



PainScored

CRIMINALIZING GOOD MEDICALCARE:

The Opioid Crisis and How to Safely Practice



Much has been written about the opioid crisis. It's a difficult social and medical problem which conflates medical pain management with destructive addiction. Inevitably, the societal blame for this complex, multifactorial problem falls on physicians who are also forced to solve the problem themselves. They are caught between a rock and hard place with greater fear of law enforcement, regulatory agencies, medical boards, hospital committees, and insurance companies.

The consequences for physicians and patients are often unfair. Regardless, it's naive to expect anything different. Lawyers create, manage and profit from laws and regulations. However, it is up to us as physicians to deal with unfair practices while we advocate for change. In this short article, we will discuss the problem and how Pain Scored fits into your risk management toolkit.

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In the last decade, the CDC became more active in opioid regulation leading to the release in March 2016 of "Guidelines for Prescribing Opioids for Chronic Pain." The guidelines are not mandatory, and are generally for new instances of chronic pain. There are exceptions for patients already on chronic opioids or documented exceptions. These recommendations did not rise to the level of a standard; regardless, they have been interpreted in draconian ways by the DEA, health systems and insurance companies to deny pain medicine.

There was also a subsequent increase in DEA and regulatory body actions against physicians. A 2020 study by Daewhan et al. evaluated the numbers and found an increase in both rates of cases and prosecutions. The Medical Board in California had close to a 200% increase in disciplinary actions related to controlled drugs in several time periods. DEA prosecutions increased from 14 per year to 18 per year with the types of charges changing from drug dealing to allegations of improper medical practice described as "prescribing without medical purpose outside the usual course of medical practice." Many investigations start, not with allegations of patient harm, but with secret analysis of clinical prescribing databases. There is no clinical context in these databases.

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When you get deeper into the topic, the ramifications become more apparent. Ronald Chapman, a lawyer who specializes in Opioid physician defense, wrote a comprehensive review of jurisprudence in this context. He writes about how federal and state prosecutors are more aggressive in investigating and prosecuting DEA registrants for prescribing "outside the course of professional practice." How is this defined? It is clouded by a US Supreme Court Decision, U.S. vs. Moore, which upheld prosecution under

the Controlled Substances Act (CSA). In the wake of the decision, federal circuit courts have had trouble understanding “legitimate medical purpose” and “usual course of professional practice.” He argues that the “misunderstanding has led to the judicial creation of a “criminal standard of care” for all appropriate prescribing.” It was revisited by the Supreme Court in Gonzales vs. Oregon which attempted to clarify but ultimately confused the matter. Since then, federal circuit court opinions have held doctors to heightened, and often shifting, standards such as “failure to recognize signs of drug diversion.”

Daewhan et al. found some interesting risk factors: age, board certification, type of degree (MD vs. DO), practice type (private practice), specialty type (pain medicine, physical medicine and rehabilitation, neurology and neurosurgery). States at highest risk are West Virginia, Pennsylvania, Kansas, Florida, Louisiana, Maine and Michigan. A group called “Don’t Punish Pain Rally” looked at Department of Justice arrests of 1772 physicians, clinic owners and pharmacists. They have also found early preliminary evidence that people of older age or color are more likely to be targeted.



New Risk Categories

1. Degree Type
2. Private Practice
3. Specialty Type
4. Location
5. Age
6. Race/Ethnicity

How does one protect themselves? Another article by Jung et al. studied DEA investigations and found that proper documentation is the key to avoiding prosecution. Ronald Chapman expands further by saying a strong defense requires, “narrowing of the standard, solid expert testimony and a strong presentation of the patient’s medical need for the prescription issued by a physician.”

Risk Mitigation Strategies

1. Risk Assessment Tools
2. Treatment Agreements
3. Urine Drug Testing

The harm of an investigation is professionally and personally devastating. Your malpractice may not cover the financial harm involved. Legal fees combine with intrusive clinic shutdowns and raids. All narcotic prescribers should look into risk mitigation strategies including Pain Scored Documentation. While a full discussion of risk mitigation is beyond the scope of this article, its clear that it starts and ends with better documentation.

Remote patient monitoring with Pain Scored may be a valuable piece of the opioid toolkit for physicians. By shifting some of the documentation burden to patients and requiring participation as part of the pain contract, responsibility for compliance shifts back towards patients. Pain Scored includes active and passive assessments with risk assessment tools. A great combination for any practice!

Adherence score

85%

26 assessments completed

Stress Score

3.5

Fatigue Score

7

Your common symptoms

53% Aching

33% Numbing

24% Tingling

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Medicine is not patriarchal and patients are not passive participants in health care. By giving them tools to learn and grow, we hope to provide caring physicians an additional way to help deal with an unfair regulatory environment.

Pain Scored Patient Application: Trends validated assessments for pain, depression, cognition, and risk.

Relief from suffering is a primary obligation of physicians. Pain continues to be inadequately treated despite decades of incremental progress. Remote patient monitoring lets physicians fulfill their mission while documenting pain scores, physical activity and emotional wellbeing. Behavior and compliance can be monitored and evidence of harm may trigger a change in therapy. Patients doing well, however, justify their interventional or medical therapies. This is part of a virtuous cycle in which patient empowerment helps with adherence and documentation.

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2. Dineen, Kelly K. And James M. Dubois, "Between a Rock and a Hard Place: Can Physicians Prescribe Opioids to Treat Pain Adequately While Avoiding Legal Sanction?", *Am J Law Med.* 2016 ; 42(1): 7-52.
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4. Ronald W. Chapman II, "Defending Hippocrates: Representing Physicians in the Wake of the Opioid Epidemic", *National Association of Criminal Defense Lawyers*, September/October 2019, pp. 40-49.

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