A SUMMARY OF NEW GUIDELINES ON OPIOID PRESCRIBING

A guide to new regulations for New York practitioners treating adults for acute and chronic pain with opioid therapy

The Linehan Law Firm, PLLC

305 Broadway, 7th Fl

New York, NY 10007

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Long Overdue Clarifications

In November of 2022, the CDC finally updated its often-misunderstood 2016 Guideline for Prescribing Opioids for Chronic Pain with the **CDC Clinical Practice Guideline for Prescribing Opioids for Pain** – a comprehensive clinical tool to assist practitioners in navigating the many difficulties in prescribing opioid analgesics like oxycodone, hydrocodone, hydromorphone, and morphine.

In recent years, many physicians completely avoided opioid prescribing or abruptly ended patient care due to a fear of disciplinary action, DEA penalties, or even criminal charges. With this update, prescribers should be able to address patient needs and feel reassured by their practice's standards in the face of regulatory scrutiny.

Sources and Disclaimer

The following summaries are based upon the CDC's recommendations, located online at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm, and do not constitute medical or legal advice. Consult with a qualified medical professional or health authority before making decisions on patient health care.

Goals of the Guideline

- Improve communication between doctors and patients about the risks and benefits of these drugs
- Improve the safety and effectiveness of pain treatment
- Mitigate pain suffered by patients
- Improve function and quality of life for patients
- Reduce risks associated with opioids – addiction, overdose, death

Deciding Whether (and What) to Prescribe

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1. Non-opioid therapies are at least as effective as opioids

The Guideline stresses that for acute pain, non-pharmacological and non-opioid therapies should be explored fully, and opioid substances should only be prescribed if the benefits to the patient outweigh the risks.

Clinicians must discuss realistic benefits and the many known risks of opioid use with patients before giving them a prescription.

Non-Opioid Alternatives

- Acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), and certain antidepressants
- Physical treatments like acupressure, spinal manipulation, remote electrical neuromodulation, massage, and exercise therapy
- Behavioral treatment, such as cognitive behavior therapy, mindfulness-based meditation

Deciding Whether (and What) to Prescribe

2. Non-opioid therapies are preferred for chronic pain.

Prescribers are urged to work with patients to establish treatment goals for their pain and functional abilities. The Guideline suggests forming a plan for discontinuing opioid therapy if the benefits to the patient are outweighed by the risks of taking opioids.

Patient Education Tips

- Advise patients that short-term opioid use can lead to unintended long-term opioid use.
- Have a plan to taper opioids as pain resolves if opioids have been used around the clock for more than a few days.
- Advise patients about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence.
- Advise patients of risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol

Determining Dosages

3. At the beginning of opioid treatment, give patients immediate-release formulations instead of long-acting ones.

These include faster-acting medications also have a shorter effect duration. Studies have demonstrated this presents a lower risk of overdose or abuse among patients.

Examples include short-term release morphine, oxycodone, or hydrocodone.

Extended-release formulations – which also include methadone and transdermal fentanyl – should only be used for daily, around-the-clock treatment when alternative options are ineffective or not tolerated.

Determining Dosages

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4. Physicians should prescribe the lowest-effective dosage for opioid-naïve patients.

As dosages and morphine milligram equivalents increase, so too do the risks of overdose and death. At certain levels, dosages may give diminishing returns in alleviating pain compared to these risks.

Specifically, the Guidelines suggests that before increasing total opioid dosage to ≥50 MME/day, prescribers should carefully reassess evidence of the benefits and risks.

CDC MME Calculations

Tools for calculating morphine milligram equivalents can be found on the CDC's website.

50 MME/day is equivalent to:

- 50 mg of hydrocodone (10 tablets of hydrocodone/ acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

Determining Dosages

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5. Prescribers should use care in adjusting opioid patient dosages.

The Guideline strongly encourages shared decision-making between doctor and patient, and suggests tapering of opioid dosages when there are predictive benefits of doing so.

Slowly tapering will minimize symptoms of opioid withdrawal, such as anxiety, insomnia, abdominal pain, and other side effects.

For patients who have taken opioids on a long-term basis, tapering plans might not be completed for several months to years, depending on patient circumstances.

If prescribers decide to reverse a taper, they should advise patients of an increased risk for overdose because of loss of opioid tolerance, educate them on overdose prevention, and offer naloxone as a preventative measure.

Duration of Initial RXs for Opioids

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6. When opioids are needed for acute pain, prescribers should prescribe no greater quantity than needed.

If a patient suffers from acute pain that did not result for surgeries or traumatic injuries, the Guideline strongly suggests non-opioid therapies.

Multiple studies have found that many patients do not use all prescribed opioids after surgery or hospital stays. Leftover, unsecured medication presents risks for diversion and accidental overdose, particularly among family members.

Clinicians are encouraged not to prescribe more opioids than necessary simply in case patient symptoms worsen. Rather, patients should be re-evaluated on a regular basis.

Duration of Initial RXs for Opioids

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7. Prescribers should re-evaluate risks and benefits within a month of starting opioid therapy for acute or chronic pain.

The Guideline strongly recommends this for patients who are at higher risk for addiction or overdose.

- Patients with mental health issues, a history of drug and alcohol abuse, or who take ≥50 MME/day.

Multiple studies have found that many patients do not use all prescribed opioids after surgery or hospital stays.

Patients should be evaluated at least every 2 weeks if they continue to receive opioids for acute pain

If opioids are continued for more than 1 month, clinicians must ensure that opioid prescribing for acute pain does not unintentionally become long-term.

Assessing Risk and Preventing Harm

Before prescribing opioids, patients must be evaluated for potential harm and risk.

The Guideline recommends screening for substance use and mental health risks as a first step, and urges practitioners to consult with specialists in these areas when needed.

Naloxone should be offered to any patient with risky health factors, such as a history of use disorder (addiction), overdose, sleep and lung disorders, or patients returning to a higher dose treatment.

Respiratory depression is a strong risk for some patients taking opioids. Use caution when prescribing opioid pain medication and benzodiazepines (e.g., Xanax) concurrently.

Consulting PDMP (prescription monitoring) data will help determine concurrent substance use and mitigate risks.

Examples of Use Disorder Criteria

- Opioids taken in larger quantities or over longer periods than intended
- Strong cravings to use
- Use resulting in failure to fulfill other obligations in employment, family, or schooling
- Recreational or occupational activities given up
- Tolerance evidenced by increasing use or diminished effects
- Withdrawal symptoms, or use of opioids to avoid such symptoms

9. Consulting state Prescription Monitoring Program data will help determine a patient's risk.

The Guideline recommends that PDMP data be reviewed before the issuance of any opioid prescription, and re-reviewed every 3 months at the minimum. This should be done for all patients, and not simply those who present with risk indications.

However, the Guidelines is careful to caution prescribers not to dismiss patients simply because PDMP data shows counter-indications. This may jeopardize patient safety. Instead, this is an opportunity to provide critical life-saving information to patients.

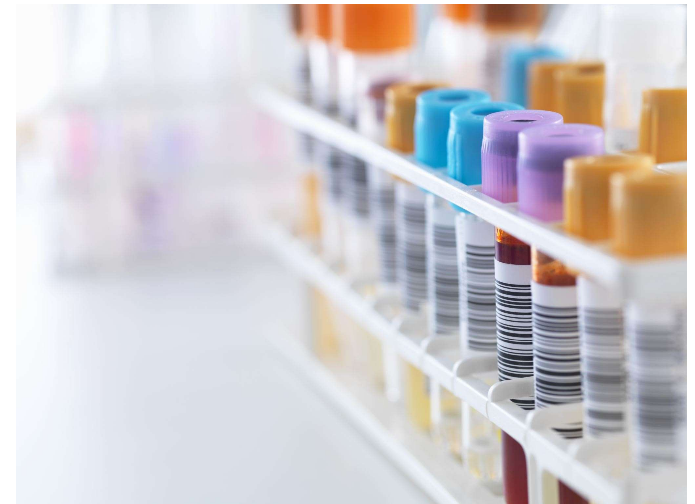
10. Consider toxicology and drug testing when prescribing controlled substances.

The Guideline is careful to recommend that clinicians use testing in a non-punitive, non-discriminatory manner.

Prescribers should stress to patients that testing is used to maximize patient safety, and will not by itself be grounds for dismissal.

Negative tests may indicate that a patient is not taking opioids as prescribed, and could be evidence of diversion to others.

Become familiar with how screening panels will detect specific substances, and use confirmatory testing when specific opioids cannot be detected in standard tests.



11. **Benzodiazepines and central nervous system depressants present particular risk with opioids.**

The Guideline identifies these drugs, which include alprazolam, muscle relaxants, and gabapentin, as presenting unpredictable risks for certain patients concurrently taking opioids.

In cases of concurrent use, these non-opioid treatments may also need to be tapered. Abrupt discontinuation could result in severe results, such as seizures and hallucinations.

Many opioid-related overdoses involve concurrent use of these drugs, often due to respiratory depression interactions.

Mental health professionals should be consulted if these drugs are being used to treat anxiety and other mental health issues.

12. Patients with opioid use disorder should be offered treatment with evidence-based medications – not detox.

Addiction to opioids is a chronic but treatable disease from which patients can recover.

The Guideline encourages clinicians to discuss use disorder in a non-judgmental, non-stigmatizing manner.

Medications like methadone and buprenorphine/suboxone have been shown to reduce the risk of overdose and death.

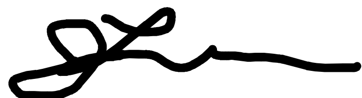
Generally, clinicians should encourage patients to receive these medications in treatment programs certified by SAMHSA.

The Guideline encourages physicians prescribing opioids in communities without sufficient treatment options to obtain a waiver to prescribe buprenorphine for opioid use disorder.

HAS OPIOID PRESCRIBING RESULTED IN LEGAL ISSUES FOR YOUR PRACTICE?

The DEA and State regulatory authorities may associate the prescribing of opioids with diversion, insurance fraud, and other misconduct.

Let's talk about keeping your practice secure.



Jeffrey Linehan
Attorney-at-Law
305 Broadway, 7th Fl
New York, NY 10007

Call us at (646) 290-7033 medicaldisciplinelawyer.com

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