Emergency Department Pain Medication Prescribing Guidelines

May 1, 2014

BACKGROUND

Prescription drug abuse has been declared an epidemic by the Centers for Disease Control and Prevention (CDC). According to the Monterey County Medical Examiner data, the leading cause of non-natural death is drug overdose. Drug overdose deaths greatly exceed deaths due to motor vehicle crashes, and the majority involves prescription drugs.

The following guidelines are a collection of recommendations modeled by the San Diego County Medical Society Prescription Drug Abuse Medical Task Force and have been adapted by the Monterey County Prescribe Safe Initiative. They draw on published medical literature, evidence-based recommendations from various professional organizations, and the best practice experience of the San Diego County providers.

These Guidelines were reviewed and adopted by the Monterey County Prescribe Safe Initiatives whose participants include:

- Community Hospital of the Monterey Peninsula (CHOMP)
- Mee Memorial Hospital (MMH)
- Natividad Medical Center (NMC)
- Salinas Valley Memorial Healthcare (SVMH)
- County of Monterey (District Attorney's Office, Health Department, Behavioral Health, Sheriff's Office, Coroner's Office)
- Monterey County Medical Society
- Hospital Association of Northern and Central California

POLICY STATEMENT

Emergency departments (EDs) will evaluate all patients who present to the ED asking for pain assessment. ED personnel will treat based on established safe practices on a case-by-case basis. EDs focus on acute pain or acute exacerbations of chronic pain. Chronic pain treatment requires continuity of care given either by a pain specialist or a primary care physician. Non-narcotic alternatives will be explored in each patient. These are guidelines, not absolute standards of care. Physician judgment is acknowledged as an important element in applying the guidelines to an individual patient circumstance.

GUIDELINES

1. **Controlled Substance Utilization Review and Evaluation System (CURES)**

    A. The California database for controlled prescription medications is the Controlled Substance Utilization Review and Evaluation System (CURES), managed by the State of California, Department of Justice.
    B. Each Emergency Department Physician (EDP) shall be encouraged to register to obtain access to the CURES database.
    C. EDP shall pull up a CURES report on patients whose history raises a red flag for controlled prescription medication abuse, misuse or diversion.
    D. Red flags shall include, but are not limited to, the following.
        a. Patient requesting specific controlled substances, based on abuse potential.
        b. Repeatedly running out of medication early.

c. Loss or theft of controlled prescription medications.
d. Unscheduled refills requested.
e. Unwillingness to try non-opioid treatments.
f. Engaging in doctor-shopping activities or prescriptions from multiple sources.

E. EDP must realize that data in CURES may be delayed by up to two weeks and not consistently uploaded by all pharmacies. The VA system and military treatment facilities do not upload data into CURES.

2. **Pain Assessment**

A. It is common to document a pain scale from 1 to 10 according to the patient's assessment. It is helpful to include a functional description of any limitations on patient's activities due to pain.
B. In an acute setting, describe patient's function and mobility.

3. **Acute or Acute on Chronic Pain Treatment**

A. Patients with acute pain and who require opioids should receive short-acting opioids, with the least number of pills needed to cover the time for pain recovery and to minimize potential diversion or sharing of medication. In the emergent setting, prescribe only 10–15 tablets of a short-acting opioid.
B. When dosing opioid naive patients, start with a short-acting opioid with a maximum dose of 4 per times daily (be careful not to exceed recommended maximum for acetaminophen of 3000 mg per day in the normal patient and 2 g per day in patients with liver impairment). Options include:
    a. TYLENOL #3 (30 mg codeine/300 mg acetaminophen)
    b. VICODIN (hydrocodone/acetaminophen) — use 5 mg
    c. NORCO (hydrocodone/acetaminophen) — use 5mg
    d. LORTAB (hydrocodone/acetaminophen) — use 5mg
    e. PERCOCET/ ENDOCET (oxycodone/acetaminophen) — use 5mg
    f. TRAMADOL/ULTRAM
        i. Start with IR 50mg q 4–6 hours (maximum 400 mg/day).
        ii. Do not use if patient has liver disease, renal disease, is on a tricyclic antidepressant or SSRI medication (deaths have been reported in patients with emotional disturbances and misuse of alcohol, tranquilizers, and other CNS active drugs).
        iii. This medication has a high abuse potential.
        iv. This medication does not show up on CURES reports and can be refilled, unlike the Vicodin or Percocet prescriptions.
        v. This is available OTC in Mexico.

4. **Chronic Pain Management in the Emergency Department**
A. The Monterey County Prescribe Safe Initiative takes the position that:
    a. Chronic pain is best treated and managed by a pain specialist or primary care physician in the outpatient setting; and
    b. Only one provider and one pharmacy should help patients with chronic prescription medications.
B. As such, our guideline for EDP is to not prescribe chronic pain medications for patients who receive medications from another healthcare provider. These chronic medications include:
    a. OxyContin

b. MSContin
c. Dilaudid
d. Fentanyl
e. Methadone
f. Opana ER
g. Exalgo, and
h. Others.

C. Because refill of misplaced medications is a red flag for diversion, EDP should not refill these controlled medications. Patients should be encouraged to report stolen medications to local law enforcement agencies.
D. It is not recommended to replace missing doses of Subutex or Suboxone.
E. Parenteral medication administration for chronic pain without an acute component is not advised. Oral pain medications and/or alternative therapies should be offered instead.

5. **Other Prescriptions**
   A. Concomitant use of long acting narcotics and benzodiazepines is not recommended due to risk of mortality. Taper benzodiazepines and consider psychiatric consultation if there is an anxiety component to the patient's perception of their pain.
   B. Concomitant use of medical or recreational marijuana is not recommended. New patients who admit to using marijuana or who have a positive marijuana screen should not be given opiates unless they agree to discontinue marijuana.
   C. Concomitant use of Phenergan with codeine in a cough suppressant formulation is not recommended due to its recreation abuse potential as "Purple Fizz." Use alternative nausea medications such as Reglan, Compazine, or Zofran.
   D. Soma (Carisoprodol) should be avoided due to high potential for abuse and diversion. An alternative muscle relaxant can be used such as Baclofen, Flexeril, Zanaflex, or Robaxin.
   E. Barbiturates should be avoided due to additive sedation effects and abuse potential.
   F. Seroquel (Quetiapine) has potential for abuse.

INFORMATION SHARING AND CASE MANAGEMENT PLANS

1. **Information Sharing:**
   A. When red flag behavior is identified the EDP may also consider seeking medical records from other providers caring for the patient and to share information derived from the ED visit with the patient's other care providers.

2. **Case Management Program**
   A. EDs shall identify methods and encourage engagement of chronic pain patients frequently visiting the emergency department in pain management plans.

REPORTING TO LAW ENFORCEMENT

1. EDPs are encouraged to report suspected prescription fraud by a patient or physician to the Monterey County District Attorney's Disability and Healthcare Fraud Unit. All calls during business hours should be made to (831)759-6671 or (831)755-5070. If law enforcement contact is needed during non-business hours, calls should be made to the local law enforcement agency to contact the on duty District Attorney investigator through dispatch.

2. Patient prescription fraud includes:
    A. Misrepresenting or concealing information to a doctor or pharmacist in order to inappropriately obtain controlled substances (i.e., reporting a lost prescription when not true, furnishing a false name, address, etc.);
    B. Doctor shopping (i.e., using multiple providers and pharmacies to get multiple prescriptions for controlled substances, without the providers and pharmacies knowing about the other prescriptions);
    C. Forging or altering a prescription; and
    D. Impersonating a prescriber in order to complete a prescription (i.e., a non-prescriber calling in a prescription to a pharmacy).

3. Patient insurance fraud may also be associated with a patient inappropriately seeking controlled substances when they use someone else's insurance information to obtain treatment or prescriptions, so an insurance claim can be billed for payment.

4. Physician prescription fraud is prescribing controlled substances outside the usual course of the doctor's practice or for a medical purpose that is not legitimate.

5. If you suspect prescription fraud:
    A. Contact the risk management department (during normal business hours or the Administrator-on-Call) immediately.
    B. You will need to provide the name of the patient, date of birth, location of occurrence, a description of the suspicion prompting reporting. It is helpful for law enforcement if you document the following in your medical record as well:
        a. The date the patient stated they last received prescription for controlled substance and which doctor prescribed it.
        b. A copy of the patient's ID card
        c. A copy of the patient's insurance card or information.
        d. A copy of the patient's CURES report.
    C. If you are contacted by a law enforcement investigator who is evaluating potential prescription fraud, contact the risk management department and be cooperative with the investigation.
    D. Contact information: Risk Management Department 831-622-2620. For emergency situations, please call 831-624-5311 and ask for the Administrator on Call to be contacted.

ADDICTION REFERRALS

If you suspect a patient may benefit from referral for addiction services, consider the resources attached.

EDUCATIONAL MATERIALS

See references attached.

REFERENCES

- Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain (Agency Medical Director's Group 2010 Update)
- Guidelines for Opioid Prescription: Why Emergency Physicians Need Support. Annuals of Internal Medicine. 4 June 2013. Volume 158 (11): 841-843.
- Prescribing Opioids: Care Amid Controversy. Recommendations from the California Medical Association's Council on Scientific Affairs. March 2014.
- ACOEM Guidelines for the Chronic us of Opioids.
- The New York City Department of Health and Mental Hygiene. Vol. 30(4): 23-30.