The Anatomy of Chronic Pain and Opioid Misuse:
Opioids and Cognitive Behavioral Therapy

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Welcome!

Thank you for joining us for Paradigm’s 2012 webinar series. Replays of past webinars are available for viewing at www.paradigmcorp.com/webinars

The Anatomy of Chronic Pain and Opioid Misuse is a three-part series of webinars about pain

**TODAY:** *Opioids and Cognitive Behavioral Therapy*

Replays are available online of all of our past webinars, including:

**Part one:** Clarification of Diagnosis and Opioid Addiction

**Part two:** Case Management, Treatment Decisions and Opioids
First a few housekeeping points....

- Slides will advance automatically
- Question & Answer period at end
- You may submit questions at any time
  - Q&A Panel is on the lower right side (If you don’t see it, click the “Q&A” button in the upper right)
  - Type a question into the lower section of the Q&A panel that appears
  - Ask “All Panelists” and be sure to click “Send”
  - If we cannot answer during the session, we will e-mail you
- Replay will be sent via email and the presentation was emailed to you this morning
- When the webinar ends, a short survey will pop up
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Inaccurate pain diagnosis and reliance on subjective pain report over objective measures often leads to trial-and-error procedural care with an emphasis on poly-pharmacy and narcotic escalation.

The term “substance use disorders” encompasses all problematic use, not just addiction. Don’t jump to label someone an addict.

The best solution for detoxification depends on the individual patient. Consider his or her willingness to wean, available support from the family and community, and the expertise and support available from the patient’s treating physician.

The right treatment in the right setting is a case by case decision.
Today we will learn...

1. How biopsychosocial factors can be treated without assigning a psychological diagnosis
2. The core elements of cognitive behavioral therapy
3. The signs that a patient might benefit from cognitive behavioral therapy
Today’s Presenters

Steven Moskowitz, MD
Senior Medical Director, Paradigm

- 28 years experience in physical medicine and rehabilitation and pain management
- 23 years in-depth experience with case management, healthcare administration and physician leadership
- Clinical expertise in both complex musculoskeletal and neurological program development
- Practiced for 16 years at a large multispecialty clinic where he worked collaboratively with physicians in neurology, neurosurgery, orthopedics, pain management, internal medicine

Michael Coupland, CPsych
Psychologist, Integrated Medical Care Solutions Group

- Charter psychologist, registered psychologist and certified rehabilitation counselor
- Co-founder of three national disability evaluation companies
- Developer of the AssessAbility Functional Medicine Evaluation and Functional Psychological Evaluation systems
- Author of many chapters, papers and articles, including AMA 6th ed. Guidelines companion text *Guides to the Evaluation of Functional Ability*
Approaching Cognitive Behavioral Therapy from the Perspective of a Treating Physician

Steven Moskowitz, MD
Senior Medical Director, Paradigm
The biomedical approach assumes that all pain symptoms have a specific physical cause and attempts to eradicate the cause directly by identifying and rectifying the presumed pathophysiology.

The biopsychosocial approach understands that chronic pain is a complex and dynamic interaction among biological, psychological, and social factors that perpetuates and may even worsen the clinical presentation. It usually includes deconditioning and poor flexibility, fear avoidance, maladaptive coping.

The biopsychosocial model is consistent with rehabilitation principles.
Maladaptive Cycle in Entrenched Chronic Pain

Physicians often misinterpret pain behaviors as representing pain generators and they increase treatment, thereby reinforcing maladaptive behavior.

- Unrealistic expectations
- Illness conviction
- Catastrophizing
- Fear avoidance
- Quick fix seeking

Maladaptive Coping
- Quick fixes
- Trial and error approach
- Lack of objective measures
- Poly-pharmacy
- Escalating interventions

Maladaptive Treatment
A study found that patients who catastrophize report experiencing pain that is **what % more intense** than patients who do not catastrophize?

- 7%
- 10%
- 22%
- 29%

Mr. Bingo, a 48-year-old Laborer with a Bad Back

- Multiple procedures include decompression of L4-5, anterior fusion of L4-5 based on discogram results, and multiple pain procedures. Possible arachnoiditis. Despite this, the patient continues to complain of lower back pain and is at home, sedentary and on high-dose opioids.

- Past medical history of alcohol abuse, smoking, obesity and sleep apnea.

- His local MD prescribed Dilaudid 32 mg per day, Opana 60 mg per day, Amrix and Lyrica.

**Impressions**

**Medical Director**
- Opioids seem ineffective
- Level of claimed disability appears excessive
- Treating physician not engaged and discounts rehabilitation potential

**Nurse Case Manager**
- Sedentary and disabled lifestyle with no goals
- Passive attitude and reliance on medications
- Close relationship with 8-year-old son
Cognitive Behavioral Therapy in the Context of Pain

A simplified definition:

“Cognitive”

refers to our beliefs, understanding and fears about pain. This is influenced by learned behavior, cultural factors, personality type.

“Behavior”

refers to how we react to pain and adversity. In chronic pain we often see pain behaviors such as symptom magnification, fear avoidance and self limitation and secondary gains, based on injured worker beliefs which may or may not be accurate or adaptive to the situation.
If cognitive behavioral therapy makes sense... why do insurance carriers fear it?
The Basics and Beyond: Cognitive Behavioral Therapy as a Tool in Chronic Pain Treatment

Michael Coupland, CPsych
Psychologist, Integrated Medical Care Solutions Group
The pain signal is passed up the spinal cord to multiple locations in the brain, including the limbic (emotional) center of 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
Biopsychosocial Model of Pain

Chronic Pain & Disability Behavior

- Catastrophic thinking
- Fear-avoidant behavior
- Perceived injustice
- History of childhood abuse
- Depression, anxiety, personality disorders
- Work attachment/age
- Lifestyle: exercise, smoking, alcohol, drugs, obesity/diet
The Conundrum

- 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

- Psychological treatment usually leads to a psychological 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 psychological diagnosis
- Specialty panel with disability management approach is short-term treatment with functional goals
What is Cognitive Behavioral Therapy?

- 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
Treating Biopsychosocial Factors with CBT

...without ‘buying’ an unwarranted psychological 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

<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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Coupland, M. Psychosocial Interventions for Chronic Pain Management *The International Journal of Industrial Accident Boards and Commissions;* Fall 2009
Cognitive Behavioral Therapy: Premise

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.
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
Can you Identify High Risk Cases Early?

**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
Inadequate response to treatment; 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.

Medication issues and/or drug problems, including 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.

Current or premorbid history of major psychiatric symptoms or disorder.

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

Cases for which certain procedures are contemplated, e.g. back surgery.
Cognitive Behavioral Therapy

Treatment Rationale: individuals must 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 restructuring to replace overly negative pain-related thoughts with adaptive, coping thoughts
  - Application and Maintenance of Coping Skills
Outcomes and Case Management Tips

Steven Moskowitz, MD
Senior Medical Director, Paradigm
Outcomes after Cognitive Behavioral Therapy

- Shorter case duration
- Lower frequency of expensive interventions including:
  - Physical therapy
  - Imaging
  - Injections

A 2010 study found that cognitive behavioral therapy was both effective in reducing low-back pain and cost-effective compared to other interventions.

CBT: An Important Tool in the Armament

CBT can be effective as part of a concerted plan and approach to pain patients.

- **Understand** that workers’ comp has peculiarities specific to it that can lead to fear and secondary gain.

- **Appreciate** that implementing isolated sequential services can push a case toward an unsuccessful biomedical approach, whereas a cohesive plan can attend to the biopsychosocial.

- **Support** the injured worker through a process of change. Cognitive behavioral treatment can facilitate this change.
Question and Answer Session

Please submit your questions for our panelists in the Q&A window on the right.

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