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H.P. 1102 House of Representatives, April 20, 2011

An Act To Reduce Opioid Overprescription, Overuse and Abuse

Received by the Clerk of the House on April 15, 2011. Referred to the Committee on Health and Human Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

HEATHER J.R. PRIEST
Clerk

Presented by Representative HINCK of Portland.
Cosponsored by Senator CRAVEN of Androscoggin and
Representatives: EVES of North Berwick, FOSSEL of Alna, HASKELL of Portland, LUCHINI of Ellsworth, McFADDEN of Dennysville, PLUMMER of Windham, SANBORN of Gorham, STRANG BURGESS of Cumberland.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA c. 255-A is enacted to read:

CHAPTER 255-A

OPIOID PRESCRIPTION FOR CHRONIC NONCANCER PAIN

§1411. Treatment of chronic noncancer pain

This section applies to the prescribing of opioid drugs for chronic noncancer pain. This section does not apply to the prescribing of opioid drugs for the management of acute pain or for the provision of palliative care, hospice care or other end-of-life care.

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus, generally limited in time to less than 6 months and typically associated with invasive medical procedures, trauma or disease.

B. "Addiction" means a primary, chronic, neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestations that is characterized by behaviors that include impaired control over drug use, craving and compulsive use that is continued despite the risk of harm.

C. "Chronic noncancer pain" means pain that is not the result of the disease of cancer or its manifestations and that persists beyond the usual course of recovery from an illness or healing from an injury or pain that causes continuous or intermittent pain over many months or years.

D. "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.

E. "Health care provider" or "provider" means a provider of health care who is licensed by the State and who is authorized to prescribe drugs by the State and by the United States Department of Justice, Drug Enforcement Administration.

F. "Hospice care" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of 6 months or less and that is provided through a multidisciplinary approach to health care, pain management and emotional and spiritual support.

G. "Opioid drug" means a drug that binds to opioid receptors found principally in the central nervous system and gastrointestinal tract.

H. "Pain management specialist" means:

(1) A physician who is board certified or board eligible in physical medicine, rehabilitation, rehabilitation medicine, neurology, rheumatology or anesthesiology, has a subspecialty certificate in pain medicine from the appropriate allopathic medical board or has a certification of added qualification in pain management from the appropriate osteopathic medical board. For the

purposes of this subparagraph, "board" for an allopathic physician means the American Board of Medical Specialties or its successor and for an osteopathic physician means the American Osteopathic Association or its successor; or

(2) An advanced practice registered nurse who:

(a) Has at least 3 years of clinical experience in a chronic pain management care setting;

(b) Is credentialed in a specialty that includes a focus on chronic noncancer pain management by a national professional association in the field of pain management or quality assurance;

(c) Has successfully completed in the last 2 years at least 18 hours of continuing education in pain management; and

(d) Devotes at least 30% of the advanced practice registered nurse's current practice to the direct provision of pain management care.

I. "Palliative care" means a model of care that improves the quality of life of a patient who suffers from a life-threatening illness and the quality of life of the patient's family with an emphasis on psychological, spiritual and emotional support through attention to prevention, assessment and treatment of pain and other symptoms.

2. Requirements. The following requirements apply to the prescribing of opioid drugs for a patient with chronic noncancer pain.

A. Prior to prescribing an opioid drug for chronic noncancer pain, a health care provider shall obtain, evaluate and document in the patient's health record the patient's health history, including but not limited to current and past treatments for pain, comorbidities, substance use and abuse and a review of information available from a pharmacist and from the Controlled Substances Prescription Monitoring Program under section 7248, and shall perform a physical examination.

(1) In performing the physical examination and evaluating the patient's health history, the health care provider shall evaluate the nature and intensity of the reported pain and the effect of the pain on physical and psychological function.

(2) The health care provider shall review available diagnostic, therapeutic and laboratory results and consultations. The health care provider shall evaluate medications taken by the patient, including indications, date, type, dosage and quantity prescribed, and shall screen the patient for risk for potential comorbidities using an appropriate screening tool that addresses:

(a) History of addiction;

(b) Abuse or aberrant behavior regarding opioid use;

(c) Psychiatric conditions;

(d) Regular concomitant use of alcohol or benzodiazepines or other central nervous system medications;

(e) Poorly controlled depression or anxiety;

(f) Evidence or risk of significant adverse events, including falls or fractures;

(g) History of sleep apnea or other respiratory risk factors;

(h) History of allergies or intolerances to prescription and nonprescription drugs, foods and environmental factors;

(i) Pregnancy and the possibility of pregnancy;

(j) Repeated visits to emergency departments in hospitals seeking access to opioid drugs; and

(k) Receipt of prescriptions for opioid drugs from more than one health care provider or provider group.

(3) The health care provider shall maintain a health record that is easily accessible and available for review that includes the health care provider's diagnosis and the treatment plan required under subparagraph (4), documentation of any recognized indications for the use of pain medications, documentation of medications prescribed, results of periodic reviews, documentation of the health care provider's instructions to the patient and a copy of the written agreement between the health care provider and the patient under paragraph D, if applicable.

(4) The health care provider shall develop and maintain a treatment plan for the patient that states the objectives of the treatment to be provided and that will be used to determine treatment success. The treatment plan must be used to document any relief from pain, any change in physical and psychosocial function and any additional diagnostic evaluations and other planned treatments. The treatment plan must include any additional treatment modalities or rehabilitation programs as appropriate for the patient, depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

B. Prior to prescribing an opioid drug for chronic noncancer pain, a health care provider shall discuss the risks and benefits of treatment options with the patient. If the patient designates another person to speak with the health care provider or if the patient lacks health care decision-making capacity, the health care provider shall conduct this discussion of risks and benefits with the person designated by the patient or with the patient's guardian or surrogate.

C. A health care provider may not knowingly prescribe an opioid drug for chronic noncancer pain for a patient who is under the care of another health care provider and who has received a prescription for an opioid drug from that health care provider except in instances of emergency care or where a health care provider is covering for or assisting the prescribing provider or there has been a transfer of care.

D. A health care provider may prescribe an opioid drug for chronic noncancer pain for a patient who has a history of substance abuse or psychiatric comorbidities or who is judged by the health care provider to be at high risk for medication abuse if, prior to the issuance of the prescription, the health care provider and patient enter into a written agreement for treatment as provided in this paragraph.

(1) The health care provider must commit to providing urine or serum screening on an ongoing basis during the course of treatment.

(2) The patient must commit to:

(a) Undergoing urine or serum screening on an ongoing basis during the course of treatment;

(b) Taking the opioid drug at the prescribed dose and frequency and following a specified protocol for lost prescriptions and early refills;

(c) Not abusing alcohol or other medically unauthorized substances;

(d) Agreeing to the release of the agreement for treatment to hospital emergency departments, urgent care facilities and pharmacies and other health care providers for treatment purposes, to other health care providers to report a violation of the agreement and to law enforcement if the health care provider reasonably believes that the patient has engaged in illegal activities; and

(e) Taking responsibility for the security of the opioid drug, safeguarding it and storing it in a safe place.

(3) The agreement must specify that:

(a) All chronic pain management prescriptions must be written by a single health care provider and dispensed by a specific named pharmacy, except that the patient may notify the health care provider and change to a new pharmacy;

(b) Photographic identification is required and a record must be kept of the person picking up the opioid drug at the pharmacy; and

(c) The agreed-upon drug therapy must be tapered off or discontinued if the patient fails to abide by the terms of the agreement and that the reason for the tapering off or termination must be entered into the patient's health record and treatment plan under paragraph A.

E. A health care provider who prescribes an opioid drug for chronic noncancer pain shall conduct periodic reviews of the patient's health, the course of treatment and any new etiology of the pain as provided in this paragraph.

(1) Except as provided in subparagraph (2), periodic review must take place at least every 6 months.

(2) For patients with a stable medical condition and nonescalating dosages of 40 milligrams of a morphine equivalent dose or less, periodic review must take place at least annually.

(3) During the periodic review, the health care provider shall determine the patient's compliance with the treatment plan under paragraph A, based on information available to the health care provider, including whether pain, function or quality of life has improved or diminished under the course of treatment, and, based on the health care provider's evaluation of progress,

whether continuation or modification of the opioid drug is necessary to achieve treatment objectives.

(4) If the patient's progress or compliance with the treatment plan is unsatisfactory to the health care provider, the provider shall consider tapering the dose or changing or discontinuing the prescribed drug when function or pain has not improved, there is evidence of significant adverse effects, other treatment modalities are indicated or there is evidence of misuse, addiction or diversion.

(5) If the health care provider determines it to be appropriate for the patient, based on information that the provider obtains in the course of treatment or during the periodic review, the provider shall adjust the drug therapy.

F. A health care provider who prescribes an opioid drug for chronic noncancer pain shall include indications for medical use on the prescription and shall require photographic identification of the person picking up the prescription drug at the pharmacy.

G. A health care provider who prescribes an opioid drug for chronic noncancer pain shall periodically review available information relating to the patient from pharmacists, hospital emergency departments and the Controlled Substances Prescription Monitoring Program established under section 7248.

H. A health care provider may prescribe opioid drugs for episodic care such as emergency or urgent care in accordance with this paragraph.

(1) The health care provider shall review any available information relating to the patient from a pharmacist, a hospital emergency department or the Controlled Substances Prescription Monitoring Program established under section 7248.

(2) The health care provider shall limit the prescription of opioid drugs for chronic noncancer pain to the minimum necessary to control the pain until the patient is able to receive care from a primary care health care provider.

(3) The health care provider shall include in the prescription indications for use or the code of a recognized international classification of disease and shall require photographic identification of the person picking up the opioid drug at the pharmacy.

(4) Except during treatment in an emergency room or urgent care center, prior to the health care provider's prescribing the opioid drug, the health care provider and patient shall enter into an agreement for treatment as provided in paragraph D. A health care provider who prescribes opioid drugs in an emergency room or urgent care center shall whenever possible communicate facts and circumstances of the opioid treatment to the patient's primary care physician.

I. Referrals to pain management specialists are subject to the provisions of this paragraph.

(1) Prior to prescribing an opioid drug for chronic noncancer pain, a health care provider may refer a patient to a pain management specialist for a consultation consisting of an office visit in person by the patient to the pain management specialist or a consultation by audio-visual electronic means if the patient is

accompanied by a health care provider and a telephone consultation between the pain management specialist and the health care provider or the electronic transfer between them of information resulting from the consultation.

(2) Prior to prescribing the opioid drug, a health care provider shall refer a patient to a pain management specialist for a consultation if the provider is considering prescribing an opioid drug at or above 120 milligrams of a morphine equivalent dosage per day unless an exemption provided in paragraph K or L applies. The health care provider who refers a patient for a consultation under this subparagraph shall document the referral in the patient's health record and shall include in the record any written report from the pain management specialist. A pain management specialist who provides a consultation for a health care provider under this subparagraph shall maintain a health record for the patient and document the consultation in that record.

(3) Prior to prescribing the opioid drug, a health care provider shall consider referring a patient to a pain management specialist for a consultation if the patient is under 18 years of age or is at risk for medication misuse, abuse or diversion.

(4) Nothing in this paragraph restricts the right of a person, the State, a municipality, a corporation or other entity to require consultation with a pain management specialist prior to the prescribing of an opioid drug for chronic noncancer pain.

J. A health care provider may prescribe a long-acting opioid drug, including but not limited to methadone, for chronic noncancer pain only if the provider has completed at least 4 hours of continuing education related to prescription drug treatments for chronic noncancer pain, undertakes the necessary careful monitoring of the patient and gives special attention to patients who are initiating the treatment.

K. Consultation under paragraph I, subparagraph (2) is not required if all of the other requirements of this section are met and if:

(1) The patient is following a tapering dosage schedule;

(2) The patient requires treatment for acute pain, requiring a temporary escalation in opioid dosage with expected return to the baseline dosage or below that dosage;

(3) The circumstances justify prescribing at or above the 120-milligram morphine equivalent dosage and the health care provider documents reasonable attempts to obtain a consultation; or

(4) The health care provider documents that the patient's pain and function are stable and that the patient is on a nonescalating dosage of opioid drugs.

L. Consultation under paragraph I, subparagraph (2) is not required if the health care provider:

(1) Is a pain management specialist;

(2) Has successfully completed within the last 2 years at least 12 hours of continuing education on chronic pain management approved by a nationally

recognized professional organization on pain management with at least 2 hours devoted to long-acting opioids, including methadone;

(3) Is a pain management practitioner working in a multidisciplinary chronic pain treatment center or an academic research facility; or

(4) Has at least 3 years of clinical experience in a chronic pain management setting and devotes at least 30% of the health care provider's practice to the direct provision of pain management care.

Sec. 2. Review. The Department of Health and Human Services shall review and evaluate the efficacy of comprehensive pain management, including physical therapy and cognitive behavioral therapy, and report back to the Joint Standing Committee on Health and Human Services no later than December 7, 2011.

SUMMARY

This bill establishes protocols for the health care provider community to follow in prescribing opioid drugs for chronic noncancer pain. It includes provisions on physical examinations, health records, periodic review of patient health and consultations with and referrals to pain management specialists. It requires the Department of Health and Human Services to review and evaluate the efficacy of comprehensive pain management, including physical therapy and cognitive behavioral therapy, and report back to the Joint Standing Committee on Health and Human Services no later than December 7, 2011.