PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)</td><td colspan="3">Lead Department:` Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 6/16/2004</td><td colspan="4">Next Review Date: 06/08/2023
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<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, M.D., MPH, MBA</td><td colspan="3">Approval Date: 06/08/2022</td></tr>
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I. RELATED POLICIES:

A. MCUP3049 – Pain Management Specialty Services
B. MCUP3101 – Screening and Treatment for Substance Use Disorders

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. PHC Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines
B. PHC Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines
C. PHC Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines
D. PHC Recommendations for Safe Use of Opioid Medications: Dental Prescribing Guidelines

V. PURPOSE:

The purpose of this guideline is to improve care for Partnership HealthPlan of California (PHC) members with chronic pain by:

A. Clarifying the roles of primary care practitioners and specialists who care for members with chronic pain. The guideline is designed to help primary care practitioners make appropriate use of pain management specialists.
B. Summarizing best practices in opioid prescribing to create a series of recommendations for safe prescribing of opioid medications.

VI. GUIDELINE / PROCEDURE:

Partnership HealthPlan is the County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 14 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications. In addition, PHC's 14 counties have long supported Substance Use Disorder (SUD) treatment services through the Drug Medi-Cal (DMC) program, including administration of

the DMC-ODS (Organized Delivery System) program in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.

This guideline recognizes the services and responsibilities of primary care providers (PCPs), pain management and other specialists in caring for members with chronic pain. This guideline is highly dependent upon the individual clinical circumstances and the delivery system. Because of these circumstances, expectations may appropriately deviate from the guideline. The PCP is responsible for coordinating all services required by the patient 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. PHC recognizes that differences in skill levels exist among PCPs and that this document serves as a general guideline to define the scope of services and the indications for specialty referral to a pain management specialist. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation. Consultation includes advice received from a telephone discussion with a specialist, e-consults, telehealth consultations and the referral of a patient to a specialist for services. When care by a specialist is required, it is the 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. The PCP should assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. FUNCTIONAL CAPACITY SHOULD BE EVALUATED AND IS THE KEY TARGET OF ANY TREATMENTS. In addition, the PCP should assess for depression, anxiety, and secondary gain along with possible alcohol or substance use disorder 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. When indicated, the PCP should assess for pain related to work injuries and ask about the relation to accidents or legal issues.
    2. A thorough physical exam should be performed as clinically indicated.
    3. The PCP should distinguish between physiologic dependence, tolerance, or addiction.
    4. A pain management agreement is an important part of the scope of pain management. PCPs should consider a pain management agreement for all chronic pain patients who they are following.
    5. A referral to a pain management center should be considered when clinically appropriate. Members should not be referred to a pain management specialist until treatable underlying causes have been evaluated thoroughly by the PCP and specialists other than pain management specialists as indicated. All psychiatric illnesses should be under treatment. Any illegal drug usage should be identified, documented and addressed. When specialty consultation is requested, the PCP is responsible for sending all relevant clinical information to the specialist. Referrals solely for purposes of reducing a PCP caseload of opioid-using patients should not be made.
    6. Consider referring a member with complex pain management as indicated under Pain Management Specialist referral or whenever the PCP feels the member would benefit from pain management evaluation based on his/her sound clinical judgment.
    7. For members who have been referred and evaluated by a pain management or other specialist, the PCP should participate in the ongoing follow-up as jointly determined by the PCP and the specialist for members with these conditions who have reached a high degree of stability.

B. Specialist Referral

    Referral to an appropriate specialist should be considered appropriate in the following situations:
    1. Pain Management Specialist
        a. Complex pain management where the diagnosis is unclear or the condition is unresponsive to standard medication and non-pharmacologic therapy for a period of 3 to 6 months.

b. Complex pain management compromised by severe functional impairment.
c. Complex pain management complicated by mental health condition or substance use disorder unresponsive to usual therapy and treatment by an appropriate behavioral health specialist.
d. For performance and/or supervision of procedures done by pain management specialists. (See MCUP3049 Attachment A – Pain Management Specialty Services.)

2. Refer to other specialists such as neurology, orthopedics, rheumatology, physical medicine and rehabilitation or behavioral health. Specific indications for referral to specialties other than pain management are beyond the scope of this guideline. The PCP should perform a careful evaluation of conditions with a known cause and initiate conservative therapy consistent with the PCP's skill and best judgment. Expert 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.
3. After initial specialist consultation or a significant change in the patient status or when the specialist terminates care of patient, the specialist is responsible to send all relevant information back to the PCP.
4. Patients with suspected substance use disorder (SUD) should be assessed by the PCP or be referred for assessment. In many instances, opioid use disorder and other SUDs can be evaluated and treated by the PCP, such as through the use of Medications for Addiction Treatment (MAT). For instance, buprenorphine or buprenorphine-naloxone (Suboxone®), naltrexone and long-acting injectable naltrexone may be prescribed by PCPs for the treatment of opioid use disorder. In the event that referral is warranted, providers and patients can call Beacon Health Options at (855) 765-9703 for referral information and options if the patient resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access departments. In addition, regardless of county of residence, for buprenorphine providers, patients and providers may visit the Partnership provider directory or the SAMHSA treatment locator website (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator). It can be helpful for PCPs or staff at the PCP office to assist patients in securing a referral connection with an assessing provider, or a substance use disorder treatment provider.

C. Opioid Prescribing Guidelines For Physicians
1. Initial treatment considerations should include non-pharmacological therapies, including physical therapy, acupuncture, chiropractic treatment, activity modifications (rest, splinting), and mobility assistance (canes.)
2. Based on provider skill level, the PCP should prescribe appropriate analgesics when indicated for the initial management of chronic pain.
   a. Initial pharmacologic treatment should rely on non-opioid analgesics, including acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDS).
   b. The use of opioids (tramadol, and opioids such as codeine, hydrocodone, methadone, oxycodone, morphine, and fentanyl) should be reserved for:
      1) Temporary use following trauma or surgery if non-opioid treatment is inadequate, with plan for discontinuation.
      2) For chronic use intermittently at the lowest doses in combination with other non-pharmacologic and non-opioid therapies.
      3) Severe functional disability, at the lowest doses in combination with other non-pharmacologic and non-opioid therapies (may involve ongoing regular doses.)
      4) Chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.

c. Before committing patients to long term regular opioid treatment that may become lifelong, the patient's age should be taken into consideration.
d. Opioids in the frail elderly may be contraindicated due to safety concerns.
e. Offer to prescribe naloxone for any patient prescribed high dose opioids (90 daily MED.)

3. Pain modulating agents should be considered when appropriate, such as tricyclic antidepressants (amitriptyline and nortriptyline), and anticonvulsants, (gabapentin, pregabalin and carbamazepine.)
4. As a minimum standard, when starting opioid therapy for acute, subacute, or chronic pain – not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease – clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
   a. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs. Certain in-office toxicology screens are covered by PHC (see Important Provider Notice on PHC website for details.) Consider a confirmatory urine test if the results of an in-office screen are unexpected, because false positive and negative screening results are common. If a patient is at higher risk for substance use disorder (SUD), diversion, or substance misuse, strongly consider more frequent toxicology screens. Ensure that the toxicology screen used can detect the relevant medications or substances of interest.
      1) Validated screening tools for substance misuse or substance use disorder can be helpful, such as:
         a) Drug Abuse Screening Test (DAST): https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69
         b) NIDA Quick Screen: https://archives.drugabuse.gov/publications/resource-guide-screening-drug-use-in-general-medical-settings/nida-quick-screen
         c) NIDA Modified ASSIST: https://www.samhsa.gov/resource/ebp/nida-modified-assist-nm-assist-clinicians-screening-tool-drug-use-general-medical
   b. Require a signed medication use agreement with the prescriber or prescribing office.
   c. Provider to check California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) report at the time of writing each controlled substance prescription, or more frequently, as required by state law.
   d. Schedule at a minimum, three office visits yearly for chronic pain and monitoring opioid use.
4. Further Recommendations for PCPs and Specialists are found in Attachment A, *PHC Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines.*

D. Community Pharmacy Guidelines
Community Pharmacies play a key role in helping prevent Opioid overdoses, Opioid induced hyperalgesia, Opioid diversion, and Opioid addiction, and have a legal responsibility to do so. PHC recommends that all community pharmacies develop policies and standards to fulfill this responsibility. For detailed recommendations, see Attachment B, PHC Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines.

E. Emergency Room Guidelines
The emergency department has two key roles in helping with community-wide efforts to control Opioid overuse: assuring acute pain is treated in a way that decreases the probability of future over-use of Opioids; working closely with primary care providers to ensure a coherent, safe approach to treating chronic pain. PHC recommendations are found in Attachment C, PHC Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines.

1. The emergency department (ED) can be a critical access point for members with SUD. ED personnel should consider screening for SUD and initiating medication-assisted treatment (MAT). See https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf

F. Dentist Guidelines
Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications. PHC recommendations are found in Attachment D, PHC Recommendations for Safe Use of Opioid Medications: Dentist Prescribing Guidelines.

G. Indicators Monitored by PHC
As part of retrospective DUR (Drug Utilization Review), PHC will monitor pharmacy claims and CURES data for high Morphine Equivalent Dose (MED) and use of multiple prescribers and pharmacies.

VII. REFERENCES:

A. American Pain Society. Guideline for the Use of Chronic Opioid Therapy in Chronic Non-cancer Pain Evidence Review. Available at: Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain - The Journal of Pain (jpain.org) Accessibility verified on March 31, 2022

B. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886920/ Accessibility verified on March 31, 2022

C. Centers for Disease Control. CDC Guideline for Prescribing Opioids for Chronic Pain. https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf Accessibility verified April 29, 2022

D. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of the College of Family Physicians of Canada. Vol 57, November 2011. Available at: http://www.cfp.ca/content/57/11/1257.full.pdf Accessibility verified on March 31, 2022

E. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Available at: http://www.prescribetoprevent.org/wp-content/uploads/2012/11/one-pager_12.pdf Accessibility verified on March 31, 2022

F. Washington State Agency Medical Directors' Group (AMDG). Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain, 2015 Update. Available at: http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf Accessibility verified on March 31, 2022

G. Washington State Agency Medical Directors' Group (AMDG). Cautious Evidence-Based Opioid Prescribing. Available at: http://www.agencymeddirectors.wa.gov/Files/PrescGuide.pdf Accessibility Verified on March 31, 2022

H. Herring, Andrew A., MD, Emergency Department Medication-Assisted Treatment of Opioid Addiction, August 2016, Available at https:/www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf. Accessibility verified on March 31, 2022

VIII. DISTRIBUTION:

A. PHC Provider Manual
B. PHC Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

Guideline/Procedure Number: MPXG5008 (previously MPQG1029 & QG100129)		**Lead Department: Health Services**
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X. REVISION DATES:

Medi-Cal
10/20/04; 03/15/06; 03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16; 04/19/17; *03/14/18; 04/10/19; 03/11/20; 04/14/21; 06/08/22

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy Kids MPXG5008 (Healthy Kids program ended 12/01/2016)
03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16 to 12/01/2016

PartnershipAdvantage:
MPXG5008 – 03/21/2007 to 01/01/2015

Healthy Families
MPXG5008 – 10/01/2010 to 03/01/2013