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Reducing Inappropriate Opioid Use in Treatment of Injured Workers

A Policy Guide

International Association of Industrial Accident Boards and Commissions
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Introduction

Over the past two decades, the use of opioids in the treatment of chronic pain has skyrocketed in North America, and the excessive and inappropriate use of these medications has caused devastation to individuals, communities, and society at large. Researchers for the Centers for Disease Control and Prevention (CDC) recently reported that 16,651 people died of opioid overdoses in the United States 2010, just one alarming statistic in what is now referred to as an epidemic (Jones, Mack, & Paulozzi, 2013).

There is wide variation in opioid use and abuse across jurisdictions, but in more than fifteen U.S. states, deaths from prescription drug overdoses now exceed deaths from traffic accidents. Death statistics, while striking, represent a small fraction of the human and financial cost of this epidemic. The CDC's report, *CDC Grand Rounds: Prescription Drug Overdoses - a U.S. Epidemic* (2012), states that for every one opioid related death, there are more than 150 people who abuse or are dependent on opioids. Using 2010 numbers, that means over two million people are abusing or addicted to these powerful drugs. Birnbaum et al (2011) estimated opioid abuse, dependence, and misuse costs at $55.7 billion in 2007.

The devastating effects of this epidemic have motivated action by local, state, and federal legislators, medical providers, law enforcement personnel, and community groups across the country. Several jurisdictions have taken action to address and monitor the use of prescription drugs in their workers' compensation system. Recognizing the need for guidance on this important subject, the International Association of Industrial Accident Boards and Commissions (IAIABC) has developed this guide to describe possible public policy responses to address inappropriate opioid use specifically in workers' compensation.

Opioids in Workers' Compensation

The impact of opioid abuse in the general population is well documented, but research is just beginning to show the extent of opioid use and abuse in the U.S. workers' compensation system. Research in this area indicates the following:

- Pharmacy costs represent an estimated 19% of workers' compensation medical costs, according to an NCCI research report. Oxycontin was the first ranked drug by dollars spent in states studied (Lipton, Laws, & Li, 2011).[1]
- In Michigan, 38% of all medical claims for injury year 2008 received narcotics (White, Tao, Taireja, Tower, & Bernacki, 2012).
- In 2011, Schedule II opioid prescriptions accounted for 6.7% of all workers' compensation prescriptions in California, an increase of more than 6 times the 2002 level (Ireland, Young, & Swedlow, 2012).

[1] Lipton, Barry, et al, "Workers' Compensation Prescription Drug Study: 2011 Update," August 2011. NCCI research reports included data collected from workers' compensation carriers across the country. The data sample includes all U.S. states, including the District of Columbia, except North Dakota, Ohio, Washington, West Virginia, and Wyoming.

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- 35 deaths in 2009 were definitely or probably related to accidental overdose of opioids in Washington State's workers' compensation system (Franklin, 2011).
- Louisiana saw the annual cumulative dose and cost of opioids per claim increase over a ten-year period from 1999 to 2009. The annual morphine equivalent dosage increased approximately 55 mg per claim per year for acute pain, and 461 mg per claim per year for chronic pain (Bernacki, Yspeh, Lavin, & Tao, 2012).

In addition to the above descriptive research, a growing number of researchers and workers' compensation experts have written about the challenges of inappropriate use for the workers' compensation system. In a 2012 *Risk and Insuranc*e article, Peter Rousmaniere reflects on this issue:

> These opioid-related deaths are the lost, invisible cases. OSHA recording does not pick them up and insurers are not required to report them to state agencies. Had there been a more accurate and timely reporting of these deaths, it is likely that the workers' comp system would have responded earlier and more forcefully to the risks inherent in opioid prescribing.

In the same article, Rousmaniere estimates that at least 200 deaths per year are attributable to opioids in workers' compensation. This estimate may be low, given that Massachusetts estimated 20 deaths a year from workers' compensation related opioid overdose (Hashimoto, 2013), and Washington State estimated 35 deaths in 2009.

Though tragic, these deaths represent only a small fraction of the consequences that stem from inappropriate opioid use. While not specific to workers' compensation, the CDC reports that misuse of prescription painkillers results in many more emergency room visits, drug dependency problems, and other disruptions of family life (CDC *Grand Rounds*, Prescription Drug Overdoses – A U.S. Epidemic, 2012). These additional challenges would likely be seen in workers' compensation cases as well.

A report produced by Lockton and Associates (2012), a nationwide brokerage and consulting firm, stated the problem in alarming terms:

> Prescription opioids are presently the number one workers' compensation problem in terms of controlling the ultimate cost of indemnity losses…There has never been a more damaging impact on the cost of workers' compensation claims from a single issue than the abuse of opioid prescriptions for the management of chronic pain.

Long term use of opioids is devastating to return to work. The problem of pain medicine prolonging disability has reached the point that it captures banner coverage by the general news media. For instance, the *New York Times* ran a feature article on delayed return to work associated with pain medication. They reported a finding by the California Workers' Compensation Institute that workers who got high doses of opioid painkillers to treat injuries like back strains stayed out of work three times longer than those with similar injuries who took lower doses (Meier, 2012).

It may be intuitively obvious that a claim involving opioid use would likely have higher total costs than claims without opioid use, all other things equal. The Accident Fund in Michigan, in conjunction with John Hopkins University, recently quantified this intuition with startling findings (White et al, 2012). They conducted a study of 1,200 workers' compensation claims made over a four year period. Their key findings:

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- Where long acting opioids were encountered in the claim file, the claim was almost 3.9 times more likely to have a final cost of >$100,000 than a claim without any prescriptions.
- Claims with only short acting opioids were 1.76 times more likely to have an ultimate claims cost of >$100,000 than claims without any prescriptions.
- Claims with non-opioid prescriptions showed no significant risk of exceeding $100,000.

The research is clear that inappropriate opioid use is a critically important topic for the workers' compensation community to address. The epidemic is damaging lives and driving up costs.

Background

The challenges of addressing inappropriate opioid use are many; it is a complex problem that touches all workers' compensation stakeholders – the injured worker, the employer, the physician, the pharmacist, the payer, the claims administrator, and others. This resource provides a guide for policymakers and administrators who are interested in implementing policy solutions to reduce the inappropriate use of opioids in the workers' compensation system.

The IAIABC recognizes that each jurisdiction has different statutory and regulatory authority. As such, the IAIABC understands that all of the elements discussed below may not be feasible in every jurisdiction. The IAIABC encourages jurisdictions to evaluate each of the elements of this guide and to use them in crafting a response that will be successful within their legislative and regulatory system. This guide includes policy examples from jurisdictions across the United States and seeks to synthesize the various responses to offer a range of possible approaches although it is not to be considered an exhaustive analysis of all examples from across the country. States including Washington, Colorado, Texas, Minnesota, and Massachusetts have been particularly proactive about implementing regulatory policies to address opioid use and abuse in workers' compensation. The impact of these policies is actively being studied and provides valuable analysis for other states interested in certain regulatory approaches.[2]

The IAIABC is a consensus-driven organization and as such, some participants may not agree with all of the policy options presented here. However there is clear consensus opinion that the IAIABC can and should provide insight on regulatory and statutory options being used to address inappropriate use of opioids in the workers' compensation system. It is the IAIABC's hope this document is a valuable resource for administrators, regulators, and other stakeholders who want to reduce the deaths and suffering that have resulted from the misuse and abuse of opioids, while allowing for the effective management of pain through drugs when appropriate and other non-drug therapies.

The risks and limitations of long-term opioid use are well documented in current medical research, particularly research focused on occupational injuries. It is important for jurisdictions to monitor the effects of policy solutions related to opioid use in workers' compensation to ensure they are successful in meeting defined objectives and that policies are aligned with the most current evidence-based medical practices. We strongly

[2] Massachusetts, Texas, and Washington have studied the impact of their opioid management policies, and all three have seen a reduction in opioid prescribing patterns over the past several years. The Appendix includes a list of the presentations and research reports that describe their results.

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encourage jurisdictions to convene a multi-disciplinary panel to explore the depth of the opioid problem and evaluate any policy proposals.

The IAIABC remains committed to monitoring and addressing this issue and will continue to share research, resources, and strategies as organizations find success in combating inappropriate opioid use.

Policy Options

Agency Coordination

Recommendation(s): A jurisdiction's policy response should include coordination among all relevant agencies with interests or oversight duties related to prescription opioid use, including health departments, insurance and workers' compensation regulators, agencies charged with regulation of pharmacies and prescribing physicians, and other governmental entities (including law enforcement) that may play a role monitoring and enforcing jurisdictional policies.

This coordination should include a review of existing statutes, rules, and relevant policies of non-government agencies (e.g. state medical societies) that address opioid prescriptions. Only in this way can agencies learn what new legal authority is needed to address specific issues in that jurisdiction.

Background and Examples:

It is very unlikely that a workers' compensation agency will have the authority and resources to implement a comprehensive policy response independently. Therefore, it is recommended that a workers' compensation agency carefully coordinate with other agencies/departments within their jurisdiction. This collaboration includes participation from the department of health, departments of medical and pharmacy licensing, department of labor, department of insurance, Attorney General's office, and various law enforcement officials.

Many jurisdictions have developed inter-agency task forces to specifically address opioid abuse. One prominent example of inter-agency collaboration is the Agency Medical Directors' Group (AMDG) in Washington State.[3] AMDG was responsible for the development of the *Opioid Dosing Guideline for Chronic non-cancer Pain* (2007) which was intended as an educational pilot to address how opioids were used to treat chronic pain. The pilot was successful and the guidelines have since been evaluated and updated to reflect current medical evidence and trends in opioid prescribing patterns.

Other states, including Michigan, Minnesota, and New York have also developed inter-agency groups seeking solutions to this complex and widespread problem.

[3] The Washington Agency Medical Directors' Group (AMDG) is made of medical directors from seven state agencies and workers to improve health care programs purchased by Washington State.

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Treatment Guidelines

Recommendation(s): Jurisdictions with existing treatment guidelines should evaluate if they adequately address safe opioid use in the treatment of injured workers. Jurisdictions without treatment guidelines should study evidence on drug use and drug-caused morbidity to determine if guidelines are needed to abate excessive or inappropriate prescription practices. The common experience is that states addressing opioid abuse in workers' compensation have made treatment guidelines an integrating mechanism for many of the recommendations presented here.

Background and Examples

Workers' compensation policy makers should carefully consider the role of treatment guidelines in any opioid policy response. One commonality of the states who have addressed the issue successfully is that they have provided clear guidance, through guidelines, on the appropriate treatment pathways for the management of chronic pain. Currently, 20 workers' compensation agencies in the United States have included guidance or implemented an opioid treatment guideline (IAIABC Opioid Index, 2012). Seven states have adopted commercial guidelines produced by ODG or ACOEM, while the other 13 have adopted state-specific guidelines (IAIABC Opioid Index, 2012)[4]. There are numerous commercial and state-developed sources for treatment guidelines on opioids, many of which are included in Appendix A.

Implementation of treatment guidelines can improve the chances that a doctor will comfortably prescribe opioids when indicated, avoid inappropriate use of opioids, and assist the patient in finding other therapies and aids for dealing with chronic pain. It is important to note that simply enacting treatment guides without deliberate and rigorous education and enforcement will produce scant benefit.

Prescribing patterns vary widely across the U.S. and even within jurisdictions.[5] Therefore, an important step in addressing this problem is for the jurisdiction to clearly identify the treatment guidelines to be utilized by medical practitioners. There are competing sources for guidelines, but not specifying one for use in a state could lead to confusion and conflict between a payer using one guideline and a prescribing physician using another. The effect of having an ambiguous standard was recently seen in New Mexico, where a proposal to adopt both ACOEM and ODG concurrently was met with stakeholder resistance.[6] Subsequently, the New Mexico Workers' Compensation Administration adopted rules selecting *Work Loss Data Institute's Official Disability Guidelines* which became effective July 1, 2013.

It is very important that policies for treatment guidelines, dispute resolution, pre-authorization, and utilization review be carefully coordinated to apply not only to the control and regulation of opioids, but also to address the realities of medical care delivery in general. Treatment guidelines, a key component for directing physician

[4] Detailed information about state implementation of treatment guidelines is found in Appendix C.
[5] There is a wide body of research that addresses the variation of treatment and prescribing patterns across jurisdictions. The CWCI report, *Prescribing Patterns of Schedule II Opioids in California Workers' Compensation,* found that just 3% of the prescribing physicians account for 55% of all Schedule II prescriptions (Swedlow, Ireland, & Johnson, 2011).
[6] The New Mexico Administrator response to public comments can be found at http://www.workerscomp.state.nm.us/public_comment_response.pdf

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care regarding chronic pain, should ideally be consistent with the provision of all medical treatment, with opioids being simply one component in the overall treatment plan for patients.

One issue jurisdictions need to deliberate when considering treatment guidelines is how they will be applied to existing workers' compensation claims. Injured workers who have been on opioids for an extended period may have additional challenges when trying to end their use of opioids and implementation of a guideline without care to existing cases could create dangers to these patients. For example, the Texas closed formulary had a two-phased implementation; with the closed formulary applying to existing claims two years following the initial implementation date. During that two year period, Texas has been proactively working with medical providers, injured workers, and claims payers to ensure a safe transition under the new guidelines.[7]

Implementation of guidelines and application of treatment guidelines to legacy claims will require careful deliberation with stakeholders. However, policymakers are cautioned against having two different standards of care applied to current and future cases, since the goal of implementing treatment guidelines is to encourage the appropriate medical treatment including the use of opioids in all workers' compensation claims.

The following issues would likely be addressed in a treatment guideline adopted by a jurisdiction. If the treatment guideline does not address these issues, a jurisdiction should consider specific guidance on the following issues:

I. Acute vs. Chronic Pain

Recommendation: Jurisdictions must decide if their response will solely address the management of chronic pain or include more comprehensive guidance on managing both acute and chronic pain conditions. Any guidance should clearly define in what situations opioid use is appropriate and discuss if there are other modalities for the treatment of pain.

Background and Examples

Pain is real and clinicians recognize it must be treated in a way that is responsive to the patient's needs. Treatment of pain must be dictated by individual circumstances.

Policymakers should discuss and understand the differences in using opioids in the treatment of acute and chronic pain. However, excessive regulation of medically justified prescription of opioids could do harm to patients by removing an effective pain treatment modality.

In particular, attempts to regulate the course of treatment with opioids in acute pain situations may run into opposition from patient advocates who worry that imposing "onerous" regulation on physicians will dissuade them from using pain medication even in incidences where it is warranted and with minimal risk, such as post-operative pain or severe trauma. Instead some argue that regulation should be focused to address the substantive, widespread problems. The alarming statistics cited at the beginning of this guide

[7] More information about the Texas transition plan for legacy claims is found at http://www.tdi.texas.gov/wc/pharmacy/index.html and in TAC 28.2.134.510.

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regarding prescription drug related deaths may not be typically associated with the use of opioids in response to short duration acute pain following a severe trauma or surgery.

On the other hand, some medical experts assert there should be guidance on the prescription of opioids, particularly their dose and duration, for acute pain associated with minor injuries. There is evidence that use of opioids in these acute settings is still associated with adverse claim outcomes, including greatly delayed return to work (Webster et al, 2007). Jurisdictions seeking direction in this area will want to review the guidelines from Utah, Washington, and ODG which include recommendations on the use of opioids in treating acute and chronic pain.[8] Other workers' compensation agencies have selected guidelines which focus mainly on opioids in managing chronic pain (See Appendix A for treatment guideline resources).

II. Monitoring Patients

Recommendation: Jurisdictions should consider providing specific requirements for how medical providers monitor and evaluate patients who are using opioids to manage chronic pain. These requirements can be included in the treatment guideline or described separately.

Background and Examples

States may wish to consider how to provide guidance or requirements on how providers will monitor patients who are using opioids to manage chronic pain. In many states, monitoring guidelines or requirements have been adopted as a part of a treatment guideline.

Elements commonly used to monitor patients include:

Opioid Plans: Whenever a prescribing medical provider engages in long term opioid treatment for chronic, nonmalignant pain, a provider should complete an opioid management plan (also called "opioid agreement") with the patient. A jurisdiction should consider, either within the treatment guidelines, or separately, a specific recommendation on when an opioid plan must be completed. Many experts consider this an important obligation between the prescribing physician and patient.

The opioid management plan should describe the:

- Limitations of opioid use in controlling the pain in question,
- Possible side effects of long term use,
- Risks of opioid dependency,
- Importance of therapy and other activities to relieve the symptoms of the injury,
- Physician's obligation to document clinically significant improvement in function and pain as a condition of use, and

[8] In June 2013, ODG released a flyer which provides a summary of ODG's evidence-based protocols related to opioid use for acute, subacute, and chronic pain. The flyer can be downloaded at: http://odg-disability.com/odgopioidflyer.pdf.

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- Patient's responsibilities, including full disclosure of all substances being taken and participation in urine drug screens as required by adopted treatment protocols.

An opioid treatment agreement that has been signed by the patient and the prescribing physician should be entered into the medical record. This agreement should be renewed at least annually with any patient on continued use of opioids.

Drug Testing: Urine drug testing should be conducted to establish a baseline immediately after the treatment agreement has been signed, and then randomly one or more times a year based on risk factors until termination of opioid use. Screening for cause (over and above random testing) should also be done as soon as practically possible after the provider has evidence of misuse, such as over-sedation, accidents, self-directed dose changes, or lost prescriptions. Unless the prescribing physician suspects concurrent use of other drugs that would be harmful in connection with his/her prescription for the patient, the minimally necessary immunoassay screening panel should be used. The panel of screens called for should include any medications or substances that the prescribing physician, based on the patient encounter, deems prudent to include in the test.

States that have enacted drug testing laws for workers' compensation and other purposes have generally required that the laboratories be certified by the College of American Pathologists, Substance Abuse and Mental Health Services Administration (SAMHSA, which is a branch of the U.S. Department of Health and Human Services) or by the state health department.[9] In addition to this certification requirement for the lab, most states enact rules on testing procedures, safeguarding the chain of evidence, confirmation testing for positive results and other quality control measures. Given the potential for testing and billing solely to enhance physician income, it would be desirable to require that the prescribing physician has no revenue sharing or other economic interests with drug testing labs to which he or she uses.

Dosage Thresholds: For patients who have daily opioid doses greater than a certain threshold or range (measured in morphine equivalent doses, MED) and for whom clinically meaningful improvement in function and pain is not documented, the regulation or statute may require a plan from the prescribing physician, referral to a qualified pain management specialist for management, or tapering off of opioids as a condition of future payment of services and prescriptions related to opioid use.

Jurisdictions including Connecticut and Washington, among others, have included a specific dosage thresholds (90 – 120 mg MED) as the trigger for certain follow-up actions. Other jurisdictions and guidelines do not indicate a specific dosage threshold to trigger treatment management steps.[10]

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[9] SAMSHA Laboratory certification is a rigorous standard that is in place to enforce the Mandatory Federal Workplace Drug Testing program and is distinguished by its strict emphasis on legal defensibility and deliberately restricted regulatory scope. SAMSHA may not be applicable to drug testing for the clinical purposes defined in this paper.

[10] There is mixed medical evidence about specific dosage thresholds related to opioid use. However, Washington developed the 120 mg MED after observing this was the point where the mortality curve began to rise.

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Checking Prescription Drug Monitoring Program (PDMP): If reference to the PDMP indicates a patient is taking other prescription drugs inconsistent with the medical record, the physician should follow-up with the patient and dispenser. It may be appropriate to share this information with the responsible workers' compensation claims payer.

It must be stressed that the objective of opioid monitoring and controls is not to thwart treating pain. As stated in the Colorado treatment guidelines:

> Objective evidence of improved or diminished function should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

III. Documentation and Reporting by Physicians

Recommendation: A jurisdiction should provide specific requirements for the documentation and reports required by physicians who are prescribing opioids to manage chronic pain. These requirements are usually not specified in detail in treatment guidelines, and could be described separately. Providers and payers need a common understanding of these requirements.

Background and Examples

Some states, such as New York, have regulatory requirements for documentation and reporting by physicians. This documentation is valuable because it keeps the claims administrator and payer informed and updated on the progress of the claim.

Documentation is an important aspect of treatment guidelines generally. Without proper documentation of what information the physician used to base his/her treatment upon, it is impossible for the claims adjuster or utilization review expert to evaluate compliance with a guideline. Thus, Louisiana, in adopting comprehensive treatment guidelines, included a section spelling out the requirements for documentation of treatments.

States should consider the consequences when providers fail to provide reasonable documentation. A mechanism should be in place that allows the claims payer to dispute payment for any/all services from a medical provider who fails to report or provide reasonable specificity.

The implementation date for any documentation requirements is an important consideration. Ideally, patients with a history of treatment with opioids before documentation requirements are adopted would benefit from the safeguards provided by regulation.

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But, experience with implementing regulations retroactively (as was the case in New York) has shown that applying a new, rigorous procedure to medical treatment initiated before the rule creates confusion and disputes that will burden the regulatory agency.[11]

The following documents may be appropriate requirements when opioids are being prescribed to manage chronic pain:

(1) Documentation of physical function and pain intensity using validated instruments at each visit;

(2) Documentation of the daily dose (mg/day) of all opioids and other Schedule II drugs prescribed;

(3) Documentation of prescriptions for other Schedule II drugs found by access to the state PDMP which are not being prescribed by the treating physician on the current claim; and,

(4) If treatment for chronic pain with opioids continues for greater than 90 days, the prescribing physician shall submit a written report to the claims payer for the workers' compensation medical services. The written report should include the following:

A. A treatment plan with time-limited goals for eliminating opioid use if clinically meaningful improvement in function and pain, using validated instruments, has not been documented to have occurred;

B. A consideration of relevant prior medical history, particularly including a history of past or current substance use or abuse, including illicit drugs, alcohol, or tobacco;

C. A consideration of relevant prior psychiatric history, particularly including affective disorders (e.g., anxiety and depressive disorders) and personality disorders;

D. A summary of specific time-limited conservative therapeutic measures rendered to the worker that focus on reactivation and return to work, including but not limited to: graded exercise, activity logs, activity coaching, and cognitive behavioral therapy. Use of passive conservative modalities in the absence of clinically meaningful improvement in function and pain will not be considered proper and necessary conservative care;

E. Documentation of drug screenings, consultations, and all other treatment trials;

F. Documentation of outcomes and responses, including a record of periodic assessment of function and pain; and

[11] The New York Workers' Compensation Board was burdened with a flood of requests by physicians to allow for "variances" from their newly mandated treatment guidelines. On February 1, 2013, the Board made several modifications to their guidelines and with the method for resolving disputed variances from the guidelines. Among the major changes were: 1) adding additional guidance on carpel tunnel syndrome, 2) allowing for a more liberalized use of chiropractic and physical medicine for neck, back, and shoulder and knee injuries, 3) simplifying forms and procedures, and 4) allowing more disputed cases to be decided by the Medical Director.

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G. Notation of other medications not related to the worker's occupational injury. This may require a complete medical examination to determine the need for continuing treatments, including ongoing drug treatments.

A state looking at documentation requirements needs to consider the burden of these requirements on the provider community. Excessive regulatory reporting requirements performed without explicit right of compensation is cited by providers as a reason for avoiding the practice of occupational medicine. Economic reasoning would suggest that without payment, compliance will be poorer than if a fair payment for explicitly documented service is allowed.

To address this issue, states will want to consider allowing compensation for the special reports (such as an opioid management agreement) and counseling that must be performed when prescribing opioids for chronic pain. However, the creation of special codes and associated payment levels needs to be carefully monitored in relation to current billing codes and rules for their application. Several states already have special billing codes in their rules. For example, Washington State allows billing for Initial Report Documenting for Opioid Treatment (1064M) and Opioid Progress Report Supplement (1057M). Similarly, Colorado allows billing for Chronic Opioid Management Reports (code DoWC). Special billing codes make the most sense in a state that has a medical fee schedule and the rule making authority to establish new billing codes and compensation levels. States that set compensation rates for opioid treatment related services must pay close attention to incentives they create to overuse or underuse these medical services.

There are other special treatment codes that could be considered in a state's fee schedule for services provided to injured workers over and above normal evaluation and management services provided during the same clinical session, including:[12]

(1) **99408 -** Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., DAST), and brief intervention (SBI) services; 15 to 30 minutes (Alcohol and/or substance [other than tobacco] abuse structured assessment [e.g., and brief intervention, 15 to 30 minutes]), to be used for completing the opioid management plan or ordering and interpreting drug testing.

(2) **99409 -** Alcohol and/or substance [other than tobacco] abuse structured screening, for example using the Drug Abuse Screening Test, and intervention greater than 30 minutes.

Correct use of codes 99408 and 99409 requires that the screening and interventional components of this service be documented in the clinical record.

Before designation of state proprietary billing codes, it is highly recommended that a state contact the IAIABC to see if a national code exists. Using nationally recognized codes will facilitate electronic billing and payment systems now being adopted by many workers' compensation systems.

[12] The codes included are CPT Codes developed by the American Medical Association: http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.page

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IV. Preauthorization and Formularies

Recommendation: If a jurisdiction adopts a treatment guideline, the conditions under which preauthorization is required must be clearly described. A jurisdiction may also want to consider a formulary describing which drugs require preauthorization before dispensing

Background and Examples

The Texas workers' compensation system has instituted a closed formulary which designates a wide list of drugs that must receive prior approval by a claims payer before dispensing. Evidence to date shows this to be effective in controlling medically unsupported use of some opioids (Texas Department of Insurance, 2013). Texas's final step is the implementation of the closed formulary for legacy claims which begins in in September 2013. The Ohio Bureau of Workers' Compensation also uses a formulary to control the use of sustained release opioids. Such a formulary would most likely be beyond the resources of a state to construct and maintain. For practical purposes, the formulary would have to be adopted by reference, as Texas does with the ODG formulary.

Absent a comprehensive formulary, regulations could include specific opioids that are not regarded as payable under the workers' compensation act without prior approval by the payer. Here are some examples of restrictions on the use of specific opioids by state workers' compensation systems:

(1) Meperidine is not indicated in the treatment of acute or chronic pain.
(2) Transcutaneous opioid analgesics are only indicated in patients with a documented disorder that prevents adequate oral dosing.
(3) Oral transmucosal and buccal preparations are only indicated for the treatment of breakthrough pain and only in patients with a documented disorder that prevents adequate dosing with swallowed medications.
(4) Approval based only if drug is used according to FDA approved indications, e.g., for use in end-stage cancer pain.

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V. Denial of Treatment and Drug Tapering

Recommendation: A jurisdiction should provide specific instructions for denial of treatment related to long term opioid use. Denial of treatment, except in extreme instances, should only be done in coordination with a drug tapering program. Instructions for denial of treatment and drug tapering can be included in the treatment guideline or described separately.

Background and Examples

Denial of payment for all future opioid treatment is a drastic step and should be allowed only with prior communication with the physician and due care for the patient's wellbeing. In particular, sudden denial of payment without warning can lead to medically dangerous withdrawal problems and is not recommended. However, in the event a patient is engaging in unsafe or illegal activities (such as drug diversion), denial of payment without tapering may be appropriate. More specifics on this are given below.

Drug tapering, the gradual reduction in dosage over several months or longer, is a medically safe strategy to reduce long-term dependence on opioids. The conditions that trigger a drug tapering program should be specifically outlined and understood by the provider, patient, and payer. Of course, the treating physician bears the primary responsibility for the management of prescription opioid use. However, states may want to consider defining the process and conditions in which a payer may deny continued payment for opioids and begin a tapering program. Any denial of payment should be subject to a dispute resolution process adopted by the state (see section on Disputes). Payment of services related to medically appropriate withdrawal/tapering treatments must accompany any strategy to deny payment of continued opioid prescriptions. Conditions and a process for safe tapering must be considered. Functional restoration programs, as an alternative to opioids in the successful management of chronic pain, may need to be coupled with drug tapering if there is to be long-term success.

The following is a general process synthesized from various state responses:

> It is the affirmative obligation of the claims adjuster to document that he/she has made contact, or attempted to make contact, with the prescribing physician and claimant (or legal representative) to indicate that payment for future opioid prescriptions may be denied due to one or more of the factors enumerated below. To deny payment and begin tapering, there should be objective evidence, supported by qualified medical experts, held by the insurer or self-insured employer that any of the following circumstances have occurred:
>
> (1) Absent or inadequate treatment documentation and a failure to comply with treatment guidelines;
>
> (2) Noncompliance with the treatment plan or opioid treatment agreement, with no reasonable expectation of changes in behavior without the threat of withdrawal of payment;
>
> (3) Clinically meaningful improvement in function and pain has not occurred within 90 days of beginning treatment with opioids; or

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(4) Evidence of misuse or abuse of the opioid medication or other drugs, or noncompliance with the attending physician's request for a drug screen.

Another issue states must consider is how payment for special reports related to drug withdrawal and tapering will be handled. In this context, "special reports" means extensive commentary beyond the course of a normal office visit requested by the relevant claim handler. As discussed above, states may want to consider adopting a more specific reimbursement code, such as that adopted by Colorado or Washington.

Continuing Education Requirements

Recommendation: Continuing education requirements specifically addressing opioids should not be adopted by the workers' compensation agency but carefully coordinated with the licensing/certification bodies within a jurisdiction.

Background and Examples

Jurisdictions should evaluate if their continuing medical education requirements appropriately address and present a balanced perspective on both pain management and the risks associated with opioid use in chronic pain patients.

Continuing education requirements are a very controversial topic for policymakers and the medical community. Many medical groups, including the American Medical Association (AMA), have recognized the importance of physician education on the safe use of opioids and have offered excellent training programs on the subject. However, the AMA has opposed additional state mandates to require such training.

It is not recommended that a workers' compensation agency add additional CME requirements that are specific to workers' compensation. However, a workers' compensation agency should work with other licensing/certification bodies to ensure that existing CME requirements adequately address the safe use of opioids in treating pain. If additional CME requirements are considered, it will require strong collaboration and political compromise with the medical community.[13]

Few medical providers engage heavily in the practice of providing long term opioid prescriptions. Data from Texas and California workers' compensation medical bills and data from New York City on overall medical practices, suggests that the majority of physicians prescribe little to no opioids to their workers' compensation patients. Thus, a broad mandate for education could be seen as a burden to the provider community at large.

One strategy to mitigate physician resistance, especially by physicians that never prescribe high level doses or refills on opioid prescriptions, is to target CME requirements at providers who have specific prescribing patterns, including those who prescribe higher dosages and extended prescriptions. However, it is important to recognize that physicians would benefit most from education before they even begin to prescribe opioids to patients, as

[13] For an overview perspective on physicians' attitudes regarding more aggressive educational requirements as a condition of prescribing opioids, see: Susan Okie, A Flood of Opioids, a Rising Tide of Deaths, *New England Journal of Medicine*, 363:1981-1985, November 18, 2010

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what they learn could alter their prescribing practices from the very beginning or persuade them to avoid using opioids in many instances. A fully functional and accurate Prescription Drug Monitoring Program (PDMP) can be used to determine when physicians need to get continuing education in opioid treatment. Proof of completion of this requirement should be submitted upon request or filed with the state agency charged with medical provider licensing.

A jurisdiction could consider a requirement for additional education in opioid treatment for physicians who prescribe for a certain duration of time (for instance, greater than 90 days) or for a dosage that exceeds a certain threshold (for instance, 120mg MED). It is recommended that educational programs substantially cover the topics included in the U.S. Food and Drug Administration's *Blueprint for Prescriber Continuing Education Program for Extended-Release and Long-Acting Opioid Analgesics*.[14]

At a minimum, educational programs should cover the following topics; among others (It is acceptable to substitute content to meet the particular needs of a practice or specialty):

(1) Assessing patients for treatment with opioid therapy
(2) Initiating therapy, modifying dosage, and discontinuing use of opioids
(3) Managing therapy with opioids
(3) Counseling patients and caregivers about the safe use of opioids
(4) Counseling patients about effective non-opioid approaches to pain management
(5) General information about opioid products and specific information about commonly used pharmacy products

Examples of educational programs that follow the existing state rules for proof of completion of CME are found in Appendix B.

Prescription Drug Monitoring Programs (PDMPs)

Recommendation: Jurisdictions should evaluate the operational status and effectiveness of their jurisdiction's Prescription Drug Monitoring Program (PDMP). Mandatory use of the PDMP before prescribing opioids should only be considered once the database is fully operational, the data accuracy is validated and it is easy to use for medical providers

Background and Examples

Prescription Drug Monitoring Programs (PDMPs) are an important element of any jurisdictional strategy to address and curtail abusive opioid practices because they help restrict patients from obtaining multiple opioid prescriptions from different doctors and pharmacies.[15]

[14] To review all the requirements contained in the *Blueprint for Prescriber Continuing Education Program,* http://www.fda.gov/downloads/drugs/drugsafety/informationbydrugclass/ucm277916.pdf

[15] A list of published studies and unpublished findings on the effectiveness and best practices for PDMPs was compiled as part of the report, "Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices" published by The Prescription Drug Monitoring Program Center for Excellence and Heller School of Social Policy and Management, Brandeis University in September 2012. The complete report can be downloaded at: http://www.pdmpexcellence.org/sites/all/pdfs/Brandeis_PDMP_Report.pdf

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According to the most recent report of the Alliance of States with Prescription Monitoring Programs (www.pmpalliance.org), forty-two states currently have a PDMP that is operational (meaning collecting data from dispensers and reporting information from the database to authorized users). However, the implementation and functionality of PDMPs varies widely across the United States. As of March 2012, all but six states allow prescribers or dispensers to access the state PDMP, but use of PDMP data still varies significantly.

Early in the development and use of PDMPs, physicians resisted mandates to routinely use PDMPs because it was an uncompensated expense to the clinician and there was concern about the accuracy of generated reports. A government affairs expert for one provider group described the situation to the authors as follows: Physicians are "very concerned" that PDMPs are not fully operational; they do not fit well into the standard work-flow of a clinician's office; and the data may be outdated or inaccurate which creates liability risks for physicians. Because of this physician "push back," only 12 states mandate use of a PDMP by physicians/prescribers in certain incidences (National Alliance for Model State Drug Laws (NAMSDL)).

Process improvements have vastly improved the ease and accuracy of PDMPs and this has helped diminish physician resistance. States with fully operational PDMPs, such as Kentucky and Ohio, encounter little physician resistance to mandated use. States may want to consider mandating that physicians, or a "delegate" under the physician's master account, consult a database before prescribing or dispensing an opioid prescription to a patient. Another consideration for a jurisdiction to consider is the geographic scope of the inquiry, i.e., under what conditions should a physician be required to check other state PDMPs (if available) for the patient in question. Some states have very simple "check box" functionality in their PDMPs for expanding the drug inquiry to other states, but interstate access is not universal at this time.

Jurisdictions should discuss the following issues when evaluating the readiness of a PDMP system for mandatory use:[16]

(1) Is the PDMP at fully operational status, with a simple and streamlined administrative process for doctors and pharmacies to register with the program?
(2) Can physicians designate delegated agents to consult the database on their behalf?
(3) Is the response time on a physician inquiry rapid, e.g., within a few seconds?
(4) Is the reporting frequency of the dispensing party sufficiently timely, e.g., within seven days of dispensing?
(5) Is there support for validating data, i.e. are there appropriate controls to ensure the quality and accuracy of data, such as avoiding mismatching two patients with the same name?

Once a PDMP is established, funded, easy to use, and contains quality data, it is more feasible to discuss mandating the use of this data by health care providers. Such a PDMP integrates easily into the normal operation of a clinic and would not create undue cost.

[16] More information on best practices related to PDMPs can be found in the report, "Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices" published by The Prescription Drug Monitoring Program Center for Excellence and Heller School of Social Policy and Management, Brandeis University, September 2012.

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Disputes

Recommendation: When there is a dispute over the course of treatment related to continued opioid use, a "fast track" for resolving the treatment dispute is advisable.

Background and Examples

Timeliness, medical judgment, medical necessity, and cost all commend a mechanism for peer review of treatment disputes, as opposed to a normal administrative hearing before an administrative law judge (ALJ). Whatever dispute procedure is used, it must give special status to resolving drug treatment disputes so that they can be resolved within days of the call for resolution. Patients on protracted treatment with opioids must be handled with extreme care to avoid sudden withdrawal problems and conflicts with their treating physician.

Below are examples of regulatory procedures for resolving disputes between the treating provider and the payer regarding payment of physician services and drug costs for the continued use of opioids:

> *Option 1:* The process described by [cite section in existing law] for the administrative resolution of disputes over necessity of treatment.[17]
>
> *Option 2:* [define specific administrative procedure recognizing the need to "fast-track" opioid management and treatment decisions]

When harm to the patient from sudden opioid withdrawal is at issue in the dispute, the following steps may be considered for use in a "fast track" review:

(1) The appropriate utilization review expert for the payer must make contact with the prescribing physician to put the physician on notice of intent to seek authority to stop payment for opioid treatment and prescription cost.

(2) Both the payer and prescribing physician or their representative should present written support for their respective positions on the advisability of continued use of opioids and file this document with the other party to the dispute and with the state agency within three business days of formal notice to the prescribing physician regarding the objection to future payment. If the payer objects to future payments, the payer should include a plan for drug withdrawal/tapering with the objection and a guarantee of reimbursement for this plan. Such a plan should be based on appropriate medical evidence and authority.

[17] Many states, including California, Texas and Wisconsin have administrative procedures for addressing treatment disputes using peer reviewers. Others, like New York and Tennessee allow for expedited decisions by the agency's medical director. The benefits of this approach include a more medically sophisticated judgment on the issues involved in the dispute and in many cases the peer review is timelier and less expensive than requiring an administrative hearing.

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Appendix A

Treatment Guideline Resources

General Resources

American College of Occupational and Environmental Medicine (ACOEM): *ACOEM's Guidelines for the Chronic Use of Opioids* (2008, revised 2011[18]) http://www.acoem.org/Guidelines_Opioids.aspx

American Pain Society and the American Academy of Pain Medicine (APS & AAPM): *Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain* (February 2009) http://www.painmed.org/files/opioid-treatment-guidelines-chronic-noncancer-pain.pdf

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain (April 2010) http://nationalpaincentre.mcmaster.ca/opioid/

Colorado Medical Board (last revision July 1, 2010). *Policy for the use of controlled substances for the treatment of pain*, 12-36-117, C.R.S.
[not specific to workers' compensation; similar standard published by the Federation of State Medical Boards]

Fishman, Scott. (2011). *Responsible Opioid Prescribing: A Clinician's Guide* (2nd Edition), Federation of State Medical Boards. http://www.fsmb.org/book/index.html

Veteran's Administration and Department of Defense: *Va/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain* (March 2003, revised May 2010) http://www.va.gov/PAINMANAGEMENT/docs/CPG_opioidtherapy_fulltext.pdf

Western Occupational and Environmental Medical Association
Chronic Opioid Use: Comparison of Current Guidelines
[This contains a good review of the literature on guidelines and a useful comparison]
Available at: http://www.woema.org/files/WOEMA_Opioid-Comparison.pdf

Work Loss Date Institute's Official Disability Guidelines
30day trial to review, evaluate and use ODG is available to anyone at:
http://odg-disability.com/orderformtrial.htm
Abbreviated version of ODG can be found for free on Guidelines.Gov at:
http://www.guidelines.gov/search/search.aspx?term=odg

"Just the facts on Opioid Management: Prudent Prescription Practice Using Evidence-Based Medicine (EBM)" is available to anyone at:
http://odg-disability.com/odgopioidflyer.pdf

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State Specific Examples and Resources

California

Chronic Pain Medical Treatment Guidelines
Effective July 18, 20019
Available at:
http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_ChronicPainMedicalTreatmentGuidelines.pdf

Colorado

Chronic Pain Disorder Medical Treatment Guidelines
Rule Revised: December 27, 2011/Effective: February 14, 2012
Division of Workers' Compensation
Available at:
http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/maperc/online/Documents/Colorado%20Guidelines%20for%20Chronic%20Pain%20Treatment.pdf

Colorado Division of Workers' Compensation: *Colorado Medical Board Policy for the Use of Controlled Substances for the Treatment of Pain* (May 1996, revised November 2004, July 2010)
http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251819778498&ssbinary=true

Massachusetts

Treatment Guidelines, No. 27 Chronic Pain
Revised February 1, 2012
Available at: http://www.mass.gov/lwd/workers-compensation/wc-pubs/cls/2012/cl-340.pdf

Oklahoma

Guidelines for Prescription of Opioid Medications for Acute and Chronic Pain
Developed and Adopted by the Physician Advisory Committee
Revised Nov. 1, 2007
Available at:
http://www.owcc.state.ok.us/PDF/Guidelines%20for%20the%20Prescription%20of%20Opioid%20Medications%20rev%2011-01-07%20COMPLETE.pdf
* Oklahoma in 2012 enacted legislation adopting the Work Loss Data Institute's Official Disability Guidelines (ODG)

Oregon

Southern Oregon Opioid Prescribing Guidelines: http://www.southernoregonopioidmanagement.org/

Texas

Texas Closed Formulary Rules
Available at: http://www.tdi.texas.gov/wc/pharmacy/index.html#rules

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The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has posted a listing of status "N" drugs published in *Official Disability Guidelines – Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary.* http://www.tdi.texas.gov/wc/dm/documents/ndruglist.xls

Texas Treatment Guideline rule:
http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=T&app=9&p_dir=N&p_rloc=145172&p_tloc=&p_ploc=1&pg=15&p_tac=&ti=28&pt=2&ch=137&rl=1

Pharmacy Benefits

- Impact of the Texas Pharmacy Closed Formulary: A Preliminary Report, 2013 - 6-Month Injuries with 9-Month Services, June, 2013. (PDF; 447kb)
- Impact of the Texas Pharmacy Closed Formulary: A Preliminary Report, 2012, October, 2012. (PDF; 818kb)
- FY 2011 Pharmacy Utilization and Cost in the Texas Workers' Compensation System, October, 2011. (PDF; 760kb)

Texas Medical Board Rules Chapter 170 – Pain Management
http://www.tmb.state.tx.us/rules/docs/Board_Rules_Effective_05-06-2013.pdf

Utah
Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain
Utah Department of Health, 2009
David N. Sundwall, MD, Executive Director
Robert T. Rolfs, MD, MPH, State Epidemiologist
Erin Johnson, MPH, Program Manager
Available at: http://www.dopl.utah.gov/licensing/forms/OpioidGuidlines.pdf

Washington
Guideline for Prescribing Opioids to Treat Pain in Injured Workers
Effective July 1, 2013
Office of the Medical Director
Available at: http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/FINALOpioidGuideline010713.pdf

Guideline for Prescribing Opioids to Treat Pain in Injured Workers, Effective July 1, 2013
http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/FINALOpioidGuideline010713.pdf

Opioid Dosing Guideline for Chronic non-cancer Pain
Originally Published in March, 2007
Sponsored by the Washington State Agency Medical Directors' Group (AMDG)
Available at: http://www.agencymeddirectors.wa.gov/opioiddosing.asp

Interagency Guideline on Opioid Dosing for Chronic non-cancer Pain 2010 Update
http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf

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Appendix B

Continuing Education Programs

The online COPE Program at the University Of Washington School Of Medicine. CME Office, University of Washington School of Medicine, Seattle, WA 98195-9441 USA

The online program of the Massachusetts Medical Society, Waltham, MA titled: *Managing Risk When Prescribing Narcotic Painkillers for Patients*, found at:
http://www.massmed.org/Content/NavigationMenu2/ContinuingEducationEvents/

The online program from the Colorado School of Public Health titled: *The Opioid Crisis: Guidelines and Tools for Improving Chronic Pain Management* found at:
http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/maperc/online/Pages/Pain-Management-CME.aspx

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Appendix C
IAIABC 2012 Opioid Index

Jurisdictions: Guidelines that Address Chronic Pain or Opioid Use

Jurisdiction	Does the jurisdiction have treatment guidelines that specifically address chronic pain or opioid use?
Alabama	No
Alaska	No
Arizona	No
Arkansas	No
California	Yes
Colorado	Yes
Connecticut	Yes
Delaware	Yes
District of Columbia	No
Florida	No
Georgia	No
Hawaii	Yes, ODG Guidelines
Idaho	No
Illinois	No
Indiana	No
Iowa	No
Kansas	Yes, ODG Guidelines
Kentucky	No
Louisiana	Yes
Maine	Yes. Board Rules and Regulations
Maryland	No
Massachusetts	Yes
Michigan	No
Minnesota	Yes
Mississippi	No
Missouri	No
Montana	Yes
Nebraska	No
Nevada	Yes, ACOEM Practice Guidelines
New Hampshire	No
New Jersey	No
New Mexico	Yes, ODG Guidelines
New York	No
North Carolina	No, but North Carolina relies on doctors to use accepted prescribing guidelines put forth by their respective specialties.
North Dakota	Yes, ODG Guidelines
Ohio	Yes, ODG Guidelines
Oklahoma	Yes, ODG Guidelines and OK Treatment Guideline for use of Schedule II Drugs
Oregon	No

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Jurisdiction	Does the jurisdiction have treatment guidelines that specifically address chronic pain or opioid use?
Pennsylvania	No
Rhode Island	No
South Carolina	No
South Dakota	Yes- Treatment standards are required for certification of case management plans.
Tennessee	Law enacted to amend the Tennessee Code
Texas	Yes, ODG Guidelines
Utah	No
Vermont	No
Virginia	No
Washington	Yes, guidelines and rules
West Virginia	Yes
Wisconsin	Yes
Wyoming	Yes

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Opioid Prescribing Requirements

Jurisdiction	Is pre-authorization required to prescribe some/all opioids?	Are patient agreements required?	Is drug testing required?
Alabama	Yes[19]	N/A	N/A
Alaska	No	No	No
Arizona	N/A	N/A	N/A
Arkansas	N/A	N/A	N/A
California	N/A	No[20]	No, but drug testing is encourages in certain instances.[21]
Colorado	N/A	Recommended	Yes[22]
Connecticut	Yes[23]	Recommended[24]	Recommended[25]
Delaware	Depends[26]	Recommended	No, but physician should deem when drug testing is appropriate.
District of Columbia	N/A	N/A	N/A
Florida	N/A	N/A	N/A
Georgia	N/A	N/A	N/A
Hawaii	N/A	N/A	N/A
Idaho	N/A	N/A	N/A
Illinois	There are no specific opioid regulations in Illinois, but pre-authorization can be part of utilization review.	N/A	N/A
Indiana	N/A	N/A	N/A

[19] Alabama: Pain management program services shall receive authorization from the employer/agent prior to providing services. No health care provider may refer the employee to another pain management program without prior authorization from the employer/agent (Alabama Administrative Code).

[20] California: A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent.

[21] California: Guidelines encourage the consideration of urine drug screening to assess the use or presence of illegal drugs (especially with issues of abuse, addiction or poor pain control).

[22] Colorado: Use of drug screening initially, randomly at least once a year and as deemed appropriate by the prescribing physician, Drug screening is suggested for any patients who have been receiving opioids for 90 days.

[23] Connecticut: Documentation of medical necessity, including gains in pain, function or work capacity, is mandatory for prescribing beyond what is described within the guidelines (using over 12 weeks duration).

[24] Connecticut: Patients continuing on opioids longer than 4 weeks should be managed under a narcotic agreement as recommended by the Federation of State Medical Boards

[25] Connecticut: A baseline urine test for drugs of abuse and assessment of function and pain should be performed prior to institution of opioids for chronic pain (2). Patients maintained beyond 4 weeks on chronic medications should have urine drug testing up to 2x/yr for stable low risk patient and more frequently for high risk patients.

[26] Delaware: Preauthorization is not required if the health care provider is a certified health care provider in the DE Workers' Compensation Health Care Payment System (HCPS). Otherwise, 19 Del. C. §2322D(a)(1) requires non-certified hc providers to "first preauthorize each health care procedure, office visit or health care service to be provided to the employee with the employer or insurance carrier." 19 Del. C. §2322D(b) allows 1 visit for the first instance of treatment before a provider must become certified.

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Jurisdiction	Is pre-authorization required to prescribe some/all opioids?	Are patient agreements required?	Is drug testing required?
Iowa	N/A	N/A	N/A
Kansas	No	No	No
Kentucky	N/A	N/A	N/A
Louisiana	N/A	Recommended[27]	No, but physician should deem when drug testing is appropriate.
Maine	No	No	No
Maryland	No	No	No
Massachusetts	Yes, in some instances[28]	Yes, for long-term opioid patients	Recommended[29]
Michigan	N/A	N/A	N/A
Minnesota	Rules are located in the document outlines Fees for Medical Services: https://www.revisor.mn.gov/rules/?id=5221&view=chapter&keyword_type=all&keyword=opioids&redirect=0	N/A	N/A
Mississippi	N/A	N/A	N/A
Missouri	N/A	N/A	N/A
Montana	Not required for treatment within the guidelines	Recommended[30]	No, but physician should deem when drug testing is appropriate.

[27] Louisiana: Patient agreement suggestions include informed, written, witnessed consent by the patient and a contract detailing reasons for termination of supply, with appropriate tapering of dose.
[28] Massachusetts: The total daily dose of opioids should not be increased above 120mg of oral morphine of the equivalent. Some patients may benefit from a higher dose if there is documented objective improvement, and a lack of significant opioid side effects.
[29] Massachusetts: A baseline initial drug screen should be performed, and the use of random drug screening at least twice and up to 4 times per year for the purpose of improving patient care.
[30] Montana: All patients on chronic opioids should have a written, informed agreement. The agreement should discuss side effects of opioids, results of use in pregnancy, inability to refill lost or missing medication/ prescription, withdrawal symptoms, requirement for drug testing, necessity of tapering, and reasons for termination of prescription.

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Jurisdiction	Is pre-authorization required to prescribe some/all opioids?	Are patient agreements required?	Is drug testing required?
Nebraska	N/A	N/A	N/A
Nevada	N/A	Recommended	Recommended[31]
New Hampshire	N/A	N/A	N/A
New Jersey	N/A	N/A	N/A
New Mexico	N/A	N/A	N/A
New York	In some cases[32]	N/A	N/A
North Carolina	N/A	N/A	N/A
North Dakota	Pre-authorization is required for all transmucosal, sublingual, and transbuccal formulations of fentanyl. This would include Actiq, Fentora, Onsolis, Abstral, and Subsys.	Recommended	Recommended
Ohio	N/A	N/A	N/A
Oklahoma	N/A	An Opioid Treatment Agreement and Informed Consent document is required for patients and physicians.	Yes, regularly and with a chain of custody
Oregon	No	No	No
Pennsylvania	N/A	N/A	N/A
Rhode Island	N/A	N/A	N/A
South Carolina	N/A	N/A	N/A
South Dakota	N/A	N/A	N/A
Tennessee	Yes[33]	Recommended that patients sign a “drug contract”	N/A
Texas	N/A	N/A	N/A
Utah	N/A	N/A	N/A
Vermont	No	No	No
Virginia	N/A	N/A	N/A

[31] Nevada: Routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that urine drug screens can identify aberrant opioid use and other substance use that otherwise is not apparent to the treating physician.

[32] New York: The Guidelines state that "Narcotic medications should be prescribed with strict time, quantity, and duration guidelines and with definitive cessation parameters... [with a] Maximum duration: 2 weeks." The Guidelines further state: "Use beyond two weeks is acceptable in appropriate cases. Any use beyond the maximum should be documented and justified based on the diagnosis and/or invasive procedures"

[33] Tennessee: The prescribing of Schedule II, III and IV controlled substances for a period greater than 90 days is subject to Utilization Review.

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Jurisdiction	Is pre-authorization required to prescribe some/all opioids?	Are patient agreements required?	Is drug testing required?
Washington	Yes[34]	Yes, when opioids are initially prescribed for chronic noncancer pain then renewed every 6 months.	Recommended[35]
West Virginia	Yes[36]	Yes, required for authorized payment for opioid use.	Recommended
Wisconsin	No	N/A	N/A
Wyoming	In some cases, during continued opioid treatment[37]	Mandatory unless the injured worker is mentally or physically incapable (2.	Mandatory monthly, random tests

[34] Washington: non-preferred opioids and opioid coverage for chronic noncancer pain require prior authorization, see http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/OutpatientDrug.asp. Fentanyl base opioids (Duragesic, Actiq, Fentora, etc) are noncovered, see http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Presc/Policy/default.asp.

[35] Washington: Drug testing is recommended when starting opioids for chronic, noncancer pain, for aberrant behaviors and monitoring chronic opioid therapy

[36] West Virginia: 58.1. No later than 30 days after the attending physician begins treatment with opioids, he/she must submit a written report to the Commissioner, private carrier, Insurance Commissioner or self-insured employer in order for the applicable to pay.

[37] Wyoming: Division Review: At the 4th month of a refill, a RN will review chart notes and supporting documentation to determine if guideline Health Care Provider documentation requirements were met. If so, the nurse will authorize a 4th month of medication.

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Processes for Identifying Opioid Addiction

State	Is there a process for identifying/treating addiction
Alabama	N/A
Alaska	N/A
Arizona	N/A
Arkansas	N/A
California	Yes. If there are repeated violations from the medication contract or any other evidence of abuse, addiction, or possible diversion it has been suggested that a patient show evidence of a consult with a physician that is trained in addiction to assess the ongoing situation and recommend possible detoxification. Chronic Pain Treatment Guidelines also include indicators for addiction and follow up suggestions.
Colorado	Yes. If addiction occurs, patients may require treatment, Refer to treatment section. After detoxification they may need long-term treatment with naltrexone, an antagonist which can be administered in a long-acting form or buprenorphine which requires specific education per the DEA.
Connecticut	Yes. Before prescribing opioids for chronic pain, potential comorbidities should be evaluated. These include opioid addiction, drug or alcohol problems and depression. Discontinue treatment or refer to addiction management if patient exhibits drug seeking behaviors.
Delaware	No
District of Columbia	N/A
Florida	N/A
Georgia	N/A
Hawaii	No
Idaho	N/A
Illinois	No
Indiana	N/A

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State	Is there a process for identifying/treating addiction
Iowa	N/A
Kansas	No
Kentucky	N/A
Louisiana	Physicians should take into consideration pre-existing factors that could lead to addiction before prescribing opioid treatment (preventative).
Maine	Yes
Maryland	N/A
Massachusetts	Preventative- no process for if addiction occurs
Michigan	N/A
Minnesota	Yes. The health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the employee's condition. In cases of incipient or actual dependency, the health care provider shall refer the employee for appropriate evaluation and treatment of the dependency.
Mississippi	N/A
Missouri	N/A
Montana	Focus on prevention and identifying factors that may lead to addiction.
Nebraska	N/A
Nevada	Yes. Prescreen for risk or addiction or abuse. Methods are outlined. Sections on *Managing Risk of Abuse and Addiction*.
New Hampshire	N/A
New Jersey	N/A
New Mexico	No
New York	N/A
North Carolina	No
North Dakota	Yes. North Dakota has instituted a triage process to identify potential problems or complications with the opioid therapy once an injured worker has been on 90 days of opioid therapy.

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State	Is there a process for identifying/treating addiction
Ohio	No
Oklahoma	No
Oregon	Not a separate process, identified by rule
Pennsylvania	N/A
Rhode Island	N/A
South Carolina	N/A
South Dakota	No
Tennessee	There is no process for identifying/treating addiction; the employer may be responsible for the cost though.
Texas	No
Utah	N/A
Vermont	N/A
Virginia	N/A
Washington	Yes. Practitioners should pay close attention to contraindications for abuse/addiction before administering opioids. Appearance of misuse of medications: Be sure to watch out for and document any appearance of misuse of medications. Acquisition of drugs from other physicians, uncontrolled dose escalation or other aberrant behaviors must be carefully assessed. In all such patients, opioid use should be reconsidered and additional, more rigid guidelines applied if opioids continue. In some cases, tapering and discontinuation of opioid therapy will be necessary.
West Virginia	No
Wisconsin	Yes. A health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the patient's condition. In cases of incipient or actual dependency, the health care provider shall refer the patient for appropriate evaluation and treatment of the dependency (DWD 81.04(4))
Wyoming	Yes. Criteria is given for when a physician should seek consultation about abuse/addiction for a patient using opioids.

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Prescription Drug Monitoring Programs (PDMPs)

State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP[38]?
Alabama	Yes	This law requires anyone who dispenses Class II, III, IV, V controlled substances to report the dispensing of these drugs to the database.	Not required
Alaska	Yes	AS 17.30.200 requires that each dispenser shall submit, by electronic means, information regarding each prescription dispensed for a controlled substance. Each dispenser shall submit the required information to the central repository at least once each month unless the board waives this requirement for good cause shown by the dispenser.	Not required
Arizona	Yes	Dispensers are required to report on a weekly basis (II-V).	Not required
Arkansas	Yes	Each time a controlled substance is dispensed to an individual, the controlled substance shall be reported to the AR PMP, using a format approved by the ADH, as soon thereafter as possible, but not more than seven (7) days after the controlled substance was dispensed.	Not required
California	Yes	Those who dispense Schedule II through IV controlled substances must provide the dispensing information to the Department of Justice on a weekly basis in a format approved and accepted by the Atlantic Associates Inc. (AAI),and the DOJ.	Not required
Colorado	Yes	Dispensing pharmacies report prescription data for schedule II-V controlled substances twice monthly.	PMP must be accessed when drug tests are ordered when prescribing long-term opioid treatment

[38] Information on mandatory utilization comes from The National Alliance for Model State Drug Laws and the National Safety Council's *Prescription Drug Abuse, Addictions, and Diversion: Overview of State Legislative and Policy Initiatives*, 2013.

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State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP?
Connecticut	Yes	Pharmacies, both in and out of state, and dispensing practitioners must submit data at least once per week (II-V)	Not required
Delaware	Yes	Dispensers are required to report daily Schedule II, III, IV, and V controlled substances and drugs of concern, as defined by the Office of Controlled Substances.	Prescriber must access the PDMP based on the prescriber's judgment about the patient's motive fore seeking a prescription.
District of Columbia	Legislation enacted	N/A	Not required
Florida	Yes	Section 893.055, Florida Statutes, requires health care practitioners to report to the PDMP each time a controlled substance is dispensed to an individual. This information is to be reported through the electronic system as soon as possible but not more than 7 days after dispensing.	Not required
Georgia	Yes	Dispensers of any Schedule II, III, IV, or V controlled substances in Georgia or to a patient residing in Georgia that *beginning May 15, 2013* dispensers are required to electronically *report* such dispensing to the Georgia Prescription Drug Monitoring Program (Georgia PDMP).	Not required
Hawaii	Yes	Dispensing activity for schedule II-IV controlled substances is reported	Not required
Idaho	Yes	Data is collected on a monthly basis from Idaho pharmacies and out-of-state mail service pharmacies licensed with the Idaho Board of Pharmacy (II-IV).	Not required
Illinois	Yes	All retail pharmacies that dispense schedule drugs are required to report their scripts to the PMP on a weekly basis (Schedule II-V)	Not required
Indiana	Yes	As stipulated by IC 35-48-7-8.1, licensed dispensers throughout Indiana—and out-of-state (non-resident) pharmacies licensed to dispense drugs in Indiana—are required to submit controlled substance prescription data to INSPECT every seven (7) days.	Not required

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State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP?
Iowa	Yes	All Iowa pharmacies that dispense outpatient prescriptions for Schedule II, III, or IV controlled substances are required to report those prescriptions to the PMP.	Not required
Kansas	Yes	Pharmacies dispensing in and into the state of Kansas must report to K-TRACS all schedule II, III and IV controlled substance prescriptions and drugs of concern that they dispense. However, when a Kansas resident actually goes to another state and physically picks up the prescription(s) in that state, that prescription technically is not dispensed in Kansas and is not to be reported to K-TRACS	Not required
Kentucky	Yes	Dispensing activity for schedule II-V controlled substances is reported.	Yes. Prescribers must query KASPER before prescribing a Schedule II or Schedule III drug with hydrocodone for the first time. The statute then requires the prescriber to query the system no less than every three months when issuing any new prescription or refill for that patient for any Schedule II or Schedule III drug with hydrocodone.
Louisiana	Yes	Pharmacies dispensing controlled substances must report those transactions through the Louisiana Board of Pharmacy (LABP) Prescription Monitoring Program (PMP). Reports must be completed at least every 7 days.	PDMP must be used to ensure compliance with pain treatment agreements.
Maine	Yes	The state legislature passed a law in 2003 that requires information about all transactions for Schedule II, III, and IV controlled substances dispensed in Maine to be reported to the state government. Pharmacies – both in and out of the state – submit data weekly.	Not required
Maryland	To begin Fall 2013	N/A	N/A

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State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP?
Massachusetts	Yes	The PMP reporting requirements (at least weekly) apply to every pharmacy registered with the Board or in a health facility registered with MDPH that dispenses a controlled substance pursuant to a prescription in Schedules II through V. In addition, effective January 1, 2011, PMP reporting requirements also apply to any pharmacy located in another state, commonwealth, district or territory that sends a Schedule II — V prescription to a person who is located in Massachusetts.	Participants must utilize the PDMP prior to seeing a new patient.
Michigan	Yes	MAPS-According to Board of Pharmacy Administrative Rule 338.3162b, all pharmacies, dispensing practitioners and veterinarians who dispense controlled substances in Schedules II-V are required to electronically report this prescription data through MAPS Online on the 1st and 15th day of every month	Not required
Minnesota	Yes	The Minnesota Prescription Monitoring Program (PMP) collects prescription data on all schedule II-IV controlled substances as well as those federal schedule V controlled substances which are designated as schedule III in Minnesota.	Methadone outpatient clinics must review the PDMP data prior to ordering a controlled substance for a patient and must review PDMP data quarterly.
Mississippi	Yes	Pharmacies and other dispensers (clinics, etc.) that are licensed by the Mississippi Board of Pharmacy are required by law to provide reporting on dispensing of schedule II-V controlled substances.	Not required
Missouri	Legislation Pending	N/A	N/A
Montana	Yes	Prescription data is reported weekly (may change to daily) all schedule II-IV controlled substances.	Not required
Nebraska	Yes	PDMP is incorporated into HIE.	Not required

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State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP?
Nevada	Yes	Information about controlled substance dispensing activities is reported weekly to the state of Nevada through their authorized data collection vendor. Pharmacies and other dispensers (practitioners) that are licensed by the Nevada Board of Pharmacy are required by law to provide such reporting to the data collection vendor in approved formats and frequencies (Schedule I-IV)	Prescriber must access the PDMP based on the prescriber's judgment about the patient's motive fore seeking a prescription or if the patient has not received a prescription for a controlled substance in the preceding 12 months.
New Hampshire	Legislation Enacted June 2012	N/A	N/A
New Jersey	Yes	Each pharmacy permit holder shall submit, or cause to be submitted, to the division, by electronic means in a format and at such intervals as are specified by the director, information about each prescription for a controlled dangerous substance dispensed by the pharmacy no less frequently than every 30 days.	Not required
New Mexico	Yes	In accordance with 16.19.29.8, each dispenser shall submit the information (Schedule II-V) in accordance with transmission methods and frequency established by the board; but shall report at least every 7 (seven) days.	A medical board licensee must obtain a PDMP report for new patients if the substance (schedule II-IV) is prescribed more than 10 days and for current patients, once every six months during continuous use of opioids.
New York	Yes	Prescription data collected for all II-V controlled substances. Also, confidential notification is sent to practitioners when a patient is receiving controlled substances from multiple practitioners.	Effective August 27, 2013, most prescribers will be required to consult the PMP registry when writing prescriptions for Schedule II, III, and IV controlled substances. Practitioners will be able to designate designees to check the registry on their behalf. Continue to check the BNE website for new information on this program.

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State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP?
North Carolina	Yes	Prescription data is collected on all schedule II-IV controlled substances.	PDMP must be accessed by the medical director of an opioid treatment program when a new patient is admitted and check at least annually.
North Dakota	Yes	Each dispenser licensed by a regulatory agency in the state of North Dakota who dispenses a controlled substance to a patient shall submit to the central repository by electronic means information regarding each prescription dispensed for a controlled substance.	Not required
Ohio	Yes	Every pharmacy (including out-of-state pharmacies) that serves outpatients and dispenses in Ohio or to an Ohio resident any controlled substance or any product containing tramadol or carisoprodol, must submit the dispensing information.	Physicians should access the PDMP is signs of drug use or diversion are observed or if opioid treatment will continue more than 12 consecutive weeks.
Oklahoma	Yes	The statute requires all dispensers of Schedule II, III, IV, and V controlled substances to submit prescription dispensing information to OBNDDC within 24 hours of dispensing a scheduled narcotic.	PDMP must be accessed when prescribing, administering, or dispensing methadone.
Oregon	Yes	Pharmacies submit prescription data to the PDMP system for all Schedules II, III, and IV controlled substances dispensed to Oregon residents.	Not required
Pennsylvania	Yes		Not required
Rhode Island	Yes	Dispensing activity reporting required for II-III	Opioid treatment programs are required to check the PDMP for each new admission, at each annual exam, and prior to advancement to a new take-home phase.

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State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP?
South Carolina	Yes	SCRIPTS- The purpose of the S.C. Reporting & Identification Prescription Tracking System (SCRIPTS) is to collect data on all Schedule II, III, and IV controlled substances dispensed in and/or into the state of South Carolina.	Not required
South Dakota	Yes	Pharmacies and practitioners that dispense any Schedule II, III, and IV controlled substances in South Dakota or to an address in South Dakota must electronically report such dispensing to the SD PDMP starting on December 12, 2011.	Not required
Tennessee	Yes	CSMD- Pharmacies within the state of Tennessee are required to upload all schedule II-V prescriptions at least twice monthly. The use of the PDMP is also covered in the new law. All pharmacies, including dispensing MD offices should be discussed.	A prescriber must check the PDMP prior to prescribing opioids at the beginning of a new treatment episode and at least annually thereafter.
Texas	Yes	Dispensers must reports scripts for Schedule II-IV controlled substances within 7 days of dispensing.	Not required
Utah	Yes	CSD- Utah law requires all outpatient pharmacies to report dispensing a controlled substance prescription (schedules II – V) within seven days. Data submitted by pharmacies is posted by the Controlled Substance Database within 24 business hours of receipt.	Not required
Vermont	Yes	At least once each week, every pharmacist-manager of a pharmacy licensed by the Vermont Board of Pharmacy, including those located outside of Vermont, shall submit a Report of Controlled Substances Dispensed to the VMPS database of all reportable prescriptions dispensed from the pharmacy to a patient in Vermont in the immediately preceding seven (7) days.	A prescriber must check the PDMP prior to writing a replacement prescription, at least annually for patients, who receive ongoing treatment with an opioid, and the first time a provider prescribes and opioid for chronic pain.

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State	Does state have PDMP?	Are dispensers required to report dispensing information to the PDMP?	When are prescribers required to check the PDMP?
Virginia	Yes	Pharmacies, non-resident pharmacies, permitted physicians, and physicians holding a permit to sell controlled substances are required to report all dispensing of any Schedule II, III, and IV controlled substances to the PMP.	Not required
Washington	Yes	Pharmacies and practitioners that dispense any Schedule II, III, IV, and V controlled substances, including samples, in Washington State or to an address in Washington, must report dispensing to the WA PMP.	Not required
West Virginia	Yes	N/A	A practitioner shall access the PDMP upon initial prescribing or dispensing of a controlled substance and at least annually thereafter.
Wisconsin	Yes	Dispensers are required to submit data to the PDMP within 7 days of dispensing a monitored prescription drug. Dispensers are encouraged to submit data as soon and as often as they like.	Not required
Wyoming	Yes	The Board collects Schedule II-IV controlled substance prescription information from all resident and non-resident retail pharmacies that dispense to residents of Wyoming.	Not required

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Mandatory Continuing Medical Education on Opioids

State	Is there mandatory Continuing Medical Education (CME) for appropriate opioid use?
Alabama	N/A
Alaska	N/A
Arizona	N/A
Arkansas	N/A
California	AB 487, signed into law on October 4, 2001, requires most CA-licensed physicians to take, as a one-time requirement, 12 units CME on pain management and the appropriate care and treatment of the terminally ill.
Colorado	When physicians are accredited in Colorado by the Colorado Division of Workers' Compensation they do take 2 hours of CME on opioids. It is not a state wide requirement for all doctors however.
Connecticut	N/A
Delaware	The continuing education requirement for OWC does not hone in on opioid use, but is more of a general overview of the HCPS.
District of Columbia	N/A
Florida	N/A
Georgia	N/A
Hawaii	N/A
Idaho	N/A
Illinois	N/A
Indiana	N/A
Iowa	N/A
Kansas	No
Kentucky	N/A
Louisiana	N/A

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State	Is there mandatory Continuing Medical Education (CME) for appropriate opioid use?
Maine	No
Maryland	N/A
Massachusetts	Effective Feb. 1, 2012, physicians applying to renew their license or obtain a new license must complete at least three (3) credits of education and training in pain management and opioid education. This requirement applies to all physicians who prescribe controlled substances
Michigan	N/A
Minnesota	N/A
Mississippi	N/A
Missouri	N/A
Montana	N/A
Nebraska	N/A
Nevada	N/A
New Hampshire	N/A
New Jersey	N/A
New Mexico	N/A
New York	N/A
North Carolina	N/A
North Dakota	No
Ohio	N/A
Oklahoma	1 hour of education of prescribing controlled substances every 2 years.
Oregon	Not workers' compensation mandated
Pennsylvania	N/A

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State	Is there mandatory Continuing Medical Education (CME) for appropriate opioid use?
Rhode Island	N/A
South Carolina	N/A
South Dakota	N/A
Tennessee	There is mandatory CME required by the BME for 1 hour each two years as part of license renewal.
Texas	N/A
Utah	N/A
Vermont	N/A
Virginia	N/A
Washington	The boards and Commissions have specific recommendation on CME through their rules.
West Virginia	One time requirement: 2 hrs. end of life care including pain management and 30 hrs. related to specialty
Wisconsin	N/A
Wyoming	N/A

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