



MASSACHUSETTS  
MEDICAL SOCIETY

# OPIOID PRESCRIBING GUIDELINES

# Opioid Prescribing Guidelines

## 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. These opioid prescribing guidelines have general applicability and are most relevant in primary care. Specialty societies and specific practice settings may have more detailed recommendations. The guidelines provide valuable guidance to physicians in their practices, as evidence of best practices.

## Elements

1. The MMS supports the adoption and dissemination of specific guidelines related to 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 more than a 90-day period. This includes patients new to the prescriber with existing opioid treatment histories, and established patients who reach a 90-day period of treatment.
4. These guidelines do not apply to patients with cancer, patients in hospice or palliative care, and inpatients of hospitals and nursing homes.
5. Physicians should review existing guidelines for their individual specialties and practice settings.

# Acute Care Guidelines

## Initiation of Opioid Treatment

1. Physicians must be familiar with and follow the requirements of opioid prescribing laws and regulations, and the use of relevant prescription monitoring programs prior to prescribing opioids.
2. Patients must be screened or assessed for pregnancy, personal or family histories of substance use disorder, mental health status, or relevant behavioral issues prior to prescribing opioids.
3. When prescribing opioids physicians should inform patients about the cognitive and performance effects of these medications, warning about the dangers to themselves and others when operating machinery, driving, and related activities while under treatment. Patients should also be informed of the unintended risks of dependence, addiction, overdose, and death.
4. Patients with complex pain conditions, serious co-morbidities and mental illness, or a history or evidence of a substance use disorder should be considered for a consultation from a colleague or referral to an appropriate specialist.
5. When clinically indicated, opioids should be initiated as a short-term trial to assess the effectiveness 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 always be the minimum dosage necessary to achieve the desired level of pain control while avoiding excessive side effects.
7. Initial duration should be short term, typically 3–5 days for most acute conditions, infrequently more than 7 days. Possible partial fill prescriptions or short term, low dosage sequential prescription approaches may be 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, especially paying close attention to benzodiazepines and other medications that may increase the risk of overdose associated with opioid use. Patients should be informed about these risks, and educated about the use of naloxone.
10. Physicians must maintain records and engage in patient assessments consistent with prescribing guidelines of relevant licensing boards.
11. Patients should be counseled to store medications securely and keep track of the number of pills used. Patients should also be reminded to never share medication with anyone, including family members and properly dispose of unused and expired pills.

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

1. There should be regularly scheduled visits for evaluation of response, benefit and complications.
2. Evaluating Opioid Treatment
  - a. Continuing opioid treatment should be a deliberate decision that considers the risks and benefits of ongoing opioid treatment for that patient. As part of the comprehensive pain care plan, patients and prescribers should periodically reassess the need for continued opioid treatment, tapering whenever possible. 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 re-evaluation of the treatment provided to date, its long-term efficacy, and risks of continued opioid therapy. Physicians should consider consulting with other physicians or initiate a referral to a specialist 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.
3. The physician should do a risk of substance abuse assessment.
  - a. 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 and alternative pain management options should be reviewed at the 90-day threshold visit and at subsequent 60- to 90-day follow-up visits. Physicians should inform patients of the risks, benefits, and terms of the continuation of opioid treatment.
6. Women of childbearing age should receive ongoing counseling on the 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.<sup>1</sup>
8. When prescribing opioids, physicians should inform patients about the cognitive and performance effects of these medications warning about the dangers to themselves and others when 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, or more frequently if required by their state laws or regulations. One goal of this review is to avoid duplicative or conflicting treatments from other prescribers.
10. Treatment Agreements
  - a. A treatment agreement plan should be established and incorporated into the medical record. It should include measurable goals for reduction of pain, reduction in opioid therapy concomitant with reduction or resolution of pain, and functional improvement. Goals should include improved function and quality of life as well as improved control of pain. The agreement should be developed jointly by the patient and the physician. It should also address what circumstances would allow a patient to receive prescriptions from other prescribers.
  - b. It may be preferable for a written treatment agreement to be signed by the patient, with an up-dated signature at least yearly.
11. Physicians should discuss risks and warning signs of opioid dependence and addiction with patients being treated for chronic pain.
12. Physicians should discuss the unintended risks of overdose and/or death, and the use of naloxone to reverse overdoses. Physicians should offer to co-prescribe naloxone to patients after such discussions.
13. Physicians who are not pain management specialists should not initiate treatment plans that call for >100 mg 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 the dose and, if not possible to do so, consultation with a pain management specialist should be obtained.
15. When clinically indicated and possible, physicians should preferentially select abuse-resistant and abuse-deterrent medications.
16. If high risk or low benefit warrants discontinuation of opioid therapy, physicians should prescribe non-opioid alternatives for continued pain management.

## 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)

## Evidence Based Methodologies for the Management and Prevention of Prescription Drug Misuse

Opioid Risk Tool (ORT) [[drugabuse.gov](http://drugabuse.gov)]

Screening, Brief Intervention and Referral to Treatment (SBIRT) [[samhsa.gov](http://samhsa.gov)]

Screening and Opioid Assessment for Patients with Pain (SOAPP) [[painedu.org](http://painedu.org)]

Screening Tool for Addiction Risk (STAR) [[practicalpainmanagement.com](http://practicalpainmanagement.com)]

## 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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Available at [www.massmed.org/opioidprescribingguidelinesext](http://www.massmed.org/opioidprescribingguidelinesext).