Avoiding the Common Pitfalls of Opioid Management

Extracting opium from the poppy bud

Keeping your patients and yourself out of trouble

Jane O. Barnwell, MD
Lisa Wynn, AZ Med. Board

Where to get additional information

- Presentation, links & sample forms:
  barnwellmd.com/refer
  Opioid CME presentation link

- For help setting up your opioid policy, etc:
  Nelson Hochberg
  email@barnwellmd.com
  928-714-7090

barnwellmd.com/refer

As noted by the https in the web address, this webpage uses AES256, which is the highest level encryption available in the public domain, and is HIPPA compliant.

Jane Barnwell, MD

Referral form:

Provider's Name: Phone: email*:

Patient's Name: Phone: email*: DOB:

Referral diagnosis:

Referral reason: **Pain:** Acute Subacute Chronic **Rehab** **Worker's Comp**

Referral type: Consult, recommendations and followup Consult and recommendations only (no followup)

Additional comments:

Clear form Send securely

Enter security code on left

[Change Image]

*Secure email will always be used for protected information.
Provider's email and phone need to be entered only once unless changed - we keep them on file.

Upload files:

You can upload up to three files up to 1mb each of the following types: .txt, .xls, .doc, .rtf, .pdf, .fdf, .img, .jpg, .png, .tif
This can be used to send us files containing patient demographics, notes, etc. Note: large files will take time to upload.

Browse... Browse... Browse...

Enter security code on left

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Clear Form

Send securely

Secure email:

Presenters

- Jane O. Barnwell, MD
  - Board certified, Physical Medicine & Rehabilitation
    - Sub specialty, Pain Management
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  - Deputy Assistant Director
    Division of Licensing, Arizona Department of Health Services
  - Arizona State University

Disclosure: In the interest of complete disclosure, the speakers at this CME Activity and the committee involved in the planning of this activity have signed a financial disclosure form and has no conflict of interest with any commercial entities or products that may have an interest in this program. This is intended to make you aware of the faculty's interests, so you may form your own judgments about such materials

Avoiding the Common Pitfalls of Opioid Management

Keeping your patients and yourself out of trouble

Jane O. Barnwell, MD

Goals of proper opioid management

1. Reduce patient suffering.
2. Not reading in the paper that your patient (or his/her friend or relative) died of an overdose from opioids you prescribed.
3. Not getting a certified letter from the board.

Objectives

1. Describe how to register with Controlled Substance Prescription Monitoring Program (CSPMP) and follow rules and guideline of applicable boards.
2. Identify more long acting opioids and more appropriate opioid selection.
3. Identify at risk patients via CSPMP program, drug testing & screening.
4. Better identify patients in trouble using opioids and better manage them.

Arizona Medical Board SPS #7

Guidelines For The Use Of Controlled Substances For The Treatment Of Chronic Pain

Arizona Medical Board SPS #7 Pain Assessment

- Medical history
- Corroboration of medical history: medical records and/or speaking with former physicians
- Psycho-social assessment re: pain and mood
- Physical examination
- Urine drug screen

http://www.azmdboard.org/Statutes-Rules/7_policy.aspx

Arizona Medical Board, Substantive Policy Statement, Guidelines For The Use Of Controlled Substances For The Treatment Of Chronic Pain

Arizona Medical Board SPS #7 Treatment Plan - Objectives

- Pain relief
- Improved physical functioning
- Diagnostic evaluations
- Analysis of inclusion and exclusion criteria for opioid management

Arizona Medical Board, Substantive Policy Statement, Guidelines For The Use Of Controlled Substances For The Treatment Of Chronic Pain

Arizona Medical Board SPS #7 Informed Consent

- Verbally advise patient:
  - risks and benefits of controlled substances
  - importance of regular visits
  - impact of recreational drug use
  - what physicians may write controlled substance scripts
  - what pharmacies may fill controlled substance scripts
  - medications must be taken as prescribed
- Pain treatment contract should state:
  - required compliance with the treatment plan
  - what the consequences of non-compliance, misuse and abuse will be
  - if abuse or diversion is found, controlled substances will be discontinued in a safe manner

Arizona Medical Board, Substantive Policy Statement, Guidelines For The Use Of Controlled Substances For The Treatment Of Chronic Pain

Arizona Medical Board SPS #7 Documentation

- Medical history and physical examination
- Related evaluation and consultations, treatment plan and objectives
- Evidence of discussion regarding informed consent
- Prescribed medications and treatments
- Periodic reviews of treatments and patient response
- Any physician-patient agreements or contracts

Arizona Medical Board, Substantive Policy Statement, Guidelines For The Use Of Controlled Substances For The Treatment Of Chronic Pain

Arizona Medical Board SPS #7 Ongoing Assessment

- Continuing evaluation of pain with any necessary modification of opioid therapy
  - I recommend at least monthly
- If clinical improvement does not occur consider:
  - discontinuing opioid therapy
  - alternative pharmacologic and nonpharmacologic modalities

Arizona Medical Board, Substantive Policy Statement, Guidelines For The Use Of Controlled Substances For The Treatment Of Chronic Pain

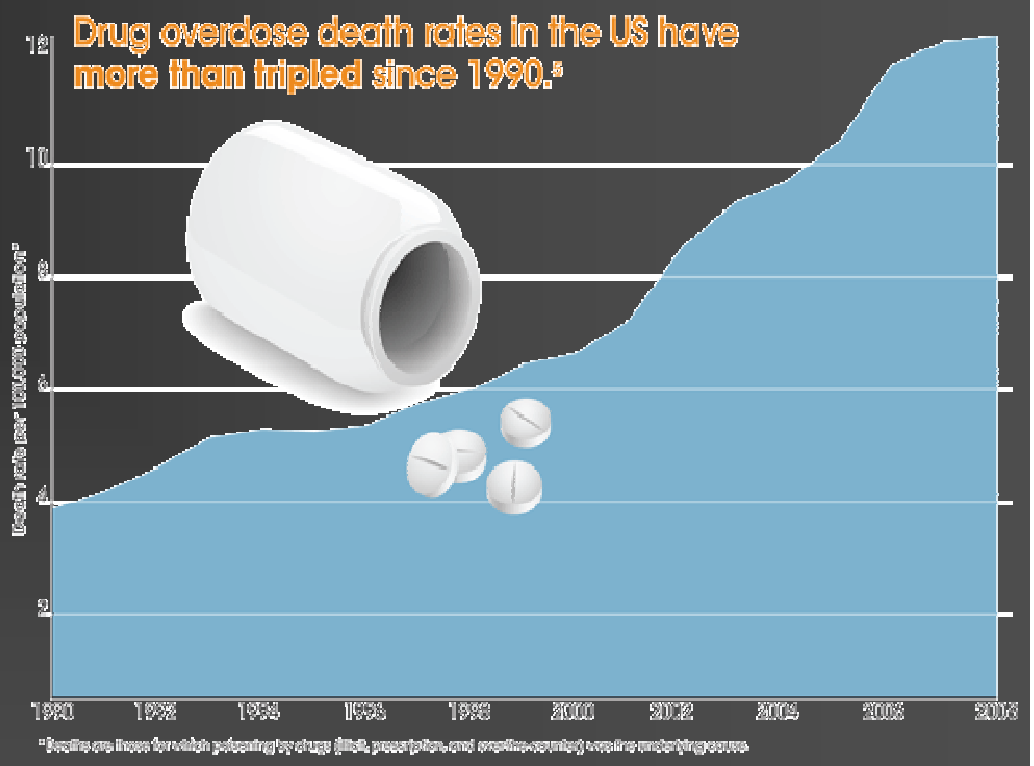
Arizona Medical Board SPS #7 Counting and Destroying Medication

- If physician wishes to see and count medication:
  - patient should display and count the medication in front of the physician (or staff member)
  - physician (or staff member) should not touch patient's controlled substances.
- If medication must be destroyed
  - patient should flush the medication down the toilet in the physician's (or staff member) presence
- Document counting and destruction

Arizona Medical Board, Substantive Policy Statement, Guidelines For The Use Of Controlled Substances For The Treatment Of Chronic Pain

Opioid misuse mortality

- Deaths from prescription opioid misuse in the United States have tripled since 1990.
- Currently there are more deaths each year from drug overdose than from automobile accidents.



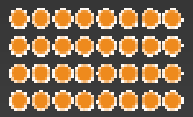
Prescription Painkiller Overdoses Policy Impact Statement, Nov 2011 CDC

The problem is more than deaths

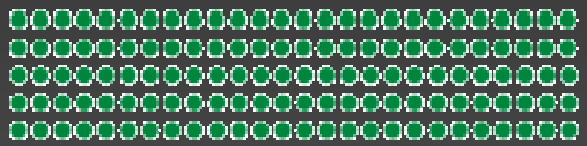
For every **1** death there are…

Based upon 14,800 prescription painkiller deaths in 2008:

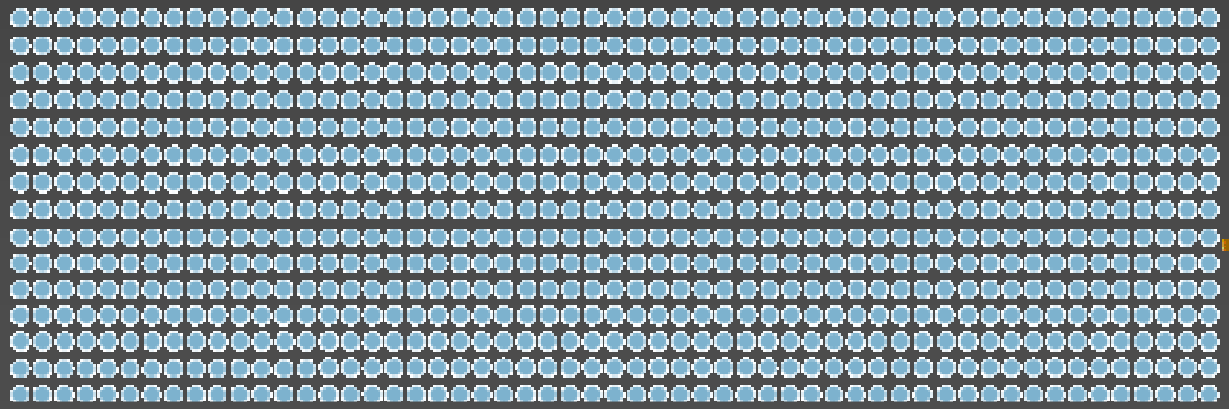
10 treatment admissions for abuse 148,000



32 ED visits for misuse or abuse 473,600



130 people who abuse or are dependant 1,924,000



825 nonmedical users 12,210,000

Prescription Painkiller Overdoses Policy Impact Statement, Nov 2011 CDC

Questions to ask yourself

- Can you effectively and safely treat a patient who lies to you or willfully withholds pertinent information from you on potentially life threatening decisions?
- Can you know a patient is telling you the truth if you don't verify?
- As healthcare providers, we prefer working with the patient as partners but some patients seeking opioids may be deceitful.

Definitions – Medical terminology

- Physical dependence
  - Physiologic accommodation to the medication
  - Rapid dose reduction or cessation causes withdrawal
- Tolerance
  - Physiologic accommodation to the medication
  - Reduced drug effectiveness over time
- Addiction
  - Compulsive use despite harm
- Pseudoaddiction
  - Drug seeking behavior as a result of inadequate pain management
  - Behavior ceases when pain is properly managed

Definitions – Legal terminology

- Doctor shopping
  - The seeking of prescription drugs under false pretenses
  - Obtaining prescription drugs from multiple providers without coordinating care
- Diversion
  - The use of legal drugs for illicit purposes

“Drug-seeking” Behavior

- “Drug-seeking” behaviors include
  - Emergency calls/visits near end of office hours
  - Refusal to undergo appropriate examination, testing, or referral
  - Repeated “loss” of prescriptions
  - Tampering with prescriptions
  - Reluctance to provide medical records or contact information for prior physician(s)
  - “Doctor shopping” for additional prescriptions
- Similar behaviors may be seen in patients with pseudoaddiction

Wilford BB. *West J Med.* 152:609-12. DEA. *Don’t be scammed by a drug abuser.* Weissman DE, Haddox JD. *Pain.* 36:363-6.

Illegal Drug-Related Behaviors

- Selling or sharing prescription drugs
- Prescription forgery
- Stealing or “borrowing” drugs
- Injecting oral formulations
- Obtaining prescription drugs from nonmedical sources
- Concurrent use of illicit drugs
- Prescriptions from multiple physicians

Adapted from: Portenoy RK. *J Pain Symptom Manage*. 11:203-17.

Aberrant Drug-Related Behaviors

- Aggressive complaining about the need for higher doses
- Requesting specific drugs
- Unapproved use of the drug
- Use of multiple pharmacies
- Multiple unsanctioned dose escalations
- Repeated episodes of prescription “loss”
- Concurrent abuse of alcohol

Adapted from: Portenoy RK. *J Pain Symptom Manage*. 11:203-17.

Outcome Prediction for Pain Treatment

Unfavorable

- Physical or sexual abuse
- Primary depression
- Diffuse complaints
- High pain focus
- Active addiction
- External locus of control/blame
- Poor support system

Favorable

- Pathology matches complaints
- Record of compliance
- Internal locus of control (accept responsibility)
- Self-efficacy
- Optimism—expectancy

Miotto K, et al. *Psychosomatics*. 37:223-35.
Dunbar SA, Katz NP. *J Pain Symptom Manage*. 11:163-71.
Marks R. *Disabil Rehabil*. 23:271-80.

Triaging New Patients

- Staff is usually better at triaging drug abusers than physicians.
- Train staff to identify warning signs
  - Argumentative & demanding behavior
  - Wants an appointment right away and late in the day.
  - Wants pain pills before seeing the doctor.
  - Has run out of pain medication.
  - Actively litigious
- Allow staff to suggest you may not be the best doctor for their needs
- Consider a policy of no controlled substance prescriptions on first visit.

Evaluating Patients

- Record review, history, exam & diagnostic data
  - Should all be consistent
- Controlled Substances Prescription Monitoring Program (CSPMP)
- Risk assessment tools: SOAPP, ORT, SBIRT
- Drug testing
- Police/court records

Arizona State Board of Pharmacy Controlled Substances Prescription Monitoring Program (CSPMP).

- **Registration is mandatory**
- **Use of CSPMP is voluntary**
  - **Registering does not provide access**
- **If you dispense controlled non-sample drugs, you are required to provide Information to the CSPMP**
- **CSPMP Information & Registration**
  - http://www.azpharmacy.gov/CS-Rx_Monitoring/default.asp

Requesting Access to CSPMP

www.azpharmacy.gov/pmp/access (practitioners).asp

Arizona State Board of Pharmacy

Controlled Substances Prescription Monitoring Program

AZ.GOV Arizona's Official Web Site

Established 1903

Search

- Home
- ASBP Home
- Affidavits
- DB Access Request Forms
- FAQs
- Forms
- Get Database Access
- Manuals
- Rules / Regulations

Login to Database

Registration / Renewal

Practitioner Procedures for Requesting Access

The CSPMP database is an electronic tool developed to provide Practitioners with a source of information regarding the controlled substance usage of a patient.

To request access to the CSPMP Database a Practitioner must:

- Follow the instructions for completing the Prescriber / Dispenser Database Access Request form.
- Complete the Prescriber / Dispenser Access Request form and Privacy Statement form.
- Create a password and place password in the designated area on the Access Request form
  - Passwords must be at least 8 characters in length.
  - Passwords must not contain dictionary words or a name.
  - Passwords must contain at least one (1) capital letter, (1) lowercase letter, and (1) number.
    For example:
    H82bYb would be acceptable
    Bob 123 would not be acceptable
    Rover9 would not be acceptable
- Print the Prescriber/Dispenser Access Request form and Privacy Statement form
- Sign and date both forms
- Have Prescriber/Dispenser Access Request form notarized
- Make a copy of your AZ Board License, DEA Registration, and current Driver's License
- Retain a copy of all forms for your records

(Note: If the Access Request form is filled in by hand, block print must be used to increase legibility.)

Contact Information

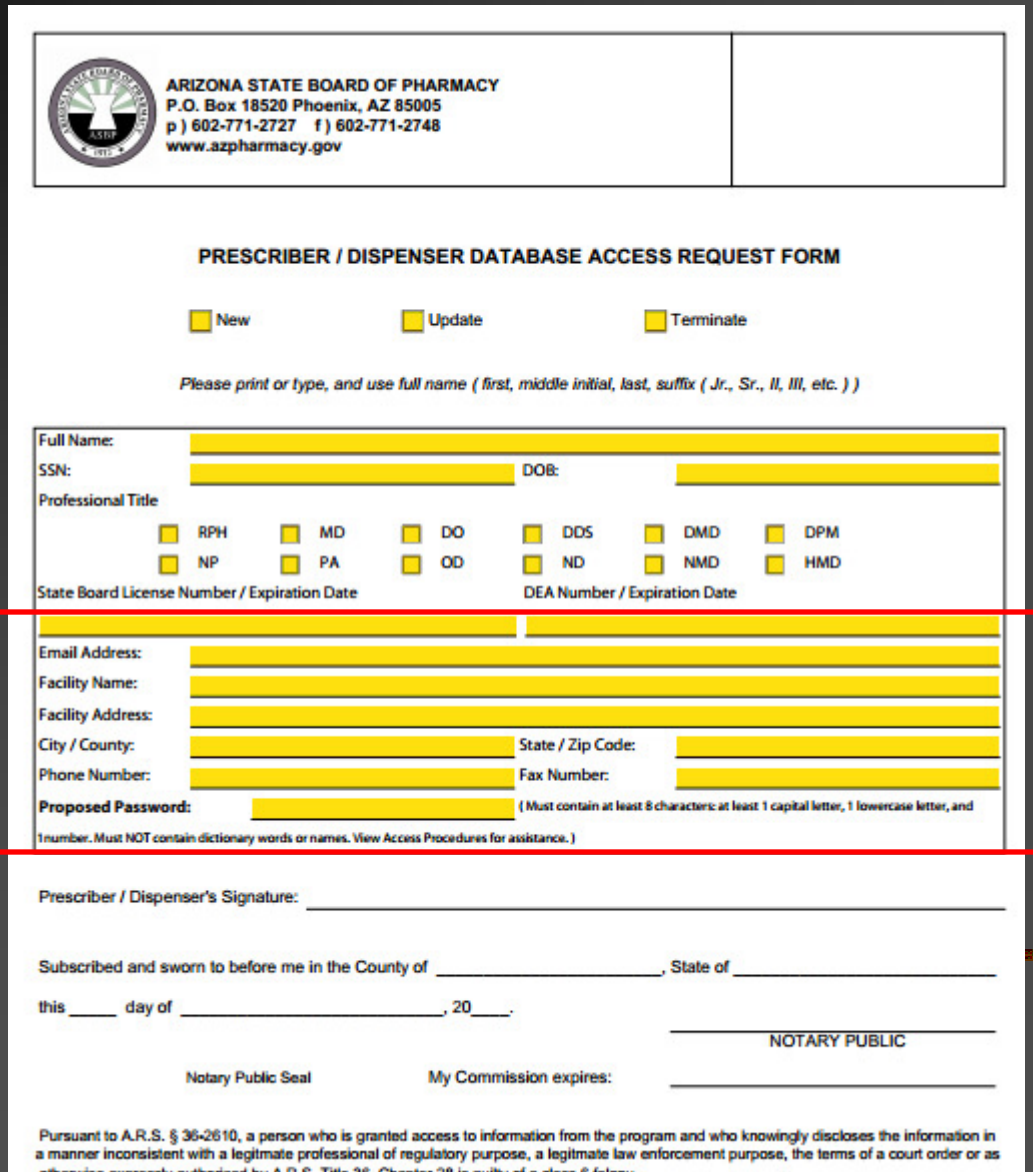
Dean Wright
CSPMP Director
Arizona State Board of Pharmacy

Physical Address:
1616 W. Adams, Suite 120
Phoenix, AZ 85007-2835

Mailing Address:
P.O. Box 18520
Phoenix, AZ 85005

Phone: (602) 771-2744
Fax: (602) 771-2748
E-mail: dwright@azpharmacy.gov

Requesting Access to CSPMP



ARIZONA STATE BOARD OF PHARMACY
P.O. Box 18520 Phoenix, AZ 85005
p) 602-771-2727 f) 602-771-2748
www.azpharmacy.gov

PRESCRIBER / DISPENSER DATABASE ACCESS REQUEST FORM

☐ New ☐ Update ☐ Terminate

Please print or type, and use full name (first, middle initial, last, suffix (Jr., Sr., II, III, etc.))

Full Name:
SSN: DOB:
Professional Title
☐ RPH ☐ MD ☐ DO ☐ DDS ☐ DMD ☐ DPM
☐ NP ☐ PA ☐ OD ☐ ND ☐ NMD ☐ HMD
State Board License Number / Expiration Date DEA Number / Expiration Date
Email Address:
Facility Name:
Facility Address:
City / County: State / Zip Code:
Phone Number: Fax Number:
Proposed Password: (Must contain at least 8 characters: at least 1 capital letter, 1 lowercase letter, and 1 number. Must NOT contain dictionary words or names. View Access Procedures for assistance.)

Prescriber / Dispenser's Signature: _____

Subscribed and sworn to before me in the County of _____, State of _____

this _____ day of _____, 20____.

_____
NOTARY PUBLIC

Notary Public Seal My Commission expires: _____

Pursuant to A.R.S. § 36-2610, a person who is granted access to information from the program and who knowingly discloses the information in a manner inconsistent with a legitmate professional of regulatory purpose, a legitmate law enforcement purpose, the terms of a court order or as

Sample CSPMP report

Fill Date	Product, Str, Form	Qty	Days	Pt ID	Prescriber	Written	RX#	N/R*	Pharm
03/06/2012	ROXICET 5-325 TABLET	30.000	15	06255xx	BN500xx	03/06/2012	0384xx	N	AC057xx
03/01/2012	ALPRAZOLAM 0.5 MG TABLET	60.000	30	06126xx	AJ794xx	10/11/2011	8404xx	N	BW718xx
02/15/2012	ALPRAZOLAM 0.5 MG TABLET	30.000	15	06126xx	BF328xx	02/15/2012	8367xx	N	BW718xx
01/26/2012	OXYCODONE-ACETAMINOPHEN 5-325	50.000	4	06126xx	MD205xx	01/26/2012	8321xx	N	BW718xx
01/21/2012	OXYCODONE-ACETAMINOPHEN 5-325	30.000	4	06126xx	BH561xx	01/20/2012	2534xx	N	BW374xx
01/20/2012	OXYCODONE-ACETAMINOPHEN 5-325	30.000	4	06075xx	BH561xx	01/20/2012	2534xx	N	BW374xx
01/12/2012	ALPRAZOLAM 0.5 MG TABLET	60.000	30	05925xx	BF328xx	08/01/2011	8286xx	N	BW718xx
01/11/2012	HYDROCODON-ACETAMINOPHEN 10-325	60.000	30	05925xx	BF328xx	01/11/2012	8283xx	N	BW718xx
12/11/2011	ALPRAZOLAM 0.5 MG TABLET	60.000	30	05925xx	BF328xx	08/01/2011	2933xx	N	AW057xx
12/06/2011	HYDROCODON-ACETAMINOPHEN 10-325	60.000	30	05925	BF328	12/06/2011	2931	N	AW057

*N/R N=New R=Refill

Prescribers for prescriptions listed

BF328xx	Fxx	HEMET CA 92544
BH561xx	Hxx	AZ 85018
MD205xx	Dxx	DALE AZ 85251
AJ794xx	Jxx	T, IDYLLWILD CA 92549
BN500xx	Nxx	ET, SUITE 104, PHOENIX AZ 85018

Pharm that dispensed prescriptions listed

AW057xx	WALGREEN ARIZONA DRUG COxx	AZ 85018,
BW718xx	WALGREEN ARIZONA DRUG COxx	Z 85018,
BW374xx	WALGREEN ARIZONA DRUG COxx	DTTSDALE AZ 85251,
AC057xx	ARIZONA CVS STORES, L.L.Cxx	, PHOENIX AZ 85018,

- Patient stated he was out of oxycodone, previously took 2 oxycodone daily and his last pain medication prescription received was Oxycodone/APAP 5/325 #50, 01/26/2012
- He did not mention alprazolam or hydrocodone

Risk Assessment Tools

- SOAPP (painedu.org/soap.asp)
  - Screener and Opioid Assessment for Patients with Pain
  - 5, 14 or 24 question assessments
- COMM (painedu.org/soap.asp)
  - Current Opioid Misuse Measure
  - Screens aberrant behaviors associated with misuse of opioid medications while on long term therapy
- SBIRT (sbirt.ireta.org/sbirt/)
  - Screening, Brief Intervention, Referral, and Treatment
  - Screening and treatment tools for alcohol and drug dependence
- ORT

SOAPP - 5

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

- How often do you have mood swings? 0 1 2 3 4
- How often do you smoke a cigarette within an hour after you wake up? 0 1 2 3 4
- How often have you taken medication other than the way that it was prescribed? 0 1 2 3 4
- How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? 0 1 2 3 4
- How often, in your lifetime, have you had legal problems or been arrested? 0 1 2 3 4

http://www.painedu.org/soap.asp

Most insurance will pay for opioid screening and counseling

Commercial

- 15-30 min 99408
- 30+ min 99409

Medicare

- 15-30 min G0396
- 30+ min G0397

AHCCCS

- Screening H0049
- Intervention per 15 min H0050

Screening and counseling may be preformed by trained staff and billed using incident to provisions.

Drug Testing in Clinical Practice

- Why test
  - Support assessment & diagnosis
  - Identify use of undisclosed substances
  - Uncover diversion
- Why test
  - Recently, in my office, a 63 year old pleasant grandmother wanting hydrocodone tested positive for cannabinoids (THC) she did not disclose.

Point of care Urine Drug Testing (UDT)

- Requires CLIA waiver
- Recommend 10 panel w/AD cup
  - Flat sided to allow copier/scanner
- Billing codes:
  - Medicare & most ins: G0430QW
  - Some others: 80101QW
- Use laboratory confirmation for denials, contested and high risk

- POC saliva testing is not yet CLIA waived

Drug Screens

Most semisynthetic & synthetic opioids not reliably detected by commonly used screens

Natural (from opium)	Semisynthetic (opium-derived)	Synthetic (man-made)
codeine	hydrocodone	meperidine
morphine	oxycodone	fentanyl
	hydromorphone	methadone
	oxymorphone	
	buprenorphine	

Shults TF. *Medical Review Officer Handbook.*

Drug Testing Process

- Typically 2-step procedure
- Step I: immunoassay **screening**
  - Laboratory-based or at point of care
  - Classify substances as present or absent
- Step II: **confirmatory** & quantitative
  - Laboratory-based specific drug identification
  - GC/MS standard
  - **No** correlation between urine or saliva drug concentration & dose
- Use reputable laboratory (DHHS, CAP certified)

GC/MS=gas chromatography/mass spectrometry

Shults TF. *Medical Review Officer Handbook.*

Laboratory drug testing

- CLIA waiver not needed if you use a CLIA certified lab and you only collect sample.
- Labs have sophisticated adulteration detection capabilities
- Most labs will bill insurance and/or patient
- Takes about one week for results

Laboratory drug testing continued

- Urine
  - Most common in clinical settings
  - Observed sample typically not used in clinical settings
  - Detection period: 1-7 days depending upon drug
- Saliva
  - Less expected by experienced drug abusers
  - Less hassle than urine
  - Detection period: 1-2 days depending upon drug
- Blood
  - Rarely used in clinical settings
  - May be combined with other blood work
  - Detection period: 1-2 days depending upon drug
- Hair or nails
  - Rarely used in clinical settings – often used in legal settings
  - Useful for detox programs
  - Detection period: hair: up to 90 days, nails: up to 6 months

Purpose of drug testing

- Do not use drug testing as your only screening tool
  - Experienced drug abusers know how to compromise many drug tests
    - See: passyourdrugtest.com/
  - Drug testing cannot accurately measure how much opioid the patient is taking
- Determine if the patient's disclosures are consistent with your findings.
  - Drug testing becomes one of your findings.

Drug Testing in Clinical Practice

- *Consideration* of whom to test
  - New patients already taking controlled substances
  - Any patient for whom you are considering prescribing controlled substances
  - Patients who request specific drugs
  - Patients who display illegal or aberrant behavior

Recommended UDT Panel

- Opioid Panel
  - Morphine, Codeine, Hydrocodone, Hydromorphone, Oxycodone
- Illegal Drugs
  - Amphetamine/Methamphetamines, Cannabinoids, Phencyclidine (PCP), Cocaine
- Benzodiazepines
  - Alprazolam, Clonazepam, Diazepam, Oxazepam, Temazepam
- Screen by immunoassay and confirm by GC/MS
- No Medical Review Officer (MRO) is necessary

Medical Explanations for Positive Results: Opiates

- Codeine metabolized to morphine
  - Prescribed codeine may explain both drugs in urine
  - Prescribed codeine does not usually explain only morphine
    - Codeine alone possible in patients who lack CYP450 2D6
  - Prescribed morphine does **not** account for codeine
  - Prescribed codeine may explain codeine with trace of hydrocodone

Shults TF. *Medical Review Officer Handbook*. Braithwaite RA, et al. *Ann Clin Biochem*. 32:123-53.
Wolff K, et al. *Addiction*. 94:1279-98. Oyler JM, et al. J Anal Toxicol. 24:530-5.

Metabolism of Opioids

oxycodone → oxymorphone

codeine → morphine ← 6-MAM ← heroin

↓ ↓

hydrocodone → hydromorphone

Not comprehensive pathways, but may explain the presence of apparently unprescribed drugs

6-MAM: 6-monoacetylmorphine, an intermediate metabolite

Dr. Howard Heit and Dr. Douglas Gourlay

UDT Results Reported as "None Detected"

- May mean any of following
  - Patient
    - Does not use drug
    - Has not recently used drug
    - Excretes drug/metabolite faster than normal
  - UDT used not sufficiently sensitive to detect drug at concentration present
    - Ask for "no threshold" testing
- In compliance testing, may raise concerns about misuse/diversion

Wolff K, et al. *Addiction.* ;94:1279-98.

Summary: Before You Order Test

- Ask patient
  - Are you taking any prescribed, OTC, or herbal drugs?
    - When was last dose? Quantity?
  - Drug abuse/addiction history
- Let laboratory know what you are looking for
  - Illicit substance
  - Prescription drug abuse
  - Presence of prescribed medication

Sample CSPMP report

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01/20/2012	OXYCODONE-ACETAMINOPHEN 5-325	30.000	4	06076xx	BH561xx	01/20/2012	2534xx	N	BW374xx
01/12/2012	ALPRAZOLAM 0.5 MG TABLET	60.000	30	05925xx	BF328xx	08/01/2011	8280xx	N	BW718xx
01/11/2012	HYDROCODON-ACETAMINOPHEN 10-325	60.000	30	05925xx	BF328xx	01/11/2012	8283xx	N	BW718xx
12/11/2011	ALPRAZOLAM 0.5 MG TABLET	60.000	30	05925xx	BF328xx	08/01/2011	2933xx	N	AW057xx
12/06/2011	HYDROCODON-ACETAMINOPHEN 10-325	60.000	30	05925	BF328	12/06/2011	2931	N	AW057

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BW374xx	WALGREEN ARIZONA DRUG COxx	OTTSDALE AZ 85251,
AC057xx	ARIZONA CVS STORES, L.L.Cxx	, PHOENIX AZ 85018,

- Patient, 4/2012: out of oxycodone; his last pain medication prescription was Oxycodone/APAP 5/325 #50, 01/26/2012
- He did not mention alprazolam or hydrocodone
- Drug test results 4/2012: positive for hydrocodone and oxycodone

Self Triage

- “I can’t afford drug testing”
  - (But I can afford Oxycontin.)
- “I can’t pee on command.”
- “I own a hemp store.”
- “You don’t trust me.”
- “I got a flat tire on the way to the lab.”
  - (The lab is two blocks away.)

Arizona Court Records

apps.supremecourt.az.gov/publicaccess/

Case Number	Name	Party Type	Birth Date	Address	Court
[illegible]	[illegible]	DEFENDANT	[illegible]	[illegible]	[illegible]nicipal
[illegible]	[illegible]	DEFENDANT	[illegible]	[illegible]	[illegible]stice
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How often, in your lifetime, have you had legal problems or been arrested? once

Are you involved in a lawsuit? ✓ no • yes: Describe:

← # 26

Opioid Treatment Agreement

- Explain that the agreement is to protect:
  - Their access to opioid therapy
  - Your prescribing authority
- Compliance expectations
- Authorization for information sharing
- Consequences of noncompliance
- Goal of improved quality of life
- Example agreement at barnwellmd.com/refer

Fishman SM, et al. *J Pain Symptom Manage*. 18:27-37.

Protecting yourself from prescription forgery

- Tamper-resistant prescription forms are required for all Medicaid (AHCCCS, IHS) patients.
- Numbered tamper-resistant prescription forms are strongly recommended for all controlled substance prescriptions.
- Keep your prescription pads secure.
- Write out numbers on prescriptions for controlled substances.
  - Examples: “12 (twelve)”, “120 (one hundred twenty)”
- Consider faxing a copy of the controlled substance prescription with the message of:

  “Confirmation only. Patient will deliver original.
  Please compare the original with this fax.
  Please call our office if patient does not deliver original within 48 hours.”

Opioid Selection

- Short-acting
  - Acute pain
  - To permit activity
    - eg, physical therapy
  - Exacerbations of pain
- Long-acting
  - Persistent moderate to severe pain
  - Baseline analgesia

Cherny NI. *Drugs*. 1996;51:714-37.
Goodman & Gilman's: The Pharmacological Basis of Therapeutics. 12th ed.

Opioid Selection$_2$

- Abuse deterrent formulations
  - Physical barriers
  - Agonist – antagonist
  - Aversion
  - Prodrugs

Managing overuse

- Repeated dosage escalations
  - Evaluate potential causes
  - Reassess risk benefit ratio
  - Evaluate adherence to treatment plan
  - Consider more frequent follow up
- Intolerable side effects or inadequate benefit
  - Consider opioid rotation

Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain,
The Journal of Pain Volume 10, Issue 2 , Pages 113-130.e22, February 2009

Managing overuse$_2$

- Taper or wean opioids
  - Repeated aberrant drug related behavior
  - Drug abuse or diversion
  - No progress toward therapeutic goals
  - Intolerable side effects

Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain,
The Journal of Pain Volume 10, Issue 2 , Pages 113-130.e22, February 2009

Discontinuation of Opioid Analgesics

- Discontinuing treatment is justifiable if no benefit is documented
- Prevent opioid withdrawal syndrome
  - Tapering regimen
  - Reduce dose while maintaining frequent dosing
- Stopping opioids does not mean stopping treatment

Cherny NI. *Drugs*. 51:714-37.

Immediate discontinuation of Opioid Analgesics

- Immediate discontinuation of Opioid Analgesics without taper is warranted if:
  - the patient is otherwise healthy and
  - you strongly suspect illegal activities or
  - the drug test is negative for prescribed medications.

  - A healthy patient may be uncomfortable from immediate withdrawal but will not die (unlike the outcome from overdose).
  - A patient doctor shopping will have other sources.
  - A negative drug test indicates the drug is not present so there will be no withdrawal.

Medical Marijuana

- What to do about medical marijuana?
  - Drug Interactions

Marijuana Drug Interactions

- **Contraindicated**
  - astemizole
  - cisapride
  - pimozide
  - terfenadine
- **Serious**
  - cerivastatin
  - dihydroergotamine
  - dronedarone
  - ergotamine
  - erythromycin
  - everolimus
  - ivabradine
  - lovastatin
  - ranolazine
  - sertindole
  - silodosin
  - simvastatin
  - sirolimus
  - sodium oxybate
  - thioridazine
  - tolvaptan
- **Significant (329)**
- **Minor (102)**

http://reference.medscape.com/drug/cannabis-ganja-marijuana-343687#3
http://answers.webmd.com/answers/1188060/does-marijuana-interact-with-any-other

False-Positive Myths: Marijuana

- OTC ibuprofen interferes with immunoassay
  - No longer true with current immmunoassays
- Medical marijuana
- Passive inhalation
  - “Side-stream” smoke
- Hemp food products

Shults TF. *Medical Review Officer Handbook.*

FINIS
part 1

Jane Barnwell, M.D.

Keeping Your Patients and Yourself Out of Trouble

Lisa Wynn
Executive Director
Arizona Medical Board

Arizona Medical Board

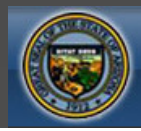
- Tasked to medically protect the health and safety of Arizona citizens
- Funded primarily by licensing and renewal fees
- 8 MDs and 4 public members of which one is a registered nurse
- Appointed by the Governor and approved by the legislature

Arizona Medical Board

- Members serve 5 year term with one possible reappointment
- Current physician membership consists of 1 anesthesiologist, 1 cardiologist, 1 family practice, 1 general surgeon, 1 orthopedic surgeon, 1 ob-gyn, and 1 emergency physician, and 1 pediatrician
- Regulate over 22,000 licensees

Medical Practice Act

A.R.S. § 32-1401.27



Lisa Wynn
AZ Medical Board

Breakdown of Board Discipline May, 2011 – April, 2012

57 Disciplinary Actions

31%	Clinical	17
28%	Impairment	16
19%	Inappropriate Prescribing	11
14%	Sexual Misconduct	8
5%	Falsifying Information	3
3%	Violating a Board Order	2

Board also issues Non-Disciplinary Advisory Letters and Non-Disciplinary CME

Case A #22289 FACTS

- Initial patient complaint of low back pain
- No documentation of previous opioid prescriptions, no previous medical records, no utilization of the CSPMP
- Minimal MRI findings
- **Initiation of opioids - Daily Morphine equivalent 720 mg**
- Physician received an anonymous tip that patient was selling medications
- Presence of methamphetamine and non-prescribed controlled substances on urine drug screen
- Absence of Methadone or Librium on urine drug screen
- **Continued prescriptions of large quantities of Methadone and Librium**

Case A #22289 FACTS continued

- Physician deviated by introducing Methadone at 120mg daily without verifying that patient was opioid tolerant and by prescribing Oxycodone 180mg daily.
- Physician deviated by initiating high dose opioids without objective verification of subjective complaints or past medical record review.
- Physician deviated by continuing high dose Methadone despite anonymous tip that patient was selling his pain medications and multiple urine drug tests with unexpected findings

Case A #22289
Previous Board History

- Findings of inappropriate prescribing of Methadone in October 2009
- Order for Non-Disciplinary Continuing Medical Education June 9, 2010
- Physician required to complete the PACE Prescribing Course within six months; completed January 2011

Case A #22289
BOARD ACTION

Following Formal Interview
June 6, 2012

- Decree of Censure
- Physician prohibited from prescribing, administering, or dispensing any controlled substances for 10 years
- Board-approved monitoring at physician's expense

Case B #11224
FACTS (Total 5 cases/complaints)

- Patient #1: 20 years old, complaints of lower back and leg pain
- At initial visit, physician prescribed oxycodone 30 mg tablets, 2 tablets 4 times a day, and Xanax.
- No appropriate previous medical records, no record of adequate physical exam, no indication of the type of pain patient reported.
- At last visit, May 2010, physician conducted urinalysis, which indicated presence of Ativan and absence of Xanax.

Case B #11224
FACTS continued

- Patient #2: 20 years old, patient #1's girlfriend, complaining of neck pain.
- No adequate review of previous medical records
- At initial visit, physician prescribed oxycodone 30 mg tablets, 2 tablets 4 times a day.
- Continued prescriptions without any further workups.

Case B #11224
FACTS continued

- Patient #3: complaints of pain
- At initial visit, physician prescribed Oxycontin 60 mg, 2 tablets 2 times per day, Oxycodone 30 mg 4 times a day, and Xanax.
- Physician did not obtain existing medical records
- Brief history and physical exam
- No assessment of enunciation of concern related to high doses of opioids
- No clear treatment plan, no referrals for other treatment, no urine drug screens.

Case B #11224
FACTS continued

- Patient #4: First visit August 2009, last visit January 5, 2010.
- Patient died on January 6, 2010 due to accidental multidrug intoxication including Oxycodone.
- Physician's records do not indicate patient's pain history or medications currently being taken.
- No record that physician reviewed previous medical records.
- No records of medications prescribed, no meaningful information in records related to patient's treatment or response to treatment.

Case B #11224
FACTS continued

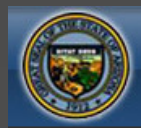
- Case also involved issuing marijuana certifications without reviewing the prescription database as required.

Case B #11224
Board History

- In August 2010, physician received a Letter of Reprimand and was required to complete the PACE prescribing course and PACE record keeping course, for a case involving inappropriate prescribing to eight patients.

Case B #11224
Board Action

- Revocation June 6, 2012



Attend a Board Meeting

- Open to the public
- Watch meetings live, view past meetings, see agendas and schedules at www.azmd.gov
- Eye opening experience

Questions? Observations? Gripes?

? ? ?

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