

# Medical Treatment Guidelines

Washington State Department of Labor and Industries

## Guidelines for outpatient prescription of controlled substances, Schedules II-IV, for workers on time-loss

L&I, in collaboration with the Washington State Medical Association, has developed two guidelines on the topic of opioids and controlled substances. These two guidelines have some areas of overlap, and some content found in one but not the other guideline. Therefore, both guidelines are included in this publication.

On the following pages you will find the first of the two guidelines, developed in 1992 and 2000. The second guideline, dealing with opioids, is located in a separate section.

Below is a table summarizing some of the differences between the two guidelines.

It is hoped that clinicians will find both guidelines helpful, depending on the circumstances of each individual patient.

### **1992 guideline on controlled substances**

- Relates to all controlled substances, not just opioids.
- Deals with treatment in the acute and subacute phases.
- Includes special tools helpful to clinicians, such as:
  - A useful chart listing examples of Schedule II, III, and IV controlled substances.
  - A list of relative contraindications for the use of controlled substances.
  - 3 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in *Attending Doctor's Handbook*.
  - Handy patient education sheet, with a message from the Washington State Medical Association.
- Includes a guideline only, with no absolute requirements in regulation or law.

### **2000 guideline on opioids**

- Relates primarily to opioids.
- Deals primarily with chronic phase.
- Includes special tools helpful to clinicians, such as:
  - Sample Opioid Treatment Agreement.
  - Functional Progress Form (optional).
  - Opioid Progress Report (required).
  - 2 hours FREE Category 1 CME with self-assessment test accredited by the American College of Occupational and Environmental Medicine, found in Provider Bulletin 00-04.
  - Billing information so providers may be reimbursed for services described.
- Includes the guideline, accompanied by regulations (WACs) and the 1998 Guideline from the Department of Health.

# Medical Treatment Guidelines

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Washington State Department of Labor and Industries

## Guidelines for outpatient prescription of controlled substances, Schedules II-IV, for workers on time-loss

Developed by the Washington State Medical Association and the Washington State Department of Labor and Industries.

Adopted 1992 by the Washington State Medical Association Industrial Insurance and Rehabilitation Committee.

### Introduction

#### **Purpose of the guidelines**

Repeated, long-term use of prescription controlled substances for chronic nonmalignant pain may be a factor in the development of long-term disability. This condition may be preventable if at-risk patients and practices are proactively identified and managed appropriately.

It is hoped that the prescribing guidelines listed below will lead to more accurate and timely identification of workers at risk for the development of long-term disability. These guidelines may also be a component of future intervention strategies aimed at preventing long-term disability.

#### **Development of the guidelines**

These guidelines were developed by the Washington State Medical Association (WSMA) Industrial Insurance and Rehabilitation Committee and the Washington State Department of Labor and Industries. They are based on information from existing prescription guidelines, literature reviews, pharmacologic and medical references, seminars, interviews of experts, and consultations with physicians who have private practices in a wide variety of specialties.

#### **Application of the guidelines**

The guidelines are intended for use in the management of chronic nonmalignant pain. Chronic nonmalignant pain is defined as pain persisting beyond the expected normal healing time for an injury, for which traditional medical approaches have been unsuccessful. Application of these guidelines is intended only for outpatient prescriptions of nonparenteral controlled substances. The nonparenteral routes of administration are considered the only acceptable routes for treating chronic nonmalignant pain in the Washington state workers' compensation system (WAC 296-20-03014).

It is recognized that the guidelines cannot apply uniformly to every patient. Also, the guidelines cannot be the sole determining basis for identifying patients at risk for a drug use problem or currently experiencing a drug use problem. Mere application of the guidelines cannot substitute for a thorough assessment of the patient or medical file by qualified health care professionals. For example, it may be acceptable to prescribe opioids to workers who are gainfully employed and not receiving time-loss. Similarly, the guidelines cannot substitute for detailed prescribing information found in many medical and pharmacologic references.

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Date Introduced: 1992.

# Medical Treatment Guidelines

## Washington State Department of Labor and Industries

These guidelines will be applied in the workers' compensation setting only. The guidelines will apply only to workers whose injuries occurred after the guidelines are adopted by WSMA and sufficient notice has been given to providers.

**ATTENTION: The Department of Labor and Industries may impose sanctions if the guidelines are not followed.**

The guidelines are intended for use by physicians who begin treatment within 6 months of the worker's injury. Patients who have been on controlled substances for prolonged periods and come under the care of a new physician present special problems. These and other problems will be dealt with in a separate publication.

Finally, while the guidelines may not conflict with state or federal laws, by necessity they cannot cover in detail all of the many rules, regulations, and policies published by the various agencies enacting and enforcing these laws.

**Table 1**  
**Documentation recommendations when**  
**controlled substances are prescribed.**

- a. A thorough medical history and physical examination and medical decision-making plan should be documented, with particular attention focused on determining the cause(s) of the patient's pain.
- b. A written treatment plan should be documented and should include the following information:
  - a finite treatment plan that does not exceed six weeks.
  - clearly stated, measurable objectives.
  - a list of all current medications (with doses) including medications prescribed by other physicians (whenever possible).
  - description of reported pain relief from each medication.
  - justification of the continued use of controlled substances.
  - documentation of attempts at weaning.
  - explanation of why weaning attempts have failed (including detailed history to elicit information on alcohol and drug use).
  - how the patient's response to medication will be assessed.
  - further planned diagnostic evaluation.
  - alternative treatments under consideration.
- c. The risks and benefits of prescribed medications should be explained to the patient and the explanation should be documented, along with expected outcomes, duration of treatment, and prescribing limitations.
- d. The treatment plan should be revised as new information develops which alters the plan.

# Medical Treatment Guidelines

Washington State Department of Labor and Industries

**Table 2**

**Relative contraindications for the use of controlled substances.**

1. *History* of alcohol or other substance abuse, or a history or chronic, high dose of benzodiazepine use.
2. *Active* alcohol or other substance abuse.
3. *Borderline* personality disorders.
4. *Mood disorders* (e.g., depression) or psychotic disorders.
5. *Other* disorders that is primarily depressive in nature.
6. *Off work* for more than 6 months.

\* Note: When special circumstances seem to warrant the use of these drugs in the types of patients noted above, referral for review is indicated.

## General information

- A. Please refer to the "Introduction" for more information on the purpose, development, and application of these guidelines.

***Physicians may be held accountable if their prescribing patterns fall outside these guidelines.***

- B. Documentation recommendations (as presented in Table 1) should be followed at all times, especially whenever the physician departs from the guidelines listed below.

## Treatment of acute pain from traumatic injuries or surgery (post-discharge):

- A. Schedule II drugs should be prescribed for no longer than 2 weeks.
- B. Schedule III and Schedule IV drugs should be prescribed for no longer than 6 weeks. (See Table 3 for examples of controlled substances.)

## Treatment of chronic non-malignant pain\*:

- A. **Extreme caution** should be used in prescribing controlled substances for workers with one or more "Relative Contraindications" (see Table 2).  
(NOTE: When special circumstances seem to warrant the use of these drugs in the types of patients listed in Table 2, referral for review is indicated.)
- B. For patients on a **combination** of opioids and scheduled sedatives:

***Treatment with combinations should usually not extend beyond 6 weeks.***

- C. For patients on opioids **OR** scheduled sedatives (but not combinations of the two):

# Medical Treatment Guidelines

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## Washington State Department of Labor and Industries

***Treatment should usually not extend beyond 3 months.***

D. Consultation or referral to a chronic pain specialist should be considered when any of the following conditions exist:

1. Underlying tissue pathology is minimal or absent, **AND** correlation between the structural derangement caused by the original injury and the severity of impairment is not clear;
  2. Suffering and pain behaviors are present, and the patient continues to request medication; or
  3. Standard treatment measures have not been successful or are not indicated.
- \* Defined as pain persisting beyond the expected healing time for an injury which traditional medical approaches have been unsuccessful.

# Medical Treatment Guidelines

Washington State Department of Labor and Industries

Table 3 Examples of controlled substances*		
Schedule II	Schedule III	Schedule IV
<p>Opioids:</p> <p>codeine fentanyl (Sublimaze, Innovar) hydromorphone (Dilaudid) levorphanol (Levo-Dromoran) meperidine (Demerol) meperidine w/ Promethazine (Mepergan) methadone (Dolophine) morphine (MS Contin, MSIR, OMS, RMS, Roxanol) oxycodone oxycodone w/ acetaminophen/aspirin (Percocet, Percodan, Roxicet, Roxiprin, Tylox).</p>	<p>Opioids:</p> <p>acetaminophen with codeine (Codalan, Phenaphen 2, 3, 4, Tylenol 2, 3, 4) aspirin with codeine (Empirin 2, 3, 4) hydrocodone hydrocodone w/ acetaminophen/aspirin (Anexsia, Azdone, Bancap, Cogesic, Damason-P, Dolacet, Duocet, Endal-HD, Hyco-Pap, Hydrocet, Hyphen, Lorcet Plus, Lorcet HD, Lortab, Vicodin, Zydone) nalorphine paregoric.</p>	<p>Opioids:</p> <p>propoxyphene (Darvon) propoxyphene w/ acetaminophen/aspirin (Darvocet, Dolene, Wygesic) pentazocine (Talwin).</p>
<p>Sedatives:</p> <p>amobarbital (Amytal)** secobarbital (Seconal)** pentobarbital (Nembutal)**.</p>	<p>Sedatives:</p> <p>any compound containing an unscheduled drug and: amobarbital ** secobarbital** pentobarbital** glutethimide (Doriden)</p> <p><u>Non-narcotic Analgesic Combinations</u> butalbital with acetaminophen/aspirin (fiorinal).</p>	<p>Sedatives:</p> <p>chloral hydrate clorazepate (Tranxene) chlordiazepoxide (Librium) clonazepam (Klonopin) diazepam (Valium) ethchlorvynol (Placidyl) flurazepam (Dalmane) meprobamate (Equanil, Miltown) oxazepam (Serax) paraldehyde (Paral) phenobarbital ** prazepam (Centrax) triazolam (Halcion).</p>
<p>* This table is not intended as an exhaustive listing of controlled substances. A few trade names have been given as examples. This listing should in no way be construed as an endorsement of any medication.</p> <p>** Barbiturates are not paid for by the Department at any time (except phenobarbital, which is allowed only for seizure disorders).</p>		

# Medical Treatment Guidelines

Washington State Department of Labor and Industries

## *To our patients*

**What you should know about the rules your doctor must follow to prescribe drugs that may be addictive.**

The Washington State Medical Association (WSMA) and the Department of Labor and Industries (L&I) believe that it may do you more harm than good to take addicting drugs for a long time.

Guidelines approved by the Washington State Medical Association must be followed by your physician.

**Please help your physician to help you—follow your doctor's instructions carefully.**

THANK YOU!

**A message from the Washington State Medical Association.**

*To the doctor: Please feel free to photocopy this sheet and distribute to your patient, preferably along with your first prescription for controlled substance.*

# Medical Treatment Guidelines

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Washington State Department of Labor and Industries

## Selected references

The following are a few of the published materials used to prepare these guidelines.

AHFS Drug Information '91, American Hospital Formulary Service, by the American Society of Hospital Pharmacists, Inc., Bethesda, MD, 1991.

“Chronic Opioid Therapy in Nonmalignant Pain,” RK Portenoy, Journal of Pain and Symptom Management, Vol. 5, No. 1 (Suppl.) February 1990, pp. S46-S62.

Guidelines for Prescribing Controlled Substances for Chronic Conditions, California Medical Association, San Francisco, CA, April 12, 1985.

“Medications in Low Back Pain,” JP Robinson and PB Brown, Physical Medicine and Rehabilitation Clinics of North America, Vol. 2, No. 1, February 1991, pp. 97-125.

“Prescribing Practices for Pain in Drug Dependence: A Lesson in Ignorance,” LM Halpern and JP Robinson, Controversies in Alcoholism and Substance Abuse, The Haworth Press, Inc., 1986.

“Unlocking the Secrets of Pain — The Treatment — A New Era,” JD Loeser, Medical and Health Annual Encyclopedia Britannica, 1988 pp 120-31.