bariatric medicine in order to continue practicing bariatric medicine/medical weight loss in the state of Mississippi. All Category 1 CME in core content of bariatric medicine should be obtained within a 24 month period.

Following the initial 01 Category 1 CME, a physician is required to obtain 30 AMA or AOA Category 1 CME in core content of bariatric medicine annually in order to continue practicing bariatric medicine and to renew certification with the MSBML. If a physician’s practice is a bariatric medicine, medical weight loss, or weight management practice as defined above or the physician collaborates, manages, oversees, or employs any licensed professional providing comprehensive treatment of obesity, the licensee must have 100 AMA or AOA Category 1 CME in the core-content of bariatric medicine or be currently certified by a board in bariatric medicine. A licensee currently practicing bariatric medicine, medical weight loss or weight management has 24 months from effective date of this regulation to comply with the initial CME requirement. All CME must be obtained within the 24 month period. Reference is made to exclusions noted in Rule 1.2, H.

Licensee must biennially obtain 60 AMA or AOA Category 1 CME in core-content of bariatric medicine before certification can be renewed with the MSBML.

F. A Medical Spa facility practice, Wellness Center practice, or other facility practice that meets the definition of Bariatric Medicine, Medical Weight Loss, or Weight Management Clinic practice shall will be subject to all rules pertaining to Bariatric Medicine, Medical Weight Loss, or Weight Management Clinics practice if the facility has a Mississippi licensed physician affiliated in any manner.

F. for which 30% or more of the patients are provided a comprehensive weight management treatment program or advertises medical weight loss to the public must include behavior modification, comprehensive nutritional education, exercise or physical therapy intervention, long-term maintenance programs, the dispensation and/or prescribing of FDA-approved medications as indicated for weight loss on a monthly basis by a physician and/or nurse practitioner/physician assistant being overseen/collaborating to provide comprehensive treatment of obesity is prohibited unless all criteria above are met.


Rule 1.7 Use of Controlled Substances for Chronic (Non-Terminal) Pain.

A. Definitions

For the purpose of Part 2640, Rule 1.7 only, the following terms have the meanings indicated:

1. “Chronic Pain” is a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if
a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than six months), then they will be considered for the purposes of this regulation to have “de facto” chronic pain and subject to the same requirements of this regulation. “Terminal Disease Pain” should not be confused with “Chronic Pain.” For the purpose of this rule, “Terminal Disease Pain” is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.

2. “Terminal Disease Pain” is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.

1.3. “Acute Pain” is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. 

2.4. “Addiction” is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

3.5. “Physical Dependence” is a physiological state of neuroadaptation to a opioid therapy substance—which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.

4.6. “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.

5.7. “Tolerance” is a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Such tolerance may or may not be evident during treatment and does not equate with addiction.

B. Notwithstanding any other provisions of these rules, a physician licensee may order, prescribe, administer, or dispense controlled substances in Schedules II, IIN, III, IIIN, IV, and V, or other drugs having addiction-forming and addiction-sustaining liability to a person in the usual course of treatment of that person for a diagnosed condition causing for the treatment of chronic pain.

C. Notwithstanding any other provisions of these rules, as to—The ordering, prescribing, administration, or dispensation of controlled substances in Schedules II, IIN, III, IIIN, IV, and V, or other drugs having addiction-forming and addiction-sustaining liability, use of said medications in for the treatment of chronic pain should be done with caution. A physician licensee may order, administer, dispense or prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:
1. Before initiating treatment utilizing a Schedule II, III, IIN, IV or V controlled substance, or any other drug having addiction-forming and addiction-sustaining liability, the physician/ licensee shall conduct an appropriate risk/benefit analysis by reviewing his or her own records of prior treatment, or review the records of prior treatment which another treating physician has provided to the physician. The risk/benefit analysis should weigh in favor of treatment and indicate that there is an indicated need for long-term controlled substance therapy. Such a determination shall take into account the specifics of each patient’s diagnosis, past treatments, and suitability for long-term controlled substance use either alone or in combination with the need for other indicative treatment modalities for the treatment of chronic pain. The results of this analysis shall be clearly entered into the patient medical record and shall include supporting documentation such as consultation or referral reports and efforts to determine the underlying pathology or cause of the chronic pain.

2. Documentation in the patient record shall include a complete medical history and physical examination and supporting studies and reports of consultation.

2.3. The diagnosis must demonstrate the presence of one or more recognized medical indications for the use of controlled substances.

3. Documentation of a written treatment plan which shall contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan should contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. The consent must also include specific requirements of the patient, such as using one physician/ licensee and pharmacy if possible, and urine/serum medication level monitoring when requested, pill counts, and the grounds for which the treatment shall be terminated (e.g., ‘doctor shopping’ behavior, adverse urine/serum screens, etc.).

4. Periodic review and documentation of the treatment course is conducted at reasonable intervals (no more than every six months) no less frequently than every 3 months, with modification of therapy dependent on the physician/ licensee’s evaluation of progress toward the stated treatment objectives must support all changes in therapy. This should include referrals and consultations as necessary to achieve those objectives.

D. No physician/ licensee shall order, administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is nontherapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.

E. No physician/ licensee shall order, administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician/ licensee’s directions. These circumstances include those patients obtaining controlled substances or other drug having addiction-forming and addiction-sustaining liability other than from more than one physician/ licensee and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other drug having addiction-
forming and addiction-sustaining liability other abusable drugs before a prior prescription should have been consumed according to the treating physician's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose of their pain medication due to an acute exacerbation of their condition but have maintained a therapeutic dose level; however, it will be required of if the treating physician to document in the patient record that such increase in dose level documents that the escalation was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.

F. No physician shall order, prescribe, administer, or dispense any controlled substance or other drug having addiction-forming or addiction-sustaining liability to a patient who is a drug addict for the purpose of “detoxification treatment” or “maintenance treatment” and no physician shall order, prescribe, administer, or dispense any narcotic controlled substance for the purpose of “detoxification treatment” or “maintenance treatment” unless they are properly registered in accordance with Section 303(g) 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one (1) day’s medication may be administered to the person or for the person’s use at one time. Such emergency treatment may be carried out for not more than three (3) days. Nothing in this paragraph shall prohibit a physician from ordering, prescribing, administering, or dispensing narcotic controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

G. When initiating opioid therapy for chronic pain, the licensee shall first run a MPMP on the patient. The licensee shall prescribe the lowest effective dosage. While there is no single dosage threshold identified below which the risk of overdose is eliminated, licensees should strive to keep daily opioid doses less than or equal to 50 mg of morphine equivalence (mEq), as dosages larger than 50 mEq per day increases risk without adding benefits for pain control or function. Licensees should avoid dosages greater than or equal to 90 mg of morphine equivalence per day and must provide significant justification for exceeding the 90 mg ceiling stated herein. If the licensee determines that a patient requires greater than 100 mg of morphine equivalence per day, the licensee must refer the patient to a pain specialist for further treatment.

H. When opioids are prescribed for acute pain, the licensee should prescribe the lowest effective dose of immediate release opioids, as the use of long acting opioids for acute non-cancer pain is prohibited. Licensees must prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less should be sufficient and more than 7 days should be avoided in absence of significant justification (Example: Postsurgical pain stemming from a significant procedure). Licensees are discouraged from prescribing or dispensing more than a three (3) day supply of opioids for acute non-cancer pain, and must not provide greater than a seven (7) day supply for acute non-cancer pain. Licensees may issue an additional seven
(7) day supply if clinically necessary, but said supply must be issued in accordance with Title 21 CFR § 1306.12 Refilling prescriptions: issuance of multiple prescriptions (i.e., the prescription must be dated on the date of issuance with ‘do not fill until’ noting the date the prescription may be filled), and such need for an additional seven (7) day supply must be documented in the chart.

I. When prescribing opioids for either chronic or acute pain, it shall be considered a contraindication to prescribe opioids concurrently with Benzodiazepines and/or Soma. However, opioids and benzodiazepines may be prescribed concurrently on a very short term basis, and in accordance with section H of this rule, when an acute injury requiring opioids occurs. The need for such concurrent prescribing must be documented appropriately in the chart. Patients who are currently on an established regimen of concomitant opioids and benzodiazepines may be allotted a reasonable period of time to withdraw from one or both substances.

J. When a licensee treats chronic noncancerous pain and/or psychiatric conditions outside the definition of a pain management practice (Rule 1.2) (G) the licensee shall actively utilize the MPMP upon initial contact with a new patient and every 3 months thereafter on any and all patients who are prescribed, administered, or dispensed controlled substances. Reports generated on patients shall span the length of time from the previous review of the MPMP so that adequate information is obtained to determine the patient’s compliance for treatment. Documentation, such as a copy of the report itself and/or reflections in the charts dictation and/or notes shall be kept within the patient’s record and made available for inspection upon request. In addition, licensees required to register under this section shall also utilize the MPMP to generate a global report to review the entire practice as a whole at least yearly. Documentation of the global report shall be kept in a separate file to be available for inspection upon request.

K. Point of service drug testing must be done each time a Schedule II medication is written for the treatment of chronic non-cancer pain. Point of service drug testing and MPMP review must be done at least every ninety (90) days for patients prescribed benzodiazepines for chronic medical and/or psychiatric conditions.

L. The use of Methadone to treat chronic and/or acute non-cancer pain is prohibited.


Rule 1.8 Drug Maintenance Requirements. All drug products which are maintained or stored in the office of a physician licensee’s office shall be maintained or stored in the manufacturer’s or re-packer’s original container. The label of any container in which drugs are maintained must bear the drug name, strength, the manufacturer's control lot number and the expiration date. Drugs which are pre-counted and prepackaged for purposes of dispensing shall be identifiable as to expiration date and manufacturer's control lot number. The containers in which drug products are maintained shall not be labeled in any false or misleading manner. The labeling requirements of this rule are in addition to, and not in lieu of, other labeling requirements of the Laws of the state of Mississippi, Rules of the Mississippi State Board of Medical Licensure, and Laws of the United States or Federal