

Workers Compensation Outlook

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Chronic Pain: Strategies for Improving Outcomes

This issue of Workers Compensation Outlook examines the costs associated with chronic pain and the challenges to managing chronic pain cases. It explains how to optimize outcomes by detecting chronic pain issues early by using clinical guidelines, utilization review, and pharmacy utilization reports as well as other clinical predictors. It also describes case management strategies — including a patient-centric, holistic approach to management; assessment tools and coaching to address cognitive and behavioral components; and drug testing — to mitigate the often-negative outcomes associated with chronic pain cases.

Chronic pain: a complex problem

Schoolchildren are often taught that pain is the body's way of telling us that something's wrong. Touch a hot stove, and the pain tells the brain to pull the fingers away. If only it were that simple.

In reality, pain is much more complex. Yes, pain occurs when the body is injured — but clinicians now recognize that pain can persist for years after damaged tissues have healed. In workers compensation, chronic pain is a growing problem that has a negative impact on costs, productivity, and quality of life. Insurers and employers alike need solutions that support improved claimant outcomes while decreasing claim costs.

A problem that hurts everyone

Chronic pain is a significant problem both inside and outside the workers compensation arena. In May 2008, the British journal *The Lancet* published a pain assessment study conducted by Princeton University economist Alan Krueger and Arthur Stone of the Stony Brook University Department of Psychiatry and Behavioral Sciences. According to their study, 26.6 percent of American women and 28.8 percent of American men suffer from daily pain. The American Academy of Pain Medicine (AAPM) notes that 76.2 million Americans suffer from pain — more than diabetes, coronary heart disease, and cancer combined. Due to the types of injuries common to workers compensation, pain is almost always a significant component, and the potential for the pain to become chronic can be high.

Widespread economic impact

Chronic pain drives costs in many ways. According to the Krueger/

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Stone study, Americans spent \$13.8 billion on prescription analgesics in 2004, and lost productivity related to pain costs employers more than \$60 billion annually. According to AAPM, "the annual cost of chronic pain in the United States, including healthcare expenses, lost income, and lost productivity, is estimated to be \$100 billion." Productivity is clearly lost when chronic pain keeps an employee away from work. Losses due to presenteeism, when employees are on the job but not performing to full capacity, are more difficult to measure, but may be greater than losses due to absenteeism.

High-dollar complex claims cost employers and insurers millions of dollars annually in medical and indemnity costs. As claims age, the likelihood of return to work diminishes and payments for medications rise. Citing The Centers for Medicare & Medicaid Services (CMS) statistics, the National Council on Compensation Insurance (NCCI) "Workers Compensation Prescription Drug Study 2008 Update" notes that although growth of prescription drugs' share of workers compensation medical costs slowed from 1999 through 2005, growth increased to 8.5 percent in 2006 due to a number of factors, including strong growth in several therapeutic classes of drugs and increased use of specialty drugs.

An article in the April 20, 2009, edition of the *Tampa Bay Business Journal* reported that workers compensation pharmacy costs reportedly increased by 5.4 percent in 2008, largely due to increases in average wholesale price and reduced availability of generic versions of OxyContin.

Challenges to managing chronic pain claims

Claims involving chronic pain can be particularly challenging for several reasons. For one, it can be difficult to identify which claims will involve chronic pain. A catastrophic injury obviously has potential to evolve to chronic pain. The trickier ones to identify are those that start out as simple strains or sprains but evolve into complex, chronic conditions. As they mature, these apparently "simple" claims are often moved to "maintenance" status. The level of intervention – claim oversight and case management – is typically decreased or eliminated. At that point, the individual has already been through the gamut of standard claim management tactics and may not be open to resolution. Helping individuals at this stage is difficult and must be evaluated on a claim-by-claim basis.

The biopsychosocial nature of chronic pain poses challenges for clinical outcomes and claims management. Krueger and Stone found that respondents with lower income or less education spent a higher proportion of time in pain and reported higher average pain than did those with higher income or more education. They reported, "the average pain rating was nearly twice as high for those in households with yearly incomes below \$30,000 as for those in households with incomes above \$100,000."

Stress, anxiety, and depression all can worsen the perception of pain. Attitude can also affect the motivation to return to work – or even to get well. If left unbroken, the cycle of pain and depression can continue to worsen over time.

Clearly, early detection and intervention is critical. However, keep in mind that claims often do not appear catastrophic at the outset; many become problematic over time, as claimants become physically deconditioned, dependent on medication, and susceptible to depression and anxiety. The challenge is to identify which claims are likely to move in that direction and to intervene as soon as possible to help support a better outcome. Fortunately, claims managers have several tools and strategies that help identify potential chronic pain problems. Make sure your insurer or third party administrator closely monitors these claims and uses the latest techniques.

When the treatment compounds the problem

Analgesic drugs can play an important role in helping to manage chronic pain, but the relief doesn't come without a price – literally and figuratively. A recent trend toward using more narcotic analgesics complicates the picture. Commonly prescribed narcotics include hydrocodone, oxycodone HCl, Actiq, OxyContin, tramadol, fentanyl, and morphine sulfate. According to the NCCI drug report, hydrocodone with acetaminophen was the number-one prescribed drug in workers compensation service year 2006. Four of the top 10 were narcotic analgesics; the top 10 also included gabapentin, a central nervous system drug prescribed for nerve pain. The NCCI drug study showed that, for claims with heavy use of Cox-2 inhibitors, the hydrocodone/acetaminophen combination increased from 8.5 percent of prescriptions in 2001 to 17.1 percent of prescriptions in 2006, after several anti-inflammatory drugs were withdrawn from the market due to cardiovascular risk.

Narcotic analgesics have drawbacks. Injured workers can experience unwanted side effects, including constipation, nausea, vomiting, or itching. They may feel drowsy or dizzy, and their reflexes may be slowed, all of which can have an impact on the ability to perform certain job tasks – and which can be dangerous for those driving vehicles, operating machinery, or caring for a dependent person. Narcotic analgesics can slow respiration, sometimes to dangerous levels.

Injured workers can develop a tolerance for narcotics and require higher doses to achieve the same level of analgesia – and narcotics may not provide complete pain relief. Some patients may become addicted and crave the drug. Addiction decreases quality of life and makes it more difficult to break the downward spiral of pain and depression.

Another potential problem with narcotics is the possibility of diversion – where a patient obtains the drugs through a legal prescription and then illegally gives or sells them to another.

Long-term narcotic therapy for chronic pain can also be costly. As claims age, the percentage of medical payments applied to prescription analgesics increases – to as much as 38 percent, according to a 2006 NCCI report on "Medical Services by Age of Claim."

Tools for early detection

With the potential pitfalls surrounding narcotic use for long-term

pain management, it makes sense that you look at prevention and early detection of problems. The American Pain Society and AAPM developed guidelines for chronic opioid therapy (COT) in noncancer injured workers. These guidelines might be useful in helping reduce the risk that such therapy is inappropriate for a given injured worker. The guidelines address patient selection and risk stratification, initiation of and titration of COT, monitoring indications for discontinuation of therapy, driving and work safety, breakthrough pain, and other issues.

Aberrant drug-related behavior – i.e., outside the agreed-upon treatment plan – may occur in as many as half of injured workers with chronic pain. Treating providers should assess the risk of substance abuse, misuse, or addiction prior to initiating therapy through a thorough personal and family history and a physical examination, as well as through screening tools.

Risk assessment tools that may be appropriate include Screener and Opioid Assessment for Patients with Pain (SOAPP) Version 1 (which can be downloaded at <http://www.painedu.org/soapp.asp>), the Opioid Risk Tool (ORT), and the Diagnosis, Intractability, Risk Efficacy (DIRE) instrument. (ORT and DIRE can be downloaded at http://www.emergingsolutionsinpain.com/index.php?option=com_content&task=view&id=346&Itemid=242.)

Providers might consider obtaining signed informed consent prior to initiating therapy. Doing so protects both injured worker and provider by laying out the benefits and potential risks, ranging from common side effects to serious adverse events associated with the therapy. Plus, it makes sense to discuss the management plan with the injured worker.

Putting the plan in writing could protect the injured worker's access to the medications and the provider's ability to prescribe. Such an agreement might require that the injured worker obtain all controlled substances from one provider or the same pharmacy. It can spell out guidelines – for example, that the narcotics cannot be given to anyone else and that they must be kept out of reach of children. It may make renewals contingent on keeping appointments or other behaviors. AAPM sample consent and agreement forms are available at www.painmed.org.

As noted previously, claims that did not begin as clinically catastrophic may become so from a financial or psychosocial perspective – which makes monitoring important. On the clinical side, the opioid guidelines suggest tools such as the Pain Assessment and Documentation Tool (PADT) (which can be downloaded at <http://www.npecweb.org/clinicaltoolbox.asp?id=26&selMenu=15,0>) and the Current Opioid Misuse Measure (COMM) (which can be downloaded at <http://www.painedu.org/soapp.asp>).

For the payers, utilization review and pharmacy utilization reports may be particularly useful to identify claims needing clinical intervention. Clinically driven predictive models can also help detect potential problems early enough in the life of the claim to allow for timely interventions. For example, today's predictive

models can assess treatment patterns and identify those at risk for surgery.

This may be useful, as an August 2007 study by the Workers Compensation Research Institute (WCRI) identified multiple failed surgeries as a common factor in unresolved claims. Applying the appropriate intervention before surgery occurs can have an impact on the outcomes of these claims.

In states that have adopted chronic pain treatment guidelines, utilization review may offer an opportunity to identify potential problems earlier in the claim, allowing for intervention through communication with the provider. If the insurer participates in a pharmacy benefits management (PBM) program, the PBM should be able to report on all medications prescribed by the claimant's physician. Regular review of such reports can identify trends such as therapeutic duplication or duplicate prescriptions, over-utilization, and prescriptions that are inappropriate for the body part or injury code. PBM reports can also show if the claimant is obtaining prescriptions from multiple physicians or dispensed by multiple pharmacies.

Clinical guidelines can help the claims handler or case manager identify optimal treatment and duration. When a claim that has exhausted what would be considered "usual and customary" treatment for the diagnosis with no documented improvement in pain level has been identified, it should trigger intervention to help prevent the claim from becoming chronic.

The need for multidisciplinary case management

Once a problem is identified, what interventions can be applied to resolve the claim?

One size definitely doesn't fit all. Each claim must be assessed on its own merits, with individual goals and recommendations. In the Opioid Treatment Guidelines, the American Pain Society/AAPM panel noted that "patients with more complex cases, including those with disabling [chronic noncancer pain, CNCP], tend to experience better outcomes if they are managed using a comprehensive approach that integrates strategies to improve pain with those that address the functional impairment and psychosocial factors that are often associated with CNCP." This patient-centric, holistic approach to management can help mitigate negative outcomes.

Most multidisciplinary pain management programs include a team consisting of a medical doctor, a psychologist/behavioral specialist, physical/occupational therapist, and a rehabilitation specialist. Similarly, the case management approach should engage all available resources, including physician advisors for consultation on the most efficacious treatment plan and peer-to-peer discussions, and the employer for return-to-work collaboration.

The case management plan should address cognitive and behavioral aspects that affect recovery as well as medical history. Consider using assessment tools that evaluate the following:

- readiness for change;
- cognitive and affective reactions to pain;
- fear of pain or re-injury;
- depression;
- impact of pain on daily life; and
- level of pain that the person currently experiences.

Assessment results should be shared with the treating provider in order to foster the cooperative collaboration necessary to improve the individual's outcome.

The case manager is key

The goal of case management is to help the individual overcome some of the challenges associated with pain and resume activities he or she previously enjoyed. Increasing physical activity is a key component of the case management program. Uniquely positioned to spend time with the individual at home, the case manager can more accurately observe and assess the individual's activities of daily living. Depending on the individual's activity level, increasing physical activity may include a daily walking program, a more structured physical therapy or work conditioning program, or a return-to-work program that includes gradual transitional work.

The individual must be a willing and active participant in the pain management process in order to reverse the downward spiral. The case manager plays a key role as a coach for the individual, providing cognitive and behavioral input such as self-instruction, relaxation techniques, and coping strategies. The case manager can coach the individual to increase assertiveness, minimize negative and self-defeating thoughts, change maladapted beliefs about the limits of his or her pain and set new goals.

Although there may be no cure for the cause of the pain, it is often possible to help the injured worker focus on things other than pain and, as a result, improve the ability to function.

Case management success story

A worker who sprained her ankle while attending an employer-required conference in 1987 was later diagnosed with Complex Regional Pain Syndrome (CRPS), Type 1, in the right leg. In 2002, she was awarded future medical care, including medications and physical therapy for pain management, with estimated lifetime medication costs of more than \$400,000. Her medications included oxycodone, OxyContin and Actiq.

In 2007, the claimant passed a fitness-for-duty exam, and her pain management physician provided a letter stating that she displayed no ill effects from the medications, which she told the physician she took only at night, and that she had been on the medications for more than two years, so her body had adapted to the narcotics. Her employer rehired her as a field

hospice nurse, a job that required her to drive to several locations, including client homes, to conduct evaluations and complete her treatment assignments.

In 2008, the claim was reviewed for case management due to the ongoing pain management treatment, associated costs, and concern over the claimant's ability to function safely at work. At the initial and subsequent contacts, the case manager observed that the claimant displayed slurred speech and complained of dry mouth, which is a frequent side effect of narcotics. When the case manager asked, the claimant admitted using medication more frequently than what she had told her physician. The case manager discussed her observations with the employer and the third-party administrator, then followed up with the claimant and her physician. The doctor said the claimant had no options other than to remain on the narcotics currently prescribed.

After the case manager provided coaching and education on medication safety, the claimant became willing to explore alternative treatment options, since she was beginning to feel uncomfortable taking the narcotics on a daily basis. At the claimant's request, the case manager helped locate a new treating physician. Today, the claimant holds a position as a field hospice nurse and continues to work and function safely in her daily routines. She is still under the care of the new pain management physician, who safely changed her medications and provided other modalities for pain management. The new treatment regimen provides relief but does not put the claimant or the organization at risk of further harm. Through management of the claim, the injured worker has been able to continue to work and function in her daily routines. Estimated future medication costs were reduced to \$36,612.

Drug testing as an additional tool

Some individuals may underreport the amount of narcotic drugs they are taking. Urine drug testing (UDT) may be useful in helping identify potential overuse earlier, so it can be addressed before it escalates and becomes more difficult to resolve. UDT can provide a number of benefits for the medical practitioner and the injured worker, yet the tool is not used frequently. According to one study, audited medical records revealed that family practice physicians used UDTs only 8 percent of the time.

When used prior to developing the treatment plan, UDT can help the physician identify any discrepancies between individual self-reported drug use and actual use. The physician then has more accurate information on which to base an individualized pharmacotherapeutic treatment regimen. Such information also lessens the likelihood that the injured worker will experience drug interactions or other negative consequences that could occur if controlled drugs were prescribed to an individual who is already taking them.

UDT may also be helpful as part of the recommended monitoring of individuals on long-term opioid therapy. Periodic testing can confirm compliance or noncompliance with the treatment plan. It can help determine whether the dosage is appropriate and can also help

identify possible abuse, misuse, or diversion of drugs. Under the new Opioid Treatment Guidelines, UDT is especially recommended for high-risk injured workers or those who have already demonstrated aberrant drug-related behaviors.

Insurers and case managers should review the benefits of UDT with treatment providers and encourage providers to use it as a tool to help them develop the most appropriate treatment plan for patients in pain.

Reducing pain all around

Chronic pain is a costly and complex problem that is difficult to manage. It demands strategies that are equally multi-faceted. Recently published recommendations regarding long-term opioid therapy, as well as tools such as utilization review, predictive modeling, data mining, and drug utilization reporting, can help identify high-risk claims to enable early intervention.

Informed consent forms and opioid treatment agreements are suggested to protect both injured worker and health care provider by spelling out the risks and benefits of treatment along with the terms of the treatment program. Employers and payers should look for pain management providers who use these types of tools, along with UDT.

Multidisciplinary case management is a useful strategy. Through education and coaching of the individual and communication with the treating provider and the employer, the case manager can help keep the claim on track and support an improved clinical outcome for the individual.

About the author

Tammy Bradley is director of case management products for Intracorp. Bradley is a Certified Case Manager with more than 20 years of comprehensive industry experience through service delivery, operations management, and product development. She holds several national certifications, including Certified Case Manager (CCM), Certified Rehabilitation Counselor (CRC), and Certified Program Disability Manager (CPDM). She is a licensed professional counselor in the state of Alabama.

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