ED LEGAL LETTER™

THE ESSENTIAL RESOURCE FOR EMERGENCY MEDICINE MALPRACTICE PREVENTION AND RISK MANAGEMENT

JANUARY 2016 Vol. 27, No. 1; p. 1-12

INSIDE

The Rise of Drug-seeking Behavior in the ED and Strategies to Manage Such Behavior

By Mary C. Malone, Esq., W. Clay Landa, Esq., and Megan K. Dhillon, Esq., Hancock, Daniel, Johnson & Nagle, PC, Richmond, VA

As the prevalence of opioid dependency and abuse continues to increase, managing individuals exhibiting drug-seeking behavior has become an important issue for ED personnel. This article examines the various approaches recommended for dealing with drug-seeking behavior in the ED and also evaluates and considers issues in implementing such approaches.

The Rise of Opioid Abuse

The number of overdose deaths related to an opioid addiction currently outnumbers the amount of overdose deaths due to all other illicit drugs. In 2009, the incidence of overdose deaths due to opioid abuse surpassed the amount of deaths associated with motor vehicle accidents for the first time in the United States. An estimated $72 billion is spent on medical costs related to opioid abuse. As opioid dependency and addiction increases, the number of ED visits by individuals seeking opioids has also grown.[1]

Although the majority of prescriptions for opioids are written by primary care physicians and internists, an estimated 45% of all opioids utilized in a non-medical manner are derived from prescriptions written in the ED.[2] Therefore, identifying individuals exhibiting drug-seeking behaviors, and curtailing the ability of those individuals to access opioids, has become an important issue for ED personnel. Since ED visits typically involve brief interactions, with little or no follow-up appointments, it can be difficult to effectively identify and manage drug-seeking individuals. Even when EDs can and have identified so called "frequent fliers" who rou-

Financial Disclosure: The following individuals disclose that they have no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study: **Arthur R. Derse**, MD, JD, FACEP (Physician Editor); **Kay Ball**, PhD, RN, CNOR, FAAN (Nurse Planner); **Stacey Kusterbeck** (Contributing Editor); **Shelly Morrow Mark** (Executive Editor); **Jonathan Springston** (Associate Managing Editor); **Mary Malone** (Author); **W. Clay Landa** (Author); and **Megan Dhillon** (Author).

ED LEGAL LETTER

ED Legal Letter™,
ISSN 1087-7347, is published monthly by
AHC Media, LLC
One Atlanta Plaza
950 East Paces Ferry Road NE, Suite 2850
Atlanta, GA 30326.
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to:
ED Legal Letter
P.O. Box 550669
Atlanta, GA 30355.

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
customerservice@ahcmedia.com.
AHCMedia.com

EDITORIAL E-MAIL ADDRESS:
jonathan.springston@ahcmedia.com.

SUBSCRIPTION PRICES:
Print: 1 year with free *AMA PRA Category 1 Credits™*: $519.
Add $19.99 for shipping & handling.
Online only: 1 year (Single user) with free *AMA PRA Category 1 Credits™*: $469

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site-licenses, or electronic distribution. For pricing information, call Tria Kreutzer at (404) 262-5482. Canada: $529 per year plus GST. Elsewhere: $529 per year.

Back issues: $83. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue's date. GST Registration Number: R128870672.

ACCREDITATION: AHC Media, LLC is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

AHC Media, LLC designates this enduring material for a maximum of 18 *AMA PRA Category 1 Credits™*. Physicians should claim only credit commensurate with the extent of their participation in the activity. Approved by the American College of Emergency Physicians for a maximum of 18.00 hour(s) of ACEP Category I credit.

AHC Media, LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 18 nursing contact hours using a 60-minute contact hour. Provider approved by the California Board of Registered Nursing, Provider #CEP14749, for 18 Contact Hours.

This activity is intended for emergency physicians and nurses. It is in effect for 36 months from the date of the publication.

tinely exhibit drug-seeking behavior through multiple ED visits, the ED must develop proper procedures to manage such patients and provide treatment. In addition, certain prescribing practices in EDs exacerbate this difficultly, namely "prescriptions for high daily doses of opioids, overlapping ED prescriptions for opioids or opioids and benzodiazepines, and receiving long-acting/extended-release opioids for acute pain conditions."[1] However, several states and cities have sought to address the rise of opioid abuse drug-seeking behavior plaguing EDs by formulating guidelines for prescribing opioids.

Guidelines for Opioid Prescribing

As opioid abuse has increased, many localities have imposed restrictions on the availability of opioids and the ability to prescribe painkillers. Ohio was one of the first states to curb opioid accessibility.[3] Ohio's guidelines stress that healthcare practitioners must evaluate the potential for non-pharmaceutical and non-opioid therapies before considering opioids. The Ohio guidelines caution healthcare providers against treating chronic pain with opioid therapy and against prescribing opioids with benzodiazepines given the potential adverse effects, including the increased risk of overdose. The guidelines recommend that opioids should only be prescribed when a "favorable risk-benefit balance" can be achieved. Ohio also crafted a policy statement to be posted in EDs, which states that staff may contact the primary care physician of an individual who presents to the ED, and staff may ask to see the individual's driver's license. The policy statement says that narcotic pain medication may not be prescribed unless ED staff can talk directly with the individual's primary care physician. The policy statement also says that before prescribing narcotics, ED staff should check the Ohio Automated Rx Reporting System to track an individual's narcotic and controlled substances prescription. Finally, under Ohio's guidelines, EDs can develop care plans for frequent users of the ED to attempt to address issues with addiction and abuse.[4]

Arkansas' Prescribing Guidelines state that before providing a prescription for opioids, an ED patient should be screened for substance abuse. ED personnel are advised to use the Arkansas Prescription Drug Monitoring Program. EDs should "perform screening, brief interventions, and treatment referrals for patients with suspected prescription opiate abuse problems." Arkansas' guidelines also caution ED personnel against providing replacement prescriptions for controlled substances and suggest that providers contact the patient's primary opioid prescriber. If the patient's chronic pain is exacerbated, the ED provider should only provide medication to last until the patient is able to see the primary care provider. The Arkansas policy stresses that only one medical provider should provide opioids to treat a patient's chronic pain, as a means to prevent opioid abuse.[5]

Massachusetts has also instituted guidelines for developing strategies to address opioid misuse. The guidelines suggest that providers consider alternative methods for pain management prior to prescribing opioids. Recommending that a patient with "chronic and complex pain" be referred to a pain specialist, the guidelines emphasize that ED providers should not prescribe long-acting or controlled release opioids. Whenever possible,

ED staff should consult with the patient's primary care physician, and emphasize the importance of follow-up care. Additionally, the Massachusetts guidelines recommend that ED staff cultivate a process to screen, identify, and address interventions for individuals who could be prescribed opioids. The guidelines recommend that ED providers review the Massachusetts Prescription Monitoring Program before prescribing opioid medications. Although Massachusetts law exempts ED personnel from checking the monitoring database when prescribing less than a five-day supply of a controlled substance, the guidelines advise checking the database whenever possible to identify patient prescription histories that indicate drug-seeking behavior. However, the guidelines counsel that a "concerning pattern of prescriptions" in the database is not an adequate reason to withhold opioids if a patient possesses an obvious source of pain. Given the importance allocated to the database by the Massachusetts guidelines, it is no surprise that the guidelines also contemplate the formation of a system for all hospitals to immediately disseminate and share ED patient histories with other EDs and urgent care centers.[6]

New York City also instituted guidelines for ED opioid prescriptions, which caution that only short-dose opioids should be prescribed, such as limiting prescriptions to a time period of three days. The guidelines suggest that follow-up care should be expedited if a longer supply is required. Further, ED staff should not replace prescriptions for lost or stolen medication. ED personnel should provide a prescription for a one- or two-day supply only after confirming the necessity of the medication with the patient's physician. The guidelines also recommend ED personnel communicate to patients the risks associated with opioid medication, as well as strategies for ensuring that the medication is not shared or stolen.[7]

The New York City guidelines, as well as the guidelines for Ohio, Arkansas, and Massachusetts, echo the policies released by the American Academy of Emergency Medicine (AAEM). AAEM states that discharge prescriptions should be limited to a supply of seven days. The AAEM guidelines also recommend that narcotics should not be prescribed for back pain, routine dental pain, migraines, and chronic abdominal or pelvic pain.

A COMMONALITY AMONG ALL GUIDELINES AND POLICIES IS A RECOMMENDATION TO UTILIZE A PATIENT DRUG MONITORING PROGRAM, CONSIDERED TO BE AMONG THE MOST PROMISING TOOLS TO ADDRESS PRESCRIPTION DRUG ABUSE.

For patients who frequently appear in the ED, AAEM suggests sending a certified letter stating that the patient will no longer be prescribed narcotics in the ED and the addition of an internal code, identifying the patient as exhibiting drug-seeking behavior, in the patient's medical record.[8]

Patient Drug Monitoring Programs

A commonality among all the guidelines and policies designed to deal with drug-seeking behavior exhibited in the ED is a recommendation to utilize a patient drug monitoring program (PDMP). PDMPs are considered to be among the "most promising clinical tools to address prescription drug abuse."[1] Most PDMPs require retail pharmacists to enter data regarding prescriptions pertaining to controlled substances into a centralized database.[9] ED staff can access the information in the database to determine a patient's prescription history, including whether the patient has obtained medication from multiple providers, whether prescriptions were filled at different pharmacies, and the frequency in which prescriptions were filled.[6] PDMPs are deemed an effective vehicle to screen and identify patients exhibiting drug-seeking behavior because the data from PDMPs supplies objective standards, allowing providers to better identify patients with a potential to abuse or misuse opioids.[10]

However, research regarding the effectiveness of PDMPs has been mixed. Research has indicated that utilizing a PDMP reduces "the prescribing of Schedule II opioid analgesics, lower[s] substance abuse treatment admission rates, and result[s] in lower annual increases in opioid misuse or abuse in states with PDMPs compared to those without them."[1] Another study, on the other hand, has shown that states with robust PDMP programs did not have lower rates of consumption of opioid drugs for the period examined. However, the study postulated that PDMPs are

most effective when used in combination with other tools to combat opioid abuse, such as tamper-resistant prescription forms.[9]

Guideline Considerations and EMTALA

Although the guidelines seek to formulate effective approaches to address non-legitimate opioid-seeking behavior, the guidelines also represent recommended strategies. All the guidelines emphasize that ED staff must be permitted to exercise medical judgment regarding the prescription of controlled substances. ED personnel must balance the goal to curb access to opioids to reduce rates of addiction and misuse against the need to ensure patients with legitimate pain receive access to necessary treatment.[1] Pain is one of the most common complaints among ED patients.[2] Managing pain presents a difficult dilemma for ED staff, given the lack of objective support in identifying and addressing pain symptoms.[11]

Adding to the complexity of pain management, many of the undesirable behaviors associated with drug seeking can also be attributed to the undertreatment of legitimate pain. In a study of drug-seeking patients in the ED, the generally accepted common characteristics of drug-seeking behaviors were rarely exhibited. The study found that the "behaviors most frequently used (headache, back pain, and 10/10 pain) are extremely common complaints in the ED, and are likely not very specific for the diagnosis of drug-seeking behavior."[12] Therefore, while the guidelines suggest methodologies to identify and manage drug-seeking patients, in practice, it can be difficult for ED staff to effectively determine whether a patient is seeking legitimate pain relief.

Another consideration that ED personnel must consider is that the guidelines may present issues regarding compliance with the Emergency Medical Treatment and Labor Act (EMTALA). In 2013, the South Carolina Hospital Association requested guidance from the Centers for Medicare & Medicaid Services (CMS) regional office in Atlanta regarding whether proposed signage addressing prescribing pain medication in the ED would violate EMTALA.[13] The proposed language in the signs mentioned that ED personnel would ask the patient about any prior history of pain medication use, ask to see a photo ID, may check the statewide prescription database regarding the patient's prescription drug use, and would only provide enough pain medication to last until the patient's physician could be contacted. The sign also stated that lost or stolen prescriptions would not be refilled, long-acting pain medications would not be prescribed, and pain medications would not be prescribed if the patient already received pain medication from another doctor or ED.[14]

> PERSONNEL MUST BALANCE THE GOAL TO CURB ACCESS TO OPIOIDS TO REDUCE RATES OF ADDICTION AND MISUSE AGAINST THE NEED TO ENSURE PATIENTS WITH LEGITIMATE PAIN RECEIVE ACCESS TO NECESSARY TREATMENT.

In response, CMS noted EMTALA's definition of an emergency medical condition (EMC) by specifically highlighting that an EMC manifests itself through acute symptoms of sufficient severity, which includes severe pain.[13] Thus, CMS implied that severe pain alone meets the definition of an EMC, even though the remainder of the statutory and regulatory definition of an EMC indicates the pain must be caused by an underlying medical condition such that the absence of immediate medical attention would place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[15]

CMS stated that the Interpretative Guidelines indicate that patients should not leave the ED based on a suggestion by the hospital or through coercion. CMS found that the language in the South Carolina hospital sign "or any similar language" that a hospital may post that is viewed by the patient prior to receiving an emergency medical screening exam could be "considered to be coercive or intimidating to patients who present to the ED with painful medical conditions, thereby violating both the language and the intent of the EMTALA statute and regulations." Although CMS acknowledged that the issue of drug-seeking behavior was an important problem facing EDs, CMS stressed that such signs may lead to the possibility that patients with a legitimate need for pain relief might be unduly coerced to leave the ED. Instead, CMS stressed that the issues raised in the sign were appropriate for discussion between the patient and the ED physician in the context of a

medical screening exam and that after performing the screening, a physician may make a decision based on professional medical judgment to withhold prescribing opioids.[13]

Conclusion

ED personnel face an increasingly difficult environment regarding the proper treatment of patients exhibiting drug-seeking behavior in the ED. Opioid abuse and overdoses are continuing to increase, many of which are related directly to prescription controlled substances. ED personnel have long been on the front lines of witnessing patients arriving at the ED in an attempt to gain access to opioids. In this role, ED personnel are put in the difficult position of having to screen and potentially treat and stabilize such patients under EMTALA while also weighing patient safety and professional concerns after prescribing pain medications to patients who appear only to be seeking such drugs for ulterior purposes.

In response to the drastic increase in overdose deaths and opioid abuse, many states have enacted guidance regarding how EDs can treat patients who may be exhibiting drug-seeking behavior. While many of these guidelines may be seen as common sense measures that will protect both the ED personnel, as well as the patients, CMS has indicated that such measures may violate EMTALA because they could unduly coerce a patient to leave the ED prior to receiving an emergency medical screening exam and any necessary stabilizing treatment. Therefore, measures put in place by EDs should stress a discussion between the physician and patient regarding the prescription of opioids in the context of the medical screening exam and treatment, but should by wary of measures that provide information to patients prior to the screening exam that could be seen as discouraging patients from receiving treatment. ■

REFERENCES

1. Prescription Drug Abuse Subcommittee, U.S. Department of Health and Human Services. *Addressing Prescription Drug Abuse in the United States*. 2012.
2. Cheng D, et al. American Academy of Emergency Medicine. Emergency department opioid prescribing guidelines for the treatment of non-cancer related pain. Issued Nov. 12, 2013. Available at: http://www.aaem.org/UserFiles/file/Emergency-Department-Opoid-Prescribing-Guidelines.pdf.
3. Huffman A. Controlling opioid abuse in the emergency department: Legitimate public policy or "legislative medicine"? *Ann Emerg Med* 2013;61:13A-15A.
4. Opiate Action Team. Ohio's opioid prescribing guidelines. Available at: http://www.opioidprescribing.ohio.gov/OOAT_TX_Guidelines.html. Accessed Nov. 16, 2015.
5. Arkansas Medical Society. Arkansas emergency department opioid prescribing guidelines. Available at: http://www.arkmed.org/resources/prescription-monitoring/. Accessed Dec. 2, 2015.
6. Massachusetts Hospital Association. MHA guidelines for emergency department opioid management. Available at: http://www.macep.org/content.asp?contentid=232.
7. NYC Health. NYC emergency department discharge opioid prescribing guidelines. Available at: http://www.nyc.gov/html/doh/html/hcp/drug-opioid-guidelines.shtml. Accessed Dec. 2, 2015.
8. American Academy of Emergency Medicine. Model emergency department pain treatment guidelines. Available at: http://www.aaem.org/publications/news-releases/model-emergency-department-pain-treatment-guidelines. Accessed Dec. 2, 2015.
9. Paulozzi L, et al. Prescription drug monitoring programs and death rates from drug overdose. *Pain Med* 2011;12:747-754.
10. American College of Emergency Physicians. ACEP Now. ED waiting room posters on prescribing pain medications may violate EMTALA. Available at: http://www.acepnow.com/article/ed-waiting-room-posters-prescribing-pain-medications-may-violate-emtala/. Accessed Dec. 2, 2015.
11. Reinisch C. A challenging case of chronic pain in the emergency department: Medical and ethical issues of management. *Adv Emerg Nurs J* 2007;29:35,37.
12. Grover CA, et al. How frequently are "classic" drug-seeking behaviors used by drug-seeking patients in the emergency department? *West J Emerg Med* 2012;13:416-421.
13. Letter from Richard E. Wild, MD, JD, MBA, FACEP, to Diane Paschal, CMS, Consortium for Quality Improvement and Survey & Certification Operations. Available at: https://www.google.com/?gfe_rd=ssl&ei=qWlcVpi5J4LF-AX-gLSIBQ#q=CMS+letter+to+diane+paschal.
14. Bitterman RA. The federal government blocks South Carolina hospitals from posting "pain management signs" in their emergency departments. *ED Legal Letter* 2013;24:73-77.
15. 42 USC § 1395dd(e); 42 CFR 489.24(b).