

# THE DWC MTUS ACOEM GUIDELINES<sup>1</sup> & FORMULARY<sup>2</sup>

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<sup>1</sup> <http://www.dir.ca.gov/dwc/MTUS/MTUS-Guidelines.html>

<sup>2</sup> <http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm>

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## SUMMARY TABLES

### SUMMARY OF IMPORTANT MTUS FORMULARY METHODOLOGY POINTS

- Formulary does not limit access to any FDA-approved drug, all non-exempt and unlisted medications are available through the usual prospective review process.
- **MTUS Drug List**
  - **Exempt drugs – No Prospective Review if in accord with MTUS**
    - Being noted as a first line therapy weighs in favor of being Exempt.
    - Recommended for most acute and or acute/chronic conditions addressed in clinical guidelines weighs in favor of being Exempt.
    - A safer adverse effects (risk) profile weighs in favor of being Exempt.
    - Drugs listed for the treatment of more common work-related injuries and illnesses weighs in favor of being Exempt.
  - **Non-Exempt & Unlisted Drugs – Prospective Review required**
  - **“Special Fill” & “Perioperative Fill”** of specified Non-Preferred drugs
    - 4-day supply of certain nonexempt drugs in limited situations
    - No prospective review of certain nonexempt drugs during the perioperative period
- Ancillary Formula Rules: Intended to support the provision of appropriate, cost effective, high-quality medical care.
  - Access to non-preferred and unlisted drugs.
  - Off-label use allowed as recommended by the MTUS guidelines.
  - Generic drug preference; requirements for brand name drug.
  - Compounded drugs must be authorized through prospective review prior to being dispensed.
  - Physician dispensing:
    - Must be authorized through prospective review prior to being dispensed.
    - May dispense up to a 7-day supply of an exempt drug on a one-time basis as long as drug treatment is in accordance with the MTUS treatment guidelines.
- **Structure of MTUS Drug List**

Drug Ingredient	Reference Brand Name	Exempt/Non-Exempt*	Special Fill**	Peri-Op***	Drug Class	Reference in Guidelines	Dosage Form	Strength	Unique Pharmaceutical Identifier(s)
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- Organized by active drug ingredient
- Reference Brand
- Exempt / Non-Exempt status
- Special Fill & Perioperative Fill
- Drug class
- Reference in Guideline “legend”
  - (✓) Recommended
  - (✗) Not Recommended
  - (⊙) No Recommendation
- Dosage Form, Strength, Product ID

### PHYSICIAN STEPS TO FORMULARY USE

1. Go to MTUS Formulary Drug List: <http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm>
  - a. Excel spreadsheet version: <http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/Final-Regulations/DRUG-LIST.xls>
  - b. PDF version: <http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/Final-Regulations/DRUG-LIST.pdf>
  - c. **Drug MUST be used in conjunction with MTUS Guidelines** (i.e., the MTUS must support use of the drug for the diagnosis/body part – see column 8, Reference in Guidelines)
  - d. See links to MTUS Guidelines on page 8
  - e. See information on page 8 re: purchase of electronic access to MDGuidelines
2. **Look up drug** in column 2, Drug Ingredient from Formulary Drug List
  - a. **If Exempt** (column 3), go to #3
  - b. If **Non-Exempt** (column 3) or if **Unlisted** (not listed in the Formulary) go to #4
  - c. **Special Fill** (column 5) go to #5
  - d. **Perioperative Fill** (column 6) go to #6
3. **Exempt** (always prescribed/dispensed in accordance with MTUS)
  - a. May be prescribed without authorization
  - b. Physician dispensed drugs limited to one 7-day supply at initial visit within 7 days of injury
  - c. Must get authorization to use Brand name if generic available
4. **Non-Exempt** or **Unlisted** (requires authorization prior to prescribing or dispensing)
5. **Special Fill** (drug may be prescribed/dispensed without prior authorization/prospective review)
  - a. Prescription at initial visit within 7 days of injury, and
  - b. supply not to exceed #days indicated, and
  - c. is a generic or single source brand, or brand where physician substantiates medical necessity, and
  - d. if in accord with MTUS
6. **Perioperative Fill** (drug may be prescribed/dispensed without prior authorization/prospective review)
  - a. Rx issued during the perioperative period (2-4 days before through 4 days after surgery), and
  - b. supply not to exceed #days indicated, and
  - c. is a generic or single source brand, or brand where physician substantiates medical necessity, and
  - d. if it is in accord with MTUS.
7. **Ancillary Formula Rules**
  - a. Off-label use: allowed as recommended by the MTUS guidelines
  - b. Generic drugs preferred
  - c. Compounded drugs must be preauthorized
  - d. Physician dispensing
    - i. Must be authorized through prospective review prior to being dispensed
    - ii. May dispense up to a 7-day supply of an exempt drug on a one-time basis as long as drug treatment is in accordance with the MTUS treatment guidelines

### SUMMARY OF IMPORTANT OPIOID & TAPERING POINTS

- **DWC MTUS Opioid Guidelines and Chronic Pain Guidelines are **presumptively correct**.**
- Physician must provide quality review of records, medical history and physical examination with recommendations that meet evidence-based medicine (EBM) guidelines.
- **Transition by 4/1/18** (for injured workers receiving ongoing drug treatment for injury prior to 1/1/18):
  - Formulary should be phased in to avoid harm from abrupt change to drug treatment.
  - Physician responsible for requesting medically appropriate & safe treatment in accordance with MTUS.
  - Treatment may include Non-Exempt/Unlisted drug if necessary for injured worker condition, or for safe weaning/tapering/transition to different drug.
  - Physician must submit RFA with ongoing drug treatment plan including tapering, weaning, transitioning to drug pursuant to MTUS or provide documentation supporting medical necessity for Non-Exempt/Unlisted/compounded drug per MTUS.
  - Previously approved drug treatment shall not be terminated/denied except as may be allowed by MTUS, and in accord with applicable UR/IMR regulations.
- Opioid use is moderately not recommended for treatment of subacute and chronic nonmalignant pain.
- The maximum daily opioid dose recommended for opioid naïve, acute or postoperative or subacute and chronic pain patients based on risk of overdose/death is 50 mg MED<sup>3</sup> (morphine equivalent dose).
- Opioid prescription should be patient specific, and limited to cases in which other treatments are insufficient and criteria for opioid use are met.
- The use of an opioid trial is recommended when other evidence based approaches for functional restorative pain therapy have been used, and documented to have provided inadequate improvement in function.
- While opioids may be effective in moderate doses in certain individuals, they also carry significant risks of harm.
- Opioid tapering/weaning must be medically safe - the goal is to safely reduce medications that are not efficacious while monitoring negative effects of withdrawal symptoms.
- It is medically unsafe and risky for the injured worker to abruptly stop taking certain medications - this is especially true in the medically compromised individual.
- While opioid tapering/weaning or detoxification may be appropriate, the real issue is the injured workers well-being and function (activities of daily living).
- Physicians who feel uncomfortable or are unsuccessful with managing an opioid taper or wean, should refer to the appropriate chronic pain specialist or addictionologist.
- The frequency/duration of a taper is dependent on multiple factors and is patient specific.
- The most common taper is 10% per week; again, tapering needs to be patient specific.<sup>4</sup>
- Guidelines support patient engagement in tapering with provision of education by the physician or others along with involvement in other active therapies including cognitive behavioral therapy and progressive physical reactivation.
- The taper should be stopped if there is objective worsening of function, excessive withdrawal, and/or intolerance. After stabilization, resumption of the taper should be attempted.
- Not all patients can be completely tapered off opioids and in specific cases, continuation of the opioid may be a consideration as well as the substitution of buprenorphine or methadone.
- The CA DWC MTUS Formulary Drug List needs to be understood by the treating physician to be used effectively.
- Treatment alternatives are supported by the CA DWC MTUS.

## CA DWC MTUS DRUG FORMULARY<sup>5</sup>

On January 1, 2018, the MTUS Drug Formulary took effect for all drugs dispensed regardless of the date of injury.

According to Section 9792.27.3, the MTUS Drug Formulary should be phased in to ensure that injured workers who are receiving ongoing drug treatment are not harmed by an abrupt change to the course of treatment. The physician is responsible for requesting a medically appropriate and safe course of treatment for the injured worker in accordance with the MTUS, which may include use of a Non-Exempt drug or unlisted drug, for an extended period where that is necessary for the injured worker's condition or necessary for safe weaning, tapering, or transition to a different Preferred drug.

For dates of injury prior to 1/1/18, if the injured worker has been receiving treatment that includes a nonexempt drug, an unlisted drug, or a compounded drug, the physician shall submit a progress report and a Request for Authorization (RFA) that shall address the injured worker's ongoing drug treatment plan. The plan should 1) set forth medically appropriate weaning/tapering/transitioning to a drug pursuant to the MTUS, or 2) provide supporting documentation to substantiate the medical necessity of, and to obtain authorization for, the nonexempt drug, unlisted drug, or compounded drug, pursuant to the MTUS.

The MTUS Drug List must be used in conjunction with 1) the MTUS Guidelines, which contain specific treatment recommendations based on condition and phase of treatment and 2) the drug formulary rules.

"Reference in Guidelines" indicates guideline topic(s) which discuss the drug. In each guideline there may be conditions for which the drug is Recommended (✓), Not Recommended (✗), or No Recommendation (⊙). Consult guideline to determine the recommendation for the condition to be treated and to assure proper phase of care use.

"Exempt" indicates drug may be prescribed/dispensed without seeking authorization through Prospective Review if in accordance with MTUS.

1. Physician dispensed "Exempt" drugs limited to one 7-day supply at initial visit within seven days of the date of injury without Prospective Review.
2. Prescription/dispensing of Brand name "Exempt" drug where generic is available requires authorization through Prospective Review.

"Non-Exempt" or "Unlisted" drug requires authorization through Prospective Review prior to prescribing or dispensing.

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<sup>3</sup> A morphine equivalent dose (MED) is the amount of opioid prescription drugs, converted to a common unit (milligrams of morphine)

<sup>4</sup> While expeditious for communication purposes, this can lead to a prolonged tapering plan as the endpoint is only reached asymptotically—practical management would suggest a tapering of 10% of the number of tablets of usual dose size each week - sdf

<sup>5</sup> <http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm>

Special Fill - Indicates the Non-Exempt drug may be prescribed/dispensed without Prospective Review:

1. Prescription at initial visit within 7 days of injury, and
2. supply not to exceed #days indicated, and
3. is a generic or single source brand, or brand where physician substantiates medical necessity, and
4. if in accord with MTUS.

Perioperative Fill – Indicates the Non-Exempt drug may be prescribed/dispensed without Prospective Review:

1. Rx issued during the perioperative period (2-4 days before through 4 days after surgery), and
2. supply not to exceed #days indicated, and
3. is a generic or single source brand, or brand where physician substantiates medical necessity, and
4. if it is in accord with MTUS.

## ***NAVIGATING THE CA DWC FORMULARY—SPECIFIC APPROACHES***

Staying within the California DWC Formulary:

1. Follow the MTUS recommendations for evaluation and treatment.
2. Use alternate "Exempt" drugs.
3. Use generics, when available.
4. Use MTUS to the injured worker's advantage.
  - a. Use the MTUS for the specific condition and the MTUS Formulary as a guide to getting specific medications authorized.
  - b. Monitor past utilization review (UR) and independent medical review (IMR) decisions to better understand what is denied and what is approved.

## ***DWC MTUS GUIDELINES***

The DWC MTUS is based on the ACOEM Guidelines. <http://www.dir.ca.gov/dwc/DWCPropRegs/Medical-Treatment-Utilization-Schedule/Medical-Treatment-Utilization-Schedule.htm>

- **ACOEM Guidelines**

- [Initial Approaches to Treatment Guideline](#) (ACOEM June 30, 2017)
- [Cervical and Thoracic Spine Disorders Guideline](#) (ACOEM May 27, 2016)
- [Shoulder Disorders Guideline](#) (ACOEM August 1, 2016)
- [Elbow Disorders Guideline](#) (ACOEM 2013)
- [Hand, Wrist, and Forearm Disorders Guideline](#) (ACOEM June 30, 2016)
- [Low Back Disorders Guideline](#) (ACOEM February 24, 2016)
- [Knee Disorders Guideline](#) (ACOEM October 28, 2015)
- [Ankle and Foot Disorders Guideline](#) (ACOEM September 2015)
- [Eye Disorders Guideline](#) (ACOEM April 1, 2017)
- [Hip and Groin Guideline](#) (ACOEM May 1, 2011)
- [Occupational/Work-Related Asthma Medical Treatment Guideline](#) (ACOEM January 4, 2016)
- [Occupational Interstitial Lung Disease Guideline](#) (ACOEM January 4, 2016)
- [Chronic Pain Guideline](#) (ACOEM May 15, 2017)
- [Opioids Guideline](#) (ACOEM April 20, 2017)

## ***MDGUIDELINES***

The ACOEM Occupational Medicine Practice Guidelines are published by ReedGroup and are accessible electronically through a subscription to the MDGuidelines website (<http://www.mdguidelines.com/>) and includes the ACOEM Formulary and a searchable interface with chapters that are updated with ACOEM's evidence-based methodology. This online tool also provides users with first access to chapters as they are updated.

California medical providers who are new subscribers may obtain an [annual commercial license](#) (click on the link to obtain the discounted license) to the ACOEM guidelines and formulary at a discounted rate of \$100/year. Other users will need to obtain license information by contacting ReedGroup / Carlos Luna: via email to [cluna@reedgroup.com](mailto:cluna@reedgroup.com) or by phone (303) 407-0682.



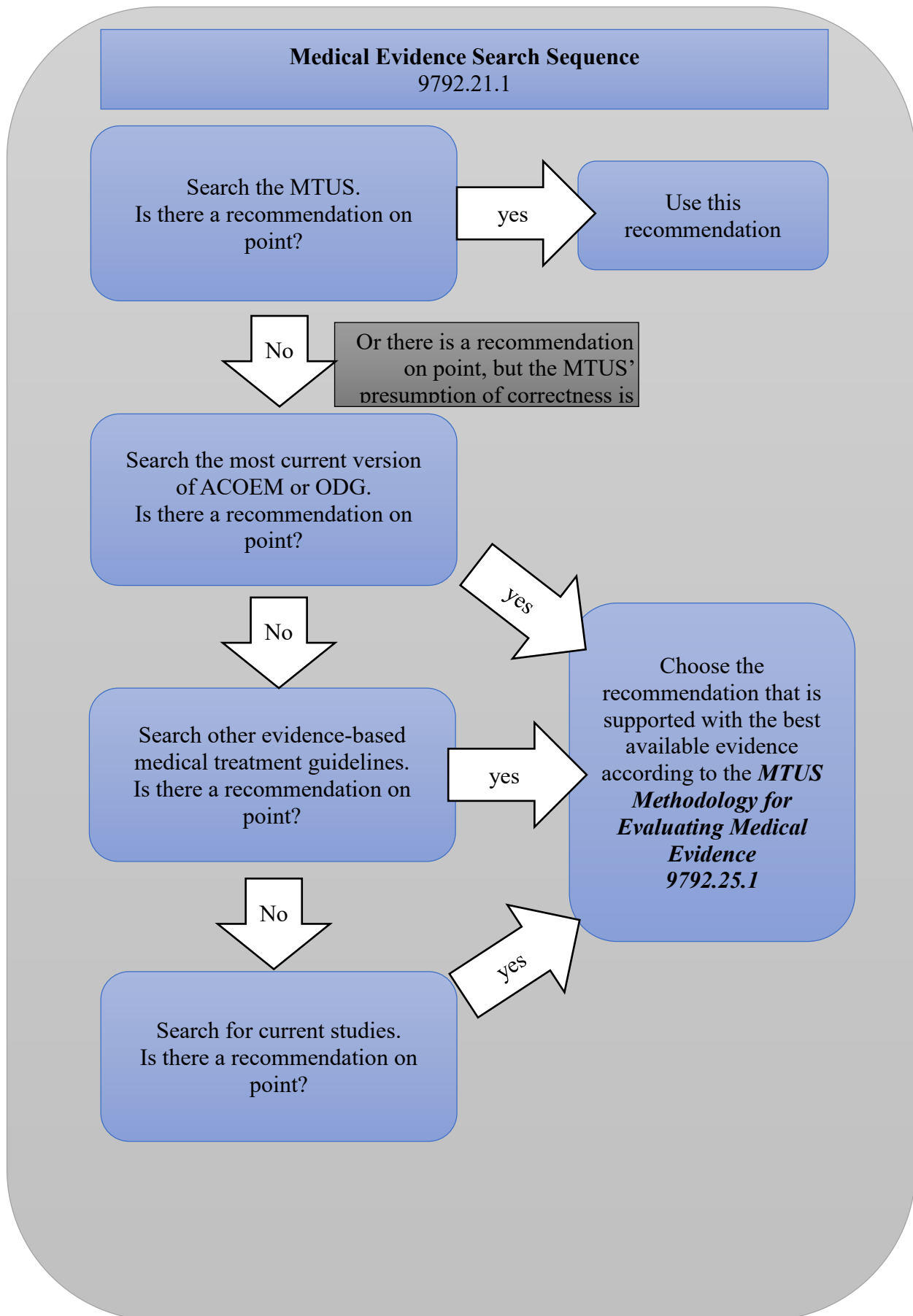
## ***MTUS SEARCH SEQUENCE: STRENGTH (OR HIERARCHY) OF EVIDENCE GUIDELINES***

The DWC MTUS search sequence to be followed can be found at **Medical Evidence Search Sequence**.

Treating physicians and medical reviewers shall conduct the following medical evidence search sequence for the evaluation and treatment of injured workers.

- (1) Search the recommended guidelines set forth in the current MTUS to find a recommendation applicable to the injured worker's medical condition or injury. *(NB: If a treater agrees with and follows the treatment guidelines as documented in the current CA MTUS, there is no need to proceed further).*
- (2) In the limited situation where a medical condition or injury is not addressed by the MTUS or if the MTUS' presumption of correctness is being challenged, then:
  - A. Search the most current version of ACOEM or ODG to find a recommendation applicable to the injured worker's medical condition or injury. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then
  - B. Search the most current version of other evidence-based medical treatment guidelines that are recognized by the national medical community and are scientifically based to find a recommendation applicable to the injured worker's medical condition or injury. If no applicable recommendation is found, or if the treating physician or reviewing physician believes there is another recommendation supported by a higher quality and strength of evidence, then
  - C. Search for current studies that are scientifically-based, peer-reviewed, and published in journals that are nationally recognized by the medical community to find a recommendation applicable to the injured worker's medical condition or injury.

The following chart is provided permission from the California Applicants' Attorneys Association (CAAA), an explanatory graphic of the **Medical Evidence Search Sequence** is provided. CAAA has graciously also provided a Link to a CAAA Bulletin, MTUS Practice Tips, at **#2 MTUS Practice Tip – Strength of Evidence Guidelines** which I highly recommend to you.



## PHYSICIAN INTEGRITY - STANDARD OF CARE/MALPRACTICE ISSUES

The physician has a moral, ethical and legal obligation to practice safe and effective medicine and to do no harm (*primum non nocere*). The physician may find himself or herself in a quagmire when prescribed medically necessary recommended treatment is denied. If evidence-based medicine guidelines truly are in contrast to the physician's treatment recommendations, then the injured worker should not suffer or be less functional. The ACOEM and CDC Opioid Guidelines are very clear in noting that each patient is unique, should have input into decision making, and that tapering/weaning/detoxification is not "one size fits all" and that the end result is quality patient care and pain management leading to life satisfaction and the highest level of function possible.

The DWC MTUS provides a search sequence to get treatment authorized (see page 9). If the physician believes that the prescribed treatment is medically necessary and within the standard of care, when there is a denial of care, the physician should follow the MTUS search sequence.

Here are some quotes regarding the standard of practice:

- National Association for Healthcare Quality <http://nahq.org/about/code-of-ethics>
  - Healthcare quality professionals' primary commitment is to the health, well-being, and safety of patients.
- NOLO <https://www.nolo.com/legal-encyclopedia/what-the-medical-standard-care-malpractice-case.html>
  - Most medical malpractice cases hinge on whether a health care professional was negligent in treating (or failing to treat) a patient. And medical negligence is always measured by the medical standard of care that applied in the specific treatment setting in which the patient was harmed. The "medical standard of care" is typically defined as the level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would have provided under the circumstances that led to the alleged malpractice.
- Judicial Council of California; Standard of Care for Healthcare Professionals, [http://www.thelaw.net/download/CCA\\_CIVIL-JURY.pdf](http://www.thelaw.net/download/CCA_CIVIL-JURY.pdf)
  - A [insert type of medical practitioner] is negligent if [he/she] fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as "the standard of care." [You must determine the level of skill, knowledge, and care that other reasonably careful [insert type of medical practitioners] would use in the same or similar circumstances, based only on the testimony of the expert witnesses [including [name of defendant]] who have testified in this case.]<sup>6</sup>

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<sup>6</sup> Judicial Council of California; Standard of Care for Healthcare Professionals, [http://www.thelaw.net/download/CCA\\_CIVIL-JURY.pdf](http://www.thelaw.net/download/CCA_CIVIL-JURY.pdf)

## OPIOID ISSUES

### *MTUS (ACOEM) OPIOID GUIDELINES*

The CA DWC MTUS is using the ACOEM Opioid Guidelines<sup>7</sup>. It is important to understand these guidelines if the physician is going to recommend and get authorization for the prescription of opioids in the treatment of injured workers.

1. Appropriate pain management is a responsibility of those treating pain.
2. It requires adequate knowledge about, and assessment of, a patient's pain and function.
3. Pain management often requires multiple pharmacological and nonpharmacological methods to appropriately control pain that should be evaluated.
4. A comprehensive history and physical examination and documentation is required.
5. A clear diagnosis is critical with treatment recommendations that are evidence-based.
6. When considering prescribing opioid, the treating physician should have a clear, quantified treatment plan and functional goals. These goals should be Specific, Measurable, Achievable, Realistic and Time-based (SMART).
7. The documentation should include a discussion and plan for the 5As:
  1. Analgesia (reduction in pain);
  2. Activity increase (improved level of functional and meaningful activities, and especially in work-related injuries, returning to work);
  3. Adverse effects (any side effects, especially constipation, dizziness, confusion and inability to function due to opioids);
  4. Aberrant behaviors (self-dose escalation, poor compliance, continued 'pain behaviors' despite use of opioids); and
  5. Affect (mood changes such as worsening of depression).
8. Documentation should include informed consent including an agreed-on opioid treatment agreement and monitoring results (urine drug testing, questionnaire screening tools, the California CURES prescription database, etc.).
9. Due to the greater than 10-fold elevated risks of adverse effects and death, considerable caution is warranted among those using other sedating medications and substances including:
  - i. Benzodiazepines,
  - ii. Anti-histamines (H1-blockers), and or

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<sup>7</sup> <http://www.dir.ca.gov/dwc/MTUS/ACOEM-Guidelines/Opioids-Guideline.pdf>

iii. Illicit substances.

10. Considerable caution is also warranted among those who (are/have):

- i. Older (>65 years),
- ii. Pregnant,
- iii. Sleep apnea, psychiatric/mental health disorders (anxiety, depression, personal salivary disorder, suicidal),
- iv. Drug-seeking behavior,
- v. current or past substance abuse,
- vi. Consuming alcohol in combination with opioids,
- vii. Renal insufficiency,
- viii. Hepatic insufficiency, and who are
- ix. Unemployed (10-fold risk of death).

11. Due to elevated risk of death and adverse effects, caution is also warranted when considering prescribing opioid for patients with any of the following characteristics:

- i. Other psychotropic medications,
- ii. Current tobacco use,
- iii. Attention deficit hyperactivity disorder (ADHD),
- iv. PTSD,
- v. Impulse control problems,
- vi. Thought disorders,
- vii. COPD, or
- viii. Recurrent pneumonia.

12. Additional risks and/or adverse effects thought to be present from other medical comorbidities.

13. Opioids are not indicated for MILD injuries (e.g., strains, tendinitis, nonspecific pain, mild to moderate low back pain).

14. Opioids MAY BE indicated for MODERATE injuries (e.g., Severe sprains of moderate or large joints, moderate trauma, moderate to severe low back pain).

15. Opioids ARE indicated for SEVERE injuries (e.g., fractures, major trauma, large burns).

16. Post-operative pain (up to 4 weeks, there is limited use of opioids as an objective therapy to more effective treatments.<sup>8</sup>

17. Opioid use is moderately not recommended for treatment of **subacute and chronic nonmalignant pain**.

1. Opioid prescription should be patient specific, and limited to cases in which other treatments are

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<sup>8</sup> Most current recommendations include provision of a three-day prescription followed by weekly prescriptions and concurrent recommendations for daily dose tapering as an active part of the postoperative recovery plan - sdf.

insufficient and criteria for opioid use are met.

2. The use of an opioid trial is recommended when other evidence based approaches for functional restorative pain therapy have been used, and documented to have provided inadequate improvement in function.
3. Screening of patients is recommended prior to initiating a trial of opioids for treatment of subacute or chronic pain.

18. The **maximum daily opioid dose** recommended for opioid naïve, acute or postoperative or subacute and chronic pain patients based on risk of overdose/death is **50 mg MED** (morphine equivalent dose).

19. Rotation of opioids is selectively recommended but should be an infrequent requirement.

20. **Buprenorphine** is selectively recommended for adjunctive treatment and opioid tapering.<sup>9</sup> Most patients are weaned without use of controlled substance medication. Buprenorphine is sometimes used for detoxification from high-dose opioids and is recommended for selected cases with opioid use at over 50–90 MG MED for at least 3 months duration as well as for the treatment of addiction. As treatment of these conditions is behaviorally and medically challenging, most are treated by an addiction specialist (e.g., high-dose patients, prior withdrawal problems, complex psychosocial confounders, complicating medical conditions). When there are complex medical issues (e.g., significant cardiovascular disease), inpatient treatment may be indicated. Buprenorphine is not generally recommended for those with no demonstrated functional gains; noncompliance; use of illicit substances; use of alcohol with opioids; and/or adverse effects of opioids (e.g., cognitive impairment, falls, poor judgment, untreated sleep apnea, psychological disorders, use of benzodiazepines). Transitioning to only an NSAID or acetaminophen for complete cessation of analgesics is/are generally preferable to substitution with buprenorphine.

21. **Breakthrough Pain (BTP)** is a transient increase in pain to greater than moderate intensity, which occurred on baseline pain of moderate intensity or less. It is also defined as “the transient exacerbation of pain occurring in a patient with otherwise stable, persistent pain.” Opioids are not recommended for routine treatment of breakthrough superimposed on chronic pain in the absence of overt trauma or acute nociceptive pathology (e.g., fracture, myocardial infarction, tooth abscess).

22. **Intrathecal Drug Delivery Systems** are not recommended for the treatment of chronic nonmalignant pain.

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<sup>9</sup> Buprenorphine is not well tolerated by all patients and therefore needs to be considered only as a potential tool in the management of Chronic Opioid Therapy and or Chemical Dependence disorder - sdf

## ***MEDICALLY SAFE TAPERING/WEANING OFF PAIN MEDICATIONS***

The ability for opioids to cause physical dependence means that when withdrawn, discomforting physical symptoms occur. To reduce the severity of withdrawal symptoms (e.g., drug craving, anxiety, vomiting/diarrhea, increased heart rate and blood pressure; sweating; tremors, anxiety), discontinuation of opioid therapy should be done through a gradual dose reduction (i.e., wean/ taper).

Each injured worker is unique when he comes to weaning/detoxification. Some injured workers can just stop abruptly without side effects and others go into severe withdrawal. The focus needs to be on function and not on the medication. Medications that increase function with little or no untoward side effects are medically reasonable.

Questions to ask: Are the medications actually making a difference? Are they making the person's life better and improving function? Are the benefits worth any side effects and negative effects? In other words, taking pain medications is a choice that each person must make by weighing the benefits vs. the risks.

When there is lack of efficacy and/or the risks appear to outweigh the benefits of taking a pain medication, reducing the dose and ultimately discontinuing the medication should be considered. This is called weaning or tapering particularly when the individual has become dependent on the medication. The term "detoxification" is sometimes used interchangeably but should be limited to cases with opioid addiction.

The goal of tapering/weaning down the dose is to safely discontinue medications that do not seem helpful in reducing pain while allowing the body to adjust while monitoring for negative effects of withdrawal symptoms. Oftentimes, people discover they feel better taking lower doses, fewer medications, or not taking medications at all.

It is dangerous to abruptly stop taking some medications (sometimes referred to as going "cold turkey"). Because the body develops physical dependence to some medications when they are taken regularly, abrupt withdrawal or too rapid a reduction in the dose of these medications can be very uncomfortable or even hazardous to one's health. It depends on the type of medication, how much, and for how long the medication has been taken.

## ***MTUS (ACOEM) OPIOID GUIDELINE RECOMMENDATIONS***

Discontinuation of opioids is recommended by the ACOEM Opioid Guidelines for acute and postoperative patients who have reached meaningful functional recovery. Discontinuation is also recommended for subacute and chronic pain patients who i) use opioids on a chronic basis, and ii) [any one of] no demonstrated function gain, noncompliance, aberrant drug screening results and/or diversion, adverse effects (e.g., cognitive impairment, falls, poor judgment, untreated sleep apnea, psychological disorders, and concurrent use of depressant medications such as benzodiazepines and diphenhydramine).

Immediate discontinuation without tapering is recommended for those who have a urine drug screen (UDS) showing unexpected absence of the prescribed drug. Among those with urine drug testing results showing nonprescribed licit or illicit substance(s) use, discontinuation is recommended, although tapering may be

advisable if the opioid is thought to be taken as prescribed (e.g., rather than partially diverted) and the doses over 50 mg MED.

Tapering is recommended if the opioid was used at a moderate or high level (e.g., above 50–90 milligram MED) on a chronic basis. Consultation with an addiction specialist or psychiatrist as recommended for complex patients (e.g., high-dose patients, prior withdrawal problems, complex psychosocial confounders, complicating medical conditions).

Transitioning to only an NSAID or acetaminophen or complete cessation of opioids is/are generally indicated.

The frequency/duration of a taper is empirical, dependent on dose, prior opioid use duration, and informed patient decision-making. Rates of the taper vary. The following are options:

- 10% per day
- 20% every 3-5 days
- 10% per week
- 25% per week
- 20–50 percent per day until lower doses reached
- Faster tapers over a few days have been safely accomplished

The speed of the taper should generally be an informed choice involving the patient, as some well prefer a faster or slower taper.

- The slowest taper in common use is 10% per week, thus lasting 10 weeks.
- A faster taper is 25% per week for 4 weeks.
- Some will opt to taper over, e.g., 10 days.

(Clear communication in tapering may be achieved by reducing the number of tablets of the chosen drug by one per day over each tapering interval. In this way the patient can have a predetermined number of tablets for that day's use described on a tapering calendar to assist in providing clear education regarding the process. If there is concern about overuse during the tapering process, weekly refills of decreasing amounts may reduce the opportunity for that overuse - sdf).

The ACOEM Opioid Guidelines offers a recommended process:

1. Develop a taper planned. Elements of the plan include: 1) agreement to taper, 2) education on expected symptoms during the taper, 3) return visits for intolerable symptoms with consideration of a pause in the taper, and 4) other treatments to be changed or substituted.
2. The provider should be supportive and engaged in the patient's care, management and concerns. 'Do not abandon' the patient. Considering engaging the patient in other active therapies during taper (e.g., progressive active exercises, cognitive behavioral therapy, education, psychiatric consultation, psychiatric medication). Consider judicious use of passive therapies (e.g., acupuncture, TENS, manipulation) as adjuncts in assisting tapering.
3. Rate of tapering is not critical, rather the direction of the doses. A typical wean is 10%/week to 10%/month in chronic pain patients and outpatient settings. Tapers may be faster in inpatient and more controlled



settings, or when use has been for short a period of time. Brief negotiated pauses in the rate of taper is acceptable.

4. Educate the patient that taper will produce symptoms. These include anxiety, emotional distress, hyperalgesia, experiencing pain in new areas. These are expected and not contraindications to taper, although if intolerable, may be a rationale for a brief pause in a taper.
5. The taper should be stopped if there is objective worsening of function, excessive withdrawal, and/or intolerance. After stabilization, resumption of the taper should be attempted. However, if there is a plateau level where function is achieved, that dose should be noted in the records and maintained for an ongoing basis. There is consideration for reattempting taper in subsequent years.

#### CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016<sup>10</sup>

When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used. A decrease of 10% of the original dose per week is a reasonable starting point; experts agree that tapering plans must be individualized based on patient goals and concerns.

In theory, the longer a patient has been on opioid therapy, the slower the taper may need to be. Additionally, tapers may need to be paused and restarted again per patient response and be more gradual once patients reach low dosages. According to these guidelines, “tapers may be considered successful as long as the patient is making progress.”

The idea behind these guideline statements is to allow patients to drive the process of weaning as much as possible because the decision to wean, after years of use, requires a significant commitment from the patient. It is important to consider that opioid weaning is not a discontinuation of care.

Once the smallest available dose is reached, the interval between doses can be extended. Opioids may be stopped when taken less frequently than once a day. More rapid tapers might be needed for patient safety under certain circumstances (e.g., for patients who have experienced overdose on their current dosage).

In many ways, opioid weaning requires as much attention, treatment, and care as opioid initiation.

Patients who are not taking opioids (including patients who are diverting all opioids they obtain) do not require tapers. Clinicians should discuss with patients undergoing tapering the increased risk for overdose on abrupt return to a previously prescribed higher dose.

Collaboration among relevant health providers and psychosocial support is needed to ensure success. While acute withdrawal symptoms may subside, depressive-like symptoms may persist for weeks or months. This is referred to as “protracted abstinence syndrome.” Protracted abstinence syndrome presents risk of relapse and continual care may be necessary to manage this risk.

Some medications may be safe to stop abruptly.

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<sup>10</sup> <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>

- a. For instance, a medication that is taken for just a few days or only taken once in a while (e.g., once a week).
- b. Medications that are prescribed when necessary (prn - as needed, not taken regularly).
- c. Some medications that do not produce physical dependence (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs – like aspirin, ibuprofen and others]).

Some medications always require medical supervision when stopped:

- a. Opioids that have been taken in regular daily doses for several days or longer.
- b. Benzodiazepines, muscle relaxants, antidepressants, and anticonvulsant medications that have been taken in regular daily doses for several days or longer.
- c. Barbiturates taken frequently for headache (butalbital).

Weaning off medications may be complicated by the potential for increased levels of pain that may accompany dose reduction, but can be done safely under medical supervision. The health care professional determines the rate at which the dose is reduced and adjustments can be made as necessary.

For example, reasonable opioid weaning protocols suggest decreasing pill intake by 10-20 percent per week, as tolerated. Hydration (drinking water), relaxation, and emotional support are all important to enhance the likelihood of success.

Sometimes weaning or discontinuing medication (especially opioids) is most safely accomplished under the close supervision of a specialist (such as a pain or addiction medicine specialist) in a medically-supervised program to prevent complications and severe withdrawal symptoms.

Symptoms of withdrawal from opioids can include:

- a. worsening of pain
- b. rapid heart beat
- c. high blood pressure
- d. sleeplessness
- e. agitation and anxiety
- f. stomach cramps, nausea, vomiting, diarrhea
- g. body aches (flu-like symptoms) and muscle cramps
- h. runny nose, sweating, tearing, yawning, goose bumps

Prescription medications that can help diminish symptoms of opioid withdrawal include:

- a. Alternative opioids:
  - i. Methadone
  - ii. Buprenorphine
- b. Non-opioid detoxification
  - iii. alpha-2 agonists (clonidine) – blood pressure needs to be monitored while taking this medication
  - iv. anti-nausea medications (e.g. ondansetron, metoclopramide)

- v. anti-diarrheal (loperamide)
- vi. muscle relaxants (e.g., tizanidine, methocarbamol, carisoprodol)
- vii. stomach relaxants (dicyclomine)
- viii. anti-inflammatory pain relievers (e.g. ibuprofen, naproxen, others)
- ix. sleep aids (e.g. trazodone, amitriptyline)
- x. anti-anxiety agents (e.g. diazepam, lorazepam) may be used for short periods (5-7 days)
- c. On occasion, alternative detoxification with phenobarbital may be offered.

#### MEDICAL BOARD OF CALIFORNIA GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN<sup>11</sup>

Discontinuing or tapering of opioid therapy may be required for many reasons and ideally, an “exit strategy” should be included in the treatment plan for all patients receiving opioids at the onset of treatment. Reasons may include:

- Resolution or healing of the painful condition;
- Intolerable side effects;
- Failure to achieve anticipated pain relief or functional improvement (although ensure that this failure is not the result of inadequate treatment);
- Evidence of non-medical or inappropriate use;
- Failure to comply with monitoring, such as urine drug screening (although ensure that this failure is not the result of a cost issue);
- Failure to comply with pain management agreement;
- Exhibition of drug-seeking behaviors (although ensure this behavior is not a result of inadequate treatment) or diversion, such as:
  - Selling prescription drugs;
  - Forging prescriptions;
  - Stealing or borrowing drugs;
  - Aggressive demand for opioids;
  - Injecting oral/topical opioids;
  - Unsanctioned use of opioids;
  - Unsanctioned dose escalation;
  - Concurrent use of illicit drugs;
  - Getting opioids from multiple prescribers and/or multiple pharmacies; or
  - Recurrent emergency department visits for chronic pain management.

If opioid therapy is discontinued, the patient whom has become physically dependent should be provided with a safely-structured tapering regimen. Opioid withdrawal symptoms are uncomfortable, but generally not life threatening.

Opioids can be stopped abruptly when the risks outweigh the benefits (in very limited situations, e.g., an example would be pending organ failure or death from respiratory depression - sdf). This is not true for benzodiazepine withdrawals, which can be life-threatening. Withdrawal can be managed either by the prescribing physician or by referring the patient to an addiction specialist.

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<sup>11</sup> [http://www.mbc.ca.gov/Licensees/Prescribing/Pain\\_Guidelines.pdf](http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf)

Approaches to weaning range from a slow 10% reduction per week for more aggressive 25-50% reduction every few days. In general, a slower taper will produce fewer unpleasant symptoms of withdrawal. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other healthcare specialist, as appropriate.

#### WASHINGTON STATE GUIDELINE ON PRESCRIBING OPIOIDS FOR PAIN

The Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain<sup>12</sup> is an excellent resource. The following is from their 2006 **Strategies for Tapering and Weaning** (Appendix 15):

##### Strategies for tapering:

From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:

- A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks).
- If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.
- Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring for often significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued.
- Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.

Recognizing and managing behavioral issues during opioid weaning: Opioid tapers can be done safely and do not pose significant health risks to the patient. In contrast, extremely challenging behavioral issues may emerge during an opioid taper. Behavioral challenges frequently arise in the setting of a prescriber who is tapering the opioid dose and a patient who places great value on the opioid he/she is receiving. In this setting, some patients will use a wide range of interpersonal strategies to derail the opioid taper. These may include:

- Guilt provocation (“You are indifferent to my suffering”)
- Threats of various kinds
- Exaggeration of their actual suffering in order to disrupt the progress of a scheduled taper

There are no fool-proof methods for preventing behavioral issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary.

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<sup>12</sup> Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain

## GETTING TO YES WITH UR & IMR

Efficient use of the California MTUS ACOEM Guidelines and the MTUS Drug Formulary Drug List requires:

1. First identifying the **body part**.
2. A specific **diagnosis** to find out what treatment or drug is recommended/no recommendation/not recommended.
  - a. It turns out that the same diagnosis with a different adjective (i.e., severe or neuropathic), can make a difference in what is Recommended/No Recommendation/Not Recommended.
3. Finding what is MTUS Treatment compliant
  - a. Go to MTUS ACOEM Guidelines <http://www.dir.ca.gov/dwc/DWCPropRegs/Medical-Treatment-Utilization-Schedule/Medical-Treatment-Utilization-Schedule.htm>.
    - i. Go to the Summary of Recommendations.
  - b. Go to the ReedGroup MDGuidelines (<http://www.mdguidelines.com/>).
    - i. Click on Resources (top right on screen to the right of Print and to the left of your name)
    - ii. Click on ACOEM Guidelines
    - iii. Click on Disorders
    - iv. Click on the body part (i.e., Knee Disorders or Shoulder Disorders, etc.) or on Chronic Pain
    - v. Click on Summary of Recommendations
    - vi. You can scroll down and see a chart with the treatments listed on the left, more specificity in the middle column, and then the 3<sup>rd</sup> column notes whether it is recommended or not.

### ***PREFERRED CHRONIC PAIN TREATMENT APPROACHES & ALTERNATIVES***

In the California workers' compensation arena, we are charged with providing the best medical care possible to "cure or relieve" from the effects of the industrial injury. Transitioning away from unnecessary and sometimes harmful medications, by itself, will be beneficial, but the real issue is assisting the injured worker in having a productive and happy life and returning to gainful employment if possible. The MTUS strongly supports a functional restoration approach.

There are a host of treatment approaches that are recommended by the MTUS and as listed in the 2017 ACOEM Chronic Pain Guidelines Update<sup>13</sup>. The emphasis is on active patient participation, psychological approaches including cognitive behavioral therapy, physical reactivation and functional restoration approaches using a biopsychosocial model. These approaches when utilized concurrently with weaning/tapering, provide the injured worker tools to avoid relapse and instead, to achieve a successful outcome.

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<sup>13</sup> <http://www.dir.ca.gov/dwc/MTUS/ACOEM-Guidelines/Chronic-Pain-Guideline.pdf>

## REPORT WRITING

You can avoid utilization review (UR) denials by excellence in report writing. Here are some bullet point recommendations.

- Physician needs to provide a clear, legible and concise history and physical examination followed by diagnoses and then recommendations for evidence-based medicine (EBM) care.
- Timely submitted reports will help expedite proposed treatment and avoid unnecessary delays unrelated to the UR process.
- Avoid boilerplate paragraphs especially with an electronic medical record (EMR).
- State how the medical treatment is supported by EBM.
- In your written report, “walk” the claims examiner, attorney, UR Reviewer through the treatment course and document how the treatment request meets EBM standards.
- The medical reporting should document that the injured individual is educated about, and understands the diagnoses. Additionally, the treater should outline the specific goals to be achieved. For example:
  - Less discomfort (pain)
  - Reduced medication usage
  - Improved activities of daily living function
    - Improved sleep
    - Increased ADLs such as personal hygiene, dressing, walking, cleaning, mowing the lawn, etc.
  - Staying at or returning to work modified or full duty.

**REPORT WRITING TEMPLATE**

Many physicians now use electronic medical record templates, but they often include, extraneous, repeated information, and worse, erroneous information. The record must be accurate.

The following is a report writing template which includes information which can help avoid denials.

<b>Brief/Concise History:</b> <i>Provide a brief history and keep it short and concise.</i>
<b>Current (relevant) Symptoms:</b> <input type="checkbox"/> Stable <input type="checkbox"/> Improving <input type="checkbox"/> Worsening <i>Don't just repeat the symptoms from the last visit unless still relevant.</i>
<b>Physical Findings (pertinent):</b> <i>Don't just repeat the same findings every visit. List only pertinent and relevant positive or changing findings.</i>
<b>Current Medications:</b> <i>List the actual medications, dose and frequency – be specific as to how many pills taken a day, week or month. Clarify any changes, reason for changes, etc. Ask yourself each visit whether the medication prescribed is truly needed and efficacious.</i>
<b>Activities of Daily Living (ADLs):</b> <i>Note +/- or no changes related to treatment. What has changed in a positive way to support the current treatment regimen? Were the goals set at the last visit met?</i>
<b>ADL Goals (for next visit):</b> <i>Use this section to note what goals are set in terms of ADLs, medication reduction and other activities.</i>
<b>Diagnoses (include ICD):</b> <i>Be careful and be specific. While the diagnoses may not change from visit to visit, make sure each visit that they are accurate.</i>
<b>Disability Status:</b> <input type="checkbox"/> MMI/P&S or <input type="checkbox"/> TD (Temporary Disability)
<b>Work Abilities/Restrictions<sup>14</sup>:</b> <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very Heavy ( <input checked="" type="checkbox"/> one and elaborate as appropriate – what are the specific restrictions that would allow the IW to return to modified work?)
<b>Work Status Capability:</b> <input type="checkbox"/> Stay at Work (SAW) <input type="checkbox"/> Return to Work (RTW) <input type="checkbox"/> Full duty <input type="checkbox"/> Modified duty (with above restrictions) <input type="checkbox"/> Cannot work in any capacity (Total Temporary Disability - TTD)
<b>Treatment Plan:</b> <i>Use some common sense. Explain your rationale in simple terms. Make it understandable to the patient, NCM, claims examiner, attorney, UR &amp; IMR reviewers, etc.</i>
<b>Prescription/Request (RFA):</b> <i>Start simple and conservative before requesting complex and invasive treatments - justify those requests.</i>
<b>Request Justification/Support per EBM:</b> <i>How will the request for treatment make a positive difference? Is it diagnostic? Will the requested procedure/treatment result in less pain, less medication usage and increased function while avoiding complications? Is the risk-benefit ratio acceptable? How does the request for treatment meet EBM guidelines? Reference the specific guideline here by page number or even copy or attach the specific supporting guideline or scientific evidence.</i>

<sup>14</sup> Physical Demand Definitions from the Dictionary of Occupational Titles (Department of Labor)

***PHYSICAL DEMAND DEFINITIONS FROM THE DICTIONARY OF OCCUPATIONAL TITLES (DEPARTMENT OF LABOR)***

Physical Demand Level	Occasional 0-33% of the workday	Frequent 34%-66% of the workday	Constant 67%-100% of the workday	Typical Energy Required
<b>Sedentary</b>	10 lbs.	Negligible	Negligible	1.5 - 2.1 METS
<b>Light</b>	20 lbs.	10 lbs.	Negligible	2.2 - 3.5 METS
<b>Medium</b>	20 to 50 lbs.	10 to 25 lbs.	10 lbs.	3.6 - 6.3 METS
<b>Heavy</b>	50 to 100 lbs.	25 to 50 lbs.	10 to 20 lbs.	6.4 - 7.5 METS
<b>Very Heavy</b>	Over 100 lbs.	Over 50 lbs.	Over 20 lbs.	Over 7.5 METS

**Sedentary Work** – Exerting up to 10 pounds of force occasionally (Occasionally: activity or condition exists up to 1/3 of the time) and/or a negligible amount of force frequently (Frequently: activity or condition exists from 1/3 to 2/3 of the time) to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

**Light Work** - Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly (Constantly: activity or condition exists 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

**Medium Work** - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.

**Heavy Work** - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.

**Very Heavy Work** - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Heavy Work.