NEW PRESCRIBING LAW FOR TREATMENT OF ACUTE AND CHRONIC PAIN

NEW LAW

WHAT YOU NEED TO KNOW ABOUT

NEW PRESCRIBING LAW FOR TREATMENT OF ACUTE AND CHRONIC PAIN

WHAT PROVIDERS DOES THIS NEW LAW APPLY TO?

Physicians, dentists, optometrists, podiatrists, physician assistants, certified nurse midwives, or advanced practice nurses authorized to prescribe controlled substances.

WHICH PATIENTS ARE EXEMPT FROM THIS NEW LAW?

The law does not apply to a prescription for a patient who is currently in active treatment for cancer, receiving hospice care from a licensed hospice or palliative care, or is a resident of a long term care facility, or to any medications that prescribed in the treatment of substance abuse or opioid dependence (medication assisted treatment).

PRIOR TO ISSUING AN INTIAL PRESCRIPTION FOR ACUTE OR CHRONIC PAIN

In cases of acute or chronic pain a practitioner is required to:

- take and document the results of a thorough medical history, including the patient's experience with non-opioid medication and non-pharmacological pain management approaches and substance abuse history;
- develop a treatment plan, with particular attention focused on determining the cause of the patient's pain; and
- access relevant prescription monitoring information under the Prescription Monitoring Program;

ISSUING AN INITIAL PRESCRIPTION FOR ACUTE PAIN

No authorized prescriber can issue an ***initial*** prescription for a Schedule II controlled dangerous substance or any opioid drug, which is a prescription drug, in a quantity

exceeding a ***five-day supply for treatment of acute pain***. There are no exceptions to this rule, not even for post-operative pain. The law does NOT address what constitutes a 5-day supply; however it does provide that any prescription for ***acute pain*** shall be the lowest effective dose of immediate-release opioid drug.

An initial prescription means that the patient has not had a prescription for that medication (or pharmaceutical equivalent) in the last year. Talking to the patient, looking at their medical record and checking the PMP is necessary to determine whether your prescription would be the patient's "initial" prescription.

ISSUING SUBSEQUENT PRESCRIPTIONS FOR ACUTE PAIN

No less than four days after the initial 5-day prescription, an authorized prescribers may issue a prescription for no more than a 30 day-supply, if necessary.

There are several options available to issue a subsequent prescription after the initial 5-day supply. The regulations require you to assess the patient prior to issuing any subsequent prescriptions, but this does not require a physical exam or office visit:

1. The patient comes into the office to pick up the physical script with or without a physical exam;

2. You can electronically prescribe the Scheduled II CDS or opioid prescription if your system is set up to e-prescribe CDS – REMEMBER e-prescribing is authorized by the feds and state; or

3. If the patient is unable to come to the office and you are not able to e-prescribe, current NJ regulations authorize you to call in an emergency oral prescription for pharmacies to dispense a Schedule II controlled substance in an amount not to exceed a 72 hour quantity necessary to treat the patient during an emergency. However, a written prescription with "Authorization for Emergency Dispensing" and the date of the oral order must be written on it and sent within seven days to the dispensing pharmacist in person or by mail/postmarked within the seven day period. *See N.J.A.C. 13:45H-7.8*

http://www.njconsumeraffairs.gov/regulations/Chapter-45H-Controlled-Dangerous-Substances.pdf

DISCUSSIONS WITH PATIENTS AND NOTATIONS IN PATIENT'S RECORD

Whether prescribing opioids for acute or chronic pain, you are now required to include a note in the patient's medical record that there was a discussion with the patient or the patient's parent or guardian, as applicable, about the risks of developing a physical or psychological dependence on the controlled dangerous substance and alternative treatments that may be available. This discussion must occur prior to the ***initial prescription and prior to issuing the third prescription.*** Once you are treating a patient for chronic pain (defined by the state has 3 consecutive months of treatment) you will be documenting this

discussion as part of the mandatory pain agreement you will enter with the patient, which is outlined further below in this notice.

Until we resolve some confusion with language of the law related to “third script” and “three months” (which is the definition of chronic pain treatment): **WE ARE ADVISING THAT YOU HAVE THESE DISCUSSIONS AT EVERY SCRIPT WRITTEN FOR A SCHEDULED II CDS OR OPIOID PRESCRIBED FOR THE TREATMENT OF PAIN.**

THE DISCUSSION: Prior to issuing the initial prescription of a Schedule II controlled dangerous substance for the treatment of pain or any other opioid drug which is a prescription drug for acute or chronic pain and again prior to issuing the third prescription of the course of treatment, a practitioner shall discuss with the patient, or the patient’s parent or guardian if the patient is under 18 years of age and is not an emancipated minor, the risks associated with the drugs being prescribed, including but not limited to:

(1) the risks of addiction and overdose associated with opioid drugs and the dangers of taking opioid drugs with alcohol, benzodiazepines and other central nervous system depressants;

(2) the reasons why the prescription is necessary;

(3) alternative treatments that may be available; and

(4) risks associated with the use of the drugs being prescribed, specifically that opioids are highly addictive, even when taken as prescribed, that there is a risk of developing a physical or psychological dependence on the controlled dangerous substance, and that the risks of taking more opioids than prescribed, or mixing sedatives, benzodiazepines or alcohol with opioids, can result in fatal respiratory depression.

The Division of Consumer Affairs shall develop and make available to practitioners guidelines for the discussion required. These guidelines are in the works, but will not be much different than our guidance above.

FINANCIAL IMPACT OF 5-DAY SUPPLY LIMIT ON PATIENTS

The law allows insurers to pro rate the patient cost for an opioid when less than a 30-day supply is prescribed. But, the law also allows the insurers to collect payment for the full 30 day supply up front, so patients will not likely see any cost reductions if they only obtain an initial 5-day supply.

PAIN AGREEMENTS NOW REQUIRED FOR TREATMENT OF CHRONIC PAIN

While the use of pain contracts for chronic pain patients (treatment 3 months or longer) has been a BME guideline in current regulation, this new law codifies that regulation and makes the use of pain management agreements mandatory when treating chronic pain, defined as the continuous treatment for pain for three months or more. This part is not necessarily new to physicians treating chronic paint patients. The law provides:

At the time of the issuance of the **third** prescription for a prescription opioid drug, the practitioner shall enter into a pain management agreement with the patient. **The way this is written the third prescription for a chronic pain patient COULD BE SOONER THAN the 3rd month of prescribing. This is one of the conflicts in the law that we are addressing.**

When a Schedule II controlled dangerous substance or any other prescription opioid drug is continuously prescribed for chronic pain, the practitioner shall:

(1) review, at a minimum of every three months, the course of treatment, any new information about the etiology of the pain, and the patient's progress toward treatment objectives and document the results of that review;

(2) assess the patient prior to every renewal to determine whether the patient is experiencing problems associated with physical and psychological dependence and document the results of that assessment;

(3) periodically make reasonable efforts, unless clinically contraindicated, to either stop the use of the controlled substance, decrease the dosage, try other drugs or treatment modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence and document with specificity the efforts undertaken;

(4) review the Prescription Drug Monitoring information; and

(5) monitor compliance with the pain management agreement and any recommendations that the patient seek a referral.

The state is not prescribing a particular agreement or form, however they are in the process of creating a one page template to assist prescribers. The intent of the pain management agreement is to cover the following concerns:

"Pain management agreement" means a written contract or agreement that is executed between a practitioner and a patient, prior to the commencement of treatment for chronic pain using a Schedule II controlled dangerous substance or any other opioid drug which is a prescription drug, as a means to:

(1) prevent the possible development of physical or psychological dependence in the patient;

(2) document the understanding of both the practitioner and the patient regarding the patient's pain management plan;

(3) establish the patient's rights in association with treatment, and the patient's obligations in relation to the responsible use, discontinuation of use, and storage of Schedule II controlled dangerous substances, including any restrictions on the refill of prescriptions or the acceptance of Schedule II prescriptions from practitioners;

(4) identify the specific medications and other modes of treatment, including physical therapy or exercise, relaxation, or psychological counseling, that are included as part of the pain management plan;

(5) specify the measures the practitioner may employ to monitor the patient's compliance, including but not limited to random specimen screens and pill counts; and

(6) delineate the process for terminating the agreement, including the consequences if the practitioner has reason to believe that the patient is not complying with the terms of the agreement.

CHANGES IN INSURANCE COVERAGE FOR ADDICTION TREATMENT

The law increases addiction treatment insurance coverage by requiring insurers to provided unlimited benefits for inpatient or outpatient treatment. The law guarantees coverage for 6 months without any prior authorization or other prospective utilization management requirements. The law also states that the benefits for outpatient visits shall not be subject to concurrent or retrospective review of medical necessity or any other utilization management review. Remember, this insurance mandate will ONLY impact state regulated health plans, not ERISA/self-funded health plans, Medicare or Medicaid.

MANDATORY CME

And, finally, the state is now requiring that you take one credit of educational programs or topics concerning prescription opioid drugs, including responsible prescribing practices, alternatives to opioids for managing and treating pain, and the risks and signs of opioid abuse, addiction, and diversion. This one credit is part of your existing 100 hours for your biennial license renewal. **This will be effective for your 2017-2019 biennial license renewal.**