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Comparison of Current Opioid Guidelines

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Clinical Issue	ACOEM Guidelines	American Pain Society Guidelines	Canadian Pain Guidelines	Colorado Guidelines	California MTUS Guidelines	Washington Guidelines
Screen all patients for opioid risks, using a questionnaire?	Yes, all patients; SOAPP is suggested	Yes. Questionnaire "likely" to help; suggest SOAPP, PADT, or COMM	Consider using questionnaire; suggest Opioid Risk Tool (ORT)	No recommendation	CAGE, SOAPP, Opioid Risk Tool (ORT), others suggested	PQ9, CAGE-AID
Initiate opioids only after treatment failure?	Yes	No. Start chronic opioids when benefits are likely to outweigh risks	Physician should document "comprehensive knowledge of the patient's pain condition"	Yes	Yes	N/A
Urine drug screen on all patients on chronic opioids?	Yes	Urine drug screens recommended "periodically" in patients at high risk for drug abuse. "Consider" urine drug screens in low risk patients	No recommendation for routine urine drug testing; physician should screen by history for aberrant behaviors	Yes	Consider	Yes
Urine drug screen only for high risk with acute pain?	Yes	Recommended	No recommendation for routine urine drug testing	Yes	Consider	Yes
Frequency of urine drug screen?	2 to 4 times a year, random	Could be as often as weekly in "very high risk" patients; no other recommendation for frequency	No recommendation for routine urine drug testing at all	At least annually	Random	Frequency of urine drug screening depends on both MED and ORT risk score (range from 1 to 4 times a year)
Pain agreements for ALL patients on chronic narcotics?	Yes	Recommend written informed consent when starting chronic opioids. Sample "Pain Agreement"	Consider in patients at high risk for abuse; norecommendation for routine use of pain agreements	Yes	Optional	Yes
Pain agreements for "high risk" patients?	Yes	No recommendation; sample "Pain Agreement" included in Appendix	No recommendation for routine use of pain agreements	Yes	Optional	N/A
Discontinue/wean opioids if no functional improvement	Yes	Yes	No recommendation	No recommendation	Yes	Yes
Increase dose of meds if additional functional improvement obtained?	Yes	Yes	Yes	No recommendation	Yes	
Maximum morphine-equivalent dose before additional screening?	N/A	200 MEQ (morphine equianalgesic dose)	200 MEQ (morphine equianalgesic dose)	N/A	N/A	120 MEQ (morphine equianalgesic dose)
Consultation with pain specialist recommended?	Yes. PRN	Primary care physician should continue to manage. Consider consult, at clinician's judgment	No	Required	Yes as per Washington	Yes, suggested if >100 MEQ, but required if > than 120 MEQ
Attempt periodic wean of opioids if functional improvement?	Yes	No recommendation	No recommendation	No recommendation	Yes	
Attempt periodic wean of meds for ALL patients on chronic opioids?	Yearly	Yes	No recommendation	No recommendation	N/A	
Psychiatry consult recommended?	Yes, especially during wean	Consider, at clinician's judgment	Referral to pain management specialist recommended for certain high risk conditions	Yes	Yes	Yes. Must have psych eval if combining narcotics with benzodiazepines, sedatives, etc.
PT recommended?	Yes, especially during drug wean and to establish HEP.	No recommendation	No recommendation		Yes	N/A
Physician to consult PDMP (Prescription Drug Monitoring Program) regularly	N/A	N/A	N/A	Yes	N/A	N/A
Other clinical advice			Discontinue or taper benzodiazepines before initiating chronic opioids	Requires the physician to prepare a written Treatment Plan. Supplemental Fee Schedule for extra documentation		Urine drug screen-first use immunoassay (less expensive); if needed after a positive result, confirmatory test (GC/MS or other)
Advice about driving?		No evidence to suggest that chronic opioid use impairs driving; warn patients not to drive if they "feel impaired"	Advise not to drive until opioid dose stabilized			

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