Response to Dr. Ehlenberger as an opioid prescribing outlier

Why a direct comparison between my practice and a typical pain-specialist benchmark is not an apples-to-apples one. The higher mean MME in my practice is the predicted result of case mix and patient tenure, not of aberrant prescribing.

Most pain specialists are interventionalists, and their opioid role is different

Long-term opioid prescribing has become increasingly concentrated among a subset of pain medicine specialists as overall prescribing has declined (Buonora et al., *JAMA Network Open*, 2026). The majority of pain specialists practice interventional pain medicine, where analgesia is delivered primarily through procedures. For those patients, procedures are often new and potentially effective, which reduces the need to escalate opioids; many interventionalists are also deliberately opioid-reluctant and intentionally hold doses low, relying on their interventions to address poorly controlled pain. A practice built on that model will naturally show lower mean MME.

My practice is the opposite denominator: long-tenured patients who have exhausted interventional options

My practice is dedicated to long-term medical management of chronic pain. Most of my patients have already tried interventional options and, for one reason or another — prior treatment failure, adverse experience, or procedural phobia — have not benefited from them. In fact, many are referred to me by interventional specialists precisely because interventions failed and their pain then relies heavily on medical opioid management. A practice that accepts patients who have failed alternatives, and is sent patients specifically for opioid management, will by definition display more opioid escalation and higher steady-state doses than an interventional practice.

The duration and escalation literature predicts exactly this pattern

- Long-term opioid therapy is associated with tolerance and escalating doses over time (Karmali et al., *Pharmacoepidemiology and Drug Safety*, 2020). My practice is 18 years old, and I care for many patients who have been on stable opioid therapy for 10, 15, and 20 or more years — some maintained on opioids since the 1980s and 1990s. This is a self-selected, long-tenured, higher-dose cohort.

- Dose escalation is front-loaded and then plateaus, leaving a persistent higher-dose subgroup as lower-dose patients discontinue (Schrader et al., *BMC Public Health*, 2024). A practice enriched for long-term survivors on therapy will therefore carry a higher central MME than one composed of newly initiated or shorter-tenure patients.

- Stable high-dose maintenance trajectories are a recognized, quantifiable pattern in long-term opioid patients (Binswanger et al., *JAMA Network Open*, 2022). Over 18 years, a medical-management practice accumulates exactly these patients.

Why this makes the comparison a false one

Benchmarking my mean MME against a peer group dominated by interventionalists compares two fundamentally different treatment models and two fundamentally different patient populations — theirs weighted toward procedure-responsive, opioid-reluctant, shorter-tenure care, and mine toward intervention-failed, long-tenured patients referred specifically for opioid management. Higher MME in my practice is the expected consequence of that case mix.

I want to be clear that I do not treat a high MME as self-justifying. Every patient is managed under a comprehensive individualized risk-mitigation protocol — controlled-substance agreement, PDMP review at each visit, scheduled urine drug testing, documented functional benefit, single-prescriber/single-pharmacy arrangement, and co-prescribed naloxone — with regimens set at the lowest dose that maintains function, consistent with the 2022 CDC guideline's caution against rigid numeric thresholds (Dowell et al., *MMWR Recommendations and Reports*, 2022).