

History & Physical Evaluation

- Take a general patient medical history.
- Take a specific patient pain history, including past treatments for pain such as medications/other surgeries/treatments. Get the names of treating physicians OR review a recent (within the last 30 days) report from a credible source and document your review and impressions.
- Obtain the patient's self-report about current pain: nature, intensity of pain, pain levels and descriptive terms, and document the patient's initial reports.
- Perform a condition-appropriate physical examination* OR, if state permits, review a recent report (within the last 30 days) from a credible source.
- Get records of past treatments for pain directly from prior providers. Review them and document review via initials or stamp. Communicate with these providers as appropriate.
- Perform patient risk assessment inquiry by asking patient about (1) his/her history of substance abuse, including alcohol, illegal drugs, and prescribed controlled drugs, and (2) all first degree family members' substance abuse, including alcohol, illegal drugs, and prescribed controlled drugs. Also evaluate patient for other high-risk medical issues, such as morbid obesity, use of tobacco, co-existing psychiatric disorders. Communicate with addiction and mental health professionals as appropriate.
- Consider whether to use an early consult/referral for pain condition, abuse issues, psychiatric disorders, etc. NOTE: Some states require an evaluation by a specialist for pain condition if long-term use of controlled substances contemplated under "intractable pain" statute.*
- Use at least one objective risk assessment tool, such as the Zung Depression Scale, DAST-20, ORT, SOAPP, PDQ, CAGE, PDI, etc. to support your decision-making and document your response to test scores in the medical record. This is critical to legitimate medical purpose and patient monitoring or supervision through a treatment plan and follow-up care schedule.
- Order initial urine drug test (comprehensive) to corroborate patient's self-report and to establish base-line clinical issues.*

Treatment Plan

You must clearly document your rationale for the treatment selected and create a plan of care. It is best to use a written treatment plan. Give serious consideration to all of the factors leading to your decision to prescribe controlled substances long-term and to your specific drug selection (important if you are selecting a drug that has attendant clinical challenges or if you are prescribing off-label). You should adjust the treatment plan to the individual patient. *You should document a working diagnosis and the pain state (acute, chronic, intractable, malignant) in a written treatment plan.* In the treatment plan:

- State whether you plan other diagnostic tests, labs, etc.
- Document clinical rationale for any medications prescribed – document medical necessity for use of controlled substances and other treatments.
- Establish goals for treatment (functional, psychosocial, etc.) (may include going back to work/staying employed, etc).
- Establish goals for acceptable functional and pain levels. Modify as changes occur.
- Establish objective methods for measuring patient's accomplishment of treatment plan goals and use periodic review to determine whether met (set actual dates).
- Establish length between office visits and how frequently patient will see physician versus mid-level practitioners.
- Document a "drug trial" if patient is new to medications or is switching medications. NOTE: Some states require a trial of non-addictive modalities or a statement why the same is not appropriate for the patient.*
- Decide how to address common/known side-effects like constipation (prophylactic approach); Educate patient on these issues in the Informed Consent.
- Determine whether there is a reason to communicate with the patient's Primary Care Physician about the treatment plan and use of controlled substances.

Informed Consent

Informed Consent is not the same as a Treatment Agreement (aka Narcotics Contract). Informed Consent is a process by which the physician explains the treatment options and recommendations to the patient and gives the patient information on treatment risks, expected benefits, treatment alternatives, and special issues, like side effects. It is best to use a written Informed Consent form and make sure it covers the following topics in clear and simple terms:

- Discuss risks of using medication prescribed (prolonged use of short- or long-acting medications, side-effects, addiction, physical dependence, tolerance).
- Discuss benefits of using medications prescribed.
- Discuss alternative treatments available to patient in lieu of medications prescribed.
- Discuss special issues re: use of medication prescribed (driving issues, operating heavy machinery, carrying a weapon, working in a coal mine, driving a school bus, etc).

Make sure to give the patient an opportunity to ask questions and document this effort. Obtain patient's signature, give patient a copy of form, and retain original in medical record. Periodically REVIEW and RENEW the Informed Consent when you undertake a substantial change in the treatment plan, meaning prescribe different medication, add in medication, or substantially increase medication dosage.

Legend

Single Asterisk (*) means this depends on state licensing board requirements and standards of care.

Double Asterisk (**) means outside source: Passik & Weinreb, *The Four A's of Pain Treatment Outcomes* (1998).

Other Sources: Federation of State Medical Boards *Model Policy for the Use of Controlled Substances for the Treatment of Pain* (May 2004)

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Agreement for Treatment

Use the Agreement for Treatment to set boundaries with patients regarding use of controlled substances and treatment plan compliance. This document is distinct from the Informed Consent. The Agreement for Treatment should emphasize patient responsibilities.

- Decide whether to use it with all of your patients or only high risk patients.* Your state may require use versus discretionary use.
- Typical terms include: (1) one physician/one pharmacy, (2) no use of other CS without advising you, (3) no purchase of CS through Internet, (4) agree to urine tests *as requested*, (5) agree to medication counts as requested, (6) agree to designation of a family member/friend as accountability partner, (7) agree to participate in family conference as requested,* (8) report ER and Outpatient visits within 24 hours of discharge, (9) agree to store and handle drugs safely at home, (10) specific HIPAA consent for necessary disclosures, and (11) understand consequences if violated (specify consequences), including discontinuation of controlled substance therapy and/or discharge from the practice.
- Address accountability issues for use of "PRN" medication (breakthrough and rescue medication) and consider patient's compliance during periodic review sessions.
- Obtain patient's signature, give patient a copy of form, and retain original in medical record.
- REVIEW periodically and renew if circumstances relating to patient's behavior/clinical situation change.

Periodic Review

Assess the patient periodically, based on the individual circumstances of the patient's case (including reference to patient's risk assessment level – low, moderate, or high risk potential for abuse and diversion of controlled substances) and according to standards of care and state licensing board guidelines and regulations. Remember the physician must see the patient at times during the periodic review process* and the timing of the physician's participation should be based on the patient's individual circumstances, the complexity of the case, the supervising agreements with mid-level providers, and the patient's risk potential for abuse/diversion.

Consider the following for periodic review:

- Use the "Four A's" - Assess the patient's Activity, Analgesia, Adverse Events, and Aberrant Drug-Related (or Non-Compliant) Behavior.** Consider using the PAD-T form** or one of my forms designed to document periodic review.
- Document whether the patient is meeting treatment plan goals.
- Consider whether the patient is more functional or maintaining functional level? Is the patient improving in the area of ADL?
- Is pain control improving? If so, document rationale for continued use of medications. If not, make necessary treatment plan adjustments.
- Document ongoing rationale for continued use of prescribed medications. Are medication changes necessary?
- Are there psychological issues to address? Should you repeat the Zung depression scale or other objective assessment tool? Should you refer patient for counseling? Are medication changes necessary?
- Is the patient handling the prescribed medications responsibly? Is there a need for a medication count? Another urine drug test? Referral?
- If the patient's function is not improving or if the patient has demonstrated aberrant drug-related behaviors, consider whether it is time to revise treatment plan or d/c meds. Likewise, consider whether to obtain a consultation or make a referral – if so, do it and document it.

Consultations & Referrals

- Consider whether a consultation or a referral is appropriate at any time during the physician-patient relationship.
- If patient has symptoms or history of depression or other psychological problem, consider mental health consult and document efforts and results.
- You may need to use a consultation or referral early in the treatment plan if the patient has a history of substance abuse or coexisting psychiatric disorder.
- Document your efforts and the results; Document corresponding changes/modifications to the treatment plan.
- Make sure you obtain reports from consultations and referrals and review each patient and file them according to appropriate documentation standards.*

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