

We Get Letters... QUESTIONS & ANSWERS FROM MIEC

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INSIDE

Identifying drug-seeking patients 1

Reducing liability exposure when treating chronic pain patients 2

To reach MIEC 2

Pain management agreement (Figure 1) 3-4

We Get Letters

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IDENTIFYING DRUG-SEEKING PATIENTS

Q: *Not long ago, a young man came to me via the ED for severe throat pain related to tonsillitis. I prescribed Vicodin, with one refill. He called me later asking for more Vicodin for a migraine, and I referred him to a neurologist, but he said he couldn't get an immediate appointment, and I let him persuade me to prescribe more Vicodin. He then reported that his housekeeper had stolen the Vicodin. I asked him to send me a police report, and even though he did not send it, I authorized more Vicodin. He asked that the prescription be sent to a different pharmacy where the pharmacist told me that the patient's orthopedist had prescribed Vicodin the day before. Eventually, I learned that the patient is a drug-abuser who failed rehab programs in two states. I realize I was "suckered" into over-prescribing for this patient, and I have withdrawn from his care. How can I prevent being taken in by other drug-seeking patients?*

A: Consider the following guidelines for fine-tuning your index of suspicion and proceeding cautiously with patients you suspect are drug-seeking:

- Be wary of patients who vigorously request specific medications. Be kind but skeptical.
- Take a thorough history of past treatment, and if a patient says that a specific medication was previously prescribed by another physician, obtain

authorization for a copy of that physician's records.

- If a patient reports a lost or stolen medication (i.e., "the dog ate it," "the prescription went through the laundry," "the housekeeper stole it," etc.) and you decide to replace it, inform the patient that you will not replace another lost dose, document the discussion, and keep your word.
- Insist on a good faith exam (required by law in most states) before prescribing or refilling after an absence; for medications that could be abused; or for patients for whom you already have a high index of suspicion related to drug-seeking behavior.
- Keep complete, detailed records of medications: indications, clinical findings or lack thereof, amount, dose, directions for use, precautions, informed consent discussion when appropriate, and patient education.
- Write prescriptions legibly or type them, and ensure that there is no room for alteration of your order (i.e., write out numbers; indicate "no refills;" be careful of placement of the zeros and decimal points, etc.).
- Ensure that patients do not have access to your prescription pads.
- Alert staff to inform you if patients' behaviors are radically different in the reception area from what they are in the exam room.
- Consider seeking a consultation for patients whose medication management becomes complex, or those who present with few clinical symptoms. Carefully document the lack of physical findings and consider

referring such patients to a pain management specialist or a psychiatrist.

■ If you decide to treat a patient for chronic pain, consider using a Medication Management Agreement (*Figure 1*).

■ Alert patients, in advance and in writing, to the best time to call to request a refill of their medications (i.e., several days before they are due to run out; on weekdays rather than weekends, etc.). If they request an untimely refill (i.e., too early if it was taken properly), refill only enough medication to last them until they can come to the office for an appointment, a good faith exam, and a re-evaluation of their condition. Do not deviate from your written refill policy except for rare, unusual circumstances in which you feel confident of the patient and the clinical necessity to do so.

■ When you prescribe a narcotic drug for the first time, use your best clinical judgment, and prescribe the lowest possible safe dose until you can assess the efficacy of the medication and determine if more—or less—would be better.

■ If you believe that you have been “suckered” by a patient and/or a patient is making unrealistic demands for medications with potential abuse consequences, you may call the Claims or Loss Prevention departments for advice on how to proceed.

■ If in doubt about your ability to identify and treat drug-seeking patients, consider a refresher course in pain management to strengthen your clinical and philosophical positions on the subject.

■ [California physician prescribers may request a Patient Activity Report (PAR), a printout that discloses the patient’s prescribing history found in

the CURES data system. (See <http://ag.ca.gov/bne/trips.htm> for more information.)]

■ [California physicians licensed on or after January 1, 2002, need to complete a CME course in pain management and end-of-life care within four years of initial licensure or by the second renewal date, whichever occurs first. All California physicians are required to complete twelve (12) hours of CME on this topic as part of the minimum of one hundred (100) hours of CME required every four years.]

■ Consider withdrawing from care from patients you believe are attempting to obtain prescriptions from you in the absence of clinically-determined necessity. (See “How to discharge a patient from your medical practice,” MIEC’s *Managing Your Practice* #2.)

REDUCING LIABILITY EXPOSURE WHEN TREATING CHRONIC PAIN PATIENTS

Q: *I am an internist treating a few patients for chronic pain. I have taken the appropriate courses to bring myself up to speed in chronic pain management and I know that some pain management patients present with limited clinical evidence of the origin of their pain; I know also, that many pain management medications have significant potential for addiction and/or abuse. How can I protect myself from the related liability hazards?*

A: Pain management specialists protect themselves by first obtaining as complete a history as possible, which they document thoroughly, as they do their examination, assessment, and their short- and long-term plans for treatment. Their informed consent discussions related to chronic pain medication use are more extensive than for short-term use, and usually

culminate in a written agreement with the patient related to the use of these medications (*Figure 1*). The agreement is a reiteration of the informed consent discussion; evidence of the patient’s willingness to comply with the safest possible course of treatment; a promise of close monitoring for drug efficacy and patient safety (e.g., routine lab tests for toxicity levels); and the consequences to the patient if he or she fails to adhere to the safe guidelines recommended by the physician. *Figure 1* is a compilation of features we have seen in a number of pain management agreements and it may be tailored to your individual policies, philosophies, and patients.

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This sample Medication Management Agreement contains elements that promote patients' understanding of their role and responsibility in their pain management treatment process. This sample agreement should be adapted to reflect the policies and procedures of individual medical practices. Some items appear in bold-faced type for emphasis. Items in bold and italic type may be formatted according to physicians' preferences.

Medication Management Agreement

The decision to use opioid (narcotic) medications was made because of my specific condition or because other treatments have not helped my pain. Because Dr. **(your name)** is prescribing such medication for me to help manage my pain, when I sign this form I acknowledge that I understand and agree to the following conditions to make my treatment as safe and successful as possible (please initial each numbered item):

- _____ 1. I am aware that the use of such medicine has certain risks associated with it, including but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia (pain reduction), addiction, and the possibility that the medicines will not provide complete pain relief.
- _____ 2. I understand that the main treatment goal is to improve my ability to function by reducing pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal, I agree to help myself by following better health habits: exercising, controlling my weight, and avoiding the use of alcohol and tobacco. I understand that only by following a healthier lifestyle can I hope to have the most successful outcome to my pain management treatment.
- _____ 3. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be fully determined and that treatment may change while I am under Dr. **(your name)**'s care. I understand, accept, and agree that unknown risks may be associated with the long-term use of controlled substances and that my physician will advise me as knowledge and training advances are made, and will make appropriate treatment changes. I also know there may be other non-opioid options for my pain control.
- _____ 4. I agree to tell my doctor about all other medicines and treatments that I am receiving. **I will not request or accept controlled substances/medications from any other physician or individual** while I am receiving such medications from Dr. **(your name)**. To do so may endanger my health and/or our physician/patient relationship. The only exception is medication prescribed while I am admitted to a hospital.
- _____ 5. I understand the following refill policy:
(for example)
 - a. ***The daily dose may not vary. The weekly/monthly dose must remain constant.***
 - b. ***Medications will not be refilled early, even if they have been lost.***
 - c. ***Medications will not be refilled on Fridays, weekends, or holidays.***
 - d. ***Medications will not be refilled by other physicians.***
- _____ 6. I agree to use **(name of pharmacy)** pharmacy, located at **(address and telephone number of pharmacy)** for all my pain medications. If I change pharmacies for any reason, I agree to notify the doctor at the time I receive a prescription and advise my new pharmacy of my prior pharmacy's address and telephone number.
- _____ 7. I agree to **keep all scheduled appointments.**
- _____ 8. At each visit, Dr. **(your name)** will evaluate me for pain relief, side effects, function, and abnormal behavior (anything indicating addiction). I understand that evaluation may also include recommended lab work to monitor my medication's efficacy. I must keep Dr. **(your name)** fully informed of any changes, Emergency Room visits, lost or stolen medications or any other circumstances affecting my health and well-being.
- _____ 9. Dr. **(your name)** may refer me to another physician for a second opinion while I am receiving controlled substances. I understand that if I do not obtain this second opinion, Dr. **(your name)** may discontinue my medications or refill them with a tapering dose to therapeutically and safely discontinue my use of them.

- _____ 10. You have my permission to discuss my (*medical condition/medication management*) with my spouse or significant other. (*Optional: include space to write in name of spouse or significant other.*)
- _____ 11. I understand that driving a motor vehicle may be hazardous while taking controlled substances and that it is my responsibility to comply with the laws of this state and conduct myself safely while taking the medication prescribed.
- _____ 12. I will not be involved in activities that may be dangerous to me or someone else if I feel drowsy or am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include but are not limited to: using heavy equipment or operating a motor vehicle, working at unprotected heights, or being responsible for another individual who is unable to care for himself or herself.
- _____ 13. I have been fully **informed** by Dr. (*your name*) regarding the potential psychological **dependence** on a controlled substance. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication I must do so slowly and under medical supervision or I may have withdrawal symptoms.
- _____ 14. **I understand that if I fail to comply** with the guidelines in this agreement and on my prescription labels; if I obtain narcotics elsewhere (even from a physician); if I use illicit drugs; if I share narcotics with others; or if I alter a prescription, our doctor-patient relationship will be terminated.

I have read this agreement. I fully understand the consequences of violating this agreement. Dr. (*your name*) has answered my questions and I agree to the terms of the agreement.

Patient name: _____

Patient signature and date: _____

Witness signature and date: _____

Copy given to patient

Some physicians may wish to include additional statements in their medication management agreements, such as:

- I will take my personal medications as directed, no more and no less. I will not tamper with prescribed medications by cutting, crushing or by any other means altering the intended dose of medication. I will not take the medications by any other than the directed route of administration (oral, trans-dermal, or rectal).
- I will not adjust the medications by myself. I will discuss with Dr. (*your name*) any change in dosage I feel I need. Some patients may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. As a result of other treatment modalities or the natural course of my disease process, my pain may decrease. My medication doses will have to be adjusted by Dr. (*your name*).
- I will not hoard my medications. If I am able to control my pain with fewer narcotics, I will inform Dr. (*your name*).
- I am responsible for keeping track of the amount of medications left on my prescription and will plan ahead for arrangements to refill my prescriptions in a timely manner so I will not run out of medications.
- I understand that I must make necessary arrangements to alert Dr. (*your name*) of my need for a refill *five (5)* working days before they run out.