Massachusetts Opioid Legislation Practice Guide

Fact Sheet:
An Act Relative to Substance Use Treatment, Education and Prevention
Contents

Mass. Opioid Legislation Practice Guide ........................................ 1
www.massmed.org/opioid-practice-guide

Fact Sheet: An Act Relative to Substance Use Treatment,
Education and Prevention .......................................................... 4
www.massmed.org/opioidbill2016

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Massachusetts Opioid Legislation Practice Guide


Included in the law are several new legal requirements related to opioid prescribing, many of which are effective immediately. This guidance addresses several key changes to prescribing laws. All of the below requirements are effective immediately and should be incorporated into your clinical practice.

New requirements for outpatient prescribing of all opiates (Schedule II through VI)

- For adults age 18 or older, **first-time opiate prescriptions** as described in paragraph (a) **should be limited to a seven-day supply**, unless one of the following exceptions in paragraph (b) apply:
  - Applicable opiate prescriptions: Until there is further guidance from the DPH, this requirement applies to **any opiate/opioid that is considered a Schedule II–VI drug**. Even prescriptions in Schedule IV or V that have a low potential for abuse are covered (e.g., butorphanol, pentazocine, Talwin, propoxyphene, codeine cough suppressants, hydrocodone cough suppressant, opium preparations of 100 mg).
  - This new requirement does not apply to any prescription designed for the treatment of substance use disorder or opioid dependence (e.g., methadone, buprenorphine, or other such medications used to address withdrawal symptoms as determined by the treating clinician).
  - Providers should document in the medical record each and every time an outpatient opiate prescription is provided to a patient for such treatments to demonstrate (if audited) that the prescription qualifies for this overall exception to the prescribing limits (e.g., “this prescription is for the purpose of substance use disorder or opioid dependence treatment”).
  - **Exceptions to seven-day supply limit**: The statute allows for first time opiate prescriptions of greater than a seven-day supply if any of the following exceptions apply: prescription is for pain related to an acute medical condition, chronic pain management, pain associated with a cancer diagnoses, or palliative care.
  - If a first time opiate prescription is being written for greater than a seven-day supply pursuant to an exception, the prescriber must do the following:
    1. Document in the medical record the specific exception for which the opiate is being prescribed; and
    2. Provide brief information about the actual condition or treatment that necessitates more than seven days; and
    3. Indicate whether there were known and available non-opiate alternatives.
Special provisions for minors

For minors under age 18, every opiate prescription as described the following should be limited to a seven-day supply, unless one of the exceptions below apply:

- **Applicable opiate prescriptions:** Until there is further guidance from the DPH, it is also important to note that this requirement applies to any opiate/opioid that is considered a Schedule II–VI drug. So even though prescriptions in Schedule IV or V have a low potential for abuse, they would be covered (e.g., butorphanol, pentazocine, Talwin, propoxyphene, codeine cough suppressants, Hydrocodone cough suppressant, opium preparations of 100 mg).

- This seven-day limit does not apply to any prescription designed for the treatment of substance use disorder or opioid dependence (e.g., methadone, buprenorphine, or other such medications used to address withdrawal symptoms as determined by the treating clinician).

- Providers should document in the medical record each and every time an outpatient opiate prescription is provided to a patient for such treatments to demonstrate (if audited) that the prescription qualifies for this overall exception to the prescribing limits (e.g., “this prescription is for the purpose of substance use disorder or opioid dependence treatment”).

- **Exceptions to seven-day supply limit for minors:** The statute allows for opiate prescriptions for minors for greater than a seven-day supply if any of the following exceptions apply: prescription is for pain related to an acute medical condition, chronic pain management, pain associated with a cancer diagnoses, or palliative care.

- If an opiate prescription is being written to a minor for greater than a seven-day supply pursuant to an exception, the prescriber must do the following:
  1. Document that the prescription is for either: (1) an acute medical condition, (2) chronic pain management, (3) pain associated with a cancer diagnoses, or (4) palliative care; and
  2. Provide information about the actual condition or treatment that necessitates more than seven days; and
  3. Indicate whether there were known and available non-opiate alternatives, and
  4. Document that there was a discussion with the parent/guardian of the known risks with the specific prescription and why it is necessary for that condition/treatment.
New requirements for Schedule II opioids

For Schedule II opioid prescriptions, all requirements cited above must be achieved, and there must be documentation in the medical record:

1. That there was a discussion with the patient of any known risks associated with the specific opioid prescription; and
2. That you have discussed the amount to be prescribed and the option to fill the prescription in a lesser amount.

There must be notation on the actual prescription that that “the patient may fill in an amount not to exceed the recommended full quantity indicated.”

New requirements for extended-release long-acting opioids in non-abuse deterrent form

1. For any prescription of extended-release long-acting opioids in non-abuse deterrent form, all requirements cited above must be achieved, and
2. Note that the prescriber performed an evaluation of the patient’s current condition, known risk factors, history of substance abuse, and current medication usage; and
3. Note that there was a discussion with the patient about the specific medication being an appropriate course of treatment based on the patient’s current medical condition or treatment.

New requirements for long term pain management with extended-release long acting opioids in non-abuse deterrent form

1. For any prescription for long term pain management with extended-release long-acting opioids in non-abuse deterrent form, all requirements cited above must be achieved, and
2. The provider should enter into a pain management treatment agreement with the patient that among other things must also address in the agreement the benefits and risks of abuse/misuse. This information must also be contained in the patient’s medical record.
Fact Sheet: An Act Relative to Substance Use Treatment, Education and Prevention

Chapter 52 — Acts of 2016*

The MMS shares the Commonwealth’s concern with drug abuse and has put forth a variety of initiatives to address the opioid crisis. We commend Governor Baker, his administration, and the State Legislature in crafting a law that offers a number of helpful measures to reduce prescription drug and opioid abuse. We also appreciate the significantly increased funding for addiction services, expanded insurance coverage, and enhancements to the state’s Prescription Monitoring Program (PMP).

Unless otherwise noted, these provisions became effective March 14, 2016.

Highlights related to the practice of medicine:

- Imposes a seven-day limit on prescribing of opiates to a patient for the first time. Provision applies to minors for every such prescription, with parental notification. For outpatient cases only. Exceptions for acute medical conditions, chronic pain, cancer and palliative care. (Section 24)

- Prescribers must check the Prescription Monitoring Program (PMP) every time for a Schedule II and III narcotic is prescribed. Maintains current statutory language requiring regulations to recognize circumstances under which such narcotics may be prescribed without first utilizing the PMP, and permits delegates to use the PMP on behalf of the prescriber. Effective Oct. 15, 2016. (Section 27)

- Allows patients to request a partially filled opioid prescription. The pharmacist must notify the prescriber within seven days. Prescribers must discuss with the patient the quantity of the prescription and the option to partial fill. Remainder of the prescription becomes void. (Section 21)

- All prescribers must complete appropriate training in pain management and addiction, to be determined by boards of registration. (Section 22)

- Prior to issuing an extended-release long-acting opioid in a non-abuse deterrent form for outpa- tient use for the first time, a practitioner must evaluate the patient’s current condition, risk factors, history of substance abuse, if any, and current medications; and inform the patient and note in the patient’s medical record that the prescribed medication, in the prescriber’s medical opinion, is an appropriate course of treatment based on the medical need of the patient. (Section 23)

- Prescriptions for extended-release long-acting opioids require the prescriber and patient to enter into a written pain management treatment agreement. (Section 23)

- Requires the Department of Public Health to establish a voluntary non-opiate directive form, indicating to all practitioners that an individual shall not be administered or offered a prescription or medication order for an opioid. Directive may be revoked at any time, in writing or verbally. Directive to be recorded in patient’s medical records. Exemptions for emergencies. Liability protections for prescribers and pharmacists. Effective Dec. 1, 2016. (Section 23)

- Establishes a benchmarking mechanism for prescribers. The Department of Public Health determines mean and median quantity and volume of prescriptions for opiates, within categories of similar specialty or practice types. Prescribers who exceed mean or median will be sent notice. Rankings are confidential, are not admissible as evidence in a civil or criminal proceeding and are not to be used as the sole basis for an investigation by the board of registration. Effective Dec. 1, 2016. (Section 29)

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• Requires the establishment of a drug stewardship program to be paid for by drug companies that makes it easier for patients to safety dispose of unwanted and unused medications. Effective Jan. 1, 2017 (Section 31)

• Requires overdose and naloxone patients in emergency departments to undergo a substance abuse evaluation by a licensed mental health professional or through an emergency service program within 24 hours. Can’t be discharged before 24 hours or before evaluation, whichever comes first. Clinicians cannot be held liable in a civil suit for releasing a patient who does not wish to remain in the emergency department after stabilization but before a substance abuse evaluation has taken place. Parents of overdose minors must be notified. Emergency departments must notify a patient’s primary care provider, if known. Private insurers must pay for substance abuse evaluations without prior authorization. Effective July 1, 2016. (Section 32)

• Requires the Mass. Behavioral Health Access website to post contact info for all insurers, including 24/7 phone number. (Section 61)

• The Division of Insurance must develop a universal intake form for intake of behavioral health and substance abuse patients. (Section 67)

• Insurers must report on medical/surgical, mental health and substance abuse disorder claims. (Section 53)

• Health Policy Commission, Department of Public Health, and Department of Mental Health directed to study availability of services for dual diagnosis patients. (Section 57)

• Special commission on incorporating pain management and safe prescribing into student training. Commission members include MMS. (Section 58)

• Special commission to study the feasibility of establishing a pain management access program. Commission members include MMS. (Section 59)

• Prohibits the sale, manufacture, or possession of powdered alcohol. (Section 41)

Other highlights:

• Authorizes the municipal police training committee to establish a training course on drug-related overdoses. (Section 1)

• Requires drivers education programs to have courses on addiction and addictive substances. (Section 14)

• Requires public schools to educate students about substance abuse prevention. Schools must develop and utilize a verbal screening tool to screen pupils for substance abuse disorders, at two different grade levels. The parent or guardian may opt out of the screening. (Section 15)

• Those who administer naloxone in good faith are not liable for acts or omissions from attempting to administer the drug to anyone believed to be experiencing an overdose (Section 37)

• The Board of Registration in Pharmacy must establish a rehabilitation program for pharmacists, pharmacy interns, and pharmacy technicians who have a substance abuse issue. (Section 38)

• Insurers, HMOs, behavioral health management firms, and third-party administrators under contract to Medicaid must cover substance abuse evaluations without preauthorization. Effective July 1, 2016. (Section 39).

*For the full text of the legislation, go to www.massmed.org/opioidbill2016/fulltext.
For more information please visit www.massmed.org/smart-and-safe.