

New Opioid Prescribing Requirements Under Recent Changes to the Pain Relief Act

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New Legislation

On March 14, 2019 Governor Lujan-Grisham signed SB 221 into law. [SB 221](#) amends the Pain Relief Act, NMSA 1978 § 24-2D-2, to impose two requirements on providers who prescribe opioids, and adds new definitions. The first new requirement is that providers educate all new patients who receive prescriptions for opioid analgesics, and that they educate existing patients on the first opioid prescription every year, regarding the risks of overdose and availability of opioid antagonists. SB 221 added new definitions for “opioid analgesic” and “opioid antagonist” as follows:

- **"opioid analgesic"** means buprenorphine, butorphanol, codeine, hydrocodone, hydromorphone, levorphanol, meperidine, methadone, morphine, nalbuphine, oxycodone, oxymorphone, pentazocine and propoxyphene as well as their brand names, isomers and combinations.
- **"opioid antagonist"** means a drug approved by the federal food and drug administration that when administered negates or neutralizes in whole or in part the pharmacological effects of an opioid analgesic in the body, including naloxone and such other medications approved by the board of pharmacy for the reversal of opioid analgesic overdoses.

Summary of Requirements

The specific new requirements of SB 221 can be summarized as follows:

- **Education.**
 1. Prescribing providers must educate new patients on the risk of overdose when prescribing any opioid analgesic for the first time.
 2. For existing patients, prescribing providers must educate those patients regarding the risks of overdose on the first occasion of each calendar year that the provider prescribes an opioid analgesic to that patient.
- **Mandatory Prescription of Antagonist.**
 1. Prescribing providers must co-prescribe an opioid antagonist if the opioid analgesic prescription is for a supply of five or more days.
 2. The prescription for the antagonist must be accompanied by written information regarding temporary effects, techniques for administration, and a warning that the person administering the antagonist call 9-1-1 immediately after administering.

Application to the In-Patient Hospital Setting

In drafting SB 221, the Legislature was clearly focused on prescriptions for opioid analgesics in the outpatient setting. An “order” in the controlled hospital setting does not raise the same concerns of overdose and antagonist availability. Moreover, the Act’s five-day supply provision excludes a majority of in-patient stays. We may expect subsequent regulations to clarify this issue and specifically exclude inpatient orders for opioid analgesics from the Act’s requirements. In the meantime, there is no question that the Act applies to opioid prescriptions for upon discharge from the hospital. Hospitals should also be vigilant with respect to opioid education regarding overdose and risk of abuse, as outpatient opioid prescriptions for pain management often follow the administration of opioids to treat pain in the inpatient setting.

Enforcement and Risk

The Pain Management Act's requirements apply to licensed prescribing providers, and are enforced by the licensing boards through their disciplinary authority, up to and including revocation of the offending provider's license. While the Act does not contain any enforcement mechanisms against hospitals or other entities, a plaintiff could rely upon the Act as a basis for establishing liability against a hospital in a negligence lawsuit. As with any legislation governing providers, SB 221 creates a potential risk for hospitals that should be evaluated and reasonably mitigated. This is especially true in the context of the current opioid crisis, which is generating an ever-increasing variety of lawsuits affecting individuals and entities at every level.

Steps to Ensure Compliance in the Hospital Setting

Depending on their unique circumstances, hospitals can take several steps to ensure compliance by providers with the new law. Those steps include:

- Educating all employed providers with prescribing authority on the requirements of the new law. This can include mandatory education for all new hires of prescribing providers, and periodic re-education for existing providers. All education should be appropriately documented. Hospitals should also consider whether non-employed prescribing members of the medical staff, or non-prescribing providers such as discharge nurses, should also receive education.
- Conducting periodic audits of medical records to ensure compliance with the law.
- Creating a written policy and procedure regarding SB 221's requirements, or modifying existing policies and procedures to include this information.
- Creating a standard education sheet for use by prescribing providers containing the required information about the prescribed opioid antagonist (information about administration and temporary effects, warning to call 9-1-1 immediately after administration).

Other Important Considerations

While the definitions in this statute distinguish chronic pain from pain associated with degenerative diseases or terminal conditions, there is no exception for the prescription of opioid analgesics in the hospice or similar extended pain treatment context. Providers should be aware that, unless some exception is created by statute or rule in the future, the new co-prescribing and education rules apply to all providers who prescribe opioid analgesics, across the board.

Finally, this law creates the problem of multiple prescriptions that, in most cases, will not be used. This raises questions of whether patients and insurers will be responsible for paying for multiple prescriptions of the opioid antagonist for longer-term recurring prescriptions. For the moment this is a statutory requirement, with no exception, so prescribers are responsible for writing an opioid antagonist prescription for every prescription of a five- or more day supply of an opioid analgesic.

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