III. Recommendations

The following recommendations were made using a systematic approach considering four domains as per the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach as detailed in the section on Methods and Appendix E in the full text OT CPG. These domains include: confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient or provider values and preferences, and other implications, as appropriate (e.g., resource use, equity, acceptability).

Given the relevance of all four domains in grading recommendations, the Work Group encountered multiple instances in which confidence in the quality of the evidence was low or very low, while there was marked imbalance of benefits and harms, as well as certain other important considerations arising from the domains of values and preferences and/or other implications. In particular, the harms due to the potential for severe adverse events associated with opioids, particularly overdose and OUD, often far outweigh the potential benefits. As such, in accounting for all four domains, these factors contributed to Strong recommendations in multiple instances.

#	Recommendation	Strength*	Category†
Initiation and Continuation of Opioids			
1.	a) We recommend against initiation of long-term opioid therapy for chronic pain. b) We recommend alternatives to opioid therapy such as self-management strategies and other non-pharmacological treatments. c) When pharmacologic therapies are used, we recommend non-opioids over opioids.	a) Strong against b) Strong for c) Strong for	Reviewed, New-replaced
2.	If prescribing opioid therapy for patients with chronic pain, we recommend a short duration. Note: Consideration of opioid therapy beyond 90 days requires re-evaluation and discussion with patient of risks and benefits.	Strong for	Reviewed, New-added
3.	For patients currently on long-term opioid therapy, we recommend ongoing risk mitigation strategies (see Recommendations 7-9), assessment for opioid use disorder, and consideration for tapering when risks exceed benefits (see Recommendation 14).	Strong for	Reviewed, New-replaced
4.	a) We recommend against long-term opioid therapy for pain in patients with untreated substance use disorder. b) For patients currently on long-term opioid therapy with evidence of untreated substance use disorder, we recommend close monitoring, including engagement in substance use disorder treatment, and discontinuation of opioid therapy for pain with appropriate tapering (see Recommendation 14 and Recommendation 17).	a) Strong against b) Strong for	Reviewed, Amended
5.	We recommend against the concurrent use of benzodiazepines and opioids. Note: For patients currently on long-term opioid therapy and benzodiazepines, consider tapering one or both when risks exceed benefits and obtaining specialty consultation as appropriate (see Recommendation 14 and the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders).	Strong against	Reviewed, New-added

#	Recommendation	Strength*	Category†
6.	a) We recommend against long-term opioid therapy for patients less than 30 years of age secondary to higher risk of opioid use disorder and overdose. b) For patients less than 30 years of age currently on long-term opioid therapy, we recommend close monitoring and consideration for tapering when risks exceed benefits (see Recommendation 14 and Recommendation 17).	a) Strong against b) Strong for	Reviewed, New-replaced
Risk Mitigation			
7.	We recommend implementing risk mitigation strategies upon initiation of long-term opioid therapy, starting with an informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies. The strategies and their frequency should be commensurate with risk factors and include: ■ Ongoing, random urine drug testing (including appropriate confirmatory testing) ■ Checking state prescription drug monitoring programs ■ Monitoring for overdose potential and suicidality ■ Providing overdose education ■ Prescribing of naloxone rescue and accompanying education	Strong for	Reviewed, New-replaced
8.	We recommend assessing suicide risk when considering initiating or continuing long-term opioid therapy and intervening when necessary.	Strong for	Reviewed, Amended
9.	We recommend evaluating benefits of continued opioid therapy and risk for opioid-related adverse events at least every three months.	Strong for	Reviewed, New-replaced
Type, Dose, Follow-up, and Taper of Opioids			
10.	If prescribing opioids, we recommend prescribing the lowest dose of opioids as indicated by patient-specific risks and benefits. Note: There is no absolutely safe dose of opioids.	Strong for	Reviewed, New-replaced
11.	As opioid dosage and risk increase, we recommend more frequent monitoring for adverse events including opioid use disorder and overdose. Note: ■ Risks for opioid use disorder start at any dose and increase in a dose dependent manner. ■ Risks for overdose and death significantly increase at a range of 20-50 mg morphine equivalent daily dose.	Strong for	Reviewed, New-replaced
12.	We recommend against opioid doses over 90 mg morphine equivalent daily dose for treating chronic pain. Note: For patients who are currently prescribed doses over 90 mg morphine equivalent daily dose, evaluate for tapering to reduced dose or to discontinuation (see Recommendations 14 and 15).	Strong against	Reviewed, New-replaced
13.	We recommend against prescribing long-acting opioids for acute pain, as an as-needed medication, or on initiation of long-term opioid therapy.	Strong against	Reviewed, New-replaced
14.	We recommend tapering to reduced dose or to discontinuation of long-term opioid therapy when risks of long-term opioid therapy outweigh benefits. Note: Abrupt discontinuation should be avoided unless required for immediate safety concerns.	Strong for	Reviewed, New-added

#	Recommendation	Strength*	Category†
15.	We recommend individualizing opioid tapering based on risk assessment and patient needs and characteristics. Note: There is insufficient evidence to recommend for or against specific tapering strategies and schedules.	Strong for	Reviewed, New-added
16.	We recommend interdisciplinary care that addresses pain, substance use disorders, and/or mental health problems for patients presenting with high risk and/or aberrant behavior.	Strong for	Reviewed, New-replaced
17.	We recommend offering medication assisted treatment for opioid use disorder to patients with chronic pain and opioid use disorder. Note: See the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders.	Strong for	Reviewed, New-replaced
Opioid Therapy for Acute Pain			
18.	a) We recommend alternatives to opioids for mild-to-moderate acute pain. b) We suggest use of multimodal pain care including non-opioid medications as indicated when opioids are used for acute pain. c) If take-home opioids are prescribed, we recommend that immediate-release opioids are used at the lowest effective dose with opioid therapy reassessment no later than 3-5 days to determine if adjustments or continuing opioid therapy is indicated. Note: Patient education about opioid risks and alternatives to opioid therapy should be offered.	a) Strong for b) Weak for c) Strong for	Reviewed, New-added

*For additional information, please refer to the section on Grading Recommendations (in the full text OT CPG).

†For additional information, please refer to the section on Recommendation Categorization and Appendix H (in the full text OT CPG).