

Mississippi Workers' Compensation Commission Guidelines for the Prescription of Opiates

I. Introduction

There is insufficient data to show the long-term use of opioids effectively treats chronic nonmalignant pain¹. Chronic pain has been variably defined but is defined within this guideline as pain that typically lasts more than three months or past the time of normal tissue healing.

There is sufficient data to show opioid pain medication use presents serious risks, including overdose and opioid use disorder. Nevertheless, opiates are commonly prescribed for pain. An estimated 20% of patients presenting to physicians' offices with non-cancer pain symptoms or a pain-related diagnosis receive an opioid prescription². In 2012, 259 million prescriptions for opioids were written in the United States, enough for every adult in the United States to have a bottle of pills³. And rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population.⁴

The use of prescription opioids has risen significantly in the last fifteen years, more so for family physicians, general practice physicians, and internal medicine physicians, compared with other specialties⁵. As the number of opioid prescriptions for chronic pain have increased, so has the incidence of addiction. From 1999 to 2014, more than 165,000 persons died from overdoses related to opioid pain medications in the United States⁶. A recent study of patients B ages 15 to 64 who received opioids for chronic noncancerous pain and were followed for up to 13 years B revealed that 1 in 550

patients died from opioid-related overdose at a median of 2.6 years from their first prescription. One in 32 patients who escalated opioid dosage greater than 200-morphine-mg equivalence died from opioid-related overdose⁷.

Opioids have also been associated with increased duration of disability, even when adjusted for injury severity in injured workers with back pain⁸.

II. Scope

These guidelines do not focus broadly on pain management, but rather focus on the use of opioids to manage non-cancer related pain. They apply to all clinicians who prescribe opioids, including nurse practitioners, physician assistants, podiatrists and dentists.

Clinicians should follow the guidelines. However, failure to follow a guideline will not warrant a denial of service, with the following exceptions: Section V.C.; VII. B. 9.; E. 2. and 3. and F. 1. and 2.

III. Acute versus Chronic Pain

A. Acute Pain

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe (a) the lowest effective dose of immediate release opioids (b) in no greater quantity than needed for the expected duration of the pain that is severe enough to require opioids. Three days or less will often be sufficient. More than seven days will rarely be needed.

B. Chronic Pain

Opioids are not the preferred treatment for chronic pain. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are expected to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

IV. Opioids Pharmacology

A. Important Distinctions

- Tolerance refers to a state of adaptation in which exposure to a drug over time causes higher doses to be required to produce the same physiologic effect and/or marked diminished effect with continued use of the same amount of that drug.
- Dependence refers to a set of disturbances and body homeostasis that lead to withdrawal symptoms which are produced with abrupt discontinuation or rapid reduction of a medication. Administration of an antagonist can also initiate withdrawal symptoms.
- Addiction is a primary chronic neuro-biological disease with genetic, psychological, and environmental factors influencing its development and manifestations. It is a behavior pattern of drug craving and seeking which leads to preoccupation with drug procurement and aberrant pattern of use.

The drug use is frequently associated with negative consequences.

B. Choice of Opioids

The following guidelines apply when choosing an opioid.

1. There is no evidence that one long-acting opioid is more effective than another in improving function.
2. There is also no evidence that long-acting opioids are superior to short-acting opioids for improving function or pain or causing less addiction.
3. Long-acting opioids should not be used in the treatment of acute, subacute, or postoperative pain.
4. When choosing long-acting opioids for chronic pain management, it is reasonable to consider cost given the lack of superiority profiles for one medication over another.
5. There is no single formula for pharmacologic treatment of patients with chronic nonmalignant pain.
6. Medications with a greater safety profile should be used initially.
7. Use of methadone requires special precautions. Methadone may cause cardiac arrhythmia due to QT prolongation and has been linked to a greater number of deaths secondary to its prolonged half-life.
8. Meperidine should not be used for chronic pain. Meperidine and its active metabolite normeperidine present a serious risk of seizure and hallucinations.

C. Dosing and Time to Therapeutic Effects

Oral route is the preferred route of analgesic administration. Transbuccal

administration should be avoided in the treatment of chronic, nonmalignant pain. Immediate release fentanyl products (Actiq, Subsys) are not to be used for chronic, nonmalignant pain.

D. Side Effects

Opioid-induced side effects vary greatly, depending on the individual patient. Common side effects include nausea, vomiting, drowsiness, unsteadiness, confusion, dry mouth, pruritus, sweating, hallucinations, myoclonus, and respiratory depression. Constipation is the most common problem associated with long-term opioid administration and should be anticipated and treated prophylactically.

E. Drug Interactions

1. Patients receiving opioid agonists should not be given a mixed agonist/antagonist such as Pentazocine because doing so may precipitate withdrawal syndrome.
2. Sedating medications should be avoided or limited to very low doses, although total elimination of sedating medications is desirable whenever clinically feasible.
 - a. Avoid concurrent opioid and benzodiazepine use whenever possible.

V. General Caveats

A. Extreme Caution Needed

Extreme caution should be used when prescribing opioids for patients with one or more of these issues:

1. history of alcohol or other substance abuse;
2. chronic benzodiazepine use;
3. uncontrolled sleep apnea;
4. severe personality disorder or other known severe psychiatric disease;
5. decreased physical and mental function with continued opioid use; and
6. addiction behaviors including preoccupation with drugs, strong preference for short- acting over long-acting opioids, use of multiple prescribers/pharmacies, use of street drugs or other patient=s drugs, not taking medications as prescribed, losing medication on more than one occasion, and criminal behaviors such as forged prescriptions

B. Warning Signs of Addiction

The following behaviors, frequently seen in patients who abuse prescription drugs, are warning signs for addiction:

1. unusual knowledge of controlled substances;
2. request for specific controlled substances;
3. claims to allergies to multiple medications;
4. demanding assessment of medication after usual clinic hours;
5. requesting refills because of loss or stolen medications;

6. physical signs of drug abuse;
7. no interest in the diagnosis;
8. failure to keep treatment or consultation appointments;
9. feigning or exaggerating physical problems;
10. pressuring the physician by eliciting sympathy, guilt or direct threats;
11. subjective complaints exceeding objective findings; and
12. attempts to transfer care after a doctor refuses to fill a prescription for a habit-forming medication.

C. Prescription Monitoring Program

The clinician shall review the patient's history on the state's Prescription Drug Monitoring Program whenever opioids are prescribed. The review (or the attempt to review the PMP if it cannot be accessed due to technical difficulties) should be documented or made part of the medical record.

VI. Conducting the Initial Evaluation

A thorough history and physical examination are the well-established foundation for diagnostic and therapeutic procedures.

A. History

The history should include:

1. general information: name, age, gender, etc.;
2. work history, including current job status and requirements of current job
3. current employment status;

4. impact on activities of daily living;
5. past and present psychological problems;
6. previous physical, emotional, or sexual abuse;
7. sleep disturbances;
8. pain history, including site of pain, visual analog scale, duration, onset, characteristics such as burning, shooting, stabbing, as well as aggravating or alleviating activities;
9. current and previous medication use;
10. history of substance abuse (i.e. alcohol, smoking, street drugs, opioids);
and

B. Review of Systems

The initial evaluation should include a standard multipoint review of systems, including symptoms of sleep apnea.

C. Physical Examination

1. The clinician should conduct and document:
 - a. a thorough physical examination, which includes a detailed musculoskeletal exam, including range of motion, mobility, provocative maneuvers, etc. and
 - b. a detailed neurologic evaluation.
2. Evaluation of nonphysiologic findings is critical in assessing if someone is a candidate for use of opioids. These signs should be measured routinely

during the patient=s care. This includes documentation of nonorganic signs such as:

- a. superficial and nonanatomic tenderness;
- b. pain with simulated axial loading and rotation;
- c. sensory and motor findings which are inconsistent with nerve root patterns or known organic dysfunction;
- d. inconsistent straight leg raise findings;
- e. overreaction to physical examination maneuvers;
- f. variability during formal exam, including variable sensory or motor exam as well as inconsistent tenderness; and
- g. inconsistencies between formal exam and observed abilities with range of motion, gait, and strength.

VII. Managing Patients Placed on Long-Term Opioids

A. Psychological Evaluation

Patients who are placed on long-term opioids (> 3 months) should undergo a psychosocial evaluation, including formal psychological testing by a psychologist with a Ph.D. or a physician with the appropriate credentials, as well as consideration for a concomitant interdisciplinary rehabilitation treatment. It is preferable that these professionals have experience in diagnosing and treating chronic pain conditions and that patients thoroughly understand the need to pursue pain management techniques in addition to medication use in order to

function with chronic pain.

B. Contraindications to Prescribing Opioids beyond Three Months

1. Opioids should be discontinued if the patient did not meet the goals to improve pain and function - particularly the functional goals - that were formulated when opioids were initiated.
2. Opioids should be discontinued if a psychological evaluation deems the patient a high-risk candidate for the use of controlled substances.
3. Opioids should be discontinued if they have not reduced the patient's subjective pain complaints by 30%, at a minimum.
4. Opioids should be discontinued if a patient cannot perform at least a sedentary level of work because of sedentary pain complaints. A patient may still be disabled from underlying significant objective physical abnormalities (i.e. severe neurologic deficit, loss of limb, severe structural orthopedic abnormalities, etc.).
5. Opioids should be discontinued if the patient cannot function secondary to side effects from the medication.
6. Opioids should be discontinued if the patient refuses non-interventional treatment options that might improve physical functioning and pain levels (i.e. physical therapy, cognitive behavioral therapy).
7. Opioids should be discontinued if the patient shows significant nonorganic behaviors, such as strongly positive Waddell's signs.

8. Opioids should be discontinued:
 - a. when the patient receives prescriptions from more than one practitioner or
 - b. when the patient has inconsistent drug screens, absent extenuating circumstances. Prior to discontinuation of the opiate, a confirmation GCMS drug screen must be done on the sample to ensure that a false-positive or false-negative has not occurred.
9. If there are extenuating circumstances which lead a clinician to believe an opioid should be continued despite one of the above contraindications, these must be clearly documented.

C. Before Starting Chronic Opioid Therapy

Before starting opioid therapy for chronic pain, clinicians should:

1. review the patient's history of controlled substance prescriptions using the state Prescription Drug Monitoring Program and make the review part of the medical record;
2. conduct urine drug testing;
3. establish treatment goals with the patient, including specific goals for improvements in pain and function, as the goal of treatment is to improve both;
4. discuss how opioid therapy will be discontinued *when* benefits outweigh risks, as opioid therapy should continue only if there is a clinically

meaningful improvement in pain and function that outweighs the risks of this treatment; and,

5. educate patients regarding the potential risks and benefits of use of chronic opioids.

D. When Starting Chronic Opioid Therapy

When initialing opioids for chronic pain, clinicians should:

1. prescribe immediate-release opioids rather than extended-release opioids;
2. use the *lowest* effective dose;
3. avoid prescribing opioid and benzodiazepines concurrently whenever possible;
4. require an opioid contract with the patient that details the clinician's expectation that the patient will comply with the prescribed medication regimen. Opioids should be terminated if the contract is broken.

Examples include but are not limited to:

- a. diversion of medication;
- b. noncompliance with drug dosing schedule;
- c. a drug screen that shows use of drugs outside of the prescribed treatment or evidence of noncompliant use of prescribed medications;
- d. a request for prescriptions outside of the defined time frame; and

- e. excessive dose escalation without physician approval.

E. Continuing Chronic Opioid Therapy

When continuing opioids for chronic pain more than three months, clinicians should:

1. conduct an ongoing review and clearly document:
 - a. improvements in the patient=s pain relief and functional status, as well as the patient=s appropriate medication use and side effects, and
 - b. the patient=s clinical status, including physical examination. (i.e. range of motion, neurologic exam, spasm, etc.) on each visit. Use of cut and paste EMR records which result in identical histories and physical examinations on each visit shall not meet this criteria;
2. Clinicians shall conduct random drug screens at least two times a year. Monthly drug screens are not indicated as they are by definition not random. If more than two drug screens are done in one calendar year, the clinician must clearly document why additional testing was required;
3. Clinicians shall review the patient=s history on the Prescription Drug Monitoring Program whenever opiates are prescribed. The review (or the attempt to review the PMP if it cannot be accessed due to technical difficulties) should be documented or made part of the medical record.

F. Escalating Opioid Dosage During Treatment

1. Before escalating opioid dosing, the clinician shall review the effectiveness of opioid treatment. Some degree of tolerance can be anticipated, but opioid therapy should be discontinued if dose escalations fail to recapture previous pain relief or restore function.
2. If the clinician escalates opioid dosing, the treatment goals of analgesic and especially functional improvement shall be specifically stated and clearly documented.

VIII. Tapering of Opioids

- A. Clinicians should evaluate the benefits and harms of continued therapy on a routine basis. If documented benefits do not outweigh harms, opioids should be tapered *and discontinued*.
- B. Patients who fail a trial of opioid medications but do not have an issue with addiction will not need to see an addictionologist. These patients can be tapered safely off their medications by their treating physicians. Weaning protocols vary. Conservative approach recommends a 10% reduction in the original dose per week. Other sources state that a 25% reduction every four days should avoid withdrawal syndrome. If drug diversion is suspected, then prescribing additional opiates is not indicated. The prescription of additional opiates in this situation will constitute a greater risk to the patient or the community than the potential for withdrawal syndrome.

IX. Opioid Abuse Disorder

A. DSM V Opioid Use Disorder Criteria

Opioid Use Disorder is specified instead of Substance Use Disorder if opioids are the drugs of abuse. A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 criteria is moderate, and 6-7 criteria is severe (APA, 2013):

1. taking the opioid in larger amounts and for longer than intended;
2. wanting to cut down or quit but not being able to do it;
3. spending a lot of time obtaining the opioid;
4. repeatedly unable to carry out major obligations at work, school, or home due to opioid use;
5. continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use;
6. stopping or reducing important social, occupational or recreational activities due to opioid use;
7. recurrent use of opioids in physically hazardous situations;
8. consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids;
9. tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (criterion does not apply when used appropriately under medical supervision); and

10. withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (criterion does not apply when used appropriately under medical supervision).

B. Mississippi Board of Medical Licensure

Once a physician recognizes that a patient has an addiction issue, per the Mississippi Board of Medical Licensure, the following applies:

No physician shall prescribe any controlled substance or other drug having addiction forming or addiction sustaining liability to a patient who is a drug addict for the purpose of >detoxification treatment= or >maintenance treatment= and no physician shall administer or dispense any narcotic controlled substance for the purpose of >detoxification treatment= or >maintenance treatment= unless they are properly registered in accordance with Section 303(g) 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are

being made for referral for treatment. Not more than one (1) day=s medication may be administered to the person or for the person=s use at one time. Such emergency treatment may be carried out for not more than three (3) days. USCODE-2011-title21/pdf/USCODE-2011-title 21-chap13-subchapl-part C-Sec823 states that a physician must be separately registered to treat substance abuse.

C. Treatment for Addiction

1. If an opioid abuse disorder manifests itself and is directly related to the use of controlled substances that were prescribed for a workers= compensation injury, the treatment for that addiction shall be compensable.
 - a. Treatment for addiction, including use of appropriate medications and psychotherapy, will be covered for one year unless the clinician documents that care beyond one year is medically necessary.
 - b. Not all patients who are addicted will require formal detoxification. Patients on lower doses of controlled substances often will not go through withdrawal. If, however, the patient is on a large dose which will cause withdrawal symptoms, then a

detoxification program is appropriate.

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