



ILLiad TN: 210894

**Request Date:** 20060809

**Borrower:** KUM

**Lending String:** \*OSU,OSU,OMC

**Patron:** Williams, Sherry

**Journal Title:** American journal of pain management.

**Volume:** 15 **Issue:** 1

**Month/Year:** 2004

**Pages:** 22-32

**Article Author:**

**Article Title:** Gilbert, J.W., Wheeler, G.R., Lingreen, R.A., Martonffy, D., Hatchett, J., Gaines, R., Stidham, S.; The ten Cs of chronic noncancer pain; universal p

**OCLC Number:** 24486718

**Imprint:** Stockton, CA ; American Cynosure, Inc.,

**ILL Number:** 22168506



**Call #:** Shelved by Unique Title

**Location:** MANS-OSU Mansfield Lib.-  
-for ILS, need by 8/14/06. Thanks!

**Charge**

**Maxcost:** \$11.00IFM

**Borrowing Notes:** Borrowing Notes; KLN MEMBER/OSU-refer to HSL/BRI 51-1197/ISI #016528/UMI CLIENT CODE # ADV281/DOCLINE SYMBOL KYUKEN (GMR-RL)

**Odyssey Address:**



**Shipping Address:**

Medical Center Library Interlibrary Loan  
University of Kentucky  
800 Rose Street  
Lexington KY 40536-0298

**Fax:** 859 323 6805

**Ariel Address:** 128.163.72.54



**Please send resend requests to Ariel**  
128.146.9.61 or fax (614) 292-3061.

**NOTICE:** This material may be protected  
by COPYRIGHT LAW (Title 17 U.S. Code).

8/14

## Practice Tips

### THE TEN Cs OF CHRONIC NONCANCER PAIN: UNIVERSAL PRECAUTIONS FOR THE TREATMENT OF THE CHRONIC NONCANCER PAIN PATIENT

John W. Gilbert, MD, Greg R. Wheeler, MD, Richard A. Lingreen, MD, Denes Martonffy, MD, Jody Hatchett, LPN, Rhonda Gaines, RN, Sharon Stidham, LPN, Tammy Sutton, RN, Gloria Westerfield, MS, Margarita McConnell, CMA, Sandra Noble, LPN, and Karen Carter, CMA

**Abstract.** A discussion of ten useful guidelines, the Ten Cs, for treatment of chronic noncancer pain is presented. The Ten Cs include continuing medical education, consultation, comprehensive history, confirmatory physical and imaging exams, contracts, consideration of alternatives and adjunctive measures, compliance and co-morbidities, control, call block, and compassion. The guidelines are used as universal precautions in a multispecialty neuroscience practice group. In five clinics over approximately 10 months, a total of 496 patients were released (37.7% for noncompliant urine drug screens and 30.0% identified by Kentucky's electronic prescription reporting system) and referred to behavioral health intervention. The Ten Cs applied to all chronic noncancer pain patients may help protect both the clinician and the patient.

**Descriptors.** drug abuse, opioid, opioid related disorders, pain, spinal injuries

AJPM 2005;15:22-32. Received: 07-26-04; Accepted: 11-05-04

### INTRODUCTION

Pain is classified as *acute* (lasting six months or less) or *chronic* (lasting longer than six months). It is also classified as *malignant*, such as cancer-related pain, or *nonmalignant*. The American Board of Neurological Surgeons recognizes the treatment of pain as part of the neurosurgeon's usual duties (1), and patients are frequently referred to the authors' practice with all of these categories of pain. Acute pain or acute exacerbation of chronic pain is by definition a short-lived problem, frequently much easier to deal with than other types of pain.

*All of the authors of this paper are in private practice at the Spine and Brain Neurosurgical Center with offices in Lexington, London, Florence, Hazard, and Pikeville, Kentucky. Reprints: www.AJPMOnline.com*

Cancer-related pain can be difficult to treat, but most clinicians do not argue the medical necessity to treat these patients with whatever is needed to free them from suffering. Chronic nonmalignant pain can be caused by spinal injury, post laminectomy syndrome, nerve injury syndromes, spinal cord injuries, fibromyalgia, trauma, or degenerative spinal diseases – all non-terminal, non-acute conditions. Such pain is the most common yet the most problematic and the most difficult to manage.

The term *nonmalignant* is a rather poor descriptor of this type of pain. Because chronic pain depresses the immune system, decreases quality of life, and leads to associated co-morbidities such as anxiety, depression, and sleep disorders, it has a "malignant" effect. *Chronic noncancer pain* may be a more appropriate term.

A few clinicians have been prosecuted for the under-

treatment of pain, usually in cases involving cancer. However, in cases of chronic noncancer pain, regulators and medical boards seem to target physicians only for over-prescribing. A physician, considered by some to be a pioneer in pain management, was even charged with murder for over-prescribing, although a judge later reduced the charges to involuntary manslaughter (2). The Association of American Physicians and Surgeons now recommends that physicians avoid or use extreme caution in treating pain at all with opiates (3).

The pain-medicine community is well aware that chronic noncancer pain is generally undertreated, but this fact is not well known in the general medical or lay communities. In 1991 and again in 1997, investigators surveyed all state medical board members in the US regarding chronic noncancer pain. In the earlier survey, most board members seemed to lack knowledge of the use of opioids in chronic noncancer pain. However, the 1997 survey found positive changes in knowledge regarding chronic noncancer pain, opiates, and acceptable medical practice (4). In the future, it is hoped that physicians specializing in pain and addiction medicine will become part of general medical school faculties and the state medical boards that regulate the practice of medicine. At present, however, pain physicians must proceed with caution.

The authors' practice has developed ten guidelines, which have been termed the Ten Cs, for the treatment of patients with chronic noncancer pain. These guidelines have proved to be useful in coordinating a practice that has grown from one to five clinics, employing physicians with different specialties in the neurosciences. The Ten Cs can be viewed as universal precautions; they have helped the authors continue quality care in today's environment. Previously established universal precautions have been well accepted and can be applied to treatment of all chronic noncancer pain to protect both the physician and the patient (5).

### THE TEN Cs

**C-1. Continuing medical education.** The authors have improved their practice of pain management through

continuing education provided by a number of professional organizations including the American Academy of Pain Medicine, the American Academy of Pain Management, and the American Society of Neuroimaging (MRI/CT). The American Academy of Pain Management has accredited the authors' clinical program, the Spine and Brain Neurosurgical Center. The state medical boards also provide model guidelines for using controlled substances for the treatment of pain. Other sources of continuing medical education include the American Pain Society, the Drug Enforcement Agency Diversion Control Program – Drug Policy and Drug Trafficking and Abuse Program Policies, the American Society of Neuroimaging, the American College of Radiology, the American Academy of Addiction Medicine, and the state boards of pharmacy. Healthcare attorneys and consultants have also helped us develop program specific guidelines.

Definitions used in the treatment of pain are not well understood by the general medical or lay communities. Patients who take opioids, steroids, or antidepressants all develop a degree of physical dependence and tolerance, and they will have withdrawal symptoms if these medications are discontinued. Unfortunately, many patients and clinicians think that withdrawal symptoms imply addiction. Misunderstanding of addiction and mislabeling of patients as *addicts* can result in unnecessary withholding of opioid medications (6). Addiction is a complex, compulsive disorder with psychosocial, biological, and behavioral components. It usually involves the continued use of medication despite harm to oneself or to others. It may involve aberrant behavior patterns, such as buying or selling medications, using medications to become intoxicated, and taking medications for causes other than pain. Patients with the disease of addiction require increasing doses of medications, but their levels of function invariably decrease. They are preoccupied with obtaining a substance despite the continued decrease in quality of life.

Important pain care lessons regarding drug dependence can be learned from continuing education. Addiction is rare, and it must be differentiated from drug abuse and dependence. The incidence of drug abuse and depen-

dence – the rate at which the condition occurs – is 0.66% for women and 1.66% for men; the highest incidence occurs in those under 30 years of age (7). The overall lifetime prevalence of drug abuse and dependence is 6.2% (7). The higher prevalence than incidence reflects the chronic nature of the condition. Although rare, once an individual becomes addicted, aberrant behaviors are likely to require chronic treatment by a combination of behavioral health and addiction physicians.

Patients on long-term opioids develop tolerance to sedation and respiratory depression but, in general, do not develop tolerance to the analgesic effect. Patients who are seen regularly and who report lower pain scales, improved function, or improved quality of life (return to work or school), and who are compliant with other measures are not addicts. These patients are simply normal, physically dependent, tolerant, chronic pain patients.

The confusion, even in the medical community, between normal physical dependence and the rare constellation of abnormal behaviors associated with addiction or opioid dependence is similar to the confusion between symptom magnification and malingering. Although many patients may show some degree of symptom magnification, true malingering – consciously feigning illness – is rare.

Continuing education will help the physician identify and understand these abnormal behaviors. Once these aberrant or addictive behaviors are identified, the prudent clinician should take the opportunity to intervene and make a *behavioral health* referral (patients seem more receptive to this term rather than mental health or psychiatrist) and addiction intervention. Addiction should be considered a chronic disease – a disease like any other, such as hypertension or diabetes.

**C-2. Consultation.** A specialist treating pain should require patients to present with a referral or a request for consultation from their primary care provider or other physician. The referral should either be written or confirmed verbally by phone. Even if a patient has an HMO that does not require a referral, the patient's primary care physician should be contacted. Pain specialists should

not accept walk-ins or self-referrals. Patients should also be asked to certify that they are legitimately seeking care (8). This general policy may help eliminate drug seekers, since to be seen, they will have to deceive both the referring physician and the pain practitioner.

A primary care physician or a nonpain specialist treating chronic noncancer pain should consider consultation with a pain specialist to confirm a pain treatment regimen or to make new recommendations. Primary care providers and family physicians, with the proper documentation, are perfectly suited to treat chronic noncancer pain. These practitioners have many insights into the patient's overall well being. Other providers and consultants frequently useful in the management of chronic noncancer pain include behavioral health specialists, social workers, physical therapists, chiropractors, occupational therapists, vocational rehabilitation counselors, and other specialists, such as neurologists, physical medicine rehabilitation physicians, internists, and radiologists.

**C-3. Comprehensive history.** A comprehensive history should begin at the front desk. At each visit, the patient should supply his most recent address, telephone number, birth date, social security number, and photo identification. On the first visit only, the staff should ask for the written referral or verbal confirmation from the referring physician. Staff members, even at the front desk, should be part of the pain management team. Discuss at staff meetings the common mode of operation of drug seekers including unusual behavior, demands for immediate attention, unusual appearance (*i.e.*, extreme, overdressed or underdressed), unusual knowledge of controlled medication, reluctance to provide information, requests for specific drugs, lack of interest in diagnosis, failure to keep appointments for tests, or exaggeration. Staff should be alert for patients who must be seen right away, come in or call in after hours, say they are traveling through town, are allergic to specific narcotics, feign pain, psychological or physical problems, lose prescriptions, or pressure staff or physicians by eliciting sympathy or guilt. If a patient exhibits anger at the front desk at the first office visit, it is not a good time to start a patient-

physician relationship. The authors send such patients elsewhere, immediately re-discuss the situation with the referring physician, and give the patient a written release before starting any patient-physician interaction.

The authors use a comprehensive history intake form, reviewed by the staff at the front desk, then by an RN, LPN, or medical assistant, and finally by the physician. The comprehensive history intake form includes the chief complaint, history of present illness, review of systems, past medical history, and family and social histories. The CAGE questions (9) are incorporated into the intake to look for probability of substance abuse (see Figure 1). Two positive responses to CAGE questions indicate a 50% probability, three positive responses a 75% probability, and four positives a 90% probability of substance abuse. No single screen or behavior is pathognomic of addiction; however, the CAGE questionnaire, modified to include drugs, is recommended as a universal precaution in the treatment of the chronic noncancer pain patient (5). Non-addicts are not likely to exhibit addictive behaviors when given an opiate; and those who exhibit such behaviors are more likely to be addicts already.

C	Have you ever thought you should <b>cut down</b> on your drinking or substance use?
A	Have you ever felt <b>annoyed</b> by others' criticism of your drinking or substance use?
G	Have you ever felt <b>guilty</b> about your drinking or substance use?
E	Do you have a morning "eye opener" to start the day?

Figure 1. The CAGE questionnaire.

The authors ask about the patient's history of drug conviction, addiction, abuse, suicidal thoughts, psychiatric care, and previous treatment at other pain clinics. The forms are signed and dated by staff and physician. The history is also dictated as part of a note to be sent back to the referring physician. Factors that modify treatment, such as previous use of nonsteroidal anti-inflammatory drugs, narcotics, muscle relaxants, chiropractic or physical therapy, other pain management measures, injective therapies, previous placement of stimu-

lators or pumps, previous treatment by other neurosurgeons or pain physicians or other pain clinics are also addressed. Patients certify the accuracy of this information when they sign in as part of their pain contract (see C-5 below). Since the history provides at least 50% of the basis of any diagnosis, the authors have the patient fill out a comprehensive history intake form at every visit.

The form documents the patient's age. The highest incidence of drug abuse/addiction occurs in individuals less than 30 years of age (7). Therefore, these patients are treated with opiates for acute pain, but non-opioid alternatives and injective therapy are preferred for chronic noncancer pain. Very rarely is a young patient placed on long-term opiate therapy without close involvement of family. A history of addiction or substance abuse is problematic. Such patients must be handled with caution. A pain physician can prescribe medication for pain but cannot prescribe opioids for addiction. While a patient with an active addiction disorder may be treated for acute pain, it is impossible to treat chronic pain in the face of untreated addiction (10).

**C-4. Confirmatory physical examination and imaging examinations.** While the comprehensive history is based mainly on subjective complaints from the patient, the physical and imaging exams are considered objective findings. However, some chronic patients may have negative physical exams and imaging studies. For example, the straight leg-raising test is positive in only about 60% of cases of symptomatic lumbar ruptured disc. A 12 to 14-point neurological muscle skeletal exam is useful for most patients, and, on the initial visit, any positives should be documented on the form. Negatives must be documented on the form also and provide an easy-to-read report to forward to the referring physician. Use of a consultation code requires a report to the physician requesting a consult per Medicare guidelines. Confirmatory imaging can be performed with magnetic resonance imaging (MRI). Pain is not a diagnosis. It is important to search for the underlying cause.

Tolerance to the analgesic effects of pain medicines is unusual. If a chronic noncancer pain patient requires increasing doses of pain medications, the clinician should

consider re-examination and re-imaging to rule-out progression of underlying disease. If progression is ruled-out and a patient requires escalating doses of opiates with no improved function or decrease in pain levels, consider referral to an addictionologist or behavioral health provider.

**C-5. Contract.** In the authors' practices, each of the patients must sign a contract or consent for treatment with or without controlled substances. Contracts may vary from 1-10 pages, but there are no ironclad agreements (11,12). The contract (*see pages 28-29*) is a teaching tool. The staff explain the expectations, philosophies, and guidelines to the patient, and the contract is witnessed and signed. It is also signed by the nursing staff and physician. It is renewed on every visit and made a part of the patient's record. Patients who are unhappy with the guidelines and unwilling to sign the contract are referred to another practice.

Patients are educated on the need to take the least amount of medication to improve function, decrease pain levels, or allow them to reach set goals. Patients should be encouraged to test their minimal limits of medication and even occasionally to try to wean themselves off pain medication. If patients have intermittent chronic pain, they should take the medications as needed. If they have constant chronic pain, the as-needed doses become scheduled with the understanding that the patient must never exceed the prescribed doses. Recently, one of the patients who had been on opioids for over four years after a series of injuries returned with the great news that she was "off all opioids" and only utilizing over-the-counter medication. She achieved this by meticulous titration of her antidepressant to high levels by her primary care physician and her willingness to test ever-lower doses of medication for pain.

The chronic noncancer pain patient should achieve at least one of the following goals – (i) decreased pain levels by visual analog scale, (ii) improved function, (iii) return to school or work. These goals are noted in the pain contract or consent for treatment.

**C-6. Consider the alternatives and adjunctive measures.**

Alternative medications or adjunctive measures can help the patient maintain a lower overall dose of opiate. Unfortunately, by the time the patients are referred to specialty care, many have already tried basic measures such as over-the-counter medication, nonsteroidal anti-inflammatory drugs, and physical or chiropractic therapy. However, patients may benefit from adjunctive therapies such as weight loss, exercise, smoking cessation, lifestyle or psychological counseling, vocational rehabilitation, occupational therapy, or biofeedback. Alternative medications may include muscle relaxants, antidepressants, and non-controlled medications such as tramadol. Among antidepressants, both serotonin and norepinephrine dampen peripheral pain signals via central mechanisms (13).

A stepped-care approach to pain management (14) usually means starting with non-controlled or even non-prescription medications, adding weaker controlled substances, and finally, long-acting opiates. Likewise, adjunctive interventions usually proceed in steps beginning with noninvasive, less costly treatments such as home exercises or physical therapy, chiropractic, biofeedback, or transcutaneous electrical nerve stimulation (TENS). Slightly more invasive and costly interventions include epidural and facet blocks, acupuncture, or peripheral electrical nerve stimulation (PENS). The most expensive and invasive technologies such as epidural stimulators, pumps, and other neurosurgical procedures are used as one of the final resorts. Chronic noncancer pain patients should have tried alternative medications in the past or be willing to try adjunctive measures as part of their ongoing treatment.

**C-7. Compliance measures and co-morbidities.** Tools such as random drug screens help confirm that the patient is taking the prescribed medications (not selling them) and is not taking illicit drugs such as THC, cocaine, or methamphetamine. All chronic noncancer pain patients should be tested. Patients are usually receptive to testing when the explanation that all such patients are tested as part of universal precautions is provided.

Kentucky is one of only two states to monitor all drugs. The Kentucky All-Schedule Prescription and Elec-

tronic Reporting system (KASPER) identifies patients who may be doctor shopping or obtaining prescriptions repeatedly from more than one physician. KASPER is one of the pain physician's most useful tools for identifying aberrant/addictive behavior; and it should be expanded nationally. Prescription drug monitoring programs should be considered a universal precaution for identifying the patient who is self-treating in an irrational poly-pharmacy, poly-physician mode.

Self-report questionnaires such as the Pain Patient Profile (P-3) can assess co-morbidities such as anxiety, depression, and somatization (15,16). The P-3 has been normalized against chronic pain patients. The Joint Commission for the Accreditation of Healthcare Organizations has released new standards that require an evaluation of the psychosocial status of patients suffering from pain (17). Over 70% of individuals who commit suicide have an underlying major depressive disorder. When chronic pain patients overdose, they usually do so with multiple medications from multiple physicians; yet pain physicians can be unfairly targeted. The universal precaution of screening with a P-3 test may help to identify patients with levels of depression higher than normal for chronic pain patients. Use of the P-3 has resulted in our referring 20-30% of our patients for behavioral health intervention.

Of 496 patients released from the authors' practice over a ten-month period, 37.7% were released for noncompliant urine drug screen and 30.0% for noncompliant KASPER. Released patients are counseled on the need for behavior modification and referred for behavioral health intervention. The prevalence of drug abuse/dependence is 6.2% (7); compliance measures should identify the 6.2% in any practice.

**C-8. Control.** The Drug Enforcement Agency (DEA) has scheduled medications as follows:

- Schedule I – substances that have no medical purpose.
- Schedule II – medications that have a high potential for abuse – these include short-acting medications such as combination acetaminophen and oxycodone hydrochloride (Tylox<sup>®</sup>, Percocet<sup>®</sup>),

generic oxycodone or hydrocodone, and longer acting medications such as oxycodone hydrochloride (OxyContin<sup>®</sup>), morphine sulfate (MS Contin<sup>®</sup>, Avinza<sup>®</sup>, Kadian<sup>®</sup>), and methadone. (Prescriptions for these drugs cannot be called in over the phone.)

- Schedule III – medications that have a lesser potential for abuse – these include combination acetaminophen and hydrocodone bitartrate (Lortab<sup>®</sup>, Loracet<sup>®</sup>, Vicodin<sup>®</sup>). (Prescriptions for Schedule III medications can be called in.)

These schedules are useful in planning adjunctive measures. For example, pure hydrocodone is a Schedule II drug, but hydrocodone with acetaminophen is a Schedule III drug. Theoretically, it should take less hydrocodone/acetaminophen than pure hydrocodone to treat the same amount of pain. Because OxyContin<sup>®</sup> has been problematic in Eastern Kentucky, the authors use methadone as a long acting-opiate. Methadone has a long half-life (12 to 24 hours). Any medication can be abused, but most methadone available on the street is prescribed or dispensed by addiction physicians to addiction patients in methadone clinics, not by pain physicians in pain clinics (18).

A drug log should be established for every chronic noncancer pain patient. It should be filled-out on every visit, dated and initialed, and no abbreviations should be used. This log makes it possible to verify a patient's medications, stability, and trends over time.

Because an unscrupulous pharmacist may give early refills for remuneration, the authors obtained DEA approval to place the following on all of our prescription pads: "Fill only at (stated name of pharmacy) Pharmacy," and above this, "No Early Refills". The first two letters and the third digit of the physician's DEA number must be hand written by the physician. It is essential to set limits on the quantity, types, and number of medications used in treatment. The authors never dispense more than 150 units of any controlled substance (the maximum dose of Schedule III drugs is four to five dosage forms per day). The authors try to manage a chronic noncancer pain patient on no more than two or three different types of controlled medications.

**Controlled Substance Agreement & Patient Contract - Conditions /Terms for Treatment**

**Between**

**SPINE & BRAIN NEUROSURGICAL CENTER - UPDATED 1/2005**

**and**

\_\_\_\_\_, herein referred to as the patient, dated \_\_\_\_\_

To receive treatment with or without narcotic pain medication, the patient must meet the following **CONDITIONS/TERMS:**

1. The patient has never been diagnosed with, treated, or arrested for substance dependence or abuse.
2. The patient has never been involved in the sale, illegal possession, dispersion, or transport of controlled substances (narcotics, sleeping pills, nerve pills, or pain pills) or under investigation or arrested for such activities.
3. ***FEMALE ONLY*** - The patient certifies that she is not pregnant. The patient agrees and understands that it is her responsibility to notify Physician Services, PSC immediately if she is planning a pregnancy, or believes that she may be pregnant.
4. The patient agrees to supply to Physician Services, PSC the name, address, and telephone number of the pharmacy that is filling the prescription of pain medication and will use only one pharmacy.
5. The patient agrees to have his/her prescriptions prescribed by Physician Services, PSC physicians, filled by only one pharmacy. In the event a pharmacy doesn't cover prescribed medication, the patient will attend another office visit to complete appropriate paperwork for pharmacy change per our controlled substance agreement. In the event of an emergency requiring another physician's attention, the patient will immediately inform his/her physician at Physician Services, PSC of such prescribing physician and dispensing pharmacy.
6. The patient agrees to allow his physician at Physician Services, PSC to send a copy of the agreement to the patient's pharmacy, referring physician(s), and all other physicians involved in the patient's care. The patient agrees to allow the physicians at Physician Services, PSC to discuss his/her care freely with other physicians.
7. The patient agrees to take the medication only and exactly as prescribed by the physicians at Physician Services, PSC. The patient agrees not to share medications with other individuals. The patient agrees that medications will only be prescribed that are on plan formulary. The patient will not drink alcohol with controlled medications.
8. The patient understands that each prescription is for a specific number of pills, designed to last a certain amount of time. **NO** early refills. **NO** exceptions.
9. The patient understands that **NO** refills will be given if the prescription does not last until the next scheduled visit.
10. The patient understands that **NO** allowance will be made for lost or stolen prescriptions or pills, or those destroyed by fire, flood, etc. If medication prescribed causes adverse reaction, patient is to stop medicine immediately and inform physician and is required to bring unused medication to next office visit. The patient will safeguard medicines.
11. The patient understands that prescriptions will be dispensed only after a scheduled office visit, not over the phone.
12. The patient understands that **NO** prescriptions for pain medication will be given over the telephone. **NO** exceptions.
13. The patient agrees that they will not seek pain medication at night, on weekends, holidays, or prior to next visit.
14. The patient agrees not to obtain pain medication from any other physician or emergency room or other person.
15. The patient agrees to keep all scheduled appointments at Physician Services, PSC. If the patient is unable to keep an appointment, he/she must give at least 24-hours advance notice. However, **NO prescriptions will be called in.**
16. The patient agrees to see the physician at Physician Services, PSC if the physician feels it is necessary to change the patient's dosage. If the physician suspects the patient is not following his/her orders when asked to cease use of a controlled substance, the patient permits Physician Services, PSC to pursue remedies which will disable the patient's driving privileges. The patient understands not to drive or operate machinery when taking controlled medications.
17. The patient allows Physician Services, PSC to call other pharmacies for poly-drug prescriptions and/or usage. All patients are required to undergo a mandatory drug screen at facility of choice (i.e., primary care physician, hospital, or walk-in clinic).
18. The patient certifies they are a legitimate patient needing legitimate care.
19. The patient understands that the physicians at Physician Services, PSC may stop treatment and cancel any prescriptions if any of the following occur:
  - a) The patient gives, sells, or misuses the pain medication, or fails to keep appointments.
  - b) The patient fails to reach goals such as decreased pain levels.
  - c) The patient attempts to obtain pain medication at night, on weekends, on holidays, sooner than next office visit, from any other physician, from an emergency room, or from any other source.
  - d) The patient is released for any reason or fails to show improved function.
20. The patient understands that an accurate diagnosis requires an accurate history, physical exam, and imaging. Therefore, treatment recommendations are not made over the phone, only in person after being seen by a physician.
21. The patient certifies that they have not provided misleading or false information or false medical history to the referring physician or physicians at Physician Services, PSC and agree they are not seeking treatment under false pretense. The patient understands that physicians base treatment, at least 50%, on history and if it is found that the patient has provided false statements they may be released. The patient agrees they (or anyone with them) don't carry concealed weapons, tape recorders, cameras, or other devices. The patient certifies they are not appearing to seek care as part of an ongoing investigation or threat of prosecution. The patient agrees to set a goal such as decreased pain, improved function, return to work, or return to school.

PATIENT INITIALS \_\_\_\_\_

DATE \_\_\_\_\_

22. The patient will adhere to the advice of the physicians regarding operation of motor vehicles or any other machinery. If the Physician Services, PSC witnesses or is able to validate information of the patient's driving under the influence (i.e., drugs or alcohol), the patient authorizes the Physician Services, PSC to notify the authorities and not be held liable for any damages which may occur.
23. Patient agrees their record may be given to Narcotic Detectives, DEA, or other authorities and will hold Physician Services, PSC harmless, and patient agrees to random drug testing.
24. I authorize Physician Services, PSC to obtain narcotic profile from DEA and release all past, present, and future profiles to anyone with written authorization to receive medical records and understand that obtaining controlled medications from more than one physician is a felony.
25. I understand that controlled medications such as codeine, Tylenol #3, Methadone, Morphine, MS Contin, Kadian, Avinza, Percocet, Tylox, OxyContin, Roxicet, Darvon, Darvocet, Ativan, Dilaudid, Lortab, Lorcet, Vicodin, Valium, Xanax, Soma, Ambien, Ativan, Fiorinal, Restoril, Hydrocodone, etc. have risks associated with their use, such as drug interactions, respiratory, depression, death, addiction, drowsiness, allergic reactions, and agree to discuss all risks/side effects with my pharmacist, family members, family physician, other treating physicians before and during treatment.
26. I understand obtaining controlled medications from more than one physician/dentist/clinic is a felony.
27. I understand that I should take the least amount of controlled medications to relieve the symptoms and should never exceed the prescribed amount and should slowly taper off all controlled substances over several weeks whenever possible. I understand that these medications are only to be taken as needed. I understand the risks of taking controlled medications up to and including death. I will take the minimal amount of medication to improve function.
28. I understand that all medications and any refills will be canceled immediately if, in the opinion of the physician/staff, an unsatisfactory psychological/psychiatric test result is received back after the patient takes the test, any allegations, suspicious information, or investigation is initiated by anyone regarding potential violations of this contract is brought to the Physician Services, PSC's attention.
29. We reserve the right to require the patient to submit to a psychological/psychiatric evaluation and/or pain patient profile and release this information as part of any medical records request.
30. The patient understands that physical dependence is a normal response to many types of medications including steroids, antidepressants, and controlled medications, but tolerance to pain relieving effects are rare.
31. The patient understands that impaired control, craving, compulsive use, continued use despite negative consequences, inability to take medications as prescribed, isolation from friends and family, doctor shopping, using illegal drugs, intoxication, apathy, depression, noncompliance, and inability to function represent abnormal behavior patterns and agree to discontinue medications, and immediately seek psychiatric care and notify Physician Services, PSC and primary care provider.
32. Patient realizes pain medication may interfere with endocrine function, i.e. interference with libido, sexual function, etc. and the patient agrees to see their family physician or endocrinologist if they have any of these problems.
33. If I develop any feelings of hopelessness, suicidal thoughts, or desire to hurt myself or others, I agree to immediately seek immediate psychiatric care and notify Physician Services, PSC and primary care provider. I will return all medications to the office if this feeling happens.
34. Patient agrees that Physician Services, PSC physicians/staff may cancel medications at any time without cause and without warning for any medical or nonmedical reason, suspicion, incarceration, or even without a specific reason, and understands to see primary care provider, mental health provider immediately when medications are canceled or treatment discontinued.
35. I understand that not taking medications as prescribed or over dosing on medications usually causes death.
36. I have told (or will tell) my family members and caregivers of my use of controlled medications for treatment of pain and they are in agreement with my treatment plan and agree to hold harmless physicians of Physician Services, PSC. I agree to discontinue treatment if family is not in agreement or my family physician is not in agreement or if I fail to reach goals.
37. I will discuss my diagnosis and treatment with family, family physician, mental health provider, second opinion physician, and if they are not in agreement, will discontinue treatment and notify Physician Services, PSC.
38. I hereby authorize any pharmacy of record to release any and all information to the physicians and/or nursing staff of Physician Services, PSC, upon their request.
39. I agree that I have been seen and examined by a Physician Services, PSC physician today and have no complaints regarding my diagnosis, treatment plan, physicians, or staff at Physician Services, PSC and if I do have problems will hand deliver it in writing to office manager today. I agree to discontinue treatment if I don't reach set goals such as decreased pain, improved function, return to work, and return to school.
40. I have read the conditions and terms stated above and have had all of my questions regarding these conditions and terms explained to my satisfaction. I have met the conditions, and I agree to honor all of the terms unconditionally. I also understand that if I violate any term of this agreement, it is cause for the physicians at Physician Services, PSC to refuse prescriptions and/or treatment. I agree that if I am unable to read or write that this has been verbally explained to me to my satisfaction.

PATIENT NAME	DATE	PHARMACY NAME
PHYSICIAN SERVICES, PSC STAFF WITNESS		PHARMACY CITY
RN/LPN/MA signature (if applicable)	PHYSICIAN	Revised 3/2004

Chronic noncancer pain patients often experience anxiety and insomnia. Satisfactory sleep should be one of the first goals. Sleep hygiene should be discussed (19), but frequently medications are required. Initially, noncontrolled substances, antihistamines, antidepressants, or nonbenzodiazepines should be considered. If benzodiazepines are required, short half-life medications such as temazepam (Restoril®), lorazepam (Ativan®), or oxazepam (Serax®) may be safer in older patients. Adults under 65 years of age may use longer half-life medications such as flurazepam hydrochloride (Dalmane®), clonazepam (Klonopin®), and chlorthalidopoxide hydrochloride (Librium®). The authors do not like to prescribe carisoprodol (Soma®), diazepam (Valium®), or alprazolam (Xanax®) because they are drugs of abuse in Kentucky. One physician should prescribe all controlled substances, and exceptions should be noted in the patient record.

A patient on a long-acting opioid (*e.g.*, methadone) may require a short-acting medication for breakthrough pain. One should try to increase the methadone slowly and eliminate the need for the breakthrough medications. Treatment should not be initiated with a long-acting Schedule II narcotic unless the patient is narcotic tolerant (already taking narcotics) or at the maximum daily dose of a Schedule III drug. Many patients referred to the program described are using as many as five controlled substances. The authors quickly taper this down to one or two.

Many working patients can manage with an antidepressant such as escitalopram oxalate (Lexapro®) in the morning, tramadol (Ultram®) and metaxalone (Skelaxin®) for pain and muscle spasms while at work; and at night, a Schedule III narcotic with a sleep enhancer such as zolpidem tartrate (Ambien®). Such a regimen can provide stable pain control and improved function over a long period. Venlafaxine hydrochloride (Effexor XR®) has been useful for overweight chronic noncancer pain patients with signs or symptoms of depression.

Patients taking Schedule II medications may be limited to a 60-day supply, though as many as three 30-day supplies may be written (20). Six months of Schedule III medications may be provided by writing five refills, but it may be more prudent to write for fewer. The amount of

opioid needed to control pain has no upper limit. The authors have selected limits for their practice and comfort level given the current regulatory environment. Though the authors prescribe for legitimate problems, the amount of drugs prescribed is one factor in calculating the sentence range in federal cases involving illegally prescribed medication (21).

**C-9. Call block.** The authors never call in controlled substances. Telephone scams used by drug seekers can be very sophisticated. In the "oh by the way" scam, a scam artist can obtain a physician's DEA number in several ways and call in a Schedule III narcotic to Pharmacy-A. After several hours, the scam artist will call posing as a pharmacist at Pharmacy-B and say, "Doctor, we have a prescription here for a narcotic under the name of 'scam artist.'" Of course, the physician replies, "I did not call in that medication." The scam artist responds, "Oh, by the way, Doctor, did you get any other calls tonight?" If the physician says, "Yes, I got a call from Pharmacy-A regarding this same individual," then the scam artist will not proceed in picking up the medication from Pharmacy-A. If the physician replies, "No, I did not get any other calls," then the scam artist will immediately visit Pharmacy-A and pick up the medication previously called in.

The best pain medication policy is *no medication changes by phone and no calling in medications on nights, weekends, or even during the day*. The patient should be seen in the office since no diagnosis can be made over the phone. Both the DEA and pharmacists will like this policy. Let them know about it. An individual who was not one of the authors' patients once tried to call in medication. The pharmacist knew the program's policy and immediately contacted narcotics detectives and had the person arrested. Another patient presented an OxyContin® prescription. The pharmacist knew that the authors do not write prescriptions for this medication, immediately contacted the DEA, and the individual was arrested.

**C-10. Compassion.** Today's medico/legal environment, which places an increased burden on pain management

physicians, makes it easy to lose one's sense of compassion. However, problem patients can usually be discovered with infrastructure such as electronic medical records, support staff, lifestyle counselors, and the universal precautions of urine drug screens, pain patient profiles, and narcotic profiles. Such patients can be referred to behavioral health practitioners. When an addictive or aberrant behavior is identified, the clinician should explain the noncompliance to the patient with compassion.

### SUMMARY

It will be helpful for the pain management practitioner to remember the Ten Cs of chronic noncancer pain.

1. Embrace *continuing medical education* and lifelong learning. Consider board certification and accreditation. Know the common terminology. And know that patients rarely become addicted.
2. Pain specialists should require a *consultation*. Primary care providers should refer patients for consultation.
3. Use a *comprehensive history intake form* on every visit.
4. Undertake a *confirmatory physical exam* or *confirmatory imaging study*.
5. Consider the use of a *contract* for treatment on every visit.
6. Consider *alternatives and adjuncts to therapy*.
7. Use *compliance measures* such as random urine drug screens, narcotic profiles, and measures to identify co-morbidities.
8. Use *control*. Require the patient to use only one pharmacy. Set general limits in guidelines.
9. Employ a system of *call block*. Prohibit staff, nurses, and physicians from calling in controlled substances.
10. Maintain *compassion* despite the increasing burden and documentation required in this endeavor.

### REFERENCES

1. Anon. What is neurological surgery? Houston: The American Board of Neurological Surgery 2004; [cited 2004 June 18]. Available from: <http://www.abns.org>.
2. Grinstead SF. War on drugs – war on pain management. Sacramento: Addiction Free Pain Management 2003; [cited 2004 June 18]. Available from: <http://www.addiction-free.com>.
3. Anon. Advice to doctors re: pain management. Tucson: Association of American Physicians and Surgeons 2003; [cited 2004 June 18]. Available from: <http://aapsonline.org/painman/advice.htm>.
4. Zacny J. Trends in medical use and abuse of prescription opioids: a critical look at the data. In: Heit HA, Savage SR, Course Co-Directors. Pain & Addiction: Common Threads V. Emerging Issues in the Use, Misuse and Diversion of Opioid Analgesics. Washington, DC: American Society of Addiction Medicine, April 22, 2004:39-64.
5. Gourlay DL. Confirmed universal precautions: a new concept in the use of opioids to treat chronic pain. In: Heit HA, Savage SR, Course Co-Directors. Pain & Addiction: Common Threads V. Emerging Issues in the Use, Misuse and Diversion of Opioid Analgesics. Washington, DC: American Society of Addiction Medicine, April 22, 2004:229-244.
6. Anon. Opioid agreements & contracts: the American Academy of Pain Management's take on the subject. Sonora, CA: American Academy of Pain Management 2002; [cited 2004 June 18]. Available from: <http://www.aapainmanage.org/members/PrescribingIssues.php>.
7. Crum R. The epidemiology of addiction disorders. In: Graham A, Schultz TK, Mayo-Smith MF, Ries RK, Wilford BB, editors. Principles of Addiction Medicine, 3rd ed. Chevy Chase, Maryland: American Society of Addiction Medicine, Inc., 2003:17-32.
8. Anon. Treatment attestation for pain management services. Sonora, CA: American Academy of Pain Management 2002; [cited 2004 June 18]. Available from: <http://www.aapainmanage.org/members/PrescribingIssues.php>.
9. Cole BE. Prescribing opioids, relieving patient suffering and staying out of personal trouble with regulators. *The Pain Practitioner* 2002, 12:5-8.

10. Heit HA. Urine drug testing (UDT): a patient-centered model. In: Heit HA, Savage SR, Course Co-Directors. Pain & Addiction: Common Threads V. Emerging Issues in the Use, Misuse and Diversion of Opioid Analgesics. Washington, DC: American Society of Addition Medicine, April 22, 2004:245-266.
11. Pembroke L. Opioid contracts for chronic pain therapy; the pros and cons. *Anesthesiology News* 2002; [cited 2004 June 21]. Available from: <http://www.anesthesiologynews.com/indexpub.cfm?pubid=3>.
12. Anon. Editorial. *Journal of Pain and Symptom Management* 1999;18:6-8.
13. Salsitz EA. The concept of hedonic tone: implications for pain, addiction, and opioid use and misuse. In: Heit HA, Savage SR, Course Co-Directors. Pain & Addiction: Common Threads V. Emerging Issues in the Use, Misuse and Diversion of Opioid Analgesics. Washington, DC: American Society of Addition Medicine, April 22, 2004:89-118.
14. Van Zundart J, Raj P, Erdine S, van Kleef M. Application of radiofrequency treatment in practical pain management: state of the art. Back and Neck Pain: Sources, Treatment and Evidence. Syllabus of the First European Scientific Meeting of the International Spinal Injection Society. Amsterdam: International Spinal Injection Society, 2004:269-277.
15. The role of psychological assessments in the treatment of chronic pain. *Bridging the Gap: A Newsletter for Pain Professionals* 1999; Fall:1,4.
16. Tollison CD, Langley JC. P-3. Pain Patient Profile. Eagan MN: Pearson Assessments 2004; [cited 2004 June 21]. Available from: <http://www.pearsonassessments.com>.
17. Anon. Pain assessment and management: an organizational approach. Oakbrook Terrace, IL: Joint Commission of Accreditation of Healthcare Organizations, 2000.
18. Savage SR. Changing policies on medical use of opioids: their potential impact on treatment, misuse, and diversion. In: Heit HA, Savage SR, Course Co-Directors. Pain & Addiction: Common Threads V. Emerging Issues in the Use, Misuse and Diversion of Opioid Analgesics. Washington, DC: American Society of Addition Medicine, April 22, 2004:3-38.
19. Anon. Tossing and turning with insomnia. JAMA Patient Page. *JAMA* 1999; 381:1056; [cited 2004 July 17]. Available from: [http://www.medem.com/search/article\\_display.cfm?path=\TANQUERAYM\\_ContentItem&mstr=/M\\_ContentItem/ZZZPBS42NAC.html&soc=JAMA/Archives&srch\\_typ=NAV\\_SERCH](http://www.medem.com/search/article_display.cfm?path=\TANQUERAYM_ContentItem&mstr=/M_ContentItem/ZZZPBS42NAC.html&soc=JAMA/Archives&srch_typ=NAV_SERCH).
20. Anon. Multiple Schedule II prescribing. Prescribing of the same medication to the same patient by the same practitioner on the same date: a state by state comparison of what is federally allowed. Sonora, CA: American Academy of Pain Management 2002; [cited 2004 June 18]. Available from: <http://www.aapainmanage.org/members/PrescribingIssues.php>.
21. Doctor's sentencing postponed. *Lexington Herald-Leader*, Friday, October 24, 2003, B3.