

National Shipbuilding Research Program Risk Management Panel



Managing Complex Claims with Psych Overlay

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AssessAbility

Integrated Medical Case Solutions (IMCS Group)

Michael Coupland, CPsych, CRC

Certified Psychologist specializing for 30 years in occupational testing and measurement;

Developer of the AssessAbility Functional Evaluation (FME) system utilized in over 160,000 functional evaluations

Author:
 MCV/VCU coursebook on disability evaluation
 AMA 6thEd text on Functional Evaluation
 IAIABC Article Chronic Pain

Expert to the Federal Government Social Security Disability Determination projects;

IMCS National Network of Psychologists

- ***COPE with Pain* biopsychosocial assessment & intervention**
- **Opioid and Polypharmacy Fit For Duty Evaluation**
- **Pre-intrathecal Pump and Implant Evaluations**
- **Functional Psychological Evaluations**

AssessAbility National Network of Physicians

- **Functional Medical Evaluation (FME)**
- **Complex Pain IME**

Objectives: The participant will learn how to...

- 1. Identify cases that have high risk of psychosocial factors associated with chronic pain and delayed recovery**
- 2. Facilitate functional recovery by identifying medical necessity pathways for medical investigations vs. pain management vs. psychiatric care vs. non-medical psychosocial factors**
- 3. Recognize the 6 most common (and costly) non-medical factors that delay recovery, so you can work with the treating physician to get the claimant to MMI**
- 4. Authorize the appropriate clinical pathways so unwarranted psychiatric impairments do become claims**



Bio-Psycho-Social Model



Diagnosis

**Physical
Health**



Are there objective findings indicative of a biomedical pain generator and is diagnosis supported by consistency analysis?

**Mental
Health**



Or are there mental health impairments 'caused' by the injury affecting medical treatment and recovery

Diagnosis



**Or is there is evidence of
bio-psycho-social factors**

Diagnosis: Physical Health

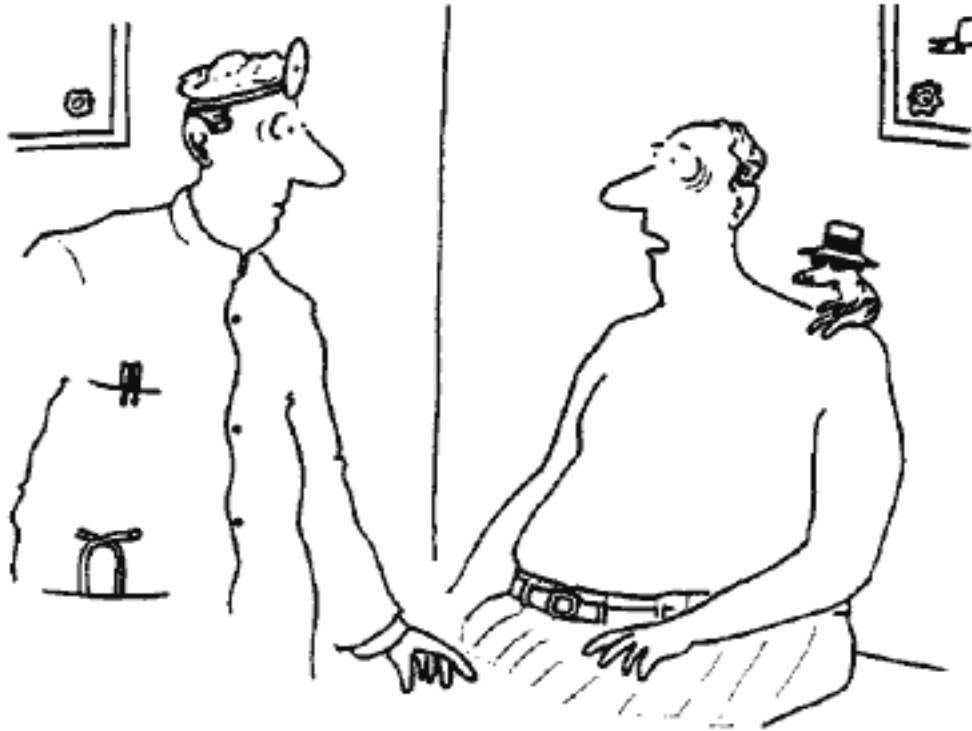
Guidelines

- Occupational Medicine Practice Guidelines (ACOEM)
- Medical Disability Advisor
- Official Disability Guidelines
- Colorado Guidelines
- Institute for Clinical Improvement

ACOEM Guidelines <Coupland> Summary

- Identify pain generators
- When there is no readily identifiable pain generator, focus on functional restoration
- Address psychosocial factors
- Evidenced based treatment (med's, interventional pain)
- Encourage, educate and engage the patient

Poor Diagnosis = Disconnected Causation and Treatment



“Doctor, I have a suspicious looking mole on my shoulder”

- **Longer durations of time loss from work**
- **More opioids**
 - More opioids correlates to poor functional recovery
- **More medical utilization**
 - PT, Imaging, Specialists, Injections
- **More needless surgery**
 - Doctors report feeling pressured into surgery

Diagnosis: Mental Health Model

Mental health problems are associated with poor treatment adherence and recovery

Mood Disorders

Major Depressive Disorder

Anxiety Disorders

PTSD

Substance Abuse Disorders

Schizophrenic & Psychotic Disorders

Somatoform & Factitious Disorders

Three Issues

1. Over diagnosis, most do not meet DSM-IV
2. ie. 'depression' appears in 41 DSM Dx.

(Coupland, Barth, Warren)

2. If accurate Dx. was the compensable injury the **cause** of the MH disorder?
3. If Accurate Dx., are they getting Best Practices Treatment



Diagnosis: Mental Health Model

Best Practices Treatment

Peer Review and Peer to Peer Call

Major Depressive Disorder (Mild or Moderate):
Medication or CBT

Major Depressive Disorder (Severe):
Medication and CBT

Major Depressive Disorder w/ Psychotic Features:
Day Program or In-Patient



Normal Recovery Time
(Medical Disability Advisor)
Average 53 days

Diagnosis: Mental Health Model

A **'Psych Eval'** is a poor fit for pain patients whose complaints are primarily subjective and who are not demonstrating frank evidence of psychopathology...Psych Diagnosis is almost a certainty

Chronic pain patients given the MMPI will almost automatically elevate certain scales to a certain degree due to their report of medical symptoms (Bradley, Haile, & Jaworski, 1992; Moore, McFall Kivlahan, & Capestany, 1988; Naliboff, Cohen, & Yellin, 1982; Pincus, Callahan, Bradley, Vaughn, & Wolfe, 1986; Prokop, 1986; Watson, 1982).



Mental Health The Conundrum-

- Psychosocial factors are the strong predictive factors for recovery and return to work (Literature Review Handout)
- Cognitive Behavioral Therapy (CBT) by a psychologist is an effective intervention for these risk factors (Handout)

HOWEVER

- Psych assessment leads to a psych diagnosis and claims costs
- Psychologists treat the whole person and therefore treat forever

THE SOLUTION

- Treat psychosocial issues without assigning a psych diagnosis
- Specialty Health Psychology panel with disability management approach, short term treatment with functional restoration goals

How to Treat Psychosocial Factors without 'Buying' an unwarranted Psych Claim

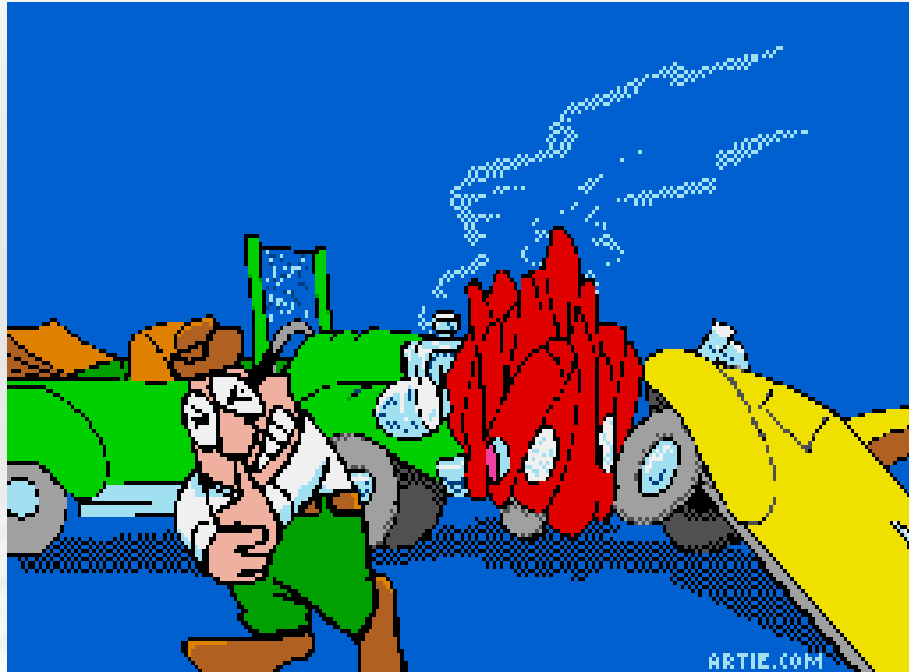
(US) The ***new 'health and behavior assessment and intervention'*** codes ensure the claimant does not become further 'medicalized'

(CDN) Use biopsychosocial descriptions

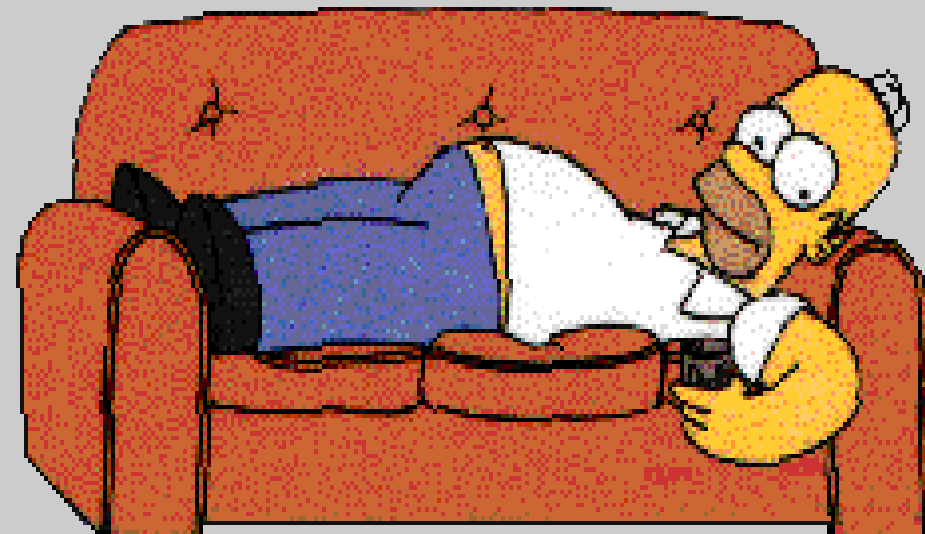
Psychiatric diagnosis and treatment codes are **NOT used** unless there is an accurate DSM-IV diagnosis and causality is addressed

CPT Code	Descriptor
96150	Initial assessment to determine biological, psychological and social factors affecting health and any treatment problems
96151	Reassessment to evaluate condition and determine need for further treatment
96152	The intervention service to modify the psychological, behavioral, cognitive and social factors affecting health and well-being

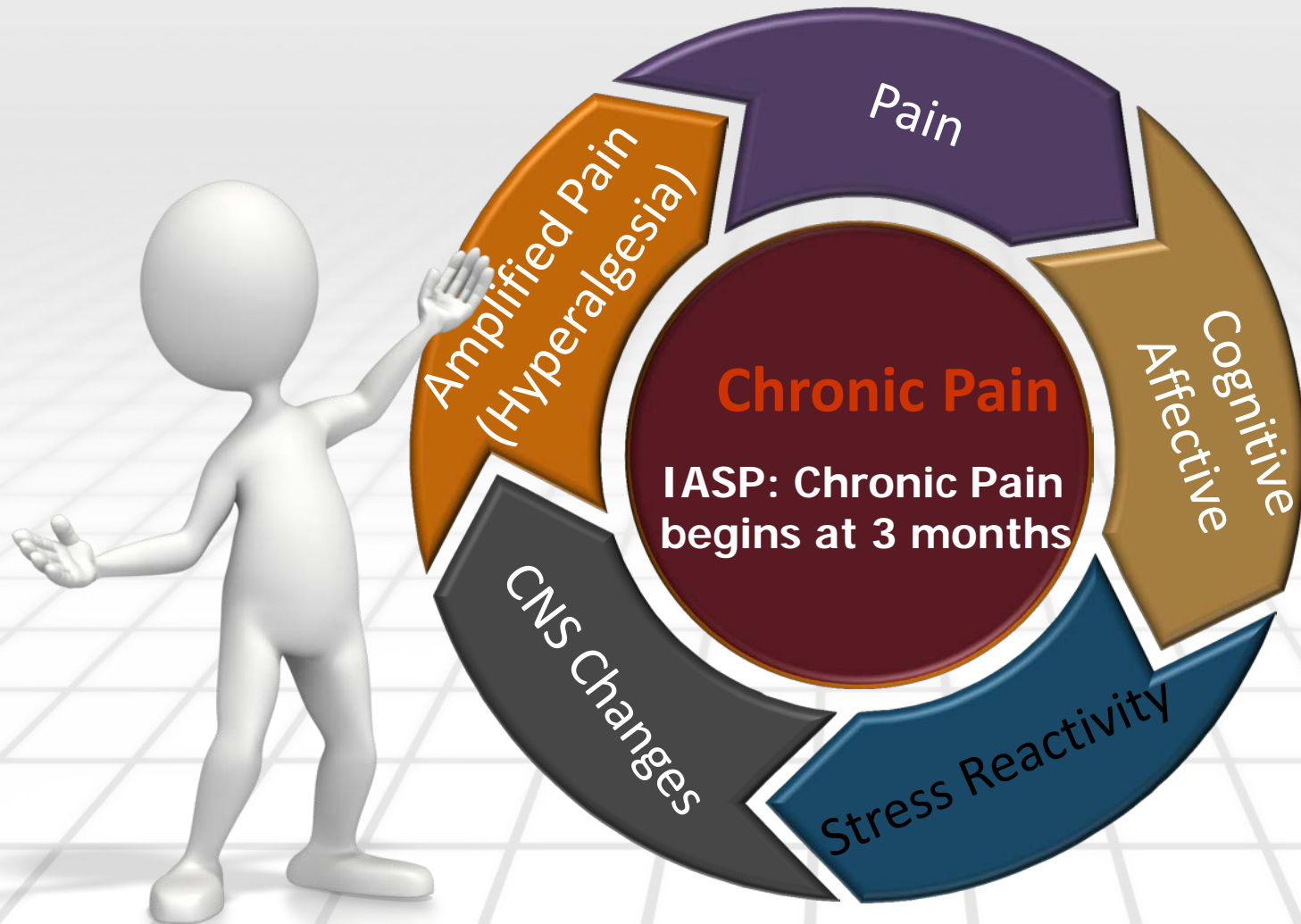
How do we get from here



.....to here?



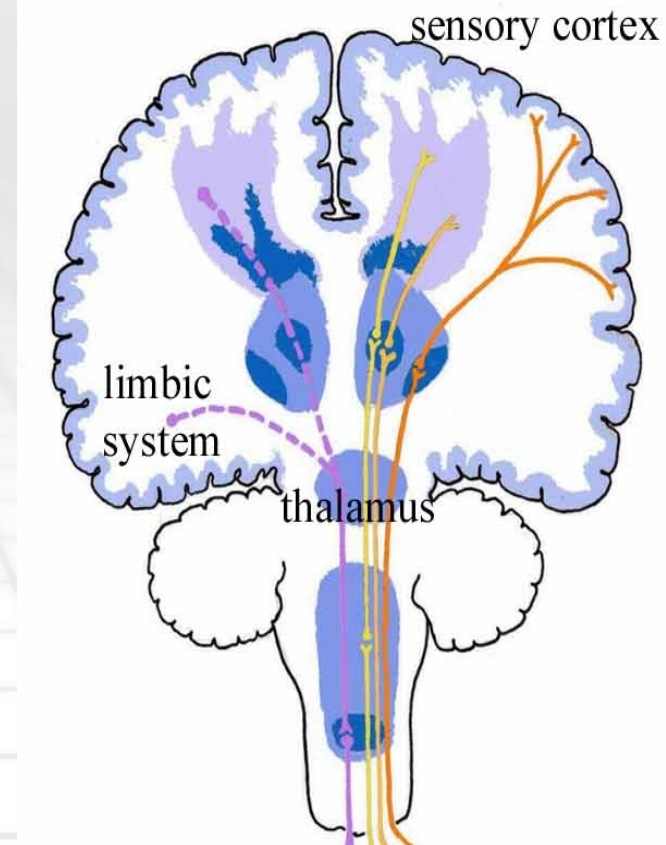
Biopsychosocial Model



Pain 101

The bane of pain is mostly in the brain

The pain signal is passed up the spinal cord to multiple locations in the brain, including the **limbic (emotional)** center of the brain.



Pain 101

The bane of pain is mostly in the brain

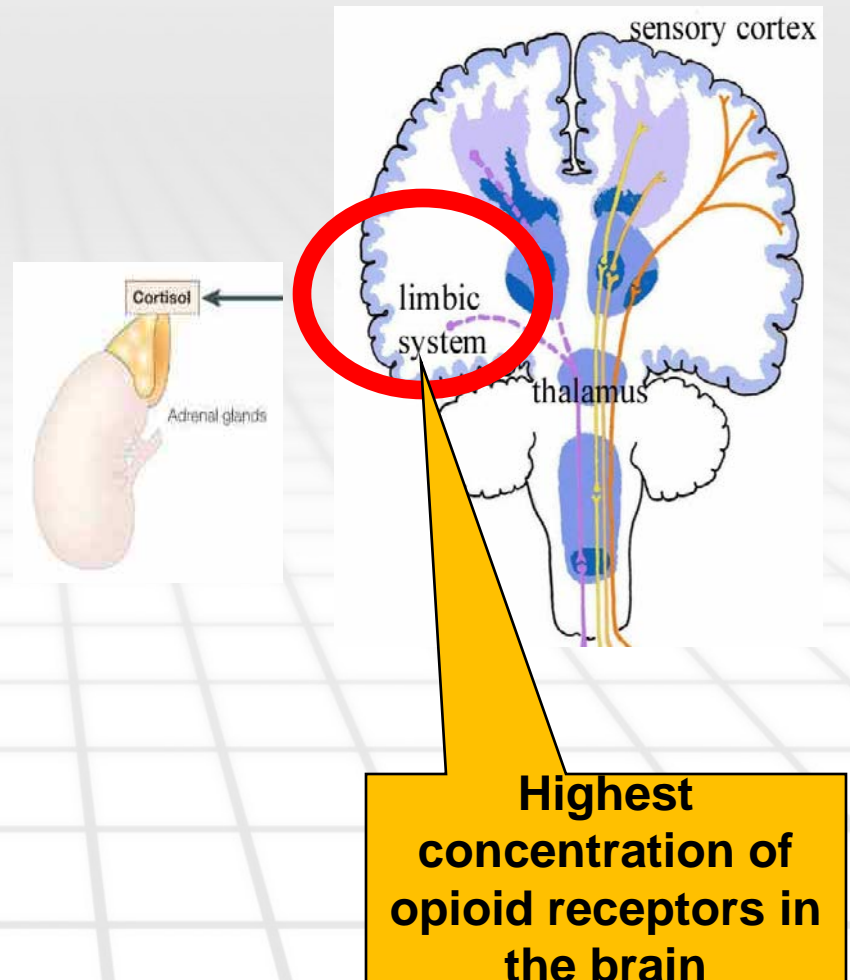
An event triggers a pain response

The individual creates an emotional and cognitive interpretation of the pain event

Some individuals hold on and **catastrophize** that response

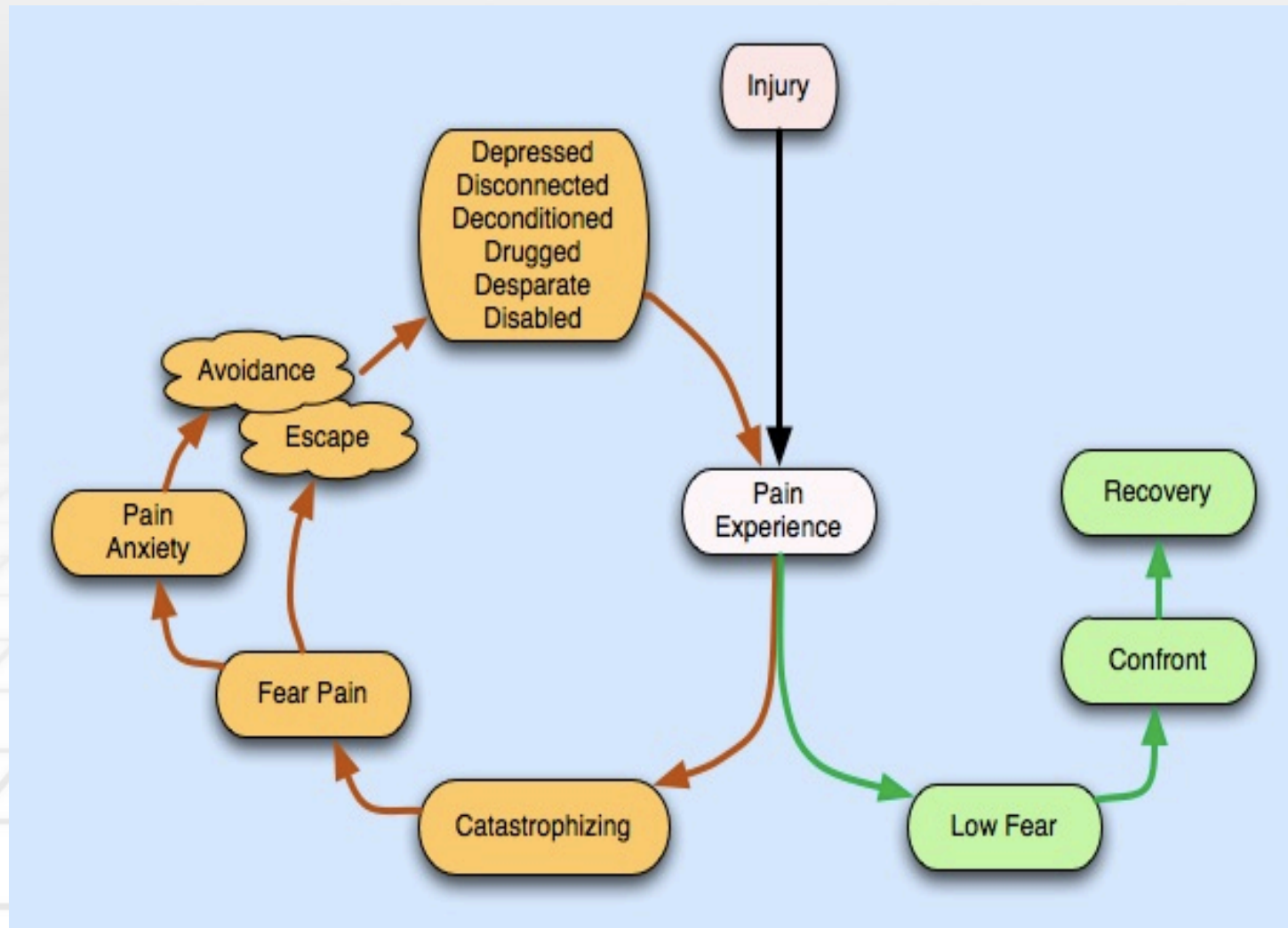
That stress excites the body's pain systems

Stress reactivity creates CNS changes



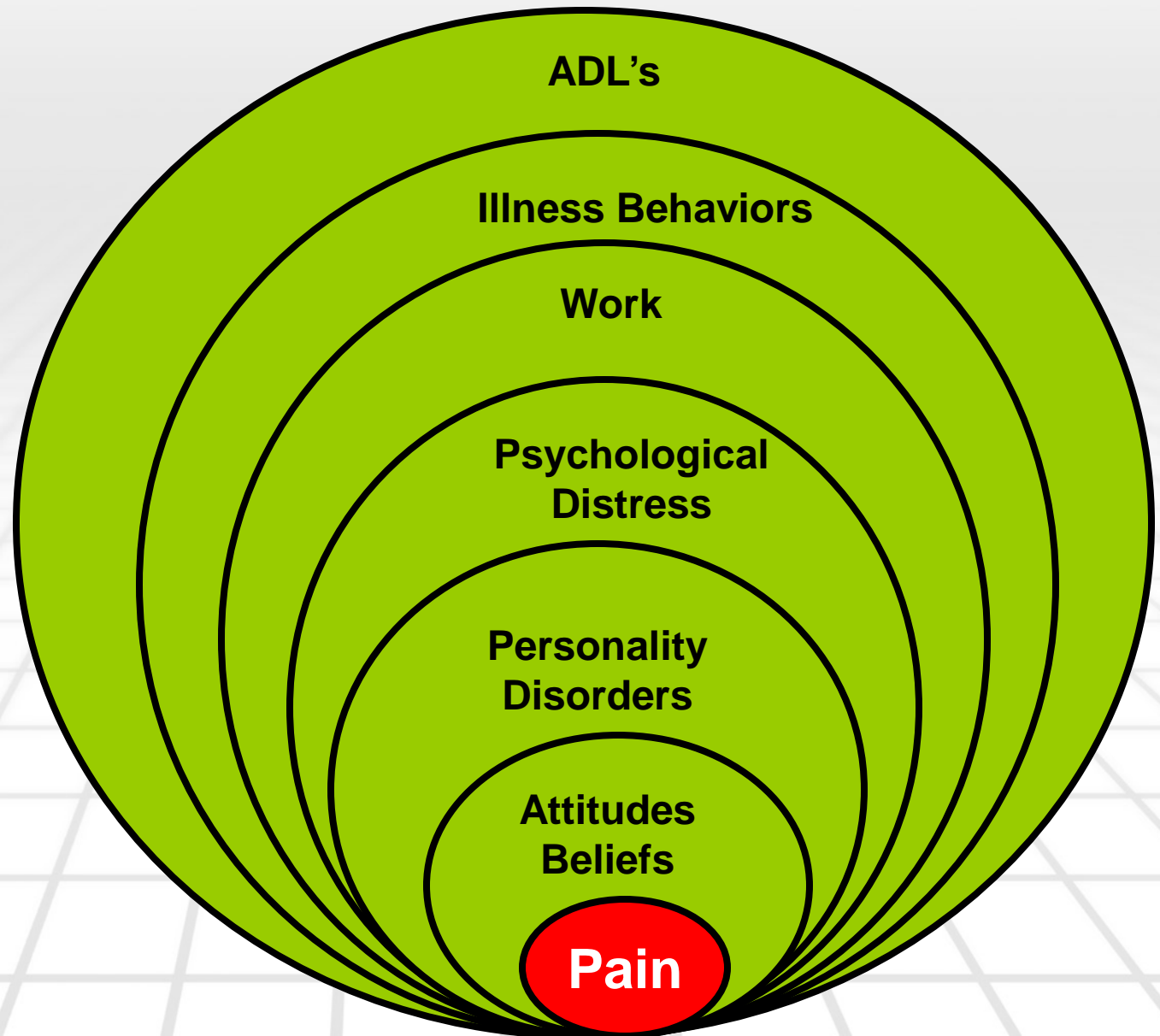
Pain 101

The bane of pain is mostly in the brain



International Association for Study of Pain (IASP) defines Chronic Pain begins at 3 months

Bio-Psycho-Social Risk Factors



Early Identification of BioPsychoSocial Risk Factors

1. Psychosocial risk factors have been validated

- a. Meta Analyses
- b. Prospective studies
- c. Control group studies

2. A Pain Score Questionnaire has been validated

- Scores correlate with time lost from work / medical spend / function, but not necessarily with pain

3. Brief cognitive behavioral therapy (CBT) interventions can successfully intervene

- less time loss / medical spend / greater function, but not necessarily less pain



BioPsychoSocial Screening

PSQ-Pain Screening Questionnaire (Linton)

PSQ 21 Questions (5 minutes)

- Pain Attitudes, Beliefs and Perceptions
- Catastrophizing
- Perception of Work
- Mood/Affect
- Behavioral Response to Pain
- Activities of Daily Living

**High Risk → Rx
Health and Behavior Assessment**



BioPsychoSocial Screening

PSQ-Pain Screening Questionnaire (Linton)

Sample Questions.....On a Scale of 1 to 10 ...

- How would you rate the pain you have had during the past week
- In your view, how large is the risk that your current pain may become permanent?
- An increase in pain is an indication that I should stop what I'm doing until the pain decreases
- I should not do my normal work with my present pain.



BioPsychoSocial Screening

Claims Indicators

- Disability Durations exceed Guidelines
- Subjective complaints > objective findings
- Multiple pain areas
- Low expectation of recovery
- Work dissatisfaction
- Depressed or anxious mood
- Comorbidities
- Alcohol and drug abuse
- Psychosocial factors; family, legal, financial
- Pharmacy Trends



Early Identification of BioPsychoSocial Risk Factors

All Claimants off work at 2-3 weeks
are assigned a Case Manager for a
telephonic consult

OR

Treating Physicians are
engaged to perform
Screening

Pain Screening Questionnaire

21 questions (web based admin and scoring)
Stratifies Claimant Risk for Chronic Pain and
Delayed Recovery

Low Risk Score

Are provided a
educational booklet

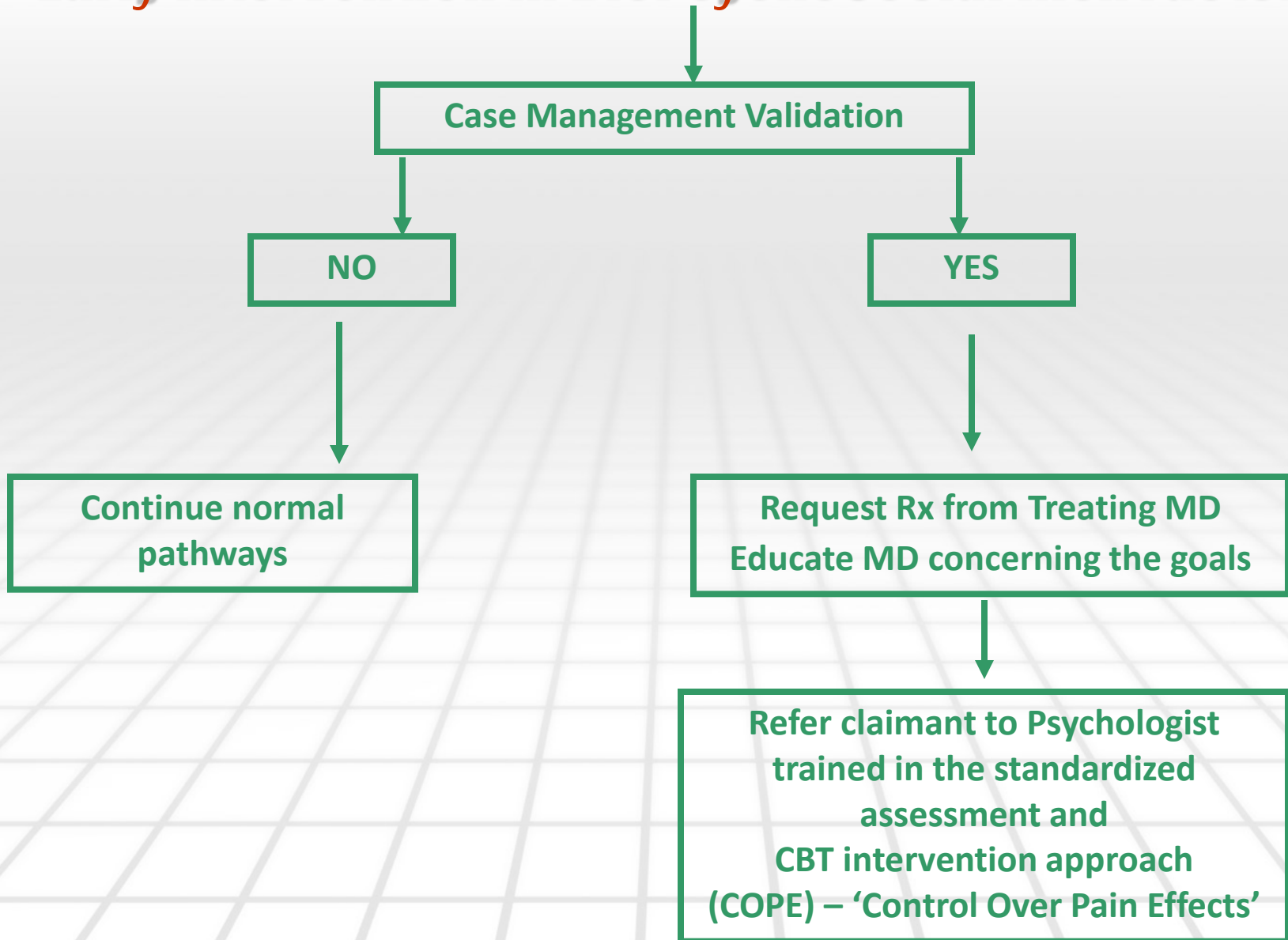
Moderate Risk Score

Are provided an
interactive workbook

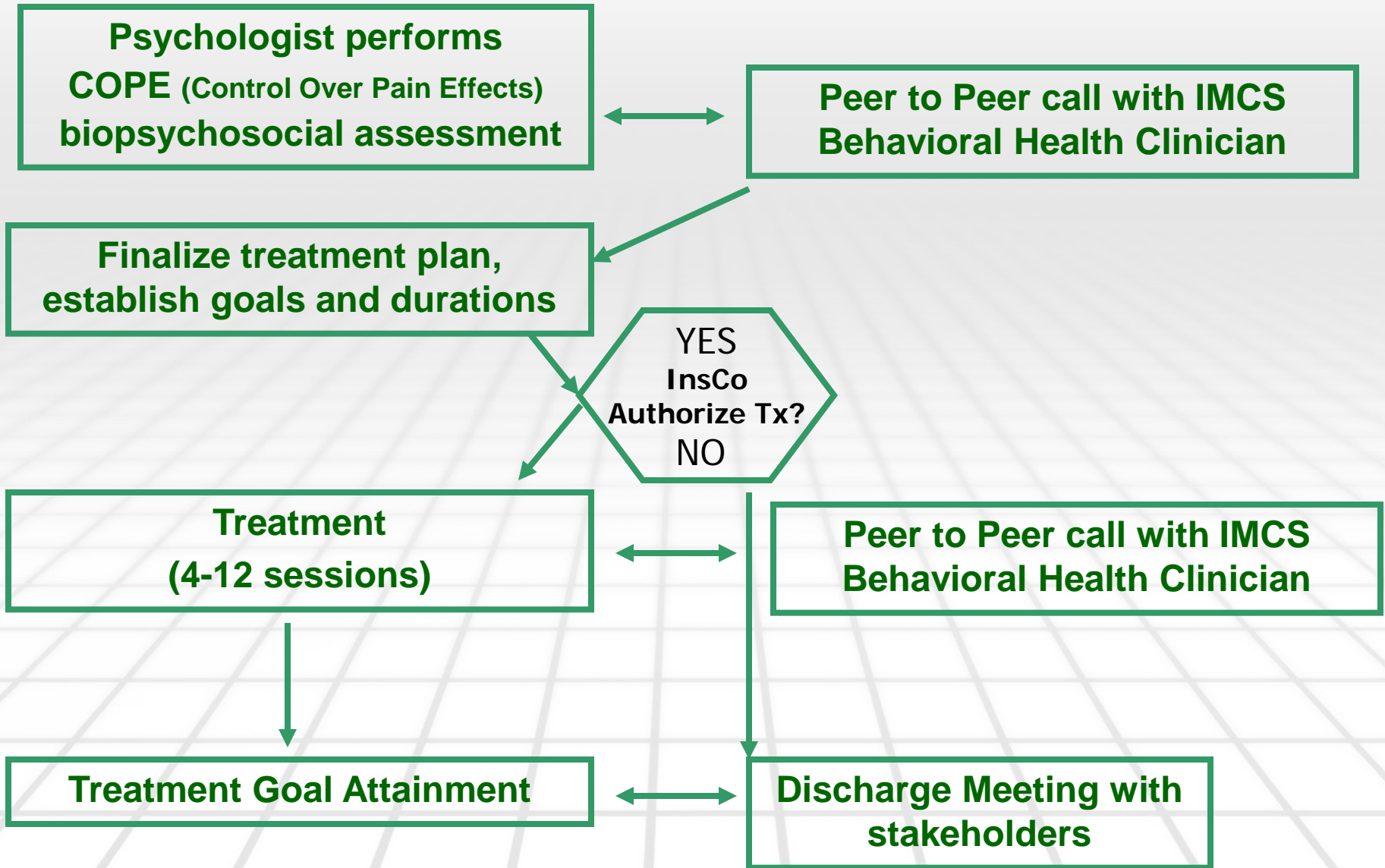
High Risk Score

Referred for Case
Management Validation

Early Intervention in BioPsychoSocial Risk Factors



WorkFlow Overview



BioPsychoSocial 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



BioPsychoSocial Assessment

Patient Testing (30 minutes)

- Catastrophic Thinking
- Fear Avoidant Behavior
- 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



BioPsychoSocial Assessment

Telephonic Peer to Peer Consult (10 minutes)

Discussion of

1. Assessment Results
2. Treatment Goals
3. Duration



BioPsychoSocial Assessment

Finalized Report (15 minutes)

1. History
2. Assessment Results
3. Assessment Summary
4. Barriers
5. Recommendations
6. Treatment Goals
7. Duration



Treatment

Integrated Care

Early Intervention (2 – 6wks)

High BioPsychoSocial Risk as Referral Trigger

- Case Management
- Guidelines-based Medical Management
- Health & Behavior Assessment and Intervention
- Active Exercise Rehabilitation



Treatment

Integrated Care

Delayed Recovery Intervention (6+ + wks)

Medical & Claims Indicators as Referral Trigger

- Case Management
- Guidelines-based Medical Management
- Opioid Tapering
- BioPsychoSocial Assessment and Intervention
- Functional Restoration
- Return to Work Coordination



Treatment

BioPsychoSocial 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

Treatment

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

Cognitive Behavioral Therapy (CBT)

Treatment Rationale: individuals need to play an active role in controlling their pain

- **Coping Skills Training**
- **PMR and brief relaxation exercises**
- **Activity pacing and pleasant activity scheduling**
- **Imagery and other distraction techniques**
- **Cognitive re-structuring to replace overly negative pain-related thoughts with adaptive, coping thoughts**
- **Application and Maintenance of Coping Skills**



Treatment

RTW Outcomes

	Control Group		Intervention Group	
	High Risk and Very High Risk	High Risk	Very High Risk	
Sample Size	36	62	109	
% claims closed at 26 weeks	33%	76%	62%	
% working at 26 weeks	17%	68%	39%	
Avg claim duration at 26 weeks	24 weeks	18.7 weeks	20.2 weeks	



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

MMI / RTW

- **MMI by physical medicine physician**
- **No MMI / PIR by in the biopsychosocial model, as physical diagnosis is the compensable diagnosis**



What to do if the case did not get Early Intervention?

Peer to Peer Review with Treating Physician
COPE with Pain Disability Reduction Program
Opioid Tapering Program
Addictionologist
Addictions Psychologist



Are Employees on Opioids & Polypharmacy Fit For Duty?

Evidence Based Medicine Meta-Analysis

(1) There was moderate, generally consistent evidence for **no impairment of psychomotor abilities** of opioid-maintained patients;

(2) There was **inconclusive** evidence on multiple studies for **no impairment on cognitive function** of opioid-maintained patients;

(3) There was strong, consistent evidence for **no greater incidence in motor vehicle violations/motor vehicle accidents** versus comparable controls of opioid-maintained patients; and

(4) There was consistent evidence for **no impairment as measured in driving simulators off/on road driving** of opioid-maintained patients.

(5) Comprehensive pharmacy database analysis of multiple medicine use (LeRoy, 2004), **higher percentages of crash-involved drivers were prescribed two or more prescriptions** than non crash-involved drivers.



Fit For Duty Evaluation

- **Review of records**
- **Patient Interview**
 - Review of medication use and alcohol and drug use
- **Standardized Neurobehavioral Status Exam:**
 - 207 symptom related questions with for concurrent validity comparison to functional testing
 - Internal validity for misrepresentation
- **Testing:** (not a 'psych eval'...new CPT pathways do not ascribe unwarranted psych diagnoses)
 - Memory / Attention
 - Executive Thinking / Judgment / Impulsivity
 - Psychomotor / Reaction Time / Vision Tracking
 - Drowsiness / Continuous Performance / Shifting Attention



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Questions?



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