

Best Practices – Summary Checklist Tools for Documenting Medical Necessity in Clinical Notes when Prescribing Opioids

- Do your notes have documentation of **pain and function** using objective tools?
 - Histories demonstrating consistent improvements in pain and function offer a safe tool to document rationale for increases in opiates
 - Best practices tools can be found at:
<http://www.partnersagainstpain.com/printouts/A7012CF7.pdf>

- Do your notes have documentation of history of **substance abuse** if present?
 - History of drug or alcohol abuse as well as past treatment and failures
 - Best practice include
 - Making a referral to DASA services at: <http://www.dshs.wa.gov/dasa/>
 - Anyone with *ongoing* substance abuse should not be on chronic opiates or should only be prescribed opioids in collaboration with a substance abuse professional

- Do your notes have documentation of **all prescriptions** including psycho-active drugs and drugs with the potential for abuse
 - Clearly documenting the medical necessity of drugs like benzodiazepines, SOMA etc
 - Best Practices include:
 - Documenting the morphine equivalent dose (MED) using the opioid dosing calculator found at:
<http://www.agencymeddirectors.wa.gov/Files/DosingCalc.xls>
 - Charting every script written with the dose and the # dispensed
 - Avoiding necessity to refill prescriptions outside a clinic visit

- Do your notes have documentation of **screening for depression** "In the past month have you been feeling overwhelmed?"
 - A best practice is to use the Patient Health Questionnaire Screener (PHQ9) found at <http://www.phqscreeners.com/>

- Do your notes have documentation assessing the **side effects of high dose narcotics**?
 - Document histories of constipation, worsening sleep apnea, impairment of operation of equipment or vehicles
 - Studies show opiates have only mild to moderate efficacy for chronic pain. Low doses are as likely to work as higher doses for chronic pain. High doses may have serious long term effects on the neuro-endocrine system. (NEJM 2003;349:1943)
 - A best practice include effective communication with patients
 - Clear upper limits on dosing say “Honestly, I don’t believe that higher doses would be safe for you. This is the maximum dose that I feel comfortable prescribing.”

- Explain to patients, “at best, chronic opiates can only take the edge off of your pain.
 - Explain to patients, “Rather than chasing the ups and downs of your pain, it's better to stay on a fixed schedule, to take the ‘edge’ off.”

- Do your notes have documentation **from past providers**
 - Contact your patient’s past provider before prescribing opiates?
 - Document a prescription history via the pharmacy or 12 month histories that are available through Medicaid at:
<http://fortress.wa.gov/dshs/maa/pharmacy/Toolkit.htm>
 - NOTE: past failure to follow a Care Plan is a big red flag

- Do your notes have documentation of **Red flags?**
 - For example: early refills, self dose escalation, "lost scripts", missed, appointments, signs of substance abuse, past care agreements
 - Best practices could include documenting pill counts between refills
 - Beware: when patients self dose-escalate, this is a huge red flag
 - Referrals for peer reviews when there is added complexity or Red Flags

Additional screens for misuse/abuse should be used and documented

- Do you use **pain contracts?**
 - Best practices include:
 - Clearly outlines expectations (frequency of visits, who can prescribe, etc.) and consequences
 - Discusses consistent clinic rules with patients (see Pt Care Agreement, refresher cards)
 - Clearly outlines escalations should there be a failure
 - Best practice pain contract include:
 1. Medications will not be refilled early.
 2. Refills require a clinic visit by appointment.
 3. No urgent requests - appointments for refills must be requested at least 2 days in advance.
 4. Lost or stolen scripts or medications cannot be refilled. They must be safeguarded.
 5. Failure to follow these policies may result in discontinuation of pain medications.
 6. An example contract can be found at:
<http://fortress.wa.gov/dshs/maa/pharmacy/ChronicPainAgreement.doc>

- Do your notes have documentation of **urine toxicology screens?**
 - Tell the patient, "This is a routine part of pain care”.
 - Best practices include:
 - Obtaining urine toxicology screens often (at 1st visit, then at random intervals 2-3 times/year or more if the patient has a history of substance abuse.)

- Tell the patient, “Leaving without giving urine today will have to be considered a positive test”
 - Tell the patient, “A positive drug screen is an indication you are in trouble with your medication. In order for me to continue to prescribe Narcotics, you will need to obtain a substance abuse assessment before our next appointment and follow the recommendation.”
 - A positive test is an automatic stop of narcotics or begins an aggressive taper plan (stopping medication letter can be found at www.gimres.org (As a licensed health care provider you must a UQ NetID to access this weblink) and a taper plan can be found at: http://paintopics.org/pdf/Safely_Tapering_Opioids.pdf
- Do your notes have documentation **of a refill plan?**
- Document exact details of your refill plan
 - Best practice:
 - Think this through at every visit. If you won't be available when the patient will be due for a refill then have the patient make an appointment with another provider.
 - Refills must occur at scheduled visits with PCP, or have a plan for when you are not available

First Clinic Visit for Patients Already on Opiates: If a new patient arrives already on chronic opiates, but without previous outside records, the odds of inappropriate use / abuse is high. In such a situation, be wary.

- As a general rule never write a script for opiates at a patient's first visit:
- Ask patients for the name and number of their previous providers and their main pharmacy.
- Do not prescribe opioids if the patient doesn't allow contact with their previous providers.
- Call the previous clinic and/or primary pharmacy right then, at the time of the first visit. Doctors are usually happy to take your call.
- Get a urine toxicology screen at first visit.
- Tell the patient leaving the clinic without giving a urine sample is unacceptable. Not giving a sample is the same as a positive test. They must wait alone in a clinic room until they can give a sample.
- Resist feeling pressured. If patients report being in (or close to) withdrawal, prescribe clonidine or refer them to their previous provider.
- For the first six months, patients will need to be seen in clinic once a month for refills -in order to more carefully assess the appropriateness of their opiate use.