MISSISSIPPI ACADEMY OF FAMILY PHYSICIANS
755 Avignon Drive
Ridgeland, MS 39157
601-853-3302 (P)
601-853-3002 (F)
www.msafp.org

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Charles Miles, MD, President
Mississippi State Board of Medical Licensure
1867 Crane Ridge Drive Suite 200-B
Jackson, MS 39216

Dear Ms State Board of Medical Licensure:

While positive steps were made in addressing concerns with the original opioid regulations, there is still work to be done to protect Mississippians with legitimate chronic pain. We hereby request an oral proceeding on this issue.

We appreciate the chance to fully explain our reservations about the proposed changes to Regulation 2640: Prescribing, Administering and Dispensing. As primary care physicians, we are on the front lines of this issue unlike any other medical specialty. Instead of hand-cuffing doctors to a one-size-fits-all practice, let's engage in further discussion and physician education to turn the tide on opioid addiction. It will be more beneficial to Mississippians to protect not only the addicts but also the legitimate chronic-pain patients with whom physicians across Mississippi have worked for years to stabilize on a low dose regimen.

Please do not punish the vast majority of physicians and patients who are acting appropriately. On behalf of family physicians, our requests are listed below.

1. Rule 1.2(K) changes the threshold for a designated Pain Management Practice from 50% of patients receiving pain medication to 30% of patients. This will place a new burden on existing practices falling within the 25 to 50 percent range, who must choose between immediately rushing to obtain Pain Management Practice certification or turning away long-time patients and sending them to Pain Management Practice clinics, which are well-known to have patient wait times of up to a year. It is unncessary. **We ask that the board compromise and change this percentage to 40%.**

2. Rule 1.7(H) restricts opioid prescriptions for acute pain to a 10-day supply. This is a one-size-fits-all regulation when you consider physicians know their patients' history of treatment and other risk factors. **We ask that the board add language that a longer prescription be allowed to treat a patient's acute pain when needed in the professional medical judgment of the licensee and the following conditions are met: (a) the duration of pain is expected to exceed 7 days, (b) the condition is documented in the patient's medical record, and (c) the licensee documents that**

no alternative to a Schedule II opioid was appropriate or sufficient to abate the acute pain associated with that condition.

3. In Rule 1.7(J), concurrent opioid and Benzodiazepine prescriptions are not permitted in the proposed regulations, and the regulation references 1.7(H) which specifically limits the amounts physicians are permitted to prescribe. These medications can be prescribed concurrently when physicians are given the ability to use their professional judgement in making decisions for the patient . **In Rule 1.7(J), we ask that the board remove the reference to regulation 1.7(H).**

4. Rule 1.7(M) prohibits physicians from prescribing Methadone outside of a Pain Management Practice. Physicians, even those outside of a Pain Management Practice, have been trained to adequately use Methodone to treat addiction. **We ask that this proposal be removed.**

5. Rule 1.7(L) lays out new requirements for point-of-service drug testing. Further clarification is needed on what physicians are expected to do with the urinalysis results. The CDC recommends utilizing a drug screen to open a dialogue and strengthen the physician-patient relationship. This proposed rule implies that if drugs are found in the urinalysis, the physician must terminate the relationship with the patient, since further treatment (or at least prescribing) is no longer allowed. **We ask that new language be added to this rule specifying what physicians do upon finding a patient is using a drug outside of what the physician has prescribed.**

6. Patients in the primary care world are already underserved, and many of them are on fixed incomes or Medicaid. Rule 1.7(L) requires that they pay for point-of-service drug testing at each encounter with the physician. Our concern is that this will be cost-prohibitive to many non-affluent patients, and we will essentially be asking them to choose between paying for food or paying for a drug test. **We ask that the point-of-service drug testing be reconsidered.**

7. It is difficult to get patients who are stable on a pain regimen for a number of years comfortable on another medication. **We ask that these regulations apply to patients beginning on a Schedule II medication in 2018.**

Most physicians are doing the right thing to take care of patients and balancing the necessity of helping their patients who experienced chronic pain with the risks of substance abuse and addiction. We urge you not to punish the physicians and patients who are acting appropriately. Together and with slight modifiicaton we can address the problem and find workable solutions.

Sincerely,

Katherine T. Patterson, MD, FAAFP
President