When opioids aren't the only answer

By Allison Pohle | September 29, 2016

Earlier this year, in the wake of harrowing statistics about opioid overdoses and deaths, the Centers for Disease Control and Prevention issued new prescribing guidelines for physicians. Opioids, the agency suggested, should not be prescribed as "first-line" therapy for chronic pain, and should be used alongside a range of alternate treatments, from anti-inflammatory medications to meditation and psychological counseling.

But getting the millions of people with chronic pain to switch to alternative treatments is a daunting task for many physicians — one that involves navigating inconsistent insurance coverage, facing resistance from patients, and changing the longtime habits of doctors themselves.

"Our training for the past 15 to 20 years has been left over from this 'pain is the fifth vital sign; you must treat all pain' mode of thinking, and people have been taught to give copious narcotics because we must treat all pain," says Melissa Rathmell, M.D., director of integrative medicine at the University of Massachusetts Medical School. "[Physicians are] now being told, 'Don't use narcotics,' but [they] aren't being given other tools."

Narcotics work by masking pain, but they don't treat the cause of it, which is why chronic pain patients often require many modalities of treatments — sometimes including opioids, Rathmell says. In many cases, the type of chronic pain patients experience will never be completely eliminated, but, rather, managed.

But while chronic pain benefits from interdisciplinary care, pain specialists note that the healthcare infrastructure is largely not set up to provide services in this way. And doctors often don't have the time or information to determine all causes of pain, or to find and treat related ailments.

For instance, chronic pain patients are more at risk for depression, says Anita Gupta, vice chair of the Division of Pain Medicine and Anesthesiology at Drexel University College of Medicine. But many physicians and pain physicians are not screening for depression or treating it.

"Some patients have anxiety disorders that have been undiagnosed, which can contribute to their fear of lowering their dosages or trying alternate therapies," Gupta says. "It's easier to keep writing a prescription than get someone into therapy."

Even when patients do receive mental health treatment or incorporate alternative therapies, many of them struggle to receive coverage from their insurance companies. Physical therapy, for example, is generally capped at a reimbursement limit of $1,960 under Medicare Part B unless the patient is eligible for an exception.

"Insurance plans will easily cover opioids and will not cover alternatives like acupuncture or exercise programs," says Peggy Compton, Associate Dean for Research, Evaluation and Graduate Programs at Georgetown University. "Opioids are very cheap, which is why it's much easier for an insurance company to tolerate them."

One reason for the lack of coverage is a lack of data: There isn't a large amount of convincing research to support their effects. Most research on pain treatment is sponsored by drug companies — and that's the information that gets published and put in front of physicians and insurers, Rathmell says.

"Non-drug methodologies are much more difficult to get funding for research because [many] are individualized and are very patient or provider intensive, so the classic double blind study is really not possible," she says. "It diminishes the perceived effect. Without drug company support, it's difficult to find the money."

And while a physician can appeal an insurance company's rejection, that process can take many months to complete, Gupta says.

"The appeal could involve another form or a peer-to-peer review, which is another doctor determining whether the treatment is necessary. It can be very tedious, and physicians just don't have time for it," she says.

The administrative challenges can leave physicians feeling as though they're barely keeping their heads above water, says Stephen Martin, a family physician and associate professor at the University of Massachusetts Medical School.

And though the CDC's recommendations are voluntary, Martin worries that doctors will take them as the gospel for prescription practices — though chronic pain patients need individual programs for tailored treatment.

"I'm all for providing a scaffolding and reinforcing interventions," for chronic pain, he says, "but that can include finding a job and getting stable housing and a great physical therapist, as well as taking opioids and using a lidocaine patch."

Some chronic pain patients have no history of drug abuse or addiction and function well on higher doses of opioids, he says. "This recommendation could lead to some arbitrary decision-making."

Still, Martin and other physicians say that, in terms of prescribing for acute pain, lowering both dosages and the number of pills provided will be a helpful step forward in combating the epidemic.

"It's hard to do this well, and it's hard to do this well over time," Martin says. "But some of the most remarkable things happen if pain is managed well. People have improved function and can take care of their grandchildren. They can keep their jobs and take care of their families, or they can pick up volunteer work. All the things that matter in this world can get better by being thoughtful about chronic pain."

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