WorkCover QUEENSLAND

Pain Intervention Guidelines

December 2020

WorkCover QUEENSLAND

Table of contents

Background

WorkCover Queensland monitors trends in the treatment and use of item codes through analysis of state-wide data. This helps us to ensure injured workers receive optimal quality of care and their return to work outcomes are maximised, whilst maintaining a financially viable scheme that also balances costs for employers.

Conditions detailed in the explanatory notes of the Medicare Benefits Schedule (MBS) also apply to the medical items schedule of fees with some exceptions, including multi-operational rule and assistant's fees. The schedule is available at worksafe.qld.gov.au.

The pain intervention guidelines are to be used as a guide for approving and billing for pain interventions. WorkCover staff will use these guidelines when approving requests for interventional procedures and associated invoices.

Where a procedure is identified for a second opinion, WorkCover staff will seek the assistance of the Medical Advisory Panel or an Independent Medical Examiner prior to approval of the procedure.

Should a medical specialist seek an exception to the guidelines, it is recommended that they contact the Customer Advisor and provide a written explanation to support the request, for consideration. Further expert medical opinion may be sought by WorkCover to assist with approving procedure requests or invoices.

These guidelines may also be used for post-payment data analysis to identify ongoing payment trends and issues.

WorkCover guidelines are based on evidence based-medicine.

WorkCover acknowledges the expertise and contribution of all stakeholders that provided comment for the review of the pain intervention guidelines.

Core principles for interventional pain procedures

Research shows that a collaborative multidisciplinary approach to persistent pain provides the most successful outcomes for patients in terms of increased function.

If pain interventions are indicated, they must not formulate the entire treatment plan.

Except for neuromodulation, pain interventions are temporary in their effect and should be provided to a worker to create a window of opportunity to actively participate in rehabilitation.

A worker's psychosocial state heavily influences the perception of pain and the outcomes of any intervention and therefore must be addressed as part of the treatment plan.

The success of pain interventions is measured in terms of increased capacity and function.

The clinical weight of comorbidities must also be considered.

Multiple operation rule

The fees for two or more operations, other than amputations (MBS Group T8 subgroup 12), performed on a patient on the one occasion should be calculated using the following rule.

Surgical procedures:

Includes surgical procedures set out in MBS Group T8, subgroups 1 to 11, 13, 16 and 17

- 100% for the item with the greatest WorkCover fee;
- plus 50% for the item with the next greatest WorkCover fee;
- plus 25% for each other item.

Orthopaedic / Hand surgery procedures:

Includes orthopaedic procedures set out in MBS Group T8, subgroups 14 and 15

- 100% for the item with the greatest WorkCover fee;
- plus 75% for the item with the next greatest WorkCover fee;
- plus 75% for each other item.

Where a medical practitioner performs both surgical and orthopaedic procedures on the one occasion, each rule applies in its entirety to the relevant items. This will result in two items with fees at 100%.

The following table illustrates how the multiple operation rule will be applied to multiple item numbers:

MBS SUB-GROUP	100% OF FEE	ORTHOPAEDIC / HAND SURGERY 100 / 75 / 75%	SURGICAL 100 / 50 / 25%
1 to 11 (Items 30001 – 44136)			✓
12 – Amputations (Items 44325 – 44376)	✓		
13 – Plastic and Recon Surgery (Items 45000 – 45996)			✓
14 – Hand Surgery (Items 46300 – 46534)		✓	
15 – Orthopaedic (Items 47000 – 50658)		✓	
16 – Radiofrequency and Microwave Tissue Ablation			✓
17 – Spinal Surgery (Items 51011 – 51171)			✓

WorkCover QUEENSLAND

Reference guide

PAIN INTERVENTION PROCECURE	DESCRIPTOR	CLINICAL INDICATION
Intradiscal Platelet-Rich Plasma (PRP) injection	Injection of PRP into the spinal disc for discogenic back pain. Usually for the treatment of intervertebral disc degeneration (IDD). IDD is not usually a work-related injury.	Not approved in WorkCover. Current evidence-based research does not support.
Intravenous (IV) infusion of Lignocaine	IV Lignocaine infusions involve the release of Lignocaine into the bloodstream.	Not generally approved by WorkCover. Only instance this intervention may be considered is for neuropathic pain. If Lignocaine treatment is requested by treating practitioner, justification will be sought from them regarding use and expected outcome, followed by a 2nd opinion to consider approval.
IV infusion of Ketamine	IV Ketamine infusions involve the release of Ketamine into the bloodstream.	Not approved in WorkCover. Current evidence-based research does not support.
Neuromodulation – Spinal cord stimulation – Root ganglion – Peripheral nerve (Codes 39130 - 39134) Putting in stimulator (Codes 21110, 23112)	Electrical modulation of the nervous system to manage neuropathic pain and improve function. Electrodes are positioned in the epidural space with the aim to replace unpleasant with pleasant sensation. Typically requested for neuropathic pain regarding spinal injuries, Complex Regional Pain Syndrome (CRPS) and hernia post-surgery complications.	May be considered if there is evidence of radicular neuropathic pain or of a nerve injury/damage. (e.g. persistent post-operative pain) For all neuromodulation requests, WorkCover will follow all of the below pathways prior to consideration for approval (also note points 12 and 13 of General Information section on this guidelines): 1. Obtain Treating pain physician report querying: – Physical and psychiatric treatment to date including response and outcomes – pain medication response to date – if a pain management program has been considered (if not, why), attendance and outcome – justification for the neuromodulation request and explanation of whether this treatment is pertaining to the work-related injury.

PAIN INTERVENTION PROCECURE	DESCRIPTOR	CLINICAL INDICATION
		2. An independent psychiatric assessment (preferably from a Psychiatrist that specialises in the treatment of pain) is also required prior to consideration IME report questions to include are: – current psychiatric status – if the injured worker is responding to treatment – if their psychiatric status is significantly contributing to the pain experienced rather than a neuropathic cause. 3. An independent pain physician IME assessment. 4. If both the psychiatric and pain physician independent IME assessments support that the neuromodulation intervention is to treat the work-related injury with expected pain reduction and functional gain outcomes, WorkCover will then firstly approve a neurostimulator trial. Success to be measured by a greater than 50% pain reduction and an increase in functional ability (based on reports from the both treating pain provider and verbal reports of the injured worker). 5. If the neurostimulator trial has been successful, WorkCover may then approve a neuromodulation surgery request. A quote will be required regarding the cost of the neuromodulation device and leads, in combination with the surgery request from the treating pain physician. NOTE: Transcutaneous approach (application via very shallow needle through the skin) is not approved in WorkCover.
Code 39138 - Percutaneous electrical nerve stimulation	Refers to applying electrical stimulation through small needles which penetrate the skin (transcutaneous application)	Not approved in WorkCover.
Spinal drug delivery	Chemical modulation of the nervous system to manage persistent pain or improve function. Spinal drug delivery is done via an implanted pump. Will need refilling.	Not approved in WorkCover. Current evidence-based research does not support.

PAIN INTERVENTION PROCECURE	DESCRIPTOR	CLINICAL INDICATION
Sympathetic ganglion block - Stellate ganglion (Code 18284) - Lumbar ganglion (Code 18286) Neurolithic block (Code 18296)	Sympathetic block can be produced with local anaesthetic deposited at the sympathetic ganglia, e.g. stellate ganglia and lumbar sympathetic ganglia.	Not approved in WorkCover. Current evidence-based research does not support.
Spinal perineural block (nerve root blocks) (Codes 18232, 18274, 18276)	An injection of steroids and local anaesthetic close to the nerve. This injection can be done under CT guidance billed under code 57341.	WorkCover will approve for treatment of acute pain only. Not approved for chronic pain.
Prolotherapy	The term "prolotherapy" is an abbreviation of "proliferative injection therapy" and is also known as sclerotherapy. Prolotherapy consists of a series of intraligamentous and intratendinous injections of solutions in trigger points near the pained area to induce the proliferation of new cells.	Not approved in WorkCover. Current evidence-based research does not support.
Medial branch nerve blocks (Code 39013)	Facet joints (also called zygapophyseal joints) are small joints of the spine that provide stability and help guide motion. They are found in the neck (cervical), upper back (thoracic) and lower back (lumbar). The medial branch nerves can be injected with a local anaesthetic and/or steroid. There are two reasons for doing this:	WorkCover will approve a nerve block as a diagnostic tool to identify the nerve sources of persistent pain. WorkCover will only approve medial branch blocks for: the accepted work related injured spinal level (eg L4/5) and a maximum of 1 disc level above (eg L3/4) and /or below the injured disc level (eg L5/S1) a maximum of 2 medial branch blocks per approved spinal level (eg. one either side of the injured disc) may be approved. (See General Information section point 5). If medial branch blocks are successful in reducing pain, radio frequency neurotomy may then be requested and can be approved.

PAIN INTERVENTION PROCECURE	DESCRIPTOR	CLINICAL INDICATION
	1. Diagnosis: If the local anaesthetic in the injection relieves the pain then it suggests that the facet joints are a source of the pain. **2.** Therapy: The steroid in the injection can reduce inflammation, reduce medial branch nerve sensitivity and provide significant pain resolution.	
Suprascapular blocks (code 18256)	Is usually done as a diagnostic test to establish efficacy of blocking this nerve in reducing persistent shoulder pain. In case of a positive response, can be followed by a pulsed RF or thermal RFN of the nerve (item 39323).	Both item numbers are usually used in conjunction with an imaging item number. 61109 for fluoroscopy or 55054 for ultrasound.
Facet joint block	Injection of local steroid anaesthetic into the zygapophyseal joint. Large proportion done by radiographers from GP referrals.	Not approved in WorkCover nor accepted as a specific diagnostic test. For a diagnostic tool, see medial branch block as an option. For treatment of back pain, the evidence-based research for steroid only injections is weak and does not support facet joint blocks as an effective treatment option ie. Poor evidence that these injections are efficacious treatment wise.
Radio Frequency Neurotomy (RFN) (Code 39118, 39323)	An interventional procedure to ablate the nerve to a lateral facet joint.	See General Information point 14 for this procedure. WorkCover will firstly approve up to 2 comparative diagnostic nerve branch blocks performed on different dates with results providing a pain reduction of above 50% (from both treating Dr and patient reporting). Consideration also to be given to the duration of pain relief prior to RFN approval). Maximum of 6 RFN's to be approved at one time (ie 3 spinal levels either side) will be approved.

PAIN INTERVENTION PROCECURE	DESCRIPTOR	CLINICAL INDICATION
		For repeat RFN requests to the same area, WorkCover will seek justification from the treating Doctor, followed by an independent IME pain physician assessment prior to approval consideration.
Pulsed Radio Frequency Neuromodulation (RFN) (Code 39323)	The use of pulsatile, high frequency, non-destructive (non-thermal) electrical energy to modulate nerve function in the dorsal root ganglion (DRG) or peripheral nerves. Main indicators are typically in the instance of lumbar radiculopathy following disc prolapse post-surgery.	WorkCover will seek written justification from the treating provider followed by an independent IME pain physician assessment, prior to approval consideration if this procedure is requested. NOTE: – If approved, Pulsed RFN does not require a prior diagnostic test (such as nerve blocks) – For spinal injuries, WorkCover will only approve up to a maximum of two spinal levels (including work related injury level) for Pulsed RFN
Steroid injections (Cortisone) into a joint or soft tissue structure (excluding spine) (Code 39100)	Injected corticosteroids have an anti-inflammatory effect. Common conditions for injections are shoulder pain, knee pain, medial and lateral epicondylitis, plantar fasciitis, carpal tunnel syndrome.	Prior approval is not required from WorkCover. NOTE: Intervention must however be for an accepted work-related injury.
Epidural steroid injections - Caudal-sacral - Lumbar - Transforaminal (Code 18232 or 39140)	A block to the nerves from the lower part of the spinal cord (the lumbar and sacral nerves) by inserting a needle injecting local anaesthetic and steroid through the gap between the tailbone and the lowest segment of the sacrum.	WorkCover will approve this intervention for only short-term treatment of sciatica or radicular pain. Injection can be done under x-ray control as a day procedure (Codes 61109 or 60506-60509 being requested in addition). If requested for chronic low back pain, WorkCover will seek justification from the treating Doctor and query if this intervention is for the work-related injury. An independent opinion will also be sought.
Botox injections (Botulinum toxin) (Codes 18292, 18350 - 18379)	Botulinum toxin injection works by preventing nerve impulses from reaching a muscle, causing the muscle to relax.	WorkCover will seek a second opinion if this procedure is requested (preferably from a Neurologist or a Rehabilitation Physician) to ensure treatment is for the work-related injury. A maximum of 3 injections to be covered if approved.

PAIN INTERVENTION PROCECURE	DESCRIPTOR	CLINICAL INDICATION
Cluneal nerve block or radiofrequency lesion ablation (e.g. percutaneous neurotomy)	Injection of the cluneal nerve with a local anaesthetic and/or steroid or ablation of the nerve. Main indicators are for damage to cluneal nerves post fusion surgery or chronic back or pelvic pain.	WorkCover will seek justification from the treating Doctor as to why they consider this treatment is pertaining to the work-related injury. A Medical Advisory Panel (MAP) opinion will also be requested.
Percutaneous ablative surgical procedures: (Codes 39121, 39124) Sympathectomy (Codes 20622, 20632, 35000-35012)	Ablative open surgical procedures. *Sympathectomy* involves a surgical procedure that destroys nerves in the sympathetic nervous system.	Rare in a WorkCover setting. Ablative open surgical procedures are generally not approved in WorkCover as evidence supports failed long term benefits. WorkCover will seek justification from the treating Doctor as to why they consider this treatment is pertaining to the work-related injury. A Medical Advisory Panel (MAP) opinion will also be requested.
Intravenous regional sympathetic block (e.g. Bier's Block) (Code 18213)	IV regional sympathetic nerve block (also called IV regional anaesthesia) is a technique used to anaesthetise one particular region of the body, for example an arm or a leg, without affecting the rest of the body.	Not approved in WorkCover. Current evidence-based research does not support.
Bisphosphonate – IV or oral	Bisphosphonates mimic substances in the body with complex actions relating to bone and calcium turnover. For treatment of CRPS injuries. Bisphosphonates done concurrently with graded motor imagery can help facilitate rehabilitation.	Can be approved by WorkCover in conjunction with graded motor imagery if diagnostic criteria is met to confirm CRPS.

General information

1. WorkCover will only approve procedures that are undertaken to treat changes caused by the work-related injury or event. Where a claim has been accepted as an aggravation of a pre-existing medical condition, WorkCover must consider whether the proposed procedure is to treat a work-related injury or pre-existing changes. If the procedure is to treat pre-existing changes, WorkCover will not be able to cover the procedure.
2. Interventional pain procedures will only be approved in circumstances where the treating medical specialist is willing to engage with WorkCover to achieve the best outcomes for the worker. This includes the requirement to respond either verbally or in writing to requests for information necessary for WorkCover to make relevant decisions regarding the proposed treatment plan.
3. For all pain interventions, these general principles should be considered:
    a. Appropriate indications exist
    b. Appropriate patient selection
    c. Multidisciplinary assessment
    d. Positive response to trial (if available)
    e. Must be used in conjunction with a self-managed rehabilitation approach
    f. Appropriate skills and adequate infrastructure of the practitioner and facility
    g. Future financial implications must be explained to the worker by the treating Doctor to allow the worker to make an informed decision regarding any ongoing costs associated with the procedure (if any)
    h. Goal is to increase capacity and function
4. Procedures will only be considered if they complement long term functional gain.
5. Levels imply intervertebral levels, not number of vertebrae. (i.e. L5-S1 = 1 level, L4-S1 = 2 levels, etc.)
6. Definitions:
    a. Aggravation: A factor which may or may not be work-related that has caused structural worsening of pre-existing changes of a permanent nature.
    b. Exacerbation: A factor which may or may not be work-related that has caused a temporary worsening of a pre-existing medical condition with no structural changes.
    c. Recurrence: A recurrence requires no identifiable incident as trigger to resumption of symptoms or signs related to the pre-existing medical condition.
    d. New injury: An identifiable new incident must be shown to have caused the injury.
    e. Disability: A decrease in, or the loss or absence of, the capacity of an individual to meet personal, social or occupational demands.
    f. Impairment: A loss, loss of use, or derangement of any body part, organ system, or organ function.
7. Indications for consideration of interventional pain procedures for persistent pain:
    a. Pain for more than three months
    b. Objective evidence of a nerve injury/damage or facet joint pathology
    c. Evidence of pain interfering with personal activities of daily living (ADL) and personal care
    d. Difficulty with returning to work due to persistent pain
    e. Pain that has not responded to medical or surgical treatment
    f. Opioid dose less than 100mg morphine equivalent

g. There is no evidence of major psychological or psychosocial issues
h. Evidence-based research must exist to support efficacy of the intervention

8. Decision-making process for interventional pain procedure requests:
   a. Consider current medical information and review pain guidelines.
   b. Consider the worker's past medical history – is further information/GP records required?
   c. Consider the worker's past and current work history – is a return to work likely?
   d. Consider the worker's comorbidities and capacity to return to work.
   e. If further information is required, request treating medical specialist (TMS) to clarify rationale for proposed procedure and relationship of procedure request to accepted WRI. TMS also to advise how the requested pain intervention is expected to increase the worker's level of function and work capacity and over what duration.
   f. If a second opinion is warranted, seek an independent medical opinion (IME/MAP).
   g. If contrary independent opinion obtained, discuss further with TMS.
   h. Consider weight of all medical information and evidence provided to make a decision.
   i. Ensure decision communicated to TMS.

9. Patient selection is key:
   a. All procedures must be considered as part of a multidisciplinary pain rehabilitation program, not as a stand-alone procedure.

10. Flags for pain intervention contra indications:
    a. Procedures with no evidence or poor evidence of outcome
    b. Patients with unresolved medical management
    c. Actively suicidal
    d. Patients who are unwilling to actively participate in rehabilitation post procedure
    e. Untreated psychiatric illness
    f. Impaired cognitive function
    g. Substance abuse (including alcohol, opioids (daily opioid dose exceeding 100mg morphine equivalent)*, benzodiazepines, marijuana, illicit drugs)**
    h. patients with:
       i. current or potential litigation
       ii. unresolved industrial difficulties
       iii. overt secondary gain
    i. Period of time off work before procedure (consider motivation for RTW)

    (* in excess of 90mg / day opioid intake considered 'high' as per Medications Regulation & Quality)

    (** Note: for workers with accepted work-related / secondary addiction issues, WorkCover may support treatment by an appropriate addiction medicine specialist.)

11. Complex Regional Pain Syndrome (CRPS)

    For the purposes of consideration of approval for pain interventions, WorkCover use the diagnostic criteria for CRPS Type 1 and 2 from the Guidelines for evaluation of permanent impairment (GEPI) Table 17.1.

    The Budapest criteria is recognised as the international diagnostic criteria for research purposes. Patients with CRPS must have completed conservative 1:1 therapy with an appropriately qualified therapist (e.g. specialised physiotherapist) prior to consideration for interventional procedures. The only evidence-based treatment for CRPS is graded motor imagery performed by a competent physiotherapist in conjunction with adequate psychiatric treatment.

12. Neuromodulation

    Must have completed a multidisciplinary pain program (MDP) with evidence of active engagement.

    MDP must include psychological/psychiatric evaluation and recommendations.

    Neuromodulation should be carried out in a multi-disciplinary (medical, functional and psychosocial) pain clinic setting where adequate assessment and long term follow-up is carried out.
    Injured worker (patient) and treating specialist to indicate that the patient understands and commits to post WorkCover claim costs regarding the neuromodulator.

13. Neuromodulation exclusion factors (if any one of these is demonstrated by the patient, neuromodulation should not be approved):
    a. Daily opioid dose greater than 90mg morphine equivalent
    b. Active psychiatric illness, including depression, anxiety, PTSD, psychosis, paranoia, anger issues
    c. Active suicidal behaviour or self-harm behaviour
    d. Alcohol or drug dependence or misuse
    e. Cognitive impairment
    f. Overt secondary gain issues
    g. Worker does not consent to future financial liability for neuromodulation costs
    h. Failed trial of neuromodulation (usually 5-day trial) – the patient does not demonstrate functional improvement and report a significant decrease in pain.

14. Radiofrequency Neurotomy (RFN) levels

    The number of injections approved in any single procedure is limited to 6.

    It is important to note that RFN is for the treatment of facet joint pain. This is separate to disc pain, although both commonly occur at the same time, not always at the same pain level.

    For spinal injuries, medial branch blocks should be done prior to RFNs to confirm diagnosis and to support approval of RFN procedure. Note: medial branch block can be approved one level above or below injury level to check where nerve root pain is stemming from.

    If RFN is recommended for sacro-iliac joints (SIJ), then only one side will be approved at a time. Diagnostic block (SIJ or lateral branch) to confirm diagnosis is required before such approval.

15. Code 61109 for fluoroscopy in an angiography suite – all procedures carried out under radiology guidance where 61109 is gold standard as it produces less radiation and better image quality. This code is approved in combination with any of the injection interventions.

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