NEED TO KNOW

Opioid Legislation FAQs

These FAQs represent a compilation of questions received from MSMS and MAFP members. Please note that this is a “living” document that MSMS intends to continuously update as new information, guidance and questions become available. The Michigan State Medical Society has also prepared an objective analysis of the recently enacted legislation which impacts prescribing practices. Please feel free to contact Stacey Hettiger at shettiger@msms.org if you have questions that have not yet been addressed.

Q: When do these new provisions take effect?

A: The prescribing provisions that impact physicians and other licensed prescribers were part of a larger eleven-bill legislative package. As a result, there are multiple effective dates and some provisions have already taken effect. However, the major issues impacting prescribing are set to become effective later this year. Below are the key effective dates for which prescribers need to be aware:

- **March 27, 2018** – if treating a patient for an opioid-related overdose, provide them with information on “substance use disorder services;” query MAPS if prescribing/dispensing buprenorphine or methadone to a patient in a substance use disorder program; and, if dispensing a controlled substance, a dispensing prescriber shall report such dispensing to MAPS. (Note: Public Act 252 of 2017 rescinded Rule 338.3162e of the Administrative Code, which exempted from mandatory MAPS reporting a controlled substance administered directly to a patient. On April 3, 2018, the Michigan Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, clarified with MSMS that it is the agency’s position that the Legislature’s repeal of the exemption does not require reporting to MAPS when a controlled substance is administered directly to a patient.)

- **June 1, 2018** – mandatory Michigan Automated Prescription System (MAPS) check if prescribing controlled substances in a quantity that exceeds a three-day supply; must be registered in MAPS before prescribing controlled substances; and, must comply with specific informed consent provisions when prescribing opioids.

- **July 1, 2018** – cannot prescribe more than a 7-day supply of an opioid within a 7-day period if treating a patient for acute pain.

- **March 31, 2019** or sooner if administrative rules enacted – must have a bona fide prescriber-patient relationship prior to prescribing controlled substances and a mechanism for following-up directly with the patient or by referral. (Note: Pursuant to Public Act 101 of 2018 signed by the Governor on April 2, 2018, the effective date of this provision has been extended to March 31, 2019, or upon the promulgation of administrative rules if before March 31, 2019.)
Q: Are all physicians required to register for the Michigan Automated Prescription System (MAPS) by June 1, 2018?

A: No. The law does not require all physicians to register for MAPS. Only those prescribing or dispensing controlled substance on or after June 1, 2018, will have to be registered with MAPS in order to be in compliance with the law. This requirement applies even if the scheduled drug is not an opioid.

MAPS Related

Q: How do I register for MAPS?

A: For registration to PMP AWARxE, please visit https://michigan.pmpaware.net/login and click on “Create Account.” You will need to know your email and what password you want to use, as well as your Controlled Substance ID, DEA Number, Professional Licensee Number, and National Provider Identifier (NPI). The Michigan Department of Licensing and Regulatory Affairs (LARA) also has a MAPS webpage at http://www.michigan.gov/lara.

Please note, your Controlled Substance License is issued by the state of Michigan and is not the same as your DEA Number. If you don’t number your CS ID, you can find it on the state’s “Verify a License” webpage by typing in your name and selecting “Pharmacy” as your occupation. Your name and ID should appear.


Additionally, MSMS has a free webinar available by visiting https://www.MSMS.org/Education/On-Demand-Webinars (click Pain and Symptom Management for all related courses including MAPS registration) for anyone interested in learning more about the updated MAPS and how to register.

Q: Do I have to register with MAPS even if I’m not writing a prescription for an opioid?

A: Possibly. Effective June 1, 2018, before prescribing or dispensing any controlled substance, the licensed prescriber must be registered with MAPS. This requirement applies even if the scheduled drug is not an opioid. Controlled substances include a wide range of medications, not just opioids.

Q: I prescribe controlled substances, but I do not dispense controlled substances. Do I still need to register with MAPS?

A: Yes. Beginning June 1, 2018, if you prescribe or dispense controlled substances, you must be registered with MAPS. In addition, before prescribing or dispensing controlled substances in excess of a 3-day supply to a patient, you must first obtain and review a MAPS report.

Q: I am a retired physician but still maintain my professional licenses including my controlled substance license. Do I still need to register for MAPS?

A: You only need to register for MAPS if you will be prescribing a controlled substances. There is no cost to register for MAPS so, you may want to consider registering should you find yourself in a position where you need to prescribe such medication (e.g., taking on a locum tenens position).

Q: Can medical residents have their own MAPS account?

A: According to the Michigan Department of Licensing and Regulatory Affairs, medical residents are allowed to have their own MAPS accounts under the role of “medical resident.”

Q: How does the state know when MAPS has been queried? (e.g., one physician on a medical staff runs the MAPS for another physician writing a prescription on the same medical staff under their own MAPS login it may appear in the system that the physician writing the prescription did not run a MAPS report before prescribing even though they did review that report.)

A: The legislation doesn’t provide specifics as to how it will be enforced. However, should there be a suspected violation of the Public Health Code and an allegation made, the law already provides the Department with the ability to investigate allegations.

Therefore, prescribers will either need software that can provide an audit trail (which the Department is making available via the NarxCare risk tool when facilities and/or practices integrate their electronic health records with MAPS) or they will need to ensure that their MAPS reports are filed in the appropriate patients’ medical records. Additionally, MSMS Legal Counsel recommends placing a copy of the MAPS report in the patient’s medical record as a recommended best practice should one need to prove this step was taken during litigation. If the prescribing physician did not pull the report from MAPS he/she should indicate on the report that it was reviewed, the date and the notation should be initialed.

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Q: How close to the time prescription is written does the MAPS check need to occur? For example, if the practice or facility runs a batch MAPS check on Thursday night before a planned Friday appointment, does that count? What if the appointment is rescheduled to a later date?

A: The law does not provide this type of timing requirement. The best practice would be to obtain the MAPS report soon before the prescription is written to make sure the prescriber is aware of all the information (within the previous 24 hours should be reasonable). If an appointment is rescheduled the MAPS report should be obtained a second time.

Q: Can MAPS reports be scanned into our electronic medical record?

A: Yes.

Q: Who must check MAPS? What if the MAPS report is obtained by the prescriber’s delegate?

A: Beginning June 1, 2018 the law requires that a prescriber of controlled substances “obtain and review” a MAPS report. The law does not prohibit a prescribing physician’s delegate from pulling a report for him/her. The best practice is for the prescribing physician to indicate on the report (which should be kept in the medical record) the date that it was reviewed and to initial.

Q: Is there a requirement to run a MAPS report at admission or presentation to the emergency department?

A: No. The legislation ties the mandatory MAPS check to the prescribing or dispensing of controlled substances.

Beginning June 1, 2018, a MAPS report must be pulled prior to prescribing or dispensing any Schedule 2-5 controlled substance (regardless of whether it is an opioid) that is written for more than a 3-day supply. The mandatory check does not apply if the drug is dispensed AND administered in a hospital or free-standing surgical outpatient facility.

Physicians and other prescribers prescribing controlled substances must be registered with MAPS to continue that prescribing on and after June 1, 2018. Also, beginning March 31, 2018, there must be a “bona fide prescriber-patient relationship” in order to prescribe a controlled substance.

Q: What if MAPS is down or the internet in the office is interrupted?

A: The law does not address this situation nor does it provide an exception from the requirement that a prescriber obtain and review a MAPS report applicable when MAPS is down or a prescriber does not have access to the internet.

Informed Consent

Q: When is informed consent required?

A: There are two instances in which written informed consent is required effective June 1, 2018. In both instances, the consent forms are required to be included in the patient’s medical record.

“Before issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid, regardless of whether the prescriber modifies the dosage during the course of treatment.” A “Start Talking Consent Form” is required to be signed acknowledging the receipt and discussion of specified information.

Before a controlled substance that is an opioid is prescribed to a patient. Patients need to sign a form that is to be “prescribed” by the Michigan Department of Health and Human Services acknowledging that he/she received information regarding the danger of opioid addiction, how to properly dispose of unused controlled substances, the fact that the delivery of a controlled substance is a felony under MI law, and the short- and long-term effects of exposing a fetus to a controlled substance (if the patient is pregnant or a female of reproductive age).
Q: Do I need to obtain informed consent each time I prescribe an opioid? Does this include for refills?

A: Yes, to both questions, based on the current language in the legislation that was passed. If the legislation is changed or contrary guidance is issued MSMS will communicate that information to members.

Q: What about prescriptions for a narcotic that are written following surgery or if the patient has uncontrolled pain when he/she returns home?

A: If the narcotic is dispensed and administered in a hospital or freestanding surgical outpatient facility the requirement that a MAPS report be obtained and reviewed does not apply. Once the patient leaves the hospital or freestanding surgical outpatient facility or if the narcotic is dispensed but not administered prior to the patient leaving then all requirements (pulling a MAPS report, consent etc.) must be complied with by the prescriber.

Q: How often must information regarding the dangers of opioids, etc. be provided? Once? Annually? Every opioid prescription? Even if a refill?

A: Until the law is clarified or authoritative guidance is issued, the best practice would be to do so each time an opioid prescription is given, even a refill.

Q: How exactly do I obtain acknowledgment that patients received the information about the dangers of opioids?

A: The law requires that following your providing the information on the dangers of opioids to a patient you must obtain the patients signature on a form (prescribed by the Michigan Department of Health and Human Services) indication that the patient received the information. This signed form is to be included in the patient’s medical record.

Q: What if the patient is unable to consent due to developmental delay, dementia, etc.? If the patient is not able to consent, can prescriptions for injuries like a fracture be provided without a family or guardian present?

A: Only in the case of an emergency or if another exception applies.

Q: Where can I find the required informed consent forms and where should they be stored and for how long?

A: MSMS Legal Counsel has drafted a Start Talking Consent Form that is available at http://MSMS.org/BeAWARE. The other form, which the law requires the Michigan Department of Health and Human Services to create, is not yet available. According to the MDHHS, they are considering merging both the minor consent (“start talking consent form”) and the patient information consent requirements into a single document. MDHHS is hopeful that the required form or forms will be available electronically on their website by April or May, well before the June 1 effective date.

Q: Can I delegate obtaining informed consent to another health professional?

A: According to the Department of Licensing and Regulatory Affairs Agency’s Bureau of Professional Licensing, a prescriber could potentially delegate the responsibility of obtaining informed consent to another health professional in accordance with existing law (MCL 333.16215).
Q: What is a bona-fide prescriber-patient relationship?

A: A bona-fide prescriber-patient relationship means a treatment or counseling relationship between a prescriber and a patient in which both of the following are present:

1. The prescriber has reviewed the patient’s relevant medical or clinical records and completed a full assessment of the patient’s medical history and current medical condition, including a relevant medical evaluation of the patient conducted in person or through telehealth.

2. The prescriber has created and maintained records of the patient’s condition in accordance with medical accepted standards.

Q: Is an in-person patient encounter required to establish a bona-fide prescriber-patient relationship?

A: No. The medical evaluation required to establish a bona-fide prescriber-patient relationship may be conducted either in-person or via telehealth, as defined in the Public Health Code.

Q: Does telehealth include just an audio connection and/or conversation over the telephone? And, how does one satisfy the requirements of a bona fide prescriber-patient relationship in that case?

A: The requirement that a bona fide prescriber-patient relationship exist includes “a patient evaluation in person or by telehealth”. Telehealth includes the use of electronic means (telephone, video conferencing, etc.). Whether and under what circumstances a telephone conversation alone will be a sufficient to satisfy the evaluation part of the requirement will be determined on a case by case basis in the first instance by the prescriber and later, when necessary, by those reviewing the prescribing in a licensing action or otherwise.

Q: If the same provider is seeing the same patient do they have to re-establish the bona-fide patient relationship each time they prescribe controlled substances?

A: According LARA, if the same health professional (i.e., doctor) is seeing the same patient, the bona-fide patient-prescriber relationship would have already been established.
Bona Fide Prescriber-Patient Relationship – continued

Q: Is there a definition of bona fide as it pertains to shared practices? What steps should be taken if a patient of a partner calls in for a prescription refill when another partner in the practice is on call coverage?

A: No. There is only one definition of “bona fide prescriber-patient relationship”. In all cases it requires both: (1) a review of the patient’s relevant medical or clinical records and a full assessment of the patient’s medical history and current medical condition including a medical evaluation of the patient performed in person or via telehealth (as defined in MCL 333.16283) and (2) the creation and maintenance of a medical record.

Q: Can I still prescribe controlled substances through telemedicine?

A: Yes, provided that you establish a prescriber-patient relationship prior to prescribing any controlled substances and comply with all other applicable state and federal laws for prescribing controlled substances.

It is important to keep in mind that notwithstanding Michigan law, which does not require an in-person encounter to prescribe controlled substances, federal law prohibits the prescribing of controlled substances on the basis of a telemedicine encounter unless the prescribing physician has conducted at least one (1) in-person medical evaluation of the patient, subject to limited exceptions that will not be available to most physicians and other prescribers. An “in-person medical evaluation” means a medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals. Even if the minimum one (1) in-person encounter requirement is satisfied, the prescription must be issued for a legitimate medical purpose in the usual course of the prescriber’s professional practice, which are longstanding legal requirements applicable to all prescriptions for controlled substances. Federal law provides that nothing is construed to imply or suggest that a one (1) in-person medical evaluation demonstrates compliance with these standards; i.e., all of the facts and circumstances surrounding the issuance of the prescription must be evaluated. Prescribers who fail to comply with the in-person medical evaluation requirement, and any pharmacy that knowingly or intentionally fills such a prescription, violated the Controlled Substances Act.

Prescribing to a Minor

Q. What is the age of majority?

A. In Michigan, the age of majority is 18.

Q. Are there special requirements for obtaining informed consent when prescribing opioids for minors?

A: Yes. “Before issuing for a minor the first prescription in a single course of treatment for a controlled substance containing an opioid, regardless of whether the prescriber modifies the dosage during the course of treatment.” A “Start Talking Consent Form” is required to be signed acknowledging the receipt and discussion of specified information. The start talking consent form must contain all of the following information:

(1) The name and quantity of the controlled substance being prescribed for the minor and the amount of the initial dose;

(2) A statement indicating that a controlled substance is a drug or other substance that the United States Drug Enforcement Administration has identified as having a potential for abuse;

(3) A statement certifying that the prescriber discussed with the minor, and with the minor’s parent or guardian or with another adult authorized to consent to the minor’s medical treatment the required topics of discussion;

(4) the number of refills, if any, that are authorized by the prescription; and

(5) A space for the signature of the minor’s parent or guardian, or the signature of another adult authorized to consent to the minor’s medical treatment, and a space to indicate the date that the minor’s parent or guardian, or another adult authorized to consent to the minor’s medical treatment, signed the form.

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Prescribing to a Minor – continued

Q. What is meant by “single course of treatment?”
A. This is not defined in Michigan’s Public Health Code. Presumably this would mean a continual treatment of a single injury or condition. We have requested that LARA clarify their interpretation of “single course of treatment” in their FAQ document that is under development.

Q. What are the exceptions to the new requirements for issuing the first prescription of controlled substances containing an opioid to minors?
A. First, the requirements apply only to prescriptions for controlled substances that contain an opioid. The requirements do not apply to other schedule 2 to 5 controlled substances that do not contain an opioid. Second, the requirements do not apply in any of the following circumstances:

1. If the minor’s treatment is associated with or incident to a medical emergency;
2. If the minor’s treatment is associated with or incident to a surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis;
3. If, in the prescriber’s professional judgment, fulfilling the requirements would be detrimental to the minor’s health or safety;
4. If the minor’s treatment is rendered in a hospice or an oncology department of a hospital.
5. If the prescriber is issuing the prescription for the minor at the time of discharge from a hospice or oncology department of a hospital; or
6. If the consent of the minor’s parent or guardian is not legally required for the minor to obtain treatment.

However, even if the requirements do not apply, and unless the controlled substance is prescribed for in-patient, the prescriber must still provide the minor patient or his or her parent, guardian or representative the following information:

(i) The danger of opioid addiction
(ii) How to properly dispose of an expired, unused or unwanted controlled substance
(iii) That the delivery of a controlled substance is a felony under Michigan law.
(iv) If the patient is pregnant or is a female of reproductive age, the short- and long-term effects of exposing a fetus to a controlled substance, including, but not limited to, neonatal abstinence syndrome.

Q. Will the state provide a “Start Talking Consent Form”?
A. Yes, the state is creating this form. We expect that it will available from the MDHHS website in May 2018. MSMS Legal Counsel has also drafted a form that meet the Act’s requirements. It is available at http://MSMS.org/BeAWARE.

Q. My office’s informed consent form for minors already includes the information required in the start talking consent form. Does that satisfy the requirements?
A. No. The start talking consent form must be on a form that is separate from any other document that a prescriber uses to obtain the informed consent for the treatment of a minor.

Prescribing Restrictions

Q: Are there limits on how much pain medication can be prescribed?
A: Beginning July 1, 2018, if prescribing an opioid for “acute pain,” the prescription cannot be written for more than a 7-day supply within a 7-day period. “Acute pain” is defined in the legislation as “pain that is the normal, predicted physiological response to a noxious chemical or a thermal or mechanical stimulus and is typically associated with invasive procedures, trauma, and disease and usually lasts for a limited amount of time.”

Q: If my patients are taking medication for chronic pain do any limits apply?
A: Under the new laws, the supply limits only apply to “acute pain.” See definition above. However, prescribers and patients should check with patients’ insurance plans as payers are implementing their own supply limits.
Q: What defines the total number of days for a prescription? For example, what if a prescription is written PRN or with a range of dosing (e.g., 1-2 tablets every 4 hours)?

A: If your prescription will result in the dispensing of more than a 3-day supply you should comply with the requirements of the new law even though it is possible that the patient may not actually take the drug for more than 3 days.

Q: When a physician prescribes a 7-day supply when treating a patient for acute pain, after the 7-day limit expires, does the patient need to return to the physician’s office for a visit to obtain another prescription or can a prescription be filled remotely (phone/e-prescribe)?

A: The “bona fide prescriber-patient relationship” must continue to exist. This may require an in person evaluation of the patient.

General Questions

Q: How does the new legislation affect delegated prescribing of controlled substances?

A: Physicians are ultimately responsible for complying with all applicable laws and regulations affecting the prescribing of controlled substances under their delegated authority. Physicians should ensure that their delegatees understand and comply with all applicable laws and regulations when prescribing controlled substances under delegated authority. Physicians may wish to review and update their agreements with physician’s assistants and/or APRNs as necessary to incorporate the new legislation and any protocols developed by the physician’s practice in furtherance of complying with the new legislation.

Q: If a prescriber elects to issue up to a 90-day supply of a controlled substance via three separate prescriptions with written instructions on each prescription (other than the first prescription, if the prescriber intends for that prescription to be filled immediately) indicating the earliest date on which a pharmacy may fill each prescription, will the MAPS check performed at that appointment be sufficient for all three prescriptions or will they have to check MAPS for the subsequent two prescriptions at the later dates?

A: As we read MCL §333.7303a of the Public Health Code, as amended, if a patient is provided multiple 30-day prescriptions of a controlled substance at a single appointment, the prescriber must obtain and review the MAPS report prior to issuing the prescriptions at that appointment. As we read the statute, the prescriber does not need to review the MAPS report prior to each prescription being filled. The date of the prescription will be key to when the prescriber must obtain and review the MAPS report. Pursuant to MCL §333.7333(7), a prescriber may not postdate a prescription for a controlled substance, but may indicate the earliest date that each prescription may be filled. If the prescriptions each have the same date of issuance and relate to the same appointment,
only one MAPS report is needed, even if the prescriptions are intended to be filled on different dates. If the prescriber issues one prescription at a time (i.e., different dates of issuance), the prescriber must obtain and review a MAPS report prior to issuing each prescription.

Q: Will prescribers still be allowed to issue multiple prescriptions for Schedule 2 controlled substances in a manner consistent with policy guidance from the U.S. Drug Enforcement Agency?

A: With respect to whether a prescriber may continue to issue multiple prescriptions for schedule II controlled substances consistent with the DEA guidelines, MCL §333.7333 of the Public Health Code continues to permit a practitioner to issue more than one prescription for a schedule II controlled substance. The one caveat is the treatment of a patient for “acute pain” pursuant to MCL §333.7333b. Per this statute, beginning July 1, 2018, a prescriber treating a patient for “acute pain” may not prescribe the patient more than a 7-day supply of an opioid within a 7-day period. “Acute pain” is defined by the statute to mean “pain that is the normal, predicted physiological response to a noxious chemical or a thermal or mechanical stimulus and is typically associated with invasive procedures, trauma, and disease and usually lasts for a limited amount of time.” This requirement will limit a prescriber’s authority to prescribe opioids to the fullest extent permitted by the DEA guidelines.

Q: How does the law apply when cough and cold medicines containing opioid ingredients are prescribed?

A: The law does not carve out situations involving the prescribing of cough and cold medicines containing opioid ingredients. Therefore, they are subject to the same requirements as any Schedule 2-5 controlled substance and any requirement specific to the prescribing of opioids such as informed consent and the 7-day limit for acute pain.

Q: Where do ADHD stimulants fall under this new law?

A: You will have to determine for each drug whether it is listed as a controlled substance on Schedules 2 through 5.

Q: How is an opioid defined?

A: “Opioid drugs” is defined in Michigan Administrative Code Rule 418.10109(i) as “opiate analgesics, narcotic analgesics, or any other Schedule C (II-III) controlled substance as identified in United States Code Controlled Substances Act of 1970, 21. U.S.C. §812. Opioid analgesics are the class of drugs, such as morphine, codeine, and methadone, that have the primary indication for the relief of pain.”

Q: What information exactly is required for me to provide to my patients about the dangers of opioids?

A: The specific information is not included in the new law. It may be included on the consent form to be developed and provided by the Michigan Department of Health and Human Services or in other clarification of the law or guidance to be issued. The Centers for Disease Control and Prevention website, www.cdc.gov, has excellent information and materials on the use and dangers of opioids.

Q: What is considered a “medical emergency” that allows exceptions to the requirement for informed consent? For example, would the treatment of an acute fracture or an acute musculo-skeletal injury be considered a “medical emergency?”

A: Only the new requirements applicable to minors contain an exception for a medical emergency. This law defines “Medical Emergency” as a situation that, in the prescriber’s good-faith medical judgement, creates an immediate threat of serious risk to the life or physical health of the minor.

Q: Would the repair of an acute laceration or removal of a foreign body embedded in soft tissue or cornea be considered “a surgery”?

A: Yes.
General Questions — continued

Q: Are there any new documentation needs (e.g., discharge summary, notes, informed consent, etc.)?

A: Consent forms (mandated) and MAPS reports (recommended) will need to be included in patients’ medical records. Additionally, in order to meet the definition of a bona fide prescriber-patient relationship, the prescriber must review the patient’s relevant records, complete a full assessment of the patient’s medical history and current medical condition, and properly document information about the patient’s condition.

Q: Any specific plans by MSMS to have a ‘toolkit’ for physicians to prepare them for the upcoming changes?

A: MSMS staff and Legal Counsel are currently working on resources to assist physicians in successfully complying with the upcoming statutory requirements. Currently, an overview of the bills that impact physician prescribing FAQs, and information on how to register for MAPS and to apply for MAPS-EHR integration are available. Other resources to come include but are not limited to best practices and template forms.

Q: Any new training needs identified? Plans for assessing the training needs?

A: There are always opportunities to enhance one’s knowledge on various topics and opioid stewardship is no exception. Training will be needed on the recently passed legislation, MAPS utilization, safe opioid prescribing, recognizing signs of addiction, best practices for treating and when to refer, MAT, etc.

MSMS currently has available the following on-demand webinars: Pain and Opioid Management, The CDC Guidelines, Treatment of Opioid Dependence, The Role of the Laboratory in Toxicology and Drug Testing, and Michigan Automated Prescription System (MAPS) Update. Additionally, there will be several in-person education sessions available in 2018.

Q: Any plans by to require new education and/or practice proof for maintaining licensure?

A: Currently, physicians are required to earn three hours of pain and symptom management CME during their licensure renewal cycle. This requirement took effect in December 2017 and counts toward the overall 150 hours that are required.

The Michigan Board of Medicine has been discussing the possibility of adding a requirement for opioid specific CME.

Q: Do the new laws apply to nursing home patients or hospice patients?

A: The way the legislation was written, it assigns most of the responsibilities to licensed prescribers and dispensing prescribers. In a few instances, exceptions are provided based on where the prescribing or dispensing is occurring.

For purposes of the mandatory MAPS check for controlled substances in a quantity that exceeds three days, there is an exception if the dispensing occurs in licensed hospital or freestanding surgical center and is administered to the patient on-site. However, the language does not provide for such an exception when the dispensing and administration occurs in a nursing homes or hospice.

In regards to the informed consent that must be obtained when prescribing an opioid to a minor, one of the exceptions provided is “if the minor’s treatment is rendered in a hospice or oncology department of a hospital or if the prescription is issued at the time of discharge from one of those facilities.”

The informed consent requirements for other patients prescribed opioids applies unless the opioid is prescribed for “inpatient use.”

In regards to the MAPS reporting requirement when dispensing a controlled substance to a patient, nursing homes and hospices, as well as other health facilities and agencies licensed under Article 17 of the Public Health Code, will continue to be exempt from that requirement when the “controlled substance is dispensed by a dispensing prescriber in a quantity adequate to treat the patient for not more than 48 hours.” The exemption for hospitals will no longer include the quantity restriction of 48 hours.
General Questions – continued

Q: Do the new requirements impact surgeries performed at health care facilities including free-standing surgical outpatient facilities when fentanyl is given during anesthesia (via IV at induction or during the procedure for pain management)?
A: No. There are exceptions to the query and consent requirements for when controlled substances are dispensed and administered in a hospital or freestanding surgical outpatient facility, in connection with an inpatient or outpatient surgery of when for inpatient use.

Q: Are there exceptions applicable when the prescribing or dispensing occurs in either a long-term care facility or a short-stay rehabilitation facility?
A: No. With the exception of hospitals and freestanding surgical outpatient facilities, noted above, it does not matter where the prescribing is done. All the requirements apply to prescribing in a long-term care facility or a short-stay rehabilitation facility.

Q: Often times patients on maintenance medications will phone-in for a refill, how does the legislation affect this long-standing practice?
A: There must be a “bona fide prescriber-patient relationship” at the time of each prescription for a controlled substance listed in schedules 2-5. This requires a review of the patient’s medical records, a full assessment of the patient’s medical history and an evaluation of the patient in person or by telehealth. The best practice would be to initial and date a note in the medical record that you reviewed it and the medical history and how you conducted the evaluation of the patient. According to LARA, once the bona-fide patient-prescriber relationship is established, it is ongoing between that specific prescriber and that specific patient (See related FAQ under Bona Fide Prescriber-Patient Relationship).

Because the law makes no distinction between an initial prescription and a refill, each time a refill is requested you will also have to (a) provide the required information (if refilling an opioid), (b) obtain the patient’s signature on the required consent form (if refilling an opioid); (c) if the prescription is an opioid and is for “acute pain” limit the prescription to a 7-day supply in a 7-day period, and (d) query MAPS if prescribing more than a 3-day supply. Until this is clarified in the law or some guidance is issued, you will no longer be able to renew a prescription without meeting these requirements.

Q: What steps must a physician take when prescribing medication upon discharge of a patient to an extended care facility? Is there additional paperwork that needs to be completed to comply with the law?
A: (1) If prescribing a controlled substance in more than a 3 day supply you must query MAPS; (2) if the patient is a minor and the prescription is for a controlled substance containing an opioid and is the first in a single course of treatment you must have the required discussion with the patient, and his/her guardian or other adult authorized to consent to the minor’s treatment, obtain the required signature on the “Start Talking Consent Form;” (3) if the prescription is for a controlled substance containing an opioid, whether the patient is a minor or not, provide the required information and obtain the required signature on the consent form provided by the MDHHS; (4) if the prescription is for “acute pain” limit the prescription to a 7 day supply within a 7 day period.