AGENCY MEDICAL DIRECTORS' GROUP

Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain:

An educational aid to improve care and safety with opioid therapy

2010 Update

What is New in this Revised Guideline

- New data, including scientific evidence to support the 120mg MED dosing threshold
- Tools for calculating dosages of opioids during treatment and when tapering
- Validated screening tools for assessing substance abuse, mental health, and addiction
- Validated two-item scale for tracking function and pain
- Urine drug testing guidance and algorithm
- Information on access to mentoring and consultations (including reimbursement options)
- New patient education materials and resources
- Guidance on coordinating with emergency departments to reduce opioid abuse
- New clinical tools and resources to help streamline clinical care

You can find this guideline and related tools at the Washington State Agency Medical Directors' site at **www.agencymeddirectors.wa.gov**

Table of Contents

Figures and Tables

Introduction

This guideline was originally published in March 2007 as an educational pilot. Sponsored by the Washington State Agency Medical Directors' Group (AMDG)[1], the original guideline and this updated version were developed in collaboration with actively practicing providers with extensive experience in the evaluation and treatment of patients with chronic pain. It is intended as a resource for primary care providers treating patients with chronic noncancer pain. It does not apply to the treatment of acute pain, cancer pain, or end-of-life (hospice) care.

Providers prescribing opioids know there is a delicate balance between the undertreatment and overtreatment of chronic non-cancer pain. This guideline provides information on the scope of the challenge, recommendations for prudent prescribing and monitoring, advice on how to get consultative assistance, and resources for educating patients.

2010 Update

In 2009, the AMDG surveyed medical providers in Washington State to assess the acceptability and usefulness of the guideline and to identify ways to improve it (available at **http://www.agencymeddirectors.wa.gov/Files/AGReportFinal.pdf**). Results of the survey support the continued use of this guideline with the addition of clinical tools and improved information for accessing specialty consultations.

Recent studies indicate a dramatic increase in accidental deaths associated with the use of prescription opioids and an increasing average daily morphine equivalent dose (MED) of the most potent opioids since 1999[1-3]. Between 1999–2006, people aged 35–54 years had higher poisoning death rates involving opioid analgesics than those in any other age group[4].

In response to the increasing morbidity and mortality associated with the increasing use of opioids, the Centers for Disease Control and Prevention[5] has released several recommendations for how health care providers can help. The recommendations include:

- Use opioid medications for acute or chronic pain only after determining that alternative therapies do not deliver adequate pain relief. The lowest effective dose of opioids should be used.
- In addition to behavioral screening and use of patient agreements, consider random, periodic, targeted urine testing for opioids and other drugs for any patient less than 65 years old with noncancer pain who has been treated with opioids for more than six weeks.
- If a patient's dosage has increased to 120 mg MED per day or more without substantial improvement in function and pain, seek a consult from a pain specialist.
- Do not prescribe long-acting or controlled-release opioids (e.g., OxyContin®, fentanyl patches, and methadone) for acute pain.

The full report can be found at **www.cdc.gov/HomeandRecreationalSafety/Poisoning/brief.htm** .

Data collected in Washington state show:

- During 2004–2007, 1,668 WA residents had confirmed unintentional poisoning deaths due to prescription opioid related overdoses[6]. Nearly half of these deaths were in the Medicaid population.
- Unintentional opioid-related overdose deaths increased 17-fold during 1995–2008.
- Hospitalizations for opioid-related overdoses increased 7-fold during 1995–2007.
- Addiction treatment admissions, where prescription opioids were the primary drug of abuse, increased from 1.1% to 7.4% between 2000 and 2009.
- Prescription opioid-related overdose deaths now exceed non-prescription opioid-related overdose deaths[7].
- The death rate from unintentional poisoning exceeded the death rate from motor vehicle crashes in 2006, and the gap continues to widen[8].

[1] The AMDG consists of the medical directors from these WA State Agencies: Corrections, Social and Health Services (Medicaid), Labor and Industries, and the Health Care Authority

The risks of opioid use are not exclusive to the adult population. According to the Healthy Youth Survey 2008 (available at **http://takeasdirected.doh.wa.gov**), Washington teens are using prescription opioid pain medicine to get high. This includes:

- 4% of 8th graders
- 10 % of 10th graders (21% of these youth obtained their prescriptions from a dentist or physician)
- 12% of 12th graders

How this guideline is organized

The purpose of Part I of the dosing guideline is to assist primary care providers in prescribing opioids for adults in a safe and effective manner.

The purpose of Part II is to assist primary care providers in treating patients whose morphine equivalent dose (MED) already exceeds 120mg/day.

Part I. Guidelines for initiating, transitioning, and maintaining oral opioids for chronic non-cancer pain

Part I of the dosing guideline will assist primary care providers in prescribing opioids for adults in a safe and effective manner when:

- Instituting or transitioning opioid therapy from acute to chronic non-cancer pain;
- Assessing and monitoring opioid therapy for chronic non-cancer pain; and
- Tapering or discontinuing opioids if an opioid trial fails to yield improvements in function and pain. An opioid trial is a period of time during which the effectiveness of using opioids is tested to see if goals of functionality and decreased pain are met. A trial should occur prior to treating someone with long-acting opioids and should include goals. If trial goals are not met, the trial should be discontinued and an alternative approach taken to treating the pain[9].

Managing chronic pain and providing appropriate opioid therapy is a challenging aspect of both primary care and specialty care practices. That is why it is critical for prescribers to be very conscious of the risks, and intentional about the treatment plan when prescribing these drugs. Best practice treatment requires attention to a number of special issues. One must balance the need for scientific evidence and skillful clinical decision making in these very complex cases.

Dosing threshold for pain consultation

The hallmark of this guideline is a recommendation to *not* prescribe more than an average daily MED of 120mg without *either* the patient demonstrating improvement in function and pain *or* first obtaining a consultation from a pain management expert. A recent cohort study supports the 120mg MED dosing threshold. It "provides the first estimates that directly link receipt of medically prescribed opioids to overdose risk and suggests that overdose risk is elevated in chronic non-cancer pain patients receiving medically prescribed opioids, particularly in patients receiving higher doses"[10]. Patients receiving 100mg or more per day MED had a 9-fold increase in overdose risk. Most overdoses were medically serious, and 12% were fatal.

High dose opioid therapy can be ineffective and/or unsafe. Higher strength pain medicines may be associated with poorer functional outcomes than lower strength opioids[11,12]. Providers must pay attention to the development of tolerance and adverse outcomes of chronic opioid use[13].

This guideline provides a calculator for determining a patient's daily MED, *and* a calculator for when the patient needs an opioid taper plan. For patients already on doses higher than 120mg MED this guideline also provides recommendations for optimizing treatment. Resources for calculating MED when patients are on one or more opioids can be found in Appendix A.

In summary, available evidence supports the following recommendations:

- The total daily dose of opioids should not be increased above 120mg oral MED without either the patient demonstrating improvement in function and pain or first obtaining a consultation from a practitioner qualified in chronic pain management.
- Risks substantially increase at doses at or above 100mg,[10] so early attention to the 120mg MED benchmark dose is worthwhile.
- Safety and effectiveness of opioid therapy for chronic non-cancer pain should be routinely evaluated by the prescriber.
- Assessing the effectiveness of opioid therapy should include tracking and documenting both functional improvement and pain relief.
- If there is evidence of frequent adverse effects or lack of response to an opioid trial, a specialty consultation should be considered. Follow the guidance for seeking consultative assistance as described in Table 1.

Table 1. Guidance For Seeking Consultative Assistance (see page 9 for more details)

Prescribing opioid doses **up to** 120mg MED/day: (Cumulative daily dose when using one or more opioids. See Table 4 in Appendix A for specific opioid thresholds.)	***Before*** exceeding 120mg MED/day threshold: (Cumulative daily dose when using one or more opioids. See Table 4 in Appendix A for specific opioid thresholds.)
▪ No assistance from a pain management consultant needed if the prescriber is documenting sustained improvement in both function and pain. ▪ Consider getting consultative assistance if frequent adverse effects or lack of response is evident in order to address: - Evidence of undiagnosed conditions; - Presence of significant psychological condition affecting treatment; and - Potential alternative treatments to reduce or discontinue use of opioids.	▪ No assistance from a pain management consultant needed if the prescriber is documenting sustained improvement in both function and pain. ▪ In general, the total daily dose of opioid should not exceed 120 mg oral MED. Risks substantially increase at doses at or above 100mg[10], so early attention to this benchmark dose is worthwhile. ▪ Seek assistance from a pain management consultant to address: - Potential alternative treatments to opioids; - Risk and benefit of a possible trial with opioid dose above 120mg MED/day; - Most appropriate way to document improvement in function and pain; and - Possible need for consultation from other specialists

Figure 1. Morphine Equivalent Dose Calculation

For patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose (see Table 5 in Appendix A for MEDs of selected medications). For example, if a patient takes six hydrocodone 5mg / acetaminophen 500mg and two 20mg oxycodone extended release tablets per day, the cumulative dose may be calculated as follows:

1) Hydrocodone 5mg x 6 tablets per day = 30mg per day.
2) Using the Equianalgesic Dose table in Appendix A, 30mg Hydrocodone = 30mg morphine equivalents.
3) Oxycodone 20mg x 2 tablets per day = 40mg per day.
4) Per Equianalgesic Dose table, 20mg oxycodone = 30mg morphine so 40mg oxycodone = 60mg morphine equivalents.
5) Cumulative dose is 30mg + 60mg = 90mg morphine equivalents per day.

An electronic opioid dose calculator can be downloaded at
www.agencymeddirectors.wa.gov/guidelines.asp

BEFORE you decide to prescribe opioids for chronic pain

Acute pain is self-limiting and lasts from a few days to a few weeks following trauma or surgery. The level of pain during an acute phase does not necessarily and accurately predict the pain level in a chronic phase. Chronic pain can result from a number of conditions, diseases or injuries and is generally considered as pain lasting more than 3 months. Because of the potentially serious adverse long term effects of opioids, it is critical that the prescriber comprehensively assess the risks and benefits of treatment prior to deciding whether to prescribe opioids. Consider opioid therapy when:

- Other physical, behavioral and non-opioid measures have failed (e.g. physical therapy, cognitive behavioral therapy, NSAIDs, antidepressants, antiepileptics), and
- The patient has demonstrated sustained improvement in function and pain levels in previous opioid trial, and
- The patient has no relative contraindication to the use of opioids (e.g. current or past alcohol or other substance abuse, including nicotine[14,15]).

Chronic opioid therapy (e.g., more than 90 days of therapy) should only be initiated on the basis of an explicit decision and agreement between prescriber and patient. The patient needs to be informed of the benefits and risks of opioid therapy of indefinite duration. Sample agreements for the prescriber and patient can be found in Appendix G.

Screening for potential comorbidities and risk factors is crucial so that anticipated risk can be monitored accordingly. Depression and anxiety disorders are frequently associated with the use of opioids[16]. Current and past substance abuse disorders appear to increase the risks of chronic opioid therapy[17-20]. If substantial risk is identified through screening, extreme caution should be used and a specialty consultation (e.g. addiction or mental health specialist) is strongly encouraged. In such cases, a baseline risk assessment using the following tools should be performed and documented in the record:

1. The Opioid Risk Tool (ORT) to screen for risk of opioid addiction
2. The CAGE-AID to screen for alcohol or drug problems
3. The PHQ-9 to screen for depression severity
4. A baseline urine drug test
5. A baseline assessment of function and pain with the 2 item Graded Chronic Pain Scale (page 7 and Appendix C)

See “Screening and Monitoring Your Patient” on Page 6 for more details and see Appendix B for samples of these screening forms.

AFTER you decide with the patient to prescribe chronic opioid therapy

When instituting chronic opioid therapy, both prescriber and patient should discuss and agree on all of the following:

- Risks and benefits of opioid therapy supported by an opioid agreement (sample agreements can be found in Appendix G)
- Treatment goals, which must include improvements in both function and pain while monitoring for and minimizing adverse effects
- Expectation for routine urine drug testing
- A follow-up plan with specific time intervals to monitor treatment

Once a decision is made to institute chronic opioid therapy, the prescriber is responsible for routinely monitoring the safety and effectiveness (improved function and pain) of ongoing treatment.

Principles for safely prescribing chronic opioid therapy

- Single prescriber
- Single pharmacy
- Patient and prescriber sign opioid agreement
- Lowest possible effective dose should be used
- Be cautious when using opioids with conditions that may potentiate opioid adverse effects (including COPD, CHF, sleep apnea, current or past alcohol or substance abuse, elderly, or history of renal or hepatic dysfunction).
- Do not combine opioids with sedative-hypnotics, benzodiazepines or barbiturates for chronic non-cancer pain unless there is a specific medical and/or psychiatric indication for the combination

and increased monitoring is initiated (see *Urine drug testing*, page 8).

- Routinely assess function and pain status (see *Tools for assessing function and pain*, page 6).
- Monitor for medication misuse (for a list of drug-seeking behaviors, see *Reasons to discontinue opioids or refer for addiction management*, page 13).
- Random urine drug testing to objectively assure compliance (see *Urine drug testing*, page 8 and detailed guidance in Appendix D).

Special care should be taken when prescribing methadone for chronic pain. One helpful article for clinicians is: *Methadone Treatment for Pain States*[21]. Also, free mentoring services are available for prescribing methadone, using the Physician Clinical Support System. See Appendix H, "Additional Resources."

Screening and monitoring your patient

Several screening tools are available to help assess risk for aberrant drug-related behavior, current or former substance abuse, and mental health disorders. High risk does not necessarily contraindicate the use of opioids but additional monitoring is indicated whenever risk is increased for any reason. Additional monitoring may include increased frequency of reassessment of pain, function, and aberrant behaviors, decreased number of doses prescribed, and increased frequency of UDT. Based on a review of the literature and the consensus of the advisory committee, the following three easy-to-use tools are recommended for their clinical utility in screening opioid therapy patients. (The following screening tools are available in Appendix B.)

Opioid Risk Tool (ORT)[22]

- Purpose: to assess a patient's risk of opioid addiction
- Brief, 5-question survey
- Easily accessible
- Currently, there is no screening tool for risk of opioid addiction that has a strong psychometric evidence base

CAGE-AID[23-25]

- Purpose: to screen for alcohol or drug problems
- Brief, 4 question-survey
- Easily accessible
- Relatively strong psychometric evidence base

PHQ-9[26]

- Purpose: to screen for, diagnose, and monitor depression severity
- Brief, 9-item questionnaire
- Easily accessible
- Superior psychometric evidence base

Additional tools are listed in Appendix B.

Tools for assessing function and pain

The key to effective opioid therapy for chronic non-cancer pain is to achieve sustained improvement in pain and physical function[27,28]. Tracking function and pain is critical in determining the patient's ongoing response to opioids and whether any improvement is consistent with potential changes in opioid dosing. Critical to this guideline, if function and pain do not substantially improve with opioid dose increases, then significant tolerance to opioids may be developing and consultative assistance is strongly recommended.

An assessment of function and pain should consistently measure the same elements to adequately determine the degree of progress. While there is no universally accepted tool to assess opioid therapy's impact on function and pain, several are available and listed in Appendix C. In particular, the AMDG recommends using the two item Graded Chronic Pain Scale[29,30] (Figure 2) as an ongoing and rapid method to easily track function and pain in the medical record. See Appendix C for instructions on scoring and interpretation.

Other functional assessment tools that may be helpful in monitoring your patient's progress include, but are not limited to:

- **SF36 Health Survey***
  www.rand.org/health/surveys_tools/mos/mos_core_36item.html
- Brief Pain Inventory*

- **www.ohsu.edu/ahec/pain/paininventory.pdf**
- ***Quick*Dash*** for musculoskeletal disorders of the upper extremities
- **www.dash.iwh.on.ca/outcome_quick.htm**
- Quality of Life Scale*
- **www.uic.edu/orgs/qli/questionaires/questionnairehome.htm**
- Oswestry Disability Index*
- **www.workcover.com/public/download.aspx?id=794&str=disability index oswestry**
- Neck Disability Index*
- **www.workcover.com/public/download.aspx?id=792&str=disability index neck**
- Short Musculoskeletal Function Assessment*

  See: **www.ejbjs.org/cgi/reprint/81/9/1245**

* These instruments have all been independently validated and may be available at websites other than those listed above.

Assessing effects of chronic opioid therapy

Chronic opioid therapy is associated with the development of tolerance to its analgesic effects[31,32]. Evidence is accumulating that opioid therapy may also paradoxically induce abnormal pain sensitivity, including hyperalgesia and allodynia[33-35]. Thus, increasing opioid doses may not improve function and pain control.

The prescriber should assess the risks and benefits of the patient's current opioid therapy. This assessment should include:

- Function and pain status (see *Tools for assessing function and pain*, page 6);
- Possible adverse effects of current opioid doses;
- Potential psychiatric disorders affecting treatment;
- Possible drug combinations or conditions that may potentiate opioid adverse effects (such as COPD, CHF, sleep apnea, current or past alcohol or substance abuse, advanced age, or history of renal or hepatic dysfunction); and
- Any relative contraindication to the use of opioids (active alcohol or other substance abuse, including nicotine[14,15], see *Urine drug testing*, page 8).

If function and pain do not improve after a sufficient opioid trial, consider discontinuing opioids (see *Tapering or Discontinuing Opioids*, page 10). When there is evidence of significant adverse effects from opioid therapy, the provider should reduce the opioid dose and reassess the patient's status.

Otherwise, if no reasons for dose reduction or discontinuation are identified, and the prescriber feels (with support of validated measures of function and pain) that the patient is benefiting from current therapy, continuation can be appropriate. Ongoing

Figure 2. Graded Chronic Pain Scale

Pain intensity and interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

therapy, however, entails ongoing assessment. The screening described above should be done on a regular basis to assess progression of therapy as the patient's condition changes over time.

Urine drug testing (UDT)

The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse, and verify compliance with treatment. When used with an appropriate level of understanding, UDT can improve the prescriber's ability to safely and appropriately manage opioid therapy (see Appendix D – *Using Urine Drug Testing to Monitor Opioid Therapy for Chronic Non-cancer Pain*).

Urine drug testing is an important part of the baseline risk assessment which prescribers should perform on all candidates for chronic opioid therapy (see *Before you decide to prescribe opioids for chronic pain*, page 5*)*. This baseline UDT should be performed on all transferring patients who are already using opioids and for those patients who you are considering for chronic opioid therapy (e.g. 3rd opioid prescription or >6 weeks after an acute injury). Prior to testing, the prescriber should inform the patient of the reason for testing, the expectation of random repeat testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify drug testing for the individual circumstances and more accurately interpret the results.

After opioid therapy has been initiated, the prescriber should randomly repeat testing at the approximate frequency determined by the patient's risk category based on the ORT or similar screening tools (see Table 2).

Although UDT and other screening tools are helpful in identifying aberrant behavior, it is also important for prescribers to use their clinical judgment in the development of a monitoring plan. Information from third parties, such as family and friends, can be helpful in evaluating behavior. Opioid prescribing should be avoided in patients with active alcohol or other substance abuse. Extreme caution should be used, and a consultation with an addiction specialist is strongly encouraged, prior to prescribing opioids for patients with a history of alcohol or other substance abuse.

Methods of testing

There is no standard UDT that is suitable for all purposes and settings[36]. Currently, two main types of UDT are available:

- Immunoassay drug testing (initial drug test or screen) – based in a lab or office (point-of-care).
- High performance chromatography/mass spectrometry (confirmatory drug test) – available only through a laboratory

Immunoassays are the most common method of testing and can be performed either in a laboratory or at the point-of-care. These tests detect the presence or absence of a drug or drug class according to a predetermined cutoff threshold.

Table 2. Recommended Frequency of UDT

Risk Category	Recommended UDT Frequency
Low Risk by ORT	Periodic (e.g. up to 1/year)
Moderate Risk by ORT	Regular (e.g. up to 2/year)
High Risk by ORT **or** opioid doses >120 mg MED/d	Frequent (e.g. up to 3–4/year)
Aberrant Behavior (lost prescriptions, multiple requests for early refill, opioids from multiple providers, unauthorized dose escalation, apparent intoxication etc.)	At time of visit (Address aberrant behaviors in person, not by telephone)

The advantages of immunoassays are their ability to concurrently test for multiple drug classes, provide rapid results and guide appropriate utilization of confirmatory testing. However, immunoassays can cross-react with other drugs and vary in sensitivity and specificity. Thus, unexpected immunoassay results should be interpreted with caution and verified by confirmatory testing.

If verification or identification of a specific drug and/or metabolite(s) is needed, then confirmatory testing is recommended. Laboratory-based confirmation uses gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS) to identify a drug or confirm an immunoassay result.

Drugs or drug classes to test

The NIDA 5 (National Institute on Drug Abuse) was established for workplace drug testing and is federally regulated. However, it does not test for many commonly prescribed or abused drugs such as benzodiazepines and semi-synthetic or synthetic opioids, which may be important in compliance testing. Thus, it may be more useful to order an expanded urine drug panel to include any of the drugs listed below in addition to drugs you are prescribing:

- Cannabinoids
- Cocaine
- Amphetamines
- Opiates
- Benzodiazepines
- Alcohol
- Barbiturates
- Oxycodone
- Methadone
- Fentanyl

Interpreting results

Interpreting UDT results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. When the immunoassay result is unexpected and the patient does not acknowledge or credibly explain the result, a confirmatory test using either GC/MS or LC/MS/MS should be ordered.

If the patient tested negative for prescribed opioids and if confirmatory testing substantiates a “red flag” result (see Table 3), the prescriber should consider a controlled taper or stop prescribing opioids immediately Prescriber may also consider a referral to an addiction specialist or drug treatment program depending on the circumstances.

Contact your local laboratory director, toxicologist or certified Medical Review Officer (MRO) for questions about drug testing or results. To locate a MRO in your area, submit a search at the following website: **www.aamro.com/registry_search.html**. If a point-of-care device is used, contact technical support from the manufacturer for questions.

Table 3. Red Flag Results

- Negative for opioid(s) you prescribed
- Positive for amphetamine or methamphetamine
- Positive for cocaine or metabolites
- Positive for drug (benzodiazepines, opioids, etc) you did not prescribe or have knowledge of
- Positive for alcohol

Specialty consultation

Specialty consultation is recommended for ongoing severe pain symptoms with no significant improvement in function despite treatment with opioids. Consultation should address possible undiagnosed conditions, psychological conditions affecting treatment, and alternative treatments. The type of consultation obtained should be determined by the patient’s presenting signs and symptoms and history. Consultation may be with, but not limited to, a physician specializing in psychiatry, neurology, anesthesiology, pain, physical medicine and rehabilitation, orthopedics, addiction medicine, rheumatology, or oncology.

Unrecognized diagnoses: In cases of severe ongoing pain symptoms with no improvement in function despite treatment with opioids, it is recommended you seek consultative assistance to address possible undiagnosed conditions. Examples include psychiatry, neurology, internal medicine, physical medicine and rehabilitation, orthopedics, addiction medicine, rheumatology, or oncology.

Psychological and addiction issues: Opioid therapy can be challenging in patients with symptoms suggestive of mood, anxiety, and psychotic disorders. Consider psychiatric and/or psychological consultation for intervention if a psychological condition is affecting treatment. Patients with signs of alcohol or other substance

abuse should be referred to an addiction specialist (see *Referrals for addiction management*, page 13).

Opioid management: Consultative assistance for opioid management and prudent prescribing of opioids should be with a pain management expert who is familiar with and endorses this guideline. Examples of when to seek assistance include:

- Patients on > 120mg MED/day
- Questions about methadone treatment
- Tapering patients off opioids
- Aberrant behavior

Although pain may be relieved at oral morphine doses up to 120mg MED/day, pain relief is not necessarily associated with psychological or functional improvement[37]. Because sustained functional improvement is so critical to effective opioid therapy for chronic non-cancer pain, the prescriber should ensure that the patient meets the following conditions before considering a dosage above 120mg MED/day:

- There are no significant psychological issues or evidence of drug-seeking behaviors, AND
- The patient has demonstrated improvement in function and pain level previously at a lower dose.

If these conditions are met, the prescriber may seek a pain management consultation or case review to support possible treatment with opioid doses above 120mg MED/day.

Consultation with a specialist does not necessitate transfer of the patient for care or ongoing opioid prescribing. However, the consultant should advise the prescribing provider on a pain management plan and may include: alternative treatments to reduce or discontinue use of opioids, explanation of the risks and benefits of a possible trial with opioids above 120mg/day MED, and the need for ongoing documentation of improvement in function and pain.

Consultations do not necessarily have to be done face to face with the patient. See Appendix E for alternate forms of consultative assistance.

Access to specialists and mentors

The names of consultants are available at **www.agencymeddirectors.wa.gov/guidelines.asp**. You may also find it helpful to contact one of the following organizations that offer credentialing or certification in pain medicine:

- American Board of Pain Medicine
- American Board of Anesthesiology with certification of added qualifications in pain management
- American Board of Physical Medicine and Rehabilitation
- American Board of Psychiatry and Neurology

The University of Washington School of Medicine and its academic medical centers offer a toll free consultation and referral service available 24 hours per day 7 days per week. This service helps link you with a faculty physician with expertise in any particular area. To access these services visit, call 800.326.5300, email **medcon@washington.edu** or visit, **http://uwmedicine.washington.edu/Patient-Care/Referrals/Pages/MEDCON.aspx**.Click on the tab, “Make a Referral” and then the tab “Expertise” and enter the specialty for which you are seeking assistance.

Tapering or discontinuing opioids

Not all patients benefit from opioids, and a prescriber frequently faces the challenge of reducing the opioid dose or discontinuing the opioid altogether. From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:

- A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks).
- If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.
- Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring often for

significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.

- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued. Rapid reoccurrence of tolerance can occur for months to years after prior chronic use.
- Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.

An **Opioid Taper Plan Calculator** is available in Appendix H, *Additional Resources*.

Recognizing and managing behavioral issues during opioid tapering

Opioid tapers can be done safely and do not pose significant health risks to the patient. Special care needs to be taken by the prescriber to preserve the therapeutic relationship at this time. Otherwise, taper can precipitate doctor-shopping, illicit drug use, or other behaviors that pose a risk to patient safety. Extremely challenging behavioral issues may emerge during an opioid taper[38].

Behavioral challenges frequently arise when a prescriber is tapering the opioid dose and a patient places great value on the opioid he/she is receiving. In this setting, some patients may feel overwhelmed or desperate and will try to convince the prescriber to abandon the opioid taper. Challenges may include:

- Focus on right to pain relief ("You don't believe I have real pain")
- Arguments about poor quality of pain care with threats to complain to administrators or licensing boards
- Attributing one's deteriorating psychological state, including suicidal thoughts, to opioid withdrawal.

There are no fool-proof methods for preventing behavioral issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary (see *AFTER you decide with the patient to prescribe chronic opioid therapy*, page 5). Serious suicidal ideation (with plan or intent) should prompt urgent psychiatric consultation[39].

Part II: Guidelines for optimizing treatment when opioid doses are greater than 120mg MED/day

Part II of this dosing guideline will assist primary care providers in optimizing treatment:

- When assessing effectiveness of opioid therapy in patients who exceed 120mg MED/day;
- When reducing the total daily opioid dose; and
- When discontinuing opioid therapy.

Assessing effects of opioid doses greater than 120mg MED/day

Ongoing opioid therapy requires ongoing assessment to optimize therapy. This is important in light of the evidence that not all patients receive pain relief from opioids and some develop hyperalgesia and other abnormal pain sensitivity with chronic high dose opioid therapy. If, after using the guidelines under *Assessing effects of chronic opioid therapy*, page 7), the prescriber feels that current treatment is not benefiting the patient, a dose reduction or discontinuation is warranted. However, if current treatment is benefiting the patient as demonstrated by objective measures of function and pain, it may be appropriate to continue, while establishing a plan to monitor therapy as the patient's condition changes over time (see *Principles for safely prescribing chronic opioid therapy*, page 5).

How to discontinue opioids or reduce and reassess at lower doses

Treatment with opioids, even at high doses, will not eliminate all chronic pain, and some patients may do better on lower doses of opioids[13,34,40]. A decrease by 10% of the original dose per week is usually well tolerated. An **Opioid Taper Plan Calculator** is available in Appendix H, *Additional Resources*. Behavioral issues or physical withdrawal symptoms can be a major obstacle to an otherwise beneficial dose reduction (see *Tapering or discontinuing opioids*, page 10, and *Recognizing and managing behavioral issues during opioid tapering*, page 11). The prescriber should assess the patient's status periodically during the tapering process. If the chosen assessment tool indicates improved patient status other than subjective pain complaints, or if there is improvement in opioid-related side effects, maintain the patient off opioids or at the new reduced dose and reassess at a later time.

Conversely, if there is evidence of functional and symptomatic deterioration following opioid taper, the prescriber may consider consulting with a pain management specialist to evaluate additional therapeutic options.

Referrals to pain centers

A referral for counseling or other support during opioid taper or dose reduction is recommended if there are significant behavioral issues. In addition, a multidisciplinary pain program may be considered when appropriate to address the psychosocial and cognitive aspects of chronic pain together with patients' physical rehabilitation[41]. Early consultative support may prevent pain from becoming a chronic disabling condition.

Recognizing aberrant behaviors during opioid therapy

Patients who exhibit aberrant behaviors may be at risk for opioid abuse. There is no universally accepted screening tool to predict aberrant behaviors with opioid therapy for chronic pain. However, it is important to identify aberrant behaviors as they can affect the medical management of your patients and help predict misue of opioids (see *Reasons to discontinue opioids or refer for addiction management*, page 13)[42].

Patients with a comorbid psychiatric condition or addiction are at higher risk of opioid misuse despite their attempts to follow the treatment plan[38,43,44]. Prescribers should intensify monitoring and scrutiny and seek a consultation with an addiction specialist if there is past or active substance dependence or abuse.

Reasons to discontinue opioids or refer for addiction management

- No improvement in function and pain or
- Opioid therapy produces significant adverse effects or
- Patient exhibits drug-seeking behaviors or diversion such as:
  - Selling prescription drugs
  - Forging prescriptions
  - Stealing or borrowing drugs
  - Frequently losing prescriptions
  - Aggressive demand for opioids
  - Injecting oral/topical opioids
  - Unsanctioned use of opioids
  - Unsanctioned dose escalation
  - Concurrent use of illicit drugs
  - Failing a drug screen
  - Getting opioids from multiple prescribers
  - Recurring emergency department visits for chronic pain management (see section on Emergency Department Guidelines in Appendix H, *Additional Resources*).

Referrals for addiction management

A patient who exhibits overt signs of alcohol or substance use disorder should be referred to an addiction specialist for appropriate treatment. Prognosis is poor for patients with a Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis of opioid dependence or opioid abuse who do not receive treatment[45,46].

Appendices

Appendix A: Opioid dose calculations

Table 4. Dosing Threshold for Selected Opioids*

Opioid	Recommended dose threshold for pain consult (not equianalgesic)	Recommended starting dose for opioid-naïve patients	Considerations
Codeine	800mg per 24 hours	30mg q 4–6 hours	See individual product labeling for maximum dosing of combination products. Avoid concurrent use of any OTC products containing same ingredient. See acetaminophen warning, below.
Fentanyl Transdermal	50mcg/hour (q 72 hr)		Use only in opioid-tolerant patients who have been taking ≥ 60mg MED daily for a week or longer
Hydrocodone	120mg per 24 hours	5-10mg q 4–6 hours	See individual product labeling for maximum dosing of combination products. Avoid concurrent use of any OTC products containing same ingredient. See acetaminophen warning, below.
Hydromorphone	30mg per 24 hours	2mg q 4–6 hours	
Methadone	40mg per 24 hours	2.5-5mg BID – TID	Methadone is difficult to titrate due to its half-life variability. It may take a long time to reach a stable level in the body. Methadone dose should not be increased more frequently than every 7 days. Do not use as PRN or combine with other long-acting (LA) opioids.
Morphine	120mg per 24 hours	Immediate-release: 10mg q 4 hours Sustained-release: 15mg q 12 hours	Adjust dose for renal impairment.
Oxycodone	80mg per 24 hours	Immediate-release: 5mg q 4–6 hours Sustained Release: 10mg q 12 hours	See individual product labeling for maximum dosing of combination products. Avoid concurrent use of any OTC products containing same ingredient. See acetaminophen warning, below.
Oxymorphone	40mg per 24 hours	Immediate-release: 5–10mg q 4–6 hours Sustained Release: 10mg q 12 hours	**Use with extreme caution due to potential fatal interaction with alcohol or medications containing alcohol**.

*Meperidine and propoxyphene products should not be prescribed for chronic non-cancer pain.

Acetaminophen warning with combination products
Hepatotoxicity can result from prolonged use or doses in excess of recommended maximum total daily dose of acetaminophen including over-the-counter products.

- Short-term use (<10 days) – 4000 mg/day
- Long-term use – 2500mg/day

Key considerations in dosing long acting opioids

- Monitoring for adequate analgesia and use of "rescue" medications (at least until the long-acting opioid dose is stabilized). All new dosage calculations should include consideration for concurrent utilization of short-acting opioids.
- If the patient is more debilitated, frail and/or has significant metabolic impairments (e.g. renal or hepatic dysfunction), consider starting at the lower end of the conversion dose range.
- Always monitor for adverse effects (nausea, constipation, oversedation, itching, etc.)

Equianalgesic dose table for converting opioid doses
All conversions between opioids are estimates generally based on "equianalgesic dosing" or ED. Patient variability in response to these EDs can be large, due primarily to genetic factors and incomplete cross-tolerance. **It is recommended that, after calculating the appropriate conversion dose, it be reduced by 25–50% to assure patient safety**.

Table 5. MED for Selected Opioids

Opioid	Approximate Equianalgesic Dose (oral & transdermal) *
Morphine (reference)	**30mg**
Codeine	200mg
Fentanyl transdermal	12.5mcg/hr
Hydrocodone	30mg
Hydromorphone	7.5mg
Methadone	Chronic: 4mg†
Oxycodone	20mg
Oxymorphone	10mg

*Adapted from VA 2003 & FDA labeling

†Equianalgesic dosing ratios between methadone and other opioids are complex, thus requiring slow, cautious conversion (Ayonrinde 2000)

Appendix B: Screening Tools

Based on a review of the literature and the consensus of the advisory committee, the first three highlighted tools are recommended for their clinical utility in screening opioid therapy patients.

	To Screen For			To Monitor	Tool Characteristics			
	Risk of Opioid Addiction	**Current/Past Substance Abuse**	**Depression, Mental/ Behavioral Health**	**Opioid Therapy**	**Administration**	**Time to Complete**	**Length**	**Available for Public Use (Cost)**
Opioid Risk Tool (ORT) See Page 19.	X				Clinician or patient self-report	5 minutes	5 (yes/no) questions	X (Free)
CAGE Adapted to Include Drugs (CAGE-AID) See Page 20.		X			Clinician	< 5 minutes	4 (yes/no) questions	X (Free)
Patient Health Questionnaire 9 (PHQ-9) See Page 21.			X		Patient self-report	< 5 minutes	10 items	X (Free)
Screener and Opioid Assessment for Patients with Pain (SOAPP-R) **www.painedu.org/soapp.asp**	X				Patient self-report	< 10 minutes	24 items	X (Free, with licensing agreement)
Alcohol Use Disorders Identification Test (AUDIT) See Page 24.		X			Clinician or patient self-report	< 5 minutes	10 items	X (Free)
Center for Epidemiologic Studies Depression Scale (CES-D) See Page 26.			X		Patient self-report	5 minutes	20 items	X (Free)
Global Appraisal of Individual Needs Short Screener (GAIN-SS) See Page 29.			X		Staff or patient self-report	5 minutes	15 (yes/no) questions	X (Free)
Current Opioid Misuse Measure (COMM) **www.painedu.org/soapp.asp**				X	Patient self-report	< 10 minutes	17 items	X (Free, with licensing agreement)

*****The tools listed in this table have demonstrated good content, face, and construct validity in screening for risk of addiction and monitoring opioid therapy. Further validation studies and prospective outcome studies are needed to determine how the use of these tools predicts and affects clinical outcomes.

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		**[ ]**		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk $\geq$ 8

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	**YES**	**NO**
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning **to steady your nerves or to get rid of a hangover?**	☐	☐

Scoring
Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	**Sensitivity**	**Specificity**
One or more **Yes** responses	0.79	0.77
Two or more **Yes** responses	0.70	0.85

(Brown 1995)

PHQ-9 — Nine Symptom Checklist

Patient Name _____ **Date** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the days** **Nearly every day**

   b. Feeling down, depressed, or hopeless
   Not at all **Several days** **More than half the days** **Nearly every day**

   c. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**

   d. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**

   e. Poor appetite or overeating
   Not at all **Several days** **More than half the days** **Nearly every day**

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the days** **Nearly every day**

   g. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the days** **Nearly every day**

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

PHQ-9 — Scoring Tally Sheet

Patient Name _____ **Date** _____

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

How to Score PHQ-9

Scoring Method For Diagnosis

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Minor Depressive Syndrome is suggested if:

- Of the 9 items, b, c, or d are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Scoring Method For Planning And Monitoring Treatment

Question One

- To score the first question, tally each response by the number value of each response:

  Not at all = 0

  Several days = 1

  More than half the days = 2

  Nearly every day = 3
- Add the numbers together to total the score.
- Interpret the score by using the guide listed below:

Score	Action
≤4	The score suggests the patient may not need depression treatment.
> 5-14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

Question Two

In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

AUDIT questionnaire: screen for alcohol misuse[1]

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2–4 times a month
- 2–3 times a week
- 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day when drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

3. How often do you have six or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

4. During the past year, how often have you found that you were not able to stop drinking once you had started?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

5. During the past year, how often have you failed to do what was normally expected of you because of drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

7. During the past year, how often have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. During the past year, have you been unable to remember what happened the night before because you had been drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- No
- Yes, but not in the past year
- Yes, during the past year

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the past year
- Yes, during the past year

Scoring the audit

Scores for each question range from 0 to 4, with the first response for each question (eg never) scoring 0, the second (eg less than monthly) scoring 1, the third (eg monthly) scoring 2, the fourth (eg weekly) scoring 3, and the last response (eg. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more is associated with harmful or hazardous drinking, a score of 13 or more in women, and 15 or more in men, is likely to indicate alcohol dependence.

[1]Saunders JB, Aasland OG, Babor TF *et al*. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption — II. *Addiction* 1993, **88**: 791–803.

STANFORD
PATIENT EDUCATION
RESEARCH CENTER

Center for Epidemiologic Studies Depression Scale (CES-D)

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the **past week**: *(circle **one** number on each line)*

During the past week...	**Rarely or none of the time** (less than 1 day)	**Some or a little of the time** (1-2 days)	**Occasionally or a moderate amount of time** (3-4 days)	**All of the time** (5-7days)
1. I was bothered by things that usually don't bother me	0	1	2	3
2. I did not feel like eating; my appetite was poor	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family	0	1	2	3
4. I felt that I was just as good as other people	0	1	2	3
5. I had trouble keeping my mind on what I was doing	0	1	2	3
6. I felt depressed	0	1	2	3
7. I felt that everything I did was an effort	0	1	2	3
8. I felt hopeful about the future	0	1	2	3
9. I thought my life had been a failure	0	1	2	3
10. I felt fearful	0	1	2	3
11. My sleep was restless	0	1	2	3
12. I was happy	0	1	2	3
13. I talked less than usual	0	1	2	3
14. I felt lonely	0	1	2	3
15. People were unfriendly	0	1	2	3

During the past week...	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7days)
16. I enjoyed life	0	1	2	3
17. I had crying spells	0	1	2	3
18. I felt sad	0	1	2	3
19. I felt that people disliked me	0	1	2	3
20. I could not "get going"	0	1	2	3

Scoring

Item Weights	Rarely or none of the time (less than 1 day)	Some of a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	All of the time (5-7 days)
Items 4, 8, 12, & 16	3	2	1	0
All other items:	0	1	2	3

Score is the sum of the 20 item weights. If more than 4 items are missing, do not score the scale. A score of 16 or greater is considered depressed.

Characteristics

Tested on 175 subjects.

No. of items	Observed Range	Mean	Standard Deviation	Internal Consistency Reliability	Test-Retest Reliability
20	1-53	16.2	10.9	.91	NA

Source of Psychometric Data

Stanford Arthritis Self-Management Study, 1996. Unpublished.

Comments

We are no longer using the CES-D in multiethnic studies because we have found that the norms for various ethnic groups differ. This scale is available in Spanish.

References

Radloff LS, The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 1977, pp.385-401.

This scale is free to use without permission

Stanford Patient Education Research Center
1000 Welch Road, Suite 204
Palo Alto CA 94304
(650) 723-7935
(650) 725-9422 Fax
self-management@stanford.edu
http://patienteducation.stanford.edu

Funded by the National Institute of Nursing Research (NINR)

Washington State Department of Social & Health Services
DASA Division of Alcohol & Substance Abuse

DIVISION OF ALCOHOL AND SUBSTANCE ABUSE (DASA)

DASA Target Data Elements
Gain Short Screening Setup

ADMISTRATION TIME
STAFF IDENTIFICATION
DATE
AGENCY NUMBER

SECTION I CLIENT IDENTIFICATION

1. LAST NAME	2. FIRST NAME	3. MIDDLE NAME	4. OTHER LAST NAME

5. GENDER ☐ Male ☐ Female	6. DATE OF BIRTH	7. SOCIAL SECURITY NUMBER	8. WASHINGTON DRIVER'S LICENSE OR ID NUMBER

9. WHICH RACE/ETHNICITY GROUP WOULD YOU IDENTIFY YOURSELF WITH (CHECK A MAXIMUM OF FOUR THAT APPLY)

☐ Cuban
☐ Mexican, Mexican American, Chicano
☐ Asian Indian
☐ Black/African American
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Guamanian
☐ Hawaiian (Native)
☐ Japanese
☐ Korean
☐ Laotian
☐ Not Spanish/Hispanic/Latino
☐ Other Spanish/Hispanic/Latino
☐ Middle East
☐ Native American
☐ Other Asian
☐ Other Pacific Islander
☐ Other Race
☐ Refused to Answer
☐ Samoan
☐ Thai
☐ Vietnamese
☐ White/European American
☐ Puerto Rican
☐ Refused to Answer
☐ Non – Federal Tribe

Tribal Code (No. 1) _____

Tribal Code (No. 2) _____

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

The following questions are about common psychological, behavioral or personal problems. These problems are considered ***significant*** *when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions Yes or No.*

Mental Health Internalizing Behaviors (IDScr 1): During the past 12 months, have you had significant problems		
a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	☐ Yes	☐ No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling sleep during the day?	☐ Yes	☐ No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	☐ Yes	☐ No
d. when something reminded you of the past, you became very distressed and upset?	☐ Yes	☐ No
e. with thinking about ending your life or committing suicide?	☐ Yes	☐ No
Each yes answer is "1" point **IDS Sub-scale Score (0 to 5)** _____		
Mental Health Externalizing Behaviors (EDScr 2): During the past 12 months, did you do the following things two or more times?		
a. Lie or con to get things you wanted or to avoid having to do something?	☐ Yes	☐ No
b. Have a hard time paying attention at school, work or home?	☐ Yes	☐ No
c. Have a hard time listening to instructions at school, work or home?	☐ Yes	☐ No
d. Been a bully or threatened other people?	☐ Yes	☐ No
e. Start fights with other people?	☐ Yes	☐ No
Each yes answer is "1" point **EDS Sub-scale Score (0 to 5)** _____		
Substance Abuse Screen (SDScr 3): During the past 12 months, did…..		
a. you use alcohol or drugs weekly?	☐ Yes	☐ No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	☐ Yes	☐ No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	☐ Yes	☐ No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	☐ Yes	☐ No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	☐ Yes	☐ No
Each yes answer is "1" point **SDS Sub-scale Score (0 to 5)** _____		

Appendix C: Tools for Assessing Function and Pain

Pain intensity and interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

Interpretation of the Two Item Graded Chronic Pain Scale – This two item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10

Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items.

For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement.

Similar pain ratings have been widely used in the Brief Pain Inventory, the Multidimensional Pain Inventory, and the Pain Severity Scale of the SF-12.

There is extensive research on the reliability, validity and responsiveness to change of these pain severity ratings, which is summarized in the following reference:

Von Korff M. Chronic Pain Assessment in Epidemiologic and Health Services Research: Empirical Bases and New Directions. Handbook of Pain Assessment: Third Edition. Dennis C. Turk and Ronald Melzack, Editors. Guilford Press, New York., In press

Appendix D: Urine Drug Testing for Monitoring Opioid Therapy

i. **Monitoring opioid therapy with urine drug testing (UDT)**

ii. **UDT algorithm for monitoring opioid therapy**

iii. **UDT clinical vignettes**

iv. **Frequently Asked Questions (FAQs) about UDT**

i. Using Urine Drug Testing (UDT) to Monitor Opioid Therapy for Chronic Non-cancer Pain[47-49]

The purpose of drug testing is to identify aberrant behavior, undisclosed drug use and/or abuse and verify compliance with treatment. If a decision has been made to prescribe opioids for chronic non-cancer pain, the prescriber should get a baseline UDT and screen all patients for risk level to develop an appropriate monitoring plan as well as a basis for consultation or referral. Although UDT and other screening tools are helpful in identifying aberrant behavior, it is also important for prescribers to use their clinical judgment in the development of a monitoring plan. The Prescriber should repeat random UDT based on the patient's risk category. There are several validated screening tools available to assess risk of aberrant behavior. The Opioid Risk Tool (ORT) provides a brief questionnaire that can easily be used in the primary care setting (see Appendix B).

Prior to drug testing, the prescriber should inform the patient of the reason for testing, frequency of testing and consequences of unexpected results. This gives the patient an opportunity to disclose drug use and allows the prescriber to modify the drug screen for the individual circumstances and more accurately interpret the results.

Risk Category	UDT Frequency	Drugs or Drug Classes to Test	Consideration
Low Risk by ORT	Periodic (e.g. up to 1/year)	• Drug you are prescribing if not listed • Amphetamines • Opiates • Cocaine • Benzodiazepines • Alcohol • Barbiturates • Oxycodone • Methadone • Fentanyl • Marijuana Testing for all drug classes may not be necessary, depending on clinical situation.	Typically, the initial (screening) drug test uses an immunoassay method to identify the presence of a drug (presumptive positive). Because of cross-reactivity and different sensitivity and specificity between immunoassays, **a second confirmatory test is required** unless result is expected or the patient has disclosed drug use. Confirmatory drug tests use gas chromatography/mass spectrometry or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS) to verify a presumptive positive result. **Contact the laboratory director, toxicologist or a certified Medical Review Officer (MRO) in your area for questions about drug testing or result.** If a point-of-care (POC) device is used, contact technical support from the manufacturer for questions.
Moderate Risk by ORT	Regular (e.g. up to 2/year)		
High Risk by ORT **or** opioid doses >120 mg MED/d	Frequent (e.g. up to 3-4/year)		
Aberrant Behavior (lost prescriptions, multiple requests for early refills, opioids from multiple providers, unauthorized dose escalation, apparent intoxication, etc.)	At time of visit (Address aberrant behaviors in person, not by telephone)		

UDT Results

Interpreting UDT results can be challenging, especially when the parent drug can be metabolized to other commonly prescribed drugs. The table on the next page may aid prescribers when interpreting UDT results. The following UDT results should be viewed as a "red flag", requiring confirmation and intervention:

- Negative for opioid(s) you prescribed
- Positive for drug (benzodiazepines, opioids, etc) you did NOT prescribe or have knowledge of
- Positive for amphetamine or methamphetamine
- Positive for alcohol
- Positive for cocaine or metabolites

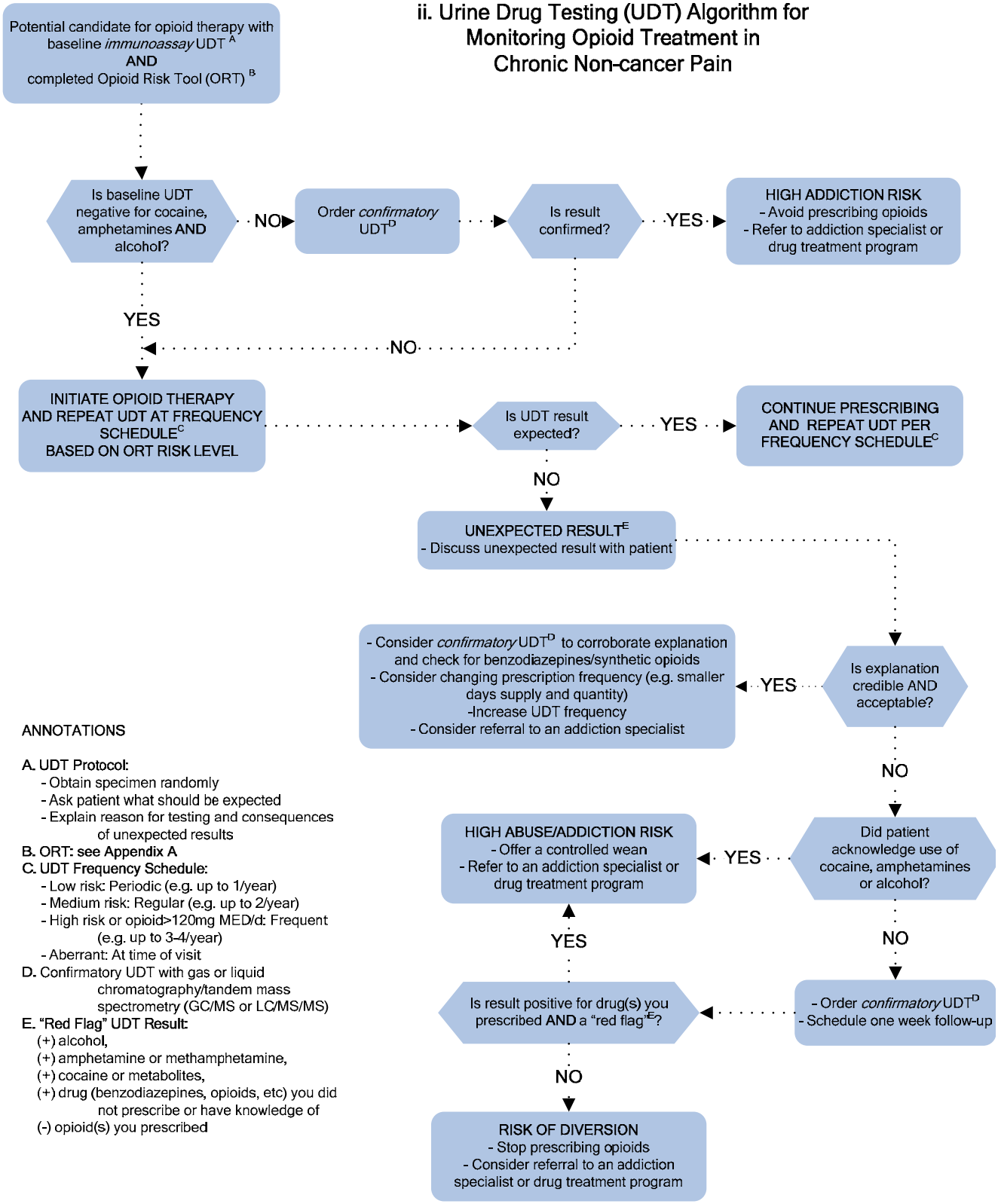
If a **confirmatory drug test** substantiates a "red flag" result AND is:

- **Positive for prescribed opioid(s)**, prescriber should consider a controlled taper and a referral to an addiction specialist or drug treatment program depending on the circumstances.
- **Negative for prescribed opioid(s)**, prescriber should stop prescribing opioid(s) and consider a referral to an addiction specialist or drug treatment program depending on the circumstances.

Drugs or Drug Classes	Detection Time in Urine*	Test to Order	Expected Results	Consideration
Opioids or "opiates" – Natural (from opium)				
Codeine (Tylenol #2/3/4)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – codeine, possibly morphine & hydrocodone	Immunoassays for "opiates" are responsive for morphine and codeine but do not distinguish which is present. Confirmatory testing is required to reliably identify drug(s) present. Since codeine is metabolized to morphine and small quantities to hydrocodone, these drugs may be found in the urine. Also, morphine may metabolize to produce a small amount (<10%) of hydromorphone.
Morphine (Avinza, Embeda, MS Contin, Kadian)	1-3 days		Opiates Immunoassay – positive GC/MS or LC/MS/MS – morphine, possibly hydromorphone	
Opioids – Semisynthetic (derived from opium)				
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – hydrocodone, possibly hydromorphone	"Opiates" immunoassays may also detect semisynthetic opioids depending on their cross-reactivity pattern. However, a negative result does not exclude use of semisynthetic opioids. Confirmatory testing (GC/MS or LC/MS/MS) is required to verify compliance with the prescribed semisynthetic opioid(s). Since hydrocodone is metabolized in small amounts to hydromorphone, both may be found in the urine. Likewise, oxycodone is metabolized to oxymorphone, so these may both be present in the urine of oxycodone users. However, the reverse is not true. In other words, hydromorphone and oxymorphone use does not result in positive screens for hydrocodone and oxycodone, respectively.
Hydromorphone (Dilaudid, Exalgo)	1-3 days	Opiates Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS –hydromorphone	
Oxycodone (Roxicet, OxyContin)	1-3 days	Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates Immunoassay – positive GC/MS or LC/MS/MS – oxycodone possibly oxymorphone	
Oxymorphone (Opana)	1-3 days	Opiates or Oxycodone Immunoassay + GC/MS or LC/MS/MS Opiates	Opiates or Oxycodone Immunoassay – positive GC/MS or LC/MS/MS – oxymorphone	
Opioids – Synthetic (man-made)				
Fentanyl	1-3 days	GC/MS or LC/MS/MS Fentanyl	GC/MS or LC/MS/MS – fentanyl & norfentanyl	**Current "opiates" immunoassays do not detect synthetic opioids.** Thus confirmatory testing (GC/MS or LC/MS/MS) is needed to identify these drugs. If the purpose is to document compliance with treatment, the laboratory can be instructed to remove the cutoff concentration so that the presence of lower concentrations can be identified.
Meperidine (Demerol)	1-3 days	GC/MS or LC/MS/MS Meperidine	GC/MS or LC/MS/MS – normeperidine, possibly meperidine	
Methadone (Methadose)	3-7 days	Methadone Immunoassay + GC/MS or LC/MS/MS Methadone	Methadone Immunoassay – positive GC/MS or LC/MS/MS – methadone & EDDP	
Propoxyphene (Darvon, Darvocet)	1-3 days	Propoxyphene Immunoassay + GC/MS or LC/MS/MS Propoxyphene	Propoxyphene Immunoassay – positive GC/MS or LC/MS/MS – propoxyphene & norpropoxyphene	
Others				
Alcohol	Up to 8 hours	Alcohol	Alcohol – see Consideration	Additional testing for alcohol metabolites, ethyl glucuronide (EtG) or ethyl sulfate (EtS), can identify alcohol up to 80 hours after consumption.
Amphetamines	2-3 days	Amphetamines, Methamphetamines or MDMA Immunoassay + GC/MS or LC/MS/MS Amphetamines	Amphetamines, methamphetamines or MDMA Immunoassay – see Consideration GC/MS or LC/MS/MS – amphetamine, methamphetamine or MDMA	Amphetamines immunoassays are highly cross-reactive so results should be interpreted cautiously, and may require consultation with the lab. They may detect other sympathomimetic amines, such as ephedrine, pseudoephedrine or selegiline. Confirmatory testing can identify which amphetamine is present.
Barbiturates	1-3 days w/short-acting; up to 30 days w/long acting	Barbiturates Immunoassay	Barbiturates Immunoassay – see Consideration	The clearance half-life of intermediate-acting barbiturates averages 24 hours. It takes about 5 to 7 half-lives to clear 98% of a drug dose. Thus, the presence of an intermediated-acting barbiturate indicates exposure within 5-7 days.
Benzodiazepines	1-3 days w/short-acting; up to 30 days w/long-acting	Benzodiazepines Immunoassay	Benzodiazepines Immunoassay – see Consideration GC/MS or LC/MS/MS – alprazolam, diazepam, clonazepam, lorazepam, etc.	Immunoassays for benzodiazepines have a 28% overall false negative rate and vary in cross-reactivity. Certain benzodiazepines (clonazepam and alprazolam) have limited detectability by most available immunoassays. Confirmatory testing is needed when use is expected or suspected.
Cocaine or benzoylecgonine	2-4 days	Cocaine Metabolites Immunoassay	Cocaine Metabolites Immunoassay – see Consideration	Cocaine immunoassays do not cross-react with other topical anesthetics that end in "caine" (e.g. lidocaine) and are highly specific for cocaine use.
Marijuana	2-4 days; up to 30 days w/chronic heavy use	Cannabinoids (THC) Immunoassay	Cannabinoids Immunoassay – see Consideration GC/MS or LC/MS/MS – THC	THC may be an indicator of the patient's risk category. Prescribers should have an office policy, discuss with the patients reason for use and adjust monitoring plan accordingly.

*detection time for most drugs depends on the drug, dose, frequency of use and individual metabolism

ii. Urine Drug Testing (UDT) Algorithm for Monitoring Opioid Treatment in Chronic Non-cancer Pain



ANNOTATIONS

A. UDT Protocol:
- Obtain specimen randomly
- Ask patient what should be expected
- Explain reason for testing and consequences of unexpected results

B. ORT: see Appendix A

C. UDT Frequency Schedule:
- Low risk: Periodic (e.g. up to 1/year)
- Medium risk: Regular (e.g. up to 2/year)
- High risk or opioid>120mg MED/d: Frequent (e.g. up to 3-4/year)
- Aberrant: At time of visit

D. Confirmatory UDT with gas or liquid chromatography/tandem mass spectrometry (GC/MS or LC/MS/MS)

E. "Red Flag" UDT Result:
(+) alcohol,
(+) amphetamine or methamphetamine,
(+) cocaine or metabolites,
(+) drug (benzodiazepines, opioids, etc) you did not prescribe or have knowledge of
(-) opioid(s) you prescribed

iii. UDT Clinical Vignettes in Chronic Non-cancer Pain

Case Studies	Discussion
New Patient: A 31-year-old female with low back pain from an injury 2 months ago. She wants to establish care. According to the patient, she was initially prescribed naproxen and hydrocodone in the emergency room. She is currently taking naproxen OTC, but no reported opioids. Her other medical conditions include depression for which she takes citalopram. You are considering prescribing opioid(s) and your suspicion for drug abuse is low. What should you do?	IF you have decided to initiate chronic opioid therapy AND prior to prescribing, you should: 1. Obtain a baseline UDT (see drug or drug classes to test, page 1); 2. Assess risk of aberrant behavior with ORT; 3. Assess psychiatric status (e.g. PHQ-9); 4. Obtain a signed opioid agreement; 5. Establish treatment goals including improvements in both function and pain; 6. Describe expectations for behavior related to use of opioids (take as prescribed, use one pharmacy, one prescriber, no early refills, no self escalation, no sharing of drugs, etc) 7. Develop a follow-up plan to monitor treatment, including the frequency of UDT's based on ORT
New Patient on Opioids: A 45-year-old male presents with severe neck pain from a motor vehicle accident 2 years ago. He has been treated with OxyContin 30mg BID and oxycodone 5mg 1 tab Q3H PRN (MED = 150mg/day). He reports no history of substance abuse. Due to "personality differences" with previous provider, he would like you to assume care and continue prescribing OxyContin and oxycodone for his neck pain. You have no medical records to confirm previous treatment. What should you do?	**Do not prescribe opioids at initial visit since records are unavailable:** • Comprehensively evaluate the patient (see Guideline – *Before you decide to prescribe opioids for chronic pain*), • Order a baseline UDT, • **Inform patient that a signed release of information form is required prior to prescribing opioids**. Also request medical records from previous provider(s) or consider contacting the previous prescriber for information on treating this patient and • Schedule a follow-up visit for when UDT results and medical records are available. On follow-up visit, if UDT is consistent and prior medical records show improved pain and function with no history of aberrant behaviors, follow steps 2 – 7 above before prescribing.
Compliance Testing in a patient on < 120mg MED/day: A 55-year-old male with chronic knee pain comes in for a routine visit. His opioid regimen consists of methadone 5mg QID and hydrocodone/acetaminophen 5/500mg 1 tab Q6H PRN (MED = 100mg/day). He has moderate risk on ORT and last random UDT was a year ago. What should you do?	Assess the risks and benefits of current opioid therapy (see Guideline – *Assessing effects of opioid therapy*). Discuss with the patient reason for testing, frequency of testing and consequences of unexpected results, order an immunoassay test for the drug classes below, and follow the UDT algorithm. • Amphetamines • Opiates • Cocaine metabolites • Methadone • Benzodiazepines • Alcohol • Oxycodone
Unexpected Results: The immunoassays from the above vignette were positive for methadone, opiates and cocaine metabolites but negative for the remainder of the drug classes tested. Confirmatory testing with GC/MS was done per laboratory protocol. The confirmatory results show methadone, hydrocodone and benzoylecgonine (cocaine metabolite). What should you do?	Discuss the unexpected results with the patient and offer a controlled taper and referral to an addiction specialist.

Point of Care Testing: A 47-year-old male with rotator cuff tendonitis has chronic shoulder pain managed with morphine SR 30mg TID and oxycodone/acetaminophen 5/325mg 1 tab Q4H PRN (MED = 135mg/day). He reports no other drug therapy. A treatment agreement has been signed by you and the patient recently. You perform a random UDT using a point-of-care testing kit. The immunoassays are positive for opiates but also positive for benzodiazepines. What should you do?	Discuss the unexpected results with the patient: • If explanation is credible (e.g. receiving treatment for anxiety from another provider), you may want to send the urine sample to laboratory to confirm his story. You may also want to discuss future expectations with the patient and request records from other treating providers for possible specialty consultation. • If explanation is not accepted (e.g. patient admits benzodiazepine use that is not prescribed for the patient), confirmatory testing is not necessary but offer a controlled taper and/or referral to an addiction specialist depending on the circumstances. • If result cannot be explained, send original urine sample to laboratory for confirmatory testing.

iv. UDT Frequently Asked Questions (FAQ)

Q **Drug screening implies that I don't trust my patients. How do I get around this?**

A Self-report of drug use has limited validity, and monitoring behavior alone can fail to detect problems revealed by UDTs. Creating a UDT policy in advance and applying it consistently to all patients on opioids may help de-stigmatize the testing. Inform patients that drug testing is a routine procedure for all patients starting or maintained on opioid therapy and it is an important tool for monitoring the safety of opioid therapy. Possible language for explaining to patient includes:

- "Ensures my capacity to provide treatment for your pain while balancing the need for safety."
- "Provides critical information needed to assess the success of your therapy."
- "Prescription medications are a common form of treatment for chronic pain. However, each person reacts differently to them. UDT enables us to identify individual risks related to your medications and avoid problems."
- "Our clinic uses 'universal precautions' in opioid prescribing, which includes UDT. This is the same as wearing gloves on all patients when drawing blood."

Q **Can I tell whether my patient has taken the dose of opioid(s) I prescribed?**

A No. It is very difficult to correlate urine drug concentration with a patient's dose. UDT can detect the parent drug and/or its metabolite(s) and demonstrate recent use of prescribed drugs and illegal substances. However, it CANNOT determine the amount of drug used and when the last dose was taken, nor can it identify the source of the drug.

Q **My patient says he is a "high metabolizer" and that is why the expected drug is not found in the urine. Is this possible?**

A A small percentage of persons are ultrarapid metabolizers. They metabolize specific drugs more rapidly than typical patients. It would be rare to take an opioid as prescribed and have a totally negative UDT. It is important that you use testing that is specific to the medication of interest and with cutoff thresholds that are extremely low.

Q **How do I deal with marijuana?**

A This is a complex issue. Marijuana is currently classified as a Schedule I drug by the DEA. For that reason, many providers will not prescribe opioids to patients using cannabis. Other providers reference State "Medical Marijuana" laws (**http://apps.leg.wa.gov/RCW/default.aspx?cite=69.51A&full=true**) and feel comfortable prescribing opioids to cannabis users. Some providers adopt a "don't ask, don't tell" policy, and request the lab to remove marijuana from the UDT so that positive results are not seen. Do your homework and create an office policy. Then disclose this policy to your patients.

Q **Would short-acting opioids show up in UDT?**

A Urine testing typically has a 1 to 3-day window of detection for most drugs depending on dose and individual differences in drug metabolism. Short-acting opioids can be detected if the lab removes the cutoff concentration so that the presence of lower concentrations is detected. If the laboratory uses LC/MS/MS, then it will have a lower limit of detection (LOD) with less interference.

Q **Why confirm results?**

A Immunoassays used in drug screening can cross-react with other drugs and vary in sensitivity and specificity. Thus, confirmation with a more accurate method may be required for clinical decision making. Confirmatory drug testing (GC/MS or LC/MS/MS) of the original specimen is recommended for unexpected results, or in cases where patients are known to be high risk. However, on occasion, even confirmatory testing requires expert assistance for interpretation. Consider consultation with the lab before discussing/confronting the patient with unexpected test results and discontinuing opioid therapy.

Q Should I use temperature and adulteration strips?

A It depends. Drug testing for clinical compliance, unlike employment testing, does not require a strict "chain-of-custody". However, if tampering is a concern, the specimen should be monitored for temperature and/or adulterants. Normal human urine should have a temperature between 90°F – 100°F, pH between 4.5 – 8.5 and creatinine >20mg/dL. Be aware that there are multiple websites and devices devoted to getting a "clean" urine drug screen.

Q Should I perform a drug screen on every visit for patients using opioids for chronic pain?

A No. Random screening based on the frequency recommended in the guideline should suffice for most patients. Those patients who you feel require drug screening on every visit, are perhaps not candidates for chronic opioid therapy.

Appendix E: Quick Reference for Obtaining Consultative Assistance – for WA Public Payers Only

Purpose of this Quick Reference Guide: This resource provides information and examples on billing codes payable in situations where consultation is recommended. The AMDG Opioid Dosing Guideline includes the best practice recommendation to seek assistance when dealing with opioid treatment that is exceeding 120mg/day MED, or when 'red flags' are evident. Payment is available to support these best practices.

Reimbursement for consultations is available and:

- **Does *not* always require face-to-face consultation.**
- **Does *not* require transfer-of-care in most situations.**
- **Can be done using email, telephone, video conferencing or webinar.**

For full code descriptions and specific payer policies, please refer to CPT® and agency websites:

Labor and Industries: **www.Lni.wa.gov/ClaimsIns/Providers/Billing/**
DSHS/Medicaid: **http://hrsa.dshs.wa.gov/pharmacy/**
Uniform Medical Plan: **http://www.ump.hca.wa.gov/provider/**

Scenarios	Recommended Action(s) and Payment codes for consultations*
CNCP patient on escalating dose of opioids, pain and function improving. Dosing about to exceed 120 mg/day MED.	Depending on complexity, one or more may be appropriate: ▪ Refer for outpatient consultation, face-to-face with patient. See billing codes 99241-99245. ▪ Telephone consultation with specialist, non face-to-face. See billing codes 99441-99443 (physicians), or 98966-98968 (non-physician health care professional- ARNPs, PAs, psychologists). ▪ Email or online consultation with specialist. See billing code 99444 (physician only) or 98969 (non-physician health care professional- ARNPs, PAs, psychologists). ▪ Telemedicine consultations. See Telehealth billing code Q3014 and specific policies. ▪ Medical Team conference. See billing codes 99366-99368. Not all payers reimburse for all codes.
Attending provider is treating a patient with escalating dose pattern, limited or no improvement in pain or function.	
Patient with comorbidities and history of depression; suspect dependence or tolerance.	
CNCP patient and provider in remote area; seek specialty assistance via telephone.	

Care, Evaluation, and Management: May be paid for providing telephonic, electronic, or face-to-face consultation.

Description	Code(s)**	Limits	Programs Paying for Service	Fee Range‡
Evaluation and Management (E/M) Codes				
New patient E/M,	99201-99205		LNI, DSHS, UMP	Up to $303.96
Established patient E/M	99211-99215		LNI, DSHS, UMP	Up to $212.28
Interdisciplinary medical team conference, 30 minutes or more, patient present	99368	Non-Physician	LNI, UMP	Up to $60.91
Medical team conference, 30 minutes or more, patient or family not present	99367	Physician only	LNI, DSHS, UMP	Up to $131.06
Medical team conference, patient or family present	99366	Non-Physician	LNI	$71.37
Teleconsultation, telemedicine, electronic communications				
Telephone evaluation and management, physician to patient, non-face-to-face.	99441-99443	Physician only	LNI, UMP	Up to $65.22
Electronic communication (Physician)	99444	Physician only	LNI	$44.30
Electronic communication (Non-physician)	98969	Non-Physician	LNI	$44.30
Telehealth originating site facility fee	Q3014		LNI,DSHS,UMP	Up to 34.19
Consultations and Special Reports				
Consultation including report, face-to-face exam of patient.	99241-99245	MD, DO, DC, ARNP	LNI,DSHS,UMP	$20.30 - $384.56
Opioids: initial report for treatment	1064M	AP† Only	LNI	$56.77
Opioids: Progress report supplement (used to assess function and pain)	1057M	AP† Only	LNI	$30.27

** For full code descriptions please refer to specific state agency payment policies and CPT® documentation.
† L&I Attending Provider
‡ Fees effective (7/2009-6/2010). For up-to-date fees see appropriate agency fee schedules.

Appendix F: Patient Education Resources

Providing quality treatment for your patients is critical, and so is educating them about the risks of taking opioid medications. Resources that can help you provide this education are listed here.

Resource	Description
Chronic Pain	
American Chronic Pain Association website **www.theacpa.org**	Education for individuals with chronic pain and their families. Includes communication tools, coping skills, ten steps to managing chronic pain, and online forums and videos.
American Pain Foundation **www.painfoundation.org**	Information and resources about pain, online support, and information specifically for military personnel and veterans.
Pain Action **www.painaction.com**	Self-assessment tools that provide individualized recommendations for evidence-based pain management, learning modules dedicated specifically to managing back pain and migraines, practical pain self-management techniques, managing the risks of opioid pain medications, and tips for pain management provided by peers.
Fibromyalgia Resources	
Fibromyalgia Information Foundation **www.myalgia.com**	Overview of fibromyalgia, diagnosis, treatment, preventive advice and new research discoveries.
Know Fibro **www.knowfibro.com**	A self-management program for people living with fibromyalgia, and fibromyalgia basics.
Headaches	
National Headache Foundation **www.headaches.org**	A headache education program centered on the key principles of headache care. Education for patients and providers.
Medication Resources **www.medicinenet.com**	Provides easy to read, in depth medical information for patients.
Mental Health Issues	
Anxiety Disorders Association of America **www.adaa.org**	General information about anxiety disorders, how to find help, and tips for managing anxiety.
Depression screening.org **www.depressionscreening.org**	Confidential online depression screening test, symptoms and treatments, personal stories and sources of help.
National Institute of Mental Health **www.nimh.nih.gov/index.shtml**	General information about mental health topics including signs and symptoms, treatment, and locating local services.
Protecting your medications	
The Addiction Technology Transfer Center Network **www.nattc.org/topics/RxAbuse/docs/safemeds.pdf**	Six tips for preventing others from stealing your prescription medicines.

Sleep National Sleep Foundation **www.sleepfoundation.org**	General information about sleep health and safety, and sleep-related problems.
Setting Patient Health Goals Structuring Your Own Management of Pain (STOMP) brochure, available at: **www.swedish.org/documents/08881_CME_Stomp%20Book_General.pdf**	Brochure is designed to help patient set health goals that will alleviate the patient's pain and improve the quality of their life. It includes general information about pain, goal-setting ideas and steps to take to achieve those goals.
Opioid Safety **http://takeasdirected.doh.wa.gov** • Pain patient page • Overdose Prevention Brochure	Includes opioid safety, possible risks from taking opioids, and warning signs of drug abuse or addiction. Tips on preventing overdoses, signs of overdose and problematic opioid use.
Sample pain treatment agreements **www.Lni.wa.gov/ClaimsIns/Files/OMD/LIOpioidTreatmentAgreement0708.pdf** **http://hrsa.dshs.wa.gov/pharmacy/ChronicPainAgreement.pdf**	The use of a pain management agreement allows for the documentation of understanding between a doctor and patient. Agreements should be discussed and signed by both parties. They can also serve as an aid for patient education.

Books	
Treat Your Own Neck and Back by R. McKenzie	Patient handbook for common neck pain will help patients learn to relieve their problems and prevent recurrence of their symptoms in the future. It covers a step-by-step system of education, awareness, exercise and prevention.
Managing Pain Before It Manages You by M Caudill	Simple set of tools to help patients live with their pain more effectively and independently.
Mind Over Mood: Change How You Feel by Changing the Way You Think by D Greenberger and C Padesky	Step by step worksheets teach specific skills to conquer common mental health issues such as depression, anxiety, and low self-esteem.
Thoughts and Feelings: Taking Control of Your Moods and Your Life by M. McKay, M.Davis, and P.Fanning	Adapts the powerful techniques of cognitive behavioral therapy into a set of tools readers can use against anxiety, depression, and obsessiveness.
The War on Pain by S. Fishman & L. Berger	An introduction to interdisciplinary pain management that integrates traditional and alternative techniques.
Heal Your Headache: The 1-2-3 Program for Taking Charge of Your Pain by D. Buchholz & S.G. Reich	Information on how to avoid triggers, use of preventative medications rather than pain relievers which can cause rebound headaches.
Chronic Pain Solution: Your Personal Path to Pain Relief by J.N. Dillard & L.A. Hirschman	Useful information on how to approach and relieve chronic pain.
Snoring and Sleep Apnea: Sleep Well, Feel Better by R. Pasculaly	This book is for people with sleep apnea, family, friends and health care professionals. Covers causes, diagnosis, treatment, and surgical techniques.

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

OPIOID TREATMENT AGREEMENT

Patient Name: _____ **Claim No.** _____

Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day. Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.
I, _____, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. _____.

1. **I understand that I have the following responsibilities:**
   a. I will take medications only at the dose and frequency prescribed.
   b. I will not increase or change medications without the approval of this provider.
   c. I will actively participate in Return to Work (RTW) efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
   d. I will not request opioids or any other pain medicine from providers other than from this one. This provider will approve or prescribe all other mind and mood altering drugs.
   e. I will inform this provider of all other medications that I am taking.
   f. I will obtain all medications from one pharmacy, when possible. By signing this agreement, I give consent to this provider to talk with the pharmacist.
   g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
   h. I agree to participate in psychiatric or psychological assessments, if necessary.
   i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:
      - 12-step program and securing a sponsor
      - Individual counseling
      - Inpatient or outpatient treatment
      - Other: _____

2. **I understand that in the event of an emergency,** this provider should be contacted and the problem will be discussed with the emergency room or other treating provider. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other provider without this provider's approval.

3. **I understand that I will consent to random drug screening.** A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

4. **I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.**

5. **I understand that this provider may stop prescribing opioids or change the treatment plan if:**
   a. I do not show any improvement in pain from opioids or my physical activity has not improved.
   b. My behavior is inconsistent with the responsibilities outlined in #1 above.
   c. I give, sell or misuse the opioid medications.
   d. I develop rapid tolerance or loss of improvement from the treatment.
   e. I obtain opioids from other than this provider.
   f. I refuse to cooperate when asked to get a drug screen.
   g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
   h. If I am unable to keep follow-up appointments.

Patient Signature	Date	Provider Signature	Date

PLEASE READ AND SIGN REVERSE SIDE

Provider:
Keep signed copy in file, give a copy to patient and send a copy to L&I.
Must renew Agreement every 6 months.

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

OPIOID TREATMENT AGREEMENT

Patient Name: _____ **Claim No.** _____

Your safety risks while working under the influence of opioids

You should be aware of potential side effects of opioids such as decreased reaction time, clouded judgment, drowsiness and tolerance. Also, you should know about the possible danger associated with the use of opioids while operating heavy equipment or driving.

Side effects of opioids

- Confusion or other change in thinking abilities
- Nausea
- Constipation
- Vomiting
- Problems with coordination or balance that may make it unsafe to operate dangerous equipment or motor vehicles
- Sleepiness or drowsiness
- Breathing too slowly – overdose can stop your breathing and lead to death
- Aggravation of depression
- Dry mouth

These side effects may be made worse if you mix opioids with other drugs, including alcohol.

Risks

Physical dependence. This means that abrupt stopping of the drug may lead to withdrawal symptoms characterized by one or more of the following:

- Runny nose
- Abdominal cramping
- Rapid heart rate
- Diarrhea
- Sweating
- Nervousness
- Difficulty sleeping for several days
- Goose bumps

Psychological dependence. This means it is possible that stopping the drug will cause you to miss or crave it.
Tolerance. This means you may need more and more drug to get the same effect.
Addiction. A small percentage of patients may develop addiction problems based on genetic or other factors.
Problems with pregnancy. If you are pregnant or contemplating pregnancy, discuss with your provider.

Payment of medications

State law forbids L&I from paying for opioids once the patient reaches maximum medical improvement. You and your provider should discuss other sources of payment for opioids when L&I can no longer pay.

Recommendations to manage your medications

- Keep a diary of the pain medications you are taking, the medication dose, time of day you are taking them, their effectiveness and any side effects you may be having.
- Use of a medication box that you can purchase at your pharmacy that is already divided in to the days of the week and times of the day so it is easier to remember when to take your medications.
- Take along only the amount of medicine you need when leaving home so there is less risk of losing all your medications at the same time.

I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of opioids to help control my pain and I understand that my treatment with opioids will be carried out as described above.

Patient Signature	Date	Provider Signature	Date

PLEASE READ AND SIGN REVERSE SIDE

Provider:
Keep signed copy in file, give a copy to patient and send a copy to L&I.
Must renew Agreement every 6 months.

Model Pain Management Agreement

I, _____(*patient receiving chronic **pain** medications),*agree to correctly use pain medications prescribed for me as part of my treatment for chronic pain. I understand that these medications may not get rid of my pain but may decrease the pain and increase the level of activity that I am able to do each day. I understand that the Pain Management Clinic will deal with my chronic pain and will not deal with any of my other medical conditions.

I understand that _____(name) will be my pain management provider and the only provider who will be ordering medications for my chronic pain.

I understand that I have the following responsibilities (initial each item you agree to):

_____I will only take medications at the amount and frequency prescribed.

_____I will not increase or change how I take my medications without the approval of my pain management provider.

_____I will not ask for refills earlier than agreed. I will arrange for refills **ONLY** during regular office hours. I will make the necessary arrangements before holidays and weekends.

_____I will get all pain medications only at one pharmacy. I will let my pain management provider know if I change pharmacies.

Pharmacy:_____Phone Number:_____

_____I will allow my pain management provider to provide a copy of this agreement to my pharmacy.

_____I will not ask for any pain medications or controlled substances from other providers and will let my pain management provider know of all medications I am taking, including non-legal drugs.

_____I understand that other physicians should not change doses of my pain medications made by another provider.

_____I will notify the Pain Management Clinic of any changes to my pain medications made by another provider.

_____I will let my other health care providers know that I am taking these pain medications and that I have a pain management agreement.

_____In event of an emergency, I will give this same information to emergency department providers.

_____I will allow my pain management provider to discuss all my medical conditions and treatment details with pharmacists, physicians, or other health care providers who provide my health care for purposes of care coordination.

_____I will inform my pain management provider of any new medications or medical conditions.

_____I will protect my prescriptions and medications. I understand that lost or misplaced prescriptions will not be replaced.

_____I will keep medications only for my own use and will not share them with others. I will keep all medications away from children.

_____In addition, I will do the following (initial each box):

- _____I must make an appointment with a drug and alcohol counselor and bring proof of following my treatment plan. Contact number is 1-800-562-1240)
- _____I must take a drug test this often: _____
- _____I agree to pill counts to prove I am using my medications correctly
- _____If I fail a drug test, I will take the drug test more often at (frequency of) _____
- _____If I fail a drug test, I will be referred to Medicaid's Patient Review and Coordination Program that restricts me to certain providers, such as a primary doctor. (**http://maa.dshs.wa.gov/PRR**)
- _____If I sell my narcotics, my name will be referred to the DSHS fraud unit.
- _____If I fail all of the above, I will be discharged from your care with no notice.

Should any of the above not show good faith efforts and my providers feel they can no longer prescribe my pain medications in a safe and effective way, I may be notified and discharged from their care.

I agree to use only the following providers. I will notify my physician of any changes in my health care and/or changes in my providers.

Provider: _____Clinic:_____Phone:_____
Provider: _____Clinic:_____Phone:_____

Patient Signature: _____

Provider Signature: _____

Appendix H: Additional Resources to Streamline Clinical Care

The following resources are available to help clinicians manage the care of chronic pain patients who are receiving opioids.

■ **Department of Social and Health Services (DSHS) Tool Kit** to help address drug and alcohol issues in Medicaid patients **http://maa.dshs.wa.gov/pharmacy/ToolKit.htm**

■ An **Opioid Taper Plan Calculator** is available and makes it easier for prescribers to calculate safe and effective taper plans for patients who would benefit from lower opioid doses. It was developed by Washington State Medicaid in collaboration with the University of Washington pain management experts. (**http://hrsa.dshs.wa.gov/pharmacy/pdf/TaperSchedule.xlsx**).

■ **DSHS Division of Alcohol and Substance Abuse** at 877-301-4557. A referral for treatment may be made to any one of the licensed opioid therapy programs (OTPs) in Washington State: **http://www1.dshs.wa.gov/DASA/services/certification/GB.shtml** and click on Appendix Q.

■ **Physician Clinical Support System** has mentors available to help you, by phone or email, with questions on methadone or buprenorphine. In addition, guidance on specific clinical questions and helpful tools can be downloaded from the website. There is no cost for this service. Once you register at **http://www.pcssmentor.org/** a mentor will be assigned to you within 2 days.

■ List of providers for pain management consultation **www.agencymeddirectors.wa.gov/guidelines.asp**

■ **Collaborative Opioid Prescribing Education (COPE)**, an online training to improve doctor-patient communications and collaborative goal-setting. COPE training is available through the University of Washington CME website: **http://depts.washington.edu/cme/online/course/EN0705**

■ **CDEMS** is the Chronic Disease Electronic Management System, a **free** Microsoft Access database application designed to assist medical practices in tracking the care of patients with chronic health conditions. Originally designed to track diabetes, asthma and adult preventive health, it has also been adapted to monitor other chronic conditions such as pain. It can produce printed progress notes, patient lists, and summary reports which can help measure quality improvement efforts. CDEMS files and User's Guide are downloadable for free at **http://cdems.com/**

■ ***My Pain Profile*** is a web based program that uses multiple tools to provide clinicians with information in an easy to use format about patients' pain, mood, quality of life, and function. Over time, it screens, monitors, and reports clinical progress on risk of opioid misuse, abuse and diversion, and the efficacy of pain treatments. This is available through the Chronic Pain Impact Network (CPAIN **www.CPAIN.com**; contact **wa.info@CPAIN.com**). Data from the CPAIN registry can help define which treatments work best in which patients and who should be referred for specialty care. Please note that CPAIN is a commercial product for which a charge is made to the insurer (not the clinician or patient) and as such cannot be endorsed by AMDG.

Appendix I: Emergency department guidelines to help coordinate care with primary care providers

The emergency department is a significant outpatient source of prescription opioids[1] yet there has been little guidance on how to treat pain in the emergency department while minimizing the potential for overdose and abuse. New *Emergency Department Guidelines to Reduce Prescription Drug Abuse* are being created by the Interagency Workgroup to Prevent Prescription Opioid Misuse, Abuse, and Overdose that will recommend safe emergency department opioid prescribing practices. See **www.consistentcare.com** for more information.

A promising approach to identify and deter patients who visit EDs to obtain prescription opioids for misuse is being implemented in Washington. The Emergency Department Information Exchange (EDIE) is a low cost HIPAA compliant system of sharing patient information between EDs. When a patient visits the ED, the EDIE instantly and automatically checks for other ED visits at participating hospitals across Washington. The EDIE notifies the ED immediately by fax when a patient is found to have a suspicious pattern of visiting the ED. The fax contains a history of the patient's ED visits for the ED physician to review prior to seeing the patient. Information such as the patient's primary care physician and instructions on how to treat the patient's chronic pain is included in the fax if the patient is enrolled in an Emergency Department Care Coordination program. EDs are encouraged to participate in information-sharing networks such as EDIE to identify and discourage patients who are doctor shopping. For more information see **www.ediecareplan.com/amdg/index.html**.

An Emergency Department Care Coordination program is a pilot program for improving the use of opioids for the treatment of patients with chronic pain who recurrently use the emergency department. The main objective is to coordinate the patient's medical and pain care in the ED with their primary care provider. After a patient is enrolled in the program, a multidisciplinary team creates a set of ED care guidelines, including specific recommendations for opioid prescribing, for each patient. For more information on emergency department care coordination programs, see **www.consistentcare.com**.

References

1. Centers for Disease Control and Prevention. Increase in poisoning deaths caused by non-illicit drugs--Utah, 1991-2003. MMWR Morb Mortal Wkly Rep 2005;54(2):33-6.
2. Franklin GM, Mai J, Wickizer T, Turner JA, Fulton-Kehoe D, Grant L. Opioid dosing trends and mortality in Washington State workers' compensation, 1996-2002. Am J Ind Med 2005;48(2):91-9.
3. Paulozzi LJ, Budnitz DS, Xi Y. Increasing deaths from opioid analgesics in the United States. Pharmacoepidemiol Drug Saf 2006;15(9):618-627.
4. Warner M, Chen LH, Makuc DM. Increase in fatal poisonings involving opioid analgesics in the United States, 1999-2006. NCHS Data Brief 2009(22):1-8.
5. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. CDC's Issue Brief: Unintentional Drug Poisoning in the United States. Available at: **http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/brief.htm**. 2010.
6. Centers for Disease Control and Prevention. Overdose deaths involving prescription opioids among Medicaid enrollees - Washington, 2004-2007. MMWR Morb Mortal Wkly Rep 2009;58(42):1171-5.
7. Sabel J. Poisoning and drug overdose. Available at: **http://www.doh.wa.gov/hsqa/emstrauma/injury/pubs/icpg/DOH530090Poison.pdf**. 2006.
8. Washington State Department of Health, Center for Health Statistics. Available at: **http://www.doh.wa.gov/ehsphl/chs/chs-data/death/download/deathE2b.xls**. Accessed March 10, 2010.
9. Utah Department of Health (2009). Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain. Salt Lake City, UT: Utah Department of Health. Accessed at: **http://useonlyasdirected.org/uploads/65026_UDOH_opioidGuidlines.pdf**
10. Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med 2010;152(2):85-92.
11. Furlan AD, Sandoval JA, Mailis-Gagnon A, Tunks E. Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side effects. CMAJ 2006;174(11):1589-1594.
12. Gross DP, Stephens B, Bhambhani Y, Haykowsky M, Bostick GP, Rashiq S. Opioid prescriptions in Canadian workers' compensation claimants prescription trends and associations between early prescription and future recovery. Spine 2009;34(5):525–531.
13. Ballantyne JC, Mao J. Opioid therapy for chronic pain. N Eng J Med 2003;349:1943-1953.
14. Brands B, Paglia-Boak A, Sproule BA, Leslie K, Adlaf EM. Nonmedical use of opioid analgesics among Ontario students. Can Fam Physician 2010;56(3):256-262.
15. Broekmans S, Dobbels F, Milisen K, Morlion B, Vanderschueren S. Pharmacologic pain treatment in a multidisciplinary pain center: do patients adhere to the prescription of the physician? Clin J Pain 2010;26(2):81-86.
16. Sullivan MD, Edlund MJ, Steffick D, Unutzer J. Regular use of prescribed opioids: association with common psychiatric disorders. Pain 2005;119:95-103.
17. Braden J, Russo J, Fan M, Edlund M, Martin B, DeVries A, Sullivan MD. Emergency department visits among recipients of chronic opioid therapy. Arch Intern Med *in press*.
18. Edlund MJ, Fan M, DeVries A, Braden J, Martin B, Sullivan MD. Trends in use of opioids for chronic non-cancer pain among individuals with mental health and substance use disorders: the TROUP study. Clin J Pain 2010;26:1-8.
19. Sullivan MD, Edlund MJ, Fan M, DeVries A, Braden J, Martin B. Risks for possible and probably opioid misuse among recipients of chronic opioid therapy in commercial and medicaid insurance plans: the TROUP study. Pain *in press*.

20. Weisner CM, Campbell CI, Ray GT, Saunders KW, Boudreau D, Sullivan MD, Merrill JO, Silverber MJ, Banta-Green CJ, Von Korff M. Trends in prescribed opioid thearpy for non-cancer pain for individuals with prior substance use disorders. Pain 2009;145:287-293.
21. Toombs JD, Kral LA. Methadone treatment for pain states. Am Fam Physician 2005;71(7):1353-1358.
22. Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the opioid risk tool. AAPM 2005;6(6):432-442.
23. Brown RL, Rounds LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wis Med J 1995;94(3):135-140.
24. Couwenbergh C, Gaag RJVD, Koeter M, Ruitter CD, Brink WVD. Screening for substance abuse among adolscents validity of the CAGE-AID in youth mental health care. Substance Use & Misuse 2009;44:823-834.
25. Leonardson GR, Kemper E, Ness FK, Koplin BA, Daniels MC, Leonardson GA. Validity and reliability of the AUDIT and CAGE-AID in northern plains American Indians. Psychological Reports 2005;97:161-166.
26. Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM 2001;16:606-616.
27. Devulder J, Richard U, Nataraja SH. Impact of long-term use of opioids on quality of life in patients with chronic, nonmalignant pain. Curr Med Res Opin 2005;21(10):1555-1569.
28. Loeser JD, Egan KJ. Managing the chronic pain patient. New York: Raven Press, 1989.
29. Von Korff M. Epidemiological and Survey Methods: Assessment of Chronic Pain. Handbook of Pain Assessment. 2 ed. New York: Guildford Press, 2001.
30. Von Korff M, Ormel J, Keefe F, Dowrkin SF. Grading the severity of chronic pain. Pain 1992;50:133-149.
31. White JM. Pleasure into pain: the consequences of long-term opioid use. Addict Behav 2004;29:1311-1324.
32. Ballantyne JC. Opioid analgesia: perspectives on right use and utility. Pain Physician 2007;10:479-491.
33. King T, Ossipov MH, Vanderah TW, Porr F. Is paradoxical pain induced by sustained opioid exposure an underlying mechanism of opioid antinocieceptive tolerance? Neurosignals 2005;14:194-205.
34. Mao J. Opioid-induced abnormal pain sensitivity: implications in clinical opioid therapy. Pain 2002;10:213-217.
35. Ossipov MH, Lai J, King T, Vanderah TW, Porreca F. Underlying mechanism of pronocieptive consequences of prolonged morphine exposure. Biopolymers 2005;80(2-3):319-324.
36. Gourlay D, Heit H, Caplan Y. Urine drug testing in primary care: dispelling the myths and designing strategies. 3rd ed Monograph PharmaCom Groups, Inc., 2006.
37. Moulin DE, Iezzi A. Randomised trial of oral morphine for chronic non-cancer pain. Lancet 1996;347(8995):143-148.
38. Passik SD, Kirsh KL, Donaghy KB, Poretnoy RK. Pain and aberrant drug-related behaviors in medically ill patients with and without histories of substance abuse. Clin J Pain 2006;22:173-181.
39. Braden J, Sullivan MD. Suicidal thoughts and behavior among adults with self-reported pain: conditions in the national comorbidity survey replication. J Pain 2008;9:1106-1115.
40. Chang G, Chen L, Mao J. Opioid tolerance and hyperalgesia. Med Clin N Am 2007;91:199-211.
41. Guzman J, Esmail R, Karjalainen K, Malmivaara A, Irvin E, Bombardier C. Multidisciplinary bio-psycho-social rehabilitation for chronic low back pain. The cochrane database of systematic reviews 2002(1):CD000963.
42. Ives TJ, Chelminski PR, Hammet-Stabler CA, Malone RM, Perhac JS, Potisek NM, Shilliday BB, DeWalt DA, Pignone MP. Predictors of opioid misuse in patients with chronic pain: a prospective cohort study. BMC Health Serv Res 2006;6(46).
43. Streltzer J. Pain management in the opioid-dependent patient. Curr Psych Rep 2001;3:489-496.

44. Streltzer J, Johansen L. Prescription drug dependence and evolving beliefs about chronic pain management. Am J Pscyh 2006;163:594-598.
45. Kakko J, Svanborg DK, Kreek MJ, Heilig M. 1-year retention and social function after buprenorphine-assisted relapse prevention treatment for heroin dependence in Sweden: a randomized, placebo-controlled trial. Lancet 2003;361(662-668).
46. Sees KL, Delucchi KL, Masson C, Rose A, Clark HW, Robillard H, Banys P, Hall SH. Methadone maintenance vs 180-day psychosocially enriched detoxification for treatment of opioid dependence a randomized controlled trial. JAMA 2000;283:1303-1310.
47. Heltsley R, Zichterman A, Black DA, Cawthon B, Robert T, Moser F, Caplan YH, Cone EJ. Urine drug testing of chronic pain patients II: prevalence patterns of prescription opiates and metabolites. J of Analytical Toxicology 2010;34(January/February):32-38.
48. Moeller KE, Lee KC, Kissack JC. Urine drug screening: practical guide for clinicians. Mayo Clin Proc 2008;83(1):66-76.
49. Standridge JB, Adams SM, Zotos AP. Urine drug screening: a valuable office procedure. Am Academy of Fam Phys 2010;81(5):635-640.

Additional References

Adams LL, Gatchel RJ, Robinson RC, Polatin P, Gajraj N, Deschner M, Noe C. Development of a self-report screening instrument for assessing potential opioid medication misuse in chronic pain patients. J Pain Symptom Manage 2004;27:440-459.

Akbik H, Butler SF, Budman SH, Fernandez K, Katz NP, Jamison RN. Validation and clinical application of the screener and opioid assessment for patients with pain (SOAPP). J Pain and Symptom Manage 2006;32(3):287-293.

Amato L, Davoli M, Minozzi S, Ali R, Ferri M. Methadone at tapered doses for the management of opioid withdrawal. The cochrane database of systematic reviews 2005(3):Art. No.: CD003409.pub3. DOI: 10.1002/14651858.CD003409.pub3.

Ayonrinde OT, Bridge DT. The rediscovery of methadone for cancer pain management. Med J Aust 2000;173:538.

Belgrade MJ, Schamber CD, Lindgren BR. The DIRE score: predicting outcomes of opioid prescribing for chronic pain. J Pain 2006;7(9):671-681.

Berman AH, Bergaman H, Palmstierna T, Schylter F. Evaluation of the drug use disorders identification test (DUDIT) in criminal justice and detoxification settings and in a Swedish population sample. Eur Addict Res 2005;11:22-31.

Berman AH, Palmstierna T, Kallmen H, Bergman H. The self-report drug use dosrders identifcation test-- extended (DUDIT-E): reliability, validity, and motivational index. J Substance Abuse and Treatment 2007;32:357-369.

Bhamb B, Brown D, Hariharan J, Anderson J, Balousek S, Fleming MF. Survey of select practice behaviors by primary care physicians on the use of opioids for chronic pain. Curr Med Res Opin 2006;22(9):1859-1865.

Butler SF, Budman SH, Fernandez K, Houle B, Benoit C, Katz NP, Jamison RN. Development and validation of the current opioid misuse measure. Pain 2007;130:144-156.

Butler SF, Budman SH, Fernandez K, Jamison RN. Validation of a screener and opioid assessment measure for patients with chronic pain. Pain 2004;112:65-75.

Butler SF, Fernandez K, Benoit C, Budman SH, Jamison RN. Validation of the revised screener and opioid assessment for patients with pain (SOAPP-R). J Pain 2007;9(4):360-372.

Caldwell JR, Rapport RJD, J.C., Hoffenberg HL, Marker HW, Roth SH, Yuan W, Eliot L, Babul N, Lynch PM. Efficacy and safety of a once-daily morphine formulation in chronic, moderate-to-severe osteoarthritis pain: results from a randomized, placebo-controlled, double-blind trials and an open-label extension trial. . J Pain Symptom Manage 2002;23(4):278-291.

Chen CH, Chen WJ, Cheng ATA. New approach to the validity of the alcohol use disorders identification test: stratum-specific likelihood ratios analysis. Alcohol Clin Exp Res 2005;29(4):602-608.

Chou R, Fanciullo GJ, Fine PG, Adler JA, Ballantyne JC, Davies P, Donovan MI, Fishbain DA, Foley KM, Fudin J, Gilson AM, Kelter A, Mauskop A, O'Connor PG, Passik SD, Pasternak GW, Portenoy RK, Rich BA, Roberts RG, Todd KH, Miaskowski C. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. J Pain 2009;10(2):113-30.

Chou R, Fanciullo GJ, Fine PG, Miaskowski C, Passik SD, Portenoy RK. Opioids for chronic noncancer pain: prediction and identification of aberrant drug-related behaviors: a review of the evidence for an American Pain Society and American Academy of Pain Medicine clinical practice guideline. J Pain 2009;10(2):131-146.

Compton P, Darakjian J, Miotto K. Screening for addiction in patients with chronic pain and "problematic" substance use: evaluation of a pilot assessment tool. J Pain and Symptom Manage 1998;16(6):355-363.

Compton P, Wu SM, Scheiffer B, Pham Q, Naliboff C. Introduction of a self-report version of the prescription drug use questionnaire and relationship to medication agreement noncompliance. J Pain and Symptom Manage 2008;36(4):383-395.

Cone EJ, Caplan YH. Urine toxicology testing in chronic pain management. Postgrad Med 2009;121(4):91-102.

Day E, Ison J, Strang J. Inpatient versus other setting for detoxification for opioid dependence. The cochrane database of systematic reviews 2005(2):Art. No.: CD004580.pub2. DOI: 10.1002/14651858.CD004580.pub2.

Dennis ML, Chan YF, Funk RR. Development and validation of the GAIN short screener (GSS) for internalizing, externalizing and substance use disorders and crime/violence problems among adolescents and adults. Amer J Addictions 2006;15:80-91.

Dennis ML, Funk R, Godley SH, Goldley MD, Waldron H. Cross-validation of the alcohol and canabis use measures in the global appraisal of individual needs (GAIN) and timeline followback (TLFB; Form 90) among adolescents in substance abuse treatment. Addiction 2004;99:120-128.

Dowling LS, Gatchel RJ, Adams LL, Stowell AW, Bernstein D. An evaluation of the predictive validity of the pain medication questionnaire with a heterogeneous group of patients with chronic pain. J Opioid Manage 2007;3(5):257-266.

Eriksen J, Sjogren P, Bruera E, Ekholm O, Rasmussen NK. Critical issues on opioids in chronic non-cancer pain: an epidemiological study. Pain 2006;125(1-2):172-179.

FDA/CDER Drugs@FDA page. Opana ER label information. Food and Drug Administration website. Available at: **http://www.fda.gov/cder/foi/label/2006/021610s001,021611s001lbl.pdf**.

FDA/CDER Drugs@FDA page. Duragesic label information. Food and Drug Administration website. Available at: **http://www.fda.gov/cder/foi/label/2005/19813s039lbl.pdf**.

Fiellin D, O'Connor P. Office-based treatment of opioid-dependent patients. N Eng J Med 2002;347:817-823.

Fiellin DA, Kleber H, Trumble-Hejduk JG, McClellan AT, Kosten TR. Consensus statement on office-based treatment of opioid dependence using buprenorphine. J of Substance Abuse Treatment 2004;27:153-159.

Fleming MF, Davis J, Passik SD. Reported lifetime aberrant drug-taking behaviors are predictive of current substance use and mental health problems in primary care patients. American Academy of Pain Medicine 2008;9(8):1098-1106.

Fritz JM, Irrgang JJ. A comparison of a modified oswestry low back pain disability questionnaire and the Quebec back pain disability pain scale. Phys Ther 2001;81:776-788.

Giang KB, Spak F, Dzung TV, Allebeck P. The use of AUDIT to assess level of alcohol problems in rural Vietnam. Alcohol & Alcoholism 2005;40(6):578-583.

Gimbel JS, Richards P, Portenoy RK. Controlled-release oxycodone for pain in diabetic neuropathy: a randomized controlled trial. Neurology 2003;60:927-934.

Gold MS, Redmond DE, Kleber HD. Clonidine blocks acute opiate-withdrawal symptoms. Lancet 1978;16:599-602.

Gowing L, Ali R, White J. Opioid antagonist with minimal sedation for opioid withdrawal. The cochrane database of systematic reviews 2006(1):Art. No.: CD002021.pub2. DOI: 10.1002/14651858.CD002021.pub2.

Gul S, Akvardar Y, Tas G, Tuncel P. The diagnostic validity of screening tests and laboratory markers in alcohol use disorders. Turkish J Psychiatry 2005;16(1).

Hansen GR. Management of chronic pain in the acute care setting. Emerg Med Clin N Am 2005;23:307-331.

Harlharan J, Lamb GC, Neuner JM. Long-term opioid agreement use for chronic pain management in primary care practice: a five year experience. Society of Gen Internal Med 2007;22:485-490.

Kalso E, Allan L, Dellemijn PLI, Faura CC, Ilias WK, Jensen TS, Perrot S, Plaghki LH, Zenz M. Recommendations for using opioids in chronic non-cancer pain. Eur J Pain 2003;7:381-386.

Kalso E, Edwards JE, Moore RA, McQuay HJ. Opioids in chronic non-cancer pain: systematic review of efficacy and safety. Pain 2004;112:372-380.

Katz NP, Fanciullo GJ. Role of urine toxicology testing in the management of chronic opioid therapy. Clin J Pain 2002;18:S76-S82.

Lima CT, Freire AC, Silva AP, Teixeria RM, Farrell M, Prince M. Concurrent and construct validity of the AUDIT in an urban Brazilian sample. Alcohol & Alcoholism 2005;40(6):584-589.

Maier C, Hildebrandt J, Klinger R, Henrich-Eberl C, Lindena G. Morphine responsiveness, efficacy and tolerability in patients with chronic non-tumor associated pain- results of a double-blind placebo-controlled trial (MONTAS). Pain 2002;97(3):223-233.

Marcus DA. Chronic Pain: A primary care guide to practical management. Current clinical practice. Second ed. Pittsburgh: Humana Press, 2009.

Marks CE, Goldring RM. Chronic hypercapnia during methadone maintenance. Am Rev Respir Dis 1973;108:1088-1093.

McCowan C, Kidd B, Fahey T. Factors associated with mortality in Scottish patients receiving methadone in primary care: retrospective cohort study. BMJ 2009;338:b2225 doi:10.1136/bmj.2225.

McDonnell MG, Comtois KA, Voss WD, Morgan AH, Reis RK. Global appraisal of individual needs short screener (GSS): psychometric properties and performance as a screening measure in adolescents. Am J Drug Alcohol Abuse 2009;35:157-160.

Michna E, Jamison RN, Pham LD, Ross EL, Janfaza D, Nedeljikovic SS, Narang S, Palombi D, Wasan AD. Urine toxicology screening among chronic pain patients on opioid therapy: frequency and predictability of abnormal findings. Clin J Pain 2007;23(2):173-179.

Morley JS, Bridson J, Nash TP, Miles JB, White S, Makin MK. Low-dose methadone has an analgesic effect in neuropathic pain: a double-blind randomzied controlled crossover trial. Palliative Med 2003;17:576-587.

O'Connor PG, Carroll KM, Shi JM, Schottenfield RS, Kosten TR, Rounsaville BJ. Three methods of opioid detoxification in a primary care setting: a randomized trial. Annals of Int. Med 1997;127:526-530.

Passik SD, Kirsh KL. The interface between pain and drug abuse and the evolution of strategies to optimize pain management while minimizing drug abuse. Experimental and clinical psychopharmacology 2008;16(5):400-404.

Passik SD, Kirsh KL, Whitcomb L, Portenoy RK, Katz NP, Kleinman L, Dodd SL, Schein JR. A new tool to assess and document pain outcomes in chronic pain patients receiving opioid therapy. Clin Ther 2004;26:552-561.

Raofi S, Schappert S. Medication therapy in ambulatory medical care: United States, 2003-04. Vital Health Stat 13 2006(163):1-40.

Reisfield G, Salazar E, Bertholf RL. Rational use and interpretation of urine drug testing in chronic opioid therapy. Annals of Clin and Laboratory Science 2007;37(4):301-314.

Readfield GM, Webb FJ, Berthold RL, Sloan PA, Wilson GR. Family physician's proficiency in urine drug-testing interpretation. J Opioid Manage 2007; 3(6):333-337.

Roth SH, Fleischmann RM, Burch FX, Dietz F, Beckon B, Rapport RJ, Rut stein J, Lacouture PG. Around-the-clock, controlled-release oxycodone therapy for osteoarthritis-related pain. Arch Intern Med 2000;160:853-860.

Rowbotham MC, Twilling L, Davies PS, Reisner L, Taylor K, Mohr D. Oral opioid therapy for chronic peripheral and central neuropathic pain. N Eng J Med 2003;348(13):1223-1231.

Sabel J, Ossiander E. Drug poisoning deaths in Washington. Presentation at: Epi Brown Bags; August 15, 2006; Olympia, WA.

Sabel J. Draft Washington State injury and violence prevention plan. Draft chapter on poisoning. March 2007. Department of Health website. Available at: **http://www.doh.wa.gov/hsqa/emstrauma/injury/pubs/icpg/default.htm**

Savage SR, Joranson DE, Covington EC, Schnoll SH, Heit HA, Gilson AM. Definitions related to the medical use of opioids: evolution towards universal agreement. J of Pain Symptom Manag 2003;26(1):655-657.

Shevlin M, Smith GW. The factor structure and concurrent validity of the alcohol use disorder identification test based on a nationally representative UK sample. Alcohol & Alcoholism 2007;42(6):582-587.

Strain EC, Bigelow GE, Liebson IA, Stitzer ML. Moderate vs. high dose methadone int he treatment of opioid dependence: a randomized controlled trial. JAMA 1999;281:1000-1005.

Sullivan M, Edlund M, Zhang L, Unutzer J, Wells K. Association between mental health disorders, problem drug use, and regular prescription opioid use. Arch Intern Med 2006;166:2087-2093.

Swiontkowski MF, Engelberg R, Martin DP, Agel J. Short musculoskeletal function assessment questionnaire: validity, reliability, and responsiveness. JBJS 1999;81-A:1245-1260.

Tellioglu T. The use of urine drug testing to monitor patients receiving chronic opioid therapy for persistent pain conditions. Med Health R.I. 2008;91(9):279-280, 282.

Titus JC, Dennis ML, Lennox R, Scott CK. Development and validation of short versions of the internal mental distress and behavior complexity scales in the global appraisal of individual needs (GAIN). J Behav Health Serv & Res 2008;35(2):195-214.

Torres LAPd, Rebollo EM, Ruiz-Moral R, Fernandez-Garcia JA, Vega RA, Palomino MM. Diagnostic usefulness of the alcohol use disorders identification test (AUDIT) questionnaire for the detection of hazardous drinking and dependence on alcohol among Spanish patients. European J General Practice 2009;15:15-21.

Trescot AM, Boswell MV, Atluri SL. Opioid guidelines in the management of chronic non-cancer pain. Pain Physician 2006;9:1-40.

Turk DC, Swanson KS, Gatchel RJ. Predicting opioid misuse by chronic pain patients: a systematic review and literature synthesis. Clin J Pain 2008;24(6):497-508.

Verdue B, Decosterd I, Buchlin T, Stiefel., Berney A. Antidepressants for the treatment of chronic pain. Drugs 2008;68:2611-2632.

Vernon H, Mior S. The neck disability index: a study of reliability and validity. J Manipulative Physiol Ther 1991;14(7):409-415.

Veteran Affairs/Department of Defense. Opioid therapy for chronic pain. Clinical Practice Guidelines June 2003. Available at: **http://www.oqp.med.va.gov/cpg/cpg.htm**.

Wallace LS, Keenum AJ, Roskos SE. Comprehensibility and readability of patient self-administered opioid assessment screening tools. J Opioid Manage 2007;3(6):338-344.

Washington State Pharmacy Association. Long-acting opioids clinical pearls for the Washington rx preferred drug list. Washington Clinical Pearls. Available at: **http://www.wsparx.org/WashingtonRx.asp**.

Washington State Department of Labor and Industries. Guidelines for outpatient prescription of oral opioids for injured workers with chronic noncancer pain. Medical Treatment Guideline July 2005. Available at: **http://www.lni.wa.gov/ClaimsIns/Files/Providers/ProvBulletins/PbFiles/PB0004.pdf**.

Watson C, Moulin D, Watt-Watson J, Gordon A, Eisenhoffer J. Controlled-release oxycodone relieves neuropathic pain: a randomized controlled trial in painful diabetic neuropathy. Pain 2003;105:71-78.

Acknowledgements

The Washington State Agency Medical Directors Group wishes to acknowledge the many advisors from both the private and public sectors who provided crucial consultation and input to this guideline. Their clinical, scientific, and technical expertise helped ensure that this guideline would be relevant, accurate, and of practical use to prescribers. Every effort was made to create a guideline as evidence-based as possible. Where scientific evidence was insufficient or unavailable, the best clinical opinions and consensus of the advisory group were used.

We are grateful for the time and efforts made by each of the following advisors:

Invited Physicians (non state agency)

Randi Beck MD, Group Health
Marie Boudreaux MD, Group Health
Alex Cahana MD, University of Washington (UW)
Gregory T. Carter MD, MS*; UW/Providence
Charles Chabal MD, Evergreen Pain Mgmt Center
Dianna Chamblin MD*, The Everett Clinic
Pamela Davies ARNP, UW / Seattle Cancer Care Alliance
Peter Dunbar MD, UW
Mark Flanery MD, Anesthesiologist
Andrew Friedman MD*, Virginia Mason Medical Center
Gordon Irving MD, Swedish Medical Center
Frank Li MD, Medical Director, Seattle Pain Center
Joseph Merrill MD, UW
Darin Neven MS, MD, Providence Sacred Heart Medical Center and Children's Hospital
Richard Ries MD, UW
Jim Robinson MD PhD, UW
Andrew Saxon MD, VA Puget Sound Health Care System and UW
Michael Schiesser MD, Internal Medicine
J. David Sinclair MD, Independent consultant – chronic pain
Mark Sullivan MD PhD*, UW
David Tauben MD*, UW Center for Pain Relief
Thomas Taylor MD, UW
Gregory Terman MD PhD, UW
Judith Turner PhD, UW
Michael Vonkorff Sc.D., Group Health Research Institute
Gerald Yorioka MD*, Snoqualmie Tribe
Thomas Wickizer PhD, UW

* Member of Labor & Industries' Industrial Insurance Medical Advisory Committee

Representatives of the following Washington State agencies also participated in creating this guideline

Department of Corrections
Department of Health
State Board of Health
Medical Quality Assurance Commission
State Board of Pharmacy
Department of Social and Health Services
Health Care Authority
Labor & Industries