AAOS
American Academy of Orthopaedic Surgeons
American Association of Orthopaedic Surgeons

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Hon. Orrin Hatch
Chairman
Committee on Finance
United States Senate
Washington, DC 20510

Hon. Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of more than 34,000 orthopaedic surgeons and residents, the American Association of Orthopaedic Surgeons (AAOS) commends the Senate Committee on Finance for recognizing the need to address the opioid epidemic devastating so many patients, families, and communities. The AAOS acknowledges this catastrophic problem and believes that comprehensive reforms must be initiated with input and assistance from all stakeholders. To be successful, stakeholders need to work together to increase research and funding for alternative pain management techniques; improve prescription monitoring; and create more effective education programs for clinicians and patients. For these reasons, the AAOS is working on several initiatives – from public service announcements to a pain relief toolkit – to encourage our members to practice safe and effective pain management and treatment.

Here we address the Committee's specific questions:

1. How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDs?

   Historically, implementing clinical practice guidelines that promote care improvement has been a challenge, but the AAOS has been the leader in developing several evidence-based clinical practice guidelines, with specific recommendations that it believes can have a significant impact on reducing patients' need for narcotic pain medications. A considerable challenge has been a mismatch between the size of incentives and the investment to measure quality targets[1]. Physicians and caregivers need to integrate performance improvement in pain management and screening and treatment for substance use disorders into new delivery model quality metrics. Questions about satisfaction with pain relief and pain medication may not be optimal quality measures.[2] We believe that payment incentives for higher scores on the Pain Management dimension of the HCAHPS survey may have created the unintended consequence of overprescribing opioids in the inpatient setting. This scoring system of "Pain as a Fifth Vital Sign" created a culture of opioid expectation among patients that made discontinuation of narcotics challenging. We appreciate the change in the Pain Management category of HCAHPS. Making evidence-based medicine, developed by medical and surgical specialties, a central part of Medicare and Medicaid programs will help mitigate patients' risk for OUD and SUD.

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Of particular concern to Medicare and Medicaid, osteoarthritis (of any joint) was the primary diagnosis that led to 11.3 million ambulatory care visits in 2009. It was estimated that 9.9 million adults had symptomatic osteoarthritis of the knee in 2010.[3] Aging baby boomers, rising obesity rates, and greater emphasis on staying active among the elderly population suggest that the emotional and physical impact of knee osteoarthritis will continue to be widespread.[3] With rising life expectancy, it is estimated that the prevalence of hip osteoarthritis will continue to increase. The number of people older than age 65 years is expected to increase from 37.1 million to 77.2 million by the year 2040.[4] Patients in this population present frequently with chronic pain and functional limitations, putting them at risk, if treated improperly, for OUD and SUD. It is imperative that clinicians and other healthcare providers treating these patients are equipped with the latest evidence-based treatment options. And, it is important that these efforts continue to be physician-led and patient-centric, which is why the AAOS has developed clinical practice guidelines (CPGs), appropriate use criteria (AUC), performance measures, and patient safety initiatives to empower orthopaedic surgeons to be leaders in delivering evidence-based, cost efficient musculoskeletal care. Below is a summary of some of the evidence-based orthopaedic-specific recommendations that will improve quality care with less reliance on opioids:

- Physical therapy has been shown to improve pain relief and, more importantly, improve functional outcomes, without relying on opioid medications.
  - Management of Hip Fractures in the Elderly[5]
    - Strong evidence supports intensive home physical therapy to improve functional outcomes. The delivery and implementation of this therapy vary, but the benefits of rehabilitative services are demonstrated in a variety of settings and across the continuum of care. There is no harm associated with implementing this recommendation.
    - Moderate evidence supports supervised occupational and physical therapy across the continuum of care, including home, to improve functional outcomes and fall prevention.
      - Further studies to establish more precise dosages and durations of rehabilitative therapies, as well as to determine the most appropriate settings would be beneficial.
    - Strong evidence supports use of an interdisciplinary care program in those patients with mild to moderate dementia who have sustained a hip fracture to improve functional outcomes.
  - Treatment of Osteoarthritis (OA) of the Knee (2nd Edition)[3]
    - Strong Evidence supports patients with symptomatic osteoarthritis of the knee participate in self-management programs, strengthening, low-impact aerobic exercises, and neuromuscular education; and engage in physical activity consistent with national guidelines.

        - Exercise interventions were predominantly conducted under supervision, most often by a physical therapist. The self-management interventions were led by various healthcare providers including rheumatologists, nurses, physical and occupational therapists, and health educators. The evidence supports the use of self-management programs in primary care patients with knee osteoarthritis.
        - Statistically significant and clinically important improvements were reported for VAS Pain, WOMAC Pain, and WOMAC Function scores.
    - Management of Osteoarthritis of the Hip[4]
        - Strong evidence supports the use of physical therapy as a treatment to improve function and reduce pain for patients with osteoarthritis of the hip and mild to moderate symptoms.
        - A meta-analysis concluded Strong evidence supports the cumulative positive effect of physical therapy on functional outcomes and pain up to nine months after treatment initiation.
- Multimodal Pain Management
    - Non-narcotic therapies and/or non-pharmaceutical therapies should be considered as first-line treatment options or in combination with judicious opioid use. We support additional research and increased funding for other non-narcotic and/or non-pharmaceutical, including nutritional, alternatives for pain management. In certain instances, these alternatives may be the most clinically appropriate and cost-effective treatment options.
    - Management of Hip Fractures in the Elderly[5]
        - Strong evidence supports multimodal pain management after hip fracture surgery.
        - Neurostimulation, local anesthetics, regional anesthetics, epidural anesthetics, relaxation, combination techniques, and pain protocols have been shown to reduce pain as well as improve satisfaction, improve function, reduce complications, reduce nausea and vomiting, reduce delirium, decrease cardiovascular events, and reduce opiate utilization. There are a large variety of techniques that result in modest but significant positive improvements in many clinical and patient-centered domains with minimal significant adverse outcomes. Using an array of pain management modalities is appropriate.
    - Surgical Management of Osteoarthritis of the Knee[6]
        - Strong evidence supports that peripheral nerve blockade for total knee arthroplasty (TKA) decreases postoperative pain and opioid requirements.
    - Management of Osteoarthritis of the Hip[4]

        - Strong evidence supports that NSAIDs improve short-term pain, function, or both in patients with symptomatic osteoarthritis of the hip.
    - Treatment of Distal Radius Fractures[7]
        - Ultrasound and/or ice are options for adjuvant treatment of distal radius fractures. A study examining the effect of low-intensity ultrasound reported statistically significant improvement in number of patients with no pain and radiographic union.
        - Studies found a significant reduction in the incidence of complex regional pain syndrome after treatment of distal radius fracture when the patients were given supplemental Vitamin C.

2. What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid? How can those barriers be addressed to increase utilizations of those non-pharmaceutical therapies when clinically appropriate?
    - Medicare payment cap for therapy services
        - We support permanent repeal the outpatient therapy caps beginning on January 1, 2018. As mentioned above, physical and occupational therapy are evidenced-based treatments with the potential to reduce patients' need for addictive opioids. An arbitrary cap on PT/OT services without regard to the evidence could create a situation in which a patient's access to care is limited.
    - Increase access and coverage of comprehensive, multimodal pain management
        - The AAOS believes physicians' enhanced understanding of opioid analgesics and alternative, multimodal pain management techniques would lead to better patient outcomes. Payers and employers need to improve access to these kinds of treatment for pain, as well as medication assisted treatment for substance use disorders.

3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?
    - The AAOS believes mental health screening needs to be part of patients' treatment protocols. Moderate strength evidence supports that mental health disorders, such as depression, anxiety, and psychosis, are associated with decreased pain relief and quality of life outcomes in patients with symptomatic osteoarthritis of the hip who undergo total hip arthroplasty (THA).[4]
        - Rolfson and Dahlberg, et al[8], analyzed 6,158 Swedish Registry patients to determine that the EQ-5D anxiety/depression domain was highly predictive for pain relief and patient satisfaction after THA. Using the WOMAC and SF-36 Short Form, Gandhi, et al[9] demonstrated that older age, year of follow-up, and greater comorbidity were

negative prognostic indicators for THA function, and proposed that risk assessment data may be effectively utilized to set realistic patient expectations after THA.

- Pre-operative substance abuse screening
    - Surgical patients using opioids preoperatively have higher complications rates, require more narcotics postoperatively, and have lower satisfaction rates with poorer outcomes following surgery, suggesting the potential benefit of psychological and opioid screening with a multidisciplinary approach that includes weaning of opioid use in the preoperative period and close opioid monitoring postoperatively.[10]
- Predictive Opioid Use/Misuse/Abuse Tools
    - Physicians and care providers need to identify patients at greater risk opioid misuse and abuse (e.g., using the opioid risk tool http://www.mdcalc.com/opioid-risk-tool-ort-for-narcoticabuse/), along with patients with symptomatic depression and ineffective coping strategies, prior to elective surgery. Physicians, the public, and policy makers should value interventions to lessen stress, improve coping strategies, and enhance support for patients recovering from injury or surgery.

4. Are there changes to Medicare and Medicaid prescription drug programs rules that can minimize the risk of developing OUD and SUD while promoting efficient access to appropriate prescriptions?
    - Improved Care Coordination and Opioid Use Tracking
        - It should be possible for a surgeon and pharmacist to see all prescriptions filled in all states by a single patient. A single prescribing physician/surgeon/practice should coordinate a patient's opioid treatment protocol, especially when dealing with patients who have ongoing/chronic pain issues. Doctors in emergency departments or other consulting physicians can determine appropriate exceptions by contacting the prescribing physician/surgeon/practice.
    - Prescription Limits
        - A prescription should only include the amount of pain medication that is expected to be used and deemed appropriate by the prescriber and based on a practice-level protocol.
        - AAOS is concerned that national standards without the requisite evidence could inappropriately limit patients' access to necessary pain management.
        - Medical and surgical specialties should be responsible for developing opioid protocols and/or guidelines specific to their fields of care so that patients are not inappropriately denied treatment. Unfortunately, there have been several instances where guidelines or recommendations have been misinterpreted, resulting in situations where patients have faced periods of inadequate pain management.

- Even as healthcare providers and regulators take steps to address the problem of opioid abuse, they must recognize that, in certain settings and for certain conditions, patients with terminal conditions and other appropriate indications should have access to opioid analgesics to manage their pain.
- AAOS maintains that it is unreasonable to expect physicians to solve the opioid crisis during an acute pain episode. It is important to distinguish between chronic and acute pain when regulating narcotic use. For example, states are restricting narcotics (e.g., the 7-day rule) and have mandated DEA logging for each narcotic prescription. These stop-gap regulations place extraordinary burden on patients and physicians treating acute pain in the post-operative period, when narcotics are necessary and warranted. Physicians often need to increase pain medication dosing as patients become more active in the days following hospital discharge. This leads patients to prematurely complete the 7-day supply.
- The AAOS supports perioperative exemptions to allow surgeons to appropriately manage pain. This is becoming increasingly important as same-day and outpatient procedures rely on adequate pain control to reduce the chance of readmission.

5. How can Medicare or Medicaid better prevent, identify, and educate health professionals who have high prescribing patters of opioids?
    - Continuing Medical Education (CME) for Physicians
        - Physician and caregiver awareness of the risks and appropriate uses of opioid medications is important. AAOS encourages development of effective education programs for physicians, caregivers, and patients. Periodic CME on opioid safety and alternative pain management strategies will help physicians reduce opioid use and misuse.
        - Provider requirements vary from state to state and different medical specialties require education tailored to meet the needs of their respective patients. A one-size-fits-all approach poses significant challenges and may have unintended consequences.
        - AAOS believes that medical professional organizations are best positioned to provide relevant and meaningful education to its members and patients.
        - AAOS is currently developing CME in this area.

6. What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as Prescription Drug Monitoring Programs?
    - AAOS supports the *MONITOR Act*, which would establish minimum standards that PDMPs must meet to receive funding from the State Targeted Response to the Opioid Crisis Grants. The legislation mandates that PMDPs must meet a uniform electronic format for reporting, increase sharing and disclosing of information, meet minimum standards for interoperability, and make information available to physicians on a timely

basis. By ensuring prescription information relating to opioids and other controlled substances is available in an easy-to-read system, interoperable across state lines, and available in a timely manner, prescribers will be able to access the most accurate and up-to-date information to help them make the best clinical decisions for their patients.

- E-prescribing: The AAOS strongly believes that electronic prescribing of medications promotes patient safety. E-prescriptions for all opioids would help not only appropriate use and patient convenience, they would provide data in a format that could provide better surveillance of excessive, inappropriate, and non-therapeutic prescribing.
    - The *Every Prescription Conveyed Securely Act* would aid orthopaedic surgeons in addressing this issue by requiring electronic prescriptions for controlled substances under Medicare Part D, including oxycodone, fentanyl, morphine, and hydrocodone. By requiring prescribers to use an online database where prescriptions are easily monitored and tracked, this bill could help eliminate doctor shopping and duplicative or fraudulent handwritten prescriptions that fuel the opioid epidemic.

Again, the AAOS commends the Committee for taking steps to address the opioid epidemic. Please feel free to contact Catherine Hayes, AAOS Senior Manager of Government Relations (hayes@aaos.org), if you have any questions or if the AAOS can serve as a resource to you.

Sincerely,

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Additional AAOS resources

- AAOS Pain Relief Toolkit: https://www.aaos.org/Quality/PainReliefToolkit/

- AAOS Information Statement on “Opioid Use, Misuse, and Abuse in Orthopaedic Practice”: https://www.aaos.org/uploadedFiles/PreProduction/About/Opinion_Statements/advistmt/1045%20Opioid%20Use,%20Misuse,%20and%20Abuse%20in%20Practice.pdf
- AAOS Evidence-Based Clinical Practice Guidelines: https://www.aaos.org/cpg/
- AAOS PSA on Opioids: https://orthoinfo.aaos.org/en/treatment/prescription-safety/

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3. Treatment of Osteoarthritis of the Knee Evidence-based Clinical Practice Guideline 2nd Edition http://www.orthoguidelines.org/topic?id=1005
4. Management of Osteoarthritis of the Hip Evidence-based Clinical Practice Guideline http://www.orthoguidelines.org/topic?id=1021
5. Management of Hip Fractures in the Elderly Evidence-based Clinical Practice Guideline - http://www.orthoguidelines.org/topic?id=1017
6. Surgical Management of Osteoarthritis of the Knee Evidence-based Clinical Practice Guideline - http://www.orthoguidelines.org/topic?id=1019
7. Treatment of Distal Radius Fractures Evidence-based Clinical Practice Guideline - http://www.orthoguidelines.org/topic?id=1003
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