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Captain Christopher M. Jones, PharmD, DrPH, MPH
U.S. Public Health Service
Acting Director
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
4770 Buford Highway, NE
Atlanta, GA 30341

RE: Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids (Docket No. CDC-2022-0024)

Dear Captain Jones:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I appreciate the opportunity to provide comments to the Centers for Disease Control and Prevention (CDC) on the proposed *Clinical Practice Guideline for Prescribing Opioids—United States, 2022* (Proposed Guideline). The Proposed Guideline makes several positive changes to the CDC’s *Guideline for Prescribing Opioids for Chronic Pain — United States, 2016* (2016 Guideline). **The AMA strongly supports the CDC’s removal of specific dosage and day limits for an appropriate opioid prescription in the recommendations in the Proposed Guideline and urges CDC to finalize their removal.** The AMA also strongly supports the CDC’s emphasis on patient-physician shared decision-making and the many areas within the Proposed Guideline calling for individualized patient care decisions. These were largely absent from the 2016 Guideline. We are similarly pleased that CDC acknowledges throughout the Proposed Guideline that the rigid limits of the 2016 Guideline have been widely misapplied and resulted in widespread harm to patients with pain, including care delayed and denied, and even death by suicide.

To build on the Proposed Guideline’s strengths, we ask the CDC to join the AMA in urging all relevant state, national and federal stakeholders, including legislatures, regulators, health plans, pharmacy chains, and pharmacy benefit management companies (PBMs) to remove all vestiges of inflexible numeric thresholds based on the 2016 Guideline. The revised guideline, when published, should have a disclaimer on every page that the CDC’s recommendations should *not* be used or interpreted as an inflexible law or policy, and that any reference to specific prescribing or treatment decisions are for illustrative purposes only and should not be deemed a standard of care or inflexible threshold. The AMA encourages CDC to go further with its disclaimer by saying that the CDC opposes the use of its recommendations to justify any law or policy with a specific threshold.

In addition to the changes to the CDC recommendations, the AMA urges CDC to undertake a national marketing and communications campaign to make clear to the general public, law enforcement, and all health care professionals that the final CDC 2022 Guideline should not be “a replacement for clinical judgment or individualized, person-centered care.” This would help to restore the balance in pain care to

show that opioid therapy is a legitimate form of treatment. It also would show that physicians who prescribe opioid therapy do so in the best interests of their patients. It would send an important signal that patients who benefit from opioid therapy are like any other patient who benefits from a prescription medication. Removing the rigid policies based on the 2016 Guideline will not undo the damage, but these are essential steps to help remove stigma for patients with pain and support individualized pain care decisions, including opioid therapy when indicated.

Overview of AMA Comments

The AMA provides specific comments on each recommendation in the Proposed Guideline below, but we begin with an overarching review for your consideration.

In sharp contrast to the 2016 Guideline, it is extremely important that there are no references in the Proposed Guideline’s recommendations to a quantity or dose of morphine milligram equivalent (MME) opioid analgesics that should not be prescribed, nor that such prescriptions be limited to a specific number of days. The AMA supports this. The report’s narrative text, however, does reference a 50 MME threshold in multiple places. These references are concerning for several reasons, including the perception that while CDC has removed the inflexible numeric thresholds from the recommendations, CDC may be tacitly encouraging use of a universal 50 MME threshold—references that despite CDC’s opposition to using numeric thresholds—will be misapplied once again. These “50 MME” references, moreover, appear to be the type of evidence that CDC says is of low quality¹ and subject to significant limitations. The references to 50 MME should be removed from the final 2022 Guideline. If they are not removed, then the AMA recommends that CDC include a disclaimer on every page of the final 2022 Guideline that CDC strongly opposes use of this numeric threshold in any policy.²

The Proposed Guideline appropriately places increased emphasis on assessing the benefits and risks of opioid therapy on an individual patient basis rather than the one-size-fits-all approach in the 2016 Guideline. There is extensive encouragement for clinicians to undertake individualized risk-benefit analysis in the 2022 guideline with respect to starting, continuing, or tapering opioid therapy. The 2016 Guideline also discussed risk, but generally argued there was greater risk of harm for opioid therapy across the board with negligible consideration of benefits. The AMA is pleased that the Proposed Guideline discusses shared decision-making in a much more positive manner than the 2016 Guideline. For example, the Proposed Guideline states: “Clinicians and patients should work together to identify

¹ The categories include type 1 evidence (randomized clinical trials or overwhelming evidence from observational studies), type 2 evidence (randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies), type 3 evidence (observational studies or randomized clinical trials with notable limitations), and type 4 evidence (clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations).

² Examples of policies: Optum: <https://professionals.optumrx.com/resources/notice-resources/opioid-safety.html>; United: <https://www.uhcprovider.com/content/dam/provider/docs/public/resources/pharmacy/opioids/Provider-opioid-qrg-2020.pdf>; Walmart: [https://corporate.walmart.com/media-library/document/walmart-efforts-to-address-opioid-crisis/ proxyDocument?id=00000175-51cb-dca8-ad77-73cfbf9c0000#:~:text=We%20restrict%20initial%20acute%20opioid,MME%E2%80%9D\)%20maximum%20per%20day.&text=Protecting%20Against%20Diversion%20%26%20Theft%20Walmart.diversion%20and%20theft%20of%20Opioids](https://corporate.walmart.com/media-library/document/walmart-efforts-to-address-opioid-crisis/ proxyDocument?id=00000175-51cb-dca8-ad77-73cfbf9c0000#:~:text=We%20restrict%20initial%20acute%20opioid,MME%E2%80%9D)%20maximum%20per%20day.&text=Protecting%20Against%20Diversion%20%26%20Theft%20Walmart.diversion%20and%20theft%20of%20Opioids); CVS: https://www.caremark.com/portal/asset/Opioid_Reference_Guide.pdf; BCBS-NC: <https://mediacenter.bcbsnc.com/news/blue-cross-nc-announces-new-opioid-prescription-and-treatment-policies#:~:text=Effective%20April%201%2C%20Blue%20Cross.is%20clinically%20indicated%20and%20appropriate; Aetna: https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/illinois/providers/pdf/Opioids-IL-PA-Guideline-ua.pdf>.

treatment goals and tailor an approach that considers both the benefits and risks of available options. Progress should be monitored over time and treatment protocols adjusted accordingly.”

The AMA supports the Proposed Guideline’s specific reference to addressing health inequities faced by historically marginalized and minoritized patient populations. The 2016 guideline did not mention equity. An additional consideration for the Proposed Guideline could include concrete recommendations on how to directly address racism as well as acknowledge and repair past harms. A good place to start is to incorporate considerations for patients with pain in the CDC’s “Promoting Health Equity” efforts.³ While acknowledging equity-based principles for overdose, there does not appear to be consideration for patients with pain. The AMA would be pleased to work with CDC to enhance its efforts in these areas.

The AMA appreciates that the Proposed Guideline recognizes that the nation’s drug overdose epidemic is being fueled by illicit fentanyl, methamphetamine, cocaine, and counterfeit pills. It is important for the CDC to take further action on this point by explicitly acknowledging that patients who benefit from opioid therapy are not the cause of the nation’s drug overdose epidemic. We also urge CDC to recognize that people who use drugs non-medically do so for a variety of reasons, including seeking relief from untreated or undertreated pain. The AMA strongly supports all efforts to reduce harmful drug use, communicate broadly about the nation’s contaminated illicit drug supply, and do so in a public health-based approach that encourages evidence-based treatment and harm reduction.⁴ Despite trends showing growing concern about heroin and illicit fentanyl, the 2016 Guideline did not address this. As a result, the 2016 Guideline has created a toxic atmosphere for patients with pain who benefit from opioid therapy while not fully addressing broader issues. And even though illicitly manufactured fentanyl currently is the main driver of the epidemic, the AMA recognizes that there are other emerging drugs of abuse. The AMA supports CDC’s efforts to make it clear that the nation’s drug overdose epidemic is complicated, fueled by the many different types of illicit substances, and growing more deadly.⁵

We believe that the CDC needs to go further in order to help remove the stigma of opioid therapy for all patients. We appreciate that the CDC has “exempted” patients with cancer, at the end of life, and with sickle cell disease from the recommendations. This is appropriate, but the 2016 Guideline has been so widely misapplied as to deny, delay, and non-consensually taper care for patients with pain in an indiscriminate manner. We, therefore, urge CDC to include specific statements in the introduction that patients with pain may benefit from opioid therapy even if they do not fall into one of the exempted categories.

³ Promoting Health Equity. U.S. Centers for Disease Control and Prevention. Last accessed April 4, 2022. Available at <https://www.cdc.gov/drugoverdose/health-equity/info.html>.

⁴ “2022 a critical year to address worsening drug-overdose crisis.” January 11, 2022. In a Leadership Viewpoint, AMA Chair Bobby Mukkamala, MD, discusses the multiple aspects to harm reduction, including removing the prescription status of naloxone, enhancing access to sterile needle and syringe services programs, decriminalizing drug checking supplies such as fentanyl test strips, and other measures to reduce mortality and the spread of infectious disease. Available at <https://www.ama-assn.org/about/leadership/2022-critical-year-address-worsening-drug-overdose-crisis>.

⁵ The AMA appreciates, for example, the CDC’s launch of a campaign to “provide information about the prevalence and dangers of fentanyl, the risks and consequences of mixing drugs, the life-saving power of naloxone, and the importance of reducing stigma around drug use to support treatment and recovery.” See, CDC Launches New Education Campaigns Aimed at Preventing Drug Overdose Deaths. October 27, 2021. Available at <https://www.cdc.gov/media/releases/2021/p1027-Preventing-Drug-Overdose-Deaths.html>.

The Proposed Guideline’s recommendations positively emphasize the need for individualized patient care decisions. The AMA strongly supports and applauds CDC for making this clear. We are extremely pleased that CDC listened to the concerns expressed by the AMA, dozens of medical societies, patient advocates, and thousands of patients with pain on this issue. As discussed below, the AMA also supports changes in several recommendations that were positively changed to place increased emphasis on individual assessment of risks and benefits rather than a sole focus on a numeric dose or quantity of an opioid analgesic. **We urge CDC to join the AMA in taking the next logical step to urge the removal of all policies that do not support individualized patient care decisions.** The Proposed Guideline *says* that there should not be any policies based on inflexible thresholds, but the agency needs to go further than this statement.

As it finalizes the Proposed Guideline, the CDC should outline in detail what actions it intends to take to engage policymakers and other stakeholders in removing the inflexible thresholds from laws, regulations, and policies. Just as the CDC undertook a comprehensive marketing and communications campaign to promote the 2016 Guideline, we urge the CDC to undertake now a similar campaign on behalf of patients with pain. This campaign should emphasize, among other things, the need to remove rigid, numeric thresholds from all policies as well as strongly support individualized patient care decisions. The national communications and marketing campaign also should emphasize the important principle stated by CDC that *“Payers, health systems, and state medical boards should not use this clinical practice guideline to set rigid standards related to dose or duration of opioid therapy, and should ensure that policies based on cautionary dosage thresholds do not result in rapid tapers or abrupt discontinuation of opioids, and that policies do not penalize clinicians for accepting new patients who are using prescribed opioids for chronic pain, including those receiving high doses of opioids.”* These actions by CDC are essential to help patients with pain.

The Proposed Guideline is intended to apply to all types of pain, but the AMA is not certain that this will help all patients with pain. The 2016 Guideline intended only to address chronic pain, and it has wreaked havoc on all patients with pain because of its widespread misapplication. With the Proposed Guideline’s focus on acute, subacute, and chronic pain, the AMA is very concerned that the misapplication of the 2016 Guideline will harm even more patients. Aside from mention of sickle cell disease, the Proposed Guideline and the 2016 Guideline have the same exceptions. The exceptions are for cancer, hospice, and palliative care. As noted above, patients with these conditions and many other conditions have faced nonconsensual tapers and denials of care from pharmacies, health insurers, and PBMs based on the 2016 Guideline despite the stated exceptions.

The AMA does not see how adding more general pain categories to which the Proposed Guideline will apply while only adding one additional disease state to those exempted will make anything clearer. Rather, just as there were numerous predictable and harmful consequences of the 2016 Guideline, we are gravely concerned that the Proposed Guideline will further muddy the waters. For example, the AMA has received and is aware of thousands of reports of primary care physicians who no longer prescribe opioid therapy because of the fear of investigation based on exceeding the 2016 Guideline. It is not unreasonable to conclude that by extending the Proposed Guideline to acute, sub-acute, and chronic pain, an even greater number of physicians will decide to no longer provide opioid therapy because inappropriate policies based on the 2016 Guideline already are law or policy in nearly every state. The AMA does not have an easy answer for this except to reemphasize that as long as policies based on the 2016 Guideline are in statute, rule or policy, patients with pain will suffer.

The AMA supports the increased consideration in the Proposed Guideline for individuals who are pregnant, postpartum, and parenting. The 2016 Guideline included some information, but the

Proposed Guideline provides additional guidance that relies heavily on evidence-based resources from the American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and other medical societies. This reliance on professional medical associations is very welcome, although greater emphasis could be placed on the needs of a pregnant individual with pain and not solely the risks of opioid therapy to a pregnant individual and the fetus or newborn. The distinction is an essential one in that the fact of a pregnancy does not automatically mean opioid therapy for pain is no longer appropriate. Moreover, there are many reports of pregnant and parenting individuals being discriminated against for using medications to treat opioid use disorder. The Proposed Guideline provides clear information, but we urge CDC to go further and stress that pregnant, postpartum, and parenting individuals deserve the highest levels of compassionate, evidence-based care for pain or opioid use disorder. Furthermore, we urge CDC to make clear that decisions to use medications for opioid use disorder (MOUD) or opioid therapy are best made in a shared decision-making process that is individualized to the patient. As discussed further below, we similarly urge CDC to make clear that withholding MOUD or opioid therapy when indicated and recommended by an individual's physician should never occur. These clear statements will help reduce stigma and improve care.

The AMA strongly agrees with the CDC about the need for greater availability and widespread use of naloxone to save lives. Our Task Force developed an issue brief several years ago identifying the overdose risks that warrant dispensing naloxone to patients and others in a position to help.⁶ The AMA also has broadened our policy and advocacy to urge the Administration to take additional action to support removing the prescription status of naloxone and making it available over-the-counter.⁷ Increasing the availability of naloxone in the community is perhaps the greatest need to save lives from overdose. That is why we are concerned that the Proposed Guideline largely ties risk of overdose to opioid prescriptions greater than 50 MME. This could have the unintended consequence of suggesting that the existence of an opioid prescription is the only risk factor for an opioid-related overdose. Just as the 2016 Guideline created the inappropriate and misleading stigma that patients who benefit from opioid therapy were the cause of the nation's drug overdose epidemic, we urge CDC to not make this mistake with naloxone. Rather than limiting the focus of who benefits from naloxone to a specific MME, we urge CDC to broaden the discussion to stress that naloxone benefits all those at risk of overdose, and the greatest need for naloxone is in the community.

The AMA agrees with the need for increased access to multimodal, multidisciplinary therapies to help patients with pain. Just as in the 2016 Guideline, the Proposed Guideline makes this point as well. Unfortunately, the Proposed Guideline only includes limited recognition of the barriers to access these therapies, including prior authorization, step therapy, and limited benefit and formulary design. These are the barriers imposed by health insurance companies, other payors, and PBMs—barriers that have not been reduced since the 2016 Guideline. As noted throughout this comment letter, the AMA supports patients' access to opioid therapy when clinically indicated. We similarly support increased access to evidence-based treatment, including:

⁶ Help save lives: Co-prescribe naloxone to patients at risk of overdose. AMA Substance Use and Pain Care Task Force. Available at <https://end-overdose-epidemic.org/wp-content/uploads/2020/05/AMA-Opioid-Task-Force-naloxone-one-pager-updated-August-2017-FINAL-1.pdf>.

⁷ Letter from AMA Executive Vice President and CEO, James L. Madara, MD, to Rahul Gupta, MD, Director, White House Office of National Drug Control Policy. February 15, 2022. Available at <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-2-15-Letter-to-Gupta-re-ONDCP-Naloxone.pdf>.

- Medication, including non-opioid pain relievers, anticonvulsants, antidepressants, musculoskeletal agents, and anxiolytics as well as opioid analgesics when appropriate.
- Restorative therapies, which include physical therapy, occupational therapy, physiotherapy, therapeutic exercise, acupuncture, osteopathic manipulative therapy, and other modalities such as massage and therapeutic ultrasound.
- Interventional procedures, such as neuromodulation, radio frequency ablation, peripheral nerve stimulation, central and peripheral nerve ablation, spine surgery and steroid injections, and other emerging evidence-based interventional therapies as part of the multimodal pain care plan.

There is significant evidence that supports these treatments, which is why we strongly urge CDC to devote increased space in the Proposed Guideline to the need to remove barriers imposed by health plans and PBMs. The Proposed Guideline makes strides in supporting individualized care for patients with pain, but patients cannot access such care without additional actions by health plans and PBMs. We recommend, therefore, that CDC use its considerable standing and influence to urge health plans and others to remove barriers to all forms of evidence-based pain care.

Structural and social determinants of health, also known as social drivers, have a large impact on inequitable health outcomes, including pain, opioid use disorder, and overdose. Due to longstanding racism, in the realm of pain, Black and Latinx patients are less likely to have their pain adequately assessed. The data show that even when there is an assessment, they are treated with more suspicion, are more likely to have treatment rejected by insurers, are less likely to be adequately treated, and are more often to have their treatment discontinued. The literature further suggests that any proscriptive aspects of a Proposed Guideline are likely to be disproportionately applied to people who identify as Black, Indigenous, and people of color, so this should be explicitly called out in the Proposed Guideline. Black and Latinx people are also less likely to have access to, be offered, or sustained on, treatment for opioid use disorder. Regarding social determinants, aspects like income, education level, and housing are tightly tied to experience of pain and access to treatment for pain and substance use disorder. Substance use disorder in particular has been clearly linked at all stages from initiation to mortality to issues ranging from insurance coverage to stable housing.

The AMA encourages CDC to devote additional discussion when finalizing the Proposed Guideline to explicitly address the longstanding racism in pain care as well as access to evidence-based treatment for opioid use disorder. This includes:

- Disparate care provided for long-bone fractures in emergency departments for Latinx patients compared to non-Latinx White patients;
- Pharmacies in predominantly non-White neighborhoods providing less access to opioid analgesic prescriptions;
- Increased likelihood of older, Black adults who report high levels of pain being undertreated for their pain;
- Methadone treatment being more common in predominantly Black and Hispanic/Latinx areas, whereas individuals in White areas have greater access to buprenorphine to treat opioid use disorder (OUD); and
- Higher incidence of drug-related overdose mortality for Black and Hispanic patients.

The AMA would be pleased to work with CDC to directly address these disturbing realities.

Neither the Proposed Guideline nor the 2016 Guideline emphasize the role of incorporating education and training on individualized patient care needs in medical and other health professional schools. The AMA strongly agrees with CDC that enhanced education and training is a key component of improving care for patients with pain. The AMA Task Force has identified and collected more than 450 resources put forward by the nation’s state and specialty medical societies and federal agencies. This scratches the surface of the types of continuing medical education (CME) and other efforts physicians undertake. Most policy efforts, however, have focused on a one-time CME mandate at the state level, which generally is not helpful as it is not specific to a physician’s specialty or practice. What would be useful, however, is increased discussion by CDC of the benefits of core curricula to be provided at the undergraduate and post-graduate levels for medical students and residents. This could include the benefits of a multimodal, multidisciplinary approach to pain care, risks and benefits of opioid therapy, stigma faced by patients with pain, and other relevant areas. The core curricula also could include education and training about how prescription drug monitoring programs (PDMPs) may contain helpful information about a patient’s prescription history, including CDC’s admonition that “risk scores should not take the place of clinical judgment.”

The final overarching comment concerns patients with an opioid use disorder. **The Proposed Guideline repeats the 2016 Guideline recommendation that “clinicians should offer or arrange treatment with medication for patients with opioid use disorder.”** This is the only recommendation supported by the highest quality, Grade 1 type evidence, which is appropriate. The AMA urges, however, that CDC go much further in identifying the challenges faced by patients and physicians in helping ensure access to affordable, evidence-based OUD care. First, as noted below, CDC should make clear that the recommendation for care includes MOUD and concomitant mental health care. At the same time, we urge CDC to recognize the widespread challenges patients face in accessing care for an OUD or mental illness, including inadequate insurance networks and widespread failures by health plans to comply with state and federal mental health and substance use disorder parity laws. We further urge CDC to make clear the limitations with the Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator, including that the locator does not identify whether a provider is actively treating patients with MOUD, accepting new patients or whether the provider accepts a patient’s insurance. The AMA further urges CDC to add language explicitly calling for removal of the federal requirement of an “x-waiver” to prescribe buprenorphine for the treatment of OUD. As the epidemic worsens, we must remove all barriers to treatment to evidence based MOUD. Removing the x-waiver will directly increase access to care and save lives.

We also strongly urge CDC to clearly differentiate patients with pain from patients with an OUD and to simultaneously recognize that patients with OUD also may have pain that requires appropriate care. One of the predictable consequences of the 2016 Guideline was for patients who benefit from opioid therapy to be viewed as being one pill away from becoming an “addict,” a pejorative term that has no place in medicine. For example, one of the disastrous effects of the 2016 Guideline was having pharmacies use the rigid numeric thresholds and apply them to MOUD. The AMA and the American Society of Addiction Medicine (ASAM) received numerous examples where patients were refused MOUD because the pharmacies said that the MOUD exceeded the MME thresholds in the 2016 Guideline. CDC clarified that was wrong in a 2018 letter to ASAM.⁸ The AMA similarly supports CDC’s

⁸ Letter to Kelly M. Corredor, Director, Advocacy and Government Relations, American Society of Addiction Medicine from Debra Houry, MD, MPH, Director, National Center for Injury Prevention and Control Centers for Disease Control and Prevention. January 4, 2018. Available at [https://www.asam.org/docs/default-source/advocacy/letters-and-comments/2018-1-4-letter-on-buprenorphine-and-cdcs-guideline-\(002\).pdf?sfvrsn=7fa840c2_2](https://www.asam.org/docs/default-source/advocacy/letters-and-comments/2018-1-4-letter-on-buprenorphine-and-cdcs-guideline-(002).pdf?sfvrsn=7fa840c2_2).

discussion points in the Proposed Guideline that physicians should be aware of the risks of OUD, but that the Proposed Guideline should not be used to deny care for patients with an OUD or other substance use disorder, or patients with pain, including for pregnant, postpartum, and parenting individuals. The ASAM National Practice Guideline⁹ includes a section on the considerations for individuals with an OUD who need care for pain. This is the type of thorough discussion that is non-stigmatizing and would be beneficial for CDC to reference when making the Proposed Guideline final.

AMA comments on the individual recommendations in the Proposed Guideline

The AMA's first recommendation is to clearly state that the Proposed Guideline supersedes and replaces the 2016 Guideline. By making this explicitly clear, CDC will send a message to all stakeholders that policies based on the 2016 Guideline should be removed. We further recommend that CDC change the title of the Proposed Guideline to try to mitigate future misapplication. As CDC has made clear, patients have suffered greatly from the misapplication of the 2016 Guideline. It was predictable and foreseeable that states, health plans, pharmacies, and PBMs would use the 2016 Guideline as inflexible policy given the CDC's status as the world's foremost public health agency. Moreover, because the 2016 Guideline was drafted by the CDC's Injury Prevention Center, it had even greater influence as stakeholders assumed that adoption of the 2016 Guideline as specific policy would lead to a reduction in injury and mortality. Unfortunately, that has not been the case, and the AMA is concerned that by suggesting the Proposed Guideline is a "Clinical Practice Guideline" it will cement the CDC's guideline in medical standards, education, policy, and practice despite CDC's explicit admonition against doing that.

Without rescinding the 2016 Guideline *and* revising the Proposed Guideline title and recommendations, state laws and other policies will further codify the 2016 Guideline because the misapplication has become sacrosanct in state laws and other policies. Calling the Proposed Guideline a "clinical practice guideline" inappropriately and inaccurately suggests that it should be the standard for pain care for trauma surgeons, Ob-gyns, neurologists, neurosurgeons, family physicians, pain medicine specialists, addiction medicine physicians, psychiatrists, and every other physician specialty. It is impossible for a single "clinical practice guideline" to possibly address the unique specialties and unique needs of patients with pain. The AMA's recommendation to change the title is aligned with CDC's support for individualized pain care treatment goals. It also furthers CDC's intent to distinguish its recommendations from policy mandates. This is why a specific call to rescind the 2016 Guideline is essential and would be further aided by also changing the title to more accurately reflect the CDC's support for individualized patient care. Calling the recommendations, a "clinical practice guideline" will not accomplish this. Therefore, the AMA recommends the following change in title:

Individualized Pain Care for Patients with Pain ~~Clinical Practice Guideline for Prescribing Opioids~~–United States, 2022

Recommendation 1

The AMA generally supports this recommendation, but additional edits are needed to improve it. Despite being titled as clinical guidance, there is extensive discussion in the underlying narrative for this

⁹ See, "Special Populations: Individuals With Pain." Executive Summary of the Focused Update of the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder. Available at: https://journals.lww.com/journaladdictionmedicine/Fulltext/2020/04000/Executive_Summary_of_the_Focused_Update_of_the.4.aspx.

recommendation and many others that function as policy guidance. For example, CDC continues to emphasize the importance of multimodal therapy and the potential benefits of nonopioid therapies in this recommendation. Yet, as AMA urged—and CDC makes clear in the narrative—access to nonopioid therapies is too often unavailable, unaffordable, and inequitable due to health insurance company barriers:

Health systems and payers should work to ensure multimodal treatment options are available, accessible, and reimbursed for patients. Public and private payers should support a broader array of nonpharmacologic interventions Reimbursement is often cited as a principle barrier to why these nonpharmacologic treatments are not more widely used....CDC will work with public and private payers with the aim of improving coverage for nonpharmacologic treatments, increasing access to non-opioid pain medication, supporting patient counseling and coordination of care, increasing access to evidence-based treatments of opioid use disorder, and enhancing availability of multidisciplinary and multimodal care.

In light of the CDC’s clear recognition of the role that health systems and payers play, the AMA, therefore urges CDC to make the following edits:

Nonopioid therapies are effective for many common types of acute pain. Clinicians should only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. In order to achieve this goal, public and private payer policies must be fundamentally altered and aligned to support payment for non-pharmacologic treatments and multimodal, multidisciplinary pain care. In addition, more evidence must be developed to inform clinical decision-making on the use of nonpharmacologic approaches, and more clinicians need to be trained in their effective use.

This edit may not be seen by CDC as “clinical” in the sense that there are clear policy-related actions being recommended. It is impossible, however, to achieve the clinical recommendation without securing the underlying policy. As described above, states, health plans, pharmacy chains and PBMs have implemented widespread restrictions on opioid therapy without any meaningful increase in access to nonopioid therapy.

Recommendation 2

The AMA generally supports this recommendation. We previously urged CDC to take a more measured approach to tapering rather than a straightforward recommendation for discontinuing opioid therapy. The CDC also positively addressed the AMA’s recommendation to ensure that a patient’s individual functioning is an essential consideration rather than simply “improvement.” For many patients, ensuring stable functioning is a successful outcome. The 2016 Guideline’s focus on “improvement” gave an imprecise view of the needs of patients with pain. The AMA recommends that to increase the patient-centered focus of the Proposed Guideline, we recommend adding the term “patients.” We also urge removing “subacute and chronic” because both opioid therapy and nonopioid therapy may be relevant for patients, and they are not necessarily mutually exclusive. As discussed above, for these recommendations to be clear, they should avoid categories such as acute, subacute, and chronic when there may be overlapping needs for patients. In line with the Proposed Guideline’s intent to engage in shared decision-making, we recommend changing “will” to “may.” Our recommendation is as follows:

Nonopioid therapies are preferred for ~~patients with subacute and chronic~~ pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for ~~patients with subacute or chronic~~ pain, clinicians should discuss with patients the known risks and realistic benefits of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy ~~may will be adjusted discontinued~~ if benefits do not outweigh risks.

Recommendation 3

As in 2016, the AMA generally supports this recommendation. We recommend, however, that CDC avoid additional distinctions between types of pain. If the CDC intends this recommendation to apply to all patients with pain, the AMA's recommended edit accomplishes that goal. The AMA, therefore, recommends the following:

When starting opioid therapy for ~~acute, subacute, or chronic~~ pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

Recommendation 4

This is a new recommendation from 2016. The AMA generally supports the overall intent of this recommendation, but we have several edits to help mitigate against unintended consequences. First, there has been significant confusion among those who have misapplied the 2016 Guideline regarding “opioid-naïve.” As written, the AMA is very concerned that pharmacies, health plans and PBMs that may not immediately be able to verify in their data systems the presence of a previous opioid prescription will arbitrarily deem the patient to be “opioid-naïve.” In fact, there are many reasons why this misapplication would occur—and the patient would be denied the prescription medication recommended by their physician as a result. For example, databases could deem a patient “opioid-naïve” if any of the following occurred:

- The patient changes health plans
- The pharmacy inaccurately enters a patient's name into the state PDMP
- The patient moves to a state where the PDMP does not have interoperability
- The PBM uses a different name for the patient than what is in the PDMP

Any of these situations could lead to a patient who is stable on opioid therapy being denied care because the designation of “opioid-naïve” would trigger a hard edit by the health plan, pharmacy or PBM to refuse to dispense opioid therapy beyond an arbitrary MME threshold that the plan or pharmacy considers appropriate for so-called “opioid-naïve” patients. In addition, the AMA urges CDC to distinguish between “opioids” and “prescription opioids.” The former includes all forms, including illicitly manufactured fentanyl and heroin. The latter, however, focuses on an FDA-approved product for pain relief. We also continue to urge that CDC avoid false distinctions between types of pain in these recommendations. The inclusion of these distinctions, even if there is some agreement in the literature, is likely to result in unintended consequences, misapplication, and harm. Therefore, the AMA urges the following edits to protect patients' access to care:

When ~~prescription opioid therapy is~~ ~~opioids are started for opioid-naïve patients~~ ~~with acute, subacute, or chronic pain~~, clinicians should prescribe the lowest dosage to achieve expected effects. If opioids are continued ~~for subacute or chronic pain~~, clinicians should *use caution when prescribing opioids at any dosage* should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients (recommendation category: A, evidence type: 3).

Recommendation 5

The AMA greatly appreciates CDC's revised recommendation. This positive change removes the inflexible thresholds that the AMA and many others have opposed because of the harms experienced by patients with pain. We support this recommendation with one caveat. Specifically, we urge CDC to remove "higher opioid dosages" because that is a subjective term without medical consensus. Using "higher opioid dosages" suggests that there is no risk to "lower opioid dosages" or that there are only risks for "higher opioid dosages," when we know patients on opioid therapy are functional on a wide range of opioid therapy dosage and quantity. Risk must be determined on an individualized basis. The AMA, therefore, recommends:

For patients already receiving ~~opioid therapy~~ ~~higher opioid dosages~~, clinicians should carefully weigh benefits and risks and exercise care when either reducing or continuing opioid dosage. If risks outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, e.g., confusion, sedation, or slurred speech, opioid therapy should not be discontinued abruptly, and clinicians should not abruptly or rapidly reduce opioid dosages from higher dosages.

Recommendation 6

Similar to recommendation 5, the AMA supports the CDC's removal of specific dose and quantity guidelines in the Proposed Guideline. We urge a further edit, however, as explained above, to distinguish between prescription opioids and illicitly manufactured opioids. In addition, the AMA recommends that the focus of this recommendation be on the treatment of pain. A recommendation to prescribe only the amount needed for the expected duration of pain is not simply for acute injuries but applies to common physician practice. The AMA urges CDC to avoid the same mistakes it made in the 2016 Guideline. Without removal of reference to the 2016 Guideline across the nation, future misapplications will occur, but we urge CDC to make the following edits to be more sensitive and accurate to the needs of all patients with pain:

When ~~opioid therapy is~~ ~~opioids are~~ needed for the treatment of acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require prescription opioids

Recommendation 7

The AMA generally supports changes made to this recommendation to focus on risk-benefit analysis rather than a preference for automatic tapering or discontinuation of opioid therapy. Similar to other comments, however, the AMA recommends additional edits to further support physician discretion and avoid confusion about which “types” of pain require close care coordination and monitoring. Just as dose and quantity should not be subject to rigid numeric thresholds, a physician’s discretion about ongoing monitoring also may vary. While some patients may require monitoring and follow-up more regularly than others, the AMA is concerned this recommendation—particularly if applied more broadly for more types of pain—would subject patients to unnecessary costs and increase stigma. Patients with pain that is well-controlled over a longer term on opioid therapy, for example, may not require four visits per year—and the resulting co-pays and cost-sharing would be unnecessary. For other patients, including those who may require a trial dose escalation or who begin a tapering protocol, more frequent follow-up evaluations may be necessary. We urge CDC to make the following changes to support the types of individualized patient care determinations that CDC has said are at the core of the Proposed Guideline:

Clinicians should evaluate benefits and risks with patients at appropriate clinical intervals determined by the physician after ~~within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain and prior to decisions whether to increase or decrease the quantity, frequency or dose of that therapy. or of dose escalation.~~ Clinicians should continue to evaluate benefits and risks of continued therapy with patients every 3 months or more frequently as clinically indicated based on a patient’s individualized needs.

Recommendation 8

The AMA supports the CDC’s new emphasis on shared decision-making in this revised recommendation. We further support the CDC removing the numeric threshold in the recommendation, and we offer an additional suggestion to further the goal of shared decision-making. As discussed above, the AMA and our Task Force have identified many risk factors that may be relevant when considering a prescription for naloxone. The CDC acknowledges this in the recommendation, but we encourage CDC to take the next step by encouraging discussion with the patient about those risk factors. We further urge a cautionary note in the recommendation that no single risk factor should be used by the physician to discontinue or deny care. An open and honest discussion with the patient builds trust and improves care. As such, the AMA recommends the following:

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone to the patient or a friend or family member when factors that increase risk for opioid overdose are present. Risk factors should be discussed with the patient, but no single risk factor should be used as a determining factor in decisions to discontinue or deny care.

Recommendation 9

The CDC has wisely removed the rigid requirement for frequency of checking a state PDMP. As we have said on many occasions, and in our previous comments to CDC, a state PDMP may contain useful information about a patient's prescription history, but we cannot ignore the fact that PDMPs have been used to stigmatize patients with pain. For example, when a patient who benefits from opioid therapy sees a new physician, the presence of long-term use of prescription opioids, whether in combination with or without other medications, is often a barrier. Patients frequently report that PDMP reports serve as a bar to care. In addition, as CDC repeatedly emphasizes throughout the Proposed Guideline, no single data point should be used to discontinue care for a patient. We urge CDC to further its strong support for continuity of care by adding to this recommendation a clear call to not use the PDMP as pretext for discontinuing or denying care. This recommendation requires additional edits to appropriately place the accomplishment of these patient-centered goals and protections. Similar to our previous recommendations, the AMA urges the following changes:

When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to help inform the provider's clinical decision-making, determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose. PDMP reports should be carefully examined but never used, by themselves, as reasons to discontinue or deny care to a patient.

Recommendation 10

The Proposed Guideline's discussion of the utility of toxicology testing is fraught with contradiction. The Proposed Guideline says that there is no evidence that evaluated "the effectiveness of toxicology screening for risk mitigation during opioid prescribing for pain;" that such testing should not be used to dismiss patients from care, that such screening is only "potentially useful" and must be considered in context with other tools, that initial tests may be inexpensive, but confirmatory tests "can add substantial costs." The AMA does not support, therefore, this recommendation's requirement that physicians "should" use such tests. Rather, this recommendation should be significantly revised to reflect the Proposed Guideline's support for individualized patient care determinations as well as shared decision-making. Forced drug tests are highly stigmatizing, and given this recommendation's level 4 quality evidence, does not merit a universal requirement. The AMA strongly recommends open and honest discussions rather than coercive testing protocols that embed distrust in the patient-physician relationship.

The AMA, therefore, recommends the following revision:

When prescribing opioids for subacute or chronic pain, potential use of drug or other toxicology testing should be made in consultation with the patient, including discussion of the limitations of such testing and assurances that test results are only one factor in ongoing treatment decisions. Drug testing should not, by itself, be a determining factor in whether to discontinue or deny care to a patient. Clinicians should consider toxicology testing to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances.

Recommendation 11

The AMA appreciates that CDC uses “opioid pain medication” in this recommendation and encourages similar use to distinguish prescription opioids from illicitly manufactured fentanyl and heroin products throughout the Proposed Guideline. The AMA also supports the changes from 2016 Guideline consistent with AMA’s previous recommendations to focus on risk/benefit analysis rather than yes/no false dichotomies. We question, however, the use of “extreme” given that it is not a medical term and potentially prejudices physicians from making clinical determinations. We point to the fact that the FDA has issued its own guidance regarding safety precautions for concomitant benzodiazepine and opioid analgesics.¹⁰ The FDA recognizes that decisions to prescribe a benzodiazepine along with an opioid analgesic do require “particular caution,” and provides the relevant safety information for physicians to consider. The AMA recommendation follows this approach:

Clinicians should use ~~extreme~~ particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.

Recommendation 12

The AMA urges CDC to match the recommendation with the narrative. In the narrative, CDC unequivocally supports MOUD as the evidence-based standard for people with an OUD. CDC also makes clear the benefits of mental health care for people with an OUD. The actual recommendation, however, creates confusion and potential danger by removing “evidence-based” from the 2016 Guideline recommendation. This could create the unintended consequence of supporting abstinence-based therapy rather than MOUD. Some patients may choose abstinence-based therapy and only use medications to treat symptoms of withdrawal, but we point out that the medical evidence for MOUD shows far greater success in retaining people in treatment and keeping them alive as compared to abstinence-based approaches. The second component that needs attention is for CDC to add specific language in support of providing behavioral health therapies to people with a substance use disorder (SUD). While there are many challenges in accessing affordable, evidence-based care for mental illness and SUDs, the AMA urges the CDC to support the provision of both. In the Proposed Guideline, the AMA found two missing policy components in the narrative to increase access to MOUD: remove the federal x-waiver and ensure SUD training is incorporated into all health care professional schools and graduate medical residency programs. As for the recommendation itself, AMA recommends the following changes:

Clinicians should offer or arrange treatment with evidence-based medications to treat ~~for~~ patients with opioid use disorder as well as evidence-based mental health care.

Conclusion

The AMA commends the CDC for recognizing the harms done to patients and physicians by the misapplication of the 2016 Guideline. We further commend the CDC for removing the rigid numeric thresholds from the Proposed Guideline. There is, however, considerable work remaining to ensure the Proposed Guideline’s recommendations and underlying narrative reflect the CDC’s stated goal to support individualized patient care determinations and remove the 2016 Guideline from existing law, regulation, and other policies. The AMA stands ready to work with CDC as it considers comments from interested

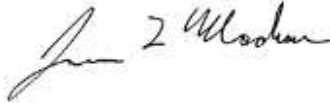
¹⁰ FDA Drug Safety Communication. U.S. Food and Drug Administration. September 23, 2020. Available at <https://www.fda.gov/media/142368/download>.

Captain Christopher M. Jones, PharmD, DrPH, MPH
April 11, 2022
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parties and works to finalize the Proposed Guideline. As the nation's leading medical association representing physicians of every specialty in every state, we urge the CDC to accept these recommendations as they are built on patient and physician experience as well as considerable data and policy analysis showing the range of unintended consequences attributable to the 2016 Guideline.

Thank you for your consideration. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,

A handwritten signature in black ink, appearing to read "James L. Madara". The signature is written in a cursive style with a large initial "J" and "M".

James L. Madara, MD