

Mandated CEUs in Pain Management and Prescribing of Opioids



Meeting the NEW TMB Requirements

Texas Pain Society
17th Annual Meeting
10-24-2025

C MSCHADE, MD, PhD, PE

- **C MSCHADE, MD, PhD, PE, FIPP**
- CMSchade, MD, PhD has over 40 years of experience in the treatment of chronic pain. He is practicing multimodal & interdisciplinary Pain Medicine at Advanced Pain Solutions in the Dallas Metroplex, Texas.
- Dr. Schade is ABA Board Certified in Integrative Pain Management, a Fellow of Interventional Pain Practice and a Diplomate of the American Board of Anesthesiology, American Board of Pain Medicine, American Academy of Pain Management, and American Board of Interventional Pain Physicians.
- Lt. Colonel Schade also served 10 years with the US Air Force as a Flight Surgeon and served as the Air Force Surgeon General's Consultant in Chemical Warfare.
- Dr. Schade is a strong supporter of patient rights and is a Director Emeritus of the Texas Pain Society, Past-President of the Texas Pain Society and the Greater North Texas Pain Society, a Texas Medical Association Delegate for 20 years, and the Presiding Officer of the PMP Advisory Committee 2020 – 2023.



CME DISCLOSURE

Policies and standards of the Texas Pain Foundation, the Accreditation Council for Continuing Medical Education, and the American Medical Association require that speakers and planners for continuing medical education activities disclose any relevant financial relationship they may have with commercial entities whose products, devices, or services, may be discussed in the content of the CME activity.

The planners and speakers of this program have nothing to disclose.



NOTICE

The Texas Pain Society (TPS) provides this information with the express understanding that

- (1) No attorney-client relationship exists,
- (2) Neither TPS nor its attorneys are engaged in providing legal advice, and
- (3) The information is of a general character.
- (4) This is not a substitute for the advice of an attorney.

Meeting Mandated Training Requirements 1/2



This program is eligible to count towards:

- (1) The eight hours of training on treatment and management of patients with opioid or other substance use disorders required for all U.S. Drug Enforcement Administration-registered practitioners,
- (2) The two hours* of CME in the study of Pain Management and Prescription of Opioids required by the Texas Medical Board. (TAC TITLE 22 PART 9 RULE §161.35 (a)(2)(C)), and
- (3) The two hours of ethics credit required each renewal cycle.

Participation in this program in no way implies the participant has fully met the federally and state-mandated training requirements. Participants are solely responsible for ensuring any mandated training requirements are completed.

NOTES:

OLD -- TMB audits approximately 2% and if you are deficient, you are usually given time to make up the missing CEUs.

NEW -- A licensing entity may not renew a HCP's license unless the licensing entity **VERIFIES** that the HCP has complied with the CEU requirements of the licensing entity.

TOC SUBTITLE A Section 112.103 **EFFECTIVE 9-1-2026**

Meeting Mandated Training Requirements 2/2



- 1) Due to recent legislation, continuing education compliance for all healthcare practitioners must be verified through a continuing education tracking system **BEFORE RENEWAL**.
- 2) CE Broker is optional until September 1, 2026. Prior to that date, licensees are required to use CE Broker only if selected for an audit. The TMB will conduct the audit through CE Broker.
- 3) The TMB will maintain its collaboration with CE Broker to fulfill this mandate. CE Broker is an online continuing education compliance platform that enables licensees to locate, track, and report their continuing education coursework.
- 4) Licensees renewing on or after September 1, 2026, must have an active basic CE Broker account and ensure that all completed continuing education coursework is reported on the platform.

TOC §156.055 Opioid CEUs for DPC Practitioners



Do You Have to Complete this Training?

(a)* A physician licensed under this subtitle who submits an application for renewal of a license that designates a **direct patient care practice**** must complete, in accordance with this section, not less than two hours of continuing medical education regarding safe and effective pain management related to the prescription of opioids and other controlled substances, including education regarding:

- (1) reasonable standards of care;
- (2) the identification of drug-seeking behavior in patients; and
- (3) effectively communicating with patients regarding the prescription of an opioid or other controlled substance.

* After two renewal cycles (Starting on 9-2019), a physician must complete not less than two hours of continuing medical education described by Subsection **(a) every eight years**.

** Primary Type of Practice: (Select one of the following):

Direct Patient Care, Medical Teaching or Medical School Faculty, Administrative Medicine, Research, Not in Practice, or Resident, Fellow.

Learning Objectives

Comply with regulatory requirements for prescribing and monitoring of controlled substances



Outline

A physician's duty
to relieve pain

Intractable Pain
Treatment Act

Mandatory Opioid
CME

TMB Rule §163
Medical Records
& PMP mandatory
checks

TMB Rule §172
Pain Management
Clinics

TMB Rule §175
Telemedicine &
Opioids

DEA Telemedicine
2025 Opioid Rules

DUTY TO RELIEVE PAIN

- The duty to relieve pain and suffering is central to the physician's role as a healer and is an obligation physicians have to their patients.
 - Existential pain should be addressed through appropriate social, psychological, or spiritual support.
-
- *The AMA Code of Medical Ethics 2017, pg 83-84*



Why Is the Patient Suffering?

The five dimensions of suffering/“pain”

- Physical “pain”
- Psychological “pain”
- Financial “pain”
- Religious “pain”
- Existential “pain”



The United Nations Says Untreated Pain is “Inhumane and Cruel”



UNITED NATIONS

“The issue remains equally compelling closer to home. Surprisingly, the UN report states that **over a third** of patients in the United States are not adequately treated.”

United Nations General Assembly,
Report of the Special Rapporteur on torture
and other cruel, inhuman, or degrading
treatment or punishment

Juan E. Mendez. New York, New York;
Human Rights Council. **2013**:51-56

Chronic Pain and High-impact Chronic Pain in U.S. Adults, 2023

- Key findings
- **Data from the National Health Interview Survey**
- In 2023, 24.3% of adults had chronic pain, and 8.5% of adults had chronic pain that frequently limited life or work activities (referred to as high-impact chronic pain) in the past 3 months.
- Chronic pain and high-impact chronic pain both increased with age.
- American Indian and Alaska Native non-Hispanic adults were significantly more likely to have chronic pain (30.7%) compared with Asian non-Hispanic (11.8%) and Hispanic (17.1%) adults.
- The percentage of adults with chronic pain and high-impact chronic pain increased with decreasing urbanization level.

CDC National Center for Health Statistics, NCHS
Data Brief No. 518, November 2024



Occupation Code Chapter 107
Intractable Pain Treatment Act
1989

Occupation Code Chapter 107

Intractable Pain Treatment Act 1/2

A physician may prescribe a controlled substance to a person for the treatment of intractable pain

BUT ...



Occupation Code Chapter 107

Intractable Pain Treatment Act 2/2



This chapter does NOT authorize a physician to prescribe or administer to a person a dangerous drug or controlled substance:



(1) For a purpose that is not a legitimate medical purpose as defined by the board; and



(2) If the physician knows or SHOULD KNOW the person is using drugs for a non-therapeutic purpose.

The Dual Horns of a True Dilemma

“We often struggle to balance reducing our patients’ pain with increasing their risk of opioid addiction.” – Vivek Murthy, MD, U.S. surgeon general, August 2016

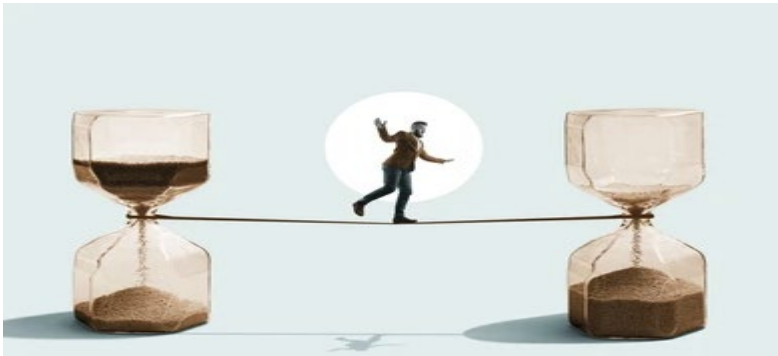
“The benefit of tolerable pain levels and functional lives may outweigh the risks of opioid use for these patients.” – CMS Opioid Misuse Strategy, Jan. 5, 2017

“AMA: ‘Inappropriate Use’ of CDC Guideline Should Stop” – Pain News Network, Nov. 14, 2018

The CDC guideline “provides recommendations only. It does not replace clinical judgment and individualized, patient-centered decision-making.” - 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

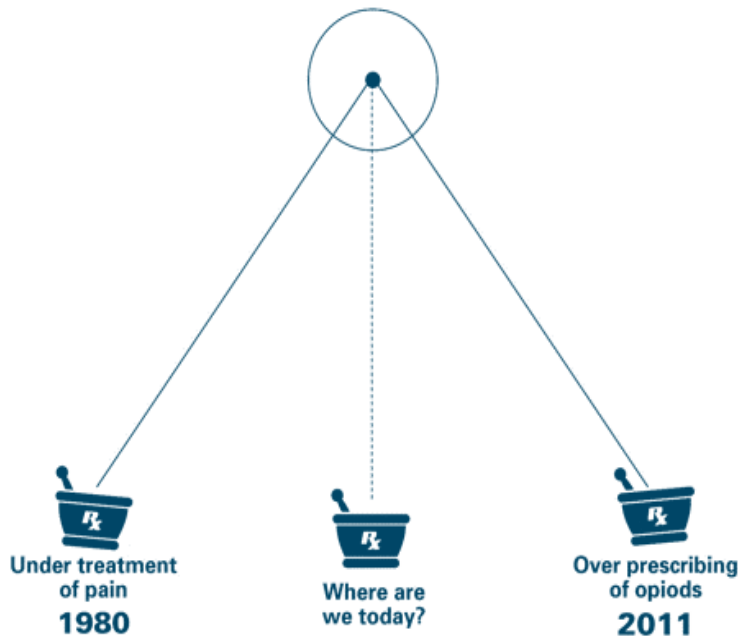


The Opioid Pendulum



Opioid **prescriptions** peaked in 2012 and then have been steadily decreasing, BUT PARADOXICALLY, Opioid **overdoses** have continued to go up until 2023.

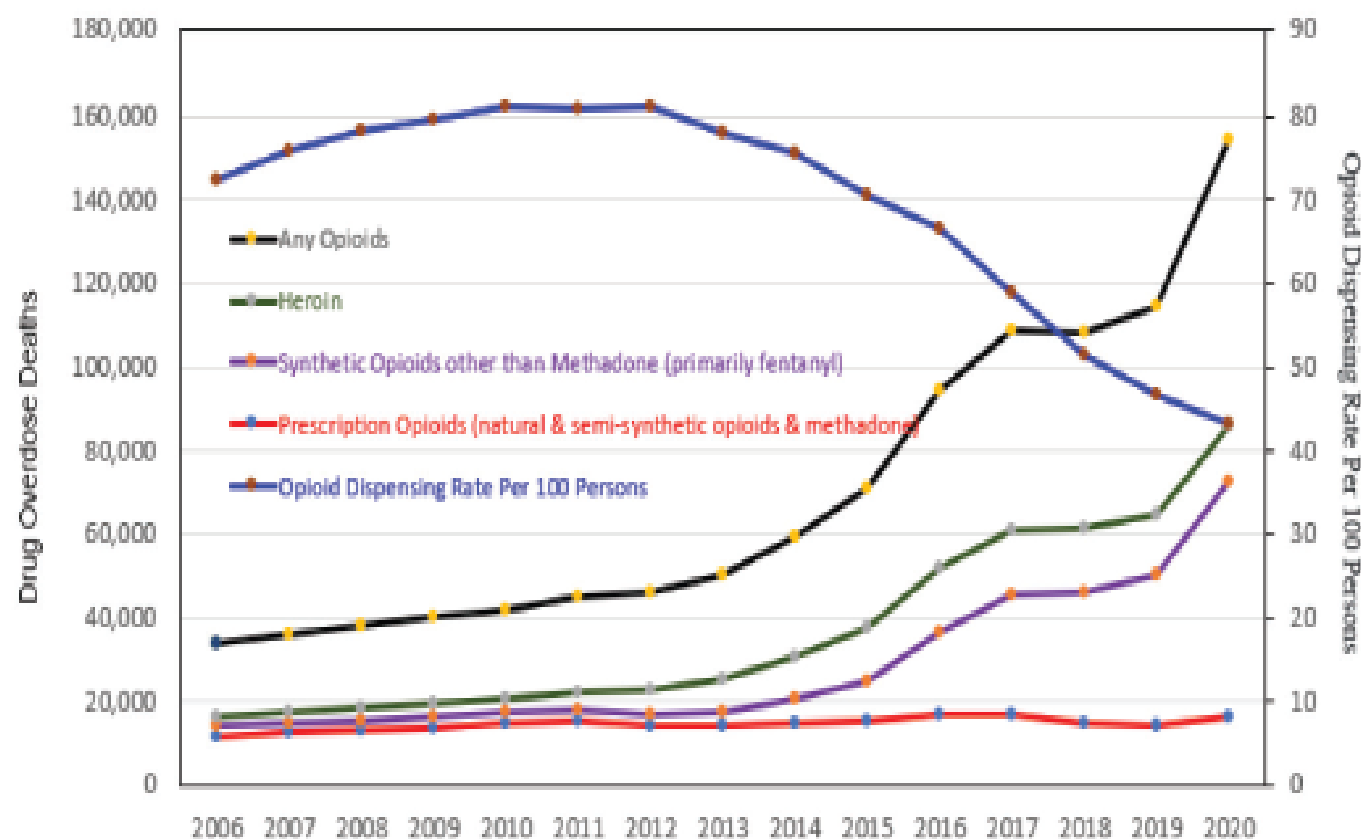
Overdose deaths **decreased** in 2023 for the first time and decreased 14% in the 12 months that ended June 30, 2024.



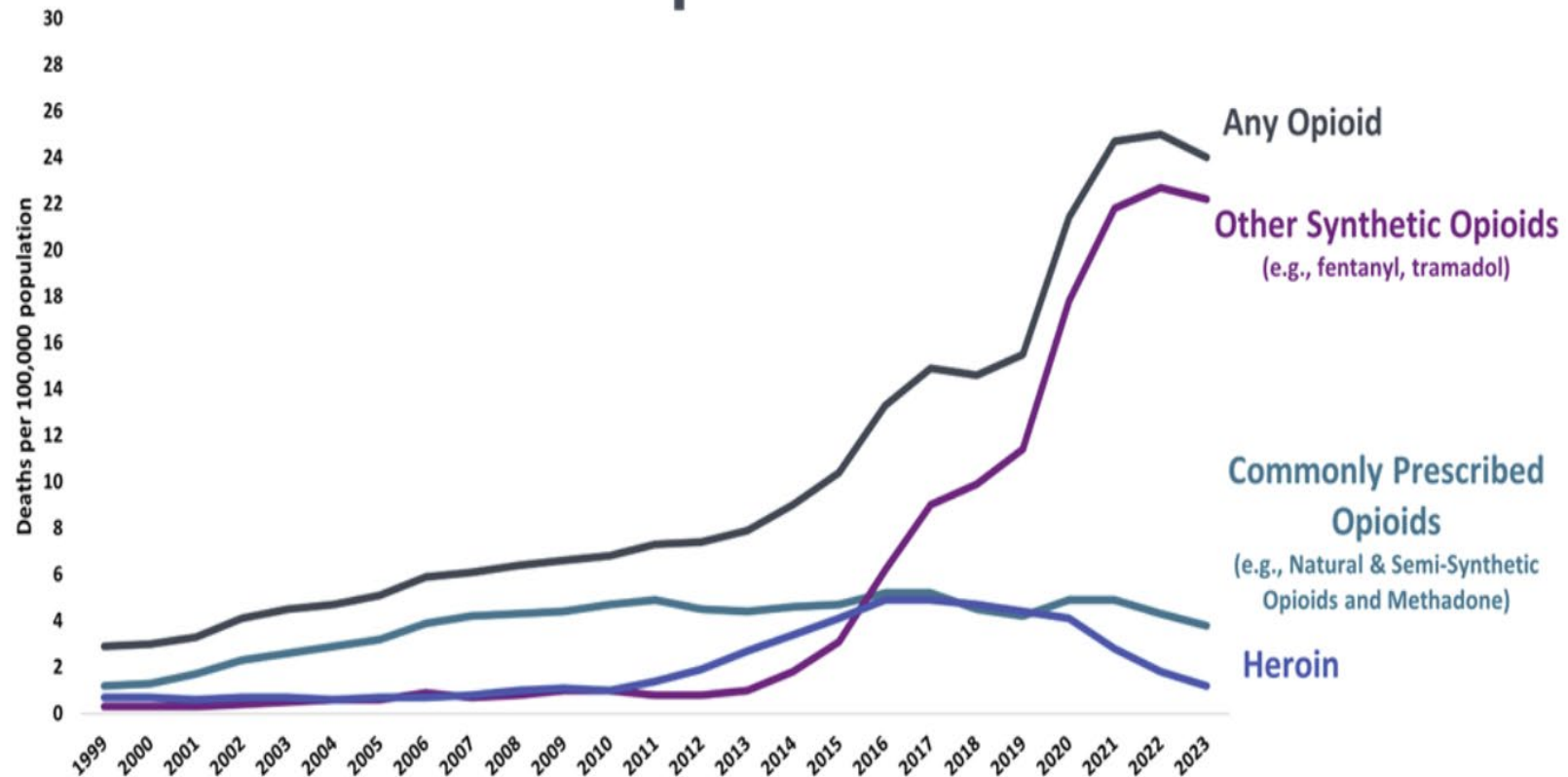
The Opioid Paradox of Overdose Deaths

Fig. 19. *The opioid paradox.*
Opioid prescriptions are declining while opioid overdose deaths are increasing.

Source: <https://www.cdc.gov/nchs/products/databriefs/db428.htm>
<https://www.cdc.gov/drugoverdose/rxrate-maps/index.html>
Accessed on 1/25/2022.



Three Waves of Opioid Overdose Deaths



Wave 1: Rise in Prescription Opioid Overdose Deaths Started in the 1990s

Wave 2: Rise in Heroin Overdose Deaths Started in 2010

Wave 3: Rise in Synthetic Opioid Overdose Deaths Started in 2013

SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2024. <https://wonder.cdc.gov/>.



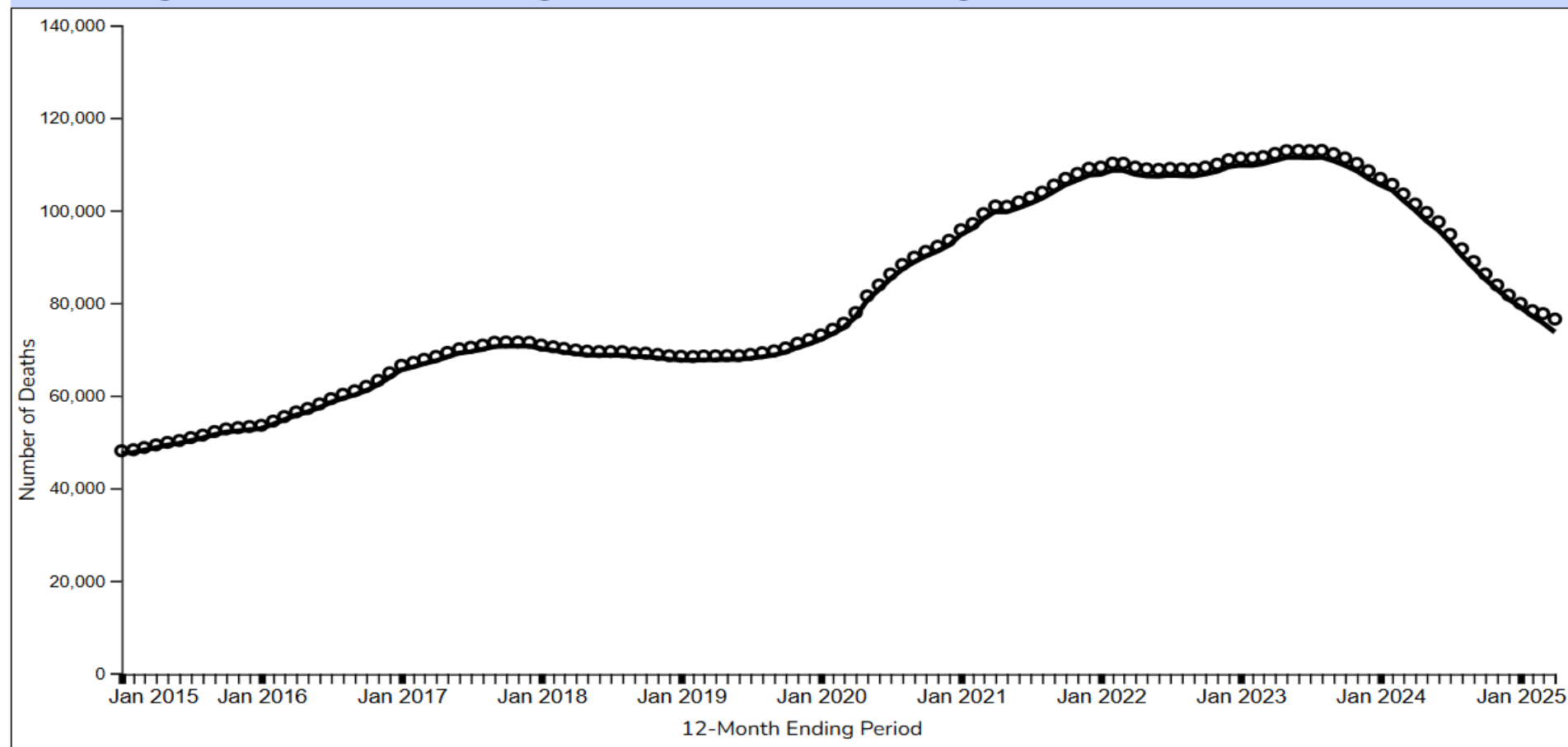
The rise in opioid overdose deaths is shown in three waves, with a slight decrease from 2022 to 2023.

12 Month-ending Provisional Number and Percent Change of US Drug Overdose Deaths

www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Based on data available for analysis on: September 7, 2025

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States

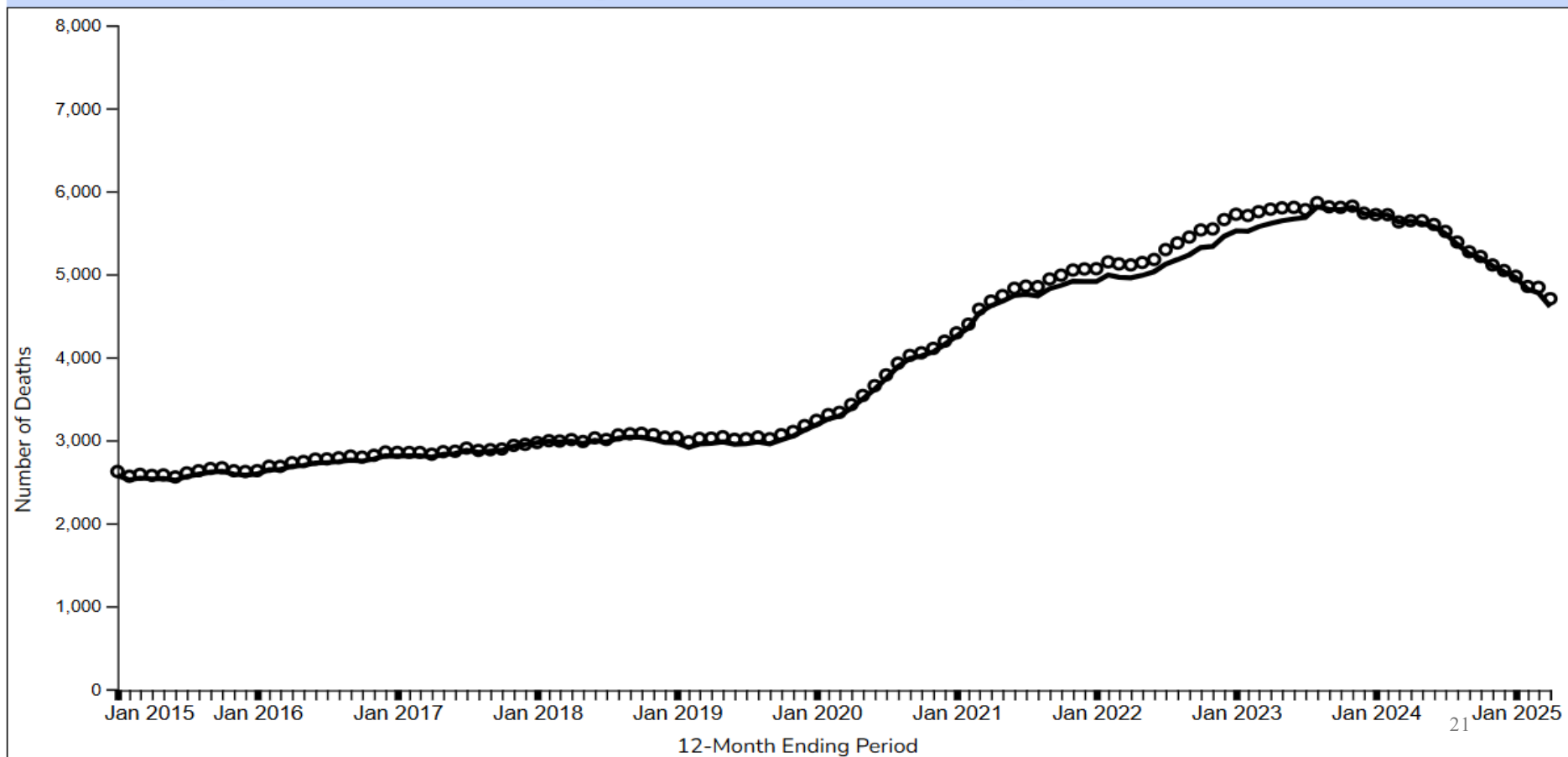


12 Month-ending Provisional Number and Percent Change of TX Drug Overdose Deaths

www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Based on data available for analysis on: September 7, 2025

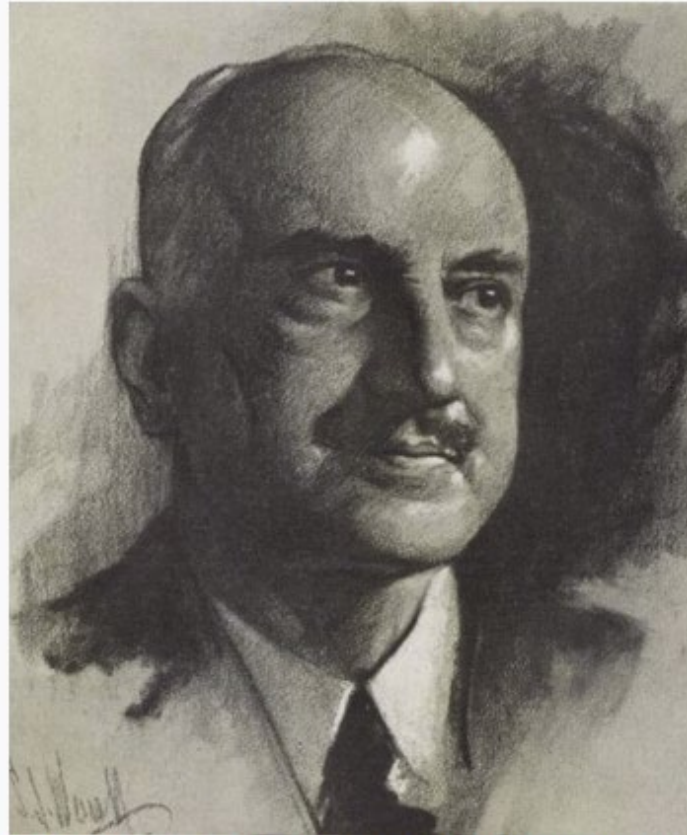
Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: Texas



“Those who cannot
remember the past are
condemned to repeat it.”
– George Santayana, *The
Life of Reason*, 1905.

Those who
cannot learn
from history
are doomed
to repeat it.

George Santayana



Santayana on the cover of a 1936 issue of
Time magazine



Message from the TMB President

- “Please note that due to the comprehensive nature of the review and reorganization, many rules have shifted to different chapters. Furthermore, most statutory language repeated in the rules was eliminated to make them less verbose.”
- “This does not mean that any specific regulation has been repealed. TMB licensees are encouraged to carefully re-review all applicable Texas Medical Board rules related to their license type.”
- “To assist licensees and stakeholders in adapting to the reorganization, the Board staff created a reference chart outlining where to find various provisions in the revised rules.”

“If you are going to prescribe opioids, then you need to memorize Rules §170 and §195.”

Dr. Zaafran - Texas Pain Society Annual Meeting 10-26-24



- But on 1-9-25 ALL the TMB Rules changed, now its:

- Rule §163: Medical Records

AND

- Rule §172: Pain Management Clinics

Sherif Z. Zaafran, M.D

President of the Texas Medical Board

RULE 163.1 Medical Records 1/2

- a) The medical record must be a complete, contemporaneous, and legible documented account of each patient encounter by a physician or delegate.
- (b) **To the extent applicable**, a medical record must include, at a minimum:
- (1) a reason for the encounter, relevant history, physical examination findings (ensuring any pre-populated fields contain current and accurate patient information), and any diagnostic test results;
 - (2) an assessment, clinical impression, and diagnosis;
 - (3) a plan for care (including diagnostics, risk factors, consults, referrals, ancillary services, discharge plan if appropriate, patient/family education, disclosures, and follow-up instructions), treatments, and medications (including amount, frequency, number of refills, and dosage);



RULE 163.1 Medical Records 2/2

(b) To the extent applicable, a medical record must include, at a minimum:

(4) late entries, if any, that indicate the time and date entered, as well as the identity of the person who made the late entry;

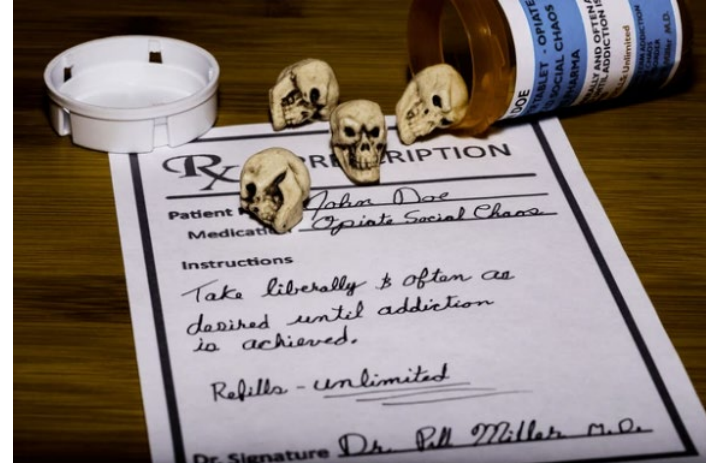
(5) summary or documentation of communications with the patient;

(6) sufficient documentation of requests for records from other providers and any records received;

(7) clear identification of any amendment or correction to the medical record, including the date it was amended or corrected and the identity of the author of the amendment or correction, with the original text remaining legible; and

(8) documentation of a review of the patient's Texas Prescription Monitoring Program (PMP) prescribing history.

RULE 172.1 Pain Management Clinics



Pain management clinics at which a majority of patients are treated for chronic pain are subject to TOC Chapter 168, **unless otherwise exempted**. In determining if the clinic is treating a majority of patients for chronic pain, one of the primary indicators is the prescribing of opioids. The board will utilize the following definitions in making that determination:

- (1) **ACUTE PAIN** -the normal, predicted, physiological response to a stimulus such as trauma, disease, and operative procedures. Acute pain is time limited to no later than 30 days **from the date of the initial prescription for opioids** during a period of treatment related to the acute condition or injury. Acute pain does not include, chronic pain, pain being treated as part of cancer care; pain being treated as part of hospice or other end-of-life care; pain being treated as part of palliative care; or persistent non-chronic pain.
- (2) **CHRONIC PAIN** -pain that is not relieved with acute, post-surgical, post-procedure, or persistent non-chronic pain treatment. This type of pain is associated with a chronic pathological process that causes continuous or intermittent pain for no less than 91 days from the date of the **initial prescription for opioids**. Medical practices treating this type of pain patient may be subject to TOC Chapter 168, Pain Management Clinics.
- (3) **POST-SURGICAL, POST-PROCEDURE, PERSISTENT NON-CHRONIC PAIN** -pain that occurs due to trauma caused by the surgery or procedure, or an underlying condition, disease, or injury causing persistent non-chronic pain. These types of pain last 90 days or less, but more than 30 days, from the **date of initial prescriptions** for opioids during a period of treatment.

TOC Chapter 168 Regulation of Pain Management Clinics

Sec. 168.002. **EXEMPTIONS**. This chapter does not apply to:

- (1) a medical or dental school or an outpatient clinic associated with a medical or dental school;
- (2) a hospital, including any outpatient facility or clinic of a hospital;
- (3) a hospice established under 40 T.A.C. Section 97.403 or defined by 42 C.F.R. Section 418.3;
- (4) a facility maintained or operated by this state;
- (5) a clinic maintained or operated by the United States;
- (6) a health organization certified by the board under Section [162.001](#); or
- (7) a clinic owned or operated by a physician who treats patients within the physician's area of specialty and who personally uses **other forms of treatment**, including surgery, with the issuance of a prescription **for a majority of the patients**.

RULE 172.2

Gold Designated Practice – 1/3



(a) A clinic may apply to be designated as a "Gold Designated Practice." In order to be eligible for a "Gold Designated Practice" status, a clinic must:

- (1) complete a board-approved application form;
- (2) provide a Medical Home Agreement, written collaborative, coordinated care agreement or memorandum of understanding to provide management and treatments of pain, that describes measures that it provides and may be used for reduction of pain such as, but not limited to:
 - (A) **multimodal treatment** such as surgery, injections, pain pumps, osteopathic manipulation, epidurals, trigger point injections, dry needling, and topical creams or patches;
 - (B) **multi-disciplinary** practices such as medication assisted tapering and weaning, computer-based training pain coaching, acupuncture, chiropractic, physical therapy, massage, and exercise/movement; or
 - (C) **collaborative care** or other behavioral health integration services such as evidenced-based cognitive behavioral therapy interventions for mental health and pain reduction, medication management and opioid weaning, patient-centered education, regular monitoring and assessments of clinical status using validated tools, assessment of treatment adherence, motivational interviewing, and a structured approach to improving the biopsychosocial aspects of pain management; and

RULE 172.2 Gold Designated Practice – 2/3

(3) In addition to providing a Medical Home Agreement, written collaborative, coordinated care agreement, or memorandum of understanding to provide management and treatments of pain described above, the clinic must either:

- (A) meet the standards for exemption under §168.002(7) of the Act, including the clinic being operated by a majority of physicians who currently hold or previously held ABMS or AOA board-certification or subspecialty certification in pain management; and
 - (i) have a majority of physicians performing or properly supervising delegates in providing other forms of treatment besides qualifying pain management prescriptions to a majority of the patients at the clinic;
 - (ii) utilization by the clinic's providers of a Medical Home Agreement signed by the primary prescriber and the patient; or
 - (iii) have a written collaborative, coordinated care agreement or a memorandum of understanding with the patient's primary physician for treating and managing the patient; or
- (B) be a Certified Pain Management Clinic (PMC) that is operated by physicians who previously held an ABMS or AOA Board-certification or sub-specialty in pain management or hold a ABMS or AOA Board-certification in an area that is eligible for a pain management subspecialty; and
 - (i) have a Medical Home Agreement signed by the primary prescriber and the patient; or
 - (ii) have a written collaborative, coordinated care agreement or memorandum of understanding providing that each physician who prescribes qualifying prescriptions will consult with a pain specialist for the patient.

RULE 172.2 Gold Designated Practice – 3/3

(b) The designation may be verified by an initial audit and is valid for five years.

(c) No further audits or inspections will be conducted during the five-year "Gold Designated Practice" period, unless:

- (1) a complaint is received or initiated by the board concerning operation of the clinic or operators at the clinic;
- (2) the clinic changes location; or
- (3) the clinic's ownership structure changes to a majority of new owners.

(d) Practices that only treat pain patients as part of cancer care or that provide only palliative care, hospice, or other end-of-life care are exempt under the Act from certification requirements as a PMC, but do not qualify for the "Gold Designated Practice" status.

RULE 172.3

Certification of Pain Management Clinics – 1/3



(a) Any clinic meeting the definition of a pain management clinic under §168.001 of the Act must be certified.

(b) Certification requires:

(1) a board-approved application filed by a physician owner of the clinic. If there are multiple physician owners, the application must be filed by one of the majority of owners, or if there are no majority owners, then each physician owner is responsible for designating one physician owner to file an application.

(2) submission of the following documentation:

- (A) proof of ownership of the clinic, which may include filing with county clerks, the Comptroller and Secretary of State, as applicable;
- (B) days and hours of operation;
- (C) name of medical director;
- (D) list of employees, including contract physicians and other healthcare providers, and their applicable education, qualifications, training and professional licenses;
- (E) protocols and standing delegation orders issued by licensed physicians to healthcare providers; and
- (F) proof of payment of the required filing fee, if applicable.

RULE 172.3 Certification of Pain Management Clinics – 2/3

(c) The Executive Director (ED) or the ED's designee reviews all applications. After reviewing the applications, the ED will send a notice of determination to the applicant which includes the ED's determination. If the application is denied, then the ED will provide the information regarding the right to appeal.

(d) Before 180 days after the expiration of the clinic's certificate, a clinic seeking renewal must submit:

- (1) a board-approved application;
- (2) documentation that establishes all providers at the clinic involved in any part of patient care have completed at least ten hours of continuing education related to pain management in the preceding two years; and
- (3) the required renewal fees, if applicable.

RULE 172.3 Certification of Pain Management Clinics – 3/3

(e) If there is any investigation pending with the board against any owner or certificate holder at the time of renewal, a provisional renewal will be issued until the investigation is resolved.

(f) Initial applications are valid for one year from the date filed, unless expressly extended by board staff.

(g) All records relating to an application or renewal of certification are considered investigative information and are confidential under §164.007 of the Act.

(h) A **request to cancel** a certificate must be accompanied by proof that the clinic no longer meets the definition of a pain management clinic under §168.001 of the Act.

RULE 172.4

Minimum Operating Standards for the Treatment of Pain 1/2



(a) Physicians treating a pain patient **MUST**:

- (1) operate in compliance with provisions of all applicable federal and state laws;
- (2) follow the standard of care; and
- (3) maintain complete, contemporaneous, and legible medical records, in the same manner as a non-pain patient, and include documentation of:

- (A) monitoring efficacy, daily functionality, description of pain relief;
- (B) **mandatory PMP checks**;
- (C) **pain contracts**, if applicable;
- (D) support for billing; and
- (E) **drug testing results** and other forms of monitoring for patient compliance with treatment recommendations.

RULE 172.4 Minimum Operating Standards for the Treatment of Pain 2/2

(C) “pain contracts, **if applicable**”

Using an Informed Consent and Pain Management Agreement (PMA) (aka pain contract) is the standard of care when treating chronic pain patients with opioids.

A sample PMA developed by the Texas Pain Society (English and Spanish) is available @

www.texaspain.org

- Free for Texas Pain Society Members (\$50 for non-members)

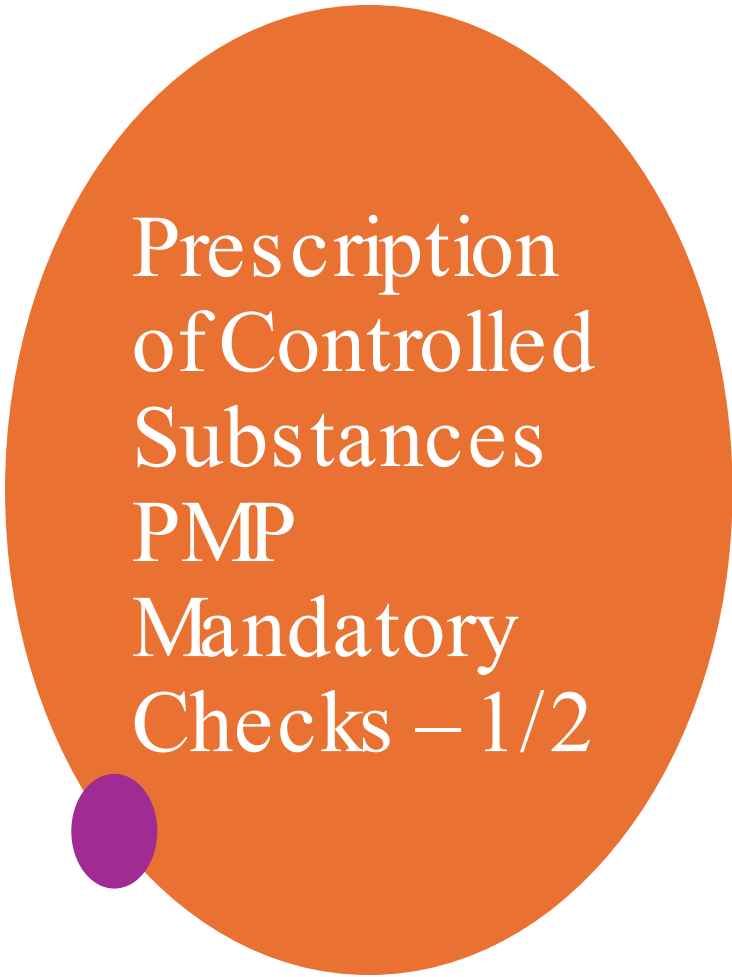


Checking the PMP!

- As of March 2020, Texas law requires prescribers to check a patient's prescribing history before every prescription for:
 - Opioids
 - Benzodiazepines
 - Barbiturates
 - Carisoprodol
- Exception: Cancer patient or a patient in hospice, lupus patient, or in situations involving disaster declarations
- You must document checking the PMP
- CAUTION: The PMP data is only stored for 2 years!
- NOTE: EMRs with integrated PMP will display the ORS first,
so scroll down to document the PMP data to be compliant.



Section 481.0764 of the Texas Health and Safety Code



Prescription of Controlled Substances PMP Mandatory Checks – 1/2

The PMP check and documentation required by this section may be done by:

- The physician, advanced practice provider, or
- An employee or other agent of the practitioner who is legally authorized under Section 481.076(a)(5)(B) of the Health and Safety Code.

TXHealth and Safety Code Section
481.076(5)(B)

Prescription of Controlled Substances

PMP Mandatory Checks – 2/2

Exceptions. The PMP check set forth under paragraph (1) of this section is **not required** in the following circumstances:

- The prescriptions are issued pursuant to **hospice** care, treatment for a patient's diagnosis of **cancer**, or treatment for a patient's **sickle cell** disease, and this is clearly documented in the patient's medical record; or
- The prescriber makes and documents a good faith attempt to comply **but is unable** to access the PMP because of circumstances outside the control of the prescriber.



TEXAS RULE 175 Telemedicine – 1/2

In accordance with Chapters 155.001 and 111 of the Texas Occupations Code, a physician may not provide telemedicine medical services to patients in Texas unless they hold a full Texas medical license.

(a) In accordance with §111.006 of the Texas Occupations Code, a valid prescription requires:

- (1) establishing a physician-patient relationship; and
- (2) compliance with all other applicable laws before prescribing, dispensing, delivering, or administering a dangerous drug or controlled substance, including, but not limited to, the Medical Practice Act and Texas Health and Safety Code, Chapters 481 and 483.



TEXAS RULE 175

Telemedicine – 2/2

(b) Requirements for Prescribing for Chronic Pain via Telemedicine. A physician **must** use audio and video two-way communication **unless** the patient:

- (1) is an established pain patient of the prescribing physician;
- (2) receives a prescription identical to the prescription issued at the previous visit; **AND**
- (3) was seen by the prescribing physician, or their delegate, in the last 90 days either;
 - (A) in-person; or
 - (B) by audio and video two-way communication.



TEXAS 10-Day Opioid Prescription Limit – 1/3



TXHealth & Safety Code Sec. 481.07636. OPIOID PRESCRIPTION LIMITS.

(a) In this section, "acute pain" means the normal, predicted, physiological response to a stimulus such as trauma, disease, and operative procedures. Acute pain is time limited. The term does not include:

- (1) chronic pain;
- (2) pain being treated as part of cancer care;
- (3) pain being treated as part of hospice or other end-of-life care; or
- (4) pain being treated as part of palliative care.

(b) For the treatment of acute pain, a practitioner may not:

- (1) issue a prescription for an opioid in an amount that exceeds a 10-day supply; or
- (2) provide for a refill of an opioid.

(c) Subsection (b) does not apply to a prescription for an opioid approved by the United States Food and Drug Administration for the treatment of substance addiction that is issued by a practitioner for the treatment of substance addiction.

TEXAS 10-Day Opioid Prescription Limit – 2/3

TXHealth & Safety Code Sec. 481.0765.

EXCEPTIONS:

(a) A **prescriber** **is not** subject to the requirements of Section 481.0764(a) if:

- (1) the patient has been diagnosed with **cancer or sickle cell disease** or the patient is receiving **hospice care**; and
- (2) the prescriber clearly notes in the prescription record that the patient was diagnosed with cancer or sickle cell disease or is receiving hospice care, as applicable.

(b) A **dispenser** **is not** subject to the requirements of Section 481.0764(a) if it is clearly noted in the prescription record that the patient has been diagnosed with **cancer or sickle cell disease** or is receiving **hospice care**.

TEXAS 10-Day Opioid Prescription Limit – 3/3

The Texas Medical Board interprets this section to mean a practitioner may write an opioid prescription for up to 10 days without a refill. However, the patient may see the practitioner in a follow-up appointment and receive another opioid prescription for up to 10 days. The law does not limit how many times this may occur.

CMS 7-Day Opioid Prescription Limit



- Seven-day supply limit for opioid naïve enrollees (hard edit)
- Medicare Part D enrollees who have not filled an opioid prescription recently will be limited to a supply of 7 days or less.
- Subsequent prescriptions filled during the plan's review window (generally 60-90 days) will not be subject to the 7-day supply limit.
- This edit should not impact enrollees who already take opioids but may occur for enrollees who enroll in a new plan that does not know their current prescription information.

Federal Telemedicine Rules for Prescribing Controlled Medications are changing 1/4

- The DEA in concert with the Department of Health and Human Services (HHS), has issued a third extension of the “COVID” telemedicine flexibilities for the prescribing of controlled medications through **December 31, 2025**.
- A DEA-registered practitioner is authorized to prescribe schedule II-V controlled substances via telemedicine, as defined in 21 CFR 1300.04(i), to a patient without having conducted an **in-person** medical evaluation of the patient.

Federal Telemedicine Rules for Prescribing Controlled Medications are changing 2/4

- On 1-16-25, the DEA announced new telemedicine rules for prescribing suboxone for SUD & for the VA system effective on 2-18-25 and one draft rule that has been posted for public comment before March 18, 2025.

BUT THEN on 3-11-25 Congress HR 1986 repealed these new rules & extended the PHE for everyone until 12-31-25

Refer to the TMA Telehealth Waiver chart, which is a living document for the current rules.

POST-PUBLIC HEALTH EMERGENCY (PHE) TELEHEALTH GUIDANCE



Physicians Caring for Texans

www.texmed.org

The waivers/services below reference Medicare payment policy only, and Medicare Advantage plans. Other payers, like Medicaid and commercial health plans, may adopt their own payment rules.

Services/Waivers	During the PHE	End Date	After the PHE Extension
Virtual direct supervision <i>Includes teaching physicians</i>	Virtual presence was added to the definition of direct supervision.	Dec. 31, 2025	Supervision is allowed through audio and video interactive telecommunication.
E-visits	E-visits are allowed for both new and established patients.	Dec. 31, 2023	E-visits are allowed for established patients only.
Virtual check-in	Virtual check-in is allowed for both new and established patients.	Dec. 31, 2023	Virtual check-in is allowed for established patients only.
Place of service (POS)	POS should be coded as if the service had been furnished in person, with modifier 95.	Dec. 31, 2023	POS should be coded with 02 – other than patient's home, or 10 – patient's home.
Originating site	Patients in a rural area no longer must receive services at an originating site.	Sept. 30, 2025	Physicians can continue to see patients regardless of their location.
Payment parity	Medicare pays as if the patient were seen in the office.	Sept. 30, 2025	Payment will be reduced to the facility rate when provided in a place other than the patient's home (POS 02). Payment will be paid at the non-facility rate when originating site is the patient's home (POS 10).
Provider types	Physical therapists, audiologists, marriage and family therapist, mental health counselors, occupational therapists, and speech pathologists are allowed to provide telehealth services.	Sept. 30, 2025	These provider types will not be able to provide telehealth services.
Telehealth platform	Physicians can use any non-public-facing remote communication platform.	Aug. 9, 2023	Physicians must use HIPAA-compliant platforms.
Prescribing controlled substances	Schedule II-V controlled substances may be prescribed through telemedicine and without a prior in-person visit.	Dec. 31, 2025	Drug Enforcement Administration will provide guidance via final regulations.
Mental health in-person visit	Not required to establish care	Sept. 30, 2025	In-person visits will be required within 6 months prior to an initial telehealth treatment and then every 12 months after.
Service address	Enrolled practice location	Dec. 31, 2025	Must add home address when that address is the distant site location for Medicare telehealth services.

RESOURCES

[List of Telehealth Services](#). This code list includes temporary services and when they will expire.

[Calendar Year \(CY\) 2025 Medicare Physician Fee Schedule Final Rule](#)

[2025 Medicare Physician Fee Schedule final rule](#) (Federal Register)

Federal Telemedicine Rules for Prescribing Controlled Medications are Changing 3/4

Prescribing controlled substances		
Schedule II-V controlled substances may be prescribed through telemedicine and without a prior in-person visit.	Dec. 31, 2025	Drug Enforcement Administration will provide guidance via final regulations.

https://www.texmed.org/uploadedFiles/Current/2016_Practice_Help/Health_Information_Technology/Telemedicine/End%20of%20PHE%20Telehealth%20Chart.pdf

Federal Telemedicine Rules

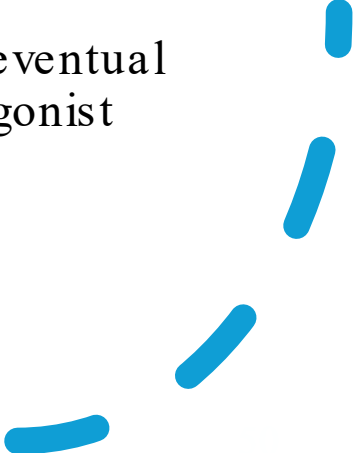
Medicare Telehealth Flexibility

Expired October 1, 2025 4/4

Effective October 1st, 2025, Congress did not renew several Medicare telehealth flexibilities which expired amid the federal government shutdown. This lapse significantly reduces coverage for non-behavioral telehealth services, although behavioral health telehealth access remains permanent.

- 1) Loss of Non-Behavioral Telehealth Coverage: Coverage reverts to pre-pandemic rules, largely limiting services to rural beneficiaries or certain facilities.
- 2) Audio-Only Non-Behavioral Services No Longer Covered: Audio-only services for behavioral health remain permanently covered.
- 3) Behavioral Health Telehealth Remains Protected: Medicare patients can still receive behavioral/mental health services from home with no geographic limits.
- 4) Operational Disruption: CMS has stated many restrictions will resume, and providers may delay submitting telehealth claims until Congress acts.

Liability for Act or Omission With Respect To Prescribing an Opioid Antagonist

- A prescriber may prescribe naloxone directly or by standing order.
 - In accordance with §Rule 170.003, Occupations Code, a prescriber who acts in good faith and in accordance with the standard of care, regardless of whether the physician follows the guidelines under this chapter, is not subject to criminal or civil liability for any professional disciplinary action for:
 - 1) prescribing or failing to prescribe an opioid antagonist or
 - 2) any outcome resulting from the eventual administration of an opioid antagonist prescribed by the physician
- 

SUMMARY

Statutes and Rules on Pain Management

Statutes



TX Occ. Code, Chapter 163:
Pain Management Clinics

TX Occ. Code §164.051(a)(6):
TMB enforcement authority

TX Health & Safety Code, Chapter 483:
Recordkeeping requirements for prescription drugs

TX Health & Safety Code § 481.075(e)(1):
Information that must be included in prescriptions

Rules



Chapter 161: Physician Licensure

Chapter 163: Medical Records

Chapter 172: Pain Management Clinics

Chapter 175: Telemedicine

www.tmb.state.tx.us/page/board-rules



TEXAS

MEDICAL BOARD
PHYSICIAN ASSISTANT BOARD
STATE BOARD OF ACUPUNCTURE EXAMINERS

Safeguarding the public through professional accountability



COVID-19

Licensing

Renewals

Licensee Resources

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Occupations Code & Board Rules

- Laws/Practice Acts
- **Board Rules**
- Proposed Rule Changes

Processes

- Enforcement Overview
- Licensure Overview
- Texas Physician Health Program

General Counsel

- Open Records
- FAQs

Required Notices

- Complaint Notice Poster for Physicians
- Private Autopsy Facility - Complaint Notice
- Tanning Advisory Statement

Position Statements

Home >> Laws & Rules >> Occupations Code & Board Rules >> Board Rules

Saturday, 01 March 2025

Board Rules

Current Board Rules

The complete and most current Board rules are available by clicking the link below. The rules are cited as: Texas Administrative Code, Title 22, Part 9, Chapters 160-164, 169-177, 179-189.

[Current Board Rules](#)

[Rule Review Reorganization Matrix](#)

Adopted Rule Changes

TMB also provides an archive of adopted rule changes by calendar year and effective date going back to 1998. To access this archive on the **Publications** section of the website click on the link below:

Laws & Rules Quick Links

- > General Counsel
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Texas Administrative Code

TITLE 22 EXAMINING BOARDS

PART 9 TEXAS MEDICAL BOARD

ALL NEW Chapters: 1-9-25

<https://texas-sos.appianportals.gov/rules-and-meetings?interface=VIEWTAC&part=9&title=22>

CHAPTER 160	GENERAL PROVISIONS
CHAPTER 161	PHYSICIAN LICENSURE
CHAPTER 162	PHYSICIAN PROFILES
CHAPTER 163	MEDICAL RECORDS
CHAPTER 164	PHYSICIAN ADVERTISING
CHAPTER 169	DELEGATION
CHAPTER 170	STANDARDS FOR USE OF INVESTIGATIONAL AGENTS
CHAPTER 171	COMPLEMENTARY AND ALTERNATIVE MEDICINE STANDARDS
CHAPTER 172	PAIN MANAGEMENT CLINICS
CHAPTER 173	OFFICE-BASED ANESTHESIA SERVICES
CHAPTER 174	BUSINESS ORGANIZATIONS
CHAPTER 175	TELEMEDICINE
CHAPTER 176	REPORTING MALPRACTICE CLAIMS
CHAPTER 177	COMPLAINTS AND INVESTIGATIONS
CHAPTER 179	PROCEDURAL RULES
CHAPTER 180	DISCIPLINARY GUIDELINES
CHAPTER 181	COMPLIANCE PROGRAM
CHAPTER 182	TEXAS PHYSICIAN HEALTH PROGRAM
CHAPTER 183	PHYSICIAN ASSISTANTS
CHAPTER 184	ACUPUNCTURE
CHAPTER 185	SURGICAL ASSISTANTS
CHAPTER 186	MEDICAL RADIOLOGIC TECHNOLOGY
CHAPTER 187	RESPIRATORY CARE PRACTITIONERS
CHAPTER 188	PERFUSIONISTS
CHAPTER 189	MEDICAL PHYSICISTS

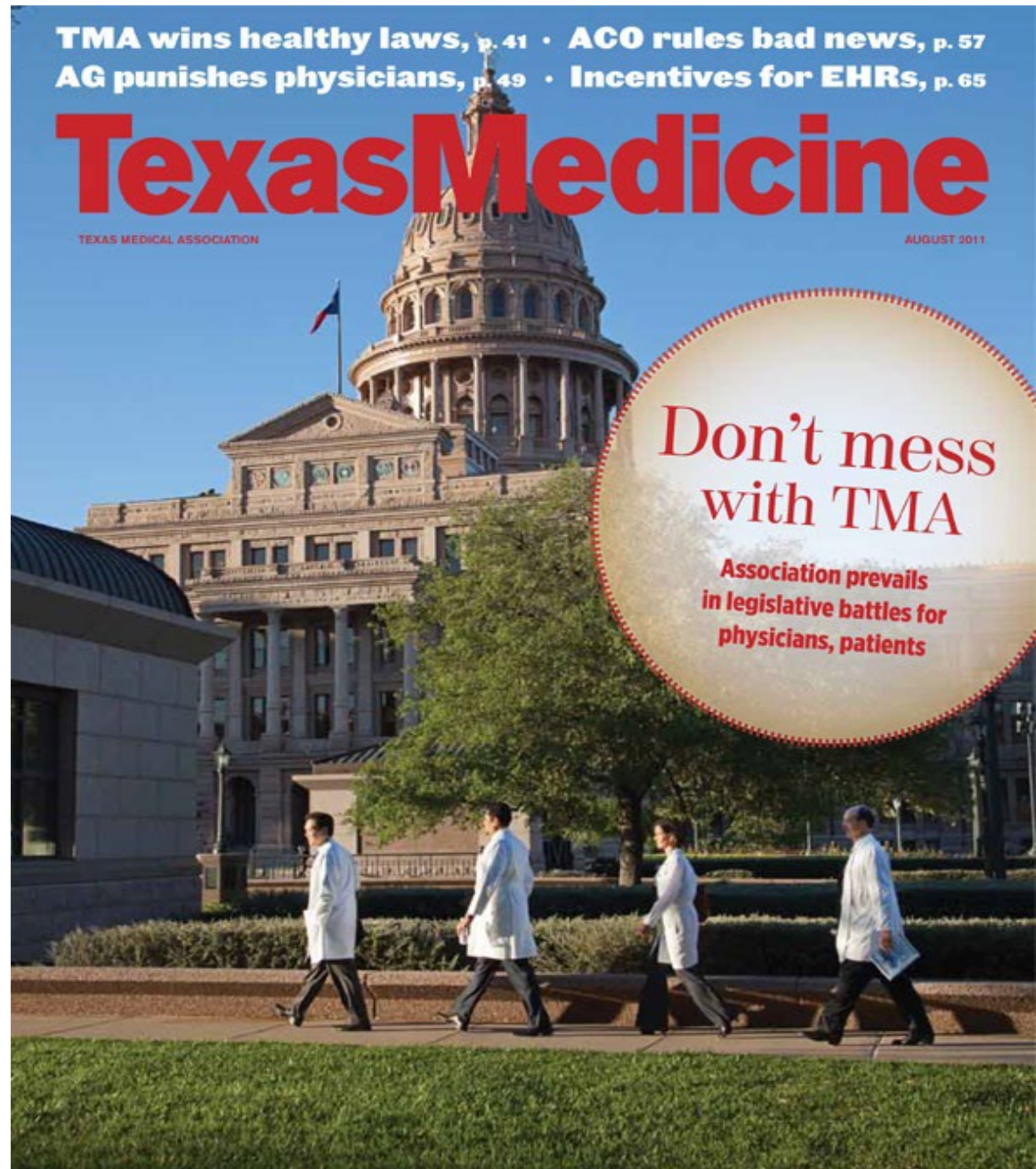
Rule Review Reorganization

NEW CHAPTER	NEW CHAPTER NAME	OLD CHAPTER(S)
160	General Provisions	161, 191
161	Physician Licensure (includes pre-licensure criminal history evaluations, licensure, registration, CME requirements, limited and temporary licenses, PIT permits, fellowship program approval, and emergency practice authorization)	163, 166, 167, 168, 171, 172, 175
162	Physician Profiles	173
163	Medical Records	165
164	Physician Advertising	164
169	Physician Delegation and Supervision	193, 197
170	Standards for the Use of Investigational Agents	198
171	Standards for Physicians Practicing Complementary and Alternative Medicine	200
172	Pain Management Clinics (including minimum requirements for treating chronic pain)	195
173	Office-Based Anesthesia	192
174	Business Organizations	177
175	Telemedicine	174
176	Health Care Liability Lawsuits	176
177	Complaints and Investigations	178, 179, 182
179	Procedural Rules	187
180	Disciplinary Guidelines	190
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182	Texas Physician Health Program	180
183	Physician Assistants	185
184	Acupuncture	183
185	Surgical Assistants	184
186	Medical Radiologic Technology	194
187	Respiratory Care Practitioners	186
188	Perfusionists	188
189	Medical Physicists	160

ADVOCACY

First Tuesdays

Brian Bruel, MD
Carlos Viesca, MD
Cheryl White, MD
C M Schade, MD, PhD



The Beatles 1967

Abby Road Album
Cover





IF YOU AREN'T
AT THE TABLE,
THEN YOU
ARE ON THE
MENU

CONCLUSION