

AdMIRable REVIEW

JOURNAL OF THE TENNESSEE
MEDICAL IMPAIRMENT RATING REGISTRY

VOLUME 11
Fall Issue
2022



**Case Law:
Appeals Board
Explores Legal
Presumptions**

NOCIPLASTIC PAIN

EDITORIAL BOARD

Christopher Acuff, PHD

University of Tennessee, Chattanooga, TN

**Christopher R. Brigham, MD,
MMS, FACOEM, FIAIME**

Brigham and Associates, Inc.,
Hilton Head Island, SC

Robert R. Davies, Esquire

Director, BWC Legal Services, Nashville, TN

La Shawn Debose-Pender, MPS

Coordinator, Memphis Region, Memphis TN

Suzy Douglas, RN

BWC Medical Services Coordinator, Nashville, TN

Mark Finks, Esquire

BWC Legal Services, Nashville TN

Jeff Francis, MA

BWC Assistant Administrator, Nashville TN

Charles S. Herrell, Esquire

Ombudsman Attorney, Nashville TN

James W. Hicks, Esquire

Ombudsman Attorney, Nashville TN

**Douglas W. Martin, MD, FACOEM,
FAAFP, FIAIME**

UnityPoint Health, St. Luke's
Occupational Medicine, Sioux City

Darlene C. McDonald

Ombudsman, Nashville TN

Kenneth M. Switzer

Chief Judge, TN CWCC, Nashville TN

Amanda M. Terry, Esquire

Director, BWC Administrative Services
BWC Legislative Liaison, Nashville TN

Marion White, MSP

Next Step Program Specialist, Nashville TN

EDITOR-IN-CHIEF

Troy Haley, Esquire

BWC Administrator
Nashville, TN

EDITORIAL STAFF

MANAGING EDITOR

Jay Blaisdell, MPA, MA

Coordinator
Nashville, TN

MEDICAL EDITOR

James B. Talmage, MD

BWC Assistant Medical Director
Cookeville, TN

MEDICAL CONTRIBUTOR

Robert B. Snyder, MD

BWC Medical Director, Nashville TN

LEGAL EDITOR

Jane Salem, Esquire

Staff Attorney, TN CWCC
Nashville, TN

RETURN-TO-WORK EDITOR

Brian Holmes, MA

BWC Director, MOST
Nashville, TN

COPY EDITOR

Sarah Byrne, Esquire

Staff Attorney, TN CWCC
Nashville, TN

DESIGN EDITOR

Kyle Jones

BWC Communications Coordinator
Nashville, TN



Views expressed in AdMIRable Review are solely those of the authors and may not reflect the official policy or position of the American Medical Association, the Tennessee Bureau of Workers' Compensation, the Tennessee Court of Workers' Compensation Claims, the Tennessee Workers' Compensation Appeals Board, or any other public, private, or nonprofit organization. Information contained in AdMIRable Review is for educational purposes only and should not be considered to be legal or medical advice. In all cases, you should consult with a licensed professional familiar with your particular situation before making any decisions.

In This Issue of AdMIRable Review

Volume 11, Fall 2022, Pages 11140 to 11164



MEDICAL

[Nociceptive Pain—New Name for an Old But Underrecognized Concept](#)



MEDICAL

[Abstracts of Interest Regarding Chronic Pain](#)



LEGAL

[Appeals Board Explores Legal Presumptions](#)



MILESTONES

[AdMIRable Review Celebrates 10-Year Anniversary](#)

Nociplastic Pain—New Name for an Old, But Underrecognized Concept

James B. Talmage, MD



Have you had a parent say to you that “life was simpler in the old days”? Older physicians can reflect over a long medical career and remember diseases we recognize and treat today that once were unknown and without treatments.

The World Health Organization (WHO) publishes the International Classification of Diseases (ICD), which is familiar to physicians and healthcare institutions because ICD code(s) are required for billing purposes. In 1978 the World Health Organization recognized more than 14,000 diseases in ICD-9 [Hamad 2021], and today over 85,000 diseases are recognized in ICD-11 (Wikipedia - ICD).

As an example of changes, in 2013 the American Psychiatric Association published the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). This created a new diagnosis “Somatic Symptom Disorder” (DSM-5 300.82, a.k.a. ICD-10 F45.1). This was conceptualized as having excessive anxiety, time, and energy devoted to somatic or physical symptoms, and a subcategory was created for those with these “excesses” due to pain. This eliminated the prior categorization of some pain as “medically unexplainable,” as most mental health practitioners cannot determine if pain is, or is not, medically explainable. Neurologists use the term “functional disorders” instead of medically unexplainable. General physicians requesting psychologist or psychiatrist consultations rarely state the pain is medically explainable or medically unexplainable. This also eliminated the prior mental diagnosis of “somatoform pain disorder” in DSM-IV-TR.

Many general physicians ignore the idea of medical “explainability” and use the biomedical model assuming that all pain is explainable as either nociceptive or neuropathic. Nociceptive pain is a normal nervous system correctly reporting to the brain pain from a “peripheral” source. Examples would be pain from a broken ankle, acute appendicitis, natural childbirth, etc. Neuropathic pain is an injured or diseased peripheral nervous system falsely reporting pain in the absence of ongoing peripheral injury, inflammation, disease, etc. Examples would be a lacerated nerve still sending out pain signals years after injury, painful diabetic neuropathy, or phantom pain felt in the part of the limb that had been amputated years ago.

In 2016 the International Association for the Study of Pain (IASP) Special Interest Group on Neuropathic Pain updated their 2008 definitions based on eight more years of published research (Finnerup, 2016). In 2016 there were TWO types of pain – nociceptive pain and neuropathic pain – using the BioMedical Model.

Despite abundant literature on the BioPsychoSocial Model of pain's clear superiority in explaining pain presentations by including psychological and social influences on pain perception, many doctors continued to view patient pain presentations exclusively through the BioMedical Model on which they were trained in medical school: "the patient's pain complaints must have a physical and identifiable source." Since it was first proposed by Engel in 1977 (Bolton 2019), the biopsychosocial model has been criticized and refined by additional science.

In 2019, medicine's conception of pain changed, as the IASP and the WHO collaborated for ICD-11 and created a new name for a type of previously unnamed pain that humans have experienced over eons of time: **Chronic Primary Pain**. Currently, however, the United States uses the ICD-10 iteration. But in January 2022, Europe changed to the ICD-11 edition, which includes this new definition of pain. Creation of the ICD-11 started in 2007 and involved over 3000 specialists from 55 countries. Even after official endorsement by the 72nd World Assembly of the WHO in May 2019, minor revisions have occurred. Europe and over 25 countries have been using ICD-11 since its current form was published in January 2022. The U.S. is expected to change from ICD-10 to ICD-11 sometime between 2025 and 2027. The U.S. has historically been slow to adopt new editions of the ICD, even though revisions were prompted by recently-published science. Prior to 2019 articles were published on Central Sensitization (Mayer 2011), but no official diagnosis existed for this concept.

The new ICD-11 term, Chronic Primary Pain (CPP): is chosen when pain has persisted for more than 3 months and is associated with significant emotional distress and/or functional disability, and the pain is not better accounted for by another condition. As with all pain, this article assumes a biopsychosocial framework for understanding CPP, which means all subtypes of the diagnosis are considered to be multifactorial in nature, with biological, psychological, and social factors contributing to each. Unlike the perspectives found in DSM-5 and ICD-10, the diagnosis of CPP is considered to be appropriate independent of identified biological or psychological contributors, unless another diagnosis would better account for the presenting symptoms. Such other diagnoses are called "chronic secondary pain" where pain may at least initially be conceived as a symptom secondary to an underlying disease. The goal here is to create a classification that is useful in both primary care and specialized pain management settings for the development of individualized management plans, and to assist both clinicians and researchers by providing a more accurate description of each diagnostic category (Nicholas, 2019).

So now we have two terms: **chronic primary pain** and **nociceptive pain** meaning almost the same thing. The first is a diagnosis, and the second is a mechanism of pain perception.

Thus, persisting pain solely from an arthritic knee (nociceptive pain) and persisting pain from a lacerated nerve or diabetic neuropathy (neuropathic pain) would be types of **chronic secondary pain**.

Pain intensity that appears out of proportion to objective pathology should trigger physicians to consider that part, or all, of the pain presentation may be **nociplastic pain**.

Many chronic pain conditions have an obscure etiology and pathophysiology, but they are characterized by a complex interplay of biological, psychological, and social factors. Currently, these conditions are covered by labels such as chronic widespread pain (CWP), fibromyalgia, complex regional pain syndrome, type I (CRPS1), temporomandibular disorder (TMD), irritable bowel syndrome (IBS), and most back pain and neck pain conditions, which invariably include vague and ambiguous terms such as “nonspecific,” “somatoform,” or “functional” (Nicholas, 2019).

The definition of the new diagnosis of CPP is intended to be agnostic with regard to etiology; in particular, it aims to avoid the obsolete dichotomy of “physical” vs “psychological,” as well as exclusionary terms that define something by what is absent, such as “nonspecific.” The meaning of “functional” is also ambiguous. Some take it to mean “all in the mind” and others as a “disorder of function” (Nicholas, 2019).

A search of the National Library of Medicine (Pubmed 2022) in October 2022 yielded 127 articles published in the last three years indexed as discussing nociplastic pain. This author has acquired 74 of these publications for this review.

Consensus is that this concept is important to recognize both in cases with no clear source for pain, as well as in cases with a potential source but with more pain and disability than expected for the degree of pathology. The importance of this concept is the recognition that a nociplastic pain presentation, or a pain presentation with a significant component of nociplastic pain (“mixed pain”), requires a different treatment approach.

Nociplastic pain does not in general respond to or improve with treatment aimed at an anatomic structure, as in a joint, disc, ligament, muscle, etc. (Fitzcharles, 2021).

It is important to recognise this type of pain, since it will respond to different therapies than nociceptive pain, with a decreased responsiveness to peripherally di-

rected therapies such as anti-inflammatory drugs and opioids, surgery, or injections (Fitzcharles, 2021).

In the past 5 years, the term nociplastic pain has been introduced, in which objective abnormalities might or might not be present, but in which the principal mechanism is sensitisation of the nervous system. Just as neuropathic pain and nociceptive pain can co-exist, nociplastic pain can be present in cases of nociceptive or neuropathic low back pain.

Studies have identified common and disease-specific changes in white and grey matter brain regions in patients with chronic low back pain, such as the dorsolateral prefrontal cortex thalamus, temporal lobes, and insula and primary somatosensory cortex, indicating that chronic pain is associated with structural reorganisation.⁴⁹ Functional changes, such as alterations in blood flow and metabolism, have also been described. A study on patients with low back pain has shown that deleterious anatomical and functional changes can be reversed with treatment (Knezevic, 2021).

Perhaps an analogy from the computer world would be helpful to physicians and to patients. Nociceptive pain might be like having a mouse or keyboard that stopped functioning. Without this input, the computer doesn't function, or perhaps the person expresses pain as a reason not to function. This can be fixed by attaching a new mouse or keyboard (or perhaps joint replacement).

Neuropathic pain might be like the cable that attaches the mouse or keyboard to the computer breaking. The computer again does not function, or the patient expresses pain as a reason not to function. Attaching a new mouse or keyboard to the computer by the same old cable will not allow the computer to function. The mouse or keyboard cable is like the peripheral nervous system that attaches the joint or disc to the brain. In computers this is fixed by attaching the device with a new cable, but unfortunately for human neuropathic pain, we only sometimes have a way to "fix" this. Nerve decompression surgery may be an example.

Nociplastic pain is considered a brain process, with no anatomic lesion on brain imaging by CT or MRI. Functional MRI and PET scans show locations where brain neurons are metabolically active in a particular fraction of a second and have resulted in the concept of brain networks, or groups of neurons, that are active simultaneously. If the "lesion" in nociplastic pain is in the brain, altered or learned neural networks seems to be currently the only postulate. The brain is theorized to "learn" by forming connections between neurons (brain cells) and strengthening connec-

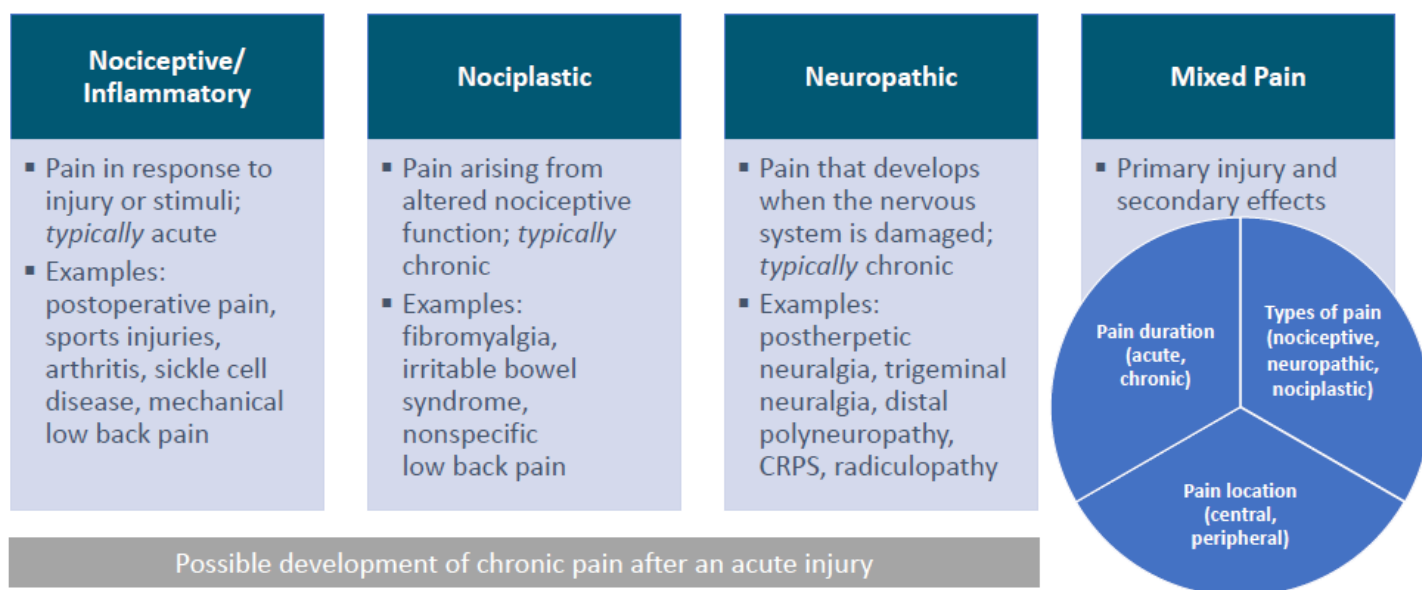
tions (synapses) between brain cells (Mikulasch, 2021; Fields, 2020; Zador, 2019; Denève, 2017).

Nociplastic pain is the mouse or keyboard functioning normally, and the cables they connect with are normal, but the computer software still won't run normally. In computers this may be fixed by restarting ("rebooting") the computer, or repairing or reuploading the software. In humans if nociplastic pain represents a learned response, with learned altered connections of neurons in the brain (new neural networks), cognitive behavioral therapy and slow graduated increases in activity and exercise may be helpful to unlearn pain. But again treatment directed toward a peripheral "pain generating structure" will not likely be helpful. If the software is malfunctioning, changing the mouse, keyboard, or cables will not "fix" it.

To further complicate this issue, "mixed pain," that includes components of two or three of these pain categories, is a possibility (Freynhagen, 2019).

While a consensus has not been reached on how to determine whether nociplastic pain is present, and if present, whether there is also nociceptive and/or neuropathic pain (i.e. mixed pain) in a specific patient, the current and evolving literature gives helpful hints.

Types of Pain



Trouvin. Best Pract Res Clin Rheumatol. 2019;33:101415.
 iasp-pain.org/resources/terminology. Nicholson. Am J Manag Care. 2006;12:S256.

One potential method to recognize nociplastic pain is diagnosis based.

Currently, these conditions are covered by labels such as chronic widespread pain (CWP), fibromyalgia, complex regional pain syndrome, type I (CRPS1), temporomandibular disorder (TMD), irritable bowel syndrome (IBS), and most back pain and neck pain conditions, which invariably include vague and ambiguous terms such as “nonspecific,” “somatoform,” or “functional” (Nicholas, 2019).

Another potential method involves history and physical examination. Standardized “pencil and paper” or computerized questionnaires ask the same questions with the same words in the same order, and therefore take some of the subjectivity out of patient history. The central sensitization inventory or the 2016 criteria to diagnose fibromyalgia may be helpful (Wolfe, 2016).

The most important part of the history taken by a physician is for the physician to document ALL places the patient hurts (where, when, known triggers, and if the pain is present all the time), and not just where the pain is from the current complaint. This is especially important in work-related incidents or injuries where the focus is on one body part. The current concepts of fibromyalgia and the identification as chronic widespread pain correlate with nociplastic pain. On physical examination the concepts of allodynia and hyperpathia should be documented, both in

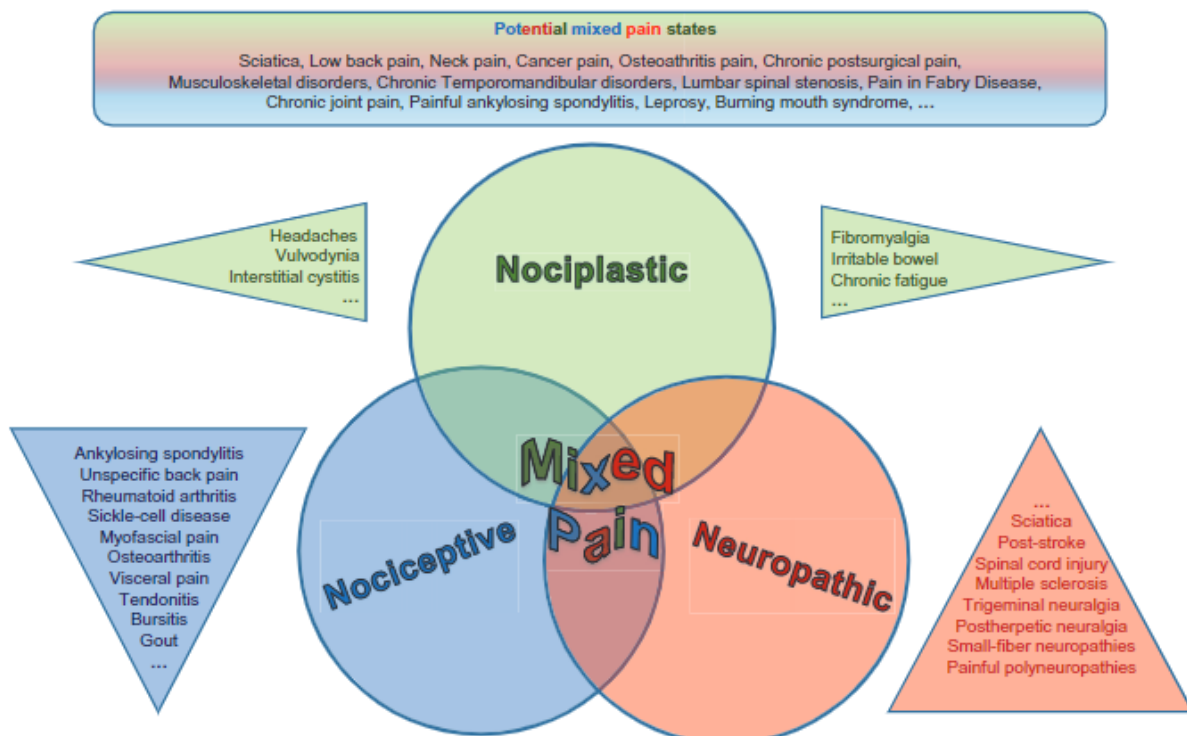


Figure 1. The three different types of pain defined by the IASP give rise to overlap which can be acknowledged as “mixed pain” (Freyenhagen©). Conditions described as “mixed pain” in the literature share a common characterization of manifesting clinically with a substantial overlap of the different known pain types.

(Potential Mixed Pain States as published in Freynhagen et al, 2019)

the area where the patient's current pain is located AND ALSO in other locations (other side of the body, and if the pain is below the diaphragm, then document above the diaphragm, etc.).

Allodynia is the perception of a stimulus as painful when that stimulus should not be painful. An example is testing light touch for allodynia by gently stroking the skin with a soft, small paint brush. This is not normally painful, but if reported as painful by the patient, nociplastic pain should be suspected.

Hyperpathia is exaggerated perception of a normally mildly painful (nociceptive) stimulus as more painful than generally expected, suggesting a lower threshold for stimuli to be perceived as painful. Examples used in published studies are pressure threshold (how hard the examiner pushes with a thumb or pressure measuring instrument before the person says "it's painful") and temperature threshold measurements (heated water in a glass test tube -- which temperature is perceived as painful).

Results of questionnaires and physical exam tests may vary by condition. If we consider chronic low-back pain, Schuttert et al published a 2021 systematic review (Schuttert et al, 2021). They screened 12,764 articles for relevance and reviewed 34 published studies in detail. They note that while there is no way to prove central sensitization in humans, it has been proven to occur in animals where the experiments include surgically implanted electrodes in their brains. We hypothesize that it should also occur in humans. Thus, they use the term "Human Assumed Central Sensitization" (HACS) as a pseudonym for nociplastic pain. Now we have three terms. Since no standardized and accepted definitions of this concept exist, or methods of how to document its presence with testing, the 34 studies use the studies' authors' "clinical judgment" as the reference standard for the presence or absence of "HACS." This is a familiar problem for physicians, as the diagnostic "reference standard" for who has fibromyalgia, myalgic encephalitis from Covid, Malingering, Painful Irritable Bowel Syndrome, etc. is typically "Clinical Judgment." No objective test exists for many conditions, including almost all mental illnesses.

Schuttert et al. concluded the Central Sensitization Questionnaire (CSI) [Mayer 2012], available in multiple languages, was the most frequently used history instrument (22 of the 34 studies).

This systematic review estimated the prevalence of HACS (a.k.a. nociplastic pain) as 71% in 16 studies of 2347 patients of the chronic low back pain patients as assessed only by the CSI.

In the eight studies that categorized patients as having just chronic low back pain or having chronic low-back pain AND pain in other anatomically unrelated body regions, the prevalence of HACS or nociplastic pain at a higher “cut point” score of 40 or greater on the CSI was 41% in those with just low-back pain and was 42% in those with both chronic low-back pain and also pain elsewhere. This suggests that this instrument at this cut point isn’t affected by the presence of pain elsewhere.

The prevalence of HACS in chronic low-back pain AND pain elsewhere patients was 61% if tactile allodynia was present on physical exam. In patients with just chronic low-back pain and no pain elsewhere, the prevalence of HACS by tactile allodynia was just 13%, suggesting the presence of pain elsewhere affects pain perception threshold. Combining these two groups yielded an overall prevalence of HACS or nociplastic pain in 49% in 128 patients with chronic low-back pain.

This example of a common condition in a workers’ compensation population suggests that treatment requests for chronic low back pain should include an assessment of whether nociplastic pain is likely present or absent in the patient in question. To the degree the patient has nociplastic pain: “it is important to recognize this type of pain, since it will respond to different therapies than nociceptive pain, with a decreased responsiveness to peripherally directed therapies such as anti-inflammatory drugs and opioids, surgery, or injections” (Fitzcharles, 2021).

If invasive treatment is being requested for chronic pain, and invasive treatment has the risk of significant potential complication with permanent sequelae, but the presence of and degree of nociplastic pain indicates little likelihood of benefit, then risk may outweigh benefit in the “calculus” of the treating provider, insurer, the utilization review doctor, and most importantly the patient – if the patient is assessed for nociplastic pain and informed of its presence and significance.

In summary:

Nociplastic pain or Chronic Primary Pain or HACS is a new name for an old concept that physicians have frequently ignored, but that has significant implications on treatment options. We should recognize that **while** there are thousands of published studies on specific conditions like low back pain, the science and study of nociplastic pain is still preliminary.

Science comes to conclusions slowly, with publication of preliminary studies, criticism of the studies leading to subsequent publication of better studies, and eventu-

ally enough evidence accumulates that a conclusion is accepted as “scientifically established.”

If our goals for treating injured workers and anyone who might have this include “Primum Non Nocere” (Latin for “first, do no harm”), requests for chronic opioid therapy and invasive pain procedures should await a good assessment of this potential confounding concept.

Over 200 published studies and multiple systematic reviews have documented that the surgical outcomes of a particular surgery are suboptimal in workers’ compensation patients compared to the outcomes in general health insurance. Perhaps a better assessment of unrecognized nociplastic pain would improve the outcomes in treatment of injured workers but possible in the general population as well.

References:

Bolton, D., & Gillett, G. (2019). *The Biopsychosocial Model of Health and Disease: New Philosophical and Scientific Developments*. Palgrave Pivot. <https://doi.org/10.1007/978-3-030-11899-0>

Denève, S., Alemi, A., & Bourdoukan, R. (2017). The Brain as an Efficient and Robust Adaptive Learner. *Neuron*, 94(5), 969–977. <https://doi.org/10.1016/j.neuron.2017.05.016>

Fields R. D. (2020). The Brain Learns in Unexpected Ways: Neuroscientists have discovered a set of unfamiliar cellular mechanisms for making fresh memories. *Scientific American*, 322(3), 74–79. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8284127/>

Finnerup, N. B., Haroutounian, S., Kamerman, P., Baron, R., Bennett, D., Bouhassira, D., Cruccu, G., Freeman, R., Hansson, P., Nurmikko, T., Raja, S. N., Rice, A., Serra, J., Smith, B. H., Treede, R. D., & Jensen, T. S. (2016). Neuropathic pain: an updated grading system for research and clinical practice. *Pain*, 157(8), 1599–1606. <https://doi.org/10.1097/j.pain.0000000000000492>

Fitzcharles, M. A., Cohen, S. P., Clauw, D. J., Littlejohn, G., Usui, C., & Häuser, W. (2021). Nociplastic pain: towards an understanding of prevalent pain conditions. *Lancet (London, England)*, 397(10289), 2098–2110. [https://doi.org/10.1016/S0140-6736\(21\)00392-5](https://doi.org/10.1016/S0140-6736(21)00392-5)

Freyenhagen, R., Parada, H. A., Calderon-Ospina, C. A., Chen, J., Rakhmawati Emril, D., Fernández-Villacorta, F. J., Franco, H., Ho, K. Y., Lara-Solares, A., Li, C. C., Mimenza Alvarado, A., Nimmaanrat, S., Dolma Santos, M., & Ciampi de Andrade, D. (2019). Current understanding of the mixed pain concept: a brief narrative review. *Current medical research and opinion*, 35(6), 1011–1018. <https://doi.org/10.1080/03007995.2018.1552042>

Hamad, A. F., Vasykiv, V., Yan, L., Sanusi, R., Ayilara, O., Delaney, J. A., Wall-Wieler, E., Jozani, M. J., Hu, P., Banerji, S., & Lix, L. M. (2021). Mapping three versions of the international classification of diseases to categories of chronic conditions. *International journal of population data science*, 6(1), 1406. <https://doi.org/10.23889/ijpds.v6i1.1406>

Knezevic, N. N., Candido, K. D., Vlaeyen, J., Van Zundert, J., & Cohen, S. P. (2021). Low back pain. *Lancet (London, England)*, 398(10294), 78–92. [https://doi.org/10.1016/S0140-6736\(21\)00733-9](https://doi.org/10.1016/S0140-6736(21)00733-9)

Mayer, T. G., Neblett, R., Cohen, H., Howard, K. J., Choi, Y. H., Williams, M. J., Perez, Y., & Gatchel, R. J. (2012). The development and psychometric validation of the central sensitization inventory. *Pain practice : the official journal of World Institute of Pain*, 12(4), 276–285. <https://doi.org/10.1111/j.1533-2500.2011.00493.x>

Mikulasch, F. A., Rudelt, L., & Priesemann, V. (2021). Local dendritic balance enables learning of efficient representations in networks of spiking neurons. *Proceedings of the National Academy of Sciences of the United States of America*, 118(50), e2021925118. <https://doi.org/10.1073/pnas.2021925118>

Nicholas, M., Vlaeyen, J., Rief, W., Barke, A., Aziz, Q., Benoliel, R., Cohen, M., Evers, S., Giamberardino, M. A., Goebel, A., Korwisi, B., Perrot, S., Svensson, P., Wang, . J., Treede, R. D., & IASP Taskforce for the Classification of Chronic Pain (2019). The IASP classification of chronic pain for ICD-11: chronic primary pain. *Pain*, 160(1), 28–37. <https://doi.org/10.1097/j.pain.0000000000001390>

Pubmed 2022: <https://pubmed.ncbi.nlm.nih.gov/?term=nociplastic+pain&sort=> Accessed on 10.19.22

Schuttert, I., Timmerman, H., Petersen, K. K., McPhee, M. E., Arendt-Nielsen, L., Reneman, M. F., & Wolff, A. P. (2021). The Definition, Assessment, and Prevalence of (Human Assumed) Central Sensitisation in Patients with Chronic Low Back Pain: A

Systematic Review. *Journal of clinical medicine*, 10(24), 5931. <https://doi.org/10.3390/jcm10245931>

Wikipedia: ICD-11. Open access at: <https://en.wikipedia.org/wiki/ICD-11>

Wolfe, F., Clauw, D. J., Fitzcharles, M. A., Goldenberg, D. L., Häuser, W., Katz, R. L., Mease, P. J., Russell, A. S., Russell, I. J., & Walitt, B. (2016). 2016 Revisions to the 2010/2011 fibromyalgia diagnostic criteria. *Seminars in arthritis and rheumatism*, 46(3), 319–329. <https://doi.org/10.1016/j.semarthrit.2016.08.012>

Zador A. M. (2019). A critique of pure learning and what artificial neural networks can learn from animal brains. *Nature communications*, 10(1), 3770. <https://doi.org/10.1038/s41467-019-11786-6>

Medical Abstracts of Interest

Regarding Chronic Pain

*Selected by James B. Talmage, MD
Published verbatim from PubMed.gov, in the public domain.*

Review. Pain. 2019 Jan; 160(1):28-37.

The IASP classification of chronic pain for ICD-11: chronic primary pain

[Michael Nicholas](#)¹, [Johan W S Vlaeyen](#)^{2,3,4}, [Winfried Rief](#)⁵, [Antonia Barke](#)⁵, [Qasim Aziz](#)⁶, [Rafael Benoliel](#)⁷, [Milton Cohen](#)⁸, [Stefan Evers](#)⁹, [Maria Adele Giamberardino](#)¹⁰, [Andreas Goebel](#)¹¹, [Beatrice Korwisi](#)⁵, [Serge Perrot](#)¹², [Peter Svensson](#)^{13,14}, [Shuu-Jiun Wang](#)^{15,16}, [Rolf-Detlef Treede](#)¹⁷; [IASP Taskforce for the Classification of Chronic Pain](#)

PMID: **30586068** DOI: [10.1097/j.pain.0000000000001390](https://doi.org/10.1097/j.pain.0000000000001390)

Abstract

This article describes a proposal for the new diagnosis of chronic primary pain (CPP) in ICD-11. Chronic primary pain is chosen when pain has persisted for more than 3 months and is associated with significant emotional distress and/or functional disability, and the pain is not better accounted for by another condition. As with all pain, the article assumes a biopsychosocial framework for understanding CPP, which means all subtypes of the diagnosis are considered to be multifactorial in nature, with biological, psychological, and social factors contributing to each. Unlike the perspectives found in DSM-5 and ICD-10, the diagnosis of CPP is considered to be appropriate independently of identified biological or psychological contributors, unless another diagnosis would better account for the presenting symptoms. Such other diagnoses are called "chronic secondary pain" where pain may at least initially be conceived as a symptom secondary to an underlying disease. The goal here is to create a classification that is useful in both primary care and specialized pain management settings for the development of individualized management plans, and to assist both clinicians and researchers by providing a more accurate description of each diagnostic category.

Medical Abstracts of Interest

Regarding Chronic Pain

*Selected by James B. Talmage, MD
Published verbatim from PubMed.gov, in the public domain.*

Review. *Lancet*. 2021 May 29;397(10289):2098-2110.

Nociplastic pain: towards an understanding of prevalent pain conditions

[Mary-Ann Fitzcharles¹](#), [Steven P Cohen²](#), [Daniel J Clauw³](#), [Geoffrey Littlejohn⁴](#), [Chie Usui⁵](#), [Winfried Häuser⁶](#)

PMID: **34062144** DOI: [10.1016/S0140-6736\(21\)00392-5](https://doi.org/10.1016/S0140-6736(21)00392-5)

Abstract

Nociplastic pain is the semantic term suggested by the international community of pain researchers to describe a third category of pain that is mechanistically distinct from nociceptive pain, which is caused by ongoing inflammation and damage of tissues, and neuropathic pain, which is caused by nerve damage. The mechanisms that underlie this type of pain are not entirely understood, but it is thought that augmented CNS pain and sensory processing and altered pain modulation play prominent roles. The symptoms observed in nociplastic pain include multifocal pain that is more widespread or intense, or both, than would be expected given the amount of identifiable tissue or nerve damage, as well as other CNS-derived symptoms, such as fatigue, sleep, memory, and mood problems. This type of pain can occur in isolation, as often occurs in conditions such as fibromyalgia or tension-type headache, or as part of a mixed-pain state in combination with ongoing nociceptive or neuropathic pain, as might occur in chronic low back pain. It is important to recognise this type of pain, since it will respond to different therapies than nociceptive pain, with a decreased responsiveness to peripherally directed therapies such as anti-inflammatory drugs and opioids, surgery, or injections.

Copyright © 2021 Elsevier Ltd. All rights reserved.

Medical Abstracts of Interest

Regarding Chronic Pain

Selected by James B. Talmage, MD

Published verbatim from PubMed.gov, in the public domain.

Review. Journal of Clinical Medicine. 2021 Dec 17;10(24):5931 ,

The Definition, Assessment, and Prevalence of (Human Assumed) Central Sensitization in Patients with Chronic Low Back Pain: A Systematic Review

[Ingrid Schuttert](#)¹, [Hans Timmerman](#)¹, [Kristian K Petersen](#)², [Megan E McPhee](#)², [Lars Arendt-Nielsen](#)^{2,3}, [Michiel F Reneman](#)⁴, [André P Wolff](#)¹

PMID: **34945226**. PMCID: [PMC8703986](#). DOI: [10.3390/jcm10245931](#)

Abstract

Central sensitization is assumed to be one of the underlying mechanisms for chronic low back pain. Because central sensitization is not directly assessable in humans, the term 'human assumed central sensitization' (HACS) is suggested. The objectives were to investigate what definitions for HACS have been used, to evaluate the methods to assess HACS, to assess the validity of those methods, and to estimate the prevalence of HACS. Database search resulted in 34 included studies. Forty different definition references were used to define HACS. This review uncovered twenty quantitative methods to assess HACS, including four questionnaires and sixteen quantitative sensory testing measures. The prevalence of HACS in patients with chronic low back pain was estimated in three studies. The current systematic review highlights that multiple definitions, assessment methods, and prevalence estimates are stated in the literature regarding HACS in patients with chronic low back pain. Most of the assessment methods of HACS are not validated but have been tested for reliability and repeatability. Given the lack of a gold standard to assess HACS, an initial grading system is proposed to standardize clinical and research assessments of HACS in patients with a chronic low back.

Keywords

HACS; QST; human assumed central sensitization; nociplastic pain; quantitative sensory testing; questionnaire; sensitization; systematic review

Case Law: Appeals Board Explores Legal Presumptions

Jane Salem, Staff Attorney, Nashville



The Appeals Board recently released a couple of noteworthy opinions about the role of legal presumptions in workers' compensation. In both cases, an employee's credible testimony tipped the scales in their favor.

First, the presumption of correctness on medical causation from an authorized treating physician was at issue in *Kaci Johnson v. Inspire Brands d/b/a Blazin Wings, Inc.* The employee reported suffering a back injury when a large cooler fell on her at work.

An authorized physician, Dr. Fereidoon Parsioon, said she needed surgery and it was work-related, but he wasn't performing surgeries anymore. So Inspire offered a panel, and Johnson chose Dr. Sam Murrell. He ultimately concluded that the proposed surgery wasn't work-related.

After an expedited hearing, the trial court ruled that the causation opinions of both physicians were entitled to the statutory presumption of correctness. The court then considered the contradictory opinions, determined Dr. Parsioon's opinion was entitled to greater weight, and ordered Inspire to provide the disputed surgery.

Inspire argued on appeal that the court erred by giving both Dr. Parsioon's and Dr. Murrell's causation opinions the presumption of correctness. But the Board rejected Inspire's characterization of Dr. Murrell as a "replacement treating physician" for Dr. Parsioon.

The Board held that the plain language of the statute states that "[t]he opinion of the treating physician, selected by the employee from the employer's designated panel of physicians ... shall be presumed correct on the issue of causation but this presumption shall be rebuttable by a preponderance of the evidence."

The judges wrote that in this case, Dr. Parsioon was selected from a panel and gave a causation opinion while he was still the authorized treating physician. After he said he was unable to perform surgery, Dr. Murrell was selected from a panel and also gave a causation opinion. So both physicians provided causation opinions at the time they were authorized treating physicians. Therefore, both opinions were entitled to the presumption of correctness.

The judges observed, “Employer has provided no legal authority to support its argument that the provision of a new or different causation opinion, even from a newly-designated authorized treating physician, serves to negate a previously offered causation opinion from an authorized, panel-selected physician.”

As for which expert to accredit, the decision boiled down to Dr. Parsioon maintaining a consistent view, while Dr. Murrell “equivocated” after some questioning by Inspire’s lawyer.

“Dr. Murrell first testified that Employee’s need for recommended surgery and diagnosis of the L5-S1 disc injury was more than fifty percent related to the work injury, then testified to the contrary on cross-examination before ultimately stating that the ‘waters are sort of muddy’ and ‘it will be up to the workers’ compensation judge to decide whether this gets addressed,’” the Board wrote.

Further, Jones testified credibly that her disabling symptoms occurred after the work incident, and she adequately explained social media posts and other activities that Inspire had questioned.

Next, the presumption of medical necessity was clarified in *Melanie Burns-Herrera v. State Industries, LLC*.

The employee injured her right shoulder at work while lifting the shell of a water heater tank.

Burns-Herrera was provided a panel of specialist physicians. She chose Dr. Jason Haslam and underwent surgery but afterward continued to complain of pain. Dr. Haslam eventually diagnosed her with adhesive capsulitis from the surgery but said that her condition would improve with time and recommended no additional treatment.

Burns-Herrera then sought a second opinion on her own with Dr. Matthew Willis, who recommended surgery for the adhesive capsulitis.

After an expedited hearing, the trial court found the authorized treating physician’s medical opinion wasn’t entitled to the statutory presumption of medical necessity. The judge ordered that the employee return to Dr. Haslam for the recommended surgery, but if he declined to perform it, State Industries should offer a new panel.

State Industries appealed, arguing that the court erred in ordering it to authorize a surgery not recommended by the authorized treating physician. The issue was whether a recommendation *not* to undergo treatment can be presumed to be medically necessary.

The statutory presumption applies to “[a]ny *treatment* recommended by a physician” selected from an employer panel, the Board reminded.

The appellate judges wrote: “Dr. Haslam offered no opinion on the reasonableness and necessity of the surgical treatment recommended by Dr. Willis. Rather, he simply stated that he would not recommend surgery in this case and had no treatment recommendation, other than stating, ‘[y]ou treat this with time.’”

The judges concluded that a statement by the authorized physician that they have no further treatment to offer is not, standing alone, “treatment” presumed to be medically necessary. “In essence, Dr. Haslam made no treatment recommendation to which the presumption of medical necessity could attach,” they reasoned.

As to which opinion to accept, the trial court found both doctors equally well-positioned to give an opinion on the necessity of surgery.

So the judge, once again, turned to the employee’s lay testimony. She credibly testified that she could no longer participate in some activities of daily living or enjoy some of her hobbies. Further, she’d complied with conservative treatment with no improvement. At the time of the hearing, it was over two years since the initial surgery; Dr. Haslam said the typical window for recovery was 18 months. The Board agreed with the trial judge.

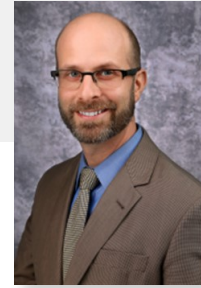
Finally, State industries challenged the conditional order that it authorize the surgery with Dr. Haslam but offer a panel if he declined to perform it.

The Board concluded that Dr. Haslam was selected from a panel, provided significant treatment, and hadn’t refused to see Burns-Herrera. The Board affirmed the court’s authority to order a new panel, if Dr. Haslam refused to provide reasonable and necessary medical treatment, citing the statute’s list of a trial judge’s duties.

Both of these Appeals Board opinions reviewed interlocutory orders, so they cannot be further appealed under the Workers’ Compensation Law.

AdMIRable Review Celebrates 10-Year Anniversary

Jay Blaisdell, MPA, MA



Ten years ago, the Tennessee Bureau of Workers' Compensation (then Division of Workers' Compensation) published the first issue ever of *AdMIRable Review*. It started primarily as a newsletter for MIR Physicians who were wanting to stay abreast of the newest developments in the Tennessee workers' compensation community. Over the last decade, as *AdMIRable Review* has needed to tackle increasingly complex topics, an editorial staff of dedicated professionals has volunteered its time and expertise to make our publication what it is today, a nationally recognized journal whose articles are cited by researchers and clinicians around the world. *AdMIRable Review's* impairment rating articles are now peer-reviewed and republished in the *AMA Guides Newsletter*. Dr. James Talmage's Covid-19 article, published in our July 2020 issue, was repurposed for the September 2020 issue of the *Journal of Occupational and Environmental Medicine (JOEM)*. Jane Salem's legal articles have been featured in the *Court of Workers' Compensation Claim's* award-winning blog. Her editorial skills, along with those of Sarah Byrne's, have raised the quality and professionalism of each issue. Brian Holmes has expanded the scope of *AdMIRable Review* to reflect the Bureau's increased emphasis on return-to-work issues. Finally, Kyle Jones has worked to improve the look of *AdMIRable Review*, updating its electronic format, wrapping all of its dense content into a user-friendly, aesthetically pleasing package with the proverbial sparkly bow. It's no wonder *AdMIRable Review's* readership has increased from a handful of physicians across Tennessee to nearly 700 workers' compensation professionals across the United States and Canada. As we reflect on our accomplishments over the past decade and look towards our future with even greater expectations, we visit with our new Editor-in-Chief, Administrator Troy Haley, who was appointed to lead the Bureau in September of this year:

AdMIRable Review (AR): Good afternoon, Administrator Haley. And thank you for helping us mark the occasion of our 10th anniversary. As a member of *AdMIRable Review's* Advisory Board over the last several years, you have offered feedback on each issue. In your opinion, how has the content and role of *AdMIRable Review* evolved since you have been involved with the publication?

Troy Haley (TH): From its inception in 2012 as a four-page newsletter, *AdMIRable Review* has grown to a 59-page professional journal (Winter 2022). It is much more



detailed now, with in-depth articles on medical topics that are widely read by health care providers, attorneys, employer representatives, insurance carriers and others interested in the workers' compensation system. I think the articles by physicians on medical topics are particularly noteworthy and impressive. Also, having a creative group of contributors and a knowledgeable editorial team has made a huge difference. The editorial staff has done fantastic work over the past ten years, and it is adMIRable how they always see each issue through from conception to completion.

(AR): Ten years ago, we wanted to provide a resource for MIR Registry Physicians. Now that you are Editor-in-Chief, do you envision *AdMIRable Review's* role in the TN Workers' Compensation Community changing in any way?

(TH): Yes. We have a new initiative called the Certified Physician Program, and I think *AdMIRable Review* will be an excellent resource for the medical providers who participate in the new program. We have access-to-care issues for injured workers in Tennessee, so the goal of the program is to make it more appealing for physicians to accept workers' compensation patients. The program is a free, online, self-paced training course designed to teach physicians additional skills to help them evaluate and treat injured workers. Once the program rules have been approved by the legislature, in exchange for accepting workers' compensation patients certified physicians will be eligible to receive enhanced fees for initial and follow-up visits and for giving final impairment ratings.

(AR): That's exciting. Up until the last couple of years, we have focused almost exclusively on impairment rating methodology. What if *AdMIRable Review* provides more articles about physician best practices for treating and evaluating injured workers? You know, like the importance of the physician "foreshadowing" expected improvement with each visit and communicating the value of returning to work to the injured worker as soon as possible. Perhaps we could also address frequently asked questions among Certified Physicians as well.

(TH): These are excellent ideas for future articles. I especially like the FAQ for Certified Physicians. That sounds like a really helpful and practical outreach tool."

(AR): We have some physicians who have been on the MIR Registry since it started in 2005. They have learned how to produce better MIR opinions by having a lot of practice over the years. These physicians are indispensable to the registry because of their commitment to the program and their experience. They obviously think being on the MIR Registry is a worthwhile experience, or they would not have remained for all of these years. We've come to know these physicians and have developed a strong working relationships with them. It would be nice to have a similar level of

physician involvement when the Certified Physician Program (CPP) gets up and running. What words of encouragement can you offer physicians who are still on the fence about seeking appointment to the Certified Physician Program? From the Administrator's perspective, what might make the CPP a worthwhile experience?

(TH): The most obvious benefit to being a Certified Physician is the additional fee for office visits and the impairment rating. Also, those physicians who are appointed to as certified physicians Program are eligible to join the MIR Registry. I think there are many physicians who have not received formal training on causation, MMI, permanent impairment, light duty, and work restrictions, and they can benefit from this type of specialized instruction.

(AR): Yes, with the enhanced fees and specialized instruction, it would appear that physicians seeking to expand their workers' compensation practice have a great resource with the Certified Physician Program. Employers and adjusters who are who are creating physician panels will likely benefit from the CPP, too, since they will be able to go directly to the Bureau's website and find physicians throughout the state who not only accept workers' compensation patients but are trained to treat them. Administrator Haley, thank you for spending some time with us to celebrate *AdMIRable Review's* 10-year anniversary. We're excited to be a part of the ongoing effort to provide quality medical care for injured workers. And we're excited to have you as our Editor-in-Chief.

(TH): My pleasure. Thank you.

AdMIRable Review Editorial Staff

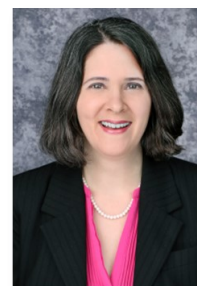
Kyle Jones

Kyle Jones is the Communications Coordinator for the Tennessee Bureau of Workers' Compensation. After receiving his bachelor's degree from MTSU, he began putting his skillset to work with Tennessee State Government. You will find Kyle's fingerprints on many digital and print publications from videos to brochures published by the Bureau. Kyle believes that visuals like motion graphics can help explain and break down complex concepts into something more digestible and bring awareness to the Bureau's multiple programs that are designed to help Tennesseans.



Sarah Byrne, Esquire

Sarah Byrne is a staff attorney for the Court of Workers' Compensation Claims. She has a bachelors' degree in journalism from Belmont University and a masters' degree in English from Simmons College in Boston. After working in religious publishing and then state government, she earned a law degree from Nashville School of Law in 2010. She first joined the Bureau of Workers' Compensation in 2010 as a mediator.



Jane Salem, Esquire

Jane Salem is a staff attorney with the Court of Workers' Compensation Claims in Nashville. She administers the Court's blog and is a former legal reporter and editor. She has run more than forty marathons.



Brian Holmes, MA

Brian Homes is the Director of Mediation Services and Ombudsman Services for the Tennessee Bureau of Workers' Compensation. In this role, he directs policy and leads twenty-three mediators and six ombudsmen as they educate the public about workers' compensation and help resolve benefit



disputes. He has had the privilege of helping thousands of injured workers, their employers, and insurance companies make informed decisions. A 17-year veteran of the Bureau, he has, of recent, created and implemented the Next Step Program, which assists unemployed workers' compensation claimants return to the workforce.

Robert B. Snyder, MD

Dr. Snyder was appointed Medical Director for the Bureau of Workers' Compensation in January, 2014 after 37 years of private practice in Orthopaedics. He graduated from Wayne State University School of Medicine in Detroit and completed two years of general surgery training at the University of Pittsburgh before he came to Nashville, completing his residency in Orthopaedics and Rehabilitation at Vanderbilt



University. Dr. Snyder has presented lectures for the American Academy of Orthopaedic Surgeons, Arthroscopy Society of Peru, the American Orthopaedic Society for Sports Medicine, the National Workers Compensation and Disability Conference, the National Association of Workers Compensation Judges, and in Tennessee: the Chiropractic Association, the Orthopaedic Society, the College of Occupational and Environmental Medicine, the Pain Society, the Neurosurgical Society, the Tennessee Medical Society, and Tennessee Attorney Memo. He has made numerous other presentations to attorneys, case managers, employers, adjusters and insurers. His activities with the Bureau have focused on Medical Treatment Guidelines, the Drug Formulary, Utilization Review, Case Management, Fee Schedules and physician/provider communications.

James B. Talmage, MD

Dr. Talmage is a graduate of the Ohio State University for both undergraduate school (1968) and medical school (1972). His orthopedic surgery training was in the United States Army. He has been Board Certified in Orthopaedic Surgery since 1979 and also was Board Certified in Emergency Medicine from 1987 - 2017. Since 2005 he been an Adjunct Associate Professor in the Division of Occupational Medicine,



Department of Family and Community Medicine at Meharry Medical College in Nashville. In 2013 he was Acting Medical Director for the State of Tennessee Division of Worker's Compensation. In 2014 he became Assistant Medical Director for the renamed Bureau of WC. He has been an author and co-editor of the AMA published books on Work Ability Assessment, and the second

edition of the Causation book. He was a contributor to the AMA Impairment Guides, 6th Edition, and he has served as co-editor of the AMA Guides Newsletter since 1996.

Jay Blaisdell, MPA, MA

Jay Blaisdell is the coordinator for the Tennessee Bureau of Workers' Compensation's Medical Impairment Rating (MIR) and Certified Physician Program (CPP) Registries. He has been the managing editor of *AdMIRable Review* since 2012, and is certified through the International Academy of Independent Medical Evaluators (IAIME) as a Medicolegal Evaluator. His articles are published regularly in the *AMA Guides Newsletter*.



Read [Previous Issues](#) of AdMIRable Review

Now searchable online by impairment rating topic or physician biography.

Submission Guidelines

AdMIRable Review accepts electronic submission for articles related to Tennessee Workers' Compensation. Manuscripts prepared in accordance with the American Psychological Association (APA) guidelines are preferred. Submission of a manuscript implies permission and commitment to publish in *AdMIRable Review*. Authors submitting manuscript to *AdMIRable Review* should not simultaneously submit them to another public-administration journal. Submission and inquires should be directed to *AdMIRable Review*, Editorial Staff, at Jay.Blaisdell@tn.gov.

AdMIRable Review

Tennessee Bureau of Workers' Compensation
220 French Landing Drive, Suite 1-B, Nashville TN 37243
p. 615-253-5616 f.615-253-5263



The Tennessee Department of Labor and Workforce Development is committed to principles of equal opportunity, equal access, and affirmative action. Auxiliary aids and services are available upon request to individuals with disabilities. Tennessee Department of Labor and Workforce Development; Authorization No. 337621, December 2019; This public document was promulgated for electronic use only.