Committee News

What You Should Know About the 2022 CDC Opioid Prescribing Guideline

Anita Gupta, DO, MPP, PharmD, FASA **Alexander Bautista, MD, MBA, FASA** **Antje M. Barreveld, MD** **Muhammad A. Farooq Anwar, MBBS, MBA**

The opioid crisis has ravaged the United States, claimed lives, and devastated many families and communities. Despite the steep decline in opioid prescriptions in the U.S. in the last few years, opioid-related mortality overall is higher than ever, and still rising. More than 100,000 Americans died from opioid overdoses in the year ending in April 2021 (*N Engl J Med* 2022;387:2011-3). During the COVID-19 pandemic, the escalating rates of mental illness and social isolation, compounded by limited access to preventative care, have also contributed to the continued increase in substance use disorders (SUD) and overdose deaths. In response to widespread debate about the 2016 Centers for Disease Control and Prevention (CDC) opioid prescribing guideline, a revised draft guideline was released in February 2022 for public comment, and a final version was published on November 4, 2022 (asamonitor.pub/3mbLWqY; asamonitor.pub/3KG9NcA).

Reassessing the 2016 CDC opioid prescribing guideline

Excess opioid prescriptions in the U.S. in the 1990s significantly drove the opioid crisis and high rates of opioid-related deaths. This crisis led the CDC to publish the 2016 Guideline for Prescribing Opioids for Chronic Pain (asamonitor.pub/3kAJ72k). Intended for primary care physicians to balance the benefits and risks of opioid treatment for chronic pain, the guideline aimed to provide a better future framework for safe and responsible opioid prescribing. However, this was not the case.

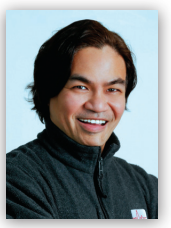
The unintended consequences of the 2016 guideline were numerous, and the impact on patients was significant. Clinicians, state legislatures, health insurers, and health care policymakers created wide-ranging and often restrictive prescribing policies that negatively impacted specific populations of chronic pain patients. For prescribers, these policies fueled fears of disciplinary action, concern for iatrogenic opioid use disorder (OUD), and use of opioids in general, and, many might argue, also led to fears of managing any acute and chronic pain (asamonitor.pub/3SJDcVd).

Barriers to pain care

The barriers to pain care resulting from the CDC guideline were also significant.

Anita Gupta, DO, MPP, PharmD, FASA
ASA Committee on Pain Medicine, Adjunct Assistant Professor, Department of Anesthesiology, Johns Hopkins School of Medicine, Baltimore, Maryland.

Antje M. Barreveld, MD
ASA Committee on Pain Medicine, and Associate Professor of Anesthesiology, Tufts University School of Medicine, Commonwealth Anesthesia Associates, Newton-Wellesley Hospital, Newton, Massachusetts.



Alexander Bautista, MD, MBA, FASA
ASA Committee on Pain Medicine, Associate Professor of Anesthesiology, and Director, Chronic Pain Fellowship Program, University of Louisville, Louisville, Kentucky.

Muhammad A. Farooq Anwar, MBBS, MBA
ASA Committee on Pain Medicine, and Assistant Professor of Anesthesiology and Pain Management, Duke University, Durham, North Carolina.

The CDC's recommendation to minimize opioids dosed higher than 90 morphine milligram equivalents (MME) per day was controversial from the patients' perspective. This threshold could not be clearly verified on a case-by-case patient basis and ultimately was deemed an arbitrary threshold by clinical expert standards. All in all, the 2016 guideline led to a one-size-fits-all approach for complex pain care.

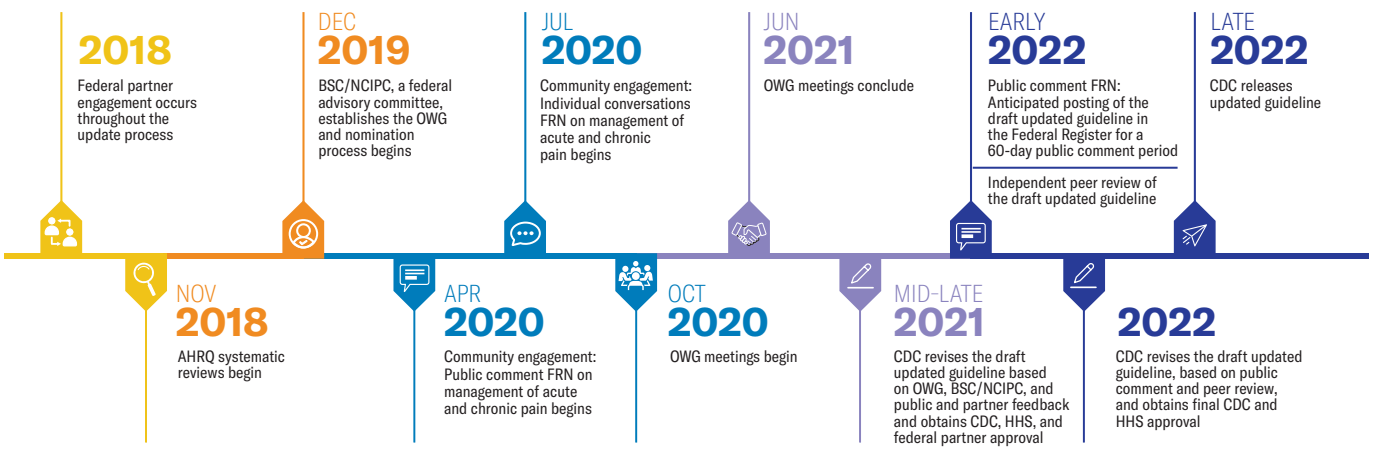
Over time, the 2016 guideline led to a range of restrictive policies, from limitations on opioid dosing to restricted health reimbursements for opioid medications across the board (asamonitor.pub/3m4v9Ga). This resulted in significant barriers for patients to accessing pain care, limited access to opioid medications, and created hurdles for physicians. From a business and practice management perspective, many pain management centers were obligated to increase their workforce to respond to prior authorization requests and insurance requests for opioid prescription approvals and denials from insurance to support patients' needs (asamonitor.pub/3m4v9Ga).

Though opioids were often overprescribed in the past, instead of making a dent in the opioid overdose crisis, restrictive prescribing caused more potential for burnout for prescribers, and the often sudden disruptions of opioid treatment increased challenges to accessing adequate pain management – as well as to increased rates of illicit drug use, overdose deaths, or death from suicide (*Prog Neuropsychopharmacol Biol Psychiatry* 2018;87:269-80).

The uptick in drug trafficking and burgeoning illicit drug markets in the U.S. have increased concern for the potential harm to patients often suffering from unrelenting pain when proper pain care or treatment options are not readily available (*Prog Neuropsychopharmacol Biol Psychiatry* 2018;87:269-80). Notably, illicit opioids and analogs are usually 50 to 100 times more potent than other common prescription opioids (*Prog Neuropsychopharmacol Biol Psychiatry* 2018;87:269-80). As a result, they pose a more significant risk to individuals and society.

PROCESS TIMELINE

Updating the CDC Guideline for Prescribing Opioids



AHRQ – Agency for Healthcare Research & Quality
BSC/NCIPC – Board of Scientific Counselors of the National Center for Injury Prevention and Control
CDC – Centers for Disease Control and Prevention
FRN – Federal Register Notice
HHS – U.S. Department of Health and Human Services
OWG – Opioid Workgroup

2022 CDC opioid prescribing guideline

The extensive 100-page 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain outlines 12 recommendations and presents several new changes in treating pain (asamonitor.pub/3KG9NcA). Specifically, this guidance includes the following important updates:

1. The guideline is intended for clinicians prescribing opioids for adult outpatients with pain – in situations other than those of sickle cell disease, cancer-related pain, palliative care, and end-of-life care. They expand guidance for acute (<1 month duration) and subacute (one- to three-month duration) pain to help primary care and other clinicians weigh the benefits and risks of opioids and other pain treatments in the outpatient setting.
2. Complex chronic pain patients managed by pain management specialists, patients receiving inpatient care, or those presenting to the emergency department are not the focus of the guideline.
3. CDC guides determining when to initiate opioids, selecting the dose and duration, conducting an appropriate follow-up, and minimizing risk to patients and providers by practicing safe prescribing. The updated guideline discusses the duration a prescription should be filled for acute or postoperative pain and dosing thresholds.
4. The document outlines the evidence for and role of nonopioid pain treatments, noninvasive pain therapies, lifestyle modifications, preventative care, and the judicious use of opioids for chronic pain.
5. One notable change from the 2016 guideline is that it no longer includes the 90 MME threshold for opioid prescription while emphasizing that doses higher than 50 MME may have a higher risk-to-benefit ratio.
6. The new guideline emphasizes that clinicians should be able to use their clinical judgment on the optimal, safe, and effective dose for each patient.
7. The document is presented as a clinical tool for improved communication between patients and clinicians to devise a more collaborative, individualized, and flexible treatment plan rather than promoting rigid prescribing practices.
8. The current guideline cautions clinicians about interpreting prescription drug monitoring programs and toxicology testing.
9. The document also focuses on assessing the risks of opioid misuse and evidence-based medication management of OUD (e.g., methadone, buprenorphine, and naltrexone). In this area, education for the anesthesiologist and pain physician has historically been lacking.
10. The guideline emphasizes the importance of co-prescribing and recommending naloxone to anyone prescribing opioids.

Call to action

ASA experts provided feedback on the February 2022 draft of the revised CDC opioid prescribing guideline, recognizing past challenges and lessons learned to promote equitable access to multimodal pain management. As experts in pain management and opioid pharmacology, there is a call to action for anesthesiologists to continue to lead and advance efforts in education, prevention, and public health awareness on the safe and responsible use of opioids when indicated for the treatment and alleviation of serious, painful conditions. In addition, anesthesiologists are poised to guide evidence-based, nonopioid, and preventative therapies for acute and chronic pain and influence access to life-saving treatments for OUD.

Future of pain care

The revised 2022 CDC opioid prescribing guideline is not without limitations. For instance, it lacks clarifications on proper precautions on safe and responsible initiation or discontinuation of opioid therapy. The updated guideline also focuses primarily on the potential harms of reducing opioid medication doses and not on the potential benefits of opioids for the appropriate population of patients for whom opioids may be indicated (such as those with adverse drug risks, poorly controlled pain, and other individualized considerations).

As a society, we need further research on innovative, safe, responsible, and effective pain care strategies, including opioid therapies. The evidence-based literature still lacks the most appropriate treatments and medications to help patients suffering from pain and the long-term comparative effectiveness of multimodal, multidisciplinary, and preventive pain therapies. However, we must maintain sight of our purpose and goal as anesthesiologists and pain physicians in providing compassionate care for our patients with safe, effective, responsible, and, most importantly, patient-centric care. ■

Disclosures: *Dr. Barreveld is a consultant for Lin Health. Dr. Gupta has served as an AMA Opioid Task Force Committee member, ASHP Commission Committee Member on Opioids, California Society of Anesthesiologists board director, FDA Special Government Employee, National Quality Forum Technical Advisor, DoD Scientific Advisor, and National Academies of Sciences Global Forum member.*