Opioids: What's an "Outlier Prescriber"? Listening Session

Moderated by: Nicole Cooney
September 17, 2019 4:30 pm ET

Table of Contents

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the feedback session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect.

I will now turn the call over to Nicole Cooney. Thank you, you may begin.

Announcements & Introduction

Nicole Cooney: Thank you. I'm Nicole Cooney from the Provider Communications Group here at CMS and I'll be your moderator today. I'd like to welcome you to this Medicare Learning Network Listening Session on Opioids: What is an Outlier Prescriber?

Signed into law on October 2018, The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also known as the SUPPORT Act, outlines national strategies to help address opioid misuse.

As part of Section 6065 of the SUPPORT Act, CMS is required to notify opioid prescribers with prescription patterns identified at outliers compared to their peers, and encourage them to reference established opioid prescribing guidelines.

Today, CMS would like your input on how best to implement this provision of the SUPPORT Act. Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.CMS.gov/npc. Again, that URL is go.CMS.gov/npc. Today's event is not intended for the press and the remarks are not considered on the record.

If you are a member of the press, you may listen in, but please refrain from asking questions during the question-and-answer session. If you have inquiries, please contact press@cms.hhs.gov.

As I mentioned, the purpose of today's session is to obtain your input on several questions. After a brief presentation, we will open the lines 4 separate times for feedback on each specific topic. And with that, I'd like to introduce Dr. Barry Marks from the CMS Office of Clinician Engagement to provide the presentation. Dr. Marks?

Presentation

Dr. Barry Marks: Nicole, thank you very much, and before we begin I would just like to thank everyone dialing into today's call for your participation, and as Nicole mentioned, the purpose of today's call relates to a specific provision of the SUPPORT Act, which is Section 6065, and we are looking for your feedback around the requirements of this section.

There are two requirements that we really would like to focus on. The first of these requires the Secretary to “after consultation with stakeholders, established thresholds based on prescriber specialty and geographic area, for identifying whether a prescriber in a specialty and geographic area is an outlier prescriber of opioids as compared to other prescribers of opioids within such specialty and area”.

And the second requirement is in reaching out to those identified outlier prescribers to include “information on opioid prescribing guidelines based on input from stakeholders, that may include the Centers for Disease Control and Prevention guidelines for prescribing opioids for chronic pain and guidelines developed by physician organizations”.

The structure of these notifications as laid out in the statute, is that the first notification must be provided to outlier prescribers no later than January 1 of 2021. The notifications are annual, and the frequency may change after five years based on stakeholder input and changes in opioid prescribing trends.

Now, for today's call, there are four areas that we are specifically focusing upon for your feedback. The first of those has to do with the setting of Thresholds and the Feedback Reports. The second area is how to identify Medical Specialty. The third, how to define Geographic Area. And the fourth are your recommendations for Opioid Prescribing Guidelines.

I'd like to take a few minutes and go a bit more deeply into each of these four areas. Regarding thresholds and feedback reports, we would ask that you consider the following questions. What information will be most useful to clinicians to evaluate their opioid prescribing patterns? For example, MME, Morphine Milligram Equivalent per prescription, days supply, or prescriptions per patient. And how would these identify areas for improvement?

How should CMS identify an outlier prescriber? What factors should CMS consider when establishing opioid prescribing thresholds for purposes of this analysis, bearing in mind that a statistical outlier may not signify inappropriate opioid prescribing?

We recognize that there is a concern that clinicians maybe reducing or discontinuing opioid prescription and management, even when it is clinically appropriate and aligned with CDC guidelines. How can CMS present opioid prescribing data to clinicians in a respectful way? What are the best authoritative sources of information to share regarding pain management and opioid prescribing? How can CMS mitigate potential negative consequences of these required notifications?

Moving then to medical specialty, how should medical specialty be defined for the purpose of this analysis? What is the best framework to capture medical specialty so that comparisons are meaningful to clinicians? We recognize that Nurse Practitioners, other Advanced Practice Registered Nurses, and Physician Assistants have limited ability to designate a medical specialty.

How can this framework be used to compare opioid prescribing by special -- by prescriber specialty in the circumstances of Advanced Practice Registered Nurses and Physician Assistants?

Regarding geographic area for analysis, the scope of practice for Advanced Practice Registered Nurses and for Physician Assistants vary by state. Since scope of practice laws impact upon opioid prescribing at the state level, should CMS analyze opioid prescribing using the state as a geographic area of analysis? Are there compelling reasons to consider a geographic area smaller than the state as the unit of analysis? Examples of that might include characterization as urban, rural, frontier, or others.

And finally, what guidelines would be meaningful and useful to clinicians receiving these communications, through which to assess their prescribing practices?

And with that, I'd like to turn this back over to Nicole. Thank you.

Feedback Session 1 -- Thresholds and Feedback

Nicole Cooney: Thank you. Before we get started, I'd like to set a few ground rules for today's session. In an effort to get to as many participants as possible, we'll spend a maximum of 3 minutes on, you know, each person's feedback and the back and forth, if there is any, with our SMEs here. Today's call is not the forum for specific questions about your medical practice or place of business. And as a reminder, today's session is being recorded and transcribed.

Our first topic for discussion is Thresholds and Feedback. Please take a moment to consider the questions on this slide as we queue up for your feedback. There will be an opportunity to get in the queue after the other topics, so please limit your questions to Thresholds and Feedback or your feedback for Threshold and Feedback for this 1st session. Nicole, we're ready for our first caller.

Operator: To provide feedback, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you're providing your feedback. So, anything you say, or any background noise, will be heard in the conference. Please hold while we compile the roster. Please hold while we compile the roster.

The first question comes from the line of Donald Taylor.

Donald Taylor: Yes, I'm Donald Taylor. I'm a Pain Practitioner in a freestanding pain clinic. And about the concerns that the clinicians are reducing or discontinuing opioid prescriptions, I'm seeing that rampantly in my area where many physicians are refusing to prescribe any opioids now for any indication, and you know I think that there's real danger here and in terms of over-correcting the problems that we have.

I'm very concerned that what we're going to see is the inability of legitimate pain patients to get any kind of opioid pain medication in the near future. So, I think that we need to look at education of physicians rather than these quasi-punitive approaches that the CMS is looking at using.

We need to have recognized experts, educating physicians on how to prescribe pain medications and when to prescribe pain medications. This is a problem to be solved by education, not simply telling doctors you're prescribing too much. Indeed, many of these physicians who may show up as outliers, may be the only physicians left in their area who are actually prescribing the appropriate amount of medications.

So, I think that the CMS has a huge job of trying to mitigate the potential negative consequences of their notifications. We're already seeing physicians panicked by this sort of stuff. This is only going to make things worse.

Dr. Barry Marks: Thank you very much.

Operator: Your next question comes from the line of Audrey Hansen.

Audrey Hansen: Hello, my name Audrey Hansen. I am with the Institute for Clinical Systems in Minnesota. And we're working on a lot of opioid initiatives, and one of our biggest issues is that there is not a common metric. We believe that Morphine Milligram Equivalent is a common metric, we picked that up from the CDC guideline and have been using that.

Unfortunately, most physicians really don't know what that is or how to use it. Their EMR don't support it in a way that's usable and they're very confused when all the different legislation comes out in the local decision by pharmacy benefits managers, insurance companies, even pharmacies to say we're only going to give you 4 days, 7 days, 3 days, 10 pills, 15 pills whatever.

And it days of what, pills of what, and what happens is that they do work around to meet their patient's needs. So, we understand clinically that certain amounts of Morphine Milligram Equivalent are helpful, and certain amounts are not, and we feel like that is the best metric. We do have trouble identifying in Minnesota which specialty, some of our mid-level providers are associated with, and we find that especially in postoperative surgical or hospital discharges, but it's not usually the surgeon that is doing the prescriptions. So, we do get mixed up data, that is all I have. Thank you.

Nicole Cooney: Thank you.

Operator: And again, to provide feedback, press star followed by the number one on your touch tone phone.

You have a question from the line of Henry Taylor.

Henry Taylor: Hi, this is Henry Taylor, Carroll County Health Department. I support the different opinions that have been stated previously. One thought, following up on the point about MME is, the core issue is how well we're taking care of our patients and whether we are providing a disservice to a particular patient for exceeding, giving excessive amounts.

So, the idea of doing the total MME per patient, for those providers whose states that don't have a PDMP in place. If there were ways that Medicare could be combining all of the MME's that person is getting within a defined period, I'll arbitrarily say per month, that would be a useful number to know because it's what would be happening with that person outside of my particular practice.

So that was point number one, is the idea of doing total MME's per patient per month probably. The second would then be related to reporting back to the clinician, what proportion of their patients are lying outside the statistical average and comparing them to a denominator of the -- compared to the patients who are being seen in that area, in that specialization.

So those were the two feedback points that I had.

Nicole Cooney: Thank you. Nicole, do we have anyone else in queue for this topic?

Operator: We do. The next is Michael McNett.

Michael McNett: Hello, I'm Michael McNett. I'm the Director of Non-Interventional Pain for Aurora Healthcare in Wisconsin. I'd like to make a couple of points. One is given that the mu opioid receptor goes from inhibitory to excitatory with a prolonged exposure, and does so faster, in the presence of higher doses. It is the slippery slope with regard to prescribing, and what we also see is that there is a more than linear increase in annualized mortality rate based on MEDD's per day.

As a result, I think that is a very valid use to look at when prescribing opioids at 100 morphine equivalent, annualized mortality is increased 880%, which is roughly 10 times what Bio-X when it was taken off the market, at 200 morphine equivalent that goes up to 2400%.

So, it would make sense I think to look to accept the CDC's guideline on maximum dosing, and I'm not sure that you know maximal dosing by specialty makes a whole lot of difference, because a person's Mu opioid receptor doesn't take, just because they walk into in pain management practice as opposed to a primary care practice.

I do think though, that it's important that as we present this to page - to providers, that they be provided access to knowledge about this. I think it would be great to have CME programs available and reference in the notices, as well as specific information on how to wean without inducing withdrawal, because a lot of patients who otherwise would not turn to the street, will do so if they're precipitated into withdrawal.

Thank you.

Nicole Cooney: Thank you.

Operator: The next feedback come from Angie Adam. Angie, your line is open. You may be muted on your end.

Angie Adam: Sorry, I don't have questions. I was just listening in on this webinar.

Operator: The next feedback is from the line of Sandy Marks.

Sandy Marks: Hi, thank you. I wonder if there's a way to tie in this new effort to the effort that CMS has had in place for a number of years with it over utilization monitoring system, because that approach takes a very individualized approach to each physician, and if a patient is receiving, I think it's more than four prescription opioids at a time from more than three or four different physicians or pharmacies, then the Part D plan contacts the physician to let them know that their patient is getting all these other prescriptions and to try to figure out what's medically appropriate or what may need to be changed.

And I think that type of an individualized approach would be a lot better way to handle this than some kind of across the board notice that just goes out in a general way to a bunch of doctors who are told that they, you know, are outliers on some statistical measure. So, I would kind of look to the OMS as a guide to how this one might be done and maybe there's a way to link the two systems together. Thank you.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Cassandra Warmack.

Cassandra Warmack: Hi, I'm Cassandra Warmack. I was wondering, and I apologize because I'm driving, whether one of the elements we are considering is other things that would depress the respiratory drive since - such as gabapentin and benzodiazepine -- if we're including that in the matrix, that could be possibly used because usually it's not solo -- it's not usually opioid themselves because it has caused mortality here with regard to the mortality that we are seeing, that was just my comment.

Nicole Cooney: Thank you.

Operator: The next feedback is from Donald Taylor.

Donald Taylor: Yeah. In relationship as to what somebody else mentioned earlier about the MMEs, I think the MMEs are very confusing for physicians. I'm a pain specialist and I actually refused to look at them, because I think it's just a waste of time to sit down and calculate them.

I think if you are a primary care physician and you make -- you get an alert that your patient's above a certain number of MMEs that may be a trigger to refer that patient to pain specialist, but I think that whole MME concept just flies right over the heads of most primary care doctors, and it's very really not a very useful way of addressing things.

Nicole Cooney: Thank you very much.

Operator: The next feedback is from Audrey Hansen.

Audrey Hansen: Thank you. I was reminded listening to people talk that there is a real difference between how they are prescribed acutely and how they prescribed chronically? Most of the information you have appears related to through that chronic patient management, but we are in Minnesota. We have a measure that accumulative MME's. So, we're checking to see if patients are going from acute to chronic. And if they've had over 700 MME cumulatively that means they are at higher risk for continuing and becoming chronic and even having trouble with their opioids.

And most of the calculations and all the rules are around chronic, and the physicians are getting very confused when we come out with post-op recommendations that are for an acute prescription. And in Minnesota, we have an effort to look at procedure-specific prescriptions postoperatively that our patients under procedure-specific, as opposed to the one-size-fits-all method that government tends to have to do just by virtue of the nature of the work.

I would also recommend that you look into what states are measuring right now and what they're doing, because some of the states are really doing a great job of modeling what you could do. Thank you.

Nicole Cooney: Thank you.

Operator: And the final feedback is from Richard Ramos.

Richard Ramos: My name is Richard Ramos. I am a Physiatrist and Pain Specialist in North Carolina. I would echo some of the comments about morphine milli-equivalents. As an example, it's an imperfect number and buprenorphine doesn't have a good MME calculation. So that need to be taken into consideration. I think the day supply is erroneous just as the last caller discussed.

These insurance companies, as well as CMS, is mixing up acute and chronic. In North Carolina, we also have a law that was recently passed that has a limit on acute pain, or postoperative pain, to five to seven days. And I have patients who have gone to the same pharmacy, as an example, the previous year, every month. And on January 1, the patient only gets a seven-day supply which then they use their insurance benefits. It's just frustrating.

CMS has to do a better job of clarifying acute and chronic. To answer your question on how can CMS present opioid prescribing data in a respectful way; very difficult. I certainly believe this is an issue that needs to be addressed, but no physician will obviously look at this as a respectful way, since obviously the CDC had to come back and say that all of these were guidelines and they were using appropriately to take patients off. As an example, I'm not saying North Carolina is the example, but we monitor physicians who have had extreme consequences or adverse events from their patients, which obviously means overdose and/or death, and those physician's get reviewed.

Obviously, I don't know how CMS would monitor, you know, 200,000 plus physicians in the country, but I think that's a better indicate -- a better way to monitor, in my opinion, outliers. So instead of getting a piece of paper from the government just because you meet one of these criteria. There are actually is a physician who has reviewed the case and comes up with some kind of decision.

So, I don't know if there's anything that's going to please any physician, but I will say this definitely means -- we definitely need to have something, and we just got to find that better measure. And MME, unfortunately are not that measure. Thank you.

Feedback Session 2 -- Medical Specialty

Nicole Cooney: Thank you. It's now time to move on to our next topic, Medical Specialty. Please consider the questions that we have on that slide. We want to limit the feedback to this topic for this session, and as a reminder we'll spend a maximum of three minutes on each exchange. Nicole, we are ready to queue up for Medical Specialty.

Operator: To provide feedback, press star followed by the one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you're providing your feedback. So, anything you say, or any background noise, will be heard in the conference. Please hold while we compile the roster.

Please hold while we compile the roster.

The first feedback comes from Donald Taylor.

Donald Taylor: Hi, this is Donald Taylor again from the Atlanta Georgia area and running Pain Clinic. I would say I think that the only way you're really going to capture this medical specialty information is having the physicians and the Nurse Practitioners and the Physician Assistants, all self-identify. You should basically contact and then also the huge task, but you're going to need to know who's an oncologist, who is the primary care doctor, who is the pain specialist.

You know to really make good sense in this information, which Nurse Practitioners and Advanced Practice Nurses are working in pain clinics, which ones are working in cancer centers, which ones are working in family practice. And beyond that, you probably also need to try and get a handle on what do you work in urban, suburban, or rural community because in the area that I'm in, very few primary care doctors prescribe any kind of opioids anymore. They send them all to the pain doctors.

As you go to the rural areas, however, there's not that many pain doctors, and the primary care doctors are having to prescribe opioids. So, I think you need to let the physicians identify not just what kind of specialists they are, but where their specialty is being practiced at, and otherwise you're never going to really get good information on this.

And you know, as somebody mentioned earlier, they didn't know where there was a surgeon writing a post-op pain meds. Well from my pain point patient, I write all their post-op pain meds. I don't let the surgeon to write it because I don't think they're confident. So anyway, that's just my opinion. Thank you.

Nicole Cooney: Thank you.

Operator: The next feedback is from Jacqueline Kaczynski. Jacqueline, your line is open.

Jacqueline Kaczynski: Hi, thank you. With the American Academy of Hospice and Palliative Medicine. I think we have particular concerns, given that our members are prescribing for patients with a serious illness or at the end of life, and that high prescribing not always be equated with bad prescribing. So, we want to make sure that the specialty is identified, but in many cases, we may have physicians who are practicing Palliative Medicine half the time and our primary care providers. So, they may not have been enrolled with the specialty code designating them in Medicare with the Palliative Medicine specialty.

There are other folks who could enroll in Medicare and designate that code and have no requirement to indicate that they actually do practice in this specialty. So, without any additional information, it may not be the most effective way of delineating among prescribers.

Medicare and Medicaid claims that provide information on patient diagnosis could potentially be better indicators of inappropriate prescribing than simply looking at the volume of prescriptions written, and we certainly want to echo the comments earlier around overall elevating the knowledge of appropriate prescribing of controlled substances across various providers and medical specialties. So, we don't see a continuation of the chilling effect on prescribing meds that’s so common now.

Nicole Cooney: Thank you.

Operator: The next feedback is from Michael McNett.

Michael McNett: Yes. I run non-interventional pain for a very large healthcare organization, but my actual background, I was originally trained in primary care. And so, I think it is important that we distinguish between board certification and what training and what field somebody may be practicing in, because as with palliative, a lot of primary care doctors are dedicating themselves to non-interventional medical management of pain, and those people may appear as outliers even though they are practicing well within CDC guidelines.

So that's all I have to say. Thank you.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Cindy Warriner.

Cindy Warriner: Yes Cindy Warriner, Richmond of Virginia. I agree with a lot of the comments that have occurred on this call. I also wanted to highlight utilizing the coordinated efforts of potentially some other groups or national organizations that have a focus on patient safety and coordinating, prescribing between specialists and primary care physicians, for example, the National Board of Pharmacy and it's interconnect program with the various state PDMP, may be an avenue that would at least be able to be used to differentiate between specialties and primary care providers.

Nicole Cooney: Thank you.

Operator: Next feedback is from Richard Ramos.

Richard Ramos: Yes, I'm from Greensboro, North Carolina. So, one of the things that I did years ago at the urging of one of the organizations I mean, which is interventional pain, but they also deal with opioids. They recommended that physicians change their designation, kind of what was talked about. So, I would not be considered an outlier with regards to opioids.

I really don't know how effective that is. I personally believe although I don't have, this is my perception, I have no evidence, but the fact that the government knows that I am a top prescriber in my locale, and do I somewhat have an X on my back, but what I try to do is do the right thing and take care of my patients and I worry about that later, but knock on wood so far no one has necessarily come knocking on my door.

The question that we were asking about though, is how do we monitor PA’s and Advanced Practice Nurses or Nurse Practitioners, well in our state, as an example, PA's cannot work unsupervised. So, I would behoove the PA to somehow get a designation like myself if they're working with me. He or she should put a designation of pain management or hospice and palliative care. So, then they wouldn't be considered an outlier.

The difficult thing with Nurse Practitioners, since they can practice independently, it would be up to them to create their own designation. So once again, they're not considered an outlier, but if I were to be truly judged against my peers, which are physical medicine and rehabilitation or physiatrist, I am at least two to three standard deviations outside what a normal physiatrist would do.

So, it really is very important that somehow CMS educates these physicians whether you are board certified or not to be able to change your designation, so you're not deemed an outlier. And again, this has nothing to do

with payment, it's really just as I was told CMS looks at this designation and if I were to be just strictly under PM&R, I am an outlier. If I'm under interventional pain management, I'm not as much of an outlier.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Diane Cornelison. Diane, your line is open.

The next feedback is from the line of Kerry Allen.

Kerry Allen: Hello, I really appreciate everybody's opinion so far. I work in Texas in Long Pharmacy, and I think when we were talking earlier, I believe it is Dr. Taylor, who was saying the primary side of care and where people are primarily practicing including rural areas, a really good indicator. So, we can aggregate data specifically in long-term care and some of these rural areas, you're not going to have access necessarily to a pain specialist.

We're going to have a transition in care who composed acute care to a chronic stay and also have palliative care. So, I think even down to a population level, saying you're primarily geriatric, primarily, you know, middle aged adults, primarily pediatric may also be useful.

Thank you.

Nicole Cooney: Thank you.

Operator: The next feedback from the line of Rick Vaglienti.

Rick Vaglienti: Hi, Rick Vaglienti, West Virginia University. The state of West Virginia developed some measures that the board of pharmacy uses for outliers that cuts across all of the specialty and physician categories. They look at average MME per prescription, total MME, number of opioid prescriptions prescribed, the number of opioid patients in a practice, and the number of opioid benzodiazepine combinations.

And if you're in the 95th percentile in four out of five of those and you are deemed an outlier. So, they ran a test case before they implemented this, and they did 15 physicians, and when they ran the program, 11 of the 15 had their practices closed or were under indictment. So, they felt pretty comfortable that they had something that was fair and was not going to punish individuals like all my fellow pain specialists who tend to write more opioids.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Henry Taylor.

Henry Taylor: Hi, this is Henry Taylor from Carroll County Health Department in Maryland. We had -- and I also work in Cecil County, Maryland. We have the first two overdose fatalities review teams in Maryland, which was on the 1st day under the current effort of overdose fatality review. And so it's not -- I'm not sure how to blend in with the discussion of specialty, but when Counties or states have efforts going when they are looking at

fatality, I think that is somehow might be a better way of looking at patterns in our community rather than the specialty of the physician.

So, I wanted to just insert that idea of whether a population approach looking at communities that are trying to examine their fatality patterns might be a better way than algorithms that look at the specialization.

Thank you.

Nicole Cooney: Thank you.

Operator: To provide feedback, press star followed by the number one on your touch tone phone.

The next feedback comes from the line of Diane Cornelison.

Diane Cornelison: Hello, this is Diane Cornelison. I am at the Cox Pain and Neurology. I am Neurologist by trade and boarded in Neurology Psychiatry. And I've been doing this, I opened the clinic 25 years ago, and I've been doing this for about 30 years. And recently because I am an outlier and there's no way to -- I don't, no way to change my identification to add also pain management because back in my day, neurologists didn't have a fellowship in pain management.

And so, my identifier is Neurology. So, if somebody could help me figure out how to navigate that, I would, because I'm definitely an outlier, and Walmart is the area that is giving all of the people who write higher prescribing. They're just basically cutting them off and saying we're not going to help you.

So if somebody has any ideas on that, I would love to have the answer and my email is xxxxx@xxxxx.com. I appreciate it, thank you.

Nicole Cooney: Thank you.

Operator: You're showing no further feedback on this topic.

Feedback Session 3 -- Geographic Areas For Analysis

Nicole Cooney: Okay, thank you. We will now move on to our 3rd topic, geographic areas for analysis. Please consider the questions on this slide as you queue up. We want to limit ourselves to this topic and keep our 3-minute maximum in mind. Nicole, we're ready to queue up.

Operator: To provide feedback, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name and organization. Please note, your line will remain open during the time you are providing your feedback.

So, anything you say, or any background noise, will be heard in the conference. Please hold while we compile the roster. Please hold while we compile the roster.

The first feedback comes from the line of Richard Ramos.

Richard Ramos: So, the question is the scope of practice for Advanced Practice Nurses and Physician Assistants. I think as CMS has looked at opioid overdose and death in general, they look at it throughout the region of the state. So, I believe the state level would be too generic and unless it's going to be significantly cost prohibitive and/or take too much time.

I think physicians like myself or these other allied healthcare professionals would definitely want to know, do they live in a portion of the state that has a problem. We all know that there is a national problem, but I will tell you, oblivious to know how bad it is in my locale.

So, I think a generic state level is a good start, but I think we need to know where the pockets are in each individual state unless it's cost-prohibitive or time-prohibitive.

Nicole Cooney: Thank you.

Operator: Again, to provide feedback, press star followed by the number one on your touch tone phone. The next feedback comes from the line of Ken Hilsbos.

Ken Hilsbos: Hi, I'd like to echo the last point and specify that in my state of West Virginia, I live in and practice in North Central West Virginia, where the most recent data that I have seen by county shows that in this entire part of the state, the opioid mortality problem appears to be about the same as the national statistics.

So there are pockets in West Virginia that are far, far worse than where I am, and I think the geographic analysis should include consideration of these pockets and is he now says occurring in the pocket or out of the pocket, there about 3 areas in this state. The issue with that could be that if you divide it up too much, you might not have enough data to analyze meaningfully. So, there's a trade off in terms of what kind of data can you get.

Nicole Cooney: Thank you.

Operator: And again, to provide feedback, press star followed by the number one on your touch tone phone. The next feedback comes from the line of Henry Taylor.

Henry Taylor: Hi, this is Henry Taylor again from Cecil and Carroll County Maryland, and several times folks were referred to the state variability under the constitution that helps as an issue that is governed by the state.

The issue is governed by the state, and not federally, so that whatever CMS does, if there were way, they might want to set sort of some minimum standards, but allowing for state efforts to be almost preemptive, or somehow recognizing the state effort that's going on if it meets or exceeds the CMS standard, then I would look for ways that your rule will may be exempt those states.

And then as I mentioned, where we County-level initiatives that are trying to do the same thing. And are you sure right now and my two counties is, we have identified some physicians and clinicians, but we're struggling with exactly the same issues as CMS. So, if we work out a way, or could get technical assistance for

approaching and getting the data for these clinicians compared to their peers, then at the county level health department and overdose fatality review teams would be a better way to intervene.

So that was the main point, recognizing that the law requires CMS to take action, what I was thinking is that you could have some ways if a jurisdiction had an effort in place that met or exceeded CMS standards and then that jurisdiction would be allowed to proceed with what it was already doing. Thank you, sorry I got a frog in my throat there.

Nicole Cooney: Thank you.

Operator: We are showing no further feedback on this topic.

Feedback Session 4 -- Recommendations On Opioid Prescribing Guidelines

Nicole Cooney: Thank you. We will move on to our final topic, as noted in the beginning of the call, we'd like to hear your recommendations on opioid prescribing guidelines. Please limit your input to this topic and keep our 3-minute maximum in mind. Nicole, we will go head and queue up.

Operator: To provide feedback, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you are providing your feedback. So, anything you say, or any background noise, will be heard in the conference.

Please hold while we compile the roster. Please hold while we compile the roster.

The first feedback comes from a line of Donald Taylor.

Donald Taylor: Hi, this is Donald Taylor conferencing from Atlanta, Georgia. I just think that, you know, there's an adage that says just because you can do something doesn't mean you have to do something. I certainly think that the CDC's guidelines have had an incredibly injurious effect on patients in the United States.

We don't really know how many deaths have occurred from suicide based on reactions from physicians to these guidelines. I do know that in my own personal practice, I have seen many. I'm not talking about 1 or 2, I'm talking about 10s and 20s. Patients who have been forcibly opioid reduced by their practitioners, essentially thrown out of the practice after having spent sometimes years on stable doses of opioid, because of the CDC guidelines.

It has been horrendous what has happened to many people in this country because of those guidelines. So my statement is if you're going to have guidelines, you need to be compassionate, you need to be careful, and you need to put some real thought into it, and not just fire from the hip, like these yahoos at the CDC did, not knowing what they were doing.

And now they're having to come back, as you probably know, they've retracted much of what they said. And unfortunately, in my area, it's many times it's been the pain practitioners who have actually fired these patients, not necessarily just primary care that is doing the same thing, but it's just been used as an excuse to get rid of

any patient that the practices says well, you know, we're really nervous taking care of you, because you're beyond the CDC guidelines and I know those guidelines were from primary care and I'm a pain specialist, and you're out of here.

And I have seen that many times, and it's just we need to develop guidelines that are rational and well thought out and they don't need to be based on how many – if you have certain number of MME, you can't exceed that. Maybe if you have a certain number of MME, you need to be seeing a pain specialist.

But you know what has been done today has just been travesty of the practice of medicine. It's reflected in the fact that opioid prescribing has decreased over the last few years dramatically, but opioid deaths have continued to increase dramatically, suggesting that it's not the physicians that are driving the problem at this stage of the game, it is the drug dealers.

And to come around and try and treat, good well-meaning physicians as if they are drug dealers is going to do irreparable harm to the medical practice of medicine in this country and is going to create a rift between government and medicine that is going to take years to heal. So just some thoughts as you proceed with this endeavor. Thank you very much.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Audrey Hansen.

Audrey Hansen: Thank you. This is Audrey Hansen from ICSI again in Minnesota and I would like to thank the previous speaker. He said that very eloquently. One of the things that we notice is that if there are no guidelines out there that are right yet. And the tendency is to make a one-size-fits-all and that does not work.

Our patients are unique, they're individual. The practices are unique and individual. And to say that one method, one amount, one day amount, everything, is not how medicine works. And our patients have been suffering from that including our palliative care patients as mentioned before.

The problem I think is that there is, so for instance, in Minnesota. We got the physicians around the table and we are working on as many guidelines as we can to understand what is the right amount, and unfortunately this takes time and resources that we aren't paid for, and so I think the funding is kind of going to the wrong thing.

And the other problem is that there's a lot of -- there's a lot of money being put towards restricting prescriptions and treating, treatment, but there's not a lot of effort going into helping the physicians understand that since mental health and medical record privacy has been separated from primary care for so long, primary care doesn't remember how to treat addiction or mental health, because it's been so separated.

And now we're saying you have to handle all of your addicted patients and get wavered to treat, and we're like, the gap in understanding has gotten too big. So, we're trying to re-educate primary care to help them understand how to recognize substance use disorder. We're trying to encourage them to treat their patients with medication-assisted treatment.

These are things that take so much time and energy and resources, and there's just no funding for that. I also feel that there are so many one-offs. So, this pharmacy will do that, that pharmacy will do that, another pharmacy benefits will make another rule. And as you've heard, there is a lot of rules. And if the government could just say stop it, you can't each make up your own rule and prohibit the care that is being provided to the patient because the patient can't keep up and the provider certainly can't keep up.

There's too much causality around it and that's why they're saying I'm not prescribing anymore. So if we can find ways to treat our patients more individually to support the work of good solid evidence-based research to find better ways to manage pain, to find better ways to understand how much is enough, how low is too low for our treatment guidelines, that would be very helpful. Thank you.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Michael McNett.

Michael McNett: Yes, I have to say I couldn't disagree more with some of the comments that I've heard here today. As you look at the actual meta-analysis regarding patient response to chronic pain, what they show is that on average once pain treatment gets past two months of duration, it provides less benefit than a patient can perceive.

When they quantify it, it comes out to about 15%? When patients need a 20 to 30% improvement in pain to go from saying that if treatment is had no benefit to saying that it's had minimal benefit. That was also established by a meta-analysis. So, we now have three meta-analyses. It shows that the pain treatment does not provide adequate benefits for a patient to appreciate.

Traditionally, it has only taken one for us to change our practices and yet doctors continue to ignore the data that is out there showing how poor-quality pain management is when they use opioids chronically. So, I think basically I'm surprised that insurance companies continue to pay for it.

I think that the bottom line is that we have to provide safe and effective treatment for our patients in pain. Opioids are neither safe nor effective. They have astronomic toxicity with imperceptible benefit. So, I think overall what we're looking at is over the next 5 to 10 years, we're going to be moving toward an attitude that chronic opioid management is considered inappropriate unless at end of life.

And so, what we have to do is develop reasonable guidelines. There is no evidence of higher dose opioid prescribing is any better than lower dose, in fact it’s associated with increased adverse effects and mortality. So, I think that we really need to be willing to accept the CDC as an interim measure and move from there. Thank you.

Nicole Cooney: Thank you.

Operator: Next feedback is from the line of Kerry Allen.

Kerry Allen: Hello, again I really – I know this is a difficult topic for everyone. I would agree that there's not a good set of guidelines out there, especially for populations that generally speaking have a lot of multi-morbidity,

and that's not taking into consideration that often there is some guidelines out there that, you know, I have to, the post-acute care and in post-surgical care where they're trying to get multi-modal efforts out there.

But it's difficult, especially in our elderly patients, and safety and adverse effect are so prevalent in those people. So, I would need more funding, and more evidence-based medicine, and more opinions based from the practitioners on the line. So that we can merge safety as well as getting other choices for people besides opioids, but also considering that people, especially older adults who have multi-morbidity, and chronic pain in particular may have very few choices other than opioids, that may have liver disease that precludes them from having a higher dose of acetaminophen that would be affected.

They may not be able to have taken NSAID due to heart issues and those kinds of things. And they may not have access to the non-pharmacological aspects due to mobility or location where they're at. So, I think this is an area that is lit for improvement and we're probably just not quite there yet.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Ken Hilsbos.

Ken Hilsbos: Hi, I practice solo family medicine in Fairmont, West Virginia, which is in Marion County in the north central part of the state, a very geriatric area, not much availability of non-interventional pain specialist. In West Virginia, a large part of the CDC guidelines were copied and pasted into state law that has had, in my experience, a catastrophic consequence for many patients.

It depends on where the patient falls in relation to that particular law, and it's my impression that even in my local area where prescription opioids are not the problem that they are in certain parts of the state. Folks who move here very often, some, you know, high-functioning person is brought in by their company and suddenly they find out they can't find a doctor.

And I have to tell them this. Under the current state laws referring to a different state law now it means in affect that the disincentives for me as a family practitioner are such that I do not accept any new patient that is already on opioid medication. I fired a patient who is not already on opioid medication. They are already my patient. They're not going to be a chronic opioid patient really under any circumstances.

So, the point is that the effort in West Virginia well intentioned, but catastrophic consequences, and we need to be really careful. My next point is that in this call I'm hearing a very, very generalized identification of the problem, and as a family medicine specialist, I don't see an opioid problem. I see a multitude of problems related to opioids.

And I think if we define what problem exactly are we trying to address, it will make it easier to design an appropriate remedy to try that we can then see how well it works. For instance, at one time there was an issue with pill mills, so-called pills mills in West Virginia, and the approach to that was in my opinion extremely ham handed and not carefully done and it probably had a lot of the intended consequences, but it also had fairly major unintended consequences.

So, we need to be very careful, we need to define what the problem is, or problems are, that we're trying to address. I think we have to be much more specific in our work as physicians, we have to be pretty exact about what is the diagnosis before we get very far thinking about what is the treatment.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Richard Ramos.

Richard Ramos: I appreciate the physician who made the comment about why are we continuing to write these medications. It's good to hear both sides of the story. Obviously, I'm more biased of continuing to write the medicines. We all know meta-analysis have their pros and cons. I'm not here to -- certainly I'm not a statistics major either, but I think we also have to look at our patients individually.

The baby boomers are coming to roost and a few years ago obviously I hardly ever saw 90-year-olds. I'm now seeing 90-year-olds on the daily if not weekly basis. In a few more years, we are going to be 100- year-old patients. And my concern about this is our surgical colleagues, no fault of their own, are just saying you're too old, can't operate.

So, these patients are having a significant amount of pain in pretty much I - they come to me because I'm the guy in town who takes care of these patients. And I don't really have a lot of options either. And I do my best to follow the guidelines even though I'm a pain specialist and I'm doing chronic pain, not acute pain.

But as I've stated earlier, I've got a target on my back just like the primary care doctors. If I have a bad outcome, rest assured I'm going to get investigated just like anyone else. But my concern is we have to have these medicines available, certainly not every person who comes in my clinic gets, you know, the cocktail of Xanax, Soma, and 30 milligram Oxycodone like the pill mills did or still do in Florida, as an example, or any other place that is considered a pill mill, that is just not acceptable medical care and that's getting lumped in to all of these well intentioned, educated physicians who are on this call, who were then getting lumped in, as we have stated earlier, with all of these outlying physicians.

And so, we're getting thrown out with the bath water, but yet we are conscientious in trying to the best of our ability to do the right thing. The only thing I would say to that physician is if he or she or a family member is in their 80s or 90s, and is not a candidate for surgery, injections don't help. They've got, as someone stated, chronic heart disease, strokes, kidney failure, and they can't do physical therapy because they develop contractures.

What are you going to offer that patient? So, to say that in two months, these medicines don't give any benefit, that's again truly determining again not to argue those studies, but 30% clinical improvement or two numbers on the pain scale. We all know that that's not meaningful in chronic pain. Chronic pain is function.

So, if our patient can go to church, can go to the doctor's appointment, can live independently. Some of those studies, I could be wrong, but don't address that. They were just looking at pain scale and 30% improvement and so a lot of these studies are missing what we see on a daily basis on the front line with individual patients showing improvement.

Now I agree with what he's saying. I don't give 20-year-olds, 30-year-old strong opioids. I say suck it up, you're going to have to live with some of this. But man, my patients who are 70 and 80, who were not surgical candidates in who are -- I mean I'm almost crying as I see them come in my office.

Physicians have to have the ability to show compassion and use these medicines, but one last comment, thank you for being patient. The only way I see that physician's dream coming true and I do worry about it. I do feel it's going to happen in my lifetime, is the government saying just like he was saying, you can only have one, two or three diagnoses for post-op pain, hospice, cancer pain, which again is not only see a small percentage, but probably not as big as chronic non-cancer pain, which again is a majority of what I treat.

Unless you have that law go through, I just don't see how I can look at a patient and not offer this medicine after all of those other treatment options are not an option or have failed. Thank you.

Nicole Cooney: Thank you.

Operator: The next feedback is from the line of Donald Taylor.

Donald Taylor: Yes. I just want to sort of echo what the previous speaker just said. The truth is that opioids are here to stay. They're the number one analgesic in our armamentarium, I don't treat meta-analysis, I treat patients. I've been doing chronic pain management with opioids for 30 years and my patients, not all of them benefits, but many of them do.

And sometimes, as the previous speaker said, it's the only thing you have left to offer these people. As a matter of fact, almost all the patients that I treat are in that situation. The only thing they had blocks; they have had surgery. Some of them are on nonsteroidal, some can't take nonsteroidal because they're on stage three or four kidney disease failure.

You really don't have any other medications that you can offer some of these patients. And I can tell you after 30 years of practice, it works for a lot of people and it works well for some of those people. I see improved function, increased ability to work on the job. I have people, they tell me they could not perform their duties at work without these medications.

I have grandparents, they couldn't pick up their children without these medications. So, these medications are here to stay. What we need to do is figure out, how we use them successfully, and how we use them safely and that is going to be through educating the physician workforce in this country, and not through draconian punitive measures against prescribers and to tell somebody they're an outlier prescriber.

Well, maybe they are, but maybe they're the only prescriber in their area who is willing to see these patients where nothing else works. So, I think we need to be very careful about how we proceed. Let's not throw the baby out with the bathwater. Let's not yield to the hysteria opioids don't work, that's just hogwash. And let's be real, let's think these drugs have been around in our armamentarium for something like 2000 years. They're not going away. Thank you very much.

Nicole Cooney: Thank you.

Operator: We show no further feedback on this session.

General Feedback Session

Nicole Cooney: Thank you. We'd like to open it up here at the end, since we've reached the end of our four specific topics, to a general session. So, if there are no other comments on these four specific topics, is there anything else you would like CMS to hear? Nicole, could you please queue folks up.

Operator: Certainly. And to provide the feedback, please press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name and organization. Please note your line will remain open during the time you're providing your feedback. So, anything you say, or any background noise, will be heard in the conference. Please hold while we compile the roster. Please hold while we compile the roster. First, we have Diane Cornelison. Diane, your line is open. Again, Diane your line is open.

Next we have Donald Taylor.

Donald Taylor: Yes, I just wanted to follow up on something somebody said earlier. I get letters from insurance companies every day on multiple patients about what I'm prescribing them. Everything from do you prescribe this 60-year-old patient 10 milligrams of amitriptyline and it's not safe to use in the elderly, and it's getting to the point where you just sort of ignore all these things because they're almost overwhelming.

I can tell you letters from the CMS to outlier prescribers are not going to be well received and if not done well, or just going to end up in the circular file like all these things we get from insurance companies. I want to reiterate -- I don't think the way to address this quote unquote “opioid crisis” is with punitive actions against physicians or actions that what do you mean and punitive or not. This will be seen as a punitive action.

I think we need to invest our money in education, not be throwing it away on just tracking how many prescriptions a physician is writing. Thank you.

Nicole Cooney: Thank you.

Operator: Next we have Ken Hilsbos.

Ken Hilsbos: This is Ken Hilsbos, family medicine, West Virginia. I'd like to go back to question that I described earlier. First of all, thank you for the opportunity to speak about this. I'm wondering can the host narrow this down any, I did not have an opportunity to, you know, study up on this law or find out what exactly you guys are after.

You know can we narrow this down, a little more narrow than we have an opioid problem.

Dr. Barry Marks: Hi, -

Ken Hilsbos: - which opioid problem or which part of the opioid situation are we most talking about here.

Nicole Cooney: Give us one second.

Ken Hilsbos: Okay, thank you.

Dr. Barry Marks: Hi, this is Dr. Marks again. So, thank you very much for that. And I appreciate that not everyone on the call may have had the opportunity to review the material that we sent out as read ahead, which included these language of Section 6065.

I think that out of respect for the other people on the call in the remaining time that we have, what I would encourage is that if you've not had a chance to review the statute that at your convenience, take a look at it. But I think that I really am anxious to get as much feedback from other folks on the call as we can in the few minutes remaining but thank you very much for raising this issue.

Operator: Next we have Jacqueline Kaczynski.

Jacqueline Kaczynski: Hi, again I'm with the American Academy of Hospice and Palliative Medicine. I wanted to echo some earlier comments around opioids being necessary, and asserting that they in fact can be used safely, and they're essential to the practice of Palliative Medicine and Hospice Medicine. And I think it's critical to elevate the knowledge of appropriate prescribing, and we are happy to partner with CMS in that endeavor.

However, I want to make sure that as we're talking again about the guidance and guidelines that we are mindful of the fact that pain is not only going to differ by condition, but by the individual, and we need to maintain the ability to individualize treatment to patients according to their history, to their circumstances, have they had complications in treatment.

What is their pain syndrome? What are risk factors? What are other underlying illnesses? Their life expectancy? The creative control and monitoring available to the treatment team what are the goals of that treatment for many patients, not just relieve this pain someone had said, but physical and mental function preserved, work, and family roles, quality of life, survival.

So, we're very concerned that they're not continue to be a chilling effect on appropriate prescribing. And I would urge CMS to set up an email box to accept any further comments on the items that were listed on the slides today. So, folks who were unable to join could continue to weigh in for a period of time. Thank you again.

Nicole Cooney: Thank you.

Operator: Next we have Cindy Moon.

Cindy Moon: Hi, I actually just wanted to reiterate the comment about setting up an email box, and I was curious about CMS's timeline and expected next steps as far as collecting additional information and putting forward its final guidelines for how these outlier prescribers can be identified, and also wondering if there are other opportunities to provide more formal feedback like through an RFI. I'm just concerned that this then you may not have, you know, gone to everyone who may be interested in commenting.

Nicole Cooney: Thank you very much for the suggestions.

Operator: Next we have Audrey Hansen.

Audrey Hansen: Hello, this is Audrey again from Minnesota. I think there's a real problem in that, we pay for it like diabetic, chronic condition management. We pay for heart failure management. We pay for lots of these chronic conditions and chronic pain is a huge time sucker for our providers. And there aren't enough dollars to give them enough support staff to help them manage these patients, especially ones who are taking some long-term opioids.

And that could be weaned and that could be finding other treatment. So, part of this is allowing enough money to be paid to the clinics to allow them to manage these patients appropriately because there are other ways to manage them. We just can't do it. Thank you.

Nicole Cooney: Thank you.

Operator: Next we have Henry Taylor.

Henry Taylor: Hi, I am Henry Taylor from two counties in Maryland. Two comments, one is I think if you look at sections 6065, the first part focuses on identifying outliers, but the second part is really doing educational message, which I think the other Dr. Taylor had really been stressing, and need to educate physicians.

And so, I think CMS might be able to fulfill by the way to mandate by really focusing on what types of educations the various clinicians need and how should education will be targeted based on geography, based on specialty, working with the different associations.

So, I think there could be a win by focusing on education, and then how do you identify the types of clinicians who need particular types of education, and that was point number one. Point number two is again a very strong appeal to use– to use stated local channels that already exist.

We've heard about very state initiatives. I'm involved in these local fatality review teams, where we bring together many different agencies in the community. We have protection from discovery. We're able to really look at the patterns of both overdoses and mortality at a local level and figure out what are the types of changes that will work, and you know maybe, in some of the outcomes of that we're able to leverage in Maryland.

We have the total cost of care. We have some efforts that are available to us to provide support to practices through a variety of means. So that's somehow, if that could be woven in into the policy. I'm not sure it needs to mandate in 6065 as much, but I do think there needs to be accommodation for state and local initiatives that are trying to do it. So those are my two comments, thank you.

Nicole Cooney: Thank you.

Operator: Next we have Regina McNally.

Regina McNally: Hi, this is not in that specific opioid, but in reference to physician specialty and geography, has CMS considered utilizing the data that's contained on the NCI file through NPES? Thank you.

Nicole Cooney: Thank you.

Operator: Next we have Richard Ramos.

Richard Ramos: Thank you again. So, I was reading the mandate of the SUPPORT Act as the other physician talked about. This whole Act is to identify outliers compared to their peers and encourage them to reference established opioid prescribing guidelines.

So number one, we do have a hospice and palliative physicians on the panel, and we all know that the CDC did not -- the CDC guidelines, they came out 2016, didn't even apply to them, but yet somehow they were being enforced towards patients she was taken care of.

So, CMS has to do a much better job of again figuring out who they really want to go after because they did go after physicians who were taking care of patients, who were in hospice care, and that didn't even qualify in the guideline.

My next point is this, again I do believe that this is good information, but CMS definitely has to be able to categorize which group physicians are in, otherwise as I've stated earlier I'm going to be deemed an outlier and does that mean I'm going to get investigated.

Number three, I do see 35 to 40% of Medicare. Obviously, I don't want to get kicked out of Medicare and Medicaid. We know that CMS has a lot of power and this cannot definitely be used punitively against physicians. Because in my opinion, the whole point of the SUPPORT Act even though the point of doing this is to prevent overdose and to take care of pill mills.

You also were possibly going to take down well-intentioned physician, of which I assume the majority are who are on this call and there can't even be many of us, but CMS has to definitely be careful. Or we're going to end up in the same problem we have with the CDC guidelines going through, and then physicians rightfully misinterpreting the guidelines in feeling they had to either get rid of these patients or I got to start decreasing you under 90 morphine milliequivalents in a 24-hour time frame and as multiple physicians have already discussed is disastrous.

So, CMS once again, I implore them. Before they run this through, they better be ready for the repercussions because I'm concerned it's going to be almost a similar thing that happened when the 2016 guidelines came oh geez . I got my mark on my back. I'm getting out of the business and I'm decreasing all my patients, etcetera.

And trust me there is not a day that goes by as I've already stated, even though I'm a quote unquote "pain specialist." I'm an outlier in my city and in my state. I am still able to sleep at night, but am I being watched by big government and don't get me wrong I'm glad I'm an American. I don't want to be anywhere else, but CMS as we are stating again, is using all of this punitive. There are very good state initiatives that possibly CMS needs to enact before this letter goes out to these outlier physicians, because all it takes is a review from a physician, although that costs money and time to really see whether or not this physician who was being an outlier is legit or not.

But totally I understand that that's going to cost time and money as we've already stated, that physicians are spending a lot of time in uncompensated work. And I'm not sure how many physicians want to review charge for CMS gratis, but they definitely better be cautious of the rolling out of this act. Because we're potentially going to see the scene, outcomes that we had when the CDC guidelines came out in 2016. Thank you.

Nicole Cooney: Thank you.

Operator: Next, we have Randall Lewis.

Randall Lewis: Yes, I am an orthopedic surgeon, probably the only one on this call. I think that there is a real need for education and everyone so far who says has stressed that has said all we need to educate people as to what they should or shouldn't prescribe.

There's been a great deal of work done in orthopedics in the past few years on what patients do not get good surgical results and what patients continue to use, abuse, overuse, and become addicted to narcotics after orthopedic procedures.

This is not a little problem. Hip and knee replacement are the most common procedures performed under Medicare, and what we're doing is looking at the end of the story and not at the beginning. There should be some indication of what the indications are for the initial prescription of opioids.

In our experience, people come to the doctor and say I have terrible pain, I can't work, I can't do this, I can't do that, but I don't want surgery. And the doctor feeling that the patient needs help etcetera, says well these pills are dangerous, you have to be careful etcetera, but I will give you some and hopefully that will get you by.

And the experience of our specialty, that is a disaster. Because you've started the patient on an inappropriate treatment which is narcotics for their arthritis pain, whether it'd be the hip or knee or anything else. And the chances are that you're going to compromise what they can do. I think that there is a real need if we're going to educate our patients to educate the physicians, the primary care physicians on the patients who should not be begun on opioids.

We should stop the huge number of patients who are getting ill, indeed and often lead to deaths, because they got the wrong medicine in the beginning. And I think as far as the indications and the geographic and specialty considerations which are part of this Act in the reason we're having this conference today should be incorporated into the recommendations from CMS, because there are many physicians who unfortunately do not have the right education and are prescribing opioids for things which, at the point where they're necessary, should go to a different sort of treatment perhaps surgery, perhaps something else.

Many of our patients should not have gotten the opioids in the beginning and it compromises everything else, period.

Additional Information

Nicole Cooney: Thank you very much. Unfortunately, that is all the time that we have today. I'd like to thank everyone for participating and thank Dr. Marks for presenting today. An audio recording and transcript will be available in about 2 weeks at go.CMS.gov/npc.

Again, my name's Nicole Cooney and thank you everyone for participating in today's Medicare Learning Network Listening Session on Opioids, What's an Outlier Prescriber. Have a great evening everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect, presenters please hold.