2018 Summary of Tennessee Opioid Prescribing Laws
An Introduction

What to Expect From This Summary

SVMIC works to keep you informed about risk issues in the medical office that may require attention. Our updated Tennessee summary will inform physicians and other prescribers of recent laws and updated regulations pertaining to prescribing opioids.

New Laws of Interest

**Public Chapter 675** *(Effective January 1, 2019)* requires prescribers to provide information to employees in writing or signage in a non-public area (break room) about reporting suspected opioid abuse or diversion.

**NOTE** Posted sign must be **11hx17w** and say 
“NOTICE: Please report any suspected abuse or diversion of opioids, or any other improper behavior with respect to opioids, to the Department of Health’s Complaint Intake Line: 800-852-2187”

**Public Chapter 883** requires all Schedule II prescriptions to be electronically prescribed by January 2020.

**Public Chapter 901** *(Effective July 1, 2018)* If > 3-day opioid Rx, a physician must obtain informed consent from a woman of childbearing age (15-44), capable of becoming pregnant, to include risks of opioids, methods of birth control and the availability of free or reduced cost birth control.

**Public Chapter 978** *(Effective July 1, 2018)* requires prescribers of buprenorphine products or other controlled substances to treat addiction prescribed to ≥25% of total patients OR ≥150 patients to be licensed as a non-residential office-based opiate treatment facility (OBOT). It also creates a task force to establish the minimum disciplinary action against opioid prescribers for significant deviation from sound medical judgment.

**Public Chapter 1040** *(Effective July 1, 2018)* All gabapentin products are now Schedule V controlled substances (Gabapentin may be used to potentiate the effects of opioids).

Important Reminders

**Naloxone Law** allows a licensed healthcare practitioner to prescribe naloxone to a person (or their family/friend) at risk of having an opiate-related overdose.

**Drug Take-back and Disposal** Federal law prohibits a physician or other prescriber from accepting unused controlled substances, which may be a criminal offense. 21 CFR 1317

Visit svmic.com for suggestions for proper disposal including referral to a take-back or collection program.

**Advanced Practitioners** Professional relationships between physicians and advanced practice providers (NPs/PAs) are no longer referred to as “supervisory” and are now termed “collaborative”.

**CSMD Delegation** Healthcare practitioners may delegate authority to check the CSMD to any licensed employee and up to 2 unlicensed persons. Delegates must be registered and obtain individual user IDs and the healthcare practitioner remains responsible for the delegate’s actions.

Disclaimer

The information provided in this summary is intended for general guidance only and does not include all laws or regulations pertaining to prescribing. This summary does not supersede the law or constitute legal advice. Those who are or may be subject to this information are strongly urged to review the applicable laws and rules and seek personal legal counsel if necessary. Revised: 8/18.
**Frequently Asked Questions**

Q. Why are partial fill prescriptions required for 10-day, 20-day, and 30-day prescriptions? **

A. The most common way that people who are not currently taking opioid medications gain access to opioids is through diversion – taking the extra opioids friends and family have received from healthcare providers. It is well documented that most patients do not use all of the opioid pain medications they are prescribed after surgery, and this is a major source of medications which are subsequently diverted to other people. By breaking the dispensing up into two parts, the goal is to reduce the amount of leftover medications. Partial fill prescriptions allow patients to take control and, if needed, receive the full duration of the prescription without going back to the prescriber.

Q. What is meant by “major physical trauma?” and “severe burn”?

A. The CSMD Committee’s proposed definitions:

- “Major physical trauma” means a serious injury sustained due to surgical intervention or blunt or penetrating forces with the potential for serious blood loss, fracture, significant impairment whether temporary or permanent, disability or death.
- “Severe Burn” means an injury sustained from thermal or chemical causes resulting in 2nd and 3rd degree burns.

Q. Where should a healthcare practitioner write the ICD-10 code and “exempt” or “medical necessity” on a written controlled substance prescription? **

A. The ICD-10 code, “exempt” and “medical necessity” can be placed in the area available for patient instructions or anywhere on the prescription where the information will be transmitted to the pharmacy as part of the prescription. The ICD-10 code selected should be for the primary disease causing the pain. **NOTE:** As a best practice, many pharmacies are requiring the word “surgery” on 20-day or post-surgical prescriptions.

Q. Does SVMIC have a sample opioid consent form?


Q. What are the changes to the requirements for checking the CSMD?

A. The new law requires the prescriber or healthcare practitioner extender to check the database before prescribing an opioid or benzodiazepine:

- At the beginning of a new episode of treatment (drug not prescribed within previous 6 months)
- Prior to the issuance of each new prescription for the controlled substance for the first ninety (90) days of a new episode of treatment
- At least every six months when that controlled substance remains part of the patient’s treatment plan

Q. Are there any exceptions for the CSMD?

A. Prescribers are not required to check the CSMD if one or more of these conditions is met (partial list only):

- The quantity of the controlled substance which is prescribed or dispensed does not exceed an amount which is adequate for a single, three-day treatment period and does not allow a refill
- The controlled substance is prescribed or dispensed for a patient who is currently receiving hospice care
- The controlled substance is prescribed for administration directly to a patient during the course of inpatient or residential treatment in a hospital or nursing home

Q. What is meant by “more than minimally invasive surgery?” **

A. Major surgery is more than minimally invasive. Minor surgery is not more than minimally invasive.

Q. Am I required to obtain a Urine Drug Screen before starting a patient on opioid medication?

A. Urine drug screening is **not required** before starting opioid medication. Pain management clinic rules and the Tennessee chronic pain guidelines have requirements for urine drug screening, with a minimum of twice annually. However, depending on the patient’s history, there may be a professional responsibility to obtain a urine drug screen prior to opioid therapy.

**These questions were originally developed by the Tennessee Department of Health. For a comprehensive list of frequently asked questions, go to https://www.tn.gov/opioids.**
Before Prescribing Opioids

Checking the Controlled Substances Monitoring Database (CSMD)

The new law requires the prescriber or healthcare practitioner extender to check the database:

- Before prescribing an opioid or benzodiazepine at the beginning of a new episode of treatment (drug not prescribed within previous 6 months)
- Prior to the issuance of each new prescription for the controlled substance for the first ninety (90) days of a new episode of treatment
- At least every six months when that controlled substance remains part of the patient’s treatment plan

Note: Prescribers also have a professional responsibility to check the database for any Schedule II-V controlled substance if doctor shopping, diversion or other misuse is suspected. Prescribers should regularly (suggest monthly) obtain their own practitioner report for unauthorized use of a prescriber’s DEA license (contact law enforcement) or for incorrect information (contact dispensing pharmacy).

Are there any exceptions?

T.C.A. § 53-10-310

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- The controlled substance is prescribed or dispensed for a patient who is currently receiving hospice care
- The controlled substance is prescribed for administration directly to a patient during the course of inpatient or residential treatment in a hospital or nursing home

REMEMBER If an employee leaves your practice, you should immediately revoke their access to the database.

Calculations of MME (Morphine Milligram Equivalent) for Commonly Prescribed Opioids

Morphine milligram equivalents (MME)/day: a measurement used to equate the strength of various drugs to morphine. One milligram of hydrocodone is equivalent to one milligram of morphine, and one milligram of oxycodone is equivalent to 1.5 milligram of morphine.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Dosage</th>
<th>Times Per Day</th>
<th>MME Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone</td>
<td>5 mg</td>
<td>3</td>
<td>15 MME</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>20 MME</td>
</tr>
<tr>
<td></td>
<td>10 mg</td>
<td>3</td>
<td>30 MME</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>40 MME</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>5 mg</td>
<td>3</td>
<td>22.5 MME</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>30 MME</td>
</tr>
<tr>
<td></td>
<td>10 mg</td>
<td>3</td>
<td>45 MME</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>60 MME</td>
</tr>
</tbody>
</table>

For easy and helpful dosage conversions, try using the CDC App, CDC Opioid Guideline. This App, including the calculator, is not intended to replace clinical judgment. Always consider the individual clinical circumstances of each patient.
Requirements to Prescribe Opioids

Rule Number One: Always consider non-opioid treatment before initiating the prescribing of opioids. Public Chapter 1039 requires that more guidelines and checkpoints between healthcare practitioners and patients are in place before an individual is put on a chronic regimen of opioids.

- **UP TO: 3-day opioid Rx**
  - MAX DOSAGE: 180 MME (60 MME/Day)
  - NO ADDITIONAL REQUIREMENTS BEFORE PRESCRIBING

- **UP TO: 10-day opioid Rx**
  - MAX DOSAGE: 500 MME (50 MME/Day)
  - INCLUDE: ICD-10 Code

**ADDITIONAL REQUIREMENTS BEFORE PRESCRIBING MORE THAN 3 DAYS OF OPIOIDS**

☐ Obtain written informed consent (risks, benefits, alternatives) that includes:
  - Risk of dependency, addiction and diversion
  - Expectations and how to use
  - Condition-specific alternatives
  - Information on neonatal abstinence syndrome and accessing contraceptives if woman is of child-bearing age (15-44 years old)

☐ Check the CSMD (see CSMD schedule on back)

☐ Conduct a thorough evaluation of the patient

☐ Document consideration of alternative treatments for pain and why an opioid was used

☐ Include ICD-10 code in the chart and on Rx

Pharmacy may fill no more than half of total prescribed amount initially

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**FOR A MORE THAN MINIMALLY INVASIVE PROCEDURE**

- **UP TO: 20-day opioid Rx**
  - MAX DOSAGE: 850 MME (42.5 MME/Day)
  - INCLUDE: ICD-10 Code and “surgery”

**SURGERY PATIENTS ONLY**

Document why the risk of an adverse outcome exceeds the risk of developing a substance use disorder or overdose event

- **UP TO: 30-day opioid Rx**
  - MAX DOSAGE: 1200 MME (40 MME/Day)
  - INCLUDE: ICD-10 Code (ADD THE WORDS “MEDICAL NECESSITY”) & 
  - ONLY AFTER DOCUMENTED TRIAL AND FAILURE OR CONTRAINDICATION OF A NON-OPIOID TREATMENT

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**Exemptions**
The following patients are exempt if the prescription includes the ICD-10 Code and the word "exempt":

- Treated for chronic pain with an opioid for 90+ days in the last year
- Active or palliative cancer treatment
- Receiving hospice care
- Diagnosis of sickle cell disease
- Seeing a pain management specialist
- Being treated for substance use disorder
- Severe burns or major physical trauma
- Patients in a licensed facility
The Tennessee Department of Health guidelines summarized below are not applicable to end-of-life care, emergency room care or acute pain. Occasional deviation from these guidelines for appropriate medical reasons is to be expected and documented. The guidelines are located at https://www.tn.gov/content/dam/tn/health/healthprofboards/ChronicPainGuidelines.pdf.

**MANAGING OPIOID TREATMENT**

- Non-opioid treatments should be tried before opioids are initiated. Opioids should be used only after all other appropriate and available treatments for the pain condition have been exhausted.
- Review of prior records
- Current diagnosis justifying opioid treatment
- Avoid benzodiazepines. If greater than 120 MME, refer to a mental health specialist.
- Goals for treatment
  - Goal is pain reduction, not elimination
  - Clinically significant improvement in function, not only “pain score”
  - PEG Scale (Pain average, Interference with Enjoyment of life, Interference with General activity)
- Document (H&P, lab tests, imaging results)
- Informed Consent
- Pain Management Agreement
- Attempted alternative treatments
- Screening of mental health disorders
- Assessment for misuse, abuse, diversion, addiction, urine drug screening and CSMD check, per guidelines

**MORPHINE EQUIVALENTS (MME)**

<table>
<thead>
<tr>
<th>Patients at:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;120 MME</td>
<td>Provider encouraged to manage</td>
</tr>
<tr>
<td>≥120 MME</td>
<td>Consult with a Pain Management Specialist (PMS)</td>
</tr>
<tr>
<td>≥120 &gt;6 months</td>
<td>Annual consultation with a PMS</td>
</tr>
</tbody>
</table>

**URINE DRUG SCREENING**

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH RISK</td>
<td>4-5 times per year</td>
</tr>
<tr>
<td>MODERATE RISK</td>
<td>3-4 times per year</td>
</tr>
<tr>
<td>LOW RISK</td>
<td>2 times per year</td>
</tr>
</tbody>
</table>

Confirmation testing is required before treatment begins.

**Tapering Protocol**

The Tennessee Department of Health does not recommend one specific protocol. A conservative approach recommends a 10% reduction in the original dose per week. Other sources state that a 25% reduction every four days should avoid withdrawal syndrome. The more rapid protocols recommend for a daily reduction of 25-50% of the previous day’s dose.

**Take Aways**

For questions regarding this summary, contact SVMIC at 1-800-342-2239 or call the following for guidance:

- Physicians and Physician Assistants, 615-532-4384
- Nurses, 615-532-5166
- Tennessee Board of Pharmacy, 615-741-2718
- Pain Clinics, 615-741-3218
- CSMD Program, 615-253-1305

To access additional regulation resources, rules, guidelines, tools and education materials on SVMIC’s website, CLICK HERE