THE COMMONWEALTH OF MASSACHUSETTS
Department of Industrial Accidents

1 Congress Street, Suite 100
Boston, Massachusetts 02114-2017

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

PHILIP L. HILLMAN
Director

CIRCULAR LETTER NO. 340

TO: All Interested Parties

FROM: Philip L. Hillman, Director

RE: Chronic Pain Treatment Guideline No. 27

DATE: March 26, 2012

Please be advised that pursuant to the provisions of M.G.L. c.152 §13 (3), the Health Care Services Board has developed, and Massachusetts Department of Industrial Accidents has adopted, a revised Treatment Guideline Number 27, Chronic Pain. This Treatment Guideline should be considered by health care providers in the treatment of injuries and illnesses sustained by injured workers.

Treatment Guideline 27 is attached hereto or maybe viewed on the Department's website: **www.mass.gov/lwd/workers-compensation/dia** and copies may be obtained by contacting the Department's Public Information Office.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

TREATMENT GUIDELINES
REVISED FEBRUARY 1, 2012

GUIDELINE NUMBER 27 - CHRONIC PAIN

I. <u>INTRODUCTION</u>:

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.

II. <u>BACKGROUND</u>:

Chronic Pain represents a specific diagnosis which refers to pain which outlasts the expected duration of the healing time for tissue injury. Common clinical manifestations include persistent complaints of pain, impaired function, and symptoms of anxiety, depression, fear and anger. Chronic pain may be associated with psychosocial problems and thus the treatment should include evidence-based psychological treatment when indicated. The purpose of an intensive short-term treatment program is the reduction of pain, reduction of physical impairments, and behavioral 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. 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 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.

III. HISTORY:
A diagnosis of Chronic Pain should be considered if:

- Pain has extended beyond the duration of expected tissue healing based on the history and physical examination by the treating practitioner.
- Significant functional impairment persists in spite of apparent healing of underlying pathology as determined by the treating practitioner.
- The recovery period exceeds the expected duration of treatment for the primary diagnosis without becoming eligible for another guideline.
- Pain persists beyond 3 months from 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 if the aforesaid considerations exist.

IV. INITIAL EVALUATION
HISTORY AND PHYSICAL EXAMINATION
Patient information should include medical and psychosocial history, mechanism of injury, pain history, medical management history, substance use/abuse, and other factors that may affect treatment outcome. Physical exam must be conducted.
Personality/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.

V. 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 and physical conditioning. Functional improvement should be documented in order to justify providing ongoing physical medicine or other sequential treatment.

1. Physical Therapy--maximum 20 visits based on treatment plan. May include aquatic therapy.
2. Occupational Therapy--maximum 20 visits based on treatment plan.
3. Chiropractic Treatment--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 an acupuncturist licensed in the state where the acupuncture service is provided. Six (6) visits allowed in first eight (8) 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.

Diagnostic Spinal Injections

Maximum of 2 diagnostic injections, at least 2 weeks apart. No more than 2 levels may be injected in a single session. Patient response must be documented such that the diagnostic value of the procedure is evident to reviewers. At a minimum, the provider should document patient response immediately Following the procedure specifying any reduction or resolution of symptoms. In general, relief should last for at least the duration of the local anesthetic used and should provide a minimum of 50% pain reduction as measured by a numerical pain index scale.

Therapeutic Spinal 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-tem relief through reduction of pain and inflammation. Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered and may be beneficial after the injection and significant pain reduction. The benefits of the injections must be documented in the record including the degree of pain reduction, the duration of pain reduction, and change in function, if any.

Epidural Steroid Injections: Must have radicular pain or radiculopathy. A series of up to 3 injections may be given at least 2 weeks apart with fluoroscopic guidance. No more than 2 transforaminal levels may be injected in one session. If there is not a minimum of 50% pain reduction as measured by a numerical pain index scale or documented functional improvement, similar injections should not be repeated. Maximum of 2 series may be done in one year based upon the patient's response to pain and function.

Zygapophyseal (Facet) Injections: Facet injections or medial branch blocks must be done with fluoroscopic guidance. Facet injections should not be performed at more than 2 joints per visit and may be repeated one time per year, if they result in a minimum of 50% pain reduction as measured by a numerical pain index scale or documented increased functional benefit for at least 3 weeks. If the first set of injections does not provide a diagnostic response of a minimum of 50% pain reduction as measured by a numerical pain index scale or documented functional improvement, similar injections should not be repeated. At least 3 weeks of functional benefit should be obtained with each therapeutic injection. If the medial branch block technique is used, then a maximum of 4 sets of injections may be done per year.

Rhizotomy for Facet Joint Pain: Must be done with fluoroscopic guidance. If the medial branch blocks provide 80% or more pain reduction as measured by a numerical pain index scale within one hour of the medial branch blocks, then rhizotomy of the medial branch nerves, up to 4 nerves per side, may be done. If the first medial branch block provides less than 80% but at least 50% pain reduction as measured by a numerical pain index scale or documented functional improvement, the medial branch block should be repeated before a rhizotomy is performed. If 50% or greater pain reduction is achieved as measured by the NPIS with two sets of medial branch blocks for facet joint pain, then rhizotomy may be performed. Pain relief must last a minimum of 120 days in order to repeat the treatment.

Rhizotomy for Sacroiliac Joint Pain: Must be done with fluoroscopic guidance. Allowed if the anesthetic block of the L4,L5 dorsal rami and S1-S4 lateral branch nerves or a Sacroiliac joint injection provides a positive diagnostic response of 80% or more pain reduction as measured by a numerical pain index scale. If the above block provides less than 80% but at least 50% pain reduction as measured by a numerical pain index scale or documented functional improvement, the sacral peripheral nerve injection should be repeated before a rhizotomy is done. If 50% or greater pain reduction is achieved as measured by the NPIS with two sets of blocks (as outlined above) for the SI joint, then rhizotomy may be performed. Pain relief must last a minimum of 120 days in order to repeat the treatment. May be repeated a maximum of 3 times per year.

Sacro-iliac Joint Injections: Must be done with fluoroscopic guidance. Two injections per joint per year allowed with a diagnostic response. If the first set of injections does not provide a diagnostic response of temporary and sustained pain relief substantiated by a minimum of 50% pain reduction as measured by a numerical pain index scale or significant documented functional improvement, similar injections should not be repeated.

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-tem 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: A series of injections with a maximum of 4 visits within the series is allowed over twelve week period. Visits should be at least 3 weeks apart. A minimum of 50% pain reduction as measured by a numerical pain index scale or significant documented functional improvement is required in order to repeat the series. Steroids should not be used in more than 2 visits of the series. Some patients may require 2 series of trigger point injections over a 1 year period.

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 that 4 injections per year.

C. PSYCHOSOCIAL
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 or operant approaches provided by licensed mental health providers trained to treat 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. Due to the risk of major depression and anxiety, psychopharmacology consultation should be available.

D. MEDICATIONS
Control of chronic non-malignant pain often involves the appropriate use of various medications. Ongoing effort to gain improvement in activities of daily living, and social and physical function as a result of pain relief should be a primary goal with the use of any medication. Consultation or referral to a pain specialist should be considered when the pain persists beyond the expected time for tissue healing of the injury. Consider consultation to a pain specialist if suffering and pain behaviors are present and the patient continues to request medication, or when standard treatment measures have not been successful or are not indicated. Narcotics often provide only limited pain reduction and improvement in function, and increase

the risk of dependence and addiction. As such, other non-narcotic and/or non-pharmacological options may be superior to narcotics. It is recommended that use of opioid analgesic and sedative hypnotic medications in chronic pain patients be used in a very limited manner, with total elimination desirable whenever clinically feasible. Tapering or a detoxification program may be necessary and this may include inpatient detoxification. Medical management should be part of an overall interdisciplinary treatment plan and return to work must be a treatment goal if medically possible.

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

A) Prescriptions from a single practitioner, and one pharmacy when possible. Prescribing physicians must be aware of and need to register to utilize the Massachusetts Prescription Monitoring Program. 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. If there has not been an overall improvement in function, opioids should be tapered and discontinued.

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 drug testing, necessity of tapering, and reasons for termination of prescription.

D) A baseline initial drug screen should be performed, and the use of random drug screening at least twice and up to 4 times per year for the purpose of improving patient care.

E) If more than two opioids are prescribed for long-term use**;** and/or the total daily dose of opioids is above 120 mg of oral morphine or its equivalent; and/or opioids with central nervous system depressants are prescribed, then a second opinion from a Pain Medicine Specialist (i.e. Board Certified) 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 120 mg of oral morphine or its equivalent. In some instances, the patient may benefit from a higher dose if there is documented objective improvement in function and pain, and a lack of significant opioid side effects.

VI. 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.

VII. 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.

VIII. MAINTENANCE MANAGEMENT

Excludes exacerbations which may require more aggressive treatment.

A. Psychological/Psychopharmacological Management: maintenance duration one visit per month.

B. Medication and Injection Management: should be linked to maintaining and/or improving function, not just pain control.

C. Physical Medicine Management: consisting of one visit per month and should be linked to maintaining and/or improving function, not just pain control.