Appendix to
Tennessee Department of Health:
Tennessee Clinical Practice Guidelines for Outpatient Management of Chronic Non-Malignant Pain

Bureau of Workers' Compensation
01.01.2017

Background

Opioids (Narcotics) and other associated analgesic medications represent more than 30% of drug costs in Tennessee Workers' Compensation claims, a significant portion of payments for long term claimants, and are associated with longer periods of disability and lost-work time.

Effective oversight and appropriate use of these medications reduce their abuse and diversion, return injured workers to employment sooner, decrease long term disability, improve life expectancy, and encourage patient function.

There are special situations in Tennessee workers' compensation that are addressed by this appendix. Each patient is assigned an "authorized treating physician, ATP" In Tennessee Code Annotated § 50-6-204(j)(2)(B), there are educational requirements and "board" criteria to be a "Pain Management Specialist" (PMS) and treat chronic pain with opioids on a long term basis.

As a result of the risks of treatment with these medications, it is important to set guidelines that may aid the practitioners and the injured workers. This would allow effective and safe management of chronic pain, in the general population and particularly in those covered under Workers' Compensation.

The use of opioids should not be considered as the initial treatment option. This Appendix is intended as a reference guide concerning the management of scheduled medications in Workers' Compensation and should be used in association with the Department of Health "Tennessee Clinical Practice Guidelines for Outpatient Management of Chronic Non-malignant Pain", https://www.tn.gov/assets/entities/health/attachments/ChronicPainGuidelines.pdf
If Opioids Have Not Relieved Your Chronic Pain, see: http://www.tn.gov/assets/entities/health/attachments/Opioids_Education_Piece_FINAL.pdf.

Pain Management Specialist Consultation or Referral

Consultation with a PMS as defined by the Tennessee Department of Health in their "Tennessee Clinical Practice Guidelines for Outpatient Management of Chronic Non-malignant Pain" may occur under the provisions listed below. The ATP should continue to manage the applicable part of the patient's care. If a referral is made for the PMS to assume the continued care of the patient, then the referring physician or chiropractor must declare that the patient has reached maximum medical improvement, that all active medical treatment has been completed for the covered injury, give a date of MMI and a permanent impairment (PI) rating. See those provisions in T.C.A. §50-6-207(1)(E).

Who Should Treat:

The **ATP** may prescribe opioids for injured Workers' Compensation patients for up to 90 days after injury or after major surgery. Opioid prescriptions for acute injury pain should be planned to cover the acute pain of injury and/or surgery, and should (in most circumstances) be discontinued well before the 90 day interval of this guideline.

At 90 days after the injury or the last major surgery:

If the patient is not on a weaning schedule and making satisfactory progress toward opioid cessation then a consultation or a referral to a **PMS** should be made.

Other criteria for a referral:

a. more than 90 MME[1] or any of the following:

b. both long and short acting opioids,

or opioids with:

c. fentanyl, Butrans patch, methadone, carisoprodol, benzodiazepines (or their derivatives), or

d. "sleeping pills" (e.g. eszopiclone, ramelton, triazolam, zaleplon, zolpidem, etc.), or

e. "muscle relaxants",

PMS Responsibilities:

It is recommended as part of the initial assessment that genetic testing for opioid metabolism be assessed if it can be obtained at a reasonable cost with pre-authorization from the insurer. Genetic testing for addiction should also be considered if this risk is assessed to be moderate or high.

When any other scheduled and/or psychoactive medications are prescribed for co-morbid mental illness rather than pain management, the **PMS** may only write the scheduled pain medication prescriptions after direct in-person or telephone consultation with the **Psychiatrist** or Primary Care Physician who is also treating the patient with scheduled, and/or sedating, and/or psychoactive medications.

Only one physician should be prescribing <u>all</u> controlled substances for chronic pain management.

When a Workers' Compensation patient is being prescribed other scheduled medications for a co-morbid mental or sleep disorder by a non-psychiatrist, use of chronic opioids for pain is generally not appropriate.

If the co-morbid mental illness appears during tapering to require continued treatment with one or more other scheduled medications or anti-psychotics or anti-convulsants, a Psychiatrist should be consulted for help with managing the mental illness during chronic pain management. The psychiatric evaluation and treatment is not

[1] The total daily dose of opioid will be assumed to be that reported on the Tennessee Controlled Substance Database report for the current dose, <u>MME</u> means daily morphine milligram equivalent dose.

the financial responsibility of the employer/insurer, unless the mental illness is accepted as work related.

Reexamination and Assessment for Opioid Treatment:

Reexamination must be performed by the **PMS** in person at least every 90 days (except in the special cases of catastrophic injury-defined in the Bureau of Workers' Compensation Rule 0800-02-07-.01(6) and persistent pain syndromes on long term stable opioid use for over two years).

Every 90 days the **PMS** must attest and document in the patient's chart that:

1. the medications continue to be medically necessary and appropriate,
2. the pain is severe enough and chronic enough to warrant the medications,
3. attempts at weaning have occurred, and document the results,
4. objective validation that the opioid treatment is effective in managing the pain.
5. other modalities are not sufficient, and
6. the treatment is directly and primarily related to the compensable injury.
7. a repeat comprehensive physical examination has been performed on that date, and is documented in the patient's chart,
8. a signed pain management agreement that is current (less than one year old) and is in the patient's chart,
9. documentation of a discussion and recommendations concerning available alternative treatment options and the response to them when ordered
10. an assessment of ***functional improvement*** using validated tools **(e.g. Oswestry, Roland Morris, Neck Disability Index, DASH, etc.).** The recorded maintenance of satisfactory activities of daily living, is not sufficient to justify the continued use of opioids without other objective and assessed alternatives,
11. documentation of satisfactory continued employment, employment applications, or vocational rehabilitation attempts, or unemployment status,
12. dates, results, and interpretation of urine drug screen tests,
13. dates and results of checking the Tennessee Controlled Substance Monitoring Database (how many prescribers, how many pharmacies, etc., compliance with pain management agreement, etc.).
14. current and recent pill count assessments of compliance with prescribing dose.
15. dates of prior violations of opioid contract, abnormal urine drug screen tests, pill counts, "lost prescriptions", etc.
16. specific documentation of the actual use and frequency of "prn" medications or opioids used for "breakthrough."

Pain management agreement, assessment tools for pain, function, risks and mental illness, urine drug screens, pill counts, CSMD should be accomplished in accord with the Department of Health Chronic Pain Guidelines.

Buprenorphine, Methadone:

Medications containing buprenorphine, with the exception of the patch, should not to be used for "pain" in Workers' Compensation and should be managed and prescribed only by a trained and federally qualified physician and by a licensed office based opiate treatment facility. Those taking oral buprenorphine or methadone for treatment of opioid addiction should not be prescribed additional opioids. Methadone is not recommended for the treatment of pain.

If the **ATP**, or the **PMS**, requests that the patient be seen between routine appointments for unannounced urine drug testing and pill counts, the patient should be reimbursed for mileage expenses at the same rate as a routine appointment.

Special Circumstances, Catastrophic Injuries and Stable Persisting Pain Syndromes:

In cases of *catastrophic injury* (defined in the Bureau of Workers' Compensation rule 0800-02-07-.01(6)) with objectively documentable source(s) of significant chronic pain: **if** the patient has been receiving chronic opioid therapy for over two years, the dose has not been escalating for the past 2 years, urine drug screening has been occurring at least twice yearly with appropriate results, pill counts have been correct, and the Tennessee Controlled Substance Database reports have been appropriate (only one controlled substance provider), no adverse events (overdose episodes, accidents attributable to medication use, etc.) have occurred, and the **PMS** has adequately documented the facts required in the above section on **Reexamination and Assessment for Opioid Treatment,** then continued opioid prescribing at current doses should be presumed to be appropriate and medically necessary.

In *persisting pain syndromes* after a work-related injury or a work-related illness: **if** the patient has been treated by a workers' compensation ATP/PMS for over two years with opioids and the opioid dose has not been escalating for the past 2 years, urine drug screening has occurred at least twice in the past year with appropriate results, pill counts have been correct, the Tennessee Controlled Substance Database reports have been appropriate (only one controlled substance provider), no adverse events (overdose episodes, falls or motor vehicle collisions or citations attributable to medication use, etc.) have occurred, and the PMS has adequately documented the facts required in the above section on **Reexamination and Assessment for Opioid Treatment,** then continued opioid prescribing at current doses should be presumed to be appropriate and medically necessary.

Pain adjuvants:

The use of Neurontin® and those antidepressants that are recognized in evidence-based guidelines as indicated for chronic pain management may be

appropriate in certain circumstances.

Aberrant Drug Screen Results:

Absence of the prescribed medications, presence of non-prescribed controlled medications, or the presence of illicit drugs on two confirmed urine drug screens is an indication for discontinuation of scheduled medication pain management. Tapering may be appropriate in some circumstances, but not for the opioid in patients in whom the urine drug testing documents the absence of the prescribed opioid (if the patient is not taking the opioid, there is no reason to prescribe more for "tapering").

Warnings, Weaning or Tapering:

Strong warnings and patient education should be carried out with each prescription refill about the dangers of the concomitant use of alcohol, sedatives, sleep medications, Neurontin®, and other medications that might interact, potentiate or interfere with the opioids. Violations of these warnings, with two urine drug screens positive for drugs not prescribed or two urine drug screens negative for the scheduled medication being prescribed, from a federally certified lab would be a failure to adhere to the pain management agreement and grounds for the denial of payment of the scheduled medications under workers' compensation as medically necessary and the subsequent institution of a weaning protocol for the patient with the positive drug screens and for prescription cessation for the patient with the negative drug screens. Since there are chances with screening for alcohol of false positive tests, each case of a positive alcohol test, each circumstance must be judged individually by the authorized treating physician/pain management specialist as to whether a positive alcohol test is a violation that represents a failure to adhere to the pain management agreement.

Since there is no proven long term benefit of opioids in most patients[2], especially by objective measures of functional improvement or improved daily activities, an annual attempt should be made to taper all chronic opioid therapy patients, except those covered in the sections on "Working Patients", "Catastrophic Injuries", and "Stable Persisting Pain Syndromes". This tapering may include multidisciplinary approaches and alternative, cognitive, or other therapies, and this will require the judgment of the QP/PMS as to the completion of the tapering to the lowest effective dose, or weaning completely off the opioid. Tapering or weaning protocols may require more frequent visits with the **ATP**, and the patient should be seen "face-to-face" by the prescribing physician only (not by a "mid-level" provider) during the weaning period.

Cost of Weaning or Tapering:

The cost for tapering or weaning (including medications designed to aid the weaning or tapering process) is the responsibility of the employer/insurer. Tapering or weaning on an out-patient basis should not exceed 6 months after the completion of

[2] Chaparro LE, Furlan AD, Deshpande A, et al. Opioids Compared with Placebo or Other Treatments for Chronic Low Back Pain: An Update of the Cochrane Review. Spine 2014; 39 (7): 556-63.

the Utilization Review appeals process *(See* TCA§ 50-6-204(j)(4)(E)) or once the weaning/ tapering process has started. Unless the recommendation of the employer's utilization review is based on the absence of the prescribed scheduled medication in urine drug screen testing, as described in the paragraph above, the employer is responsible for payment of office visits and medications prescribed during weaning or tapering.

The co-administration of psychoactive medications with opioids significantly increases the probability of serious complications, including death, and should generally not be used. Withdrawal/tapering/weaning should be carried out one drug at a time as an outpatient. If multiple drugs are to be withdrawn simultaneously, this may need to occur in an in-patient drug treatment facility.

In-patient detoxification (coupled with functional restoration) may be medically necessary in certain situations where there are extra risk factors such as, but not limited to: very high doses of narcotics or other medications, cardiovascular disease, seizure disorders, multiple medications to taper, and/or major psychiatric conditions. In-patient treatment may also be necessary if severe medical or psychiatric complications (including suicidal threats or attempts) occur as a direct result of the tapering. When in-patient weaning/detoxification is appropriate, it is the financial responsibility of the employer/insurer.

Marijuana:

The Bureau of Workers' Compensation does not recognize the use of marijuana for work related injuries or illnesses even if it is obtained on the recommendation from a physician in a state that has legalized marijuana for medical or recreational purposes. Two positive urine or blood drug screens from a federally certified lab for marijuana will be considered a violation of the pain management agreement (*See* T.C.A. § 50-6-204(j)(4)) and will result in denial of further pain management treatment under workers' compensation with Schedule II, III, and IV medications and may start an appropriate weaning protocol. Other non-scheduled medications and other non-pharmacologic modalities may continue to be reasonable and medically necessary**.**

Safety:

Each patient must be evaluated by the treating physician with documentation at each visit as to the patient's safety and the safety of others for work activities such as driving, operating machinery, or heavy lifting. The long term use of narcotics in workers that do heavy lifting is not recommended.

Certain safety sensitive jobs (as defined in the TCA§ 50-9-103(16) (B)), are in general not consistent with the taking of certain medications[3]. The treating physician is responsible for assessment and documentation of a discussion with the patient and patient's employer as to the rationale and safety of the employee and others when the

[3] Hegmann KT, Weiss MS, Bowden K, et al. ACOEM Practice Guidelines: Opioids and Safety-Sensitive Work. JOEM 2014; 56 (7): e46-e53.

employee is both being prescribed a controlled substances and is working in a safety sensitive occupation.

The TN Drug Free Workplace Act defines safety sensitive jobs. Those individuals can have unannounced and/or random tests, if the employer is participating in the Drug Free Workplace Program.

Testing must go to a federally certified lab, and the results must be evaluated by the physician Medical Review Officer. In general, use of controlled substances is not appropriate in patients who continue to work in safety sensitive jobs. Employers may designate additional job categories as "safety sensitive" and have personnel policies that prohibit use of controlled substances by employees in those designated safety sensitive jobs.

Working Patients:

In the special circumstance where the patient is employed full-time, it is generally not appropriate for denials or dosage modifications to occur by an utilization review organization or pharmacy benefits manager without direct contact with and approval by the prescribing authorized treating physician, who will consider whether the recommendation would potentially compromise the patient's continued employment. If continued opioid use is felt by the prescribing physician to be crucial to permit continued employment, then that opioid use will be considered medically appropriate.

Pregnant Patients covered under Workers' Compensation:

A patient who is maintained on chronic opioids, who notifies her prescribing physician (**ATP/PMS**), that she has become pregnant while receiving opioids or any other scheduled medications under Workers' Compensation should be managed according to the recommendations in the Department of Health Chronic Pain Guidelines.

Alternative Treatment Options:

Cognitive behavioral therapy, acupuncture, massage therapy, support groups, functional rehabilitation programs, and other non-pharmacologic treatments have been shown to be effective in the functional improvement and the quality of life in patients with chronic pain and an alternative to opioids. These treatments should be an integral part of the overall treatment course for injured workers suffering from chronic pain.