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PRACTICE MANAGEMENT

PM&R

American Academy of Physical Medicine and Rehabilitation Position Statement on Opioid Prescribing

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The American Academy of Physical Medicine and Rehabilitation (AAPM&R) is the national medical organization representing more than 10,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists use a diverse toolbox of cutting edge, evidence-based, and time-tested pain management treatments to create individual and multimodal solutions to maximize function and quality of life.

The AAPM&R recognizes that the current opioid epidemic is one of the most devastating public health threats to our society. With three out of four drug overdose deaths involving an opioid in 2022, inappropriate opioid use poses a significant risk to individual patients and society at large.[1] In addition, our specialty recognizes that chronic pain is the cause of suffering for more than 50 million Americans.[2] The AAPM&R and our specialty's goal is to avoid adverse events associated with opioid usage, including addiction, misuse, abuse, diversion, and death. Our specialty strives to mitigate overprescribing and reduce stigma as well as the undertreatment of chronic pain. Pain issues in patients with opioid use disorder still require treatment, and physiatrists take this into account when devising the appropriate multimodal treatment plan for these patients.

Many physiatrists are leaders of health care teams that provide essential care for patients presenting with

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both acute and long-term pain management needs. They work to minimize pain, maximize functioning, and improve patients' quality of life by using multidisciplinary approaches and multimodal treatments. Although physical therapy, behavioral health, nonopioid medications, and interventional procedures may be better treatment options compared with opioids alone, multimodal treatments are more effective and well accepted.[3] The AAPM&R strongly advocates that payers review their policies and improve availability of and access to evidence-based, multimodal treatments for pain, including pain psychology, multidisciplinary team management, and medication options.

Although there is moderate evidence for pain relief with opioid therapy for patients with moderate to severe chronic musculoskeletal pain (e.g., chronic low back pain and arthritis), careful patient selection is recommended before initiating chronic opioid therapy.[4] Evidence on the effectiveness of opioids for the management of chronic pain is mixed, and the balance between meaningful benefits to the individual patient versus the risks of adverse events with opioids compared to controls is questionable.[5] Given the lack of consistent evidence showing sustained functional benefit of long-term opioid therapy and moderate evidence outlining harms, careful patient selection and regular review are required, and therapeutic benefits need to clearly outweigh the harms associated with their use.

The decision-making process associated with treating an individual patient's chronic pain is incredibly complex. Each patient suffers in a unique way, and this is the framework of the biopsychosocial model of care. The treatment plan for a given patient should be informed only by the treating physician and the patient. The physician–patient dyad is crucial to the health, well-being, and betterment of each patient and, ultimately, society. It is for this reason that the AAPM&R advocates against the interference of treatment from payers, pharmacists, governmental and regulatory agencies, and other third parties.[6] *The diagnosis and treatment of a particular patient are the work of a physician*.

It is the AAPM&R's position that:

- **The primary goal of pain management is optimization of function.**

  The physiatric philosophy is to approach a patient's functional status and design a means of achieving functional goals rather than to first approach a patient's symptomatology when treating acute and/or chronic pain. Preceding a prescription for an opioid drug, a shared decision-making process incorporating patient input that explores all appropriate treatment options and results in clearly defined functional and quality of life goals should occur. Functional status should be assessed and monitored with documentation of functional improvement/optimization to validate continuation of chronic opioid therapy

- **Pain management should be multidisciplinary and multimodal.**

  There is evidence for multimodal and multidisciplinary pain management programs for patients with chronic pain.[4] Multidisciplinary pain management includes the development of an individualized treatment plan that is based on the biopsychosocial model of pain including interprofessional collaboration with specialists such as occupational therapists, pain psychologists, and psychologically informed physical therapy. However, lack of consistent availability or insurance coverage of such treatment options limits the reach and effectiveness of the multidisciplinary approach. Choices for multimodal pain management may be limited in many patients (e.g., higher risk of adverse events with use of nonsteroidal anti-inflammatory drugs in older adults, patients with renal disease, patients with prior gastric bypass surgery, history of gastric or duodenal ulcers, patients with history of coronary artery disease, patients on anticoagulation, etc.). Therefore, shared decision making between the patient and the treating physician to identify goals and develop a comprehensive and specific pain management strategy that considers the age, gender, and ethnic, spiritual, and cultural preferences of the patient is recommended.[4]
  The AAPM&R will continue to advocate for patient access to comprehensive multimodal and multidisciplinary therapies for pain management, including psychological evaluation and management, rehabilitation therapies, and more medication options, like buprenorphine, without the undue burden of prior authorization.

- **Opioid dosages should be the lowest necessary to achieve the best functional outcome.**

  Physiatrists recognize that pain is a subjective and personal experience that widely varies by patient and condition. It is important to treat all patients individually and use the opioid dosage appropriate for the particular pain syndrome. Standardized criteria of mild, moderate, and severe pain are not appropriate categorizations, as all individuals experience pain uniquely, and a specific plan for each patient should be formulated. Moreover, although dosing above the Centers for Disease Control and Prevention's recommendations[7] should be considered on an individual basis, limiting the days of medication or the maximum morphine equivalent dose for chronic pain is not appropriate. Although buprenorphine has been highlighted as a treatment of opioid use disorder, it may be a key tool in management of chronic pain disorders given its decreased risk of adverse effects

including respiratory depression and mitigating symptoms of opioid withdrawal.[8,9] Physiatrists treating patients with acute and chronic pain should continually assess both levels of pain and function to evaluate the feasibility of decreasing or discontinuing an opioid.

- **Chronic opioid therapy should be accompanied by appropriate risk stratification and ongoing risk management.**

  From the start of care, physiatrists should educate the patient to understand the clinical pathologic process; all potential treatment options including the patient's individual risks, benefits, and alternatives; and, most important, understand that the goal is to restore function by minimizing pain. Appropriate risk management also includes signed controlled substance agreements, regular urine drug screening, and regular checks of the state prescription monitoring databases. The patient's initial risk level for possible misuse and/or diversion should be screened by a validated scale, and patients should be screened throughout their therapy.
  In the past several years, an emphasis has been placed on the ubiquitous availability of naloxone to minimize the risk of overdose. Although naloxone is still not readily available for a variety of reasons (e.g., costs, stigmatization), it is still a valuable and necessary option for use in complex settings. The AAPM&R endorses the American Medical Association (AMA)'s Opioid Task Force's position statement on the appropriate coprescribing of naloxone.[10]
  For those patients who have been diagnosed with opioid use disorder (OUD), utilization of medication-assistance therapy has dramatically reduced the incidence of overdose-related deaths and complications. The AAPM&R endorses the AMA's Opioid Task Force's position statement on protecting patient access to evidence-based treatment and preventing barriers to care for patients with OUD.[11]

- **Opioid therapy for new onset of acute pain should be limited with regular assessment.**

  Acute pain can be adequately treated with both nonpharmacologic and/or nonopioid therapies. Nonopioid therapies are at least as effective as opioids for many types of acute pain. Providers should maximize the use of nonpharmacologic and nonopioid therapies as appropriate for the specific condition and consider opioid therapy for acute pain only if the benefits outweigh the risks. In concordance with diagnostic workup, opioid prescription may be appropriate for acute conditions such as burns, complex pelvic fractures, and ischemic limb pain. When opioids are prescribed, the AAPM&R supports limiting opioid prescriptions for acute pain, including postoperative pain, to the lowest effective dose and ≤3–7 days (or as defined by state limits) with regular provider reassessment
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- **Every physiatrist who prescribes opioids maintains a commitment to patient safety and continuing education**

  The AAPM&R has long encouraged its members and their health care teams to continually advance their knowledge regarding pain management and proper opioid prescribing. The AAPM&R believes that physician education for the safe use of opioid analgesics continues to be one of the most effective means of decreasing the risk of morbidity and mortality associated with the use of opioid drugs. Our specialty is committed to ensuring patient safety, and the AAPM&R supports member efforts to understand and implement best practices for pain management.
  The AAPM&R recognizes that both the opioid epidemic and acute and chronic pain management are difficult and complex issues. The AAPM&R is committed to advocating within our specialty for the adoption of best practices related to pain management and opioid prescribing. The AAPM&R continues to collaborate with various other medical specialties to provide a unified voice on this critical issue to make tangible, impactful changes to enhance physician education and increase safety for patients and the public.

DISCLAIMER

This AAPM&R Position Statement is intended to provide general information to physiatrists and is designed to complement advocacy efforts with payers and policymakers at the federal, state, and regional levels. The statement should never be relied on as a substitute for proper assessment with respect to the specific circumstances of each case a physiatrist encounters and the needs of each patient. This AAPM&R statement has been prepared with regard to the information available at the time of its publication. Each physiatrist must have access to timely relevant information, research, or other material that may have been published or become available subsequently.

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