

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-A-19

Subject: Prior Authorization Requirements for Post-Operative Opioids
(Resolution 208-A-18)

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee B
(Charles Rothberg, MD, Chair)

1 INTRODUCTION

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3 At the 2018 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD) referred Resolution 208-A-18, "Prior Authorization Requirements for Post-Operative
5 Analgesia," introduced by the Pennsylvania Delegation, which asked:

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7 That our American Medical Association strongly oppose prior authorization requirements for
8 postoperative analgesia equivalent to five days or less so as to prevent patient suffering.

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10 Reference committee testimony generally was supportive of the original resolution given
11 physicians' and patients' experiences with legislative and other policies focused on hard thresholds
12 for opioid prescribing post-surgery and other acute care settings. Yet, there was concern raised
13 regarding taking a position to oppose all prior authorization or other utilization management
14 protocols. The AMA Council on Medical Service and Council on Legislation were among those
15 who asked that our Board take this resolution back for consideration, discussion and present clear
16 recommendations to further the intent of the original resolution.

17 18 DISCUSSION

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20 There are multiple, competing and often contradictory trends that define the nation's opioid
21 epidemic. Opioid-related mortality continues to increase, but data from the Centers for Disease
22 Control and Prevention (CDC)¹ show that the nation's opioid overdose and death epidemic
23 continues to be driven by increases in death due to illicit fentanyl. Deaths due to prescription
24 opioid- and heroin-related causes appear to have plateaued but remain at historic highs. In 2017:

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26 • 28,466 died from illicit fentanyl-related overdose (19,413 in 2016).
27 • 15,482 died from heroin-related overdose (15,469 in 2016).
28 • 14,495 died from prescription opioid-related overdose (14,487 in 2016). (More than 60
29 percent of people who misused prescription opioids steal them or obtain them from a
30 family member or friend.²)
31 • 3,194 died from methadone-related causes—the lowest number since 2003. (The data does
32 not distinguish whether methadone was used for pain or for the treatment of opioid use
33 disorder.³)

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35 At the same time, opioid prescribing in the United States continues to decrease. Between 2013-
36 2017, retail filled opioid prescriptions decreased by 22.2 percent with a total of 196 million opioid

1 prescriptions filled in 2017.⁴ Decreases occurred in every state. The most common opioid
2 prescription was for less than 30 days and less than 50 morphine milligram equivalents (MME).
3 From 2014 to 2016, opioid prescriptions written for fewer than 30 days decreased from 150.4
4 million to 126.5 million; and opioid prescriptions of less than 50 MME decreased from 175.6
5 million in 2014 to 158.0 million in 2016.⁵

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7 Policymakers for the past several years have focused almost entirely on mandating a few specific
8 policies or approaches that they believe would help end the epidemic. These include enacting
9 legislation in nearly four out of five states to require physicians to use a state prescription drug
10 program (PDMP); mandating content-specific continuing medical education (CME) in more than
11 half of the states; and prohibiting a prescription for an opioid analgesic if it is greater than a certain
12 number of days or for a greater than a certain MME.

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14 Restrictions on opioid prescribing also have been implemented by health plans, national pharmacy
15 chains and pharmacy benefit management companies.⁶ Many of these policies follow the
16 publication from the CDC entitled, “CDC Guideline for Prescribing Opioids for Chronic Pain —
17 United States, 2016 (the Guideline).”⁷ In the Guideline’s introduction, CDC stated:

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19 The recommendations in the guideline are voluntary, rather than prescriptive standards. They
20 are based on emerging evidence, including observational studies or randomized clinical trials
21 with notable limitations. Clinicians should consider the circumstances and unique needs of
22 each patient when providing care.

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24 Many of the state legislative and other policies enacted and/or implemented since then, however,
25 justify the day/dose limit for acute pain based on the CDC Guideline. The HOD addressed this in
26 Policy D-120.932, “Inappropriate Use of CDC Guidelines for Prescribing Opioids.” And while it is
27 common for state opioid restriction policies to allow for exceptions for patients with cancer, in
28 hospice or who require palliative care, to name a few, there generally is no exception for when
29 post-operative surgical care might require a prescription for a greater number of days or dose
30 strength than a particular state might allow.

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32 State policymaking also has resulted in no consistency between opioid restriction or other laws. For
33 example, some states require checking the PDMP prior to prescribing any controlled substance or
34 limited to only opioid analgesics. Other states require a PDMP check every 90 days (or another
35 interval) for repeated prescriptions, and other states require a check only once per year. With
36 respect to CME mandates, the number of hours and specific nature of the CME vary by state. The
37 Board notes that the AMA Opioid Task Force has gathered more than 400 state- and specialty-
38 specific resources to help promote the availability of education and training that is relevant and
39 meaningful to a physician’s specific practice and patient population.⁸ The Board thanks all those
40 Federation partners who have contributed to this effort.

41
42 With respect to opioid prescribing, physicians and other prescribers of controlled substances have
43 borne a considerable amount of blame. The AMA and countless physician organizations have
44 accepted responsibility for both working to reduce patients’ pain and the medical community
45 acknowledges its role in having in the past increased opioid prescribing as one way to help
46 alleviate patients’ pain. The AMA also has supported efforts by law enforcement and others to stop
47 illegal activities such as pill mills and the AMA and countless physician organizations have made
48 considerable progress in urging physicians to be more judicious in their prescribing decisions as the
49 above data show. The Board knows, however, that there is much more work to do before the
50 epidemic will end.

1 The AMA continues to stress the need for evidence-based decision making on the part of
2 policymakers with respect to restrictions on opioid prescribing. Given that state policies have been
3 the result of political negotiations rather than scientific evidence, it is possible that a course
4 correction could be made. One such direction could be to follow the patient-centric
5 recommendations of the U.S. Department of Health and Human Services, "Draft Report on Pain
6 Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations,"⁹ which
7 includes among its many positive recommendations, support for:

8

- 9 • Individualized treatment as the primary goal of acute pain management, accounting for
10 patient variability with regard to factors such as comorbidities, severity of conditions,
11 surgical variability, geographic considerations, and community/hospital resources.
- 12 • Improved pain control, faster recovery, improved rehabilitation with earlier mobilization,
13 less risk for blood clots and pulmonary embolus, and mitigation of excess opioid exposure.

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15 Similarly, as physicians continue to play a leading role in reducing opioid prescriptions and
16 advocating for patients' access to opioid analgesics when appropriate, there is a great need to
17 remove prior authorization for multidisciplinary and multimodal pain care, including non-opioid
18 alternatives. This has been one of the central findings of AMA spotlight analyses of efforts in the
19 Medicaid agencies of several states,¹⁰ but the AMA also continues to hear regularly from
20 physicians about commercial health insurance companies who resist removing prior authorization
21 hurdles as well as their limited efforts to increase access to non-opioid alternatives. The Board
22 strongly recommends that health insurance companies work with physicians and the nation's
23 medical societies to remove barriers to non-opioid pain care.

24

25 There are good examples in the pain stewardship and other comprehensive pain care programs that
26 have been implemented in many areas of the country. This includes programs at Kaiser
27 Permanente, Geisinger Health System, Intermountain Health Care and the University of Chicago,
28 to name a few. There also continues to be emerging research focusing on the most appropriate
29 length and dose of an opioid prescription post-operatively. This includes for procedures ranging
30 from rhinoplasty,¹¹ gynecologic and abdominal surgery,¹² care delivered in the emergency
31 department,¹³ as well as mastectomy, general surgery and musculoskeletal procedures.¹⁴

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33 There generally are three common elements to these efforts by systems and researchers. First, they
34 all have engaged in extensive data review to determine what baseline of opioid prescribing was
35 taking place in the system and for the specific procedures. Second, they all discovered that while
36 opioid prescribing overall could be reduced, none put a hard threshold on the amount given post-
37 operatively or following an acute care episode. And third, even when guidelines were established
38 for physicians, those guidelines provided a range rather than a single number. In the systems,
39 furthermore, and as noted above in Medicaid, there is increasing realization that while opioid
40 sparing protocols may be beneficial, patients must not be left without sufficient forms of pain care.
41 That is, opioid reductions may have occurred, but the focus for these physicians has been on
42 improving patient outcomes.

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44 AMA POLICY

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46 AMA has extensive policy supporting the principle that utilization management policies, clinical
47 practice guidelines and clinical quality improvement activities must be based on sound clinical
48 evidence, data and allow for variation based on individual patient needs (e.g., Policy H-320.949,
49 Clinical Practice Guidelines and Clinical Quality Improvement Activities). AMA policy also
50 promotes patient access to comprehensive, multidisciplinary, multimodal pain care, including
51 working with all stakeholders to promote research and develop evidence to support quality pain

1 care. This includes promoting safe opioid prescribing and promoting a public health approach to
2 ending the nation's opioid epidemic (e.g., Policy D-160.981, Policy H-95.990, "Promotion of
3 Better Pain Care and Drug Abuse Related to Prescribing Practices"). And, it includes AMA strong
4 support for "timely and appropriate access to non-opioid and non-pharmacologic treatments for
5 pain, including removing barriers to such treatments when they inhibit a patient's access to care."
6 (Policy D-450.956, "Pain as the Fifth Vital Sign.") It should also be stressed that AMA's efforts to
7 reduce prior authorization burdens and protect patients' access to medically necessary therapy
8 extend far beyond only post-operative pain care (e.g., Policy H-320.939, "Prior Authorization and
9 Utilization Management Reform" and the grassroots advocacy campaign based on the online hub,
10 FixPriorAuth.org).

11
12 **RECOMMENDATIONS**
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14 The Board recommends that the following recommendation be adopted in lieu of Resolution 208-
15 A-18, and that the remainder of the report be filed.

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- 17 1. That our American Medical Association (AMA) advocate for state legislatures and other
18 policymakers, health insurance companies and pharmaceutical benefit management companies
19 to remove barriers, including prior authorization, to non-opioid pain care. (New HOD Policy)
- 20 2. That our AMA support amendments to opioid restriction policies to allow for exceptions that
21 enable physicians, when medically necessary in the physician's judgment, to exceed statutory,
22 regulatory or other thresholds for post-operative care and other medical procedures or
23 conditions. (New HOD Policy)
- 24 3. That our AMA oppose health insurance company and pharmacy benefit management company
25 utilization management policies, including prior authorization, that restrict access to post-
26 operative pain care, including opioid analgesics, if those policies are not based upon sound
27 clinical evidence, data and emerging research. (New HOD Policy)

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29 Fiscal Note: Less than \$500.

REFERENCES

¹ Kaiser Family Foundation analysis of CDC, National Center for Health Statistics. Opioid overdose deaths by type of opioid. Available at <https://www.kff.org/state-category/healthstatus/opioids/>

² National Survey on Drug Use and Health (NSDUH), Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services, available at <https://www.samhsa.gov/data/sites/default/files/nsduh-ppt-09-2018.pdf>

³ Substance Abuse and Mental Health Services Administration. The National Survey on Drug Use and Health: 2017. Available at <https://www.samhsa.gov/data/sites/default/files/nsduh-ppt-09-2018.pdf>

⁴ Xponent, IQVIA, Danbury, CT, Accessed March 2017; PayerTrak, IQVIA, Danbury, CT, Accessed March 2018.

⁵ Centers for Disease Control and Prevention. Annual Surveillance Report of Drug-Related Risks and Outcomes — United States, 2017. Surveillance Special Report 1. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2017. Accessed [date] from https://www.cdc.gov/drugoverdose/pdf/pubs/2017_cdc-drug-surveillance-report.pdf

⁶ See, for example, October 3, 2018, AMA letter to Walmart SVP Paul Beahm, expressing AMA's concern for one-size-fits-all corporate policy. Available at <https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-10-3-Letter-to-Walmart-FINAL.pdf>

⁷ Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.
DOI:<http://dx.doi.org/10.15585/mmwr.rr6501e1>

⁸ AMA opioid microsite. See <https://www.end-opioid-epidemic.org/education/>

⁹ U.S. Department of Health and Human Services "Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations," December 2018. Available at <https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html#2.1.1-acute-pain>

¹⁰ See, for example, spotlight analyses of Colorado: https://www.end-opioid-epidemic.org/wp-content/uploads/2019/01/AMA-Paper-Spotlight-on-Colorado-January-2019_FOR-WEB.pdf; and Pennsylvania: <https://www.end-opioid-epidemic.org/wp-content/uploads/2018/12/AMA-Manatt-PAMED-spotlight-analysis-FINAL-for-release.pdf>

¹¹ Patel, Sagar, et al. Opioid Use by Patients After Rhinoplasty. *JAMA Facial Plast Surg*. 2018;20(1):24-30. doi:10.1001/jamafacial.2017.1034. Available at <https://jamanetwork.com/journals/jamafacialplasticsurgery/fullarticle/2660014>

¹² Mark, Jaron et al. Opioid Prescription Protocol for Pain Management After Gynecologic and Abdominal Surgery, *JAMA Netw Open*. 2018;1(8):e185452. doi:10.1001/jamanetworkopen.2018.5452. Available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2717556>

¹³ Chang, Andrew, et al. Effect of a Single Dose of Oral Opioid and Nonopioid Analgesics on Acute Extremity Pain in the Emergency Department, A Randomized Clinical Trial. *JAMA*. 2017;318(17):1661-1667. doi:10.1001/jama.2017.16190. Available at <https://jamanetwork.com/journals/jama/fullarticle/2661581>

¹⁴ Scully, et al. Defining Optimal Length of Opioid Pain Medication Prescription After Common Surgical Procedures. *JAMA Surg*. 2018 Jan 1;153(1):37-43. doi: 10.1001/jamasurg.2017.3132. Available at <https://www.ncbi.nlm.nih.gov/pubmed/28973092>