Berwick Pain Associates

1175 Ferris Avenue - Berwick, PA 18603

Pain Management Evaluation

Re: James Jones

Clinician: Alex Poirier
Administrator: Connor Smith

Testing Date: 04/29/2016
Date of Birth: 03/20/1969

Sex: Male
Age: 47 years

Tests and Methods:

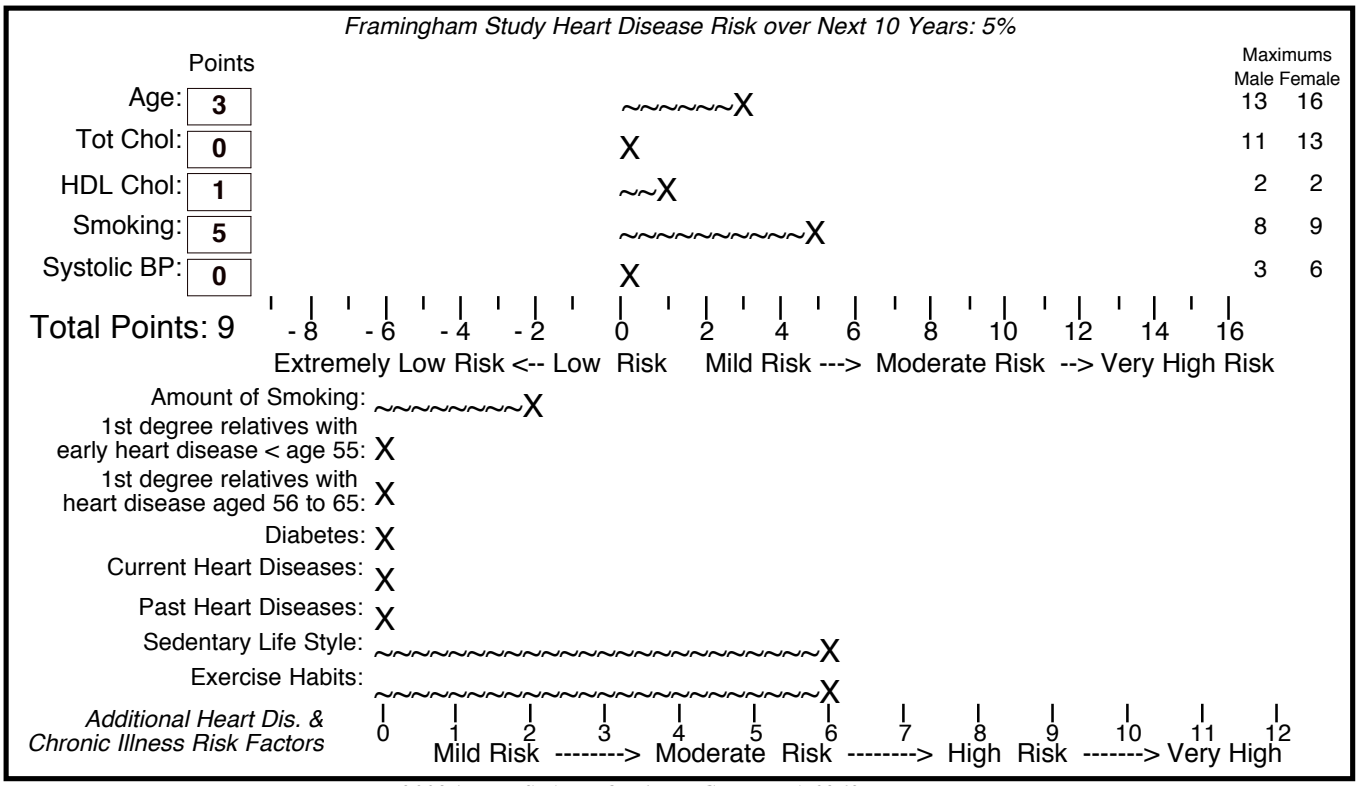
Belle Browne Pain Scale; Screener & Opioid Assessment for Pain Patients-Rev (SOAPP-R); Screening Instrument for Substance Abuse Potential (SISAP); Opioid Risk Tool (ORT); CAGE Sub Abuse Questionnaire (CAGE); Alcohol Use Disorders Identification Test (AUDIT); Patient Health Questionnaire-9 (PHQ); PHQ-Panic; PHQ-2; DSM-5 Cross-Cutting Symptom Measure (CCSM); Generalized Anxiety Disorder 7-item (GAD-7); and 7-item Instrumental ADL Test.

Health Status:

Mr. Jones is a 47-year-old, married man who reports nearly unbearable pain (i.e., 8/10 on the Belle Browne Pain Scale). Given severe pain he was evaluated for Somatic Symptom Disorder and for Illness Anxiety given his concern over a possible undiagnosed illness with nonspecific symptoms (e.g., dizzy, faint or memory loss). Also complaints of depression contributing to pain were examined. Opioid addiction risk was assessed due to high daily pain. These issues started about two years ago. Although no sleeping difficulty was described, sleepiness during the day was noted as causing very significant compromise in life quality; he notes having used two medical sleep interventions. Medical conditions (over the past five years) include knee replacement. His last physical exam was two years ago. Available history indicated no previous psychiatric hospitalizations, no past inpatient chemical dependency treatment and two past medical-surgical hospitalizations. Family history is positive for: attention deficit disorder in the patient, himself; diabetes in his maternal grandmother; illegal drug use in a brother; and alcoholism in an uncle. Also, reported was depression in 2 aunts.

Three BP readings were taken; as they differed by less then 20 mmHg their average (126/91) was used here. Based on height of 70 inches and weight of 195 lbs a Body Mass Index (BMI) of 28 was obtained. Most recent total cholesterol was reported as 135 mg/dL, LDL level was 135 mg/dL, and HDL was 45 mg/dL. Mr. Jones currenty smokes but he wants to quit; his present cigarette usage is under half a pack per day. Mr. Jones reports he has about two drinks daily, but he is thinking about quitting. He reports last using marijuana or hashish 13 months to two years ago. Mr. Jones described a very low general physical activity level in daily life; his current activity level is the same as last year. Regarding a physical fitness routine, he reported rarely engaging (less than once per month) in sustained exercise for at least 30 minutes at a time.

Mr. Jones' prescribed medications are not supervised; a pill box is not used. Two medications are taken, up to one time daily. He has no problems with understanding, taking and ordering his medications. No problems in managing either instrumental or basic activites of daily living (ADLs) were noted. Traditional pain therapies tried and found helpful include; TENS machine and spinal block; however ice/heat had not helped. Alternative pain therapies tried that helped include; exercise, chiropractic and massage; however homeopathy and naturopathy have not helped. Mr. Jones noted interest in no standard pain therapies (like pain medication, OT/PT, counseling, etc.). In contrast, he reported interest in several alternative pain treatments; acupuncture, meditation, Yoga, Reiki and aromatherapy.



Duration: 1 Hours 12 Minutes

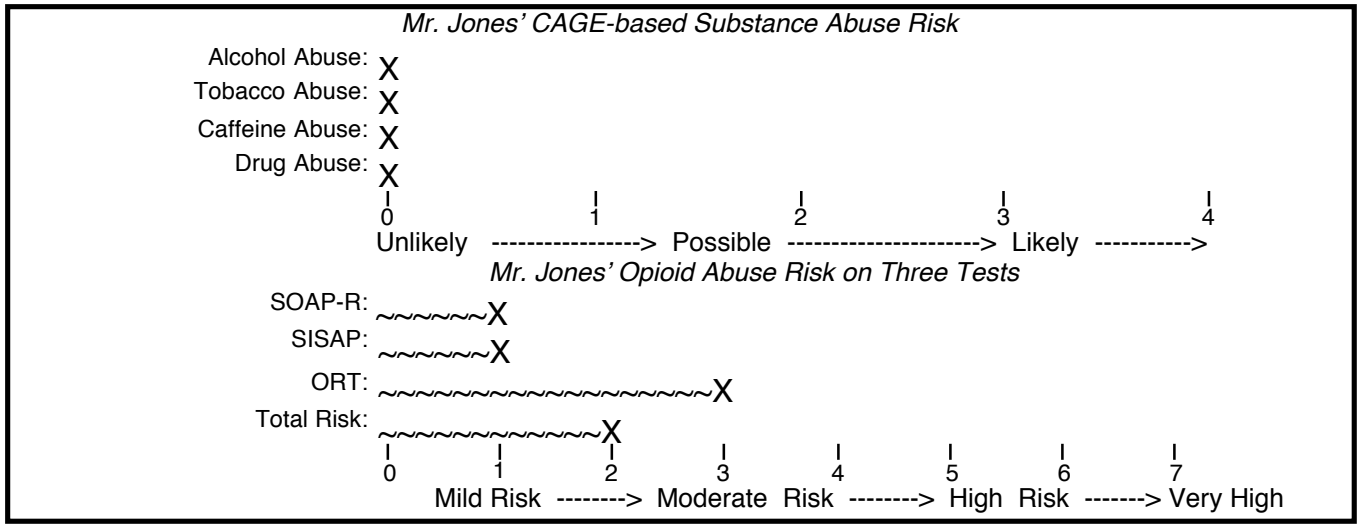
Assessment Results:

Mr. Jones reported that his daily life has been greatly distressed and disrupted due to pain, illness or health issues Chronic (lasting 6 months or more) discomfort included headache, low back, joint/bone, muscle, upper back and sciatic pain. One neurophysiological symptom (inability to walk) occuring over the last several (≥2) years was reported not due to a stressor or emotional conflict. Mr. Jones rated his health as fair.

Problems interfering with falling asleep (a noisey sleep environment), and staying asleep (pain/aches/ discomfort, need to urinate and snoring/breathing problems) were reported. Medical sleep therapies tried and found helpful include zolpidem-Ambien and a short-acting benzodiazepine; while trazodone have not helped. Interest was expressed in one other medical sleep intervention; e.g., an SSRI. Alternative sleep treatments like melatonin have not helped. Still, interest was expressed in nonmedical sleep interventions; e.g., herbal remedies and Valerian root.

The PHQ-9 indicated mild depression based on indicators over the past two weeks. These problems were described as causing some difficulty in ability to function at work, home and/or socially. A Major Depressive Episode (MDE) was reported within the past two years due to taking little interest/pleasure in daily activities for most of a two week period.

Testing with the GAD-7 found moderate signs of generalized anxiety. Minimal anxiety was seen on the CCSM, which was inconsistent with moderate anxiety apparent on the GAD-7. No report of panic-like symptoms was offered.



Mr. Jones' Opioid Abuse Risk on Three Tests

Summary:

Mr. Jones is a married, 47-1 year-old man evaluated on April 29th, 2016. Framingham Points indicated a low risk of heart and/or other chronic disease over the next ten years. Strengths included very low total cholesterol and an optimal systolic blood pressure. Health risk factors were apparent; HDL level was lower than optimal and smoking was a significant risk factor at his age. His BMI of 28 fell in the overweight range. Obesity increases the risk of 30 serious medical conditions like diabetes type 2. Mr. Jones' BMI is higher than 29% of male Americans which, while under the average for his age, is still unhealthy.* However, having a high school education may reduce risk of future obesity by about 4% over less than HS.** His BP of 126/91 fell in the prehypertension (meaning he has a high likelihood of developing HTN) range.

Criteria were met for F45.8 Brief Somatic Symptom Disorder with Predominant Pain (consistent with the old DSM-IV Pain Disorder dx.). A neurophysiological symptom not due to medical issues or drugs was reported, consider: F44.4 Conversion Disorder with Abnormal Movement (inability to walk), Persistent-without psychological stressors.

Significant sleep dysfunction was reported for which three medical sleep interventions have been tried of which two (zolpidem-Ambien and a short-acting benzodiazepine) helped, while one was of no benefit. Interest in one other medical sleep intervention was reported. One nonmedical (alternative) sleep therapy has been tried, which was not helpful. Some interest was expressed in alternative sleep therapies likely due to not finding them helpful in the past.

While the SOAPP-R and the SISAP questionnaire both suggested low opioid abuse risk, the ORT indicated moderate risk for prescribed drug abuse. Overall (based on these three measures), there was a mild level of risk for abuse of opioids in this patient. Heavier drinking was reported. Given only mild-to-moderate signs of depression causing mild difficulty at work, home, and/or socially a Major Mood Disorder is unlikely, even though a Major Depressive Episode within the last two years was reported. Anxiety measures varied, but showed none-to-moderate levels anxiety; this could be due to inattentiveness on the test measures.

Three traditional pain interventions have been tried of which two (TENS machine and spinal block) helped, while one (ice/heat) was of no benefit. Five nontraditional (alternative) pain therapies have been tried of which three (exercise, chiropractic and massage) helped, while two (homeopathy and naturopathy) were of no benefit. Mr. Jones indicated curiosity about many complementary therapies having found them more helpful than not. When asked directly he expressed quite a bit of interest in traditional treatments, but more interest was apparent for alternative therapies.

Recommendations:

- Treatment should consider his fair Framingham (9/16 risk points) health level.
- Psychotherapy, pain medications, and other interventions for a Somatic Symptom Disorder (old DSM-IV Pain Disorder Dx) with significant pain should be considered.
- Given very significant sleep difficulty; one problem interfering with falling asleep and a few issues causing awakening should be reviewed.
- Interest in a medical sleep intervention (an SSRI) and complementary therapies (herbal remedies and Valerian root) could be explored.
- Daily use of one prescribed sleeping pill (now or in the past), along with benzodiazepine use, suggests risk of dependency.
- There is a mild risk for opioid abuse based on measures given here.
- A strong desire to quit smoking is a major step to cessation, support and counsel this.
- Despite quite a bit of interest in traditional pain interventions, he has tried only a few. Additionally he expressed extremely high interest in complementary pain treatments, and he has tried several.
- Additional interview and education to explore minimal-to-moderate anxiety may be helpful.

*CDC prevalence norms, 2003
**CDC Behavior Risk Factor Surveillance System, 2001

Addendum:

12 tests and techniques were administered to Mr. Jones. Total testing time was 1 hour 12 minutes. Psych. testing can be billed for 1 unit of technician assisted (CPT 96102) computer testing. If a qualified healthcare professional (i.e., physician, NP or CNS, PA or psychologist) personally did the testing, then bill 96101.

PQRS Measures Given that can be Reported via Billing the Following Specified PQRS CPT Codes:
• Measure #131 (Pain Assessment) indicated nearly unbearable pain–8/10 on the Bell Browne Scale and pain/ illness/health issues reportedly cause great distress and disruption in daily life quality; thus, results are positive and follow-up planning should be documented. Bill PQRS code: G8730. If a follow-up plan cannot be done (e.g., pt too confused to participate, refused, etc.) document why and bill PQRS G8939.
• Measure #173 (Unhealthy Alcohol Use assessed via the AUDIT) was negative for risk in men. Bill PQRS 3016F.
• Measure #128 (Body Mass Index, BMI) fell in the overweight range, if a follow-up plan is documented bill PQRS G8417. If a follow-up plan cannot be done (e.g., patient is too ill, in hospice, psychotic, etc.) document why and bill PQRS G8938.
• Measure #134 (Screening for Clin Depression) included the PHQ-9 which indicated
• Measure #226 (Tobacco use) yielded a self-report as a current smoker. If brief counseling (≤3 minutes) is offered, bill PQRS 4004F. If counseling was not done due to medical reasons document why (e.g., limited life expectancy) and bill 4004F and use 1P as a modifier.
• Measure #370 (Depression Remission at Six Months)
• Measure #371 (Depression Utilization of the PHQ-9 Tool) can be billed if the patient has a prior diagnosis of depression or dysthmia. However, the 2016 CPT II codes are not yet established for this procedure. Make a note as you can back bill the code, when established, for a year.

If a Registry is Used, These Measures Can Be Reported as Given:
• Measure #414 (Eval or Interview for Risk of Opioid Misuse) if the patient has been prescribed opiates for more than six weeks and you give the PME (or SOAAP-R, ORT or SISAP).