Client Services Procedure Manual

Procedure: 64.00
Subject: Use of Opioid Medication for Compensable Injuries

64.01 Introduction

This document discusses the procedural aspects of Policy HC-14 “Use of Opioid Medication for Compensable Injuries”. At the end of this document are three Tables. Table 1: *Criteria for Rating the Severity of Pain-Causing New Injury* is to be used by decision makers in rating the severity of new injuries in order to determine future opioid coverage. Table 2: *Criteria for Rating the Severity of Pain-Causing Recurrence of Injury* is to be similarly used by decision makers in rating the severity of recurrences of injury. Table 3: *Opioid Coverage for Various Phases/Types of Pain in Injured Workers* provides a quick reference summary of the provisions of Policy HC-14, as it pertains to coverage of opioid medications for the various phases and types of pain encountered by injured workers.

As a further reference for decision makers and/or external health care providers, the Appendix contains a brief discussion of pain and its various types/phases, WorkplaceNL’s *Guidelines for the Use of Opioids in the Treatment of Chronic Non-Cancer Pain in Injured Workers*, and a Glossary of Terms.

64.02 Claim First Received By Decision Maker

The decision maker, which will normally be the Intake Adjudicator, will make a determination regarding the severity of injury (i.e., *Minor, Moderate, or Severe* - see Table 1) for all claims accepted and assigned a Nature of Injury (NOI) Code designating a drug formulary that contains opioids. Once this determination is made, the decision maker will make the appropriate designation on the AS400 system, which will then automatically place the claim into the appropriate formulary. In the formulary category designated for minor injuries, opioid coverage will generally not be extended beyond 14 days post-injury. In the formulary category designated for moderate-severe injuries, opioid coverage will be continued as clinically indicated.

Consultation with a WorkplaceNL Medical Consultant will be sought if there is any concern or difficulty with rating the severity of an injury. Also, if a new claim is being referred to a Medical Consultant by a decision maker for reasons other than injury severity, the Medical Consultant’s opinion and recommendation regarding injury severity should also be requested at the same time.

Once the claim is accepted and the injury severity rated, the decision maker will place an additional case worksheet (in addition to the acceptance case worksheet) on the system, indicating the body part or region injured, the mechanism of the injury, the injury type (e.g. soft tissue injury, repetitive strain injury, fracture, dislocation, etc.), along with the injury severity rating. The case worksheet will also indicate whether the worker is entitled to or receiving opioids under other claim(s), and will also indicate whether the worker has had opioid problems/issues under other claim(s).

An acceptance letter will be system generated to the worker, the treating health care provider, and the provider advising what has been accepted as compensable. This will include the body part or region injured, the mechanism of the injury, the injury type, and the severity rating. The criteria used for rating the injury severity, the definition of the severity rating (i.e. *Minor, Moderate or Severe*), and the worker’s opioid entitlement under Policy HC-14 for that particular claim will also be stipulated.

The severity rating of an injury may be changed at any time by a decision maker if reasonable and objective evidence supporting such change is received by the WorkplaceNL.

64.03 Recurrences and Reinstatements

In the case of recurrences or re-instatements, coverage of opioids will be handled similarly to a new injury, keeping in mind the nature & severity of the original injury, the time elapsed since that injury, and whether the worker is receiving opioids at the time of the recurrence/re-instatement. The decision maker must first make a determination regarding the compensability of the recurrent or re-instatement. In cases where the recurrence/re-instatement is accepted as compensable, the following two scenarios may arise:

1. Worker still receiving opioids for original injury:

In such cases, a severity rating for the recurrence/re-instatement is not required. The worker's opioid coverage entitlement will remain the same as that prior to the recurrence/re-instatement. Once the decision is made, the decision maker places an acceptance case worksheet on the system, indicating that the recurrence-re-instatement has been accepted and that opioid coverage will continue as prior to the recurrence/re-instatement. The decision maker will also notify the worker and health care provider in writing of the decision and the worker's opioid coverage entitlement.

2. Worker no longer receiving opioids for original injury

In such cases, the decision maker must rate the severity of the recurrence/re-instatement as *Minor, Moderate, or Severe* using the criteria in Table 2. A Medical Consultant should be consulted if questions or concerns arise. In cases where the recurrence/re-instatement is accepted, the decision maker places an acceptance case worksheet on the system, indicating the date of the original injury, the body part or region injured, the mechanism of the injury, the injury type, and the original injury Severity Rating; the date, mechanism, and severity of the recurrence/re-instatement; along with the worker's opioid coverage entitlement following the recurrence/re-instatement. The decision maker also forwards an acceptance letter to the worker and health care provider that includes the above information, as well as the criteria used to rate the severity of the recurrence/re-instatement and the worker's opioid coverage entitlement following the recurrence/re-instatement.

As for new injuries, claims involving recurrences/re-instatements that are rated *Minor* will be placed in the appropriate non-opioid formulary on the 15th day post- recurrence/re-instatement. Claims involving recurrences/re-instatements that are rate *Moderate* or *Severe* will be placed in the appropriate formularies containing oral opioids only on the 15th day post-recurrence/re-instatement. The information contained in Table 3 pertains to New Injuries as well as Recurrences/Re-Instatements.

Opioid coverage entitlement will thereafter be determined the same as for new injuries.

The following is a sample case for rating the severity of recurrences/re-instatements (see Table 2):

Example 1: A mechanic suffers a soft tissue back strain injury from helping to lift a transmission. The symptoms and signs include moderate-severe pain, significant decreased range of movement (ROM), and obvious muscle spasm. Clinical findings and investigations reveal no evidence of disc injury or

neurological compromise. The injury is rated as Moderate and the worker is off work for 3 months. Opioids are prescribed during the worker's time off work. Once treated and medically rehabilitated, the opioids are discontinued. Six months following return to work (i.e. 9 months post-injury), the worker develops similar back symptoms after bending down to pick up a small wrench and files for a re-instatement. The symptoms and signs include some pain with ROM, no notable muscle spasm, and no neurological signs. As a re-instatement of the original injury, this would most likely be rated as a Minor re-instatement and opioids would be covered only during the acute period (i.e. up to 14 days).

For recurrences/re-instatements, any compensable underlying pathology must also be considered.

Example 2: A MRI following the above mechanic's original injury reveals a small lumbar disc herniation. This is still rated as a Moderate injury. The worker returns to work (with modification of some duties) four months after the injury. A year and a half after return to work, the worker bends to pick up a small wrench and immediately develops back pain and numbness in the right leg. Symptoms and signs now include moderate-severe back pain, burning & numbness down the right leg and into the foot, and positive neurological signs including a loss of the right ankle reflex. A second MRI reveals that the worker now has a large right-sided lumbar disc herniation at the same level of the original small herniation. Surgery is recommended. This would likely be rated as a Severe recurrence of the original Moderate back injury.

In some cases, what is claimed to be a re-instatement or recurrence may be a new injury.

Example 3: The same mechanic in Example 1 suffers a low back soft tissue strain injury from helping to lift a transmission. Clinical examination and radiological investigation reveal no evidence of disc injury or neurological compromise. Again, the injury is rated Moderate. The worker is off work for 3 months and requires opioids during this period. Following this, the worker returns to regular duties with no problems and six months after return to work, lifts a truck battery from the floor and turns to place it on the workbench. In doing so, the worker experiences excruciating low back pain and a burning/numbness down the right leg. A subsequent MRI reveals a large lumbar disc herniation. One might view this as a recurrence of the original injury, however, considering the lack of evidence of a disc or neurological injury from the original incident, the fact that the worker worked for six months with no problems, the nature and mechanism of the second incident, along with clear evidence of a new large disc herniation and new neurological signs, the weight of evidence would support the second incident to be a new and more significant injury than the original injury. In this circumstance, the new injury would likely be rated as Severe.

64.04 10 Weeks Post-Injury

At 10 weeks post-injury, most, if not all, minor injuries should be resolved and the claims closed. Those claims remaining open and active at 10 weeks should largely involve moderate to severe injuries.

At this point in the claim, a system-generated flag will appear to the decision maker indicating the claim number, the worker's name, and the fact that the worker is continuing to receive opioids (e.g. *"999999, John Doe, currently receiving opioids")*. The decision maker will confirm this from recent Form 8/10 reports and through the Claimsecure System.

In the case of more severe or complicated injuries, where the need for ongoing opioid coverage is reasonably obvious, the decision maker will refer the case to a WorkplaceNL Medical Consultant to determine if opioid coverage can be continued. If the Medical Consultant agrees, the decision maker documents his/her decision in the case worksheet (case worksheet) and notifies the worker and the treating health care provider in writing of the decision to provide a 4-week extension of opioid coverage beyond the 12-week post-injury mark.

64.05 12 Weeks Post-Injury

At 12 weeks post-injury, there are essentially six scenarios that may arise:

1. **The health care provider reports the worker no longer requires opioids for injury-related pain.**

In this instance, the decision maker either asks the Medical Consultant to move the worker to the appropriate non-opioid formulary, or restricts the opioid drug classes on the Claimsecure System. Also, the decision maker documents his/her decision in the case worksheet and notifies the worker and the health care provider of the decision in writing.

2. **The health care provider reports the worker still requires opioids for injury-related pain and the recommendation is supported by WorkplaceNL.**

In this instance, the decision maker refers the case for review by a Medical Consultant. If the Medical Consultant supports the recommendation, and the decision maker concurs, the decision maker documents his/her decision in the case worksheet and notifies the worker and health care provider in writing of the decision to provide a 4-week extension of opioid coverage.

3. **The health care provider reports the worker still requires opioids for injury-related pain and the recommendation is not supported by WorkplaceNL.**

The decision maker refers the case for review by a Medical Consultant. If the Medical Consultant does not support the recommendation, he/she must consult with the treating health care provider to discuss & determine if the evidence supports ongoing opioid coverage on the basis of the worker’s injury. The Medical Consultant must document the outcome of this consultation in the case worksheet and offer an opinion as to whether the medical evidence does or doesn’t support ongoing opioid coverage on the basis of the worker’s compensable injury.

If the decision maker determines that the balance of evidence is in favor of continuing opioid coverage on the basis of the worker’s compensable injury, again the decision to provide a 4-week extension of opioid coverage is documented in the case worksheet and communicated to the worker and health care provider in writing.

If, on the other hand, the decision maker determines that the balance of evidence is *not* in favor of continuing opioid coverage on the basis of the worker’s compensable injury, his/her decision is documented in the case worksheet and communicated to the worker and health care provider in writing. In such cases, the decision maker either asks the Medical Consultant to move the worker to the appropriate non-opioid formulary, or restricts the opioid drug classes on the Claimsecure System.

4. **The health care provider reports the worker's pain is now Chronic Pain and that continued opioid coverage is needed on this basis and the recommendation is supported by WorkplaceNL.**

In this instance, the decision maker again refers the case for review by a medical Consultant. If the Medical Consultant supports the recommendation, and the decision maker concurs, the decision maker's decision to continue opioid coverage on the basis of Chronic Pain is documented in the case worksheet and communicated to the worker and health care provider in writing, and early referral to a Chronic Pain Management Program is considered by the decision maker in consultation with the Medical Consultant.

5. **The health care provider reports the worker's pain is now Chronic Pain and that continued opioid coverage is needed on this basis and WorkplaceNL does not support the recommendation.**

The decision maker refers the case for review by a Medical Consultant. If the Medical Consultant does not support the recommendation, he/she must consult with the treating health care provider to discuss and determine if the evidence supports ongoing opioid coverage on the basis of 'injury-related' Chronic Pain. The Medical Consultant must document the outcome of this consultation in the case worksheet and offer an opinion as to whether the medical evidence does or doesn't support ongoing opioid coverage on the basis of 'injury-related' Chronic Pain.

If, in such cases, the decision maker determines that the balance of evidence supports the worker's ongoing pain to be 'injury-related' Chronic Pain (i.e. the Chronic Pain is compensable), the decision maker documents his/her decision in the case worksheet, notifies the worker and health care provider of the decision in writing, and asks the Medical Consultant to move the worker to F 21 (Chronic Pain Formulary). Early referral to a Chronic Pain Management Program is considered by the decision maker in consultation with the Medical Consultant.

If, on the other hand, the decision maker determines that the balance of evidence does not support the worker's ongoing pain to be 'injury-related' Chronic Pain (i.e. the Chronic Pain is not compensable), the decision maker must also make a determination whether the worker's ongoing disability is compensable.

If the decision maker determines the balance of evidence supports the worker's ongoing disability is compensable, he/she documents this decision in the case worksheet, notifies the worker and health care provider of the decision in writing, and either asks the Medical Consultant to move the worker to the appropriate non-opioid formulary, or restricts the opioid drug classes on the Claimsecure System.

If, instead, the decision maker determines the balance of evidence supports the worker's ongoing disability is not compensable, the decision maker closes the claim and notifies the worker and health care provider of the decision in writing.

6. **The health care provider reports the worker's ongoing pain is not related to the worker's compensable injury.**

As in the previous scenario, the decision maker must now determine if the worker's ongoing disability is compensable. Consultation with a Medical Consultant and the treating health care provider may be necessary to decide such cases.

If the decision maker determines the worker's ongoing disability is compensable, he/she either asks the Medical Consultant to move the worker to the appropriate non-opioid formulary, or restricts the opioid drug classes on the Claimsecure system. Also, the decision maker documents his/her decision in the case worksheet and notifies the worker and health care provider of the decision in writing.

If, on the other hand, the decision maker determines the worker's ongoing disability is not compensable, he/she closes the claim, documents the decision in the case worksheet and notifies the worker and health care provider of the decision in writing.

64.06 14 & 16 Weeks Post-Injury

1. At the 14-week post-injury mark, a flag identical to that at the 10-week post-injury mark will appear on the decision maker's Activity Management System. Again, this flag will indicate the claim number, the worker's name, and that he/she is currently receiving opioids. The procedure from here onto the 16-week post-injury mark is identical to that at the 10- and 12-week post-injury marks.

2. In those scenarios where at 12 weeks a 4-week extension of opioid coverage was provided, at 16 weeks, opioid coverage will continue on an indefinite basis with periodic file reviews to determine ongoing opioid coverage entitlement.

In cases where opioid coverage is extended beyond 16 weeks, the system will flag these cases every 8 weeks. When these flags appear, the decision maker should consult with a Medical Consultant if he/she is unsure whether opioid coverage should continue.

64.07 Additional Circumstances for Extended Opioid Coverage Beyond 16 Weeks:

1. Non-Disabling Intermittent Pain:

These are cases where the worker has returned to work or is participating in early and safe return to work with the pre-injury employer or the labour market re-entry program for alternative work, but who requires periodic opioids for intermittent pain control. WorkplaceNL will provide ongoing coverage for oral opioids only in such cases. Injectable opioids are not covered for these cases. Also, coverage for such cases should be reviewed periodically.

2. Non-Disabling Chronic (i.e. continuous) Pain:

These are cases where the worker is able to work but requires regular daily opioid dosing for chronic pain. Such cases are expected to be relatively rare. Caution is recommended to ensure these workers do, in fact, require ongoing daily opioids. The decision maker should consult with a Medical Consultant in such cases. The Medical Consultant, in turn, may choose to consult with the treating health care provider. In such cases (as per Table 3), a Therapeutic Agreement must be in place. Long-acting oral opioids with infrequent short-acting doses of the same opioid for breakthrough pain are covered for such cases. The Chronic Pain Report Form, however, is not required for these cases.

64.08 Claims Beyond 16 Weeks (Refer to Table 3)

To summarize, beyond the 16-week post-injury mark, there should essentially be five types of claims still receiving opioids:

1. **Those receiving opioids for Ongoing Injury-Related Pain**

These claims will usually involve more severe injuries. They should be reviewed periodically to determine ongoing opioid coverage entitlement. For such cases, short-and long-acting oral opioids are covered. Such cases may also include workers who have had some form of invasive treatment (e.g. surgery).

2. **Those receiving opioids for Chronic Cancer Pain**

In the early or non-advanced stage of a cancer, short or long-acting oral opioids are usually sufficient and will be covered. Exceptions, however, will be considered.

In the advanced or end-stage of a cancer, on the other hand, oral or parenteral (injectable) opioids will be covered as needed.

3. **Those receiving opioids for Non-Disabling Intermittent Pain**

These are cases where the worker has returned to work or is participating in early and safe return to work or labour market re-entry, but who requires ongoing intermittent opioids to control intermittent pain. For such cases, short-acting oral opioids will be covered. These cases should be reviewed periodically.

4. **Those receiving opioids for Non-Disabling Chronic Pain**

These are cases where the worker is able to return to work but who requires regular daily opioids for chronic (i.e. continuous) pain. Long-acting oral opioids with infrequent short-acting oral doses of the same opioid for breakthrough pain may be covered for such cases. A Therapeutic Agreement must be in place for continued opioid coverage. Therapeutic Agreement forms will be mailed to workers with decision letters. The worker must then bring this to his/her treating health care provider for discussion and signing, by both the worker and the treating health care provider. The treating health care provider keeps his/her copy for the worker's chart. The worker then takes the remaining two copies to the pharmacy where the dispensing pharmacist also signs the Therapeutic Agreement Form. The worker is then given his/her copy and the pharmacist faxes a copy of the pharmacy's copy to WorkplaceNL.

As for the Chronic Pain Report Form, this will not be required in these cases, as long as the worker is able to continue working. In these cases, for standard Form 8/10 is considered sufficient for monitoring and reporting.

5. **Those receiving opioids for disabling Chronic Pain**

For these cases, the worker's chronic pain must be accepted as compensable. A Therapeutic Agreement must also be in place for continued opioid coverage. As well, the Chronic Pain Report Form must be used in these cases for monitoring and reporting. The Therapeutic Agreement Form will be mailed to workers with decision letters. The worker must bring this to his/her treating health care

provider for discussion and signing, by both the worker and the treating health care provider. The treating health care provider keeps his/her copy for the worker's chart. The worker then takes the remaining two copies to the pharmacy where the dispensing pharmacist also signs the Therapeutic Agreement Form. The worker is then given his/her copy and the pharmacist faxes a copy of the pharmacy's copy to WorkplaceNL.

Long-acting oral opioids with infrequent short-acting oral doses of the same opioid for breakthrough pain may be covered. Short-acting oral opioids alone will not be covered. Injectable opioids, also, will not be covered. Transdermal opioids may be covered for individuals unable to tolerate oral opioids. Opioid suppositories may be covered on an exception basis.

In order for opioid coverage to continue in these cases, there must be a documented sustained improvement in the worker's pain and function. Finally, once a stable chronic pain treatment regime has been established, 4-6 doctor visits per year are considered adequate and reasonable for clinical monitoring and prescription refill. As such, WorkplaceNL will only cover this number of doctor visits unless there is a reasonable and documented rationale (related to the compensable condition) for any additional visits.

64.09 Cessation of Opioid Coverage

Under Policy HC-14, coverage for opioid treatment may be discontinued where:

1. The current status of the worker's compensable injury or condition no longer requires opioids;
2. There is insufficient evidence to support that the treatment is beneficial to the compensable injury;
3. There is evidence that the treatment is causing more harm than benefit;
4. The treatment is contributing to maladaptive pain behavior, unhealthy psychological dependence, and/or addiction; and/or
5. The treatment is a contributing factor to the worker's inability to fully participate in medical rehabilitation and/or return-to-work efforts.

The opinion and recommendation of a Medical Consultant will be sought in cases where the decision maker determines one or more of the above circumstances may exist. If the Medical Consultant does not feel there is a reasonable basis for concern, he/she may recommend close monitoring of the case. If, on the other hand, the Medical Consultant agrees there is a reasonable basis for concern, he/she will consult with the treating health care provider and document the outcome of this consultation in the case worksheet.

If, following this consultation, it is determined that cessation of opioid coverage is *not* indicated, the Medical Consultant may again recommend close monitoring of the case. If, however, it is determined that cessation of opioids *is* indicated, the Medical Consultant may recommend cessation of opioid coverage and may also make a recommendation regarding the conditions of such cessation (i.e. whether, and for what duration, a tapering period may be indicated).

If a tapering period is not indicated, the decision maker will document his/her decision in the case worksheet and will notify the worker, the treating health care provider, and the pharmacist in writing. In such cases, opioid coverage will cease immediately upon notification. If, on the other hand, a tapering

period is indicated, the decision maker will, in consultation with the Medical Consultant and the treating health care provider, set out the conditions of cessation in his/her letter to the worker, the treating health care provider, and the pharmacist.

Note: Once opioid coverage has been discontinued, WorkplaceNL may not approve coverage for any additional opioids in relation to the compensable injury. Further, any decision regarding coverage for opioid treatment for new or subsequent injuries will take into consideration the past experience and outcomes of opioid treatment for that individual.

64.10 Addiction

According to the Canadian and American Pain Societies, addiction is more a function of ‘host’ (i.e. patient) characteristics. These include individual psychological traits, socio-cultural context, the addicting substance or behaviour, and biogenetic predisposition (the latter appearing to be the most influential risk factor). Research shows that the appropriate use and monitoring of opioids to treat pain relatively rarely leads to opioid addiction. Evidence suggestive of addiction includes, but is not limited to:

i. Multiple episodes of early prescription refills,
ii. Double doctoring,
iii. Using street sources of opioids,
iv. Inability to acknowledge psychosocial contributors to pain,
v. The perception that no interventions other than opioids have any impact on pain and suffering,
vi. Persistent over-sedation and/or euphoria, and/or
vii. Deteriorating level of function despite evidence of adequate pain.

When there is evidence suggestive of opioid addiction, the decision maker will seek the opinion of a Medical Consultant. If the Medical Consultant does not feel there is a reasonable basis for concern, he/she may recommend close monitoring of the case. If, on the other hand, the Medical Consultant feels there is a reasonable basis for concern, he/she will consult with the treating health care provider and document the outcome of this consultation in the case worksheet

If, following this consultation, the Medical Consultant determines that there isn’t sufficient evidence of current or impending addiction, he/she may again recommend close monitoring of the case. If, however, it is determined that there is sufficient evidence of current or impending addiction, the Medical Consultant may recommend cessation of opioid coverage. In this case, the Medical Consultant will also make a recommendation as to whether a tapering period supervised by the treating health care provider is adequate intervention (assuming the health care provider is agreeable), or whether a formal Addiction Intervention (i.e. specialist or multidisciplinary intervention) is indicated. In such cases, the decision maker must decide firstly whether opioid coverage will be discontinued and secondly whether it is reasonable for WorkplaceNL to cover the Addiction Intervention.

In cases where a tapering period supervised by the treating health care provider is agreed upon, the decision maker documents his/her decision in the case worksheet and notifies the worker and health care provider in writing of the conditions of cessation, including the date opioid coverage will cease. In cases where formal Addiction Intervention is indicated, the decision maker will consult with the Medical Consultant and the treating health care provider to determine what intervention is available, reasonable, and beneficial for the worker. The decision maker documents his/her decision in the case

worksheet and notifies the worker, the treating health care provider, and the pharmacist in writing of the conditions for coverage of the formal Addiction Intervention. The decision maker also makes the arrangements for and monitors the Addiction Intervention (in consultation with a Medical Consultant where needed).

If the worker refuses Addiction Intervention or fails to complete the intervention process without just cause, opioid coverage will be discontinued. Also, the decision maker will determine the worker's further entitlement to benefits under Policy EN-17 "Interruptions and Delays in Work Injury Recovery". Again, the decision maker documents his/her decision in the case worksheet and notifies the worker, the treating health care provider, and the pharmacist accordingly in writing

Note: Once coverage for opioids has been discontinued, WorkplaceNL may not approve coverage for any additional opioids in relation to the compensable injury. Further, any decision regarding coverage of opioid treatment for new or subsequent injuries will take into consideration the past experience and outcomes of opioid treatment for that individual. Finally, for claims in which opioid coverage has been discontinued under the sections for *Cessation of Opioid Coverage* or *Addiction*, decision makers will have the ability to add comments to the file that will be flagged for future reference on those claims.

64.11 Exceptional Circumstances

In cases where the circumstances of a case are such that the provisions of Policy HC-14 cannot be applied or to do so would result in an unfair or unintended result, WorkplaceNL will decide the case based on its individual merits and justice. Such a decision will be considered for that specific case only and will not be precedent setting.

Reference: *Policy HC-14 Use of Opioid Medication for Compensable Injuries*

Amendment History

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TABLE 1: CRITERIA FOR RATING SEVERITY OF PAIN-CAUSING INJURY

Severity of Pain-Causing Injury will be judged from:

i. Mechanism of injury,
ii. Objective clinical / investigative findings reported following the injury, and
iii. Degree and duration of pain one would expect to result from the injury.

Decision Maker should consult Medical Consultant

Definitions:

***Minor* –** injury *not* expected to limit worker's ability to return to pre-injury work and/or to earn at pre-injury level beyond a short period of disability (usually 4 weeks or less) or to cause moderate-severe pain requiring opioid analgesics beyond the Acute Phase (1 – 2 weeks post-injury).

Example:
Most soft tissue injuries resulting from negligible or mild force / trauma; uncomplicated, small to medium size lacerations; minor burns to small body area (e.g. finger, hand, forearm, etc.)

***Moderate* –** injury *not* expected to limit worker's ability to return to pre-injury work and/or earn at pre-injury level beyond the normal expected healing time for that injury (usually no more than 4 – 12 weeks) or to cause moderate-severe pain requiring opioid analgesics beyond the Subacute Phase (2 – 12 weeks post-injury).

Example:
Uncomplicated fractures (e.g. wrist, ankle, etc.); uncomplicated low back strain injuries from lifting or from a fall; moderate burns to larger body area (e.g. truck or extremities).

Severe – injury is expected to result in long-term (6 months or longer) inability to return to pre-injury work and/or earn at pre-injury level and possibly even permanent partial or total disability. Such injuries may also result in long-term moderate-severe pain requiring opioid analgesics.

Example:
Major accidents, falls, or other significant trauma resulting in multiple soft tissue injuries and/or boney fractures and/or major spinal injury; major burns to large body area (e.g. trunk, head, and neck area or trunk and extremities).

TABLE 2: CRITERIA FOR RATING SEVERITY OF PAIN-CAUSING RECURRENCE OF INJURY

Severity of Pain-Causing Recurrence will be judged from:

i. Nature & severity of original injury (or resultant condition),
ii. Time elapsed since that injury,
iii. Degree to which the original injury/condition is resolved at time of recurrence,
iv. Time elapsed since opioids last needed on basis of that injury/condition,
v. Mechanism of recurrence,
vi. Objective clinical / investigative findings reported following the recurrence, and
vii. Degree and duration of pain one would expect to result from the recurrence, taking the above into account.

Decision Maker should consult Medical Consultant

Criteria / Guide:

Minor:

a. Original injury (or resultant condition) was rated Minor or Moderate, or would have been so rated under Policy HC-14,
b. Evidence supports original injury (or resultant condition) completely resolved 6 months or more,
c. Worker hasn't needed opioids in past 6 months or longer,
d. Mechanism of recurrence would support a Minor injury if a new injury were being claimed,
e. Objective clinical / investigative findings following recurrence would support a Minor injury if a new injury were being claimed.

Moderate:

a. Original injury (or resultant condition) was rated Moderate or Severe, or would have been so rated under Policy HC-14,
b. Evidence supports original injury (or resultant condition) not completely resolved at time of recurrence, or would be expected to result in intermittent flare-up of symptoms,
c. Worker hasn't needed opioids in past 3-6 months,
d. Mechanism of recurrence would support a Minor or Moderate injury if a new injury were being claimed,
e. Objective clinical / investigative findings following recurrence would support a Minor or Moderate injury if a new injury is being claimed.

Severe:

a. Original injury (or resultant condition) was rated Severe, or would have been so rated under Policy HC-14,
b. Evidence supports original injury (or resultant condition) not resolved at time of recurrence, or would be expected to result in deterioration / degeneration and worsening of symptoms over time,
c. Worker may have needed opioids as a result of original injury on an intermittent basis within past 3 months,

d. Mechanism of recurrence would support a Moderate or Severe injury if a new injury were being claimed,
e. Objective clinical / investigative findings following recurrence would support a Moderate or Severe injury if a new injury were being claimed.

NOTES: Recurrences

1. When rating Recurrences for injuries that occurred prior to May 1, 2004, the decision maker, in consultation with a Medical Consultant, must rate the original injury (or resultant condition), using the criteria in Table 1 for rating a New Injury. This rating must take into consideration whether events subsequent to the original injury (e.g. invasive treatments / surgical procedures necessitated by the original injury, subsequent compensable injuries or recurrences to same body area, or deterioration / degeneration normally expected to result from the original injury over time) may have worsened the severity of the original injury or resultant condition over time.

2. When consulting a Medical Consultant regarding the severity rating of a Recurrence, the decision maker should provide a brief but meaningful summary of the case, including:

    a. the date and mechanism of the original injury and that of any subsequent injuries or recurrences to the same body area,
    b. any subsequent invasive treatments necessitated by the original injury or by subsequent injuries or recurrences to same body area,
    c. time lost from work following the original injury, any subsequent injuries or recurrences to the same body area, and any subsequent invasive treatments,
    d. the worker's pre-injury job and current work or rehab status, and
    e. when the worker last received opioids on what basis.

3. When offering an opinion regarding the severity rating for a recurrence, the Medical Consultant must use his/her best clinical judgment to determine which rating is best supported by the overall weight of evidence and balance of reasonable medical probability. If in doubt, reasonable inference should be made in favor of the worker.

4. The closer the temporal proximity between the original injury and a recurrence, the more likely the recurrence will receive that same severity rating as the original injury.

5. In cases where the mechanism of a recurrence and/or the clinical / investigative findings following the recurrence are supportive of a severity rating beyond that of the original injury, consideration should be given to whether, in fact, a New Injury has occurred.

6. Likewise, in cases where a worker has been asymptomatic for several months or longer following a Minor or Moderate soft tissue strain injury, the development of similar symptoms following a new work incident may be indicative of a New Injury rather than a Recurrence of the original injury.

TABLE 3: USE OF OPIOIDS FOR VARIOUS PHASES/TYPES OF PAIN IN INJURED WORKERS

PAIN PHASE/TYPE	QUALIFIER	ANY ROUTE OF ADMINISTRATION	ORAL ROUTE ONLY	TYPE
Acute	1-14 days following a minor injury.	No	Yes	Short-acting Oral
	1-14 day following a moderate-severe injury or invasive treatment or while in hospital.	Yes		Short-acting oral or injection
Subacute	2-12 weeks following a minor injury	Opioids not covered		
	2-12 weeks following a moderate-severe injury or invasive treatment.	No	Yes	Short or Long-acting oral
	12-16 weeks (i.e. 4-week extension) following more severe injuries with clear organic basis for pain.	No	Yes	Short or long-acting oral
	16+ weeks (i.e. exceptional cases) where clear evidence of organic basis for ongoing pain.	No	Yes	Short or long-acting oral
Chronic Malignant (Cancer)	Early/non-advanced stage	Oral route normally adequate in early/non-advanced stage		Short or long-acting oral
	Advanced or end-stage	Yes		Short or long-acting oral or injection
Chronic Non-Malignant (non-cancer) –see Guidelines in Appendix	Therapeutic Agreement in Place. Chronic Pain Reporting Form used. Treatment resulting in improved pain and function	No	Yes	Long-acting oral with infrequent short-acting oral rescue dosing
	Treatment not resulting in improved pain and function and/or signs or evidence of opioid misuse, abuse or addiction and/or significant adverse side effects.	Opioids not covered		
Recurrent Flare-ups following moderate-severe injury	Worker working, but needs intermittent opioids to remain at work. Consult Med. Officer	No	Yes	Short-acting oral.
Chronic Pain but Working	Worker has chronic pain but chooses and can manage to work.	No	Yes	Long-acting oral with infrequent short-acting oral rescue dosing

*****Note: Exceptions to the above will be considered on the merits of the individual case.**

APPENDIX: WorkplaceNL Guidelines for the Use of Opioids in the Treatment of Chronic Non-Cancer Pain in Injured Workers

Introduction:

This Appendix includes a brief discussion of pain and its various types/phases, WorkplaceNL's *Guidelines for the Use of Opioids in the Treatment of Chronic Non-Cancer Pain in Injured Workers*, a Bibliography of sources used, and a Glossary of Terms.

Pain:

Pain is defined by the International Association for the Study of Pain as *"an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage".* It is a multidimensional subjective experience whose perception is influenced by cognitive, behavioral, environmental, and cultural factors and whose presence cannot be validated or objectively measured.

Pain is traditionally divided into Acute and Chronic pain. Some authors suggest that adding Sub-Acute pain (also known as Short-Term pain), as a transition stage from Acute to Chronic pain, is a useful distinction. Chronic pain is further subdivided into Chronic Cancer and Chronic Non-Cancer Pain (CNCP).

In general, acute and subacute pain following an injury (e.g. strained ligament, broken bone, lacerated tissue, etc.) is "normal" pain due to tissue damage and the normal healing processes. It serves a protective function and lasts until sufficient healing has occurred – typically days to weeks. It is usually associated with discernible organic pathology on clinical examination or investigation.

Chronic Cancer Pain can be nociceptive (i.e. due to tissue invasion or destruction) or neuropathic (i.e. due to damage to pain nerves). There is usually clinically discernible tissue damage on examination or investigation. The concept of "Total Pain", as it relates to cancer, recognizes the contribution of psychosocial factors to the degree of suffering.

Chronic Non-Cancer Pain persists beyond the usually expected time frame for normal tissue healing and/or resolution of the painful condition. It serves no known protective function and is considered by some to be a maladaptive response to a painful stimulus. Some research suggests that chronic non-cancer pain results from neurochemical and physical *"rewiring"* of pain pathways in the CNS called *"sensitization"* and *"neuronal plasticity".* There is also research suggesting there may be a genetic predisposition to the development of Chronic Non-Cancer Pain. Whatever the explanation, CNCP can have a severe impact on an individual at several levels (e.g. physical, emotional, psychological, social, and occupational). The longer CNCP persists, the more likely it is that psychological factors play an increasing role in the suffering and disability of the patient.

WorkplaceNL Guidelines for the Use of Opioids in the Treatment of Chronic Non-Cancer Pain in Injured Workers

1. Prevention is the first step in treating chronic non-cancer pain (i.e. chronic pain) in injured workers. Prevention of the development of debilitating chronic pain requires prompt and effective treatment of pain, education and reassurance regarding the meaning and significance of pain, promotion of independence, facilitation of rehabilitative efforts, encouragement to resume normal activities, and early return to gainful employment.

2. Opioids also can play a role in the treatment of chronic pain in injured workers, provided they cause no harm and provided they do not themselves contribute further to a worker's disability.

3. Opioids should not be considered first-line treatment for chronic pain. They should only be chosen when other non-opioid medications in conjunction with 'adjunctive modalities' (e.g. active physical therapy, exercise, education, reassurance, development of coping strategies, etc.) have failed to provide sufficient pain relief to enable the injured worker to begin to resume normal activities and to participate in rehabilitation and return-to-work efforts.

4. Prior to commencing opioid treatment for chronic pain, an adequate biopsychosocial assessment should be performed, including a brief screening for addiction potential. It is important to understand the diagnosis, or at least the probable underlying pathophysiology. If there is no reasonable understanding of the underlying pathophysiology and/or if there are concerns regarding potential adverse effects or impact of the treatment, the introduction of opioids is questionable.

5. Health care providers must balance pain relief with functional improvement when treating chronic pain in injured workers. It is inappropriate to focus solely on pain relief to the detriment of the worker's quality of life and ability to function.

6. Except in extenuating circumstances, long-term use of opioids should be under the direction of *one physician* and prescriptions should be dispensed by *one pharmacy*.

7. Prior to the commencement of opioid treatment for chronic pain in injured workers, a written *Therapeutic Agreement* between the worker, the prescribing health care provider and the dispensing health care provider must be agreed upon and signed by all three parties. This agreement is intended both to set clear boundaries for the appropriate use of opioid analgesics and as a clinical tool for providing informed consent. Therapeutic Agreement Forms will be provided to physicians by WorkplaceNL. Copies of such agreements will be filed with WorkplaceNL and reviewed and/or renewed at the discretion of WorkplaceNL.

8. When opioids are indicated for chronic pain*, long-acting oral opioid agonists* are the preferred, safest, and most efficacious choice. It may be wise to switch to a long-acting oral opioid agonist as soon as chronic pain is evident (perhaps even during the subacute phase in some cases) in order to provide more stable and sustained analgesia and to hopefully prevent the development of maladaptive chronic pain behavior.

9. The dosing regimen for chronic pain therapy should be on a *time-contingent* (i.e. set regular dosing), rather than a pain-contingent (i.e. as needed) basis.

10. Except at the beginning of a therapeutic trial or for occasional breakthrough pain, *short-acting oral opioids* are *not* indicated for the treatment of chronic pain. Once on an established long-acting oral opioid regimen, the need for short-acting oral opioids should be infrequent. When they are needed, however, the breakthrough opioid should be a short-acting form of the long-acting opioid the worker is already taking (i.e. same drug – short duration of action). The frequent need for 'rescue dosing' is an indication that either the long-acting opioid dose needs to be adjusted or the individual's pain is not fully responsive to opioids. The latter is an indication to consider modalities other than opioids to treat the worker's chronic pain.

11. In keeping with evidence-based recommendations, a step-wise approach to the treatment of chronic pain is recommended. When opioid therapy is indicated (i.e. non-opioid analgesics have proven inadequate), one would typically start with a combination opioid/non-opioid analgesic (e.g. acetaminophen + codeine +/- caffeine). If one reaches the maximum daily dose of acetaminophen and the escalation of the opioid appears to be improving the worker's level of pain and function, one can then step up to oral morphine (or other pure opioid agonist) in a round-the-clock (i.e. time-contingent) dosage.

12. At the commencement of opioid therapy for chronic pain, short-acting oral opioids are recommended:
- To determine if the worker's pain is responsive to opioid medication, and
- To determine the optimal dose required.

Increases in dosage may occur twice weekly as long as:
- There continues to be responsiveness to the opioid, and
- There are no unmanageable adverse effects.

Once a stable and effective short-acting oral opioid dose is reached, the worker should then be switched to a long-acting oral opioid in an equianalgesic dosage.

13. Where an increasing opioid dose is having little or no positive impact on a worker's pain and function, the physician needs to consider whether opioids are effective and/or appropriate for the condition being treated. In the absence of objective benefit to the worker and especially when notable adverse effects (e.g. physical side-effects, psychological sequelae, deteriorating function, and/or signs of over-dependence or addiction) are evident, serious consideration should be given to discontinuing opioid therapy altogether.

14. During the commencement and titration phase of opioid therapy, monitoring should occur once or twice weekly. Special attention must be given to pain control and functional improvement at every visit. Titration to an effective short-acting dose can, in most cases, be accomplished within 4 weeks. This period may be longer in some cases, however, if side-effects necessitate switching to other opioids. Once an effective short-acting dosing regimen is reached, the worker should be switched to an equianalgesic long-acting opioid. During the transition to a long-acting opioid, and for the subsequent 8-12 weeks following, monitoring every 2-4 weeks is considered reasonable and adequate. Once on an established long-acting opioid regimen, *monitoring* every 9-12 weeks (i.e. *4-6 visits per year*) is considered adequate. In this setting WorkplaceNL will not cover additional doctor visits unless there is a reasonable and adequately documented medical rationale for such additional visits.

15. Agonist-antagonist opioids (e.g. Talwin) have a poorer side-effect profile, are of questionable benefit in the treatment of chronic pain, and therefore will *not* be covered by WorkplaceNL for this purpose.

16. Demerol (meperidine) and Leritine (anileridine) are short-acting opioids which may lead to accumulation of the toxic metabolite normeperidine. These two opioids are not recommended in the treatment of chronic pain and therefore will *not* be covered by WorkplaceNL for this purpose.

17. Combinations analgesics containing barbiturates (e.g. Fiorinal) are short-acting analgesic/sedative medications which have a poorer side-effect profile, and have questionable utility beyond the acute phase of pain. Thus, such medications will *not* be covered by WorkplaceNL for the treatment of chronic pain.

18. Rectal and transdermal opioids will be considered on an individual basis at the request of the treating physician. Such medications will not be covered simply as a matter of convenience. Coverage will only be considered in those rare cases where it is appropriately demonstrated and documented (i.e. over a reasonable period of time) that significant adverse side-effects or other medical conditions preclude the use of any/all oral opioids.

19. The concomitant use of sedative or hypnotic benzodiazepines and opioids in chronic pain sufferers is discouraged, as the potential for adverse side effects and dependency is increased. As such, benzodiazepines or other sedative/hypnotic drugs will *not* be covered or included in WorkplaceNL's Chronic Pain Formulary. Emotional or depressive symptoms are best treated with anti-depressant medication, when indicated. Sleep disturbance is best treated with effective pain relief and, when indicated, one of the sedating tricyclic anti-depressants (e.g. Amitriptyline), when indicated.

20. In complex or difficult cases, treating physicians should consider appropriate specialist or multidisciplinary consultation. WorkplaceNL will determine the appropriateness of such consultations and will, to the best of its ability, facilitate the process when it is seen to be reasonable and necessary. In such cases, the treating physician is expected to work in co-operation with the recommendations of the specialist or multidisciplinary group to ensure the worker receives optimal and appropriate treatment. If there is a difference of opinion regarding medication recommendations, WorkplaceNL may elect to cover only those medications (and dosages) that the evidence best supports to be appropriate and optimal treatment.

GLOSSARY OF TERMS

Acute Pain: Pain immediately following an injury or invasive treatment (e.g. surgery) that results from tissue damage - usually lasts for hours to several days.

Addiction: A disease process involving the use of psychoactive substances wherein there is loss of control, compulsive use, craving, and/or continued use despite adverse social, physical and psychological consequences.

Agonist-Antagonist: Refers to an opioid medication that possesses both agonist and antagonist properties. An opioid agonist produces analgesia (pain relief), while an antagonist 'antagonizes' this effect. An example of a true opioid agonist is Morphine. An example of an opioid agonist-antagonist is Talwin (pentazocine).

Analgesic: Refers to a medication that is designed to relieve pain.

Chronic Cancer Pain: Pain associated with advanced or end-stage cancer.

Chronic Non-Cancer Pain (or Chronic Pain): Pain that persists beyond the expected time frame for normal tissue healing and/or resolution of the painful condition – usually up to 3 months for most injuries or invasive treatments (e.g. surgery).

Chronic Pain Syndrome: An older term used to describe a constellation of symptoms, characterized primarily by chronic pain, but also associated with persisting physical, emotional, psychological, social and occupational dysfunction.

Equianalgesic Dosage: Refers to doses of different pain medications that provide the same level of pain relief (i.e. analgesia).

Organic Pain: A term used to refer to pain that has a reasonably obvious physical basis (e.g. broken bone, torn soft tissue, nerve root impingement, etc.). Some authors differentiate Organic Pain from Chronic Non-Cancer Pain on the basis that CNCP is known to be significantly influenced by psychological, social, cultural, economic, and occupational factors.

Opioids: Refers to natural or synthetic narcotic analgesics that have opiate-like physical activities.

Oral Administration: refers to the administration of a medication by mouth.

Parenteral Administration: Refers to the administration of a medication by some form of injection (i.e. intravenous, intramuscular, subcutaneous, intrathecal, etc.).

Physical Dependence: A physiological state of adaptation to a specific psychoactive substance characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence does not necessarily correlate with addiction and may be a normal consequence of long-term opioid therapy.

Psychological Dependence: A subjective sense of need for a specific substance, either for its positive effects or to avoid any negative effects associated with its abstinence. While psychological dependence does not necessarily equate with addiction, in cases where opioid therapy is not proving to be of adequate and appropriate benefit, suggestion or evidence of psychological dependence should be of concern to the treating health care provider.

Subacute Pain: The period of pain experience between the acute phase and the chronic phase – pain persisting beyond 1-14 days (the acute phase) and lasting up to 3 months. Pain beyond 3 months, in the absence of objective evidence of an organic (i.e. physical) cause, is considered chronic pain. Subacute pain is usually less intense than acute pain and is regarded as organic pain/discomfort experienced during tissue healing and remodeling.