Subject: Pain Management

Objectives:

Managing pain and restoring function are basic goals in helping a patient with chronic non-cancer pain. Federal and state guidelines require that all patients have the right to adequate pain assessment including documentation of the location, intensity, quality, onset, duration, effects of, and exacerbating factors.

It is the intent of this pain management policy to define guidelines for management of both Acute and Chronic Non-Cancer Pain. The objectives are as follows:

I. To ensure members with chronic non-cancer pain are treated with respect and dignity according to the same basic principles as other chronic illnesses.

II. To ensure that members with Acute or Chronic Non-Cancer Pain receive appropriate, timely, and optimal assessment of their pain with a treatment plan, which includes assessment tools and regular follow-up assessments.

III. To ensure that the pain assessment includes all aspects of the member’s functioning, including physical, psychological, social and work-related factors.

IV. To ensure that all Providers and Clinical Office Staff are properly educated on Pain Management Rules and Guidelines set by the State of Oregon.

V. To Adapt and Follow the Healthy Columbia Willamette Coalition (HCWC) Standard for New Opioid Prescriptions for Patients with Chronic Non-Cancer/Non-Terminal Pain.

Definitions:

I. Acute Pain is a type of pain that is directly related to tissue injury. It is of short duration, 3 months or less, and gradually resolves as the injured tissues heal. Examples of Acute Pain are Surgery, an Injury such as a Fracture, Tear, or Laceration, or an Infection or Inflammatory Process.

II. Chronic Non-Cancer Pain is a type of pain that extends beyond the expected duration of healing, or 3 months. Chronic Pain is defined as persistent and can be either continuous or recurrent, and of sufficient duration and intensity.
Subject: Pain Management

There are four types of chronic non-cancer pain. These types are:

A. Neuropathic Pain. This is pain produced by damage or dysfunction of the nervous system. Examples of Neuropathic Pain are:
   1. Sciatica
   2. Diabetic Neuropathy
   3. Trigeminal Neuralgia
   4. Post Herpetic Neuralgia

B. Muscle Pain. This is the most common form of pain and may be due to:
   1. Muscle Strain
   2. Direct Trauma
   3. Vascular Insufficiency
   4. Fibromyalgia
   5. Myofascial Pain Syndromes

C. Inflammatory Pain. Pain that is caused by inflammatory chemicals that directly stimulates primary nerves that carry pain information. Examples of Inflammatory Pain are:
   1. Arthritis
   2. Infection
   3. Tissue Injury
   4. Post-operative Pain

D. Mechanical/Compressive Pain. Pain that is caused by mechanical pressure or stretching that directly stimulates the pain sensitive neuron. Examples of Mechanical/Compressive Pain are:
   1. Neck and Back Pain
   2. Degeneration of Disks or Facets
   3. Fractures and Obstruction
   4. Dislocation or Compression of Tissue

III. A Consultation is an evaluation of a patient by a specialist in a related anatomic or pain discipline with recommended treatment options and then the patient returns to the primary care physician for implementation (ICSI, 2005).

IV. A Referral is where the patient is being sent to the specialist for not only evaluation, but also ongoing care with little or no long term involvement by the
Subject: Pain Management

In 2014, the Patient Safety Subcommittee of the American Academy of Neurology requested a review of the science and policy issues regarding the rapidly emerging public health epidemic of prescription opioid-related morbidity and mortality in the United States. Over 100,000 persons have died, directly or indirectly, from prescribed opioids in the United States since policies changed in the late 1990’s. In the highest-risk group (age 35-54 years), these deaths have exceeded mortality from both firearms and motor vehicle accidents. While there is evidence for significant short-term pain relief with opioids, there is no substantial evidence for maintenance pain relief or improved function over long periods of time without incurring serious risk of overdose, dependence, or addiction. Fifty percent of patients taking opioids for at least 3 months are still on opioids 5 years later.

Policy:

I. Tuality Health Alliance (THA) members will have access to appropriate and effective pain management. The treatment plan will be based on the following:
   A. Type of Pain (Acute or Chronic Non-Cancer Pain)
   B. Onset of Pain
   C. Intensity of Pain
   D. Current and/or past treatments for the pain, if any
   E. Underlying or Co-Existing Disease Processes
   F. Effect of the Pain on Physical and Psychological Function
   G. History of Substance Abuse
   H. History of Mental Illness
   I. Current Medication List

II. For members with Acute Pain resulting from injury or surgery, the goal is Adequate Analgesia, but should be time limited. Opiates should be prescribed with great caution in the context of substance abuse. Opioid dosages above 120
Subject: Pain Management

MED/day are not permitted. The concomitant use of Benzodiazepines and Opioids is inadvisable due to the synergistic effect of those drugs, resulting in respiratory depression. Experienced Clinicians can judge the average length of time that an acute injury should require opioids, and a step-down approach to Non-Opioid Analgesics is recommended after that time.

III. Providers Prescribing Opioids for “Intractable” or Chronic Non-Cancer Pain should be treated according to Oregon Revised Statutes (ORS), and the Oregon Administrative Rules (OAR) 847-015-0030.

IV. According to the above mentioned rules and regulations:
   A. Acute pain treatment will be time limited, 3 months or less, with Opioid Dosages not to exceed 120 MED/day. Concomitant use of Benzodiazepines is inadvisable.
   B. Acute Musculoskeletal Pain should be treated conservatively with Physical Therapy and Conditioning, Heat, Ice, Good Sleep Hygiene, Good Nutrition, Weight Loss, or Pool Therapy. If these measures are ineffective, introduction of NSAIDS or Acetaminophen can be explored. Skeletal Muscle Relaxants should be a last resort, and utilized acutely after an injury and discontinued thereafter.
   C. Chronic Non-Cancer Pain Management with a patient already taking daily Opioids should follow these guidelines:
      1. Previous patient records should be evaluated before prescribing. Perform Alcohol and Drug Use Screen to identify use disorders and confirm medications are not being diverted.
      2. A PDMP Report should be created prior to each office visit and included in the medical record.
      3. An initial Urine Drug Screen should be performed, and randomly thereafter to evaluate for illicit substances or opioids not currently prescribed.
      4. If Opioids are to be continued, a THA Pain Management Contract will be initiated. Copies of this signed agreement will be kept in the patient’s Provider file, THA Case Management File, and on the ED Care Plan. If the member violates this Contract, the authorization for further Opioids will immediately end.
Subject: Pain Management

5. Weekly appointments are encouraged to evaluate compliance, effectiveness and safety.
6. Concomitant use of Alcohol, Benzodiazepines, Sedative-Hypnotics, and Marijuana should be avoided.
7. For members receiving dosages higher than 120 MED/day, a Tapering Protocol must be initiated. The MED Dose Equivalency table should be used as a guide for dosing.

<table>
<thead>
<tr>
<th>OPIOID</th>
<th>APPROX. EQUIV. DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>200mg</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5mg</td>
</tr>
<tr>
<td>Methadone Chronic: 4mg</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20mg</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10mg</td>
</tr>
<tr>
<td>Fentanyl Transdermal</td>
<td>12.5mcg/hr</td>
</tr>
</tbody>
</table>

**Slow-Taper Protocol:**
1. *Long-acting opioids:* Decrease total daily dose by 5-10% of initial dose per week.
2. *Short-acting opioids:* Decrease total daily dose by 5-15% per week.
3. Once 25-50% of the total dose is reached, the rate of taper can be slowed to 5% per week.
4. Patient should have weekly appointments, and aberrant behaviors should be addressed by referral to a behavioral health specialist as soon as possible to assure patient compliance and safety.
5. Consider use of adjuvants for management of withdrawal symptoms:
   a. Antidepressants to manage irritability and/or sleep disturbances
   b. Hydroxyzaine for insomnia and anxiety
   c. Anti-epileptics for neuropathic pain
   d. Clonidine for autonomic withdrawal symptoms
Subject: Pain Management

   e. NSAIDS for myalgia
   f. Anti-diarrheal agents for diarrhea

D. Consider a Slow-Taper Method for patients currently taking Benzodiazepines after achieving a reduced baseline dose of Opioids.

E. Encourage patient participation in Individual and/or Group Substance Abuse Therapy.

F. Chronic Musculoskeletal Pain should be managed with Physical Therapy and Conditioning, Heat, Ice, Good Sleep Hygiene, Good Nutrition, Weight Loss, and Pool Therapy. Opioid pain medications are not appropriate treatment or the standard of care to chronic musculoskeletal pain. NSAIDS and muscle relaxants should be used sparingly and only in cases of flare-ups or concurrent pain conditions.

G. All Opioids will require Prior Authorization by THA Case Management. Patients receiving Opioids and have a signed Pain Contract on file will be monitored for compliance. Any violation of the Pain Contract will result in a block being placed in the pharmacy system for any further refills or new Opioid Prescriptions.

H. Consider a transition to Buprenorphine from a Credentialed Physician, with weekly visits to a Buprenorphine Clinic.

V. Coordination of Care
   A. The Primary Care Physician will be responsible for coordinating referrals/consultations with specialists to address the pain or its underlying cause.
   B. The Primary Care Physician's office will be encouraged to contact the THA Case Management Department if assistance is needed.
   C. A Prior Authorization is required for all referrals to a Pain Management Clinic.
      1. Supportive Documentation must accompany the referral request, including need for referral and thorough Pain Assessment.
      2. THA Pain Contract must be signed by the patient and Physician and accompany the referral request if the patient is currently receiving opioids.
   D. Members desiring to enter a Detoxification program should be referred to Hooper Detoxification Stabilization Center of Portland.
Subject: Pain Management

1. Members or Primary Care Physicians should call Hooper for specific admission information.
2. THA Case Management will have active participation with all members admitted to Hooper, supporting after-care needs via the Community Outreach Specialists.
   a. Member success will be reinforced by Case Management with regular phone communication and meeting members at provider appointments when available.
   b. Community Resources will be provided to members upon request, including Behavioral Health Provider information.

References:
Healthy Columbia Willamette Coalition (HCWC); Opioids for Chronic Non-cancer Pain: A Position Paper of the American Academy of Neurology; Oregon Pain Guidance Opioid Prescribing Guidelines 2015; Medical Review Institute of America, Anesthesiology and Pain Medicine Review; Oregon Health Authority – Mel Kohn, MD MPH.

Formulated: August 2003
Reviewed: April 2015
Revised: June 2007
December 2009
June 2012
April 2015

THA Plan Director
THA Medical Director