DEFENDING MEDICAL ISSUES RE

CHRONIC PAIN UNDER NEW DIA

TREATMENT GUIDELINES REVISED

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I. INTRODUCTION:

A. Stipulate: Chronic Pain Syndrome (CPS) Real, Painful, Totally Disabling, Medical Syndrome.

B. EE Has Statutory Right, MGL Chapter 152, Section 13 & 30, to Reasonable, Necessary and Adequate Medical Care and Treatment Regarding CPS.

C. CPS Medical Care Goals and Objectives: Less Pain; Increased Activities of Daily Living (ADL); Increased Ability/Likelihood to Return to Work.

D. Medicare Care Regarding CPS Treatment Should Be: Effective; Clinically Proven; Science-based, with Multi Treatment Modalities, Via Multi Medical Specialists; to Achieve Intended Therapeutic Results Short/Med/Long-term for CPS Injured Employee (EE).

E. Pursuant to Treatment Guideline #27 Revised February 1, 2012.

II. RESOLVED: WHAT ARE INSURER RIGHTS UNDER TREATMENT GUIDELINES #27 AND HOW CAN DEFENSE ATTORNEY ADVANCE INSURER INTERESTS IN TREATING CPS INJURED EE:

A. Insurer Obligations Regarding Medical Care and Treatment of Injured EE Set by Statute, Case Law, and Guidelines #27:

1. Reasonable.

2. Necessary.

3. Adequate.

4. Causally related to industrial injury.

B. Insurer Obligations in Care and Treatment CPS/EE:

1. Obligated to Pay for Multi Treatment Modalities.

2. With Multi Licensed Medical Providers and Specialists.

3. Within Stated Timeframes of Guideline #27.

C. Treatment and Therapeutic Procedures/Non-Operative Procedures (Guideline #27) Permitted by Guideline #27 (V (A)):

1. Physical Therapy.

2. Occupational Therapy.

3. Chiropractic Treatment.

4. Work Hardening/Work Conditioning.

5. Acupuncture.

6. Surface EMG and Thermal BioFeedback.

7. Physical Agents and Treatment Modalities.

8. Specific Testing Provided;

    a. functional/work/physical capacity evaluations;

    b. job site evaluation;

    c. vocational assessment;

    d. work tolerance screening.

9. Orthopedics/Prosthetics/Equipment

D. Diagnostic and Therapeutic Injections (V (B)):

1. Diagnostic Spinal Injections.

2. Therapeutic Spinal Injections.

3. Epidural Steroid Injections.

4. Facet Injections/Zygapophyseal.

5. Rhizotomy for Facet Joint Pain.

6. Rhizotomy for Sacroiliac Joint Pain.

7. Sacroiliac Joint Injections.

8. Therapeutic Neuromuscular Injections.

9. Trigger Point Injections.

10. Botulinun Toxin Injections.

E. Psycho Social Treatment/Therapy (V (C)):

1. Psychosocial Treatment Important Component in Effective Total Management of CPS with Prompt Implementation, "As Soon As Problem is Identified."

2. Goal Oriented Treatment Indicated, Inclusive of:

   a. individual therapy;

   b. group therapy;

   c. cognitive/behavioral therapy;

   d. operant therapy.

3. Treat Pain with Secondary Depression/Anxiety Consults As Needed.

4. Psychopharmacology Consult and Prescription Psychopharmaceuticals Appropriate As Soon As Identified and Needed.

5. All Within Specific Numbered Treatment: Weekly; Monthly, *Etc.*

F. Prescription Medications: Meds Reasonable, Necessary, and Appropriate in Treatment of Chronic/Non-Malignant Pain: (V (D)):

1. Primary Goal or Prime Directive Regarding Care and Treatment CPS Patient, Especially Regarding Prescription Meds, Should Be To Provide For:

   a. improvement in activities of daily living;

   b. improvement in social and physical function; and

   c. pain relief/reduction.

2. Narcotic Pain Prescription – Limited Tool in the Large Tool-Kit to Treat CPS (V (D))

   a. provides only limited pain reduction;

   b. provides only limited pain improvement;

   c. with material and clinical risk of;

(1) dependency and/or;

(2) addiction.

3. Non-Narcotic and Non-Pharmacological Options "May Be Superior to Narcotics," For Treatment Relief of CPS (V (D)).

4. Use of Opioids Analgesics and Sedative Hypnotic Meds in Treating CPS Patient Should Be Used in Very Limited Manner with Specifically Identified Patients in Certain Circumstances:

a. "with total elimination desirable;"

b. "whenever clinically feasible" (V (D)).

5. Tapering/Detoxification May Be Necessary, Including Inpatient Detox, As Needed, to End Addiction/Dependency.

6. Medical Management Within Overall Interdisciplinary Treatment Plan is Necessary.

7. "Return to Work Must Be Treatment Goal if Medically Possible." (V (D)).

G. Ongoing/Long-Term Opioid Management:

1. Long-Term Opioid Management CPS EE Permissible.

2. But Multiple Actions Required and Administered and Monitored.

3. Opioid Prescription Medication Requires Reasonable, Necessary, and Adequate Chronic Narcotic Pain Prescription Plan:

a. prescription from one (1) doctor;

b. prescription from one (1) pharmacy;

c. with doctor and pharmacy prescription use monitored via Mass Prescription Monitoring Progress Plan;

d. with ongoing review and documentation narcotic pain relief (V (D) (a-h).

(1) pain relief metrics and goals:

(a) decreased pain: documented pain relief;

(b) improve function: measure functional change;

(c) appropriate medication use;

(d) monitor side effects.

e. prescriptions and # visits identified.

f. "without overall improvement in function," taper and discontinue (V (D) (b)). Opioids as pain reliever.

4. Doctor/Patient Contract:

a. informed consent;

b. testing;

c. tapering;

d. side-effects;

e. withdrawal;

f. no refills for lost prescriptions;

g. warnings regarding results of use during pregnancy;

h. reasons for termination of prescription specified;

5. Initial Baseline Drug Screening.

6. Subsequent Random Drug Screening;

a. 2 – 4 x a year;

b. purpose: improving patient care;

7. Limitation on Number and Dosage Opioids/Narcotic Prescription Meds:

a. if more than two (2) opioids prescribed at same time;

b. if prescription opioid is 120 milligram oral morphine or or more;

c. or if central nervous system treatment drug is prescribed;

d. a second opinion from a pain medicine specialist Board Certified is strongly recommended for said high dosage medications and/or high doses to be continued.

8. Inpatient Treatment May Be Appropriate in Complex CPS Cases.

9. Referral Pain Specialist May Be Indicated.

10. Lab Monitoring is Necessary.

11. Total Dose Opioid/Day No More Than 120 Milligram Oral Morphine.

12. Alterative, if Total Dose is More 120 Milligram Opioid/Day, If and Only If, Benefits of Pain Medication Documented:

a. improved function;

b. decreases pain;

c. significant opioid with lack of side effects (V (D) (H))

H. Treatment Disallowed In CPS Patient (VI):

1. Physical Modalities, Treatment Only.

2. Duplication of any Services For EE/Patient with Treatment by More Than One (1) Medical Discipline.

3. No Repeat Diagnostic Studies Without:

a. "significant change in symptoms;"

b. "or objective clinical tendon" (V (D) (H)).

I. Patient Education (VII):

1. Participate Actively in Treatment Plan.

2. Employee Takes Active Role In:

   a. establishing "functional outcome goals" with;

   b. knowledge regarding, "adverse effects of inactivity" (VII)

3. Return to Work:

   a. "strongly encouraged" (VII);

   b. "should be discussed with patient" (VII).

J. Maintenance Management:

1. Psychological/Psychopharmacological Maintenance:

   a. one (1) visit per month.

2. Medication Injection Management:

   a. one (1) visit per month;

   b. maintain and/or improve function;.

   c. "not" limited to pain relief (VII (B)) only.

3. Physical Medical Management:

   a. one (1) visit per month;

   b. maintain and improve function;

   c. not just pain control (VII (c)).

III. CP TREATMENT GUIDELINES # 27 – INSURER'S SHIELD AND SWORD:

A. Insurer Obligated Pay for Effective Care and Treatment CPS/EE as Defined, Described with Specificity Above.

B. Based on Science, Best-Practices and Clinically-Proven Interdisciplinary Approach to CPS to Healthcare Services.

C. Shield: Pay For All Reasonable and Necessary Care Pursuant to, Consistent With, and Prescribed For Employee by Licensed Medical

Provider(s): Doctor; Hospital; Chiropractic; Psychiatrist; Therapist; *etc., etc.*, Only.

D. Sword: Continue Paying Only if Reasonable, Necessary, and Adequate Past, Present, and Future, Regarding CPC Healthcare Services.

IV. GUIDELINES # 27 AS INSURER'S SHIELD:

A. Diagnosis of Chronic Pain (III).

B. Obligated to Pay for Treatment, If and Only If Diagnosis is Consistent with Chronic Pain, as Defined and Described, Pursuant to Guideline#27, (Section III), Based on:

1. History;

2. Diagnosis:

3. Diagnostic Testing.

C. CPS Defined/Described as:

1. Pain Beyond Duration Expected for Tissue Healing Based on History, Physical Examination, by Treating Doctor;

2. Significant Persistent Functional Impairment Despite Healing of Underlying Tissue Pathology, per Treating Doctor;

3. Recovery Exceeds Duration Expected of Treatment for Primary Diagnosis Without Eligibility for Other Treatment Guidelines/Diagnosis(s);

4. Pain Persists More Than Three (3) Months From Date of Injury or Date of Onset of Pain/Chronic.

D. Is Diagnosis Accurate/Inaccurate; Credible/Non-Credible:

1. Consistent With Guidelines

2. Inconsistent With Treatment Guidelines

E. If and Only If, Totality Medical Evidence, Clearly Based on History, Physical Examination, and Extended Pain, Beyond Expected Recovery, With Significant Loss of Function, is This Alleged CPS Patient Eligible for Specified and Costly #27 Care and Treatment Healthcare Services (III).

F. IF CPS Benefits Claimed by EE Without Diagnosis Consistent With CPS per (III), Claim is Denied.

G. Any CPS Claim Should Be Evaluated Fairly, Timely, and Carefully.

H. Submit CPS Claim to Utilization Review for Analysis and Finding.

I. But Claims Makes Final Determination with or without IME/Peer Review, *etc*, Regarding CPS Healthcare Services Request.

J. Evaluate Carefully All Care and Treatment Submitted:

a. Is it documented?

b. Are treatment goals evident regarding:

1. decrease pain;

2. improve function;

3. return to work promoter.

c. Not duplicative regarding ongoing parallel care and treatment with any other healthcare provider.

d. Apply above analysis to any and all CPS Claims re:

1. physical medicine;

2. diagnostic spinal injections;

3. therapeutic spinal injections;

4. therapeutic neuromuscular injections;

5. psychosocial evaluation, care, and treatment; and

6. prescription medication.

V. GUIDELINE #27 AS SHIELD (I and II and III):[1]

[1] I am indebted to Mike Kelly, ARM, AIG, VP/Claims Manager AIM Mutual Insurance for his knowledge, enthusiasm, experience, and kindness in sharing AIM experience in managing chronic pain issues effectively from insurer's perspective at the DIA Healthcare Services September 2012 day long symposium on Treatment Guideline 27.

A. Not Any and Every Tool in the Large and Often Costly Tool-Kit for Diagnosis, Care, Treatment, and Management of Chronic Pain is Reasonable, Necessary, or Adequate, Even if Causally Related.

B. Treatment Must Be Effective. It should be:

1. Science or Evidence Based;

2. Clinically Proven;

3. Supported by Objective Clinical Findings and Valid Clinical Rational;

4. In Furtherance of Goals/Objectives of Chapter 152 and Guideline #27 to Provide to CPS Injured EE Quality Healthcare Services;

5. Chronic Pain Should be Treated by Appropriate Evaluation Pursuant to Treatment #27 Processes, Protocols, and Timeframes;

6. Chronic Pain Should not be Diagnosed in First Instance or if Diagnosed, CPS Treatment Should Not Continue When CPS/EE, "Exhibits Symptoms of Exaggerated Pain Behavior, Addictive Behavior and [/or] Factitious Disorder. (II).

C. Chronic Pain Treatment and Continued Chronic Pain Treatment must be Necessary: Demonstrated by Objective Clinical Improvement.

D. Absent Objective Clinical Improvement, the Chronic Pain Treating Doctor Must Justify Necessity of Continued Said Requested Care by Providing:

1. a clinical rational for ongoing care;

2. with supporting, objective, clinical findings.

E. Treatment Pursuant to Timeframes of Reg 27 are Best Practices.

F. Physical/Medical Chronic Pain Treatment if an only if:

1. focus is functional training;

2. focus is physical conditioning;

3. with documented functional improvement to justify ongoing physical/medical care and treatment.

G. Surgical and Therapeutic Injections regarding CPS:

1. Are Appropriate Surgical and Therapeutic Injections Care Treatment Chronic Pain Guidelines:

a. are not curative;

b. are diagnostic;

c. are used in conjunction with other treatment modalities;

d. always reassess for functional improvement pre vs post injection;

e. measure pain relief short-term/long-term;

f. look for at least 50% pain relief per numerical pain index;

g. look for pain reduction, duration, pain reduction, and change in function.

2. Look for Significant Functional Improvement.

K. Psycho-Social Care CPS EE:

1. Yes, Pain has Real, Causally-Related, and Disabling, Psychological Component.

2. Need Psychiatric Counseling Real in CPS EE.

3. Appropriate Psychology Includes Cognitive, Behavioral, or Operant Treatment Protocols.

4. By Licensed Mental Health Professional

5. Look for Progress (or absence of lack thereof) and Improvement, Mood, Sleep, Attention, Activities of Daily Living, *etc.*

L. Medical Records Review/Analysis:

1. Review with Care and Detail Pursuant to 27 Guidelines.

2. Nonnarcotic before Narcotic Prescription Pain Meds.

3. Prescription Medications at Minimum Dosage before Maximum Narcotic Prescription Dosage, by Primary Care Doctor/RX Provider.

4. Prescription Contracts with Pharmacy and Physician.

5. Random Drug Test.

6. No More Than 120 Milligrams Per Day, Absent Documents Exigent or Circumstances.

VI. INSURER COMPLAINT DISCO CARE/TREATMENT/DENY PER TREATMENT GUIDELINE 27:

A. Insurer Should File Complaint to Discontinue Regarding Ongoing, Non-Complaint 27 Care, Treatment, Services, Providers, *etc.*

B. Insurer Should Deny Chronic Pain Treatment Requests

C. Violative Treatment Guideline #27

D. Basis for Complaint to Discontinue or to Deny CPS Treatment EE Request:

1. UR Denial.

2. IME/Peer Review.

3. Reasoned Claims Department Action/Denial/Letter.

4. With Options at Conference for Administrative Judge Other Than and Not Limited to Deny, Discontinue, One and Done: Compromise Pre-Hearing and Pre-IPE Regarding Contesting Care, Treatment, Drugs, *etc.*

E. Emphasize Necessity of Treatment per 27:

1. Appropriate;

2. Pursuant to Prevailing Standards of Care;

3. Objective Clinical Improvement;

4. Evidence-Based;

5. Science-Based;

6. Clinically Proven;

7. Decreases Pain;

8. Increases Function;

9. Restores Earning Capacity;

10. Promotes Return to Work;

11. Increase Activities of Daily Living;

12. Improve/Restore Mood/Affect, Behavior;

13. Promote Return to Work With or Without Restrictions Full or Part-Time as Medically Indicated;

14. Is Care/Treatment Requested/Reviewed Supported by a Valid Clinical Rationale with Supporting Objective Clinical Findings with:

    a. measurements;

    b. timeframes;

    c. outcomes;

F. Is Diagnosis Correct Regarding CPC.

G. Is Care Evidence–Based.

H. Is Treatment Necessary/Appropriate.

I. What Are Risk Factors For:

1. Developing CPS;

2. Maintaining CPS.

J. Restoration Earning Capacity and Return to Work are Legitimate Goals, Social, Economic, Legal, Medical, and Humane Per #27.

K. Beware of Drug Dependency.

L. Distinguish Drug Addicted vs Drug Dependent Behavior.

M. Insurer Evaluation CPS Should be Based on Totality Best Medical Evidence Available:

1. Is Diagnosis of CPS Correct?

2. Is Care/Treatment Appropriate Per 27?

3. Is EE Receiving, or Likely to Objective, Measurable, Identifiable, Demonstrable Benefits from Treatments, Drugs, Physicians, in Issue?

4. Is Objective Clinical Improvement Noted Based on:

a. improved function?

b. decreased pain?

c. increased activities of daily living?

d. restoration of earning capacity?

VII. CONCLUSION:

A. Pay All Care and Treatment Pursuant to and Consistent with #27.

B. Deny Any and All Care and Treatment Not Pursuant to and Consistent #27.

C. Discontinue Ongoing Treatment Pursuant to #27, Not Reasonable, Not Necessary, Not Adequate and Not Demonstrating Objective Clinical Improvement.

D. Note: Treatment Pursuant to #27 Not Demonstrating Objective Clinical Improvement May Be Continued as Necessary, Only with a Valid Clinical Rationale With Supporting Objective Clinical Findings from Licensed Healthcare Professional Service Provider.

E. Chronic Pain Treatment is Ineffective for Employees With Symptoms of Exaggerated Pain Behavior, Addictive Behaviors, and Factitious Disorders; such as Employee is not Entitled to CPS Treatment.

F. Contact me by phone or email with any questions or concerns in this new, emerging, and evolving area of the law.

G. Good Luck with CPS EE Claims and Insurer Claims Administration Management.

THE COMMONWEALTH OF MASSACHUSETTS

Department of Industrial Accidents

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DEVAL L. PATRICK
Governor

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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. 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 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.