Episode 29 – Licensee Duty to Report Controlled Substance Prescribing Misconduct

Intro music: 0:00

Podcast introduction: 0:09
Blowing the whistle on a colleague isn't a comfortable thing to do. But if you are a licensee of the North Carolina Medical Board and you know, a physician or PA, who is up to no good with their opioid prescribing, you don't really have a choice. A 2019 state law requires that you report prescribing misconduct. Hello, and thank you for joining me. I'm Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this as MedBoard Matters. On this episode, we present the final installment of our two-part series on North Carolina's duty to report statute. In part one, we discussed the requirement for physicians and PAs to report sexual misconduct by another licensee to the medical board. Now we're tackling the second piece of that law, which requires the reporting of any fraudulent prescribing, drug diversion or theft of controlled substances. The why behind this part of the law is probably obvious, but just for the record, the opioid overdose epidemic is unfortunately still going strong. And while a large majority of overdose deaths are known to be caused by drugs obtained from someone other than a licensed prescriber, we also know that many people initially develop opioid use problems when taking prescribed opioids medications. So, our state is especially interested in stamping out any hint of illicit or inappropriate prescribing, which led the General Assembly to establish this reporting requirement. To help our licensees understand their obligations under the law, I've asked NCMB's Director of Investigations, Pat Berckmiller to explain exactly what is required by the duty to report statute.

Interview with Pat Berkmiller: 1:52
JFB: Will, Pat, thank you so much for joining me once again on MedBoard Matters.

PB: Glad to be here.

JFB: If we could start just by defining, what do we mean when we say prescribing misconduct? What does that encompass?

PB: Well, thanks, Jean. Under that second duty to report, it's under 90-5, all of our licensees have a duty to report to the medical board, actually in writing, within 30 days of just having knowledge that there is an incident that they reasonably believe that occurs involving fraudulent prescribing. And fraudulent prescribing is essentially any type of misuse of prescribing authority, drug diversion or actual theft of a controlled substance by another person who is actually another licensee of our Board. And that is all encompassing when we talk about things like drug diversion that is defined as transferring those controlled substances or a prescription of a controlled substance for a number of reasons, and a lot of those reasons are outlined. One of them is for personal use, meaning that the licensee is using it for him or herself. Another reason would be for diverting it to an immediate family member. And in the Medical Practice Act, they define that immediate family member as a spouse, a parent, a child, sibling or someone in that stepfamily or an in-law. It could also be to any other person that lives with that licensee. So, a roommate, any type of financial bond to a relationship where they're providing housing to another person. And then it could also be to an individual with whom the licensee is having some type of intimate relationship with. And then lastly, it's kind of we call the catchall where there is an

individual that there's just no legitimate medical purpose to be receiving that particular prescription, and that would be a diversion category as well.

JFB: Okay. That sure sounds like a very comprehensive definition. And it also sounds like there's probably some overlap between fraudulent prescribing and drug diversion, because if you're prescribing a medication for the sole purpose of transferring it to another person, that's not legitimate prescribing either, right?

PB: That's correct. In fact, if we look back at just in general without talking about this duty to report, we have prescribing to family members. And last year, we had a number of cases, over two dozen, involving prescribing to family members. And that is covered, obviously, in a…in a position statement that the Board has as issued as well. So, there is overlap.

JFB: I'm glad you mentioned that. I think that's an important thing for our licensees to be reminded of, is that North Carolina does have a position statement that basically says that outside of minor acute illnesses and emergencies, you really should not be prescribing to immediate family members. And actually, it was already specifically prohibited by rule to prescribe controlled substances to any immediate family member. So, this new requirement goes further and says not only should you not do it, if you're aware of somebody else prescribing in an illegitimate way, it is your obligation to report that to the medical board so it can be investigated. I'm thinking, you know, some of our licensees are probably a little bit tired of hearing about the opioid overdose crisis, quite frankly. And frequently when talking with licensees or participating in professional outreach, one of the comments that I hear pretty regularly is why are we still talking about fraudulent prescribing? If you look at overdose death numbers, the vast, vast majority are people who are using street drugs. They're not obtaining medications from a prescriber necessarily; they're obtaining them from a drug dealer. What's our answer to that? Why are we still talking about fraudulent prescribing?

PB: Well, it's a great question. I don't know why we're still talking about it, but it still does occur. We have some examples I could give you that we have seen are, for example, the theft of samples where there is easy access to having something that is not part of a prescription where those medications are being diverted. We also see things like skimming. So we have some fraudulent prescribing that is obviously going on there where it's coming off of someone else's prescription. We also have seen purchase back schemes where a legitimate patient receives a prescription, but receives a prescription in the either a higher amount than what is necessary in that prescribing setting. And then the licensee is known to purchase back or provide some service to obtain some of those meds back to the actual licensee for them for that diversion. So again, those are some other examples of that fraudulent prescribing. And again, they…they still come to our attention.

JFB: As far as the practical side of how does somebody make a report, let's just talk a little bit about that. If somebody is aware of a colleague who is engaged in some sort of suspicious prescribing, how would they let the Board know?

PB: The easiest way for the duty to report to occur from another licensee, is on our professional's health care reporting form and that's right on our website. It's a very easy link to get to. And keep in mind that when there is any type of hesitation of whether a licensee should report on another licensee, keep in

mind that all reports that are made in good faith without any type of fraud or…or malice, it's actually immune from any civil liability. And that's important to understand that this is a big enough crisis that is going on. And if we see something, we really need to say something. Now, obviously, if some report is made in bad faith, you know or there is a reason that somebody is doing something for some malicious nature, that can actually constitute unprofessional conduct and it could be grounds for discipline under the Medical Practice Act. So likewise, if they are aware that such conduct is going on and they don't report it, that could also constitute grounds for unprofessional conduct. So, I think it's like anything. Be aware that you can most certainly report something if it is done in good faith. There is really no issue from the medical board then reporting such.

JFB: Right. Can we talk a little bit about the incidence of cases that involve prescribing issues? We do track that. You know, I believe the category that we have is generally prescribing it doesn't necessarily single out controlled substances, but it is something that we've tracked for a number of years. And I'd be curious to know how stable those numbers have been, if they've been rising? Falling flat? What does it look like?

PB: So, our prescribing numbers have essentially been going up, like with a lot of our cases. In 2022, we had 375 prescribing cases. And as you said, we don't break them down into whether they involve controlled substances or not. But one of the things that I can say is that our diversion cases have actually gone down. So, looking at those numbers across the board, the impact we get as a result of the decreasing in certain areas is a direct result of some of these educational outreach programs that we're involved in with visiting PA schools and other areas of education that we put out through our communications. There's additional exposure through other licensing boards because they're basically doing the same thing in getting that word out. So, I think that's something that is definitely helps us in getting these prescribing cases under control, but they are slowly on the rise. So, I will say that prescribing cases are definitely…

JFB: So over prescribing cases, diversion specifically was down.

PB: Yes.

JFB: Um, that's interesting. So, uh, it brings to mind you mentioned the outreach that we're doing. And I certainly like to believe that the work that the Board is doing to educate its licensees and students and prescribers generally is making an impact. But I think everyone knows, or if they don't know they should, that the medical board is not the only agency out there of course, that is paying attention to opioid prescribing. I mean, there are many, many others; insurance companies, DEA, pharmacies, you know, lots of different entities are watching this. And many of them have their own initiatives. And I wondered if you could talk a little bit about that, some of the efforts that you're aware of that are out there to sort of identify prescribing misconduct?

PB: Sure. So, we can get a lot of information that comes in through local pharmacists. They are essentially the eyes and ears of what's going on…on the street. And they have a great impact in spotting issues when they observe prescription data, which raises red flags to them. And that might be through address correlation, that may be through a relative of a licensee that is coming in and something just not quite right with that prescription. How the prescription was filled. Delays in pick up in those types of

things. So, there's definitely a larger presence with our local pharmacists who are filling these, to watch for those red flags. The other thing that I'd like to bring your attention to is the data analytics that is done by the major pharmacies. These large companies have put a lot of money into artificial intelligence within their data mining operations, and they're able to easily code that AI in order to spot trends and anomalies, which requires then further investigation, because they're obviously trying to curb the issues that they see affecting their companies directly. And then lastly, I can touch on insurance companies. So likewise, they're using data analytics without a doubt, in all of their special investigation units or their SUIs. And when they find these cases, they actually can result in termination of credentialing in the carrier's network. And because there's such an increased scrutiny, it can have a high financial impact to a licensee if they're not being able to be carried by a certain insurance carrier within their network. So, all of these things are used as different tools to combat not only the opioid crisis that we're facing, but also with just fraudulent prescribing cases.

JFB: Right. Good. Well, thanks for touching on that. I just wanted to be clear for any licensees listening that we're not putting this on their shoulders solely. Certainly. I mean, this is just kind of closing a loop that they're having previously been a requirement for licensees individually to report this. There are plenty of others that are looking out for it and that do regularly report to the medical board. Another thing that I thought about is it might be useful to listeners to hear some examples of the types of cases that we've seen involving the types of prescribing misconduct that if a licensee became aware of, they would need to report. I can recall in my years with the Board, cases where it was clear that the licensee was not actually engaged in the practice of medicine. Patients would come in and there was a set fee for give me $100 or $150 and I'll write you a prescription for whatever opioid you like. So, we have that on the extreme end, all the way on up to a well-intentioned licensee who maybe starts out really trying to help people, but perhaps doesn't have the education and training to really appropriately identify, diagnose and treat conditions for which opioids would be appropriate. Can you think of any specific cases that have been particularly memorable since you've been with the Board?

PB: There's one that stands out in my mind, and it was a case where we had a sole provider and it was a cash model, and the cash model was that that provider would not take insurance. And so, there was some financial interest that was placed there and a set fee to receive a prescription of a certain size. So, whenever you have something like that, as far as the model is concerned, these are the types of things that are easily detectable and likewise came to our attention as a result of a dissatisfied customer who did not receive what they felt was an appropriate amount of medication for the amount of money that was paid. So that is one example. And I would say that was that's on the extreme side.

JFB: wow! But that's pretty I mean, I don't mean to laugh, but it is sort of comical that yeah, a dissatisfied customer…so somebody who is seeking an illegitimate prescription reported the licensee for failing to give them enough medication.

PB: The quantity that they felt was the…

JFB: Quantity that they wanted for the…

PB: for the dollar amount. Yes.

JFB: Well, you know, thanks very much to that patient for bringing it to the Board's attention. It probably did not have the effect that they wanted. Is there anything else that we haven't talked about that you'd like to discuss related to the prescribing misconduct requirement?

PB: I would say that the North Carolina Medical Board is not against the prescribing of controlled substances. We're really focusing on the safe prescribing of controlled substances. And as we talked about, the Board has a number of position statements that cover these various topics in regards to prescribing. We have the Duty to Report that has been added into the Medical Practice Act and then obviously the Stop Act of 2017 is a major player in this as well to try to just make sure that we have the proper authority that is given and that the patients who need to be prescribed appropriately are being done so.

JFB: You know, I'm really glad that you mentioned that. One of the things that I like to say whenever I'm talking with someone, a member of the public, a licensee about the North Carolina Medical Board's stance on opioid prescribing, I always like to say that the medical board is not anti-opioids, it is pro-appropriate care. And I think that really does sum up where the medical board is. I mean, I think everything that I've ever seen or heard the Board do related to opioids, has always acknowledged that opioids have an appropriate role in medicine. Some people need them, they have their uses, but what's not okay is this illegitimate prescribing or excessive prescribing. So, I think that's important to keep in mind that the Board is not looking to stop all opioid prescribing or get rid of opioids entirely. It's just looking for that safe and responsible prescribing. Thank you so much for talking with me about this. I really appreciate it as always.

PB: Thank you Jean.

Interlude: 15:43
Pretty straightforward stuff, really. If you see something, say something. Now, we could have ended the episode right here, but we know that the prescribing environment for medical professionals is tremendously challenging, even scary. Quite a few prescribers have simply washed their hands of opioids, and the North Carolina Medical Board frequently hears from patients with pain that it is unbelievably difficult to access treatment. And quite frankly, we don't want to do anything to make that worse by stoking prescribers fears about the duty to report statute. So, I have invited NCMB's Chief Medical Officer, Dr. Karen Burke-Haynes, to help with damage control. So, stick with us for more on NCMB's stance on opioid prescribing and on the Board's commitment to helping licensees ensure that they can prescribe opioids in a safe and responsible manner.

Interview with Dr. Burke-Haynes: 16:40
JFB: Dr. Burke Haynes, thank you so much for joining me to talk about this topic.

KBH: Thank you, Jean, for the opportunity.

JFB: Of course. As you know, we spent the first portion of the podcast talking about this new requirement of law that says that if a licensee of the Board is aware of illicit or illegitimate prescribing going on by another licensee, that they do have a legal obligation to report it to NCMB. And we want our licensees certainly to be informed and to understand that requirement under the law. At the same time, I've been doing the work that I do in education and outreach long enough for the Board to have spoken

with many, many patients, many, many prescribers. And I know that licensees who prescribe controlled substances are operating in a very difficult environment. There is a great deal of fear about doing the wrong thing. And in putting this message out to our licensees, quite frankly, I don't want to make that worse. So, I wanted to invite you here to talk with me for our licensees benefit about, you know, what the Medical Board's stance is on controlled substances. And I thought I might begin by asking you, you know, what would you say to a licensee who's listening to this podcast, and they're hearing that now the state of North Carolina wants them to report colleagues who aren't doing the right thing. What would you say to them about controlled substance prescribing?

KBH: You know, Jean, thanks for this opportunity to offer perhaps some clarity and if nothing else, introduce some points of reference for the licensees of North Carolina to consider. First and foremost, nothing changes in some ways with this requirement in the sense that the ethics of our profession drive the concept of accountability and consideration of the good of our patients. And we know that this responsibility begins with a licensee who's empowered with a prescription pad, empowered with the mantle that comes with being clinicians, walking into an exam room and interacting with patients. It's a very powerful dynamic. It is a space that introduces a very intimate kind of collaboration with patients. And so, we must be a space that's honored, a space that is…um, there's value in pausing from time to time to acknowledge the very powerful dynamic that exists in that space and with that responsibility. And so I believe that a component of the relationship that licensees have with each other is that responsibility to be certain that we are all a part of the safety net that keeps the integrity of the practice of medicine whole. Of course, the North Carolina Medical Board is specifically charged with this responsibility, but it doesn't take away the responsibility that individual licensees have, nor our institutions to be a part of that safety net. And let's reframe this then in that stating that the Board is asking simply that, and the legislation puts some emphasis on this to do a thing that licensees really have a responsibility to do as part of our code and ethic of conduct. If there is the potential for harm, there is a need to respond to that. I believe that the legislation gives us then a pathway and a way for licensees to honor that part of the commitment that actually is inherent in the profession.

JFB: So, Dr. Burke-Haynes, I think it's probably worth pausing and acknowledging that when the Board looks at its enforcement work and looks at the cases that do involve substandard or illicit prescribing, specifically, it's a small percentage of the overall care that is being provided to patients with pain. In the state of North Carolina. It's a small number. We see the cases where things go wrong. What we don't see is probably what is the majority of care going on out there, which is not substandard.

KBH: Exactly. So, Jean, you're highlighting the point that the majority of licensees within the state are practicing well within the standard. And our goal here is to continue the efforts to guide those who are perhaps for lack of education, have not been keeping up or a smaller number yet who might be engaging in practicing that are nefarious, to be aware of this population and to be aware of the need to report or share or address these shortcomings that might exist in their practice.

JFB: Well, thank you for that. I just think it's important to put that out on the table. So, I guess, what are the things that concern you and keep you up at night, when you think about the licensees who are out there still prescribing controlled substances to their patients, trying to provide the best care they can for their patients, but they're operating in what we've discussed as a culture of fear. And when I say that

most people probably know what I'm talking about, but still just the level of scrutiny that people who prescribe controlled substances are under. I think probably we could not have imagined that the climate would be such as it is, you know, ten, 20 years ago.

KBH: I absolutely agree with that, Jean. I think it's quite clear that they are managing through moving targets. I think specifically of the CDC Guidelines - 2016 and now the current updated guidelines that are being sorted through for the impact on their implementation. There's regulatory responses statewide. Nationally. There is quite a bit of activity in that space that understandably causes some level of anxiety and even fear, as you've pointed out. I do think, as you've said, that the majority of licensees have managed to work their way through this. They're moving into a new settled place. There's still more work to be done to support that. And to that extent, the Board continues its commitment to sharing information on its websites through educational materials and CME webinars, for the purpose of helping to answer those questions when moments of doubt might arise. Am I doing this the way that is appropriate within my medical community? There are places that you can go to as reference points to help reassure and confirm once practice is within the norm for the state.

JFB: Right. And that is as good an opening as I can imagine for me to talk about the fact that NCMB collaborated with subject matter experts in the state and with CME providers in the state to create new controlled substances, continuing medical education for the benefit of our licensees and others who prescribe controlled substances. And Dr. Burke-Hayne, you, of course, led that project for NCMB. Would you talk about the product that was produced and perhaps some of the specific topics that were included in this round?

KBH: Absolutely. So first, I'd like to acknowledge and give a great thanks to our collaborators at Wake, AHEC and UNC. The goal of this CME two product was to update elements of the control prescribing CMEs that had been previously produced by the Board with a focus on addressing alternatives to opioid prescribing, the matters of weaning and some light touch in managing the patients who present to your practice who may have violated pain agreements. And this, I believe, is a helpful series in addressing some of the challenges that we have seen in our complaints presented here to the Board.

JFB: I think that is great information. I speak from the perspective of someone who talks quite frequently with pain patients and unfortunately what I'm hearing from many of the pain patients who call is that there isn't a lot of tolerance for people who are not fully compliant. You know, I have spoken with many patients indeed, who call and report that they were dismissed from care because they didn't show up for a pill count or because they didn't take their medication exactly as directed. And I think many of our licensees would probably be surprised to hear that the medical board doesn't want them to immediately discharge a patient under those circumstances. Could you talk a little bit more and I know this is some of the content that is touched on in the CME modules, but could you sort of talk through from the clinician’s perspective about, you know, what would be a more constructive way to respond to circumstances like the ones I just mentioned?

KBH: Thank you, Jean. May I start by simply saying and I find in a moment like this, it's so important to have the audience recognize the North Carolina Medical Board does not establish the standard of care for the state of North Carolina. So, might I say that the comments that I'm about to make reflect on the standard within the community? What the Board is actually looking for is engagement, documentation

and an understanding of the plan of action determined by that licensee in dialog with their patient. I'll give you an example. We have a patient who might come in for a routine follow up for chronic pain management. There's a urine drug screen that had been obtained. There is an aberrant, what we call an aberrant urine, and either it can be that something that they should have in their urine is not there a controlled substance or something not prescribed to them is present in the urine. This is oftentimes a scenario that leads to a patient dismissal. May I say that the Board is not looking for a licensee to terminate that relationship. I think what would be absolutely acceptable, the spectrum could be from the licensee who decides that they want to not absorb that risk, could terminate. Yes, the Board won't act against that. But the Board is also embracing a licensee who might approach that situation with curiosity. I see that you have this abnormality in your urine. Let's sit down and talk about what the significance of this and how we can move forward. And I think that that is as much a reasonable response as clinician who might decide they no longer want to continue that relationship.

JFB: Yeah, I think that is so helpful. You know, I should say if licensees would just believe that I think that it would make patients' lives a lot easier based on the calls we get again. So, thank you for touching on that. Do the recent CME modules also talk about what to do if you genuinely suspect that your patient has crossed that threshold and doesn't actually need the medications for pain, but maybe they're developing substance use disorder?

KBH: So, some percentage of patients who are on long term opioids or someone who might be introduced into your practice might have actually a substance use disorder. We recognize that. And it is important for licensees to be thinking about this in the course of their conversations with their patients and in managing their care. Examples. Two pathways. A substance use disorder does not always mean an addiction, and it's important for licensees to continue their own path of education around the difference in someone who might be dependent on a medication and someone who's addicted. Addicted typically infers behavioral changes and lifestyle changes and changes in the executive functions of the brain that causes a highly disrupted lifestyle. And a substance use dependance is typically manifested as someone who is quite functional in their story, but there is a physiologic need for medication that sometimes is threatened when your patient hears they are going to be tapered rapidly or have their medications discontinued. So, the need to have a deeper understanding of these different diagnoses, then their implications and resources within the community that you might be able to access to support ongoing care, is an excellent strategy for continuing your relationships with patients as you're defining who they are and how they are responding to medication management. The impact from a regulatory perspective, it's the licensee's choice around how much they might choose to manage a patient who falls into either of those categories. We're not compelling licensee to manage addicted patients, but it would be a reasonable consideration to seek support within the community. The Board would view that favorably and has no prohibitions to licensees either continuing care in partnership or transferring that care.

JFB: Absolutely. I think that's a really important point, and I know our clinical partner actually on the CME project was the Addiction Medicine Fellowship program at UNC-Chapel Hill. I happen to know that they are building a sort of a hub and spoke approach to support people in communities who are managing patients with substance use disorder. So that may well be a resource is that, you know, you do have the option to manage somebody in your own practice with support from specialists who are

experts in addiction medicine, or you may have the opportunity to refer. But I think the message again that I'd like to underscore, which you have done beautifully, is the Board's expectation is not that you excise patients who are not compliant or patients who appear to be addicted or misusing controlled substances. You do have that option to intervene and refer to treatment. I feel strongly that that is one of the best ways that clinicians and the community can help address the opioid overdose crisis is by helping to shepherd people into treatment to the greatest extent possible.

KBH: I absolutely agree with that. And again, I cannot reinforce enough how important it is. I think it reinforces the idea that the Board is not interested in driving a clinicians' response in their exam room. We are simply concerned that good practice is being employed and documentation of your decision as a clinician in compliance with the state's regulations are being adhered to.

JFB: Well, is there anything else that we should touch on as part of this conversation?

KBH: I would just strongly encourage ongoing engagement, discussion, take advantage of the materials on the Board's website as one resource that you can use to support your practice, maintain a sense of curiosity, stay educated regarding policies and continue the good work that our state is known for in the care of our patients' requiring opioids for management.

JFB: Wonderful. Well said. Well, Dr. Burke-Haynes, thank you again for joining me. I really appreciate your expertise.

KBH: Thank you, Jean, for giving me the opportunity.

Episode closing: 31:47
Well, that brings us to the end of this episode of MedBoard Matters. I hope you found it helpful and informative. Be sure to check the podcast show page at www.ncmedboard.org/podcast for links to the opioid CME modules and other information and resources. As always, you can send comments and questions to podcast@ncmedboard.org. And don't be shy about telling your colleagues about the information you got from this podcast. We love new listeners. This is your host, Jean Fisher Brinkley. Thanks for listening. I hope you will join me again.