

Contra Costa Health Plan

Utilization Management.

Title: Coordinating Chronic Pain Management Care

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Author: Chris Cammisa, MD, Medical Consultant

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Author: Chris Cammisa, MD, Medical Consultant and Florence Chan, RN, UM Director

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Reviewed: Lynn Soloway RN, Auth & UM Director

Reviewed 4/12/2021, 6/2021, 5/20/2022

Reviewed: Dennis Hsieh, MD, JD, CMO

Reviewed 9/2023

Reviewed: Dr. Irene Lo, MD, FACS, CMO

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Reviewed: Jill Perez, RN, UM Director

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Applies to:

Medi-Cal

Medicare

Commercial

BHC

State Sponsored

All N/A

Regulatory/Accreditation:

DMHS:

HCFA:

DHS:

Other Reg. References:

NCQA:

N/A

Units:

Administration

Advice Nurses

All Staff

Business Services

Case Management

Health Ed/Cultural Ling.

Marketing

Member Services

Planning, Survey, Reg Affairs

Provider Affairs

Quality Management

Auth/Utilization Management

POLICY

Contra Costa Health Plan (CCHP) follows product line specific, evidence-based guidelines or adopts guidelines established by nationally recognized organizations in the decision-making process as described in policy [UM15.002- Utilization Review Criteria and Guidelines](#). The Health Plan utilizes [Apollo Medical Review Criteria Guidelines for Managing Care, Pain Evaluation and Management, Chronic/Persistent Pain; Management, and Pain Management Resources- Overview](#) for pain management care. Decisions are based on appropriateness of care and service and the member's existing coverage.

Guidelines are available to providers and members. Please refer to policy [UM 15.030- Disclosure of Utilization Management Criteria and Guidelines](#) for details.

PURPOSE

The purpose of this guideline is to improve coordination of care for CCHP members with chronic pain by clarifying the roles and responsibilities of primary care practitioners (PCPs) and specialists who care for members with chronic pain. The guideline is designed to assist primary care practitioners make appropriate use of pain management specialists and to facilitate coordination between providers.

PROCEDURE

I. INITIAL REFERRAL to Pain Management and PCP Responsibilities

The PCP is responsible for coordinating all services required by the member except when precipitous circumstances preclude the PCP's participation. 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. CCHP recognizes that differences in expertise exist among PCPs and that this document serves as a general guideline to define the scope of services and the indications for referral to a pain management specialist/pain management center (PMS/PMC). When care by a specialist is required, it is the **shared responsibility** of the PCP and the specialist to coordinate all services.

A. The PCP **is** responsible for providing the following basic pain management services:

1. Assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. In addition, the PCP should assess for depression, anxiety, and secondary gain such as compensation issues along with possible alcohol or substance abuse 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, and a specific diagnosis should be made if possible. When indicated, the PCP should assess for pain related to work for work injuries and ask about the relation to accidents or legal issues.
2. Perform a thorough physical exam as clinically indicated.
3. Distinguish between physiologic dependence or tolerance and addiction. A pain management agreement is an important part of the scope of pain management. The PCP should consider a pain management agreement for all chronic pain members whom they are following and to perform routine regular urine toxicology screening for members treated with chronic opioid therapy for non-cancer pain.

Based on the American Academy of Pain Medicine (AAPM) \, the guidelines for prescribing opioids should be an extension of the basic principles of good professional practice and include:

- i. **Evaluation of the patient:**
 - a. Evaluation should initially include a pain history and assessment of the impact of pain on the patient, a directed physical examination, a review of previous diagnostic studies, a review of previous treatments, a drug history, and an assessment of coexisting diseases or conditions.
 - b. When appropriate, the patient should undergo a baseline drug screening exam.
- ii. **Developing a treatment plan:**
 - a. Treatment planning should be tailored to both the individual and the presenting problem. Consideration should be given to different treatment modalities, such as an interventional approach, a formal pain rehabilitation program, the use of physical medicine and psychological and behavioral strategies, or the use of medications, depending upon the physical and psychosocial impairment related to the pain.
 - b. Opioids should be prescribed only if the physician reasonably concludes that other treatment modalities will be inadequate to address the patient's pain.
 - c. If a trial of opioids is selected, the physician should ensure that the patient or the patient's guardian is informed of the risks and benefits of COT and the conditions under which opioids will be prescribed.

- d. Continued use will be contingent upon demonstrated improvement in analgesia, physical function and quality of life – and absence of significant adverse events and maladaptive behaviors.
 - iii. Obtaining consultations as needed:
 - a. Consultation with a Pain Medicine or other specialist may be warranted, depending on the expertise of the practitioner and the complexity of the presenting problem.
 - iv. Performing periodic review of treatment efficacy
 - a. Review of treatment efficacy should occur frequently to assess the functional status of the patient, continued analgesia, adverse effects, quality of life, and indications of medication misuse.
 - b. Monitoring of compliance is a critical aspect of chronic opioid prescribing, using such tools as random urine drug screening, pill counts, and where available, review of prescription monitoring data base reports.
 - c. Close follow-up and reexamination is warranted to assess the nature of the pain complaint and to ensure that opioid therapy is still indicated.
 - Attention should be given to the possibility of a decrease in global function or quality of life as a result of opioid use.
 - v. Documentation:
 - a. Documentation is essential for supporting the evaluation, the reason for opioid prescribing, the overall pain management treatment plan, any consultations received, and periodic review of the status of the patient
4. Prescribe appropriate analgesics when indicated for the initial management of chronic pain including acetaminophen, NSAIDs, and opioids.
 5. When appropriate, consider pain modulating agents, such as tricyclic antidepressants (amitriptyline and nortriptyline), and anticonvulsants (gabapentin and carbamazepine).
 6. Refer the member to a pain management specialist/program/clinic when clinically appropriate. Members should not be referred to a chronic pain clinic until a specific diagnosis has been made and treatable underlying causes have been evaluated thoroughly by the PCP and specialists other than pain management specialists. All psychiatric illnesses should be actively treated. Any illegal drug usage should be identified, documented and addressed.
 7. When a pain management consultation is requested and deemed medically appropriate, send all relevant clinical information to the specialist.
 8. The PCP should consider referring a member with a complex pain syndrome as indicated below in I (E).

Please note, prior to referring the member for a pain management consultation, the PCP is responsible for either completing the pain management specialty evaluation form (Attachment A) in ccLink or the ccLink Provider Portal or the requesting provider may provide the necessary information to Health Plan staff in lieu of completing this form.

B. CCHP utilizes Apollo's Pain Management guidelines as noted in "POLICY" section, above. Pain management services include a) medications, b) interventional techniques such as epidural injections of spinal cord stimulators, c) behavioral methods, d) physical treatments, such as physical therapy, acupuncture or chiropractic. The guidelines states that a referral to interventional pain management services management program or clinic may be covered for severe persistent disabling 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 (such as evidence-based nonpharmacological therapies).

Pain management services include

- a) medications,*
- b) interventional techniques such as epidural injections or spinal cord stimulators,*
- c) behavioral methods,*
- d) physical treatments, such as physical therapy, acupuncture or chiropractic.*

C. For members who have been referred to and evaluated by pain management or other specialist, the PCP should participate in the ongoing needs of the member unrelated to the specialty care services.

D. In collaboration with the pain specialist, the PCP should determine transitional and follow-up care for members who have reached clinical stability.

E. A referral to Pain Management may be considered appropriate in the following conditions:

- 9. Complex pain syndrome where the diagnosis is unclear OR the condition is unresponsive to ***active management by the primary physician and/or other specialists***
- 10. Complex pain syndrome compromised by severe functional impairment.
- 11. Complex pain syndrome complicated by a mental health condition or substance abuse problem unresponsive to usual therapy and referral to an appropriate Behavioral Health Specialist.
- 12. For procedures performed by pain management specialists, such as epidural injections, for conditions likely to respond to the procedure.
- 13. Evaluation of axial pain without evidence of radiculopathy prior to a surgical evaluation.

B. Other specialty 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. Other specialty care may include, but are not limited to, neurology, orthopedics, rheumatology, physical medicine, rehabilitation and/or behavioral health.

II. INDICATIONS for Ongoing Pain Management Services

Ongoing pain management services with a Pain Management Specialist or at a Pain Management Center (PMS/PMC) may be approved as individual follow up visit(s) or in 6-month increments case rate when ALL of the following are met:

A. The member is receiving interventional pain management services such as epidural

injections or complex pain medication titration or conversion to formulary opioids not usually performed by a PCP.

- B. The member is in active treatment or where the patient’s condition is unstable or medication regimen is being titrated by the specialist.
- C. The goal(s) of the PMS/PMC services have been clearly defined AND the member is making progress toward the goals but has not yet achieved the goals.
- D. The member is actively participating and adherent to the pain management program.
- E. The member does not have a condition that would exclude participation in PMS/PMC program such as a severe psychiatric disorder or a chemical dependency disorder.
- F. The PMS/PMC is routinely submitting progress reports to the member’s PCP.

III. EXCLUSION From or Discontinuation of PMS/PMC Services

Pain Management services are not available or may be discontinued when:

- A. The services do not meet all the guidelines in Section I(E) and Section II.
- B. A member has a severe psychiatric disturbance that would not allow them to comprehend and retain new learning. The documentation indicates that the member is not demonstrating progress toward achieving stated goals within a reasonable period of time AND the timeframe is included on the plan of care.
- C. The member has attained his/her pain management goals or has plateau and no longer require the skills of the PMS/PMC.
- D. Clinical documentation indicates a duplication of services (e.g., an overlap of physical and occupational therapies).
- E. The requested pain management modalities/services/treatments are excluded from the member’s benefit package (e.g., homeopathic).
- F. The chronic pain has resulted from a mental condition, rather than from any physical cause.
- G. After initial PMS/PMC consultation, a significant change in the member’s status or when it is determined that ongoing pain management care can be performed by the PCP. The PMS/PMC is responsible for forwarding all relevant clinical information to the PCP.

IV. Referral Sources for Coexisting Conditions

Some members with chronic pain conditions are found to have coexisting mental health conditions and substance abuse problems. Referral information for Mental Health and Substance Abuse providers are:

	Contact Number for Mental Health
CCHP Medi-Cal	1-888-678-7277
CCHP Commercial	1-877-661-6230 option 2

	Contact Number for Substance Abuse
Alcohol & Other Drug Services (AODS)	1-800-846-1652
BAART (Antioch)	925-522-0124
BAART (Richmond)	510-232-0874

REFERENCE

Apollo Managed Care Consultants, Medical Review Criteria Guidelines for Managing Care, Pain Management, and Pain Evaluation and Management, Eleventh Edition, 2023

Attachment A



REFERRAL FORM FOR PAIN MANAGEMENT SPECIALTY EVALUATION

To be completed and signed by the PCP and submitted to CCHP for review.

Upon approval, please forward a copy of this form to the PAIN MANAGEMENT SPECIALIST PRIOR TO THE INITIAL CONSULT VISIT.

Please note, if the information below is clearly documented, the requesting provider may provide a copy of such information to Health Plan Staff in lieu of completing this form.

1. Diagnosis _____
2. Duration of condition _____
3. Diagnostic evaluation completed to date including urine toxicology results

4. Therapeutic modalities tried AND results (physical therapy, chiropractic, TENS etc.)

5. Other specialists consulted and the results of those consultations

6. Current medications

7. Medications previously tried and failed

8. Implementation of and adherence to a Pain Agreement

Requesting Provider Signature

Date Attachment B

Information about Opioid Prescriptions

Opioids are medications that can help to decrease pain. Examples of opioids include codeine, morphine, methadone, oxycodone, Percocet, Vicodin, and Fentanyl. Opioids cannot take away chronic pain completely. Instead, the purpose of these medicines is to make it easier for you to do the activities in your day-to-day life. Your Primary Care Provider may talk to you about treating your chronic pain with opioids. If so, you need to know that opioids can cause:

Sleepiness or confusion. When you first start taking opioids, and if you ever increase your dose, you should not drive or operate machinery if you feel sleepy. Other medications can make you even sleepier if you take them with opioids, so talk to your Primary Care Provider about any medications, including over-the-counter medications, you take. Confusion caused by opioids may or may not get better over time.

Constipation or nausea. Constipation is a common side effect of opioids. If you get constipated, try increasing the fiber and fruit in your diet, or take a stool softener like Colace. If you get nauseated, try taking the medication after meals.

Insomnia or Depression. Many people who take opioids for a long time develop problems sleeping at night. Many people also get depressed.

Risk in Pregnancy. If you continue to use opioids while you are pregnant, there is a risk that the child will be opioid dependent at birth. We strongly recommend using safe and effective birth control while taking opioids. If you become pregnant or are planning to get pregnant, tell your Provider about it right away.

Physical Dependence. It is very common for your body to get used to taking the medication. Dependence means that if you stop taking the medication abruptly, your body will have a withdrawal reaction. You cannot die from opioid withdrawal, but it feels awful. Opioid withdrawal symptoms include pain, muscle aches, anxiety, diarrhea, nausea, sweating, runny nose, tears, and insomnia. If you miss an appointment with your provider and call for refills too late, you may run out of medication and go into withdrawal. So, it is very important that you come to all of your appointments. If you want to stop taking opioids and avoid these symptoms, you should talk with your Primary Care Provider about tapering off over days or weeks.

Tolerance. Tolerance means that after taking opioids for a while, the medication doesn't have the same benefits, even though the pain is no worse and the dose has stayed the same. If your body adapts to the medication so that it loses strength, you may need to increase the dose or taper off and

stop the medication.

Overdose. A high dose of opioids can be fatal. Too much opioid medication can stop your breathing. It is important that you keep medication where children and pets cannot get to it.

Alcohol. Mixing alcohol and opioids is especially dangerous. For your safety, it is important that you tell your provider how much alcohol you drink. If your provider learns that you are misusing alcohol or drinking unsafely, your provider will stop the medication.

Misuse. Some people use opioids to get high or they sell the medication to make money. Misuse is dangerous so your provider will follow a system to make sure that you are using the opioids safely.

Because of the problems that opioids can cause, it is a controlled medicine. That means that there are laws that your provider and you must follow in order to use them.

Controlled Medicines Agreement. You will sign an agreement with your provider that describes what you can expect from your provider and what your provider expects from you when treating chronic pain with opioids. The agreement will be reviewed at least once a year. It will also be reviewed if you change providers or break the agreement.

One Provider. You will select one clinician to be your Primary Care Provider. Only that provider or their designee will prescribe opioids to you. With the help of clinic and pharmacy staff, the two of you will work as a team with the goal of caring for your health. You must see your provider at least Every three months to continue receiving opioid prescriptions for chronic pain. If you are unhappy with your care, you may change your provider within your clinic, or you may switch to another provider site.

One Pharmacy. You will select one pharmacy where you will fill all of your controlled medicine prescriptions. Your pharmacist and provider will work together to make sure that the medicines you take are safe for you.

Specialty Clinics. For your safety, you can only get ongoing prescriptions for controlled medicines from one place. For that reason, if you are being treated for opioid addiction at a methadone clinic or if you get medicine from an outside pain clinic, you will not receive controlled medicines from your provider. Most CCHP providers do treat opioid addiction with methadone.

No Early Refills. You will not be given early refills for any reason. So, it is important to keep your medicine safe and secure, as if it were jewelry or cash. If you take more medicine than your provider tells you to use, you will run out of medicine.

Refill Requests. You must allow seven working days for your opioid prescription to be refilled. You can request prescription refills during regular health center hours. No refill requests made outside business hours will be processed.

My signature indicates that I received a copy of the information above and discussed it with my provider.

(Adapted from LifeLong Medical Care's Information Sheet to Patients for use by CCHP providers at

their discretion. CCHP is most grateful to Dr. Joshua Kayman, Associate Medical Director of Behavioral Health at LifeLong, for sharing this information.)

Attachment C

<p><i>SAMPLE</i> CHRONIC PAIN MEDICATION AGREEMENT, PAGE 1</p>	
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Chronic Pain Medication Agreement between (patient) _____

and (primary care provider) _____, MD/DO/FNP.

In order to provide chronic narcotics safely and effectively:

- _____ 1. The patient should keep regular appointments with his/her primary care provider at
Initial _____.
- _____ 2. All prescriptions for “controlled medications” should be filled at only one pharmacy,
Initial which will be _____. This may be changed
If the patient and provider agree. “Controlled medications” are drugs that are regulated
by the Department of Justice or Drug Enforcement Agency. Examples are opioid pain
medications such as morphine, methadone, hydrocodone (Vicodin), codeine, or
_____.
- _____ 3. All routine prescriptions for controlled medication should be written by the primary care
Initial Provider. If he/she is not available, another physician will write a prescription.
Medications will be refilled at regular visits and not after hours or on weekends.
- _____ 4. If the patient requires Emergency Department care which includes opioid pain
medicines,
Initial he/she will bring a copy of or describe this agreement to the doctor. The patient will
be responsible for informing his/her primary care provider of any Emergency
Department visits by the next working day. The patient consents to the release of the
Emergency Department records and any other, past or future, medical records for
Review by his/her primary care provider.
- _____ 5a. The patient agrees to random, supervised using tox screens and/or breathalyzer tests
Initial to be sure that nonprescribed mind or mood altering substances are not being used
[including but not limited to opioids (“narcotics”, e.g., heroin), cocaine, and other
Stimulants, alcoholic beverages, benzodiazepines, (e.g., Valium) or other depressants
and marijuana.]

A refusal to do a tox screen may be interpreted as the same as a positive test. A positive test, confirmed by our reference lab, may result in a gradual reduction of

long-acting opioid analgesics or a clonidine-based detoxification. If this should occur, non-opioid pain treatment modalities will still be offered through Contra Costa Regional Medical Center & Health Centers.

Page 1

Original: Medical Record
Copy: Patient

Continued on next page
CHRONIC PAIN MEDICATION AGREEMENT

SAMPLE
CHRONIC PAIN MEDICATION
AGREEMENT, PAGE 2

OR

_____ 5b. The patient agrees to follow his/her primary provider's advice and use alcoholic
Initial beverages in moderation, when doing so will not cause the patient medical or
other problems.

The patient agrees to random, supervised urine tox screens and/or breathalyzer Tests as requested by the examining provider to affirm that nonprescribed mind Or mood altering substances are not being used [including, but not limited to, Opioids ("narcotics", e.g., heroin), cocaine and other stimulants, benzodiazepines or other depressants, and marijuana.]

A refusal to do a tox screen may be interpreted as the same as a positive test. A positive test, confirmed by our reference lab, may result in a gradual reduction of long-acting opioid analgesics or a clonidine-based detoxification. If this should occur, non-opioid pain treatment modalities will still be offered through Contra Costa Regional Medical Center and Health Centers.

_____ 6. The patient has received information about the risks and benefits of chronic opioid
Initial Medication and has had all of their questions answered satisfactorily.

This agreement should be reviewed and revised periodically, every 3 to 6 months, or as appropriate.

Patient

Date

Primary Care Provider

Date

Witness

CPM initialed by _____ on (date) _____

Page 2

Original: Medical Record
Copy: Patient

See next page for information on chronic opioid medications.
CHRONIC PAIN MEDICATION AGREEMENT