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The Use and Abuse of Pain Management in Accident Cases

I. Pain Management Techniques used to treat patients and inflate claims

Pain management has become used as a tool to increase the value of first party claims and personal injury recoveries. The concept of pain management from a medical prospective can be both simple and complex.

Depending on the cause of the pain, there are various techniques utilized by pain management providers to treat the pain. The treatment techniques utilized are sometimes unnecessary and excessive. Pain management services increase the cost of a Workers' Compensation or no-fault claim and increase the value of a bodily injury claim thus, creating an increase in the amount of dollars needed to settle a claim.

Recently, we have seen pain management techniques becoming a major part of the multidisciplinary medical facility.

In order to understand pain management and observe its abuse, we need to discuss the different techniques utilized. These techniques include:

- Interventional procedures
- Medication management
- Physical therapy or chiropractic therapy
- Psychological counseling
- Acupuncture and other alternative therapies with referrals to other medical specialists

Our main focus will be to discuss the medication management procedures specifically, the use of opioid medication, compound creams and injections.

The use of pain management techniques should be guided by the history of the pain, its intensity, duration, aggravating and relieving conditions, and structures involved in causing the pain.

In order for a portion of the body to cause pain it must have a nerve supply, be susceptible to injury, and stimulation of the structure should cause pain. The concept behind most interventional procedures for treating pain is that there is a specific structure of the body with nerves wherein these nerves are being irritated, generating the pain.

The role of the pain management specialist is to identify the precise source of the problem, isolate it and figure out optimal treatment.

Types of Pain

The common type of pain that is seen in automobile type accidents is considered nociceptive pain. This is pain in the arms, legs, back and nociceptive pain can be divided into two parts, radicular and somatic.

Radicular pain is pain that stems from irritation of the nerve roots. For example, from a disc herniation. It travels down the leg and/or arms in the distribution of the nerve that exits from the nerve root at the spinal cord. (*See* MedicineNet.com; What is Pain Management? Relief for back, knee pain, etc.)

Associated with radicular pain is radiculopathy which essentially is weakness or numbness. This is the tingling or loss of reflexes that is seen in the symptoms that a patient complains of when there is a nerve root injury.

Somatic pain is pain that is limited in the back or extremity region. So, it is not radiculopathy. It is pain that is in a localized area.

The problem with somatic pain, is that it is extremely difficult to determine the cause of same. There is no exact diagnosis. In fact, the cause of most back pain that is localized is not identifiable. There are three structures in the back which could cause localized pain and these are facet joints, the discs themselves and the sacroiliac joint which is in the lower portion of the lumbar spine. (*See* MedicineNet.com; What is Pain Management? Relief for back, knee pain, etc.)

Facet joints are small joints in the back of the spine that provide stability and limit how far you can bend back and twist. The discs are the shock absorbers of the spinal column. Discs are located between the boney building blocks of the vertebra. The sacroiliac joint is the joint at the buttock area that serves for normal walking and helps transfer weight from the upper body to the legs.

Pain Management Procedures

Pain management techniques that have been utilized and have been shown to increase the cost of the claim and are often abused are opioid medications prescribed way too frequently, the use of injections (epidural and/or trigger points) as well as facet joint injections and compound creams.

Pills and Creams

The use of opioid medications by pain management doctors has been somewhat curtailed based upon the ongoing opioid epidemic. What we have seen is a change from opioid medication taken orally to compound creams used to rub on the affected areas.

We see abuse in compound creams. Compound creams are a topical pain relief treatment and are quite often, extremely expensive where the cost for same would be $2,000 to $3,000 per tube. These are often abused in multidisciplinary clinics and by pain management providers.

Compound creams are not medically necessary and do not really do the job needed to relieve pain or reduce the symptoms of localized pain. They are done to inflate the cost of the claim and usually provide a basis for a hidden kickback between the provider and the pharmacy in question. In order to have a legitimate prescription for compound cream, the prescription written must be specific to the patient in question with detailed percentages of the type of medication used to formulate the cream. Thereafter, only properly licensed pharmacists can properly fill these prescriptions.

We have also uncovered abuse with opioid pain medications often utilized to entice patients to continue their treatment if they are addicted to such medications and often utilized for payment purposes of kickbacks which we have seen in a recent investigation conducted in the state of New Jersey where runners were being paid in opioid medication.

We have also seen recent news flashes wherein medical doctors have been arrested for over prescribing opioid medication for purposes of maintaining the patient base in question and driving up patient referrals.

Scientists have shown that the use of opioid medications and/or pain creams are really ineffective in the treatment of pain and there is more benefit for the patient to have physical therapy modalities and massage rather than opioid or compound creams.

Injections

We have also seen an increase in the use of trigger point and epidural injections. We have seen medical providers specifically the multidisciplinary clinics overuse trigger point injections and epidural spinal injections and often utilize guiding procedures to increase the costs of these injections.

Trigger point injections are an effective treatment modality for providing swift relief of symptoms from fibromyalgia, headaches and myofascial pain syndrome. A person who receives trigger point injections after sustaining injuries due to an automobile collision is typically treated for myofascial pain. Myofascial pain syndrome is a common painful muscle disorder characterized by myofascial trigger points.

There are two types of trigger points, active trigger points are areas of extreme soreness and latent trigger points which are dormant areas that cause weakness and restriction of movement. Myofascial pain is treated with over the counter non-steroidal anti-inflammatories, bed rest, massage, hot/cold modalities, active exercise and physical therapy. Only after conservative methods are attempted may the use of trigger point injections be considered.

Typically, a patient should not be subjected to injections unless the patient experiences pain for more than three months and has been intolerant of conservative treatment for at least one month. Often, we see the abuse of trigger point injections. In addition, we see the use of fluoroscopic guidance for trigger point injections when same is unnecessary and the doctor could easily use the injection and locate the point of the injection based upon palpation of the muscle area.

Most often, myofascial pain is peripheral nerve pain or neuropathy and it responds well to trigger point injections assuming conservative care was attempted.

Epidural injections are a combination of Corticosteroid and local anesthetic pain relief. Epidural injections are used to temporarily reduce the symptoms associated with lumbar stenosis. It is used only when nonsurgical treatment like the treatment for myofascial pain fails to provide relief.

We also see an abuse of epidural injections. Epidural injections should be done with the use of fluoroscopic guidance and/or a spot x-ray which is a more conservative and cost-efficient method than fluoroscopic guidance. The reason there is a need for guidance for epidural injections is because of the injection of the medication into the spinal column.

We see the use of these injections on a regular 30-day cycle in the care of patients involved in automobile losses. We see it done prematurely within the first month of care. We often see that the trigger point and epidural injections lack medical necessity when they are being performed.

The use of ultrasonic and fluoroscopic guidance in connection with the performance of trigger point and epidural injections are done solely for the purposes of inflating fees. Ultrasonic guidance of trigger point injections is considered medically unnecessary since the area of muscle can be easily identified by palpating the infected areas and listening to the patient's objective complaints.

A physician utilizing his/or palpation skills to determine an injection site is part of the performance and charge under the CPT code. A charge under the CPT code for fluoroscopy is only appropriate where epidural injections are legitimately rendered. However, the epidural injections rendered are usually medically unnecessary at the point in time they are being performed.

We also often see abuse in the use of excessive CPT code values when billing for examinations done in conjunction with the rendering of trigger point and epidural injections. Quite often, these are upcoded procedures.

Most often, we see the use of trigger point and epidural injections to drive the value of the claim and the value of the personal injury recovery.

Facet joint injections are also utilized in pain management. The facet joint is a joint in the spinal column that restricts the movement of the spinal column to move forward or backward and/or to twist. A facet joint injection is utilized to remove pressure off the disc region of the spinal column. It is a local pain management procedure utilized by injection with guidance into the facet joint specifically. Often, the medication used is Lidocaine. (*See* MedicineNet.com; What is Pain Management? Relief for back, knee pain, etc.)

II. Fraud and Abuse

The extensive use of trigger point injections and epidural injections early on in the care of the patient accomplishes two objectives. The first objective is to increase the first party claim in a PIP state and/or enhance any potential Workers' Compensation claim.

Value Drivers

The second objective is to increase the value of the personal injury action. A simple whiplash case can have its value increased by subjecting the patient to unnecessary trigger point injections, compound creams and/or epidural injections providing proof of ongoing care and intrusive type treatments. Specifically, in epidurals where the allegations can be made that the epidural injections are akin to a surgery given the fact that it takes place in an ambulatory surgical center.

Doing multiple trigger points and multiple epidurals increases the value of the personal injury claim wherein we see the result of a simple whiplash case normally settled for $5,000 resulting in settlement demands in excess of $100,000. We also see the use of guidance either fluoroscopic or ultrasound guidance to drive costs of the first party claim and essentially increase the value of the personal injury claim.

Kickbacks

We have also seen the use of pain medication used for purposes of drawing patients to a clinic specifically for those who may have a prior addiction which generates patient volume for the provider in question. We have also seen in recent months medical doctors being indicted for the abuse of prescription opioids and also being arrested for these types of abuses. We have seen fraudulent ring activity where the investigation has determined that in lieu of cash, opioid pain medication was being distributed to runners to provide patients to the clinic. This was the subject of an Attorney General investigation in the state of New Jersey. (*See* Mercury Indemnity Company of America v. Jephte Noel, et al. Superior Court of New Jersey Law Division: Somerset County Docket No: SOM-L-135-15).

Therefore, we see the abuse and we see that the abuse is designed to increase the overall value of a first party claim which then translates into an increased value of the personal injury claim.

III. How to Combat this Abuse

One of the methods of stopping this abuse is through the regulatory process. Various states have attempted to restrict the abuse of prescription opioids and we have seen Regulations introduced in various states with success. The most widely regulated area is in the prescriptions of opioids themselves and restricting physicians from dispensing the medications directly from their office. This permits a third-party pharmacist to be involved in the care of the patient.

Regulations

There is an obvious opioid epidemic that is sweeping the country. The statistics are staggering in the amount of deaths that are taking place due to overdose and addiction to pain medications.

Therefore, states have decided to regulate the dispensing of these medications. This has been part of the method to address this abuse that we have seen in pain management specifically, in the opioid oral medications. We have seen regulations adopted by the states of Florida, Massachusetts, Pennsylvania and Texas. Texas and Massachusetts are particularly proactive in addressing and regulating opioid abuse. Florida has also been more active and has seen success as a leader among states by putting forth an Anti-Pill Mill Legislation. In 2010, Florida H.B. 7095, established standards of care for physicians who prescribe narcotic-grade pills. The law requires physicians to register with the Florida Department of Health and to write prescriptions on counterfeit-proof paper. Physicians who overprescribe face a minimum fine of $10,000 and suspension of their license for six months. The law also bans physicians from on-site dispensing of the more commonly abused drugs, such as oxycodone and hydrocodone.

More recently, Governor Rick Scott announced that during the upcoming legislative session, he will propose major legislation and more than $50 million as part of his 2018-2019 recommended budget to combat opioid abuse in Florida.

The proposed legislation will include:

- Placing a three-day limit on prescribed opioids, unless strict conditions are met for a seven-day supply;

- Requiring all healthcare professionals that prescribe or dispense medication to participate in the Florida Prescription Drug Monitoring Program, a statewide database that monitors controlled substance prescriptions; and

- Additional reforms to fight unlicensed pain management clinics, require continuing education courses on responsibly prescribing opioids, and create new opportunities for federal grant funding.

The proposed investment of more than $50 million will include funding for:

- Substance abuse treatment;
- Counseling and recovery services; and
- The Florida Violent Crime and Drug Control Council.

Pennsylvania which records some of the highest rates of opioid use amongst injured workers, has recently passed legislation. In November of 2016 the following bills were signed into law: Act 126 SB1367 (Yaw): This bill amends Title 35 (Health and Safety) to establish restrictions on physicians' ability to prescribe opioids to minors, including limiting prescriptions to seven days and requiring physicians to take a number of steps before issuing the first prescription in a single course of treatment. This bill passed unanimously in the Senate on 9/28/16.

Act 125 SB1368 (Killion): This bill establishes a safe opioid prescribing curriculum in medical colleges and other medical training facilities offering or desiring to offer medical training. The curriculum must include: current, age-appropriate information relating to pain management; alternatives to opioid pain medications; instructions on safe prescribing methods in the event opioids must be prescribed; identification of patients who are at risk for addiction; and, training on managing substance use disorders as chronic diseases.

Act 124 SB1202 (Yaw): This bill amends the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act requires continuing education in pain management, addiction and dispensing for prescribers and dispensers. The Governor's Office successfully passed an amendment that would require prescribers to check the ABC-MAP every time they prescribe an opioid or benzodiazepine. In addition, the Administration's amendment would require dispensers to input prescription data to the ABC-MAP within 24 hours of dispensing. Current law gives dispensers (who are required to enter information into the ABC-MAP when they dispense an opioid or other controlled substance) 72 hours to log in and enter information.

Act 122 HB1699 (Brown): This bill mandates that hospital emergency departments and urgent care centers may not prescribe opioids in quantities that last more than seven days and they may not write refills for opioid prescriptions.

Act 123 HB 1737 (Maher): This bill would allow all federal, state and local law enforcement entities, hospitals, assisted living facilities, home health care agencies, long-term care nursing facilities, hospice, and commonwealth licensed pharmacies to serve as drop-off locations for any extra, unwanted, or expired prescription drugs or over-the-counter pharmaceutical products.

Recognizing the strong correlation between opioid use and physician discretion in the Workers' Compensation area, Massachusetts enacted a broad physician related regulatory reform. As of February 2012, physicians in Massachusetts are legally obligated to take a continuing education course on pain management and the use of opioids.

As part of these courses, physicians are provided treatment guidelines to deal with chronic pain, focusing on treatments outside of prescription based pain medication. The Regulation also calls for a written agreement between the patient and the doctor, random drug screening and second opinions when an opioid dosage exceeds 120mg per day.

In addition, Massachusetts runs an active prescription drug monitoring program which is also seen in forty-six other states. In 2016, in passing Bill H.4056, Massachusetts became the first state in the U.S. to limit opioid prescriptions to a 7-day supply for first-time adult prescriptions. The law also places a 7-day limit on any opiate prescription for minors. The law does make some exceptions to this rule, and also allows longer-term supplies for people with cancer, chronic pain or those who need palliative care.
Other notable provisions include:

- Prescribers must check the Massachusetts Prescription Monitoring Program (PMP) before prescribing a Schedule II or Schedule III drug. The PMP is designed to keep patients from receiving multiple prescriptions from different doctors.

- Physicians and pharmacists must inform patients about the dangers of opioid addiction when a drug is prescribed and dispensed.

- Anyone who administers the anti-overdose drug Naloxone to someone suspected of overdosing is protected from civil lawsuits.

Screening mechanisms will be created that schools can use to identify students who may be at risk for addiction. Opioid education will also be incorporated into high school athletics and driver education.

We have also seen significant legislation in the state of Texas wherein Texas has created a list of drugs which prior to dispensing, must receive prior approval by a claim's payer. The implementation of this formulary list in the state of Texas has appeared to have an effect greater than most other legislative initiatives.

In addition, Texas' most recent efforts to battle opioid abuse includes new legislation to eliminate pain management clinics that dispense narcotics to patients without an exam. Texas has become one of nine states that implements such a legislation. Effective September 1, 2017, Texas-licensed pharmacies are required to report all dispensed controlled substances records to the Texas Prescription Monitoring Program (PMP) no later than the next business day after the prescription is filled. The 85th Texas Legislature changed this requirement, which previously allowed for seven days to send the information. The reporting requirement applies to all controlled substances in schedules II – V. *See,* TEX. HEALTH & SAFETY CODE ANN. §§ 481.075 to -.0761, -.127, -.128 (2005) 37 TEX. ADMIN. CODE §§ 13.71 to -.86.

Florida's efforts to shutting down the pill mills has been successful. Florida was once notorious for its "pill mills", pain clinics and doctor's offices in which patients are dispensed a month's supply of any number of prescriptions including opioids. In response to this problem, Florida's legislator enacted a broad legislation targeted at physician dispensing of opioids.

The legislation enacted in 2011, has shown measurable results in curbing opioid use in injured workers. As part of the 2011 reform, physicians who practice medicine in Florida are prohibited from onsite dispensing of schedule two and schedule three controlled substances which includes strong opioids such as Oxycodone and Hydrocodone. Florida Law considers violating the prohibition a third-degree felony that can result in at least a six-month suspension of a license to practice medicine.

Indiana also passed a regulation that will limit physicians dispensing in an effort to eliminate opioid abuse. Hawaii also took similar measures to curb opioid abuse. However, rather then allowing physicians to continue receiving reimbursement at an inflated average wholesale price, reimbursement of physician dispensers will be capped at the original manufacturers national drug code which is a much lower rate.

Additionally, the Maryland legislator considered two bills, House Bill 368 and Senate Bill 482 aimed at codifying the existing practice of allowing patients to choose a pharmacy to fill their Workers' Compensation prescriptions. Patient choice ensures continuity of care by allowing the patient to continue to use their trusted pharmacy that has an understanding of their medical history.

Investigations and Litigations

In addition to legislative regulations, other avenues of curbing the abuse consist of SIU investigations into staged activity, runner schemes and an overview of abusive clinics. To have oversite over abusive clinics, SIU investigators can utilize onsite inspections, medical record expert review to determine the medical necessity of the treatments and medications being prescribed.

In addition, pharmacies can be inspected and reviewed for compliance with compound cream requirements. If abuse continues, fraudulent treatment protocol suits can be commenced which are affirmative litigations seeking to curtail the abusive nature of the medical clinic in question. In order to build a case against these providers, the use of examinations under oath of patients and providers can also be undertaken depending upon the policy of insurance and the state regulation. (*See* The CLM Magazine August 2017: American on Opioids)

Affirmative litigations seeking to curtail the fraudulent treatment protocol and abuse of opioid medications and/or pain management techniques are an effective tool in subsiding the growth of these treatment protocols in any given state.