OKLAHOMA
State Board of
Osteopathic Examiners

Educational Audit Checklist

The checklist below is intended as an educational resource and should not be considered an exhaustive list of all that should be included in a patient's medical record. OSBOE intends to use the below during the course of an educational audit to assist in determining if remediation may be required.

Physicians should use their professional judgment and adhere to applicable state and federal laws and guidelines when prescribing and monitoring opioid treatment.

- ☐ At the initial visit for opioid therapy (acute or chronic pain), was a treatment plan created with the focus on determining the cause of the pain and establishing treatment goals?
- ☐ Prior to the initial opioid prescription(s), was the patient educated on opioid risk, the dangers of mixing opioids with other substances, and the potential for abuse? Was the education/discussion documented in the patient's chart?
- ☐ Was the patient's Prescription Monitoring Program (PMP) checked prior to the initial prescription of opioid(s), and if treatment continued past the initial prescription(s) was the PMP checked at least every 180 days with proper documentation?
    a. If there was any concern about the patient's PMP, did the physician address the issue and document/educate the patient on the patient provider agreement? Were any actions taken by the physician for the violation of the patient provider agreement?
- ☐ When was the Patient-Provider agreement signed: (third prescribed for an opioid drug, patient received benzodiazepines and opioids together (even if it is only a one-time RX), Patient requires more than 100 Morphine Milligram Equivalents (MMEs), patient is pregnant, or the parent or legal guardian if the patient is a minor)
- ☐ Was the Plan of Treatment that was created at initial visit reviewed every three (3) months with documentation showing the benefits of opioid treatment?
- ☐ What was the frequency of the visits for the renewal of opioids for the first year?
- ☐ Did the patient complete one (1) year of compliance with the patient provider agreement? If so, was the patient seen every three (3) to six (6) months for review of the treatment plan and assessment?
- ☐ Did the physician periodically make a reasonable effort, unless clinically contraindicated, to either stop opioids, decrease dose, or try alternate drugs/treatments in an effort to reduce the potential for abuse or opioid use disorder?
- ☐ Was proper screening done at each visit for opioid use disorder and, if so, is the provider using the appropriate tools available to prevent diversion and abuse? Did

the physician have any concerns or was further screening done to ensure the patient was not showing signs or cues that reflect opioid use disorder?

- Were Urine Drug Screens (UDS) conducted regularly or when the physician felt there was a concern about abuse or diversion?
    a. If the physician was aware of past or present substance abuse disorder were UDS done monthly?
- At any point during treatment was there an increase in opioids? If so, did the physician properly document the reasoning for the increase and possible decrease/tapering in the future?
- Was the face of the prescription properly documented with “chronic” or “acute” pain with dosing instructions?
- Does the physician maintain and adopt a written policy for qualifying opioid therapy patients?
- Overall, do the patient’s records tell a complete and thorough story of the patient’s treatment journey with the physician?