

MEDICAL PROTOCOLS: INTRODUCTION

STATE OF CONNECTICUT WORKERS' COMPENSATION COMMISSION
EFFECTIVE: 1-1-1996 – REVISIONS/UPDATES: 7-1-2012; 7-1-2013; 4-1-2014; 4-1-2015; 8-15-2015; 11-1-2015; 2-15-2016



CONTENTS	BACKGROUND	NEW	EFFECTIVE DATES	FUTURE UPDATES	ACKNOWLEDGMENTS
I. INTRODUCTION <ul style="list-style-type: none">▪ Background▪ New▪ Effective Dates▪ Future Updates▪ Acknowledgments	Workers' Compensation Medical Protocols first became effective on January 1, 1996 as a result of legislative changes to Section 31-280 of the Workers' Compensation Act. The Workers' Compensation Commission (WCC) uses these Medical Protocols to evaluate whether a particular treatment is reasonable and appropriate based on the diagnosis of a worker's injury or illness.	In consultation with practitioners, insurers, and the Medical Advisory Panel, new Medical Protocols for Psychological Pain Assessment and Treatment became effective in 2016 to assist practitioners in effective pain management for injuries occurring within the workers' compensation arena. Revisions to various Medical Protocols reflect the latest changes in the medical field regarding new procedures, treatments, and diagnostic tests: <ul style="list-style-type: none">▪ Protocols for treatment of injuries to the cervical spine and lumbar spine were revised in 2012 and updated in 2013 and in 2015.▪ Protocols for treatment of injuries to the knee were revised in 2015.▪ Protocols for treatment of injuries to the hand, wrist, and elbow were revised in 2015.▪ Protocols for treatment of injuries to the shoulder were revised in 2014.	<ul style="list-style-type: none">▪ February 15, 2016: Psychological Pain Assessment and Treatment<ul style="list-style-type: none">– created▪ November 1, 2015: Cervical Spine Lumbar Spine<ul style="list-style-type: none">– update▪ August 15, 2015: Knee<ul style="list-style-type: none">– revision▪ April 1, 2015: Hand, Wrist, and Elbow<ul style="list-style-type: none">– revision▪ April 1, 2014: Shoulder<ul style="list-style-type: none">– revision▪ July 1, 2013: Cervical Spine Lumbar Spine<ul style="list-style-type: none">– update▪ July 1, 2012: Cervical Spine Lumbar Spine<ul style="list-style-type: none">– revision▪ July 1, 2012: Opioid Management<ul style="list-style-type: none">– created	The Workers' Compensation Medical Protocols will continually be revised and updated, as appropriate. The WCC advises practitioners, insurers, and other concerned parties to periodically check for announcements of revisions and updates on the WCC website: wcc.state.ct.us	The WCC thanks the medical professionals who have spent – and continue to spend – many hours working with us to bring the most appropriate treatment, and the highest standard of care, to injured workers in Connecticut.
II. MEDICAL PROTOCOLS: Psychological Pain Assessment and Treatment <ul style="list-style-type: none">▪ 6 pages					
III. MEDICAL PROTOCOLS: Opioids (management of) <ul style="list-style-type: none">▪ 1 page					
IV. MEDICAL PROTOCOLS: Cervical Spine (neck) <ul style="list-style-type: none">▪ 9 pages					
V. MEDICAL PROTOCOLS: Lumbar Spine (back) <ul style="list-style-type: none">▪ 9 pages					
VI. MEDICAL PROTOCOLS: Shoulder <ul style="list-style-type: none">▪ 4 pages					
VII. MEDICAL PROTOCOLS: Hand (hand, wrist, elbow) <ul style="list-style-type: none">▪ 22 pages					
VIII. MEDICAL PROTOCOLS: Knee <ul style="list-style-type: none">▪ 4 pages					



PSYCHOLOGICAL PAIN ASSESSMENT & TREATMENT – PAGE 1 of 6

INTRODUCTION

INTRODUCTION

Pain is a complex phenomenon. Many factors contribute to and modify pain.

It is generally accepted that pain generators include both somatic and psychic elements. These factors are further modified by complex social variables.

What is generally referred to as "pain" by most laypersons is a subjective experience. As such, "pain" is a psychological experience and product of complex biopsychosocial phenomena.

Consequently, the diagnosis of the causes of "pain" and associated treatment of "pain" is an enormously challenging endeavor often complicated by insistent demand for relief. Neither biological / medical, psychological, nor environmental / social strategies may suffice.

It is clear from the literature that the highest rates of diagnostic and treatment efficacy are represented by integrated biopsychosocial and interdisciplinary models and delivery systems.

Psychological approaches to diagnosis and treatment appear to many to be a "black box." However, even casual scrutiny reveals similar uncertainties, ambiguities, and knowledge limitations in biological / medical methods.

Psychological / neuropsychological procedures for assessment and treatment of emotional, behavioral, and motivational aspects of pain continue to evolve in accuracy and efficacy.

Inclusion of these methods in an integrated approach to pain management is increasingly and widely recognized as essential.

PROTECTED HEALTH INFORMATION

Protected Health Information in the psychological domain enjoys a higher level of HIPAA protection than general medical information.

All health care providers responsible for collection, storage and dissemination of Psychological Protected Health Information have a legitimate and formal obligation to support these standards.

Providers must familiarize themselves with the operational details of these obligations and implement them rigorously in their clinical settings.

Generally, this is accomplished by the identification and segregation of Psychological Protected Health Information with distinct procedures and documents for authorization of information release.

RECOMMENDED TIMELINES

As with all the recommendations the timelines are to be taken as guidelines and not mandates.

It is recommended that the greatest flexibility and discretion be given to providers' application of the diagnostic criteria in the earliest care time frame of INTAKE TO 4 WEEKS.

The vast majority of patients in the workers' compensation system flow through the system of care without complication.

The recommended baseline demographic data is meant to be collected as early as possible to enhance focus on those patients for whom any complication, or question of potential complication, may arise.

The timing of initial collection and documentation of these demographics will vary according to the type of treatment venue and the associated baseline population characteristics.

Optimal timing in any given clinical setting will be responsive to the earliest possible thresholds for potential treatment complications.

FORENSIC CAVEATS

Advanced diagnostic procedures and technologies allow for objective measurement and documentation of symptom over- and under-reporting, dissimulation of psychopathology, and malingered neurocognitive impairment.

It is neither cost-effective nor conducive to clinical care to prematurely implement forensic assessment.

It is similarly ineffective to delay forensic assessment despite repeated and ongoing indications of diagnostic / claim invalidity.

When properly designed and implemented the entire continuum of psychodiagnostic data collection contributes to a stepwise incremental evaluation of symptom validity.

The formal administration of a detailed and objective forensic assessment simply represents the final phase of this systematic analysis and, as such, is integrated into the entire continuum of care.



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INTAKE TO 4 WEEKS (with consideration of date of injury)

DIAGNOSTIC CRITERIA	DIAGNOSTIC STUDIES	TREATMENT	GOALS OF TREATMENT
<p>Demographic screening to identify:</p> <ul style="list-style-type: none"> ▪ any previous psychological diagnosis / treatment, including: <ul style="list-style-type: none"> – psychiatric hospitalization – outpatient psychotherapy / counseling – psychopharmacological treatment (e.g., antidepressants, anxiolytics, etc.) ▪ diagnosis and / or treatment of any drug or alcohol abuse or dependence – e.g., life interference such as: <ul style="list-style-type: none"> – relationships – work – DWI – detoxification – inpatient / outpatient rehabilitation – 12-step participation ▪ prior treatment for work-related pain ▪ prior workers' compensation claim with pain-related lost time <p>Physician discretion based on anomalies of case presentation or course . . .</p> <p>AND / OR</p> <p>. . . positive response to any one of 4 questions obtained by any provider (above)</p>	<p>Recommended:</p> <ul style="list-style-type: none"> ▪ monitor medical progress ▪ refer for psychodiagnostic interview: <ul style="list-style-type: none"> – positive responders on demographic screen – individuals based on physician discretion 	<p>Recommended:</p> <ul style="list-style-type: none"> ▪ medical monitoring ▪ implementation of psychodiagnostic interview-generated recommendations <p>and / or</p>	<p>Medical regimen compliance with:</p> <ul style="list-style-type: none"> ▪ expected decreased VAS ratings ▪ functional improvement



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1-3 MONTHS

DIAGNOSTIC CRITERIA	DIAGNOSTIC STUDIES	TREATMENT	GOALS OF TREATMENT
<p>Physician determination of:</p> <ul style="list-style-type: none"> ▪ lack of expected improvement ▪ atypical presentation ▪ treatment noncompliance 	<p>Psychodiagnostic interview:</p> <ul style="list-style-type: none"> ▪ by qualified psychological / psychiatric provider ▪ with administration of standardized screening tools, such as: <ul style="list-style-type: none"> – ODI – BDI 	<p>Recommended, per examination results:</p> <ul style="list-style-type: none"> ▪ continued medical management ▪ enhanced monitoring ▪ rehabilitative psychotherapy ▪ compliance contingency management regimens ▪ emotional-behavioral contraindications to medical management – e.g.: <ul style="list-style-type: none"> – primary / secondary gain – polypharmacy – interventional procedures including: <ul style="list-style-type: none"> ○ injections ○ blocks ○ surgery 	<p>Support medical treatment goals with:</p> <ul style="list-style-type: none"> ▪ enhanced medical regimen compliance ▪ pain reduction ▪ functional improvement



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GREATER THAN 3 MONTHS

DIAGNOSTIC CRITERIA	DIAGNOSTIC STUDIES	TREATMENT	GOALS OF TREATMENT
<ul style="list-style-type: none"> ▪ continued failure of expected medical improvement ▪ onset of new symptoms ▪ unexpected symptom variability ▪ compromised treatment compliance 	<p>Recommended:</p> <ul style="list-style-type: none"> ▪ formal psychological examination: <ul style="list-style-type: none"> – by qualified psychological provider – expanding diagnostic interview – administration of self-report inventories ▪ personality inventories, with: <ul style="list-style-type: none"> – response bias scales (e.g., MMPI-2RF, PAI, MCMI, etc.) – additional self-report inventories directed at medical and pain patients (e.g., MBMD, BHI-2, etc.) 	<p>Recommended, per examination results:</p> <ul style="list-style-type: none"> ▪ continued medical management ▪ enhanced monitoring ▪ rehabilitative psychotherapy ▪ compliance contingency management regimens ▪ emotional-behavioral contraindications to medical management – e.g.: <ul style="list-style-type: none"> – primary / secondary gain – polypharmacy – interventional procedures including: <ul style="list-style-type: none"> ○ injections ○ blocks ○ surgery 	<p>Support medical treatment goals with:</p> <ul style="list-style-type: none"> ▪ enhanced medical regimen compliance ▪ pain reduction ▪ functional improvement



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GREATER THAN 6 MONTHS

DIAGNOSTIC CRITERIA	DIAGNOSTIC STUDIES	TREATMENT	GOALS OF TREATMENT
<ul style="list-style-type: none"> ■ continued failure to demonstrate functional improvement ■ lack of response to pharmacological strategies ■ lack of response to interventional strategies ■ marked noncompliance ■ marked litigiousness ■ failed drug screen ■ repeated loss of medications ■ other compromises of medication contracting ■ positive findings on PMP 	<p>Recommended:</p> <ul style="list-style-type: none"> ■ forensic examination: <ul style="list-style-type: none"> – by qualified psychological / neuropsychological provider – include: <ul style="list-style-type: none"> ○ systematic analysis of ability suppression ○ systematic analysis of response bias ○ formalized battery of screening measures ○ forced choice measures ○ self-report inventories with validity scales (IME?) 	<p>Recommended, per examination results:</p> <ul style="list-style-type: none"> ■ continued medical management ■ enhanced monitoring ■ rehabilitative psychotherapy ■ compliance contingency management regimens ■ emotional-behavioral contraindications to medical management – e.g.: <ul style="list-style-type: none"> – primary / secondary gain – polypharmacy – interventional procedures including: <ul style="list-style-type: none"> ○ injections ○ blocks ○ surgery 	<p>Support medical treatment goals with:</p> <ul style="list-style-type: none"> ■ enhanced medical regimen compliance ■ functional improvement <p>Cessation of care, on the basis of:</p> <ul style="list-style-type: none"> ■ documented unreasonableness ■ unnecessary evaluation ■ unnecessary treatment



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PROCEDURE BASE CRITERIA

DIAGNOSTIC CRITERIA	DIAGNOSTIC STUDIES	TREATMENT	GOALS OF TREATMENT
<ul style="list-style-type: none"> ▪ surgical interventions for pain reduction (in the absence of neurological compromise) ▪ interventional pain management procedures, including: <ul style="list-style-type: none"> – trials – permanent placement of implanted devices 	<p>Recommended:</p> <ul style="list-style-type: none"> ▪ formal psychological examination: <ul style="list-style-type: none"> – by qualified psychological provider – expanding diagnostic interview – administration of self-report inventories ▪ personality inventories, with: <ul style="list-style-type: none"> – response bias scales (e.g., MMPI-2RF, PAI, MCMI, etc.) – additional self-report inventories directed at medical and pain patients (e.g., MBMD, BHI-2, etc.) 	<p>Recommended, per examination results:</p> <ul style="list-style-type: none"> ▪ continued medical management ▪ enhanced monitoring ▪ rehabilitative psychotherapy ▪ compliance contingency management regimens ▪ emotional-behavioral contraindications to medical management – e.g.: <ul style="list-style-type: none"> – primary / secondary gain – polypharmacy – interventional procedures including: <ul style="list-style-type: none"> ○ injections ○ blocks ○ surgery 	<p>Support medical treatment goals with:</p> <ul style="list-style-type: none"> ▪ enhanced medical regimen compliance ▪ pain reduction ▪ functional improvement

MEDICAL PROTOCOLS: OPIOIDS – PAGE 1 of 1

STATE OF CONNECTICUT WORKERS' COMPENSATION COMMISSION
EFFECTIVE JULY 1, 2012



OPIOID MANAGEMENT OF THE INJURED PATIENT

OVERVIEW

Proper opioid management is essential for the safe and efficient care of injured patients. The WCC recognizes that some injured patients may require opioids for the management of their acute and chronic pain. It is not the intention of the WCC to restrict the proper medical use of this class of medications, however responsible prescribing is mandatory. Additionally, studies have shown that injured workers placed on high dose opioids early in the post-injury period may experience a slower recovery, more difficulty with returning to work, more difficulty with weaning, and more frequently end up on long term opioids.

During the first two weeks post injury, low dose, short acting opioids may be appropriate for those with more severe injuries. Even during the acute phase it is preferred that the injured worker avoid opioid medications when possible. During the remaining portion of the acute and subacute period, attempts should be made to wean and discontinue opioid medications as appropriate (i.e., as symptoms improve) and as soon as possible. Dose escalation during these periods should be avoided, as the injury should be stabilized and healing. Medications that are deemed to be inappropriate for the vast majority of injured patients include immediate release, ultra-short acting sublingual and nasal opioid preparations. Long acting opioids are not recommended in the acute and sub-acute phases of treatment. In addition, following major surgical interventions, as acute postoperative pain resolves attempts should be made to wean medications as soon as possible, again avoiding dose escalation beyond the acute post-operative period.

Opioids are not meant to completely eliminate pain, but to ease symptoms and improve function (i.e., improvement of work capacity, ADLs, sleep and sexual function). Any continuation of medications beyond the first two week period must include proper documentation of improvement in pain level (VAS or other screening tool) and improvement in function or work capacity. At each visit history should be obtained to ensure medications are providing the desired pain reducing effect and looking specifically for side effects such as over sedation, cognitive impairment, or inappropriate medication usage. Any patient maintained beyond a four week period on chronic medications should have appropriate compliance monitoring documented. This should occur through history, screening questionnaires, prescription monitoring programs queries, urine drug tests (up to 2x / yr. for a stable, low risk patient and more frequently as indicated for high risk patients), and/or pill counts, as deemed appropriate by the physician. Patients continuing on opioids longer than 4 weeks should be managed under a narcotic agreement as recommended by the Federation of State Medical Boards. Medical necessity should be documented as to the need for all opioid prescriptions in terms of measured improvement in pain, function or work capacity.

If an injured patient requires opioid maintenance longer than 12 weeks, evaluation / consultation and treatment by a physician with appropriate specialty training in pain management should be considered. Documentation of medical necessity, including gains in pain, function or work capacity, is mandatory for prescribing beyond what is described within these guidelines.

The total daily dose of opioids should not be increased above 90mg oral MED (Morphine Equivalent Dose) unless the patient demonstrates measured improvement in function, pain or work capacity. Second opinion is recommended if contemplating raising the dose above 90 MED.

Before prescribing opioids for chronic pain, potential comorbidities should be evaluated. These include opioid addiction, drug or alcohol problems and depression. A baseline urine test for drugs of abuse and assessment of function and pain should be performed prior to institution of opioids for chronic pain.

GUIDELINES FOR PRESCRIBING

Single prescriber

Single pharmacy

Opioid agreement

Caution should be used with:

- combination therapy
- sedative-hypnotics
- benzodiazepines
- barbiturates
- muscle relaxants

Routine assessment of pain and function, if there is no improvement

Weaning of opioid

REASONS TO DISCONTINUE OPIOIDS OR REFER FOR ADDICTION MANAGEMENT

No measured improvement in function and / or pain,

or

Opioid therapy produces significant adverse effects,

or

Patient exhibits drug-seeking behaviors or diversions such as:

- selling prescription drugs
- forging prescriptions
- stealing or borrowing drugs
- frequently losing prescriptions
- aggressive demand for opioids
- injecting oral / topical opioids
- unsanctioned use of opioids
- unsanctioned dose escalation
- concurrent use of illicit drugs
- failing a drug screen
- getting opioids from multiple prescribers
- recurring emergency department visits for chronic pain management

If there is no measured improvement in pain, function, ADLs or work capacity after three (3) months of opioid medication, the prescribing physician must justify the continued use of opioids and should consider weaning of the opioid.

Opioids may allow the patient to return to work safely and more expeditiously and therefore may be indicated; nevertheless, attempts to wean these medications and avoidance of dose escalation should be the goal of treatment.

This document is meant as a guideline for the practitioner and should not supplant proper medical judgment.

SAMPLE OPIOID EQUIVALENCY TABLE

OPIOID	MED
Codeine	0.15
Fentanyl Transdermal	2.4
Hydrocodone	1
Hydromorphone	4
Methadone up to 20mg	4
Methadone 21-40mg	8
Methadone 41-60mg	10
Methadone >60mg	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3