

Summary of 2022 CDC Practice Guideline for Prescribing Opioids for Pain

November 2022

On Nov. 3, the Centers for Disease Control and Prevention (CDC) published the [2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain](#), which updates and replaces the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.

The updated, voluntary guideline provides 12 evidence-based recommendations for clinicians who prescribe opioids for outpatients 18 years of age and older with acute pain (duration less than one month), subacute pain (duration of one to three months) or chronic pain (duration of three months or more). The recommendations do not address the use of opioid pain medication in children and adolescents aged <18 years. The report notes, “The available evidence concerning the benefits and risks of long-term opioid therapy in children and adolescents remains limited, and few opioid medications provide information in their labeling regarding safety and effectiveness in pediatric patients.” The report points to guidelines and recommendations from the [Michigan Opioid Prescribing Engagement Network](#) for children undergoing surgical procedures.

The guideline addresses the following four areas:

- Determining whether or not to initiate opioids for pain (Recommendations 1 and 2)
- Selecting opioids and determining opioid dosages (Recommendations 3, 4 and 5)
- Deciding duration of initial opioid prescription and conducting follow-up (Recommendations 6 and 7)
- Assessing risk and addressing potential harms of opioid use (Recommendations 8, 9, 10, 11 and 12).

Care setting

The updated guideline includes recommendations for primary care clinicians and other clinicians managing pain in outpatient settings such as “surgeons, emergency medicine clinicians, occupational medicine clinicians, physical medicine and rehabilitation clinicians, and neurologists”. The recommendations “do not apply to care provided to patients who are hospitalized or in an emergency department or other observational setting from which they might be admitted to inpatient care. These recommendations do apply to prescribing for pain management for patients when they are discharged from hospitals, emergency departments, or other facilities.”

Stakeholder input

The CDC attained input from the Board of Scientific Counselors of the National Center for Injury Prevention and Control (a federally chartered advisory committee), the public, and peer reviewers.

AAOMS submitted [comments](#) to the draft guideline earlier this year, noting support of the guidelines’ flexible and patient focused approach, while requesting some information be added to the recommendations for further emphasis, as many stakeholders may only look to the recommendations and not the supporting material. In the final guideline, the CDC included a suggestion by AAOMS and other stakeholders that Recommendation 1 emphasize the need for discussion of the risks/benefits of opioid therapy for acute pain, as Recommendation 2 includes for subacute and chronic pain. AAOMS’s suggestion to include in Recommendation 4 a definition of “dosage above levels likely to yield diminishing returns,” such as 50 MME/day or higher, was not included; however, it was included in the

Implementation Considerations for that section. Additionally, the CDC did not include a suggestion by AAOMS to add a recommendation related to the pediatric patient population – particularly with regard to acute pain.

Guideline application

The CDC notes in the Introduction section that the 2016 guideline was misapplied by stakeholders, which resulted in rapid opioid tapers and rigid application of opioid dosage thresholds to the detriment of the patient. The updated guideline clarifies in the Rationale subsection of the Introduction, that the guideline is intended to provide “voluntary clinical practice recommendations for clinicians that should not be used as inflexible standards of care. The recommendations are not intended to be implemented as absolute limits for policy or practice across populations by organizations, healthcare systems or government entities.”

Recommendation development

CDC developed this clinical practice guideline using the method developed by the GRADE working group (<https://www.gradeworkinggroup.org>).

Recommendation types:

- Category A recommendation: Applies to all persons; most patients should receive the recommended course of action.
- Category B recommendation: Individual decision-making needed; different choices will be appropriate for different patients. Clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.

Evidence types:

- Type 1 evidence: Randomized clinical trials or overwhelming evidence from observational studies.
- Type 2 evidence: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.
- Type 3 evidence: Observational studies or randomized clinical trials with notable limitations.
- Type 4 evidence: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

Summary of recommendations relevant to OMS

Members are encouraged to review all 12 Recommendations and related Implementation Considerations in their entirety in the [2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain](#). Below are key aspects of the recommendations related to OMS.

- Nonopioid therapies “are at least as effective” as opioids for many common acute pain conditions, including low back pain, neck pain, pain related to other musculoskeletal injuries (e.g., sprains, strains, tendonitis, and bursitis), pain related to minor surgeries typically associated with minimal tissue injury and mild postoperative pain (e.g., simple dental extraction), dental pain, kidney stone pain, and headaches including episodic migraine (see Recommendation 1).
- Opioid therapy has an important role for acute pain related to severe traumatic injuries (including crush injuries and burns), invasive surgeries typically associated with moderate to severe postoperative pain, and other severe acute pain when NSAIDs and other therapies

are contraindicated or likely to be ineffective (see Implementation Considerations under Recommendation 1).

- Clinicians should maximize use of nonopioid pharmacologic therapies (e.g., topical or oral NSAIDs, acetaminophen) and nonpharmacologic therapies (e.g., ice, heat, elevation, rest, immobilization, or exercise) as appropriate for the specific condition and only consider opioid therapy for acute pain if benefits are anticipated to outweigh the risks (see Recommendation 1).
- Nonopioid therapies are preferred for subacute and chronic pain (see Recommendation 2).
- When diagnosis and severity of acute pain warrant the use of opioids, clinicians should prescribe immediate-release opioids (see Recommendation 3) at the lowest effective dose (see Recommendation 4) and at no greater quantity than needed for the expected duration of pain severe enough to require opioids (see Recommendation 6).
- Clinicians should prescribe and advise opioid use only as needed (e.g., hydrocodone 5 mg/acetaminophen 325 mg, one tablet not more frequently than every 4 hours as needed for moderate to severe pain) rather than on a scheduled basis (e.g., one tablet every 4 hours) (see Implementing Considerations under Recommendation 1) and encourage and recommend a brief opioid taper if opioids are taken around the clock for more than a few days (see Implementation Considerations under Recommendation 6).
- Clinicians should evaluate risk for opioid-related harms and discuss risk with patients (see Recommendation 8) as well as review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose (see Recommendation 9)
- Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently (see Recommendation 11) and offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder (see Recommendation 12).

[AAOMS efforts to address prescription drug abuse](#)

AAOMS is proud of the efforts the Association has made the over past decade to encourage OMSs to reduce their opioid prescribing. More specifically, AAOMS:

- Published prescribing recommendations that urge non-narcotic pain medicine – rather than opioids – be utilized as a first-line therapy to manage a patient's acute and post-surgical pain.
- Developed an information card on the Safe Use and Disposal of Prescription Medications.
- Advocated in support of legislation to allow patients to partially fill prescriptions to reduce the excess of opioids susceptible to diversion.
- Partnered with SAMHSA and NIDAMED to create continuing education (CE) on opioid abuse and make it available to AAOMS members.

- Provides CE webinars and CE programs to AAOMS membership on opioid misuse and abuse as well as regularly features information and resources about opioid abuse in AAOMS publications.
- Promotes the DEA's National Prescription Drug Take Back Days to AAOMS members.
- Participates in and promotes to AAOMS membership the Partnership to End Addiction.

Next steps by the CDC

CDC notes in the section entitled, “Conclusion and Future Directions” that it will “evaluate this clinical practice guideline to identify the effects of the recommendations on clinician and patient outcomes and on health disparities, including intended and unintended consequences...CDC will revisit this clinical practice guideline when remaining evidence gaps have sufficiently been addressed and another update is warranted.”

Questions? Please contact advocacy@aaoms.org.