Chronic Opioid Clinical Management Guidelines for Wisconsin Worker's Compensation Patient Care

Emerging medical evidence shows that the previously pursued practice patterns of using higher dose chronic opioids rarely results in sustained improvements in pain control and function, but has resulted in increased addiction and death nationally over the last 10 years. These Clinical Guidelines will assist you in managing your patients with chronic pain.

For any worker's compensation patient who will need opioid treatment for a period of more than 90 days, the treating physician should follow these guidelines and or consider referral to a Pain Management specialist.

The following steps for patients who require chronic opioid treatment for a worker's compensation injury should be followed:

1. **The Pain Generator Must be Adequately Evaluated**

   - A clear etiology and diagnosis of the pain should be identified and documented at every visit. "Chronic Back/Neck Pain" is a symptom, not a diagnosis.

   - Not all pain conditions are opioid responsive; therefore, not all diagnoses that cause pain are appropriate for chronic opioids. Chronic headaches and fibromyalgia would be examples of diagnoses that are not appropriate to be treated with chronic opioids.

   - If you are not able to identify (a) specific medical diagnosis(es) responsible for the patient's pain, then consider that the patient has not been properly worked up for a pain generator or the patient does not have a medical diagnosis that warrants the use of chronic opioid therapy. If the patient requires further work up, document what the evaluation plan is while the patient is on the opioids (initial visit and possibly thereafter if indicated).

2. **Non-opioid Options Need to be Presented to the Patient**

   - Opioid therapy truly needs to be considered a last resort.

   - All alternative treatment options must be discussed with the patient.

   - Some examples of non-opioid therapy would be chiropractic treatment, physical therapy, cognitive behavioral therapy, massage therapy, local injections, non-opioid pain medications, surgery, integrative medicine and TENS units.

3. **Patient Criteria for Long Term Opioid Therapy?**

   - The following criteria help to identify appropriate candidates (all of these should be specifically documented in the medical record):

     - Patients ***must*** have persistent (i.e. daily) moderate to severe pain (pain 5 and over on the 10 point scale).
     - Patients ***must*** have daily, describable functional limitations due to pain.
     - Identifiable medical diagnosis, known to be appropriate for chronic opioids therapy (i.e. the pain generator/Diagnosis is not chronic pain syndrome, pain, or headache etc).
     - **Minimum risk profile as identified by standard screening (SOAPP recommended).** Formalized risk assessment on the first visit should be done using an established tool, such as SOAPP (a self-report questionnaire available online that the patient fills out and you score. SOAPP information can be found at www.painedu.org/soapp-development.asp and downloadable at the same site after registering).
     - Absence of or, if present, concurrent treatment with psychiatrist of coexistent psychiatric conditions should be included.
     - Patient is not actively using illegal substances **(urine drug screening before starting chronic opioid therapy is imperative)**. Part of the risk assessment should include searching the Prescription Drug Monitoring Database (the State-housed depository of all

controlled Substance prescriptions filled at any Wisconsin pharmacy for every person that receives a scheduled medication, accessible for registration at http://dsps.wi.gov/Default.aspx?Page=cccf5c16-98f8-41c6-8906-ce29763de6c4) prior to writing a prescription for any scheduled medication. This enables you to identify whether or not the patient is getting opioids or other scheduled medications from a provider other than you and therefore exhibiting a high risk behavior or potentially violating the treatment agreement.

- **Lack of other aberrant behaviors (make certain to carefully review the patient's past history for evidence of failure to follow previous opioid treatment agreements).** Consider searching the Prescription Drug Monitoring Program (**pdmp@wisconsin.gov**) and or the Wisconsin Circuit Court site, at http://wcca.wicourts.gov/index.xsl to help identify if the patient has had any previous drug-related legal problems, which can identify at-risk individuals.
- Potential chronic opioid therapy benefits should outweigh the risks.

For patients with high SOAPP scores and unclear clinical conditions, consideration can be given to not offering chronic opioid therapy because the risks outweigh benefits. If the patient is already on them, they could be appropriately discontinued.

If the patient is not appropriate to receive chronic opioids for the pain condition, clearly explain in your note, and why you came to that conclusion.

4. Required Documentation and Management on Initial and Subsequent Visits for Patients on, or Starting, Chronic Opioids

- Informed consent discussion documented on the first visit.
- Opioid treatment agreement ("narcotic contract") should be signed before starting opioids and yearly afterwards.
- **Chronic opioid therapy is a goal-directed therapy, and goals must be stated so that if they are not met, the medications can be appropriately discontinued.** Goals of chronic opioid therapy include
  - ***Sustained*** pain reduction (at least 30% as compared to pre-treatment).
  - ***Sustained*** functional improvement.
  - Strict compliance with the opioid treatment agreement.
- It is important to have objective information regarding pain and functional abilities that can be followed over time in order to ensure that therapy goals are being obtained and sustained; therefore, ***such assessment needs to be documented at each visit.***
  - Pain assessment using the standard 10-point pain scale is appropriate. In addition, it is often helpful for the patient to rate "best pain," "average pain" and "worst pain" on the 10-point scale.
  - The Oswestry scale can be used for low back pain patients. The Brief Pain Inventory (long or short forms) and/or SF-12 can be used for all types of pain patients. All are self-report scales and available online.
- The Oswestry Disability index with instructions can be found and downloaded from http://www.aadep.org/documents/filelibrary/presentations/pmd_evaluation martin_and pilley_aafp/Appendix_D_The_Oswestry_Disability_E42C3CC567278.pdf
- The SF-12 can be downloaded from http://ckm.osu.edu/sitetool/sites/orthopublic/documents/research/trauma/SF12.pdf
- Document the patient's general appearance, functionality in the office setting and mentation to show that there are no observable adverse effects or toxicities associated with medications. Also,

document whether or not thee observations are consistent with whatever pain ratings the patient provides. This should be done every visit.

- **The SOAPP tool should be re-administered any time the patient shows any aberrant behavior**

- Visit intervals of no longer than once every month while you are actively titrating any patient are advisable. The patient is in the titration phase any time you are actively adjusting medications and it is not appropriate to adjust medications and have the patient return at intervals greater than 4 weeks. Stable patients can be seen every other month.

- Consider explaining to patients on higher doses of opioids that newer clinical evidence demonstrates that lower doses of opioids are just as effective in maintaining sustained functional improvements and pain reductions and are safer; therefore, you would like to begin to wean the medications and closely follow the patient's functional and pain scores. Very frequently, as opioids are weaned, patients have minor and short-term/self-limiting increases in pain scores with no significant functional decline and they do just fine as the opioids continue to be weaned.

- Address known side effects. It is highly unusual for a patient who is compliant with taking chronic opioids to ***not*** have constipation; therefore, all patients should be on appropriate medication (Senna or Miralax are good choices). If a patient claims to not be constipated, consideration should be given to diversion/noncompliance and immediate urine drug screening is recommended. Of course, it is always possible a compliant patient is not constipated, but that is the exception, not the rule.

- **Compliance monitoring is mandatory for all patients on chronic opioid therapy, regardless of age.**

    - Urine drug screen first visit and with aberrant behavior.
    - Pill counts thereafter and/or unannounced urine drug screens.
    - Make certain to be familiar with the limitations, if any, of the specific urine drug screen that you are performing. For example, some "standard" drug screens do not identify synthetic opioids even if the patient is taking them as prescribed.

- Clinical Management Tool: Always assess and document **The Five A's"**:

    1. **A**nalgesia – adequate pain relief with opioids,
    2. **A**ctivity increase – increase in activities and function,
    3. **A**dverse effects – such as drowsiness and mental changes that effect function suggest inappropriate use,
    4. **A**berrant behavior – such as stolen or loss of opioids, frequent refills, obtaining opioids from multiple physicians or Urine Drug Test revealing NO opioids or other non-prescribed drugs, and
    5. **A**ffect – changes in mood-more depression and anxiety with opioids (Remember that when opioids are used appropriately the individuals function and mood improves and when used inappropriately the individuals function and mood or adversely effected)

5. Opioid Dosing and Guidelines

- **Chronic opioid therapy is a goal directed therapy. If the patient is not meeting the goals of therapy, opioids should be discontinued**.

- The following lists general morphine dose equivalents (MDE), which can facilitate conversion from one opioid to another (all in oral doses). Specific cross-tolerance varies from patient to patient and so care need be taken when converting from one to another.

    - 30 mg of morphine = 20 mg of oxycodone = 6 mg of hydromorphone = 10 mg of oxymorphone = 20 mg of hydrocodone = 120 mg of codeine
    - 50 mg of morphine = 25 mcg of transdermal fentanyl (this varies widely from 30 to 134 mg or morphine)
    - Buprenorphine patches 5 mcg = 10 mg morphine

- Methadone is a high risk drug and consideration should be given to not using it unless you have advanced training in pain management or the use of methadone.

- "Atypical" pain medications such as tramadol (immediate and extended release forms) and tapentadol (immediate release) can often be used instead of opioids and tend to have less problems with diversion and abuse.

- Oxycodone is highly desirable on the street and there are many other opioid alternatives; oxycodone products should be considered the last line opioid.

- It is becoming increasingly popular to treat patients with very high doses of immediate release opioid without the use of an extended release opioid. There is absolutely no physiological/pharmacological reason that immediate release products work fine but extended release products "don't work for me." Generally, this is because the immediate release opioids are much easier to abuse and divert than the extended release opioids, not because the extended release opioids "don't work."

- Once a patient reaches an opioid dose of 50 mg MDE, then the patient should be placed on an extended release opioid product.

- Not all pain is opioid responsive and, by the time you get to 120 MDE, if the pain is opioid responsive, the patient should report some sustained improvements in pain and function.

- Recent information indicates that doses over 120 mg MDE usually do not provide increased analgesia compared to doses under 120 MDE. This is considered a dosing "soft ceiling" and so if this dose is breached, be certain to clearly document what goals are expected to be attained with dose escalation. If the patient doesn't meet goals by a dose of 180 – 200 MDE, then the patient has opioid-unresponsive pain and the opioids should be appropriately discontinued.

- There is no clinical evidence that doses above 200 MDE per day result in improved analgesia. Doses of 200 MDE per day or above have 9 times the chance of adverse events. This is considered a dosing "hard ceiling" such that rarely this dose needs to be breached.

6. Alternative Pain Medications to Opioids

- Because there are many other chemical systems that participate in maintaining pain, it is perfectly reasonable to start **other adjunctive medications (tricyclics, SSRI's, gabapentin, tizanidine, other anticonvulsants, duloxetine, etc.) to help with chronic pain management at any point in the patient's treatment.** Such adjunct medications should be used in conjunction with taking advantage of side effects they may have that are beneficial (sleep induction for tricyclics and trazadone, for example).

- Daily dosing of "muscle relaxers" is **not indicated** for the treatment of chronic pain but may be helpful in treating their disordered sleep. **Carisoprodol specifically is NOT recommended for this purpose (oxycodone + diazepam + carisoprodol = "the holy trinity" on the street).**

    - Cyclobenzaprine immediate release or extended release is often effective and well tolerated at bedtime.

- **If benzodiazepines have been prescribed specifically as part of the patient's pain reduction treatment, then consideration should be given to discontinuing via a taper**. There is no evidence that this class of medication helps with pain reduction and adverse medication effects are many times more likely when patients are on benzodiazepines and opioids together. If benzodiazepines and opioids are necessary, then consultation with psychiatry is recommended to assist with whatever condition for which the benzodiazepines are needed since they are not indicated for management of chronic pain.

7. Addiction, Pseudoaddiction and Aberrant Behaviors Definitions

- Physicians improperly using the terms “addiction” and “drug seeking” is common in chronic pain management; however, “drug seeking” and “addiction” are not necessarily the same thing and they both have very negative stigma for our patients. ***Please use the appropriate terminology*** in your documentation.

- Likewise, “tolerance,” “physiologic dependence” and “addiction” are ***not*** the same thing. Do not use them interchangeably. Tolerance is the ability to “get used to” the medication such that increasing doses are needed over time in order to achieve the same results that had been achieved at lower doses of the substance. Physiologic dependence is a normal and totally expected outcome of using certain classes of substances (beta blockers, digitalis, benzodiazepines, opioids and alcohol) and is evidenced by identifiable withdrawal syndromes. The entities are different and documentation should not reflect confusion of the concepts.

- Addiction means that a patient is displaying particular maladaptive psychological behaviors associated with the opioid. If you think the patient is truly “addicted”, you must refer the patient to a licensed practitioner for appropriate treatment. Indicators of addiction include:

    - Any indication that the patient is using the pain medication for anything other than pain relief (frequently expressed as “I feel better” even though the objective pain assessments and functional scores are no better than pre-treatment or the patient vigorously objecting to changes in medication regimen when there is no objective evidence present opioid therapy is achieving any pretreatment goals).
    - Despite negative consequences directly related to the patient inappropriately taking/obtaining the medication (missing work, loss of personal relationships, stealing/lying to get more opioids, etc.), the patient cannot address them/stop taking the medication because the desire for the substance outweighs all else.
    - Craving the opioid for no apparent reason (i.e. pain doesn’t drive the desire for the drug).
    - ***Inability to reduce their medication dose even though the plan is to wean off the medication.*** This is a strong indicator of addiction. The non-addicted patients will typically wean off the medications as directed (provided that the titration is slow enough to avoid withdrawal). However, patients who are addicted will not be able to follow the directions.

- **“Aberrant behavior” is a general term describing abnormal patient behavior revolving around their opioid medications. Common examples of aberrant behavior include:**

    - Request for early refills, ***for any reason***
    - Noncompliance with the treatment agreement
    - Known criminal activity surrounding their medications or illegal substances “accidental” or purposeful)
    - Evidence of intoxication of any substance
    - Incorrect pill counts
    - Drug screen abnormalities
    - Patients admitting they use their medications for any purpose other than pain control (“I get high”, “I like how they make me feel”)

- Sometimes, a patient with certain (not all) aberrant behaviors may be demonstrating them because pain is undertreated (e.g. criminal activity is never a reasonable sign of undertreated pain). This type of patient realizes that when more opioid than prescribed is taken, pain is reduced and function improved. This type of behavior is called **“pseudoaddiction.”** Pseudoaddicted patients are often branded “addicts” and “drug seekers” as they try to find pain relief and, often, they run out of medication early, and sometimes also seek opioids from other providers. For this patient, if he or she receives the proper dose of opioid, their aberrant behaviors cease. Therefore, it is important to properly identify ***why*** the patient is exhibiting aberrant behaviors.

- ***Therefore, not all patients with aberrant behaviors are addicted***. The problem is that, many times, as soon as one or more aberrant behaviors are identified, the patient is labeled a “drug seeker” or “addicted.” That is not always true. It is important to understand this so that the true

nature of the aberrant behavior is identified and dealt with properly and so that the patient does not become inappropriately labeled, stigmatized and, especially, improperly treated.

- Clinical Management Tool: Assess and document **The Four C's" seen with addiction are:**

  1. **C**ompulsive use,
  2. **C**ontinued use despite harm,
  3. **C**ravings for the drug, **and**
  4. **C**ontrol impaired, over the use of opioids

8. Tapering and Discontinuing Opioids

- It is perfectly valid (at any point in treatment), to determine that the patient is not an appropriate candidate for long term opioids. State the reasons why clearly in your note. Indicators that the patient is not appropriate for chronic opioid therapy are basically that he or she does not meet their treatment goals or they are addicted. Consider the following as reasons to start to taper and discontinue chronic opioid therapy:

  - Unacceptably high risk assessment (SOAPP) scores.
  - Evidence of addition (must refer to addictionologist).
  - Noncompliance with opioid treatment agreement.
  - Failure to meet goals of therapy.
  - Opioid-induced hyperalgesia (fairly common), in which chronic opioid therapy patients become "hypersensitive" to pain, even to the point that non-painful stimuli elicit pain. Painful stimuli can cause incontrollable pain. The only way to treat this is to discontinue opioids.

- **If the patient is not a chronic opioid candidate, the medication must be appropriately discontinued.** Because of the expected physiological dependence associated with this class of medications, the patient's opioid dose needs to be titrated down. Titration also allows for the assessment of whether or not the patient may truly be appropriate for the opioid. If the patient has true opioid responsive pain that only responds to the higher doses of the medication, then as you titrate the dose down, there will be sustained and dose-dependent increases in pain and decreases in function. It is common that as opioids are weaned to off, patients have periods of slightly worsened pain and/or decreased function, but the majority of patients "get over these bumps" such that weaning is overall tolerated. If during the weaning process, a patient does have persistently increased pain (with consistently elevated pain scores) and decreased function (with consistently worsened functional scores), then it is reasonable to increase the opioid medication back to the lowest dose at which the patient was doing well in the medication wean.

  - Generally, decreasing the dose by 10% every three to five days is usually well tolerated but rates even slower than this are not unreasonable. The key is that the wean is tolerated so that the patient can get off the medication.
  - Do not change a patient from one opioid to another to "make weaning easier". Changing a patient to methadone or any other opioid in order to more easily wean them off their opioids is considered addiction medicine and one needs a special license from the DEA in order to do this. Simply leave the patient on the present opioid, document the patient is not appropriate for chronic opioid therapy and is not addicted but because of physiologic dependence the medication needs to be decreased slowly to avoid withdrawal and gradually lower the dose and follow them very closely (no more than once every four weeks).
  - Referral to an Addictionologist or Psychiatrist with experience in withdrawing and eliminating use of opioids should be part of the *"exit strategy"* in Chronic Opioid Treatment.

9. When should Subspecialty Consultation be Considered?

- For any worker's compensation patient who will need opioid treatment for a period of more than 90 days, the treating physician should follow these guidelines and or consider referral to a Pain Management specialist.

- Pain specialists can consult to evaluate:
    - And comment upon the appropriateness of chronic opioid therapy in a given patient.
    - And administer local injections for pain control in the case of pain generators that are known to respond to such.
    - Patients with aberrant behaviors.
    - Patients above the previously-described dosing ceilings and you cannot wean down.
    - Patients on methadone for pain control (methadone is a high risk drug and should only be used by specialists or practitioners trained to use methadone for pain control).
    - Opioid induced hyperalgesia.

- Any chronic pain patient who has not gone to physical therapy should be seen not only for home exercises but also for energy conservation techniques.

- Patients that are known to have active psychiatric diagnoses (bipolar, depression, schizophrenia, etc.) and/or on benzodiazepines are probably best co-treated with psychiatry.

- Cognitive behavioral therapy has been shown to be of significant benefit to chronic pain patients and, if available, should be requested.

- If the patient has been diagnosed with opioid addiction, then you must refer the patient to a licensed practitioner for appropriate treatment.

Chronic Opioid Assessment and Documentation Checklist

- □ Documentation of work up for etiology of pain with a **clear medical diagnosis** stating the specific pain generator(s) the diagnosis must be appropriate for chronic opioids (redocument every visit).
- □ Clearly state if the patient is appropriate for non-opioid therapy, such as PT, cognitive behavioral therapy, injections, etc.
- □ Address known side effects (every visit).
- □ Formalized risk assessment using SOAPP, COMM or DIRE on the first visit and intermittently if patient demonstrates aberrant behavior.
- □ **Document functional assessment at each visit** – as example with Oswestry scale or SF-12.
- □ Rate pain using 0 – 10 scale with rating of best pain, worst pain and average pain (every visit with specific relation of scores from past visits to now).
- □ Opioid agreement signed (initial and yearly afterwards).
- □ **Compliance monitoring –** Urine drug screen first visit and pill counts thereafter or unannounced urine drug screens.
- □ Informed consent discussion documented on first visit.
- □ Document general appearance and functionality every visit to show that there are no observable adverse effects associated with the medications.
- □ **Consider subspecialty referral or co-management in patients with aberrant behaviors, patients that score "high risk" on the risk assessment tool, opioid induced hyperalgesia and unclear pain conditions.**
- □ Is the Patient on more than 120 MDE? If so, clearly document why that is the case since there is very little evidence that doses higher than this benefit the patient.
- □ Is the Patient on more than 200 MDE? NO literature supports this as more effective than lower doses. Medication-related adverse events are 9 times more likely with these doses than at lower doses.
- □ Is the patient on a benzodiazepine and an opioid? If so, strongly consider discontinuing one or co-managing with psychiatry. There is no evidence that benzodiazepine use is of benefit in treating chronic pain and adverse events when mixed with opioids are very high.

Note that the referred–to standardized assessment tools are all available for download online (see reference section).

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