

1 **DRAFT MEETING MINUTES**

2
3 **Boards of Medicine and Osteopathic Medicine**
4 **Pain Management Clinic Standards of Practice Joint Committee Meeting**

5
6 **Hyatt Regency Orlando Airport**

7
8 **September 10, 2010 at 8:00 am**

9
10 The meeting was called to order at 8:00am. Those present for all or part of the meeting
11 included the following:

12 **Members Present:**

Fred Bearison, M.D., Chair
Ronald Burns, D.O., Vice Chair
Brigitte Goersch, Consumer Member
Joel Rose, D.O.
Steven Rosenberg, M.D.
Lisa Tucker, M.D.
Gary Winchester, M.D.

Court Reporter:

American Court Reporting
Heather Howard
407-896-1813

Staff Present:

Larry McPherson, Executive Director, Board of
Medicine
Anthony Jusevitch, Executive Director, Board
of Osteopathic Medicine
Ed Tellechea, Board of Medicine Counsel
Donna McNulty, Board of Osteopathic
Medicine Counsel
Nancy Murphy, Paralegal
Crystal Sanford, Program Operations
Administrator, Board of Medicine
Christy Robinson, Program Operations
Administrator, Board of Osteopathic
Medicine

Others Present:

Kim Berfield, DOH Deputy Secretary
Lucy Gee, MQA Division Director
Eulinda Smith, DOH Communications Office

13
14 **Note- these minutes are only a summary of the discussions. For exact testimony or**
15 **comments, please refer to the official transcript of the meeting.**

16
17 **I. Board Counsel and Committee Chair Opening Remarks**

18
19 Mr. McPherson began the meeting by giving an overview the previous legislation and the history
20 of the Joint Committee. He reiterated the two goals of this meeting: to look at standards for
21 approval of accreditation entities and to come up with the number of Schedule II and III
22 controlled substances and Alprazolam prescriptions that can be written in a 24 hour period for a
23 pain management clinic.

24
25 Dr. Bearison thanked the staff and committee for their dedication and hard work and recognized
26 the extraordinary amount of time that each person has dedicated to the committee.

27
28 **Discussion Regarding Approval of Accreditation Organizations**

29
30 The committee heard testimony from several interested parties.

31
32 Paul Sloan, First Choice Pain Care Clinic- Mr. Sloan advised the committee he was in the
33 process of obtaining clinic accreditation through the AAAHC and noted it was a very thorough

1 and rigorous process. He voiced support of the AAAHC and the American Academy of Pain
2 Management (AAPM) as accrediting organizations.

3
4 Charles Chase, MD, Vice President of the Florida Society of Anesthesiologists- Dr. Chase
5 recommended approving only those organizations that were approved by the Center of
6 Medicaid/Medicare Services (CMS): The Joint Commission, AAAHC and AAAASF.

7
8 Rusty Huseman, Esquire, Dr. Maria-Bianca Natal, Lennie Duensing, and Dr. Larry Short,
9 American Academy of Pain Management (AAPM)- Mr. Huseman asked the committee to keep
10 in mind that the office surgery and pain clinic accreditation processes were distinctly different.
11 Ms. Duensing noted the AAPM was the largest pain management organization with 5000
12 members, of which 60% were physicians. The AAPM gave a power point presentation
13 explaining their pain program accreditation process. The speakers were asked if they are
14 currently recognized by any state or national organization, to which they replied no. They noted
15 5 pain programs currently held their credential in Florida. They also indicated they have not
16 applied for this type of approval in any other states. Their surveyors are clinicians or
17 administrative personnel. They were asked to provide the committee with the total number of
18 Florida facilities that were ever approved through their organization as follow up. Dr. Long
19 indicated that approximately 90% of facilities receive approval.

20
21 Jennifer Hoppe, Associate Director of State Relations, The Joint Commission- Ms. Hoppe noted
22 her organization did not forward surveyor reports to state agencies per their policy. She
23 recommended the facility submit a copy of the survey results to the Board, if needed. She
24 indicated The Joint Commission was approved in all 50 states (for various services) and CMS
25 but they were not recognized by the NCQA. A concern was raised regarding the survey results
26 not being forwarded to state agencies. Ms. Hoppe advised the results could be sent if the facility
27 signed a release. Ms. Hoppe explained their inspectors were physicians or masters prepared
28 nurses. She clarified that full accreditation cannot be given prior to patient care being rendered
29 at a facility. Ms. Hoppe stated The Joint Commission would be willing to include the Florida
30 laws and rules as a part of their accreditation process.

31
32 Tom Terranova, Director of Legislative and External Affairs, AAAASF- Mr. Terranova advised
33 the committee that the AAAASF would have no barriers to providing the Boards with all survey
34 results. He cautioned that with accreditation there are often many preliminary deficiencies, thus
35 a lot of paperwork. Mr. Terranova indicated they were recognized in several states
36 (approximately 27) and all surveyors were either board certified or board eligible. He also noted
37 all physicians working in a facility would need to be board certified or board eligible.

38
39 There was discussion concerning the availability of survey results to the public and it was
40 suggested that all results be made available on the Board's website. Mr. McPherson suggested
41 the results be made available upon request.

42
43 Marc Gerber, MD- Dr. Gerber voiced concern with patient care and suggested that any
44 approved accreditation entity be required to review patient charts as part of the accreditation
45 process. He voiced concern with relinquishing DOH inspection authority for approval of pain
46 clinics.

47
48 There was discussion about requiring accrediting organizations to inspect patient charts as part
49 of the accreditation process if approved by the Boards.

1 Debbi Conn, Licensed Risk Manager, Universal Healthcare- Ms. Conn advised the accreditation
2 bodies are not currently inspecting according to the Florida laws and rules (for office surgery
3 facilities).
4

5 Mr. Tellechea clarified the office surgery statute did not provide oversight for the national
6 accreditation entities but the pain clinic laws provided appropriate oversight for the Boards to
7 determine standards for the accreditation of pain clinics.
8

9 **Break for 15 minutes.**

10
11 Mr. McPherson suggested the committee look at the office surgery rule as a template for
12 creating the pain clinic accreditation rules. Mr. Tellechea asked the committee to give the basic
13 parameters and ideas of the language and they would bring the language back for review and
14 discussion at the next meeting.
15

16 Dr. Tucker referenced section 64B8-9.0092(2)(d)1. and 4., changing as appropriate to
17 “experience in pain management” and adding the AAPS and AOA.
18

19 Dr. Winchester suggested not including (2)(d)2. or 3.
20

21 Other items that were discussed were:
22

- 23 1. The accreditation entity must, at a minimum, comply with Florida standards.
- 24 2. The accreditation entity must agree to submit the survey reports and accreditation
25 reports to the Boards (or have the facility sign a waiver allowing the reports to be sent to
26 the Boards).
- 27 3. The accreditation entity must, at a minimum, be willing to include the Florida laws and
28 rules during their accreditation process.
- 29 4. The chart review (as part of the accreditation process) should be restricted to a board
30 certified pain management physician.
31

32 There was additional discussion about having the survey and inspection results available to the
33 public. Mr. Tellechea indicated the survey results should be readily accessible as they may be
34 helpful in evaluating clinics. Mr. McPherson voiced concern about the Board offices serving as
35 the repository for the survey results as it would create a workload issue. He suggested that
36 interested parties get the results directly from the accrediting organization. Dr. Rose had
37 concerns that the accrediting body would not make the survey reports available to the public
38 due to confidentiality. It was suggested that the clinic have their most recent survey available in
39 the clinic for public inspection.
40

41 Mr. McPherson asked the committee to consider not requiring the department to be the
42 repository of the survey results. Mr. Tellechea was asked to bring back language with different
43 options on this issue.
44

45 Dr. Tucker also asked that the Boards be made aware of any deficiencies that are found and
46 when/if they are corrected.
47

48 Mr. Tellechea cautioned the committee not to make the rules too restrictive or the accrediting
49 organizations will not be willing to accredit pain clinics in Florida.
50

51 Dr. Burns referenced section (4)(e) of the rule as good language regarding clinics with “an
52 immediate threat”.

1
2 It was clarified the surveyors do not have to be Florida licensed.

3
4 Mr. Tellechea clarified that the organizations must be nationally recognized. They would have to
5 be recognized in more than one jurisdiction.

6
7 Mr. Tellechea advised the committee that the record should be kept open for 5-7 days to allow
8 for public written response.

9
10 **Action Taken:** Dr. Rosenberg moved to keep the record open for 5 business days. Dr. Tucker
11 seconded the motion, which passed unanimously.

12
13 There was discussion concerning full accreditation versus provisional accreditation.

14
15 Mr. McPherson also suggested the accreditation organization be required to notify the
16 department of any changes in a clinic's accreditation status.

17
18 Mr. McPherson advised department inspections may not be completed by board certified pain
19 management physicians.

20
21 There was discussion regarding the length of time of accreditation. It was suggested the rule
22 specify that a clinic must maintain their accreditation to maintain their approval or require the
23 "clinic" to get reaccredited every three years. Mr. Tellechea said he would look at the possible
24 options and provide language.

25
26 **Discussion Regarding the Number of Prescriptions in a 24-hour Period**

27
28 Mr. McPherson reiterated the focus of the discussion was to come up with an appropriate
29 number of Schedule II and III controlled substances, and Alprazolam, prescriptions that could be
30 given in a 24-hour period within a pain management clinic.

31
32 Charles Chaes, MD- Dr. Chase recommended a limit of 2 prescriptions per day/per patient with
33 the caveat 2nd or 3rd month prescriptions were not included in the "2". If the 2nd or 3rd month
34 prescriptions were included, the overall total should be 6 per day/per patient.

35
36 Mr. McPherson suggested the committee look at the number of patients that could be
37 legitimately seen in a 24 hour period and base the total number of prescriptions per clinic off of
38 the appropriate patient total as a starting point.

39
40 Dr. Chase was asked how many patients, in his opinion, could be seen in one day. Dr. Chase
41 indicated approximately 30-40 patients could be seen. He also voiced concern that illegitimate
42 pain clinics were only writing prescriptions for one month and requiring the patient to come back
43 for additional refills.

44
45 Dr. Chase was asked if he felt the number of patients that could be seen would be lessened by
46 the change in statute requiring that the physician conduct the patient examination. He felt the
47 number of patients could remain the same but the physician may have to work longer hours to
48 complete paperwork, etc.

49
50 Dr. Winchester suggested clarifying, in rule, that the 2nd and 3rd month prescriptions would be
51 considered one prescription for purposes of this rule.

1 Dr. Rosenberg voiced concern with maintaining adequate patient care and suggested utilizing a
2 formula per physician/patient, rather than creating an arbitrary number.

3
4 Stanley Dennison, Jr., MD- Dr. Dennison suggested physicians should not be given a limit as
5 each patient may need different and individualized treatment.

6
7 Harold Cordner, MD, Florida Society of Interventional Pain Physicians- Dr. Cordner offered
8 clarification that a “refill” was different than 2nd and 3rd month prescriptions. He recommended
9 the formula should be per patient/per physician basis. He commented 2 per patient would be
10 too restrictive and would recommend 5 prescriptions per patient/per physician/per day.

11
12 Dr. Winchester offered a possible definition of prescription for consideration:

13
14 “For purposes of this rule only, a prescription is defined as a written prescription for 24 hours
15 that may include up to 2 “do not fill before dates” of the same medication.”

16
17 Mr. Tellechea advised he would craft language for the committee to review at the next meeting.

18
19 There was discussion as to whether these rules would apply to cancer patients that are being
20 treated in a pain management clinic. Mr. Tellechea and Ms. McNulty stated they would look into
21 this synopsis.

22
23 Dr. Rose suggested including a statement indicating that the numbers do not apply to patients
24 being treated for malignant pain in the definition.

25
26 Chris Nuland, Esquire, Florida Academy of Pain Medicine- Mr. Nuland commented that a limit
27 per clinic was inappropriate as patients’ needs varied. Mr. Nuland suggested that a prudent
28 physician would spend at least 15 minutes with each new patient, with a maximum number of
29 40 patients per day. He proposed measuring the number of prescriptions as a weekly or
30 monthly average, rather than evaluating the number of patients on a daily basis, to account for a
31 varying number of patients. Mr. Nuland recommended 5 prescriptions per new patient/per
32 day/per clinic.

33
34 Dr. Rose suggested the need to look at the quantity of pills prescribed in one prescription, in
35 addition to the total number of prescriptions given to a patient.

36
37 Dr. Winchester suggested mirroring the FDA’s language pertaining to the “do not fill before date”
38 language.

39
40 Deborah Tracy, MD, President, Florida Society of Interventional Pain Physicians- Dr. Tracy
41 commented she spends approximately 50 minutes with each new patient. She indicated that
42 she disagreed with the new law as it could create an access to patient care issue. She
43 suggested the formula should be at least 5 prescriptions per patient/per day/ per clinic. She
44 noted the formula should be more generous, rather than more restrictive, to ensure little or no
45 interruption of patient care. Dr. Tracy also advised the committee to look at the methodology for
46 auditing the number of prescriptions (by prescribed date versus by fill date).

47
48 Mr. McPherson asked Dr. Tracy for an approximate % of new patients seen daily in her practice.
49 Dr. Tracy testified she sees approximately 3-5 new patients per day. She also noted she can
50 see approximately 50 patients per day because she utilizes physician extenders.

1 Marc Gerber, MD- Dr. Gerber suggested that very few legitimate physicians could see 5
2 patients per hour, for an 8 hour day, while upholding the appropriate standard of care. He
3 indicated that he spends 45 minutes to an hour with new patients. Dr. Gerber recommended
4 the formula of 3 prescriptions per patient/per day/per clinic (not including the “do not fill before
5 dated” prescriptions). He indicated he sees approximately 25 patients a day. Dr. Gerber
6 testified that 120-200 prescriptions per day/per provider should be more than adequate, as not
7 all pain patients are being treated with Schedule II or III or Alprazolam.

8
9 Dr. Winchester suggested the committee should consider the average of 3-4 prescriptions per
10 patient/per day.

11
12 Dr. Rosenberg voiced concern with basing the total number on “providers” in the definition as
13 non-reputable clinics could potentially hire many extenders in an attempt to up the number of
14 prescriptions that could be written per day.

15
16 Paul Sloan, First Choice Pain Care Clinic- Mr. Sloan testified the physicians in his clinic see
17 approximately 25 patients per day; they spend approximately an hour to an hour and a half with
18 each new patient; and they see approximately 4 new patients per week. Mr. Sloan testified the
19 Florida Medicaid program specifies no more than 4 Schedule III or IV prescriptions per patient,
20 unless there is prior authorization. He suggested utilizing a similar formula- no more than 4 per
21 patient unless there was very specific documentation justifying the additional prescription in the
22 chart. He indicated the average patient in his clinic is given approximately 3 prescriptions and
23 he does not use physician extenders. Mr. Sloan voiced concern with the repercussions to a
24 clinic when a physician is unable to come to work and patients have to be doubled up.

25
26 Dr. Tucker recommended the committee consider 120 prescriptions per physician/per day, the
27 average of the testimony heard during the meeting.

28
29 Michael Creamer, DO, Florida Society of Physical Medicine and Rehabilitation- Dr. Creamer
30 testified the new law was inappropriate and places undue restrictions on physicians. Dr.
31 Creamer asked that any rule include the term “provider” so extenders could be included. He
32 was in agreement with the 4 prescriptions per patient/per day formula but disagreed with a limit
33 per clinic.

34
35 Dr. Albert Ray, Florida Academy of Pain Medicine- Dr. Ray testified that pill mills typically have
36 many extenders and make their money off of volume. He indicated he and his colleagues
37 agreed that a maximum of 25-30 patients per day should be seen. He stated 30 minutes to two
38 hours is needed for an initial patient consult and his follow-ups can be approximately 15
39 minutes. He suggested 3 prescriptions per patient/per day.

40
41 **Break for lunch at 12:10.**

42
43 **Tab 1- Review and Approval of July 24, 2010 Joint Committee Meeting Minutes**

44
45 **Action Taken:** Dr. Burns moved to approve the minutes as presented. Dr. Tucker seconded
46 the motion, which passed unanimously.

47
48 **Action Taken:** Dr. Winchester moved to set up the formula for the number of prescriptions in a
49 24 hour period as 150 monthly prescriptions per physicians per 24 hour period, not including the
50 “do not fill before dated” prescriptions (based on 3 prescriptions per patient). Dr. Tucker
51 seconded the motion. There was discussion regarding the formula.

1 Mr. Tellechea suggested including the standard of care language in the rule.
2
3 Dr. Winchester restated and clarified the formula and motion: based on 50 patients per day, the
4 formula would be 3 monthly prescriptions per patient/per physician, not to exceed 150
5 prescriptions per day and not including the “do not fill before date” prescriptions.
6
7 The motion passed unanimously.
8
9 Dr. Bearison thanked the audience and interested parties for their input and comments.
10
11 **There being no further business the meeting adjourned at 1:20pm.**