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)

INTRODUCTION

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

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

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

DISCUSSION

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

- 28,466 died from illicit fentanyl-related overdose (19,413 in 2016).
- 15,482 died from heroin-related overdose (15,469 in 2016).
- 14,495 died from prescription opioid-related overdose (14,847 in 2016). (More than 60 percent of people who misused prescription opioids steal them or obtain them from a family member or friend.\(^2\))
- 3,194 died from methadone-related causes—the lowest number since 2003. (The data does not distinguish whether methadone was used for pain or for the treatment of opioid use disorder.\(^3\))

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

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prescriptions filled in 2017. Decreases occurred in every state. The most common opioid
prescription was for less than 30 days and less than 50 morphine milligram equivalents (MME).
From 2014 to 2016, opioid prescriptions written for fewer than 30 days decreased from 150.4
million to 126.5 million; and opioid prescriptions of less than 50 MME decreased from 175.6
million in 2014 to 158.0 million in 2016.

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

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

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

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

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

With respect to opioid prescribing, physicians and other prescribers of controlled substances have
borne a considerable amount of blame. The AMA and countless physician organizations have
accepted responsibility for both working to reduce patients’ pain and the medical community
acknowledges its role in having in the past increased opioid prescribing as one way to help
alleviate patients’ pain. The AMA also has supported efforts by law enforcement and others to stop
illegal activities such as pill mills and the AMA and countless physician organizations have made
considerable progress in urging physicians to be more judicious in their prescribing decisions as the
above data show. The Board knows, however, that there is much more work to do before the
epidemic will end.
The AMA continues to stress the need for evidence-based decision making on the part of policymakers with respect to restrictions on opioid prescribing. Given that state policies have been the result of political negotiations rather than scientific evidence, it is possible that a course correction could be made. One such direction could be to follow the patient-centric recommendations of the U.S. Department of Health and Human Services, “Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations,” which includes among its many positive recommendations, support for:

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

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

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

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

AMA POLICY

AMA has extensive policy supporting the principle that utilization management policies, clinical practice guidelines and clinical quality improvement activities must be based on sound clinical evidence, data and allow for variation based on individual patient needs (e.g., Policy H-320.949, Clinical Practice Guidelines and Clinical Quality Improvement Activities). AMA policy also promotes patient access to comprehensive, multidisciplinary, multimodal pain care, including working with all stakeholders to promote research and develop evidence to support quality pain
care. This includes promoting safe opioid prescribing and promoting a public health approach to ending the nation’s opioid epidemic (e.g., Policy D-160.981, Policy H-95.990, “Promotion of Better Pain Care and Drug Abuse Related to Prescribing Practices”). And, it includes AMA strong support for “timely and appropriate access to non-opioid and non-pharmacologic treatments for pain, including removing barriers to such treatments when they inhibit a patient’s access to care.” (Policy D-450.956, “Pain as the Fifth Vital Sign.”) It should also be stressed that AMA’s efforts to reduce prior authorization burdens and protect patients’ access to medically necessary therapy extend far beyond only post-operative pain care (e.g., Policy H-320.939, “Prior Authorization and Utilization Management Reform” and the grassroots advocacy campaign based on the online hub, FixPriorAuth.org).

RECOMMENDATIONS

The Board recommends that the following recommendation be adopted in lieu of Resolution 208-A-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for state legislatures and other policymakers, health insurance companies and pharmaceutical benefit management companies to remove barriers, including prior authorization, to non-opioid pain care. (New HOD Policy)

2. That our AMA support amendments to opioid restriction policies to allow for exceptions that enable physicians, when medically necessary in the physician’s judgment, to exceed statutory, regulatory or other thresholds for post-operative care and other medical procedures or conditions. (New HOD Policy)

3. That our AMA oppose health insurance company and pharmacy benefit management company utilization management policies, including prior authorization, that restrict access to post-operative pain care, including opioid analgesics, if those policies are not based upon sound clinical evidence, data and emerging research. (New HOD Policy)

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/


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


