



STATE STRATEGIES FOR ADDRESSING PRESCRIPTION DRUG ABUSE

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ISSUE

What strategies are states using to address prescription drug abuse? Have any states enacted legislation mandating drug testing for individuals with long-term prescriptions for controlled substances?

OLR Report [2014-R-0233](#) also addresses prescription drug abuse in Connecticut and recent legislation considered in other states.

SUMMARY

States have implemented various policy strategies to reduce and prevent prescription drug abuse and related deaths. This report highlights some of these strategies, including (1) statewide prescription drug monitoring programs, (2) regulating “pill mills” (e.g., health care entities that indiscriminately or inappropriately prescribe individuals controlled substances), (3) increasing access to opioid antagonists (medication to treat a drug overdose), and (4) mandating continuing medical education on pain management and prescription drug abuse for certain health care providers.

Additionally, we found three states (Indiana, Kentucky, and Washington) that mandate drug testing (e.g., urine testing) for certain patients prescribed long-term opioid pain medications. Tennessee law encourages, but does not require, such testing. However, the law required the state’s health department to issue treatment guidelines for prescribing controlled substances for chronic pain management; these guidelines include the use of mandatory urine testing for such patients.

Please note, this report does not address prescription drug abuse related to public assistance or workers’ compensation programs.

PRESCRIPTION DRUG ABUSE

The federal Centers for Disease Control and Prevention (CDC) has classified prescription drug abuse as an epidemic in the United States. In 2012, prescription drug overdoses accounted for 53% of all U.S. drug overdose deaths. Of these deaths, 72% involved opioid analgesics (e.g., prescription painkillers such as oxycodone, hydrocodone, and fentanyl). Additionally, in 2011, approximately 1.4 million emergency department visits involved the nonmedical use of prescription drugs and almost half of these visits were related to opioid analgesics.

The CDC notes that the significant increase in opioid overdose deaths parallels a similar increase in the prescribing of these drugs, as U.S. sales of opioid pain relievers quadrupled from 1999 to 2010. Likewise, substance abuse treatment admission rates for opioid abuse were seven times higher in 2010 than in 1999.

STATE STRATEGIES

Prescription Drug Monitoring Programs

Almost all states track prescription drug abuse through statewide prescription drug monitoring programs (PDMPs). According to the [PDMP Training and Technical Assistance Center](#), 49 states (excluding Missouri) and the District of Columbia have implemented a PDMP.

If you would like information on Connecticut's PDMP, please let us know. Below we summarize the common features of PDMPs across the states.

Program Overview. A PDMP is a statewide electronic database which collects data on prescriptions dispensed for controlled substances in the state. The program is administered by a designated state agency and is designed to help prevent and detect the diversion and abuse of prescription controlled substances, such as opioid pain medications.

Generally, these programs require pharmacists to enter data on filled prescriptions into the electronic database to prevent patients from attempting to fill a prescription at more than one pharmacy. Many states require prescribing practitioners to consult the database before prescribing a controlled substance to ensure the patient has not attempted to obtain a prescription from multiple practitioners (e.g., "doctor shopping").

Program Design. According to the [Bureau of Justice Assistance](#), PDMPs are organized and operated differently across states in terms of (1) the types of prescription drugs they collect data on (although all states collect information in Schedule II controlled substances such as methadone, morphine, and oxycodone); (2) the frequency of data collection; (3) who can access the database; and (4) compliance and enforcement mechanisms.

However, most states use PDMPs to:

1. prevent and reduce prescription drug abuse,
2. identify and investigate potential cases of illegal drug use or professional misconduct,
3. distribute educational information,
4. promote public health initiatives, and
5. implement early intervention or prevention programs.

Interstate Data Sharing. Many states share PDMP data with other states, allowing an authorized user in another state to set up an account with the PDMP and receive information directly from the database. According to the National Alliance for Model State Drug Laws, as of December 2013, [45 states](#) (1) shared PDMP information with other states' programs (19 states), (2) allowed out-of-state users to access their program database (eight states), or (3) both (18 states, including Connecticut). Florida, Georgia, Missouri, Nebraska, and Pennsylvania do not authorize interstate data sharing.

Pill Mill Regulation

A "pill mill" generally refers to a physician's office, pharmacy, clinic, or health care facility that routinely prescribes or dispenses controlled substances inappropriately or indiscriminately. According to the National Conference of State Legislatures (NSCL), at least nine states (Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, Ohio, Texas, and West Virginia) enacted legislation in the past few years to provide state oversight of pain management practices.

For example, in 2011, Florida enacted legislation that established standards of care for physicians who prescribe controlled substances. Among other things, the law requires (1) these physicians to register with the state health department and write prescriptions on counterfeit-proof paper and (2) prohibits them from on-site dispensing of the most abused controlled substances, such as oxycodone ([2011 HB 7095](#)).

As another example, Ohio enacted 2011 legislation that, among other things, requires the state's (1) pharmacy board to license pain management clinics and (2) medical board to adopt rules for clinic operations and physician care. It also established limits on the amount of controlled substances physicians, dentists, and podiatrists may prescribe in any:

1. 72-hour period to an amount of controlled substance that does not exceed the amount necessary for the patient's use in a 72-hour period and
2. 30-day period to an amount that does not exceed 2,500 dosage units.

The legislation also authorizes the pharmacy board to impose a fine of up to \$5,000 against a pain management clinic that operates illegally or improperly. The state medical board may impose a similar fine of up to \$20,000 against a physician who violates its rules ([2011 HB 93](#)).

Access to Opioid Antagonists

A number of states have addressed opioid drug overdose by removing statutory barriers to accessing opioid antagonists and seeking emergency care. An opioid antagonist, such as naloxone, rapidly reverses the symptoms of an opioid drug overdose. They are not addictive and do not cause a "high" or pose any serious health effects when taken by a person not suffering from a drug overdose.

Historically, state laws generally discouraged or prohibited the prescription of these medications to a person (1) other than the intended recipient (e.g., third-party prescriptions) or (2) who a physician did not personally examine (e.g., standing order prescription).

However, according to the Network for Public Health Law, at least 25 states, including Connecticut, and the District of Columbia have enacted legislation (1) increasing access to naloxone and (2) providing civil and criminal immunity to health care providers who prescribe and dispense the medication and lay persons who administer it. Additionally, at least 21 states, including Connecticut, and the District of Columbia have enacted "Overdose Good Samaritan Laws" that provide civil and criminal immunity to individuals who call 911 for emergency care for themselves or another person experiencing a drug overdose.

Continuing Medical Education

Some states require health care providers who prescribe or dispense controlled substances to complete continuing medical education (CME) courses on pain management and opioid prescriptions as a condition of licensure. We found at least eleven states (California, Florida, New Mexico, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Utah, and West Virginia) with such a requirement.

For example, Utah requires physicians who prescribe controlled substances to complete at least four CME hours each license renewal period on this subject. Specifically, these hours must address:

1. the scope of the state and national controlled substance abuse problem,
2. all elements of the Food and Drug Administration’s (FDA) “Blueprint for Prescriber Education,”
3. national and state resources available to prescribers to help determine appropriate controlled substance and opioid prescribing,
4. office policies and procedures, and
5. patient record documentation for controlled substances and opioid prescribing ([Utah Code Ann. § 58-37-6.5](#)).

As another example, New Mexico law requires all health care providers who are registered and licensed with the FDA to prescribe opioid medications to complete CME in non-cancer pain management. Each profession’s regulatory board must establish specific CME requirements, such as the number of required hours and course content ([NMSA § 24-2D-5.1](#)).

MANDATORY PRESCRIPTION DRUG TESTING LAWS

We found three states (Indiana, Kentucky, and Washington) that mandate drug testing (e.g., urine testing) for certain patients prescribed opioid pain medications. Tennessee law encourages, but does not require, practitioners prescribing controlled substances to patients for long-term, pain management to mandate urine testing. However, the Tennessee Department of Health issued guidelines in September 2014 that include the use of mandatory urine testing for such patients.

Below we provide brief summaries of these states’ laws.

Indiana

In 2013, the Indiana legislature enacted "Pill Mill" legislation that, among other things, required the state's Medical Licensing Board to adopt an emergency rule establishing standards and protocols for prescribing controlled substances ([IC § 25-22.5-13](#)). The emergency rule, which took effect in December 2013, requires patients who are prescribed a certain amount of opioid medications to sign a "treatment agreement" that subjects them to annual drug screening (e.g., urine testing) as a condition of treatment. The board's final rule, which takes effect November 6, 2014, requires such drug screening whenever a physician deems it medically necessary, instead of annually ([844 IAC 5-6](#)).

Final Rule. Starting January 1, 2015, the final rule requires physicians to perform such drug screening on patients who are prescribed (1) more than 60 opioid-containing pills per month for over 90 days, (2) a morphine equivalent daily dose of more than 15 milligrams for over 90 days, or (3) a hydrocodone-only extended release medication that is not in an abuse deterrent form. The final rule does not apply to terminally ill patients or those enrolled in hospice or palliative care programs ([844 IAC 5-6-9](#)).

The final rule specifies criteria physicians must consider when determining if drug monitoring testing is medical necessary, such as whether the patient is believed to be (1) misusing the medication, (2) taking other medications or illicit drugs, or (3) diverting the medication to another person ([844 IAC 5-6-9](#)).

In addition to mandatory drug screening, the treatment agreement includes:

1. treatment goals;
2. the physician's prescribing policies, including requiring the patient to take the medication as prescribed and not share it with another person;
3. authorization for the physician to conduct random pill counts;
4. the requirement that the patient inform the physician about any other controlled substances he or she is taking; and
5. reasons why the physician may change or discontinue the prescription ([844 IAC 5-6-5](#)).

Physicians must meet with patients at least once every four months, or more frequently if patients require changes to their medication and treatment plans. Physicians must also check the state's prescription drug monitoring database before prescribing controlled substances, and at least annually thereafter ([844 IAC 5-6](#)).

Lawsuit. In January 2014, the American Civil Liberties Union (ACLU) of Indiana filed a lawsuit in U.S. District Court against the Medical Licensing Board, alleging that the board's emergency rule mandating annual drug screening for patients prescribed opioid medications for pain treatment is unconstitutional, as it constitutes an unreasonable search under the U.S. Constitution's Fourth Amendment.

The lawsuit, which seeks class action certification, was filed on behalf of an individual who has been prescribed these medications for over 18 years to treat chronic pain. The court has not yet issued a ruling (*Wierciak v. Individual Members of the Medical Licensing Board of Indiana*, No.1:14-cv-00012-SEB-DML, S.D. Ind. 2014).

Kentucky

Kentucky law and regulations generally require physicians to use drug screenings (e.g., urine testing) when prescribing or dispensing long-term controlled substances (i.e., more than 90 days) to patients over age 16. The requirement applies to controlled substances (except those classified as Schedule V) that are used to treat pain and related symptoms associated with a primary medical complaint ([KRS § 218A.172](#) and [201 KAR 9:260](#)).

Specifically, state regulations require physicians, when prescribing or dispensing long-term controlled substances, to perform an initial drug screening and subsequent screenings "in a random and unannounced manner at appropriate times" ([201 KAR 9:260](#)). The Kentucky Board of Medical Licensure, the state's regulatory body, developed the following drug screening [intervals](#) for physicians:

1. at least once per year if the patient is considered "low risk";
2. at least twice per year if the patient is considered "moderate risk";
3. at least three to four times per year if the patient is considered "high risk"; and
4. at each office visit if the patient exhibits aberrant behavior, such as multiple lost prescriptions, multiple requests for early refills, multiple providers prescribing opioids to the patient according to the state's PDMP, unauthorized dose escalation, and apparent intoxication.

If the drug screenings or other information available to the physician indicates the patient is misusing the controlled substance, the physician must:

1. taper the patient off of the controlled substance;
2. immediately stop prescribing or dispensing the controlled substance; or
3. if appropriate, refer the patient to an addiction specialist, mental health professional, pain management specialist, or drug treatment program ([201 KAR 9:260](#)).

Additional Requirements. In addition to performing drug screenings for such patients, physicians must obtain patients' complete medical histories, develop and periodically review treatment plans, perform periodic physical examinations, and ensure patients receive annual preventive health screenings. Physicians must see patients monthly until an appropriate dosage of the controlled substance is achieved and proper monitoring is in place to minimize the likelihood of prescription misuse.

Physicians must also review reports from the state's PDMP before writing an initial prescription and every three months thereafter, to ensure that patients are not obtaining prescriptions for controlled substances from multiple providers ([KRS § 218A.172](#) and [201 KAR 9:260](#)). When appropriate, they must also conduct random pill counts to ensure patients are appropriately taking the controlled substances appropriately.

Tennessee

Tennessee law requires any health care practitioner who prescribes controlled substances to patients in long-term drug therapy (i.e., for 90 days or more) to consider mandatory drug testing ([Tenn. Code Ann. § 53-11-308](#)). While the law does not mandate drug testing for these patients, it required the Tennessee Health Department, by January 1, 2014, to issue [treatment guidelines](#) for prescribing opioids and other controlled substances for chronic pain management ([Tenn. Code Ann. § 63-1-401](#)).

These guidelines, which are updated annually, require prescribing practitioners to perform urine drug testing on chronic pain patients before starting opioid therapy and at least twice per year thereafter. Patients considered to be at moderate or high risk for drug abuse are tested at least three to five times per year.

The guidelines do not apply to end-of-life or emergency room care or acute pain management.

Washington

In 2010, the Washington legislature directed the state's Medical Quality Assurance Commission to adopt stricter rules on dispensing opioid medications for chronic, non-cancer pain management (except for hospice or other end-of-life care) (RCW § 18.71.450 & WAC 246-919-850 et. seq.). The rules, which took effect in 2012, require patients to sign a written treatment agreement if they (1) are at high risk for medication abuse or (2) have a history of substance abuse or co-occurring psychiatric conditions. The treatment agreement subjects patients to random urine testing whenever their physician requests it. Additionally, the treatment agreement:

1. requires patients to take medications at the prescribed dose and frequency with a specific protocol for lost prescriptions and early refills,
2. specifies reason why the physician may reduce or discontinue the patient's drug treatment therapy,
3. requires all chronic pain management prescriptions to be provided by a single prescriber or multidisciplinary pain clinic and dispensed by a single pharmacy or pharmacy system, and
4. prohibits patients from abusing alcohol or using other medically unauthorized substances ([WAC 246-919-856](#)).

The agreement also authorizes (1) physicians to notify authorities if they believe a patient engaged in illegal activities and (2) other practitioners to report violations of the agreement to physicians ([WAC 246-919-856](#)).

Periodic Patient Evaluations. Physicians must periodically review a patient's course of treatment, health status, and treatment compliance at least every six months. If the patient is receiving a daily dose of 40 milligrams or less of morphine, or its equivalent, such reviews must take place at least annually ([WAC 246-919-857](#)). Physicians must also check the state's PDMP before prescribing opioid medications, and periodically thereafter ([WAC 246-919-857](#)).

Physicians may only prescribe a long-acting opioid medication, such as methadone, if they (1) are familiar with its risks and use, (2) are prepared to conduct careful patient monitoring, and (3) completed at least four hours of related continuing education ([WAC 246-919-858](#)).

Required Consultation With Pain Management Specialist. The law requires physicians to refer patients prescribed opioid medications that exceed a certain dosage threshold to a pain management specialist for a mandatory consultation. Specifically, patients prescribed a daily dosage at or above 120 milligrams of morphine, or its equivalent, must meet with a pain management specialist. If the consultation takes place by telephone, computer, or other remote method, the patient's prescribing physician must also attend.

RESOURCES

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