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PROFESSION

States try more aggressive Rx opioid controls

Stricter oversight of physicians includes setting dosage limits and requiring CME.

By KEVIN B. O'REILLY, amednews staff. *Posted Oct. 17, 2011.*

The effort to reduce painkiller overdoses and deaths is moving beyond prosecuting so-called pill mills to direct regulation of any physician who prescribes opioids for patients with chronic noncancer pain.

The strictest regulation of opioid prescribing is in Washington state. In July, rules affecting osteopathic physicians and nonphysician prescribers took effect. The rules, which cover allopathic physicians starting in January 2012, include detailed instructions on how to evaluate and care for patients with chronic noncancer pain. Also required are written treatment plans known as "patient contracts" that call for mandatory, periodic urine screenings.

The rules mandate that primary care doctors consult with board-certified pain specialists before prescribing daily morphine-equivalent doses of 120 mg or greater -- the first dosage threshold of its kind in the U.S.

In June, Ohio began mandating that physicians working at pain clinics -- practices where more than 50% of patients are prescribed opioids -- complete 20 hours of pain medicine continuing medical education every two years. Physicians who own pain clinics, must register with the medical board, comply with patient-tracking requirements and undergo random site inspections.

Ohio's actions come on the heels of similar pain clinic rules adopted in Florida in 2010. Florida and six other states make medical licensure contingent on physicians completing CME courses related to pain management or prescribing controlled substances.

Meanwhile, 36 states have prescription-monitoring programs up and running, and an additional 12 states and the District of Columbia have enacted legislation authorizing them. Half of these programs, which aim to identify pill mills and stop substance-abusing patients from "doctor shopping," have been established within the last five years.

Fatal poisonings from opioid overdoses tripled to nearly 14,000 nationwide between 1999 and 2006, according to the Centers for Disease Control and Prevention. Opioid-related emergency department visits doubled to more than 300,000 between 2004 and 2008. In 2009, deaths induced by any kind of prescription drug totaled 37,845 across the country. That figure exceeded the number of traffic-related fatalities by 1,561, the CDC said.

Nearly 1,700 Washington residents died of unintentional opioid poisonings between 2004 and 2007, and opioid-related hospitalizations rose seven-fold between 1995 and 2007, according to data released by state government agencies.

"The pendulum has swung too far in terms of liberal use of opioids. Now it's swinging back the other way," said Mimi Pattison, MD, chair of Washington's medical board, the Medical Quality Assurance Commission, which wrote the state's rules.

Other states are likely to follow Washington's lead in scrutinizing doctors' prescribing of opioids, said Dr. Pattison, a hospice and palliative care physician in Tacoma, Wash.

"It's something we're going to see around the country," she said. "Everybody is in the same position in terms of rising [opioid-related] death rates and nobody's come up with anything better at this point."

Preventing overdoses

Florida, Maine, Minnesota, New Mexico, Tennessee, Utah and West Virginia are among the states where officials are monitoring whether Washington's approach succeeds, said Alex Cahana, MD, a proponent of the state rules and chief of the pain medicine division at the University of Washington School of Medicine.

By requiring primary care physicians to evaluate and measure patients' response to opioids and consult with specialists, the new rules could push more doctors to see when the medicines are not helping, Dr. Cahana said.

"There's a growing body of knowledge from research that shows that, many times, escalating doses of opioids do not result in improved pain, mood and functioning," he said.

Though the rules have yet to take effect for most physicians in the state, the Washington State Medical Assn. has received reports from doctors who say they plan to avoid prescribing opioids altogether due to the added regulatory burden.

The association has objected to the prescriptive nature of the rules, saying they ought to allow physicians more flexibility to use their clinical judgment.

Patients with chronic pain already have complained to county medical societies about greater difficulties finding physicians willing to treat them. More than two-thirds of community health clinics surveyed in September by the American Pain Foundation, a patient advocacy group, said they will not treat chronic pain patients. An additional 10% of the 103 clinics surveyed said they will treat these patients, but not with opioids. The survey did not ask whether these refusals were due to the impending rules.

The new regulations are "ideologically driven," said Michael Schiesser, MD, an addiction-medicine specialist in Bellevue, Wash., who has worked closely with the state medical association in objecting to the regulatory provisions. "There are major problems in trying to solve this whole mortality and complications issue with addiction, diversion and otherwise," he said. "But there are a whole lot more people out there with pain, whether it's addressed by a doctor or not, than there are these complications. We're really throwing out the baby with the bathwater here."

About 40% of Dr. Schiesser's patients live with chronic pain. Nationwide, more than 116 million Americans struggle with such pain each year, an Institute of Medicine panel said in July. Medical expenses and lost productivity linked to chronic pain cost the U.S. as much as $635 billion annually.

The American Medical Association has policy that supports balancing patient access to appropriate pain treatment with the need to reduce diversion and misuse. It opposes linking Drug Enforcement Administration registration with added training requirements.

In May, the Obama administration lent its support to federal legislation to make DEA authorization to order controlled substances contingent on completing opioid prescribing CME.

Washington's dosage rules came in response to a Jan. 19, 2010, *Annals of Internal Medicine* study showing patients with chronic pain taking a 100 mg morphine-equivalent daily dose are nine times likelier to overdose than patients on 20 mg.

The state's 120 mg morphine-equivalent dose threshold could have unintended consequences, said Scott M. Fishman, MD, former president of the American Academy of Pain Medicine.

"While this is extremely well-intended, it sends exactly the wrong message -- that you don't need to be concerned or vigilant until you get to high doses," said Dr. Fishman, who spoke on behalf of the academy and is chief of the pain medicine division at the University of California, Davis, Health System. "Doctors need to be concerned from day one."

ADDITIONAL INFORMATION:

Tracking prescription drugs

Nearly every state has enacted or established a prescription drug-monitoring program. These programs typically allow physicians and public health and law enforcement officials to see which controlled substances patients are getting and where they get them. Eight states require at least some physicians to take CME courses related to pain-medicine prescribing.

Click to see data in PDF.

No prescription-monitoring legislation or program: Missouri, New Hampshire

Enacted prescription-monitoring program legislation: Alaska, Arkansas, Delaware, District of Columbia, Georgia, Florida, Maryland, Montana, Nebraska, New Jersey, South Dakota, Washington, Wisconsin

Have operational prescription-monitoring programs: All other states

Require physicians to take CME related to pain management or controlled-substances prescribing: California, Florida, Ohio*, Oklahoma, Oregon, Rhode Island, Tennessee, West Virginia

*Ohio's requirement applies only to physicians working in clinics where more than 50% of patients have chronic pain and are treated with opioids.

Sources: "Status of Prescription Drug Monitoring Programs," Alliance of States with Prescription Monitoring Programs, Sept. 13; American Medical Association

WEBLINK

Washington State Dept. of Health pain-management rules (**www.doh.wa.gov/hsqa/professions/painmanagement**)

Washington State Medical Assn. on opioid-prescribing rules (**www.wsma.org/medical_professionalism/clinical-resources.cfm**)

"Opioid prescriptions for chronic pain and overdose: a cohort study," *Annals of Internal Medicine*, Jan. 19, 2010 (**www.ncbi.nlm.nih.gov/pubmed/20083827**)

"Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy: 2010 Update," Washington State Agency Medical Directors Group

(**www.agencymeddirectors.wa.gov/files/opioidgdline.pdf**)

"Frequently Asked Questions About permanent Rule 4731-29-01: Standards and Procedures for the Operation of a Pain Management Clinic," State Medical Board of Ohio, August (**www.med.ohio.gov/pdf/rules/FAQ re perm Rule 4731-29-01.pdf**)

Florida Dept. of Health pain clinic registration (**www.doh.state.fl.us/mqa/medical/me_pain.html**)

"Prescription Monitoring Frequently Asked Questions," Alliance of States with Prescription Monitoring Programs (**www.pmpalliance.org/content/prescription-monitoring-frequently-asked-questions-faq**)

"Emergency Department Visits Involving Nonmedical Use of Selected Prescription Drugs -- United States, 2004-2008," *Morbidity and Mortality Weekly Report*, June 18, 2010 (**www.cdc.gov/mmwr/preview/mmwrhtml/mm5923a1.htm**)

"Deaths: Preliminary Data for 2009," *National Vital Statistics Reports*, March 16 (**www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_04.pdf**)

"Relieving Pain in America: A Blueprint for Transforming Care, Education, and Research," Institute of Medicine, June 29 (**www.iom.edu/relievingpain**)

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