



PCP Treatment & Referral Guidelines

PAIN MANAGEMENT

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I.	Chronic Pain Information	Page 2-3
II.	The Role of the Primary Care Physician in Chronic Pain Management	Page 3-4
III.	Referrals for Evaluation, Possible Procedure(s), Medication Advice Physical and Behavioral Therapy as Indicated	Page 4-6
IV.	Referrals by PCP for Diagnostic and Therapeutic Procedures only	Page 6
V.	Determining When to Initiate or Continue Opioids for Chronic Pain	Page 6
VI.	Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation	Page 7
VII.	Assessing Risk and Addressing Harms of Opioid Use	Page 7

I. Chronic Pain Information

Chronic pain is defined within this guideline as pain that typically lasts >3 months or past the time of normal tissue healing

A) Chronic pain can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation, or an unknown cause. However, few studies have been conducted to rigorously assess the long-term benefits of opioids for chronic pain (pain lasting >3 months) with outcomes examined at least 1 year later

B) It is estimated that over 100 Million people in the U.S. have chronic pain

C) Chronic Pain can be a disease in itself. Care must be tailored to each person's experience. There is mounting evidence of a significant increasing trend over the last decade of opioid prescribing with an associated increase in opioid overdose deaths.

D) While the United States represents only about 5% of the world's population, it consumes more than 80% of all opioids.

E) There were 1,882 opioid overdose deaths in 2017 in California. There were more than 21 million opioid prescriptions in California in 2017. There were 4,281 opioid overdose ER visits in 2017 in California.

Treatment for chronic pain is shifting away from reliance on just medication management and toward comprehensive, multimodal care that can include medication therapy. Chronic pain programs enable the delivery of coordinated, interdisciplinary, outcome-driven care that supports patients as they learn to manage and live with chronic pain. Because chronic pain patients are not a homogenous group, tiered treatment options can most efficiently and effectively treat these patients.

Chronic pain management programs employ a comprehensive, multimodal treatment approach that improves function and quality of life for patients suffering from chronic pain as a result of trauma, neurological degeneration, neuropathy, arthritis or other chronic conditions.

Chronic pain programs enable the delivery of coordinated, interdisciplinary, outcome-driven care that supports patients as they learn to manage and live with chronic pain. Treatment protocols include cognitive, behavioral and physical therapies, manual treatments and interventions and medication management. All pain management programs should have a well-developed, regularly enforced drug screening policy. Patients who fail a screening should be provided with appropriate resources to help them through addiction issues and, subsequently, enter the pain program.

The Centers for Disease Control and Prevention (CDC) recently released a guideline for primary care clinicians who care for adults with chronic pain (i.e., lasting longer than three months or past the time of normal tissue healing) in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care (4).

This guideline is intended to help clinicians decide whether and how to prescribe opioids for chronic pain; offer safer, more effective care for patients with chronic pain; improve clinician-patient communication; and prevent opioid use disorder and opioid-related overdose. The guideline is based on a rigorous evidence review using the Grading of Recommendations Assessment, Development, and Evaluation framework with input from various expert groups, medical organizations, clinicians, patients, advocacy groups, state agencies, national partners, a federal advisory committee, and the general public.

Among its 12 recommendations are the following especially important points that can help clinicians make treatment decisions for patients with chronic pain:

A) Nonopioid therapy is preferred for management of chronic pain. Opioids should not be used as routine therapy outside of active cancer treatment, palliative care, or end-of-life care. When opioids are used, they should be combined with other therapies to improve benefits for patients.

B) When opioids are used, the lowest effective dosage should be prescribed to reduce the risk of opioid use disorder and overdose. Three days or less will often be sufficient; more than seven days will rarely be needed.

C) Clinicians should use caution when prescribing opioids, closely monitor all patients receiving opioids, and continue opioid therapy only after reevaluating the patient to determine whether the benefits outweigh the risks.

D) When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

E) Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

F) Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

G) Realistic expectations should be discussed with the patient. It is rare for a patient with chronic pain to be entirely pain free from pain management modalities. In addition, the goal is to improve and optimize the patient's ability to function with pain.

The full CDC guideline is available at <https://www.cdc.gov/drugover-dose/prescribing/guideline.html>

II. The Role of the Primary Care Physician in Chronic Pain Management

The Primary Care Physician is responsible for providing the initial evaluation and management for a patient with chronic pain based on her/his skill level. The PCP is responsible for coordinating all services required by the patient except when precipitous circumstances arise. The PCP should provide those services which can be provided within his/her competence and should obtain consultation when additional knowledge or skills are required

Consultation includes advice received from a telephone discussion with a specialist and the referral of a patient to a specialist for services. When care by a specialist is required, it is the responsibility of the PCP and the specialist to coordinate all services.

The primary care physician is responsible for providing the following basic pain management services:

A) The PCP should assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. In addition, the PCP should assess for depression, anxiety, and secondary gain along with possible alcohol or substance abuse and should include a thorough medication history. The many possible causes of chronic pain, including osteoarthritis, rheumatoid arthritis, and other inflammatory conditions, degenerative disease and neuropathic pain should be considered. When indicated, the PCP should assess for pain related to work injuries and ask about the relation to accidents or legal issues.

B) A thorough physical exam should be performed as clinically indicated.

C) The PCP should prescribe appropriate analgesics when indicated for the initial management of chronic pain including acetaminophen, NSAIDs, tramadol, and opioids such as codeine, hydrocodone, oxycodone, morphine and other opioids.

D) The PCP should distinguish between physiologic dependence or tolerance and addiction.

E) A pain management contract is an important part of the scope of pain management. PCPs should consider a pain management contract for all chronic pain patients whom they are following.

F) A referral to a pain management specialist should be considered when clinically appropriate. Patients should not be referred to a pain management specialist until treatable underlying causes have been evaluated thoroughly by the PCP and other specialists as indicated. All psychiatric illnesses should be under treatment. Any illegal drug usage should be identified, documented and addressed. When specialty consultation is requested, the PCP is responsible for sending all relevant clinical information to the specialist.

G) Once the patient is stabilized as determined by the pain management physician, the PCPs should resume the ongoing pain management care of the patient. Occasionally there may be circumstances where the patient may need periodic referral back to the pain management specialists for acute exacerbations or more complex pain management needs of the patient. This collaborative approach enables PCPs to motivate patients to continue the progress they've made, reinforce the biopsychosocial model for treating pain, and communicate with the interdisciplinary team about patients who may be relapsing.

Referrals for those on chronic opiates or multiple drugs are not intended to transfer the care of the patient or the chronic prescription needs of the patient to a pain specialist. Instead they are intended to enable expert review of the patient's regimen with suggestions for improvement when appropriate and review and/or implementation of a pain contract with the patient. It is essential that the patient be informed that the referral is not to eliminate pain, but rather to improve the patient's ability to function with the pain and to insure that the patient's medication regimen is optimized, and that the pain specialist will not be taking over their care.

The referring physician can expect that the pain specialist will conduct a thorough review of the patient, order any necessary studies, perform a procedure if indicated, review with the patient pertinent issues about chronic pain management including drug testing and a pain contract, make changes to the patient's drug regimen if indicated, and see the patient for a return appointment once or twice if needed after a change in regimen. This information and recommendations for future management will be provided to the referring physician to assist in the future management of the patient, including the referring physician's provision of necessary prescriptions.

III. Referrals for Evaluation, Possible Procedure(s), Medication Advice, plus Physical and Behavioral Therapy as Indicated

General

Prior authorization of the referral is required.

A) Pain Specialist physician provides a consultation, makes recommendations and when appropriate directs the care of the patient.

- 1) The medical evaluation includes
- 2) Medical record review, imaging study review.
- 3) A standard patient contact for history & physical examination.
- 4) A psychosocial evaluation that may include psychological testing and interpretation.
- 5) Preparation of a typed report.

B) A treatment plan is developed including recommendations from multiple disciplines as appropriate: the pain specialist, psychologist, physical therapist, and other staff professionals. A summary report and treatment plan is created and can include recommendations regarding:

- 1) Stress Management

- 2) Coping with Negative Emotions
- 3) Nutrition
- 4) Exercise
- 5) Sleep
- 6) Relationships/Family
- 7) Interventions/Modalities/Advanced Therapies
- 8) Medications
- 9) Spirituality

C) Treatment plans frequently include a variety of modalities such as ongoing medical and psychological care plus procedures if appropriate.

D) The role of the Pain Specialists professional is concluded with the implementation of the treatment plan. Patients who have no indication for a procedure and instead need a focus on medication, PT, and behavioral health may require just two or three visits, whereas more complex cases may require 6 – 12 months.

E) Conditions Excluded

- 1) Untreated alcoholism or drug abuse. Treatment must include active participation in a treatment program, e.g. AA or NA.
- 2) Untreated psychiatric illness
- 3) Referrals for “Secured Prescriptions (triplicate prescriptions)” only.

F) Patient Selection

a) The patient most likely has a treatable source of pain:

- 1) Lumbar disc disease.
- 2) Zygapophyseal joint arthropathy (including whiplash).
- 3) Sensory nerve entrapment syndromes.
- 3) Post herpetic neuralgia.
- 4) Complex regional pain syndrome (RSD)
- 5) The referring physician requests the Pain Specialist physician determine the treatment options or level of pain care needed when the pain diagnosis is established.

b) The referring physician requests the Pain Specialist physician provide diagnostic consultation for:

- 1) Pain of spinal origin.
- 2) Chronic and recurrent Headache Syndromes.

c) Patients who need intensive pain management while being worked up by the referring physician or specialist for a medical condition causing the pain, e.g. cancer pain, pelvic pain, abdominal pain.

d) When a primary care clinician determines he/she needs specialty opinion on the quantity, dosage and interactions of pain and neuroactive medications for a patient with chronic pain

e) When a patient needs and wants help in reducing opiate usage, and the referring physician feels that this is beyond his/her ability.

f) When a procedure may improve the pain

g) When a patient is chronically receiving more than 60mg daily of morphine equivalent opiates (this is about one Vicodin 5/325 QID) and does not wish to try to reduce or stop using opiates.

G) Treatment plans may include:

- a) Diagnostic and treatment procedures.

- b) Biofeedback.
- c) Physical therapy
- d) Behavioral therapy
- e) Medications

IV. Referrals by PCP for Diagnostic and Therapeutic Procedures only:

General

Prior authorization of the referral is required.

- A) The care of the patient remains under the direction of the referring physician.
- B) Patients are referred directly and do not require a pre-procedure office consult.
- C) The Pain Specialist physician verifies that the requested procedure is appropriate and safe for the patient.
- D) Common procedures and diagnoses include:
 - 1) Intervertebral Disc Disease.
 - 2) Zygapophyseal (Facet) Joint Disease.
 - 3) Radicular Pain (Sciatica).
 - 4) Complex Regional Pain Syndrome (RSD).
 - 5) Sensory Nerve Entrapment Syndrome.
 - Meralgia Paresthetica
 - Post Inguinal Herniorraphy
 - Post Thoracotomy
 - 6) Spinal Stenosis.
 - 7) Herpes Zoster.
 - 8) Post Herpetic Neuralgia.
- E) Conditions Excluded
 - 1) Infection
 - 2) Coagulation abnormality (Patients need to be off Coumadin for three days).
 - 3) Uncontrolled medical conditions, e.g. diabetes, hypertension, cardiac disease, thyroid disease.
 - 4) Patient weight over 375 pounds.
 - 5) Facial pain.
 - 6) Untreated mental illness.
- F) The role of the Pain Specialist physician is concluded with the performance of the requested procedure and management of any complications of the procedure.

V. Determining When to Initiate or Continue Opioids for Chronic Pain

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

VI. Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≈ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≈ 90 MME/day or carefully justify a decision to titrate dosage to ≈ 90 MME/day.
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

VII. Assessing Risk and Addressing Harms of Opioid Use

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≈ 50 MME/day), or concurrent benzodiazepine use, are present.
9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

* All recommendations are category A (apply to all patients outside of active cancer treatment, palliative care, and end-of-life care) except recommendation 10 (designated category B, with individual decision making required); see full guideline for evidence ratings.

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