CDC Guidelines for Pain Management



Arthur Ollendorff, MD

Head for the Hills Conference

October 24, 2026

Arthur Ollendorff, MD, FACOG, FASAM

OB/GYN and Addiction Medicine
Carilion Clinic

Professor of OB/GYN
Professor of Heath Systems & Implementation Science
Virginia Tech Carilion School of Medicine

aollendorff@carilionclinic.org

Financial Disclosures

- None

Objectives for today



Apply the CDC clinical practice guideline to select appropriate treatment (opioid, nonopioid, or combination) for at least three patient cases involving acute, subacute, and chronic pain.



Develop a multimodal pain management plan that combines at least two nonopioid pharmacologic or nonpharmacologic therapies for a given patient scenario.

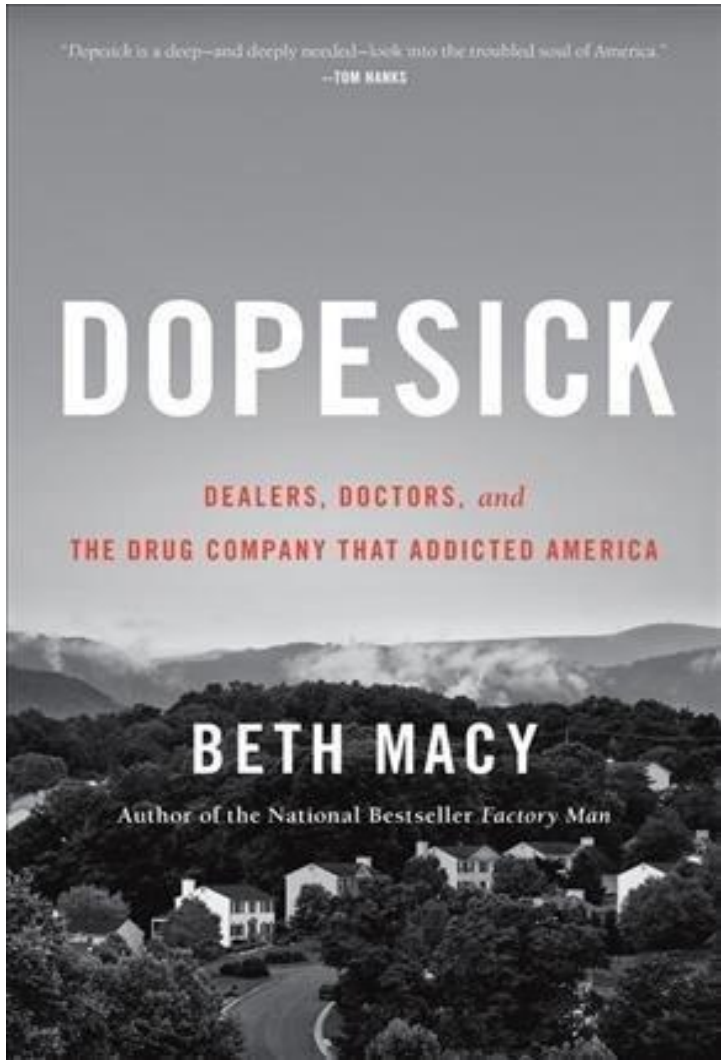


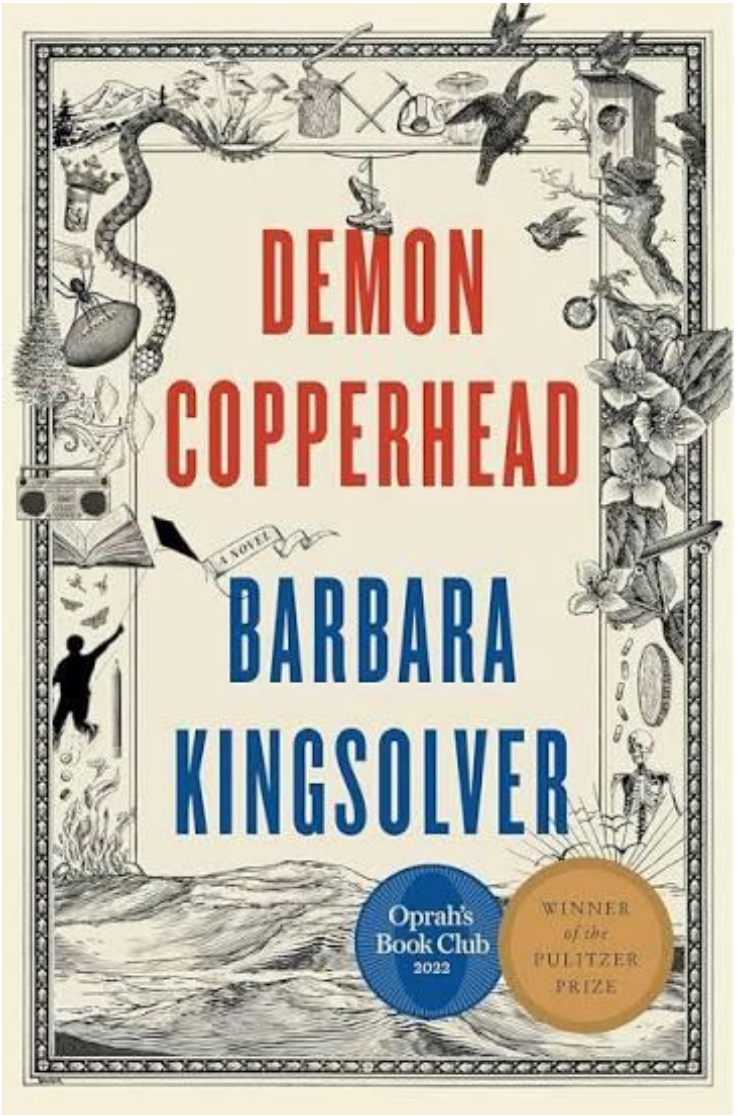
Recognize the risks of inappropriate opioid prescribing

How Will We Use Our Time

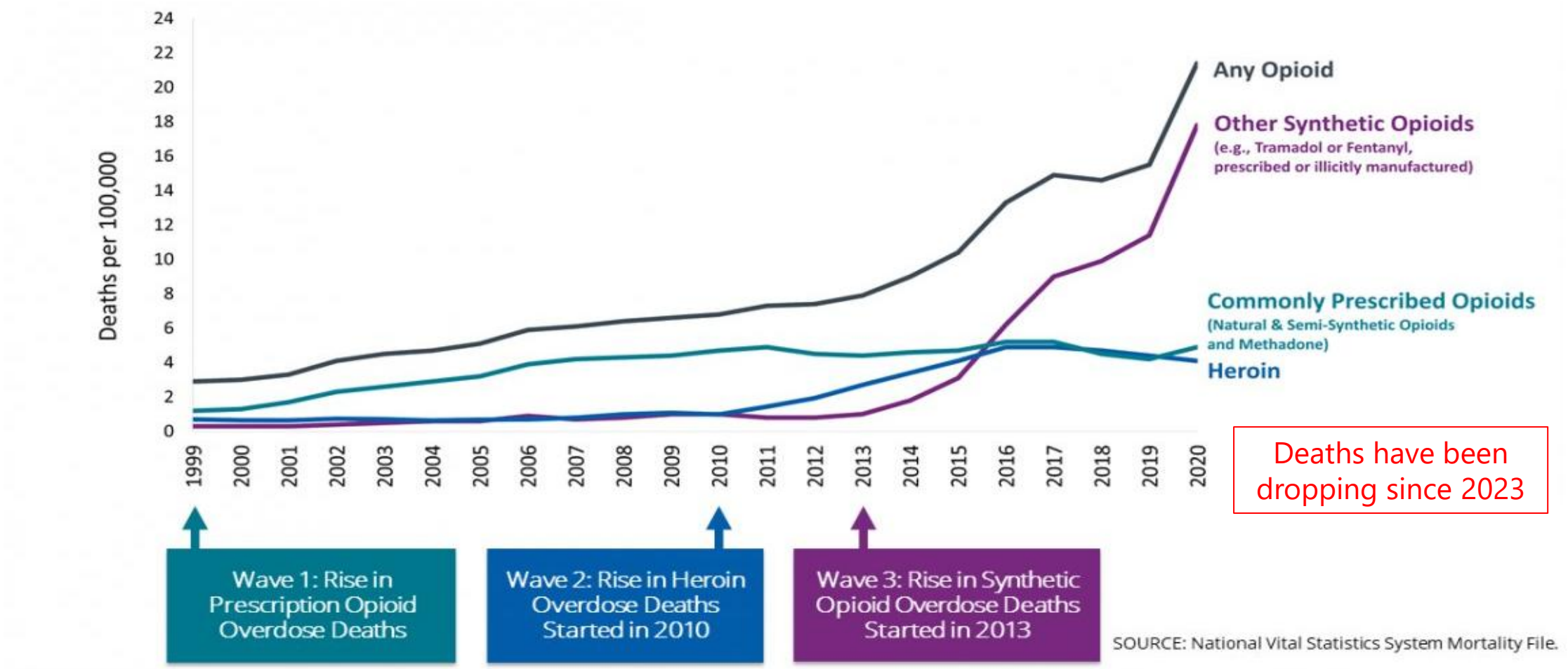
Topic	Duration	Teaching Modality
CDC Pain Management & Virginia Prescribing Law	25 minutes	Didactic
Case Study	10 minutes	Group Activity
Q&A	15 minutes	Group Activity




"Dopesick is a deep—and deeply needed—look into the troubled soul of America."
—TOM HANKS
DOPESICK
DEALERS, DOCTORS, and
THE DRUG COMPANY THAT ADDICTED AMERICA
BETH MACY
Author of the National Bestseller Factory Man


DEMON
COPPERHEAD
A NOVEL
BARBARA
KINGSOLVER
Oprah's
Book Club
2022
WINNER
of the
PULITZER
PRIZE

THREE WAVES OF OPIOID DEATHS



HOW DO WE BALANCE RISK AND NEED FOR PAIN CONTROL?





CONSIDERATIONS WHETHER OR NOT TO INITIATE OPIOIDS FOR PAIN

- U.S. consumes ~80% of world's opioid supply
- Opioids moderately more effective than placebo for short-term pain relief
- Effects average 20-30% improvement in pain vs. placebo
- Data indicates that opioids may be no more effective than an NSAID alone for acute pain
- Friedman 2015: For LBP, adding oxycodone/acetaminophen to an NSAID did not improve pain or function at 1 week

Mathieson et al J Intern Med 2020;287:458; Richards et al. Br J Pain 2021

PERSISTENT USE OF OPIOIDS AFTER SURGERY



International Journal of Obstetric Anesthesia 54 (2023) 103644

Contents lists available at ScienceDirect

International Journal of Obstetric Anesthesia

journal homepage: www.elsevier.com/locate/ijoa

Short Report

Persistent opioid use after cesarean delivery in the United States of America: a systematic review

R. Landau [a,*], P.F. Cavanaugh [b], M. DiGiorgi [b]

[a] Division of Obstetric Anesthesia, Columbia University College of Physicians and Surgeons, New York, NY, USA
[b] Pacira BioSciences, Inc., Parsippany, NJ, USA

"these data suggest that as few as 1440 and as many as 26,400 individuals from the 1.2 million undergoing CD each year in the USA may have persistent opioid use past the fourth trimester."

R. Landau, P.F. Cavanaugh, M. DiGiorgi. Persistent opioid use after cesarean delivery in the United States of America: a systematic review. International Journal of Obstetric Anesthesia (2023). Volume 54.

CLINICAL EVIDENCE REVIEW



- Opioids associated with small improvements in short-term (<6 months) pain and function compared with placebo, with reduced effectiveness over time
- Opioid therapy associated with increased risk of serious harms that increases with opioid dosage
- No clear threshold below which there is no risk
- No validated, reliable way to predict which patients will suffer *serious* harm

Mathieson et al J Intern Med 2020;287:458; Richards et al. Br J Pain 2021

IF YOU CHOOSE TO PRESCRIBE OPIOIDS…



CDC GUIDING PRINCIPLES



Individualized Assessment

Treat pain appropriately, whether or not opioids are part of the plan.



Person-Centered Care

Recommendations are voluntary and flexible to each patient's needs.



Multimodal & Multidisciplinary

Address physical, behavioral, and social factors together.



Avoid Misapplication

Don't turn guidance into rigid policy that can harm patients.

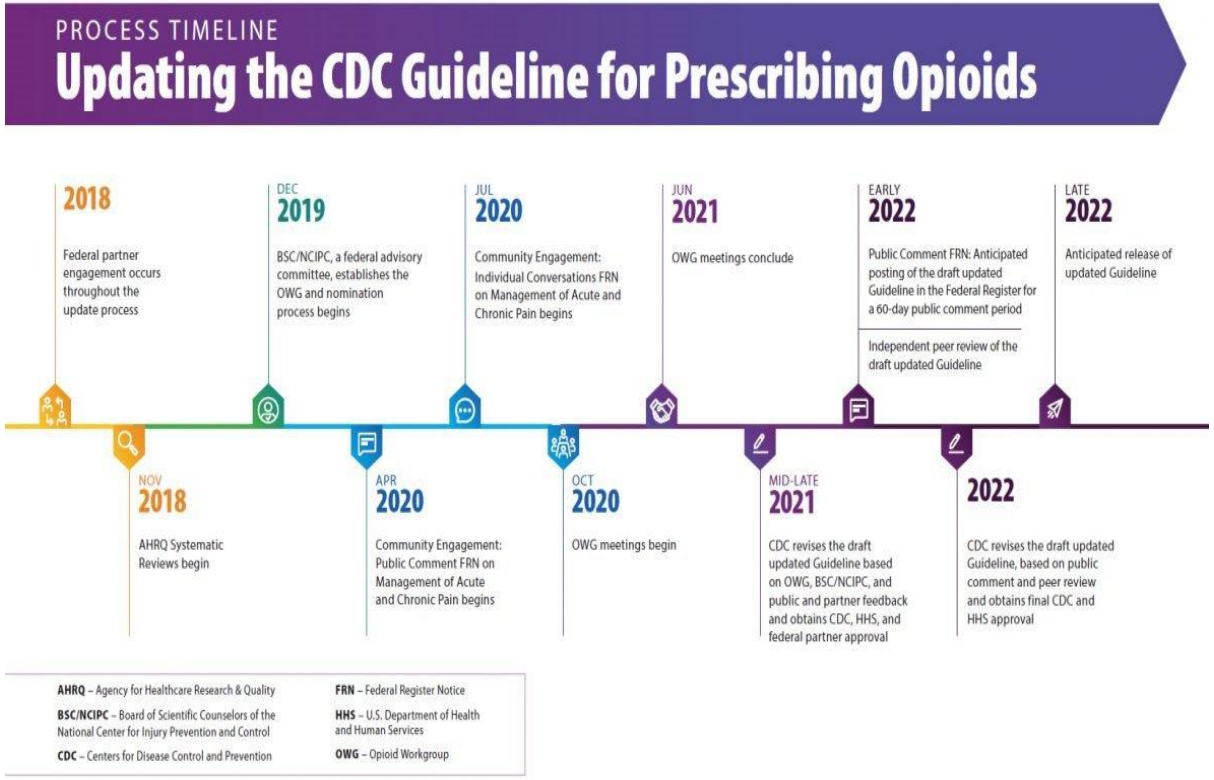


Health Equity

Ensure culturally appropriate, accessible care for all patients.

SCOPE OF THE 2022 CDC CLINICAL PRACTICE GUIDELINE FOR PRESCRIBING OPIOIDS FOR PAIN

- Expanded recommendations on use of opioids for **acute pain** (duration <1 month)
- Expanded to include **subacute pain** (duration of 1-3 months)
- Includes **chronic pain** (duration of >3 months)
- Applicable outpatient settings include clinician offices, clinics, and urgent care centers
- Includes prescribing for pain management when patients are discharged from hospitals, emergency departments, or other facilities
- Does not apply to:
  - providing care to patients while hospitalized or in an emergency department
  - managing pain for cancer, palliative care, sickle cell disease, or end-of-life care.



EXPANDED RECOMMENDATIONS ON ACUTE PAIN

- Nonopioid therapies are at least as effective as opioids for many common types of acute pain, including
  - low back pain
  - neck pain
  - other common musculoskeletal conditions
  - minor surgeries or dental procedures
  - kidney stone pain
  - headaches

Taper when discontinuing opioids following continuous use for more than a few days



DETERMINING WHETHER TO INITIATE OPIOIDS FOR ACUTE PAIN (DURATION <1 MO)

- Nonopioid therapies are at least as effective as opioids for many common types of acute pain.
- Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.
- Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.



DETERMINING WHETHER TO INITIATE OPIOIDS FOR SUBACUTE PAIN OR CHRONIC PAIN (DURATION >3 MONTHS)

- Nonopioid therapies are preferred for subacute and chronic pain.
- Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and **only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient**.
- Before starting opioid therapy for subacute or chronic pain, clinicians should **discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued** if benefits do not outweigh risks.



NON-OPIOID TREATMENTS FOR SPECIFIC CHRONIC PAIN CONDITIONS

- **Back pain or osteoarthritis:** exercise, physical therapy, weight loss, manual therapies, psychological therapies, mindfulness-based stress reduction, yoga, acupuncture, multidisciplinary rehabilitation, topical NSAIDs, duloxetine, systemic NSAIDs
- **Neck pain:** mind-body practices (yoga, tai chi, or qigong), massage, acupuncture
- **Fibromyalgia:** exercise, physical therapy, cognitive behavioral therapy, myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture, multidisciplinary rehabilitation, tricyclic and SNRI antidepressants, NSAIDs (topical diclofenac), prega*balin and gabapentin*
- **Neuropathic pain:** tricyclic, tetracyclic, and SNRI antidepressants; selected anticonvulsants, capsaicin, lidocaine patches



VIRGINIA LAW: BEFORE YOU PRESCRIBE

1. 18VAC85-21 (Virginia Board of Medicine) governs opioid and buprenorphine prescribing by physicians and PAs; parallel rules apply to APRNs, dentists, podiatrists, and optometrists.
2. Does **not** apply to pain related to cancer, sickle cell disease, hospice/palliative care, inpatient or ED care, or patients in an approved clinical trial.
3. Before initiating opioids for acute or subacute pain: perform a history and physical exam, **query the PDMP**, and assess the patient's history and risk of substance misuse.
4. Opioid prescriptions must be issued electronically (EPCS) per Code of Virginia §54.1-3408.02, unless a statutory exemption applies; a hardship waiver may be requested from the Board.
5. Patient counseling on addiction/overdose risk, reasons for the prescription, alternatives, and CNS-depressant interactions is **mandatory** before an opioid prescription for acute or chronic pain, and must be documented in the record.

18VAC85-21-10, -21, -22, -30; Code of Virginia §§54.1-3408.02, 54.1-2522.1

Be certain you know the laws and regulations in the jurisdiction you practice

RISK ASSESSMENT

Administration

- On initial visit
- Prior to opioid therapy
- Predicts misuse behaviors if prescribed opioids

Scoring

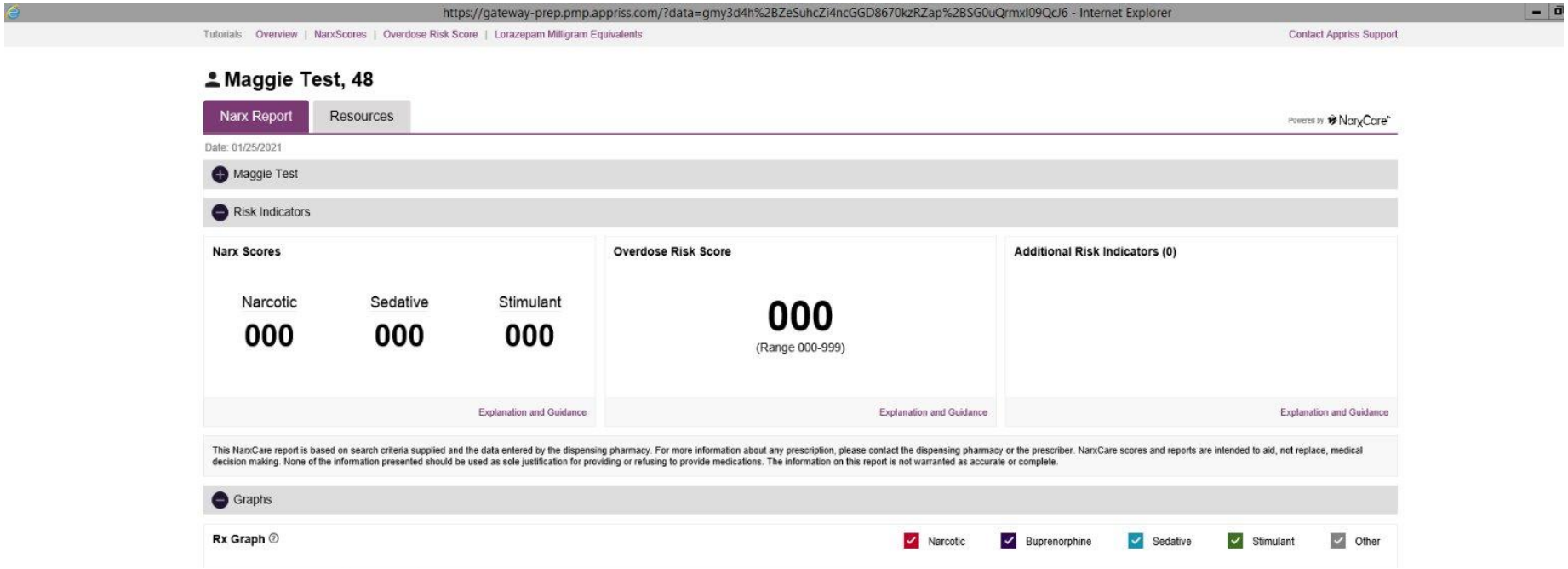
- 0-3: low risk
- 4-7: moderate risk
- > 8: high risk

Mark each box that applies	Female	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 if between 16-45 yrs)	☐ 1	☐ 1
4. History of preadolescent sexual abuse	☐ 3	☐ 0
5. Psychological disease		
ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
Depression	☐ 1	☐ 1
Scoring totals	_____	_____

Webster & Webster. Pain Med. 2005;6:432

PRESCRIPTION MONITORING PROGRAM

- To access PDMP: https://virginia.pmpaware.net/login



VIRGINIA LAW: ACUTE & SUBACUTE PAIN PRESCRIPTION LIMITS

1. Nonpharmacologic and non-opioid treatment must be considered before opioids for acute (<1 month) and subacute (1–3 month) pain.
2. When opioids are used, initiate with a **short-acting opioid** at the lowest effective dose for the fewest days.
3. Quantity limit: opioid prescriptions for acute or subacute pain may not exceed a **14-day supply**, absent extenuating circumstances clearly documented in the record. (Updated Jan. 2, 2025 - previously a 7-day limit.)
4. Postoperative opioids are limited to **no more than 14 consecutive days within the immediate perioperative period,** absent documented extenuating circumstances.
5. A PDMP query is required at initiation whenever an opioid course is anticipated to last **more than 7 consecutive days**; limited exemptions exist (e.g., PMP outage, sole-source pharmacy in a nursing/assisted living facility, sickle cell pain).

18VAC85-21-30, -40; Code of Virginia §54.1-2522.1

VIRGINIA LAW: MME THRESHOLDS & SAFEGUARDS

1. Document the reason in the medical record whenever a prescribed dose exceeds **50 MME/day** for acute, subacute, or chronic pain.
2. Before exceeding **120 MME/day**, document reasonable justification in the record or refer to/consult a pain management specialist.
3. Prescribe an FDA-approved opioid reversal agent (**naloxone**) whenever risk factors are present: prior overdose, substance misuse history, doses >120 MME/day, or concomitant benzodiazepine use.
4. Co-prescribing opioids with benzodiazepines, sedative hypnotics, carisoprodol, or tramadol is limited to extenuating circumstances, clearly documented in the record.
5. When these medications are co-prescribed, document a **tapering plan** to reach the lowest effective doses.

18VAC85-21-40(B)-(C), -70(B)-(D)

VIRGINIA LAW: CHRONIC PAIN COMPLIANCE

1. Before starting opioids for chronic pain (>3 months), document **informed consent** and have the patient sign a written **treatment agreement** covering monitoring, expectations, and reasons for discontinuation.
2. Query the PDMP at initiation and at least **every 3 months** thereafter; obtain a urine drug screen or serum medication level at initiation and at least annually.
3. Document the rationale to continue opioid therapy at least every 3 months, including evidence of **functional** benefit.
4. Regularly evaluate for opioid use disorder; initiate treatment, consult, or refer when indicated.
5. Buprenorphine mono-product (tablet form) may **not** be prescribed for chronic pain; combination buprenorphine/naloxone is required except in specific, documented circumstances.

18VAC85-21-60, -70, -90, -100, -150

DOSES EXCEEDING 50 MME/DAY

- Dosage increases to >50 MME/day are unlikely to improve pain control and function relative to risk
  - Consider including increased frequency of follow-up
  - **Offer naloxone** and overdose prevention education to both the patient and the patient's household members

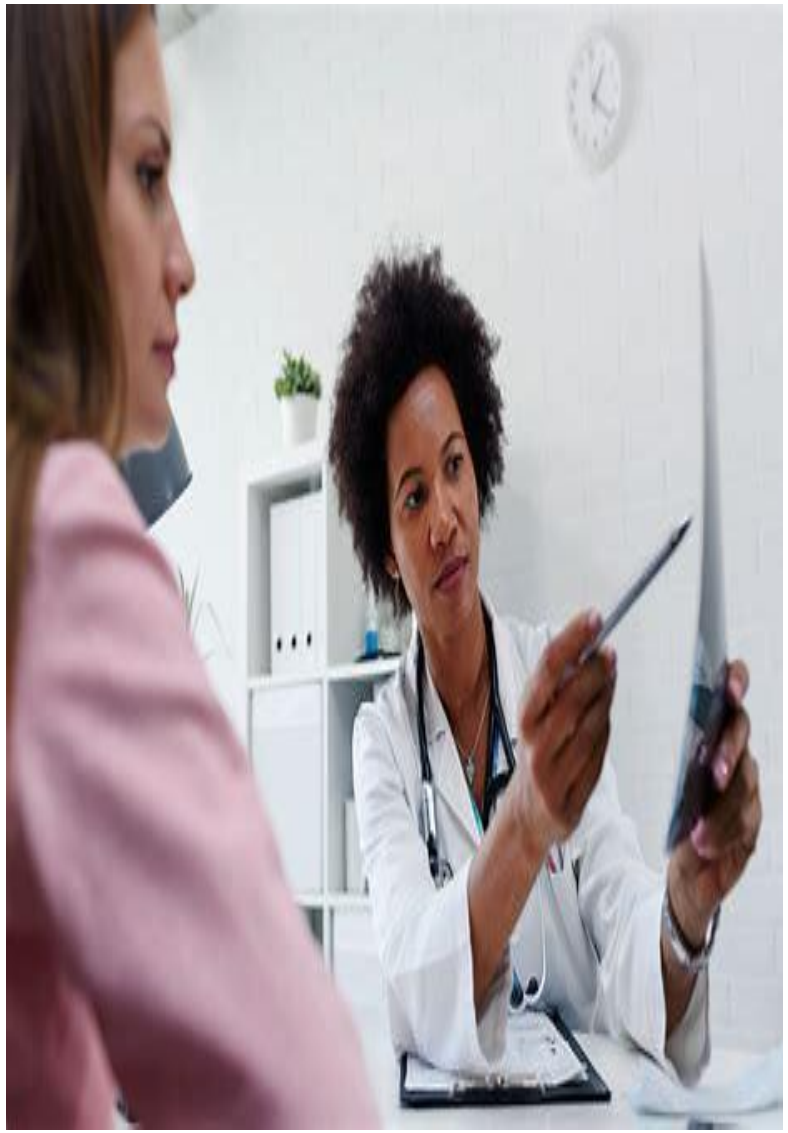
- >120 mgs per day of morphine equivalents is associated with greater rates of opioid misuse, inadvertent overdose, and death.

- Recent evidence suggests that many of these complications involved **co-prescribing of BZD's** and opioids, particularly in patients with major depression and/or anxiety disorders
  - Total dose may be less important than the subgroup who is prescribed opioids and BZD co-prescribing



PATIENT EDUCATION

- Establish protocol for breakthrough pain
- Review common SE: constipation, dry mouth, nausea, vomiting, drowsiness, pruritus, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping
- If formulations are prescribed that combine opioids with acetaminophen, advise patients of the risks of taking additional over-the-counter products containing acetaminophen.
- Discuss effects that opioids might have on a person's ability to safely operate a vehicle or other machinery
- Increases risks for respiratory depression
  - Benzodiazepines, other sedatives, alcohol, nonprescribed or illicit drugs (e.g., heroin), or other opioids
- Planned use of precautions to reduce risks
  - Naloxone
  - Safe storage (risk to other household members)
  - Dispose of unused pills



SELECTING OPIOIDS AND DETERMINING OPIOID DOSAGES

- For patients not already taking opioids, the lowest effective dose can be determined using product labeling as a starting point
- The lowest starting dose for opioid-naïve patients is often equivalent to a single dose of approximately 5–10 MME or a daily dosage of 20–30 MME/day.
- Clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids

HOW MUCH IS 50 OR 90 MME/DAY FOR COMMONLY PRESCRIBED OPIOIDS?

50 MME/day:

- 50 mg of hydrocodone (10 tablets of hydrocodone/acetaminophen 5/300)
- 33 mg of oxycodone (~2 tablets of oxycodone sustained-release 15 mg)
- 12 mg of methadone (<3 tablets of methadone 5 mg)

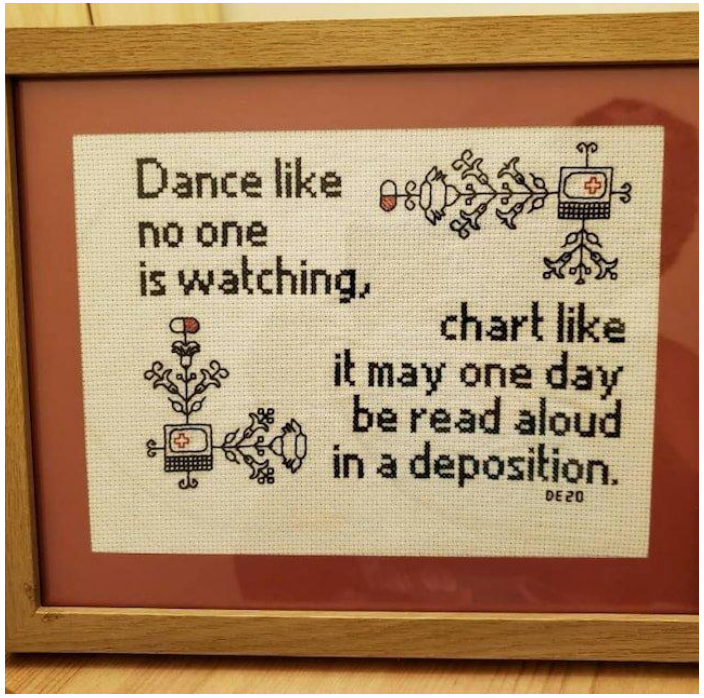
90 MME/day:

- 90 mg of hydrocodone (9 tablets of hydrocodone/acetaminophen 10/325)
- 60 mg of oxycodone (~2 tablets of oxycodone sustained-release 30 mg)
- ~20 mg of methadone (4 tablets of methadone 5 mg)

https://www.cdc.gov/opioids/providers/prescribing/pdf/calculating-total-daily-

PAIN MANAGEMENT DOCUMENTATION

- ❑ Thorough description of pain
- ❑ Current and past treatments
  - Obtain treatment records
- ❑ Underlying medical conditions
- ❑ Effect of the pain on physical and psychological function, QOL, and ADL
- ❑ Past psychiatric history, past substance use history, family history
- ❑ Opioid Risk Tool
- ❑ Presumptive diagnosis for the origin of the pain
- ❑ Document treatment plan
  - Measures of treatment progress (pain relief and improvement in physical and psychosocial function, quality of life, ADLs)
- ❑ Medication prescribed (date, type, dose, quantity)
- ❑ PDMP query



HOW TO OPIOID TAPER

Use over 1 year

- 10% per month or slower

Use for weeks to months

- ~10% of original dose per week, slowing to ~10% of remaining dose near the target

Struggling to tolerate?

- Slow down taper
- Maximize nonopioid treatments
- Address behavioral distress

Other tips

- Switch to extended-release opioids
- Collaborate with a pharmacist
- Assess behavioral health needs

CASE STUDY

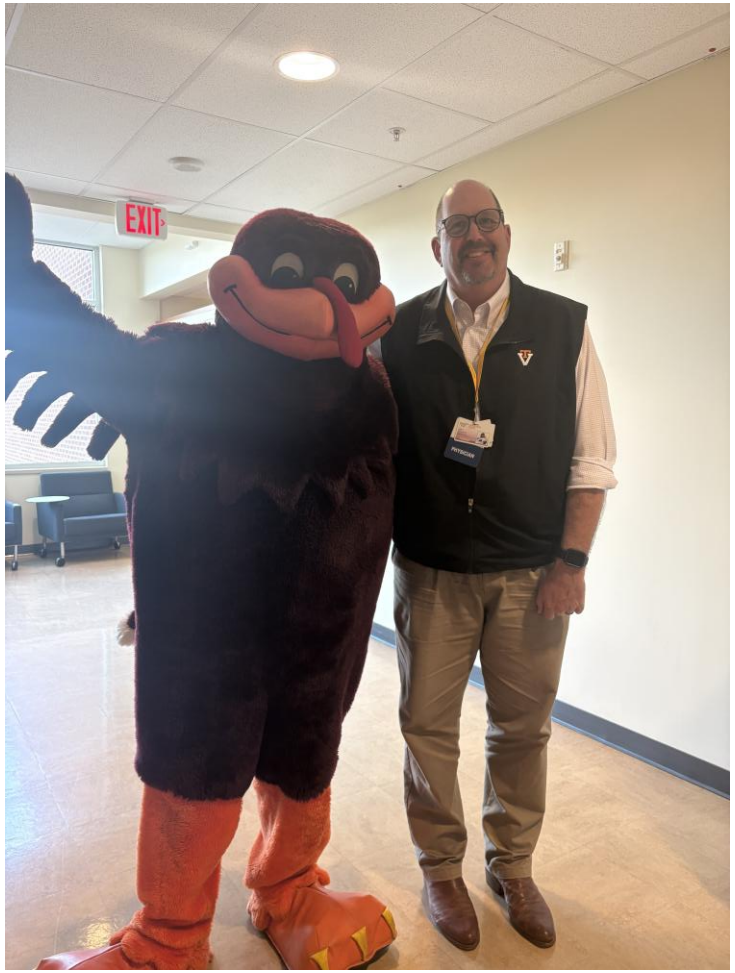
A 52 year-old office worker sees you to address lower back pain for the past 3 years
Medical History is notable for Type 2 diabetes, hypertension, occasional migraines

Presenting Symptoms

- Persistent lower back pain rated at 6/10 on the pain scale
- Pain is exacerbated by prolonged sitting and standing
- Occasional radiation of pain to the left leg
- Morning stiffness that improves throughout the day
- Difficulty performing daily activities and reduced quality of life

After a comprehensive assessment, including physical examination and imaging (MRI), the diagnosis is chronic lower back pain attributed to lumbar disc degeneration and mild osteoarthritis.

HOW WOULD YOU MANAGE THESE SYMPTOMS?



HOW AI WOULD MANAGE THIS?

1. Initial Assessment and Education
   - Education: Explain the nature of chronic back pain, the importance of a multidisciplinary approach, and realistic expectations regarding treatment outcomes.
   - Self-Care: Educate on proper posture, ergonomics at work, and techniques to minimize strain on the back.

2.Medication Management
   - Nonsteroidal Anti-Inflammatory Drugs (NSAIDs): For pain relief and inflammation reduction.
   - Acetaminophen: As an alternative if NSAIDs are contraindicated or ineffective.
   -Topical Analgesics: For localized pain relief.
   - Muscle Relaxants: If there is significant muscle spasm, prescribed for short-term use.

3. Physical Therapy
   - Strengthening Exercises: Focus on core strength.
   - Stretching Exercises: To improve flexibility and reduce muscle tension.
   - Posture Training: Educate on correct body mechanics, especially while sitting and lifting.
   - Heat/Cold Therapy: Apply as needed for pain management.

HOW AI WOULD MANAGE THIS?

4. Lifestyle Modifications
   - Weight Management: Encourage a healthy diet and exercise to maintain a healthy weight
   - Regular Exercise: Recommend low-impact activities
   - Ergonomic Adjustments: Advise on an ergonomic chair and workstation

5. Psychosocial Support
   - Cognitive Behavioral Therapy (CBT)
   -Support Groups: Encourage participation to share experiences and gain emotional support.

6. Advanced Interventions (If initial Treatment Fails):
   - Epidural Steroid Injections: To provide temporary relief of inflammation and pain.
   - Referral to a Specialist: Consider referral to a pain management specialist or a spinal surgeon if conservative treatments do not yield sufficient improvement.
   - Alternative Therapies: Explore options such as acupuncture, massage therapy, or chiropractic care, based on preferences and response to initial treatments.

7. Regular Follow-up
   -Reassess the effectiveness of the treatment plan every 3-6 months and make necessary adjustments based on feedback and clinical outcomes.

Key Takeaways

- Nonopioid first
- When you prescribe, start low dose and for short duration
- Know your federal and state regulations
- Taper gradually and test thoughtfully

QUESTIONS?



Topics In Addiction Medicine Prompts

QUESTION

How do use urine drug testing in your practice?

POLL

I will be sure to review with my team at work, that urine drug testing/toxicology is not to be used as a general screen to diagnose substance use disorders.

1. True (raise your right arm)
2. False (raise your left arm)

Perinatal Example: Screening

- Universal screening starting at the first prenatal visit (or comparative well visit) and using a validated **verbal screening tool**
- If a patient screens positive, the guidelines recommend a brief intervention and referral to treatment
  - Consider diagnostic model! YOU ALREADY KNOW HOW TO DO THIS!
- Multidisciplinary long-term follow-up should include medical, developmental, and social support

Committee on Obstetric Practice American Society of Addiction Medicine, American Society of Addiction Medicine, The American College of Obstetrics and Gynecologists Women's Health Care Physicians. Opioid Use and Opioid Use Disorder in Pregnancy. 2017;(711):14.
Slide by Olivia Caron

USE THE DIAGNOSTIC MODEL



1

Diagnostic criteria using the DSM V criteria checklist:

- Mild
- Moderate
- Severe

2

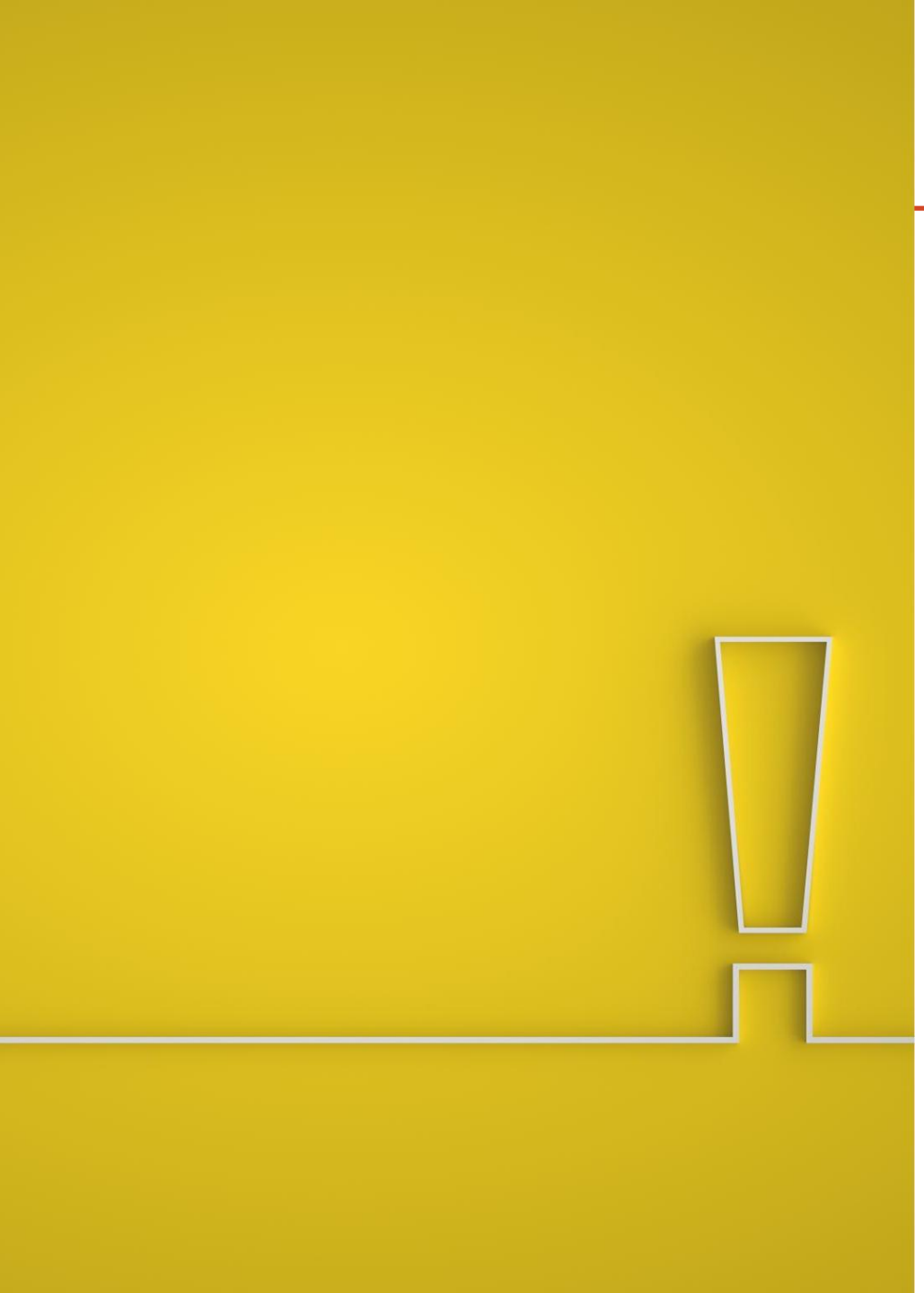
ASSESS ACUITY/SEVERITY

- COWS, SOWS
- CIWA-Ar
- Urine Toxicology/BAC

3

REVIEW TREATMENT OPTIONS

- Assessment of level of Care (Ex: ASAM Criteria, ASI)



Urine drug testing/ toxicology is an assessment tool.

EXAMPLE: URINE DRUG TOXICOLOGY DECISION GRID

	Screening population with no history of substance use or use disorder	Screening population with history of substance use, without history of substance use disorder	Assessment of population with history of substance use disorder/in remission	Assessment of population with substance use disorder, engaged in treatment	Assessment of population with substance use disorder, not currently engaged in treatment
Perform verbal validated screening tool	Yes	Yes	No	No	No
Perform Maternal Urine Toxicology	**No**	**No**	Yes, only **after consent** is obtained	Yes, only **after consent** is obtained	Yes, only **after consent** is obtained

Created by M Ramage 2022