Contra Costa Health Plan *Utilization Management.*

Title: Coordinating Chronic Pain Management Care **Policy #: UM15.048**

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Applies to:

☐ Medi-Cal ☐ Medicare ☐ Commercial

☐ BHC ☐ State Sponsored ☒All ☐ N/A

Regulatory/Accreditation:

☐ DMHS: ☐ HCFA: ☐ DHS:

☐ Other Reg. References: ☐ NCQA: ☐ N/A

Units:

☐ Administration ☐ Advice Nurses ☐ All Staff

☐ Business Services ☐ Case Management ☐ Health Ed/Cultural Ling.

☐ Marketing ☐ Member Services ☐ Planning, Survey, Reg Affairs

☐ Provider Affairs ☐ Quality Management ☒ Auth/Utilization Management

POLICY

Contra Costa Health Plan (CCHP) follows product line specific, evidence-based guidelines or adopts guidelines established by nationally recognized organizations in the decision making process as described in policy UM15.002- Utilization Review Criteria and Guidelines. The Health Plan utilizes Apollo Medical Review Criteria Guidelines for Managing Care, Pain Management, and Pain Evaluation and Management for pain management care, which includes initial consultation, follow up care and discontinuation of services. Decisions are based on appropriateness of care and service and the member's existing coverage.

Guidelines are available to providers and members. Please refer to policy *UM 15.030- Disclosure of Utilization Management Criteria and Guidelines* for details.

PURPOSE

The purpose of this guideline is to improve coordination of care for CCHP members with chronic pain by clarifying the roles and responsibilities of primary care practitioners (PCPs) and specialists who care for members with chronic pain. The guideline is designed to assist primary care practitioners make appropriate use of pain management specialists and to facilitate coordination between providers.

PROCEDURE

I. INITIAL REFERRAL to Pain Management and PCP Responsibilities

The PCP is responsible for coordinating all services required by the member except when precipitous circumstances preclude the PCP's role. The scope of the responsibility is comprehensive, (i.e. all required services including preventive services). The PCP should provide those services which can be provided within his/her competence and should obtain consultation when additional knowledge or skills are required. CCHP recognizes that differences in skill level exist among PCPs and that this document serves as a general guideline to define the scope of

services and the indications for referral to a pain management specialist/pain management center (PMS/PMC). When care by a specialist is required, it is the **shared responsibility** of the PCP and the specialist to coordinate all services.

A. The PCP **should be** responsible for providing the following basic pain management services:

1. Assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. In addition, the PCP should assess for depression, anxiety, and secondary gain such as compensation issues along with possible alcohol or substance abuse and should include a thorough medication history. The many possible causes of chronic pain, including osteoarthritis, rheumatoid arthritis, and other inflammatory conditions, degenerative disease and neuropathic pain should be considered and a specific diagnosis should be made if possible. When indicated, the PCP should assess for pain related to work for work injuries and ask about the relation to accidents or legal issues.

2. Perform a thorough physical exam as clinically indicated.

3. Distinguish between physiologic dependence or tolerance and addiction. A pain management agreement is an important part of the scope of pain management. The PCP should consider a pain management agreement for all chronic pain members whom they are following and to perform routine regular urine toxicology screening for members treated with chronic opioid therapy for non-cancer pain.

4. Based on American Pain Society guidelines, the Primary Care Practitioner is expected to perform these basic services for members receiving chronic opioid therapy (COT):

    i. Ask the member to establish and maintain a primary care relationship with the provider.
    ii. Complete and document initial and periodic detailed pain evaluations.
    iii. Engage the patient in setting goals with respect to pain control and their ability to function in the setting of chronic pain. Often complete elimination of pain is not an achievable goal and an improved ability to function is more realistic. Providers should emphasize this reality with patients.
    iv. Providers should periodically reassess patient's progress toward meeting goals.
    If the patient is not achieving the goal, continuing opioids may not be appropriate.
    v. Review and document risk factors for opiate misuse, addiction, or adverse effects.
    vi. Establish a Controlled Medicines Agreement on all patients on COT.
    vii. Provide education and written materials to patients about the risks of COT
    viii. Follow guidelines for reassessing risk, revising management, and/or discontinuing COT.
    ix. Monitor safety and compliance of COT use based on urine drug screens, Patient Activity Reports, pill counts, and/or patient report.

x. Refer for alternate treatment modalities and specialists for the management of pain.
xi. Follow criteria for discharge from care for serious legal or safety violations concerning COT.

5. Prescribe appropriate analgesics when indicated for the initial management of chronic pain including acetaminophen, NSAIDs, and opioids.

6. When appropriate, consider pain modulating agents, such as tricyclic antidepressants (amitriptyline and nortriptyline), and anticonvulsants (gabapentin and carbamazepine).

7. Refer the member to a pain management specialist/program/clinic when clinically appropriate. Members should not be referred to a chronic pain clinic until a specific diagnosis has been made and treatable underlying causes have been evaluated thoroughly by the PCP and specialists other than pain management specialists. All psychiatric illnesses should be actively treated. Any illegal drug usage should be identified, documented and addressed.

8. When a pain management consultation is requested and deemed medically appropriate, send all relevant clinical information to the specialist.

9. The PCP should consider referring a member with a complex pain syndrome as indicated below in I (E).

Please note, prior to referring the member for a pain management consultation, the PCP is responsible for either completing the pain management specialty evaluation form (Attachment A) or the requesting provider may reference the location of such information for Health Plan staff in lieu of completing this form.

B. CCHP utilizes Apollo's Pain Management guidelines as noted in "POLICY" section, above. The guidelines states that a referral to a pain management program or clinic may be covered when *persistent pain >3 months that is* ***"unresponsive to active management by the primary physician or in-plan specialists evidenced by adjustment/escalation in medication management and failure of other appropriate conservative modalities"*** *is required for coverage of pain management services. Pain management services include a) medications, b) interventional techniques such as epidural injections or spinal cord stimulators, c) behavioral methods, d) physical treatments, such as physical therapy, acupuncture or chiropractic.* Additionally and as appropriate, a referral to the Pain and Wellness Clinic should be considered for members in the Regional Medical Center network.

C. For members who have been referred to and evaluated by pain management or other specialist, the PCP should participate in the ongoing needs of the member unrelated to the specialty care services.

D. In collaboration with the pain specialist, the PCP should determine transitional and follow-up care for members who have reached clinical stability.

E. A referral to Pain Management may be considered appropriate in the following conditions:
    1. Complex pain syndrome where the diagnosis is unclear OR the condition is unresponsive to ***active management by the primary physician or in-plan specialists evidenced by adjustment/escalation in medication management and failure of other appropriate conservative modalities***
    2. Complex pain syndrome compromised by severe functional impairment.
    3. Complex pain syndrome complicated by a mental health condition or substance abuse problem unresponsive to usual therapy and referral to an appropriate Behavioral Health Specialist.
    4. To perform and/or supervise procedures done by pain management specialists such as epidural injections for conditions likely to respond to the procedure.
    5. Evaluation of evaluate axial pain without evidence of radiculopathy prior to a surgical evaluation.

F. Other specialty consultation should be considered in situations where the diagnosis is uncertain, the member has not responded to usual conservative therapy or specialty care is required based on the diagnosis. Other specialty care may include neurology, orthopedics, rheumatology, physical medicine, rehabilitation or behavioral health.

II. INDICATIONS for Ongoing Pain Management Services

Ongoing pain management services with a Pain Management Specialist or at a Pain Management Center (PMS/PMC) may be approved as individual follow up visit(s) or in 6-month case rate increments (Case Rate I or Case Rate II-see below for description) when ALL of the following are met:

A. The member is receiving interventional pain management services such as epidural injections or complex pain medication titration or conversion to formulary opioids not usually performed by a PCP.
B. The member is in active treatment or where the patient's condition is unstable or medication regimen is being titrated by the specialist.
C. The goal(s) of the PMS/PMC services have been clearly defined AND the member is making progress toward the goals but has not yet achieved the goals.
D. The member is actively participating and adherent to the pain management program.
E. The member does not have a condition that would exclude participation in PMS/PMC program such as a severe psychiatric disorder or a chemical dependency disorder.
F. The PMS/PMC is routinely submitting progress reports to the member's PCP.

III. EXCLUSION From or Discontinuation of PMS/PMC Services

Pain Management services are not available or may be discontinued when:
A. The services do not meet all the guidelines in Section I (B) and (E) and Section II.
B. A member has a severe psychiatric disturbance that would not allow them to comprehend and retain new learning.

C. The documentation indicates that the member is not demonstrating progress toward achieving stated goals within a reasonable period of time AND the timeframe is included on the plan of care.
D. The member has attained his/her pain management goals or has plateau and no longer require the skills of the PMS/PMC.
E. Clinical documentation indicates a duplication of services (e.g., an overlap of physical and occupational therapies).
F. The requested pain management modalities/services/treatments are excluded from the member's benefit package (e.g. homeopathic).
G. The chronic pain has resulted from a mental condition, rather than from any physical cause.
H. After initial PMS/PMC consultation, a significant change in the member's status or when it is determined that ongoing pain management care can be performed by the PCP. The PMS/PMC is responsible for forwarding all relevant clinical information to the PCP.

IV. Referral Sources for Coexisting Conditions

Some members with chronic pain conditions are found to have coexisting mental health conditions and substance abuse problems. Referral information for Mental Health and Substance Abuse providers are:

	Contact Number for **Mental Health**
CCHP Medi-Cal	1-888-678-7277
CCHP Commercial	1-877-661-6230 option 4

	Contact Number for **Substance Abuse**
Alcohol & Other Drug Services (AODS)	1-800-846-1652
BAART (Antioch)	925-522-0124
BAART (Richmond)	510-232-0874

DEFINITION

Case Rate I: 6-month period of professional fees in the office setting with the PMS/PMC.

Case Rate II: 6-month period of professional fees in the office setting and in an ambulatory surgery center with the PMS/PMC.

REFERENCE

Apollo Managed Care Consultants, Medical Review Criteria Guidelines for Managing Care, Pain Management, and Pain Evaluation and Management, Eleventh Edition, 2018

Chou, Roger, et al. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. The Journal of Pain, Volume 10, Issue 2 , Pages 113-130.e22, February 2009

CONTRA COSTA HEALTH PLAN

A Division of Contra Costa Health Services

REFERRAL FORM FOR PAIN MANAGEMENT SPECIALTY EVALUATION

To be completed and signed by the PCP and submitted to CCHP for review.

Upon approval, please forward a copy of this form to the PAIN MANAGEMENT SPECIALIST PRIOR TO THE INITIAL CONSULT VISIT.

Please note, if the information below is clearly documented and available in the electronic health record and that record is available and accessible to the CCHP UM staff, the requesting provider may reference the location of such information for Health Plan in lieu of completing this form.

1. Diagnosis _____
2. Duration of condition _____
3. Diagnostic evaluation completed to date including urine toxicology results

   _____

   _____
4. Therapeutic modalities tried AND results (physical therapy, chiropractic, TENS etc.)

   _____

   _____
5. Other specialists consulted and the results of those consultations

   _____

   _____
6. Current medications

   _____

   _____
7. Medications previously tried and failed

   _____

   _____
8. Implementation of and adherence to a Pain Agreement

   _____

   _____

_____ _____

Requesting Provider Signature **Date**

Information about Opioid Prescriptions

Opioids are medications that can help to decrease pain. Examples of opioids include codeine, morphine, methadone, oxycodone, Percocet, Vicodin, and Fentanyl. Opioids cannot take away chronic pain completely. Instead, the purpose of these medicines is to make it easier for you to do the activities in your day-to-day life. Your Primary Care Provider may talk to you about treating your chronic pain with opioids. If so, you need to know that opioids can cause:

Sleepiness or confusion. When you first start taking opioids, and if you ever increase your dose, you should not drive or operate machinery if you feel sleepy. Other medications can make you even sleepier if you take them with opioids, so talk to your Primary Care Provider about any medications, including over-the-counter medications, you take. Confusion caused by opioids may or may not get better over time.

Constipation or nausea. Constipation is a common side effect of opioids. If you get constipated, try increasing the fiber and fruit in your diet, or take a stool softener like Colace. If you get nauseated, try taking the medication after meals.

Insomnia or Depression. Many people who take opioids for a long time develop problems sleeping at night. Many people also get depressed.

Risk in Pregnancy. If you continue to use opioids while you are pregnant, there is a risk that the child will be opioid dependent at birth. We strongly recommend using safe and effective birth control while taking opioids. If you become pregnant or are planning to get pregnant, tell your Provider about it right away.

Physical Dependence. It is very common for your body to get used to taking the medication. Dependence means that if you stop taking the medication abruptly, your body will have a withdrawal reaction. You cannot die from opioid withdrawal, but it feels awful. Opioid withdrawal symptoms include pain, muscle aches, anxiety, diarrhea, nausea, sweating, runny nose, tears, and insomnia. If you miss an appointment with your provider and call for refills too late, you may run out of medication and go into withdrawal. So it is very important that you come to all of your appointments. If you want to stop taking opioids and avoid these symptoms, you should talk with your Primary Care Provider about tapering off over days or weeks.

Tolerance. Tolerance means that after taking opioids for a while, the medication doesn't have the same benefits, even though the pain is no worse and the dose has stayed the same. If your body adapts to the medication so that it loses strength, you may need to increase the dose or taper off and stop the medication.

Overdose. A high dose of opioids can be fatal. Too much opioid medication can stop your breathing. It is important that you keep medication where children and pets cannot get to it.

Alcohol. Mixing alcohol and opioids is especially dangerous. For your safety, it is important that you tell your provider how much alcohol you drink. If your provider learns that you are misusing alcohol or drinking unsafely, your provider will stop the medication.

Misuse. Some people use opioids to get high or they sell the medication to make money. Misuse is dangerous so your provider will follow a system to make sure that you are using the opioids safely.

Because of the problems that opioids can cause, it is a controlled medicine. That means that there are laws that your provider and you must follow in order to use them.
Controlled Medicines Agreement. You will sign an agreement with your provider that describes what you can expect from your provider and what your provider expects from you when treating chronic pain with opioids. The agreement will be reviewed at least once a year. It will also be reviewed if you change providers or break the agreement.

One Provider. You will select one clinician to be your Primary Care Provider. Only that provider or their designee will prescribe opioids to you. With the help of clinic and pharmacy staff, the two of you will work as a team with the goal of caring for your health. You must see your provider at least everythree months to continue receiving opioid prescriptions for chronic pain. If you are unhappy with your care, you may change your provider within your clinic or you may switch to another provider site.

One Pharmacy. You will select one pharmacy where you will fill all of your controlled medicine prescriptions. Your pharmacist and provider will work together to make sure that the medicines you take are safe for you.

Specialty Clinics. For your safety, you can only get ongoing prescriptions for controlled medicines from one place. For that reason, if you are being treated for opioid addiction at a methadone clinic or if you get medicine from an outside pain clinic, you will not receive controlled medicines from your provider. Most CCHP providers do treat opioid addiction with methadone.

No Early Refills. You will not be given early refills for any reason. So it is important to keep your medicine safe and secure, as if it were jewelry or cash. If you take more medicine than your provider tells you to use, you will run out of medicine.

Refill Requests. You must allow seven working days for your opioid prescription to be refilled. You can request prescription refills during regular health center hours. No refill requests made outside business hours will be processed.

My signature indicates that I received a copy of the information above and discussed it with my provider.

(Adapted from LifeLong Medical Care's Information Sheet to Patients for use by CCHP providers at their descretion. CCHP is most grateful to Dr. Joshua Kayman, Associate Medical Director of Behavioral Health at LifeLong, for sharing this information.)

SAMPLE CHRONIC PAIN MEDICATION AGREEMENT, PAGE 1	

Chronic Pain Medication Agreement between (patient)_____

and (primary care provider) _____, MD/DO/FNP.

In order to provide chronic narcotics safely and effectively:

_____1. Initial — The patient should keep regular appointments with his/her primary care provider at _____.

_____2. Initial — All prescriptions for "controlled medications" should be filled at only one pharmacy, which will be _____. This may be changed If the patient and provider agree. "Controlled medications" are drugs that are regulated by the Department of Justice or Drug Enforcement Agency. Examples are opioid pain medications such as morphine, methadone, hydrocodone (Vicodin), codeine, or _____.

_____3. Initial — All routine prescriptions for controlled medication shoud be written by the primary care Provider. If he/she is not available, another physician will write a prescription. Medications will be refilled at regular visits and not after hours or on weekends.

_____4. Initial — If the patient requires Emergency Department care which includes opioid pain medicines, he/she will bring a copy of or describe this agreement to the doctor. The patient will be responsible for informing his/her primary care provider of any Emergency Department visits by the next working day. The patient consents to the release of the Emergency Department records and any other, past or future, medical records for Review by his/her primary care provider.

_____5a. Initial — The patient agrees to random, supervised uring tox screens and/or breathalyzer tests to be sure that nonprescribed mind or mood altering substances are not being used [including but not limited to opioids ("narcotics", e.g., heroin), cocaine, and other Stimulants, alcoholic beverages, benzodiazepines, (e.g., Valium) or other depressants and marijuana.]

A refusal to do a tox screen may be interpreted as the same as a positive test. A positive test, confirmed by our reference lab, may result in a gradual reduction of long-acting opioid analgesics or a clonidine-based detoxification. If this should occur, non-opioid pain treatment modalities will still be offered through Contra Costa Regional Medical Center & Health Centers.

OR

_____ Initial 5b. The patient agrees to follow his/her primary provider's advice and use alcoholic beverages in moderation, when doing so will not cause the patient medical or other problems.

The patient agrees to random, supervised urine tox screens and/or breathalyzer Tests as requested by the examining provider to affirm that nonprescribed mind Or mood altering substances are not being used [including, but not limited to, Opioids ("narcotics", e.g., heroin), cocaine and other stimulants, benzodiazepines or other depressants, and marijuana.]

A refusal to do a tox screen may be interpreted as the same as a positive test. A positive test, confirmed by our reference lab, may result in a gradual reduction of long-acting opioid analgesics or a clonidine-based detoxification. If this should occur, non-opioid pain treatment modalities will still be offered through Contra Costa Regional Medical Center and Health Centers.

_____ Initial 6. The patient has received information about the risks and benefits of chronic opioid Medication and has had all of their questions answered satisfactorily.

This agreement should be reviewed and revised periodically, every 3 to 6 months, or as appropriate.

_____ _____
Patient Date

_____ _____
Primary Care Provider Date

_____
Witness

CPM initialed by _____ on (date)_____