Managed Care Matters

Joseph Paduda's weblog on managed care for group health, workers compensation & auto insurance, covering health care cost containment, health policy, health research, and medical news for insurers, employers, and healthcare providers.

## April 21, 2014

# Reviewing California's draft opioid guidelines

Posted by Joe Paduda on April 21, 2014 | Link to this post | Comments (1)

**California released their new opioid guidelines; not to put too fine a point on it but they are underwhelming. That's my layman's perspective.**

A good friend and colleague, who also happens to be the Medical Director of a worker's compensation insurer, provided a professional's perspective which is below.

I've taken the liberty of moving what I believe is a key takeaway to the top: "**This DWC *Guideline* is a review of eight existing guidelines—it is not a *de novo* review of primary sources.**

The DWC has posted for comment its guideline [link added] for the use of opioids in WRIs. It sets out to accomplish three goals:

1. To provide a set of best practices for safe and effective prescribing of opioids in the context of WRIs in the acute, subacute and chronic phases;
2. To prevent and reduce opioid-related long-term disability, morbidity, mortality and substance abuse and misuse; and
3. To recommend opioid prescribing practices that promote functional restoration.

Its intended audience is clinicians, utilization reviewers and insurers.

Below is a summary and review of this 321-page document. It is not exhaustive, but I trust it will be useful as a starting point for discussion and further evaluation.

In my opinion, the best parts of this proposed *Guideline* are

1. Discouraging the use of opioids in minor injuries
2. Encouraging the use of other therapies before considering opioids
3. Encouraging lowest effective dose, time limits on opioid use
4. Encouraging the prescription of opioids for use at night and when the patient is not working
5. Listing relative contraindications for the use of opioids
6. Suggesting that current substance abuse (or illicit substance use) is a[n absolute] contraindication to opioid treatment
7. Encouraging education and informed consent
8. Encouraging education about safe storage and disposal of opioids
9. Recommending that CNS depressants (including antihistamines, benzodiazepines and alcohol) should not be used concurrently with opioids
10. Requiring the use of CURES [California's prescription drug monitoring program], treatment agreements and UDT
11. Limiting UDT to baseline plus two to four times yearly; limiting UDT to prescribed and additional opiates, alcohol, amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, fentanyl, methadone and oxycodone
12. Emphasizing the importance of documented functional improvement as a prerequisite to continued opioid use
13. Giving criteria for discontinuation (lack of pain reduction or functional improvement; intolerance or severe side effects; or non-compliance)
14. Recommending MED documentation at every patient visit
15. Recommending opioid weaning semiannually for IWs on ≥ 80 mg MED

In my opinion, problematic parts of this proposed guideline are

1. Although addressing opioids only (the MTUS addresses chronic pain separately), this *Guideline* includes "rest" as a treatment for pain (paradoxically, rest is considered a "physical activity" in this *Guideline*). Unless rest is clearly defined (for example, it may be appropriate to rest/immobilize a joint, depending on the clinical situation) and it is taken to mean bed-rest or inactivity, the "cure" may be worse than the disease.
2. Likewise, this *Guideline* recommends complementary and alternative modalities "such as acupuncture". What other treatments fall in this category? They do not elaborate and they do not address the requirement for effective, evidence based treatments and that's a concern because it may open a door that providers will take advantage of—especially in California. Are they opening the door to massage, chiropractic, TENS, magnet therapy,

hyperbaric oxygen, homeopathy, Chinese herbal medicine, etc.? You would have to reference the *MTUS Chronic Pain Guideline* to answer this question and this *Guideline* should point the reader to this fact.

3. Guidelines as to when to discontinue opioids are absolute in some places, but very flexible in others. For example, the Executive Summary states that, "In order for opioids to be prescribed beyond the acute phase, there should be no contraindicated comorbidities..." In the Abbreviated Treatment Protocol and elsewhere the *Guideline* recommends that the prescriber "consider and document relative contraindications...If these conditions are present, written documentation must be provided to justify the use of opioids."
4. Aberrant use of medications or substances (as evidenced in an inconsistent UDT, for example) is indicated as an absolute disqualifier for further opioid prescribing in one section; however, another section invalidates that pronouncement (see below, footnote 9).
5. The use of CNS depressants, such as sedatives, hypnotics, $H_1$ antihistamines, benzodiazepines and alcohol seem to be an absolute contraindication in the Recommendations. However, Section 7 (Concurrent Use of Benzodiazepines and Other Sedative Hypnotics During Chronic Opioid Treatment) only recommends counseling the patient against using these substances concurrently and states that, "If, after careful consideration, the clinical decision is made to prescribe other sedatives or muscle relaxants to patients on chronic opioid treatment, counseling should be provided to stagger dosing to avoid excess sedation and potentially disastrous complications." It seems to me that avoiding disastrous complications, including "fatal overdose events" should be a physician's first priority. This also flies in the face of one of the three purported goals of the *Guideline*: "to prevent and reduce opioid-related long-term disability, morbidity, mortality and substance abuse and misuse."
6. Urine alcohol testing (as recommended as part of UDT by this *Guideline*) is not accurate and may not be clinically useful.

The proposed ***Guideline* was completed before the publication of the new *ACOEM Opioid Guidelines* (March 2014) which, in my opinion, is far superior as a thorough and true evidence-based practice guideline.** [emphasis added]

My colleague's review provides necessary insight into the pros and cons with the Guidelines. **To DWC's credit, they are looking for comments, and I'd encourage you to submit yours here; deadline is TODAY..**

**My layman's suggestion would be rather simple – adopt ACOEM and be done with it.**

This entry was posted in Pharmacy, PBMs, and Pharma costs, Workers Comp by Joe Paduda. Bookmark the permalink [http://www.joepaduda.com/2014/04/reviewing-new-opioid-guidelines/].

ONE THOUGHT ON "REVIEWING CALIFORNIA'S DRAFT OPIOID GUIDELINES"

Mark Walls
on April 21, 2014 at 12:28 PM said

Enforcing guidelines in California is a bigger issue than developing. Too much of their "guidelines" have little teeth, so the medical providers just do what they want and file liens. Until NO authorizatoin starts meaning NO payment in California, this won't change.