THE DWC MTUS ACOEM OPIOIDS GUIDELINE & PAIN MANAGEMENT TREATMENT OPTIONS

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SUMMARY OF IMPORTANT OPIOID & TAPERING POINTS

- **DWC MTUS** Opioid Guidelines and Chronic Pain Guidelines are **presumptively correct**.
- Physician must provide quality review of records, medical history and physical examination with recommendations that meet evidence-based medicine (EBM) guidelines.
- **Transition by 4/1/18** (for injured workers receiving ongoing drug treatment for injury prior to 1/1/18):
    - Formulary should be phased in to avoid harm from abrupt change to drug treatment.
    - Physician responsible for requesting medically appropriate & safe treatment in accordance with MTUS.
    - Treatment may include Non-Exempt/Unlisted drug if necessary for injured worker condition, or for safe weaning/tapering/transition to different drug.
    - Physician must submit RFA with ongoing drug treatment plan including tapering, weaning, transitioning to drug pursuant to MTUS or provide documentation supporting medical necessity for Non-Exempt/Unlisted/compounded drug per MTUS.
    - Previously approved drug treatment shall not be terminated/denied except as may be allowed by MTUS, and in accord with applicable UR/IMR regulations.
- Opioid use is moderately not recommended for treatment of subacute and chronic nonmalignant pain.
- The maximum daily opioid dose recommended for opioid naïve, acute or postoperative or subacute and chronic pain patients based on risk of overdose/death is 50 mg MED[1] (morphine equivalent dose).
- Opioid prescription should be patient specific, and limited to cases in which other treatments are insufficient and criteria for opioid use are met.
- The use of an opioid trial is recommended when other evidence based approaches for functional restorative pain therapy have been used, and documented to have provided inadequate improvement in function.
- While opioids may be effective in moderate doses in certain individuals, they also carry significant risks of harm.
- Opioid tapering/weaning must be medically safe - the goal is to safely reduce medications that are not efficacious while monitoring negative effects of withdrawal symptoms.
- It is medically unsafe and risky for the injured worker to abruptly stop taking certain medications - this is especially true in the medically compromised individual.
- While opioid tapering/weaning or detoxification may be appropriate, the real issue is the injured workers well-being and function (activities of daily living).
- Physicians who feel uncomfortable or are unsuccessful with managing an opioid taper or wean, should refer to the appropriate chronic pain specialist or addictionologist.
- The frequency/duration of a taper is dependent on multiple factors and is patient specific.
- The most common taper is 10% per week; again, tapering needs to be patient specific.[2]
- Guidelines support patient engagement in tapering with provision of education by the physician or others along with involvement in other active therapies including cognitive behavioral therapy and progressive physical reactivation.
- The taper should be stopped if there is objective worsening of function, excessive withdrawal, and/or intolerance. After stabilization, resumption of the taper should be attempted.
- Not all patients can be completely tapered off opioids and in specific cases, continuation of the opioid may be a consideration as well as the substitution of buprenorphine or methadone.
- The CA DWC MTUS Formulary Drug List needs to be understood by the treating physician to be used effectively.
- Treatment alternatives are supported by the CA DWC MTUS.

OPIOID ISSUES

MTUS (ACOEM) OPIOID GUIDELINES

The CA DWC MTUS is using the ACOEM Opioids Guideline[3]. It is important to understand these guidelines if the physician is going to recommend and get authorization for the prescription of opioids in the treatment of injured workers.

1. Appropriate pain management is a responsibility of those treating pain.

2. It requires adequate knowledge about, and assessment of, a patient's pain and function.

3. Pain management often requires multiple pharmacological and nonpharmacological methods to appropriately control pain that should be evaluated.

4. A comprehensive history and physical examination and documentation is required.

5. A clear diagnosis is critical with treatment recommendations that are evidence-based.

6. When considering prescribing opioid, the treating physician should have a clear, quantified treatment plan and functional goals. These goals should be Specific, Measurable, Achievable, Realistic and Time-based (SMART).

7. The documentation should include a discussion and plan for the 5As:

    1. Analgesia (reduction in pain);
    2. Activity increase (improved level of functional and meaningful activities, and especially in work-related injuries, returning to work);
    3. Adverse effects (any side effects, especially constipation, dizziness, confusion and inability to function due to opioids);
    4. Aberrant behaviors (self-dose escalation, poor compliance, continued 'pain behaviors' despite use of opioids); and
    5. Affect (mood changes such as worsening of depression).

8. Documentation should include informed consent including an agreed-on opioid treatment agreement and monitoring results (urine drug testing, questionnaire screening tools, the California CURES prescription database, etc.).

9. Due to the greater than 10-fold elevated risks of adverse effects and death, considerable caution is warranted among those using other sedating medications and substances including:

[1] A morphine equivalent dose (MED) is the amount of opioid prescription drugs, converted to a common unit (milligrams of morphine)
[2] While expeditious for communication purposes, this can lead to a prolonged tapering plan as the endpoint is only reached asymptomatically–practical management would suggest a tapering of 10% of the number of tablets of usual dose size each week - sdf
[3] http://www.dir.ca.gov/dwc/MTUS/ACOEM-Guidelines/Opioids-Guideline.pdf

i. Benzodiazepines,
ii. Anti-histamines (H1-blockers), and or
iii. Illicit substances.

10. Considerable caution is also warranted among those who (are/have):

i. Older (>65 years),
ii. Pregnant,
iii. Sleep apnea, psychiatric/mental health disorders (anxiety, depression, personality disorder, suicidal),
iv. Drug-seeking behavior,
v. Current or past substance abuse,
vi. Consuming alcohol in combination with opioids,
vii. Renal insufficiency,
viii. Hepatic insufficiency, and who are
ix. Unemployed (10-fold risk of death).

11. Due to elevated risk of death and adverse effects, caution is also warranted when considering prescribing opioid for patients with any of the following characteristics:

i. Other psychotropic medications,
ii. Current tobacco use,
iii. Attention deficit hyperactivity disorder (ADHD),
iv. PTSD,
v. Impulse control problems,
vi. Thought disorders,
vii. COPD, or
viii. Recurrent pneumonia.

12. Additional risks and/or adverse effects thought to be present from other medical comorbidities.

13. Opioids are not indicated for MILD injuries (e.g., strains, tendinitis, nonspecific pain, mild to moderate low back pain).

14. Opioids MAY BE indicated for MODERATE injuries (e.g., Severe sprains of moderate or large joints, moderate trauma, moderate to severe low back pain).

15. Opioids ARE indicated for SEVERE injuries (e.g., fractures, major trauma, large burns).

16. Post-operative pain (up to 4 weeks, there is limited use of opioids as an objective therapy to more effective treatments.[4]

[4] Most current recommendations include provision of a three-day prescription followed by weekly prescriptions and concurrent recommendations for daily dose tapering as an active part of the postoperative recovery plan - sdf.

17. Opioid use is moderately not recommended for treatment of **subacute and chronic nonmalignant pain**.

    1. Opioid prescription should be patient specific, and limited to cases in which other treatments are insufficient and criteria for opioid use are met.
    2. The use of an opioid trial is recommended when other evidence based approaches for functional restorative pain therapy have been used, and documented to have provided inadequate improvement in function.
    3. Screening of patients is recommended prior to initiating a trial of opioids for treatment of subacute or chronic pain.

18. The **maximum daily opioid dose** recommended for opioid naïve, acute or postoperative or subacute and chronic pain patients based on risk of overdose/death is **50 mg MED** (morphine equivalent dose).

19. Rotation of opioids is selectively recommended but should be an infrequent requirement.

20. **Buprenorphine** is selectively recommended for adjunctive treatment and opioid tapering.[5] Most patients are weaned without use of controlled substance medication. Buprenorphine is sometimes used for detoxification from high-dose opioids and is recommended for selected cases with opioid use at over 50–90 MG MED for at least 3 months duration as well as for the treatment of addiction. As treatment of these conditions is behaviorally and medically challenging, most are treated by an addiction specialist (e.g., high-dose patients, prior withdrawal problems, complex psychosocial confounders, complicating medical conditions). When there are complex medical issues (e.g., significant cardiovascular disease), inpatient treatment may be indicated. Buprenorphine is not generally recommended for those with no demonstrated functional gains; noncompliance; use of illicit substances; use of alcohol with opioids; and/or adverse effects of opioids (e.g., cognitive impairment, falls, poor judgment, untreated sleep apnea, psychological disorders, use of benzodiazepines). Transitioning to only an NSAID or acetaminophen for complete cessation of analgesics is/are generally preferable to substitution with buprenorphine.

21. **Breakthrough Pain (BTP)** is a transient increase in pain to greater than moderate intensity, which occurred on baseline pain of moderate intensity or less. It is also defined as "the transient exacerbation of pain occurring in a patient with otherwise stable, persistent pain." Opioids are not recommended for routine treatment of breakthrough superimposed on chronic pain in the absence of overt trauma or acute nociceptive pathology (e.g., fracture, myocardial infarction, tooth abscess).

22. **Intrathecal Drug Delivery Systems** are not recommended for the treatment of chronic nonmalignant pain.

[5] Buprenorphine is not well tolerated by all patients and therefore needs to be considered only as a potential tool in the management of Chronic Opioid Therapy and or Chemical Dependence disorder - sdf

MEDICALLY SAFE TAPERING/WEANING OFF PAIN MEDICATIONS

The ability for opioids to cause physical dependence means that when withdrawn, discomforting physical symptoms occur. To reduce the severity of withdrawal symptoms (e.g., drug craving, anxiety, vomiting/diarrhea, increased heart rate and blood pressure; sweating; tremors, anxiety), discontinuation of opioid therapy should be done through a gradual dose reduction (i.e., wean/ taper).

Each injured worker is unique when he comes to weaning/detoxification. Some injured workers can just stop abruptly without side effects and others go into severe withdrawal. The focus needs to be on function and not on the medication. Medications that increase function with little or no untoward side effects are medically reasonable.

Questions to ask: Are the medications actually making a difference? Are they making the person's life better and improving function? Are the benefits worth any side effects and negative effects? In other words, taking pain medications is a choice that each person must make by weighing the benefits vs. the risks.

When there is lack of efficacy and/or the risks appear to outweigh the benefits of taking a pain medication, reducing the dose and ultimately discontinuing the medication should be considered. This is called weaning or tapering particularly when the individual has become dependent on the medication. The term "detoxification" is sometimes used interchangeably but should be limited to cases with opioid addiction.

The goal of tapering/weaning down the dose is to safely discontinue medications that do not seem helpful in reducing pain while allowing the body to adjust while monitoring for negative effects of withdrawal symptoms. Oftentimes, people discover they feel better taking lower doses, fewer medications, or not taking medications at all.

It is dangerous to abruptly stop taking some medications (sometimes referred to as going "cold turkey"). Because the body develops physical dependence to some medications when they are taken regularly, abrupt withdrawal or too rapid a reduction in the dose of these medications can be very uncomfortable or even hazardous to one's health. It depends on the type of medication, how much, and for how long the medication has been taken.

MTUS (ACOEM) OPIOID GUIDELINE RECOMMENDATIONS

Discontinuance of opioids is recommended by the ACOEM Opioid Guidelines for acute and postoperative patients who have reached meaningful functional recovery. Discontinuance is also recommended for subacute and chronic pain patients who i) use opioids on a chronic basis, and ii) [any one of] no demonstrated function gain, noncompliance, aberrant drug screening results and/or diversion, adverse effects (e.g., cognitive impairment, falls, poor judgment, untreated sleep apnea, psychological disorders, and concurrent use of depressant medications such as benzodiazepines and diphenhydramine).

Immediate discontinuation without tapering is recommended for those who have a urine drug screen (UDS) showing unexpected absence of the prescribed drug. Among those with urine drug testing results showing nonprescribed licit or illicit substance(s) use, discontinuation is recommended, although tapering may be

advisable if the opioid is thought to be taken as prescribed (e.g., rather than partially diverted) and the doses over 50 mg MED.

Tapering is recommended if the opioid was used at a moderate or high level (e.g., above 50–90 milligram MED) on a chronic basis. Consultation with an addiction specialist or psychiatrist as recommended for complex patients (e.g., high-dose patients, prior withdrawal problems, complex psychosocial confounders, complicating medical conditions).

Transitioning to only an NSAID or acetaminophen or complete cessation of opioids is/are generally indicated.

The frequency/duration of a taper is empirical, dependent on dose, prior opioid use duration, and informed patient decision-making. Rates of the taper vary. The following are options:

- 10% per day
- 20% every 3-5 days
- 10% per week
- 25% per week
- 20–50 percent per day until lower doses reached
- Faster tapers over a few days have been safely accomplished

The speed of the taper should generally be an informed choice involving the patient, as some well prefer a faster or slower taper.

- The slowest taper in common use is 10% per week, thus lasting 10 weeks.
- A faster taper is 25% per week for 4 weeks.
- Some will opt to taper over, e.g., 10 days.

(Clear communication in tapering may be achieved by reducing the number of tablets of the chosen drug by one per day over each tapering interval. In this way the patient can have a predetermined number of tablets for that day's use described on a tapering calendar to assist in providing clear education regarding the process. If there is concern about overuse during the tapering process, weekly refills of decreasing amounts may reduce the opportunity for that overuse - sdf).

The ACOEM Opioid Guidelines offers a recommended process:

1. Develop a taper planned. Elements of the plan include: 1) agreement to taper, 2) education on expected symptoms during the taper, 3) return visits for intolerable symptoms with consideration of a pause in the taper, and 4) other treatments to be changed or substituted.
2. The provider should be supportive and engaged in the patient's care, management and concerns. 'Do not abandon' the patient. Considering engaging the patient in other active therapies during taper (e.g., progressive active exercises, cognitive behavioral therapy, education, psychiatric consultation, psychiatric medication). Consider judicious use of passive therapies (e.g., acupuncture, TENS, manipulation) as adjuncts in assisting tapering.
3. Rate of tapering is not critical, rather the direction of the doses. A typical wean is 10%/week to 10%/month in chronic pain patients and outpatient settings. Tapers may be faster in inpatient and more controlled

settings, or when use has been for short a period of time. Brief negotiated pauses in the rate of taper is acceptable.

4. Educate the patient that taper will produce symptoms. These include anxiety, emotional distress, hyperalgesia, experiencing pain in new areas. These are expected and not contraindications to taper, although if intolerable, may be a rationale for a brief pause in a taper.
5. The taper should be stopped if there is objective worsening of function, excessive withdrawal, and/or intolerance. After stabilization, resumption of the taper should be attempted. However, if there is a plateau level where function is achieved, that dose should be noted in the records and maintained for an ongoing basis. There is consideration for reattempting taper in subsequent years.

CDC GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN — UNITED STATES, 2016[6]

When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used. A decrease of 10% of the original dose per week is a reasonable starting point; experts agree that tapering plans must be individualized based on patient goals and concerns.

In theory, the longer a patient has been on opioid therapy, the slower the taper may need to be. Additionally, tapers may need to be paused and restarted again per patient response and be more gradual once patients reach low dosages. According to these guidelines, "tapers may be considered successful as long as the patient is making progress."

The idea behind these guideline statements is to allow patients to drive the process of weaning as much as possible because the decision to wean, after years of use, requires a significant commitment from the patient. It is important to consider that opioid weaning is not a discontinuation of care.

Once the smallest available dose is reached, the interval between doses can be extended. Opioids may be stopped when taken less frequently than once a day. More rapid tapers might be needed for patient safety under certain circumstances (e.g., for patients who have experienced overdose on their current dosage).

In many ways, opioid weaning requires as much attention, treatment, and care as opioid initiation.

Patients who are not taking opioids (including patients who are diverting all opioids they obtain) do not require tapers. Clinicians should discuss with patients undergoing tapering the increased risk for overdose on abrupt return to a previously prescribed higher dose.

Collaboration among relevant health providers and psychosocial support is needed to ensure success. While acute withdrawal symptoms may subside, depressive-like symptoms may persist for weeks or months. This is referred to as "protracted abstinence syndrome." Protracted abstinence syndrome presents risk of relapse and continual care may be necessary to manage this risk.

Some medications may be safe to stop abruptly.

[6] https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf

a. For instance, a medication that is taken for just a few days or only taken once in a while (e.g., once a week).
b. Medications that are prescribed when necessary (prn - as needed, not taken regularly).
c. Some medications that do not produce physical dependence (e.g., acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs – like aspirin, ibuprofen and others]).

Some medications always require medical supervision when stopped:

a. Opioids that have been taken in regular daily doses for several days or longer.
b. Benzodiazepines, muscle relaxants, antidepressants, and anticonvulsant medications that have been taken in regular daily doses for several days or longer.
c. Barbiturates taken frequently for headache (butalbital).

Weaning off medications may be complicated by the potential for increased levels of pain that may accompany dose reduction, but can be done safely under medical supervision. The health care professional determines the rate at which the dose is reduced and adjustments can be made as necessary.

For example, reasonable opioid weaning protocols suggest decreasing pill intake by 10-20 percent per week, as tolerated. Hydration (drinking water), relaxation, and emotional support are all important to enhance the likelihood of success.

Sometimes weaning or discontinuing medication (especially opioids) is most safely accomplished under the close supervision of a specialist (such as a pain or addiction medicine specialist) in a medically-supervised program to prevent complications and severe withdrawal symptoms.

Symptoms of withdrawal from opioids can include:

a. worsening of pain
b. rapid heart beat
c. high blood pressure
d. sleeplessness
e. agitation and anxiety
f. stomach cramps, nausea, vomiting, diarrhea
g. body aches (flu-like symptoms) and muscle cramps
h. runny nose, sweating, tearing, yawning, goose bumps

Prescription medications that can help diminish symptoms of opioid withdrawal include:

a. Alternative opioids:
    i. Methadone
    ii. Buprenorphine
b. Non-opioid detoxification
    iii. alpha-2 agonists (clonidine) – blood pressure needs to be monitored while taking this medication
    iv. anti-nausea medications (e.g. ondansetron, metoclopramide)

v. anti-diarrheal (loperamide)
vi. muscle relaxants (e.g., tizanidine, methocarbamol)
vii. stomach relaxants (dicyclomine)
viii. anti-inflammatory pain relievers (e.g. ibuprofen, naproxen, others)
ix. sleep aids (e.g. trazodone, amitriptyline)
x. anti-anxiety agents (e.g., diazepam, lorazepam) may be used for short periods (5-7 days)

c. On occasion, alternative detoxification with phenobarbital may be offered

MEDICAL BOARD OF CALIFORNIA GUIDELINES FOR PRESCRIBING CONTROLLED SUBSTANCES FOR PAIN[7]

Discontinuing or tapering of opioid therapy may be required for many reasons and ideally, an "exit strategy" should be included in the treatment plan for all patients receiving opioids at the onset of treatment. Reasons may include:

- Resolution or healing of the painful condition;
- Intolerable side effects;
- Failure to achieve anticipated pain relief or functional improvement (although ensure that this failure is not the result of inadequate treatment);
- Evidence of non-medical or inappropriate use;
- Failure to comply with monitoring, such as urine drug screening (although ensure that this failure is not the result of a cost issue);
- Failure to comply with pain management agreement;
- Exhibition of drug-seeking behaviors (although ensure this behavior is not a result of inadequate treatment) or diversion, such as:
    - Selling prescription drugs;
    - Forging prescriptions;
    - Stealing or borrowing drugs;
    - Aggressive demand for opioids;
    - Injecting oral/topical opioids;
    - Unsanctioned use of opioids;
    - Unsanctioned dose escalation;
    - Concurrent use of illicit drugs;
    - Getting opioids from multiple prescribers and/or multiple pharmacies; or
    - Recurrent emergency department visits for chronic pain management.

If opioid therapy is discontinued, the patient whom has become physically dependent should be provided with a safely-structured tapering regimen. Opioid withdrawal symptoms are uncomfortable, but generally not life threatening.

Opioids can be stopped abruptly when the risks outweigh the benefits (in very limited situations, e.g., an example would be pending organ failure or death from respiratory depression - sdf). This is not true for benzodiazepine withdrawals, which can be life-threatening. Withdrawal can be managed either by the prescribing physician or by referring the patient to an addiction specialist.

[7] http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

Approaches to weaning range from a slow 10% reduction per week for more aggressive 25-50% reduction every few days. In general, a slower taper will produce fewer unpleasant symptoms of withdrawal. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other healthcare specialist, as appropriate.

WASHINGTON STATE GUIDELINE ON PRESCRIBING OPIOIDS FOR PAIN

The Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain[8] is an excellent resource. The following is from their 2006 **Strategies for Tapering and Weaning** (Appendix 15):

Strategies for tapering:

From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:

- A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks).
- If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.
- Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring for often significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued.
- Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.

Recognizing and managing behavioral issues during opioid weaning: Opioid tapers can be done safely and do not pose significant health risks to the patient. In contrast, extremely challenging behavioral issues may emerge during an opioid taper. Behavioral challenges frequently arise in the setting of a prescriber who is tapering the opioid dose and a patient who places great value on the opioid he/she is receiving. In this setting, some patients will use a wide range of interpersonal strategies to derail the opioid taper. These may include:

- Guilt provocation ("You are indifferent to my suffering")
- Threats of various kinds
- Exaggeration of their actual suffering in order to disrupt the progress of a scheduled taper

There are no fool-proof methods for preventing behavioral issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary.

[8] Washington State Agency Medical Directors' Group Interagency Guideline on Prescribing Opioids for Pain

PREFERRED CHRONIC PAIN TREATMENT APPROACHES & ALTERNATIVES

In the California workers' compensation arena, we are charged with providing the best medical care possible to "cure or relieve" from the effects of the industrial injury. Transitioning away from unnecessary and sometimes harmful medications, by itself, will be beneficial, but the real issue is assisting the injured worker in having a productive and happy life and returning to gainful employment if possible. The MTUS strongly supports a functional restoration approach.

There are a host of treatment approaches that are recommended by the MTUS and as listed in the 2017 ACOEM Chronic Pain Guidelines Update[9]. The emphasis is on active patient participation, psychological approaches including cognitive behavioral therapy, physical reactivation and functional restoration approaches using a biopsychosocial model. These approaches when utilized concurrently with weaning/tapering, provide the injured worker tools to avoid relapse and instead, to achieve a successful outcome.

ACOEM Chronic Pain Guideline
Summary of Recommendations

Laboratory Tests for Chronic Persistent Pain	Recommended
Needle EMG and Nerve Conduction Study to Diagnose	Recommended
FCEs For Chronic Persistent Pain	Recommended
Aerobic Exercise for Chronic Persistent Pain	Recommended
Strengthening Exercise for Chronic Persistent Pain	Recommended
Aquatic Therapy for Chronic Persistent Pain	Recommended
Yoga for Other Chronic Persistent Pain	Recommended
Oral NSAIDs for Chronic Persistent Pain	Recommended
Acetaminophen for Chronic Persistent Pain	Recommended
Gabapentin and Pregabalin for Chronic Persistent Pain	Recommended
Duloxetine (Cymbalta) for Chronic Persistent Pain	Recommended
Muscle Relaxants for Acute Exacerbations of Chronic Persistent Pain	Recommended
Topical NSAIDs for CPP When Target Tissue Superficial	Recommended
Lidocaine Patches for Chronic Persistent Pain	Recommended
Acupuncture for Chronic Persistent Pain	Recommended
Psychological Evaluation for Chronic Persistent Pain	Recommended
Biofeedback	Recommended
Cognitive Behavioral Therapy	Recommended

[9] http://www.dir.ca.gov/dwc/MTUS/ACOEM-Guidelines/Chronic-Pain-Guideline.pdf