Coping with Opioid Guidelines and Compassionate Care

Laxmaiah Manchikanti, MD


Compassion is to look beyond your own pain, to see the pain of others.
Yasmin Mogahed
quotefancy

Guidelines are like a religion

Her husband died by suicide. She sued his pain doctors — a rare challenge over an opioid dose reduction

By Andrew Joseph Nov. 22, 2021

Reprints

CaSonya Richardson-Slone poses near her home in Odessa, Fla. Richardson-Slone's husband died by suicide in 2017 after being denied pain medication.

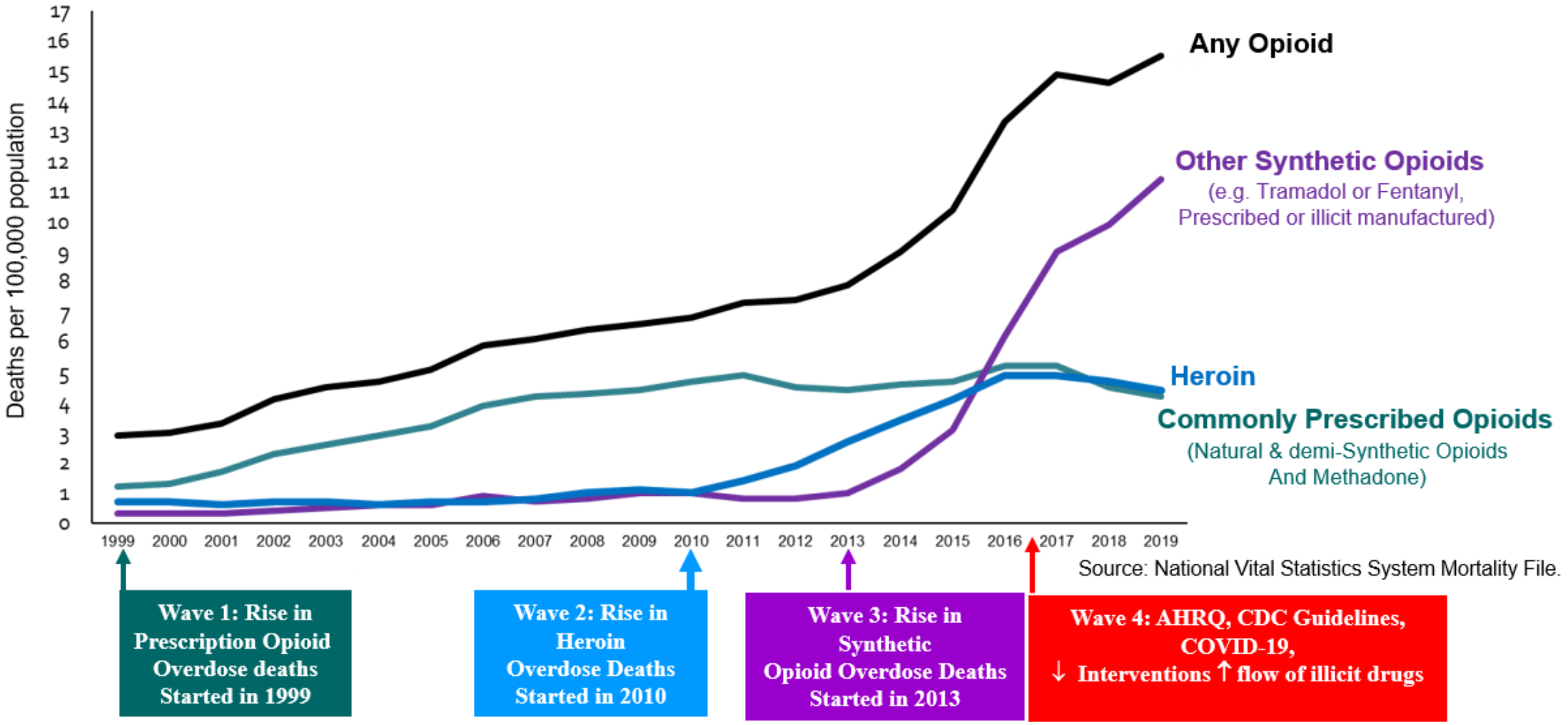
EVE EDELHEIT FOR STAT

For six years, Brent Slone had relied on opioid medication to tame his agonizing pain — and then he ran out. He raced to resolve the hang-up over his prescription. He tracked down old medical records, he called his pain clinic repeatedly, he even showed up at the door. But the final word came down: no refills until an appointment almost a week away.

"they denied script im done love you," Slone, 40, texted his wife on the afternoon of Sept. 12, 2017. He killed himself shortly after.

In an unusual step, his wife then sued the clinic and its physicians — a rare legal challenge to doctors over their decisions to reduce patients' opioid doses.

Four Waves of the Rise in Opioid Overdose Deaths



Redrawn and modified from CDC figure

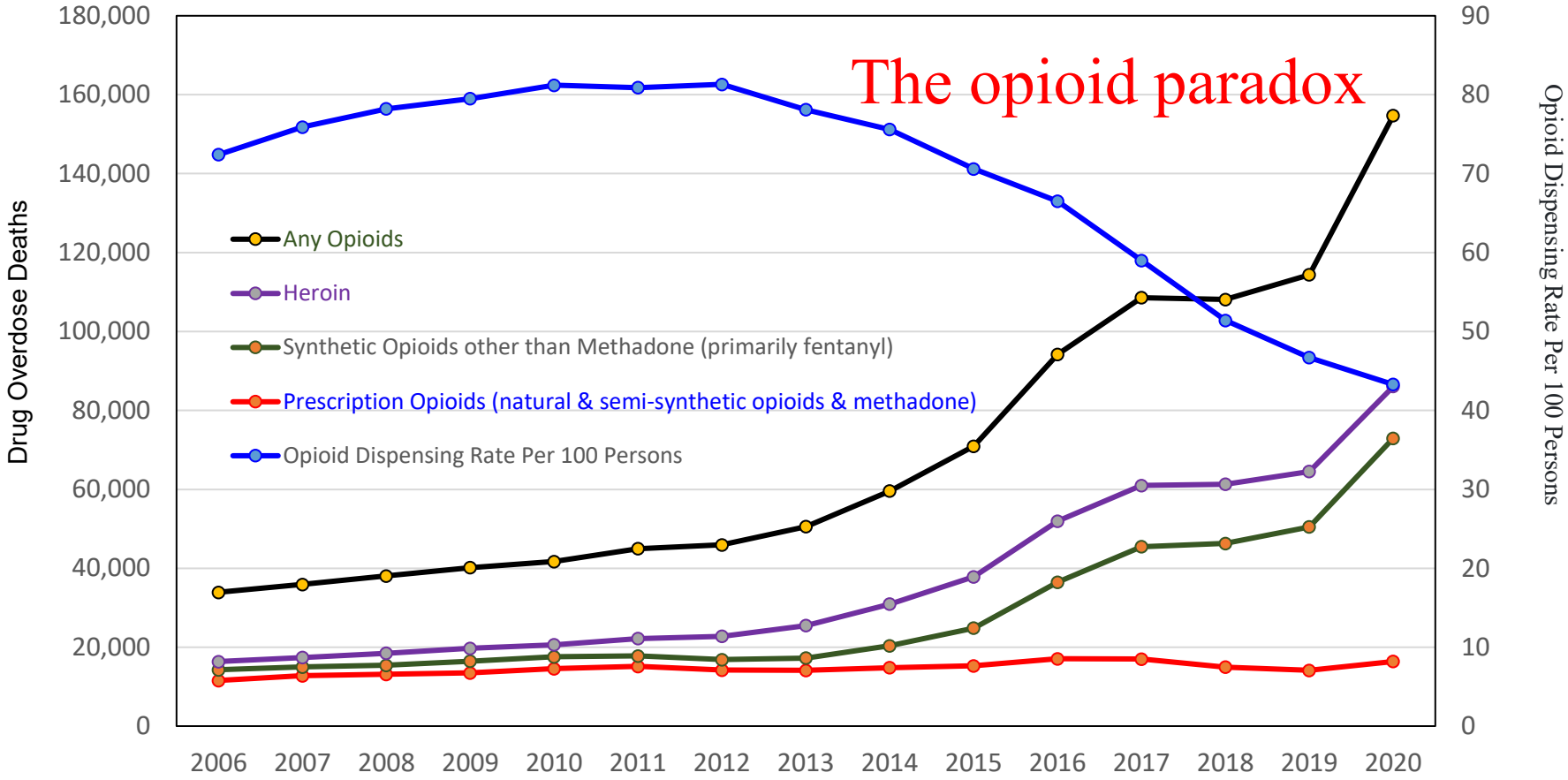
FOURTH WAVE: CAUSES (Illicit Drug Epidemic)

Confluence of multiple factors

- Increasing demand with reduced access to opioids
  - CDC guidelines
    - Application and misapplication
    - Converted into regulations
  - Regulatory atmosphere – tragic failure of systems
  - COVID-19 Pandemic
  - Policies of interventional techniques
- Increased availability of illicit drugs
  - Border policies
  - Cartels

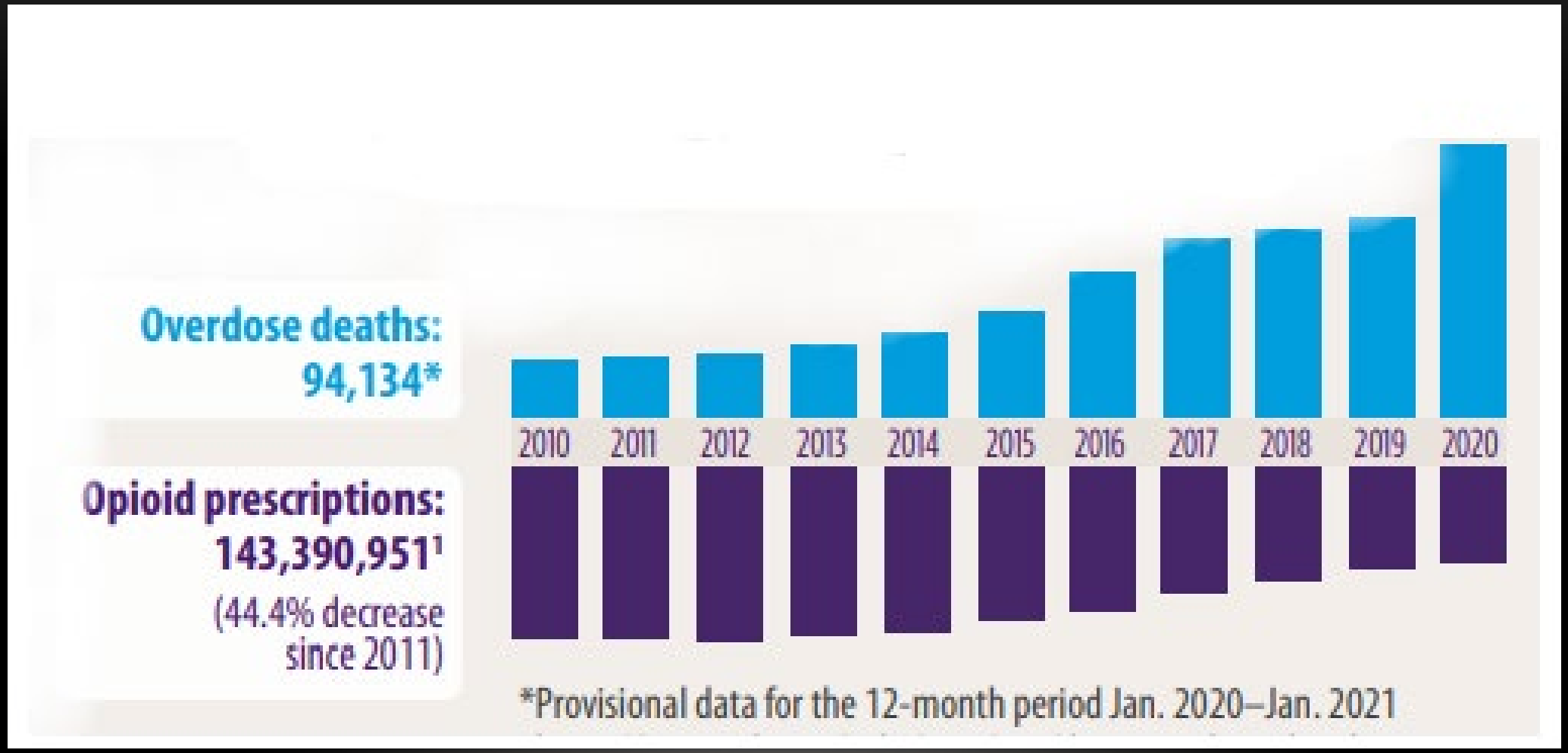
Prescription opioids abuse is least of all problems

Opioid prescriptions are declining while opioid overdose deaths are increasing

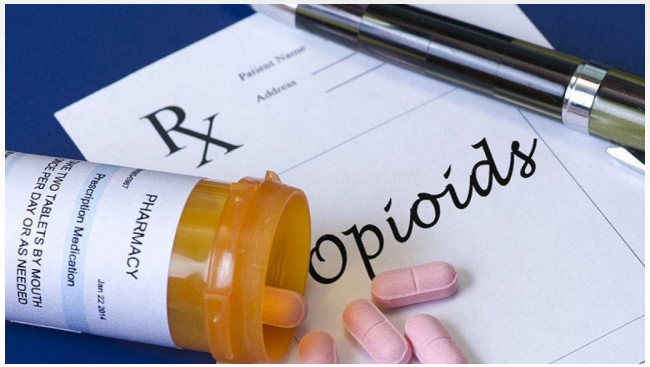


Source: https://www.cdc.gov/nchs/products/databriefs/db428.htm
https://www.cdc.gov/drugoverdose/rxrate-maps/index.html Accessed on 1/25/2022

Reductions in opioid prescribing have not led to reductions in drug-related mortality

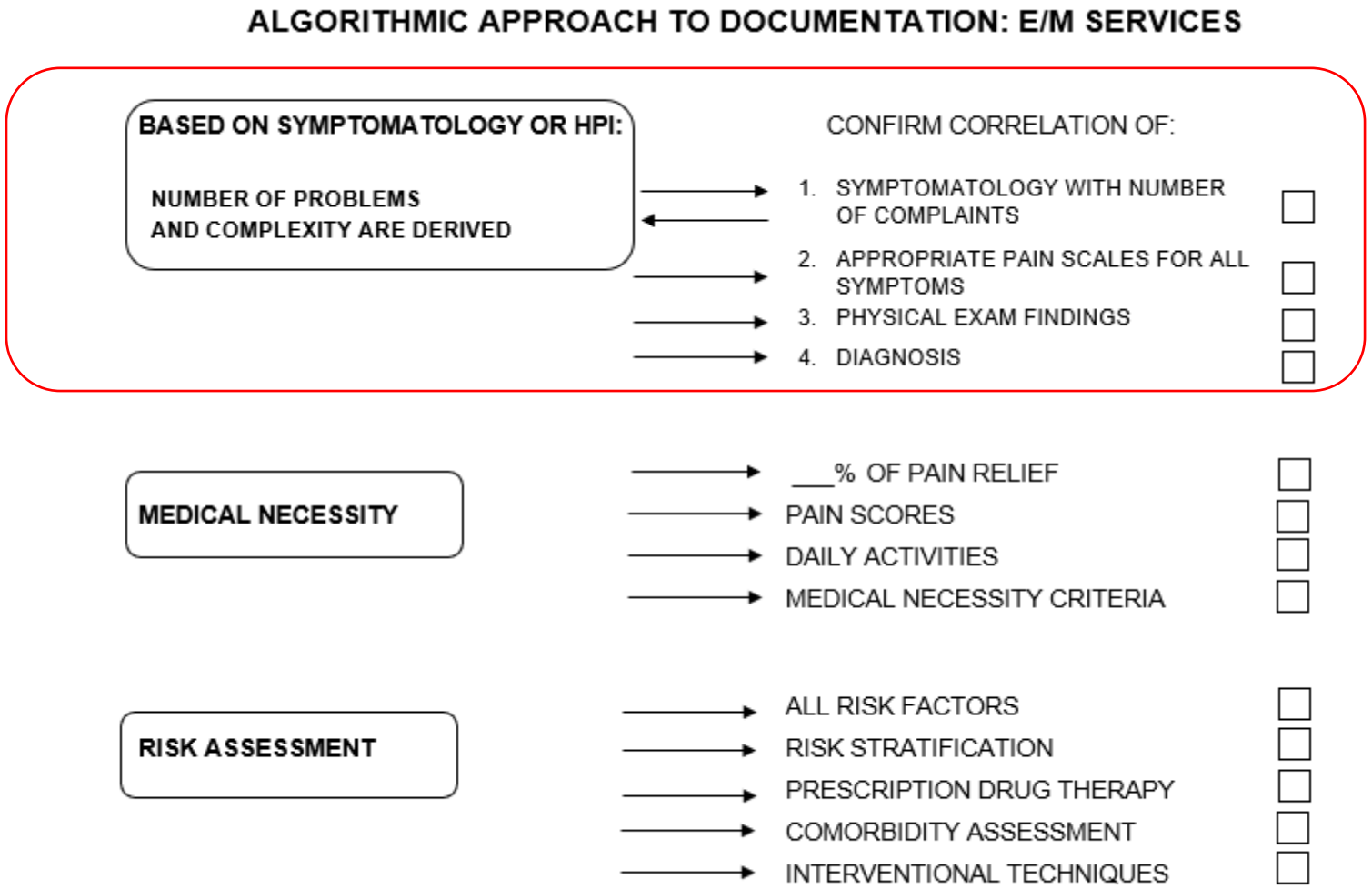


Source: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm



Opioids Prescribing

ALGORITHMIC APPROACH TO DOCUMENTATION: E/M SERVICES



The most significant changes include:

- MDM has always been part of the algorithm for choosing a level of service but will now be the sole determinant of level of service (unless the provider intends to bill based on time).

MDM in 2021 will be based on:

- Number and complexity of problems addressed
  - Including status (*e.g.* uncomplicated, exacerbation) and timeline (*e.g.* acute, chronic)
- Amount and/or complexity of data reviewed and analyzed
  - This category attempts to quantify the amount of data, efforts to gather data, and communications utilized to evaluate a patient. Collection of more data leads to a higher level of MDM.
- Risk of complications and/or morbidity or mortality

Overview of Major E/M Revisions for 2021: Office or Other Outpatient Services Compared to Other E/M Codes

Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use Key Components (History, Examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use Key Component (History, Examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates. *Time is **not** a descriptive component for E/M levels of emergency department services*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

12

LEVEL OF RISK	MANAGEMENT OPTIONS SELECTED

Moderate	• Minor surgery with identified risk factors and interventional techniques
	• Prescription drug management
	  ○ Opioids
	  ○ NSAID's
	  ○ Antiepileptic drugs (AEDs)
	  ○ Benzodiazepines

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury Example: Chronic low back pain - Characteristics etc.	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source; • review of the result(s) of each unique test; • ordering of each unique test **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment** • Exercise program • Physical therapy • NSAID's • Ordering X-Rays • Referral

14

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99204 99214	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury Examples: ○ Chronic Low back pain ○ Chronic neck pain ○ Chronic low back pain with exacerbation or worsening ○ Chronic chest wall pain	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source; - ER, MD • Review of the result(s) of each unique test; - Imaging, UDI • Ordering of each unique test; - MRI, UDI • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management ○ Opioids ○ Adherence mentoring ○ Referral • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health ○ Housing, transportation, income, racism, discrimination etc.

15

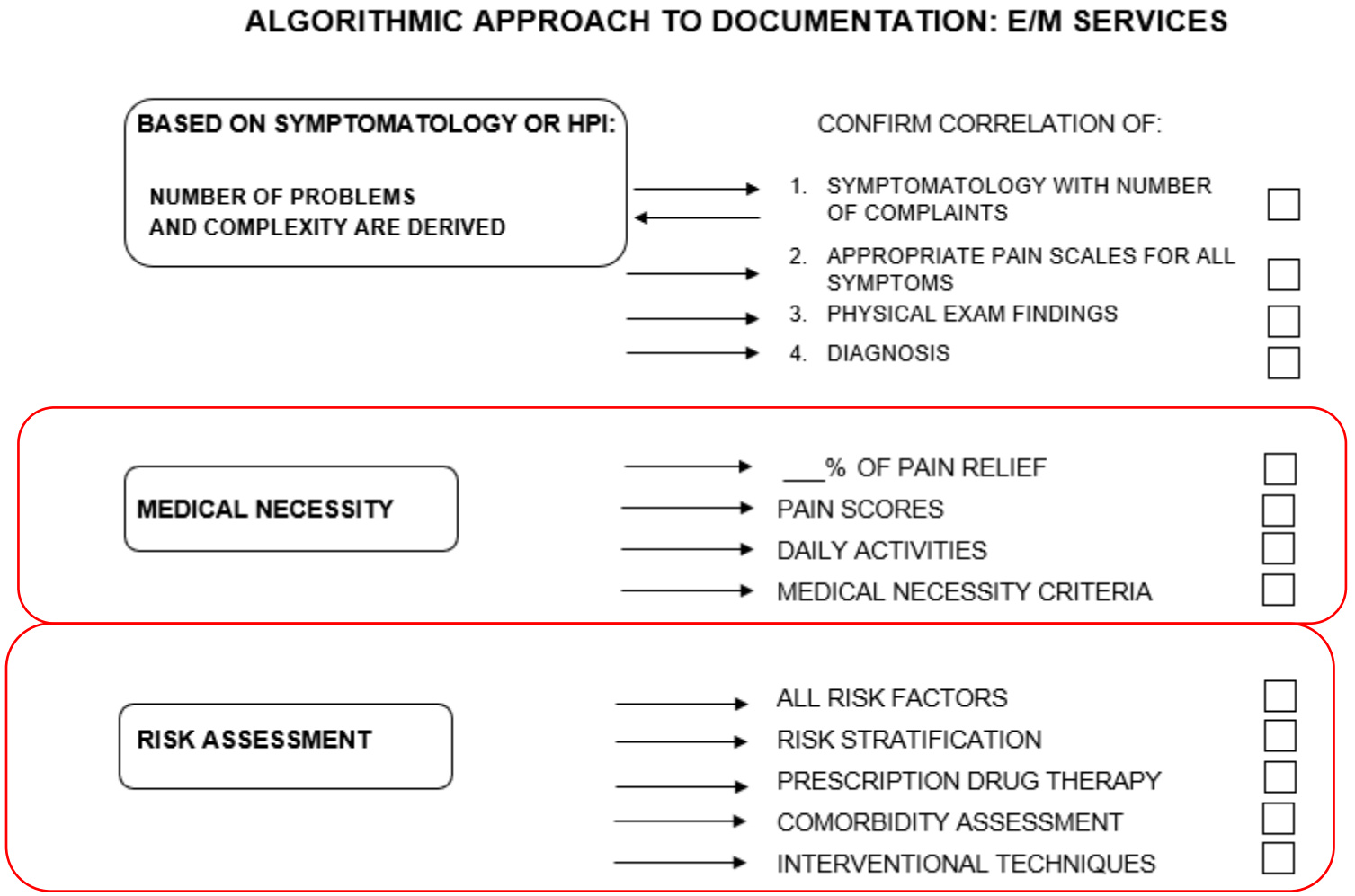
Prescription Drug Management

Please clarify that Prescription Drug Management in the Moderate Row of the MDM chart does NOT include refills or continue current medication(s). It appears from the Q & A this would only include increasing or decreasing a medication or a new medication. Would you please clarify how a refill or continue current medication (without a refill being needed at that visit) would be considered by CGS?

- Only documenting 'reviewed' on the medication list does not support Prescription Drug Management. Prescription drug management includes a dosage increase or decrease (or the addition of a new medication) based upon clear documentation of a problem addressed and data reviewed for patient management. If the provider is addressing a problem that includes continuing a prescription drug (or refill) in their education and medical decision making to manage the diagnosis, then it may be included in Prescription Drug Management.
- The provider may also choose to use qualifying factors of Total Time when choosing the E/M level of service.

Medical Necessity
&
Level of Risk

ALGORITHMIC APPROACH TO DOCUMENTATION: E/M SERVICES



24. **Indications for Opioids and/or Interventional Techniques:**

- ☑ Pain and disability of moderate-to-severe degree
- ☑ Organic problem with physical diagnosis
- ☑ Inadequate response to conservative modalities
- ☑ No contraindications
- ☑ Deterioration without therapy
- ☑ Compliance with exercises
- ☑ Unable to tolerate other modalities
- ☑ Compliant with Opioid Therapy
- ☑ Improvement in pain and function
- ☐ Ability to work
- ☑ Compliance with interventional techniques
- ☐ Unable to afford or accept other modalities
- ☐ _____

25. **Tobacco cessation program** ☐ Current smoker ☐ Non-smoker ☑ Stopped in _____

Patient was advised ☐ Decrease smoking ☑ Quit smoking ☐ Decrease or quit

☐ **Provided Edu. Material** ☐ **Discussed relevant issues**

Risk: I have identified the potential negative consequences of tobacco use:

☑ Cancer ☐ COPD ☑ vascular disease ☐ harm to pregnancy

☑ shortness of breath ☐ impotence ☐ infertility ☑ respiratory infections

☑ **Rewards:** I have discussed in depth potential benefits of stopping tobacco use including:

☐ improved health ☑ food will taste better, improved sense of smell

☐ saving money ☑ feeling psychologically better ☑ improved appearance.

Discussion of concerns with:

☐ a fear of failure, ☐ weight gain, ☐ lack of support, ☐ depression, ☐ withdrawal symptoms at ☐ todays appt. provided additional direction toward quitting/or decreasing their intake of tobacco products.

☐ **Repetition:** I will continue to discuss the list above at future appointments to:

Tobacco cessation program

☐ Unable ☐ Agreed ☑ Participating

☐ Cold turkey ☐ Self cessation ☐ Nicorette gum ☐ Nicotine patch

☐ Wellbutrin ☐ Chantix ☐ Behavioral therapy ☐ Hypnosis

☐ Combination therapy ☐ Staying on track

26. **Weight management program:** ☐ NA ☐ Declined ☐ Unable ☑ Agreed ☐ Participating

☐ Self-cessation by watching what you eat ☑ Low calorie diet ☐ Low carb

☐ High protein and high fiber ☑ Physical Exercise ☐ Drug Therapy

INDICATIONS FOR OPIOIDS AND/OR INTERVENTIONAL TECHNIQUES:

Pain and disability of moderate-to-severe degree

Organic problem with physical diagnosis

Inadequate response to conservative modalities

No contraindications

Deterioration without therapy

Compliance with exercises

Unable to tolerate other modalities

Compliant with Opioid Therapy

Improvement in pain and function

Compliance with interventional techniques

TOBACCO CESSATION PROGRAM:

Patient is a current smoker. I advised the patient to decrease smoking.

I have encouraged the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation, health concerns, age, gender, and other important patient characteristics.

We discussed about various aspects of negative consequences of tobacco use. I have identified the following negative consequences for the patient cancer, chronic obstructive pulmonary disease (COPD), vascular disease, shortness of breath, respiratory infections.

We also discussed about various rewards and benefits of not smoking as follows: improved health, food will taste better, improved sense of smell, feeling psychologically better, improved appearance.

I will continue to discuss the list above at future appointments.

As discussed, patient is already participating in tobacco cessation program: decreased to 1/3 ppd from 3 ppd.

WEIGHT MANAGEMENT PROGRAM:

Patient is agreed to participate weight management program: Low calorie diet, Physical Exercise

27. CONTROLLED SUBSTANCE MANAGEMENT

A. Opioids Intake on Average Since Initial Visit: ☐ Not on opioids

☐ significantly reduced ☐ reduced ☐ no change ☐ increased

Opioids Intake on Since Last Visit: ☐ Not on opioids

☐ significantly reduced ☐ reduced ☑ no change ☐ increased

B. Discussions of Opioids Intake ☐ Not on Opioids

☑ Continuum of care, opioid dosing, and appropriate use of opioids

Side effects: ☐ Constipation ☐ Nausea ☐ Allergy ☐ Drug Interactions

☐ Lack of adequate response

C. Discussions of Non-Compliance & Other Issues of Opioids (If Applicable):

☐ Inappropriate intake of medications ☐ Use of illicit drugs

☐ Obtaining opioids from others ☐ Demand for additional medication

☑ Request for additional medication ☑ Combination of other psychoactives

☐ Discontinue Opioids ☑ Opioid and benzo risks & complications

☐ Due to lack of adequate response

☑ Advised about tapering: ☑ Yes ☐ No Acceptance ☐ Yes ☑ No

☑ Advised about Suboxone: ☑ Yes ☐ No Acceptance ☐ Yes ☑ No

☐ Side effects ☐ _____

D. De-escalation/moderation of opioids: ☐ Suboxone therapy ☐ Weaning

28. Discussion of comorbidities and interactions included the following:

☑ Obesity (insulin-resistance and inflammation)		☑ Chronic opioid therapy (immunosuppression, hormonal deficiencies, dependency, cognitive dysfunction)	
☑ Smoking (effect on metabolism of opioids)		☑ Post traumatic stress disorder	
☐ Sleep apnea syndrome (hypoxia and death)		☑ Benzodiazepines (increasing death rates with opioids)	
☐ Diabetes (inflammation, neuropathy, and metabolic syndrome)		☑ Other psychotherapeutic drugs	
☐ Illicit drug use and their consequences		☑ Depression	☑ Anxiety
☐ Bipolar disorder		☐ ADHD	☐ Schizophrenia
☑ Pulmonary problems	☐ High BP	☐ Low BP	☐ Cardiac Problems
☐ Personality Disorders	☐ _____		

CONTROLLED SUBSTANCE MANAGEMENT

OPIOID INTAKE SINCE LAST VISIT:

The patient opioid intake is not changed since last visit.

DISCUSSIONS OF OPIOIDS INTAKE:

We also had a discussion regarding Continuum of care, opioid dosing and appropriate use of opioids, request for additional medication, combination of other psychoactive drugs.

Advised about tapering and patient acceptance is no.

Advised about Suboxone therapy and patient acceptance is no.

The discussion included risks and potential complications associated with opioids. The risks described included, but were not limited to, drowsiness, sedation, dependence, tolerance, addiction, nausea, and problems with cognition. The patient was informed about the potential interactions of various drugs with alcohol. Adverse effects of these drugs in the elderly, immunosuppressed, hormonally deficient, those suffering with sleep apnea syndrome, on oxygen supplemental therapy, other respiratory disorders, and cardiovascular disorders were explained. Falls and fractures related to opioids were also discussed. Specific discussions in relation to hormonal disturbances and suppression leading to various other issues such as impotence, sexual dysfunction, and fatigue including opioid hyperalgesia were stressed. The discussion also included the dangers of mixing other drugs and alcohol, along with the dangers of operating an automobile while under the influence of these medications. We discussed that the use of any other illicit drugs or medications from others also is not only illegal, but extremely dangerous. Advised to immediately report any type of side effects and present to a hospital emergency room if major problems ensue. The patient expressed understanding and agreement.

DISCUSSION OF COMORBIDITIES AND INTERACTIONS INCLUDED THE FOLLOWING:

Discussed comorbidities and interactions of opioid with smoking (effect on metabolism of opioids), pulmonary problems, chronic opioid therapy (immunosuppression, hormonal deficiencies, dependency, cognitive dysfunction), post-traumatic stress disorder, benzodiazepines (increasing death rates with opioids), other psychotherapeutic drugs, depression, anxiety.

Urine Drug Testing

How Often Should You Perform Adherence Monitoring UDT?

Risk Group	Baseline	Frequency
Low Risk	Prior to Initiation of COT	Random testing 1-2 times every 12 months for prescribed medications, non-prescribed medications that may pose a safety risk if taken with prescribed medications, and illicit substances based on patient history, clinical presentation, and/or community usage.
Moderate Risk	Prior to Initiation of COT	Random testing 1-2 times every 6 months for prescription medications, non-prescribed medication that may pose a safety risk if taken with prescribed medications, and illicit substances, based on patient history, clinical presentation, and/or community usage.
High Risk	Prior to Initiation of COT	Random testing performed 1-3 times every 3 months for prescribed medications, non-prescribed medications that may pose a safety risk if mixed with prescribed and illicit substances based on patient history, clinical presentation and/or community usage.

How Often Should You Perform UDT?

Per Noridian-Note: Any additional definitive UDT beyond recommendations above must be justified by the clinician in the medical record in situations in which changes in prescribed medications may be needed, such as:

- Patient response to prescribed medication suddenly changes
- Patient side effect profile changes
- To assess for possible drug-drug interactions
- Sudden change in patient's medical condition
- Patient admits to use of illicit or non-prescribed controlled substance.

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R)

		Never	Seldom	Sometimes	Often	Very Often
		0	1	2	3	4
1	How often do you have mood swings?	○	○	○	○	○
2	How often do you smoke a cigarette within an hour after you wake up?	○	○	○	○	○
3	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	○	○	○	○	○
4	How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
5	How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
6	How often have you attended an AA or NA meeting?	○	○	○	○	○
7	How often have you taken medication other than the way that it was prescribed?	○	○	○	○	○
8	How often have you been treated for an alcohol or drug problem?	○	○	○	○	○
9	How often have your medications been lost or stolen?	○	○	○	○	○
10	How often have others expressed concern over your use of medication?	○	○	○	○	○
11	How often have you felt a craving for medication?	○	○	○	○	○
12	How often have you been asked to give a urine screen for substance abuse?	○	○	○	○	○
13	How often have you used illegal drugs (for example, marijuana, cocaine, etc.)) in the past five years?	○	○	○	○	○
14	How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○

Please answer the questions as honestly as possible below using the following scale:

0 = Never
1 = Seldom
2 = Sometimes
3 = Often
4 = Very Often

Urine Drug Screen Orders

Consent to Testing and Use of Results: The specimen identified on this form is my own. I have not adulterated it in any way. I am voluntarily submitting this specimen for analysis by my provider to Pain Management Centers of America (PMCA). I authorize PMCA to release the test results to the ordering provider. Financial/Insurance Authorization: I assign my insurance benefits (if any) and authorize any insurance payments to be paid directly to Pain Management Centers of America (PMCA), for the laboratory services ordered by my provider. I authorize my provider and insurance company (if any) to release to PMCA and its agents any information needed to determine insurance benefits for the laboratory services ordered. I consent to PMCA appealing on my behalf any denial of payment by my insurance company (if any) for the laboratory services ordered, and further consent to the release by PMCA my practitioner, or my insurance company (if any), of any medical records or other information necessary for insurance claims processing and any appeal.

Patient Signature: _____ **Date:** _____

SPECIMEN COLLECTION INFORMATION (URINE):

Collector's Name: _____ Date: _____ Time: _____ Specimen Temperature Meets Criteria:

__YES __NO; If NO, Actual Temp (◦F): _____ ***(Read within 4 minutes, acceptable range is 90.5 – 99.8°F)***

PRESUMPTIVE DRUG SCREENING: Reasons for Ordering and Description of Testing Performed

Establish Baseline:_____ Follow-Up/Adherence Monitoring:_____ Follow-Up/Potential Non Compliance:_____

Presumptive drug screening will be performed to provide a qualitative assessment of drugs/drug metabolites present in/absent from this specimen. Definitive drug testing (if applicable) shall be performed (1) in the event of an inconsistent positive/negative presumptive screen result; or (2) for prescribed medications on the laboratory test menu that do not have a presumptive screen test; or (3) at the provider's request.

PATIENT RISK ASSESSMENT: RISK STRATIFICATION EXPLANATION FOR SCORING (Please check the boxes)

□ Smoking (1-4) (2)	□ ADD/ADHD, OCD, Bipolar, Schizophrenia (1-6) (3)	□ PTSD (1-4) (2)	□ Depression (1-4) (2)
□ Anxiety (1-4) (2)	□ Somatization Disorder (3)	□ Rx Drugs from Others (1-4) (2)	□ Sexual Abuse (3-6) (2)
□ More Medication (1-4) (2)	□ High-Dose Opioids >90 (2-4) (2)	□ Benzodiazepine (1-4) (2)	□ Methadone (2-4) (2)
□ Suicidal Attempts (5)	□ Drug Overdose (5)	□ Dealing in Drugs (5)	□ Soma (2-4) (2)
□ Doctor Shopping (2-8) (3)	□ Sleep Apnea Syndrome (2)	□ Fibromyalgia (1)	□ Rx Drugs from Street (5)

RISK STRATIFICATION SCORE: _____ **SOAPP SCORE:** _____ **FINAL SCORE:** _____

(score calculated above) (score copied from SOAPP page) (Risk Stratification + SOAPP)

OVERALL RISK: Very High Risk (≥ 24): _____ High Risk (14-23): _____ Moderate Risk (7-13): _____ Low Risk (< 7): ____

POMI: __ Negative (0 or 1 Yes) __ Positive (2 or more YES

CURRENT PRESCRIBED MEDICATION: (mark/circle medication & write date of last dose) □ NO MEDS

Medications	Date Last Dose	Medications	Date Last Dose	Medications	Date Last Dose
Alprazolam (Xanax)		Hydrocodone (Lortab, Norco, Vicodin)		Oxymorphone (Opana)	
Amitriptyline (Elavil)		Hydromorphone (Dilaudid)		Phenobarbital (Luminal, Primidone)	
Amphetamine (Adderall, Vyvanse)		Lorazepam (Ativan)		Phentermine (Adipex)	
Buprenorphine (Suboxone, Butrans)		Meperidine (Demerol)		Pregabalin (Lyrica)	
Butalbital (Fioricet)		Methadone (Methadose, Dolophine)		Tapentadol (Nucynta)	
Carisoprodol (Soma)		Methylphenidate (Ritalin, Concerta)		Temazepam (Restoril)	
Clonazepam (Klonopin)		Morphine (MSContin, Embeda, Kadian)		Tramadol (Ultram)	
Codeine (Tylenol #3, #4)		Naloxone (Narcan)		Zolpidem (Ambien)	
Cyclobenzaprine (Flexeril)		Naltrexone (Revia, Depade)			
Diazepam (Valium)		Nortriptyline (Pamelor)		Other:	
Fentanyl (Duragesic, Subsys)		Oxazepam (Serax)			
Gabapentin (Neurontin, Gralise, Horizant)		Oxycodone (Oxycontin, Percocet, Xtampza)			

LISTED CODE ARE FOR MEDICARE AND MEDICAID
MAY ADD OTHER CODES FOR OTHER INSURERS

SPINAL

LUMBAR

- ☐ M51.36 Lumbar region, other intervertebral disc degeneration
- ☐ M51.37 Lumbosacral region, other intervertebral disc degeneration
- ☐ M51.16 Lumbar region, intervertebral disc disorders with radiculopathy

CERVICAL

- ☐ M54.2 Cervicalgia
- ☐ M47.812 Cervical region, spondylosis without myelopathy or radiculopathy
- ☐ M47.813 Cervicothoracic region, spondylosis without myelopathy or

THORACIC

THORACIC

- ☐ M51.14 Thoracic region, intervertebral disc disorders with radiculopathy
- ☐ M51.15 Thoracolumbar region, intervertebral disc disorders with

SUBSTANCE ABUSE/PSYCHOLOGICAL/CARDIAC

- ☐ F11.11 Opioid abuse, in remission
- ☐ F11.13 Opioid abuse with withdrawal
- ☐ F11.20 Opioid dependence, uncomplicated
- ☐ F11.23 Opioid dependence with withdrawal
- ☐ F11.288 Opioid dependence with other opioid-induced disorder
- ☐ F12.13 Cannabis abuse with withdrawal
- ☐ F55.8 Abuse of other non-psychoactive substances
- ☐ F19.132 Other psychoactive substance abuse with ithdrawal with perceptual disturbance
- ☐ F19.20 Other psychoactive substance dependence, uncomplicated
- ☐ Z91.19 Patient's noncompliance with other medical treatment and regimen
- ☐ Z79.891 Long-term (current) use of opiate analgesic

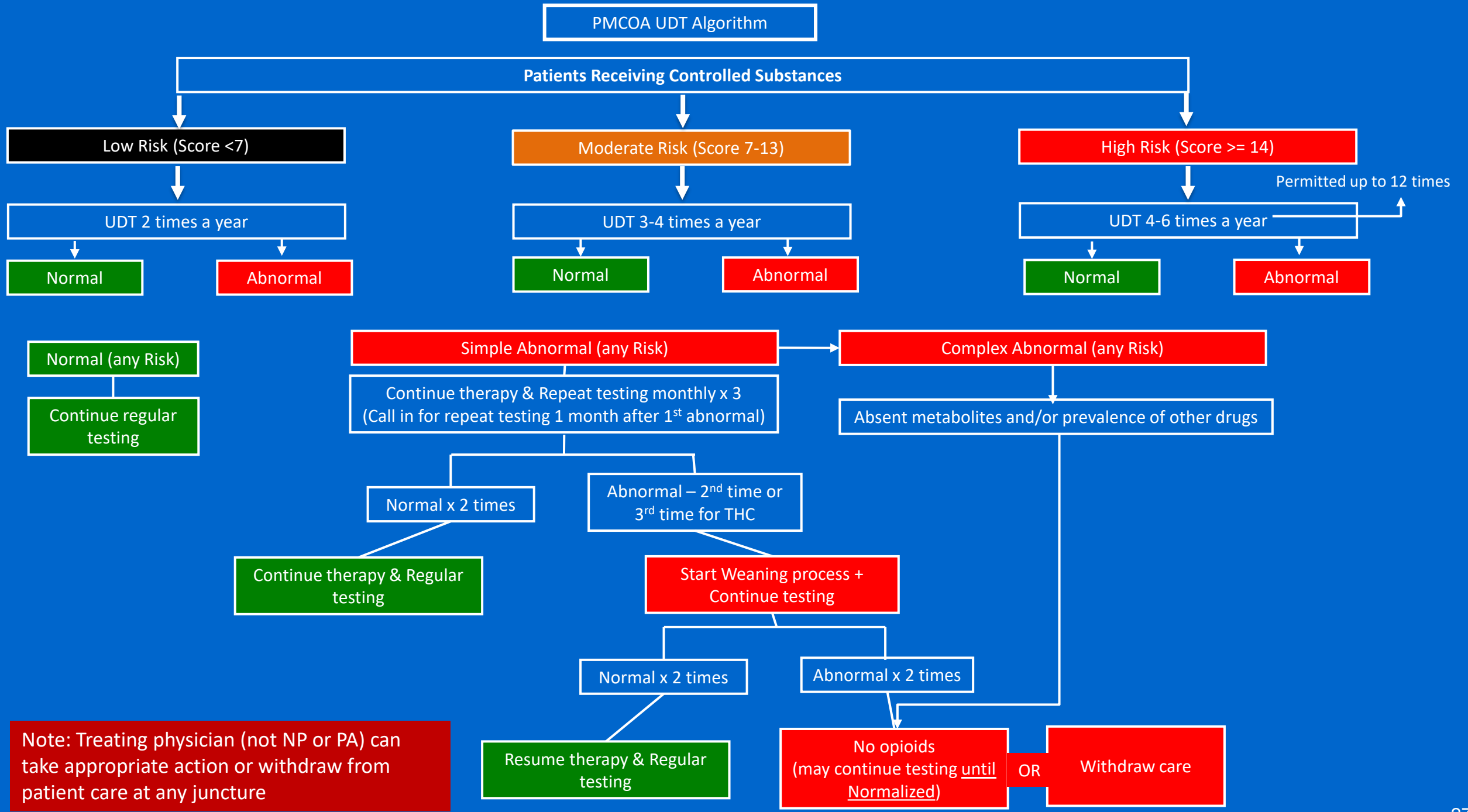
☐ M60.852 Other myositis, left forearm

☐ M60.9 Myositis, unspecified

☐ M47.27 Lumbosacral region, other spondylosis with radiculopathy

☐ M60.821 Other myositis, right upper arm
☐ M60.822 Other myositis, left upper arm
☐ M60.831 Other myositis, right forearm
☐ M60.832 Other myositis, left forearm

☐ M60.872 Other myositis, left ankle and foot
☐ M60.88 Other myositis, other site
☐ M60.89 Other myositis, multiple sites
☐ M60.9 Myositis, unspecified

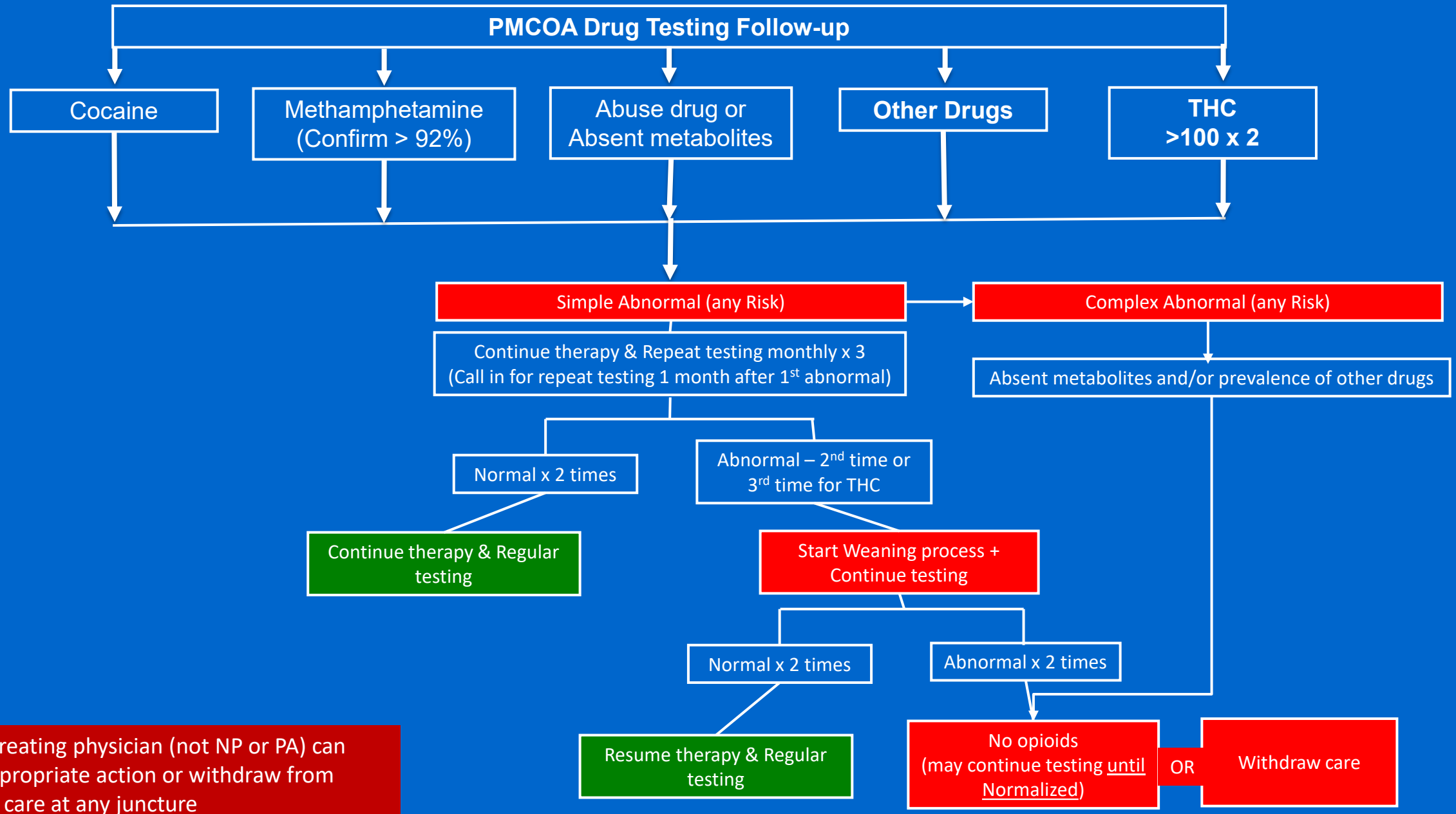

PMCOA UDT Algorithm
Patients Receiving Controlled Substances
Low Risk (Score <7)
Moderate Risk (Score 7-13)
High Risk (Score >= 14)
Permitted up to 12 times
UDT 2 times a year
UDT 3-4 times a year
UDT 4-6 times a year
Normal
Abnormal
Normal
Abnormal
Normal
Abnormal
Normal (any Risk)
Continue regular testing
Simple Abnormal (any Risk)
Complex Abnormal (any Risk)
Continue therapy & Repeat testing monthly x 3
(Call in for repeat testing 1 month after 1st abnormal)
Absent metabolites and/or prevalence of other drugs
Normal x 2 times
Abnormal – 2nd time or
3rd time for THC
Continue therapy & Regular testing
Start Weaning process +
Continue testing
Normal x 2 times
Abnormal x 2 times
Resume therapy & Regular testing
No opioids
(may continue testing until Normalized)
OR
Withdraw care
Note: Treating physician (not NP or PA) can take appropriate action or withdraw from patient care at any juncture

Withdrawal of care
vs
Discharging patient

Weaning or Discharge

Withdrawal of care

Abandonment



Note: Treating physician (not NP or PA) can take appropriate action or withdraw from patient care at any juncture

Pain Management Centers of America

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Management of Abnormal Drug Testing Results without Discharging the Patients:

A patient is on **Percocet 10, TID**. The weaning plan will be as follows:

Percocet 7.5 mg, TID X 1 month
Percocet 5, TID X 1 month
Percocet 5, BID X 1 month
Percocet 5, once daily X 2 weeks
Then STOP

A patient is on **Hydrocodone 10, QID**, the weaning plan will be as follows:

Hydrocodone 7.5 mg, QID X 1 month
Hydrocodone 7.5 mg, TID X 1 month
Hydrocodone 5.0 mg, TID X 1 month
Hydrocodone 5.0 mg, BID X 2 weeks
Hydrocodone 5.0 mg, once daily X 2 weeks
Then STOP

A patient is on **Hydrocodone 7.5 mg, TID**, the weaning plan will be as follows:

Hydrocodone 5.0 mg, TID for 1 month
Hydrocodone 5.0 mg, BID for 1 month
Hydrocodone 5.0 mg, once daily for 2 weeks
Then STOP

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31