



Physicians Guide to Appropriate Opioid Prescribing in Noncancer Patients

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Disclosure

- Dr. Munzing and Dr. Cummins have no relevant financial interests to disclose

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Goals & Objectives

- Participants will be able to:
 - Identify Legitimate vs Illegitimate Opioid Prescribing
 - Utilize Standards of Care for Controlled Substance Prescribing
 - Identify “Red Flags” for Potential Controlled Substance Abuse / Diversion and Use in Prescribing Decision Making

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Soaring Towards Improved Outcomes and Patient Safety



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Crooked Docks vs Crooked Docs



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High Profile in 2015 and 2016



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Undercover states this is his "Back MRI" What Do You See???



Conviction – 17 counts – 3 years in prison – September 2016

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Los Angeles Times – Oct. 30, 2015

California doctor convicted of murder in
overdose deaths of patients



By Martin Martinez, Lisa Hirsch and Emma Spangler - Orange County Register

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Stranger than Fiction: High Profile and Salacious Case

17 felony convictions.

[Dr. Kim - Channel 7 News Report](http://abc7.com/news/dirty-doctor-busted-by-dea-with-doggy-x-ray-undercover-stripper/1615329/)

<http://abc7.com/news/dirty-doctor-busted-by-dea-with-doggy-x-ray-undercover-stripper/1615329/>

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Dangerous / Common Combinations

- **"Holy Trinity"** –
 - Oxycodone, Benzodiazepine, Soma
- **"Houston Cocktail"** –
 - Norco, Xanax, Soma
- **"Sizzurp"** –
 - Promethazine with codeine cough syrup, Jolly Ranchers candy, fruit flavored cola

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Celebrity Overdose Deaths



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Avoiding Falling off the Cliff: Potential Consequences

- Patients
 - Addiction
 - Overdose
 - Death
- Physicians
 - Loss of Medical License
 - Prison



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Physicians Decisions Are Difficult: Appropriate Opioid Prescribing Quiz

- Appropriate or Not???
- Assumptions:
 - New patient being seen
 - The only information you have is as stated
 - All the information is accurate
- You must decide:
 - Based on this information, do you prescribe (new or refill) an opioid medication?
 - YES OR NO???
 - Why (very brief comments)???

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Poll Question: Case #1

- 80 year old male
- Severe lumbar (back) disc herniation and severe degenerative changes on MRI ~ 8-10 years prior
- Saw neurosurgeon after failing Physical Therapy and meds at that time
- Patient declined surgery due to age

- **Your call – Yes or No???**

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Poll Question - Case #2

- 50 year old male
- Chronic severe R knee pain x 30+ years
- Cause - history of severe osteomyelitis (bone infection) causing dramatic knee deformity – seen easily by inspection
- X-ray confirmation
- History of drug addiction (25 years prior)
- Seen by orthopedics - no surgery possible due to R knee deformities

- **Your call – Yes or No???**

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Quiz Answers It's Not that Easy to Decide at Times

- 1 No No current pain (my dad)
- 2 Yes Treat addicts in true pain - monitor VERY carefully

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Outdated Information - WRONG

"The risk of addiction is much less than 1%"

Porter J, Jick H. *Addiction rare in pain patients treated with narcotics.*
New Engl J Med. 1980 Jan 10;302(2):123

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Pain = 5th Vital Sign

1990's Physicians encouraged to increase medications to eliminate pain (**Assumed no harm**)

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Overuse of Prescription Medications: Scope of the Problem

- Prescription Drug Overdose Deaths > Illicit Drugs (2013 Data)
 - 43,982 – Total overdose deaths annually
 - 22,767 (51.8%) Prescription drugs related
 - 16,235 – Total – prescription opioids (~44/day)
 - 6,973 – Total – prescription benzodiazepines
 - Many from a combination of 2 or more drug classes

Centers for Disease Control and Prevention. National Vital Statistics System mortality data. (2013). Available from URL: http://www.cdc.gov/nchs/data/health_data

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Overuse of Prescription Medications: Scope of the Problem

- Nearly 2 million Americans, aged 12 or older, either abused or were dependent on opioids in 2013

Centers for Disease Control and Prevention. National Vital Statistics System mortality data. (2013). Available from URL: http://www.cdc.gov/nchs/data/health_data

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Overuse of Prescription Medications: Scope of the Problem

- Emergency Department Visits (2011 Data)
 - 2.5 million – Drug misuse / abuse
 - 1.4 million (56%) – Prescription drugs
 - 501,207 (20%) – Anti-anxiety / insomnia drugs
 - 420,040 (17%) – Opioid analgesics

Substance Abuse and Mental Health Services Administration. Highlights of the 2011 Drug Abuse Warning Network (DAWN) findings on drug-related emergency department visits. The DAWN Report. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration; 2013. Available from URL: <http://www.samhsa.gov/daurn/2011/0104000172/0127-0a-v01n-hp01n01n.htm>

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Poll Question: Which of the following predict misuse of prescription opioids?

- A. Race
- B. Literacy
- C. Disability
- D. Socioeconomic status
- E. All of the Above
- F. None of the Above

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Cultural Competence

DO NOT PREDICT

- Gender
- Race
- Literacy
- Disability
- Socioeconomic status

PREDICT RX MISUSE

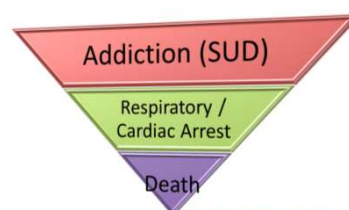
- Hx EtOH/drug abuse*
- Hx EtOH/drug-related criminal conviction
- FHx EtOH/drug abuse
- Psychiatric disorder

*Includes nicotine

Opioid Risk Tool - Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction. Webster LR, Webster R. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the opioid risk tool. Pain Med. 2005; 6 (6): 432

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Major Risks of Opioids



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Basic neurochemistry 3-minute detour

Best day ever



Dopamine units

In despair and feeling hopeless...



Dopamine units

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How our body is built to work

Best day ever



Average day



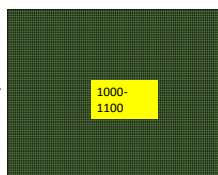
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Best day ever



First dose of heroin



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Over time with daily use...

Heroin or opioid painkillers

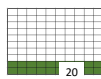


Your daily dose is needed just to feel normal.

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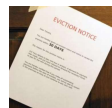
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Happiest Possible Day
Long term opioid exposure, off opioids



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Worst Possible Day
Long term opioid exposure, off opioids
Lack of motivation



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For 100 patients starting
on opioid therapy

25 will become long-term
opioid users

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Family Physicians, Residents
& Medical Students

25 will become long-term
opioid users

25 will become long-term
opioid users

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Family Physicians, Residents
& Medical Students

For 100 long-term users,
how many misuse?

Up to 56%
Over a lifetime

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Family Physicians, Residents
& Medical Students

Challenges for Physicians, Law
Enforcement and Prosecutors



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General Principles

- Act like a doctor – evaluate and manage appropriately
- Pain
 - Acute Pain – serves a function, may be helped by opioids (based on severity)
 - Chronic Pain – does not serve a function, may result in neurological changes in pain sensation, requires multidimensional approach, opioids often poor choice

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General Principles

- 90- day cliff (or much shorter)
- Non-pharmacologic alternatives and adjunct treatments
- Non-opioid alternatives
- Start low and go slow – very limited prescription numbers
- Trust but verify
- Documentation – be thorough!

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Likelihood of Chronic Opioid Use

- Increased - **3rd day** of Rx and each additional day after the 3rd day
- Sharpest increase – after 5th and 31st day
- 2nd refill
- 700 morphine mg equiv. cumulative dose
- Initial 10-day or 30-day supply
- Opioid Use 1 year later
 - 1 day – 6%
 - 8 days – 13.5%
 - 31 days – 29.9%

CDC MMWR – March 17, 2017 / 66(10); 265-269

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CDC Prescribing Guidelines (2016)

Published JAMA – March 15, 2016

2016 CDC Recommendations for Controlled Substances

- Avoid benzodiazepines with opioids [increases risk of overdose death ~ten-fold versus only opioid use]
- Periodic benefit / risk evaluation, including PDMP (CURES) and Urine Drug Screen
- Non-pharmacologic and non-opioid tx – first line
- Chronic pain – avoid opioids – risk outweighs benefits for most
- Discuss risk / benefits with patients and document
- Establish realistic goals – prior to opioid starts
- Start immediate release – avoid Methadone as first line – higher risk

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CDC Prescribing Guidelines (2016)

Published JAMA – March 15, 2016

- Additional precautions if dose exceeds 50 MME mg /day
- “Generally avoid increasing the dosage \geq 90 MME mg/day
- Should only give 3 days max for acute pain for most non-traumatic, non-surgical pain
- Avoid combinations – short and long acting opioids
- Concerns – may limit opioids for some for whom they may benefit

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FDA Black Box Warning – Sept 2016

- Avoid prescribing (or using) opioids and benzodiazepines concurrently
- Significant risk of respiratory depression (difficulty / slower breathing)
- Higher risk of overdose death

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Definitions (General Terms)

- Tolerance** – Marked increase in amount or decrease in effect
- Dependence** – Tolerance; Withdrawal symptoms if stop; Substance taken to relieve withdrawal; Persistent desire to quit
- Abuse** – Recurrent use – failure to fulfill major role obligation – work, home, school; recurrent use – physically hazardous situations; recurrent substance related legal problems; continued use despite recurrent social / interpersonal problems caused / worsened by substance

Revised DSM-IV

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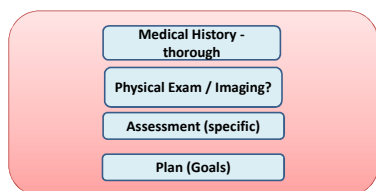
Controlled Substance Medications:

Drug Classes (Examples)

Drug – Generic	Brand Names	Schedule	Class
Hydrocodone	Norco, Vicodin	II	Opioid (pain)
Oxycodone	OxyContin, Percocet	II	Opioid
Morphine	MS Contin	II	Opioid
Methadone	Methadose	II	Opioid
Alprazolam	Xanax	IV	Benzodiazepine (anxiety, insomnia)
Lorazepam	Ativan	IV	Benzodiazepine
Carisoprodol	Soma	IV	Muscle Relaxant

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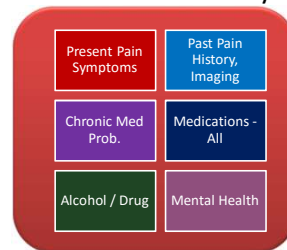
Controlled Substance Prescribing: Core Elements



Adapted from the Medical Board of California; American Academy of Pain Medicine; American Pain Society

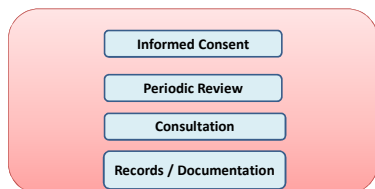
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Medical History



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Controlled Substance Prescribing: Core Elements



Adapted from the Medical Board of California; American Academy of Pain Medicine; American Pain Society

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Informed Consent

- Verbal discussion - document
- Written documentation
- Benefits > Risks to use opioids
- Controlled Substance Agreement
 - Often Reviews Physician and Patient Responsibilities
 - Important to be Followed
 - May include: Effectiveness, Risks, Side Effects, Dependence, Addiction Issues

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Periodic Review: The 5 "A's" Plus

- Analgesia
- Activity or Function
- Adverse Effects
- Affect
- Aberrant behaviors
- Prescription Drug Monitoring Program (PDMP) – CURES in California
- Urine Drug Screening (UDS)
- Updated History, Exam, and Assessment
- Taper medications when possible

Adapted from the 4-"A's" - Passik SD, Weinreb HJ. Managing chronic nonmalignant pain: overcoming obstacles to the use of opioids. Adv Ther. 2000;17:70-80.

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Controlled Substance Prescribing: Core Elements



Adapted from the Medical Board of California; American Academy of Pain Medicine; American Pain Society

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Key Appropriate Prescribing Elements

- Thorough evaluation prior to prescribing, including behavioral/mental health
- Current / past Alcohol & Drug use / abuse
- Opioid Risk Evaluation (Opioid Risk Tool)
- Assessment/Goals – as specific as possible
- Individualize treatment – Function > Pain Improvement
- Start low and go slow – up titrate and down titrate
- Trust but verify what your patients say
- Only one opioid at a time if at all possible
- Avoid opioid and benzodiazepine combination
- Long acting opioids have lower addictive qualities
- Addicts will try anything to get what they want - BEWARE

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Undercover Visit Slide Here

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List Red Flags for Abuse / Diversion – Group Exercise

- 1
- 2
- 3
- 4



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Poll Question: Which of the Following Red Flags Confirm Opioid Abuse / Diversion?

- A. Early refills of the opioid medication(s)
- B. Prescriptions from multiple physicians (not only opioids)
- C. Driving long distance to see the physician
- D. All of the above
- E. None of the above

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Prescribing “Red Flags” for Abuse / Diversion

- Early refills / Claims that the medications were lost or stolen
- Escalating dosages or combinations
- Use of multiple pharmacies concurrently
- Obtaining Controlled Substances from multiple physicians or doctor shopping
- Excessive amounts or drug combinations
- Obtaining or buying Controlled Substances from family, friends, or others
- Giving or selling Controlled Substances to family, friends, or others
- Use / abuse of alcohol
- Use of THC / marijuana - even with a Marijuana Card

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Prescribing “Red Flags” for Abuse / Diversion

- Use of drug culture street lingo for the names of the medications or other drugs
- CURES reports that provide inconsistent results
- Urine drug screens that provide inconsistent results
- Patients driving long distances to see the physician
- Multiple family members or those residing in the same household receiving identical or similar Controlled Substances
- Failure to improve
- Drug overdoses

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Physician Drug Monitoring Program (PDMP) – CURES in California – 48 States [Example]

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CURES Exercise: Identify Red Flags

Date	Medication	#	Pharmacy	Physician
6/4/14	Norco 10/325	240	CVS	Smith
6/4/14	Xanax 2 mg	90	CVS	Smith
6/24/14	Norco 10/325	240	CVS	Smith
6/24/14	Xanax 2 mg	90	CVS	Smith
7/15/14	Norco 10/325	240	CVS	Smith
7/15/14	Xanax 2 mg	90	CVS	Smith
7/15/14	Soma 350 mg	90	CVS	Smith
7/18/14	Percocet 10/325	240	Rite Aid	Jones
7/18/14	Ativan 2 mg	60	Rite Aid	Jones
8/5/14	Norco 10/325	120	CVS	Smith
8/5/14	Soma 350 mg	90	CVS	Smith
8/5/14	Xanax 2 mg	90	CVS	Smith
8/5/14	OxyContin 30 mg	120	Albertsons Pharm	Smith
8/10/14	Percocet 10/325	240	Rite Aid	Jones
8/10/14	Ativan 2 mg	60	Rite Aid	Jones

CURES Exercise

- Early refills
- Multiple doctors
- Multiple pharmacies
- Escalating dosages
- MED > 100 mg/day
- Multiple concurrent opioids
- Opioids and Benzodiazepines
- “Holy Trinity” combination

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How to Say “No”

- Doctor – Patient therapeutic relationship
- Risks – Benefits
- Alternatives
- It’s worth the time and effort

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Investigators of Physicians

- Drug Enforcement Administration (DEA)
- Local Law Enforcement
- State Medical Boards
- Medicare Audits
- Medi-Cal or Medicaid Audits



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Who Reports Physicians?

- Family members of addicts / patients who overdose or die
- Fellow physicians or ERs who see the inappropriately managed patients
- Pharmacists
- Coroners
- Medicare or Medicaid audits
- Informants

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Improving Patient Safety and Outcomes



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References

- Medical Board of California Guidelines for Prescribing Controlled Substances for Pain – 1994, 2003, 2007, and 2014
- DEA Regulation 21 C.F.R. 1306.04 – Purpose of issue of prescription
- "Opioid Prescriptions for Chronic Pain and Overdose: A Cohort Study", *Annals of Internal Medicine*, Kate Dunn, PhD, et al; January 19, 2010 [MED dosing information / risks]
- "Use of Opioids for the Treatment of Chronic Pain" – American Academy of Pain Medicine, <http://www.painmed.org/files/use-of-opioids-for-the-treatment-of-chronic-pain.pdf>
- "Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain", American Pain Society – American Academy of Pain Medicine Opioids Guideline Panel – February 2009 – *Journal of Pain* – [http://www.pain.org/article/S1526-5900\(09\)00831-6/fulltext](http://www.pain.org/article/S1526-5900(09)00831-6/fulltext)
- Washington State Agency Medical Directors' Group – in conjunction with the Interagency Guideline on Opioid Dosing for Non-cancer Pain

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References

- World Health Organization – Guidelines for Pain Management
- American Pain Society – Guidelines for Pain Management
- American Academy of Pain Medicine Pain Management Guidelines
- Drug Enforcement Administration
- Centers for Disease Control - Overdose and Overdose death statistics
- National Forensic Laboratory Information System (NFLIS) data – found at: http://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2012/sept_2012/houston/drug_trends_1002.pdf

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Opioid Prescribing Review

- "Physician Guide to Appropriate Opioid Prescribing for Noncancer Pain", *The Permanente Journal*
- *Author – Timothy Munzing, MD*
- <https://doi.org/10.7812/TPP/16-169>



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Q&A



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