Behavioral Medicine and Coaching Solutions for Chronic Pain Claims

Michael Coupland, RPsych, CRC IMCS Group Inc.
Becky Curtis,

Integrated Medical Case Solutions

President and Founder
Michael Coupland, CPsych, CRC

- Charter and Registered Psychologist (AB)
- Specializing for 30 years in Occupational testing and measurement;
- Developer of the AssessAbility Functional Evaluation (FME) system utilized in over 150,000 functional evaluations
- Author:
  - AMA text on Functional Evaluation
  - Author of IAIABC Article Chronic pain
  - CoAuthor of Outcome Study on Early Intervention
- Expert to the Federal Government Social Security Disability Determination projects;
Chronic Pain & Disability Behavior

Neurobehavioral Model of Chronic Pain

- Lifestyle: Exercise, Smoking, Alcohol and Drugs, Obesity / Diet
- Work Attachment / Age
- Depression / Anxiety
- Personality Disorders
- Hx of Childhood Abuse
- Perceived Injustice (retribution owed)
- Fear Avoidant Behavior (Guarding)
- Catastrophic Thinking

Cortisol, substance p, serotonin, Norepinephrine, vasodilatation, vasoconstriction

Neurobehavioral Effects of Opioids

- Increase SAR
- Turn off innate pleasure responses
- Paired association of Pleasure with initiating reason for opioids
- Release Dopamine (Pleasure)

Dependence & ‘Addiction’

Demotivation, compromised ability to regulate unsafe behaviors
**Strategy**

*TREAT* delayed recovery issues yet

*AVOID* ‘buying’ a psych claim

**PHYSICAL MEDICINE PROCEDURE CODES**

for

**HEALTH PSYCHOLOGISTS**

within

Integrated Medical Delivery model

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**How to Treat Psychosocial Factors without ‘Buying’ an unwarranted Psych Claim**

New codes established

*Health and behavior assessment and intervention*

Psychiatric diagnosis and treatment codes are **NOT used**

**The Physical Diagnosis is the working diagnosis**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
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<tbody>
<tr>
<td>96150</td>
<td>Initial assessment to determine biological, psychological and social factors affecting health and any treatment problems</td>
</tr>
<tr>
<td>96152</td>
<td>The intervention service to modify the psychological, behavioral, cognitive and social factors affecting health and well-being</td>
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Claims Indicators

- Inadequate or delayed recovery
- Chronic pain diagnosis
- Medication issues and/or drug problems
- Compliance issues with prescribed medical treatment
- Psychosocial factors negatively impacting recovery
- Catastrophic injuries
- Pre-surgical clearance for back surgery, pump, spinal stimulator
- PTSD claims

WORKFLOWS.....Chronic Pain

via PBM / Pain Peer Review

Peer Review Physician determines that …

- Opioid regimen is not Best Practices
- Opioid regimen does not meet specific State Guidelines
- Use of opioids for longer than medically indicated
- Use in dosages higher than recommended
- Use in combination with other legal drugs & OTC meds
- Use in combination with illicit drugs
- Use when performing tasks when medication use is contraindicated
- Treating Physician has agreed to…
  - Opioid Tapering and/or COPE with Pain Program

WORKFLOWS.....Opioid Abuse
WORKFLOWS.....Attending Physician Prescribes Program

Treating MD Rx
COPE with Pain
CPT 96150/96152

Referral to IMCS
Web based
Secure Email
Phone

WORKFLOWS

IMCS Psychologist performs COPE with Pain assessment

Finalize treatment plan, establish goals and durations

COPE with Pain Treatment (4-12 sessions)

Discharge Meeting with Adjuster/NCM Conference

Peer to Peer call
Adjuster/NCM Conference

YES
Authorize Tx?
NO

Treatment Goal Attainment

Peer to Peer call
Adjuster/NCM Conference
COPE with Pain Assessment

Patient Interview (45 minutes)
- Medical / Psychiatric History
- Psychosocial History
- Mental Status Exam
- Current symptoms reported
  - Onset History
  - Aggravating factors
  - Relieving factors
  - Interference with tasks
- Medications
- Current Vocational Status, Work Attitudes

COPE with Pain Assessment

Patient Testing (30 minutes)
- Catastrophic Thinking
- Fear Avoidant Behavior
- Perceived Injustice Scale
- Alcohol and Drug Abuse / Opioid Abuse Risk
- History of Stress / Trauma / Abuse
- Depression and Anxiety
- Social Support / Stress
- Work Attitudes / RTW Beliefs
- Health Locus of Control
COPE with Pain Assessment

Telephonic Peer to Peer Consult (10 minutes)
Discussion of
1. Assessment Results
2. Appropriateness / Barriers
3. Treatment Goals
4. Duration

COPE with Pain Treatment

Integrated Medical Care

Employer/Carrier
- Case Management
- Guidelines-based Medical Management
- Active Exercise Rehabilitation
- Return to Work Coordination

IMCS
- COPE with Pain Cognitive Behavioral Therapy
Treatment

COPE with Pain Intervention Plan

✓ Specific Functional Intervention Goals (i.e.)
  ▪ Fear of re-injury
  ▪ Sleep hygiene
  ▪ Work issues
  ▪ Engagement in Activities

✓ Intervention Duration (4-12 sessions)

✓ Barriers

Goal Attainment Scaling

Coupland, M. Psychosocial Interventions for Chronic Pain Management. The International Journal of Industrial Accident Boards and Commissions; Fall 2009

COPE with Pain

Cognitive Behavioral Therapy (CBT)

✓ CBT is brief and time-limited.

✓ A sound therapeutic relationship is necessary for effective therapy, but not the focus.

✓ CBT is a collaborative effort between therapist and client.

✓ CBT is based on stoic philosophy.

✓ CBT is structured and directive.

✓ CBT is based on an educational model.

✓ Homework is a central feature of CBT.
Treatment

RTW Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Control Group</th>
<th>Intervention Group</th>
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<tbody>
<tr>
<td></td>
<td>High Risk and</td>
<td>High Risk</td>
</tr>
<tr>
<td></td>
<td>Very High Risk</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Sample Size</td>
<td>36</td>
<td>62</td>
</tr>
<tr>
<td>% claims closed at 26 weeks</td>
<td>33%</td>
<td>76%</td>
</tr>
<tr>
<td>% working at 26 weeks</td>
<td><strong>17%</strong></td>
<td><strong>68%</strong></td>
</tr>
<tr>
<td>Avg claim duration at 26 weeks</td>
<td>24 weeks</td>
<td>18.7 weeks</td>
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Coupland, M., Margison, D. Early Intervention in Psychosocial Risk Factors for Chronic Pain, Musculoskeletal Disorders and Chronic Pain Conference, Feb 2011, Los Angeles, CA

Treatment

Outcomes @26 wks+

High Risk vs. Low Risk Psychosocial
- 9% Fewer Pt. get Physical Therapy
- 10% Fewer Pt. get Imaging Studies
- 13% Fewer Pt. get Injections
- 6% Fewer Pt. get Surgeries
- 5% More Pt. get Vocational Rehabilitation

Coupland, M., Margison, D. Early Intervention in Psychosocial Risk Factors for Chronic Pain, Musculoskeletal Disorders and Chronic Pain Conference, Feb 2011, Los Angeles, CA
Case Closed: MMI / RTW

✓ No MMI or Impairment Rating by IMCS Psychologist
✓ Treatment is under the COPE with Pain codes
✓ Physical diagnosis is the ONLY compensable diagnosis

The Problem of Pain

• Chronic pain affects an estimated 116 million people
• The costs are estimated at $635 billion per year in medical treatment and lost productivity
• The costs are more than cancer, heart disease and diabetes combined
• More people die from prescription drug misuse each year than from use of heroin and cocaine combined.
• 40 overdose deaths each day from prescription opioids
"Ridiculous, stupid, inhumane and many, many more adjectives to describe the unjust treatment we as pain patients are having to face in this state," states someone who will remain anonymous. "I never realized how difficult (impossible) it would be to find a compassionate doctor like you in my own state." Says an anonymous pain sufferer.
“The promise that high-powered drugs could provide a cure-all the key to winning the “War on Pain” was an empty one. Pain, mankind’s oldest enemy, is not defeated easily and sometimes not defeated at all. Ultimately, people who suffer from recurring pain, experts say, have to look to themselves.”

Barry Meier, A World of Hurt
“The notion of brain plasticity is fundamental to new developments in pain management. There is recognition that the same neuronal changeability that contributes to the persistence of pain could potentially allow its resolution. Evidence suggests that ‘focused attention’ can increase neuronal plasticity and hence be used to positively reprogram brain pathways.”
What we focus on, we empower and enlarge.
“The longer we have been negative, angry and passive, the more brain change we will need to make. Because of the plasticity in our brain, everything is reversible. “In the same way that muscles and joints can be made more healthy and robust, so too can the homunculus arrangements in your brain.”

Explain Pain, Butler, Moseley, NOigroup Publishing, Australia, 2003, pg 76

What Coaching Can Do For Chronic Pain

Coaching empowers
Coaching motivates
Coaching moves people forward
The Coach Approach

Builds a working relationship based on respect for the patient’s ability to choose the right path for functionality.

This style increases self-motivation.

The patient has a greater sense of ownership.

Patient will be more likely to start making and continue behavior change.

TCC’S Program

• One year program
• Monthly goals and assessment of progress
• Assessments
• Individual Coaching
• Group Coaching Tele-Classes
• Education and Motivational Materials
"One way to avoid resistance is to encourage people to progress from one stage to the next rather than trying to pressure them to take action for which they are not prepared."

Transtheoretical Model of Change, Stages of Change

Client #1, 2009
Office visits, C-Spine Cat Scans, epidurals, EMG, trigger point injections, facet injections, cervical radio ablations, MRI's, PT, medications, TCC.
Total cost related to pain: **35,990.76**

Client #1, 2010
Total cost related to pain: **00.00**
We can’t reimburse them for their old life
but we can help them create a new one

Questions?