MEDICAL PROTOCOLS: OPIOIDS – PAGE 1 of 1

OPIOID MANAGEMENT OF THE INJURED PATIENT

Overview

Proper opioid management is essential for the safe and efficient care of injured patients. The WCC recognizes that some injured patients may require opioids for the management of their acute and chronic pain. It is not the intention of the WCC to restrict the proper medical use of this class of medications, however responsible prescribing is mandatory. Additionally, studies have shown that injured workers placed on high dose opioids early in the post-injury period may experience a slower recovery, more difficulty with returning to work, more difficulty with weaning, and more frequently end up on long term opioids.

During the first two weeks post injury, low dose, short acting opioids may be appropriate for those with more severe injuries. Even during the acute phase it is preferred that the injured worker avoid opioid medications when possible. During the remaining portion of the acute and subacute period, attempts should be made to wean and discontinue opioid medications as appropriate (i.e. – as symptoms improve) and as soon as possible. Dose escalation during these periods should be avoided, as the injury should be stabilized and healing. Medications that are deemed to be inappropriate for the vast majority of injured patients include immediate release, ultra-short acting sublingual and nasal opioid preparations. Long acting opioids are not recommended in the acute and sub-acute phases of treatment. In addition, following major surgical interventions, as acute postoperative pain resolves attempts should be made to wean medications as soon as possible, again avoiding dose escalation beyond the acute post-operative period.

Opioids are not meant to completely eliminate pain, but to ease symptoms and improve function (i.e. - improvement of work capacity, ADL's, sleep and sexual function). Any continuation of medications beyond the first two week period must include proper documentation of improvement in pain level (VAS or other screening tool) and improvement in function or work capacity. At each visit history should be obtained to ensure medications are providing the desired pain reducing effect and looking specifically for side effects such as over sedation, cognitive impairment, or inappropriate medication usage. Any patient maintained beyond a four week period on chronic medications should have appropriate compliance monitoring documented. This should occur through history, screening questionnaires, prescription monitoring programs queries, urine drug tests (up to 2x/yr. for a stable, low risk patient and more frequently as indicated for high risk patients), and/or pill counts, as deemed appropriate by the physician. Patients continuing on opioids longer than 4 weeks should be managed under a narcotic agreement as recommended by the Federation of State Medical Boards. Medical necessity should be documented as to the need for all opioid prescriptions in terms of measured improvement in pain, function or work capacity.

If an injured patient requires opioid maintenance longer than 12 weeks, evaluation/consultation and treatment by a physician with appropriate specialty training in pain management should be considered. Documentation of medical necessity, including gains in pain, function or work capacity, is mandatory for prescribing beyond what is described within these guidelines.

The total daily dose of opioids should not be increased above 90mg oral MED (Morphine Equivalent Dose) unless the patient demonstrates measured improvement in function, pain or work capacity. Second opinion is recommended if contemplating raising the dose above 90 MED.

Before prescribing opioids for chronic pain, potential comorbidities should be evaluated. These include opioid addiction, drug or alcohol problems and depression. A baseline urine test for drugs of abuse and assessment of function and pain should be performed prior to institution of opioids for chronic pain.

Guidelines for Prescribing

Single prescriber

Single pharmacy

Opioid Agreement

Caution should be used with combination therapy, sedative-hypnotics, benzodiazepines, barbiturates, and muscle relaxants

Routine assessment of pain and function, if there is no improvement, weaning of opioid

Reasons to Discontinue Opioids or Refer for Addiction Management

No measured improvement in function and/or pain,

or

Opioid therapy produces significant adverse effects,

or

Patient exhibits drug-seeking behaviors or diversion such as:

- Selling prescription drugs
- Forging prescriptions
- Stealing or borrowing drugs
- Frequently losing prescriptions
- Aggressive demand for opioids
- Injecting oral/topical opioids
- Unsanctioned use of opioids
- Unsanctioned dose escalation
- Concurrent use of illicit drugs
- Failing a drug screen
- Getting opioids from multiple prescribers
- Recurring emergency department visits for chronic pain management

If there is no measured improvement in pain, function, ADL's or work capacity after 3 months of opioid medication, the prescribing physician must justify the continued use of opioids and should consider weaning of the opioid.

Opioids may allow the patient to return to work safely and more expeditiously and therefore may be indicated, nevertheless attempts to wean these medications and avoidance of dose escalation should be the goal of treatment. This document is meant as a guideline for the practitioner and should not supplant proper medical judgment.

Sample Opioid Equivalency Table

OPIOID	MED
Codeine	0.15
Fentanyl Transdermal	2.4
Hydrocodone	1
Hydromorphone	4
Methadone up to 20mg	4
Methadone 21-40mg	8
Methadone 41-60mg	10
Methadone >60mg	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

MEDICAL PROTOCOLS: INTRODUCTION

BACKGROUND

Workers' Compensation Medical Protocols first became effective on January 1, 1996 as a result of legislative changes to Section 31-280 of the Workers' Compensation Act.

These protocols will be used by the Commission to evaluate whether a treatment is reasonable and appropriate based on the diagnosis of injury or illness.

The protocols are not meant to be absolute; there must be room for medical judgment. Medical providers are urged to contact the insurer, if they feel that a treatment pattern other than the published protocol is required.

It is expected that the payer will work with the provider to ensure that the injured worker receives the most appropriate treatment.

NEW

In consultation with practitioners, insurers and the Medical Advisory Panel, the medical protocols for treatment of injuries to the lumbar spine, cervical spine, and shoulder have been updated. These revisions reflect the latest changes in the medical field regarding new procedures, treatments and diagnostic tests.

Additionally, protocols for opioid management have been created. The Commission recognizes that some injured workers may require opioids for the management of their acute and chronic pain.

Proper opioid management is essential for the safe and efficient care of injured workers.

EFFECTIVE DATES

The effective date of the revised portions of the protocols (shoulder) is April 1, 2014.

The effective date of the revised portions of the protocols (lumbar spine and cervical spine) is July 1, 2012.

The effective date of the newly-created opioid management protocols is July 1, 2012.

The other portions of the protocols (musculoligamentous injury of the hand or leg) continue in effect, having first become effective on January 1, 1996.

FUTURE UPDATES

The Commission, along with practitioners, insurers and the Medical Advisory Panel, is currently working on updates to the medical protocols for treatment of injuries to the knee, hand, and foot/ankle.

These will be published upon completion.

The WCC will continue to update all protocols as appropriate.

Check the Commission's website at *wcc.state.ct.us* for notification of updates to the medical protocols.

ACKNOWLEDGMENTS

The Commission is grateful to the medical professionals who have spent and continue to spend many hours working with us to bring the most appropriate and the highest standard of care to injured workers in Connecticut.