Pain In The Time Of Opioid Denial: An Interview With Aric Hausknecht, M.D.

By Josh Bloom — July 30, 2017

Aric Hausknecht, M.D., (1) who is a neurologist and a specialist in pain management, kindly agreed to speak with me about how changing opioid laws and regulations have affected his practice and patients, as well as what these changes will mean for pain patients across the U.S.

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JB: Dr. Hausknecht, thank you for taking the time to speak with me about the radical changes in the way opioid analgesics are being viewed and prescribed. I believe that this is one of our most important public health issues at this time, and it is urgent to address it very quickly. Do you share this sense of urgency?

AH: I believe that we have reached the level of a crisis. On one hand, patients in pain have limited access to opioid analgesics and doctors across the country are being deterred from providing legitimate prescriptions. These patients in pain will end up self-medicating in potentially dangerous ways or will have inadequately treated pain. On the other hand, misuse and abuse of prescription narcotics have reached epidemic proportions and drug overdose is the leading cause of death from unintentional injury in the USA. It is going to be a challenge to reconcile these dual public health burdens.

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JB: I have been contacted by a number of pain advocacy groups. Although I have no data at this time, anecdotally it would seem that there is now considerably more patient suffering and that stories about suicides are not uncommon. Has this been your experience?

AH: I have not seen any suicides but certainly my patients are suffering more because of limited access to medications and are also struggling to get prescription coverage. The struggle for prescription coverage in and of itself can cause considerable stress and this is detrimental to controlling pain. It is very disconcerting to a patient that relies on pain medications to function on a day to day basis to worry about whether or not he will have his medications in the future. It also drives a wedge in between the doctor and patient since they have a difficult time understanding or accepting that it is not the doctor who is limiting these prescriptions. Many of my chronic pain patients are able to work as long as they have their medications. Without them, they would not be at work. Many of my patients cannot get out of bed if they don’t have their pain medications. It is a cruel and unusual punishment to deny these patients access to opioid analgesics.

JB: We are now routinely seeing “tapering” —sometimes severe— of the doses that long-term pain patients have been receiving with the intent of weaning them off opioids entirely. Regulators have strongly urged fixed, mandatory daily morphine milligram equivalents (MME).

AH: I believe that each patient should be treated and evaluated on an individual basis. It is inappropriate to assign a fixed MME to a patient. I try to prescribe the lowest possible MME that will adequately control the pain but this is a process of titration and it is unique to each patient. Additionally, I employ poly pharmacy and generally, my chronic pain patients will be on several other adjunctive medications.
JB: *Let me follow up.* States are beginning to pass laws that place a 100 MME per day cap on the daily dose of opioids. Do any of your patients require higher doses?

AH: I have some chronic pain patients that take more than 100 MME. For these patients, the medications are effective. Once again, each patient is unique and it is inappropriate to assign a ceiling or mandatory fixed MME. Some patients will tolerate and respond to doses of more than 100 MME and others won’t. It is the pain practitioner’s responsibility to make this determination clinically and should not be arbitrarily assigned.

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JB: Have you been forced or “encouraged” to wean patients off opioids? How do your patients react to this? Have you or your colleagues stopped accepting new chronic pain patients?

AH: Insurance companies have employed significant pressure to wean patients off of opioid analgesics. I have received numerous “peer reviews” recently by doctors and nurses who retrospectively review patient records and make a recommendation to wean off medications, citing various sources. There is never actually an evaluation of the patient.

Additionally, many of my chronic pain patients receive their coverage through the New York State Workers Compensation System. [2] The WCB has passed regulations that, in my opinion, significantly reduce access to opioids, although purportedly they were designed to guide care. I find the guidelines are prohibitive and require burdensome medical care that is difficult, if not impossible, to provide such as mandatory psychological testing and counseling and bi-weekly visits.

Additionally, the WCB has enacted a new form wherein an insurer can just check a box on a form and the medical provider is required to submit a letter of medical necessity in order to maintain the prescriptions:

"Request for Further Action by Carrier/Employer (Form RFA-2): An insurer may request a hearing specifically to consider whether the claimant should be weaned from opioids. Form RFA-2 has been changed to include a new hearing purpose under the Medical Issues section of the form. To request a hearing to consider opioid weaning, check the box on Form RFA-2 labeled “Opioid Weaning under Non-Acute Pain Guidelines.”

Many doctors have stopped prescribing opioids altogether. I receive phone calls all the time from patients looking for a new pain doctor because their previous physician stopped prescribing. The New York State Department Of Health laws have significantly deterred doctors from prescribing opioids. Requirements include checking the NYS DOH Prescription Monitoring Program every time, utilizing a cumbersome system to e-prescribe, which involves software and the internet and text messaging simultaneously in order to obtain a one-time passcode (these two steps alone take at least 10 minutes for every prescription), a law that limits the first prescription to a seven-day
supply, and a law that requires doctors to take a CME course and attest to it. It is pretty clear that the powers that be in New York State do not want doctors to prescribe opioids.

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**JB: How are these changes affecting your approach to pain management?**

**AH:** I am definitely more cautious about prescribing opioids, but I have always been very careful in my office and have adhered to strict guidelines. All patients sign a pain management agreement. All patients are subject to random urine toxicity testing. All patients are required to engage in adjunctive treatment such as physical therapy and non-opioid medications. My approach has not changed too much, and I have been steadfast in my commitment to provide pain relief for my patients. But for sure, I don’t write as many opioid scripts as I used to. And for sure, all of these regulations have significantly increased my workload and overhead.

**JB: There is considerable controversy about the role of legally prescribed and appropriately used opioids in the current overdose crisis. While the CDC maintains that over-prescription of opioids for pain patients is root the cause of today’s problems, literature reviews suggest that addiction is rare in these cases. In your practice, how often do you see addiction?**

**AH:** It is an accepted medical fact that pain patients on opioids that are properly managed are unlikely to become addicted. In my practice, I rarely see patients that become addicts. I see human beings who are suffering from pain that is relieved by opioid analgesics.

**JB: One regulatory response is to offer “alternative modalities,” from drugs such as NSAIDs, Tylenol, off-label antidepressants and seizure medications, to acupuncture, yoga, meditation, and cognitive behavior therapy. Do you have pain patients who have successfully made this transition or have failed?**

"Tylenol is by far the most dangerous drug ever made."

**AH:** I employ all of these alternative approaches that you mentioned (as well as physical therapy, chiropractic, and exercise). Each patient is unique and it is the responsibility of the pain practitioner to determine which of these modalities are appropriate. But for chronic pain patients on opioids, it is unlikely that any of these modalities will eliminate the need for medications altogether.

**JB: The current meme is that opioid pills responsible for most overdose deaths. But a closer examination reveals that deaths “from pills” usually involve other drugs, especially benzodiazepines and alcohol. Additionally, fatalities arise due to liver failure from the acetaminophen (Tylenol) that is combined with the opioid in most pills. Do you agree?**

**AH:** I agree. Tylenol is by far the most dangerous drug ever made.
JB: This is a complex, difficult situation with no easy answers. How would you even begin “fix” it?

AH: The first step is to acknowledge that there is a crisis. The second step is to gather together some of our great thinkers including doctors, nurses, educators and public health administrators to brainstorm and come up with some recommendations. Based upon these recommendations, national clinical studies should be initiated. And I stress national because there is so much disparity between the States in regard to pain management and opioid prescriptions. The approach should be the same from state to state, just like it is for stroke or heart attack treatment. Once the trials have been completed, maybe we can start making some meaningful changes.

Aric Hausknecht, M.D. is a New York-based neurologist and pain management specialist who currently practices at Complete Care, a community-based outpatient clinic. Dr. Hausknecht’s training included stints at Memorial Sloane Kettering Cancer Center, NY Hospital Cornell Medical Center, Beth Israel Medical Center, and Mount Sinai School of Medicine, all in New York. He is board certified in neurology and certified in pain management.