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Drug Control Program
Prescription Monitoring Program
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Prescriber Guide to Interpreting Prescription Monitoring Program Data

This guide is designed to assist prescribers in understanding the scope and limitations of the patient prescription history reports and electronic alerts of the Massachusetts Online Prescription Monitoring Program (MA Online PMP). Developed in consultation with pain and addiction specialists, it provides guidance in treating all patients including those for whom prescribers may have concern. It is important to note that, whether in the context of an electronic alert or a routine patient prescription history lookup, this guide does not mandate any particular action on the part of the prescriber.

About the MA Online PMP

The MA Online PMP is a secure website that can be utilized by authorized providers to retrieve the most recent twelve months' of Schedule II - V dispensed prescription histories on their patients. It is a tool that supports safe prescribing and dispensing and assists in addressing prescription drug misuse and abuse. Use of MA PMP by prescribers can enable the early identification of behaviors suggestive of drug misuse, abuse or diversion and trigger early intervention. By viewing a patient's prescription history, a provider can avoid duplication of drug therapy or possible drug interactions, and coordinate care by communicating with other providers to improve clinical outcomes and overall patient health.

Unsolicited Report Alerts

Email alerts are sent to MA Online PMP enrolled prescribers when any patients with prescriptions records associated with their Drug Enforcement Administration (DEA) registration number are identified as exceeding specified thresholds for prescriptions from multiple prescribers and dispensers. Unsolicited reports are designed to help prescribers assess whether a patient's prescription history indicates possible drug misuse, abuse or diversion.

An alert message contains a computer generated case ID number that the prescriber enters into a specified field in the MA Online PMP. Entering the case ID enables the prescriber to retrieve the patient's prescription records – referred to as the Unsolicited Report - that triggered the alert. The case ID retrieves the prescription profile as it appeared when the alert was generated. To get an accurate prescription history for the same patient at a later point in time (when additional prescriptions may have been loaded into the PMP), the prescriber should search for the patient using the first name, last name, and date of birth that appeared on the unsolicited report. MDPH does not require a provider to take any action that he or she believes to be contrary to a patient's best interests.

It is important to understand that the MA PMP does not send any confidential information in the alert email message. And the MA PMP likewise instructs alert recipients to not send email correspondence containing confidential information. Since the case ID included in the email alert is a non-confidential computer generated number, that number can be sent to the PMP to expedite correspondence.

Limitations of PMP data

PMP reports contain data reported by pharmacies and may have limitations (e.g., spelling or keying errors, missing information) or inconsistent information (e.g., use of nicknames). Therefore, it may be necessary to verify the accuracy of the information in the prescription history with other prescribers and/or dispensers listed before taking clinical action. The MA Online PMP database includes Schedule II-V prescription records for the most recent 12 months. In general, it takes up to two to three weeks between dispensing of a prescription and its inclusion in the Online PMP. Please refer to the MA Online PMP splash page for any current advisories regarding PMP data.

Assessment

The PMP report should be interpreted in the context of a complete patient assessment, not in isolation. As a first step, review reports and records:

- Review and verify PMP prescription history for possible inaccuracies.
- Review prior medical record if available.

Other elements of a complete patient assessment may focus on pain, sleep disorders, anxiety, and/or depression:

- Evaluation of pain in addition to general history (including location, character, severity, effect on work, sleep daily activities).
- Physical examination and documentation (including painful area and nervous system with focus on sensory function).
- Psychosocial Evaluation (including how pain is impacting relationships and family, signs of depression, anxiety, suicidal thoughts).
- Validate and document justifications for chronic opioid therapy (benefits are outweighing risks; patient is compliant).
- Informed consent including benefits and risks and reasons for discontinuing opioid therapy.
- History of risk factors for prescription drug abuse, such as history of substance abuse or mental health issues in patient or family.
- Patient Provider Agreement including patient responsibilities to avoid improper use, policies on lost medication, refills, use of urine drug screens, education about safe storage and disposal and provider responsibility to treat patient with respect, answer questions and provide means to reach him or her in case of emergency.
- Individualized written treatment plan including functional goals.
- Consultation with specialists when indicated.
- Review of outside medical records or contacting other providers.
- Interviews with “significant others” (spouses, family, employers, etc.).
- Periodic review of treatment goals.

Addressing concerns about prescription activity

Listed below are some options for action in response to possible concerns about the patient's prescription activity.

- Discuss with patient: The first clinical step in response to potential concerns raised by a PMP report is generally to discuss them with the patient. This can include
  - Attempts to determine the causes of the observed behavior, for example:
    - ·administrative (changed doctor, etc.)
    - ·under-treatment of symptoms, e.g., pain, anxiety
    - ·misunderstanding of the rules of treatment
    - ·prescription drug abuse
    - ·criminal behavior (e.g. theft of doses by family member or guest, prescription drug rings, forgery, dealing, etc.)
- Administration of a Brief Intervention, a 1-2 minute talk with the patient to: express concern over the pattern of behavior; discuss how drug abuse begins and emphasize its negative consequences (on health, employment, finances, friends and family, etc.); and clarify expectations (e.g., receiving controlled medications from only one prescriber, using one pharmacy). See http://www.samhsa.gov/prevention/sbirt/ for resources on interventions
- Physical examination for drug abuse (e.g. track marks, skin lesions, nasal septal damage).
- Increase the intensity of patient monitoring (e.g., urine toxicology, pill counts and early refills) and establish limits on refills or lost medications. For example, a Patient Provider Agreement (e.g., narcotic contract) noted previously under Assessment is widely believed to support patient-clinician communication, see http://www.ncbi.nlm.nih.gov/books/NBK92049/#ch5.s8 for further information.
- For persistent non-compliance, options include one or more of the following:
  - Tapering drug therapy over several weeks to avoid withdrawal; consider incorporating non-opioid pain treatments.
  - Referring to specialists, e.g., pain specialist, for evaluation of continued controlled substance prescribing.
  - Referring to addiction management (see Resources below).

Additional Considerations

It is desirable for patients with addictive disorders and/or complex chronic pain problems to maintain a relationship with a primary care provider, even if the management of the pain and/or addiction will be conducted primarily by specialists.

Discontinuation of the patient relationship may be required when (1) patients are excessively disruptive or unable to comply with office policies; (2) frank criminal behavior precludes a working relationship. However, it is important to attempt to maintain continuity of care or management for patients upon discontinuation. Referral to other providers with appropriate experience and capabilities is strongly encouraged.

There is no requirement for the provider to take action that he or she believes to be contrary to the patient's best interests. Abrupt cessation of drug use may precipitate serious withdrawal syndromes (e.g., seizures in the case of benzodiazepines).

If the provider believes that a crime has been committed, such as misrepresenting oneself to obtain controlled substance prescriptions, it is the right of the provider or staff to contact law enforcement and/or other providers. In criminal matters HIPAA restrictions generally do not apply. Legal input in difficult cases may be helpful.

Additional Resources

- MA Online Prescription Monitoring Program: www.mass.gov/dph/dcp/onlinepmp
- Directory of treatment programs: http://db.state.ma.us/dph/bsas/search.asp.
- Responsible Opioid Prescribing – A Clinician's Guide, Second Edition, by Scott M. Fishman, MD, CME accredited by Federation of State Medical Boards, Waterford Life Sciences, 2012. URL: http://www.fsmb.org/book/ (link to Federation of State Medical Boards recommendation)
- MA Board of Registration in Medicine (BORIM) regulations regarding termination of patient relationship: http://www.mass.gov/eohhs/gov/departments/borim/.: BORIM Phone: 781-876-8200
- Mass State Police, Narcotic Section Phone: 781-659-9842.