COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF INDUSTRIAL ACCIDENTS

CHRONIC PAIN TREATMENT GUIDELINE
REVISED MAY 2016

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.

II. BACKGROUND:

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 than 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. Opioids may only provide limited pain reduction and improvement in function, and increase the risk of dependence and addiction. As such, other non-opioid/or non-pharmacological options may be superior to opioids. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. Before starting opioid therapy for chronic pain, 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. 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 analgesic and sedative hypnotic medications in chronic pain patients be used in a very limited manner, with total elimination desirable whenever clinically feasible and/or resolution of the underlying cause of the pain. 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. 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 opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. 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 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.

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 with 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, and a lack of significant opioid side effects.

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.

J) Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone 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.

GENERAL GUIDELINES FOR OPIOID DISCONTINUATION AND TAPERING
Patients should not be abandoned
After determining that the failure of the pain treatment plan was not due to opioid under-dosing and/or inadequate medication time schedules, discontinue opioids when:
Pain resolution;
Lack of functional improvement;
Decrease in functioning;
Aberrant drug screening result and/or diversion;
Serious non-adherence;
Intolerance or severe adverse side effects;
Hyperalgesia; and
Decreased effects from opioid.

- Patients treated for acute pain who are opioid-naïve should generally require no tapering.
- Patients with acute pain treated with continuous opioids over 50mg MED for longer than 3 weeks duration may benefit from brief tapering over three to seven days.
- Tapering plan for patients treated with opioids for subacute and chronic pain varies depending on prior opioid dose and duration.
- 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, and psychological treatment may be beneficial during the tapering process.

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.

LINKS: **www.agencymeddirectors.wa.gov/opioiddosing.asp**
www.massmed.org/opioid-guidelines/
www.cdc.gov/drugoverdose/prescribing/guideline.html

SAMPLE

PATIENT UNDERSTANDING FOR OPIOID TREATMENT

Patient Name: _____

Doctor Name: _____

I am taking a pain medicine called **OPIOIDS** to help reduce my pain.

I agree (the *patient must initial each box to show agreement):*

☐ I will take my pain medicine exactly the way my doctor tells me to. That means I will take the right amount of pain medicine at the right time.

☐ I will tell my doctor about any new medical problems.

☐ I will tell my doctor about all medicine I take, and will tell my doctor if I am given any new medicines.

☐ I will tell my doctor if I treat with another medical provider, or if I go to the Emergency Room.

☐ I will only get my pain medicine prescription from this doctor. My doctor's name is listed on the top of this page.

☐ If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away.

☐ I will only get my pain medicine from one pharmacy (drug store).

☐ I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to function with my pain and have the best outcome.

☐ I understand the dangers to myself and others when driving and participating in safety sensitive activities while taking opioids.

☐ When I am asked, I will get lab tests to see if I am taking my medicines the right way.

☐ If the lab tests show that I am not taking the medicines the way I should, my doctor may cut down or stop my medicine or send me to a specialist or special program to help care for me.

☐ I will store my pain medicine in a safe place where other people cannot take it.

☐ I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment.

☐ My doctor may stop giving me pain medicine if:

- I do not follow this agreement.
- The pain medicine is not helping me.
- I'm not meeting my goals in active therapy.
- My pain or my functions do not improve.
- I have bad side effects from the pain medicine.
- I become addicted to the pain medicine.
- I give or sell the pain medicine to someone else.

☐ I am not pregnant and I will call my doctor as soon as possible if I think I may be pregnant.

☐ I understand that alcohol use when taking opioid medication is extremely dangerous. I will not take any other drugs unless I am told to do so by my doctor.

Patient Signature: Date:

I attest that this form was reviewed by me with the patient and all questions were answered.

Prescriber Signature: Date:

Adapted from New York State Workers' Compensation Board
New York Non-Acute Pain Medical Treatment Guidelines

SAMPLE

PATIENT INFORMED CONSENT FOR OPIOID TREATMENT

Patient Name: _____
Doctor Name: _____

I plan to take a pain medicine called OPIOIDS. This pain medicine may help reduce my pain but it may also cause some serious problems. The problems may be worse if I mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

- ⇨ Confusion
- ⇨ Poor judgment
- ⇨ Nausea/Vomiting
- ⇨ Stomach ache
- ⇨ Constipation (hard stools that may be painful to push out).
- ⇨ Sleepy or drowsy feeling
- ⇨ Poor coordination and balance (such as feeling unsteady, tripping, and falling)
- ⇨ Slow reaction time
- ⇨ Slow breathing or I can stop breathing - which could cause me to die
- ⇨ More depression (such as feeling sad, hopeless, or unable to do anything)
- ⇨ Dry mouth
- ⇨ Increased feeling of pain (hyperalgesia)
- ⇨ Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit)
- ⇨ For men: the pain medicine may lead to less interest in sex and poor sexual performance
- ⇨ For pregnant women, the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine

- I will tell my doctor if I have any of the problems listed here.
- I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.
- I understand that these problems may get better when I stop taking the pain medicine.
- I understand that my physician will be checking the Prescription Monitoring Program as required by state law.
- My doctor has reviewed the serious problems that this pain medicine may cause with me.
- My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature: Date:

I attest that this form was reviewed by me with the patient and all questions were answered.

Prescriber Signature: Date

Adapted from New York State Workers' Compensation Board
New York Non-Acute Pain Medical Treatment Guidelines