MedPOINT MANAGEMENT	**Clinical Protocol:** Pain Management	
	ORIGINAL EFFECTIVE DATE: 05/22/2011	**REVIEWED/REVISED DATE(S):** 08/13/2021
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PROTOCOL OVERVIEW

The goal of this protocol is to help the primary care provider manage patients with chronic or persistent pain by providing guidance about how to manage pain and guidance about when to refer for specialized pain management services. Due to the world wide opioid crisis, the world health organization has retired their guidelines and have started a revision process in 2019 but has not produced a new guideline as of mid 2021. As such, Centers for disease control's 2016 guidelines have been referred to as below:

GENERAL PRINCIPLES

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate
2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety
3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day
6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed
7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids
8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months
10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible
12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder

INDICATIONS

Referral for pain management services

There are many indications for pain management services including:

1) Joint pains (I.e. Shoulder, Knee and Hip),
2) Inpatient pain management services for cancer related pain / ob / post operative pain / sick cell / methadone management
3) Pain infusion pump maintenance
4) Chronic opioid management
5) Cancer related pain
6) Chronic pain syndromes (abdominal / pancreatitis / chest pain / pelvic pain)
7) Back pain (Lumbar and cervical commonly)

Pain management services include: Medications Interventional techniques such as epidural injections or spinal cord stimulators Behavioral methods Physical treatments, such as physical therapy, acupuncture or chiropractic

Interventional pain management services may be considered medically necessary for pain that: Persists for more than 3 months; AND Is unresponsive to active management by the primary physician or in-plan specialists, as evidenced by: Adjustment/escalation in medication management, and Failure of other appropriate conservative modalities.

Multidisciplinary pain management programs are medically necessary when all of the following is met:

If a surgical procedure or acute medical treatment is indicated, it has been performed prior to entry into the pain program; and Member has experienced chronic non-malignant pain (not cancer pain) for 6 months or more; and Member has failed conventional methods of treatment; and Member has undergone a mental health evaluation, and any primary psychiatric conditions have been treated, where indicated; and Member's work or lifestyle has been significantly impaired due to chronic pain; and Referral for entry has been made by the primary care physician/attending physician; and The cause of the member's pain is unknown or attributable to a physical cause, i.e., not purely psychogenic in origin.

RECOMMENDED RECORDS

- Current clinical notes documenting member's signs and symptoms and treatmentpreviously tried, e.g., medication use, local injections
- Chronic long-standing back pain
- Pain unrelieved by conservative measures

CITATIONS

- https://www.who.int/news/item/27-08-2019-who-revision-of-pain-management-guidelines
- https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm
- Apollo 20th edition, 8th online, 2021 revision 3/6/2021, AN 105