Primary Care

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COMMON PRACTICE

Chronic Pain Management

Deaths from prescription-opioid overdose have increased dramatically in the United States. Efforts to improve pain management resulted in quadrupled rates of opioid prescribing, which propelled a tightly correlated epidemic of addiction, overdose and death from prescription opioids.

It has become increasingly clear that opioids carry substantial risks of addiction and overdose with limited evidence of benefits for the treatment of chronic pain. Partial agonists such as buprenorphine may carry a lower risk of dependency. However, all full mu-opioid-receptor agonists (almost all products on the market) are no less addictive than heroin.

The prevalence of opioid dependence may be as high as 26 percent among patients in primary care receiving opioids for chronic non-cancer-related pain. Risk-stratification tools do not allow clinicians to predict accurately whether a patient will become addicted to opioids, although persons with a history of mental illness or addiction are at higher risk.

On March 15, 2016, the Centers for Disease Control and Prevention (CDC) released a "Guideline for Prescribing Opioids for Chronic Pain" to chart a safer, more effective course. The guideline is designed to support clinicians caring for patients outside the context of active cancer treatment or palliative or end-of-life care. The guideline was developed using a rigorous process that included a systematic review of the scientific evidence and input from hundreds of leading experts and practitioners, other federal agencies, more than 150 professional and advocacy organizations, a wide range of key patient and provider groups, a federal advisory committee, peer reviewers and more than 4,000 public comments.

CDC recommendations included:

- Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain.
- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients for pain and function, and a plan to discontinue medicine if benefits do not outweigh risks.
- Before starting and periodically (at least every three months) during opioid therapy, clinicians should discuss with patients known risks and

realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.
- When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when increasing the dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing the dosage to ≥90 MME/day.
- Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
- Clinicians should evaluate benefits and harms with patients within four weeks of starting opioid therapy for chronic pain or of dose escalation.
- Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose-such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day) or concurrent benzodiazepine use-are present.
- Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data at least every three months to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose.
- When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
- Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

In August 2016, the U.S. Surgeon General released a toolkit to help clinicians treat chronic pain effectively and safely. Blue Cross & Blue Shield of Mississippi is implementing a comprehensive approach to these guidelines that include an Opioid Prior Authorization process beginning in March.

In an effort for all of us to improve HCC scores, to accurately reflect how truly complex patients are, we need to use a specific code--F11.20--for patients with long-term opioid use. The American Society of Interventional Pain Physicians listed the evidence-based strength recommendations in relation to the guidelines.

Click here for the recommendations

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