Avoiding the Common Pitfalls of Opioid Management

Keeping your patients and yourself out of trouble

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

Extracting opium from the poppy bud
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
Presenters

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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 SPS #7
Treatment Plan - Objectives

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

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

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

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.)
Requesting Access to CSPMP

ARIZONA STATE BOARD OF PHARMACY
P.O. Box 18520 Phoenix, AZ 85065
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: __________________________
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 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 legitimate professional of regulatory purpose, a legitimate law enforcement purpose, the terms of a court order or as otherwise provided by law, is guilty of a class 1 misdemeanor.
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**
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

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<tr>
<th>Commercial</th>
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<th>AHCCCS</th>
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<td>15-30 min</td>
<td>Screening</td>
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<tr>
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<tr>
<td>30+ min</td>
<td>30+ min</td>
<td>Intervention</td>
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<td>99409</td>
<td>G0397</td>
<td>per 15 min</td>
</tr>
<tr>
<td></td>
<td></td>
<td>H0050</td>
</tr>
</tbody>
</table>

Screening and counseling may be performed 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

Jane Barnwell, MD
## Drug Screens

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

<table>
<thead>
<tr>
<th>Natural (from opium)</th>
<th>Semisynthetic (opium-derived)</th>
<th>Synthetic (man-made)</th>
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</thead>
<tbody>
<tr>
<td>codeine</td>
<td>hydrocodone</td>
<td>meperidine</td>
</tr>
<tr>
<td>morphine</td>
<td>oxycodone</td>
<td>fentanyl</td>
</tr>
</tbody>
</table>
<pre><code>              | hydromorphone                | oxymorphone         |
              | oxymorphone                  | methadone           |
              | buprenorphine               |                     |
</code></pre>

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

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

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

<table>
<thead>
<tr>
<th>Fill Date</th>
<th>Product, Str, Form</th>
<th>Qty</th>
<th>Days</th>
<th>Pt ID</th>
<th>Prescriber</th>
<th>Written</th>
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*N/R N=New R=Refill

Prescribers for prescriptions listed

BN328XX | HXX | REMEDY CA 92544
BH561XX | DXX | 8XX 85019
MD205 | DXX | SELLE AZ 85251
AJ794XX | JXX | ST, IDYLWILD CA 92549
BN500XX | NXX | 8XX 85019

Pharm that dispensed prescriptions listed

AWC55XX | WALGREEN ARIZONA DRUG CO xx | AZ 85019
BW718 | WALGREEN ARIZONA DRUG CO xx | AZ 85019
BW574 | WALGREEN ARIZONA DRUG CO xx | OTTOSAUL AZ 85251
AC505XX | ARIZONA CVS STORES, L.XXX | 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.)
How often, in your lifetime, have you had legal problems or been arrested? Once
Are you involved in a lawsuit? No • yes: Describe:
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

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

- 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,
Managing overuse

- 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,
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

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)**

False-Positive Myths: Marijuana

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

Shults TF. Medical Review Officer Handbook.
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
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.
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.
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.
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.
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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