Maintenance Management of Chronic Pain in Adults

Maintenance Therapy with Opioids for Non-Malignant Pain

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All patients receiving opioids or any controlled medication chronically should be regularly assessed for adherence to the medication regimen and treatment plan, including non-pharmaceutical and additional pharmaceutical adjunct therapies, side effects, functional improvements, and any behaviors suspicious for substance use disorder and/or diversion. The medication regimen and treatment plan should be reviewed regularly and adjusted using findings from these assessments.

Regular Visits:

- All patients should be evaluated for improvements in the functional capacity and decreased pain at each follow-up visit to monitor progress toward shared goals for opioid therapy. *The Pain, Enjoyment, General Activity (PEG) Tool* should be used to document response to therapy and to develop goals of treatment. If no improvement is noted after an adequate trail of medication, consideration should be given to tapering and discontinuing opioid medication. Adjunct therapies should be continued as indicated.
- The condition for which the opioid or controlled substance is being used to treat should be documented in the assessment and plan of each office visit for these medications, including dose and schedule of the controlled substances, number of pills prescribed, additional medications to be used, adjunct therapies to be used, and plans for follow-up and refills.
- Other treatments tried or considered should be documented in the chart and the rationale for continuation of the controlled substances including opioids.
- Opioids and controlled substances should be done cautiously to improve function and improve pain toward shared treatment goals. It is recommended that the maximum dose does not exceed 90 mg daily of morphine equivalent daily (MED) dose except on rare occasions. If a patient reaches a threshold of 120 mg daily MED be reached with the patient not achieving adequate pain relief, the dose should either be maintained or slowly tapered and referral considered to a pain management specialist or medication adjusted treatment.
- Some patients may be considered for transition to long-acting pain medication after more than 6 months or more on chronic opioid medications. If a long-acting opioid medication is deemed appropriate and the patient does not tolerate transition to the chosen long-acting medication or if the patient declines transition, the physician may choose to continue the short-acting medications or taper and discontinue the medications if deemed no longer clinically appropriate.

Interval Monitoring:

- ORT should be repeated semi-annually and as clinically indicated
- PHQ-9 should be completed annually and as clinically indicated. Other behavioral medicine screening tools should be completed based on clinical indication or at the discretion of the physician.
- It is recommended that patients be seen monthly with the start or continuation of chronic opioids or other controlled substances to asses medication benefit toward treatment goals, side effects, and adherence to treatment recommendations. After a patient has been stable for several months on the same regimen and at the clinician's discretion, the patient may follow-up in the office less frequently but no less than every 3 months. Any change in symptoms, dosage change, or any concerns should prompt more frequent office visits.

CSMD:

- The Tennessee prescription monitoring database MUST be queried quarterly or more often as clinically indicated or at the discretion of the physician.
- It is also recommended the clinician query the CSMD in the following situations:
    - whenever the patient is being prescribed a benzodiazepine or another controlled substance,
    - whenever the patient is determined to potentially be at risk for substance abuse or misuse or,
    - whenever the patient demonstrates behaviors deemed to be suspicious for misuse or abuse of opioid medications or other controlled substances such as loss of a prescription, request for early refill,s or other behaviors deemed suspicious by the clinician

Medication Refills:

- Ideally, follow-up visits for refills are scheduled prior to the patient leaving an office visit addressing the condition for which controlled substances are prescribed with his or her primary care physician to avoid lapse in medications and ongoing evaluation of the treatment plan
- If a refill is needed and a follow-up appointment has not been made, the patient is expected to call the office 3-7 days prior to needing the refill to schedule an appointment.
- If the patient's primary care physician is unavailable, another physician should provide appropriate continuation of therapy; a patient should not be denied an appropriate refill of the chronic opioid or controlled substance because his or her clinician is unavailable.

UDS/UDT:

- All patients on chronic opioids or other controlled substances must undergo random UDS testing. UDS testing is required at least every 6 months or at any time at the discretion of the clinician.
- The UDS/UDT results should be used as one piece of information along with a comprehensive history and physical examination in considering continuation of opioids. If the UDS/UDT is positive for drugs of abuse other than marijuana, no further opioids should be prescribed and the clinician should discuss the decision with the patient and offer a referral to medication assisted treatment.
- If the UDS/UDT is positive for marijuana, there are no red flags, and opioids are deemed appropriate, opioids might still be continued but the patient should be counseled regarding the health risks of marijuana use and its illegal status in Tennessee. Additionally, the patient should be advised that should future drug tests be positive for marijuana, no further opioids with be prescribed.
- If the UDS is positive for an opioid prescription medication prescribed by another clinician for the chronic problem or if there is information/evidence that the patient is obtaining opioid medication for his/her chronic problem from multiple clinicians, opioid medications should be discontinued. The patient should be offered a referral to medication assisted treatment.
- If the UDS is negative for the prescribed opioid or controlled substance medication and this is expected per patient report (delayed follow-up appointment or another reason deemed reasonable to the clinician), the medication may be continued with only a 30-day supply provided and more frequent follow-up appointments planned for evaluation and monitoring of adherence to the treatment regimen.
- If the UDS is negative for the prescribed medication and this is NOT expected, the UDS will be repeated immediately. Only one-month or less amount of the controlled substance will be provided and a repeat UDS ordered at the next follow-up visit. If the repeat UDS is also unexpectedly negative, no further opioid or controlled substance will be provided.
- A urine drug screen or urine drug testing can be a valuable tool to assure adherence to prescribed controlled medications and to assist in the identification and treatment of patients' with substance use disorders. Unfortunately, UDS has the potential to be misused to stigmatize and profile patients and to inappropriately discontinue medications. Clinical judgment by physicians ordering UDS in patients they suspect may be diverting or have substance use disorder has been shown to be highly inaccurate. Implicit bias may affect clinical judgment leading to changes in testing interpretation in clinical practice.
- Interpreting UDS/UDT results: Interpretation is not as simple as a positive or negative result. To interpret the results appropriately the concept of interference must be understood. This is especially important when the results are used to influence clinical decisions with inappropriate actions being taken on presumptive results that could have detrimental consequences to the doctor-patient relationship and the treatment plan. Both false positive and false negative results can occur. Cross-reactivity with common

prescription and over-the-counter medications (NSAIDS, decongestants, and antacids) can cause false positive results, necessitating the need to obtain a comprehensive medication list prior to ordering a UDS.

The following table is only an example of false positive results that could occur but is not a comprehensive list:

Common False Positives

Drug Screen	Source of False Positives
Amphetamine	Bupropion, labetalol, pseudoephedrine, trazodone
Benzodiazepine	Sertraline, HIV antivirals
Cannabinoids	NSAIDs, PPIs, HIV antivirals
Cocaine	Coca tea leaf, topical anesthetics with cocaine
Opioid	Quinolones, diphenhydramine, naloxone, quetiapine, verapamil, ranitidine, quinine
PCP	Dextromethorphan, diphenhydramine, ibuprofen, venlafaxine, tramadol

- Drug testing should be a therapeutic tool used to monitor therapy, provide reinforcement and explore substance use behavior. Results of testing should be employed to achieve these objectives. Results should be presented in a non-confrontational and compassionate manner. Unexpected results will inevitably be encountered and requires a systematic approach to address. It can conflict with the patient's self-report, the medication the patient is taking, medications prescribed, or a substance misuse pattern. If the results conflict with the patient's self-report, the results should be confirmed if at all possible before a clinical decision is to be made to alter the treatment plan. If confirmatory test results are contrary to the patient's self-report, it is recommended that a discussion occur to explore the value of the doctor-patient relationship and the consequences for recurrent use of other drugs/medications and failure to adhere to the treatment plan. A patient-centered approach is recommended. Caution is advised when considering abrupt discontinuation of a patient's medication. The patient should be informed of the concern for substance misuse and offer referral to medication assisted treatment. Abrupt discontinuation of opioids or benzodiazepines can lead to significant harm.

Aberrant Behavior:

- Any evidence of diversion of the medication (such as selling the medication or giving it to others) will result in termination of the Controlled Substance Agreement and no further controlled substances will be provided.
- Any evidence of ongoing high-risk behavior (hospitalization for drug overdose, positive drug screens for illicit street drugs, unsanctioned dose changes, obtaining opioids from outside or multiple clinicians, or other aberrant behavior) will result in termination of the

Controlled Substance Agreement and no further controlled substances will be provided. Recommendation and referral to medication assisted treatment should be offered to the patient.

- Lost or stolen medications will not be replaced. The patient should be evaluated for the safety of abrupt discontinuation of the controlled substance to determine if any medications should be given to avoid withdrawal or patient harm.