Pain Management

Policy Number: Board #2012-001

Effective Date: April 20, 2012

Application: Applies to constituents of the **Board for Volunteer Firefighters and Reserve Officers (BVFF).**

Approved by: Members of the State Board: Jaymes Hughes, Mark Watenpaugh, Martin Spani, Miland Walling, and Brian VanCamp

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Purpose - To provide direction to BVFF employees and physicians when working with constituents (patients) who need help managing their pain as a result of their fire service or law enforcement injury.

In 2010, Washington State health officials published a two-part guideline to give providers direction in managing their patients' pain. The guideline was developed by state health officials and practicing physicians with input from state government and patients. The exact recommendations can be obtained through the Agency Medical Director's Group.

State agencies, after reviewing the guidelines and their own applicable rules and laws, are to set policies regarding pain management. These policies are not developed as cost-cutting measures. They are developed in response to the dramatic increases in deaths associated with the increased use of opioids to treat pain. Between 1995 and 2008, unintentional opioid deaths increased 17-fold (Agency Medical Directors' Group, Washington State's guideline on use of opioids for chronic non-cancer pain – frequently asked questions, June 2010, page 4). The BVFF's policy was developed with the safety and well-being of our first responders in mind.

Policy Statement - All BVFF constituents and their physicians wishing to seek pain management through opioid use will be required to adhere to the following agency policy for pain management:

1. Opioids include, but are not limited to:
    a. Morphine – trade names include MS Contin, Kadian, Oramorph and Avinza
    b. Methadone
    c. Oxycodone – available by itself (Oxycontin) or in combination with acetaminophen (Percocet), aspirin (Percodan), or ibuprofen (Combunox)
    d. Fentanyl – Available as transdermal patch (Duragesic), oral transmucosal (Actiq), or buccal (Fentora)
    e. Hydrocodone – combined with either acetaminophen (Vicodin, Lorcet, etc.), or ibuprofen (Vicoprofen)
    f. Codine – available by itself or in combination with acetaminophen (Tylenol 3) or asprin
    g. Propoxyphene – available by itself (Darvon), or in combination with acetaminophen (Darvocet)

2. The use of the following opioids will generally not be covered except under specific conditions and MUST be preauthorized:
    a. Opioids in combination with sedative-hypnotics (such as benzodiazepines or barbiturates)
    b. Meperidine
    c. Tramadol (Ultram) in combination with other opioids
    d. Carisoprodol (Soma)
    e. Combination agonists and mixed agonists/antagonists such as butorphanol (Stadol); dezocine (Dalgan), nalbuphine (Nubain) and pentazocine (Talwin)
    f. Barbituarates
    g. Outpatient prescriptions of parenteral dosage forms of any drugs
    h. Injectable opioids
    i. Transdermal fentanyl system (Duragesic)

3. Temporary opioid pain management vs. chronic pain management: Chronic pain, for BVFF purposes is considered pain that continues for greater than six weeks after injury.

4. Opioid pain management for chronic pain can only be used when:
    a. Subjective reports by the patient are supported by objective observations, and
    b. Other physical, behavioral, and non-opioid measures have failed (such as physical therapy, cognitive behavioral therapy, NSAIDs, antidepressants, antiepileptics), and
    c. The patient has demonstrated sustained improvement in function and pain levels in previous opioid trial, and
    d. The patient has no relative contraindication to the use of opioids (such as current or past alcohol or other substance abuse, including nicotine).

5. When prescribing opioids for chronic pain, the attending physician must submit the following written reports:
    a. **Within 30 days:** an initial written report (billed as a 1064M) that must include:
        i. A treatment plan with time-limited goals;
        ii. A consideration of relevant prior medical history;
        iii. A summary of conservative care rendered to the worker that focused on reactivation and return to work;
        iv. A statement on why prior or alternative conservative measures may have failed or are not appropriate as sole treatment;
        v. A summary of any consultations that have been obtained, particularly those that have addressed factors that may be barriers to recovery;
        vi. A statement that the attending physician has conducted appropriate screening for factors that may significantly increase the risk of abuse or adverse outcomes (such as a history of alcohol or other substance abuse); and
        vii. An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement must be renewed every six months. The treatment agreement must outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, the physician's need to document overall improvement in pain and function, and the worker's responsibilities.
    b. **Every 60 days:** an opioid progress report (billed as a 1057M) must be submitted. This form is provided by the BVFF.

c. **Every 6 months:** an opioid treatment agreement (billed as a 1057M) must be submitted. This form is provided by the BVFF.
d. In addition to those reports, the attending physician must submit the following information at least every **60 days** when treating with opioids:
    i. Documentation of drug screenings, consultations, and all other treatments
    ii. Documentation of outcomes and responses, including pain intensity and functional levels; and
    iii. Any modifications to the treatment plan.

6. Once a patient is receiving opioids for chronic pain, the physician and patient must adhere, at minimum, to the following visit frequency:
    a. **For the first four months:** The patient must visit the prescribing physician in the office every 2 weeks
    b. **After the first four months:** The patient must visit the prescribing physician in the office every 6-8 weeks

7. Urine drug testing:
    a. Should be performed on all patients prior to prescribing opioids for chronic pain management
    b. Should be performed on all patients transferring to a new physician and are already using opioids for chronic pain management
    c. Prior to drug screening, all physicians should complete the Opioid Risk Tool (Form provided by BVFF)
        i. Patients that score as a low risk should be randomly tested once a year
        ii. Patients that score as moderate risk should be randomly tested twice a year
        iii. Patients that score as high risk, or are receiving more than 120mg MED/day should be randomly tested four times a year
        iv. Any patients displaying aberrant behavior (lost prescriptions, multiple requests for early refill, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.) should be tested at the time of their visit
    d. Drug screening should include:
        i. The NIDA 5
        ii. Cannabinoids
        iii. Cocaine
        iv. Amphetamines
        v. Opiates
        vi. Benzodiazepines
        vii. Alcohol
        viii. Barbiturates
        ix. Oxycodone
        x. Methadone
        xi. Fentanyl
    e. Red flags:
        i. Negative for the opioid(s) the physician prescribed
        ii. Positive for amphetamine or methamphetamine
        iii. Positive for cocaine or metabolites
        iv. Positive for drug (benzodiazepines, opioids, etc.) not prescribed or by the treating physician
        v. Positive for alcohol

8. Payment for opioid medication will be denied for:
    a. Missing or inadequate documentation
    b. Noncompliance with the treatment plan
    c. No substantial improvement in pain and functional status after three months of opioid treatment
    d. Evidence of misuse (including the giving or sale) of opioids or other drugs, noncompliance with the attending provider's or BVFF's request for a drug screen
    e. Requests of early refills

9. Second opinions: The BVFF will require that any covered member receiving a Morphine Equivalent Dose (MED) of greater than120mg MED/day will be required to receive a second opinion regarding pain management from an L&I approved pain management specialist. In addition, the BVFF may require that patients that are using opioids in conjunction with sedative-hypnotics, benzodiazepines, anti-depressants, muscle relaxants, or alcohol receive a second opinion from an L&I approved pain management specialist.

    Payment for opioid medication will be discontinued 30 days after BVFF has requested a second opinion if the member does not schedule an appointment. In addition, if the member does not attend the consultation within 60 days of the BVFF request, payment will be discontinued. An electronic opioid dose calculator can be downloaded at www.agencymeddirectors.wa.gov/guidelines.asp.

10. Chronic pain management and Permanent Partial Disability Awards (PPD)
    a. Chronic pain management will not be covered once a PPD award has been accepted for all constituents who's injury occurred after July 1, 2012
    b. Physicians should speak with their patients about other sources of payment for opioids when the BVFF can no longer pay
    c. Weaning can be done safely by way of a slow taper. Patients who undergo intensive treatment programs in a pain center or a drug rehabilitation center can be tapered off opioids in 1-2 weeks. Patients being treated in an office-based practice should be tapered more slowly, but the taper should NEVER take more than 3 months.