Opioid Prescribing Part 1: A Practical Guide to Appropriate Documentation

Inadequate documentation rarely is a cause for regulatory scrutiny in patients with hypertension or diabetes, but it is a very common reason for medical board discipline when it comes to treatment of chronic pain patients with opioids.

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Pain is one of the most common reasons patients visit a health care professional. Professionals spend a great deal of time learning how to diagnose and treat pain-related medical problems but much less time learning how to document the process. Traditionally, documentation by physicians has been minimal—just enough information was scribbled in the chart so that the diagnosis, medications prescribed, procedures done, and referrals were recorded.

With the advent of electronic health records (EHRs), documentation is more detailed but often consists primarily of checking appropriate boxes. Although inadequate documentation rarely is a cause for regulatory scrutiny in patients with hypertension, diabetes, chronic obstructive pulmonary disease, etc., it is a very common reason for medical board discipline when it comes to treatment of chronic pain patients with opioids. Even if a physician is caring, knows his or her patient well, asks the right questions, is satisfied with the patient's answers, and concludes that the patient is benefiting from the medications and is not abusing them—if this information is not documented in the chart, from a medicolegal perspective, it didn't happen.

In this first part of a 2-part series, I will address appropriate documentation for opioid prescribing, and in Part 2, I will outline appropriate follow-up documentation of patients with chronic pain taking opioids.

Documentation Guidelines: Initial Visit

Guidelines for the use of opioids for pain and their documentation are widely available.[1-5] Any clinician who prescribes opioids or other controlled substances for chronic pain must read and be familiar with the Federation of State Medical Boards Model Policy for the Use of Controlled Substances for the Treatment of Pain.[2] This document has formed the basis for many of the individual state guidelines. It summarizes both the necessary elements of the initial work-up and follow-up of chronic pain patients, as well as the necessary elements of documentation of these actions (Table).

On the first visit, the record should include information about the history of the problem, the type and intensity of the pain, results of previous diagnostic studies, and treatments. If this is an ongoing problem, you need to know (and document) what medications were tried in the past, including doses and duration, and if a medication was stopped, the reason. You need specific information about past treatments to better determine how to treat the patient. He or she may be unable to provide this information as thoroughly as you need, which is why it is essential to request old records. The patient needs to sign a release that includes contact information for prior relevant physicians. The signed release belongs in the chart, and it is useful to give a copy to the patient to review at home. On follow-up visits, you need to check whether you received the old records. If not, look into this and document your ongoing efforts to obtain the old records. When they arrive, the physician needs to actually review the old records rather than just initialing and filing them. They may contain useful information not only about the patient's pain problem but also about psychosocial factors and issues of compliance.

Table. Elements of Initial Work-up for Opioid Prescribing

Required Elements for Documentation

- Medical history and physical exam
- Diagnostic, therapeutic, and laboratory results
- Evaluations and consultations
- Treatment objectives
- Informed consent and agreement for treatment
- Discussion of risks and benefits
- Treatments
- Medications (including date, type, dosage, and quantity prescribed)
- Instructions
- Periodic reviews
- Urine drug screen results

Recommended Additional Areas To Document

- Old records, especially those relevant to the presenting problem
- Pain intensity level on each visit
- Levels of functioning and quality of life on each visit
- Patient's subjective complaints and provider's observations
- Patient's explanations for any drug-related aberrant behaviors, requests for early refills, etc.
- Description of provider's thinking process when making changes in medications, evaluation of lab and imaging results, recommendations for other treatments, and evaluation of urine drug tests and aberrant behaviors

Especially on the first visit, the record should give you a picture not only of the specific problem, but also an overall view of the patient. This includes their medical history and current physical functioning as well as their psychological and social circumstances. Are they able to drive? Are they employed—if so, what do they do? How's their sleep? Do they live alone? Do they have a family? Chronic pain often is associated with depression, so ask about depression, anxiety, and other psychiatric problems. It also is important to assess their risk for drug abuse or diversion. This includes asking about their personal and family history of cigarette, drug, and alcohol use, and current use of these substances. The patient also needs to fill out one of the several available risk assessment tools such as Opioid Risk Tool[6] or Screener and Opioid Assessment for Patients with Pain (SOAPP).[7] Document the results of these surveys.

Baseline Urine Drug Screen

If the patient already is being prescribed opioids, or if you are considering opioids as part of the treatment plan, it is wise to obtain a baseline urine drug screen (UDS). If the patient reports current use of any opioid, benzodiazepine, or other controlled drugs, ask him when the last dose of each medication was taken, and document the date and time he or she reports. When evaluating the results of a UDS, it is essential to have this information on record; if the last dose was taken at least 5 half-lives before the timing of

the UDS, a negative result for the drug is to be expected and is not necessarily a reflection of diversion. This is particularly important when the opioid in question is prescribed prn (as needed) and indeed is being used intermittently.

Whenever a UDS is ordered, you or your assistant should document the time of the last dose of each drug. You should review the results of the UDS and document your thinking and action on any unexpected result. If it is not clear whether an unexpected drug in the urine could be a legitimate metabolite of a prescribed drug (ie, actually an expected finding), call the clinical laboratory and discuss the result with their toxicologist. For example, a patient on oxycodone can be expected to also have oxymorphone in the urine; hydrocodone is metabolized to hydromorphine; and codeine is metabolized to morphine. For each pairing, both are expected in the urine. There are several references that provide helpful information regarding UDSs.[4,8-10]

Prescription Monitoring Program

Another useful tool, now provided by most states in the US, is the state's Prescription Monitoring Program (PMP), an updated list of all controlled substances prescribed to each patient in that state, accessible to prescribers and other categories of professionals (varies by state). Health care professionals no longer need to depend on pharmacists to find out whether a patient is obtaining opioids and other scheduled drugs from multiple providers—it is all on your state's prescription monitoring website. Document in the patient's chart that you have checked the patient's history on the website and whether there are any results of concern. (Efforts are in progress for states to share their PMP websites so that it will be possible to see what prescriptions are being obtained in other states; this can be useful especially in communities that border on more than one state.)

Documentation of Treatment Plan and Goals

Following the initial assessment, it is important to document your treatment plan and goals. You and the patient should discuss the goals of treatment, including not only pain relief but also specific areas of improvement in function. These goals should be as specific and measurable as possible (eg, "be able to walk 15 minutes at a time," "do a 10-minute home exercise program 3 days a week"), so that on subsequent visits you can review these goals and see whether progress is being made. Documentation of the plan also should include a list of all prescriptions given, including dose and quantity, as well as referrals for lab tests, imaging studies, and physical therapy or other specialists. Having a written list at the end of the visit makes it easy during the next visit to remember to check on the results of the plans.

It is very important for the record to reflect the professional's thinking regarding his or her decisions. This is not something that is possible simply by checking appropriate boxes. Your template should include spaces in which you can explain your thinking and decision-making. This is especially true with regard to making changes in doses or specific medications. The clinician should also document the outcome of discussions between you and the patient regarding dealing with abnormal UDS results, early refills, or other unanticipated events, including the patient's explanation. There should also be space for describing specifics of the patient's functioning. Examples are: can drive, walks the dog 15 minutes per day, and, able to lift 25-lb grandchild. It is not enough to check a box or just write a number (eg, 1-10) when summarizing the patient's functioning.

Another increasingly common situation is the tendency of prescribers to cut and paste past entries into the current EHR. According to an article in *American Medical News*, "Copying and pasting information is common within EHRs, but the practice sometimes can lead to confusion and endanger patient care."[11] A recent guide to EHR documentation states, "Copying and pasting . . . H&P or formulations is risky, as errors in editing may jeopardize the credibility of the entire note."[12]

Multiple office notes with identical information can make it difficult to know what actually happened. When the record contains identical physical exam results on every visit, there's no way to subsequently determine whether a physical exam was done at all on that visit. Identical presenting complaints prevent us from knowing what the patient actually was experiencing on that visit. Copy-and-paste worsens patient care by depriving the professional of useful information about the patient's current status. It also makes it impossible to reconstruct the physician's thinking process and very difficult to defend the physician against legal or licensing board allegations.

Part 2 of this article will describe appropriate evaluation and documentation of follow-up visits.

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Exercise Improves Joint Pain In Breast Cancer Patients

Breast cancer patients who develop joint pain as a result of taking aromatase inhibitors can markedly ease their pain by engaging in moderate daily exercise, according to a presentation by investigators from Dana-Farber Cancer Institute, Boston, and Yale University at the San Antonio Breast Cancer Symposium.

"This is one of the first studies to identify an approach—particularly a non-medical approach—that can effectively lower joint pain for these patients," stated the study's senior author, Jennifer Ligibel, MD, of the Susan F. Smith Center for Women's Cancers at Dana-Farber. "Arthralgia, which occurs in up to half of breast cancer patients who take aromatase inhibitors, is one of the major drawbacks of these drugs," said Dr. Ligibel. "The pain leads many to discontinue the drugs, which can increase the chance that the cancer will return. Exercise offers an attractive option for patients who want to continue taking these drugs but who are burdened by their side effects."

The study involved 121 postmenopausal women who were taking aromatase inhibitors for breast cancer and who rated their joint pain as mild or greater on a standard pain-evaluation questionnaire. Sixty-one of the women were randomly assigned to participate in 2 supervised strength training sessions per week and to engage in an average of 150 minutes of aerobic exercise per week. The remaining 60 patients followed their normal daily activities.

After a year, joint pain scores decreased by 20% among the women in the exercise group compared with 3% improvement in the non-exercise group. The severity of joint pain also decreased significantly more in those who exercised than in those who didn't, as did the degree to which pain interfered with their lives.

Aromatase inhibitors are approved for the management of hormone receptor-positive cancers. Currently, three aromatase inhibitors are approved by the US Food and Drug Administration: anastrazole (Arimidex), exemestane (Aromasin), and letrozole (Femara).

The lead author of the study was Melinda Irwin, PhD, MPH, who leads the Yale HOPE (Hormone & Physical Exercise) Study, which recruited the participants in the current study.