McDowell, Robert

From: Robin Huffman <rhuffman@ncpsychiatry.org>
Sent: Wednesday, December 06, 2017 9:47 AM
To: Henderson, Meredith
Cc: Stein, Anna H; Ashwin Patkar, M.D.; Wyatt, Stephen A; Katy Kranze
Subject: [External] Proposed Workers' Compensation Pain Management Rules Comments
Attachments: Proposed Workers Compensation Pain Management Guidelines 12.5.17.pdf

Hello Meredith,

Attached you will find comments on the draft rules for the provision of pain management to workers' compensation claimants submitted by the NC Psychiatric Association (NCPA). NCPA is the voluntary professional association for physicians who specialize in psychiatric care. We represent over 900 members and are affiliated with the American Psychiatric Association.

Sincerely,
Robin Huffman

Robin B. Huffman
Executive Director
NC Psychiatric Association
4917 Waters Edge Drive, Suite 250
Raleigh, NC 27606
C: 919-606-7861
P: 919-859-3370
F: 919-851-0044

NORTH CAROLINA
Psychiatric
Association

Comments
Proposed Workers' Compensation Pain Management Guidelines
December 6, 2017

The North Carolina Psychiatric Association's Additions Committee has reviewed the Workers' Compensation Pain Management Guidelines at the request of Ashwin A. Patkar, M.D. and Stephen Wyatt, D.O, both members of the OPDAAC Committee and the NCPA Addiction's Committee. Our committee had concerns about the limitation of the maximum number of urine drug tests to 4 per year for patients on controlled substances.

The new Workers' compensation Pain Management Rules policy on urine drug test sets an artificial maximum number of tests per year rather than basing it on individual patient and clinician determined need. We recommend that the maximum number of 4 tests per year should be replace by up to a maximum of 12 tests per year if the clinician can document a rationale that improves patient safety and care.

Since there is an overlap between chronic pain and risk of addiction with long term opioid therapy, we have outlined the clinical and scientific rationale below.

Inability to discriminate between individual drugs within class.

- One of the limitations of presumptive screening lies in its inability to differentiate between the wide array of chemicals contained within a single drug class. For example, Amphetamine (commonly known by its trade names Adderall and Vyvanse) cannot be distinguished from Methamphetamine ("Crystal Meth") in a presumptive drug screen. Thus, a patient honestly taking an Amphetamine prescription would have the same test results as a patient illegally abusing Methamphetamine.

- Another example of this phenomenon is the inability of presumptive drug screens to differentiate between Heroin and the many prescription opiates, such as Morphine (MS Contin, Kadian), Hydrocodone (Norco, Lortab, Vicodin), and Oxycodone (Oxycontin, Percocet, Roxicodone). Thus, a patient correctly taking Hydrocodone to ease back pain would test no differently than a patient addicted to Heroin. The lack of clarity inherent in presumptive drug screen results could cause many patients abusing life-threatening, illicit substances to go undetected and thus cause unnecessary harm to the health of these patients.

Inability to discriminate between drug and metabolite leading to potential for diversion of buprenorphine (Suboxone) treatment for opioid addiction.

- Another weakness of presumptive drug screening is its inability to differentiate between prescription medications and the metabolites of those medications. This weakness becomes especially apparent in patients prescribed Buprenorphine (Butrans, Suboxone) to treat opioid addiction. It is not uncommon for patients prescribed this medication to divert the medication. A presumptive drug screen can be easily adulterated into reporting a false positive for these patients when a small amount of powder, scraped from a Buprenorphine pill, is added to a patient's urine sample. The machine reports a positive for Buprenorphine, and the medical decisions that are based on that false positive could endanger the patient.

Failure to detect illicit drug use due to high cutoff levels.

- Presumptive drug screening can also fail patients due to the extremely high concentration cutoffs utilized by these methods. Cutoffs for drug classes in this type of testing are often around 300 – 500 ng/mL. It is common for patients who have either not taken a prescription for several days or who have slightly higher than normal medication metabolism rates to have drug concentrations of 50—100 ng/mL or even lower in their urine. These patients, despite correctly following the orders of their physicians on how to accurately take their medications, would be flagged as incorrectly taking those medications by a presumptive drug screen.

Presumptive drug screening is susceptible to false positive results due to the highly unspecific nature of the testing.

- Because the testing casts such a broad net by detecting entire classes of chemicals, rather than specific molecules, it is not uncommon for these tests to report false positive results. For example, immunoassay machines, one of the common pieces of equipment used for presumptive drug screens, frequently report positive results for Methadone (Methadose, Dolphine) whenever a patient is taking Tapentadol (Nucynta). Thus, a physician unaware of this phenomenon could easily believe that a patient prescribed Tapentadol is instead abusing Methadone.

- Another example is the common false positives reported by point-of-care urine sample cups. Ranitidine (Zantac), a medication that serves as an antacid and antihistamine, when dissolved in water and placed into a point-of-care cup, causes false positives for Methamphetamine, Phencyclidine, Opiates, and Oxycodone. A patient taking Ranitidine for acid reflux could potentially be dismissed from their provider's practice if the presumptive screen provided by the point-of-care cup is the only test method being utilized by the physician.

Workers Compensation Pain management Rules are not consistent with standard of care guidelines for Medication Assisted Treatment (MAT) for opioid addiction.

- Several national and federal organizations have published guidelines on urine drug testing that permit accurate detection, monitoring and reduction in diversion of medications (buprenorphine, methadone) for treatment of opioid addiction. These include:

    - National Practice Guidelines of the American Society of Addiction Medicine (http://www.asam.org/quality-practice/guidelines-and-consensus-documents/npg/complete-guideline)

    - Responsible Opioid Prescribing Guidelines by Federation of State Medical Boards (http://www.fsmb.org/state-medical-boards/education-meetings/CME)

    - Urine Drug Testing guidelines by Center for Lawful Access and Abuse Deterrence (http://claad.org/wp-content/uploads/2015/11/Barthwell-Barnes-NAADAC-150916.pdf).

  None of them have arbitrary restrictions on number of urine drug testing to be performed and, as a matter of fact, recommend "frequent" use of urine drug screens for monitoring.

Current Workers Compensation Pain management Rules run contrary to state and national efforts to combat the opioid addiction and overdose epidemic through increasing evidence based treatment.

- More than 125 persons die per day from drug overdoses in the US, a vast majority from opioid overdoses. There has been a concerted effort to expand evidence based care for addiction that includes appropriate monitoring of treatment for adherence and diversion.

Taking the above facts into consideration, we ask you to reevaluate the medical safety and utility of the proposed workers' compensation pain management rules. Our members are committed to providing effective care for their patients and hope that their views will be taken into consideration.