

THE AMERICAN ASSOCIATION OF LIFE CARE PLANNERS

JOURNAL OF

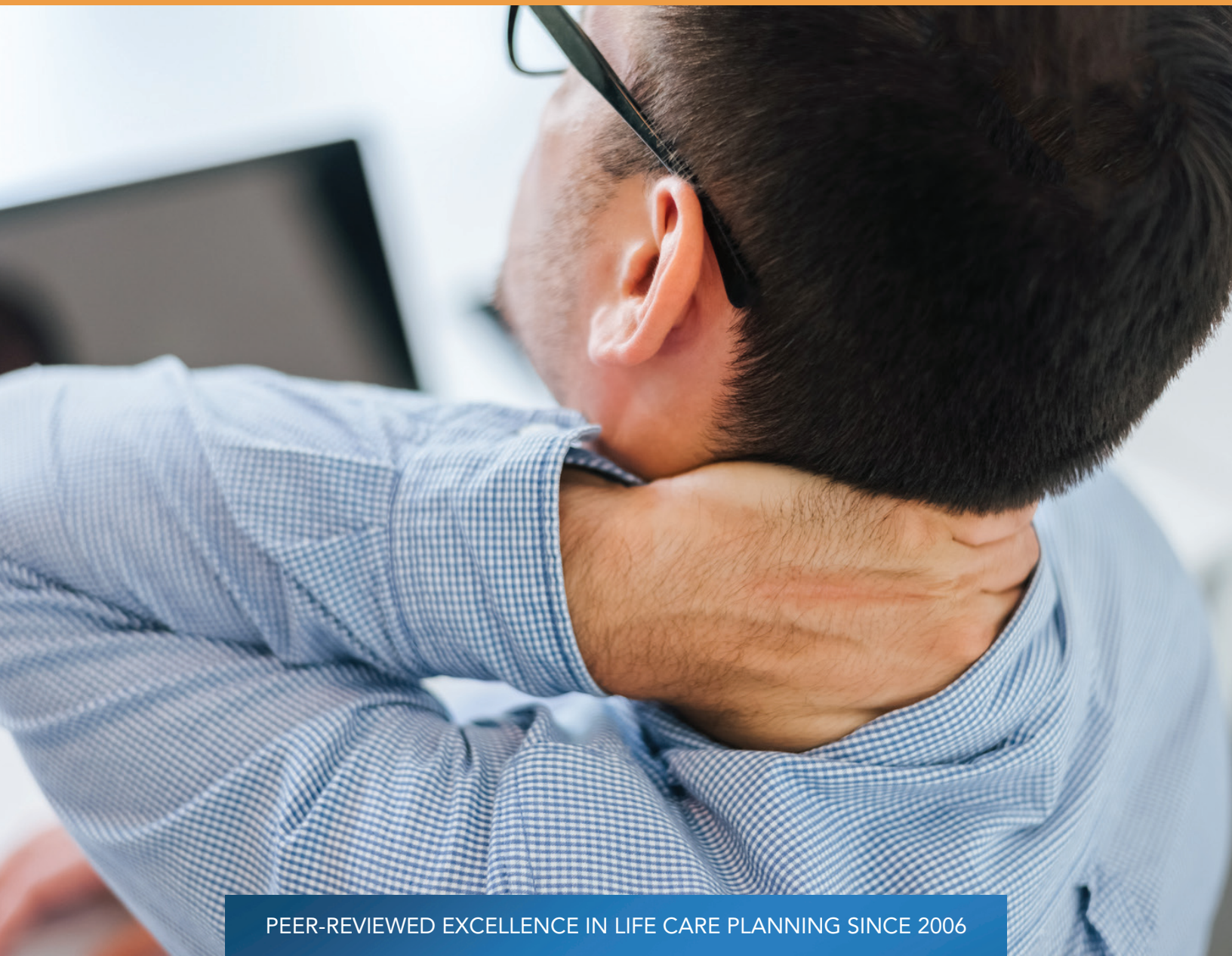
NURSE LIFE CARE PLANNING

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From the Editor

Hello Life Care Planners,

As busy professionals, summer can often feel like a difficult time. One in which we are drawn to activities of leisure that feel like an affordable piece of luxury. Torn by our needs, we revert to our responsibilities and reject the other options.

I know that this isn't an irresponsible choice to make, but I want to encourage you to find the joys in the things we cannot avoid. We have the advantage of doing what we do, not because it is the only option left to us in order to survive, but because we are uniquely suited to it. We have talents, insights, experiences, or simple joys that make us the professionals that we are.

As the summer wraps up, revisit this thing that makes you powerful practitioner, and luxuriate in that, if time will not allow you to luxuriate at the beach.

And if you have made it to the beach, consider it anyway as the lazy clouds drift overhead.

“Rest is not idleness, and to lie sometimes on the grass under trees on a summer’s day, listening to the murmur of the water, or watching the clouds float across the sky, is by no means a waste of time.”

– John Lubbock

Stephen Axtell

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Information for Authors

Information for Authors

AANLCP® invites interested nurses and allied professionals to submit article queries or manuscripts that educate and inform the Nurse Life Care Planner about current clinical practice methods, professional development, and the promotion of Nurse Life Care Planning. Submitted material must be original. Manuscripts and queries may be addressed to the Editor. Authors should use the following guidelines for articles to be considered for publication. Please note capitalization of Nurse Life Care Plan, Planning, etc.

Text

- Manuscript length: 1500 – 3000 words
- Use Word® format (.doc, .docx) or Pages (.pages)
- Submit only original manuscript not under consideration by other publications
- Put the title and page number in a header on each page (using the Header feature in Word)
- Place author name, contact information, and article title on a separate title page
- Use APA style (Publication Manual of the American Psychological Assoc. current edition)

Art, Figures, Links

- All photos, figures, and artwork must be in JPG or PDF format (JPG preferred for photos).
- Line art must have a minimum resolution of 1000 dpi, halftone art (photos) a minimum of 300 dpi, and combination art (line/tone) a minimum of 500 dpi.
- Each table, figure, photo, or art must be submitted as a separate file, labeled to match its reference in text, with credits if needed (e.g., Table 1, Common nursing diagnoses in SCI; Figure 3, Time to endpoints by intervention, American Cancer Society, 2019). Graphic elements embedded in a word processing document cannot be used.
- Live links are encouraged. Please include the full URL for each.

Editing and Permissions

- The author must accompany the submission with written release from:
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- All authors must disclose any relationship with facilities, institutions, organizations, or companies mentioned in their work.
- All accepted manuscripts are subject to editing, which may involve only minor changes of grammar, punctuation, paragraphing, etc. However, some editing may involve condensing or restructuring the narrative. Authors will be notified of extensive editing. Authors will approve the final revision for submission. The author, not the Journal, is responsible for the views and conclusions of a published manuscript.
- Submit your article as an email attachment, with document title articlename.doc, e.g., wheelchairs.doc

All manuscripts published become the property of the Journal. Submission indicates that the author accepts these terms. Queries may be addressed to the care of the Editor at: journal@aanlcp.org

Manuscript Review Process

Submitted articles are peer reviewed by Nurse Life Care Planners with diverse backgrounds in life care planning, case management, rehabilitation, and nursing. Acceptance is based on manuscript content, originality, suitability for the intended audience, relevance to Nurse Life Care Planning, and quality of the submitted material. If you would like to review articles for this journal, please contact the Editor.

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A Message from the President

Dear Members, Colleagues and Fellow Nurse Life Care Planners,



Summer – a time of fun and happiness, joy, and freedom. The days seem long, with extra sunlight, filled with warmth, playfulness, spontaneity, and lots of outdoor time. This season has always energized me. Maybe growing up in a country where rainy, cloudy days were plenty, the bright summer days seemed to be a time where ideas and creativity came to me easier. Maybe it was due to my travels during that time, experiencing other cultures and ways of living that opened my mind to think outside the box. Even though I am now living in Southern California, where the smell of sunscreen seems to linger in the air year-round, and the palm trees and sound of seagulls represent my vision of summer, I still find myself with more energy and ideas than I can handle.

Keep a work-life balance - for many of us managing our business, navigating time with loved ones, clients, patients, and dedicating time to commitments we made and care for - this is easier said than done. My list is long with all the ideas/tasks I, the board members, and the committee members have for AANLCP. So many opportunities, brilliant plans, and exciting ideas! I must remind myself, that as a nurse, collaboration, intra- and interprofessional, ensures not just a better outcome, but also offers an environment where everyone is able to develop in their practice. And I think of all the ones who are currently working together to achieve the Association's goals and vision. I am thankful for you all, your dedication, your time, enthusiasm, and time volunteered!

Not everything has to fit into the summer months. Sure, deadlines set for our patients and clients must be met, but not every task on the list has got to be completed. For now, I'm letting the summer fill me up with energy and my travels with new experiences. While we all continue to work and strive towards the Association's goals, we will come back in August to meet, collaborate, discuss, create, and exchange ideas to continue providing you with resources and support to achieve excellence as Nurse Life Care Planners/Life Care Planners.

I wish each one of you balance during the summer. To recharge during those bright weeks, to find time to spend outdoors with loved ones while meeting the needs of your patients and fulfilling the tasks your business requires. Remember, there is an entire community out there for you to connect with. Each one of us knows the importance of collaboration, joint effort, and teamwork. Reach out through the mentorship program, get on the google listserv or sign up for a committee!

Thank you, members for your continued participation, support and enthusiasm!

Please reach out to me to share your ideas, suggestions, and comments that might have arisen from the summer months. If you would like to get more involved with the Association, we would love to welcome you as a member of one of our committees.

With gratitude,

Andrea Nebel, RN, BSN, CNLCP

President, AANLCP | president@aanlcp.org

“When the sun is shining, I can do anything; no mountain is too high, no trouble too difficult to overcome.” — Wilma Rudolph

Methodology Memo

By Rebecca A. Reier BS RN, CRNA (Ret.), CCS-P



Pain Management from the Fiscal Side - Auditing, Coding, and UCR

Keywords: UCR and pain, Billing and Coding, AMA and UCR

The Nurse Life Care Planner may be asked to evaluate previous pain management services or determine the coding and reasonable value for future services.

Although the formation of pain therapy as a field of medicine began in the 1960s, there has been a surge in the specialty of Pain Management since its formal foundation in 1978. Subsequently there has been a surge in confusion between the services, coding issues, the medical record and customary charges.

The typical patients requiring Interventional Pain Management may have trauma due to injury or chronic pain due to disease. The majority of providers for Pain Management are Board Certified Pain Management Anesthesiologists but orthopedic, rehabilitation, physical therapy, and chiropractic providers also perform various components of Pain Management.

Fiscal Responsibility – An Enduring Adage

The provider
**CANNOT bill for
what was NOT
done.**

The provider
**CANNOT bill for
the cost NOT
incurred.**

Auditing

The medical record must document the services provided. Commonly used templates within the electronic medical record (EMR) are very useful – but a chronic dependence on a generic description can lead to serious issues such as denial of revenue to fraud or malpractice allegations.

Therefore, it is mandatory that the medical record contain all of the appropriate descriptions of the service – be it an interventional procedure (i.e., requiring an Operative Report) or a treatment description that contain all of the elements necessary to indicate components of the service being billed. Certain timed treatments such as those in physical therapy have mandatory documentation of the exact amount of time spent in the therapy.

Coding

CPT, HCPCS and ICD-10 codes are the language with which the provider communicates what was done and why. Non-specific terminology and unlisted codes should rarely, if ever, be present.

The increase in more complex and costly procedures by Interventional Pain Management physicians requires precise coding and medical necessity determinations. Such services include a variety of percutaneous and minimally invasive discectomy procedures, radiofrequency nerve ablation, vertebroplasty, and spinal cord stimulation in addition to the usual array of epidural, transforaminal, facet, and other nerve blocks.

Generic use of treatment templates easily leads to denials, poor revenue and the ever-present threat of fraudulent and/or abusive billing practices.

Upcoding and unbundling are serious infractions of coding rules. The Office of the Inspector General has dramatically increased prosecution of providers for such billing practices based on the misuse of correct coding.

What are the most common infractions in Pain Management?

- Charges for levels of injections that are not documented properly.
- Unbundling of fluoroscopy.
- Incorrect CPT codes.

- Services performed at a facility other than the provider's office are subject to a Site of Service reduction. The physician is not providing the overhead of a facility.
- Performance of a bilateral procedure (i.e., modifier L, R or -50) or another non "add-on" procedures at the same date of service are subject to a multiple procedure reduction. The provider did not perform the other side or other procedures on a different date of service.

What Constitutes a Usual, Reasonable and Customary (UCR) Charge and Defines the Value for Customary Rate?

The following discussion relates to the use of a non-discounted rate per the American Medical Association policy (i.e., the "sticker" price).

i. The AMA policy states the conditions for which a charge is customary and reasonable and NOT a discounted rate. This definition is clearly an industry standard.

ii. The value of fees is most often determined by access to a reliable database² with a range of percentiles in a specific geographic area for a specific service (per CPT, HCPCS or DRG codes). These figures fit The AMA definition which states that "customary" refers to the range of usual fees charged in the same geographic area for the same services" without a discount.

To further define the UCR, the American Association of Nurse Life Care Planners (AANLCP) has published that the range of customary fees "typically fall within the 75th to 80th percentile.

The successful review or preparation of future pain management services by the Nurse Life Care Planner follows the industry standards of Auditing for sound documentation, Correct Coding rules and the determination of Usual, Customary and Reasonable pricing.

The AMA adopts as policy the following definitions:

- "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);
- a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and
- a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

The AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.

² **Life Care Planning and Case Management 4th Edition Chapter 30** p 746

Reier, Rebecca. (2020). Bill Review: The Analysis of Claims for Healthcare Service **AALNC Legal Nurse Consulting Principles and Practice 4th Edition Chapter 28**, p 680.

³ **Life Care Planning and Case Management 4th Edition Chapter 30** p 731. "When obtaining pricing for services and items, it is important that the costs be usual, customary and reasonable (UCR) and not discounted. Usual and customary typically fall within the 75th or 80th percentile."

REFERENCES

Life Care Planning and Case Management 4th Edition Chapter 30 p 746

Reier, Rebecca. (2020). Bill Review: The Analysis of Claims for Healthcare Service **AALNC Legal Nurse Consulting Principles and Practice 4th Edition Chapter 28**, p 680.

Life Care Planning and Case Management 4th Edition Chapter 30 p 731.

Contributors to this Issue



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As President of Med-Econ, Inc., a medical practice management company, Rebecca's experience spans a period of 45 years involving billions of dollars in coding and billing for medical charges for groups ranging from single practitioners to 40-member groups in over 22 specialties.

She authored Chapter 28 in the AALNC Textbook on Principles and Practices, Fourth Edition regarding the Medical Record and the concept of Usual, Customary and Reasonable aspects of medical charges

Her educational background includes a summa cum laude BS in Biology and Secondary Education from the University of Charleston and a Certified Coding Specialist (CCS-P) from the American Health Information Management Association.



Melinda Pearson, LMSW, CLCP

has been providing rehabilitation services since 1997, when she earned her Master's in Social Work. For more than 25 years, she has been providing services for people with traumatic brain injuries under the New York State Department of Health TBI Medicaid Waiver Services. This has given Melinda the unique experience of supporting people with disabilities for years beyond leaving the rehabilitation setting. Melinda continues to support injured people in the community and her experience has culminated in the provision of Life Care Plans for plaintiff and defense attorneys.

Melinda has been providing life care plans and medical cost projections for Promedica Verity Group since December 2021. She is a licensed Social Worker and she is board certified through the International Commission of Health Care Certification as a Life Care Planner since 2019.



Jenn Masse, RN, BSN, MBA, CNLCP, CBIS

has been a registered nurse since 2002 with experience in telemetry, neurosurgical ICU, research, and dialysis. She obtained her MBA and transitioned into management and a strategy/growth position. After 8 years in the corporate world, while still wearing scrubs daily, she decided to step into something new. She entered into the world of cost projections and Nurse Life Care Planning.



Patti Mazurkiewicz, MS, RN, CLCP, CRC, LCPC, NCC

has over thirty years of experience as a registered nurse, mostly in a rural hospital setting. She recently went into business for herself and is owner of Angel Nurse Consulting, LLC in Montana providing nurse care management, life care planning, and mental health counseling services. She obtained a master's degree in rehabilitation and mental health counseling and is a licensed clinical professional counselor as well as having certifications in Life Care Planning and rehabilitation counseling. Patti can be reached at angelnurseconsult@gmail.com



Dawn Cook, RN, CLCP, CNLCP

is a registered nurse and certified nurse life care planner. In the past ten years, she has given her deposition testimony over 130 times and testified in Court 14 times. Dawn Cook is published in the Journal of Nurse Life nCare Planning on topics related to life care planning and she has spoken at national conferences regarding life care planning, expert witness testimony, and past medical bill analysis.

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An Alternative to Opioids:

One Orthopedics Surgeon's Approach to Being a Part of the Solution.

By Jenn Masse



Keywords: Acute pain, Orthopedic Surgery, Orthopedic pain

NURSING DIAGNOSES TO CONSIDER NANDA-I 2021-2023

1. Domain 12.Comfort. Class1. Physical Comfort. Acute pain
2. Domain 1. Health Promotion. Class 2. Health Management. Readiness for enhanced health management
3. Domain 9.Coping/Stress Tolerance. Readiness for enhanced coping

The word opioid is rarely used these days without words like 'epidemic' or 'crisis' following close behind. But how are Nurse Life Care Planners part of the conversation? I remembered a TED Talk I attended a few years ago, where an orthopedic surgeon laid out a pragmatic and strategic approach for narcotic-free surgical interventions.

But where were these options in my reports? Had I ever had a conversation with a subject that involved navigating addiction alongside their care? So I found that physician, Dr. Jason (Jay) DeMarco, and asked for a bit of his time to pick his brain on the logistics of his approach.

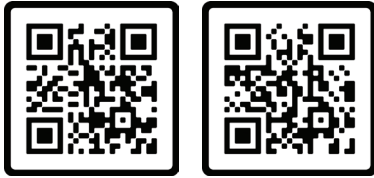
The opioid epidemic is considered a public health emergency, with 136 deaths per day and climbing.

~ The National Center for Drug Abuse Statistics

Dr. DeMarco opened our conversation by noting that it would be hard to find someone not personally affected in some way by addiction. He reflected on a couple of more memorable patients that shaped the way he practices, and he hopes conversations like ours would lead to more discussions regarding the navigation of addiction in the medical field.

On that note, I queried how someone could find a doctor that offered a narcotic free or "narcotic-thoughtful" surgical intervention, and his answer was unfortunately disheartening.

Research regarding pain receptors continues to mature, leading to a larger understanding of opioid induced hyperalgesia:



If someone is talking surgery with a doctor, then most likely they have “married” them in the sense of providing surgery. Dr. DeMarco stated that patients would have to be their own advocates and ask tough questions of their physicians up front. Dr. DeMarco is up front that he does not prescribe narcotics for anyone that is not having surgery, period.

He then noted that the cultural shift from narcotic prescriptions has almost gone completely the other way – those who control their pain with narcotics can’t get it prescribed. Prescribers know the DEA is watching, and while prescribing practices have changed, effective pain management has not been addressed.

But what are the nuts and bolts? The logistics and mechanics? As in, how do you manage the pain/who manages after the procedure/during recovery/etc.? Let’s walk through a shoulder replacement as an example.

Dr. DeMarco’s research supports his approach. Scan QR code for article:



Preoperatively, Dr. DeMarco reiterated the importance of having a “game-plan” conversation with the surgeon so that everyone is on the same page and that there are no surprises. He briefly touched on the multiple therapies patients can access, such as TENs units, dry needling, and cupping, just to name a few. Dr. DeMarco starts Celebrex, Tylenol, and sometimes gabapentin prior to surgery. In relation to our theoretical patient, an icing machine is the star of the show. Dr. DeMarco spoke to the benefits of proper cooling/icing and the top of the list was pain control.

On the day of surgery, the patient is given Celebrex and Gabapentin. Anesthesia places a dense nerve block that will cover pain for about 12-18 hours post-operatively. No specific certification is needed for catheter placement, as

it is completed by either the operating physician or the anesthesiologist. Often, the catheter used when placing the initial block is left in place and utilized for the pump.

Before attaching, the On-Q bulb is filled with a bupivacaine-type medication that provides approximately 4ml an hour, or roughly 60-72 hours’ worth of coverage, until empty.



Post-operatively, the patient will continue around-the clock Tylenol and/or Ibuprofen. Gabapentin and/or Celebrex type medications are available should the preoperative assessment and agreed-upon gameplan warrant/call for it. After the patient goes home, the PA and On-Q rep are available for troubleshooting, with the operating surgeon as back-up. Three days after the procedure, the patient will pull the catheter out at home.

A multimodal pain management regimen include around-the-clock acetaminophen and an anti-inflammatory, both showing positive efficacy outcomes:



When asked what surgical procedures were off the table with this approach, he responded that most orthopedic procedures are completely doable, however, the spine can get tricky. When asked if there were contraindications for this approach (thinking comorbidities /age/etc.), Dr. DeMarco responded that those unable to take anti-inflammatories would be a concern, as would those with COPD (contraindicated due to certain blocks affecting the diaphragm), however obesity played no factor in the decision making.

Assuming Dr. DeMarco doesn’t hit a home run every time he performs surgery, he supplies #10 tablets of narcotics for breakthrough pain. He noted that patients often had a hypersensitive response when the initial block wears off, and he found that is the rare time his patients might take a stronger medication. Per Dr. DeMarco, “One patient out of ten might take all prescribed narcotics for breakthrough pain.”

Then I got to the bottom line, per se, and asked if narcotic-free management is a more expensive or less expensive approach for surgical interventions? Dr. DeMarco stated that it is more expensive in the short-term, but with a worthwhile long-term outcome.

So I challenged that and did some quick calculations, using the Charleston, SC area. Please note I did not include

preoperative clearance, the surgical procedure itself, or post-operative physical therapy. This pricing comparison is for pain management purposes only.

A prescription for Hydrocodone #60-90, 10/325mg, is \$68.43 - \$99.29. The total price range for the On-Q bulb, catheter, regional block/catheter placement, Ice Machine, and non-narcotic medication is \$3,473.94 - \$5,728.88.

As surgical interventions continue to be a part of our Life Care Plans and medical cost projections, we need to be making sure patients are aware of the options that will give them the most holistically positive outcome. Dr. DeMarco highlighted that surgery can quickly become an entryway into addiction and that nothing he does is novel or new. Addressing addiction when discussing surgery can promote a beneficial result for not only the patient and family but the system as a whole.

Associated links:

[Jay DeMarco: Opioid Epidemic – One Fix from a Physician TED Talk](#)

Pricing research:

Per On-Q representative for the local area:
On-Q pain pump total cost range: \$15-\$305
Catheter range, \$30-\$125

Pricing for regional block and ultrasound guided catheter placement:

Procedure: \$318.28, including facility fee \$1,581.26
Procedure: \$399.80, including facility fee \$3,451.20

Post-operative Ice Machine

Purchase option range: \$2,755 - \$4,599.99
Rental fee: \$300, per two weeks

Around the clock Tylenol/Ibuprofen for 30 days, nightly Gabapentin for 30 days, using geographically filtered

GoodRx retail pricing:

Gabapentin 100m g #30, \$17.20
Tylenol/Ibuprofen, \$30.48



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Pain After a Brain Injury

An Overview of Classification, Experience, and the Management of Pain.

By Melinda Pearson, LMSW, CLCP



Keywords: Brain injury (BI), Chronic pain, TBI, Pain management

NURSING DIAGNOSES TO CONSIDER NANDA-I 2021-2023

1. Domain 5. Perception. Class 4. Cognition-Ineffective Impulse Control
2. Domain 12-Comfort. Class 1. Physician Comfort- Chronic pain syndrome
3. Domain 10-Life Principles. Class 3-Spiritual Distress

Abstract

An acquired brain injury (ABI) refers to all injuries after birth, and traumatic brain injuries (TBI) are a form of ABI resulting from when a sudden trauma causes damage to the brain. Both result in a range of neurological, cognitive, and emotional factors that can contribute to the perception of pain. This article serves to help life care planners by exploring common pain, classification and assessment of pain, and pain management treatment modalities for people with brain injuries.

Pain after a brain injury is often common and persistent, requiring pain management to improve daily living and quality of life for injured people. Pain that is caused by brain injuries may be acute, chronic or could be complex regional pain syndrome (CRPS). It may present as nerve pain, body pain, and/or headaches. Pain can have serious consequences affecting the ability to cope with daily stressors, depression, anxiety, social withdrawal, feelings of inadequacy, and feeling beaten down. Interventions addressing pain management include relaxation techniques, increasing pleasurable activities, CBT, sleep improvement, occupational therapy (OT), Physical Therapy (PT), Progressive Goal Attainment Program (PGAP) recreational therapy, vocational therapy, functional restoration, hyperbaric oxygen, pharmacotherapy, nerve blocks, and neurostimulation.

As a licensed social worker, working 23 years in home and community support programs, helping people adjust to their new lives post brain injury, I have observed how pain can destroy lives over time. I have also witnessed how complicated and difficult it can be to diagnose and treat people experiencing pain who also have brain injuries. Earlier in my career, I worked with a participant as their counselor. John had a spinal fusion which caused chronic pain, and was drug-seeking, reportedly for pain reduction. His mental health was poor at best, with depression and volatile outbursts of anger. He was prone to catastrophizing

and felt a great injustice regarding his situation. His cognitive functioning was also poor because he was often confused, had poor judgment, difficulty attending, and his memory was poor. He struggled socially because of his temper outbursts, and depressive symptoms.

He was caught in a downward spiral because he perceived pain and 'protected' his body by not moving, used food for comfort with major weight gain, and was prescribed opiates, which he abused. The doctors in the area caught on to the drug-seeking behavior and cut him off. He was not a candidate for a baclofen pump, and he complained that cocktail injections were not effective. Ketamine was just starting to be researched for chronic pain at the time, and Progressive Goal Attainment Programs were unavailable. He didn't have the support of an interdisciplinary team to get ahead of his pain prior to it becoming chronic. It was difficult to discern the side effects of drug use vs. body pain and mental health vs. pain reaction. Sadly, he passed away due to medical issues that may have been avoided.

Pain Classification and Common Pain Found After a Brain Injury (BI).

Pain classification can be neurogenic/neuropathic pain where the nerves themselves cause pain. Nociceptive pain is caused by the activation of the nociceptors. This can be somatic pain or visceral pain. Somatic pain is localized and is in the muscle, bone, or deep tissue, while visceral pain can be general, like cramping, and can occur in the internal organs. Radicular pain is related to the spine. Acute pain is short term, and is a result of an injury, disease or inflammation which can become chronic. Chronic pain is pain that lasts over three months, and can cause problems such as depression, anger, anxiety, and overall distress. "Pain types and contributing factors are not mutually exclusive. Often patients have more than one type of pain as well as overlapping contributing factors." (Lambert, 2010).

The patient self-reporting pain is the best indicator of measurement and using the Universal Pain Assessment Tool is effective for people with communication difficulties. (Dugashvili, Giorgi, Et al.)

Chronic Pain After BI

Chronic pain is pain lasting at least 3 to 6 months. Accumulating evidence suggests that chronic pain is common after BI. However, it is difficult to tease out if the pain is attributed to the brain injury itself, co-occurring injuries, or psychological factors. Many studies focus on the most common type of pain, the headache. The most common sites of pain after a TBI besides the headache are the neck, back, shoulders, extremities and TBI associated pain which has been characterized primarily as musculoskeletal. As John's case presented above, chronic pain can result from

injuries suffered at the same time as the head injury. Between 10-20 percent of patients develop neurogenic heterotopic ossification after TBI. Late onset pain syndromes have also been reported with symptoms arising 6 months or longer after the brain injury. (Melton. 2017) "If a patient with TBI has been diagnosed with chronic pain, it is difficult to estimate how long they may experience it and whether it will resolve." (Melton ,2017) Chronic Pain Associated with Traumatic Brain Injury: Causes and Management. <https://www.clinicalpainadvisor.com/chronic-pain/chronic-pain-associated-with-traumatic-brain-injury-causes-and-management/>

Common Sites of Pain Following a BI and the Types of Sensations.

Pain can be different for each individual. It can be experienced as hot or burning, sharp, tingly, a dull aching, throbbing, pressure, and numbing sensations. Common types of pain following a TBI include headaches, neuropathic pain, musculoskeletal pain and visceral pain. These can be better understood by considering their location:

1. Head: Many survivors of TBI experience headaches at some point in recovery. Headaches can start immediately, or they may happen months after the incident. Headaches can be long-lasting and can be experienced beyond one year. They impede the ability to complete daily living tasks and can cause challenges for thinking, attention, and memory. There can be a change in the brain, neck, and skull. Headaches can also be caused by chemical imbalances in the brain following head trauma. People can experience migraines, tension headaches, and cervicogenic headaches that start in the neck. If someone had pre-existing headaches, a BI can make this worse. There can also be neurological or nerve pain, spasticity, muscle or bone pain, and co-occurring injuries. For example, if an accident results in a loss of limbs, there could be phantom limb pain, stump pain and pain due to damaged nerves. (Melton, 2017). BI is also associated with chronic regional pain syndrome (CRPS). It is possible to see this when the survivor has spasticity. Post-traumatic stress disorder is commonly found in people who have experienced all levels of BI severity. "An analysis of comorbidities among soldiers with TBI identified patients with pain and PTSD as belonging to the same cluster. Known as the "polytrauma triad," the high prevalence of chronic pain, TBI, and PTSD present as some of the most common concerns among the Operation Enduring Freedom (OEF), Iraqi Freedom (OIF), and New Dawn (OND) veterans." (Irvine, 2017) It is important to note that due to potential cognitive limitations, treatment needs to be individualized because each individual may have barriers preventing engagement in a treatment regimen.

2. Neuropathic pain: The brain and central nervous system process pain signals. Often the identifiable finding in people with chronic pain will be related to the peripheral nervous system. Findings with allodynia (pain due to a

stimulus that doesn't normally cause pain) and hyperalgesia (Increased sensitivity to pain and an extreme response to pain) are useful. Signs and symptoms of upper motor neuron dysfunction will provide clues to the existence of potentially painful conditions such as multiple sclerosis or myelopathy due to cervical spinal stenosis. Patients with hemiplegia or hemiparesis may present with central type pain syndromes. When a nerve is injured, it can cause problems with communication between the nerves that were damaged and the brain. Often, prescription medication can treat this kind of pain. Chemical changes in the brain can also cause these perceptions of pain. (Irvine, 2017)

3. Musculoskeletal pain: This is pain of the muscles, joints or bones that can be caused by overuse, arthritis, and general wear and tear. For example, transfers and wheelchair use can create pain in the body. If someone develops pain from the physical exertion of using a wheelchair, transfers can become difficult. Furthermore, transfers can injure muscles causing difficulty with use of the wheelchair. Muscle spasm happens when muscles and joints are strained from spasticity. The brain injury can cause muscles to spasm or tighten suddenly.

Symptoms can be triggered by stretching, urinary tract infections, constipation or hemorrhoids, injury to the muscle tendon or bone, tight clothing, emotional stress, and skin irritations. Spasticity is treated when it creates problems such as pain but it also can limit motion, breathing, increase falls, poor positions, skin pressure ulcers, hygiene issues and can interfere with normal activity and hand use. Other indications of musculoskeletal pain may be an obvious deformity, atrophy, asymmetry, cyanosis, asymmetry of limb temperature, identified trigger points, and identified joint pathology. (Lambert, 2010)

4. Visceral pain: Visceral pain occurs in the abdomen, and it can be anything from cramping to a dull ache. Sometimes this pain is felt as referred pain.

The Experience of Pain After a Brain Injury.

Pain may not be solely biological. Psychological and environmental factors can influence our pain perception. Stress or depression can increase pain and conversely, being relaxed can reduce pain levels. In the case of psychological pain, it may be a benefit to utilize cognitive behavior therapy (CBT) to support the person by helping them learn the tools to reduce stress so that their pain can also be reduced. This presents an opportunity for collaboration between a licensed mental health provider and a physical therapist, (PT).

According to the Model System Knowledge Translation Center, pain may be exacerbated by issues inherent in brain injuries such as lack of sleep, fatigue, anxiety and mood swings and the combination of this and pain can have serious consequences affecting ability to cope with daily life including the following:

Sleep deprivation: Most people with a TBI who experience chronic pain also report sleep disturbances. Lack of sleep can result due to pain and this deficit can also increase the experience of pain. This fatigue is a heavy tired feeling which can interfere with normal everyday tasks and can affect memory and thinking. (MSKTC TBI Factsheet)

Cognitive effects of pain: People in pain have difficulty thinking through complex ideas. Memory and focus can be affected, and people afflicted with these effects are often irritable or unable to deal with a moderate amount of stress.

Anxiety: Anxiety and pain are closely associated and they can both increase the severity and duration of symptoms of one another. It leads to people catastrophizing and can also affect cognitive processes such as attention and memory.

Depression: When someone is experiencing pain, they can develop feelings of hopelessness and often feel isolated. Multidisciplinary pain management including CBT, medication, and recreation can help to relieve the symptoms of depression and pain.

PTSD: This is a condition where people may feel stressed or afraid when they are safe. Flashbacks are common and scary, elevating the feeling of anxiety. Pain and PTSD can limit activities, the person isolates, and the pain can increase.

(MSKTC TBI Factsheet)

Assessments

Early management of pain can alleviate chronic pain in the future so early assessment will lead to more positive outcomes. Assessments with patients who have a BI can be difficult due to cognitive and communication challenges. Delayed diagnoses are a risk for chronic pain because people with chronic pain suffer significant losses in ability to perform ADL's and recreational activities, resulting in psychological distress such as depression. It is a vicious circle because this distress can then worsen the perception of pain. Once pain is chronic, it is important to find the root cause of the pain and reconstruct what happened to treat it appropriately.

"Once the root cause is identified, the consultant can refer to the right doctor. In the meantime, icing pain is essential and, myofascial and somatic pain tactile intervention addressing the sensation with sensory treatment works well. Pain from the nerve, muscle, disc, bone, and/or articulating pain can be the primary generator." (Turk, 2022).

It may be challenging to identify the cause of depression in TBI as it may be caused by the brain injury itself, or it may be caused or exacerbated by chronic pain. It is critical to connect the patient with the appropriate specialist for optimal treatment. Psychiatrist and psychiatrists may collaborate to provide the most effective treatment plan. (Fleischer, 2022)

Management of Pain After TBI.

Pain can change thoughts that influence our emotions, increasing the experience of pain. Pain can also result from complex regional pain syndrome (CRPS). Exercise, social activities, and hobbies can help to distract from thoughts focusing on pain, which often makes the pain worse.

Working with a physiatrist could also help to formulate an exercise program specifically for an individual's pain management program. As an intervention, a doctor or therapist can establish a baseline as it relates to quality of life and the ability to participate in activities. Physiotherapy strategies may include electrical stimulation of the affected region, heat/cold therapy, ultrasound, massage therapy, manual therapy, spasticity management, relaxation techniques, increasing pleasurable activities.

The biopsychosocial approach model has led to the development of the most therapeutic and cost-effective interdisciplinary pain management programs. There are implications that there is an interaction between the psychosocial and physiological processes. The gate control theory of pain emphasized the significant role that psychosocial factors potentially play in the perception of pain. It is posited that higher cortical functions contribute to the gating mechanism. This allows for psychosocial phenomena to directly affect the subjective experience of pain. Negative states of mind such as learned helplessness, loss of hope, and catastrophizing tend to intensify the sensory output while strategies for decreasing stress and increasing coping mechanisms close the gate. The biopsychosocial model combines physical, psychological, social, cognitive, affective, and behavioral measures to assess the person's unique pain condition. (Gatchel, 2021)

This model is designed to teach coping skills without pharmacological dependency. The focus is on assertiveness vs. avoidance and includes spiritual counseling, pre-vocational needs, cognitive strategies, and nutrition. (Terry, 2022)

The Progressive Goal Attainment Program (PGAP) is an evidence-based treatment program for reducing disability associated with pain, depression, PTSD, cancer, and other chronic health problems. This is a time-limited standardized intervention designed to reduce psychosocial barriers to the rehabilitation process. (PGAP®. 2022.)

Research findings suggest that psychosocial intervention provided by psychotherapists, can lead to meaningful reductions in psychosocial risk factors for pain and disability and may contribute to more positive rehabilitation outcomes. (Sullivan, 2010)

Pharmacological Pain Management Interventions.

"There are a variety of medications and medical interventions that could be effective in reducing pain, but medications are not the sole focus of treatment in pain management, they can be used when needed to meet overall goals of therapy in conjunction with other treatment modalities." (Lambert, 2010)

Pharmacological Treatments to Consider

Pharmacological treatments can be very effective when combined with other modalities. Some medications to consider includes: over the counter medications such as Ibuprofen and Acetaminophen; Antidepressants, which have been shown to have a therapeutic effect on pain; Anti-epileptic medication, such as Gabapentin, have reportedly helped with pain; Opiates such as codeine, keep in mind the major side effects; Topical medications such as ointments and creams applied directly to the area that is in pain.

Other treatments to consider

- Nerve blocks
- Injections
- Neurostimulation
- Surgery

Conclusion

Recently, there was a study on epidural spinal injections which found that, although the injections brought some relief, two years later there was no difference in the pain. Diet therapy may be the future of pain management. (Maisel, Gerda, 2022) Evidence is suggesting an integrative lifestyle approach that addresses all aspects of chronic pain over traditional pharmaceutical approaches. There is growing interest in the use of diet therapy as an adjunct to core therapy. This could be challenging because patients may have multiple financial, physical, psychological and practical difficulties obtaining the food they need for a specific diet. (Philpot, Et al, 2019) That said, it is evident that pain management is heading towards a holistic approach. Combining this holistic approach with the medical treatment team specializing in brain injury may be the best approach at this time. Anecdotally, John would have benefitted from a team of specialists and had he had his injury twenty years later, he may have survived and lived a better life post injury.

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**REMEMBER TO
WASH YOUR HANDS**

Follow social distancing guidelines

**Thank a caregiver, be kind
and take care of each other!**





Mental Pain: The Connection with Chronic Pain

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Keywords: Pain Treatment, Chronic pain,
Pain management

NURSING DIAGNOSES TO CONSIDER NANDA-I 2021-2023

1. Domain 5- Perception/Cognition. Class 4.
Cognition-Disturbed thought process
2. Domain 4-Activity/rest. Class 5. Self-Care -
Self-neglect
3. Domain 6-Self-perception. Class 1- Helplessness

Feeling Pain

Feeling sad hurts. As does feeling lonely, fearful, guilty, worthless, ridiculed, or embarrassed. Grief also hurts. Having an altered or absent body part, losing a job and the economic security it once provided, and facing a much-changed way of life can also hurt.

Certain metaphors, such as feeling as if there were a lump in your throat, feeling sick to your stomach, or feelings of heartache, often represent how emotions affect the body's systems. Instead of releasing emotions, holding onto them

can result in uncomfortable physical sensations. Hurt feelings do not involve actual tissue damage, however the effect is similar.

Feeling pain can be thought of as an emotional or physical phenomena. When a person says, "my feelings are hurt," this statement translates to an understanding that negative emotional pain was felt and is a concept understood by most people. When a person says "my joints ache, or I have nerve pain" these statements translate to an understanding that physical pain is felt and is typically differentiated from an emotional concept.

Terms used for this article will be mental pain and chronic pain for purposes of clarity for the reader, though the subject matter is anything but clear.

Chronic pain is a subject well researched and has evolved with different definitions from a time-limited explanation such as pain lasting longer than normal tissue healing time, to a disease process in and of itself. However, identifying a symptom and a disease using the same word can create ambiguity. Therefore, a universal term is helpful when health care providers communicate.

Chronic pain can be described as persistent pain without an actual known cause. Authors Raffaelli et al. (2021) explain that "the mere fact of not having found any causes does not mean that there are no causes, but that they may not have

been discovered yet." Furthermore, they explain chronic pain as the outcome of a dynamic interaction among biological, psychological and social factors, which perpetuates and aggravates the pain itself, individual disability and the response to interventions

Chronic pain can create numerous problems including fatigue, anxiety, depression, and a poor quality of life (Geneen et al., 2017). Understanding the relationship between mental pain and chronic pain can help the Life Care Planner plan for the services warranted.

The Pain Connection

Mental pain is typically thought of as experiencing negative emotions or feelings such as sadness or anxiety. Ever wonder where emotions are located in the brain and how they seem to produce physical symptoms? Conceptualizing the emotional pain process can be taxing. In a 2015 study by Wager, et al., researchers analyzed human emotional brain activity patterns. The authors found the sub cortical regions of the brain (previously considered to be the prevailing location of emotion) were not the only place emotional centers were to be found. Emotions exist as patterns across multiple brain networks, including the cortex and the brainstem. More importantly, the findings were consistent with views proposing that emotions are differentiated by a combination of perceptual, mnemonic, prospective, and motivational elements.

Mental pain and chronic pain are clinically related and can affect the brain, actually changing it. In a review study, Cheng et al., 2022 noted "the development of chronic pain and depression are associated with changes in neuroplasticity in overlapping regions of the brain."

Additionally, in a conference paper, authors Bras, Dordevic, Gregurek, & Bulajic, (2010) describe the interaction between chronic pain and mental pain as a "psycho-physiological behavioral pattern that cannot be divided into independent psycho-social and physical components." The authors go on to describe the physiological pain process noting "there are many complex mechanisms involved in pain processing within the central nervous system, being influenced by genetics, interaction of neurotransmitters and their receptors, and pain-augmenting and pain-inhibiting neural circuits." However, other than the central nervous system, numerous factors affect how pain is processed, including cultural belief systems, resilience, or past life experiences.

When physical pain and mental pain merge and do not subside within a reasonable amount of time, it is termed chronic, and the effects can snowball into an abyss of despair. Williams, Fisher, Hearn, & Eccleston, (2020) note for some people, persistent pain leads to disability, depression, anxiety and social isolation. Han & Pae, (2015) found when clients experience depression and pain, they share "elevated levels

of depressed mood, alexithymia, anger, decreased energy and fatigue, cognitive defect, increased vulnerability to stress, heart rate variability and sleep disturbance (decreased REM latency)."

Emotional pain and physical pain can feed off each other as well, much like a symbiotic relationship. Authors Bras, Dordevic, Gregurek, & Bulajic, (2010) describe chronic pain as "a psychosomatic disorder with physical, mental, social and spiritual components as well as one of the best examples of the interconnectedness of body and mind in clinical medicine." The risk of mental pain also increases when physical pain is more diffuse and severe, decreasing the quality of life.

It appears there is correlation, but is there evidence of causation between mental and chronic pain? Han & Poe (2015) note "although increasing evidence indicates that the relationship between both clinical conditions might be bidirectional, the question remains whether the specific neurobiological changes cause either pain or depression or are merely a consequence of each condition." Understanding the connection between physical and emotional pain is critical and helps the Life Care Planner validate the need for treatment modalities. A bidirectional diagram (Figure 1) illuminates "the ways in which biological, psychological, behavioral and social factors influence both pain and depression, and offers a way to the optimal therapeutic approach" (Han & Pae, 2015)

Furthermore, in a 2022 study, authors Cheng et al., found chronic pain and depression exacerbated one another. They also noted that "overall, people living with the comorbidity report poorer well-being and functionality compared to those living with CP [chronic pain] alone."

Depression and Anxiety: Asking the Right Questions

Depression is one example of mental pain. Han & Pae (2015) note several studies showing individuals with pain have an increased risk for depression in a lifetime compared to the standard populace. Clients with depression are also associated with having greater impairment in functional capacity. This is an important factor to recognize prior to performing the client assessment. If there was no evidence of depression or anxiety found in the progress notes, it does not mean the Life Care Planner should skip questions regarding those emotions.

During the assessment phase of data collection, knowledge of emotional symptoms will assist the Life Care Planner in asking questions they might not have considered. Depression and anxiety are two common negative emotions portraying mental pain. Some individuals are quite proficient at hiding their feelings and putting up a brave front. Disclosure of mental pain can be difficult. Admitting feelings of sadness

or anxiousness can bring about feelings of shame or guilt, interpreting their emotions as a sign of weakness. Therefore, it is not surprising when clients minimize their symptoms. In order to put the client at ease, sensitivity, tact and empathy are welcoming qualities to have as a Life Care Planner.

Subjective signs of depression may include feelings of sadness, emptiness, or hopelessness, a markedly diminished loss of interest or pleasure, change in appetite, sleep problems (insomnia or hypersomnia), psychomotor restlessness or slowing down, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, indecisiveness, recurrent thoughts of death (American Psychiatric Association, 2013).

Objective indicators may include a change of more than 5% of body weight over a one-month period of time (American Psychiatric Association, 2013), weepiness, slowed body movement, slumped shoulders or head (body posture), and downturned lips or downcast eyes (facial expressions).

Subjective signs of anxiety may include excessive worry, feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance (American Psychiatric Association, 2013).

Objective symptoms may include pacing, hyperventilation, sweating, restlessness, trembling or shaking.

Questions to consider asking during the interview:

- Do you feel sad?
- Do you feel angry?
- Have you cried?
- Do you have trouble sleeping?
- Do you have ruminating thoughts or negative self-talk?
- Do you feel irritable?
- Do you isolate yourself?
- Do you want to hurt yourself? (If during the interview, signs indicate concern of suicide or self-harm)

Depending on the answers, follow up questions may be warranted. Suggestions may include, "tell me more about that," or "can you give me an example of a time you felt that way."

Suicide/ideation

Emotional pain can be severe enough to cause a person to inflict self-harm or take their own life. Coping with chronic pain and mental pain can be extremely difficult for some individuals. Bras, Dordevi, Gregurek, & Bulaji, (2010) note "patients with long-term chronic pain have more suicidal

ideas, thoughts and attempts." Using a multi-disciplinary approach to teach coping skills is supported in a 2017 document written by Stone et al.

Ideally, the availability of multiple strategies and approaches tailored to the social, economic, cultural, and environmental context of individuals and communities are desirable as they may increase the likelihood of removing barriers to supportive and effective care and provide opportunities to develop individual and community resilience

Nursing diagnoses to consider (NANDA, 2022)

- Chronic pain
- Anxiety
- Grieving
- Chronic sorrow
- Risk for suicide

Treatment

When developing a Life Care Plan, understanding pain and emotion is essential. For instance, the mood of a client can influence his/her day-to-day functioning. When a client is in pain or feels anger or sadness, getting dressed or doing a daily home exercise program can be more burdensome, if able to be done at all. Obesity or insomnia are other conditions that can exacerbate symptoms, leading to a cycle of dysfunction. Furthermore, individuals who experience chronic pain are at a higher risk than the normal population in developing maladaptive avoidance responses to stressors, often resulting in impaired functionality, social withdrawal, anxiety and depression (Becker, Navratilova, Nees, & Van Damme, 2018).

Multimodal/Multidisciplinary Therapies

Using a multidisciplinary approach to address chronic pain and emotional pain is supported by research. According to a review article by Han & Pae (2015) "Psychosocial and behavioral factors play a significant role in the experience, maintenance, and exacerbation of pain. CBT alone or within the context of an interdisciplinary pain rehabilitation program has the greatest empirical evidence for success."

There are many variables to consider when determining what therapeutic modalities to include in a Life Care Plan. In a 2016 article on CDC guidelines, authors Dowell, Haegerich, & Chou explain that utilizing a single modality of treatment is less effective in reducing pain and improving function than multimodal and multidisciplinary therapies. They note "nonpharmacologic therapy (such as exercise therapy and CBT) should be used to reduce pain and improve function in

patients with chronic pain.” They also reported “nonopioid pharmacologic therapy (such as NSAIDs, acetaminophen, anticonvulsants, and SNRIs) should be used when benefits outweigh risks and should be combined with nonpharmacologic therapy” (Dowell, Haegerich, & Chou, 2016).

Keeping Active

Because physical and emotional pain are related, learning coping skills to manage one type of pain results in, at least partial, management of the other type of pain as well. Therefore, including treatment modalities to address physical pain could include such treatments as physical therapy. In a 2017 Cochran overview, Geneen et al. reported “General advice now is to keep active – whether to affect the pain directly or to combat the other problems associated with it.” Furthermore, the authors noted “According to the available evidence (only 25% of included studies reported on possible harm or injury from the intervention), physical activity did not cause harm.”

Besides the cost of physical therapy, other cost options for physical activity include gym memberships, exercise classes such as yoga, or home exercise equipment.

Current Procedural Terminology (CPT) codes for physical therapy that may be relevant:

- 97162 (evaluation)
- 97110 (routine) – use for development of a home exercise program (HEP)

Counseling

Individuals who experience an injury or chronic illness, and recover from the physical pain, find themselves challenged in coping with their new life, changed forever by a disability and/or impairment. Negative self-talk, mind chatter, or ruminating thoughts can drive the emotions of a person to a very dark place. Learning how to accept a disability can go a long way in improving an individual’s life, especially if they struggle with resentment, blame or anger. Psychological counseling is a treatment to consider for emotional regulation. According to authors of the 2020 Cochran Database of Systematic Reviews, Williams, Fisher, Hearn, & Eccleston, report “Psychological treatments (talking and behavioral therapies) aim to help people change the way they manage pain, to minimize disability and distress.”

Keep in mind that one size does not fit all, and individual circumstances must be considered. Psychological counseling can also help manage stress by teaching relaxation techniques, such as meditation, breathing exercises and biofeedback (American Psychological Association, 2013). A litigation process alone can activate stress in a client, and a

case can go on for several years if not settled in mediation or arbitration.

Utilizing a holistic philosophy, a counselor can provide psychoeducation for nutrition, exercise, sleep, stress management, or spirituality. Psychological counseling can also address other challenges the client might experience such as relationship conflicts or lack of coping skills. The following list comprises certain types of psychotherapies that may be helpful to a client. However, the types of therapy listed below do not require specific codes.

- Cognitive Behavioral Therapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Mindfulness-Based Stress Reduction (MBSR)
- Emotional Regulation Therapy (ERT)
- Internal Family Systems (IFS)

CPT codes for psychological counseling that may be relevant:

- 90791 (diagnostic evaluation)
- 90834 (individual therapy <50 minutes)
- 90837 (individual therapy >50 minutes)
- 90846 (family without client)
- 90847 (family with client)
- 90792 (psychiatry evaluation)
- 99211-99214 (psychiatry treatment)
- 90833 (medication management-30 minutes)
- 90836 (medication management-45 minutes)
- 90838 (medication management-60 minutes)

Biofeedback CPT codes:

- 90901 Biofeedback
- 90875 Biofeedback with psychotherapy <50 minutes
- 90876 Biofeedback with psychotherapy >50 minutes

The number of sessions should be determined on an individual basis. The emotional damage from a chronic illness or injury resulting in cognitive and/or physical disabilities affects individuals differently and depends on numerous factors including support systems, past experiences, comorbidities, resilience, optimism, perceptions, cultural upbringing, and age. For instance, a child may need additional sessions during certain developmental growth periods. Suicide ideation warrants additional sessions. On the other hand, an individual who experienced a catastrophic injury who has a supportive family and friends, an optimistic outlook on life in general, and high resilience may need fewer or no additional counseling sessions. However, variables usually change as a person grows older, whether it is loss

of the parental or spousal support system or exacerbation of complications. Considering an allowance of a minimum number of psychological sessions in a lifetime is reasonable.

Medical care is determined on a case-by-case basis, such as choosing what drug classification of antidepressant to prescribe. The same considerations need to be determined for treatments of clients experiencing mental pain.

Medications

Critical thinking skills of the Life Care Planner are put to task when determining what treatment is warranted to optimize a client's functioning when it comes to medication treatments. Collaborating with health care providers plays an important role in determining what pharmaceutical treatment best serves the client. Weighing outcomes using a harm-benefit analysis must be commenced. The 2016 CDC Guidelines for determining treatment for chronic pain are as follows.

Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate

The authors also include information regarding nonopioid medications as follows Nonopioid pharmacologic therapy (such as NSAIDs, acetaminophen, anticonvulsants, and SNRIs) should be used when benefits outweigh risks and should be combined with nonpharmacologic therapy.

The CDC developed a clinical tool PDF titled Nonopioid Treatments for Chronic Pain which described the following nonopioid medication guidelines for the use in treating chronic pain. These medications, their use, and the possible harms are listed below:

- Acetaminophen – first-line analgesic – possible Hepatotoxica
- Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) – first-line analgesic– possible Cardiac, gastrointestinal, and renal effects
- Gabapentin – first-line agent for neuropathic pain – possible sedation, dizziness, and ataxia
- Pregabalin – approved for fibromyalgia – possible sedation, dizziness, and ataxia
- Tricyclic antidepressants (TCAs) – first-line neuropathic pain, fibromyalgia, headaches – possible anticholinergic and cardiac toxicities
- Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs) – first-line neuropathic pain and fibromyalgia – Safer than TCA

Topical treatments, which are often safer alternatives to systemic medications:

- Lidocaine – neuropathic pain
- NSAIDS – localized osteoarthritis
- Capsaicin – musculoskeletal and neuropathic pain – Initial flare/burning, irritation of mucus membranes

Laboratory testing will need to be included in the Life Care Plan to monitor for toxicity in clients taking these medications, due to the longevity of taking them or due to toxic effects.

CPT codes for laboratory testing that may be relevant:

- 80076 Hepatic panel
- 80069 Renal panel

Summary

Emotions are a part of being human, but when chronic negative emotions create dysfunction in life, there are treatments that can help. When completing a Life Care Plan for a client experiencing chronic pain, either mental or physical, take note when they disclose one type of pain, the other type of pain is possible as well. Asking the client the right questions will help reveal the complete picture.

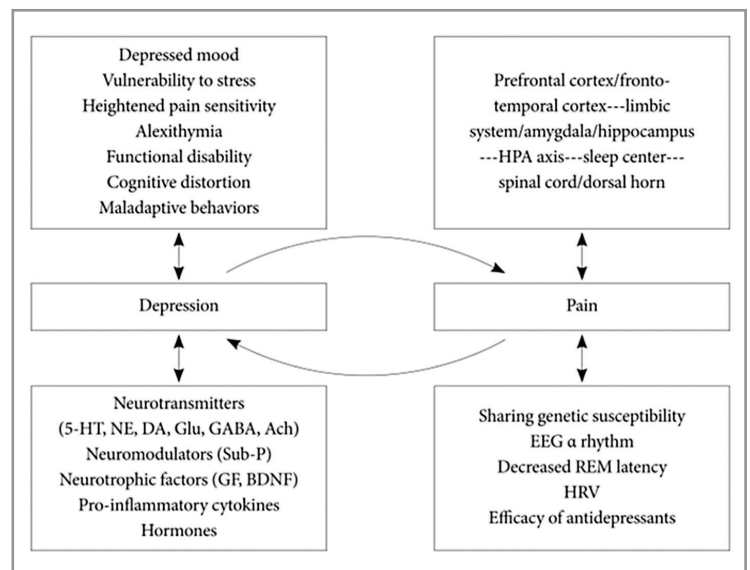


Figure 1. Bidirectional diagram depicting the association of pain and depression in pathophysiology and symptomology (Han & Pae, 2015)

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What to Bring to a Deposition

By Dawn Cook, RN, CLCP, CNLCP

Keywords: Deposition, Due Diligence, Trial Preparation

You have been asked to provide dates that you are available for a deposition, then a date has been chosen and now you need to prepare for this deposition. Remember that you are not required to bring anything unless there is a request in your notice of deposition. However, you obviously need something to jog your memory and to quote the dollars and cents of your report.

Sometimes there are no requests for bringing anything in. In this case, I bring a binder with what I think is relevant, generally a copy of my CV, fee schedule, testimony log, retainer agreement, and invoices. I also bring my report/s and any material that I want to have on hand. Examples are rebuttals to my report or physician reports that support my report. I don't print out medical records unless there is something special I want to refer to, for example, an operative report in the case of reviewing bills.

Not every case has a deposition. I estimate that I give my deposition testimony in about 20% of the cases that I produce an expert report. Some states may be like Utah where the opposing counsel EITHER gets your report OR your deposition. During these depositions, they still can't see your report.

You don't always have your deposition taken before a trial. I have gone directly to Court without a deposition in New Mexico and California.

Notice of Deposition (NOD):

Before your deposition, be sure to obtain the actual Notice of Deposition, to confirm the date and time (and sometimes location) of your deposition. There may be instructions about what you are expected to bring with you in the subpoena duces tecum or subpoena for the production of evidence.

Attorney Consultation:

I usually call my retaining attorney after I receive the NOD to discuss. There are sometimes new federal or state laws or rulings that mean you may not be required to bring emails or drafts or other particulars that you might consider bringing. As well, there are often requests for things that you may not have (see sample of Subpoena Duces Tecum). Examples are past deposition transcripts, lists of all cases you have consulted upon, and lists of testimony before the past "four-year" interval. Your retaining attorney may need to make filings or motions to object to some of the things in the notice.

Entire File:

What is your entire file, you may ask? In the distant past, you may have kept all relevant material about this case in a physical file. This would include intake, agreements, invoices, medical records, correspondence, time records, reports, and notes.

In the world of electronic records, you may store most of these things in a "folder" on your computer. But you may have medical records "in the cloud" and invoicing through your bookkeeping service. Your time records may be a word file or maybe through a time-keeping service such as Harvest and others. You may keep your updated CV, fee schedule and testimony log on your personal computer but not with any particular case. Signed copies of retainer agreements may be in file for this case or in the cloud with other records.

You may have taken notes directly into your report and not have another place where notes from discussions could be found. You may continuously update your report and therefore have no "drafts" or "previous versions" to present. If you did take handwritten notes, you may have scanned them to your computer and have them in a file. Letters to physicians may never have been printed, but may be created on your computer, then emailed or electronically faxed to an office, and returned the same way. You may have these as a file in the patient's folder or screenshot directly into your report.

Medical Records:

You likely never printed out any medical records and therefore don't have any handwritten notes or post-it notes attached, so these can remain electronic. Check with your retaining attorney, who may advise you on whether you need to produce these or not. It may be that your retaining attorney has a file of all the records that were sent to you, and the law firm can produce these (electronically, of course) on your behalf. I consider CD-ROM and flash drives with medical records to be electronic and destroy these devices, as well as all electronic records, once the case is settled.

If you are asked to produce the medical records electronically before the deposition, I use the HIPPA-complaint service "Hightail" to transfer them to my retaining attorney. This service can take very large volumes of records. You could also share the records via drop box or one of many services that they may have been originally sent to you.

If you received medical records physically, you may be asked to bring them with you. In the case of a Zoom/virtual deposition, check to see how this may be accommodated. If you are asked to scan these into your computer, be sure to confirm that you will get paid for your time doing this. Don't take these to a business store to be scanned, as they can't maintain HIPPA standards.

Alternatively, you could mail them back to the retaining attorney who could present these for the deposition. In the past ten years that I have been doing this work, I have received medical records in a box a couple of times, but I ask them to resend them electronically, and I return the physical records or shred them, after checking with my retaining attorney.

Your Reports

Your report/s will have already been received by opposing counsel, so there is no need to send another copy unless they ask for it. However, you may need to produce materials that did not end up in the report. If there are notes, screenshots of internet research, communications with the law firm or physicians, or emails in your report, bring the original copies to be entered as exhibits.

Drafts: They may ask for drafts of your report. If this is a Federal case or in a state that uses federal rules, you may not need to produce any drafts. Check with your retaining attorney, however, as some states (like Alaska) use some rules as federal guidelines and not others.

Notes: If you have any notes that you used to create your report, you are required to bring these too. Think about your interview of the plaintiff, did you have a special form for the interview and write notes as you went along? Or did you have the outline of the interview in your laptop computer and simply typed as you interviewed? If there are no handwritten notes, there is nothing to produce.

Photos: You may have taken photos when interviewing the plaintiff. Even photos that you didn't put into the report must be produced for deposition discovery. It is helpful if you carefully plan your shots so that you can just take the ones that end up in the report. Be sure to label them in the report and save all photos so you can produce them as requested. If you used your cell phone to take pictures, be sure to delete them after uploading them to your computer.

Research: You may have done cost research for your report. If you didn't include the web addresses, copies of catalogs, screenshots from computer research, or letters to/from physicians in your report, be sure to bring them as exhibits for your deposition.

Timekeeping and Bookkeeping

You may have a handwritten account of time spent on the case or a Word file or you may have a timekeeping app that projects the time into an invoice for the attorney. Whatever you have for tracking time spent on the case needs to come with you to the deposition.

You need to produce invoices even if they have not yet been paid.

You may be asked if you have done additional work since the last invoice, such as reviewing additional material, talking with the retaining attorney, updates with the plaintiff, producing your file, and any study you have had, to prepare for the deposition. If you have not produced an invoice for this time, you may be asked to estimate the additional time and amount of money that will be invoiced in this case.

Emails and Other Communications

Part of your file that you may need to produce (i.e. bring to the deposition) is all your email communication for this case. This would include emails with the law firm, the plaintiff, physicians, cost research emails, etc. You may be asked for "all" communication such as letters and phone logs.

Be sure to ask about this, as some may be protected and do not need to be produced.

Other Things You May Choose to Bring:

Records for Reference During Deposition:

You may wish to bring some printed records for your deposition, maybe an operative report or an expert's report. It's OK to bring them, but you may be required to submit these as exhibits. They may be photocopied during your deposition along with anything else you brought and entered as evidence. Be sure to explain why you brought them.

If you are doing a rebuttal report or if there is a rebuttal against your report, you may want to bring a copy of this, to reference as you give your opinions. If there are handwritten comments or highlighting, you may be asked to explain. Again, it will likely be entered as evidence.

Timeline Notes:

You may be asked what date you were first contacted by the law firm, when you received records, when you had phone discussions with the law firm, and other timeline discussions. If this is not in your report or invoices, you may want to bring a brief list of critical dates. Again, this may be copied and entered into evidence.

Submitting Your File Before Your Deposition

In the age of remote/virtual depositions or for some state guidelines (California for instance) you may be required to send your "entire file" a few business days before the scheduled deposition. Since you would generally run this by your retaining attorney first if you were having an "in-person" deposition, you should send your file to your retaining attorney, and then they will forward this to the opposing attorney unless you are advised otherwise. Don't send it directly to the opposing attorney unless your retaining attorney advises you to do this.

Finally

You will generally be asked about your qualifications, what you reviewed to form your opinions, your methodology to come to an opinion and what your opinions are. Your binder should help you to explain all your opinions and the basis of your opinions.

Remember, anything you bring to a deposition is discoverable and will likely be copied and put into the record. But with the above list, you should be bringing what you are required to bring, and what will be helpful for you to be able to explain your opinions for the record.

Sample of *subpoena duces tecum*

Documents and/or Tangible Things to Be Produced

The information is pursuant to California Code of Civil Procedure 2034.415)

1. The deponent's entire file(s) for this case
2. All documents/tangible things/electronically stored information and/or evidence reviewed by the expert in preparation for his/her deposition.
3. A copy of the deponent's curriculum vitae, or resume, and, if not included within said curriculum vitae, a list of each, and every article, books, treatises, or other literature authorized by the deponent whether published or not published.
4. All documents/tangible things/electronically stored information (including, but not limited to, depositions, statements, journals, articles, bills, reports, medical records, hospital records and charts and other documentation) or items of evidence given to and/or reviewed by the deponent in this case.
5. The original and drafts of all animations, graphics, photographs, images, models, diagrams, renditions, sketches or drawings of any item or thing that has been used by or will be used by the deponent in connection with this case.
6. All documents/tangible things/electronically stored information that establishes the basis for the deponent's expert opinion(s) to be rendered in this case.
7. All documents/tangible things/electronically stored information that reflects communications (including memoranda of oral communications) between the deponent and/or his/

her office staff and any other person wherein this case was mentioned, discussed and/or referred to.

8. Any and all books, treatises, articles, publications, journals (or journal articles and/or learned documents of any sort referred to or relied upon by the deponent in forming his/her expert opinions to be rendered in this case.

9. If any items listed in number 8 are unavailable, all documents/tangible things/electronically stored information that reflect the title, author, publisher, date, volume chapter, and/or page information.

10. Copies of any notices, announcements, advertising materials, or any other form of printed materials whatsoever pertaining to the availability of the deponent's services as an expert consultant, including, but not limited to, any such documents the deponent has mailed or otherwise distributed to anyone within the last four years.

11. Any and all transcripts or other documents/tangible things/electronically stored information reflecting deposition or trial testimony given by deponent in any case where deponent has testified (whether in deposition or at trial) as an expert where the expert was retained by the Defendant or for any motor vehicle case.

12. All documents/tangible things/electronically stored information that reflects the number of times the deponent has been retained and/or testified as an expert for the Defendant, as an expert for Defendant's law firm, as an expert for the insurance carrier for any of the Defendants and/or as an expert for any plaintiff.

13. Any and all lists or compilations (including any Federal Court disclosures) that reflect each case wherein the deponent was retained as an expert and testified at deposition or a trial (including the name of the case; the name of the parties; the name and address of the court wherein the case was filed; and the name, telephone number and address of the attorneys for all parties.)

14. All documents /tangible things/electronically stored information that reflect the amount of compensation paid or to be paid to the deponent for his/her services, in this case, including but not limited to, a record of all charges billed, and the total number of hours spent in this matter.

15. Any and all reports (including drafts) that reflect the deponent's expert opinions and/or review of records in this case.

16. Any billing records for services rendered by the deponent or anyone acting at his/her direction or behalf in connection with this case, and the work and consultation thereof including all time records showing time spent and the expenses incurred.

17. All documents/tangible things /electronically stored information that reflects any experiments and/or re-creations considered or performed by the deponent in this case, including but not limited to photographs and videotape of said experiments and/or re-creations.

18. Copies of all articles and/or publications referenced in the deponent's authored by the deponent.

19. Copies of all documents/tangible things/electronically stored information given by the deponent or on the deponent's behalf to participants or attendees at any of the deponent's presentations referenced in the deponent's CV and the actual PowerPoints or slides or presentations shown.

20. All documents/tangible things/electronically stored information which reflect the amount of money earned by the deponent (or his/her firm) acting as a consultant or expert witness in any type of claim or action for the period from 2011 through 2021.

21. All documents/tangible things /electronically stored information that evidence or reflect contracts, agreements or arrangements between the deponent and any law firms or insurance companies with regard to compensation to be paid to the deponent (or his/her firm) for work done on multiple matters, claims or files.

22. All documents/tangible things/electronically stored information that establishes or from which it can be established the percentage of matters where the deponent has been retained by the defendant versus the plaintiff for the last 10 years.

23. All documents/tangible things/electronically stored information that evidence or reflect court orders where the deponent's testimony has been limited or excluded.

25. If the expert has utilized a computer program or software to calculate any value or to test any assumptions or conclusions, a copy of all data files relating to the work (in native format as well as excel, word, or PDF), all graphics or reports that can be generated for the testing done, the data used or ultimate calculations and a copy of all manuals relating to the software used.

26. If the expert is relying on simulations, crash tests crash test data for any assumptions or opinions in this matter, all evidence relating to the simulations, all crash tests, and all crash test data.

27. As to any scientific techniques or methods used (like correlating a change in velocity to injury potential or whether a particular injury can occur in a particular event), all documents establishing the foundation for the techniques/methods, including but not limited to all studies all peer-reviewed articles, peer-reviewed publications and all other documents/tangible things/electronically stored information showing (1) the reliability of the technique/method, (2) the expert is qualified to give an opinion on the subject; and (3) the correct scientific procedures were used and (4) the scientific technique/method is sufficiently established to have gained general acceptance in the relevant scientific community.

If any of the above items, as described in Nos. 1 through 26 are unavailable at the time and place of the deposition, the deponent is requested to identify where such items are located, who has possession of them, and how they may be obtained through the processes of the Court. The deponent's entire file(s) for this case.



TRANSPARENCY

Patti Mazurkiewicz MS, RN, CLCP, CRC, LCPC, NCC

Have you ever looked at the disclosure statement of a research article? If a conflict of interest (COI) statement is present, do you heed the warning? Research articles are one of the many tools used by Life Care Planners to support recommendations included in the Life Care Plan. Using reliable and valid research will increase the Life Care Planner's confidence in the sources used and add credibility to the Life Care Planner.

Not only does the COI disclosure statement provide transparency, but it can also reveal a potential for bias. Making a habit of looking at disclosure statements may keep the Life Care Planner out of hot water in the event a COI is known. It is good practice for the Life Care Planner to remain skeptical to determine if there are risks for misrepresentations, based on the COI statement. For example, if financial or personal gain is possible, based on the outcomes of the research, the potential for misrepresentation increases. If a COI statement is present, the Life Care Planner should contemplate whether the article should be used as a reference.

In a 2020 editorial, author Sharma explained the importance of COI statements. She wrote "such disclosure is intended to help readers critically evaluate whether any conflicting

interests exist, and are unduly influencing conclusions drawn and recommendations made." Sharma also revealed that "many instances of bias in medical research associated with financial COIs have been documented, particularly in the pharmaceutical and medical device industries."

Other groups of stakeholders, other than Life Care Planners, such as lawmakers and government agencies, should also be familiar with disclosure policies of scientific research studies and publications. Remaining impartial is crucial when making informed decisions, especially when their decisions affect others. Common sense and logic are at the forefront of making those important decisions and can be imperative to the health and safety of the public. There is too much at risk otherwise, as evidenced by how the passage and marketing of OxyContin occurred.

The public's safety depends on safe and effective medication regulations. The FDA "reviews scientific and clinical data to decide whether to approve drugs based on their intended use, effectiveness, and the risks and benefits for the intended population, and also monitors drugs for continued safety after they are in use" (The General Accounting Office, 2003).

Misrepresentation of information seems to have contributed to a burgeoning, ongoing public crisis. In 1995 the U.S. Food and Drug Administration (FDA) approved the opioid OxyContin, the brand name of oxycodone, a scheduled II drug manufactured by Purdue Pharma L.P. “for the treatment of moderate-to-severe pain lasting more than a few days, as indicated in the original label” (United States. General Accounting Office. 2003). “The OxyContin label originally approved by FDA indicated that the controlled-release characteristics of OxyContin were believed to reduce its potential for abuse” (United States. General Accounting Office. 2003).

According to the December 1995 timeline of selected FDA activities and significant events addressing opioid misuse and abuse document (fda.gov):

At the time of approval, FDA believed the controlled-release formulation of OxyContin would result in less abuse potential, since the drug would be absorbed slowly and there would not be an immediate “rush” or high that would promote abuse. In part, FDA based its judgment on the prior marketing history of a similar product, MS Contin, a controlled-release formulation of morphine approved by FDA and used in the medical community since 1987 without significant reports of abuse and misuse.

In July 2001 the FDA changed the OxyContin label and described the reasoning for “additional stronger warnings about the potential for misuse and abuse” (fda.gov). The General Accounting Office (2003) presented the following updates concerning addiction and the new 2001 OxyContin label in the Highlights of GAO-04-110, a report to congressional requestors, as follows:

In addition to the black box warning, FDA also changed the language in the original label that described the incidence of addiction inadvertently induced by physician prescribing as rare if opioids are legitimately used in the management of pain. The revised label stated that data are not available to ‘establish the true incidence of addiction in chronic patients.’

If data was not available to establish the true incidence of addiction in chronic patients, what data regarding addiction did the FDA use when they approved OxyContin in 1995? The reports indicate a belief, as opposed to data, was part of the FDA’s decision-making process. Did the FDA take into consideration who sponsored the OxyContin research studies? Was there a COI disclosure statement? Data collected to render conclusions and evidence actually speaks for itself. When other methods are utilized to sway opinions, the skepticism radar should rise. Once OxyContin gained approval from the FDA, other methods used by them to market OxyContin came to light. Authors Stoicea et al. (2019) reported

The shift to opioids being considered a national health concern started with the promotion of drugs like oxycodone

by Purdue Pharma, with a bonus system applied to the sales of the drug in an attempt to influence prescription rates.

In a (2009) article titled “The promotion and marketing of oxycontin: commercial triumph, public health tragedy,” Zee (2009) described Purdue’s promotional campaign reporting they “trained its sales representatives to carry the message that the risk of addiction was ‘less than one percent’.” Furthermore, Zee explained how the company cited studies by Porter and Jick, authors of a study researching narcotic use and addiction. Porter and Jick wrote a letter to the editor of the New England Journal of Medicine (NEJM) highlighting the results of their work. That letter to the editor titled “Addiction Rare In Patients Treated With Narcotics” follows:

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients’ who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had a history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients, Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

As shown, important information was omitted regarding the length of time the patients were hospitalized, rendering it impossible to make valid conclusions based only on the letter itself. Research done in an acute setting over a period of days as opposed to a period of weeks, months, or years is not an accurate representation of addiction risk for long-term opioid use. The 1980 letter to the editor has been cited over 500 times. “For reasons of public health,” an editor’s note in the NEJM was added May 31, 2017 stating “readers should be aware that this letter has been ‘heavily and uncritically cited’ as evidence that addiction is rare with opioid therapy (nejm.org).

Transparency and ethical practice, especially in the realms of healthcare, is imperative to the health and safety of the public, let alone the effects of public trust. When organizations do not follow ethical guidelines for the sake of financial gains, many innocent people may be harmed. One of Purdue’s advertisements for OxyContin in another medical journal triggered a violation response from the FDA. In May 2000, the FDA

issued an untitled letter to Purdue regarding a professional medical journal advertisement for OxyContin. FDA noted that among other problems, the advertisement implied that OxyContin had been studied for all types of arthritis pain when it had been studied only in patients with moderate-to-severe osteoarthritis pain, the advertisement suggested OxyContin could be used as an initial therapy for the

treatment of osteoarthritis pain without substantial evidence to support this claim, and the advertisement promoted OxyContin in a selected class of patients— the elderly— without presenting risk information applicable to that class of patients (The General Accounting Office, 2003)

Important decisions, involving public healthcare especially, can have disastrous consequences if judgements are based on incomplete data and beliefs. An important decision made in 1995 appears to have had a ripple effect, and since that time, it is unclear if consequences for those responsible will prevail.

As shown, readers of research and data who make decisions that affect others, need to understand the significance of what a conflict of interest represents as well as the aftermath. Life Care Planners also need to heed those same warnings, for the sake of the profession. Being critical of sources used in the Life Care Plan can spare the Life Care Planner a need for explanation. If more questions arise than answers, the materials used may need to be reconsidered.

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Reviewers

We would like to give a special thank you to our reviewers for their insight, medical acumen, and collaboration in creating this issue.

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Chris Daniel - Your suggestions for expansion and increased depth lead to more useful articles in the final draft.

All feedback is blinded, coordinated through, and developed with the author by the editor.



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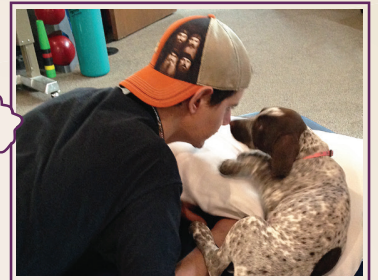
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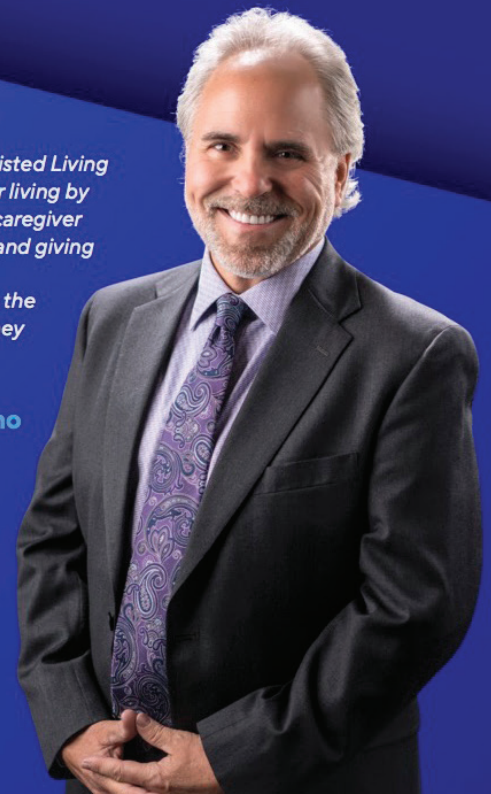
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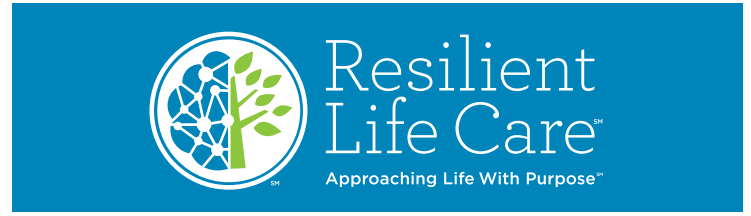
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LOOKING AHEAD

2022

Fall: Joint Care

2023

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Summer: Mental Health

Fall: Interacting with Other Disciplines

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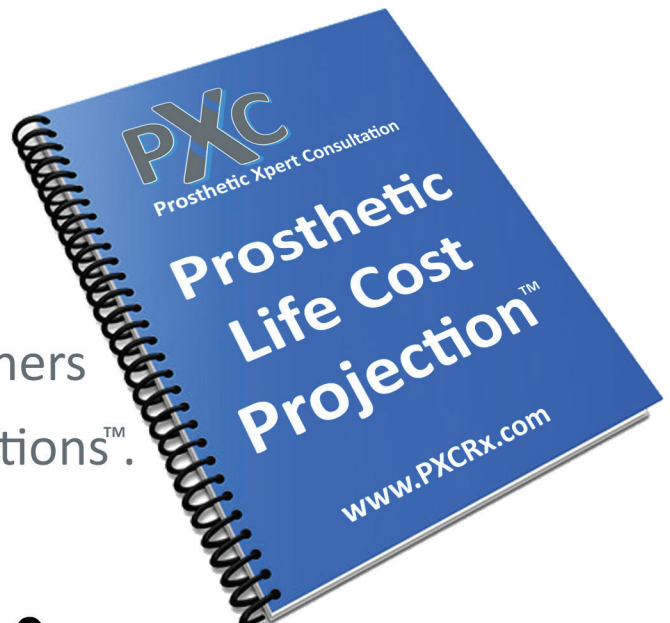
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