

Standards for Medical Records When Prescribing Controlled Substances for the Treatment of Chronic, Non-Cancer Pain

20:47:07:01. Standards for medical records when prescribing controlled substances for the treatment of chronic, non-cancer pain. The standards for medical records when a physician prescribes controlled substances for the treatment of chronic non-cancer pain include each of the following listed items:

- (1) Copies of the signed informed consent and any treatment agreement required by the physician;
- (2) The patient's medical and psychosocial history;
- (3) The results of all physical examinations and all laboratory tests;
- (4) Confirmation that the appropriate state prescription drug monitoring programs have been accessed, and the date of that access, or an explanation why they were not accessed;
- (5) The results of all risk assessments, including results of any screening instruments used;
- (6) A description of the treatments provided, including all medications prescribed or administered, with the date of prescription or administration, the name and type of the medication, and the dosage and quantity of medication prescribed or administered. The medical records must include all prescription orders for opioid analgesics and other controlled substances, whether written, telephoned, faxed, or electronically transmitted;
- (7) Instructions to the patient, including discussions with the patient and, if appropriate, significant others of the risks and benefits of opioid analgesics, including the risks of addiction, overdose, and death; proper use and storage of medication; proper disposal of unused medications; and the use of naloxone products to reverse overdose;
- (8) Results of ongoing assessments, including, when appropriate, urine drug tests, of patient progress or lack of progress in terms of pain management and functional improvement;
- (9) Notes on any evaluations by and consultations with specialists;
- (10) Any other information used to support the initiation, continuation, revision, or termination of treatment. Any steps taken in response to aberrant medication use by a patient and aberrant behaviors related to a prescription for an opioid analgesic;
- (11) Medical records of past hospitalizations or treatments by other providers, to the extent obtained by the physician;
- (12) Authorization for release of information to other treatment providers; and
- (13) Name, address, and telephone number of the patient's pharmacy.

Source: 43 SDR 57, effective October 20, 2016.

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-29, 36-4-30.

References: Federation of State Medical Boards Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain; Federation of State Medical Boards Model Policy on Data 2000 and Treatment of Opioid Addiction in the Medical Office.

20:47:07:02. Definition of chronic pain. For the purposes of section 20:47:07:01, the term, chronic pain, means ongoing, recurrent, or persistent pain lasting beyond the usual course of an acute illness or injury or that is three months or longer in duration.

Source: 43 SDR 57, effective October 20, 2016.

General Authority: SDCL 36-4-35.

Law Implemented: SDCL 36-4-29, 36-4-30.