SUBSTANTIVE POLICY STATEMENT #7

Guidelines for the Use of Controlled Substances for the Treatment of Chronic Pain

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ARIZONA MEDICAL BOARD

9545 East Doubletree Ranch Road, Scottsdale, Arizona 85258

GUIDELINES FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF CHRONIC PAIN (SPS 7)

The Arizona Medical Board ("Board") strongly urges physicians to view effective pain management as a high priority in all patients, including children and the elderly. Pain should be assessed and treated promptly, effectively and for as long as pain persists. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment. Pain treatment may involve the use of several drug and nondrug treatment modalities, often in combination. For some types of pain the use of drugs is emphasized and should be pursued vigorously; for other types, the use of drugs is better de-emphasized in favor of other therapeutic modalities. Physicians should have sufficient knowledge or consultation to make such judgments for their patients.

Drugs, in particular the opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedure and cancer. Physicians are referred to the U.S. Agency for Health Care Policy and Research Clinical Practice Guidelines as a sound yet flexible approach to the management of these types of pain.

The prescribing of opioid analgesics for other patients with intractable non-cancer pain also may be beneficial, especially when efforts to remove the cause of pain or to treat it with other modalities have been unsuccessful. For the purposes of these guidelines, intractable pain is defined as:

A pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and surgeon and one or more physicians and surgeons specializing in the treatment of the area, system or organs of the body perceived as the source of the pain.

Therefore, these guidelines are an attempt to communicate to physicians who prescribe opioids

for intractable pain not to fear disciplinary action from this Board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain. Also, physicians should use sound clinical judgment, and care for their patients according to the following principles of responsible professional practice.

I. STATUTORY ABILITY TO DEVELOP GUIDELINES

Pursuant to Arizona Revised Statutes § 32-1403(A)(3), the Board may develop and recommend standards governing the profession in Arizona.

II. GUIDELINES FOR PATIENT CARE WHEN PRESCRIBING CONTROLLED SUBSTANCES FOR CHRONIC PAIN

A) Pain Assessment

Pain assessment should occur during initial evaluation, after each new report of pain, at appropriate intervals after each pharmacological intervention, and at regular intervals during treatment. Unless a patient is terminally ill and death is imminent (in which case the diagnosis is usually evident and diagnostic evaluations may be of little value and discomforting to the patient), the evaluation should include:

1. Medical history, including the presence of a recognized medical indication for the use of a controlled substance, the intensity and character of pain, and questions regarding substance abuse;
2. Corroboration of medical history by reviewing patient's medical records and/or speaking with patient's former physicians. Patients frequently seek out a new prescribing physician after their previous prescribing physician has terminated them for non-compliance, substance abuse, and/or drug diversion;
3. Psycho-social assessment, which may include but is not limited to:
    a. The patient's understanding of the medical diagnosis, expectations about pain relief and pain management methods, concerns regarding the use of controlled substances, and coping mechanisms for pain;
    b. Changes in mood which have occurred secondary to pain (i.e., anxiety, depression); and
    c. The meaning of pain to the patient and his/her family.
4. Physical examination, including a neurologic evaluation and examination of the site of pain.
5. Urine drug screen, testing for commonly abused street drugs as well as prescription pain drugs that are known abused or diverted drugs. Such screening will help identify drug abusers and drug diverters.

B) Treatment Plan

A treatment plan should be developed for the management of chronic pain and state objectives by which therapeutic success can be evaluated, including:

1. Pain relief;

2. Improved physical functioning;

3. Proposed diagnostic evaluations (i.e., blood tests, radiologic, psychological and social studies such as CAT and bone scans, MRI and neurophysiologic examinations such as electromyography); and
4. Analysis of inclusion and exclusion criteria for opioid management: Inclusion criteria includes a clear diagnosis consistent with symptoms, all reasonable alternative therapies

have been explored; the patient is reliable and communicates well, there has been informed consent or a treatment agreement signed; Potential exclusion criteria include a history of chemical dependency, major psychiatric disorder, chaotic social situation, or a planned pregnancy.

C) Informed Consent

The physician should advise the patient, guardian, or designated surrogate of the risks and benefits of the use of controlled substances. The patient should be counseled on the importance of regular visits, the impact of recreational drug use, the number of physicians and pharmacies used for prescriptions, taking medications as prescribed, etc.

The physician and the patient should enter into a pain treatment contract that specifically states the patient's required compliance with the treatment plan and what the consequences of non-compliance, misuse and abuse will be. It is particularly important that patients understand that they will be discontinued from the prescribed controlled substances, in a safe manner, should it be revealed that they are abusing or diverting drugs.

D) Ongoing Assessment

The assessment and treatment of chronic pain mandates continuing evaluation, and if necessary, modification and/or discontinuation of opioid therapy. If clinical improvement does not occur, the physician should consider the appropriateness of continued opioid therapy, and consider a trial of alternative pharmacologic and nonpharmacologic modalities.

E) Consultation

The physician should refer the patient as necessary for additional evaluation to achieve treatment objectives. Physicians should recognize patients requiring individual attention, in particular, patients whose living situations pose a risk for misuse or diversion of controlled substances. In addition, the prescription of controlled substances to patients with a history of substance abuse requires extra care, monitoring, and documentation, and may also require consultation with an addiction medicine specialist.

F) Documentation

The physician must maintain adequate, accurate and timely records regarding items A-E from above. "Adequate Records," pursuant to A.R.S. º32-1401(2), "means legible records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, adequately document the results, indicate advice and cautionary warnings provided to the patient, and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the treatment." Specific to chronic pain patients, the documentation should include:

1. The medical history and physical examination;
2. Related evaluations and consultations, treatment plan and objectives;
3. Evidence of discussion regarding informed consent;
4. Prescribed medications and treatments;
5. Periodic reviews of treatments and patient response; and
6. Any physician-patient agreements or contracts.

G. Counting and Destroying Medication

The physician may desire to see and count a patient's medication to determine if the patient is taking the medication as prescribed. The patient should display and count the medication in front of the physician. Under no circumstance should the physician touch a patient's controlled

substances. If the medication must be destroyed, the patient should flush the medication down the toilet in the physician's presence. The physician should document this fact in the patient's chart.

H. Post-Dated Prescriptions

Post-dated prescriptions are illegal in the State of Arizona. Therefore, physicians may not issue post-dated prescriptions.

I. Referral of Patients with Active Substance Abuse Problems

Patients discovered to have an active substance abuse problem should be referred to either a detoxification and rehabilitation program or to an appropriate maintenance program for addicts.

III. COMPLIANCE WITH LAWS AND REGULATIONS

A. Prescribing Controlled Substances

To prescribe controlled substances, physicians must comply with all applicable laws, including the following:

1. Possess a valid current license to practice medicine in the State of Arizona; and
2. Possess a valid and current controlled substances Drug Enforcement Administration registration for the schedules being prescribed.

B. Dispensing Controlled Substances

To dispense controlled substances, physicians must comply with all applicable laws, including the following:

1. Possess a valid current license to practice medicine in the State of Arizona;
2. Possess a valid and current controlled substances Drug Enforcement Administration registration for the schedules being prescribed;
3. Comply with Arizona Revised Statutes § 32-1491, et seq. and A.A.C. R4-16-201 through R4-16-205; and
4. Comply with 22 CFR 1306.07(a) if controlled substances are dispensed for detoxification

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