

[REDACTED]

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**From:** [REDACTED]  
**Sent:** Thursday, February 22, 2018 1:02 PM  
**To:** opioids,  
**Subject:** FW: Senate Finance letter re: Opioid recommendations

**From:** [REDACTED]  
**Sent:** Thursday, February 22, 2018 9:22 AM  
**To:** [REDACTED]  
**Subject:** FW: Senate Finance letter re: Opioid recommendations

I told him I'd pass it along even though he is late...

**From:** [REDACTED]  
**Sent:** Wednesday, February 21, 2018 5:52 PM  
**To:** [REDACTED]  
**Subject:** Re: Senate Finance letter re: Opioid recommendations

Hi Natalie,

Sorry it took me several days to respond. I had to hit the ground running when I left Washington. I have had a chance to look at the questions regarding opioid use disorder and have a few thoughts.

The state of Kentucky passed House Bill 1 in 2012. One aspect of this bill was to require health care providers to obtain an historical record of past controlled substance prescriptions written for any patient given a new controlled substance prescription. This report is known as Kentucky All Schedule Prescription Electronic Reporting or KASPER. I am enclosing an example with the patient identifiers marked out. This report allows the prescriber to see the amount and frequency of controlled substance prescriptions. In addition the upper right corner has a box with a number identifying the active cumulative morphine equivalent. This number helps the prescriber determine if the patient is at risk for becoming a chronic user.

A report like this on a national scale would be of immense help to a prescribing physician. Currently there is no data bank available to determine if a patient has obtained a controlled substance prescription in another state. A doctor armed with this knowledge could much more readily identify an abuser.

In addition the active cumulative morphine equivalent number could be used to identify those patients at risk for addiction. If a patient has over a certain predetermined number it could trigger a letter to the physician alerting him that this may be an at risk patient needing intervention such as counseling or medication changes.

Lastly, I am a surgeon. As such I deal a lot with acute pain. These patients often need opiates; however, minimizing their use helps decrease the risk that some patients may develop addiction. There are some long acting local anesthetic agents that can reduce the amount of opioids used post operatively. Unfortunately they cost several hundred dollars. This expense is not reimbursed by private insurance or Medicare in the outpatient setting. This makes it cost prohibitive and unavailable. Long acting anesthetic blocks can also reduce opioid use in the post operative period. Not all surgeons are educated as to their value, and not all hospitals have anesthesiologists trained to perform these blocks. Educating physicians through continuing medical education and providing adequate reimbursement for anesthetic blocks would further their use.

I know that this response is late and I apologize. I would like to make myself available if you have follow up questions of need input on other health care matters.

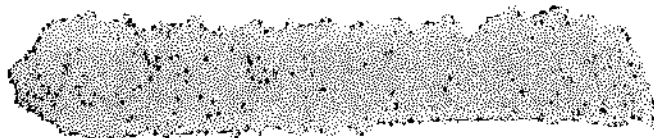
Sincerely,

Charles Papp, M.D.

President Elect Lexington Medical Society



Patient Name:



Patients that matched the search criteria:

Pat ID

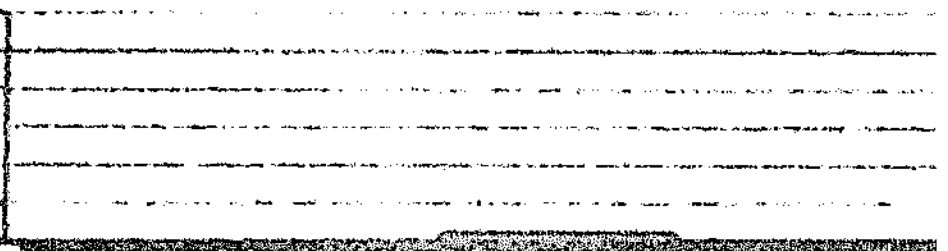
Patient Name

DOB

1



120  
100  
80  
60  
40  
20  
0



Sent from my iPad

On Feb 14, 2018, at 12:29 PM, [REDACTED] wrote:

It was great meeting with you all yesterday. I wanted to follow up with the Senate Finance Committee letter requesting input from health care industry groups on potential policy changes to Medicare and Medicaid as part of their efforts to address the opioid crisis. Please see the attached letter for the specific questions addressed by the Committee. If you have recommendations you would like to provide, please send them to me by COB TOMORROW and I will pass along to the committee.

<Senate Finance opioid recommendation letter.pdf>