Texas Medicaid

Opioid Prescribing Recommendations in Adults

Executive Summary

Purpose:
This intervention is designed to promote the safe and cost-effective prescribing of opioids.

Why Issue was Selected:
This educational intervention provides prescribing recommendations to address the over-prescribing and misuse of opioid pain relievers. Recommendations are to:
1. Prescribe the lowest effective dose and duration of opioid analgesia when an opioid is indicated for acute pain. Clinicians should reduce variation in opioid prescribing for acute pain.
2. Closely monitor the patient during the post-acute pain period. The post-acute pain period is a critical time to halt the progression to chronic opioid use.
3. Avoid initiating chronic opioid therapy and carefully manage any who remain on opioid medication. The evidence to support chronic opioid analgesic therapy for chronic pain is insufficient at this time, but the evidence of harm is clear.

Recommendations do not apply to opioids prescribed for patients who are experiencing pain caused by cancer, patients receiving hospice care, or opioids prescribed as medication-assisted therapy to treat opioid dependency.

Program Specific Information:

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<td>Initial Opioid Use &gt;7 Day Supply</td>
<td>886</td>
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<td>Opioid Use 90 to 300 MME per Day</td>
<td>163</td>
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<td>Overutilization of Opioids</td>
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<td>Currently Using Opioids &gt; 300 MME per Day for &gt;120 days with History of Opioid Overdose</td>
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Setting & Population:
All adult patients receiving opioids in the past 90 days.

Types of Intervention:
Cover letter and modified profiles.
### Main Outcome Measures:

The performance indicators will be re-measured when six months of outcome data are available.

### Anticipated Results:

- Prevent individuals from transitioning from opioid use for acute pain following an injury or surgery to long-term opioid use.
- Reduce the variation in opioid prescribing practices among Texas health care providers.
- Ensure that individuals who are on long-term opioid therapy for chronic pain are carefully monitored and patient safety is a top concern.

### Performance Indicator #1: Initial Opioid Use > 7 Day Supply

**Why has this indicator been selected?**

Provider should prescribe the lowest effective dose and duration of opioid analgesia when an opioid is indicated for acute pain.\(^1\-^3\)

**Candidates (denominator):**

All adult patients who have been enrolled in Medicaid for > 120 days and received opioid analgesics in the last 90 days.

**Exception criteria (numerator):**

Candidates who received a >7 day supply of initial opioid prescription.

### Performance Indicator #2: Opioid Use 90 to 300 MME per Day

**Why has this indicator been selected?**

Prescribers should avoid initiating chronic opioid therapy and carefully manage any who remain on opioid medication. The evidence to support chronic opioid analgesic therapy for chronic pain is insufficient at this time, but the evidence of harm is clear.\(^1\-^4\)

**Candidates (denominator):**

All adult patients who received opioid analgesics in the last 90 days.

**Exception criteria (numerator):**

Candidates who received 90 to 300 MME of opioid prescription

### Performance Indicator #3: Opioid Use >300 MME per Day

**Why has this indicator been selected?**

Prescribers should avoid initiating chronic opioid therapy and carefully manage any who remain on opioid medication. The evidence to support chronic opioid analgesic therapy for chronic pain is insufficient at this time, but the evidence of harm is clear.\(^1\-^4\)

**Candidates (denominator):**

All adult patients who received opioid analgesic in the last 90 days.

**Exception criteria (numerator):**

Candidates who received > 300 MME of opioid prescription

### Performance Indicator #4: Overutilization of Opioids

**Why has this indicator been selected?**

Overutilization of opioids may indicate a need for coordination of care and evaluation whether these prescriptions are being used according to the prescriber’s directions.

**Candidates (denominator):**

All adult patients receiving an opioid in the most recent 60 days.
Exception criteria (numerator): Candidates without cancer that received >7 opiate and/or tramadol claims within the last 60 days and received > 3 different opiate agents.

Performance Indicator #5: Opioid Use: History of Dependence

Why has this indicator been selected? All opioids are controlled substances and pose a risk of physical and psychological dependence in some patients.

Candidates (denominator): All adult patients receiving an opioid in the most recent 60 days.

Exception criteria (numerator): Candidates with at least two ICD-9/10 claims for substance abuse or history of dependence (excluding tobacco dependence) submitted in the last 720 days and have met the criteria for either Doctor Shopper (>3 prescribers and >3 pharmacies, Overutilization or Multiple Prescribers (>4 prescribers).

Performance Indicator #6: Currently Using Opioids more than 300 MME per Day for >120 days with History of Opioid Overdose

Why has this indicator been selected? There is limited evidence of long-term beneficial effects of long-term opioid therapy in improving chronic pain and functioning. And, continued use increases the likelihood of opioid use disorder and risk of overdose.

Candidates (denominator): All adult patients receiving >300 MME per day of an opioid for more than 120 days in the last 180 days.

Exception criteria (numerator): Candidates who have a diagnosis of opioid use disorder in the past 720 days.

References:

RE: Caring for Your Patients Receiving Opioids

Dear Dr. <<Name>>:

The goal of this quality management program is to assist you in caring for your patients receiving opioids. Prescribing recommendations are provided to address the over-prescribing and misuse of opioid pain relievers in Texas. This initiative is based on recommendations from the CDC Guideline for Prescribing Opioids for Chronic Pain available at: https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1er.pdf.

Opioid Prescribing recommendations are as follows:

1. Prevent people from transitioning from opioid use for acute pain following an injury or surgery to long-term opioid use.
2. Reduce the variation in opioid prescribing practices among Texas health care providers.
3. Ensure that people who are on long-term opioid therapy for chronic pain are carefully monitored and patient safety is a top concern.

Recommendations do not apply to opioids prescribed for patients who are experiencing pain caused by cancer, patients receiving hospice care, or opioids prescribed as medication-assisted therapy to treat opioid dependency. The three key principles that underlie the opioid prescribing recommendations are provided below in Table 1.

Beginning September 1, 2019, pharmacists and prescribers will be required to check the patient’s Prescription Monitoring Program (PMP) history before dispensing or prescribing opioids, benzodiazepines, barbiturates, or carisoprodol. Currently, pharmacists and prescribers are encouraged to check the PMP to help eliminate duplicate and overprescribing of controlled substances, as well as to obtain critical controlled substance history information. To register, go to www.texas.pmpaware.net/login

<table>
<thead>
<tr>
<th>Opioid Use Indicator Summary</th>
<th>Number of Patients with Opportunities*</th>
</tr>
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<tbody>
<tr>
<td>Initial Opioid Use &gt;7 Day Supply</td>
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</tr>
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*Based on data from May 18, 2018
We acknowledge that there may be clinical variables influencing an individual patient’s management that are not apparent in claims data. However, we believe the issues identified may assist you in caring for your patient(s). It is possible that your license number may have been inadvertently assigned to the claim as an error at the pharmacy during the billing process. **Also, some prescribed medications as well as some recommended laboratory monitoring or physical examinations may not appear on the patient’s profile because they may have been privately purchased or were not billable to Medicaid Services.** We thank you for reviewing this information and caring for Texas Medicaid patients, and we welcome the opportunity to discuss any comments or concerns you may have about our quality management program. Please feel free to call our office at 1-866-923-7208 with questions or concerns. If your mailing address is incorrect, it must be updated through the Texas Medical Board online at [http://www.tmb.state.tx.us/page/change-address](http://www.tmb.state.tx.us/page/change-address).

Sincerely,

Medicaid Drug Use Review Board  
Vendor Drug Program H-630

### Table 1: Opioid Prescribing Recommendations: 1-3

<table>
<thead>
<tr>
<th>1.</th>
<th>TX Medicaid opioid limits are starting at 300 MME per day, but will gradually decrease to &lt;90 MME per day to allow providers to work with their patients to decrease MMEs per day.</th>
</tr>
</thead>
</table>
| 2. | Prescribe the lowest effective dose and duration of opioid analgesia when an opioid is indicated for acute pain. Clinicians should reduce variation in opioid prescribing for acute pain.  
- Avoid prescribing more than a three day supply or 20 pills of low-dose, short-acting opioids. Limit the entire prescription to 100 MMEs.  
- Prescribe no more opioids than will be needed for initial tissue recovery following more extensive surgical procedures and traumatic injury. Limit the initial acute prescription to no more than seven days or up to 200 MME, unless circumstances clearly warrant additional opioid therapy. Limit the entire prescription to 200 MME (not 200 MME/day).  
- Check the Prescription Monitoring Program (PMP) whenever prescribing an opioid for acute pain. |
| 3. | Closely monitor the patient during the post-acute pain period. The post-acute pain period is a critical time to halt the progression to chronic opioid use.  
- Assess and document risk factors for opioid-related harm and chronic opioid use during the post-acute pain phase, including depression, anxiety, substance abuse, fear avoidance and pain catastrophizing.  
- Prescribe opioids in multiples of seven days, with no more than 200 MME per seven-day-period, and no more dispensed than the number of doses needed. Prescribing should be consistent with expected tissue healing and expected tapering.  
- Avoid prescribing in excess of 700 MME (cumulative) in order to reduce the risk of chronic opioid use and other opioid-related harms.  
- Develop a referral network for mental health, substance use disorder, pain education and pain medicine. |
| 4. | Avoid initiating chronic opioid therapy and carefully manage any who remain on opioid medication. The evidence to support chronic opioid analgesic therapy for chronic pain is insufficient at this time, but the evidence of harm is clear.  
- Prescribe opioids at the lowest dose, with no more than 50 MME/day. Avoid increasing daily dosage to 90 MME/day or above.  
- Actively work to lower risks when initiating long-term prescribing and continue efforts through the duration of therapy. Strategies and frequency should be commensurate with risk factors.  
- Face-to-face visits with the prescribing provider should occur at least every three months. Prescribers should offer to taper use to a reduced dose or to discontinuation at least every three months.  
- Offer or arrange evidence-based treatment for patients with opioid use disorder. |
Health care professionals should consider prescribing physical therapy for chronic pain. The Centers for Disease Control and Prevention (CDC) Guideline recommends nondrug approaches, such as physical therapy over long-term or high-dosage use of addictive prescription painkillers.4

The CDC guideline for prescribing opioids for chronic pain states that nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.4

While there are certain conditions - including cancer treatment, palliative care, and end-of-life care - where opioid prescription for chronic pain may be appropriate, the CDC cited numerous cases where opioid use could be significantly reduced or avoided altogether.4

The guideline states that many nonpharmacologic therapies, including physical therapy, weight loss for knee osteoarthritis, psychological therapies, such as cognitive behavioral therapy (CBT) and certain interventional procedures can ameliorate chronic pain. There is high-quality evidence that exercise therapy (a prominent modality in physical therapy) for hip or knee osteoarthritis reduces pain and improves function immediately after treatment and that the improvements are sustained for at least 2-6 months. Previous guidelines have strongly recommended aerobic, aquatic, and/or resistance exercises for patients with osteoarthritis of the knee or hip. Exercise therapy also can help reduce pain and improve function in low back pain and can improve global well-being and physical function in fibromyalgia.4

Physical therapists partner with patients, their families, and other health care professionals to manage pain, often reducing or eliminating the need for opioids. Research has shown that a simple education session with a physical therapist can lead to improved function, range of motion, and decreased pain.4

References:
Based on submitted pharmacy and medical claims data through May 2018, the following individual has been identified with the issue(s) listed below for your consideration.

<table>
<thead>
<tr>
<th>Prescriber Name</th>
<th>«Prov_Physician_Name»</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>«Recip_Last_Name», «Recip_First_Name»</td>
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<td>Patient ID</td>
<td>«Recip_ID»</td>
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<tr>
<td>Patient DOB</td>
<td>«Recip DOB»</td>
</tr>
<tr>
<td>Provider Message</td>
<td>«Prov_message»</td>
</tr>
</tbody>
</table>
**Initial Opioid Use >7 Day Supply:** According to pharmacy claims data, your opioid naïve patient has received a new opioid prescription in the past 90 days for > 7 days supply. Evidence suggests most acute indications require use of an opioid for 3-5 days. Prescribers are encouraged to start with the lowest effective dose of an immediate-release opioid, for only the number of days that the pain is expected to be severe enough to require opioids. Please review use of the opioid in this patient and determine if any changes in prescribing of opioids could be recognized now or in the future.

**Opioid Use 90 to 300 MME per Day:** According to pharmacy claims data, it appears your patient has received opioids at a dose between 90 mg - 300 mg morphine milligram equivalent (MME) per day, in the past 90 days. High-dose opioids put patients at risk for addiction and overdose. At 90 mg MME or more, the risk of overdose death increases 10 times and the CDC recommends avoidance of MME >90. Please evaluate this patient’s opioid dose, consider a taper in the daily MME, and alternatives to opioids for pain management. Also ensure your patient has access to naloxone and has been educated about its use.

**Opioid Use >300 MME per Day:** According pharmacy claims data, it appears your patient has received >300 mg morphine milligram equivalent (MME) per day in the past 90 days. High-dose opioids put patients at risk for addiction and overdose. A dose of 50mg MME per day doubles the risk of opioid overdose death, compared to 20 mg MME or less per day. At 90 mg MME or more, the risk increases 10 times. Please evaluate this patient’s opioid dose, consider a taper in the daily MME, and alternatives to opioids for pain management. Also ensure your patient has access to naloxone and has been educated about its use.

**Overutilization of Opioids:** According to pharmacy and medical claims data, it appears your patient has received >7 opioid claims within the past 60 days, including >3 different opioid agents. While your patient may have a clinical indication for an opioid, there is concern about coordination of care and whether these prescriptions are being used according to physicians’ directions. Please review these opioid prescriptions and determine the best outcome for your patient.

**Opioid Use and History of Dependence:** According to pharmacy and medical claims data, your patient has received opioid prescriptions in the past 60 days from either >4 prescribers, or >3 prescribers and also filled at >3 pharmacies, while having a history of a substance abuse disorder. If you determine that your patient has an opioid use disorder, please evaluate the pain management regimen in this patient; consider alternative pain treatments, and/or a opioid dependence program.

**Currently Using Opioids > 300 MME per Day for >120 days with History of Opioid Overdose:** According to pharmacy claims data, your patient has received an opioid/s at a morphine milligram equivalent (MME) > 300mg per day for a duration of >120 days. There is limited evidence of long-term beneficial effects of long-term opioid therapy in improving chronic pain and functioning. And, continued use increases the likelihood of opioid use disorder. Please review this patient’s level of pain, continued need for an opioid, and if appropriate, document a plan to taper the daily MME to safer levels. Also ensure your patient has access to naloxone and has been educated about its use.