Oral and maxillofacial surgeons:
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American Association of Oral and Maxillofacial Surgeons

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June 9, 2021

Congresswoman Annie Kuster
Co-Chair
Bipartisan Addiction and Mental Health Task Force
Cannon House Office Building 320
Washington, D.C. 20515

Congressman Brian Fitzpatrick
Co-Chair
Bipartisan Addiction and Mental Health Task Force
1722 Longworth House Office Building
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Congressman David Trone
Co-Chair
Bipartisan Addiction and Mental Health Task Force
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Congresswoman Jaime Herrera Beutler
Co-Chair
Bipartisan Addiction and Mental Health Task Force
2352 Rayburn House Office Building
Washington, D.C. 20515

Dear Bipartisan Addiction and Mental Health Task Force Co-Chairs:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional association that represents more than 9,000 oral and maxillofacial surgeons (OMSs) in the United States, I applaud your work to create the Bipartisan Addiction and Mental Health Task Force. AAOMS supports your efforts to reduce opioid addiction and looks forward to working with you to achieve this goal.

Oral and maxillofacial surgery is the surgical specialty of dentistry. As such, management of our patients' pain following invasive procedures is an important aspect of providing the best quality patient care. As lawful prescribers, we know, when used appropriately, prescription opiates enable individuals with acute and chronic pain to lead productive lives and recover more comfortably from surgical procedures. We also recognize, however, that pain medication prescribed following oral and maxillofacial surgery is frequently the first exposure many American adolescents have to opioids, and roughly 12 percent of all immediate-release opioid prescriptions in the United States are related to dental procedures.[1]

Dentists, including OMSs, have a responsibility to ensure we do not exacerbate a growing public health risk while ensuring our patients receive the relief they need following complex dental procedures. We believe OMSs must demonstrate safe and responsible opioid prescribing for acute and postoperative pain in their patients, which includes accessing the state's prescription-drug monitoring program as well as educating the patient and family about potential risks – and the safe use, storage and disposal – of opioid analgesics.

[1] Denisco R, Kenna C, O'Neil M, et al. Prevention of prescription opioid abuse: The role of the dentist. JADA. 2011; 142(7): 800–810.

We are pleased to share with the task force the initiatives that AAOMS has taken over the last several years to ensure we are doing our part to reduce opioid abuse.

We believe the most important step to reduce usage of opioids for dental procedures is to educate our own membership about the potential for opioid abuse. These educational efforts implemented by AAOMS include:

- Published prescribing recommendations that urge non-narcotic pain medicine – rather than opioids – be utilized as a first-line therapy to manage a patient's acute and post-surgical pain.
- Partnered with SAMHSA and NIDAMED to create continuing education (CE) on opioid abuse and make it available to AAOMS members.
- Provide CE webinars and CE programs on opioid misuse and abuse.
- Promote the DEA's National Prescription Drug Take Back Days to AAOMS members.
- Developed an information card on the Safe Use and Disposal of Prescription Medications.
- Participate in and promote to AAOMS membership the Partnership for Drug-Free Kids Medicine Abuse Project.

Data, provided in the attached document, suggest these educational efforts are working. More specifically, 89 percent of OMSs surveyed have reduced the number of opioids prescribed for wisdom teeth extraction, while 97 percent of OMSs report that they do not refill a prescription following wisdom teeth extraction.

Despite the progress we have made as a specialty, we recognize that the country still faces huge challenges in overcoming the opioid epidemic and that new initiatives and policy changes will be needed. As you may be aware, the National Center for Health Statistics recently reported provisional data that showed the reported number of drug overdose deaths occurring in the United States increased by 26.8 percent from the 12 months ending in September 2019 to the 12 months ending in September 2020.[2] Clearly, the COVID-19 pandemic has worsened the opioid epidemic and now is not time to rest on our laurels.

As the Task Force works towards new policy goals, we would like to make the following recommendations should new legislation at the federal level be considered:

- **Continuing Education (CE)**
  - AAOMS supports CE, but to be most effective, it should be managed at the state level because CE has traditionally been under the purview of the states.
  - Any CE requirement should be appropriately proportionate to CE requirements for other topics and customized so it is relevant to each type of prescribing situation.
  - Any federal requirement should either exempt prescribers in states with existing requirements or supersede those state requirements so prescribers are not subject to duplicative requirements.
  - Provider specialty organizations (such as AAOMS) should be included as accepted practitioner training organizations for CE requirements.

- **Prescription Drug Monitoring Programs (PDMPs)**
  - AAOMS supports properly funded PDMPs that are updated in real time by dispensers and interoperate between states.

[2] Provisional Monthly Drug Overdose Deaths from September 2019 to September 2020. National Center for Health Statistics. Available at: https://nchstats.com/2021/04/14/provisional-monthly-drug-overdose-deaths-from-september-2019-to-september-2020/. Accessed June 5, 2021.

- Approved auxiliary personnel should be authorized to access the system on the practitioner's behalf.

- **Prescribing Initiatives**
  - AAOMS appreciates the development of prescribing guidelines. In 2017, AAOMS published prescribing recommendations for the management of acute and postoperative pain for the OMS patient that urge non-narcotic pain management – rather than opioids – be utilized as a first-line therapy to manage a patient's acute and post-surgical pain.
  - Any effort by government entities to develop prescribing guidelines should recognize the unique care provided by OMSs by involving them in the development process and avoiding a one-size-fits-all approach as pain management needs vary patient to patient.
  - Partially filling a prescription with the option to acquire the remaining amount only when necessary should be encouraged because this would lessen the risk of diversion of unused medications.
  - Any dosage limitation restrictions should allow provider discretion because the management of pain severity varies by procedure and patient.
  - Collaboration should occur with appropriate agencies to secure approval of innovative solutions for alternative pain management options, reducing the need for opioids. This would include pharmaceuticals, such as bupivacaine HCL, that extend the length of surgical site anesthesia.
  - Allow dentists to refer their Medicare patients directly to physical therapy. Current law requires that OMSs seek a referral from an allopathic or osteopathic physician and/or work with such a physician to establish a therapy plan when an OMS believes physical therapy should be part of a patient's treatment. Such consultation not only is inefficient and unnecessary, but costly to both Medicare and beneficiaries while delaying patient access to alternative pain management therapies.

AAOMS commends the task force on its efforts to curb the misuse of prescription drugs. As attachments to this letter, we have included our prescribing recommendations, *Opioid Prescribing: Acute and Postoperative Pain Management*, and survey data on prescribing trends among our membership. We welcome an opportunity to discuss these issues in detail and work with you to explore all possible solutions. Please contact Jeanne Tuerk, manager of the AAOMS Department of Governmental Affairs, at 800-822-6637 or jtuerk@aaoms.org for additional information.

Sincerely,

B.D. Tiner, DDS, MD, FACS
AAOMS President

Attachments

White Paper

American Association of Oral and Maxillofacial Surgeons

Opioid Prescribing: Acute and Postoperative Pain Management

Oral and maxillofacial surgeons must demonstrate safe and competent opioid prescribing for acute and postoperative pain in their patients. Responsible prescribing of opioids must be a priority, including accessing the state's prescription-drug monitoring program as well as educating the patient and family about potential risks – and the safe use, storage and disposal – of opioid analgesics. Because prescribing protocols evolve over time, practitioners also should stay informed of the latest public health trends, including possible alternatives to opioid pain treatment.

It is the position of AAOMS that the practitioner-patient relationship must be upheld, allowing for practitioner judgment in the management of a patient's pain – including drug types, dosages and treatment durations. Pain management decisions should be individualized and only determined after a careful assessment of the level of risk to – and condition of – the patient. While oral and maxillofacial surgeons should ultimately make all final prescribing decisions, the recommendations in this AAOMS White Paper are intended to provide direction and serve as a supportive resource.

Considerations and recommendations for the management of acute and postoperative pain include the following:

- A nonsteroidal anti-inflammatory drug administered pre-emptively may decrease the severity of postoperative pain.
- A perioperative corticosteroid (dexamethasone) may limit swelling and decrease postoperative discomfort after third-molar extractions.
- A long-acting local anesthetic (e.g., bupivacaine, etidocaine, liposomal bupivacaine) may delay onset and severity of postoperative pain.
- The oral and maxillofacial surgeon should avoid starting treatment with long-acting or extended-release opioid analgesics.
- Providers should prescribe non-steroidal anti-inflammatory drugs (NSAIDs) as first-line analgesic therapy, unless contraindicated. If NSAIDs are contraindicated, providers should prescribe acetaminophen (N-acetyl-p-aminophenol [APAP]) as first-line analgesic therapy.
- NSAIDs and APAP, taken simultaneously, work synergistically to rival opioids in their analgesic effect, but dosage levels and times of administration should be carefully documented to prevent overdosage.
- When indicated for acute breakthrough pain, consider short-acting opioid analgesics. If opioid analgesics are considered, start with the lowest possible effective dose and the shortest duration possible.
- When prescribing opioids, state law may require prescribers to access the state prescription drug-monitoring program (PDMP). If there is any suspicion of patient drug misuse, abuse and/or addiction, the OMS should access the PDMP. To assess for opioid misuse or addiction, use targeted history or validated screening tools.
- All instructions for patient analgesia and analgesic prescriptions should be carefully documented.
- When deviating from these prescribing recommendations – or those required by state laws or institutions – the oral and maxillofacial surgeon should document the justification for doing so.

Oral and maxillofacial surgeons also should:

- Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies and/or referral to specialists for follow-up, as clinically appropriate.
- Limit the prescriptions of opioid analgesics to patients currently taking benzodiazepines and/or other opioids because of the risk factors for respiratory depression.

- Inform patients that the recommended maximum daily dose of acetaminophen should not exceed 3,000 mg. To avoid potential APAP toxicity, an oral and maxillofacial surgeon choosing to prescribe an opioid should consider one that is ibuprofen-based.
- Counsel patients that the recommended maximum daily dose of ibuprofen is 3,200 mg. Note: Higher maximal daily doses have been reported for osteoarthritis while under the direction of a physician.
- Educate patients on the expectations of postoperative pain management and the anticipated levels of relief.
- Not prescribe acetaminophen with codeine to treat pain in children younger than 12. For more information, visit the FDA Drug Safety site.

For management of chronic pain, refer to the Centers for Disease Control's Guideline for Prescribing Opioids for Chronic Pain.

OMS Efforts to Prevent Prescription Drug Abuse

Oral and maxillofacial surgeons are part of the solution.

89%

Reduced opioid prescribing for wisdom teeth extractions

89 percent of OMSs have reduced the number of opioids prescribed for wisdom teeth extraction.

97%

Do not refill a prescription

97 percent of OMSs report they do not refill a prescription following wisdom teeth extraction.

72%

Prescribe ibuprofen

72 percent of OMSs report they prescribe ibuprofen alone or with an emergency supply of opioids for all OMS surgical procedures.

93%

Prescribe less than a 3-day supply

93 percent of OMSs prescribe less than a 3-day supply – up from 74 percent in 2017.

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Source: 2017, 2018 and 2019 AAOMS membership surveys