

PATIENT COMPLIANCE CODING:

CONTROLLING PATIENT ACCESS TO NARCOTIC MEDICATION

ONE PHYSICIAN'S EXPERIENCE

By Dr. Robert Ben Mitchell, D.O.

Member - American Academy of Pain Management

Affiliations: none

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ABSTRACT:

Opium derivatives such as morphine and its analogs have been used for centuries to alleviate and control pain (1). These medications have proven to be safe and effective treatments when used appropriately and under the guidance of knowledgeable physicians. However, like any medication, adverse effects are possible when opiates are improperly prescribed by physicians or improperly used by patients. The goal of this paper will be to address one solution to these problems by outlining a technique called Patient Compliance Coding (PCC). PCC is a proprietary tool developed at my Chronic Pain Management Program (CPMP) to ensure patients follow instructions when using narcotic medications. During 2003, I used PCC with my entire patient population to increase their compliance with medication regimens and eliminate adverse outcomes such as overdose deaths. It is being presented here for the first time in publication for other physicians to use and study, that we may better understand its function in and benefits to both the field of pain management and our patients.

KEY WORDS:

1. Patient Compliance Coding (PCC)
2. Overdose Deaths
3. Medication Access
4. Narcotic Medications
5. Pain Management
6. Chronic Pain Management Program (CPMP)

INTRODUCTION:

I run a small private practice in North Miami, Florida, where I provide chronic pain management to approximately 75 patients. Treatment is provided on an out-patient basis only, with in-patient care provided as needed by physicians other than myself. Demographically, in this practice males outnumber females 3 to 2, their ages range from 24 to 65 years of age (mean: 44 years), and all are ambulatory with or without assistance, except for two females who are permanently wheelchair bound. On average, patients in my practice have suffered from their current chronic pain problem(s) for 5 to 6 years, experience chronic pain on a daily basis over 25% of their bodies, and receive 50% to 75% relief from their chronic pain through the medications that I prescribe. Also, with pain medication, the average patient is able to work 20-30 hours per week and is responsible for 26% to 50% of their household's financial income. Thus, pain medication plays a significant role in maintaining the quality of these patients' lives.

Given the importance of pain medicine to my patients, I want them to follow the medication instructions I give them. Unfortunately, this does not always happen, as in any given week, 5% to 10% of my patients complain that they have run out of pain medication prior to their scheduled refill dates. There are many reasons why this might occur. Some times patients have problems beyond the physician's control, such as addictive habits, the selling or sharing of medication, and other behavioral problems which fall outside the realm of both this paper and chronic pain management (2). On the other hand, there are patients who have a documented medical need for pain medicine, but they also have difficulty following the instructions for using it. These are the patients which will be

addressed in this paper.

When opiates are given for pain management, they are usually prescribed on a time related basis. For instance, a patient may be instructed to use one to two pills of 30 mg instant release morphine every six hours, if needed, for pain. The patient has, by this prescription, some latitude on how and when to use the medication. They may find in the morning that they need two pills (60 mg), while six hours later in the early afternoon one additional pill (30 mg) is sufficient for pain control. Ultimately, the compliant patient will not use more than 60 mg (two pills) in any six hour period, or more than eight pills (240 mg) in any twenty-four hour period.

When a patient receives a prescription for pain medication, they have in their possession what may seem like a magic wand they can wave to make their pain disappear. However, unlike medication instructions, chronic pain is not constant. It fluctuates throughout the day, from day to day, and from week to week. These changes in pain can be due to multiple factors, including activity level, emotional states, financial stress and weather changes (3). Though pain medication prescriptions should take into account reasonable alterations in symptoms, at times these fluctuations can be far in excess of what either the patient or physician anticipates. Under these circumstances, the patient may need to use more medication than is being prescribed. When this occurs, before going above their regimen, a patient should call their physician to report their exacerbation of symptoms and to discuss alternatives toward alleviating their increased pain. However, this does not always occur, as patients sometimes self medicate beyond their prescriptions without physician knowledge or approval.

When a patient immediately informs their physician of alterations in pain symptoms, it gives them both the opportunity to discuss the patient's situation and consider beneficial diagnostic and treatment alternatives: re-evaluation of the patient's pain etiology, therapeutic exercises, the use of non-narcotic adjuncts, re-titrating the current narcotic, and/or switching to another narcotic are just a few examples. In addition, patient communications about such problems helps the physician to evolve a more accurate understanding of the dynamics surrounding each patient's individual pain syndrome. Also, when physicians respond to such patient communications with reassuring changes in the treatment plan, patient confidence and satisfaction with their physician rises, making future communication more likely. These are positive reinforcements which benefit both parties in their ongoing efforts toward providing pain relief for the patient.

When patients do not communicate with their physicians about significant changes in their pain profiles, negative factors come into play. Physicians lose trust in their patients' ability to follow instructions and may actually start to withdraw pain medication from them. To stem the tide of patients who might otherwise run out of medication early, doctors may require them to sign treatment contracts which stipulate that the physician will not prescribe more pain medication before a scheduled refill date under any circumstances (4). Patients, in turn, may feel abandoned when their physicians take a "misuse it - you lose it" approach. Is it reasonable to assume that a patient who has exceeded their prescription and runs out of pain medication before their scheduled refill date will now agree to stay in pain until their next appointment? Furthermore, is it medically ethical to require a patient to do this when withdrawal can be provoked with

sudden cessation of narcotics (5)? These are important questions that every physician prescribing pain medication must address.

It is beyond this paper to examine the entire scope of factors - medical, psychological, social, economic, etc. - which complicate patient compliance with pain medication (6). For countless centuries, all physicians seeking to control pain have been challenged by these demons in the machine, and today we are no closer to fully understanding most of them than were our predecessors. However, until such time as these influences can be properly disposed of, a practical solution for dealing with them is crucial to the success of any treatment plan. Therefore, at my Chronic Pain Management Program (CPMP), I have developed a system called Patient Compliance Coding (PCC) which helps to alleviate much of the controversy regarding patient access to pain medication.

THE PCC SCALE:

I began to formulate the concept of PCC in late 2002, implementing a prototype with all of my patients by the year's end. From then on, it rapidly developed into its current format by March of 2003. As such, PCC is currently based upon two principles:

1. A patient cannot overuse or lose what they do not have.
2. It is the physician's responsibility to determine how much medication a

patient can safely possess for self-dispensing at any given time and still remain in compliance with their prescribed regimen.

In my CPMP, I regularly schedule patients for two week follow-up appointments during ongoing treatment. At any given time, 90% to 95% of my patients are fully compliant with their medication use and appear at their scheduled visits without having exceeded their prescribed regimen. They also bring in excess medication if they did not need to use the maximum of what they were dispensed. However, some patients get ahead of their medication, or run out of it before I am scheduled to see them again. Rather than refuse them further treatment until their appointed follow-up and, thus, force them to acquire help elsewhere or run the risk they may suffer withdrawal, I use PCC to encourage patients to communicate their problems with me.

The basis of PCC is a six step percentage scale - 0%, 20%, 40%, 60%, 80%, and 100% - upon which all patients are continually graded throughout their treatments. At their initial intake visit, the methodology and importance of PCC are explained to each patient, and they are all started at a compliance code rating of 100%. Then, each time they are seen again, their compliance coding is recalculated based upon the patient's performance since the preceding prescribing date. Some behaviors decrease the PCC (ex: increased medication use beyond their prescription without first consulting the doctor), while others increase it (ex: communicating a problem prior to making changes in their regimen). Thus, if a patient's behavior deteriorates, then their PCC rating goes down, and when the patient's behavior improves their PCC rating goes up. By continually updating a

patient's compliance characteristics, PCC provides a better understanding of their ability to properly use medication and report unanticipated problems not sufficiently addressed within the current regimen.

Once the PCC for a given patient is known, appropriate intervention can be employed to increase the patient's safe use of their pain medication. As proof of its effectiveness, I tracked overdose deaths of patients in my CPMP over the past three years, as verified by local county medical examiner reports. In 2001 and 2002, prior to the induction of compliance coding at my CPMP, there were two cases both years of patients' deaths by pain medication overdose. PCC was instituted at the end of 2002, and for 2003 there were no such deaths. Amongst the many things I do to inform and educate my patients about the safe use of their pain medication, the use of PCC in 2003 was the only significant change during these three years.

While all patients in my CPMP deserve to use pain medication, not all of my patients should have large quantities of pain medication in their possession at any given time. Ultimately, however, it is my responsibility to distinguish how much medication a patient can be safely dispensed. This is the key to using PCC. Patients who maintain a 100% compliance code have demonstrated that they are capable of following the instructions I have given them. In addition, they call me if they have symptoms which exceed what can be controlled within their prescribed regimen. These patients work with me to help them establish safe and effective relief from their pain. In recognition of their compliance, these patients may receive from the pharmacy, at one time, all of the medication needed until their next appointment. However, if their PCC score declines,

intervention is begun.

At 80% PCC, patients are still allowed to receive their full inter-appointment dispense of medication at one pharmacy visit. However, extensive counseling is done to discuss the reasons the patient's compliance rating has dropped, in an effort to reinforce positive behavior in the future. Below this 80% level, significant changes occur.

At 60% PCC, the patient still receives their full daily allotment of medication, however, during the two weeks in-between their appointments they will have to go to the pharmacy twice: the day of their current appointment, and one week later. On each dispensing date they will only be allowed to fill half of the full amount of medication needed between appointments. Thus, they receive their daily medication as required, but they are not allowed to possess two weeks worth all at once.

At a score of 40% the patient can possess at any given time no more than one-third of the medication needed between visits. They are still seen once every two weeks, but they must go to the pharmacy every 5-6 days and pick-up medication three times between their appointments. If the PCC drops further still, so does both the amount of medication the patient may have in their possession at any one time and the length of time between appointments.

At 20% PCC, the patient must now be seen once per week, and they must go to the pharmacy every 3-4 days (usually twice per week). Weekly appointments and multiple fills every week are often burdensome for patients. However, it is better to inconvenience a patient than to increase their risk of overdosing on pain medication due to their difficulty in accurately metering out larger quantities of medicine.

Finally, at 0% PCC, patients are also seen weekly by appointment, but they must go to the pharmacy every 1-2 days (three or more times every two weeks). Unfortunately, patients who continue to display difficulty with self-administration at this level of PCC are discharged from my care, as I am currently unable to provide any safer method of dispensing medication to them.

While specific examples of how to use PCC will be given later (see Examples Of Using PCC below), the percentage scale discussed above can be summarized in tabular form as follows:

<u>PCC Score</u>	<u>Patient Seen Every</u>	<u>Medication Dispensed Every</u>
100%	2 weeks	14 days
80%	2 weeks	14 days (with counseling)
60%	2 weeks	7 days
40%	2 weeks	5 - 6 days
20%	1 week	3 - 4 days
0%	1 week	1 - 2 days

The goal of PCC is to allow patients to have the daily medication they need, without giving them access to more medication than they can demonstrate responsibility for at one time. Not all patients have the discipline to limit their use of this magic wand. This is not to say that such patients are bad people who do not deserve medication to manage their pain. It simply means that the physician must take responsibility for

dispensing amounts of medication which are in proportion to each patient's compliance characteristics. By using PCC, patient compliance and medication dispensing behaviors can be objectively calculated and controlled.

CALCULATING PCC:

The singular factor which determines PCC is the patient's ability to follow instructions. Keeping in mind that behavioral problems such as addictive personalities and the selling or sharing of medication are beyond the scope of pain management and this discussion, patients violate medication regimens in one of two ways: they either use medication ahead of time or they lose medication. In the first case, the patient has increased their dosage beyond the prescribed regimen without their physician's approval. If the patient had first called the physician and both agreed that it was appropriate to increase use of the medication prior to the next scheduled appointment, then this would not be a problem: the regimen would have been altered when the patient received new instructions. I always tell my patients, "It is not a problem to have a problem - it is a problem to have a problem and not tell me about it." When patients fail to consult with their doctors prior to such increases, they are cutting physicians out of the treatment loop and may be entering uncharted or, worse yet, unsafe territory.

The second way in which patients violate their regimens is to lose medication. Lost medication presents a danger not only to the patient, but to others as well. A patient who loses medication may not be able to refill the lost amount in time to avoid the onset

of withdrawal symptoms. In addition, there is the added danger of not knowing where the medication is. Did they leave it where a child may now have access to it? Did someone else steal it to use in an unauthorized or even dangerous fashion? What will be the final disposition of the unaccounted for medication, and who might be affected by it? These are all serious questions which arise anytime pain medication is lost.

Since they will both run out early, patients who lose pain medication are treated the same way as those who overuse it. Patients who have lost their medicine might complain that they are being treated unfairly, as they did not use the missing medication. However, the physician has no way of confirming the disposition of lost medication (did the patient really lose it, or are they trying to cover up the fact that they exceeded their regimen without the physician's approval?). Therefore, lost medication results in the same consequences as medication overuse: the PCC is lowered so that the patient may continue treatment while avoiding the risk of withdrawal or the need to seek assistance elsewhere.

To calculate changes in PCC, my CPMP combines two separate point systems. The first of these is concerned with communication and asks, "Did this patient use their medication within its prescribed limits, or communicate to me that there was a problem before they exceeded those limits?" If the answer to this question is yes, then this is good communication and the patient gets plus-one (+1) communication points. If, however, the answer to this question is no, then this is poor communication and they get minus-one (-1) communication points.

It would be ideal if all patients called me before exceeding their regimen, but this is not always practical. If the patient has a sudden spike in symptoms at three in the

morning, they may take an additional pill or two at that time rather than pick up the phone to call the doctor. Over the one to two weeks scheduled between appointments, one or two pills here or there can suddenly add up to being two to three days short of medication. Thus for practical reasons, if a patient calls me with at least two days of medication left as per their prescribed regimen (not the patient's altered version of the regimen), then they are given credit for fair communication and assigned zero (0) communication points. The communication point system can be tabulated as follows:

<u>Medication Remaining</u>	<u>Communication</u>	<u>Communication Points</u>
On schedule per the regimen	Good	+1
At least 2 days worth	Fair	0
Less than 2 days worth	Poor	-1

The second point system I use to calculate PCC is concerned with medication. At each scheduled appointment, and whenever a patient calls to tell me they have overused or lost medication, I inquire as to how many pills they have left. I then subtract this number from the amount they were originally dispensed to determine how many pills they have used (and/or lost) on a daily average basis since their last dispense date. If the patient is within their prescribed regimen, then they receive plus-one (+1) medication points. On the other hand, if there is an increase of less than 10% over what they were prescribed, then the patient receives zero (0) medication points. For an increase of 10% to 24% they receive minus-one (-1) medication points, from 25 to 49% they receive minus-two (-2)

medication points, from 50% to 99% they receive minus-three (-3) medication points, and from 100% and beyond they receive minus-four (-4) medication points. The medication point system can be tabulated as follows:

<u>Medication Increase</u>	<u>Medication Points</u>
0 %	+1
1 - 9 %	0
10 - 24 %	-1
25 - 49 %	-2
50 - 99 %	-3
100 % or more	-4

Once both the patient's communication and medication points are calculated, they are used to adjust the PCC. Therefore, each time a patient has an appointment or unanticipated problem, it is an opportunity for them to improve or diminish their PCC score. However, special consideration must first be given to determine how often to change a patient's compliance code rating. Some patients call my office every day or two to report a significant item or issue. Does this mean I should give them plus-one (+1) communication points each time? No. I have taken the position that treatment for pain is a right, but access to medication is dependent upon compliance. It only takes a moment through overused or lost medication to show me that someone is non-compliant. In contrast, it takes considerable time for a patient to prove to me that their compliance has

truly improved. Thus, while I will reduce a patient's PCC one level (-20 percentage points) every time they accrue a single negative communication or medication point, I will only increase PCC at regularly scheduled appointments. In addition, if an increase is indicated, I will usually change the PCC only one level (+20 percentage points) per visit, regardless of the total number of positive communication or medication points earned. Finally, if there are any extenuating circumstances, the variety of which are too numerous to discuss here, the PCC may be further altered beyond the calculated score as the physician deems appropriate (see Examples Of Using PCC, #3, below).

EXAMPLES OF USING PCC:

1. Overuse of medication: Patient X is a 45 year old male who suffers chronic lower back pain due to a herniated L4-5 disc from lifting boxes at work eight years ago. Orthopaedic evaluation determines he is a surgical candidate, however, patient X refuses surgery due to the risk of losing his current mobility. X has been under treatment at my CPMP for the past two years. By using pain medication, he is able to continue to work, though he is no longer supposed to do any lifting.

Patient X is prescribed oxycodone 5 mg, one every four hours if needed for chronic back pain, with a maximum of 6 tablets per day. He has 100% compliance, returning every two weeks for follow-ups, and at his last appointment on May 1st he received a single prescription of 84 tablets (6 tablets per day times 14 days). One May 12th, however, three days prior to his next scheduled appointment, X calls to tell me that

he ran out of medication that morning due to lifting boxes at work. Immediately I recalculate his PCC (see point tables above):

Communication points: The patient called after he ran out of medication, so he receives minus-one (-1) communication points.

Medication points: The patient used 84 pills in 11 days, rather than over 14 days as instructed, averaging 7.6 pills per day (84 divided by 11). This is a 27% increase over his prescribed regimen of 6 pills per day. Therefore, he receives minus-two (-2) medication points.

Patient X has earned a total of minus-three (-3) communication and medication points. He is rescheduled to be seen that day (May 12th), and his compliance code rating drops three levels from 100% to 40%. Hence, his next appointment after the 12th will be two weeks later on May 26th. In addition, he will have to go the pharmacy three times between these appointments, each time picking up approximately one-third of the total medication he will need between the visits. As his flare in lower back pain has subsided by the time I see him on the 12th, I keep X on the same medication regimen. He also receives extensive counseling at each visit regarding the proper use of his pain medication and why he should avoid lifting at work, and his pain syndrome is reviewed to determine if any new diagnostic or treatment approaches are warranted (none currently are).

During the two weeks between May 12th and May 26th, patient X refills his medication three times as instructed, and he does not overuse the prescribed amount (this is verified by a daily medication log all patients in my CPMP are instructed to use). At his follow-up on May 26th, I again recalculate his PCC rating:

Communication points: The patient used the medication as prescribed and receives plus-one (+1) communication points.

Medication points: The patient used no more than 84 pills over 14 days as prescribed and receives plus-one (+1) medication points.

X has earned a total of plus-two (+2) communication and medication points at this visit. His compliance code rating, however, is only increased to 60%, as I will elevate PCC no more than one level between each appointment (see Calculating PCC above). Therefore, he stays on two week follow-ups, but may now go weekly to the pharmacy before his next appointment in June. If he continues displaying proper medication use at this first visit in June, he will again accrue a total of two more communication and medication points, and his compliance code rating will again be elevated by one level to 80% (earning him one dispense of medication for the two weeks between appointments). Finally, if he remains in good compliance until his second appointment in June, his rating will be returned to 100% as before the incident in May.

Through PCC, patient X was allowed to continue his treatment with me, but under greater restriction until such time as he had successfully demonstrated his ability to accurately self-dispense his medication between appointments.

2. Lost medication: Patient Y is a 29 year old female who suffers from cervical radiculopathy affecting her right arm and hand which began after a car accident two years ago. Neurological evaluation determined she is not a surgical candidate, and physical therapy combined with a series of three epidural injections have provided her with little relief. She is a high school science teacher and has been enrolled in my CPMP for six months, with a consistent compliance code rating of 100%. At her most recent visit on October 10th, I prescribed her hydromorphone 4 mg, #½ to #1 every 8 hours if needed (maximum of 3 per day). She received a single prescription for 42 tablets (3 tablets per day times 14 days), and she was scheduled for follow-up in two weeks on October 24th. Eight days later, on October 18th, Y calls to say that someone stole her pocket book at school and that all of her medication was in it. Immediately I recalculate her PCC (see point tables above):

Communication points: The patient had no medication when she called, so she receives minus-one (-1) communication points.

Medication points: The patient's lost medication is treated the same as used medication (see Calculating PCC above) with

no pills remaining after 8 days. This is equivalent to her having used 5.25 pills per day (42 divided by 8), which is a 75% increase over her prescribed regimen of 3 pills per day. Therefore, she receives minus-three (-3) medication points.

Patient Y has earned a total of minus-four (-4) communication and medication points. She is rescheduled to be seen that day (October 18th), and her compliance code rating drops four levels from 100% to 20%. Hence, her next appointment after the 18th will be one week later on October 25th, and she will have to go the pharmacy twice between these appointments (once every three to four days), each time picking up approximately one-half of the total medication she will need between these visits. Though Y will likely object to this treatment and feel like she is being punished for something that she did not do, she will receive extensive counseling on the dangers of lost medication (see Calculating PCC above) and the need for patients to be responsible for their medication at all times. If things go well, at her one week follow-up on October 25th, her compliance code rating will be elevated to 40%, returning her to appointments every two weeks. However, like patient X (see example #1 above), she will be required to continue making multiple visits to the pharmacy between appointments until she at least reaches the 80% rating level.

3. Other (non-medication) issues: Patient Z is a 58 year old male who has been

unemployed for the past twelve years due to a back injury he suffered while snow skiing. A spinal fusion six years ago of the affected area (T4-6) did not improve his situation. Z is able to do little exercise because of his back, so the benefits of physical therapy have been limited. He has smoked two packs of cigarettes per day since he was a teenager, eats a mostly high carbohydrate diet, is 60 pounds overweight, and refuses to make needed behavioral changes in his lifestyle. Due to the onset of both significant COPD and IDDM approximately four years ago, he is no longer a candidate for further surgery. He is being followed by both his primary care physician and a pulmonologist, and he has been enrolled in my CPMP since last year for pain medication management only. I maintain Z on a regimen of daily oral morphine which allows him to adequately perform all of his activities of daily life (ADL's) and instrumental activities of daily life (IADL's), and he enjoys a modest social life with his wife and family. He has never lost or overused his medication, and his compliance code rating has always been 100% throughout his treatment with me.

One month ago I instructed Z to get lab work done, which all patients in my CPMP routinely do at least once every six months (a CBC with differential and platelet count, a metabolic panel, and liver function tests). I do not draw blood in my office, so patients must go to an outside clinic or lab to have it done. Z has procrastinated on doing this, so at his most recent appointment on March 16th, I explain to him that I am decreasing his compliance code rating to 80%, and that at each visit he continues to come without his completed lab work, I am going to decrease his compliance code rating by another 20 percentage points. Therefore, if he does not bring me his lab work by his next appointment on March 30th, his compliance code rating will drop to 60% and he will have

to pick-up his medication twice before his first appointment in April. However, I tell him that as soon as he brings me his labs, I will return his compliance code to 100%.

I explain to Z the importance of these simple labs and the early warning signs they can give us regarding potential health problems. While his medication use has been exemplary, I feel that by not doing his lab work in a timely fashion, he is placing himself in danger the same as if he had overused his medicine (what if his labs indicate kidney problems which might make the current level of medication inappropriate due to complications of elimination leading to a toxic build-up of metabolites?). Therefore, I am using PCC to inspire this patient to comply with all of his instructions, and not just those involving the use of his pain medication. The effectiveness of this technique is apparent, as Z brought me his lab results 6 days later on March 22nd (everything was fine, including his BUN and creatinine levels).

SPECIAL CIRCUMSTANCES:

The purpose of PCC is not to punish patients, but to ensure their safety. Through communication and medication points, patients can elevate or drop their standing along the PCC scale, thereby continuing their treatment safely by not allowing them to have too much medication in their possession at any one time. PCC can even be used to address concerns other than medication use, as outlined in example #3 above.

When a patient's PCC drops below 80% and I write several prescriptions for them

to fill during the one to two weeks between their regularly scheduled appointments, I do not make them come back to my office every time they need to go to the pharmacy. Instead, at each appointment they are given several prescription slips, each of which is specifically written to be filled on only one specified date. Keeping in mind that it is illegal to post-date a prescription (7), this is accomplished by writing on each slip, directly above the name of the medication being prescribed, the following restrictive statement:

FILL ONLY ON MM/DD/YY

For example, a patient who has a PCC of 60% will need to fill two prescriptions during the two weeks between appointments: a prescription the day of the current appointment, and one a week later in-between the two appointments. If the current appointment date is June 12, 2003, then the two prescription slips are both properly dated 06/12/03 (the date they were written). However, on each respective slip, just above the medication's name, the following restrictive statement is added:

<u>Prescription</u>	<u>Restrictive Statement</u>
Week 1	FILL ONLY ON 06/12/03
Week 2	FILL ONLY ON 06/19/03

To reinforce the restricted fill dates, I highlight these statements with yellow marker so as they stand out for the pharmacist to easily see. This helps to ensure the

patient is only dispensed the amount of medication appropriate to their current PCC score.

Unfortunately, no system is perfect, and a problem may arise when patients are given prescription slips prior to their designated fill dates: some patients will claim to lose a slip before they could fill it. This does not happen often, but when it does the question arises as to whether the patient actually lost the prescription slip, or are they trying to get an additional dispense of medication? There is usually no way to know for sure which of these two instances is true, however, steps must be taken to ensure it does not happen again. In these exceptional cases, I further enhance the restrictive statement as follows:

FILL ONLY ON MM/DD/YY AT XYZ PHARMACY

Under these circumstances, to avoid any appearance of physician coercion, the patient is asked which pharmacy they prefer to use. From then on, while their PCC is below 80%, the patient must fill their prescriptions only on the specified dates and only at the specified pharmacy. Now, if the patient ever complains again of a lost prescription slip, I can check with the selected pharmacy to verify whether or not it has been filled.

Finally, during periods a patient is under greater than normal stress (problems at work or home, pending surgery, death of a loved one, etc.) and, therefore, at greater risk of non-compliance, to better ensure safety I will purposefully reduce and hold their PCC score below it's calculated value until such time as the stressor in question has resolved.

CONCLUSION:

Like any tool, PCC is best used as a finely tuned instrument, and not as a sledge hammer. Whether treating patients with acute or chronic symptoms, each pain management program will have to individually modify PCC to fit the needs of its patient population. Overall, my patient population maintains an average compliance code rating of 80%, with approximately two-thirds of them scoring at or above the 80% level. The data I derived from this small group can neither confirm nor deny the usefulness of this technique. However, it does suggest that further evaluation of PCC is warranted to provide us insights regarding the potential benefits of this tool in both out-patient and institutional settings. Standing alone, PCC is no more or less likely to be useful than any other method a pain management physician might employ. However, combined with the other facets of a multi-disciplinary approach to chronic pain management, PCC may be a valuable and vital component for providing safe and effective relief to those suffering from pain.

DEDICATION:

This paper is dedicated to my parents Carol and Bert Mitchell, my brother David Mitchell, and my best friend Joy Dann. Collectively, they have suffered the pain of my ongoing growth and development as both a physician and a person, with little or no complaints. I thank you.

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