Mental Health Claims in Workers Compensation

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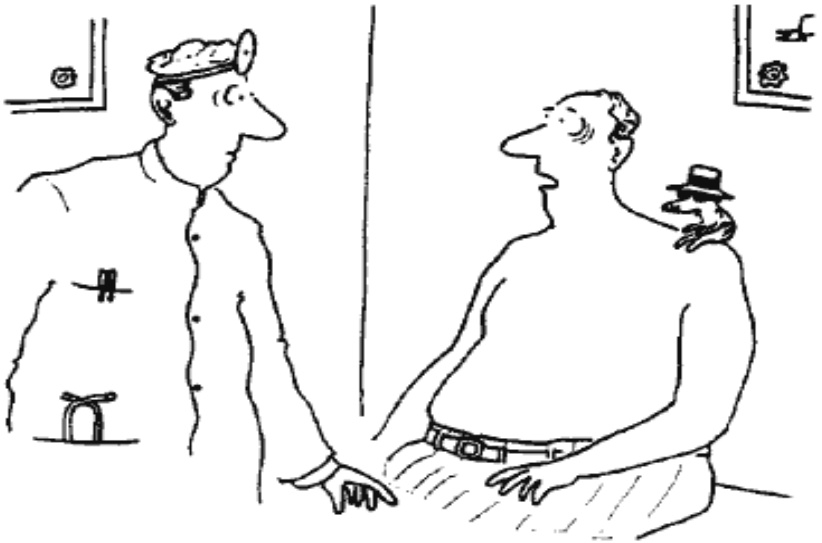
Mental Health claims can arise from:

- Physical Mental
- Mental Mental
- Mental Physical

Each state & federal system has regulations about coverage



"Doctor, I have a suspicious looking mole on my shoulder."

Physical Mental Claims

- A 'Psych Eval' is a poor fit for pain patients whose complaints are primarily subjective and who are 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).
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"Your pulse is very, very weak !"

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

Strategy

TREAT delayed recovery issues yet

AVOID ‘buying’ a psych claim

PHYSICAL MEDICINE PROCEDURE CODES

for

HEALTH PSYCHOLOGISTS

within

Integrated Medical Delivery model

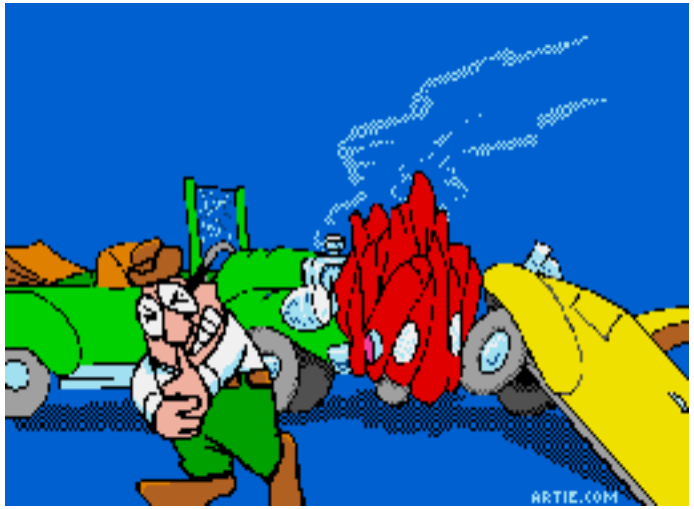
How to Treat Psychosocial Factors without 'Buying' an unwarranted Psych Claim

- New codes established
- Health and behavior assessment and intervention
- Psychiatric diagnosis and treatment codes are NOT used
- The Physical Diagnosis is the working diagnosis

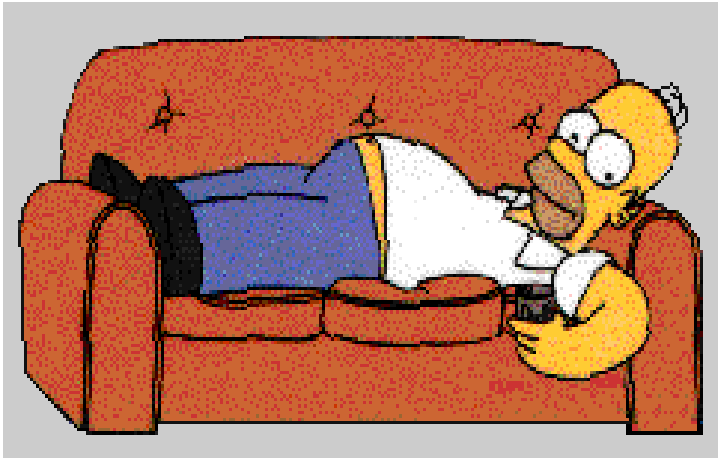
CPT Code	Descriptor
96150	Initial assessment to determine biological, psychological and social factors affecting health and any treatment problems
96152	The intervention service to modify the psychological, behavioral, cognitive and social factors affecting health and well-being

Unfortunately Medicare set the fee for this new code very low for psychologists to provide care under; and we request authorization harmonized with the rates for 'psych' codes

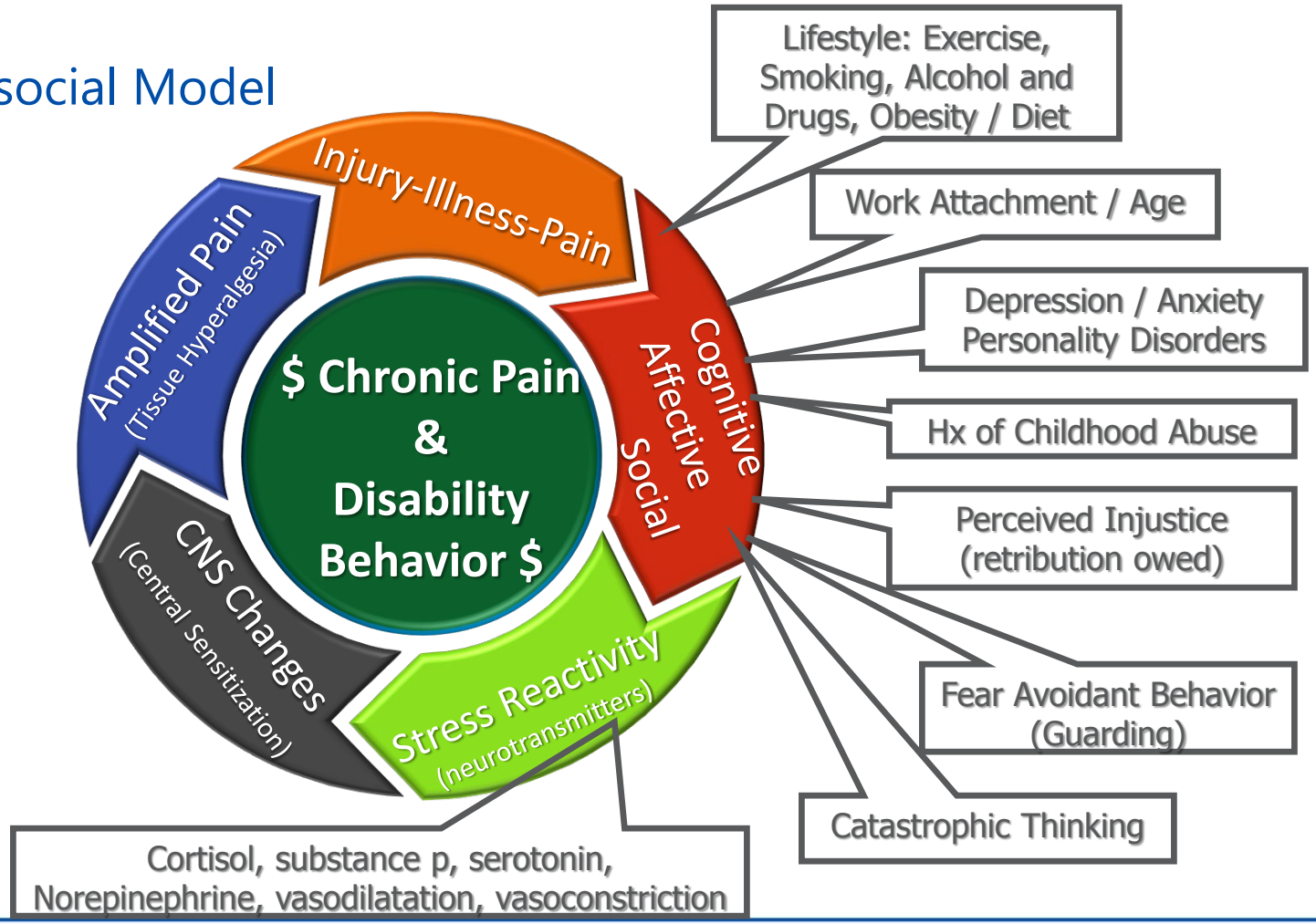
How do we get from here….



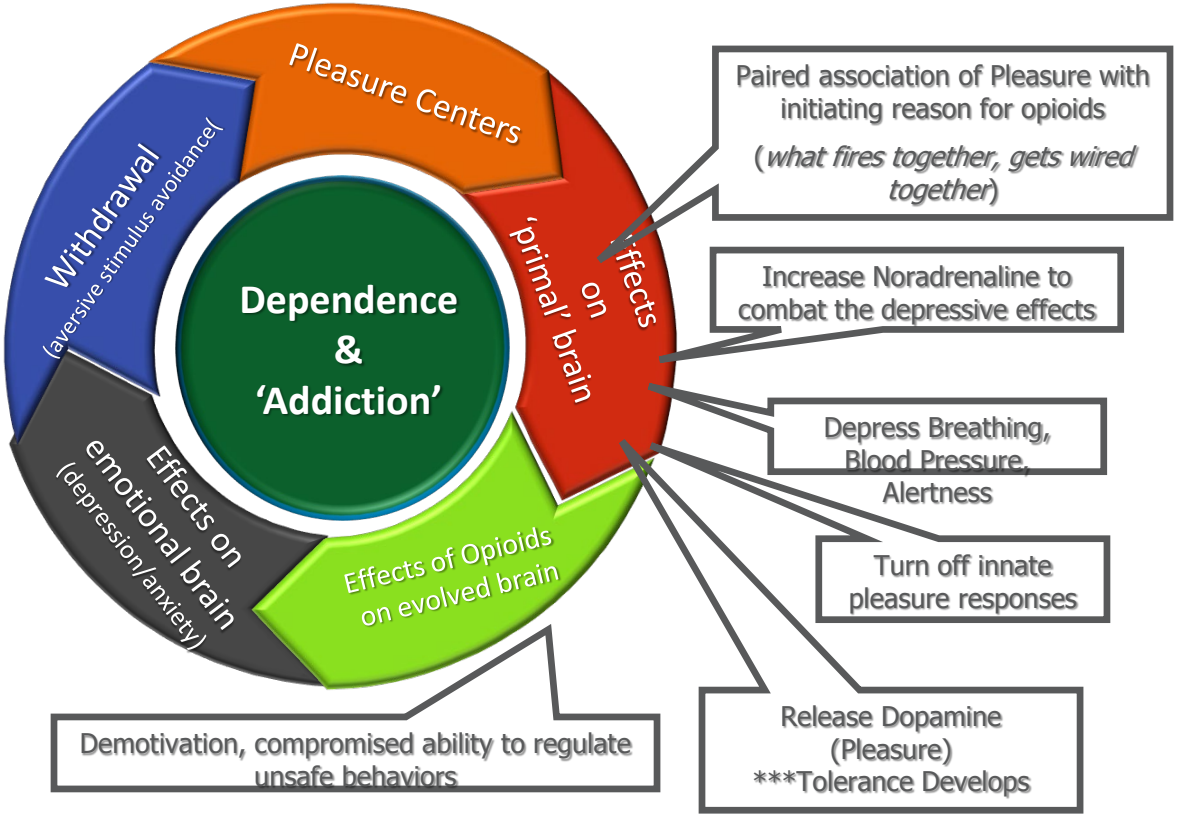
……to here?



Biopsychosocial Model



Neurobehavioral Effects of Opioids



Poll Question

The most predictive factor of delayed recovery from a musculoskeletal injury are what factors?

- Severity of Injury
- Psychosocial factors
- Secondary Gain
- Litigation

Identification of Patients for Health and Behavior CBT Referral

- Inadequate or delayed recovery
  - Failed conservative care (guarding behavior, failed PT)
  - Subjective complaints outweigh objective findings
  - Medically Unexplained Symptoms (MUPS)
  - 'Chronic Pain, Generalized pain, Migrating' pain, Central sensitization pain
  - Lack of functional improvement
- Hx of Substance Abuse, Medication issues and / or drug problems and / or aberrant UDS; opioid / benzo use over expected durations
- Compliance issues with prescribed medical treatment
- Psychosocial / Psychiatric factors negatively impacting recovery
- Pre-surgical clearance for back surgery, pump, spinal stimulator
- PTSD overlay (but not accepted claim)
- CRPS, Phantom Limb,
- Catastrophic injuries; SCI, TBI, Burns, Electric Shock
- Behavioral Issues: Insomnia, Obesity, Smoking

Early Identification of BioPsychoSocial Risk Factors

1. Psychosocial risk factors have been validated
   - Meta Analyses
   - Prospective studies
   - Control group studies

2. A Pain Screening Questionnaire has been validated
   - Scores predict time loss / medical spend /function

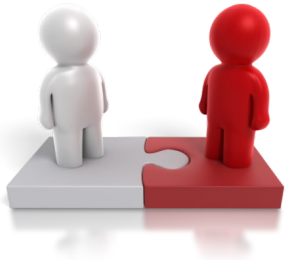
3. Brief Cognitive Behavioral Therapy (CBT) interventions can successfully intervene
   - Less time loss / medical spend /greater function

Early Intervention Screening

PSQ-Pain Screening Questionnaire

PSQ 10 Questions (3-5 minutes)

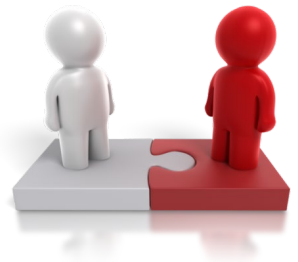
- Pain Attitudes, Beliefs and Perceptions
- Catastrophizing
- Perception of Work
- Mood/Affect
- Behavioral Response to Pain
- Activities of Daily Living



Early Intervention Screening

PSQ-Pain Screening Questionnaire

- 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.



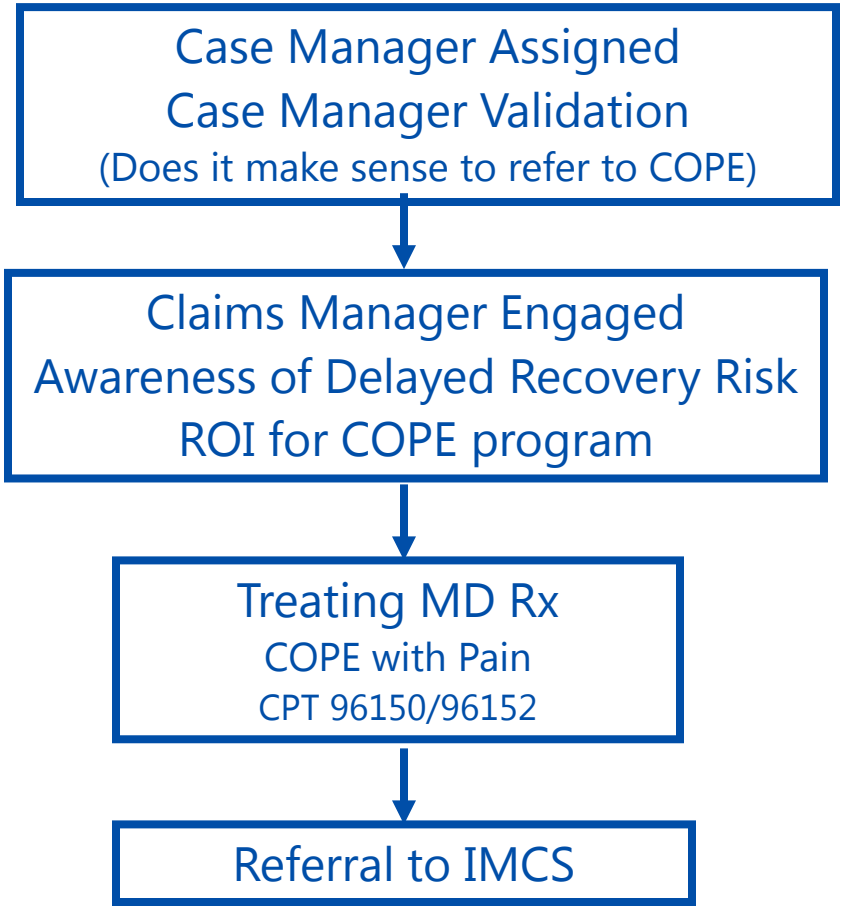
PSQ Screening Outcomes

In collaboration with Safeway-Albertsons

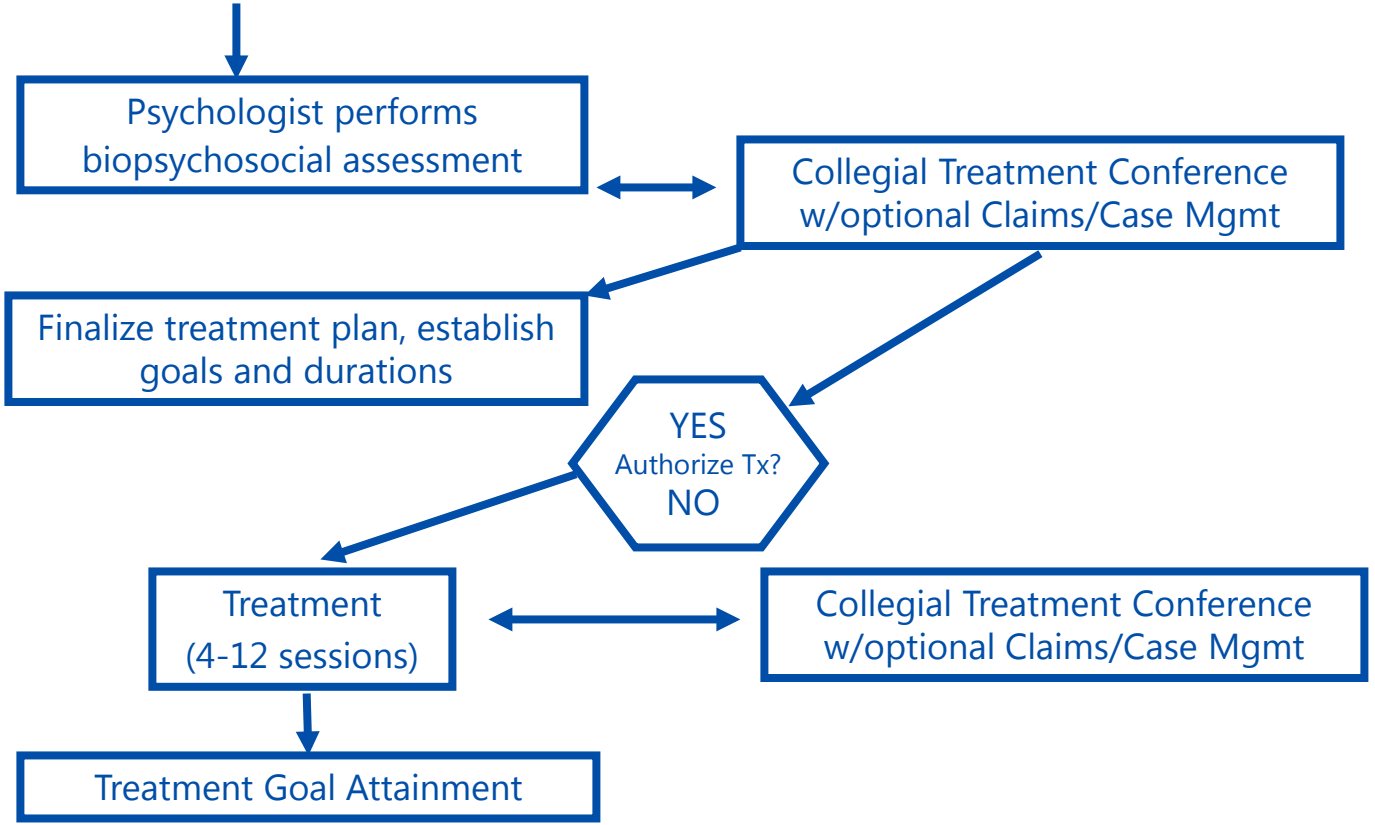
Total 2015 dataset	Avg Total Medical Paid	Avg TTD Days	Avg Total Indemnity Paid	Avg Total Incurred
all with PSQ N=1822	$5,565	49	$5,100	$14,707
Did not take PSQ N=117	$12,668	133	$12,680	$34,129
Low Risk N = 1031	$1,249	7	$811	$2,683
Low-Moderate Risk N=307	$5,576	59	$5,184	$15,302
Moderate Risk N=145	$10,216	104	$11,567	$28,585
High Risk N=192	$13,895	119	$12,317	$36,765
Very High Risk N=148	$20,494	177	$19,473	$55,589

Summary: The PSQ is very predictive of disability duration and claims costs

Workflow



Integrated Medical Case Solutions



COPE with Pain

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.

CBT Treatment Modalities

Behavioral Therapies			
☐ PMR	☐ Mindfulness	☐ Sleep Hygiene	☐ Autogenic\Guided Imagery
☐ Clinical Hypnosis	☐ Autohypnosis	☐ Journaling\Scaling	☐ Diaphragmatic Breathing
☐ Psychoeducation	☐ Biofeedback	☐ Neurofeedback	☐ Operant Conditioning
Other Behavioral Tx:			
Cognitive Therapies			
☐ Identify Triggers	☐Trigger Hierarchy	☐ Cognitive Distortions	☐ Reframing
Other Cognitive Tx			
Neuroplastic Integration Pain Therapies			
☐ Mirror Therapy	☐ EMDR	☐ Neurofeedback	☐ Sensorimotor Integration
Activity Pacing			
☐ Active Exercise	☐ Return to Work	☐ Graded Activity Pacing	☐ Systematic Desensitization
Other Activity Tx:			
Other Therapies			
☐ ACT Therapy	☐ Social Support	☐ Structural Family Tx.	☐ Motivational Interviewing

Poll Question

Cognitive Behavioral Therapy (CBT) uses what modalities to work towards improved patient outcomes?

- Cognitive reframing
- Relaxation exercises
- Activity pacing
- All of the above

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

Outcomes

Medical Utilization 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

Total Claims Costs Outcomes

Safeway Albertsons 2015 California Claims Study

- 78 injured workers with high scores participated in COPE with Pain. The average total paid was $36,629.
- 82 workers were referred but did not participate in the COPE with Pain program. The average total paid was $44,356.
- 82 injured workers with high scores were not referred to the COPE with Pain program. Their average total paid was $73,488.
- The treatment averaged 6 sessions

Case Closed: MMI / RTW

- No MMI or Impairment Rating by IMCS Psychologist
- Treatment is under the COPE with Pain codes
- Physical diagnosis is the ONLY compensable diagnosis

Mental Mental Claims

A subset of states allow mental-mental claims, and those states vary their definition of the ‘stressor’ allowable.

- Compensability for Mental-Mental Injuries: 27 States contain statutory language expressly allowing compensation for nonphysical mental (mental-mental) injuries or stress under limited circumstances
- Mental-Mental and Mental-Physical Exclusions: One State specifically denies compensability for both “mental-physical” and “mental-mental” injuries
- Personnel Actions: 21 States specify that stress arising out of personnel actions is not compensable. One state has regulation specifically for workplace stress (CA Stress Claims)
- Diagnosis for Mental Compensation: 10 States require psychological diagnosis for compensable mental injuries
- American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM): 8 States require the use of the DSM in diagnosing mental injuries
- First Responders have state specific regulations for Mental Mental or PTSD specifically

****Specific state list available upon request

Diagnosis using DSM-5

Diagnostic Criteria exist for Mental Health Diagnoses

› Example: Posttraumatic Stress Disorder (f43.1)

A. The person has been exposed to actual or threatened death, serious injury, or sexual violence in one of the following ways:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or friend
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s); this does not apply to exposure through media such as television, movies, or pictures

"I'd say it's PTSD, but if work comp insists on a second opinion, I'll say it's Generalized Anxiety Disorder"

Diagnosis of PTSD

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- (2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Diagnosis of PTSD

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Diagnosis of PTSD

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep

(2) irritability or outbursts of anger

(3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Causality of Mental Health Disorders

- The science of causality and mood disorders is well reviewed in Melhorn JM, Ackerman WE. AMA Guides to the Evaluation of Disease and Injury Causation: Second Edition. Chicago, IL: American Medical Association; 2013: Chapter 16: Mental Illness.
- The science suggests that mood disorders are multifactorial in origin with genetic and life event factors. This chapter summarizes that 'potentially relevant scientific investigations have been pervasively inadequate for the purpose of justifying legal causation to claims involving mental illness".
- Causality and apportionment rules vary state to state. Therefore a best practice is to document the relative weighting of the typical comorbid factors

Factor	Clinical Remarks	Causality Weighting
Pre-existing psychiatric history	As determined during clinical exam & records review	xx%
Family of origin (genetic) psychiatric disturbance	As determined during clinical exam & records review	xx%
Non-occupational life stressors	As determined during clinical exam & records review	xx%
Medical/metabolic etiology.	As determined during clinical exam & records review	xx%
Personality/Characterological traits	As determined during clinical exam & records review	xx%
Occupational Personnel Actions	As determined during clinical exam & records review	xx%
Occupational Stress Exposure	As determined during clinical exam & records review	xx%

Treatment for PTSD

Best Practices

- PTSD has shown the best response when Cognitive Behavioral Therapy (CBT) is utilized.
- CBT utilizes principles of learning and conditioning to treat this disorder and includes components from both behavioral and cognitive therapy.
- Exposure/Desensitization is a treatment recognized as being effective in treating PTSD. Types of exposure therapy include imaginal exposure, which involves exposure to the traumatic event through mental imagery; and in vivo therapy, where a client confronts the actual scene or similar events that are associated with the trauma.[1]

[1] Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence; National Academy of Sciences; Fall 2007.

Treatment for PTSD

- Medications can be utilized in addition to CBT. Patient preference and involvement need to be considered as part of the decision to prescribe specific medications. The severity of symptoms should also be considered. Two selective serotonin reuptake inhibitors (SSRIs) have been approved by the FDA to treat PTSD; sertraline (Zoloft) and paroxetine (Paxil). SSRIs address all common symptom clusters of PTSD. Benzodiazepines (Valium and Klonopin) should be avoided "as there is no evidence they are beneficial in the treatment of chronic PTSD and [there is] some evidence that they can increase the likelihood of developing PTSD when prescribed in the acute aftermath of trauma exposure."[1]

- [1] Care for Returning Service Members: Providing Mental Health Care for Military Service Members Returning from Iraq and Afghanistan; Christopher Erbes, et al; Minnesota Psychologist, November 2007.
- [1] Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence; National Academy of Sciences; Fall 2007.

Outcomes for COPE with Trauma Referrals

Analysis of 166 referrals for a healthcare employer for the COPE with Trauma program during 2017

- Average 4 treatment sessions
- Returned to work with accommodations at first office visit in 65% of cases
- Returned to work full duty at discharge in 75% of cases

Poll Question

The Gate Control Theory of Pain can be mediated by non-pharmaceutical CBT techniques the patient can learn?

- No, it is biologically implausible
- Yes, patients can mediate their own pain through psychoeducation and activity pacing, core principles of CBT

Questions?

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