THE MONTHLY PUBLICATION FOR CAP MEMBERS

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Case of the Month

Look for the Red Flags of Prescription Drug Abuse

by Gordon Ownby

Physicians may be forgiven for a feeling of whiplash after emerging from an era of pain-medication permissiveness to today's opioid vigilance. Nevertheless, practitioners must always be alert to the warning signs of a patient who is abusing the trust of the physician-patient relationship.

Dr. A, an anesthesiologist and pain-management interventionist, began seeing a 28-year-old patient who reported a right shoulder snowboarding injury and surgery five years earlier. The patient said he was constantly dealing with aches and pains arising from reinjuries. Physical therapy had not helped and the patient reported a history of taking five to six Norco pills daily for three to four years. He also reported having used Vicodin, Lortab, ibuprofen, Motrin, Flexeril, Soma, and Ultram for pain.

Based on his examination of the patient, Dr. A diagnosed cervicalgia and myositis and prescribed Feldene, Ultram, and Norco for pain.

The patient returned to Dr. A monthly with varying complaints of neck and back pain. In addition to Norco, Dr. A's prescriptions early in his care included Robaxin and Relafen. On his third visit, the patient said his pain was 8/10, with increased back pain related to work activity as a delivery-truck driver. Dr. A found no radiculopathy or neurologic deficits. He continued the Robaxin and Norco, and put the patient on light work duty. He suspended the Relafen.

Two days following that third visit, Dr. A received a letter from the California Department of Justice that included a CURES report showing the patient receiving Norco prescriptions from several other providers at multiple pharmacies. When Dr. A asked his patient about this report at the next month's visit, the patient responded that he had been the victim of identity theft and that the other prescriptions were not his. Dr. A did not dispute the patient's explanation, continued the medications, and renewed a prescription that the patient had from another physician for Wellbutrin.

Monthly visits continued into the next year with Dr. A's impression continuing to be cervicalgia and lumbago. The Robaxin and Norco prescriptions were continued. At one visit early in the year, Dr. A renewed the patient's prescriptions for Wellbutrin and Lexapro, noting that the patient had reported his PCP was out of town.

During the early part of the year, Dr. A received two letters from Medco, the first concerning the patient's use of Wellbutrin "significantly greater than the six-month minimum as recommended by the American Psychiatric Association" and the second showing the patient

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receiving multiple prescriptions by multiple providers. Dr. A's records show the patient explaining that he had received opioid prescriptions from his dentist and orthodontist for some dental work.

The monthly visits continued, and Dr. A charted a plan to attempt to wean the patient off some of the medications. A new prescription of Norco was reduced from 150 pills to 135, and prescriptions for Wellbutrin, Lexapro, and Robaxin were discontinued, as was a prescription for Percocet, which Dr. A had prescribed as a Norco substitute for several months. Dr. A re-prescribed Wellbutrin and Lexapro at a subsequent visit when the patient complained of difficulty without those medications.

The patient continued to see Dr. A monthly throughout the next year, reporting pain ranging from 6-8/10. Dr. A continued to prescribe Xanax and Norco. Following a work-related vehicular accident, the patient reported stress in looking for new employment and from his marriage. At one point, the patient specifically asked Dr. A to switch his medication from Norco to Opana ER, stating that Norco was no longer helping. At the next visit, Dr. A prescribed Opana ER for daily use, while decreasing the Norco to twice daily.

The next year brought more stable employment for the patient and a better exercise routine. Dr. A decreased the patient's Opana ER to every third day while maintaining the Norco and Xanax medications. Monthly visits continued into the next year with the patient reporting mid-year that he had been hit by a car while riding his bike and had been diagnosed with a knee contusion. Per the patient, X-rays of the knee were negative for a fracture but he felt pain in his left knee while walking and standing.

With the patient's knee pain continuing, Dr. A ordered an MRI, which showed a meniscus tear. Dr. A maintained the patient's pain medications while the gentlemen pursued physical therapy and orthopedic treatment.

In the first half of the next year's treatment with Dr. A (now at year five), Dr. A was alerted by a pharmacy that his patient was receiving Methadone from several providers. A CURES report run by Dr. A revealed the patient was receiving Norco, Xanax, and Methadone from several providers. When Dr. A asked the patient about the CURES report at the next visit, the patient told Dr. A that his stepbrother had been using his identification to get pain medications from other physicians. Dr. A documented the discussion and continued the patient's medications without change until several months later, when he decreased the Opana ER to every fourth day.

Monthly visits continued into the next year. Late in year six, Dr. A received a medical record request from a deputy public defender, who explained that he was representing the patient in what appeared to be a criminal matter.

Early in year seven, the patient reported that he had been in an automobile accident and complained of increased neck stiffness and spasms in the neck and right upper back. Dr. A requested that the patient continue the physical therapy as prescribed by the urgent care facility that he had visited. Dr. A maintained the patient on his medications and also prescribed Tizanidine, a muscle relaxant.

After a two-month hiatus, the patient returned to Dr. A, reporting that he had been called to active military service until being placed on disability status. Dr. A wrote his regular prescriptions for Opana ER every three days, Xanax daily, and Norco four times a day.

Later that day, the gentleman returned to Dr. A's office, reporting that he was tired and needed to sleep. Dr. A found a place for the patient to sleep. After finishing with his other patients, Dr. A awoke the patient and called the patient's wife, who picked him up.

Later that day, the patient was found blue with shallow breathing and after a 911 call, was taken by ambulance to the community hospital after receiving Narcan in the field. His diagnosis at the hospital was possible opiate overdose and aspiration pneumonia. Dr. A was not contacted regarding the admission.

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When the patient returned to Dr. A two months later, Dr. A confronted the patient with a new CURES report that he had run showing the patient getting medications from various other providers. The patient claimed that his cousin had been using his identity to get medications from other physicians. Dr. A told the patient that he needed proof of the identity theft and that he would start weaning the patient off his medications. Dr. A reduced the Norco and Opana ER, discontinued the Xanax, and told the patient that he would be discharged from his care without proof of the claimed identity theft. The patient never returned.

In a subsequent lawsuit, the patient claimed that Dr. A's treatment caused him to become addicted to pain medications. This addiction caused him to lose his job as delivery truck driver and ultimately his driver's license. In the lawsuit itself, the patient referred to the day of his hospitalization and alleged that he "collapsed at [defendant's] medical office . . . because of the pain medications and [defendant] then failed to render appropriate medical care to him." He also claimed that his addiction resulted in two felony convictions, which severely impacted his employment opportunities. Other damages alleged included medical expenses he incurred while in jail and restitution that he owed as a result of his criminal convictions. (As it turned out, the two months of military call-up that he told Dr. A about was actually time spent incarcerated.) The patient testified in deposition that he had used illicit drugs during the time of his treatment with Dr. A but that Dr. A never requested that he submit to a drug test. The lawsuit was resolved informally.

Do physicians treating pain with medications need to be constantly suspicious of their patients? That's a question best left to individual situations. Certainly, though, physicians who use patient drug contracts, consult with specialists to determine underlying causes for their patients' pain, screen for other drug use, and act decisively after suspicious CURES reports can help avoid exposure when a patient's next pursuit is them.

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

March 2020

Risk Management and Patient Safety News

New Rules and Regulations for Physician Assistants

CAP Risk Management and Patient Safety Department

If Physician Assistants (PAs) — a type of advance practice professional — are part of your practice, then you need to know that the rules and regulations for the supervision of PA's were recently changed. Senate Bill No. 697, Physician Assistants: Practice Agreements: Supervision, was signed on October 9, 2019 and took effect on January 1, 2020.[1]

According to SB 697's sponsors, statutory limitations were overly burdensome and duplicative of other protections built into the healthcare system. SB 697 and the related Section 3500 of the Business and Professions Code references, the "growing shortage and geographic maldistribution of healthcare service" and its purpose of "encourage[ing] the effective utilization of the skills of physicians and surgeons . . . by enabling them to work with qualified PAs to provide quality care." The California Medical Association stated that "SB 697 allows for more autonomy to each medical practice as to their functional relationship with their PAs." By removing the perceived burdens and duplications, SB 697 places more control in the hands of physicians and surgeons over the methods of supervision of PAs.

You are encouraged to read the entire text of SB 697, but there are several changes of note in SB 697 that may affect your practice and have risk management implications:

1. Multiple physicians and surgeons are allowed to supervise PAs compared to the prior requirement that a single physician supervise a PA. The ratio of one physician for every four PAs remains the same.[2]
2. The PAs' medical records no longer require review by a supervising physician.
3. The supervising physician(s) must be available by telephone or other electronic means and no longer needs to be physically available.
4. The supervision agreement for PA's will be changed from a delegation of services agreement (DSA) to a "practice agreement." Multiple physicians or an agent for the staff of the physicians or healthcare system can sign the practice agreement. DSAs in effect prior to January 1, 2020 will remain in effect.

It is hard to predict how some of these changes will affect risk, claims, and liability in 2020 and beyond. For example, in the event of a claim, it is likely that plaintiff attorneys will argue that each of the signatories to the practice agreement (physicians or/and healthcare systems) are vicariously liable for the acts and omissions of the PA. Therefore, it is never too early to start the discussion, so here are a few thoughts to help you anticipate issues and put risk reduction processes and methods in advance.

The shift from single-physician supervision to multiple-physician supervision is a significant shift with new risk issues. There should still be a specific physician in charge and available at all times. You do not want a lapse because Dr. X thought Dr. Y was supervising the PA. Clear coverage processes and schedules are one way to prevent lapses.

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The change from "physically available" to available by phone or electronic means, in conjunction with the elimination of the requirement for record review, creates additional risks. PAs still require supervision. In fact, a strong argument can be made that the relaxing of forms of supervision implies that other robust and specific processes, policies, and procedures, and guidelines for PAs would be indicated to prevent a decline in the quality of supervision. Moreover, the elimination of requirements for chart review and physical availability does not mean that they cannot be included in the practice agreement.

We are in a time of rapid healthcare evolution and change. It will be interesting to see how AB 697 will affect the delivery of healthcare and the risk management changes that will come with. If you have any risk issues that arise related to PAs or any other issues, you are encouraged to contact the Physician Assistant Board of California, review the SB 697 informational bulletin[3], or consult with an attorney. If you are a CAP member, be sure to call the CAP Risk Management Hotline at 800-252-0555. For more information about PAs, you may review the CAP Advanced Practice Professionals Focused Review.[4]

Questions or comments related to this article should be directed to riskmanagement@CAPphysicians.com.

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[1]Full text of SB 697 with analysis can be found at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB697.

[2]Within a general acute facility, the practice agreement must establish policies and procedures to identify the supervising physician and surgeon.

[3]Department of Consumer Affairs. Physician Assistant Board. SB 697 Information Bulletin at https://pab.ca.gov/forms_pubs/sb697faqs.pdf

[4]CAP's 'Leveraging Data: A Focused Review of Advanced Practice Professionals" can be found at http://www.capphysicians.com/articles/new-data-dive-study-leveraging-data-focused-review-advanced-practice-professionals.

March 2020

Medicare Versus Your Employer Group Plan

Switching to Medicare Can Be Financially Beneficial to You

If you are 65 or older, you face a dilemma your younger coworkers do not, and that is this: *Is your employer-provided health insurance plan really your best possible option?* The honest answer is: *Maybe. It depends.*

To qualify for Medicare coverage, you must be at least 65 years old and a U.S. citizen (or a permanent resident who has lived in the U.S. for the last five years). You must have also paid into, or be married to someone who has paid into, Medicare taxes for 10 years. You may also qualify to enroll in Medicare if you're under age 65 and will be on SSDI (Disability) after the 24-month waiting period.

Breaking Down Medicare (A, B, C, D…etc.)

- **Medicare Part A** – Covers hospital expenses, such as in-patient stays, hospice care, skilled nursing facilities, as well as some at-home health services. Note: It does not cover long-term assisted living care.
- **Medicare Part B** – Covers the medical expenses related to doctor visits, outpatient procedures and tests, along with therapy and assistance from aides or skilled nurses on a part-time basis.
- **Medicare Part C** – Also known as "Medicare Advantage." Combines A, B, and D (drug plans) into a group HMO plan administered by an insurance provider and at a very cost-effective price. (Sometimes at no charge!)
- **Medicare Part D** – Covers medications or prescription drugs.
- **Medicare Supplemental Plans** – These are also known as "Medigap plans" that provide you with supplemental insurance (supplemental to Medicare Parts A, B, and D).

If you are 65 or older and working in an office with 20 or fewer full-time employees, you are required to have both Medicare Part A and Part B. Your employer is the secondary payer in this situation and has no requirement to pay for coverages and services that are covered by Medicare (the primary payer). An employee not enrolled in both Medicare A and B is at risk of being financially responsible for any Medicare coverages, copays, and coinsurance payments. One instance of hospitalization could quickly escalate into thousands of dollars of debt. If you are part of a company with 20 or fewer full-time employees, it is recommended that you sign up for Medicare A and B now to avoid this risk.

Signing up for Medicare A and B is optional for employees who are 65 or older and working for an employer with 21 or more full-time employees. There are a number of reasons why an employee would choose not to enroll now. The most common is that the employee's spouse is younger (under age 65) or the employee still has dependents (under age 26) that are enrolled in a group medical plan. Other considerations would include if the employer offers a Health Reimbursement Account (HRA) or Flexible Spending Account (FSA) plan and the employee wants to continue participating in these plans.

Contrary to what you may have heard, Medicare can actually provide you with more comprehensive coverage and at a lower cost – in some cases a significantly lower cost – than your employer-sponsored group medical plan. Premiums for employer-sponsored group plans have seen a steady trend in increase each year, while coverages have been downgraded to lower cost/reduced coverage plans with higher deductibles and copays.

Medicare-qualified employees have options. When declining the employer group health plan and changing to Medicare, the cost for insurance often becomes much less. For example, Part A and Part B is as low as $144.60 a month, depending on income, and the level of coverage is often increased in the form of lower copays, lower deductibles, and lower out-of-pocket expenses. It is really important for anyone over age 65 or nearing age 65 to look closely at his or her options in order to make the most informed and best decision.

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When it comes to the cost of medical insurance, the level of coverage and quality of care, your best choice might just be Medicare. To learn more, contact CAP's Medicare Licensed Agent Bill Graham at Ashbrook Clevidence for a free consultation. Call Mr. Graham at **800-447-4023**, or email **billg@aclevidence.com**.

Governor Remains Focused on Healthcare in New Budget

by Gabriela Villanueva

The $222 billion state budget for fiscal year 2020-2021 submitted by Gov. Gavin Newsom in January shows a continuing priority on the expansion and accessibility of healthcare. Overall, the 2020 budget proposal mirrors themes and items from the 2019 budget, with signs of the Governor expanding previous priorities.

Here are some highlights that build on items initiated in last year's budget and reappearing in 2020:

Medi-Cal Expansion. The Governor's budget proposes expanding comprehensive Medi-Cal coverage to income-eligible seniors aged 65 and older, regardless of immigration status, beginning no sooner than January 1, 2021. The proposal assumes 27,000 seniors will gain coverage and would include eligibility to both Medi-Cal and In Home Supportive Services programs. This is building on the Governor's 2019 proposal passed by the Legislature to expand coverage to adults up to age 26, also regardless of immigration status.

Reforms Aimed at Improving Healthcare Affordability. The Governor's budget proposes several new reforms aimed at improving affordability of healthcare for Californians. Just as in 2019 with the passage of the individual mandate and additional state-funded subsidies (in addition to federal subsidies) for health insurance (i.e., Covered California), the Governor is extending the scope with two major proposed initiatives in 2020.

• The first is to establish an Office of Healthcare Affordability responsible for increasing price transparency and developing cost containment strategies for the healthcare industry.

• The second is to build on last year's efforts to control drug spending by establishing (1) a uniform statewide schedule of prices at which drugs would have to be sold, and (2) a state contract with drug manufacturers to create California's own brand of generic drugs that would be available for purchase statewide. If passed, it would create a first-in-the-nation proposal to market and sell generic prescription drugs for California residents under a government-run operation.

Increased Tobacco-Related Taxes for Healthcare. In the Governor's 2019 budget, he increased funding from Prop. 56 tobacco tax investments by more than $1 billion. In 2020, Governor Newsom is proposing a tax increase on e-cigarette products. The proposal would increase taxes on vaping cartridges based on nicotine levels, raising current taxes by $2 for each 40 milligrams of nicotine in the product. The California Medical Association would like to see these new dollars directed to healthcare workforce development programs like the physician loan repayment program and graduate medical education funding already established under the Proposition 56 tobacco tax.

Link to California State Budget 2020-2021:

http://www.ebudget.ca.gov/2020-21/pdf/BudgetSummary/FullBudgetSummary.pdf

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Public Policy

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March 2020

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The information in this publication should not be considered legal or medical advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.