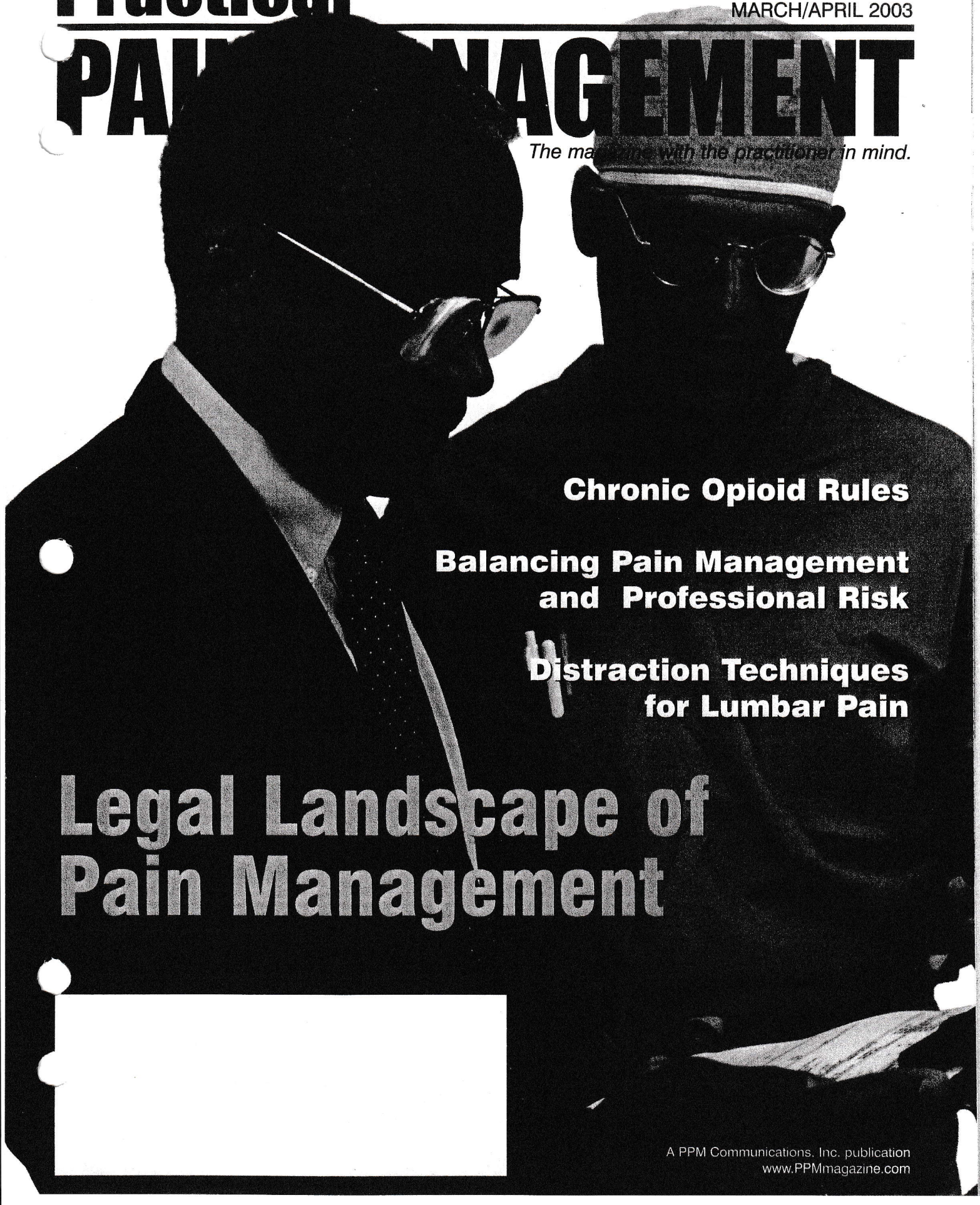
VOLUME 3, ISSUE 2
MARCH/APRIL 2003

Practical PAIN MANAGEMENT

The magazine with the practitioner in mind.



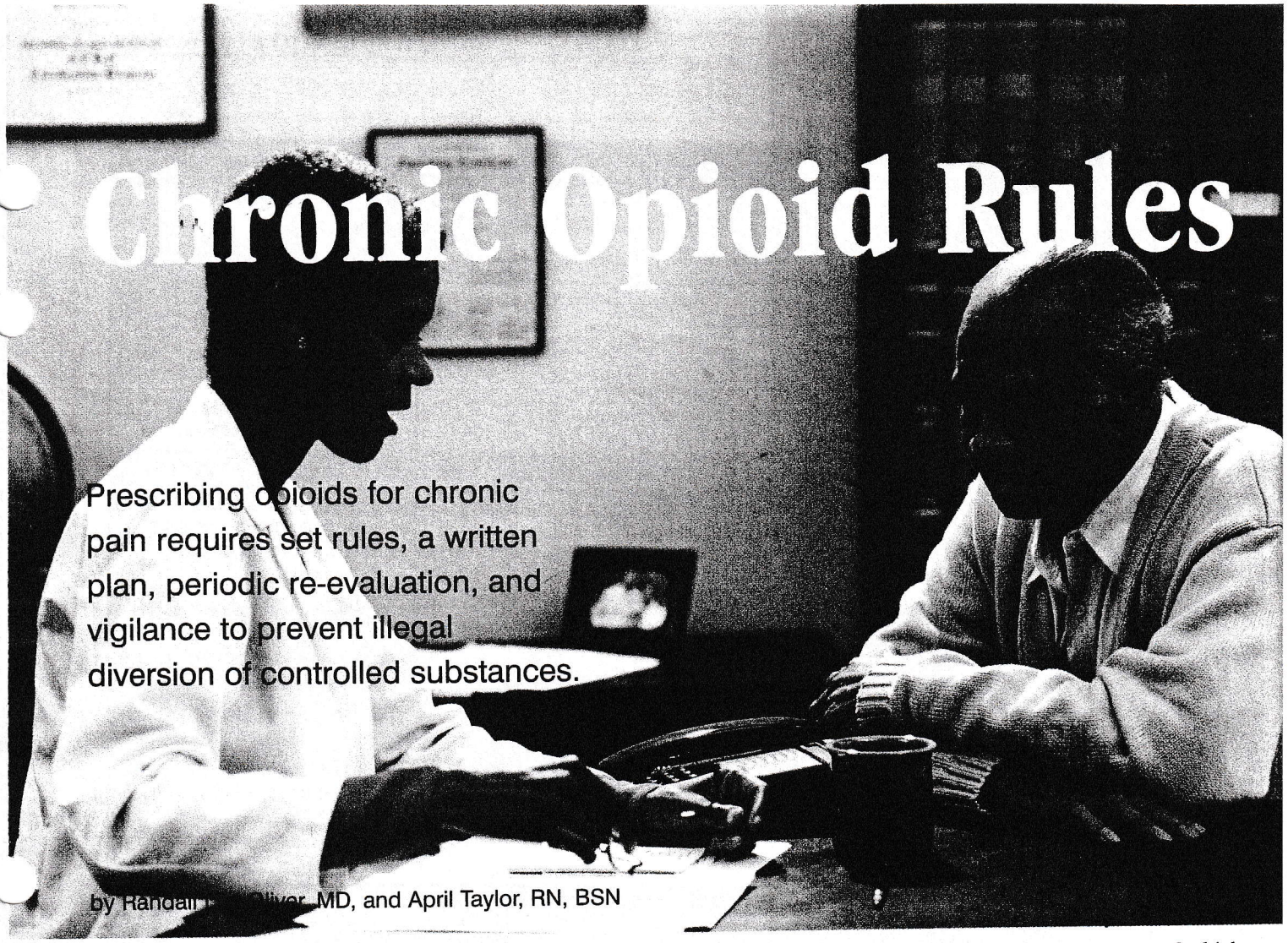
Chronic Opioid Rules

Balancing Pain Management and Professional Risk

Distraction Techniques for Lumbar Pain

Legal Landscape of Pain Management

A PPM Communications, Inc. publication
www.PPMmagazine.com



Chronic Opioid Rules

Prescribing opioids for chronic pain requires set rules, a written plan, periodic re-evaluation, and vigilance to prevent illegal diversion of controlled substances.

by Randall [illegible]liver, MD, and April Taylor, RN, BSN

Opioids are potentially dangerous medications that can lead to accidental overdose, death, or impairment around machinery, or while driving an automobile. Therefore—even for the chronic pain patients who generally need opioids to improve functionality—they should be used judiciously and wisely.

Patients may be frustrated by the burden of these rules, not being able to adjust their own medication, or take as much medication as they want. The patients' idea of an ideal opioid would be one they could take whenever they wish in whatever amount they wish. However, this class of medications is not one that patients can safely be trusted to adjust on their own.

Giving a patient an addictive medication and allowing them free access to timing and dosage is out of the question — there must be physician supervision. No one can self-supervise one's own addictive medication, even if the patient is not an addict and the medication is clearly indicated. It is critical to set rules and parameters. The patient must follow the plan for the benefit of both the patient and the physician. If the patient fails to comply, then it is a potentially dangerous situation for both. The key to appropriate chronic pain management is to establish rules (or guidelines) for treatment and then tailor the care to each individual. Following these rules lowers the risk of supporting drug diversion in the patient who plays the role of a chronic pain sufferer in order to sell or abuse opioids. More importantly, these rules will provide the chronic pain patient with proper care.

The Federation of State Medical Boards of the United States, Inc. guidelines want physicians to follow a "usual course of professional practice" to find a balance between appropriate patient care and risk of investigation. Their focus is on appropriate treatment and documentation, not on quantity or chronicity of opioid prescriptions.[1] Appropriate treatment reduces pain and ensuing pain relief improves function—whereas addiction decreases function.[2] Co-morbid conditions must also be treated, treating the whole person and improving overall functioning.[2,3] A multidisciplinary approach gives the patient multiple options, of which opioid therapy is only one part.

Chronic pain is one co-morbidity in the Chronic Pain Syndrome. Once pain has become chronic, all parts of a patient functioning are affected. Insomnia, fatigue, sexual dysfunction, depression and anxiety also occur. Each co-morbidity worsens the others and, in turn, lowers functioning.[3] Pain can be categorized as nocioceptive or neurogenic. Nocioceptive has a physical origin of pain that is opioid receptive. Neurogenic pain is chronic with often no observable physical origin of pain.[4] Neurogenic pain will demonstrate incomplete opioid response or none at all.

Opioids play an important part of the overall pain treatment program — but only a part and never 100%. Proper application of opioids varies from patient to patient — from significant usage in one patient (good response, no tolerance, little co-morbidities) and minimal usage in another (poor response, neurogenic pain, tolerance, addiction, co-morbid diseases). This article discusses the rules for the use of opioids in the patients for whom they

	Rules	Warning Signs	Success
1	**Single physician Single pharmacy**	Self-pay (using insurance with another MD) No referring MD (has another MD) Out of town (another MD in his hometown) Obtaining opioids or other narcotics from other physicians or from the street	No signs of another doctor or pharmacy
2	**Thorough H&P, including documentation**	Hysterical or overrated pain scale Psych abnormalities Lack of other chronic pain indicators Normal or hysterical physical exam Normal tests	Realistic pain scale Level pain scale Objective findings Documentation of disorder that correlates with level of pain
3	**Urine drug screen**	Negative drug screen for prescribing drug Positive for other opioids or illicit drugs	Positive for prescribed drug only
4	**Make appropriate consults**	Accusatory of other physicians Patient refuses referrals, consults or testing	Patient agrees to timely consults Patient follows-up with ongoing psych treatment
5	**Monthly visits**	Frequent phone calls Early refills Stories No significant improvement in pain or function with dose increases from month to month Wide ranging pain scale Office visits overly devoted to drug	Pain decreases in response to dose or proportional to dose escalation Improvement should be seen month to month until a tolerable level of pain is reached
6	**Co-morbid conditions treated**	Fatigue, anxiety, depression, insomnia & sexual dysfunction continues	Co-morbid conditions improve Function improved Support of a relative or friend in process of improving pain/function
7	**A signed contract**	Concurrent use of other illicit drugs or addictive drugs Non-adherence to contract rules Acceleration of drug use other than prescribed	Follows rules
8	**Long-acting opioids for chronic pain; short-acting for breakthrough**	Inconsistent opioid response Intolerant of Duragesic patch Preference for short acting opioids Intolerant or dislike of other opioids except their drug of choice	Function and/or activity increased significantly Preference for long-acting opioids Level pain scale
9	**Maximum effective dose**	Tolerated dose is infinite Overwhelming concern for drug Short-acting opioids work better than long-acting opioids at equivalent doses Never happy with any dose and always wanting dose escalation Pain level never changes despite dose change	Patient accepts pain level will never be zero Equianalgesic action across long-acting opioids Rational use of breakthrough medication
10	**Avoid opioids in drug abusers**	History of illicit drugs, alcohol abuse, and prescription drug abuse	No history or evidence of substance abuse

FIGURE 1. *Summary of Rules of Opioid Prescribing*

are indicated and illustrates signs of success and failure[5,6,7,8] (see Figure 1).

Rule No. 1

There should be a single prescribing physician using a multidisciplinary approach to pain management. Dosages must be monitored and re-evaluated with monthly visits and, because there is only one managing physician, the risk of overdose and withdrawal is eliminated.

Rule No. 2

Complete a thorough history and physical. Not only does this mean performing a thorough H&P, but also generating a detailed documentation of it.[9] Releases should be signed for any previous providers regarding previous treating doctors and/or substance treatment and/or psychological evaluations. The release must give permission for the physician to talk with other professionals regarding pain and associated co-morbid conditions only. HIPPA regulations forbid blanket releases, so the release must be specific. The contract needs to specify that the physician or his staff will be contacting previous caregivers or pharmacists. Refusal to sign a release prevents the

Chronic Narcotic Evaluation Checklist

by Dr. Randall L. Oliver, MD

Signs of Opioid Addiction

1. ❑ Overwhelming concern for drug
2. ❑ Frequent phone calls
3. ❑ Office visit devoted to discussing drug
4. ❑ Early refills
5. ❑ Stories
6. ❑ Concurrent use of other addictive drugs, such as tranquilizers
7. ❑ Concurrent use of other illicit drugs, such as marijuana
8. ❑ History of alcohol abuse
9. ❑ Obtaining opioids or other narcotics from other physicians or from the street
10. ❑ Acceleration of drug use other than prescribed
11. ❑ Self-pay
12. ❑ No referring MD
13. ❑ Out of town
14. ❑ Intolerant or dislike of other opioids except their drug of choice
15. ❑ Intolerant of Duragesic patch in particular
16. ❑ Preference of short-acting opioids
17. ❑ Short acting opioids work better than long-acting opioids at equivalent doses
18. ❑ Inconsistent opioid response (such as, the opioid does not last as long as it should) For example, Lortab works one hour or Oxycontin only lasts four hours *(Pay particular attention to the patch effect which lasts less than seventy-two hours.)*
19. ❑ Inconsistent opioid response (such as, the pain level decreasing only marginally; it takes the edge off)
20. ❑ A wide ranging pain scale (such as, the pain going from 2 out of 10 to an 8 out of 10 during the same month)
21. ❑ A hysterical or overrated pain scale (such as, the pain is a 10 out of 10 all of the time)
22. ❑ Psych abnormalities (such as severe depression, severe anxiety, bipolar disorder, personality disorder, psychosis)
23. ❑ Lack of other chronic pain indicators (such as little or no depression, anxiety, fatigue or insomnia)
24. ❑ Normal physical exam
25. ❑ Normal laboratory, x-ray, or other testing parameters; that is — no objective findings
26. ❑ No significant improvement in pain or function with significant dose increases
27. ❑ Fibromuscular disease
28. ❑ Accusatory of other physicians
29. ❑ Hysterical exam (such as a patient who moans and groans and otherwise relates a severe amount of pain and discomfort during the exam)

Signs of Opioid Success

1. ❑ Decreasing depression
2. ❑ Decrease in fatigue
3. ❑ Decrease in anxiety
4. ❑ Pain decrease response to dose or proportional to dose escalation
5. ❑ Function and/or activity increased significantly, especially in proportion to dose escalation
6. ❑ Patient contentment with medication
7. ❑ Relative or friend support improvement in pain/function (such as, improvement in personal relationships)
8. ❑ No development of tolerance
9. ❑ Level pain scale
10. ❑ Patient follows-up with ongoing psychological treatment, which shows improvement in psychological mental health function.
11. ❑ Decrease in insomnia

Notes:

Patient_____

Physician Signature_____

01/2003

Explanation of Checklist Questions

Signs of Opioid Addiction

1. Element of CAGE[8]
2. Violates the plan
3. Element of CAGE[8]
4. Violates the plan
5. Veracity
6. Increases the risk to you and increases the potential for overdose, side effects, abuse and addiction
7. First do no harm — addict
8. First do no harm — addict
9. First do no harm — addict
10. Violates the plan
11. Using insurance for other physician
12. Has other physician the patient is not telling about
13. Has other physician the patient is not telling about
14. Allowing for some individual variability — it is unlikely that one mu receptor agonist will work great if another does not work at all
15. Longest acting, so least favorable to addict-no peak or "buzz"
16. Short-acting, so most favorable to addict
17. Short-acting, so most favorable to addict
18. Scientific medicine — Lantus 24h, NPH 12h, Reg 4h
19. Like to see objective evidence of response to drug
20. Objectivity — if VAS pain is 2 one day and 8 the next day, then there should be concern that the opioid is not working
21. Non-objective — cannot measure so cannot follow treatment; usually neurogenic and opioid unresponsive or psych association
22. Compounding problem — need to treat this first — pain may be a consequence of psych and therefore the opioid is only treating the symptom; e.g. MTHA secondary to stress; the approach should be stress treatment, not Lortab. Also, be aware that bipolar condition increases the risk of addiction.[10,11]
23. Probable drug addict
24. No diagnosis, so no treatment
25. No diagnosis, so no treatment
26. Opioid does not work, so avoid use
27. Not particularly opioid responsive — needs more attention to sleep and depression
28. Attempting to flatter the physician: "He's bad, I know you are good." The physician tends to write a script to be the hero. The patient knows this!
29. Patient trying too hard to impress

Signs of Success

Objective, measurable improvement in function without signs of addiction, tolerance or abuse.

physician from managing the drug properly and should raise a flag for further investigation.

Physician problems with the DEA regarding opioids almost always arise from lack of documentation matching the prescription. Included in documentation is an explanation of the diagnosis, rationale for the treatment plan and an ongoing, updated treatment plan. Diagnosis needs to be thorough. Low back pain is not a diagnosis. It is a symptom. The diagnosis could be degenerative disk disease, osteoarthritis or spondylosis. Documentation should also include the rationale for giving opioids, such as a completion of a substance abuse screen, psychological exam, failure of other treatments and interference with function. The physician must be prepared to explain why unusually larger doses or frequency changes have been prescribed.

Before a physician prescribes a chronic opioid, the patient must have failed first line treatments. Chronic opioid use is not appropriate until non-opioid options have been tried and found inadequate. These include NSAIDs, Ultram, trigger-point injections, physical therapy, and chiropractic care. Documentation of this failure must be shown.

Rule No. 3

Perform urine drug screens on suspected abusers. Remember that the drug screen should be positive for the prescribed drug and no others. Addicts will commonly use the entire drug early in the month, run out and be negative on the drug screen. Alternately, they will sell the prescribed drug, take another and test positive for those non-prescribed substances.

Rule No. 4

Make appropriate consults; share the responsibility of treatment of the chronic pain syndrome. Appropriate consults may include a pain specialist, orthopedist, neurosurgeon and psychological specialist. Psychological examination by a professional trained in addiction is necessary to determine past or potential for abuse and manipulation. Since most chronic pain patients will eventually develop severe depression and/or anxiety as part of the syndrome, psychological care must be addressed as part of the overall treatment of chronic pain. Psychological care is an important part in any multidisciplinary approach to help the patient accept and cope with the psychological effects of chronic pain.

Rule No. 5

Co-morbid conditions must be identified and treated. The chronic pain syndrome is multifaceted and involves the whole body and the whole person. Pain cannot be controlled unless the co-morbid conditions of fatigue, insomnia, sexual dysfunction, anxiety and depression are also controlled. Not only is it poor medical care to treat a chronic pain patient with opioids as the only treatment — while not addressing the other issues — it is a red flag for a reviewing agency.

Rule No. 6

Monthly visits with accompanying documentation of symptoms and improvement of function is necessary to show continued need for the opioids. Constant re-evaluation for success and monitoring for warning signs of addiction or abuse is an ongoing process. Always write a prescription for opioids contingent on a patient evaluation — do not "call in" opioids! This is

a red flag for investigators. Be firm and do not make exceptions — no visit means no medication.

Certain patients will make numerous excuses regarding why they cannot come to an office visit and simultaneously warning that they will go into withdrawal if the physician does not fill the opioid early or in the absence of a visit. The answer to this is that they knew the risks when they signed the contract and the contract demands monthly visits. It is the patient's choice to not follow the contract and the physician's responsibility to not reward inappropriate behavior. This is a form of manipulation on the part of the patient. Threatening, manipulation and bargaining are signs of drug addiction. Do not be bullied into breaking your own contract by an uncooperative patient. Just remember to chart the conversation and reference to your contract.

At each monthly visit, update the continued need for the medication and functional status and impairment. Function is more important than the level of pain. For example, last month a patient rated his pain a 9 out of 10 and you prescribed a long-acting opioid. This month he rates his pain a nine but he also states that he has been able to interact with his family and assist with the household duties. An improvement in function has occurred and he receives benefits of improved relationships, a sense of participation and being needed. This is adequate reason to continue the opioid, despite the pain rating of nine. After stabilization, periodically try to decrease the dose (by 25%). Reevaluate! Do not just start oxycontin 20 BID and leave it forever without reevaluation (and documentation of such). This medication has potential for abuse and improper prescribing and inadequate documentation raises a red flag for investigators.

The patient must bring in unused medication at each visit. Hoarding may occur even if seen monthly. If a patient is seen Oct. 10, then Nov. 8, and then Dec. 6, he or she will then have two extra days each month. This equals an extra months supply in a year. Hoarding is not necessarily an indication of bad behavior. Normal patients will "hoard" due to a fear response. However, the doctor must keep track of the total dispensed. If such a patient, over a three month period, admits to having six days extra medication left over, there is no problem. However, if he or she has used the extra and has none left, then there is a problem.

Rule No. 7

A signed contract or opioid agreement should be on file. The contract must easily and completely describe the risks and benefits of opioid use. A contract or agreement also needs to explain in simple, direct terms the consequences of breaking the rules of the contract. It is also important to be firm and enforce the consequences. Tolerating rule-breaking by the patient allows the patient to manipulate the physician. Secondly, all patients should have appropriate care and monitoring with no preferential treatment. If a contract is signed, it should be enforced.

> *"Each patient needs to be monitored closely for risks and benefits and reevaluated at every visit for the continued need of opioid therapy."*

You do not have to treat everyone and you will not make everyone happy. Giving a non-compliant patient opioids is a severe medicological risk! Changing the rules is not an option. Set your rules and standards in advance. Patients who do not comply either do not get opioids or do not receive your treatment. A common problem is what to do with the non-compliant patient.

Consequences for non-compliance is key. Either force the patient to follow the plan—or quit seeing the patient. Only give opioids to patients who follow the plan. There is risk to the physician and the patient if the rules are not followed. It is okay to refuse opioids to a non-compliant patient. The opioids may improve functioning in a compliant patient, but the withholding of opioids is not life-threatening. There are other options besides opioids. The non-compliant patient is a drain on the physician and medical staff and lowers their compassion and time for the compliant patients.

The contract should also include the rule that the patient may only use one pharmacy to obtain opioid prescriptions and that the physician will check other pharmacies if abuse or diversion is suspected. The benefit of one pharmacy is that the pharmacy will stock the medication so that it is available when needed. Problems occur when a whole prescription cannot be filled or medication has to be ordered. Also the pharmacy will monitor the patient for you. A relationship between the pharmacist and the physician is beneficial. Also remember that most reports of drug abuse starts with a pharmacist's suspicion — either of the patient or the physician. The pharmacist is your best ally in preventing controlled substance abuse. Keep in close contact and friendly terms with them — they will warn you of potential problem patients. Note that they are also obligated to warn the DEA of potential problems with physicians.

Rule No. 8

Use long-acting opioids for chronic pain and avoid the short-acting opioids — except for breakthrough pain. Breakthrough pain should not be occurring more than twice daily. If breakthrough treatment is necessary more than twice a day, the maintenance opioid should be increased. Avoid mixing long-acting opioids with other long-acting opioids and, likewise, short-acting opioids with other short acting-opioids.

Rule No. 9

When prescribing long acting opioids, the dose should be determined by the maximum effective dose, not the maximum tolerated dose. Maximum tolerated dose would be infinite because you can gradually work up to any dose. Maximum effective dose is the dose that gives the maximum functionality while recognizing that relief in a chronic pain patient is not a totally pain-free state. Contractual dose escalation to obtain 100% pain relief is a fruitless endeavor.

Rule No. 10

Do not prescribe opioids to drug abusers. Although every person deserves pain treatment, it is against the physician and the drug addict's best interest. A drug addict has no ability to control him or herself when narcotics are present. The drive for stimulation from the drug is stronger than relief from pain. Other non-narcotic options are available. To screen for drug addiction, ask the four CAGE questions:[8]

C. Have you ever thought you should *cut down* on your drinking or substance use?

A. Have you ever felt *annoyed* by other's criticism of your drinking or substance use?

G. Have you ever felt *guilty* about your drinking or substance use?

E. Do you have an *eye-opener* (start your day with alcohol or other substances)?

Summary

Each patient needs to be monitored closely for risks and benefits and reevaluated at every visit for the continued need of opioid therapy. Figure 2 is a checklist to use to determine if the opioid is successful or becoming addictive or abused. Opioid prescribing should be one component of a balanced multidisciplinary approach to pain relief and improved functionality. Concurrent treatment options might include physical therapy, chiropractic, injection, as well as other treatments. ■

Dr. Oliver is Medical Director of the Oliver Headache & Pain Clinic, a regional pain center in Evansville, IN, and President of the Indiana Pain Academy. He regularly lectures, writes, does research and conducts seminars on multidisciplinary pain management. He can be contacted at Oliverclinic@cs.com.

April Taylor is a research writer on multiple projects for Dr. Oliver. She is also a diabetes nurse educator for critical cardiac care patients at Methodist Hospital, Indianapolis, Indiana.

References

1. Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. Federation of State Medical Boards of the United States, Inc. www.FSMB.org May 1998.

2. Drawing the Line Between Pain Management and Addiction. Psychopharmacology Update. 2001. 12(9): 1-4.

3. Oliver RL and Taylor A. Fatigue: The art of thorough assessment in chronic pain syndrome. American Journal of Pain Management. 2001. 11; 137-147.

4. Fine PG(ed) and Vallerand AH(ed). Optimizing Treatment of Chronic Pain with Opioid Therapy.Appropriate. Opioid Pharmacotherapy for Chronic Pain Management: a multimedia CME program. Division of Continuing Medical Education Discovery International. http://www.discovery-intl.com 2002.

5. Opioids for the Treatment of Chronic Pain. RxReview. AdvancePCS. http://www.advancepcsrx.com 2002.

6. Nicholson B. Pain Relief and Opioids: benefits, concerns and prescribing issues. The Royal Society of Medicine Press. http://www.rsm.ac.uk 2001.

7. Staats P and Johnson R. New Perspectives on the Pharmocology of Opioids and Their Use in Chronic Pain (CME monograph). The John Hopkins University School of Medicine. 2001.

8. Cole BE. Prescribing Opioids, Relieving Patient Suffering and Staying Out of Personal Trouble with Regulators. The Pain Practitioner. 2002. 12(3) 5-8.

9. Irick N. Considerations for the Management of Pain with Schedule II Drugs. Indiana Medicaid Drug Utilization Review Board Newsletter. 2001. 4(2)1-2.

10. Managing the Complex Pain Patient with Psychiatric Co-morbidity. Symposium Spotlight. 2002. 5:5-7.

11. Robbins L. Long-Acting Opioids for SevereChronic Daily Headache. Lifeline. National Chronic Pain Outreach Association. Spring 2000.