



Feb. 15, 2019

Vanila Singh, MD
Chair, Pain Management Best Practices Inter-Agency Task Force
U.S. Department of Health and Human Services
Office of the Assistant Secretary for Health
200 Independence Avenue SW Room 736E
Washington, DC 20201

Dear Dr. Singh:

On behalf of the American Association of Oral and Maxillofacial Surgeons (AAOMS), the professional organization that represents 9,500 oral and maxillofacial surgeons (OMSs) in the United States, I applaud the effort you and members of the Pain Management Best Practices Inter-Agency Task Force have undertaken over the last nine months to identify, review and propose updates to gaps or inconsistencies between best practices for pain management. We are pleased to offer comments to the task force in response to your *Federal Register* notice (83 FR 67729) on Dec. 31, 2018.

Clinical Best Practices 2.0 and Approaches to Pain Management 2.1

AAOMS appreciates the development of prescribing guidelines, which may be helpful to practitioners as they determine the proper course of postoperative treatment for their patients. In the absence of other prescribing guidelines, AAOMS developed our own prescribing recommendations in 2017 for the management of acute and postoperative pain for the OMS patient. These recommendations urge non-narcotic pain management as a first-line therapy to manage a patient's acute and postsurgical pain. Task force members identified under Section 2.1 that inconsistencies and fragmentation of pain care limit best practices and patient outcomes. AAOMS supports the task force's recommendation to address this gap by encouraging coordinated and collaborative care so long as the individual needs of each patient are recognized and the resulting efforts do not impede a practitioner's ability to lawfully provide pain relief to the patient.

Acute Care 2.1.1

We applaud the task force's broad description of acute pain because acute pain is complex and can stem from a variety of causes ranging from surgical to injury or trauma. Furthermore, what may start out as acute pain may easily evolve into chronic pain. AAOMS supports recommendations made in this section to encourage utilization of non-opioid therapies in the perioperative setting. As noted in the previous section, AAOMS prescribing recommendations urge non-narcotic pain management as a first-line therapy to manage a patient's acute and postsurgical pain. A number of our members also use alternative pain management techniques such as a non-opioid, postsurgical, long-acting local anesthetic on their patients. Insurance reimbursement for this and other alternative techniques often is lacking, which may negatively impact their utilization; therefore, AAOMS supports in particular recommendation

1c, which advocates appropriate reimbursement and authorization policies be developed to encourage multimodal approaches for acute care pain management in the perioperative and peri-injury setting.

AAOMS also supports the report's recommendation for the development of multimodel guidelines for the clinical management of acute pain associated with common surgical procedures and trauma management, including the CDC's *Guideline for Prescribing Opioids for Chronic Pain*, so long as such guidelines do not inhibit the patient-practitioner relationship or limit the practitioner from having the final say regarding the management of a patient's pain, including drug types, dosage and treatment duration.

Medication 2.2

AAOMS recognizes that prescribing guidelines may be helpful to practitioners as they determine the proper course of postoperative treatment for their patients. However, AAOMS encourages any guidelines to recognize the unique care provided by OMSs by involving them in the development process and avoid a one-size-fits-all approach as pain management needs vary from patient to patient. AAOMS specifically applauds recommendations 2b and 2c, which encourage physicians and other healthcare providers to utilize evidence-informed guidelines when considering opioid treatment and that "the type, dose and duration of opioid therapy should be determined by the treating clinicians according to the individual patient's need and pain condition."

AAOMS also supports recommendations under this section that encourage safe medication storage and disposal of excess medication. AAOMS has advocated for expanding take-back locations to make it easier for patients to discard unused medication. We also publicize and encourage our members to promote take-back initiatives to their patients. Finally, AAOMS was an early advocate for allowing partial fills of prescriptions to reduce waste and potential diversion.

2.2.1.1 PDMPs

AAOMS agrees with the task force that PDMPs can play an important role in identifying opioid misuse and diversion by patients as well as leading to informed prescribing once the clinician has a full picture of a patient's medication history. AAOMS also agrees with the task force that prescribers are more likely to use PDMPs that provide data in real time, are easy to use, identify potential issues of concern (such as multiple prescriptions or prescribers) and do not impose burdensome time constraints. AAOMS supports, in particular, recommendations under this section that call for enhanced clinician training on accessing and interpreting PDMP data, allow the healthcare provider team to determine when to use the PDMP and advocate against PDMP mandates without proper clinical indications to avoid unnecessary burdens in the inpatient setting. With regard to this last recommendation, AAOMS believes it should be amended also to include the outpatient setting, as PDMP checking can be very time-consuming for clinicians who perform routine office-based surgery throughout the day that may necessitate opioid prescribing. Furthermore, we support the report's recommendation for enhanced PDMP interoperability across state lines as well as within and outside federal healthcare entities. Finally, we applaud the recommendation that EHR vendors integrate PDMP data with their systems at no additional cost to providers, helping minimize prescriber barriers to accessing PDMP data.

3.2.2 Patient Education

AAOMS believes educating patients about the nature of their pain – whether acute or chronic – and options for managing it can play an essential role in reducing opioid abuse. AAOMS supports recommendations 1a and 2a to prioritize patient access to education tools and encourage provider discussion about postsurgical pain management during the preoperative visit. In fact, AAOMS has made available a variety of patient education resources and encouraged our members to disseminate them to their patients.

3.2.3 Provider Education

AAOMS applauds the task force's recognition that clinical education is most effective when a variety of media and instructional techniques are used and it is tailored to both the type and skill level of the practitioner. AAOMS is committed to educating our membership about the potential for opioid abuse. Likewise, we have offered or encouraged our members to participate in education, including CE courses presented through federal agencies in a variety of formats – from webinars to educational pamphlets and in-person programs at our Annual Meeting. Furthermore, AAOMS supports provider education starting at the dental or medical school level and continuing through residency and into practice. Furthermore, AAOMS believes professional associations similar to ours can play a leading role in tailoring education to the types of real-world prescriber-patient scenarios that occur, making such education more effective.

3.3.1 Medication Shortage

Similar to other healthcare professionals, AAOMS members have been impacted over the years by shortages of various intravenous and oral drugs. AAOMS supports the three recommendations of this section that suggest FDA monitor, report or prioritize availability of key opioid and nonopioid medications, make available alternative sources for such drugs when shortages do occur and support the Agency Drug Shortages Task Force in its mission to find solutions to prevent critical drug shortages.

3.3.2 Insurance Coverage for Complex Management Situations

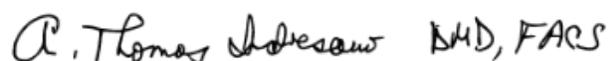
As previously noted, long-acting analgesia site injections during surgery may reduce or even eliminate the need for postsurgical opioid pain management. Insurance companies do not always reimburse for these methods, making patients responsible for the cost of such medications. AAOMS supports recommendation 3a for CMS and other payers to align their reimbursement guidelines for nonopioid pharmacological therapies with current clinical practice guidelines.

Recognition of Dentists as Prescribers

By failing to reference dentists alongside our medical colleagues throughout the report, the task force overlooks the role of dentists in managing patient pain, particularly in the post-surgical dental setting. As lawful prescribers, our members take seriously their role in providing pain relief and want to be part of the solution to the nation's opioid abuse epidemic. Adequately referencing dentists throughout the report sends the message that government and stakeholder entities value the role dentists can play in reducing prescription drug abuse. Therefore, unless the context in the report dictates otherwise, AAOMS requests that where "physician" or "medical" is used, "dentist" and "dental" be used alongside or that "physician" be defined early in the report to include dentists, which is the definition used by the Joint Commission and the Centers for Medicare and Medicaid Services.

Again, AAOMS appreciates the time and expertise task force members have contributed to this important report. We hope the appropriate decision-makers will take seriously your recommendations and work toward best ways to implement them. Furthermore, we welcome an opportunity to discuss these issues in greater detail. Please contact Jeanne Tuerk, manager of the AAOMS Department of Governmental Affairs, at 800-822-6637 or jtuerk@aaoms.org for additional information.

Sincerely,



A. Thomas Indresano, DMD, FACS
AAOMS President