Will Adding Methadone to Controlled Substance Monitoring Programs Help Psychiatrists Prevent Prescription Drug Overdoses?

To the Editor: Prescription drug abuse is a public concern, and the rate of prescription-related overdoses has been steadily increasing since 1999.[1,2] Controlled substances are typically obtained legally. Twenty-one percent of patients using pain relievers for nonmedical purposes received the medication from one doctor, while 53% obtained them from a friend or family member who had been prescribed the medication by a doctor.[3] In contrast, 4% bought them from a drug dealer or stranger.[3] The nonmedical use of psychotherapeutics ranks second as the most commonly abused substances, with 2.7% of adults over 26 years of age reporting use.[3] In addition to these statistics, the Centers for Disease Control and Prevention estimates that Medicaid users are 6 times more likely to die of an overdose from prescription medications.[4] It has been shown that the use of Controlled Substances Prescription Monitoring Programs (CSPMPs) reduces prescription drug abuse.[5] In addition to these programs, many states have begun to enact Medicaid Provider Lock-Ins (MPLIs). These programs were put in place in an effort to curb excess use of Medicaid benefits, avoid duplication of services by providers, and prevent excess prescriptions for controlled substances. MPLIs have been shown to save states millions of dollars.[6] Research on their efficacy in counteracting prescription drug abuse is lacking. The following case is important for psychiatrists and addiction medicine specialists in demonstrating how a patient may be bypassing an MPLI and receiving relatively contraindicated medications.

Case report. Mr A, a 60-year-old white man with a psychiatric history of bipolar disorder and benzodiazepine and opioid dependence presented to our clinic already on methadone maintenance therapy. Medications prescribed by his outpatient psychiatrist included olanzapine, gabapentin, fluoxetine, and 140 mg of methadone from a methadone clinic. Mr A asked to be prescribed benzodiazepines for anxiety, but the treating physician did not comply with his request because of Mr A's history of dependence and relative contraindication, and central nervous system depression was a consideration. Importantly, he also had been hospitalized several times for benzodiazepine overdose.

A search of Arizona's (AZ) CSPMP showed that Mr A had recently been prescribed benzodiazepines from several different prescribers, but it did not show the 140 mg of methadone that he had been prescribed at his methadone treatment clinic. In an effort to prevent Mr A from receiving multiple benzodiazepine prescriptions, an MPLI was placed on the patient's electronic file. After the lock-in was placed, to continue filling new benzodiazepine prescriptions, Mr A began going to different physicians and pharmacies. He would then pay "out-of-pocket" for services, which circumvented the MPLI, and the patient was able to keep receiving and filling new benzodiazepine prescriptions while still taking his methadone maintenance therapy.

Methadone contributes to a great amount of prescription drug overdoses.[7] We contacted the AZ CSPMP manager directly and were informed that methadone treatment programs, including office-based programs, are exempt from reporting methadone to the AZ CSPMP. Prescribers who do not know that the patient is taking methadone and who check the CSPMP may inadvertently prescribe medications that place the patient at risk of central nervous system depression.

MPLIs can be circumvented by a patient who pays for services out-of-pocket. MPLIs should be used concurrently with a CSPMP to help prevent prescription drug abuse. Methadone prescriptions need to show up on a state's CSPMP database. That way, the patient's other prescribers who are checking the CSPMP know that a patient is receiving methadone treatment and will not inadvertently prescribe relatively contraindicated medications. Clinicians in other states should review their state's CSPMP regulations to see if methadone will appear when they are performing CSPMP checks on patients.

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