

# CHRONIC PAIN

## TREATMENT GUIDELINES

*recommended by the*  
**PHYSICIAN ADVISORY COMMITTEE**  
*and adopted by the Oklahoma Workers' Compensation Court Administrator*

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### **Introduction**

The Physician Advisory Committee (PAC), a statutorily created advisory body to the Oklahoma Workers' Compensation Court, has been directed by Oklahoma Statute to propose, adopt, and recommend treatment guidelines for injured Oklahoma workers. The PAC is composed of nine members; three appointed by the Governor, three appointed by the President Pro Tempore of the State Senate, and three appointed by the Speaker of the Oklahoma House of Representatives. By statute, the Governor's appointees must include a doctor of medicine and surgery, a family practitioner in a rural community of the state, and an osteopathic physician; the President Pro Tempore's appointees must include a doctor of medicine and surgery, a doctor of medicine or an osteopathic physician, and a podiatric physician; and the Speaker's appointees must include an osteopathic physician, a doctor of medicine or an osteopathic physician, and a chiropractic physician.

We received input from a wide variety of sources including employers, insurance carriers, and health care providers, including member physicians of the Oklahoma Society of Anesthesiologists, Inc. Appropriate scientific literature and statutory provisions (Title 63, Oklahoma Statutes, Section 2-551) were reviewed, together with the Oklahoma Board of Medical Licensure and Supervision's Guidelines for Prescribing Controlled Substances For Intractable Pain, and practice parameters of the various specialty societies (The American Academy of Pain Medicine, International Association for the Study of Pain, and American Pain Society). Treatment protocols from Minnesota and Washington also were utilized.

The philosophy of this Committee has been "keep it simple". We also believe that, for the guidelines to stand the test of time, they must be **fair** and **reasonable**.

The objective of the Chronic Pain Treatment Guidelines is to provide standards for prompt, reasonable and appropriate treatment for chronic pain associated with work place injuries and to expedite optimum recovery and return to work, while containing medical costs in the workers' compensation system.

The first step in achieving this objective requires that an employer and/or employee report a compensable injury in a timely fashion to ensure there is no delay in the treatment of the compensable injury. It is important that the employer work with the insurance carrier and health care providers to ensure the injured worker is given the opportunity to return to work in either a modified or full duty status as quickly as medically possible.

These guidelines are not to be used as a fixed treatment protocol, but rather identify a normal course of treatment, and reflect typical courses of intervention. It is anticipated that there will be injured workers who will require less or more treatment than the average. It is acknowledged that in atypical cases, treatment falling outside these guidelines will occasionally be necessary. However, those cases that exceed the guidelines' level of treatment will be subject to more careful scrutiny and review and will

require documentation of the special circumstances that justify the treatment. These guidelines should not be seen as prescribing the type and frequency or length of intervention. Treatment must be based on patient need and professional judgment. This document is designed to function as a guideline and should not be used as the sole reason for denial of treatments and services. These guidelines do not affect any determination of liability for an injury under the Oklahoma Workers' Compensation Act, 85 O.S., Section 1, et seq., and are not intended to expand or restrict a health care provider's scope of practice under any other statutes. These guidelines are not intended to supersede applicable provisions of the Oklahoma Workers' Compensation Court's Schedule of Medical Fees.

## **I. CHRONIC PAIN - DEFINITIONS**

### **A. Definition of Pain** – from the Subcommittee on Taxonomy of the International Association for the Study of Pain (IASP).

“An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”

### **B. Chronic Pain** – In the past chronic pain has been defined as pain that persists for greater than six months. The greatest definition of chronic pain, the one this committee prefers, is “pain that persists a month beyond the usual course of an acute disease or a reasonable time for an injury to heal or that is associated with chronic pathological process that causes continuous pain or pain recurs at intervals for months or years.”

### **C. A Chronic Pain Management Program** is defined as “a program organized to reduce pain, improve the quality of life, and decrease the dependence on the health-care system, for patients with chronic pain, which interferes with physical, psychological and vocational functioning, through the provision of coordinated, goal-oriented, interdisciplinary team services in an inpatient and/or outpatient setting.”

The minimum standards of a comprehensive outpatient pain treatment facility should include the following:

1. Interdisciplinary evaluation by a team consisting of the program director and a group of identified designated individuals who are well qualified in managing chronic pain and represent more than one discipline.
2. Adequate medical supervision, preferably from a full-time professional staff.
3. Adequate medical support services and consulting services from a psychiatrist and/or psychologist, provisions for patient evaluation, and appropriate allied therapies.
4. Organized evaluative processes for screening and selection of patients.
5. Appropriate facilities to evaluate patients for medical, psychological, social, and environmental causes and effects of chronic pain.
6. Procedures for expeditious integration of this information to formulate a diagnostic opinion and to implement a management strategy involving multimodal treatment.

7. Record review and maintenance.
8. Quantitative measures of dysfunction.
9. Extensive rehabilitation goals, including detoxification, improved function, psychological counseling, and stress management/pain control.
10. Informed consent for treatment.
11. Periodic re-evaluation of progress and the results of therapy.
12. Vocational and avocational counseling with a view to productive placement.

A typical program should be physician or psychologist directed with the physician having experience and an interest in pain management. Other disciplines typically involved would be physical therapy, occupational therapy, psychology, case management, other nursing or social worker. The pain management program should have access to other specialties including anesthesiology, internal medicine, rheumatology, neurology, physical medicine, orthopaedic surgery, neurosurgery, and other disciplines as needed.

- D. **When to Refer:** Statistically, there is a significant decrease in return to work at the six month point of a pain syndrome. A team evaluation should be performed on those patients who meet the criteria of chronic pain which is one month past the expected healing time.

## II. STANDARDS OF PAIN TREATMENT CENTERS

- A. **Major Comprehensive Pain Center:** The major comprehensive pain center is an organized facility with both space and personnel committed to the evaluation of the interaction of the physical, emotional, and sociological aspects of chronic pain problems that possesses the capability to develop a multidisciplinary approach to pain management.

To be identified as comprehensive, a pain center must have *all* of the following:

1. Space and beds assigned solely to the pain center;
2. Full-time professional staff of more than one discipline;
3. Full-time supportive staff (secretarial, nursing, physical/occupational therapy, etc.);
4. An organized evaluative process for screening and selection of patients;
5. Record review and maintenance;
6. Participation of consultants from multiple disciplines;
7. Routine psychological assessment;
8. Ongoing research activities;
9. An organized training program;
10. Availability of therapy appropriate to the physical and psychosocial problems; and
11. Periodic evaluation of the results of therapy.

- B. **Comprehensive Pain Center:** The comprehensive pain center is an organized facility with individuals or groups managing a wide variety of chronic pain syndromes that is unable to fulfill *all* the criteria of a major comprehensive pain center. This center should have the personnel and facilities for evaluation of the psychosocial, as well as the physical aspects of chronic pain behavior, and for administration of therapy appropriate to the problems found. To be identified as a comprehensive pain center, eight of the criteria required for major comprehensive pain centers must be met.

C. **Syndrome-Oriented Pain Center:** The syndrome-oriented pain center is an organized facility that provides in-depth study of all aspects of a particular pain syndrome and offers acceptable treatment programs for that syndrome. Such center would include, for example:

1. Low back-pain centers;
2. Headache centers;
3. Arthritis centers;
4. Oral facial – pain centers;
5. Causalgia and reflex-sympathetic dystrophy centers;
6. Cancer pain centers;
7. Central pain - syndrome centers; and
8. Spinal cord – injury centers.

D. **Modality-Oriented Pain Center:** The modality-oriented pain center is a facility that offers the chronic pain patient the appropriate therapy as defined by the specialty of the center, although other therapies may be used as adjuncts. This center may or may not provide extensive evaluative processes. Such centers would include, for example:

1. Nerve-block clinics;
2. TENS clinics;
3. Acupuncture clinics;
4. Biofeedback clinics;
5. Mental health centers;
6. Neurosurgical centers; and
7. Rehabilitation centers.

### III. GUIDELINES FOR IMPLANTABLE PAIN MANAGEMENT DEVICES

The effectiveness of spinal cord stimulation and intrathecal opioid administration has been documented. However, a patient selection protocol remains the key to successful outcomes.

#### **Patient Selection Protocol**

1. A diagnosis for the patient's chronic pain has been proven and documented.
2. Alternative pain management techniques have been exhausted and proved to be ineffective in the management of the patient's intractable pain.
3. A pre-implantation psychological evaluation is required. If issues such as secondary gain, unrealistic expectations, psychosocial pathology, or psychologic pathology are uncovered the implantation of a pain management device should be canceled or postponed until these issues can be resolved.
4. A temporary trial of the planned implantable pain management device is required. Evidence of subjective and objective improvement should be documented. If the trial does not result in subjective and objective improvement the patient should not be selected as a candidate for the implantable pain management device.

#### **IV. LONG TERM OPIOID THERAPY IN CHRONIC NONCANCER PAIN PATIENTS**

Long term opioid use may be the treatment of choice for a select subgroup of chronic pain patients. Concerns regarding long term opioid use include risks of addiction and respiratory depression. Side effects include tolerance, diversion, constipation and sedation, among others.

The goal of long term opioid therapy in the noncancer pain patient should include both enhanced comfort and improved physical and psychosocial functioning.

It is suggested that physicians treating patients with long term opioid therapy be familiar with these conditions:

- Physical dependence,
- Respiratory depression and other side effects,
- Tolerance,
- Addiction, and
- Pseudo addiction.

Principles of good medical practice should be used when prescribing opioids. The following guidelines were adapted from the consensus statement from The American Academy of Pain Medicine and the American Pain Society.

The analgesic benefits of opioids should be balanced against the potential adverse consequence of long term use.

All patients who remain on opioid therapy after one year are recommended to obtain a second opinion to continue on opioid therapy or an acceptable treatment plan be offered by the treating physician for continuation of opioid therapy. The second opinion must be obtained through the Independent Medical Examiner (“IME”) System from a physician determined to have expertise in pain management or chronic pain as determined by the IME System.

Effective chronic pain management with consideration of opioid therapy should include:

- Documenting all aspects of the patient’s assessment and care;
  - Taking a history and physical examination, including a drug and pain history;
  - Conducting appropriate studies;
  - Developing a working diagnosis and treatment plan;
  - Establishing a rationale for the treatment selected;
  - Patients should have failed standard pain management techniques such as physical therapy, non-opioid medication and adequate aggressive psychological treatment including cognitive behavioral methods;
  - Educating patients and ensuring that they understand their physician’s treatment methods and goals. Consider having patient sign an informed, written and witnessed consent form before beginning treatment;
  - Formulating a mandatory follow-up protocol. It is suggested bi-weekly for the first month and every two months thereafter assessing treatment efficiency and side effects;
  - Opiates with long duration of action such as controlled-release oral morphine, methadone, oxycodone or transdermal duragesic patch are preparations of choice;
  - All prescriptions should optimally be obtained from a single physician;
  - Consulting with specialists in pain medicine when warranted;
- Using a multidisciplinary approach;

- There will be continuing review of the patient's case with attempts to decrease dosage, and use non-opiate means of pain control; and
- Once on stable medical regime, not required to be refilled by specialist.

## V. REFLEX SYMPATHETIC DYSTROPHY

A. **Introduction:** These guidelines for treatment of sympathetically mediated pain (SMP), complex regional pain syndrome (CRPS) and/or reflex sympathetic dystrophy (RSD) are intended to provide:

1. Basis for establishing or excluding the diagnosis of SMP or RSD;
2. Goals for treatment;
3. Endpoints of treatment; and
4. Basis for determining work status and/or work restrictions.

B. **Complex Regional Pain Syndrome (CRPS):** Regional (spontaneous and evoked) pain with autonomic, sensory and motor changes following a noxious event, disproportionate to the degree of trauma, occurring in an extremity, with or without obvious nerve injury. It has been differentiated into two types:

Type 1 RSD (no major identifiable nerve injury)

Type 2 Causalgia - occurs after partial injury of a nerve or one of its branches, (i.e. peripheral nerve lesion)

Both types may be accompanied by sympathetically mediated pain (SMP). SMP can be defined as pain relieved by sympathetic blockade (not accompanied by weakness or sensory block to either warm or cold stimuli and with an increase of temperature in ipsilateral extremity).

DIAGNOSIS - Unfortunately, RSD/CRPS is a clinical diagnosis and has no clearly identifiable abnormality which can be reliably demonstrated by any current test. It is a clinical diagnosis; therefore some of the symptoms and physical signs may not be present in all patients. The only constant symptom is pain. Response to sympathetic blockade is not present in all patients, i.e., sympathetically independent pain (SIP).

C. **CRPS/RSD - Type 1:**

1. **History:**  
Develops after an initiating noxious event or immobilization  
Unilateral extremity onset (rarely may spread to another extremity)  
Symptom onset usually within a month.

*Exclusion criteria:*

- Identifiable major nerve lesion (CRPS - Type 2)
- Existence of anatomic, physiologic, or psychological conditions that would otherwise account for the degree of pain and dysfunction. An active search or attempt to ascertain underlying cause of pain should precede or accompany this diagnosis.

2. **Symptoms:**  
 Pain (spontaneous or evoked)  
 Allodynia - diffuse burning pain  
 Aching, throbbing  
 Hyperalgesia to light touch, temperature change, or joint motion
  
3. **Physical Signs:**  
 Vasomotor signs - temperature, color, edema  
 Sudomotor signs - hyperhidrosis  
 Allodynia, hyperesthesia  
 Motor - muscle atrophy, increased physiologic tremor  
 Trophic changes - skin shiny; nails brittle, ridged; hair coarse, sparse; atrophy
  
4. **Confirmatory Test:**  
 Thermogram  
     Sympathetic block - stellate ganglion, lumbar sympathetic, or IV sympathetic regional blocks which relieve pain (at least 50%) in absence of sensory block. The duration of pain relief usually exceeds the duration of local anesthetic used in the block. Underlying pain generators may continue, adding separate component to overall pain. A second sympathetic block may be required to confirm a positive or negative response to the initial sympathetic block.  
 Triple phase bone scan  
 Radiographs indicating unilateral regional osteoporosis

**CRPS/RSD** - Pain with physical findings or vasomotor and/or sudomotor signs plus at least one confirmatory test is positive.

**CRPS or RSD** occurs as a complication of another preceding injury and usually involves upper or lower extremities which may include any, but not necessarily all of the following conditions: edema; local skin color changes of red or purple; local dyshidrosis; local alteration of temperature regulation; local skin texture changes; reduced passive range of motion in contiguous joints; osteoporosis in underlying bony structures demonstrated by radiographs; typical findings of reflex sympathetic dystrophy on bone scan. A universal symptom is pain, allodynia, or hyperalgesia which may precede the above clinical findings. These conditions may involve increased sympathetic tone to the affected limb which contributes to increased activity of afferent pain fibers and increased vasoconstriction, which are normally inhibited by proprioceptive input at the spinal cord level. Sympathetically mediated pain may precede CRPS or RSD and probably represents a continuum.

Once diagnosis of SMP or CRPS/RSD is established, a treatment plan should be developed.

The key to successful resolution of SMP/CRPS/RSD is early diagnosis and early treatment (within first six weeks).

5. **Goals of Treatment:**  
 Maintain or restore function of extremity  
 Return to full or previous level of employment  
  
 Reduce or eliminate pain

Minimize disability

6. **Treatment:**

a. **Physical therapy** - Goal: to restore/preserve function of extremity. This is the cornerstone of treatment. Proprioceptive afferents inhibit sympathetic vasoconstriction and pain receptors; simply put, movement of an extremity with RSD inhibits sympathetic activity. Usual physical therapy for SMP/CRPS/RSD includes:

- (1) Range of motion, both passive and active
- (2) Muscle strengthening and toning exercises
- (3) Superficial heating - hot packs, hot soaks, heating pads, whirlpool
- (4) Deep thermal - diathermy, ultrasound
- (5) Electrical stimulation - TENS
- (6) Cooling - ice packs, cold soaks (caution - vasoconstriction from cold can exacerbate SMP/CRPS/RSD)

Please refer to Worker's Compensation guidelines regarding physical therapy.

b. **Sympathetic blocks** - Goal: to decrease sympathetic efferent stimulation to affected extremity. These are most helpful early (1st 6-26 weeks). After six months, the response/cure rate is very low. Pain relief from sympathetic blocks should last longer than the duration of the local anesthetic agent; with successive blocks, duration of pain relief should gradually increase. During pain-free intervals, aggressive physical therapy should be performed, to maximize range of motion and functional use of extremity. Sympathetic blocks should be accompanied by ongoing physical therapy; sometimes the main benefit of sympathetic blockade is the facilitation of physical therapy. The frequency of blocks early in the course of treatment may be 2 - 5x/week, depending on response to treatment. The frequency should gradually decrease (e.g., 3x/week x 2 weeks, 2x/week x 1 week, 1x/week, etc.) as the duration of pain relief increases. If no response occurs after 1-2 weeks of intensive treatment (e.g. improvement in pain, swelling, function, color or temperature), blocks should not be continued.

c. **Nerve Blocks**

- (1) Stellate ganglion
- (2) Lumbar sympathetic, classic approach vs. epidural
- (3) Intravenous regional sympathetic blocks - Bier block (tourniquet technique using local anesthetic and/or:
  - (a) Guanethedine
  - (b) Bretylium
  - (c) Phentolamine
- (4) Continuous epidural sympathetic block
- (5) Trigger point injections (TPI) - Localized myofascial pain can occur as a result of chronic pain and may respond to injections of local anesthetics. TPI's are considered adjunctive and not primary forms of treatment.

d. **Pharmacological Treatment** - Goal: non-narcotic modulation of pain. Ideally, medication should be initiated individually, and given long enough to evaluate therapeutic response. Narcotics are sometimes required, but usually are not

successful in managing chronic non-malignant pain. Classes of medications found to be useful include:

- (1) NSAIDS
- (2) acetaminophen
- (3) anticonvulsants
  - (a) carbamazepine (Tegretol)
  - (b) gabapentin (Neurontin)
- (4) GABAnergics
  - (a) baclofen
  - (b) clonazepam
- (5) Serotonergics
  - (a) tricyclic antidepressants - amitriptyline
  - (b) serotonin re-uptake inhibitors-fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil)
- (6) Antiarrhythmics
  - (a) mexilitine
- (7) Alpha blockers
  - (a) phentolamine
- (8) Alpha agonists
  - (a) clonidine

These different classes of medications can be used in conjunction by physicians knowledgeable about their uses, side effects, and drug interactions.

- e. **Surgery:** SMP/CRPS/RSD are not surgically remedial. In selected patients, surgical sympathectomy can produce pain relief, but often with relapse. Any surgical procedure should be considered only in the context of producing improved function, and not solely for pain control. Surgery in an affected extremity can exacerbate SMP/CRPS/RSD or produce relapse. Sympathetic neuroablative procedures should be performed in patients only after demonstrated success with sympathetic blocks.

Dorsal column stimulators or morphine pumps, should be considered only in patients who have had failures in all other treatment modalities, are not candidates for other forms of treatment, and have been evaluated for these devices by a multidisciplinary pain treatment center (psychological, medical, physical rehabilitation, anesthesiology) and have had a successful trial therapy prior to permanent device placement.

- f. **Re-evaluation:** After beginning treatment for SMP/CRPS/RSD, periodic re-evaluation every 2 to 4 weeks regarding the efficacy of physical therapy, sympathetic blocks, and medications is recommended. Work restrictions, length of workday, or time off work should be reviewed and adjusted as necessary. Communication between carriers, providers, and the patient can establish and revise treatment plans. Education regarding initial injury, pathophysiology of SMP/CRPS/RSD, home treatment (exercise, diet, avoidance of exacerbating factors) is helpful for patients.

Initial treatment duration of three (3) months is reasonable. If progress is evident (improvement in function, pain, swelling, etc.), then additional treatment for further improvement or maintenance therapy may be required.

If no progress is seen after 2-3 weeks of intensive treatment (physical therapy, sympathetic blocks, medication) re-evaluate diagnosis and treatment. Consider referral to multidisciplinary pain treatment center for chronic pain treatment.