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Information about Opioid Medications  
for Patients, Prescribers and Policymakers

# Opioid Therapy and Physician Communication Guidelines



Medication  
Storage



Medication  
Disposal



Prescriber  
Education



Patient  
Information

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Guidelines were last updated on August 20, 2015.

Current version is available at

[www.massmed.org/opioid-guidelines](http://www.massmed.org/opioid-guidelines).

Adopted by the Massachusetts Board of Registration in Medicine:

August 2015



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# Best Practice Guidelines — Recommendations

## Position on Guidelines

The Massachusetts Medical Society (MMS) supports the position that physicians must use their best clinical judgment in the treatment of all patients. Guidelines exist in many areas to help physicians achieve the best possible outcomes for patients. We recognize that this document creates opioid prescribing guidelines that have general applicability and are most relevant in primary care. Specialty societies and specific practice settings may have more detailed recommendations for the care of patients. These guidelines have been adopted by the Board of Registration in Medicine and incorporated into their comprehensive advisory to physicians on prescribing issues and practices. The guidelines will provide valuable guidance to physicians in their practices and as evidence of best practices and to the Board in its responses to patient complaints, accusations of substandard care, or accusations of inappropriate prescribing.

Deviation from prescribing guidelines is not a *per se* violation of standards of care. As MMS policy states: “Practice guidelines are not intended to be unique or exclusive indicators of appropriate care. Any physician should be able to demonstrate that the care rendered is safe and appropriate, even if it may vary from the guidelines in some respects.”

## Elements

- 1. The MMS supports the adoption and dissemination of specific guidelines related to the prescribing of opioids.**
- 2. Separate guidelines are needed for treatment of acute and chronic pain.**
- 3. Chronic pain guidelines apply to patients who receive opioids for a more than 90-day period. This includes transferred patients with opioid treatment histories and existing patients who reach a 90-day period of treatment.**
- 4. Guidelines do not apply to patients with cancer, patients in hospice or palliative care, and inpatients of hospitals and nursing homes.**
- 5. Work is ongoing with appropriate specialists and specialty societies to review opioid prescribing issues and guidelines unique to specialties and practice settings. Physicians should review existing guidelines for their individual specialties.**

# Acute Care Guidelines

## Initiation of Opioid Treatment

1. Physicians must be familiar with and follow the requirements of the law and regulations on use of the prescription monitoring program prior to initiating opioid treatment.
2. Patients should also be screened or assessed for pregnancy, personal or family histories of substance use disorder, mental health status, or relevant behavioral issues.
3. Physicians prescribing opioids should inform their patients about the cognitive and performance effects of these prescriptions and warn them about the dangers to themselves and others in operating machinery, driving, and related activities while under treatment.
4. Patients with complex pain conditions, serious co-morbidities and mental illness, or a history or evidence of substance use disorder should be considered for consultation from a colleague or specialist referral.
5. When clinically indicated, opioids should be initiated as a short-term trial to assess the effects and safety of opioid treatment on pain intensity, function, and quality of life. In most instances, the trial should begin with a short-acting opioid medication.
6. The starting dosage should be the minimum dosage necessary to achieve the desired level of pain control and to avoid excessive side effects.
7. Duration should be short term with possible partial fill prescriptions or short term, low dosage sequential prescription approaches considered.
8. Physicians should be aware of published dosing guidelines for pediatric patients and consider body weight and age as a factor in treating pediatric patients.<sup>1</sup>
9. Concurrent prescriptions should be reviewed, including paying close attention to benzodiazepines and other medications that may increase the risks of harm associated with opioid use.
10. Physicians must maintain records and engage in patient assessments consistent with prescribing guidelines of the Board of Registration in Medicine, which are available on the Board's website.
11. Patients should be counseled to store the medications securely, never share with others, and properly dispose of unused and expired prescriptions.

## Common Elements of Best Practices for Ongoing Opioid Treatment of more than a 60-Day Duration

1. There should be regular visits scheduled for evaluation of progress.
2. Evaluating Opioid Treatment
  - a. Continuing opioid treatment should be a deliberate decision that takes into consideration the risks and benefits of ongoing opioid treatment for that patient. Patients and health care providers should periodically reassess the need for continued opioid treatment, tapering whenever possible, as part of the comprehensive pain care plan. A second opinion or consultation from a colleague or specialist may be useful in making that decision.
  - b. Routinely assess function and pain status. An assessment of function and pain should consistently measure the same elements to determine the degree of progress.

## Chronic Pain Guidelines

### Threshold for Considering Pain Chronic

1. The MMS supports a duration of treatment of 90 days, consistent with the Institute of Medicine's definition in the 2011 report *Relieving Pain in America*<sup>2</sup>, rather than morphine equivalents to trigger these guidelines.
  - a. This time period should trigger a face-to-face reevaluation of the treatment provided to date, its long-term efficacy, and risks of continued opioid therapy. Physicians should consider consulting with other physicians or referrals as part of the process in developing and implementing an ongoing treatment plan.

### Common Elements of Best Practices When a 90-Day Treatment Threshold Is Reached (To be implemented before continuing further opioid treatment)

1. A detailed reevaluation of the patient's history and a physical should be done as soon as possible after the 90-day threshold is reached.
2. The physician should have the patient complete an objective pain assessment tool. The MMS will work with an advisory group to provide recommended tools.
3. The physician should do a risk of substance abuse assessment.
  - a. The MMS will develop a list of recommended tools with assistance from the Massachusetts Chapter of the American Society of Addiction Medicine (MASAM).
  - b. The physician should consider the use of appropriate baseline urine drug testing if the risk assessment or other evidence indicates there may be issues with use of other drugs or with compliance with prescribed treatment.

4. The physician should tailor a diagnosis and treatment plan with functional goals at the initial 90-day threshold visit and every 60 to 90 days thereafter.
5. Chronic pain is multidimensional. Physicians should inform patient of the risks, benefits, and terms of continuation of opioid treatment. Alternative pain management options should be reviewed at the 90-day threshold visit and at subsequent 60 to 90 day follow-up visits.
6. Women should be counseled again on risks associated with opioid treatment and pregnancy.
7. Physicians should be aware of published dosing guidelines for pediatric patients and consider body weight and age as a factor in treating pediatric patients.
8. Physicians prescribing opioids should inform their patients about the cognitive and performance effects of these prescriptions and warn them about the dangers to themselves and others in operating machinery, driving, and related activities while under treatment.
9. The physician should review the patient's current prescription monitoring program record at the 90-day threshold visits and at every 60- to 90-day follow-up visit thereafter. One goal of this review is to avoid duplicative or conflicting treatments from other providers.
10. Treatment Agreements
  - a. A treatment agreement plan should be established and incorporated into the medical record that includes measurable goals for reduction of pain, reduction in opioid therapy concomitant with reduction or resolution of the pain, and improvement of function. Goals should include improved function and quality of life as well as improved control of pain, and should be developed jointly by the patient and the physician. It should address what circumstances would allow a patient to receive prescriptions from other providers.
  - b. It may be preferable for such a treatment agreement to be signed by the patient, with an updated signature at least yearly.
11. Physicians should discuss risks and warning signs of opioid dependence and addiction with their chronic pain patients.
12. Physicians should discuss naloxone and its use to reverse overdoses. Physicians should offer to prescribe naloxone to their patients after such discussions.
13. Physicians who are not pain management specialists should not initiate treatment plans that call for in excess of 100 milligrams of morphine equivalent opioids per day without a documented consultation with a pain management specialist.
14. If a patient is currently receiving >100 mg morphine equivalent per day a plan should be instituted to begin tapering of the dose and, if not possible to do so, consultation with a pain management specialist should be obtained.
15. When possible, physicians should preferentially select abuse-resistant and abuse-deterrent medications when clinically indicated.
16. If high risk or low benefit warrants a discontinuation of opioid therapy, physicians should prescribe non-opioid alternatives for continued pain management.

# Opioid Prescribing Guidelines — References

Federation of State Medical Boards — *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain*; July 2013. Available at: [http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pain\\_policy\\_july2013.pdf](http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/pain_policy_july2013.pdf)

## State-Based Guidelines

Indiana State Medical Association, adopted by Indiana Medical Licensing Board. *Indiana Pain Management Prescribing Final Rule*; September 2014. Available at <http://www.ismanet.org/pdf/legal/IndianaPainManagementPrescribingFinalRuleSummary.pdf>

Oklahoma State Department of Health. *Opioid Prescribing Guidelines for Oklahoma Health Care Providers in the Office-Based Setting*; September 2014. Available at [http://www.ok.gov/health2/documents/UP\\_Oklahoma\\_Office\\_Based\\_Guidelines.pdf](http://www.ok.gov/health2/documents/UP_Oklahoma_Office_Based_Guidelines.pdf)

Utah Department of Health. *Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain*; 2010. Available at <http://health.utah.gov/prescription/guidelines.html>

The Department of Veterans Affairs and the Department of Defense. *Clinical Practice Guideline: Management of Opioid Therapy for Chronic Pain*; May 2010. Available at [http://www.va.gov/painmanagement/docs/cpg\\_opioidtherapy\\_summary.pdf](http://www.va.gov/painmanagement/docs/cpg_opioidtherapy_summary.pdf)

Washington State Agency Medical Directors. *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An education aid to improve care and safety with opioid therapy*; updated in 2010. Available at <http://www.agencymeddirectors.wa.gov>

## Specialty Society-Based Guidelines

American Pain Society/American Academy of Pain Medicine. *Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain*; 2009

Chou R, Fanciullo GP, Fine PG, Adler JA, Ballantyne JC, Davies P et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*. 2009;10(2):113–130

American College of Occupational and Environmental Medicine. *Guidelines for the Chronic Use of Opioids*; 2011. Available at <http://www.agencymeddirectors.wa.gov/opioiddosing.asp>

Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, Boswell MV, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 1 — evidence assessment. *Pain Physician*. 2012

Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, Boswell MV, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2 — guidance. *Pain Physician*. 2012;15(3 Suppl):S67–116

## Resources

Massachusetts Medical Society — Smart and Safe

Resources for physicians and patients for opioid abuse prevention and treatment: [www.massmed.org/smart-and-safe](http://www.massmed.org/smart-and-safe)

## Endnotes

<sup>1</sup>American Academy of Pediatrics. The assessment and management of acute pain in infants, children, and adolescents. *Pediatrics*. 2001;108(3):793–797. Available at <http://pediatrics.aappublications.org/content/108/3/793.full>

<sup>2</sup>Institute of Medicine (US) Committee on Advancing Pain Research, Care and Education. *Relieving Pain in America: A Blueprint For Transforming Prevention, Care, Education, and Research*. Washington, (DC): National Academies Press (US); 2011



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