The nurse in the upscale senior residential center reported that “Sarah” gets very sedated every night after taking her oxycodone IR 15 mg tablet but never when she takes it the other three times daily. While waiting while the nurse administered the evening dose of oxycodone to “Sarah” it was observed that “Sarah” was taking the oxycodone while drinking her second glass of white wine. She readily admitted that was her nightly practice.

Eighty-three year old “Mrs. Brown” was admitted to the hospital after falling for the fifth time in two weeks. Concerned that her confusion and falls were due to her pain medications, her oxycodone ER was reduced from 60 mg every 12 hours to 40 mg and her oxycodone IR was reduced from 30 mg to 15 mg every 4 hours. Her confusion increased over the next few days. When asked if she ever has a glass or two of wine at night with her pain medicine, “Mrs. Brown” said yes and her husband clarified that “she drinks a whole bottle of wine every night after she takes those pills.”

Alcohol is important in many cultural and social activities, and moderate consumption of red wine in particular has been associated with health benefits. At the same time, inappropriate and excessive alcohol intake is associated with cardiovascular disease, breast cancer and trauma (CDC, 2014; O’Keefe, Bybee & Lavie, 2007). In one review of 32,000 older adults diagnosed with trauma including falls and motor vehicle collisions, one half had recently consumed alcohol and 72% had blood alcohol levels in excess of 80 mg/dL (Zautcke, Cocker, Morris & Stein-Spencer, 2002).

Using alcohol to self-medicate physical, emotional and psychological pain is not unusual. It is estimated that approximately one third of older adults develop alcoholism during older age while the majority grows old with alcoholism (Quinlan-Colwell, 2010). When studying the correlation between alcohol and chronic pain, Brennan, Schulte and Moos (2005) found that older adults with a history of risky behavior with alcohol were more likely to report greater pain, use alcohol to manage pain, and consume more alcohol while doing so.

Older people living with chronic pain may not appreciate the danger of continuing to use alcohol while taking analgesic medications. Although it is important to educate older adults and their caregivers about the perils of alcohol and medications, the majority of health care providers do not discuss alcohol consumption in any way with patients (CDC, 2014). Ageism and a lack of awareness of alcohol misuse as a geriatric problem contribute to inadequate assessment, discussion and education. Creating a safe, private, and non-threatening environment is essential for the assessment of alcohol consumption. Screening tools such as the CAGE or the MAST-G (Michigan Alcoholism Screening Test – Geriatric Version) are simple and easy to use (USHHS, 2014).

When screening results indicate concern, it is recommended that the health care provider assess the type and quantity of alcohol, instances of blackouts, as well as falls and illnesses related to alcohol.

(continued on page 2)
Substance Abuse and Mental Health Services Administration (SAMHSA) recommends the FRAMES approach for immediate intervention:

- Feedback about screening results and the inferences for their health
- Responsibility of the older adult to implement change
- Advise and educate the older adult about the need to change risky alcohol behaviors and the potential consequences of not doing so
- Menu of options such as a “Drinking Agreement”; Alcoholics Anonymous; or local therapists can increase the odds that the person will seek effective treatment
- Empathic counseling style will engage rather than alienate patients who have problematic alcohol consumption
- Self-efficacy enhancement is important when engaging the older person and as the person progresses with safer alcohol consumption or abstinence (US DHHS, 2001).

Regardless of the setting (outpatient, hospital, extended living, etc.), it is important that all health care providers (HCPs) know that older adults can and do abuse alcohol and the abuse may be in conjunction with taking pain medications. The first step in the process of recovery is to identify that there is risky or abusive behavior. Universally asking all older adults about their alcohol consumption increases the likelihood of identifying those who need intervention. It also becomes a standard practice with which HCPs become more comfortable.

REFERENCES


A recent Op Ed appeared in the New York Times highlighting the opioid epidemic: “Pain Killer Abuses and Ignorance (3/2/2015),” describing the contentious landscape that healthcare providers who treat pain (particularly those who prescribe) are in these days, as well as patients who experience pain and want relief.

The New York Times Op Ed outlined the seemingly controversial practice of prescribing opioids, in the face of a rising opioid-related death toll, and the lack of “solid evidence that opioids are effective in relieving long term chronic pain.” The article cited two much publicized reports. One was a large research study (2/17/15, Annals of Internal Medicine) which reviewed the use of chronic opioid therapy (defined > 3 months), as lacking efficacy in relieving pain, and the multiple “dangers” of adverse side effects of opioids (OD, fracture, heart attacks, endocrine effects, sexual dysfunction). The other report cited was the highly publicized National Center for Health Statistics (NCHS) report released earlier this year on the patterns of use of opiates, and mortality rates from opioid overdoses, beginning in 1988.

NCHS data revealed usage of opioids doubled from 1988 to 1994 and in 2011 to 2012. From 1999 to 2013 opioid related deaths actually quadrupled. With opioid overdose / death rates at all time high, everyone from patients to policy makers (including President Obama, who has recently dedicated $100 million in new investments to prevent opioid related deaths) are paying attention to opioid prescribing and asking for answers.

A recent Washington Post article on “The Legal Drug Epidemic” (3/11/2015), started out with the bold question: “When is this country going to wake up –really wake up—to the catastrophe that prescription opioid painkillers have caused since they came into widespread use in the early 1990s?” Charles Lane, author, cited recent 2013 data that opioids “killed” (via overdose) 16,235 people”. He compared that death toll to deaths from traffic accidents in 2013 (which totaled less than 8,000) and to victims of murder in 2013 (approximately 14,000). The total death toll from prescription opioid overdoses from 1999 to 2013 was 175,000 “three times the US body count in the Vietnam War”. This metaphor seems to imply that opioid prescribers are “killing our own people” [my words] in a similar fashion to the way we fought a War and lost troops in the early 1970s. The author takes a strong tone of consternation, stating that “The epidemic was brought to you….by the American establishment—corporate, governmental, and medical—which blessed the wider use of modern opioids in the belief that pain was vastly undertreated, and that new formulations would not be addictive”.

The blame for the Opioid Epidemic has become a hotly contested topic, and there is no shortage of culprits to be found. Pharmaceutical companies are blamed for their economic investment. Prescribers are blamed for lack of education, lack of boundaries, lack of time, biases, and for wanting to avoid “bad reviews” on patient surveys and in social media (see Anna Lembke’s famous article in NEJM “Why Doctors Prescribe Opioids to Known Opioid Abusers”, 10/15/2012). Patients are blamed for their drug lust and pill popping natures, desire to be “cured” and the American cultural value of not tolerating being ‘uncomfortable’.

Regulatory agencies such as the FDA are blamed for being too lax, and being influenced by pro-Pharma lobbyists. The DEA is blamed for being not proactive enough on “pushers”, or known high prescribers with unethical practices. Prescription Monitoring Records are not easily accessed by all providers (currently only physicians and pharmacists can access) and are blamed for being inaccurate, out of date, time intensive, and not corroborated across state lines.

In my perspective the opioid epidemic is a system based problem born out of many interests and intentions, and as such, it will take system level change to address it.

There is no question that most widely abused analgesics today are opioids, such as morphine, oxycodone or hydrocodone. They work by activating mu-opioid receptors on the surface of cells in the brain, spinal cord and other organs, which are responsible for modulating pain perception. Activating these receptors triggers a release of dopamine in the brain, which can cause euphoric effects in many people. In the early 2000s to recently, addicts began to favor use of prescription opioids over illicit / “street” drugs because they were easily obtained and less expensive than some illicit drugs. In addition, opioids became a drug of experimentation and initiation into drug culture for many young people.
Addicts can and will abuse anything. An even more serious problem arose when the utility of opioids for chronic pain patients was questioned, accidental deaths rose, and the dosing for non-cancer pain became more excessive. There is no question that opioids have been overprescribed. And while it is true that the data to support long term opioid use in chronic pain patients is lacking, critics of this viewpoint argue that such studies have not been performed because they would be difficult to conduct, very expensive to fund, and take numerous years to objectively conclude findings that are needed now...(or really, yesterday). Critics also question whether the lack of data (“insufficient evidence”) supports interpretation that opioids are completely non-viable for the treatment of pain, and therefore grounds for the termination of opioid therapy and tapering of opioids over 3 to 6 months.

While the politics of the Opioid Epidemic are hashed out, however, it is the patients who suffer. Despite all the rhetoric, public outcry and blame, the main issue that is missed entirely is that we need solutions for the 100 million Americans that continue to have pain irrespective of the Opioid Epidemic. One thing that opioids never did was “cure” pain. In the best case scenario with opiates, pain was masked or put in control. But the multitude of other variables that are affected by pain or injury [muscle weakness and deconditioning, weight gain, loss of sleep, loss of sexual activity, inability to pace, work restrictions or loss, reduced enjoyment, feelings of embarrassment, low self worth, loss of meaning/purpose, loss of hope] all remain obstacles to recovery, even in the presence of a “good” medication (and perhaps more so in the presence of medication that is not working, or when side effects outweigh benefit). Medication never was a full solution for treating pain.

Chronic pain is a biopsychosocial phenomenon that requires treating the whole person. The Opioid Epidemic offers a real opportunity to revisit our ways of treating pain and a new motivation for attempting non-medication based treatments for chronic pain, many of which have far fewer side effects than opioid therapy. There are many methods of treating chronic pain, including other drug classes, supplementation, and non-pharmacological modes of treatment such as exercise, self management, physical therapy, cognitive behavioral therapy, meditation/mindfulness, acupuncture, laser treatment, electrical stimulation, to name a few.

Rehabilitation experts have long promoted that effectively treating the whole person with refractory chronic pain includes sleep restoration, physical reconditioning, psychotherapy for pain coping skills, calming of the central nervous system, restoring mood and hopefulness for the future, and teaching patients self management skills for a lifetime. As pain providers, we need to be recommending these evidence based treatments that address the multiple “life problems” that patients with pain suffer, and by doing so, allow them to have a better quality of life.

I have seen many people hurt by long term opioid treatment, but I have also seen a subset of people helped by it. The answer to the Opioid Epidemic is not to leave people without any treatment whatsoever. The answer is to impose smart regulations that are informed and to return to the basics of rehabilitation by including multiple avenues for pain relief at the earliest point in an injury or illness. This would entail system level change, with appropriate education of prescribers, understanding non-medication based treatments along with medication-based treatments, and rational reimbursement of chronic pain treatments that don’t simply focus on medication. Thankfully, some insurers are recognizing these trends and reimbursement for non-opioid based treatments in pain is improving in some sectors.

At our Annual Meeting in Orlando, Sept 25th—27th, our nationally recognized team of pain treatment experts will be discussing treating the “Whole Person” with pain. Novel and established non-opioid treatments for pain will be discussed in detail. This will be one of the most comprehensive discussions in any setting this year. The newest regulations and recommendations for opioid treatment in chronic non-cancer pain will also be shared.

Don’t miss it! See you in Orlando!
Help us plan our 2016 annual meeting in New Orleans!

The 2016 Meeting Planning Committee needs you! Participate in planning the speaker agenda, poster session, and other aspects of the annual meeting. This committee does require a commitment to short monthly calls. Our next meeting will be held in New Orleans, so we’re especially eager for volunteers who work in or are familiar with the area. Email info@southernpainsociety.org if you’re interested in being an integral part of our next meeting.

Recent Article Round-Up

by Mordecai Potash, MD

Bring my name up to anyone who has spent any time on the Southern Pain Society board recently or anyone associated with the LSU Pain Medicine Fellowship Program and they will tell you; “Mordi finds the most interesting articles on pain management… and he never ever hesitates to share them!” So, when time came to contribute to this issue of SPS News, several folks that I have repeatedly e-mailed suggested that I pick some of the most interesting readings from this pain management smorgasbord and present these to SPS readers.

One article that really caught my eye was a news feature and editorial published in the February issue of Nature – arguably the world’s leading journal of the natural sciences. Physicians may dream of publishing a paper in the New England Journal of Medicine, but real life scientists know that Nature is where the action - and prestige - lies!

Sara Reardon wrote a news feature; “Neuroscience in court: The painful truth” that describes past attempts and emerging technologies to image pain as a tool for validating legitimate pain and weeding out malingering for secondary gain [1]. As an accompanying editorial describes, having a scientifically valid ‘pain-o-meter’ would revolutionize the fields of pain management and research, as well as the practice of disability evaluations and injury law. [2]

Ms. Reardon describes attempts by Millennium Magnetic Technologies (MMT) to use functional magnetic resonance imaging (fMRI) as a way of demonstrating whether a person is actually experiencing pain. MMT boasts that since 2013 they have had ten or so ‘customers’ (all plaintiffs in lawsuits) and that their scan results helped these plaintiffs reach a settlement. However, researchers in this area caution that the imaging of pain – especially chronic pain – is still in its infancy and an emerging (and very unsettled) area of scientific inquiry.

Tor Wagner, a neuroscientist at the University of Colorado has conducted an fMRI study examining the brains of subjects exposed to either warm or hot objects. fMRI results can usually demonstrate whether or not the subject is touching an object that is painfully hot versus just warm. But Dr. Wagner points out that this is an acute pain phenomenon and there is still a 10% error rate at that.

As far as chronic pain, Dr. Vania Apkarian at Northwestern University has studied dozens of individuals soon after a back injury and then a year later to see if he could visualize the subtle ‘signature’ of this chronic pain in the brain using fMRI techniques. Dr. Apkarian readily admits that the changes visualized by fMRI are inconsistent and that these changes may be due to anxiety and/or depression secondary to pain (or other causes) as oppose to the physical manifestation of chronic pain itself.

With billions of dollars potentially at stake, other companies are also jumping into the fray with their own proprietary testing. Chronic Pain Diagnostics is developing its own test, using a subject’s response to noxious stimuli compared to controls. However, the data that this technique is reliable comes from a single study conducted by the company itself – which has a financial stake in seeing positive results! The feature concludes with legal case presentations where these pain imaging techniques have been used to help litigants reach a settlement, suggesting that it will continue to be used in medico-legal cases even before conclusive data is presented at reputable scientific outlets.

In late January, Professor Rebecca Haffajee and her colleagues at Harvard Medical School published interesting views on the mandatory use of prescription drug monitoring programs (PDMPs) in the Journal of the American Medical Association [3]. Unless you are the Rip Van Winkle of pain management, you know that PDMPs are state-run databases that store information on controlled substance prescriptions for query by clinicians and, sometimes, by law enforcement. You also know that a growing number of states and healthcare professional organizations are recommending that clinicians consider checking PDMPs during treatment using controlled substances.

Professor Haffajee reiterates that 49 of 50 states have PDMPs (sorry, Missouri!) and 22 of these 49 states mandate that prescribers check their state’s PDMPs before writing for controlled substances [author note - In order to not totally take a cheap shot at Missouri, I want to point out that Missouri legislators, health professionals, and patient advocates are waging a growing campaign to bring a
PDMP to the Show Me State as documented at http://mopdmpnow.org/.

Professor Haffajee’s group remarks that there are obvious reasons for clinicians to choose to check a patient’s PDMP report, such as the presence of aberrant behaviors prior to or during treatment, but the clinical studies supporting mandatory checking of patients’ PDMP reports is scant and inconclusive. Thus far, studies best document a decline in “doctor shopping” after PDMPs are implemented. But, it is unclear if mandatory queries of PDMPs lead to a real difference in doctor shopping versus clinician-initiated voluntary queries. It is even less clear that a reduction in “doctor shopping” leads to a reduction in opiate overdoses.

Professor Haffajee and her colleagues express no doubt that the emergence of PDMPs is an important tool for clinicians to consider regularly utilizing when their practice employs medications with the known potential for overdoses or drug diversion. What is in doubt is if mandatory checking of patients’ PDMP records is the best use of that tool or rather use a series of incentives to encourage their use such as discounts for malpractice insurance or limited liability from lawsuits if PDMP reports are diligently obtained and utilized in patient care.

Tying into this article on PDMPs was a recent article [4] and an editorial [5] in Pain Medicine, the journal of the American Academy of Pain Medicine. Dr. Suzanne Nielsen and her colleagues in Australia and the United States examined a group of 1,220 chronic non-cancer pain patients taking long-term opioids (LTO) daily and further divided these patients into four groups based on their use of benzodiazepine (BZP); #1 – daily users of BZPs (along with their LTOs), #2 – use of BZPs within the last month but not daily, #3 – Had used BZPs while taking LTOs but not in the last month, #4 – Patients who had never used BZPs while taking LTOs.

The use of BZPs was associated with a startling number of patient characteristics. Patients who had used BZPs in the past month (daily or less often) had greater reports of pain severity & its interference with activities, were more likely to be prescribed more than 200mg of morphine or its equivalence daily for pain control, were more depressed and despondent, and engaged in more substance use compared to patients whose last BZP was more than a month ago (or never). Most alarming was that BZP in the past month was highly associated with an increased risk of emergency health care services (ambulance transport, emergency room presentation). Dr. Nielsen and her colleagues conclude that daily BZP use, along with daily LTO use, is not consistent with safe opioid prescribing – or at least not in the group of over 1,200 patients they studied.

An accompanying editorial from Dr. Martin Cheatle and Dr. Rachel Shmuts at the University of Pennsylvania’s Department of Psychiatry discusses these findings. As they point out, it is difficult to tell if patients who have more depression, anxiety, impulsivity, or other risk factors are more likely to be prescribed BZPs…or does the daily use of BZPs (especially when combined with LTOs) lead to more emotional distress and disturbance in behaviors. Put more simplistically, are the BZPs the chicken or the egg… and which came first anyways?

Dr. Cheatle and Dr. Shmuts also point out that a recent review of opioid prescribing guidelines found a range of different recommendations regarding the use of BZPs co-prescribed with LTOs. Guidelines ranged in their advice from not recommending BZP use at all if LTOs are employed, to making sure that prescribers discuss with patients the elevated risk...
risk in using these two types of medications together, to simply watching for adverse effects or drug-drug interactions when these two classes of medications are used together.

Dr. Cheatle and Dr. Shmuts also remind readers that there are several psychiatric conditions where benzodiazepine use can be an essential component of symptom management – if not as a long-term treatment than at least as a “bridge” treatment while other psychotropic medications are given time to be adjusted and take effect. They remind readers that innumerable studies have also found a higher prevalence of these psychiatric conditions in patients suffering from chronic pain compared with controls.

I find a synergy in the conclusions from these articles and – as I have done with other articles – will use their conclusion to inform my own approach to pain management. The articles in Nature document that we are far away from having a ‘pain-o-meter’ that we can reliably use as a short cut to taking a good history and performing a sound clinical exam. The JAMA article points out that PDMPs are here to stay and have an important role in patient safety but the jury is still out on whether they should be used in every case where opioid-containing medications are prescribed or are instead better reserved for patients with specific elevated risk factors. The articles in Pain Medicine strongly suggest that the use of benzodiazepine in chronic pain patients is one of those risk factors – but it is unclear if it a cause of aberrant behaviors in chronic pain or rather more frequently employed in patients who display aberrant behaviors while suffering with chronic pain.

Either way, it would be sound to faithfully employ clinical risk reduction techniques such as PDMPs (as well as urine drug screening and good coordination of care between specialists) in patients that are using benzodiazepines along with opioid containing pain medications.

References


March Brought Stormy Weather to Alabama in the Form of Blue Cross Blue Shield Draft Policy 566 by Leanne Cianfrini, PhD

At last year’s SPS meeting, I reviewed Medicare recommendations for documentation of medical necessity regarding Urine Drug Testing (UDT) orders. Practitioners were also encouraged to review any complicated relationships with their laboratories and to reclaim control over the choice of testing panel for individual patients. At my own back door in Alabama, however, an unexpected storm was brewing. In February 2015, Blue Cross Blue Shield of Alabama (BCBS-AL) published a draft proposal (Policy Draft 566, "Urine Drug Testing in Pain Management") that would have effectively stopped coverage for confirmatory, quantitative urine drug testing. BCBS-AL traditionally holds well over 80% of the insurance market share in the state, so this policy could have negatively affected a large amount of legitimate chronic pain patients, impacted accuracy of provider oversight of compliance monitoring for substance abuse and diversion, and indirectly endangered community safety.

The Draft 566 language included a nod to risk assessment and stratification, summarized guidelines on drug testing frequency from ASIPP, APS/AAPM, VA/DoD, etc., and acknowledged that immunoassay (IA) tests can fail to recognize similarly structured drugs within the same class. Although the policy correctly noted that “opinions vary on the optimal frequency of urine drug screening,” it seems as though BCBS-AL used the ambiguity to justify moving quantitative testing to ‘investigational’ status. So, the draft policy indicated that coverage would be offered for one baseline IA urine drug screen prior to initiating chronic pain therapy using a controlled substance. Also, qualitative (again, IA only) tests could be considered medically necessary for monitoring up to three times per year. The part that most concerned providers across Alabama and neighboring states was that, effective for dates of service on or after March 16, 2015: Quantitative urine or blood drug testing does not meet BCBS-AL’s medical criteria for coverage and is considered investigational.

Now, to be fair, it has been obvious for awhile that some independent labs and physician-owned laboratories have used/abused the insurance reimbursement system

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extensively and, frankly, this was a lucrative venture for those entities. This was done by several legitimate means of coding and billing, but also by exploiting loopholes. Some labs pushed 'comprehensive,' extensive (and expensive!) testing panels for all patients instead of instructing providers to choose individualized confirmatory analyses based on IA results. Some physicians with a financial stake required patients to be tested at every visit, even monthly, regardless of their risk level and compliance history. Charges were allowed for each single-drug analysis as well as for specimen validity testing. Cost-cutting measures from the insurance reimbursement standpoint were inevitable to curb this rampant abuse – and it seemed like the new 2015 CPT coding structure for quantitative drug testing would effectively put limits on such charges.

So, this Alabama draft policy spurred an uproar in our local medical community. An online petition secured over 750 comments and signatures from providers and patients in Alabama, Florida, Georgia, and Tennessee. A letter was submitted by the Director of Policy and Advocacy of the Center for Lawful Access and Abuse Deterrence (CLAAD). Comments were submitted directly to BCBS, legislators, and the Medical Association of the State of Alabama (MASA).

Most of the commentary reinforced the need for confirmatory testing to get past the rates of false positives and false negatives with point-of-care (POC) IA screening. Providers pointed out the benefit of testing for metabolites to determine that the parent drug was taken and processed by the patient rather than delivering scrapings of the pill into the urine. Clinicians noted that POC testing alone cannot detect the alcohol metabolites EtG and EtS that are present up to 80 hours after drinking alcohol. Patients themselves wrote in to note the importance of accurate testing to allow them continued access to their effective pain management plans. Patients were concerned about being discharged based on inaccurate screens. Obviously, physicians would still be free to order quantitative testing for confirmation of IA results. However, the cost would now be passed on to patients, making appropriate controlled substance treatment for their chronic pain conditions even more expensive. If physicians did decide to limit their monitoring programs to qualitative screens only, it could open up issues of increased/undetected diversion, false positives or negatives leading to unfair reprimands and changes to effective treatment regimens, and undetected substance abuse. The consensus among providers seemed to be that IA screening is a ‘conversation starter’ at best, but that confirmatory testing provides more accurate, reliable information that is medically necessary to achieve the standard of care in the field of pain management.

MASA also did not agree with the proposed policy change, as it ran “counter to the standard of care and could increase physicians’ exposure to liability” (MASAlink newsletter, March 6, 2015). Indeed, Draft 566 went against Alabama medical board guidelines for the prescribing of controlled substances. Members of the MASA Board of Censors met with BCBS-AL representatives. After these discussions, BCBS representatives indicated they would take another look at the policy. So, as it stands now, BCBS-AL will start evaluating the use of quantitative testing over the next several months to determine patterns of abuse in the number of tests submitted for reimbursement. The revised policy now up for review and consideration changed the wording regarding quantitative/confirmatory UDT, stating that it meets medical criteria for coverage for up to 3 confirmatory tests per qualitative UDS when specifically requested by the treating physician and the test results are necessary for treatment planning under the following conditions:

- The result of the qualitative drug screen is positive
- The result of the qualitative drug screen is negative
- and the negative finding is unexpected or inconsistent with the patient’s current medication pro-

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UDT would still be non-covered for:

- Routine qualitative urine drug testing (e.g., testing at every visit, without consideration for specific patient risk factors, current clinical presentation, current medication program or how the test findings will impact treatment options).
- Quantitative UDT without qualitative UDT
- The use of comprehensive confirmatory panels.

So, it is more important than ever to document your orders for both qualitative/IA screening and quantitative confirmatory testing. Don’t choose a comprehensive panel on each and every patient, and acknowledge that most patients (especially those at a low risk level as determined by psychological evaluation and/or risk screening tools like the ORT or SOAPP-R) do not need to be tested at every visit. Documentation should also be provided regarding the test results – they should not just be entered in the chart without review or commentary. Providers should show clinical utility of the tests ordered, including a review of metabolites vs. parent drug. The way the policy reads now sounds as though the provider is required to provide clinical justification line-by-line for each individual substance to be tested. This will certainly be a time burden, but it looks as though this is the way the winds are blowing, even on a national level. For now, we’re glad that Alabama’s largest insurance provider is respecting their own tagline and “covering what matters” for patients who are trying to cope with the chronic illness of pain.

Sneak preview of our fantastic meeting hotel in Orlando (Sept 25-27th):
The Omni Orlando Resort at Championsgate.

A group rate will be available and will be included in our meeting brochure coming in May.

Photos courtesy of:  http://www.omnihotels.com/hotels/orlando-championsgate