Medical Examining Board

Department of Safety and Professional Services

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Wisconsin Medical Examining Board Opioid Prescribing Guideline Amended 12/2022

Guideline Scope and Purpose

To help providers make informed decisions about acute and chronic pain treatment -- pain lasting longer than three months or past the time of normal tissue healing.

Opioids pose a potential risk to all patients. The Guideline encourages providers to implement safe practices for responsible prescribing which includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely injured patients.

Guideline Core Principles Identify and treat the cause of the pain, use non-opioid therapies

Use non-pharmacologic therapies (such as yoga, exercise, cognitive behavioral therapy and complementary/alternative medical therapies) and non-opioid pharmacologic therapies (such as acetaminophen and anti-inflammatories) for acute and chronic pain. Don't use opioids routinely for chronic pain. When opioids are used, combine them with non-pharmacologic or non-opioid pharmacologic therapy, as appropriate, to provide greater benefits.

Start low and go slow

When opioids are used, prescribe the lowest possible effective dosage and start with immediate release opioids instead of extended-release/long-acting opioids. Only provide the quantity needed for the expected duration of pain.

Close follow-up

Regularly monitor patients to make sure opioids are improving pain and function without causing harm. If benefits do not outweigh harms, optimize other therapies and work with patients to taper or discontinue opioids, if needed.

Guideline Focus Areas

The Guideline addresses patient-centered clinical practices including conducting thorough assessments, considering all possible treatments, treating the cause of the pain, closely monitoring risks, and safely discontinuing opioids. The three main focus areas in the Guideline include:

Determining when to initiate or continue opioids

- Selection of non-pharmacologic therapy, non-opioid pharmacologic therapy, opioid therapy
- Establishment of treatment goals
- Discussion of risks and benefits of therapy with patients

Opioid selection, dosage, duration, follow up and discontinuation

- Selection of immediate-release or extended-release and long-acting opioids
- Dosage considerations
- Duration of treatment
- Considerations for follow-up and discontinuation of opioid therapy

Assessing risk and addressing harms of opioid use

- Evaluation of risk factors for opioid-related harms and ways to mitigate/reduce patient risk ▪ Review of prescription drug monitoring program (PDMP) data
- Use of urine drug testing
- Considerations for co-prescribing benzodiazepines
- Arrangement of treatment for opioid use disorder

Opioid Prescribing Guideline

1. **The guideline is not intended for patients who are in active cancer treatment, palliative care, sickle cell or end-of-life care.** Although not specifically designed for pediatric pain, many of the principles upon which they are based could be applied there, as well.

2. In treating acute pain, non-opioids should be considered first. If non-opioids are not efficacious, opioid therapy may be considered if benefits are anticipated to outweigh the risks. Before prescribing opioid therapy for acute pain, realistic benefits and known risks of opioid therapy should be discussed. Consultation should be considered if diagnosis and treatment is outside the scope of the prescribing practitioner. If a practitioner is not familiar with safe opioid prescribing, they are not required to prescribe.

3. Nonopioid therapy is preferred for subacute and chronic pain (pain greater than 3 months). If non-opioids are not adequate and expected benefits for pain and function outweigh risks, opioids may be acceptable. Risks and benefits should be discussed. The goal is to establish treatment goals and functional improvement and how opioid therapy will be discontinued. Therapies such as physical therapy, behavioral health, yoga etc. should be considered. If pain is beyond the expected healing period of surgery or trauma or etiology of pain is unclear, a consultation with a pain specialist (completed an ACGME fellowship) should be placed. A patient should have at least 30% improvement in pain scores, functional improvement, no signs of abuse or aberrant behavior and side effects screened for such as sedation or constipation.

4. Patients should not receive opioid prescriptions from multiple physicians. There should be a dedicated provider such as a primary care or pain specialist to provide all opioids used in treating any patient's chronic pain, with existing pain contracts being honored.

5. Physicians are encouraged to review the patient's history of controlled substance prescriptions using the Wisconsin Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations

that put him or her at high risk for overdose. As of April 2017, Wisconsin state law requires prescribers to review the PDMP before prescribing any controlled substance for greater than a three-day supply.

6. Prescribing of opioids is strongly discouraged in patients taking benzodiazepines or other respiratory depressants (gabapentin, lyrica, muscle relaxants, sleep aids). Benzodiazepines triple the already high increases in respiratory depression and annual mortality rates from opioids. If they are used concurrently, clear clinical rationale must exist.

7. Patients presenting for chronic pain treatment should have a thorough evaluation, which may include the following:

    a. Medical history and physical examination targeted to the pain condition.
    b. Nature and intensity of the pain.
    c. Current and past treatments, with response to each treatment.
    d. Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e., renal disease, sleep apnea, chronic obstructive pulmonary disease (COPD), etc.).
    e. Effect of pain on physical and psychological functioning.
    f. Personal and family history of substance abuse.
    g. History of psychiatric disorders associated with opioid abuse (bipolar, attention deficit disorders (ADD/ADHD), sociopathic, borderline, untreated/severe depression).
    h. Medical indication(s) for use of opioids.
    i. Use of an opioid risk tool

8. Components of ongoing assessment of risk include:

    a. Review of the Prescription Drug Monitoring Program (PDMP) information.
    b. Periodic urine drug testing (including chromatography) – at least yearly in lowrisk cases, more frequently with evidence of increased risk.
    c. Violations of the opioid agreement.
    d. Periodic pill counts may also be considered for high-risk patients.

9. All patients on chronic opioid therapy should have informed consent consisting of:

    a. Specifically detailing significant possible adverse effects of opioids, including (but not limited to) addiction, overdose, and death. It is also recommended practitioners discuss with patients the effect opioid use may have on the ability to safely operate machinery or a vehicle in any mode of transportation.
    b. Treatment agreement, documenting the behaviors required of the patient by the prescribing practitioner to ensure that they are remaining safe from these adverse effects.

10. Opioids should be prescribed in the lowest effective dose. Literature shows diminished returns for doses above 50 morphine equivalents. This includes prescribing the lowest effective dose for the shortest possible duration for post-operative care and acutely injured patients. Given that there is no evidence base to support efficacy of doses over 90 MMEs, with dramatically increased risks, dosing above this level is discouraged, and appropriate documentation to support such dosing should be present on the chart. It is understood there is variation in response to opioid doses.

11. Prescribing of opioids is strongly discouraged for patients abusing illicit drugs. These patients are at extremely high risk for abuse, overdose, and death. If opioids are prescribed to such patients, a clear and compelling justification should be present.

12. During initial opioid titration, practitioners should re-evaluate patients every 1-4 weeks. During chronic therapy, patients should be seen at least every 3 months, more frequently if they demonstrate higher risk.

13. Practitioners should consider prescribing naloxone for home use in case of overdose for patients at higher risk, including:

    a. History of overdose (a relative contraindication to chronic opioid therapy).
    b. Opioid doses over 50 MMEs/day.
    c. Clinical depression.
    d. Evidence of increased risk by other measures (behaviors, family history, PDMP, UDS, risk questionnaires, etc.).

    The recommended dose is 0.4 mg for intramuscular or intranasal use, with a second dose available if the first is ineffective or wears off before Emergency Medical Services (EMS) arrives. Family members can be prescribed naloxone for use with the patient.

14. All practitioners are expected to provide care for potential complications of the treatments they provide, including opioid use disorder. As a result, if a patient receiving opioids develops behaviors indicative of opioid use disorder, the practitioner, when possible, should assist the patient in obtaining addiction treatment, either by providing it directly (buprenorphine, naltrexone, etc. plus behavioral therapy) or referring them to an appropriate treatment center or provider willing to accept the patient. Discharging a patient from the provider's practice solely due to an opioid use disorder is not considered acceptable.

15. If a patient has had chronic pain and has not been evaluated by a pain specialist (completed an ACGME fellowship) in the last 5 years, a referral should be placed.

    This Guideline is effective on 12/27/2022, the date of publication to the Department's website.