written agreement between physician and patient outlining patient

responsibilities may be necessary for safe and responsible opioid prescribing. Such an agreement should include:

- urine/serum medication levels and baseline screening when requested;
- number and frequency of all prescription refills;
- reasons for which drug therapy may be discontinued (e.g., violation of agreement)
- requirement that the patient receive all controlled substance prescriptions from one physician and one pharmacy whenever possible.

Periodic Review – Review of treatment efficacy should occur periodically to assess any new information about the etiology of the pain or the patient's state of health, the functional status of the patient , continued analgesia, opioid side effects, quality of life, and indications of medication misuse. Periodic re-examination is warranted to assess the nature of the pain complaint and to ensure that opioid therapy is still indicated. Attention should be given to the possibility of a decrease in global function or quality of life because of opioid use.

Consultation – Consultation with a specialist in pain medicine or with a psychologist may be warranted, depending on the expertise of the practitioner and the complexity of the presenting problem. The management of chronic pain in patients with a history of addiction or a co-morbid psychiatric disorder requires special consideration, but does not necessarily contraindicate the use of opioids.

Medical Records – The physician must keep accurate, legible and complete records that provide sufficient information for another practitioner to assume continuity of the patient's care. These records should contain at a minimum the following:

1. The medical history and physical examination,
2. Diagnostic, therapeutic and laboratory results that support the diagnosis,
3. Evaluations and consultations,
4. Treatment objectives,
5. Discussion of risks and benefits,
6. Documented verbal and/or written informed consent,
7. Treatments,
8. Medications (including date, type, dosage and quantity prescribed),
9. Instructions and agreements, and
10. Periodic reviews.

The physician must maintain current records in an easily accessible manner, and the records must be readily available for review.

Termination from Medical Practice

Circumstances may arise which lead the prescribing physician to terminate the treating physician/patient relationship. In such cases, the physician has a medical and ethical responsibility to make an effort to ensure that the patient does not undergo uncontrolled, abrupt withdrawal from the prescribed controlled substance. This can be accomplished by tapering the medication, arranging for inpatient detoxification, or providing continued

care and prescription(s) to cover a realistic, limited period during which the patient has the opportunity to find a new treating physician and/or obtain admittance to an opioid detoxification program.

Compliance With Controlled Substances Laws and Regulations – To prescribe, dispense or administer controlled substances, the physician must be licensed in the State and comply with applicable federal and State regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration for specific rules governing controlled substances as well as applicable State regulations.

Section III: **Definitions**
For the purpose of these guidelines, the following terms are defined as follows:

Acute Pain – Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.

Addiction – Addiction is a primary, chronic, neurobiological disease, with genetic psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

Chronic Pain – Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain – An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence – Physical dependence is a state of adaptation that is manifested by drug class specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction -The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Substance Abuse – Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance – Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time . Tolerance may or may not be evident during opioid treatment and does not equate with addiction.