COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

CHRONIC PAIN TREATMENT GUIDELINE

REVISED OCTOBER 2024

I. INTRODUCTION:

This clinical guideline has been created to consistently improve health care services for injured workers by outlining the appropriate evaluation and treatment processes for the management of chronic pain which has been determined to be work related. The guideline should be used as a tool to guide health care providers of different professional disciplines to provide quality care to injured workers. The guideline is not intended to be a substitute for appropriate medical judgment, and is written to be broad enough to allow for a wide range of diagnostic and treatment modalities, and to purposely allow for philosophical and practice differences among professional disciplines of health care practitioners who provide care to injured workers with chronic pain. It is expected that approximately 10% of cases may fall outside of this guideline and may be reviewed and approved on a case-by-case basis. If objective clinical improvement is delayed or slower than expected, the treating provider must justify the necessity of continued care with a valid clinical rationale, with supporting, objective clinical findings. Timeframes for specific interventions commence once treatments have been initiated, not on the date of injury.

The absence of a diagnosis of "chronic pain" by the treating health care practitioner does not preclude the use of this treatment guideline.

II. BACKGROUND:

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. Often, pain serves as a symptom warning of a medical condition or injury. In these cases, treatment of the underlying medical condition is crucial and may resolve the pain. Pain may persist despite successful management of the condition that initially caused it, or because the underlying medical condition cannot be treated successfully. Adapted from The New England Journal of Medicine- https://www.nejm.org

Chronic pain is pain that persists or recurs for longer than 3 months, or pain which outlasts the expected duration of the healing time for tissue injury. It may be characterized by functional disability (interference in daily life activities and reduced participation in social roles) or emotional distress (anxiety, anger/frustration, or depressed mood). Chronic pain is multifactorial: biological, psychological, and social factors contribute to the pain syndrome. The diagnosis is appropriate independently of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms. Chronic pain with the presence of significant comorbidities is now often categorized as "High Impact Pain," and typically requires interdisciplinary assessment and management from clinicians who have special expertise in pain management from disciplines of pain medicine, pain psychology, rehabilitation medicine, and others depending upon the patient's presenting problems. Adapted from The New England Journal of Medicine- https://www.nejm.org

Counseling and/or psychological treatment may be necessary when chronic pain is associated with additional problems. The purpose of an intensive short-term treatment program is the reduction of pain, reduction of physical impairments, and management of chronic pain behaviors. The goals are to: maximize the function of the injured worker in work-related activities and/or activities of daily living, optimize medical treatment and seek a balance between appropriate treatment of pain and safety in the use of opioids, central nervous system depressants, and over-the-counter analgesics. How a patient is taking their medications should be reviewed at follow-up to monitor adherence with the treatment plan, effectiveness, and side effects.

Patients receiving therapeutic treatments should be released or returned to duty during the rehabilitation period at the earliest appropriate time. Continued treatment should be monitored using objective and subjective measures such as: return to work or maintaining work status, fewer work restrictions or performing activities of daily living, decrease in usage of ineffective medications, adjustment of effective medications, improved emotional status, and measurable functional gains such as increased range of motion or increase in strength.

A cure for chronic pain may not be expected. Management of chronic pain may be lifelong requiring repeat cycles of the chronic pain treatment plan. A diagnosis of chronic pain or a recommendation for chronic pain treatment may be inappropriate when a patient has other conditions that may make treatment ineffective. Treatment may be ineffective when a patient exhibits symptoms of exaggerated pain behavior, addictive behaviors, and factitious disorders.

Stigma and Bias with Chronic Pain

While suffering occurs in all patients with persistent pain, those with work injuries are particularly vulnerable and likely to suffer from stigma associated with their assessment and care. They show a higher incidence of psychiatric and substance use disorder symptoms when compared to other non-work injured groups, another problem that may engender discomfort and reluctance-to-treat on the part of medical providers. Patients and their families also may harbor similar biases about the common psychosocial consequences of pain, and every effort should be made to normalize these symptoms as being common consequences of a chronic pain condition. Direct efforts should be undertaken to identify these biases and reduce their impact on the patient in order to facilitate the best treatment outcome.

III. INITIAL EVALUATION

HISTORY AND PHYSICAL EXAMINATION

Patient information should include medical and psychosocial history, mechanism of injury, work history with details of the job and tasks, pain history, medical management history, substance use disorder, and other factors that may affect treatment outcome. Patients with chronic pain present with significantly higher risk for death by suicide than other medical populations, and thorough assessment of depression and its related risks is required. Physical exam must be conducted.

- Assessment should include potential facilitators and barriers to recovery, such as work organization factors, physical workplace exposures, psychosocial, and individual risk factors (e.g., substance use, psychological factors). Job dissatisfaction is a predictor of poor outcome. However, job related dissatisfaction may be due to factors related to the work structure or environment that may require addressing at the employer level.

- If facilitators and barriers to recovery are identified, the treating provider should provide or facilitate access to appropriate additional resources, usually via referral. Such resources may include consulting with those with expertise in delayed recovery, which will likely include mental health providers. The treating provider may also need to discuss work organization factors and physical workplace exposures with the employer.

- It may be valuable to have an assessment performed by a health care practitioner who has training and experience in diagnosing and treating pain disorders in injured workers.

- It may be valuable to have a work site assessment.

- Assessment should include brief, standardized screening instruments (e.g., see MA Neck and Back Treatment Guideline) that address the facilitators and barriers to achieving effective pain management and return to work, as well as focused treatment recommendations that can be integrated into the patient's overall care.

Psychosocial/Psychological Evaluation
All patients who are diagnosed as having chronic pain should be referred for a psychosocial evaluation as well as concomitant interdisciplinary rehabilitation treatment whenever appropriate. Initial exam to be performed by a psychologist with a PhD, PsyD, EdD credential, or Psychiatric MD/DO may perform the initial comprehensive evaluations. It is recommended that these professionals have experience in diagnosing and treating chronic pain disorders in injured workers. A clinical evaluation should be conducted, and psychological functioning tests may be valuable. When treatment involves a multidisciplinary approach, one primary medical practitioner should coordinate the care and monitor the treatment plan in conjunction with other health care specialists.

IV. TREATMENT AND THERAPEUTIC NON-OPERATIVE PROCEDURES

A. PHYSICAL MEDICINE

Treatment modalities may be utilized sequentially or concomitantly depending on chronicity and complexity of the problems. Services should not be duplicative. The focus of treatment should be functional training, physical conditioning, and pain reduction where this is possible. Functional improvement should be documented in order to justify providing ongoing physical medicine or other sequential treatment.

1. Chiropractic Treatment--maximum 20 visits based on treatment plan.
2. Physical Therapy--maximum 20 visits based on treatment plan. May include aquatic therapy.
3. Occupational Therapy--maximum 20 visits based on treatment plan.
4. Work Conditioning/Work Hardening Program--maximum 20 visits, up to 4 hours/visit based on treatment plan. This program allows for intensive physical therapy subsequent to the initial course of physical therapy. Must have a return-to-work goal. Patient may be participating in the program while working in a restricted capacity.
5. Acupuncture--Must be ordered by a licensed MD, DC, DO, PA, NP, or PT and performed by a health care practitioner licensed to perform acupuncture in the state where the acupuncture service is provided. Eight (8) visits allowed in first six (6) weeks of acupuncture treatment. Thereafter, the ordering practitioner may request additional visits if there is documentation of objective improvement in functional activity or when the symptomatic benefit facilitates progression in the patient's treatment program. Maximum visits are not to exceed sixteen (16) visits in twelve (12) weeks. The ordering/treating practitioner cannot be the provider of the acupuncture service.

6. Surface EMG and Thermal Biofeedback-- Limited to treatment of chronic headaches. To be provided in conjunction with other psychosocial intervention, maximum 12 sessions.
7. Physical agents and modalities--maximum of 1 allowed per treatment session.
8. Special Tests
   a. Functional/Work/Physical Capacity Evaluation.
   b. Job Site Evaluation.
   c. Vocational Assessment.
   d. Work Tolerance Screening-- Initial evaluation and may monitor improvements every 3 to 4 weeks up to a total of 6 evaluations.
9. Orthotics/Prosthetics/Equipment

B. DIAGNOSTIC AND THERAPEUTIC INJECTIONS

Injection therapy should not begin before 6 weeks post injury in order to prevent the exclusion of effective conservative treatment. However, if the patient is unable to participate in rehabilitation because of severe pain, injection therapy should be allowed. These injections are seldom meant to be "curative" and when used for therapeutic purposes they are employed in conjunction with other treatment modalities for maximum benefit. Reassessment of the patient's status in terms of functional improvement should be documented after each injection.

Therapeutic Neuromuscular Injections

May be used after initial conservative treatments have not provided significant pain relief or functional improvement. The purpose is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation. Injections and active treatment/exercise should be done concurrently. The benefit of the injections must be documented in the record including the degree of pain reduction, the duration of pain reduction, and any change in function.

Trigger Point Injections: Not more than 4 visits per 12-month period. Visits should be at least 3-4 weeks apart. A minimum of 50% pain reduction as measured by acceptable pain scales, such as the Numerical Pain Intensity Scale (NPIS), and significant documented functional improvement is required in order to repeat the procedure. Functional improvement should last at least 1 month and must include measurable improvement in physical activity goals.

Botulinum Toxin Injections: May be useful in musculoskeletal conditions associated with muscle spasm, especially in the cervical area. There should be evidence of limited range of motion prior to the injection. May be useful in central neurological conditions that produce spasticity or dystonia (e.g., brain injury, spinal cord injury, or stroke). Repeat injections allowed with a minimum of 50% pain reduction as measured by a numerical pain index scale or significant functional improvement. There should be at least a 90-day interval between re-administration. No more than 4 injections per year.

C. PSYCHOSOCIAL/PSYCHOLOGICAL

Treatment is recommended as an important component in the total management of a patient with chronic pain and should be implemented as soon as the problem is identified. Goal oriented treatment should be

cognitive, behavioral, mindfulness-based, or operant approaches provided by licensed mental health providers experienced in treating patients with persistent pain. Specific treatments have been shown to be effective in individual or group format. Treatment frequency is 1 to 2 times weekly for the first 8 weeks (excluding hospitalization, if required). Thereafter, 2 to 4 times monthly with the exception of exacerbations which may require increased frequency of visits, not to include visits for medication management. Treatment duration is 2 to 6 months with a maximum of 6 to 12 months, not to include visits for medication management. For select patients, longer supervised treatment may be required and, if further counseling beyond 6 months is indicated, functional progress must be documented. Treatment should be part of an overall interdisciplinary treatment plan, and return to work must be a treatment goal if medically possible and providing the job tasks and environment can be made safer and supportive for a gradual resumption of activities. Due to the risk of major depression and anxiety, psychopharmacology consultation should be available.

D. MEDICATIONS

Before initiating or maintaining a patient on opioid therapy for chronic pain, a formal risk assessment should occur, addressing risks and benefits of this treatment. Studies support a potential pain reduction benefit for a small subset of patients, although empirical data supporting gains lasting longer than one year are lacking. Studies do not demonstrate objective improvements in function. Especially at higher doses, serious risks of chronic opioid therapy can include development of opioid use disorder, death from overdose, breathing problems during sleep, hypogonadism, immunosuppression, chronic constipation, bowel obstruction, and hyperalgesia, i.e., increased sensitivity to feeling pain. Risks for any poor outcome including overdose are significantly increased with the patient who is also being managed on multiple other medications for pain, i.e., polypharmacy. Presence of multiple medical and psychiatric comorbidities also potentiate risk. It should be noted, however, in the absence of empirical data supporting long-term opioid therapy (LTOT), a small number of patients have fared well with LTOT. This highlights the importance of treating each chronic pain patient through an individualized treatment plan, which may include LTOT for certain patients.

All patients who are on opioid therapy for chronic pain should be provided with education about risk, complete a written treatment agreement, and be assessed by a pain physician or pain psychologist with experience in opioid risk stratification. Formal validated screening measures also are available, as well as use of the state prescription drug monitoring program and urine toxicology assessment. All patients should receive naloxone, and household members should receive education, to mitigate overdose risk.

As with other forms of pain treatment, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks associated with LTOT. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

It is recommended that use of opioid analgesics and sedative hypnotic medications in chronic pain patients be used in a very limited manner, with total avoidance desirable whenever clinically feasible and/or resolution of the underlying cause of the pain. However, comorbid chronic pain and refractory anxiety often exist, and co-prescription of these types of agents require more careful patient monitoring rather than complete preclusion.

On-Going, Long-Term Opioid Management – Actions should include:

A) Prescriptions from a single practitioner, and one pharmacy when possible. Clinicians should review the patient's history of controlled substance prescriptions using state Prescription Drug Monitoring Program (PDMP) data to determine whether the patient is receiving opioids from multiple sources or dangerous combinations that put the patient at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and at every prescribing visit during opioid therapy for chronic pain. The Massachusetts Prescription Monitoring Program may be accessed at **www.mass.gov/dph/dcp/onlinepmp.**

B) Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Visits initially at least every 2-4 weeks for the first 2-4 months of the trial, then at least once every 6-8 weeks while receiving opioids.

C) Patient Physician Agreement – All patients on long term opioids must have a written, informed agreement. The agreement should discuss side effects of opioids, results of use in pregnancy, inability to refill lost or missing medication/prescription, withdrawal symptoms, requirement for random drug testing and pill counts, necessity of tapering, and reasons for termination of prescription. The agreement should NOT be unilateral, i.e., physician responsibilities within the relationship should be delineated as well as those of the patient. Abandonment must not be a consequence of agreement violation.

D) A baseline initial drug screen should be performed before starting opioid therapy, and the use of random drug screening at least twice and up to 4 times per year, or more if clinically indicated, for the purpose of improving patient care. Based on the empirical literature, the higher the individual patient's risk, the more frequently the patient should undergo screening.

E) If more than two opioids are prescribed for long-term use**;** and/or the total daily dose of opioids is above 90 MME/day; and/or opioids and other central nervous system depressants are prescribed, then a second opinion from a Pain Medicine Specialist is strongly recommended.

F) Inpatient treatment may be appropriate in complex cases as well as referral to a Pain Specialist.

G) Laboratory monitoring as indicated.

H) The total daily dose of opioids should not be increased above 90 MME/day. In some instances, the patient may benefit from a higher dose if there is documented objective improvement in function and pain, a lack of significant opioid side effects, and a lack of signs of opioid misuse or abuse, all of which should be assessed on each visit.

I) Multidisciplinary treatment including non-opioid pain medication and non-pharmacological therapies, including but not limited to home exercise, chiropractic treatment, physical therapy, and psychological treatment may be beneficial. "Multidisciplinary" should be defined as coordinated treatment by multiple disciplines in which the providers communicate with each other in order to develop and implement treatment that takes into consideration the patient's complex biopsychosocial needs.

J) Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate these risk factors into the management plan strategies to mitigate risk, including offering naloxone especially when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

K) Clinicians should, if possible, offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. Prescribing practitioners should be mindful of the impact of prescribing opioids relative to safety sensitive positions; and provide a prescription for naloxone and overdose education to patient and household members.

GENERAL GUIDELINES FOR OPIOID DISCONTINUATION AND TAPERING

Patients should not be abandoned

Tapering may be necessary. Medical management ideally should be part of an overall interdisciplinary treatment plan and return to work must be a treatment goal if medically possible. If a patient meets criteria for a diagnosis of Substance Use Disorder (SUD), admission to a formal substance use treatment facility should take precedence over other components of care.

Tapering to a reduced dosage or discontinuing opioid therapy should be considered if:

- Resolution of the painful condition.
- The patient received other treatment(s) resulting in pain reduction and thus no longer requires the same opioid dose.
- The patient requests a dosage reduction and/or there are significant side effects that are refractory to management.
- The patient fails to achieve or maintain significant pain relief or functional improvement despite reasonable dose escalation.
- The patient is on a dosage of ≥ 50 MME per day without clear evidence of benefit outweighing risk.
- Evidence of opioid misuse (e.g. challenges with adherence to prescribed schedule, repeated dose increases, problematic urine toxicology screening or PDMP results, evidence of diversion, using for reasons other than prescribed).
- The patient shows warning signs of overdose risk.
- The patient has had an overdose or other serious event.
- The effects of opioids are resulting in serious medical or psychiatric comorbidities.
- The patient is receiving medications (e.g. benzodiazepines) or has medical conditions (e.g. sleep apnea, pulmonary disease, liver disease, kidney disease, fall risk, or mental health conditions) that increase risk for adverse outcomes.
- Additionally: The patient is on a dosage of ≥ 90 MME per day unless there is clear evidence tapering is harmful.

Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Tapering long-term opioid analgesics remains a practice area for which there are few well-designed studies. Nonetheless, practical guidance is available from resources that promote best practices. The most widely used guideline is the HHS Guide for Clinicians on the Appropriate Dose Reduction or Discontinuation of Long Term Opioids.
https://www.hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf

Immediate discontinuation of opioids is always discouraged and can place the patient at great risk for overdose and other morbidities as well as mortality. For the patient on opioids for over one year and/or on high doses (≥ 90 MME), a structured taper is recommended. Medically assisted tapers may be considered and unless contraindicated, offered to the patient. Frequent follow-up during tapering period is recommended. Assessments should illicit information to develop a treatment plan that addresses the taper, pain, function, and co-morbidities. Assessments should include those related to mood changes and other psychiatric comorbidities. Chronic medical conditions can increase the risk of continued opioid use and should be managed in tandem. If the patient is pregnant, consider postponing the taper and ensure the patient will deliver at a facility that will be equipped for treatment of neonatal opioid withdrawal syndrome. For pregnant patients, tapering may cause adverse antenatal outcomes such as premature labor or spontaneous abortion.

Fear of withdrawal and fear of increased pain are common. Anxiety can be reduced, and a successful taper is more likely with high frequency clinician contact, e.g., weekly visits, or regular communication by virtual visited or other electronic means. Interdisciplinary care, including behavioral management of anxiety, is always recommended for patients with psychiatric comorbidities common to chronic pain. “Crises” commonly occur during tapering, typically involving an increase in pain, and efforts to continue the course of care should be encouraged. A pain increase may not be related to inadequate dosing or “too rapid” of a taper. Although successful tapering may reduce the patient’s pain, all tapering protocols should include other pain management interventions that focus on reducing the patient’s distress and improving overall function. A harm reduction framework and approach may be applicable to patients on long-term opioid therapy to prevent opioid related deaths. Not all patients are immediately ready to begin a taper. A motivational interviewing approach with high frequency patient contact should be used to engage the patient and shared decision-making increases the success of tapers. If the patient is resistant to referral or change in opioid use, continue to work with them, provide information, and continue to encourage appropriate referral. There are serious risks for continuing a patient on opioids when opioids are contraindicated, and decision-making should occur within a clear time period e.g. one month time frame.

- Recommendations for tapering schedules vary and should always be individualized. The rate of opioid taper should be adjusted based on patient-specific factors such as the severity of withdrawal symptoms. Tapering may be based on duration of opioid use:
  - Less than or equal to 3 days of scheduled use or as needed: no taper required
  - > 3 days but < 7 days of scheduled use: 50% reduction over two days
  - 7 days but less than or equal to 1 month: 20% reduction every 2 days
  - More than or equal to 1 month but less than or equal to 1 year: 10% reduction every week
  - More than or equal to 1 year: 10% reduction each month

Ref: Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. Cdc clinical practice guideline for prescribing opioids for pain - united states, 2022. *MMWR Recomm Rep.* 2022;71(3):1-95.

- Consultation with an addiction/pain medicine specialist or behavioral health specialist with expertise in pain management is recommended for complex patients.
- Multidisciplinary treatment including non-opioid pain medication and non-pharmacological therapies, including but not limited to home exercise, chiropractic treatment, physical therapy, acupuncture, and psychological treatment may be beneficial during the tapering process.
- Prescribe naloxone and instruct the patient and family/household members in overdose prevention. The potential impacts of tapering and discontinuation include opioid withdrawal and unmasking or exacerbation of previous medical and psychosocial conditions. These symptoms are treatable and involvement of other specialists may be considered before the taper is started. Considerations for delayed or slow tapering may be appropriate. Tapering may also increase overdose risk as tolerance to a higher dose is lost in less than one week.

E. NEUROMODULATION

When conventional treatment strategies for neuropathic pain such as Medications, Chiropractic Treatment, Physical Therapy, and Injections are not effective or medication side effects are not tolerable or endanger the patient, there may be a role for neurostimulation as an adjunctive strategy for treating pain. Neurostimulation involves the implantation of a small device that sends safe levels of electricity directly into the spinal cord for the purpose of pain relief. There are varying types of stimulation including traditional, burst, dorsal root ganglion, and high frequency with the latter representing newer technology that are paresthesia sparing or paresthesia-free. Newer technologies may be superior in that they relieve axial spine pain as well as radiculopathy.

Outcome data support use of neuromodulation for pain relief, although studies have shown less effect with respect to objective changes in function or return to work. Other adjunctive treatments are recommended to achieve the goals other than pain relief, and neurostimulation should not generally be considered the sole treatment intervention for chronic pain. Spinal cord stimulation (SCS) is most commonly used in conditions such as chronic axial back and radicular pain, complex regional pain syndrome, or other nerve injuries. SCS has demonstrated efficacy in angina and peripheral vascular disease thought to be secondary to decreased sympathetic innervation resulting in improved circulation.

Dorsal root ganglion stimulation (DRG) is another type of neurostimulation which primarily targets focal neuropathic pain located in the trunk and/or limb. In some cases, peripheral nerve stimulation (PNS) or peripheral nerve field stimulation (PNFS) is considered for treatment of neuropathic pain. In general, these procedures are less invasive traditional SCS approaches, although there are fewer studies demonstrating efficacy.

After appropriate screening, a temporary implantable device is implanted for a trial of typically 3 to 10 days. When success is achieved with 50% pain with the trial, a second outpatient procedure is conducted for permanent implantation. Subsequent visits are conducted in order to adjust the device to achieve maximum pain relief/coverage of the affected area. Interdisciplinary care, including physical medicine treatment, is recommended post-procedure after clearance from the treating practitioner.

See section IV. TREATMENT AND THERAPEUTIC NON-OPERATIVE PROCEDURES A. PHYSICAL MEDICINE.

As the standard of care, all patients being considered for SCS/PNS are required to have a psychological assessment by a clinician with expertise in pain assessment. In addition to standardized testing, content of the assessment includes a review of relative risk factors for poor outcome. These include evaluation for untreated conditions such as depression, posttraumatic stress disorder, substance use disorder, thought disorder, or marked somatization including multiple-site pain. Perhaps the most salient variable to assess is whether a patient is realistic in his/her expectations regarding the amount of relief to be expected. Fears associated with undergoing a procedure that involves an implantable device should be addressed at the evaluation. Multiple site pain may predict poor outcome, and it must be clear to the patient which pain site is being targeted. During this assessment, the examining clinician should elucidate patient goals associated with pain relief and functional goals should be specific and recorded in detail, with the expectation that they will be reviewed upon follow-up by the physician or psychologist after completion of the procedure. It is also imperative that the patient have a full understanding of the procedure, possess clear outcome goals, and be aware of any medical risks. Good social support is also imperative for a successful trial and implant.

V. TREATMENT NOT ALLOWED

1. Physical agents and modalities not allowed as the only treatment procedure.
2. Duplication of any services for patients being treated by more than one discipline.
3. Repeat diagnostic studies without a significant change in symptoms and/or objective clinical findings.

VI. PATIENT EDUCATION

Includes encouraging the patient to take an active role in establishing functional outcome goals and information regarding the adverse effects of inactivity. Return to work is strongly encouraged and should be discussed with patient.

Education of and communication with stakeholders should be a primary emphasis in treatment of work-related injury or illness. Stakeholders include but are not limited to the patient, the patient's family, designated employer and employee representatives, and insurance representative(s). Education for the injured worker should include identification of workplace hazards that could cause or contribute to re-injury and what employers should do to eliminate, reduce, or prevent these hazards. Management of symptoms and awareness of any related symptoms that might necessitate a call or visit to the treating health care provider should also be discussed. Education for the employer could include identifying and addressing workplace hazards that could cause or contribute to future injury for this and/or other workers. Depending upon the patient's presentations, modified work options should be discussed. This

information should be documented in the treatment plan. Initial assessment of function and updates during recovery should be included in communications with stakeholders, specifically referencing functional level as it relates to the activities of the job. Practitioners should develop and consistently implement effective verbal and/or written communication strategies that educate stakeholders as well as facilitate timely referrals (e.g., for physical medicine) when indicated.

Barriers to Education: Inconsistent Messaging, Health Literacy, and Cultural Barriers

Consistent, evidence-based education is a mainstay of care with chronic pain. The issue is especially salient with this group as the patient typically sees multiple concurrent providers who may fail to cross-communicate, resulting in frustration and poorer outcomes. The patient's level of health literacy, language, and cultural barriers should also be assessed, and efforts should be made to ensure that the patient understands and actively participates in their care. With chronic pain, the patient who is empowered to take a self-directed approach to their care will show better outcomes in contrast to the patient whose approach is mostly passive. The clinician can reinforce this autonomy and independence.

VII. MAINTENANCE MANAGEMENT

Treatment should be linked to maintaining and/or improving function, not just pain control. Excludes exacerbations which may require more aggressive treatment.

A. Medication and Injection Management
B. Physical Medicine Management: maintenance duration one visit per month.
C. Psychological/Psychopharmacological Management: maintenance duration one visit per month.

Injured workers on long term opioids may benefit from the Department of Industrial Accidents Opioid Alternative Treatment Program (OATP) – Section 19A Medical Mediation Agreement.

LINKS:

https://www.hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf
www.massmed.org/opioid-guidelines/
www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm
https://www.hss.edu/conditions_patient-guide-opioid-tapering.asp#:~:text=Fast%20tapering%20is%20the%20process,usually%20cause%20severe%20withdrawal%20symptoms.