PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Dental Prescribing Guidelines

Introduction

Partnership HealthPlan is the County Organized Health System (COHS) covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

Effective Jan. 1, 2028, Partnership will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Therefore, federal guidelines are cited throughout this policy attachment.

Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications and prevention of chronic opioid misuse and diversion. Partnership has reviewed the literature on this topic, and has the following recommendations for our dental colleagues:

Recommendations

Partnership recommends dentists prescribe high dose NSAIDs for acute dental pain. (Studies show opioids are inferior for dental pain, and no more effective than placebo.)

Dentists should not prescribe opioids for patients already on opioid pain meds prescribed by another physician.

Dentists should also adhere to the Primary Care Clinician Prescribing Guidelines below:

1. If narcotic pain medication is prescribed, limit use to short periods (i.e., no more than 4 days) and only for conditions that are typically associated with more severe pain.

2. Discuss the risk of opioid dependence, opioid addiction, tolerance, and hyperalgesia with patients initiated on opioid treatment.

3. Assess for risk of substance use disorder and diversion, using a standardized tool if needed (see appendix for example). If patient is at high risk, consider baseline urine toxicology screen, use of non-opioids modalities to treat pain and carefully balance need for adequate analgesia against risk of misuse/diversion/overdose and behavioral destabilization.

4. Patients between 18 to 25 years of age are at increased risk of misusing prescription drugs, so patients in this age range should be screened carefully.

5. Initiation and continuation of use of opioid pain medications for chronic, non-cancer and non-terminal pain should be weighed carefully by any prescriber. It is not appropriate for a dentist to prescribe chronic opioids. This should be done by the primary care provider.
NOTE: There are standards required by Partnerhip to PCPs and Specialists covering patients with chronic pain or chronic opioid use. These may be found in MPXG5008 itself.

6. Chronic use of opioid medication (particularly when combined with other sedating medications such as benzodiazepines and muscle relaxants) or alcohol use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid induced hyperalgesia, which ultimately causes the patient increased pain and debility. Unlike acute pain or pain associated with metastatic cancer or end-of-life care, the goal of opioid therapy for chronic non-cancer, non-terminal pain is improved functioning, not necessarily elimination of pain.

7. When prescribing opioids, review the patient's controlled-substance history. Review Controlled Substance Utilization Review and Evaluation System (CURES) no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every three months thereafter if the substance remains part of the treatment of the patient.

8. For patients reporting current methadone or buprenorphine maintenance for opioid use disorder, consider contacting either their Narcotic Treatment Program (NTP) to verify dosing and standing with their program (methadone) or their buprenorphine or naltrexone provider to verify dosing and obtain analgesia recommendations. Do not adjust or discontinue methadone dosing without consultation with the patient's NTP. Methadone and buprenorphine maintenance dosing (e.g., daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.

9. Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of prescribed forms of naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to, in regulations, require employers to include naloxone in workplace first-aid kits by December 2028.

Other Guidelines for Safe Opioid Prescribing

Emergency Room Guidelines
Community Pharmacy Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from these other guidelines

1. According to the Centers for Disease Control (CDC) 2022 Guidelines, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.

2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.

3. Require a signed medication use agreement with the prescriber or prescribing office, renewed yearly.

4. Regularly check the CURES database in all patients being prescribed opioids at each time a prescription for a controlled substance (Schedule I-IV) is being authorized. Consider checking a CURES report when prescribing Schedule V controlled substances, as well. If a finding on the CURES report is not consistent with patient history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.

5. Schedule at least three office visits yearly for chronic pain patients using opioids.

6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g., "must last 28 days".) The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.

7. Recommend, prescribe, or furnish naloxone to patients, family, friends, and close contacts of those at risk of overdose. CAs of 2026, naloxone is available over the counter at pharmacies, online retailers and community organizations without a prescription. Medi-cal Rx covers both prescription and OTC naloxone with no copayments. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to in regulations to require employers to include naloxone in workplace first-aid kits by December 2028.

References

Links verified June 22, 2026

A. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009)
B. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67,
C. Centers for Disease Control. Overdose Prevention.
D. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of The College of Family Physicians of Canada. Vol 57, November 2011.
E. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone.
F. Silverman S, Opioid Induced Hyperalgesia: Clinical Implications for the Pain Practitioner. Pain Physician 2009: 12:679-684.

Appendix

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.