

Drug Abuse and MRO Responsibilities: Federally Regulated Testing and Beyond

Hazards are ever-present in the steel plant environment, and a heightened awareness and emphasis on safety is a necessary priority for our industry. This monthly column, coordinated by members of the AIST Safety & Health Technology Committee, focuses on procedures and practices to promote a safe working environment for everyone.



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Since workplace drug testing and the role of the medical review officer (MRO) were first created in the non-military public and private sectors as a consequence of the Drug-Free Workplace Act of 1988, multiple changes have taken place. These changes include, but are not limited to, the following:

1. An increase in both the number and usage of drugs of abuse. This includes not only the current opioid epidemic, semi-synthetic opioids, but also “designer” drugs such as synthetic cannabinoids.
2. An increase in both the types and validity of drug testing media available with different strengths and weaknesses in duration of detection, ability to falsify, etc.
3. The role of the MRO has continued to evolve, but most MROs are only up to date on regulations, not societal developments. Despite 1 and 2 above, most MROs apply federal regulatory mandates to even non-regulated drug testing due to federal regulations guiding the role, training and certification of the MRO.* Training courses emphasize the regulatory role as to ensure that physicians attending the courses can pass regulated MRO certification exams that comply

with federal regulatory requirements.

This article provides a concise review of both current federal regulated testing with its limitations and non-federal drug testing with its strengths/weaknesses, and those that pertain to the role of the MRO. It will discuss aspects of commission and omission with regard to MRO application of regulated mandates to non-regulated testing and offer concrete recommendations on drug testing and MRO selection from an employer standpoint.†

Regulated federal drug testing has been slow to adapt to the increase in number of drugs available and usage of drugs of abuse. As of 1 January 2018, federal regulated testing now includes semi-synthetic opioids, but the primary body medium tested is still urine‡ with accompanying limitations in the ability to detect non-Substance Abuse and Mental Health Services Administration (SAMSHA) drugs of abuse and the ability of the donor to falsify results. Most importantly from a safety standpoint, federal regulations (with one exception) now prohibit the MRO from reporting a lab positive result with any safety-related concerns to the employer until the donor’s prescribing medical provider contacts the MRO for a period of up to five days.¹

†Due to the length and complexity of the topic, non-federal regulations and laws, e.g., state, will not be addressed in this article. The reader is advised to seek appropriate legal advice for the state(s) in which the non-federal regulated testing is performed.

‡The current exception being saliva permitted as a screen for alcohol testing.

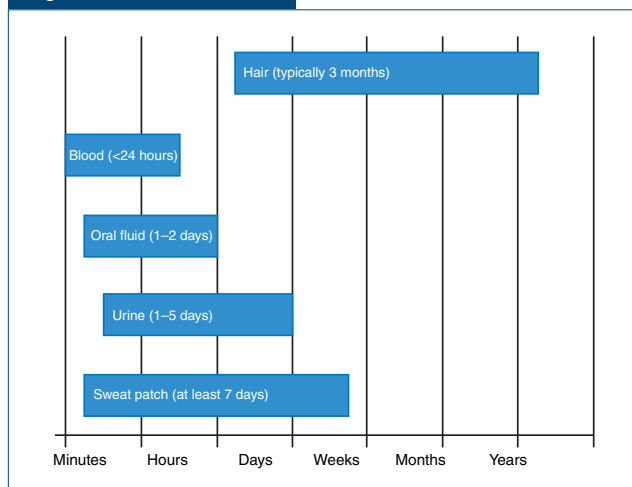
*Although not statistically validated, this is the authors’ experience from monitoring MRO email lists, discussions with MROs, administering a drug testing program for a Fortune 100 corporation, etc.

Comments are welcome.

If you have questions about this topic or other safety issues, please contact safetyfirst@aist.org.

Please include your full name, company name, mailing address and email in all correspondence.

Figure 1

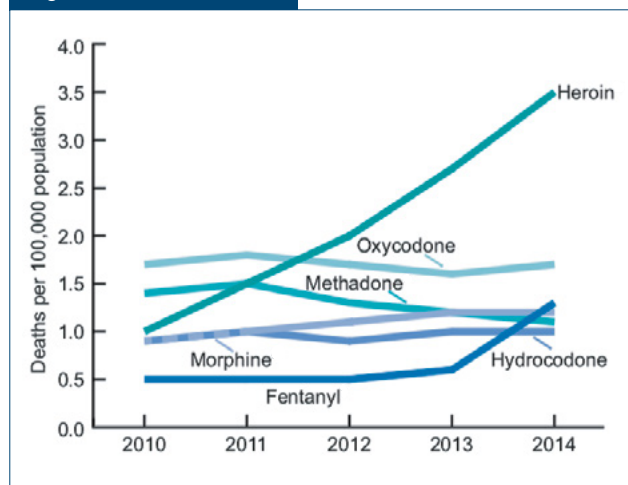


Specimen detection times. Source: Medical Review Officer Certification Council.²

Prior to 1 January 2018, regulated testing was limited to breath/saliva for alcohol and urine for the so-called National Institute on Drug Abuse “NIDA 5:” cocaine, PCP, amphetamines, opiates (e.g., morphine, codeine, heroin) and marijuana. Effective 1 January 2018, regulated drug testing was expanded to include the NIDA 5 and four opioids (hydrocodone, oxycodone, hydromorphone and oxymorphone). While the regulated drug panel has been expanded, regulated testing for drugs of abuse and the impact on workplace and public safety are still consequentially limited by the following:

1. The body media, or specimen, tested. Urine, in particular, is limited by multiple methods of dilution, substitution and adulteration even with mandated observed specimens. The detection time for most substances is so brief that an abuser can abstain for only a few days prior to testing and produce a negative result (Fig. 1).² For example, a habitual cocaine user abstaining prior to providing a urine sample could have a negative result, but then immediately resume abusing after the sample is provided, and subsequently be placed in a safety-sensitive position. In addition, dependent upon the scenario (e.g., pre-employment, last-chance agreement, for cause, etc.), the appropriateness of the media tested varies.
2. The scope of drugs of abuse tested. For example, marijuana metabolite testing has been present since the start of regulated drug testing. However, in 2015, multiple states issued alerts or notices due to an increase in poison center control calls and hospitalizations due to synthetic cannabinoids.³ Regulated

Figure 2



Drug overdose deaths in the U.S. involving selected opioids, 2010–2014. Source: Center for Disease Control.⁴

drug testing does not cover synthetic cannabinoids. Likewise, regulated testing does not detect carfentanyl, an opioid 5,000 times more potent than heroin.

Thus, although performed from worthy motives (such as legal compliance, safe workplace, etc.), the uncritical application of regulatory mandates to areas of non-regulated drug testing can have serious repercussions for both the employer and employee (or prospective employee) in terms of types of drug testing (e.g., an undue emphasis on urine testing, limited drugs detected, etc.) and MRO recommendations for drug testing and consequent interpretations. Most MRO bias in assessing and interpreting non-regulated testing, in the authors’ experience, comes from either inappropriate application of regulated testing mandates to non-regulated testing and/or “commodity” MRO services[§] offered with a discounted price minimizing the time spent on the MRO investigating lab-positive results. In that regard, there are at least two important compromises made:

1. The reporting of potential safety-related issues of drug testing in donors with positive results and safety-sensitive job requirements. For example, a hot metal crane operator or

[§]Typically, these are offered by online services coupling drug testing with “secure” online delivery of MRO interpretation with drastically reduced pricing. In the authors’ experience, the pricing is discounted so severely that positive tests are not explored as due by the MRO beyond compliance with federal regulations. In the authors’ opinion, this behind-the-scenes method is driven by the need for the employer of the MRO to reduce time spent by the MRO in order to increase production and the profitability of the service.

commercial motor vehicle driver whom the MRO reports as negative secondary to the donor having a valid prescription but with no consideration of misuse, abuse and/or overall safety.

2. Failing to investigate the safety-related considerations of why the prescription medication was issued, e.g., oxycodone for lower back pain in an employee expected to perform manual labor.

Thus, these results are often simply reported as MRO-negative with no further comment but with potentially disastrous results for the donor, co-workers, and/or members of the general public as well as liability issues.

Fig. 2 displays the number of overdose deaths attributable to selected opiates/opioids from 2010 to 2014.⁴ While regulated NIDA 5 testing would detect both heroin and morphine, it would not detect the other synthetics/semi-synthetics listed (i.e., oxycodone, methadone, hydrocodone or fentanyl). Despite the increase in death rates for these substances, regulated testing was not updated to detect these drugs until this past year. Moreover, other legal opioids, including fentanyl and methadone, are still not detected.

As a result of these limitations, many MROs have great difficulty in dealing with both an expanded panel of substances tested as well as body specimens that are more appropriate for the use being considered (such as hair, which covers up to three months of prior drug usage in pre-employment and random testing versus urine). However, since non-regulated testing limits of detection, detection cutoff levels and removal of potentially adulterating substances are not necessarily equivalent among different labs offering to test the same body specimen (e.g., hair wash technique and passive contamination of cocaine issues), the MRO must be familiar with the techniques and parameters of the lab being utilized.⁵

While non-regulated drug testing effectively discourages current employees from using illicit substances and screens potential employees through a wider panel and more accurate drug detection, both MROs and human resources (or company equivalent) must be aware of potential conflicts between the drug tests used and the collective bargaining agreement (CBA) conflicts. The CBA between a company and the union may prohibit drug testing, or specify that expanded drug testing cannot be used.

In brief, although a company with employees covered by federal regulated testing must comply with the applicable federal regulations, it would behoove the company to cover the same employees and also non-covered employees with a separate, non-regulated program. It would be advantageous for a company with only non-covered employees under the federal

regulations to utilize a program with expanded testing of drugs of abuse, body media tested appropriate for the reason tested (e.g., hair for pre-employment and random testing, saliva for cause testing, etc.). When needed, the company should use an MRO familiar with the safety-sensitive issues and job requirements, and who is willing to pursue verified test positives beyond the rationale of a licit prescription for the lab-positive drug.

Case Studies

Having provided basic background drug testing and MRO information, this section will feature real-life cases and advice for employers in selecting MROs and how employers can best address these issues to ensure the safest workplace for their employees and the general public.[¶]

In the following scenarios, the perspective of each author will be identified as Charles P. Prezgia (CPP) or Charles F. Prezgia (CFSP).

Case One — I (CPP) was working in one of four non-associated clinics, and one particular clinic had a medical director who was a certified MRO and was board-certified in emergency medicine. As I was the only other certified MRO in the clinic, he and I would share the MRO duties dependent upon who was present at the time in the clinic. In this particular case, I happened to follow up on an OxyContin lab-positive where the other physician had initially called and contacted the donor. According to the donor, he had a valid prescription for OxyContin and would provide it for review. I happened to be on duty at the clinic when the prescription was produced and given to the clinic MRO-A (medical review officer assistant). The MRO-A presented the material to me along with the MRO form already marked “negative” as the donor had a presumed valid prescription (which the MRO-A had verified with the pharmacy). At this point, I intervened and asked the MRO-A for the documentation as to why the test was performed and whether the donor’s position had any noted safety-sensitive functions associated with it. I subsequently found out that the donor was a 53-year-old male who was working through a union local for a contractor at a petrochemical facility. The reason for the drug test (expanded urine panel) was “reasonable suspicion,” as on the second day of the job, the donor had been driving a repair vehicle and backed into the facility’s equipment, causing tens of thousands of dollars of

[¶]Names, dates and other incidental material have been changed to protect the identities of the individuals and institutions involved with the exception of myself. Otherwise the cases substantially reflect the facts.

damage. I informed the MRO-A that I could not sign off the confirmed lab-positive as an MRO-negative without speaking to the employer to see if safety-sensitive functions were involved. Simultaneously with the employer being contacted by the MRO-A, the facility medical director was also contacted by the MRO-A and wanted to know why I was inquiring about safety-sensitive functions as the donor “...has a prescription and this isn’t mandated like the (Department of Transportation).”

Case Two — This case involved a corporation with whom I (CPP) consult who, secondary to work performed in major refineries, was part of a consortium of contractors whose drug testing sites and MRO were selected by a third-party administrator (TPA) approved by the refineries in question. Similar to the first case, the panel was expanded to include synthetic and semi-synthetic opiates of urine. In this particular case, the corporation’s employee had a slip-and-fall resulting in the fracture of two lumbar vertebrae with treatment including Percocet for pain. Although there was no reasonable suspicion testing at the time of the incident, the corporation had mandated return to work testing as well as a safety policy prohibiting any employee from working while on narcotic pain medications. Although his return to transitional work was not to one of the consortium refineries but to one of the corporation-owned repair facilities, he still had to have his return to work testing performed through the consortium TPA. As expected, it took three days to process the specimen consistent with a presumptive positive and the result was an MRO-negative. Because of my involvement with the corporation, the employee signed a release so I could obtain the actual laboratory results, which were positive for metabolites of Percocet. Again, the MRO had called it as negative with no insight or consideration as to why the test was done and any relevant company policies. The MRO’s specialty was family medicine.

Case Three — This case involves a colleague who works in the petrochemical industry that utilizes non-regulated drug testing. This colleague related to us (CPP and CFSP) that a medical provider at an employee health center overheard two employees (about to be drug tested) discussing with each other how they had to be “more careful” since the new drug testing protocol included synthetic cannabinoids.

Case Four — I (CFSP) was rotating at an occupational medicine clinic and was requested to directly observe a urine specimen (due to same-gender observation rules). Direct observation requires and includes a full-frontal view of the urine as it leaves the human body. The method that this clinic used for “direct observation” was for the observer to stand behind the donor,

and consequently the observer would be unable to observe if there was any adulteration and/or prosthetic device utilized by the donor. I immediately brought the improper procedure to the attention of the MRO-A, who appeared confused about why I thought this presented a problem. I discussed the situation with the office manager, who initiated re-education with the employees regarding direct observation.

These four cases illustrate what can happen, unbeknownst to employers, with many MRO-negative results in the non-regulated arena, whether due to failure of the clinic, the limited drug panel or the failure of the MRO to realize safety hazards.

So, what is an employer to do when selecting testing and an MRO(s) for non-regulated testing? Both as consultants and certified MROs, the authors rely on the lists of “Do’s” and “Don’ts” in the following sections.

The Don’ts

1. Don’t assume that any clinic or third-party administrator offering MRO services actually utilizes a certified MRO with non-regulated drug testing and occupational health experience. Even clinics and TPAs with certified MROs often use physicians whose experience and clinical area of certification is not in workplace health and safety (i.e., emergency medicine, family medicine, etc.).
2. Don’t assume that because two laboratories offer the same non-regulated testing that the specimen testing processes are equivalent in forensic rigidity (e.g. hair testing, etc.). Be familiar with the limitations of the lab in areas of cutoff levels, passive contamination issues, etc. Also, be familiar with exactly what is being tested for when comparing non-regulated panels from different laboratories. For example, opiates for one lab might mean only morphine, codeine and heroin, whereas the other could include additional semi-synthetic opiates as well.
3. Don’t implement non-regulated drug testing without consultation and discussion with your company’s human resources and legal departments if necessary. A positive drug test that was performed against the CBA may be thrown out and expose the company to legal liabilities. In addition, dependent upon the CBA, it might be best not to use an MRO until a positive is grieved in arbitration.
4. Don’t assume the drug screening process is correct. The weakest link in the drug collection process remains chain-of-custody.

At the very least, there should be annual site visits and meetings with the designated drug collection clinic to ensure that all processes and procedures are being properly performed. Specific questions, such as, “How is an observed collection performed?” should be asked, and anything less than a clear and concise answer should be a red flag that the clinic and observers may need re-education and follow-up auditing to assure a correct collection process.

5. Don't perform point-of-care-testing (POCT) or other drug testing on one body media and then confirm positives with a second media. In other words, don't perform a POCT on urine then confirm with saliva. Drugs and their metabolites have different half-lives in different media and thus a positive in one media is not necessarily a positive in a different media.

The Do's:

1. Make sure that your MRO understands your company policies for safety and safety-sensitive functions.
2. With any testing, make sure your MRO is supplied with the reason for the test and safety-sensitive functions associated with the donor's position.
3. Make sure your MRO is certified by one of the two certifying organizations, the Medical Review Officer Certification Council (MROCC) or the American Association of Medical Review Officers (AAMRO). They should also demonstrate experience with non-regulated testing as well as having attended continuing medical education courses that focus on non-regulated testing preferably within the last two years and every other year thereafter. If needed, ask for references from other companies that use non-regulated testing for whom the MRO has provided service.
4. Preferably utilize an MRO who is either board-certified in occupational medicine and thus understands non-regulated job safety-sensitive issues or, at least, has more than five

years of experience with occupational health from an in-plant clinic.

5. If you must use an MRO without the above recommendations, offer and give the MRO a site visit to your worksite so that the MRO can better understand the safety-sensitive nature of the worksite, and the hazards that an impaired employee presents not just to him/herself but to the other employees and the general public.
6. Involve your MRO in reviewing CBAs with companies, especially regarding third-party vendors and the material marketed.

Conclusions

In summary, the foregoing is a review of:

1. The shortcomings of solely relying on the drug testing methods of federal regulated programs and MROs who only apply federal regulations.
2. The caveats and potential benefits/deficits involved when utilizing non-regulated state of the art drug testing methods.
3. The elements of selecting MROs willing to go the extra mile in the areas of safety-sensitive functions and essential job requirements in assessing the significance of positive drug tests beyond simple verification of a valid drug prescription.

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