Minnesota Chapter

January 26, 2022

The Honorable Robert Bierman
House District 57A
Minnesota House of Representatives
100 Rev. Dr. Martin Luther King Jr. Boulevard
State Office Building, Room 579
St. Paul, MN 55155-1232

Re: MNSAM's Comments on HF 1851

Dear Representative Bierman,

On behalf of the Minnesota Chapter of the American Society of Addiction Medicine (MNSAM), the medical specialty society representing physicians and clinicians in Minnesota who specialize in the prevention and treatment of addiction, thank you for your interest in reforming the guidelines for prescribing opioids. We appreciate the opportunity to comment on this salient issue. While we respect that you are trying to find solutions for patients with chronic pain, we write today to express concern with specific provisions of your bill, HF 1851, that we believe may have a counterproductive impact on opioid addiction and opioid overdose deaths.

If enacted, HF 1851 would modify the definition of and prescribing criteria for intractable pain under Minnesota Statutes 2020, section 152.125.[i] However, in pursuit of these ends, the bill would codify other major changes to pain management guidelines with significant implications for patients and providers alike. Please note the following concerns:

1. Subdivision 1 of the bill revises the state's definition of palliative care, stretching it beyond traditionally understood boundaries. In common practice, definitions of palliative care are narrow. A widely cited World Health Organization (WHO) definition associates palliative care solely with providing comfort to individuals with "life-threatening illness." [ii] In contrast, Subdivision 1's amended definition allows palliative care along with curative treatment for patients with "nonterminal" diagnoses. However, the bill does not provide characteristics or examples of qualifying nonterminal conditions. Without adjustment, we are concerned that this broadened language could be interpreted to allow any patient with pain to qualify for highly specialized, palliative care. **We respectfully urge that you reconsider this expanded definition of palliative care.**

2. Further, Subdivisions 1a and 2 outline revised criteria for the evaluation and treatment of intractable pain, as well as the administration of controlled substances for intractable pain. For the treatment of intractable pain in nonterminal patients, HF 1851's criteria state: "the cause of the diagnosis of intractable pain, whether confirmed or perceived, must not interfere with medically necessary treatment, including but not limited to prescribing or administering a controlled substance in Schedules II to V of section 152.02." This specific language of this section implies that patients without

confirmation of an organic reason for their pain could receive controlled substances, ie opiates, for pain management. We believe that this standard in the treatment of perceived pain is too broad and runs counter to medical best practice in pain management.

Medical best practice indicates that the treatment of pain using opioids be subjected to higher standards than those included in HF 1851's wording of "perceived pain". For instance, ASAM's National Practice Guideline recommends: "For all patients with pain, it is important that the correct diagnosis of pain etiology be made and that a suitable pain treatment be identified. Nonpharmacological treatments (e.g. psychosocial treatments, physical therapy) have been shown to be effective for many types of pain and should be considered. If pharmacological treatment is thought necessary, then nonopioid analgesics … may be useful and should be considered first." [iii] Further, according to the Guideline for Prescribing Opioids for Chronic Pain published by the Centers for Disease Control and Prevention (CDC),[iv] "Clinicians should always exercise caution when considering or prescribing opioids for any patient with chronic pain outside of active cancer, palliative, and end-of-life care and should not overestimate the ability of these tools to rule out risks from long-term opioid therapy." Based upon this guidance, it is clear that prescription opioid treatment for intractable pain should only be considered after a specific pain diagnosis has been established and non-opioid treatment modalities have been exhausted. For practitioners with limited experience in pain management or addiction medicine, we fear that HF 1851's enhanced treatment flexibility could be misapplied, inadvertently enabling inappropriate prescribing of opioids for perceived pain without confirmation. This was the main cause of the "opioid epidemic" that has been plaguing this country for the last 20 yrs. **As such, we strongly recommend that you clarify or eliminate any use of the term "perceived pain" in this section to minimize possible confusion among providers.**

3. We are concerned by the "good faith" standard that is set for disciplinary action in Subdivision 2. According to the revised language, "no {practitioner} acting in good faith, shall be subject to any civil or criminal action or investigation, disenrollment, or termination by the commissioner of health or human services solely for prescribing a dosage that equates to an upward deviation from morphine milligram equivalent dosage recommendations." This amended standard is cause for concern because it affords blanket immunity to practitioners on the sole basis of attesting to act in "good faith." More alarmingly, under this revision, practitioners are expressly allowed to prescribe above morphine milligram equivalent dosages. We fear that this relaxed standard could reinforce improper prescribing of controlled substances for intractable pain, especially when paired with HF 1851's other changes to prescriber guidelines.

4. Additionally, Subdivision 2 sets forth updated standards for tapering of controlled substances. According to this proposed bill, practitioners dispensing controlled substance treatments, including opioid analgesics, "must not taper a patient's medication dosage solely to meet a predetermined morphine milligram equivalent dosage or threshold if the patient is stable and compliant with the treatment plan, is benefiting from the level of medication currently being prescribed or previously prescribed, and is in compliance with the patient-provider agreement." However, there are a myriad of issues with this standard regarding tapering. For example, the proposed bill fails to define what constitutes a "stable" or a "compliant" patient. Additionally, the language restricts managed tapering of patients "benefiting from the level of medication", although there is no standard for how this would be determined. Thus, Subdivision 2 sets an unusually high standard to taper medication. Based on established guidance, practitioners should be able to taper dosage if a patient's condition improves over time or to determine the least effective dose needed.[v] **We urge that you revise HF 1851's conditions**

for tapering opioid medications to better align with medical best practice and to avoid development of opioid dependence to the extent possible.

5. Lastly, Subdivision 5 sets the terms of patient-provider agreements for intractable pain treatment. Under HF 1851, patient-provider agreements must include information about medication, dosage, and reflect any changes in dosage. These terms place onerous requirements on practitioners and may further discourage attempts to taper a patient's controlled substances. Additionally, we worry that the proposed reporting requirements of this nature may encourage practitioners to prematurely increase dosages rather than engaging in more gradual titration. **Therefore, we urge that you revise the proposed rules relating to the patient-provider agreement to afford practitioners increased discretionary authority over changes in dosing for controlled substances.**

In summary, we believe that the scope of HF 1851 is too broad in the enhanced flexibilities that it allows. We worry that these flexibilities run counter to medical best practice on the use of opioid medications for pain management and jeopardize overreliance on prescription opioids for pain patients. Overprescribing of opioids can lead to misuse, diversion, opioid use disorder (dependence) and overdose deaths. **Prescription opioids alone accounted for nearly 14,000 overdose deaths in the United States in 2019, which is a rate of over 38 deaths per day.**[VI] We also believe that in the process of liberalizing elements of the treatment process, HF 1851 simultaneously constricts the discretionary authority of qualified practitioners to manage dosing.

We would like to offer suggestions on how to improve HF 1851, so it achieves its aims of optimizing treatment of chronic pain, while minimizing risks. **As such, representatives from MNSAM would greatly appreciate the opportunity to meet with you to discuss these issues in greater detail.** Thank you for considering our perspective and we hope to work with you further. Please contact me at JoAn.Laes@hcmed.org or if you have any questions or concerns.

Sincerely,

JoAn Laes, MD, FACMT, DFASAM
President, Minnesota Society of Addiction Medicine

CC: The Honorable Athena Hollins
The Honorable Jeremy Munson
The Honorable Samantha Vang
Dave Renner, Minnesota Medical Association (MMA)
Juliana Milhofer, Minnesota Medical Association (MMA)
Tara Erickson, Minnesota Society of Interventional Pain Physicians (MSIPP)

[i] *HF 1851: Status in the House for the 92nd Legislature (2021 - 2022)*. Minnesota Legislature. (2021). Retrieved December 29, 2021, from https://www.revisor.mn.gov/bills/bill.php?b=House&f=HF1851&ssn=0&y=2021

[ii] World Health Organization. (2002). National Cancer Control Programmes. Policies and managerial guidelines. *World Health Organization, Geneva*, (2).

[iii] ASAM Board of Directors . (2020). The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder: 2020 focused update: Erratum. *Journal of Addiction Medicine*, *14*(3), 267. https://doi.org/10.1097/adm.0000000000000683

[iv] Dowell, D., Hagerich, T. M., & Chou, R. (2016, March 18). *CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016*. Centers for Disease Control and Prevention. Retrieved December 29, 2021, from https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[v] Dowell, D., Jones, C., & Compton, W. (2019, October). *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics*. US Department of Health and Human Services . Retrieved December 29, 2021, from https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf

[VI] Centers for Disease Control and Prevention. Drug Overdoses. . National Center for Injury Prevention and Control