



December 4, 2018

The Honorable Kate Brown  
Senior Health Policy Advisor Tina Edlund  
Members of the Oregon Chronic Pain Task Force  
Members of the Value Based Benefits Subcommittee  
Members of the Health Evidence Review Commission

Re: Health Evidence Review Commission  
Chronic Pain Task Force Revised Proposal

We, the undersigned, write to respond to the above-mentioned document released by the Chronic Pain Task Force regarding opioid medication coverage for Oregon Medicaid patients. In our view, the Task Force embraces a state-mandated treatment change that contravenes the three major national and international guidelines on prescribing opioids for chronic pain. These guidelines include: The Centers for Disease Control and Prevention Guideline for Opioid Prescribing,<sup>1</sup> the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain,<sup>2</sup> and the VA/DOD Clinical Practice Guidelines for Opioid Therapy for Chronic Pain V. 3.0 – 2017.<sup>3</sup>

It is also inconsistent with the 2019 Medicare Advantage and Part D Rate Announcement and Call Letter, from Centers for Medicare & Medicaid Services.

The Task Force proposes required changes to care for current opioid recipients that are far more aggressive than any existing guidelines or any other current law or mandate, and it does so without evidence or regard to the potential harm or benefit to patients. Many patients who stand to be affected by this proposed policy currently benefit from long-term opioid therapy to manage their complex conditions, maintain their quality of life, and participate in activities of daily living.

Below we will offer six observations about the proposed policy that raise particular concern:

1. We observe that the Task Force proposals are not supported by the very evidence review it commissioned. According the review:
  - a. **“There was scant evidence on harms associated with tapering strategies.”** (p.34)

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<sup>1</sup> 1. CDC Guidelines

[https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm](https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm)

<sup>2</sup> 2017 Canadian Guidelines

<http://www.cmaj.We.wouca/content/suppl/2017/05/03/189.18.E659.DC1/170363-guide-1-at-updated.pdf>

<sup>3</sup> VA/DoD Clinical Practice guidelines for Opioid Therapy for Chronic Pain V. 3.0 - 2017

<https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf>

- b. **“None of the newer studies since 2017 provide any information on adverse outcomes.”**  
(p.6)
  - c. **“All the evidence on opioid tapering was of low quality.”** (p.4)
  - d. **“Policymakers and clinicians are interested in information on the effect of tapering when it is not initiated by the patients, but we found very little information on this issue.”**
  - e. **There is *low or no quality evidence* for non-consensual tapering of opioid prescriptions to zero.**
2. The Oregon Chronic Pain Task Force is proceeding with a proposal to reduce patients to either 0 MME, 50 MME, or in exceptional circumstances up to 90 MME (circumstances unspecified), despite its own contractor’s findings that:
- a. The evidence to support non-consensual, mandatory forced opioid tapering is weak to nonexistent
  - b. The evidence regarding harms is not yet collected or analyzed.
3. Of great concern, the Oregon Chronic Pain Task Force offers no monitoring or outcome measures. Several questions must be addressed before initiating a practice that lacks evidentiary support:
- a. Are these patients doing well, or are they in distress?
  - b. Has tapering affected their quality of life and or their activities of daily living?
  - c. How is their chronic or intractable pain being managed now?
  - d. Have any alternatives offered been efficacious?
  - e. Did they die, either through suicide or from the effects of untreated pain?
  - f. Did they have to move to another state or medical practice in order to maintain treatment?
  - g. Were they forced to seek out illicit substances or drugs?
  - h. Were they forced to self-medicate with any other substances, including alcohol, in order to manage their pain?
4. The Chronic Pain Task Force claims that the following study, Comparing Pain and Depressive Symptoms of Chronic Opioid Therapy – Patients Receiving Dose Reduction and Risk Mitigation Initiatives with Usual Care,<sup>4</sup> supports mandatory forced tapers to zero opioids.
- a. This study in fact **contradicts** the expected outcomes claimed by the Chronic Pain Task Force.
  - b. The study is a comparison of clinics that received a variety of dose reduction initiatives.
  - c. It is unclear if these dose reductions were voluntary or mandated. There is no evidence that the safety of patients was improved, or that their functioning improved compared to those who did not.

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<sup>4</sup> <https://www.sciencedirect.com/science/article/pii/S1526590017307332>

- d. Most critically, the initiatives in this paper did not attempt what is proposed by the Chronic Pain Task Force: mandatory, unidirectional taper to 0 MME for certain pain syndromes and arbitrary dose limits for patients with differing intractable pain syndromes.
5. Also of concern is the Task Force’s reference risk assessment tools. If by this, they are referencing the Opioid Risk Tool created by Lynn Webster, MD., this tool has recently been shown to be invalid as a self-assessment tool in clinical population of people with pain as a self-assessment tool.<sup>5</sup> Dr. Webster himself recently wrote an editorial stating that this tool should not be used. As such, the Task Force has no validated risk assessment tool for prescription opioids.
  6. Finally, many of the exceptions are confusing, most notably, the notion that centralized pain syndrome is an ICD-10 diagnosis with specific, delineated meanings and therefore, treatment to relieve these pain syndromes is somehow not warranted.
    - a. Centralized pain syndrome is not a diagnosis. It is a term given somewhat arbitrarily and without criteria. The authors reference that centralized pain syndrome is “sometimes coded as chronic pain syndrome.” That term is also vague and applied variably. The Chronic Pain Task Force has moved somewhat from its earlier position of disallowing opioid medication beyond 90 days, but it has created exceptions that are confusing to clinicians and are inconsistent with scientific understanding of pain processing.
    - b. The Task Force states that the use of opioids should be avoided due to evidence of harm for patients with fibromyalgia, however, there is a lack of data to inform this statement. Furthermore, there are several high-quality randomized, controlled trials that demonstrate certain pain medications, such as Tramadol, are effective in the treatment of fibromyalgia. Two of these studies were conducted in Oregon by academic experts in fibromyalgia:
      - a. <https://www.ncbi.nlm.nih.gov/pubmed/16082646>;  
<https://www.ncbi.nlm.nih.gov/pubmed/12753877>

Given that **the interventions proposed by the Task Force will become the most aggressive in the nation**, that they are untested, lack evidence, and are unsupported both by the Task Force’s commissioned contractor and by all major professional guidelines, we must ask:

“What evidence does the Chronic Pain Task Force have to support a policy dictating forced, non-consensual opioid tapering policies--evidence that is not known by the international experts who wrote the CDC Guideline, The Veteran’s Administration/Department of Defense Guideline, and the 2017 Canadian Guideline?”

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<sup>5</sup> <https://academic.oup.com/painmedicine/article/19/7/1302/4839255>  
<https://academic.oup.com/painmedicine/article-abstract/19/7/1382/4835592?redirectedFrom=fulltext>

None of these entities has endorsed mandated, unidirectional forced opioid tapering for any specific ICD-10 codes, as the Chronic Pain Task Force has done.

We thank all parties for allowing us the ability to engage with you on this matter. Your attention to our serious concerns is greatly appreciated. As the policy decisions made by Oregon officials will reverberate across the country, the decisions made will be of great interest to people with pain, professionals, and to the media.

Each signatory has expressed their willingness to work with Oregon Medicaid officials, the distinguished Task Forces, and the Health Evidence Review Commission, to detail their concerns more directly and provide any assistance that will help protect the health of Oregon Medicaid patients.

Sincerely,

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