2018 CLM & Business Insurance Workers Compensation Conference
May 22-24, 2018 in Chicago

Tailoring Complex Pain Treatments: Strategies for Working with Providers

Today's learning objectives include how to

- Identify common psychosocial factors that cause delayed recovery
- Summarize psychosocial observations to have meaning to a provider
- Learn effective strategies to encourage treating physicians to incorporate psychosocial factors into treatment
- Understand how to account for psychosocial needs when a provider is reluctant to engage

I. Psychosocial Factors Magnify Perception of Pain and Disability, which leads to pain behaviors

In contrast to the biomedical model, which attributes disease to biological factors and manages it with endless diagnostics, drugs and surgical interventions; the biopsychosocial model holds that disease outcome is based on the interaction of factors, including the biomedical, such as ongoing tissue injury; those that are psychological, including mood, personality, behavior, beliefs and coping skills; and the social, encompassing cultural, familial, socioeconomic and vocational aspects of the injured worker's life.

Under the biopsychosocial model, disease management includes rehabilitation, health literacy, adjustment, compliance and self-care.

First, a few important terms must be clarified.

Pain is an unpleasant sensory and emotional experience with actual or potential tissue damage or one that is described in terms of such damage. Suffering is distress and perceived hardship. Some people express severe pain/suffering beyond actual or potential tissue damage. Suffering out of proportion to pain often reflects a poor ability to cope with adversity.

Disability perception is an individual's perceived degree of disability. This does not always correlate with physical pathology. It can strongly correlate with unstable psychosocial issues.

Dramatic suffering and magnified disability perception can add up to unstable psychosocial behavior.

Most Predictors of Poor Outcome/Chronicity Are Psychosocial

These include:
Maladaptive coping behaviors[1]
Nonorganic signs[1]
Functional impairment[1]
General health status
Presence of psychiatric comorbidities[1]
Previous work injury with extended lost time[2]
History of substance abuse
Family history of being on compensation
Chronic opioids
Geographic factors/providers[2]

Sources: 1. Chou et al. Will this patient develop persistent disabling low back pain? JAMA 2010; 303(13):1295-1302. 2. Early Predictors of Chronic Work Disability, A Prospective, Population-Based Study of Workers, With Back Injuries

These psychosocial comorbidities are often missed and important to share with the physician
80% depressed; 70% anxiety/panic attacks; 30-60% personality disorders

Source: Manchikanti et al. Pain Physician 2013; Owen et al. Evidence based PM for the PCP

Physicians often poorly account for psychosocial issues Pain is treated as a vital sign and suffering is not recognized. Those reporting the greatest pain and disability are most likely to be prescribed opioids. Patients complaining of severe pain and disability are at greatest risk of aberrant drug-taking behaviors. This is why mental illness is strongly associated with opioid use for pain.

Physicians commonly underestimate the degree of psychosocial comorbidities in their pain patients unless psychometric testing is performed.
Source: Daubs, et al. J Bone Joint Surg AM. 2010

Not adequately accounting for psychosocial factors has an impact on outcomes. Examples include, opioids prescribed for suffering rather than for pain (chemical coping), back surgery for non-specific lower back pain and spinal cord stimulators for failed back surgery.

The goal of addressing psychosocial issues with treating physicians is to foster optimal outcomes. Addressing psychosocial issues - especially suffering -- improves function, reduces healthcare utilization and optimizes return to work.

In order to avoid undue compensability of psychosocial issues, it's important to limit treatment to psychosocial issues related to the general medical condition, to offer Cognitive Behavioral Therapy and to carefully follow health and medical codes.

II Case Study: Claimant Mr. B Walks into A Pain Medicine Office

Mr. B is a 46-year-old male injured worker injured on April 17, 2015.

His diagnosis includes degenerative disc disease, lumbar vertebrae 5 and sacral vertebrae 1 radiculopathy, and failed back syndrome. He complains of left leg numbness and pain and back pain, with pain at an 8 on a scale of 10.

His comorbidities include obesity, Attention Deficit Disorder, and a prior rotator cuff repair, and possible alcohol abuse.

He is taking these medications: Lyrica; OxyContin 20 mg, 6 per day; Fentanyl patch 25 mcg every 48 hours (MEDD 240 mg) ; Xanax .5 mg, 3 per day, Relistor, Testosterone patch.

Mr. B has had these treatments: Laminectomy lumbar4-5, repeat laminectomy L4-5 and L5-S1; and fusion of L4-S1. He has had multiple ESI, facet injections and facet neurotomy (radiofrequency).

He remains out of work and is interested in additional medications or surgery to help his pain. He drives a motorcycle and works on cars, has three children under 12, and his wife also has chronic pain.

III. How to Communicate Better With Physicians

Let's go over some strategies for communicating better with physicians who rely mainly on the traditional biomedical approach.

Understand How Doctors Process Information So they can better receive your information

The first thing to know is how physicians process information, so that we know how to better present it to them. They make very quick fact-based decisions, and they don't have a lot of time, so a long discussion for them is cringe-worthy.

A collaborative discussion on how to help them make their job easier is received much better. Doctors prefer data-based arguments and learnings during presentations.

Doctors are focused on the best interests of their patients. So, we can facilitate some of those discussions and show doctors that with a psychosocial aspect we're helping them benefit the patient and family.

Four Levels of Communication: *SOAR* to Better Outcomes with Different Physician Types

Here are four levels of communication that are frequently used with physicians. The first is sharing information about an injured worker that the doctor may not have. Second, to actually offer assistance to get other resources involved such as some CBT or a CBT evaluation. Third, it's sometimes necessary to arrange for these things. And finally, there may be times when it's best to adjudicate, especially with a more structured picture of the biopsychosocial model.

Three Levels of Physician Engagement with Psychosocial Issues

Typically, you'll encounter three types of doctors: those who are actively engaged with psychosocial issues, those who aren't so engaged but will hear you out about psychosocial issues, and lastly the outlier doctors who aren't interested in psychosocial management at all.

A lot of doctors believe that psychosocial issues are due to the pain, but not necessarily a contributor toward pain. So, some of our work needs to be changing that belief system or pointing that out to them.

Actively engaged physicians tend to take a comprehensive history of the injured worker, include a broad psychosocial history and focus on function and activity. In Mr. B's case, the doctor emphasizes Mr. B's PT and home exercise program. He resists medication escalation.

Your Intervention in Mr. B's case is to share information you have about him, including past history: prior injuries, substance abuse history, premorbid medications list; potential functional inconsistencies; unrealistic goals; and recent psychosocial assessment findings.

Passively engaged physicians tend to take a comprehensive history, a cursory psychosocial history and emphasize the Visual Analog Scale of pain. After hearing about Mr. B's pain rating of 8/10, he orders an MRI and enumerates a number of medication and interventional treatment options. He is willing to discuss rehabilitative options. Importantly, he may let Mr. B drive the care plan.

You can best intervene by offering assistance, such as a Cognitive Behavioral Therapy assessment, other psychosocial support, and rehabilitative services such as specialized Physical Therapy or a pain program, information on latest guidelines on opioid risk; and a pre-visit MD conference or summary.

Resistant physicians tend to take a comprehensive history, a cursory psychosocial history, focus heavily on the Visual Analog Scale of pain, and apply no meaningful functional measures. After hearing about Mr. B's pain rating of 8/10, this physician orders several diagnostic tests and prescribes several medication changes and interventional treatment options. He also provides a video on spinal cord stimulators.

Here, your best intervention is to arrange alternatives to this provider by addressing liability and risk concerns with him or her while working with the claims professional to identify a new provider and get a second opinion and also educating the injured worker about treatment options beyond those that may have been discussed.

In extreme cases of resistance to treating psychosocial issues, you may have to resist and adjudicate, enforcing Standard of Care by considering what a reasonable and prudent physician would do in the case. These three points are the basic standard: First, do no harm; look to evidence-based literature; and exhaust conservative evidence-based treatments. Failure to exhaust conservative evidence-based treatments prior to higher-risk or non-evidence-based treatments is a breach in the standard of care and unethical.

In summary

Psychosocial issues are ubiquitous in complex pain. Though obvious to us, they may be less apparent to treating physicians.

Case managers and adjustors can help physicians manage psychosocial issues by understanding how to engage the individual physician and communicating your concerns.