



**Recommendations of the Committee on Workers Compensation and Personal Injury  
and The Special Advisers on Prescription Drug Abuse  
Approved by the CMS House of Delegates  
September 21, 2013**

The Public Health and Safety Challenges of Treating Chronic Pain: The Medical Perspective.  
A Proposed CMS Platform

Long-term CMS goal:

**Recommendation 1:** To assure access to compassionate, evidence-based care for patients who suffer from acute and chronic pain.

**Recommendation 2:** To significantly reduce the potential for medically inappropriate use and diversion of prescribed medications – that is, to help prevent the medical, psychological and social consequences, including addiction, overdose and death.

**Recommendation 3:** That the prescription drug diversion and abuse crisis requires a multi-pronged, coordinated strategy that includes a public-health focus, positive incentives to promote physician education and public awareness, useful tools that physicians can use at the point-of-care to support medical decision making, concerted attention to increase access to addiction treatment and recovery, and appropriate enforcement.

CMS strategies:

CMS will work collaboratively with all stakeholders and elected officials to achieve the CMS long-term goal. CMS supports:

**Recommendation 1:** Review of current evidence to understand the epidemiology of medically inappropriate use and diversion while concurrently developing strategies to address the misuse, abuse and diversion of opioids.

**Recommendation 2:** Development and promotion of new tools, along with existing resources and educational materials that enable physicians to appropriately prescribe opioids and narcotic medications, and to avoid inappropriate prescribing.

**Recommendation 3:** Development and implementation of an educational campaign for the public and providers that is continually assessed to further target outreach.

**Recommendation 4:** Partnering with other stakeholders to obtain the best consensually defined outcomes for Colorado.

**Recommendation 5:** Screening and referrals to treatment programs in Colorado. Advocate for increased resources and access to evidence based abuse and addiction treatment programs.

**Recommendation 6:** Establishment of a monitoring and tracking system for intervention strategies that allows expert evaluation and adjustments to intervention strategies.

CMS specifics:

I. Prescription Drug Monitoring Program (PDMP)

Background: The Electronic Prescription Drug Monitoring Program was originally authorized by law in 2005 and reauthorized in 2011(C.R.S Title 12, Article 42.5, Part 4). The PDMP provides a secure database of controlled substance prescriptions that have been dispensed by registered Colorado pharmacies. The purpose of the database is to provide objective information to assist prescribers and pharmacists in providing appropriate treatment for their patients. The program allows practitioners and pharmacists to gather information about the patients they serve and to ensure that their prescribing and dispensing is appropriate for the circumstances presented. The information collected by the PDMP is only accessible online by health care practitioners licensed by the state for the specific patient being reviewed.

Patients may receive their own personal PDMP data by submitting a written request form available from the “Consumers” tab. Law Enforcement officials may submit requests to receive PDMP data, via the forms available in the “Law Enforcement” tab. A court order or subpoena is required for such release. Regulatory Boards within the Division of Professions and Occupations or the Director of the Division of Professions and Occupations may obtain prescriber data. Here again, a court order or subpoena is required to affect such release.

The information in the PDMP is considered a medical record, and falls into the statutory provisions concerning policies, procedures, and references to the release, sharing, and use of medical records and health information. Those licensees with online accounts are not permitted to share their user name or password, office staff may not utilize the PDMP on their behalf, and they may only access information on patients they are caring for. The law provides that individuals that inappropriately access, utilize, or release information from the PDMP may be fined.

Each prescriber must disclose to patients for whom he/she is prescribing a controlled substance that the patient’s prescription information will be loaded into the PDMP and may be queried by authorized individuals. Each pharmacy must disclose to patients who are receiving controlled substances that their prescription information will be loaded into the PDMP and may be queried by authorized individuals. The Colorado State Board of Pharmacy has contracted with Health Information Designs (HID) to administer the database and manage the collection of the data. All information is transferred to and from the database via a secure web portal or secure file transfer.

The PDMP issues subject to discussion during the recent efforts to address prescription drug abuse are outlined below and include policy recommendations for consideration by the House of Delegates.

**Recommendation 1:** Funding: CMS should support appropriate funding for PDMP and begin the process of exploring funding alternatives.

Background: PDMPs must be adequately funded, maintained, and modernized to ensure their long-term ability to help combat prescription drug abuse. Under Colorado law, if there are insufficient funds to maintain the program, the division may collect an annual fee of no more than \$17.50 (2011-2013), \$20.00 (2013-2015), and \$25.00 thereafter. Fees assessed to pharmacies for non-compliance with the program go to the Colorado General Fund.

California is considering enacting legislation that would require all physicians to register with the PDMP or have automatic registration and an assessment fee as a condition of renewal of license. This assessment would be an additional 1.16% fee with a cap of \$7.00 that would be put into the PDMP trust. All prescribers would pay this assessment. This increase license fee could be added as a condition of renewal that could be deposited into a dedicated trust for maintenance and modernization of PDMP. If the fee is to be assessed on prescribers, the PBMs, wholesalers, distributors should share in this responsibility. In Washington, a long-term consistent source of funding for the PDMP is a portion of Medicaid fraud recovery.

**Recommendation 2:** Work Flow: PDMPs should be reliable and available at the point-of-care as part of the prescriber's workflow process. To the extent possible, real-time access, or as close to real-time access should be available to physicians. PDMPs must be designed so that up-to-date information is available when physicians query the database and are considering a decision to prescribe a controlled substance.

Background: Currently, the dispensing pharmacies report to the Colorado PDMP twice monthly. There can be a delay of about 25 days from date dispensed to when the data is available in the PDMP. Oklahoma PDMP has implemented real-time data collection.

**Recommendation 3:** Integration with other systems: The PDMP must be integrated with other systems. PDMP databases should ensure connectivity across state lines and to all patient populations, including those within the Veterans Administration health system, Indian Health Services, Department of Defense, Medicaid and Medicare.

Background: Methadone clinics are excluded from the PDMPs by federal statute and this issue is being addressed by MCs internally. Colorado is interconnected with 5 states, including Arizona, New Mexico, Kansas, Illinois, and Connecticut. As Colorado and other states implement systems of electronic prescribing of controlled substances (EPCS), Colorado should consider integrating EMTs, EPCS with PDMP data.

**Recommendation 4:** Delegated Access: Support the concept that a specific individual designated by a prescriber could be accredited to access the PDMP under specific conditions (e.g.-- unique identification code issued to the individual, and perhaps some legally binding certification to attest to that the designated person understands the legal restrictions and conditions under which they may access the PDMP, and the penalties for unauthorized access). The designee may need to have a different level of PDMP access, i.e., designees cannot view DEA numbers or names of prescribers.

Background: Twenty other states have adopted different forms of access to PDMP for delegates. Twelve states permit prescribers to delegate access to PDMP record. Some PDMPs permit prescribers to delegate only to a licensed health care professional, while

others allow non-licensed administrative staff to be delegated. New York's statute requires the delegates to be employees of the same practice as the prescriber. Access to PDMP by delegates should be subject to the same restrictions on use of the data as required under the act for the prescribers.

**Recommendation 5:** Institutional Access: Provide for institutional access to the PDMP.

Background: Twelve states allow entity access, including healthcare facilities. Staff is collaborating with CHA on appropriateness of entity access. For example, Virginia law defines a "dispenser" as a person or entity authorized by law to dispense a controlled substance or to maintain a stock of controlled substances for the purpose of dispensing.

**Recommendation 6:** The PDMP process should continue to be voluntary. Colorado should conduct recruitment campaigns to increase awareness about the PDMP and induce prescribers and pharmacists to enroll.

Background: In most states with operational PDMPs, enrollment and utilization are voluntary. Greater public outreach on the part of PDMPs could raise awareness about the prescription drug abuse epidemic and the role PDMPs can play in its mitigation. Enrollment in and use of the PDMP by medical practitioners is key to achieving its full potential in helping to ensure safe prescribing and dispensing, and in reducing diversion and abuse of controlled substances.

One of the most significant challenges facing PDMPs has been the slow increase in enrollment in and use of PDMPs by prescribers and pharmacists. Rates of enrollment among prescribers are well below 50 percent in most states. As of 6/12/13, 30% of all Colorado physicians have accounts to query the PDMP.

Appropriate rates of enrollment need to be studied, taking into account that many providers prescribe infrequently and that a relatively small proportion of prescribers are responsible for issuing most controlled substance prescriptions. Data from the Massachusetts PDMP indicate that just 30 percent of all those who prescribed an opioid at least once in 2011 were responsible for 88 percent of all opioid prescriptions in 2011 (MADPH Advisory Council Presentation, 2012). This suggests that to maximize the effectiveness of PDMPs, recruitment strategies could be focused on the most frequent prescribers of those controlled substances implicated in abuse and diversion.

Certain categories of potential PDMP users are a high priority for enrollment given the impact their use of PDMP data would likely have in improving prescribing and dispensing, and in reducing diversion and abuse of prescription drugs. Primary among these are the most frequent prescribers of controlled substances, such as the top 10 percent in terms of prescriptions per year, as well as those prescribers with relatively high proportions of suspected doctor shoppers in their practices. Such prescribers are readily identifiable using PDMP data and can be encouraged to enroll in and use the PDMP via letters and alerts, either electronically or by mail.

In 2010, Utah's PDMP analyzed its data to identify top prescribers, then contacted them electronically, resulting in a rapid rise in enrollment among this group. Massachusetts is currently conducting an initiative to identify prescribers with relatively high proportions of doctor shoppers in their practices; these prescribers are receiving letters suggesting they join and use the Massachusetts PDMP. These prescribers' enrollment in and utilization of the

PDMP will be monitored, along with any changes that may occur in the proportion of possible doctor shoppers in their practices.

**Recommendation 7: Outcomes Data:** The PDMP process should capture data on whether the use of the PDMP decreases abuse of prescription-controlled substances, diversion and abuse, and reduces overdose death rates, hospitalizations and ER visits, and improves health outcomes at the patient and community levels in Colorado.

Background: A number of factors can affect health outcomes besides the PDMP. This fact complicates studies of the impact of PDMPs.

**Recommendation 8: Unsolicited Reports:** Colorado physicians should explore the use of unsolicited reports provided by the PDMP to identify potential educational opportunities for physicians. Physicians will want to shape the types of unsolicited reports provided to prescribers and depending on the patient population served by the physician, i.e., pain management and palliative care would require different criteria.

Background: Some PDMPs send out unsolicited reports based on PDMP data suggesting questionable activity such as doctor shopping or inappropriate prescribing such as by a pill mill. Recipients of unsolicited reports sent by states could include prescriber, pharmacists, and licensure boards. Unsolicited reports can serve several functions: inform prescribers and pharmacists that patients may be abusing or diverting controlled substances; help prescribers make better decisions about prescribing controlled substances, thus improving patient care; and inform potential end users about the PDMP and its value. Identify patients at risk for undertreated pain or abuse, misuse, and diversion who have demonstrated overuse of opioids above a designated threshold. They could be required to select one prescriber (lock in program) or flagged as at-risk to providers and pharmacies.

Law Enforcement-Access to PDMPs:

**Recommendation 1:** Support opportunities to train District Attorneys (DA) and law enforcement about PDMP (consistent with the legal access provided).

**Recommendation 2:** Options for law enforcement (LE) access to the PDMP should protect the confidentiality of patient-sensitive information and incorporate medical involvement. Support maintaining the current standard of PC (probable cause).

Background: The current “probable cause-search warrant” standard is well understood by LE and the judiciary. Some states have decreased the threshold for access by LE to the PDMP to a “valid investigation” standard. These lower standards are more subjective and not well understood by the judiciary. Some states have designated specific officers to access PDMP. Other states require grand jury to authorize access by LE. Irrespective of the standard adopted, there should be strict prohibitions for releasing the information from the PDMP to anyone, including media, etc.

The Colorado’s AG’s office has indicated they are not interested in receiving unsolicited reports; rather they want LE to have unrestricted access to the PDMP through their access number to be able to review all data they determine are relevant to an investigation. This means that LE (and the CMB) would be allowed to waive confidentiality and review the information in the PDMP without establishing some showing that a crime has been

committed or that an inquiry is within the authority of the agency, the demand is not too indefinite, and that the information sought is reasonable relevant to the inquiry.

## II. Licensing Boards Standardization

**Recommendation:** All prescribing Boards should agree upon and set the same minimal standards for opioid prescribing. All providers including pharmacists, nurse practitioners, dentists etc. should be held to using the same standards.

Background: The standards for providing on-going opioid management for chronic pain patients are well delineated and universal. Using the same standards will not only improve management of patients but also allow appropriate conversations between pharmacists, as they are trying to decrease inappropriate prescriptions, and providers who can explain how they are following the standards. In addition, all providers are concerned about remaining licensed and thus are sensitive to boards standards. The Colorado Board of Medicine is currently updating its policy 10-14, the policy for the use of controlled substances for the treatment of chronic, non-cancer pain. All prescribers, pharmacist and members of continuum of care should work together to insure appropriate access to necessary medications for patients with legitimate medical needs.

## III. Physician Education

Background: Continuing voluntary medical education is a vital component to assure safe prescribing and effective relief of moderate to severe pain. Education about PDMPs, how to use them, and the value of the data for prescribers would likely encourage enrollment in and effective utilization of PDMP.

**Recommendation 1:** Educational programs for physicians should be from a peer reviewed recognized education source, be easily available to physicians and provide CME accredited documentation of completion of educational program. Professional school curriculum should include opioid education emphasizing concern for abuse and diversion as well as medically appropriate of chronic and acute pain.

**Recommendation 2:** Educational programs for physicians should help physicians to be able to identify at-risk prescribing practices and implement strategies to minimize the potential consequences of opioid prescribing (including abuse, diversion, as well as other adverse consequences).

**Recommendation 3:** Educational programs for physicians should be developed for physicians and should be tailored to meet a physician's practice and population needs and help physicians to be able to identify the best practices for the management of chronic, non-cancer pain.

**Recommendation 4:** Educational programs for physicians should work with others responsible for education of other health care professionals to ensure that education is coordinated, consistent in message, and promotes members of the health care team working together toward safer opioid prescribing.

**Recommendation 5:** Encourage the use of validated screening tools such as the NIDAMED's Clinical Screening Tool or the Screener and Opioid Assessment for Patients with

Pain, as well as other tools to help physicians identify patients at risk for prescription drug abuse and to monitor patients who receive controlled substances for aberrant behaviors that may be indicative of addiction. These approaches can foster appropriate interventions and treatment.

**Recommendation 6:** The education programs for management of chronic non-cancer pain and for opioid prescribing practices should be evaluated for their ability to demonstrate understanding, intent to change practice behavior, and objective outcomes such as changes in prescription patterns, changes in utilization of alternative ways of treating chronic non-cancer pain, utilization of billing codes reflecting use of PDMP, counseling and other measures that are included in current treatment guidelines. Coroner death rates can be used to educate as well. If a feedback loop is created to let prescribers know that their patient died of drug related death it may promote safe prescribing.

#### IV. Law Enforcement-Public Safety

Background: Law enforcement also plays a role to support efforts to prevent abuse and diversion. This crisis, however, requires a public health focus-as opposed to strictly law enforcement focus-to emphasize the treatment and recovery needs of addicted patients.

**Recommendation 1:** CMS supports enforcement actions to halt “pill mill” activities, including efforts to halt criminal activities related to the prescribing and distribution of medically unindicated pain medications by rogue prescribers or dispensers.

**Recommendation 2:** CMS does not support unfettered access by LE to PDMP data that would allow “fishing expeditions.”

#### V. Prescription Drug Abuse as a Public Health Issue: That CMS support:

**Recommendation 1:** Public awareness to address the role of opioids and safety.

**Recommendation 2:** Public health programs that include support for community-based programs that provide access to training for the use of opioid antagonists, such as naloxone, that have no potential for abuse and that saves lives.

**Recommendation 3:** Increased education, funding and support for take back events and disposal programs can help remove unused and unwanted prescription medications from the public environment.

**Recommendation 4:** Support for addressing the demand side for these prescriptions-more resources for prevention and addiction treatment and recovery as well as support for other non-medical measures to treat and self manage chronic pain.

**Recommendation 5:** Work with public health colleagues on public awareness around safe storage, not sharing medications.

Respectfully Submitted

Members, CMS Committee on Workers Compensation and Personal Injury (CWCPI) and the Special Advisers on Prescription Drug Abuse

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