OPIOID PRESCRIBER SAFETY AND SUPPORT OPSS

# Ongoing Opioid Prescribing & Stewardship: A Safety Guide for Providers

*(For patients in whom opioid tapering is not currently appropriate or who require ongoing therapy under close monitoring)*

## Before Continuing Opioid Therapy

Opioid therapy should be continued only after a documented attempt or consideration of tapering has been made. If tapering is not feasible—due to patient stability on the current dose, prior failed taper attempts, severe functional decline with reduction, or complex pain syndromes — the prescriber must transition into more active opioid stewardship, or may consider transition to a safer agent.

Stewardship means structured, defensible, and data-supported opioid management that prioritizes patient safety, regulatory compliance, and provider protection.

(Refer to: *Opioid Tapering: A Practical Guide for Providers* for detailed taper identification, pacing, and patient communication strategies.)

## Goals of Ongoing Opioid Stewardship:

1. Maintain safety and function while minimizing physiologic and behavioral risk.
2. Identify complications early (endocrine, cognitive, respiratory, behavioral).
3. Reassess taper readiness and alternative therapy opportunities.
4. Document a clear, legitimate medical purpose and ongoing benefit.

## Core Visit Requirements, Risk Mitigation, Education & Documentation Every Visit

- Assess pain and function using the PEG-3 Scale (“Pain, Enjoyment, General Activity”).
- Review non-opioid and multimodal pain plan; document discussions or changes.
- Discuss **Opioid-Induced Hyperalgesia (OIH)** and multimodal options as part of ongoing
- education.
- Attempt periodic dose reduction or rotation when appropriate and clinically safe.
- Review and document side effects (e.g. constipation, sedation, libido, cognition, falls, as found in the Opioid Informed Consent form).
- Address mood, sleep, and psychosocial factors each visit.
- Reinforce safe use, storage, and disposal of opioids.

**Every Prescription or Refill**

• Review the PDMP (Prescription Drug Monitoring Program) and document findings (“PDMP reviewed; no overlapping prescribers or early fills”).

**Every 3–6 Months (High-Risk Patients) / Annually (All Others)**
• Perform random urine drug screening (UDS) using immunoassay ± LC/MS confirmation; interpret and document results.

**Every 6–12 Months**
• Complete mental-health and misuse screening using PHQ-9, GAD-7, COMM, DAST-10, and AUDIT-C+2.

**Annually (All Patients on Chronic Opioids)**
• Prescribe or renew naloxone (mandatory for ≥ 50 MME/day or sedative co-use); provide education on overdose recognition and response.
• Evaluate sleep-apnea risk using Epworth or STOP-BANG.
• Perform endocrine function screening—testosterone (men), estradiol (women), and cortisol as indicated.
• Review and sign the controlled-substance agreement and informed consent.
• Assess gait and fall risk (especially ≥ 65 years) using a Timed-Up-and-Go or equivalent.
• Reassess ongoing benefit, risks, and functional goals; ensure documentation reflects current medical necessity.

**Baseline (Prior to or at Initiation of Therapy)**
• Obtain initial UDS, endocrine baseline labs, and (for methadone) an EKG to assess QTc.
• Establish diagnosis supported by imaging or specialist input.
• Discuss risks, benefits, non-opioid alternatives, and treatment agreement.

**Methadone or Cardiac-Risk Patients**
• Perform baseline and annual EKG (QTc > 450 ms requires intervention).

**As Needed**
• Reassess taper readiness and document shared decision-making discussions.
• Follow up on abnormal test results promptly; document interpretation and plan.
• Update non-opioid pain strategies, referrals, and multimodal interventions as needed.

For additional detail, refer to “Multimodal Analgesia for Pain Control” in the *Compass Opioid Prescribing and Treatment Guidance Toolkit*

Regulatory & State Law Disclaimer:
Verify and comply with state medical board, DEA, and institutional policies on opioid prescribing, PDMP review, UDS frequency, and informed consent. This guide reflects national best practices and is for educational purposes only — it does not replace local regulation or clinical judgment.

## Sample Provider Documentation (Assessment & Plan):

"A shared decision-making discussion was held regarding ongoing opioid therapy, potential taper options, and non-opioid alternatives.

The patient expressed understanding of risks and benefits and agrees with the current plan. Patient continues on long-term opioid therapy for medically verified **[insert diagnosis]**, supported by imaging and specialist evaluation.

Tapering discussed and deferred; will reattempt as feasible.

PDMP reviewed **[date]**; consistent.

UDS **[date]** performed to increase safety and reduce risk of diversion; results within expectations.

Naloxone prescribed and reviewed.

Side effects minimal.

Mood, sleep, and endocrine screenings completed.

Non-opioid modalities (NSAIDs, PT, duloxetine) reviewed.

Benefits outweigh risks; pain stable (**PEG = 3/10** on current regimen).

Function improved and maintained on current treatment plan

Patient able to maintain ADLs, **[insert examples of activities]**, enjoy time with grandchildren, and perform daily chair yoga on current regimen.

Methadone EKG up-to-date.

Any abnormal findings will be followed up and documented per stewardship protocol.

Screening for opioid use disorder performed **[date]** and negative.

Controlled substance agreement and informed consent reviewed and signed as of **[date]**."

## Common Medical/Legal Issues Related to Opioid Prescribing:

**State medical boards and DEA auditors often cite the following deficiencies:**

- Failure to act on abnormal UDS results or document clinical response.
- Failure to document a legitimate medical reason for ongoing opioids, diagnosis supported by
- objective findings (imaging, specialist notes)
- Failure to record non-opioid therapy trials or contraindications
- Failure to show ongoing functional outcomes and quality-of-life metrics
- No screen for OUD/inappropriate prescribing of opioids for patients with OUD
- Inadequate risk–benefit reassessment or “stale” progress notes.
- Missing functional goals or evidence of improvement.
- Lack of PDMP review or documentation of it.
- No or expired opioid treatment agreement / consent.
- Concurrent prescribing of sedatives without justification.
- Failure to prescribe naloxone for high-risk patients.
- Insufficient initial evaluation before starting opioids.
- Failure to coordinate care across prescribers or specialists.
- Over-prescribing or non-individualized dosing.
- Ignoring diversion risk, pill counts, or early refills.
- Untreated or unassessed co-occurring mental health conditions.
- Vague or non-specific diagnoses (“chronic pain NOS”).
- Copy-forward/Copy-paste charting or templated notes lacking individualization.

## Attachments & Screening Tools:

- Pain Management Visit Template
- Naloxone & Overdose Prevention Handout
- Naloxone Training Video
- Safe Storage and Disposal of Medications
- PEG Scale – Pain / Enjoyment / General Activity
- Epworth Sleepiness Scale
- STOP-BANG Questionnaire
- COMM – Current Opioid Misuse Measure
- PHQ-9 / GAD-7 – Depression & Anxiety
- DAST-10 / AUDIT-C – Substance & Alcohol Screening
- Side-Effect Checklist for Chronic Opioid Therapy
- Naloxone Education Sheet

## PEG Scale – Pain / Enjoyment / General Activity

**Instructions:** Ask the patient to rate each item on a scale from **0 (no pain/no interference)** to **10 (worst pain/complete interference)** based on the past week. Add the three scores and divide by 3 to get an average ("PEG Score").

**1. Pain**
What number best describes your pain on average in the past week?
0 1 2 3 4 5 6 7 8 9 10

**2. Enjoyment of Life**
What number best describes how, during the past week, pain has interfered with your enjoyment of life?
0 1 2 3 4 5 6 7 8 9 10

**3. General Activity**
What number best describes how, during the past week, pain has interfered with your general activity?
0 1 2 3 4 5 6 7 8 9 10

**Scoring:** (Pain + Enjoyment + General Activity) ÷ 3 = PEG Score

**Interpretation:** Higher scores indicate greater pain impact and functional limitation.

## Epworth Sleepiness Scale

**Instructions:** For each situation, choose the most appropriate number:

0 = Would never doze 1 = Slight chance of dozing 2 = Moderate chance 3 = High chance

**Situation**

Sitting and reading 0 1 2 3

Watching TV 0 1 2 3

Sitting inactive in a public place (e.g., theater or meeting) 0 1 2 3

As a passenger in a car for an hour without a break 0 1 2 3

Lying down to rest in the afternoon 0 1 2 3

Sitting and talking to someone 0 1 2 3

Sitting quietly after lunch without alcohol 0 1 2 3

In a car, stopped in traffic 0 1 2 3

**Total Score:** ____ (>10 suggests excessive daytime sleepiness)

## STOP-BANG Questionnaire

**Instructions:** Yes = 1 point No = 0 points (Score ≥3 = high risk for sleep apnea)

S – Do you snore loudly (louder than talking or heard through closed doors)?

T – Do you often feel tired, fatigued, or sleepy during the daytime?

O – Has anyone observed you stop breathing during sleep?

P – Do you have or are you being treated for high blood pressure?

B – BMI >35 kg/m²?

A – Age >50 years?

N – Neck circumference >16 in (40 cm)?

G – Gender: male?

**Total Score:** ____ / 8 (3+ = high risk)

## COMM – Current Opioid Misuse Measure

**Instructions:** Circle how often each statement applies to you in the past 30 days.

0 = Never 1 = Seldom 2 = Sometimes 3 = Often 4 = Very Often

1. I have used my pain medicine more often than prescribed.
2. I have run out of pain medicine early.
3. I have borrowed pain medicine from someone else.
4. I have felt a strong need or urge for more pain medicine.
5. I have visited multiple doctors to get more pain medicine.
6. My family has expressed concern about my pain medicine use.
7. I have used my pain medicine for reasons other than pain.
8. I have had trouble thinking clearly or remembering things.
9. I have taken pain medicine to help me sleep or calm down.
10. I have felt angry or upset when questioned about my medicine.
11. I have used alcohol or other drugs more than I meant to.
12. I have needed early refills or replacements for lost prescriptions.
13. I have worried about running out of pain medicine.
14. I have taken more medicine when pain increased unexpectedly.
15. I have had to visit emergency departments for pain medicine.
16. I have felt that my pain medicine no longer works well.
17. I have used my medicine to improve my mood.

**Scoring:** Add the numbers circled for all 17 items.

**Score ≥9** suggests current misuse; discuss results with provider.

## PHQ-9 – Depression Questionnaire

**Instructions:** Over the last 2 weeks, how often have you been bothered by any of the following problems?

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading or watching TV
8. Moving or speaking so slowly that other people could have noticed, or being so fidgety or restless that you move around more than usual
9. Thoughts that you would be better off dead or of hurting yourself in some way

**Total Score:** ____ (5–9 mild • 10–14 moderate • 15–19 moderately severe • 20–27 severe)

## GAD-7 – Anxiety Questionnaire

**Instructions:** Over the last 2 weeks, how often have you been bothered by the following problems?

0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

1. Feeling nervous, anxious, or on edge
2. Not being able to stop or control worrying
3. Worrying too much about different things
4. Trouble relaxing
5. Being so restless that it's hard to sit still
6. Becoming easily annoyed or irritable
7. Feeling afraid as if something awful might happen

**Total Score:** ____ (5–9 mild • 10–14 moderate • 15+ severe)

## DAST-10 – Drug Abuse Screening Test

**Instructions:** Answer Yes or No for each of the past 12 months.

1 point for each "Yes" answer.

1. Have you used drugs other than those required for medical reasons?
2. Do you use more than one drug at a time?
3. Are you always able to stop using when you want to? (No = 1 point)
4. Have you had "blackouts" or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse, parent, or friend complain about your drug use?
7. Have you neglected your family or missed work because of drug use?
8. Have you engaged in illegal activities to obtain drugs?
9. Have you experienced withdrawal symptoms?
10. Have you had medical problems due to your drug use (e.g., memory loss, hepatitis, seizures)?

**Total Score:** ____ (0 = none • 1–2 = low • 3–5 = moderate • 6–8 = substantial • 9–10 = severe)

## AUDIT-C – Alcohol Use Screening

**Instructions:** Circle one answer for each question.
1. How often do you have a drink containing alcohol?
(0) Never (1) Monthly or less (2) 2–4 times/month (3) 2–3 times/week (4) 4+times/week

2. How many drinks containing alcohol do you have on a typical day?
(0) 1–2 (1) 3–4 (2) 5–6 (3) 7–9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

**Total Score:** ____ (≥4 for men or ≥3 for women indicates risky drinking)**Side-Effect Checklist for**

## Chronic Opioid Therapy

**Instructions:** Ask the patient to rate each from 0 (none) to 10 (severe).

Constipation ___

Nausea ___

Drowsiness ___

Confusion ___

Dizziness ___

Dry mouth ___

Itching ___

Sweating ___

Sexual dysfunction ___

Weight gain/loss ___

Mood changes ___

Sleep disturbance ___

Appetite changes ___

**Comments / Plan:** _____

# Naloxone Education Sheet

**What It Is:**
Naloxone is a rescue medication that reverses an opioid overdose and restores breathing.

**When to Use It:**
If someone becomes very sleepy, cannot wake up, or stops breathing after taking an opioid.

**How to Use:**
1. Call 911 immediately.
2. Administer naloxone nasal spray (insert tip into one nostril, press plunger).
3. If no response in 2–3 minutes, give a second dose in the other nostril.
4. Stay with the person until help arrives.

**Storage:**
Keep at room temperature and out of sunlight.

**Prescription / Education Provided:** _____ **Date:** _____

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## Annotated Bibliography & Key Resources

*(For Ongoing Opioid Prescribing, Monitoring, and Stewardship)*

**1. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022**
Centers for Disease Control and Prevention. *MMWR Recommendations and Reports*, Vol. 71, No. 3 (2022): 1–95.
cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm
**Summary:** The foundational federal guidance on opioid prescribing. Defines best practices for initiation, continuation, and tapering of opioids, along with PDMP use, non-opioid alternatives, and naloxone co- prescription. Updated in 2022 to emphasize individualized, patient-centered care and the avoidance of abrupt discontinuation.

**2. HHS Guide for Clinicians on Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics (2019)**
U.S. Department of Health and Human Services.
hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf
**Summary:** The definitive federal reference on safe tapering practices. Outlines when and how to reduce opioid doses, warning against abrupt cessation. Includes patient engagement, withdrawal management, and documentation strategies.

**3. VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain (2022)**
U.S. Department of Veterans Affairs and Department of Defense.
healthquality.va.gov/guidelines/Pain/cot/
**Summary:** Evidence-based guideline designed for complex chronic pain management. Provides detailed monitoring intervals, endocrine and sleep screening, and risk stratification strategies that can be applied broadly to non-VA settings.

**4. CMS — Prescribing Opioids: Provider Resources and Tapering Guidance**
Centers for Medicare & Medicaid Services (CMS).
cms.gov/about-cms/story-page/prescribing-opioids
**Summary:** Offers concise provider checklists for safe opioid prescribing, co-prescribing with benzodiazepines, PDMP utilization, and naloxone access. Useful for compliance with Medicare program audits and payer documentation requirements.

**5. U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose (2018)**
U.S. Department of Health and Human Services, Office of the Surgeon General.
hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-naloxone/index.html
**Summary:** Reinforces the national expectation that naloxone be prescribed for any patient at increased
risk of overdose—including those on ≥ 50 MME/day or concomitant sedatives.

**6. National Academy of Medicine (NAM) — Best Practices to Support Tapering Patients on Long- Term Opioid Therapy (2020)**
NAM Perspectives Discussion Paper, by Rich R., Chou R., Mariano E., et al.
nam.edu/perspectives/best-practices-research-gaps-and-future-priorities-to-support-tapering-patients-on-long-term-opioid-therapy-for-chronic-non-cancer-pain-in-outpatient-settings
**Summary:** Key research summary highlighting evidence gaps, patient-centered tapering models, and best practices to avoid withdrawal crises. Excellent for provider education and quality improvement planning.

**7. American Academy of Family Physicians (AAFP) — Tapering Long-Term Opioid Therapy**
*American Family Physician*, 2020; 101(1): 49–56.
aafp.org/pubs/afp/issues/2020/0101/p49.html
**Summary:** Practical clinical guide for family physicians managing chronic opioid therapy, including taper algorithms, patient engagement techniques, and withdrawal treatment strategies.

**8. Medical Board of California — Guidelines for Prescribing Controlled Substances for Pain (2022)**
Medical Board of California.
mbc.ca.gov/Download/Publications/pain-guidelines.pdf
**Summary:** One of the nation's most comprehensive state-level prescribing frameworks. Covers medical- necessity documentation, PDMP use, UDS follow-up, functional goal tracking, and disciplinary trends.

**9. Kentucky Board of Medical Licensure — Clinical Pocket Guide: Tapering and Discontinuing Opioids (2019)**
kbml.ky.gov/prescribing-substance-abuse/Documents/Clinical_Pocket_Guide_Tapering-a.pdf
**Summary:** A succinct reference for taper initiation, withdrawal symptom management, and alternative treatment planning, emphasizing documentation of shared decision-making.

**10. Nebraska Department of Health and Human Services — Opioid Tapering Flow Chart (2020)**
dhhs.ne.gov/DOP%20document%20library/Opioid%20Tapering%20Flow%20Chart.pdf
**Summary:** Provides practical visual aids for stepwise tapering decisions and patient communication; often cited by state boards as an example of structured protocol documentation.

**11. FDA — Safety Communication on Sudden Opioid Discontinuation (2019)**
U.S. Food and Drug Administration.
fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes

**Summary:** Alerts clinicians to the dangers of abrupt dose reductions or discontinuation, requiring labeling updates for all opioid products.

**12. JAMA Network Open — Association of Opioid Dose Tapering With Overdose or Mental Health Crisis (2021)**
Agnoli A. et al., *JAMA Network Open* 2021; 4(8): e2114551.
jamanetwork.com/journals/jamanetworkopen/fullarticle/2782478
**Summary:** Large cohort study demonstrating increased risk of overdose and mental health crises following abrupt or unsupported opioid tapering. Reinforces need for slow, collaborative dose reduction.

**13. BMJ — Stopping Opioid Prescriptions and Risk of Overdose or Suicide in U.S. Veterans (2020)**
James J.R. et al., *BMJ* 2020; 368: m283.
bmj.com/content/368/bmj.m283
**Summary:** Found that discontinuation of long-term opioids without structured follow-up significantly increased suicide and overdose risk, underscoring the importance of continuity of care.

**14. American Pain Society / American Academy of Pain Medicine — Clinical Guidelines for Chronic Opioid Therapy (2009, reaffirmed)**
Chou R. et al., *Journal of Pain* 2019; 10(2): 113–130.
jpain.org/article/S1526-5900(08)00831-6/fulltext
**Summary:** The original multi-society framework introducing the "risk–benefit evaluation," informed consent, and functional-goal documentation concepts still in use today.

**15. Federation of State Medical Boards (FSMB) — Guidelines for Chronic Pain Prescribing (2017)**
fsmb.org/siteassets/advocacy/policies/pain-policy---guidelines-for-the-federation-of-state-medical-boards.pdf
**Summary:** Outlines common disciplinary pitfalls, emphasizing PDMP, UDS interpretation, medical necessity documentation, and co-prescribing safety—key foundation for most state policies.

**16. National Institute on Drug Abuse (NIDA) — Opioid Facts and Treatment Resources**
nida.nih.gov/publications/research-reports/misuse-prescription-drugs
**Summary:** Provides patient and provider educational materials on opioid pharmacology, tolerance, dependence, and addiction risk.

**17. Endocrine Society — Clinical Practice Guideline: Opioid-Induced Endocrinopathy (2020)**
Fleseriu M., et al., *Journal of Clinical Endocrinology & Metabolism.*
academic.oup.com/jcem/article/105/10/3270/5879168
**Summary:** Details the physiologic effects of opioids on sex hormones and adrenal function.

Recommends testosterone or estradiol testing for patients on chronic opioids with fatigue, depression, or sexual dysfunction.

**18. American Society of Addiction Medicine (ASAM) — National Practice Guideline for the Treatment of Opioid Use Disorder (2020 Update)**

asam.org/quality-care/clinical-guidelines/national-practice-guideline

**Summary:** Defines standards for identifying and managing opioid use disorder in patients receiving long-term opioids; supports medication-assisted treatment (MAT) and transition to buprenorphine when appropriate.

**19. Pain Medicine Journal — Opioid-Induced Hyperalgesia: Mechanisms, Diagnosis, and Clinical Implications (2021 Review)**

Lee M. et al., *Pain Medicine* 2021; 22(4): 800–810.

academic.oup.com/painmedicine/article/22/4/800/6122815

**Summary:** Current understanding of OIH, how to differentiate it from tolerance, and the importance of dose reduction or rotation in management.

**20. American College of Physicians (ACP) — Nonpharmacologic and Nonopioid Pharmacologic Treatment for Chronic Pain (2017)**

Qaseem A. et al., *Annals of Internal Medicine* 2017; 166(7): 514–530.

acpjournals.org/doi/10.7326/M16-2458

**Summary:** Evidence-based ranking of non-opioid therapies—exercise, CBT, mindfulness, acupuncture, and others—for low back pain and other chronic conditions.

**21. Federation of State Medical Boards (FSMB) — Opioid Prescribing: Overview of Board Disciplinary Trends (2021)**

fsmb.org/advocacy/news-releases/fsmb-releases-2021-opioid-policy-summary

**Summary:** Lists the top disciplinary citations nationally: failure to act on abnormal UDS, lack of legitimate medical reason, missing PDMP review, and inadequate documentation of medical necessity.

## Primary Regulatory Sources

**1. Federation of State Medical Boards (FSMB)**
• *Guidelines for Chronic Pain Prescribing* (2017)
• *Opioid Prescribing: Overview of Board Disciplinary Trends* (2021)
fsmb.org/advocacy/news-releases/fsmb-releases-2021-opioid-policy-summary
fsmb.org/siteassets/advocacy/policies/pain-policy---guidelines-for-the-federation-of-state-medical-boards.pdf
**Contribution:** FSMB aggregates disciplinary data from all 70 U.S. medical and osteopathic boards. The 2021 report explicitly lists "failure to act on abnormal UDS," "failure to document legitimate medical reason," "copy-forward documentation," and "expired agreements" among the top enforcement citations.

**2. Medical Board of California**
• *Guidelines for Prescribing Controlled Substances for Pain* (2022)
mbc.ca.gov/Download/Publications/pain-guidelines.pdf
**Contribution:** California's guideline is frequently used by other states as a benchmark. It details common causes of investigation and discipline: absent PDMP checks, lack of treatment agreement, inadequate reassessment, concurrent sedatives, and insufficient documentation of medical necessity.

**3. DEA Diversion Control Division – Practitioner's Manual**
dea.gov/resources/practitioners-manual
**Contribution:** Lists "failure to maintain adequate medical records," "prescribing outside usual course of
practice," "failure to justify diagnosis," and "lack of coordination with other prescribers" as violations of
21 CFR 1306.04(a) ("legitimate medical purpose" standard).

**4. State Board Disciplinary Reports (summaries from FSMB and state newsletters)**
• Florida Board of Medicine Annual Discipline Reports (2018–2023)
• Texas Medical Board Disciplinary Summaries (2019–2022)• North Carolina Medical Board Quarterly Disciplinary Actions (2020–2023)
**Contribution:** Consistent findings: lack of PDMP documentation, failure to act on abnormal drug screens, poor record keeping, excessive refills without evaluation, vague diagnoses ("chronic pain NOS"), and failure to reassess risk–benefit.

**5. CMS "Opioid Prescribing: Provider Resources"**
cms.gov/about-cms/story-page/prescribing-opioids
**Contribution:** Emphasizes naloxone, PDMP, treatment agreements, and documentation of medical necessity to avoid Medicare compliance penalties.

**6. American Academy of Family Physicians (AAFP)**
*Tapering Long-Term Opioid Therapy* (2020)
aafp.org/pubs/afp/issues/2020/0101/p49.html
**Contribution:** Notes that common quality failures in opioid management include lack of functional reassessment, absent PDMP review, and inadequate documentation of shared decision-making.

**7. FSMB/National Academy of Medicine Joint Commentary (2020)**
*Safe Opioid Prescribing and Risk Mitigation: Lessons From State Boards*
**Contribution:** Discusses repetitive deficiencies cited across states — particularly "copy-forward charting" and "failure to justify ongoing opioid therapy."