

Washington State's guideline on use of opioids for chronic non-cancer pain—frequently asked questions

Washington State health officials published the two-part guideline in 2010 to help providers prescribe *opioids*, or narcotics, for chronic non-cancer pain in a safe and effective manner. The guideline is intended as an educational aid for primary care providers treating adult patients.

Part 1 of the guideline includes recommendations for initiating and monitoring opioid therapy and advice on when to seek additional help from specialists. **Part 2** describes strategies for managing treatment of patients who are using high-dose opioids.

This document provides answers to some frequently asked questions about the guideline.

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Questions about why and how the guideline was developed

1. Who developed the guideline and why is it necessary?

State health officials and actively practicing physicians who specialize in pain management developed the guideline. Boards and commissions that set practice standards reviewed the guideline. The workgroup also received input from others in state government and the medical and scientific community.

The Agency Medical Directors' Group (AMDG) that sponsored this guideline consists of the medical directors of five Washington State agencies: Corrections, Health, Health Care Authority, Labor and Industries, and the state's Medicaid program.

Public health, safety, and welfare are best served by treatments which have been found to be both safe and effective. Where it was previously thought that unlimited escalation of opioid doses for chronic non-cancer pain was probably safe, evidence now suggests that prolonged, high-dose opioid therapy may be associated with increased risks and limited benefits. Providers and their patients may not be aware that higher doses may increase risk without improving pain or physical function.

State agencies have received numerous requests from medical providers for clear and easy-to-use guidelines.

2. What is new in the 2010 updated guideline?

- New data, including some scientific evidence to support the 120mg MED dosing threshold
- Tools for calculating dosages of opioids during treatment and when tapering
- Validated screening tools for assessing substance abuse, mental health, and addiction
- Validated two-item scale for tracking function and pain
- Urine drug testing guidance and algorithm
- Information on access to mentoring and consultations (including reimbursement options)
- New patient education materials and resources
- Guidance on coordinating with emergency departments to reduce opioid abuse and/or diversion
- New clinical tools and resources to help streamline clinical care

3. What are some examples of commonly used opioids?

- Morphine - trade names include MS Contin, Kadian, Oramorph and Avinza.
- Methadone
- Oxycodone - available by itself (Oxycontin) or in combination with acetaminophen (Percocet), aspirin (Percodan) or ibuprofen (Combunox).
- Fentanyl - available as transdermal patch (Duragesic), oral transmucosal (Actiq) or buccal (Fentora).
- Hydrocodone - combined with either acetaminophen (Vicodin, Lorcet, etc.) or ibuprofen (Vicoprofen).
- Codeine - available by itself or in combination with acetaminophen (Tylenol No. 3) or aspirin.
- Propoxyphene - available by itself (Darvon) or in combination with acetaminophen (Darvocet).

4. What does the data show?

A recent studyⁱ “provides the first estimates that directly link receipt of medically prescribed opioids to overdose risk and suggests that overdose risk is elevated in chronic non-cancer pain patients receiving medically prescribed opioids, particularly in patients receiving higher doses”¹⁰. Patients receiving 100mg or more per day of morphine equivalent dose (MED) had a 9-fold increase in overdose risk. Most overdoses were medically serious, and 12% were fatal.

Data collected in Washington State show:

- During 2004-2007, 1,668 WA residents had confirmed unintentional poisoning deaths due to prescription opioid related overdoses. Nearly half of these deaths were in the Medicaid population.
- Unintentional opioid-related overdose deaths increased 17-fold during 1995-2008.
- Hospitalizations for opioid-related overdoses increased 7-fold during 1995-2008.
- Addiction treatment admissions, where prescription opioids were the primary drug of abuse, increased from 1.1% to 7.4% between 2000 and 2009.
- Prescription opioid-related overdose deaths now exceed non-prescription opioid-related overdose deaths⁷.
- The death rate from unintentional poisoning exceeded the death rate from motor vehicle crashes in 2006, and the gap continues to widen.

The risks of opioid use are not exclusive to the adult population. According to the Healthy Youth Survey 2008 (available at <http://takeasdirected.doh.wa.gov>), Washington teens are using prescription opioid pain medicine to get high. This includes:

- 4% of 8th graders
- 10 % of 10th graders (21% of these youth obtained their prescriptions from a dentist or physician)
- 12% of 12th graders

5. What is causing the increase in opioid-related unintentional deaths?

At present, the primary cause of the increased unintentional death rate is unclear. It is likely due to a combination of factors such as prescription opioid misuse and abuse, the increase in use of prescription opioids with an increase in average daily dose and the development of tolerance to opioids. The increase in deaths parallels the increase in the medical use of opioid painkillers during the last 15 years because of a movement toward more aggressive management of pain.

Opioids become particularly dangerous when used in conjunction with other medications – sedative-hypnotics, benzodiazepines, anti-depressants or muscle relaxants – or with alcohol. Some health conditions like sleep apnea, chronic obstructive pulmonary disease or congestive heart failure, may also place patients at increased risk for opioid toxicity.

6. How could the most potent pain relievers be ineffective?

High-dose opioids can be ineffective in three ways:

- First, increasing doses of opioids may not be associated with a parallel improvement in pain and physical function. This is called tolerance.

- Second, patients that use opioids chronically may experience a paradoxical increase in their pain. With this abnormal pain sensitivity, patients may also experience different types of pain in other parts of the body. For example, a gentle touch on the skin might feel painful in someone with low back pain.
- Third, not all patients have pain that is responsive to a specific opioid or to opioids in general.

7. How do you know what doses are safe?

There is no clearly defined “safe” opioid dose. The guideline does not say that a dose above 120 mg/day of morphine equivalents is necessarily unsafe, nor that doses below this are guaranteed to be safe. Instead, the guideline recommends assessment of risk and benefit of opioid use for chronic non-cancer pain. Careful attention is urged for doses above 120 mg morphine equivalents per day if pain and function have not improved.

8. Is Washington State unique in developing an opioid dosing guideline?

Similar guidelines have been developed by the Veterans Administration, the Department of Defense, in Utah, in Canada, and by national pain societies and organizations. The AMDG guideline is unique in that it names a specific dosing threshold as a marker for when to seek consultation from a pain specialist.

9. Is the guideline a cost-cutting measure?

No. The guideline was developed in response to dramatic increases in deaths associated with prescribed opioids. The goal of the guideline is to improve the safety and effectiveness of opioid treatment for chronic non-cancer pain, not to cut costs.

Questions about the goals and scope of the guideline

10. What are the state’s goals for the guideline?

To prevent unnecessary deaths and injuries associated with opioid medications prescribed for CNCP by:

- a. Providing a clear, easy-to-use guideline and tools for primary care providers in prescribing opioids in a safe and effective manner
- b. Raising awareness of the risks and possible ineffectiveness of increasing doses of opioids
- c. Providing strategies to taper or discontinue opioids when indicated
- d. Providing strategies to support patients through the process

11. How will the state determine if the goals are being met?

State agencies continuously monitor prescribing patterns, injury, death and hospitalization data related to prescription opioid use. This information is used to determine when and how to improve policies or regulations. In addition to tracking these data:

- An evaluation of the effect of the original 2007 guideline was conducted in 2009. Results of the evaluation supported the continued use of the guideline with the addition of clinical tools and improved information for accessing specialty consultations. The evaluation report can be found at <http://www.agencymeddirectors.wa.gov/Files/AGReportFinal.pdf>.
- A second evaluation is planned to begin in late 2010.

12. Who reviewed the guideline?

Nearly 30 practicing health care providers experienced in pain management from both the private and public sectors provided consultation on this guideline and more providers from across the country gave their input.

This is a consensus based guideline; every effort was made to create a guideline as evidence-based as possible. Where scientific evidence was insufficient or unavailable, the best clinical opinions and consensus of the advisory group were used.

Medical directors and staff from eight state agencies also contributed to and reviewed this guideline.

13. Will medical providers be required to follow the guideline?

The AMDG developed the guideline as an educational aid. It is possible, due to legislation passed by the Washington State Legislature in 2010, that similar recommendations will be put into a regulation requiring medical providers to adhere to certain ‘best practices’ when prescribing opioids for CNCP.

14. How can providers learn about the guideline?

Efforts to educate providers include:

- Publication of the guideline with two free hours of CME (continuing medical education) available at the Agency Medical Directors’ Group website: www.agencymeddirectors.wa.gov/
- Presentations at professional association meetings and conferences
- Coordinated publications by agencies participating in the Agency Medical Directors’ Group

15. Does the guideline apply to treatment of cancer pain?

No. The guideline applies only to the treatment of chronic non-cancer pain — not to the treatment of cancer pain, end-of-life or hospice care, or acute pain (including surgery-related pain).

16. Does the guideline recommend doses for children and the elderly?

No. The guideline was developed for adults with chronic non-cancer pain and does not specifically address dosing requirements for elderly patients or children.

17. Are providers required to follow the recommendations of pain specialists?

No. The opioid guideline is designed to assist the primary care provider to prescribe in a safe and effective manner. Consultation with a pain specialist and compliance with pain specialist recommendations is advised, but not required.

18. Will the state develop a method for tracking opioid prescriptions?

It is not known at this time if the state will implement a prescription monitoring program to track opioid prescriptions.

Questions about the medical and insurance aspects of the new guideline

19. Will pain be adequately treated using this guideline?

Treatment with opioids, even at very high dosages, does not guarantee freedom from chronic pain. The guideline is intended to assist providers in seeing that treatment is both effective and safe. If the use of opioids has not reduced pain while increasing or maintaining function, the guideline may help improve care through:

- Reducing the dosage,
- Seeking specialist consultation, or
- Modifying treatment in other ways.

20. How does one determine the total dose if more than one opioid is being taken?

The guideline provides a basic conversion table to help providers determine the dosage levels of different opioids by converting them to *morphine equivalents*, a basic unit of measurement. Providers can calculate the total daily opioid

dosage with the help of an online tool available at www.agencymeddirectors.wa.gov/opioiddosing.asp.

21. Some patients take doses higher than 120 mg morphine equivalents per day and function well. Does the guideline recommend that providers decrease their doses?

No. Even at these higher doses, if the beneficial effect (improved pain and physical function) is clear, then continuation of therapy may be appropriate. The guideline recommends that providers continue to monitor therapy for safety and effectiveness.

For patients currently using opioids without improvement in function and pain or who are showing signs of dependence, tolerance, or addiction, the guideline provides strategies for reducing doses and criteria for deciding when to seek additional help from specialists.

22. How will providers evaluate a patient's current therapy?

The guideline recommends that providers evaluate if opioid treatment is helping to reduce pain and improve function (e.g., work or engage in normal activities). The guideline references a number of assessment tools that providers could use routinely in conducting this evaluation.

23. Is there a problem accessing specialists for consultation?

Yes. Access to medical care, specialists in particular, is a problem throughout the nation. The guideline may assist primary care providers to safely and effectively manage chronic non-cancer pain without the need for specialist consultation. Additionally, state agencies are attempting to improve access to pain specialists through the use of technologies such as video conferencing. The agencies have also made a list of doctors with experience managing pain available at (there are other qualified doctors besides those listed): www.agencymeddirectors.wa.gov/.

24. Does insurance (public or private) pay for specialty consultations?

Public programs operated by state agencies will pay for specialty consultations, either face to face, or via electronic means. Check each agency program for details. Patients with private insurance will need to check with their own plan to determine coverage.

25. Does insurance (public or private) pay for alternative treatments such as acupuncture and massage?

It depends on the insurance program. Please check with the appropriate payer's policy or benefits plan to determine coverage for alternative treatments.

26. Does the guideline give examples of diagnoses that are appropriate to treat with opioids?

No. The guideline provides best practice information including tools and recommendations about what steps to follow to increase the likelihood that treatment will help and not harm patients with CNCP.

27. Are there conditions that should not be treated with opioids?

Yes. The guideline identifies some of the medical conditions which place patients at increased risk for opioid-related toxicity. The guideline urges caution when prescribing opioids to patients with these conditions.

28. Does the guideline affect patients in opioid substitution programs who are receiving medications for pain management in addition to methadone?

Yes. Patients in opioid substitution programs may also experience chronic non-cancer pain and may receive opioid medication to manage their pain provided function is improved and pain is relieved. The guideline does not specifically address this issue, but coordination of care is recommended between the provider treating pain and the provider treating addiction.

29. If a provider inherits a patient on more than 40 mg of methadone per day, what should be done?

The guideline provides information on how to assess effectiveness of therapy in terms of improvement in function and pain relief. If function continues to improve and pain is relieved, continuation of current therapy may be appropriate.

30. Should a provider avoid prescribing opioids to all patients with a history of substance abuse?

Yes, with active substance or alcohol abuse, providers should not prescribe opioids. If the abuse history is remote or if the patient is participating in a substance abuse treatment program, the patient may be a candidate for opioid therapy. Under these circumstances, the provider should consult with an addiction specialist prior to initiating opioid therapy. The provider may then evaluate treatment options and establish a follow-up plan to monitor for safety and effectiveness as detailed in the guideline.

ⁱ Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid

prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med* 2010;152(2):85-92.