Case Study #1

A 34-year-old male presented to a family medicine physician for chronic low back pain. The physician is comfortable prescribing opioids and has many patients on scheduled drugs. The patient has had chronic pain for many years and undergone multiple treatments including physical therapy, steroid injections and many medications. On presentation, the patient was on Robaxin and oxycodone (four times a day). His past history is positive for hypertension and alcohol abuse, although he stated he hasn’t drank in the past year. He works as a laborer.

On exam, the patient is in moderate distress with his back pain. His BP is elevated at 160/100. Low back and neurologic exam are normal. The physician institutes OxyContin 10 mg BID for pain control and Clonazepam for muscle spasm. On a follow-up visit two weeks later, the OxyContin is increased to 20 BID.

Two days after that visit, the patient picks up his medication at a local pharmacy. The next morning, the patient is found unarousable by his roommate and declared dead at the scene by paramedics. The cause of his death is polysubstance drug overdose with evidence of oxycodone, benzodiazepines and alcohol on his toxicology screen. A lawsuit is filed against the physician.
Case Study #2

The physician first sees the patient, a 35-year-old female, about three years ago. The patient was diagnosed with severe fibromyalgia and the physician instituted hydrocodone APAP 5/325. He is now prescribing 240 pills a month. There is a lot of publicity around the opioid epidemic and the physician worries that he is giving too much medication. This is only one of a handful of patients in his practice on opioids.

As time goes on, the patient is increasingly belligerent to the physician’s staff and he decides to terminate her from his practice. The physician writes a dismissal letter to the patient. There are several loud and angry phone calls during the next month. Three months later, the physician receives a complaint letter from the medical board. The physician calls the risk manager at MagMutual and asks, “did I do anything wrong here?” The issue is discussed and legal assistance is arranged to help write the response letter to the Board.

Case Analysis

The first case revolves around the issue of responsible prescribing. Was there adequate assessment of the risk factors for accidental overdose in this patient and was the therapy appropriate for the diagnosis? Is there thorough documentation around the risks and benefits of opioids and were there attempts to wean and use alternative treatments? Were there discussions with the patient about the issues of polypharmacy and concurrent use of alcohol? Was there an opioid treatment agreement in place? If the answers to these questions are addressed in a well-documented manner that shows reasonable care, then this will be a very defensible case.

The second case involves the physician’s legitimate concern for opioid overuse. Did he go over a tapering schedule with the patient? Was there an adequate bridge of medicine while the patient transitioned to another provider? Did he discuss the risks, benefits and alternatives of beginning and escalating the opioid therapy for a chronic non-cancer indication? These questions will be raised if the physician finds himself defending his actions against an abandonment allegation.

Discussion

Pain medication use and abuse has received increased coverage in the lay press and with good reason; as noted in the recently released Guidelines for Prescribing Opioids from the CDC:

Opioid pain medication use presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States. In the past decade, while the death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly.

While opioids can be part of an effective pain management plan, the potential for misuse can have tragic results. The new guidelines from the CDC are intended to help primary care providers determine when, or if, to prescribe opioids for the treatment of chronic pain. While every case deserves individual consideration, in general opioids for chronic pain should be reserved for palliative care, end-of-life comfort care and treatment of pain from cancer. Other points to consider when opioids are, or might become, part of the treatment plan:
Consider alternate treatments for chronic pain such as physical therapy, biofeedback, massage or relaxation therapy.

- If initiating opiates, start at the lowest possible dose. If continuing a treatment plan you have inherited from another provider, consider a tapering plan.
- Have a process in place to monitor patients who are on long-term opiates. Periodic re-assessment of the need for opiates should be documented.

The guidelines from the CDC can be found here:

http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm [1]

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