RHODE ISLAND MEDICAL SOCIETY

New LAWs and Existing REGULATIONS for Opioid Use in Managing Acute and Chronic Pain

A quick reference guide prepared by the Rhode Island Medical Society for physicians and other prescribers
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NEW LAWS

What is the key element of Rhode Island's new opioid prescribing laws?

The key element is the following new opioid prescribing limit, which became effective **JUNE 28, 2016**:

- **Initial opioid prescriptions for outpatient adults may not exceed 30 morphine milligram equivalents (MMEs) or 20 total dosages.**
- This limit does not apply to Medication Assisted Treatment (MAT) for opioid dependence or to palliative care.
- Pediatric patients will have a different limit. The new law requires the Department of Health to set separate maximum opioid dosage limits for pediatric patients, but the Department has not yet done so as of this writing. Prescribers should use discretion when prescribing opioids for children and youth.
- Revised regulations will be forthcoming from the Health Department. As always, RIMS will intervene with the Department as needed to shape the regulations, and RIMS will keep its members apprised of developments.

EXISTING REGULATIONS and ANTICIPATED IMPACT of the NEW LAWS

Who is subject to the opioid prescribing regulations?

Every health care professional who maintains a State of Rhode Island Controlled Substances Registration (CSR), also known as the Drug Enforcement Agency (DEA) number, and who prescribes opioids is subject to the regulations. Every such health care professional must be a registered user with the state's Prescription Drug Monitoring Program (PDMP) www.ripmp.com; under the new law such registration now happens automatically upon initial CSR/DEA registration or upon renewal. Under legislation introduced by RIMS and enacted by the General Assembly in 2014, registered users may then designate a staff member to routinely query the PDMP, once the primary user is registered.

What is "acute pain" under the regulations?

"Acute pain" is considered to be the normal, predicted physiological response to a chemical, thermal, or mechanical injury and typically is associated with invasive procedures, trauma, and disease. "Acute pain" generally results from nociceptor activation in damaged tissues and typically resolves once the tissue damage is repaired. The duration of acute pain varies.

Palliative care and medication assisted therapy (MAT) for opioid addiction are exempt under the new law.

What is "chronic pain" under the regulations?

"Chronic pain" is considered to be pain lasting longer than ninety (90) days, excluding pain requiring palliative care.

What if my patient has "chronic pain" as defined in the regulations as pain lasting more than 90 days?

Practitioners prescribing opioids for more than 90 days for patients who have chronic pain must have a signed written patient treatment agreement that is a part of the medical record. The written agreement may be started at any point, at the practitioner's discretion, but no later than after ninety (90) days of treatment with an opioid medication.

The content of the written patient agreement for treatment is at the practitioner's discretion.

Sample pain treatment agreements may be downloaded from www.health.ri.gov/saferx

Again, palliative care and medication assisted therapy (MAT) for opioid addiction are exempt from these requirements.

Is there a periodic review requirement for chronic pain patients?

Yes. Required periodic reviews include a PDMP check at least every 3 months and an in-person visit at least every 12 months. At the 12-month visit the practitioner shall determine:

(1) Patient's degree of adherence to any medication treatment plan.
(2) Whether pain, function, or quality of life have improved or worsened, using objective evidence.
(3) Whether continuation or modification of medications for pain management treatment is necessary based on the practitioner's evaluation of progress towards treatment objectives.

The practitioner shall consider tapering, changing, or discontinuing treatment when:

(1) Function or pain does not improve after a trial period; or
(2) There is reason to believe there has been misuse, addiction, or diversion.

When must the PDMP be checked?

All professionals with a CSR must query the state's Prescription Drug Monitoring Program (www.ripmp.com) either in person or through a designee and document the query in the medical record:

1) Before initiating any opioid treatment.
2) At least every 90 days for patients being treated for chronic pain (palliative care and MAT excepted).
3) Upon initiating or renewing opioid therapy using an intrathecal pump.

How up to date is the prescription information in the PDMP?

Pharmacies are now required to transmit opioid prescription information to the PDMP within one business day of dispensing any opioid prescription. Thus, PDMP information should be much more current than in the past.

Can my office access the PDMP through our EMR ("single sign-on")?

Theoretically yes, but medical offices will have to work with their EMR vendors to effectuate this. The new laws now permit EMR vendors to access the PDMP for the purpose of installing single sign-on functionality for the EMR used by a practice.

What about alternatives to opioids for treating chronic pain patients?

Chronic pain often requires a multidisciplinary approach. Patients will often benefit from appropriate consultation not only with pain management specialists, but also with other professionals. Chiropractors, acupuncturists, behavioral health specialists and physical therapists are examples of clinicians who may be able to help alleviate patients' chronic pain through other than medication.

Can I refer or require a chronic pain patient to see another practitioner?

Yes, a practitioner may refer or require a patient to seek care from another practitioner for ongoing treatment. The referring practitioner shall facilitate a safe transition of care for any patient being referred to another practitioner. Safe transition shall include documented practitioner-to-practitioner contact regarding the patient and appropriate steps to prevent a disruption in the patient's continuity of care for pain management.

Indications for referral to other professionals may include:

- Patients self-escalating their doses.
- Early refills.
- Inadequate pain relief.
- Co-existing morbidities such as a need for dialysis, chronic liver disease, prior history of a substance disorder, or prior over-dose.

NB: Revised regulations incorporating and codifying the changes required by the new laws will be forthcoming from the Health Department. As always, RIMS will intervene with the Department as needed to shape regulations appropriately. RIMS will keep its members apprised of developments.