MINNESOTA PHYSICIAN

NOVEMBER 2015

THE INDEPENDENT MEDICAL BUSINESS JOURNAL

Volume XXIX, No. 08

The importance of a pain management plan

A guide for primary care physicians

BY DAVID SCHULTZ, MD

Treating patients with chronic pain is often complicated and labor intensive. Managing chronic pain with long-term opioids is a controversial practice as the U.S. is experiencing an epidemic of opioid-induced morbidity and mortality. According to recent Centers for Disease Control and Prevention (CDC) data, the overdose death rate from prescription opioids more than tripled from 1990 to 2013 and opioid overdose is now the leading cause of injury death in the U.S. Doctors who prescribe long-term opioids to treat chronic pain are increasingly being held liable for patient overdoses, patient traffic accidents, and drug-related patient injuries. As a physician prescribing opioids, you could be sued for causing addiction, wrongful death, and patient injury; you could be investigated by the medical board and lose your medical license; you could even be prosecuted for murder. Reimbursement for managing opioids is low and does not adequately compensate the physician for the time, effort, and liability risks involved.

Why prescribe opioids?

Why should any sane primary care physician manage opioids in chronic pain patients? The following reasons come to mind:

- As physicians, we want to help our patients.
- Uncontrolled pain can have harmful physical effects such as elevated blood pressure and elevation of stress hormone levels.
- Chronic pain can imprison the patient in a sedentary lifestyle and lead to suicide from chronic anxiety and depression. Opioids allow some patients to get out of bed and lead a more normal life.
- Opioids, even at high dose, do not harm the body's organs, unlike NSAIDs and acetaminophen, which, according to the American Journal of Gastroenterology, cause thousands of American deaths each year from bleeding or liver damage respectively.
- Some chronic pain patients achieve excellent pain relief, better physical functioning, and life-changing improvement with minimal side effects on long-term opioids and never become addicted.
- Opioids have been the standard of care for pain management for over 100 years.

If you weigh the pros and cons and make an informed decision to manage your chronic pain patients, with or without opioids, a pain management plan will help to keep your patients safe and you out of trouble.

The importance of a plan

A pain management plan is important in part because it lends structure and thoughtful logic to the management of a complex, controversial, and high-risk disease state. According to the Institute of Medicine, 100 million Americans suffer from chronic pain and one quarter of them have pain that is severe enough to reduce their quality of life. Recent NIH data suggests that 9.4 million Americans take opioids for long-term pain management and approximately 2.1 million may be considered addicted. There is little scientific evidence to prove that opioids are effective after six months of continuous use. In 2014, the American Academy of Neurology concluded that the risks of long-term opioid treatment for headaches and chronic low back pain likely outweigh the benefits. In 2015, an NIH Panel on Opioids concluded, "There is insufficient evidence for every clinical decision that a provider needs to make regarding use of opioids for chronic pain." Nonetheless, most experienced physicians agree that a substantial number of chronic pain patients benefit from long-term opioids and use them responsibly.

A comprehensive pain management plan will facilitate safe opioid prescribing, help legitimate patients achieve pain relief, and reduce abuse and diversion of prescription opioids. The plan should consider the following.

1. ***Identify and document the pain diagnosis you are treating.*** Chronic radiculopathy, complex regional pain syndrome, failed back surgery syndrome, and rheumatoid arthritis are well-defined pain diagnoses that have been historically treated with opioids. Fibromyalgia and chronic headache are more ephemeral diagnoses for which opioid management would be more controversial.

2. ***Determine the relative abuse and diversion risk for each patient.*** It is possible to assess pre-treatment addiction risk by using screening questionnaires such as OTORI, ORT, SOAPP-R, and DIRE while screening questionnaires such as PMQ, COMM, and PDRQ may identify abuse once treatment has started. According to a 2013 VA study by Zedler et. al., the 14 item OTORI screening questionnaire may be the best tool to predict opioid overdose prior to starting treatment. The most important medical history items associated with opioid abuse include personal or family history of addiction and comorbid psychiatric conditions.

3. ***Identify specific, achievable patient goals for chronic pain therapy before beginning opioids.*** For example:

   - The patient will go shopping for groceries without assistance once per week.
   - The patient will attend their child's school functions twice per week.
   - The patient will stay out of bed for at least 14 hours per day.

A comprehensive pain management plan will facilitate safe opioid prescribing.

4. ***Define your opioid philosophy and rules for opioid prescribing in writing.*** For example:

   - Chronic opioids will be provided to you at the lowest possible dose that relieves pain and improves function in conjunction with multidisciplinary physical and psychological therapies and referral for interventional procedure as appropriate.
   - You agree to obtain opioids only from this medical practice. If you obtain controlled substances from any other source, you must inform us immediately.
   - Lost and/or early prescriptions will not be refilled.
   - Random urine drug screens will be performed.
   - We will involve family members in the evaluation and treatment process whenever possible.
   - Functional improvement is as important as pain relief and we will regularly measure physical function.

Your patient should sign a formal "Opioid Agreement," which describes your requirements and expectations for the patient. Sample opioid agreements are available online and should be reviewed and customized to your medical practice and your prescribing philosophy.

5. ***Define a ceiling dose for opioids.*** Death rates are increased in patients who take high doses of opioids so consider a ceiling dose for the opioids you prescribe. Data from Washington State suggests that capping a maximum opioid dose at 100–200 morphine mg equivalents per day can reduce overdose mortality. Combining appropriate non-addicting medications such as anti-inflammatories, acetaminophen, nerve stabilizing medications, and antidepressants will help to keep the opioid dose as low as possible.

6. ***Facilitate multidisciplinary management.*** Chronic pain is most effectively treated when multidisciplinary resources are utilized so consider referring your patient to a physical therapist, psychologist, psychiatrist and/or an interventional pain clinic as appropriate. Regular physical therapy combined with a home exercise program will help maximize physical function. Treating anxiety, depression, and comorbid psychiatric conditions with psychological or psychiatric evaluation and therapy is equally important to the success of any pain management plan. Referral to an interventional pain clinic is appropriate for patients who may benefit from interventional procedures such as:

   - Epidural steroid injections for disc herniation
   - Sympathetic blocks for complex regional pain syndrome
   - Medial branch radiofrequency ablation for axial spine pain of facet origin
   - Spinal cord stimulation for intractable neuropathic pain
   - Implant of an intrathecal infusion pump for targeted drug delivery in patients who are refractory to or experience unacceptable side effects from oral opioids

7. ***Emphasize Prescription Monitoring Program (PMP) database checks and urine drug screening.*** It is important to check the PMP database before dispensing any opioid prescription and to perform urine drug screening (UDS) at baseline and randomly during opioid therapy. According to the Centers for Medicare & Medicaid Services (CMS), PMPs have resulted in improved prescribing patterns, decreased use of multiple providers and multiple pharmacies, and a reduction in substance abuse hospital admissions. Studies from Washington state and Canada have shown that PMPs in combination with UDS, patient education, pill counts, and written opioid agreements can reduce prescription opioid abuse by 50 percent. Low-risk patients may be appropriate for urine drug screening every six months whereas higher risk patients should be screened more frequently.

Conclusion

Finally, be sure to follow your written plan and protocols. If you continue to prescribe opioids in the face of positive urine drug screens and multi-provider prescriptions evident in the PMP, you put your patient's safety and your medical license at risk. If pain is not relieved and function not improved, consider weaning opioids. Weaning protocols are available and typically include reduction of opioid dose by 10 percent to 30 percent per week depending on circumstances. If a patient is actively abusing opioids, inpatient detoxification may be appropriate.

David Schultz, MD, is founder and medical director of MAPS Medical Pain Clinics and MAPS Applied Research Center. He is board-certified in anesthesiology and pain medicine.