PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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<tr><td colspan="4">Policy/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td colspan="2">☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/12/2026</td></tr>
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I. RELATED POLICIES:

A. MCUP3049 – Pain Management Specialty Services
B. MPBP8007 – Screening and Treatment for Substance Use Disorders

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, 2028, Partnership HealthPlan of California 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. Partnership Advantage enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

A. Partnership Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines
B. Partnership Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines
C. Partnership Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines
D. Partnership Recommendations for Safe Use of Opioid Medications: Dental Prescribing Guidelines

V. PURPOSE:

The purpose of this guideline is to improve care for Partnership HealthPlan of California (Partnership) members with chronic pain by:

A. Clarifying the roles of primary care practitioners and specialists who care for members with chronic pain. The guideline is designed to help primary care practitioners make appropriate use of pain management specialists.
B. Summarizing best practices in opioid prescribing to create a series of recommendations for safe prescribing of opioid medications.

VI. GUIDELINE / PROCEDURE:

Policy/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/16/2004			**Next Review Date: 08/12/2027** **Last Review Date: 06/11/ 2025 08/2/2026**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

A. 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 developed community-wide guidelines to promote safer use of opioid medications. In addition, Partnership supports Substance Use Disorder (SUD) treatment services through the Drug Medi-Cal (DMC) program, including administration of the DMC-ODS (Organized Delivery System) program in several counties.
   1. This guideline recognizes the services and responsibilities of primary care providers (PCPs), pain management and other specialists in caring for members with chronic pain.
   2. This guideline is highly dependent upon the individual clinical circumstances and the delivery system. Because of these circumstances, expectations may appropriately deviate from the guideline.
   3. The PCP is responsible for coordinating all services required by the patient except when precipitous circumstances preclude the PCP's role. The scope of the responsibility is comprehensive (i.e., all required services including preventive services).
      a. The PCP should provide those services which can be provided within his/her competence and should obtain consultation when additional knowledge or skills are required. Partnership recognizes that differences in skill levels exist among PCPs and that this document serves as a general guideline to define the scope of services and the indications for specialty referral to a pain management specialist. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation.
         1) Consultation includes advice received from a telephone discussion with a specialist, e-consults, telehealth consultations and the referral of a patient to a specialist for services. The Centers for Disease Control (CDC) notes that in practice context where virtual visits are part of the standard of care (e.g., in remote areas where distance or other context makes follow-up visits challenging) or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the clinician to communicate with and/or observe the patient through telehealth modalities might be conducted.
         2) When care by a specialist is required, it is the responsibility of the PCP and the specialist to coordinate all services.
         3) PCPs and specialists may find guidance through various federal and state agencies, including the Medical Board of California, which has published its Guidelines for Controlled Substances for Pain. These guidelines are updated to provide a framework for clinician use while also encouraging the development of treatment plans customized for their patients.

B. The PCP should be responsible for providing the following basic pain management services:
   1. The PCP should assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. Functional capacity should be evaluated and is the key target of any treatment. In addition, the PCP should assess for the presence of psychiatric disorders, substance use disorders, and substance misuse. Assessment should include a thorough medication history. The many possible causes of chronic pain, including osteoarthritis, rheumatoid arthritis, and other inflammatory conditions, degenerative disease and neuropathic pain, should be considered. When indicated, the PCP should assess for pain related to work injuries and ask about the relation to accidents or legal issues.
   2. A thorough physical exam should be performed as clinically indicated.
   3. When medications with addictive/dependence potential are being used or being considered, the PCP should distinguish between physiological dependence, tolerance, or addiction/substance use disorder.
   4. A pain management agreement is an important part of the scope of pain management. PCPs should consider a pain management agreement for all chronic pain patients who they are following.
   5. A referral to a pain management center should be considered when appropriate. Members should not be referred to a pain management specialist until treatable underlying causes have been evaluated

thoroughly by the PCP and specialists other than pain management specialists as indicated. All potential co-occurring psychiatric illnesses should be evaluated and under treatment when appropriate. Any illegal drug usage should be identified, documented and addressed. When specialty consultation is requested, the PCP is responsible for sending all relevant clinical information to the specialist. Referrals solely for purpose of reducing a PCP caseload of opioid-using patients should not be made.

6. Consider referring a member with complex pain management as indicated under Pain Management Specialist referral or whenever the PCP feels the member would benefit from pain management evaluation based on their sound clinical judgment.
7. For members who have been referred and evaluated by a pain management or other specialist, the PCP should participate in the ongoing follow-up as jointly determined by the PCP and the specialist for members with these conditions who have reached a high degree of stability.
8. The CDC recommends that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months for most patients. For those at higher risk for OUD or overdose, more frequent clinical reassessments are recommended. "Higher risk" includes those enumerated by CDC Clinical Practice Guideline for Prescribing Opioids for Pain and the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2020) (e.g., those with family history of substance use disorders, history of trauma, age between 18-25 years old, co-occurring depression or other mental health conditions, a history of SUD or overdose, taking ≥50 MME/day, or taking other CNS depressants). In addition, the National Institute on Drug Abuse (NIDA) offers the Opioid Risk Tool (ORT-OUD) that providers can administer at an initial visit to assess risk for future opioid use disorder prior to beginning or continuing opioid therapy for pain management.

C. Specialist Referral

Referral to an appropriate specialist should be considered appropriate in the following situations:

1. Pain Management Specialist
   a. Complex pain management where the diagnosis is unclear, or the condition is unresponsive to standard medication and non-pharmacologic therapy for a period of 3 to 6 months.
   b. Complex pain management compromised by severe functional impairment.
   c. Complex Regional Pain Syndrome (CRPS).
   d. Complex pain management complicated by mental health condition or substance use disorder unresponsive to usual therapy and treatment by an appropriate behavioral health specialist.
   e. For performance and/or supervision of procedures done by pain management specialists. (See MCUP3049 Attachment A: Medical Necessity Criteria for Pain Management Procedures.)
2. Refer to other specialists such as neurology, orthopedics, rheumatology, physical medicine and rehabilitation or behavioral health. Specific indications for referral to specialties other than pain management are beyond the scope of this guideline. The PCP should perform a careful evaluation of conditions with a known cause and initiate conservative therapy consistent with the PCP's skill and best judgment. Expert consultation should be considered in situations where the diagnosis is uncertain, the member has not responded to usual conservative therapy or specialty care is required based on the diagnosis.
3. After initial specialist consultation, or a significant change in the patient status or when the specialist terminates care of patient, the specialist is responsible to send all relevant information back to the PCP.
4. Patients with suspected substance use disorder (SUD) should be assessed by the PCP or be referred for assessment. In many instances, opioid use disorder (OUD) and other SUDs can be evaluated and treated by the PCP, using Medication for Addiction Treatment (MAT). Treating opioid use disorder

with buprenorphine/buprenorphine-naloxone, or naltrexone extended-release injection is within the scope of primary care practice. Another MAT for OUD, methadone, is available for outpatient treatment only through certified narcotic treatment programs (NTP) with some exceptions for acute care hospitals and emergency department settings. PCPs cannot prescribe methadone for the treatment of OUD under the pretext of treating pain. However, sublingual buprenorphine products can be prescribed simultaneously for both pain and OUD. Naltrexone products should not be co-prescribed with any opioid medication, as naltrexone is an opioid receptor antagonist. If referral is warranted, providers and patients can call Partnership Behavioral Health Access Line at (855) 765-9703 for referral information and options if the patient resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano counties. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access department: a list of phone numbers may be found under "Benefits: Alcohol and Drug Treatment" at https://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx In addition, regardless of county of residence, for buprenorphine providers, patients and providers may visit the Partnership Provider Directory or the Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator website (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator). It can be helpful for PCPs or staff at the PCP office to assist patients in securing a referral connection with an assessing provider, or a substance use disorder treatment provider.

5. For facts about buprenorphine and important points to review with the patient, see the SAMHSA Buprenorphine Quick Start Guide at https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf.
6. Additional training materials and live mentoring can also be obtained through:
   a. The Provider's Clinical Support System (PCSS): https://pcssnow.org
   b. The University of California, San Francisco National Clinician Consultation Center warmline: https://nccc.ucsf.edu/clinician-consultation/substance-use-management/
   c. CA Bridge program: https://bridgetotreatment.org/addiction-treatment/ca-bridge/

D. Opioid Prescribing Guidelines for Physicians

1. Initial treatment considerations should include non-pharmacological therapies, including physical therapy, acupuncture, chiropractic treatment, activity modifications (rest, splinting), and mobility assistance (canes.)
2. Based on provider skill level, the PCP should prescribe appropriate analgesics when indicated for the initial management of chronic pain.
   a. Initial pharmacologic treatment should rely on non-opioid analgesics, including acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDS).
   b. The use of opioids (tramadol, and opioids such as codeine, hydrocodone, methadone, oxycodone, morphine, and fentanyl) should be reserved for:
      1) Temporary use following trauma or surgery if non-opioid treatment is inadequate, with plan for discontinuation.
      2) For chronic use intermittently at the lowest doses in combination with other non-pharmacologic and non-opioid therapies.
      3) Severe functional disability, at the lowest doses in combination with other non-pharmacologic and non-opioid therapies (may involve ongoing regular doses).
      4) Chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
   c. Before committing patients to long-term regular opioid treatment that may become lifelong, the patient's age should be taken into consideration, and the risks of physiologic dependence and misuse potential should be discussed with patients.
   d. Opioids in the frail elderly may be contraindicated due to safety concerns.
   e. 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, to require employers to include naloxone in workplace first-aid kits by December 2028.

3. Pain modulating agents should be considered when appropriate, such as tricyclic antidepressants (amitriptyline and nortriptyline), and anticonvulsants, (gabapentin, pregabalin and carbamazepine.)
4. As a minimum standard, when starting opioid therapy for acute, subacute, or chronic pain – not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease – clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
    a. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
    b. Consider a confirmatory urine test if the results of an in-office screen are unexpected, because false positive and negative screening results are common.
    c. If a patient is at higher risk for substance use disorder (SUD), diversion, or substance misuse, strongly consider more frequent toxicology screens.
    d. Ensure that the toxicology screen used can detect the relevant medications or substances of interest.
        1) Validated screening tools for substance misuse or substance use disorder can be helpful. Please refer to Attachment A of policy MPBP8007 *Screening and Treatment for Substance Use Disorders* for a table of Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT), including validated tools for pregnant people.
    e. Consider a signed medication use agreement with the prescriber or prescribing office.
    f. Provider to check California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) report at the time of writing each controlled substance prescription, or more frequently, as required by state law.
    g. The CDC recommends, for most patients, a suggested interval of every three months or more frequent office visits for chronic pain and monitoring opioid use.
    h. Educate patients on proper safe storage of opioid medications to help prevent diversion (i.e., lock boxes).
    i. Utilize CURES, pill counts, and urine drug screens to minimize the potential for diversion/resale or distribution of prescribed opioid medications.
4. Further Recommendations for PCPs and Specialists are found in Attachment A: Partnership Recommendations for Safe Use of Opioid Medications - Primary Care & Specialist Prescribing Guidelines.

E. Follow-up and monitoring during chronic opioid therapy
1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change.
2. Patients who are transitioned to or have dosing increases of methadone should be seen within three days, or within one week for other ER/LA opioids.

F. Community Pharmacy Guidelines
Community Pharmacies play a key role in helping prevent Opioid overdoses, Opioid induced hyperalgesia,

Opioid diversion, and Opioid addiction, and have a legal responsibility to do so. Partnership recommends that all community pharmacies develop policies and standards to fulfill this responsibility. For detailed recommendations, see Attachment B, Partnership Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines.

G. Emergency Department (ED) Guidelines
The ED has two key roles in helping with community-wide efforts to control Opioid overuse: assuring acute pain is treated in a way that decreases the probability of future over-use of Opioids and working closely with primary care providers to ensure a coherent, safe approach to treating chronic pain. Partnership recommendations are found in Attachment C, Partnership Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines.
1. The ED can be a critical access point for members with SUD. ED personnel should consider screening for SUD and initiating Medication for Addiction Treatment (MAT). See these articles:
   a. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department https://www.annemergmed.com/action/showPdf?pii=S0196-0644%2821%2900306-1
   b. Emergency Department Medication-Assisted Treatment of Opioid Addiction https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf

H. Dentist Guidelines
Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications. Partnership recommendations are found in Attachment D, Partnership Recommendations for Safe Use of Opioid Medications: Dentist Prescribing Guidelines.

I. Indicators Monitored by Partnership
As part of retrospective Drug Utilization Review (DUR), Partnership will monitor pharmacy claims and CURES data for high Morphine Equivalent Dose (MED) and use of multiple prescribers and pharmacies.

VII. REFERENCES:

A. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) – Download accessibility verified June 22, 2026
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, Accessibility verified on June 22, 2026
C. Centers for Disease Control. Overdose Prevention. Accessibility verified April 23, 2026
D. CDC. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. Accessibility verified June 22, 2026.
E. 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. Accessibility verified on June 22, 2026
F. Hawk K, Hoppe J, Ketcham E, et al. Consensus recommendations on the treatment of opioid use disorder in the emergency department. Ann Emerg Med. 2021;78(3):434-442. doi:10.1016/j.annemergmed.2021.04.023
G. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Accessibility verified on June 22, 2026
H. Herring, Andrew A., MD, Emergency Department Medication-Assisted Treatment of Opioid Addiction, August 2016. Accessibility verified on April 2, 2026
I. Medical Board of California, Guidelines for Prescribing Controlled Substances for Pain, July 2023. Accessibility verified June 22, 2026
J. SAMHSA Buprenorphine Quick Start Guide. Accessibility verified on June 22, 2026
K. The Provider's Clinical Support System (PCSS) Medications for Opioid Use Disorders. Accessibility verified on June 22, 2026

L. The University of California, San Francisco National Clinician Consultation Center warmline. Accessibility verified on June 22, 2026
M. UpToDate. Use of opioids in the management of chronic pain in adults. (2026) Accessibility verified June 22, 2026
N. American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2020) https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
O. National Institute on Drug Abuse (NIDA) Opioid Risk Tool – OUD (ORT-OUD) https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/20/04; 03/15/06; 03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16; 04/19/17; *03/14/18; 04/10/19; 03/11/20; 04/14/21; 06/08/22; 09/13/23; 08/14/24; 06/11/25; 08/12/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

Partnership Advantage (effective Jan. 1, 2028)
06/11/25; 06/10/26; 08/12/26

PREVIOUSLY APPLIED TO:
Healthy Kids MPXG5008 (Healthy Kids program ended 12/01/2016)
03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16 to 12/01/2016

PartnershipAdvantage:
MPXG5008 – 03/21/2007 to 01/01/2015

Healthy Families
MPXG5008 – 10/01/2010 to 03/01/2013