

**PALMETTO PAIN MANAGEMENT
PAIN MANAGEMENT & SPINAL DIAGNOSTICS
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To: SCWCC Narcotics Use Advisory Committee

From: Ezra B. Riber M.D.

As a practicing anesthesiologist/pain physician for the past 27 years and having participated in the last WC Prescription Drug Abuse Prevention Council meeting, I submit the following comments regarding the treatment of injured workers with chronic pain issues.

Opioid Prescribing Requirements

Prior to prescribing opioids for chronic pain management patients, physicians should be required to conduct an initial evaluation of the patient to assess the etiology of pain, formulate a treatment plan to include non-opioid options if appropriate. When opioid treatment is deemed necessary, risk of substance abuse should be assessed and the potential risks and benefits discussed and outlined in a "pain contract" which also addresses expectations and proper use of opioids. The treatment plan should include, but not be limited to, the following:

- possible side effects of long term opioid use;
- the risks of opioid dependence;
- safe storage practices;
- goals of the treatment;
- the patient's consent to drug monitoring testing in circumstances where the physician determines that such testing is medically necessary;
- a requirement that the patient take the medication as prescribed;
- a prohibition on the sharing of medication;
- a requirement that the patient inform the physician of any other controlled substances prescribed or taken by the patient; and
- reasons the opioid therapy may be changed or discontinued by the physician.

In addition, patients who are started on an opioid regimen must be scheduled for periodic follow-ups, during which time the prescriber will check for compliance with the opioid treatment program, opioid agreement and also assess the patient's progress including functionality. The Indiana opioid prescribing requirements outline additional measures that this Council should consider adopting as a part of its opioid management protocols.

Mandatory Use of the Prescription Monitoring Program

Physicians should be required to check the state prescription monitoring program database prior to prescribing. This is vital to curtailing abusive opioid practices because it helps to restrict patients from obtaining multiple opioid prescriptions from different providers. Specifically,

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physicians should be required to check the database at the outset of an opioid treatment plan, and periodically thereafter, and review whether the database records are consistent with the physician's knowing of the patient's controlled substance use history.

Role of the Pain Physician

Revising the current evaluation and treatment protocols by involving trained pain specialists to see the injured worker *early* in the treatment process could **shorten treatment periods**, expedite return to work, and reduce opioids prescribed. Pain physicians are typically asked to get involved when all else has failed. Physicians like myself inherit opioid dependent/polypharmacy patients who have undergone exhaustive conservative and/or surgical treatment through many providers they may have seen before getting to us.

How can we help? Many of us have the experience, training and expertise to determine if a patient *is* a surgical candidate and we can recommend that referral early on. If they are surgical but require e.g. spinal diagnostics, we can perform those as well so that the surgeon has additional useful information to evaluate the patient's candidacy for an operation. We can also exhaust conservative treatment options prior to scheduling surgery. In those situations where surgical candidacy is less obvious, however, earlier diagnosis (e.g. facet) and rule out (RSD) by a trained pain specialist can expedite recovery time and mitigate the prescribing of unnecessary opioids.

If, however, the injured worker is *not* surgical we can develop a non-surgical treatment plan which focuses first on pain relief followed by improving functionality. Currently the algorithm focusing on functionality (PT first) is a set up for failure without pain control first. Surgical and non-surgical providers may cumulatively add medications and send patients to therapy multiple times. Then with no improvement a plaintiff attorney may get involved, psychological evaluation may be considered, and additional referrals may be recommended as the treatment continues off track. After months and sometimes years, the patient is finally sent to a pain physician who can try to sort out all that has happened since the original incident but is now also dealing with a patient who is saying "nothing has worked yet" which puts us in a compromised position from the outset, dealing with polypharmacy and opioid dependence.

If the patient is an obvious surgical candidate, appropriate referral is made and the above scenario is avoided. Physicians like myself can identify and recommend surgical consultation in more complex injuries (e.g. significant comprehensive pathology in the cervical or lumbar spine) and know that those cases should immediately be referred to surgery and not be delayed with PT or injections which can just prolong the patient's recovery time.

I would propose that we select and follow a subset of injured workers that see the pain specialist very early on. A treatment plan can be implemented. This would result in a greater percentage injured workers brought to maximum medical improvement ("MMI") more quickly, improve the potential to return to work, lessen the issues of opioid dependency, and reduce the time/costs spent in treatment. Stated another way, we can also identify much earlier those who are not likely to improve.

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For those who are already opioid-dependent, a number of trained pain physicians are also qualified to treat with Suboxone or similar molecule. This treatment coupled with counseling allows many individuals who would otherwise be focused on obtaining opioids to become functional and productive.

Employing the above recommendations will promote responsible and effective prescribing of opioids. Furthermore, involving the trained and experienced pain physician early on in treatment can improve outcomes for injured workers, and reduce costs by shortening the time to MMI. I thank the Narcotics Use Advisory Council for the opportunity to comment on this important issue.

Respectfully submitted,



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