The Psychology of Pain within the Biological Model

Michael Coupland, CPsych, CRC
Integrated Medical Case Solutions (IMCS Group)
Integrated Medical Case Solutions

National Panel of Psychologists

• Biopsychosocial Pain Evaluations
• Functional Psychological Evaluations
• Opioid Assessment and Intervention
• Early Identification of Chronic Pain and Delayed Recovery

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 150,000 functional evaluations
Author: AMA text on Functional Evaluation / IAIABC Article Chronic pain
Expert to the Federal Government Social Security Disability Determination projects;
Over 150 presentations to Insurance Companies Employers, TPA’s and industry conferences
DISCLOSURE

Michael Coupland has a beneficial stock ownership in IMCS Group regarding the content of this presentation
The Psychology of Pain within the Biological Model

This model addresses:

1. Claimants whose subjective complaints outweigh the objective findings
2. Claimants with challenging pain generating diagnoses
3. Claimants who are opioid dependent, addicted or drug seeking
The psychobiology of pain
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.
The psychobiology of pain

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:

Catastrophize that response

Have a fear-avoidant reaction (guarding)

That stress excites the body’s pain systems

Stress reactivity creates CNS changes
Chronic Pain & Disability Behavior

Biopsychosocial Model of 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

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Is there objective pathology, biochemistry, physiology to which medical solutions (surgery, pharmaceuticals, PT) can ‘normalize’ the patient to MMI.

Or is there a behavioral or psychological syndrome that reflects an underlying psychobiological dysfunction which has clinically significant distress or disability, not merely an expectable response to common stressors and losses or a culturally sanctioned response to a particular event.

The OLD Paradigm: ‘Silo’ Biomedical / Mental Health Model

Biomedical Model

Mental Health Model
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
Psychosocial factors are the strongest predictive factors for recovery and return to work

Cognitive Behavioral Therapy (CBT) by a psychologist is an effective intervention for these risk factors

**HOWEVER**

Psych treatment usually leads to a psych diagnosis and claims costs

Psychologists treat the whole person and therefore treat forever

**THE SOLUTION**

New AMA CPT codes treat psychosocial issues without assigning a psych diagnosis

Specialty panel with disability management approach is short term treatment with functional goals
How to Treat Biopsychosocial Factors without ‘Buying’ an unwarranted Psych Claim

‘Health and Behavior Assessment and Intervention’

Reasonable and necessary for the patient (CMS Definition):

- Who has an underlying physical illness or injury, and
- For whom there is reason to believe that a biopsychosocial factor may be significantly affecting the treatment, or medical management of an illness or an injury, and
- For whom there is documented need from the patient’s attending physician that he or she needs psychological assessment to successfully manage his/her physical illness to resolve the psychological barriers to the management of his/her physical disease and activities of daily living

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

- Occupational Medicine Practice Guidelines (ACOEM)
- Medical Disability Advisor
- Official Disability Guidelines
- Institute for Clinical Improvement
- State Guidelines (i.e. CO, WA)

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
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 Screening Questionnaire has been validated:
   • Scores predict time loss / medical spend / function, but not pain

3. Brief Cognitive Behavioral Therapy (CBT) interventions can successfully intervene:
   • less time loss / medical spend / greater function, but not necessarily less pain
Early Intervention 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
Delayed Recovery Claims Indicators (‘Yellow Flags’)

a. Inadequate recovery; duration which exceeds the typical course of recovery; failure to benefit from indicated therapies or to return to work when medically indicated; or a persistent pain problem which is inadequately explained by the patient’s physical findings.

b. Medication issues and/or drug problems: This includes any suspicion of drug overuse or misuse, aberrant drug behavior, substance abuse, addiction, or use of illicit substance, or for any case considered for chronic use of opioids.

c. Current or premorbid history of major psychiatric symptoms or disorder.

d. Catastrophic injuries with significant pain related or other dysfunction, e.g. spinal cord injury.

e. Cases for which certain procedures are contemplated, e.g. back surgery.
Psychologist performs COPE (Control Over Pain Effects) biopsychosocial assessment.

Finalize treatment plan, establish goals and durations.

COPE Treatment (4-12 sessions)

Treatment Goal Attainment

Peer to Peer call with IMCS Behavioral Health Clinician

YES
Authorize Tx?
NO

NCM Conference

Peer to Peer call with IMCS Behavioral Health Clinician

NCM Conference

Discharge Meeting with stakeholders
Health and Behavior Assessment (CPT 96150)

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
Health and Behavior Assessment (CPT 96150)

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
Health and Behavior Intervention (CPT 96152)
Cognitive Behavioral Therapy (CBT)

Pain is inevitable, suffering is optional
Cognitive Behavioral Therapy (CBT)

Our thoughts cause our feelings and behaviors, not external things, like people, situations, and events.

We can change the way we think so we think/feel/act even if the situation does not change.
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.
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
Cognitive Behavioral Therapy (CBT)

Patients who come to accept their pain as a chronic condition have:

- Less pain, less pain distress and depression
- Increased activity level, social interactions, work and ADL involvement,
- Decreased medication use, and utilization of medical services.
- Stabilization of mood, attitude and energy

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Psychobiology of CBT

Cognitive Techniques:
✓ Cognitive reframing
  - decreases anxiety and depression,
  - decreases catastrophic thinking

Behavioral Techniques:
✓ PMR, mindfulness, graded exercise pacing
  - normalizes flexion relaxation phenomenon (FRP)
  - decreases pain scores
  - increases ROM and gait stability
## RTW Outcomes

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<tr>
<th></th>
<th>Control Group</th>
<th>Intervention Group</th>
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<tbody>
<tr>
<td></td>
<td>High Risk and Very High Risk</td>
<td>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>17%</td>
<td>68%</td>
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<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
- MMI by physical medicine physician
- No MMI / PIR by psych when treatment is under H&B codes, as physical diagnosis is the compensable diagnosis
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

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Questions?

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