Issue 2 | 2016

RISK MANAGER
Medical Assurance Company of Mississippi

START LOW. GO SLOW.

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

By Maryann Wee, BSN, RN - Vice President of Risk Management

In March 2016, the CDC published a "*Guideline for Prescribing Opioids for Chronic Pain*." This was prompted by the "epidemic" of abuse of prescribed opioids for pain. The recommendation addresses the prescribing of opioid pain medication for patient 18 years or older, who are not in active cancer treatment, palliative care, or end-of-life care. The guideline was formulated for the primary care setting, but it has implications for all specialties.

The clinical practices addressed in this guideline include:

- Determining when to initiate or continue opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care
- Evaluating opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risks and addressing harms of opioid use

The CDC has developed clinical tools that break down the 12 recommendations of the new guideline and which offer providers suggestions for incorporating them into their practices.

Clinical tools available through the following links to the CDC Website:

Guideline for Prescribing Opioids for Chronic Pain

Checklist for Prescribing Opioids for Chronic Pain

Non-Opioid Treatments for Chronic Pain

Calculating Total Daily Dose of Opioids for Safer Dosage

Highlights of the CDC Recommendations

Evaluating patients. Patients should be evaluated within one to four weeks of starting opioid therapy or having a dose escalation. Then, providers should evaluate the benefits and harms of continued therapy every three months. **This is in contrast** to six months in the Mississippi Board of Medical Licensure (MSBML) regulations for prescribing controlled substances.

Calculating dosage. Physicians are encouraged to calculate the morphine milligram equivalent (MME) per day of the opioids the patient is taking. Specific actions should be considered when the daily number of MMEs are at the 50 and 90 or more levels. This link demonstrates the calculation of the MME:

Calculating Total Daily Dose of Opioids for Safer Dosage

Using tools to assess progress. The patient's pain and function level should be assessed regularly with validated instruments. This is more than just the 10-point pain scale. A Three- Item PEG (Pain, Enjoyment and General Activity) Assessment Scale is cited. The CDC defines a score of less than 30 percent of improvement in pain and function as a point to consider in reducing the dose or tapering the opioids.

Assessing Benefits and Harms of Opioid Therapy

Pain contracts. Pain contracts are not specifically named in the CDC recommendations, but the recommendations do advise both setting treatment goals and discussing the risks and benefits at the beginning of the treatment, as well as periodically during the treatment. The MSBML regulations require a written treatment plan, which helps to accomplish treatment goals.

Using Prescription Monitoring Program (PMP). The recommendations state that clinicians should review PMP data when starting opioid therapy for chronic pain and periodically during opioid therapy — ranging from every prescription written to every three months. The use of the PMP has been very successful in identifying abuse problems in patients.

Urine Testing. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

Concurrent Prescribing. The recommendations state that clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

Several years ago, the MACM staff worked with the Mississippi Bureau of Narcotics and the Mississippi Professionals Health Program to produce information for our insureds about treating chronic pain. This booklet includes the current rules, regulations, and laws in Mississippi governing the treatment of pain with controlled substances by prescribing physicians. This booklet is now being used by the Mississippi Board of Medical Licensure and is given to every newly-licensed physician.

Treating Chronic Pain: What You Need to Know

Again, these are guidelines with recommendations. MACM recommends physicians and other providers evaluate and treat individual patients as is clinically appropriate.

As A Reminder . . .

A tricky area with which the MACM Risk Management Department is often confronted is physicians prescribing controlled substances for family members, close friends and employees. From a risk management standpoint, the best plan is to avoid this practice unless these family members, close friends and employees are legitimate patients in your practice and their treatment is appropriately documented just as any other patient's treatment would be.

GOVERNMENT GUIDELINES, PRACTICE PARAMETERS AND SPECIALTY STANDARDS: SWORDS OR SHIELDS?

By Stephanie Edgar, JD - Legal Counsel

The paramount question in any medical malpractice case is whether there was a breach of the standard of care. But, what is the standard of care? In every medical malpractice case tried before a Mississippi jury, the jury is instructed that the standard of care is what a reasonably prudent minimally competent physician in the same field of practice, and having available the same general facilities, services, equipment and options, would not have done under the same or similar circumstances or the failure to do some act such a physician would have done under the same or similar circumstances.

Now, putting the legalese aside, the standard of care is a medico-legal term, which at least in Mississippi, sets the level at that which a minimally competent practitioner would practice under similar circumstances. Hopefully, you recognize that both the official legal definition and my attempt to simplify that definition are riddled with tons of subjectivity.

This is why expert witnesses are such vital components in medical malpractice cases. Both sides designate experts to refute what the other side's expert claims is the standard of care. When the jury begins its deliberation, both sides hope that their expert was more believable to the jury than the other side's expert.

But, what happens when there is a government guideline, a practice parameter or a specialty standard present that addresses the precise situation which led to your being sued?

For example, assume that you treat chronic pain patients with opioids. Further assume that one of your patients overdoses on hydrocodone, a medication that you prescribed, and you get sued. The plaintiff's lawyer, unless he's had his head under a rock for the last several years, will be well aware of the opioid epidemic in this country. Likewise, he'll be armed with authorities such as the CDC's *Guideline for Prescribing Opioids for Chronic Pain*. So, it should come as no surprise to anyone when the central issue in the case becomes whether you effectively and timely evaluated the risks and benefits of opioid therapy with this particular patient.

As the discovery process unfolds, everyone in the case learns that you started this patient on hydrocodone, and she was scheduled for a return visit to your office six weeks later. Unfortunately, the overdose occurs during week five—one week prior to her scheduled return visit and one week after the CDC says you should have seen her back in clinic.

What ends up occurring is that the plaintiff's lawyer and his expert will try to make what's in this guideline be the standard of care. And both will use it in such a way that it's almost like a recipe. So, if you're baking a cake and the recipe calls for an egg and a stick of butter, unless you're a whiz in the kitchen, you're going to mindlessly follow these steps and presumably, end up with the perfect cake.

Applying that same rationale to medicine, because the CDC's *Guideline for Prescribing Opioids for Chronic Pain* (the recipe) says that "[C]linicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain…", and you hadn't planned to see this patient again until six weeks after starting hydrocodone, you botched the recipe. The plaintiff's lawyer will argue and his expert will testify that this amounts to a breach of the standard of care. The result is that the very recommendations which were created with the best of intentions to assist you in managing chronic pain patients will be used as a sword against you.

Practice parameters and specialty standards are often used similarly, although, many of these contain decent disclaimers, which state that the recommendations are simply that—recommendations that are not intended to establish the standard of care. While such a disclaimer is never fool-proof, it can be used by a medical malpractice defendant to explain to a jury that practice parameters and specialty standards are tools designed to assist practitioners; however, ultimately, a physician's treatment must be individualized for each patient and must be based on sound, clinical judgment. Simply put, this is the method by which the plaintiff's attorney's sword is converted to your shield in the courtroom.

HOUSTON'S HANDOFFS

By Gerry Ann Houston, MD - Medical Director

In most of the cases I review from the MACM claims files, the names of the insured physicians are not used. With the focus of this *Risk Manager* being the prescribing of opioids for chronic pain, I thought a review and discussion of one of my own personal claims would be appropriate. The file was finally closed in 2006 with a favorable outcome; however, upon reviewing the records and the current CDC Guidelines, I know I would have done things much differently should I be seeing the patient today.

> *The patient is a 45 year old male referred in 1997 for evaluation and treatment of his sickle cell anemia. At the time I initially saw him, his primary physician had given him Lorcet 10, but he related that in New Orleans (where he had previously lived) his physician had him on Oxycontin. Since he said the Oxycontin controlled his pain and kept him out of the emergency room for treatment of his crises, I prescribed him Oxycontin with Lorcet for breakthrough.*
>
> *Over the next several years, the patient was seen at regular intervals for follow up; he, however, would quite often call early for refills with multiple reasons why he was out of meds. He visited relatives out of town and left his meds there. He had a car accident, and the meds were left in the wrecked vehicle. His home was burglarized, and the meds taken. He was in jail for a week, and his meds were confiscated.*
>
> *In 2001, I was notified by Medicaid that he was getting opioid prescriptions from multiple physicians and was using multiple pharmacies to fill these. I confronted him and did not give him any more prescriptions. He failed to show for his scheduled follow up appointments.*
>
> *My next encounter was in 2002 when I was notified that a suit was filed against me, multiple other physicians who had prescribed Oxycontin to this patient, several pharmacies that filled the prescriptions, and Purdue Frederick, the manufacturer of the drug. The claim was that the plaintiff "sustained injury from the Oxycontin, including addiction to the drug".*
>
> *MACM provided me with an excellent defense counsel, who over the next several years, spent countless hours doing research, filing court documents, taking depositions, and talking with experts. Eventually summary judgment was granted by Hinds County. The patient appealed, and in 2006 the Mississippi Supreme Court upheld the summary judgment. The facts revealed that the plaintiff's claim "arose from his own behavior which amounted to fraud and subterfuge, namely acquiring multiple prescriptions from multiple doctors".*

Looking over my records in this case, it's hard to believe some of the things I did, or more importantly did not do. At the time all my office notes were handwritten, not very detailed, and often lacking proper documentation. There was no Prescription Monitoring Program (PMP), no patient contracts/agreements for long term opioid use, and no established guidelines or recommendations for prescribing opioids. (In fact that long ago, we called them "narcotics", not "opioids".)

If that same patient was referred today, before prescribing an opioid, the proper course would be to go to the PMP website and see if the patient had been or was currently being prescribed opioids. Though the patient did have sickle cell anemia with frequent painful crises, he should not have been getting prescriptions from multiple physicians. By communicating with all the physicians and pharmacists involved, a plan would be formulated to decide who would assume primary care of this patient and provide his opioid prescriptions. And once a plan was in place, the use of his multiple providers would be discussed with the patient, and the new plan reviewed with him and implemented.

A patient contract or agreement between the patient and the prescribing physician can outline the risks and benefits associated with the opioid and also can help to establish parameters for his opioid use. The agreements may require the patient to see only one practitioner, use only one pharmacy, take medications as prescribed (no early refills), or provide urine or blood to screen for substance abuse or to ensure that meds are being taken as prescribed.

When this malpractice journey finally ended, the "good guys" won. But if a similar claim was filed today, I wonder if the outcome would be the same. Fortunately, practice patterns, standard of care, and published guidelines have improved or been updated, all to better protect the physician, who will in turn be providing better care for the patient.