

Opioid Prescribing Part 2: Appropriate Documentation Of Follow-up Visits

Documentation of the initial evaluation of a chronic pain patient is only the beginning. Follow-up office visits, urine drug screens, phone calls, emails, and communications with family need to be meticulously documented and an up-to-date medication chart must be kept.

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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 scribbled in the chart so that the diagnosis, medications prescribed, procedures done, and referrals are 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.

In Part 1 of this series, I described current recommendations and requirements for documentation of visits with patients who are prescribed opioids and other controlled drugs for chronic pain, with an emphasis on the initial visit.¹ In Part 2, I will address appropriate documentation of evaluation and assessment in follow-up visits.

Documentation Actions

Documentation reflects the prescriber's actions, so first let's address how frequently patients should be seen for their pain problem, how often they need a physical exam, how often a urine drug screen (UDS) should be obtained, and whether a patient may be given prescriptions without being seen. The guidelines for all of these decisions are general and, unfortunately, what sometimes happens in practice is that these decisions are based on economic rather than medical factors.

Frequency of Visits

This depends on how stable the patient is and on how comfortable the health care professional is with the patient's ability to adhere to the recommended regimen. If the patient is on a stable dose of medication and is doing well, then a visit every 1 to 2 months is generally considered reasonable. If the patient is on a relatively low dose of opioids, then 3 months is often adequate. If the patient has significant psychosocial issues, is a recovering addict, has exhibited difficulty with compliance, has a new additional pain issue, or the dose is being adjusted, etc., then the patient may need to be seen weekly, and, at times, there may even need to be telephone contact in between the visits.

Frequency of Physical Exams

Most guidelines do not specify how often a physical exam is required. Again, this depends on how stable the patient is and the provider's comfort level. In my practice, on each visit vital signs are taken, and the patient's gait (and other functions related to the patient's specific pain problem) are observed and documented. The frequency of a detailed physical exam focuses on the diagnosis (not a comprehensive physical exam involving the entire body), depending on the patient's stability. In my practice, (a pain specialty practice, not primary



care), stable patients undergo a focused physical exam every 4 to 6 months. That being said, some states require a physical exam on every visit. But again, such rules do not specify the extent of the physical exam.

Frequency of Urine Drug Screens

Published guidelines do not specify a required frequency for UDS. Some prescribers routinely obtain a urine specimen from patients on every visit, which is not a useful approach. The goal of a UDS is to determine 1) whether a patient is taking controlled drugs as prescribed, and 2) whether the patient is taking controlled drugs that were not prescribed, and/or is using illegal drugs. Patients who expect to be asked to provide a urine specimen can prepare for it by researching how long prescription drugs and drugs of abuse stay in the urine, and by not using them in the days immediately preceding the appointment. And they can also make sure they have prescribed drugs in their body on the day of appointment. The point is, it is more useful to obtain random UDS. In my practice, UDSs are obtained 1) at random, 2 to 3 times a

year, plus 2) any time I have any concerns about compliance. Patients do not know in advance when a urine sample would be requested.

Prescribing Without an Office Visit

Because insurance companies generally pay for only 30-day quantities of a medication and the Drug Enforcement Agency (DEA) does not permit Schedule II prescriptions to have any refills on them, the question arises about what to do for the second month (the month between appointments) for stable patients who medically need to be seen only every 2 months. Published guidelines do not mandate an office visit when a patient needs a prescription for a controlled substance. The DEA permits writing multiple prescriptions for Schedule II drugs for up to 90 days as long they are dated on the date they were written. Within the body of the second and subsequent prescriptions, write "Do not fill until . . ." Pharmacists are not permitted to fill a prescription before that date. There are other circumstances when a patient may need a prescription without being seen—for instance, if a

phone conversation results in the prescriber agreeing to increase the dose, the patient will need an early refill. It is certainly permissible for patients to pick up a prescription without being seen for an office visit, but it is important, of course, to document that the prescription was provided to the patient.

Review of Previous Office Visit

At the start of the visit, the clinician should review with the patient the plans documented in the record for the preceding office visit and the outcomes of each plan. Did the patient have any lab tests and imaging studies that were ordered? Are the results in the chart? Was a UDS done? Were the results “consistent” (ie, good)? If not, the clinician needs to determine and document whether the “inconsistent” results have a legitimate explanation (see Part 1¹¹) and, if not, what action was taken. Also, has the patient seen any specialist to whom he or she was referred, and, if not, is there a pending appointment? Have old records arrived? Is there anything in the record that needs to be discussed with the patient? If the medication regimen was changed, what was the result? Were there any new side effects? The information learned from the answers to these queries should be documented.

Documenting the “5 A’s”

An easy way to remember the elements necessary to ascertain and document at each follow-up visit is the “5 A’s.” These are based on the 4 A’s originally suggested by Passik and Weinreb²:

1. *Analgesia*: The level of pain, such as on a scale of 1 to 10.
2. *Activities of daily living*: What the patient actually does (be as specific as possible: “Walking the dog for 15 minutes, about half a mile.”)
3. *Adverse effects*: For example, ask

about constipation, which can be an ongoing problem.

4. *Aberrant drug-related behaviors*: For example, “Ran out early because. . .” or “Leaving on vacation, needs early refill,” or “Urine positive for cocaine.”

If some aberrant behavior is reported or becomes apparent, the clinician needs to address the issues that have been raised and make a plan to deal with them. The discussion and plan should be documented in the record.

Many clinicians have now added a 5th A: Affect—that is, the patient’s mood. Depression and anxiety exacerbate pain; many chronic pain patients are chronically depressed and require antidepressants and/or psychotherapy. The outcome of antidepressant treatment should be assessed. Document the outcome of antidepressants prescribed, as well as the outcome of any recommendation you have made for psychotherapy or psychiatric consultation. Include any other relevant psychosocial issues that have impacted the patient’s life.

Note that a physical examination is not part of the “5A’s.” This is because, as mentioned above, a physical examination usually is not required on every visit before a prescription can be given. Of course, if the patient reports a change in symptoms, then a focused physical exam is in order. It is, however, desirable to document your observation of the patient in motion and at rest, their vital signs, and their level of alertness.

Documentation Of Assessment and Plan

Assessment is not synonymous with diagnosis. All too often clinicians simply cut and paste (or else write in an old-fashioned paper record) the patient’s ICD-9 code (soon to be ICD-10) and the name of the diagnosis. This is not the goal of the Assessment

section; rather, the goal is to summarize and document the patient’s current medical status, level of compliance, and also the clinician’s reasoning for continuing the same regimen, making changes in the patient’s medication management, making a new referral, modifying the goals, and discussing any issues of compliance. This section is the place for the clinician to explain his thinking and justify his decisions.

The final section, the Plan, should contain a list of medications prescribed on that visit (including the quantity, dose, and fill date, and any refills), as well as any referrals made or diagnostic tests ordered. It is not sufficient to simply write—or check a box—“continue current regimen.” At the next visit, it is very useful to be able to refer to this section to clarify exactly what was prescribed and what other actions were taken. This system makes it less likely that the clinician will forget to follow up on decisions made and actions taken during the preceding visit.

Master List of Medications—Updated!

One of the most common mistakes that clinicians make in their opioid prescribing is to inadvertently prescribe larger quantities of controlled substances than intended. This is one of the most common allegations directed at prescribers by regulators. The usual reason is that the clinician did not realize that the refill was given earlier than necessary, or that refills had already been written for Schedule III or IV medications on a previous visit. Clinicians may find themselves scrolling through pages and pages of notes of prior visits, trying to figure out when the next script is due—a process that takes time and often is not successful.

The solution in the medical record is to have a dedicated page listing every medication and dose prescribed, and then updating the latest quantity, the

date the prescription was written, as well as the fill date (which may differ from the date the prescription was written!), and any refills. You must remember that any time a prescription is renewed by phone, email, or fax between visits, you or a staff member must document this on the master medication list! Having a unified list that is easy to access makes for a very efficient way of always having the big picture about the prescribing history of each medication.

Document Electronic Communication: Phone Calls, Faxes, emails

In the treatment of chronic pain, it often is helpful to communicate with the patient when doses or medications have been changed. You may wish to check up on the patient after a few days on the new dose, or the patient may call or email with concerns or follow-up questions. At this point, you may agree on a change in dosage. All such communication needs to be documented, so that you will know the exact dosage the patient is on and any additional medication prescribed. Documentation also is key, so that the record will reflect that there was communication between you and the patient.

Communication With Family Members: What About HIPPA?

The principal reason that treating chronic pain with opioids is controversial is the potential for drug abuse or diversion. There are several ways that clinicians can reduce this risk. One is to ask the patient about their history of addiction or abuse. Of course, this approach may or may not be productive as there is always the possibility of

dishonesty. A second is to keep careful records of the quantities and dosages prescribed, obtain random UDSs, and follow up on any suspicious behavior. Yet another is to seek outside sources of information. This includes obtaining medical records from prior physicians and accessing your state's online Prescription Monitoring Program to see if controlled substances have been obtained from other prescribers. (Of course, some of these may be legitimate—unrelated hospitalizations and injuries, dental work etc.—so you need to follow up on these reports).

Another useful source of outside information is the patient's family. How do you respond when a relative phones you and says he or she wants to give you some information about your patient so that you'll have the real story? And let's say the patient has not given you signed permission to speak with this relative. What do you do?

Too many clinicians either refuse to speak with the relative, or else say to them a version of, "I'm sorry, I can't talk with you because I don't have permission." Taking this approach deprives you of hearing what might be very relevant and useful information. It also can increase your risk of getting sued. For example, following the death of a patient from a polydrug overdose, which included both medications prescribed by the physician and other opioids obtained on the street, his family sued the physician for malpractice, explaining, "I kept trying to tell his doctor that my daughter was a drug addict, getting drugs on the street, but he wouldn't talk with me."

A better approach, while remaining HIPPA-compliant, is to say to the caller, "I can't say anything, but I'm ready to listen." Then document in the chart

who called and what the caller said. Of course, having this information then brings up the problem of what to do with it, including having to decide how credible the information is. This is another whole area of uncertainty, but the bottom line is that it is wise to listen to the information and consider your options. In the above case, an initial option might have been to ask the patient for a UDS. In any case, the clinician needs to document the phone call and what his or her plan is.

Summary

Treating chronic pain with opioids requires unusually good documentation. Clinicians are advised to review their record keeping and modify their EHRs to be able to efficiently document the necessary elements described above. ■

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