



## Pain Management Clinical Practice Guideline

### OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the management of pain. The CPG discusses the assessment and treatment of acute and chronic, neuropathic and nociceptive pain, as well as behavioral health implications of chronic pain. In addition, the CPG outlines the organizations that WellCare aligns with regarding pain management and relevant Measurements of Compliance and Measureable Health Outcomes. WellCare has a separate “*Palliative Care (HS-1045)*” Clinical Practice Guideline that more broadly addresses best-practices for improving quality of life and anticipating/minimizing suffering caused by a chronic and / or life-threatening illness.

### OVERVIEW

Pain is cited as the most common reason Americans seek health care and is a major contributor to health care costs. Approximately one in every four Americans has suffered from pain lasting longer than 24 hours, and an estimated 25 million adults (11%) have reported a pain event that occurred every day for at least a 3-month period. Chronic pain is the most common cause of long-term disability.<sup>1,2</sup> 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.”<sup>3</sup> The characterization of pain as a temporal process (continuum of pain) begins with an acute stage and potentially progresses to a chronic state:<sup>4</sup>

- **Acute pain:** a time limited and expected physiologic effect of trauma, disease, surgery or illness that may progress to a chronic pathological state<sup>4</sup>
- **Chronic Pain:** a complex biopsychosocial condition that has a distinct pathology with biological, psychological, and cognitive correlates that may interfere with many aspects of a person’s life (high impact chronic pain)<sup>4</sup>

Pain is categorized along various dimensions; one of the most useful is the division of nociceptive vs. neuropathic pain:

- **Nociceptive pain:** results from activity in neural pathways secondary to actual tissue damage or potentially tissue-damaging stimuli.<sup>5</sup> Examples: sprains, fractures, burns, bruises, inflammation from infection or arthritis.
- **Neuropathic pain (NP):** chronic pain that is initiated by nervous system lesions or dysfunction and can be maintained by a number of different mechanisms. Three common conditions that are associated with acute and chronic NP are diabetic peripheral neuropathy (DPN), postherpetic neuralgia (PHN), and cancer.<sup>5</sup>

Pain conditions are diverse and require individualized assessment and treatment; pain is a subjective experience with both psychologic and sensory components. In addition, pain may be present even in the absence of tissue damage.<sup>5</sup>

## Hierarchy of Support

### GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Academy of Neurology (AAN) [neuropathic pain], the American Academy of Pain Medicine (AAPM), and the World Health Organization (WHO) [pediatric pain], and the American Pain Society (APS) [low back pain and pain related to sickle cell disease]. When there are differing opinions noted by national organizations, WellCare will default to the

Member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to pain management, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with AAN, AAPM, WHO, and APS. Highlights from their respective publications are noted below.

### **AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)**

The Agency for Healthcare Research and Quality (AHRQ) and the National Quality Measures Clearinghouse recognizes the following clinical process quality measure related to pain management as developed by the Institute for Clinical Systems Improvement (ICSI):

- Assessment and management of chronic pain: percentage of patients 18 years and older diagnosed with chronic pain with functional outcome goals documented in the medical record. ([click here](#)).

AHRQ also has 5 clinical outcome quality measures related to pain management developed by the American Medical Directors Association outlined as such:

- Percent of patients with documentation of:
  - Reduction of pain symptoms
  - Achieving pain control goals after treatment
  - Adverse drug reactions to pain medications
  - Severe opioid-related constipation or fecal impaction
  - Controlled adverse drug reactions to pain medications

For other National Quality Measures Clearinghouse measures related to pain management, click [here](#).

### **AMERICAN ACADEMY OF NEUROLOGY (AAN)**

The AAN provides several guidelines/recommendations related to neuropathic pain including (but not limited to):

- |  |   |
|--|---|
| • Treatment of Painful Diabetic Neuropathy                               | • Treatment of Postherpetic Neuralgia   |
| • Use of Epidural Steroid Injections to Treat Radicular Lumbosacral Pain | • Efficacy of Transcutaneous Electric Nerve Stimulation in the Treatment of Pain in Neurologic Disorders  |
| • The Diagnostic Evaluation and Treatment of Trigeminal Neuralgia        | • Management of Adults with Acute Migraine in the Emergency Department                                    |
| • Acute and Preventive Pharmacologic Treatment of Cluster Headache       | • Pharmacologic Treatment for Episodic Migraine Prevention in Adults                                      |
| • Botulinum Neurotoxin in the Treatment of Autonomic Disorders and Pain  | • Pharmacological Treatment of Migraine Headache in Children and Adolescents                              |
| • Botulinum Neurotoxin for the Treatment of Movement Disorders           | • Evaluation of Distal Symmetric Polyneuropathy: Role of Autonomic Testing, Nerve Biopsy, and Skin Biopsy |
| • Botulinum Neurotoxin for the Treatment of Spasticity                   | • Efficacy and Safety of Medical Marijuana in Selected Neurologic Disorders                               |
| • Complementary and Alternative Medicine in Multiple Sclerosis           | • Intravenous Immunoglobulin in the Treatment of Neuromuscular Disorders                                  |

The organization also endorses several other organizations, including the American Chronic Pain Association (ACPA), in the support of patients living with chronic pain and their families. These resources can be accessed [here](#).

### **AMERICAN ACADEMY OF PAIN MEDICINE (AAPM)**

The American Academy of Pain Medicine (AAPM) has four clinical guidelines for the use of treating those with pain:

- Methadone for Pain Management: Improving Clinical Decision Making
- Acute Pain and Cancer Pain
- Medical Treatment Utilization Schedule Proposed Regulations
- Use of Opioids for the Treatment of Chronic Pain

*For the Primary Care Provider: When to Refer to a Pain Specialist* is a position statement (available [here](#)) to help primary care Providers determine when it is appropriate to refer a Member to a pain specialist and/or behavioral health services. Additional position statements from the AAPM are available [here](#).

### **WORLD HEALTH ORGANIZATION (WHO)**

WellCare recommends review of the *WHO Guidelines on the Pharmacological Treatment of Persisting Pain in Children with Medical Illnesses* (available [here](#)) which include the following topics:

- Classification of pain in children, which is critical to selecting an effective treatment approach
- Evaluation of persisting pain, which guides differential diagnosis of the cause(s) of pain, and assist choice of diagnostics to investigate or confirm diagnosis
- Pharmacological treatment, including using the right analgesics based on the characteristics of the pain, and:
  - Use a two-step approach (paracetamol and ibuprofen for mild pain, opioids considered for moderate/severe persisting pain)
  - Dose at regular intervals
  - Use the appropriate route (avoid painful routes when appropriate)
- A summary of WHO recommendations for improving access to pain relief.

The guidelines do not include pain management for acute traumas, perioperative and procedural pain. Also, chronic complex pain where there is no evidence of ongoing tissue disruption such as fibromyalgia, headache, or recurrent abdominal pain is not addressed, as treatment of these conditions requires a multimodal approach. Non-pharmacologic therapy (cognitive, behavioral, physical, and supportive therapies) is also beyond the scope of these guidelines.

### **AMERICAN PAIN SOCIETY (APS)**

The APS has published four clinical guidelines (available [here](#)) for the use of treating those with pain:

- Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Non-Cancer Pain
- Guideline for the Management of Acute and Chronic Pain in Sickle-Cell Disease
- Methadone Safety: A Clinical Practice Guideline from the American Pain Society and College on Problems of Drug Dependence
- Interventional Therapies, Surgery, and Interdisciplinary Rehabilitation for Low Back Pain
- Diagnosis and Treatment of Low Back Pain

### **CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)**

The CDC has published recommendations (available [here](#)) for the treatment of chronic pain regarding opioids:<sup>9</sup>

- Guidelines for determining when to initiate or continue opioid for chronic pain
- Opioid selection, dosage, duration, follow up, and discontinuation
- Assessing risk and addressing harms of opioid use

## **Evidence Based Practice**

### **MEASUREMENT OF COMPLIANCE**

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Measures of Compliance*.

NOTE: To access Clinical Policy Guiding Documents visit [www.wellcare.com](http://www.wellcare.com) – select the Provider tab, then “Tools” and “Clinical Guidelines”.

## Care Management

The goals for Care Management is to support the Member's ability to self-promote their health and management of pain, encourage healthy behaviors to minimize risks to health and wellbeing, and remove barriers preventing the Member from achieving those goals. Thorough assessment is the cornerstone to creating an individualized, effective pain management strategy. Members should receive education and coaching regarding the elements of pain to recognize and be prepared to describe to the practitioner to help with appropriate diagnosis and treatment:<sup>6</sup>

- **Characteristics**

*Neuropathic*: burning, shooting, tingling, radiating, lancinating, electric or numbness

*Nociceptive (somatic/ visceral)*: achy, throbbing, dull, squeezing, pressure, cramping, bloating, deep, stretching

- **Severity / Intensity**: often successfully communicated using some version of a visual or numeric pain scale)
- **Duration**: Comes and goes? Constant but worse or better depending on associated factors?
- **Associated Factors**: what makes it better / worse? (i.e. certain activity, weather, medications, massage, relaxation, heat/cold)
- **Location(s)**: identify all locations, each may have different descriptions
- **Impact of Pain**: how does pain affect daily activities, social engagements, work/school attendance, sleep
- **Side Effects of Medication**: loopy, groggy, anxious, constipated

For Members who are nonverbal or cognitively impaired, the Care Team should educate and coach the Member's caregivers regarding the cues of pain to recognize and be prepared to describe to the practitioner such as grimacing, crying or yelling (or increased frequency/intensity thereof), and protective body movements/posturing.

**Integrated Care Management**: Since pain is highly subjective, the Care Team's assessment of the pain sufferer as a whole person, including all relevant biological, social, psychological, and spiritual dimensions pertaining to etiology and impact of pain, is essential. **Patients with chronic pain often experience reduced function in both their physical and mental health, as well as a decrease in sleep, employment, immune function and damaged interpersonal relationships.**<sup>10</sup> Integrated care management for pain requires the interdisciplinary Care Team to work collaboratively to overcome obstacles and alleviate the Member's pain through:<sup>7</sup>

- Member access to Pain Medicine services
- Prioritizing routine and event-related pain assessment and management
- Treatment of underlying conditions that contribute to pain
- Care Team awareness of pain treatment-related substance misuse, abuse, addiction, and diversion, including risk assessment and management
- Assessing for appropriateness of including a pain specialist on the Member's Care Team (if not already included)
- The Care Team should also assess risk of depression and poor coping skills to share with appropriate Provider(s) if risks identified.

**Opioid Usage in Managing Pain**: There is no substantial evidence that shows an improvement in either pain or function with long-term opioid use for the management of chronic pain. Considering the substantial risk for serious side effects such as overdose and addiction with long term opioid use, non-pharmacologic treatments and non-opioid medications are preferred for managing chronic pain, with the exception of terminal illnesses. Opioid alternatives are also recommended for mild to moderate acute pain. If opioids are prescribed, the following guidelines should be followed:<sup>10</sup>

- Immediate Release (IR) opioids should be prescribed over Extended Release (ER) or Long-Acting (LA) opioids.<sup>10</sup>
- For acute pain, IR opioids should be prescribed at the lowest effective dose with a reassessment completed no later than 3-5 days to determine if adjustments or continuation of opioid therapy is needed.<sup>10</sup>
- Opioid usage should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy.<sup>9</sup>
- Realistic goals for pain and function should be discussed with the member before opioid therapy is started, and a plan should be set for discontinuing opioids if benefits are not outweighing the risks.<sup>9</sup>
- Members should be evaluated for benefits and harms within 1-4 weeks of starting opioid therapy, or after a dose increase, and opioids should be tapered off if benefits are not exceeding the risks.<sup>9</sup>

- Factors that increase the risk of opioid overdose include:<sup>9</sup>
  - History of past overdose
  - History or family history of substance use disorder
  - Opioid dosage of >50 Morphine Milligram Equivalents (MME) per day
  - Concurrent benzodiazepine use
  - History of mental health conditions
- Members who are high risk should be given a naloxone prescription or have other strategies in place to lower the risk of overdose.<sup>9</sup>
- A review of the state's Prescription Drug Monitoring Program (PDMP) should be completed prior to prescribing opioids, and occasionally throughout treatment.<sup>9</sup>
- Members should have a urine drug test before opioid treatment is prescribed and at least annually after, should use only one pharmacy to fill their medications, and should keep their medications in a locked or secure location.<sup>9</sup>

### MEASURABLE HEALTH OUTCOMES

Targeted Health Outcomes (Extended Program Goals) result from successful Member self-management (see Case Management Objectives).

1. The Member reports no impact of pain symptoms on sleep and/or activity over a specific period of time after the start of Case Management engagement. Member-specific goals should reference impact of pain on Member's sleep and activity.
  - To measure successful Member self-management, the Member's response to pain assessment are used; information related to sleep and activity is used, comparing initial to subsequent assessment responses.
2. The Member experiences no uncontrolled pain requiring acute medical care and intervention. The case manager compares the recent utilization frequency for pain management to the frequency prior to CM engagement.

To measure successful Member self-management, Case Management monitors for ED and inpatient authorization / utilization related to the primary diagnosis of uncontrolled pain. In absence of ED and inpatient utilization, authorizations and claims data, or to otherwise demonstrate less frequent need for acute medical intervention, CM may use Provider and/or Member narrative.

### CASE MANAGEMENT GOALS

Case Goals should target specific care gaps and/or adherence issues, and measure the Member's progress towards self-management and adherence which will lead to the targeted health outcomes above. Examples:

- Member's description of pharmacologic and non-pharmacologic techniques (such as meditation) over the last 30 days matches the Provider's prescribed pain management plan.
- Member reports satisfaction with pain management regime over last 14 days.
- The results of the Member's pain interview portion of the assessment score shows Member is receiving good pain control within 30 days of case management engagement.
- Improved function such as being able to walk a certain distance or complete a hobby or a daily task for a sustained period of time without needing a rest within 30 days of case management.
- Engaging in an exercise program such as yoga or physical therapy exercises at least 30 minutes a day at least 4 days a week within 30 days of case management engagement.

Specific for Members requiring hospitalization: The Member participates in Provider follow-up visit within 7 days of hospital discharge.

### CASE MANAGEMENT OBJECTIVES

Case Management objectives should focus on improving the Member's self-management skills – objectives include:<sup>8</sup>

- Applying various non-pharmacological options such as:
  - Cognitive Behavioral Therapy (CBT)
  - Physical Therapy
  - Exercise / Movement / Stretching / Yoga
  - Ice therapy

- Heat therapy
- Tens unit
- Aromatherapy
- Massage
- Relaxation techniques / meditation / guided imagery
- Learning about the various pain management techniques and options available
- Working with the Provider or pain specialist to select specific pain management options to utilize
- Identifying barriers to managing pain – cultural, financial, medication concerns (fear of addiction, side effects)
- Discussing the pain management regime including what works and what doesn't with the Provider
- If pain is unresolved, discussing possible pain management specialist with the Provider
- Considering complementary / alternative medicine with the Provider (e.g., acupuncture, herbal supplements)
- Staying as active as possible, attempting good posture as able
- Using adaptive equipment and ergonomic tools/techniques as recommended by the health care team
- Taking medications as prescribed, including pain medication
- Understanding the importance of taking medications on schedule to minimize breakthrough pain (it is easier to avoid breakthrough pain than to regain control)
- Participating in a support group that focuses on coping with pain
- Keeping a pain log if recommended by your Provider, and sharing results at each visit
- Attending all appointments as scheduled
- Making sure you follow the safety labels for pain medications (i.e. no driving, fall risk strategies)
- Aiming for a healthy weight (overweight and obesity increase strain on muscles, joints, and heart)

### MEDICAL AND BEHAVIORAL INTEGRATION

Pain and related iatrogenic causes (like side effects of pain treatment / pharmacology) can influence a Member's capacity to understand information, apply reason and judgment, and make decisions that are fully voluntary and autonomous. The Care Team must remain aware of these potential influences on a Member's decision-making capacity. The psychiatric aspects of pain, and chronic pain more specifically, have to be considered as part of the holistic care of a Member requiring pain management. Pain can occur alongside other diseases and conditions (e.g. depression, post-traumatic stress disorder, traumatic brain injury).<sup>1</sup> Chronic pain is associated with behavioral disorders (including depression, anxiety, and substance abuse), although the nature of the relation, especially in terms of cause and effect, is often unclear. However, regardless of cause and effect, it may prove necessary to treat both the depression and the pain to reach the Member's goals. Refer to the following WellCare Clinical Practice Guidelines: *Major Depressive Disorders in Adults (HS-1008)*, *Depressive Disorders in Children and Adolescents (HS-1022)*, and *Substance Use Disorders (HS-1031)*.

In the absence of identifiable or known physiological mechanisms, physical symptoms such as pain may indicate specific syndromes classified as somatoform disorders, including hypochondriasis, conversion disorder, psychogenic pain disorder, and somatization disorder. The American Family Physician article, "[Somatic Symptom Disorder](#)" offers guidance on differential diagnosis.

### MEMBER EDUCATIONAL RESOURCES

WellCare contracts with Krames/StayWell for Member educational materials utilized by Case Managers. Items are available to review with Members to address knowledge gaps. Case Managers verbally educate Members on the topics below related to the management of pain. (Titles may also be sent to the Member).

NOTE: Links (if available) are internal for WellCare Care Management staff:

- [Medicine for Pain](#)
- [Understanding Chronic Pain](#)
- [Understanding the Pain Response](#)
- [Measuring Your Pain](#)
- [Communicating About Pain](#)
- [Hospice: Importance of Managing Pain](#)
- [Delivering Pain Medicine](#)
- [The Cycle of Chronic Pain](#)
- [Managing Your Child's Pain](#)
- [Common Myths About Pain Medicines](#)
- [Pain Management After Surgery](#)
- [Your Child's Medicine: Managing Pain](#)
- [Managing Chronic Pain: Therapies for Mind and Body](#)
- [Managing Post-Op Pain at Home: Non-Medication Relief](#)
- [Managing Post-Op Pain at Home: Medicines](#)
- [Understanding Transcutaneous Electrical Nerve Stimulation \(TENS\)](#)

- [Managing Chronic Pain: Medicines](#)

Providers may wish to research the titles above related to diabetes that Case Managers utilize with Members.

### Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Depressive Disorders in Children and Adolescents (HS-1022)*, *Major Depressive Disorders in Adults (HS-1008)*, and *Substance Use Disorders (HS-1031)*. NOTE: Clinical Policies can be accessed by going to [www.wellcare.com](http://www.wellcare.com) – select the Provider tab, then “Tools” and “Clinical Guidelines”.

### References

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10. United States Department of Defense, Department of Veterans Affairs. (2017). VA/DoD clinical practice guideline for opioid therapy for chronic pain (pp. 1-198). Washington, DC: The Office of Quality, Safety and Value, VA.

### Disclaimer

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Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona  
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)  
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)

### Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
4/5/2018	<ul style="list-style-type: none"> <li>• Approved by MPC. Included item from the CDC and information on managing pain.</li> </ul>
4/6/2017	<ul style="list-style-type: none"> <li>• Approved by MPC. New.</li> </ul>