

Considerations in treating patients with chronic pain

Russell G. Thornton, JD

Without question, the medical management of chronic pain patients presents primary care practitioners with significant challenges. Often these patients do not improve to the point that they no longer require medication management and other routine medical services (1). These patients also generally take up a disproportionate amount of the practitioner's time at office visits, and they are often uninsured and/or have limited financial means. It is also well publicized that state and federal authorities, primarily the Texas Medical Board (TMB), have made the evaluation of medical treatment of chronic pain a focus of their policing authority (2). Unfortunately, the current form-over-substance approach of the TMB and other regulatory agencies may be a major reason for primary practitioners' flight from seeing chronic pain patients. In spite of the fact that TMB rules specifically provide that the substance of a practitioner's actions should trump the rules' documentation (form) requirements (3), this directive is frequently not followed by the TMB when evaluating medical treatment of chronic pain patients. Against these disincentives to handle chronic pain patients are sentiments that chronic pain is frequently undertreated and/or inadequately managed (4).

These circumstances place primary care practitioners in a difficult and unenviable situation. Primary care providers are frequently the only health care provider a patient wants to see or can afford to see. Thus, primary providers are often a chronic pain patient's only hope. Most providers have a true desire to help these patients, but many times this desire is outweighed by the disincentives mentioned above.

These circumstances have appeared to stratify primary care practitioners into three classes. The first is a small class of practitioners who have decided to fight for these patients. The second is a class of practitioners who want to do the right thing but are understandably intimidated by entities like the TMB and are not sure what to do. Those in the third group have decided that these patients are simply not worth the practical and regulatory headaches. The primary aim here is to provide some pointers to the second and third classes of providers so these patients will not become orphans, and to provide some insight to help protect the first class of providers.

TEXAS MEDICAL BOARD RULES

The first thing any provider who treats a chronic pain patient needs to do is to spend about 20 to 30 minutes reading the TMB guidelines on pain management ("guidelines") (5). These guidelines cover only 4 pages, so 20 to 30 minutes is probably much more than one would need to digest this information. These guidelines are easily accessible through the TMB's website at <http://www.tmb.state.tx.us/rules/rules.php>.

There are several key points to take away from the guidelines. First and foremost, chronic pain treatment must be based on "sound clinical judgment" (6). The guidelines provide that sound clinical judgment "results from evidence-based medicine and/or the use of generally accepted standards of care" (6). This directive is the most problematic for practitioners in TMB proceedings because "generally accepted standards of care" is an extremely subjective and nonspecific concept. Like beauty, what is a generally accepted standard of care is in the eye of the beholder. This difficult situation is even further complicated by the fact that in TMB proceedings, the experts retained by the TMB to review cases often do a pretty shoddy job of reviewing the relevant records and information provided. In my experience, TMB expert reviewers almost routinely level at least one criticism (and oftentimes more) that is directly refuted by objective data in the materials provided.

The guidelines do provide some very explicit statements that support those who endeavor to treat chronic pain. These statements include:

- "Patients deserve to have medical treatment for their pain, whether the pain is acute, or chronic, mild or severe" (7).
- "Drugs, including opiates, are essential tools for the treatment of pain" (8).
- "Physicians should not fear board action if they provide proper pain treatment. The board will not look solely at the quantity or duration of therapy" (9).

In addition to these background principles, the guidelines provide some specific benchmarks that are used to assess a practitioner's treatment of chronic pain (10). These benchmarks

From Stinnett Thiebaud & Remington LLP, Dallas, Texas.

Corresponding author: Russell G. Thornton, JD, Stinnett Thiebaud & Remington LLP, 4800 Fountain Place, 1445 Ross Avenue, Dallas, Texas 75202 (e-mail: rthornton@strlaw.net).

include the initial and follow-up evaluation of the patient, the need for a treatment plan, documentation of informed consent related to the treatment provided, and periodic review of the treatment plan. The guidelines also speak of a formal chronic pain agreement and consultations and referrals.

On first blush, these guidelines might seem burdensome. The fact of the matter, however, is that the information required by the guidelines is already routinely obtained and considered by providers. The issue is just a matter of realizing what is important under this unique circumstance and having your documentation set you up for success rather than failure.

The thing to keep in mind here is your likely audience. That audience will likely be a licensing board that is skeptical towards chronic pain and that tends to look at form over substance. Another unfortunate reality is the fact that the “experts” utilized by the TMB to review such matters appear to search for problems. Reviewers do not seem focused on an objective evaluation of the circumstances or really looking to see if the patient’s treatment is justified. The TMB’s expert reviewers appear to look for “holes” in the documentation. If a hole exists, a violation of the standard of care is dogmatically asserted, despite the fact that a considered review of the pertinent materials would reasonably support the treatment provided. This failure to approach the review in an impartial and objective manner unfairly places the practitioner at a disadvantage from the outset and places even more emphasis on documentation.

More often than not, providers who are criticized for their management of a patient’s chronic pain actually provided reasonable treatment. The problem is that they failed to adequately document the reasons for their actions, or lack thereof. Providers are most frequently criticized for not having a “treatment plan” and for not having shown that the use of narcotic medications was “therapeutic,” meaning that it was of benefit to the patient. With these thoughts in mind, here are some suggestions on how to adequately, validly, and quickly provide some of the key documentation that will help you in the event your actions are later reviewed.

MANAGING THE GUIDELINES

I would like to primarily focus on two guideline requirements: the initial patient history requirement and the treatment plan requirement.

The guidelines require the initial patient history to include the (a) nature and intensity of pain, (b) current and past treatments, (c) underlying and/or comorbid conditions, (d) effect of chronic pain on the patient, (e) history or concerns about substance abuse, and (f) indications for use of a narcotic or similar scheduled medication (11). Candidly, this is not a burdensome requirement. Any decent initial history should pretty much cover these areas. The thing here is to appreciate the information that will really help if your actions are later reviewed. The “current and past treatments” and “effect of chronic pain treatment on the patient” history requirements merit particular attention.

Complete documentation of the patient’s current and past treatments is important because it allows the practitioner to set

the framework through which his treatment plan and subsequent actions should be evaluated. For example, documentation that the patient has had prior extensive evaluation and workup (including documentation of the specifics of that prior evaluation and workup) should raise the threshold at which consultation and referral for other treatment options are needed and provide justification from the outset for a plan that may simply involve long-term medication use. In contrast, if the patient has no prior evaluation or workup, the burden falls on the practitioner to diagnose the underlying cause of the patient’s pain, and the threshold for recommending consultation and referral regarding the existence of definitive therapy is very low.

Complete documentation of the effects of chronic pain on the patient is another area that provides the practitioner a significant benefit if his or her conduct is reviewed in the future. By thoroughly documenting how chronic pain is adversely affecting the patient, the practitioner has from the outset many avenues through which to substantiate the benefit of his or her treatment of this patient’s chronic pain.

The most frequent omission I see in chronic pain patient records is documentation of how the pain affects the patient. Without question, the burden of chronic pain is not limited to the fact that the patient must deal with constant pain. Chronic pain not only hurts patients, it prevents them from functioning; that is to say, they cannot do things they need or want to do. Chronic pain more often than not interferes with sleep, prevents any significant physical exercise, and adversely impacts the patient’s ability to work and earn a living. These things, in turn, adversely affect the patient’s general health, mood, and personal relationships.

Effective documentation does not take much of an effort. It is simply a matter of adding a little bit more information. Something along these lines should be more than adequate and quite effective:

Mrs. Smith presents 15-month history of constant, severe localized pain in her lower back. She has been previously evaluated and found to have early degenerative changes in her lumbar spine. Surgery is an option, but the patient is concerned that it will not relieve her pain. She relates that this pain prevents her from standing at work and from any physical activity. Over the past 15 months she has gained 25 pounds and is worried about her hypertension getting worse. She also relates that her husband complains she is constantly irritable and never wants to do any of the activities they used to enjoy together.

With this backdrop, the practitioner is now able to justify initial treatment with medication and is set up to show the reasonable and beneficial effect of that treatment at future visits. This initial history provides the practitioner the ability to show therapeutic benefit in multiple ways. Benefit can be shown through (a) something less than constant pain, (b) something less than severe pain, (c) the ability to work, (d) the ability to participate in physical activity, (e) weight loss, (f) improved or stable blood pressure because of activity and/or weight loss, (g) improved mood, and/or (h) improved interpersonal relationships.

If one documents a thorough pain impact baseline from the outset, it is much easier to quickly document on future visits how treatment is beneficial, i.e., that it is therapeutic. The key thing to remember and to document initially is how that pain adversely affects the patient on a day-to-day basis. Then, on future visits, the practitioner can document how treatment has helped the patient improve on any elements of that initial baseline.

Along with the failure to document the effect of chronic pain and the impact of subsequent treatment, the most frequent deficiency seen is absence of the required “treatment plan” (12). While reason would dictate that it is intuitive—the “plan” is to treat the patient’s pain with medication and allow improvement of the impact the pain has on other areas of the patient’s life—keep your audience in mind. The TMB and its reviewers are looking to see if this box can be checked off. If not, you will be criticized. Again, effective documentation does not need to be extensive. For example, a sufficient plan might be:

Lortab 5/325 t.i.d. #90 for Mrs. Smith’s back pain. Mrs. Smith does not want to consider surgery at this time. Mrs. Smith to return in 4 weeks for reevaluation.

Particularly, when tailored to a well-documented history, this should be an adequate “initial” treatment plan. The adequacy of this treatment plan in the future will depend on the patient’s history (i.e., whether the patient has had prior diagnostic studies and/or previously been evaluated for definitive treatment) and response to treatment. Keep in mind that your records must reflect “periodic review” of the treatment plan (13). On follow up, remember to focus on how the patient is progressing towards the treatment objectives, i.e., the baseline pain problems (14). If improvement from baseline continues or is maintained, one is hard-pressed to claim treatment was not therapeutic or that the plan needs to be changed. This goes back to and emphasizes the “effect of chronic pain” issue discussed above, since that information provides the reasons why this patient’s chronic pain merits treatment with medications, as opposed to some other “plan.”

The guidelines’ requirement for consultations and referrals is pretty subjective. The guidelines state that consultations and referrals should be obtained “as necessary” (15). The guidelines also state that if you are dealing with a patient who has a history of substance abuse or a comorbid psychiatric disorder, consultation and referral “should be considered” (15). Here again, the initial history is the key to meeting this requirement. In the event the patient has been previously tested and evaluated, and this is documented in the initial history, the necessity for consultation and referral should be relatively remote. If the patient has not had any prior testing or evaluation, consultation and referral might be more of a necessity.

When referrals and consultations are made, it is also important to document the patient’s response to these recommendations, especially when they are not accepted by the patient. It is not unusual for a patient to decline the recommendation for a consultation or referral. There are justified and reasonable bases for declining these recommendations.

One justified reason is the inability to pay for further evaluation and consultation. The fact of the matter is that a significant increase in patient cost is associated with evaluation and treatment of various conditions that cause chronic pain. Computed tomography, magnetic resonance imaging, and other diagnostic studies are quite expensive, and the facilities that provide these services often demand a significant amount of money up front, even from patients who are well insured. In addition, pain management and other specialists charge quite a bit more for office visits than primary providers.

Another justified reason for declining “definitive” treatment is that the patient does not want to run the risk that such treatment is unsuccessful. For example, the patient may have previously had a bad surgical experience. In fact, I can recall a specific instance in which the patient had multiple sources for her chronic pain, including chronic back pain and chronic pelvic pain. The patient had elected surgery in an effort to treat her pelvic pain, but the outcome was not very beneficial. Given that experience, the patient understandably had no desire to undergo back surgery for the treatment of her back pain.

Whatever the reason, the key is to document why the patient declined other options, so that your decision to continue to treat the patient medically is justified and reasonable. Absent documentation of a reason why the recommendation was not followed, a provider runs the risk that the “plan” is perceived as being nothing more than pushing drugs.

CONSIDERATIONS OUTSIDE OF THE GUIDELINES

The guidelines do not require written chronic pain agreements (16) but state only that a provider “should consider” use of such agreements as is reasonable under the circumstances (16). Primary care organizations, however, now appear to favor the use of pain treatment agreements (17). Thus, while the guidelines do not require the use of written agreements, it is probably in your best interest to have such an agreement with each of your chronic pain patients. Form agreements are available and easily accessible on the internet (18).

While not required by the guidelines, it is also probably a good idea to make (and document) efforts to either (a) wean patients down/off of narcotic pain medications and/or (b) control their pain with nonnarcotic pain medications. These efforts are of particular importance when definitive treatment options are available to the patient, but the patient elects, for whatever reason, to not pursue those options. Absent these efforts, you again run the risk that your treatment plan will be prejudicially viewed as nothing more than billing the patient for office visits so that he or she can get medications.

CONCLUSION

There are four key points to document when treating chronic pain patients: (a) their prior treatment history, (b) all facets of how their pain adversely affects them, (c) the reasons a medical management plan is reasonable, and (d) subsequently how that medical management plan helps the patient. The extra time and effort spent up front should make subsequent documentation easier because you already have a

baseline from which it is easy to judge and document how the patient is responding to therapy, whether or not the plan is benefiting the patient, and whether further consultation or referral is needed.

The irony about the use of medications to manage chronic pain is that this therapy is perceived to be and treated differently than other situations in which a legitimate medical condition is treated with long-term medication management. The reality is, however, that there is really nothing different about using medications long term for pain management than there is for using medications long term for the treatment of other chronic medical conditions like diabetes, hyperlipidemia, and hypertension. Medications used for treatment of these conditions all have significant potential side effects, including end-organ damage and death, just as with narcotics.

The sad thing about the situation with chronic pain patients is that regulatory bodies like the TMB place an undue burden on them, in contrast to other patients with chronic medical conditions. It is a sad fact that for many patients with diabetes, hyperlipidemia, and hypertension, those conditions are self-inflicted. It is also a fact that the definitive treatment for these conditions is often something less risky than medications or surgery: i.e., diet and exercise. These patients, and their providers, however, are not asked to forgo medication management because definitive and/or other less risky options exist.

In contrast, a patient's chronic pain is generally not self-inflicted. It is often the result of an on-the-job injury or motor vehicle accident. Further, definitive treatment, i.e., surgery, often has significant risks and may not resolve the patient's chronic pain. Why is it that these patients must forgo medications for a risky treatment that may not work? Something seems wrong here.

1. Marcus DA. Treatment of nonmalignant chronic pain. *Am Fam Physician* 2000;61(5):1331–1338, 1345–1346.
2. See, e.g., Texas Medical Board. Board suspends Victoria physician, two Houston pain clinics [press release]. Austin, TX: Texas Medical Board, April 28, 2011. Available at <http://www.tmb.state.tx.us/news/press/2011/042811.php>; accessed May 16, 2011. Texas Medical Board. Medical Board suspends four pain clinics in Houston, Highlands [press release]. Austin, TX: Texas Medical Board, February 22, 2011. Available at <http://www.tmb.state.tx.us/news/press/2011/022211b.php>; accessed May 16, 2011.
3. Texas Administrative Code [TAC], Title 22, Part 9, §170.3(b).
4. Haddox JD, Joranson D, Angarola RT, Brady A, Carr DB, Blonsky ER, Burchiel K, Gitlin M, Midcap M, Payne R, Simon D, Vasudevan S, Wilson P. *The Use of Opioids for the Treatment of Chronic Pain. A Consensus Statement from the American Academy of Pain Medicine and the American Pain Society*, 1996. Available at <http://www.ampainsoc.org/advocacy/opioids.htm>; accessed May 16, 2011.
5. TAC, Title 22, Part 9, §§170.1–170.3.
6. TAC, Title 22, Part 9, §170.1(4).
7. TAC, Title 22, Part 9, §170.1(1).
8. TAC, Title 22, Part 9, §170.1(2).
9. TAC, Title 22, Part 9, §170.1(5).
10. TAC, Title 22, Part 9, §170.3(a).
11. TAC, Title 22, Part 9, §170.3(a)(1)(B).
12. TAC, Title 22, Part 9, §170.3(a)(2).
13. TAC, Title 22, Part 9, §170.3(a)(5).
14. TAC, Title 22, Part 9, §170.3(a)(5)(B).
15. TAC, Title 22, Part 9, §170.3(a)(6).
16. TAC, Title 22, Part 9, §170.3(a)(4).
17. See, e.g., Hariharan J, Lamb GC, Neuner JM. Long-term opioid contract use for chronic pain management in primary care practice. A five year experience. *J Gen Intern Med* 2007;22(4):485–490. Teichman PG. Improving patient care: a tool for safely treating chronic pain. *Fam Pract Manag* 2001;8(10):47–49.
18. See <http://www.webmd.com/pain-management/guide/pain-management-pain-treatment-agreement>; <http://www.texmed.org> (type in pain agreement under the search).