Workers' Comp

Virginia Adopts Opioid Prescribing Limits

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The Virginia Board of Medicine published a new rule on July 9, 2018. This rule institutes new regulations governing the prescribing of opioids and buprenorphine in all areas of health care, including workers' compensation and auto medical payments.

The rule covers both acute and chronic pain settings and **will become effective on August 8, 2018**.

Below is a summary of the new rule:

- Does not apply to acute or chronic pain related to cancer, sickle cell, patients in hospice care, patients in palliative care, patients admitted to a hospital, nursing home or assistive living facility using a sole-source pharmacy, or patients enrolled in an authorized clinical trial
- Acute pain is defined as: pain that occurs within the normal course of a disease or condition or as the result of surgery for which controlled substances may be prescribed for no more than three months
- Chronic pain is defined as: nonmalignant pain that goes beyond the normal course of a disease or condition for which controlled substances may be prescribed for a period greater than three months

For management of acute pain:

- Non-pharmacologic or non-opioid treatment should be considered first
- Practitioner should perform a physical exam related to the cause of the pain
- Practitioner is required to check the Prescription Drug Monitoring Program to determine patient's opioid use history
- If opioids are deemed necessary, the practitioner should prescribe the lowest effective dose for the shortest possible duration
- Initial opioids should be short-acting
- Initial prescription is limited to seven days, unless extenuating circumstances are clearly documented in the patient's medical record

- Opioids prescribed for post-surgical pain are limited to a 14 day supply
- Practitioner should carefully consider and document reasons to exceed 50 MME/day
- If exceeding 120 MME/day, practitioner should consult with or refer patient to a pain management specialist
- Nalaxone shall be prescribed for patients at risk for overdose or receiving doses in excess of 120 MME/day, or when also taking a benzodiazepine
- Prescriber shall only co-prescribe opioids with benzodiazepines, sedative hypnotics, carisoprodol or tramadol when extenuating circumstances are present and shall document the medical record with a tapering plan to reach the lowest doses possible
- Buprenorphine is not indicated for acute pain in an outpatient setting, unless practitioner has a SAMSHA waiver and is treating addiction

For management of chronic pain:

- Practitioner shall perform a comprehensive physical exam and review of medical history, including a mental status evaluation to determine nature and extent of pain and any substance abuse risk or history
- Practitioner is required to check the Prescription Drug Monitoring Program to determine patient's opioid use history
- Practitioner shall discuss with the patient the risk of opioid use, the patient's responsibilities when using opioids and an exit strategy for discontinuing opioids
- Non-pharmacologic or non-opioid treatment should be considered first
- Practitioner should carefully consider and document reasons to exceed 50 MME/day
- If exceeding 120 MME/day, practitioner must document medical record with justification and should consult with or refer patient to a pain management specialist
- Nalaxone shall be prescribed for patients at risk for overdose or receiving doses in excess of 120 MME/day, or when also taking a benzodiazepine
- Practitioner should document justification for continued opioid therapy every three months
- Buprenorphine mono-product, in tablet form, shall not be prescribed for chronic pain
- Opioids should not be co-prescribed with benzodiazepines, sedative hypnotics, carisoprodol, or tramadol without medical justification
- Patient should be regularly evaluated for signs of substance abuse disorder
- Practitioner shall include a signed treatment agreement for chronic pain in the medical record, along with documentation of informed consent
- Random drug testing should be performed to evaluate proper adherence to opioid treatment

The new rule also contains guidance for prescribing buprenorphine for treating addiction

Virginia joins a large number of states who have enacted limits for prescribing opioids. In other states, these prescribing limits have demonstrated effectiveness at reducing the prescribing of opioids. We applaud the Virginia Board of Medicine for their thoughtful approach and look forward to working with our customers to help them maximize the benefit of the new rule and to reduce the use of opioids, where practical, with their Virginia claimants.

To view complete text of the new rule in the Virginia Register, please click here.

If you have questions about this alert, or for any other legislative or regulatory questions, please contact Brian Allen, Vice President of Government Affairs, at Brian.Allen@mitchell.com or by telephone at 801.903.5754.



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