

Chapter DWD 81

WORKER'S COMPENSATION TREATMENT GUIDELINES

DWD 81.01	Purpose and application.	DWD 81.09	Upper extremity disorders.
DWD 81.02	Incorporation by reference.	DWD 81.10	Complex regional pain syndrome of the upper and lower extremities.
DWD 81.03	Definitions.	DWD 81.11	Inpatient hospitalization guidelines.
DWD 81.04	General treatment guidelines; excessive treatment.	DWD 81.12	Guidelines for surgical procedures.
DWD 81.05	Guidelines for medical imaging.	DWD 81.13	Chronic management.
DWD 81.06	Low back pain.	DWD 81.14	Health care provider advisory committee.
DWD 81.07	Neck pain.		
DWD 81.08	Thoracic back pain.		

DWD 81.01 Purpose and application. (1) PURPOSE.

(a) The purpose of this chapter is to establish guidelines for necessary and appropriate treatment of patients with compensable worker's compensation injuries under s. 102.16 (2m), Stats., and s. DWD 80.73.

(b) The guidelines contained in this chapter are factors for an impartial health care services review organization and a member from an independent panel of experts established by the department to consider in rendering opinions to resolve necessity of treatment disputes arising under s. 102.16 (2m), Stats., and s. DWD 80.73.

(c) Sections DWD 81.01 to 81.13 do not affect any determination of liability for an injury under ch. 102, Stats., and are not intended to expand or restrict a health care provider's scope of practice under any other statute.

(2) APPLICATION. All treatment shall be medically necessary as defined in s. DWD 81.03 (10). In the absence of a specific guideline any applicable general guidelines govern. A departure from a guideline that limits the duration or type of treatment may be appropriate in any of the circumstances specified in s. DWD 81.04 (5). All limitations on the duration of a specific treatment modality or type of modality begin with the first time the modality is initiated after November 1, 2007. This chapter does not apply to treatment of an injury after an insurer has denied liability for the injury, except in cases in which the guidelines apply to treatment initiated after liability has been established.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.02 Incorporation by reference. The ICD-9-CM diagnostic codes referenced in this chapter are contained in the fourth edition of the International Classification of Diseases, Clinical Modification, 9th Revision, 1994, and corresponding annual updates. This document is incorporated by reference.

Note: This volume is published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, and may be purchased through the Superintendent of Documents, United States Government Printing Office, Washington, D.C. 20402. It is on file at the Worker's Compensation Division of the Department of Workforce Development and at the office of the Legislative Reference Bureau.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.03 Definitions. Unless otherwise provided, in this chapter:

(1) "Active treatment" means treatment specified in ss. DWD 81.06 (4), 81.07 (4), 81.08 (4), 81.09 (4), and 81.10 (2) that requires active patient participation in a therapeutic program to increase flexibility, strength, endurance, or awareness of proper body mechanics.

(2) "Chronic pain" means complaint of persistent pain beyond 12 weeks of appropriate treatment provided under this chapter. It is persistent with verbal and nonverbal pain behaviors that exceed the identifiable pathology and medical condition. It is pain that interferes with physical, psychological, social, or vocational functioning.

(3) "Condition" means the symptoms, physical signs, clinical findings, and functional status that characterize a person's complaint, illness, or injury related to a current claim for compensation.

(4) "Day" means calendar day.

(5) "Emergency treatment" means treatment that is required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death, or is immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.

(6) "Etiology" means the anatomic alteration, physiologic dysfunction, or other biological or psychological abnormality that is considered a cause of the patient's condition.

(7) "Functional status" means the ability of an individual to engage in activities of daily living and other social, recreational, and vocational activities.

(8) "Initial nonsurgical management or treatment" is initial treatment provided after an injury that includes passive treatment, active treatment, injections, and durable medical equipment under ss. DWD 81.06 (3), (4), (5), and (8), 81.07 (3), (4), (5), and (8), 81.08 (3), (4), (5), and (8), 81.09 (3), (4), (5), and (8), and 81.10 (2). Scheduled and nonscheduled medication may be a part of initial nonsurgical treatment. Initial nonsurgical management does not include surgery or chronic management modalities under s. DWD 81.13.

(9) "Medical imaging procedure" is a technique, process, or technology used to create a visual image of the body or its function. Medical imaging includes X-rays, tomography, angiography, venography, myelography, computed tomography scanning, magnetic resonance imaging scanning, ultrasound imaging, nuclear isotope imaging, positron emission tomography scanning, and thermography.

(10) "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and to cure or relieve a condition consistent with any applicable treatment guidelines in this chapter. If ss. DWD 81.04 to 81.13 do not apply, the treatment must be reasonable and necessary for the diagnosis and to cure or relieve a condition consistent with the current accepted standards of practice within the scope of the provider's license or certification.

(11) "Neurologic deficit" means a loss of function secondary to involvement of the central or peripheral nervous system. This includes motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.

(12) "Progressive neurologic deficit" means any neurologic deficit that has become worse by history or been noted by repeated examination since onset.

(13) “Passive treatment” is any treatment modality specified in ss. DWD 81.06 (3), 81.07 (3), 81.08 (3), 81.09 (3), and 81.10 (2). Passive treatment modalities include bedrest, thermal treatment, traction, acupuncture, electrical muscle stimulation, braces, manual and mechanical therapy, massage, and adjustments.

(14) “Static neurologic deficit” means any neurologic deficit that has remained the same by history or been noted by repeated examination since onset.

(15) “Therapeutic injection” is any injection modality specified in ss. DWD 81.06 (5), 81.07 (5), 81.08 (5), 81.09 (5), and 81.10 (2). Therapeutic injections include trigger point injections, sacroiliac injections, facet joint injections, facet nerve blocks, nerve root blocks, epidural injections, soft tissue injections, peripheral nerve blocks, injections for peripheral nerve entrapment, and sympathetic blocks.

(16) “Week” means calendar week.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.04 General treatment guidelines; excessive treatment. (1) GENERAL. (a) All treatment shall be medically necessary treatment. A health care provider shall evaluate the medical necessity of all treatment under par. (b) on an ongoing basis. This chapter does not require or permit any more frequent examinations than would normally be required for the condition being treated but may require ongoing evaluation of the patient that is medically necessary and consistent with accepted medical practice.

(b) The health care provider shall evaluate at each visit whether initial nonsurgical treatment for the low back, cervical, thoracic, and upper extremity conditions specified in ss. DWD 81.06 to 81.09 is effective according to subds. 1. to 3. No later than any applicable treatment response time in ss. DWD 81.06 to 81.09, the health care provider shall evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in all of the following:

1. The patient’s subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

2. The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

3. The patient’s functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record or successive reports of work ability of less restrictive limitations on activity.

(c) Except as otherwise provided under ss. DWD 81.06 (3) (b), 81.07 (3) (b), 81.08 (3) (b), and 81.09 (3) (b), if there is not progressive improvement in at least 2 criteria of par. (b) 1. to 3., the modality shall be discontinued or significantly modified, or the health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to an allied health professional directly providing the treatment.

(d) The health care provider shall use the least intensive setting appropriate and shall assist the patient in becoming independent in the patient’s own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

(2) DOCUMENTATION. A health care provider shall maintain an appropriate record of any treatment provided to a patient. An appropriate record is a legible health care service record or report that substantiates the nature and necessity of a health care service being billed and its relationship to the work injury.

(3) NONOPERATIVE TREATMENT. A health care provider shall provide a trial of nonoperative treatment before offering or per-

forming surgical treatment unless the treatment for the condition requires immediate surgery, unless an emergency situation exists, or unless the accepted standard of initial treatment for the condition is surgery.

(4) CHEMICAL DEPENDENCY. A health care provider shall maintain diligence to detect incipient or actual chemical dependency to any medication prescribed for treatment of the patient’s condition. In cases of incipient or actual dependency, the health care provider shall refer the patient for appropriate evaluation and treatment of the dependency.

(5) DEPARTURE FROM GUIDELINES. A health care provider’s departure from a guideline that limits the duration or type of treatment in this chapter may be appropriate in any of the following circumstances:

(a) There is a documented medical complication.

(b) Previous treatment did not meet the accepted standard of practice and meet the guidelines in this chapter for the health care provider who ordered the treatment.

(c) The treatment is necessary to assist the patient in the initial return to work where the patient’s work activities place stress on the part of the body affected by the work injury. The health care provider shall document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan, and treatment delivered on each visit, the patient’s response to the treatment, and efforts to promote patient independence in the patient’s own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

(d) The treatment continues to meet 2 of the following 3 criteria, as documented in the medical record:

1. The patient’s subjective complaints of pain are progressively improving as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

2. The patient’s objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

3. The patient’s functional status, especially vocational activity, is objectively improving, as evidenced by documentation in the medical record or successive reports of work ability of less restrictive limitations on activity.

(e) There is an incapacitating exacerbation of the patient’s condition. Additional treatment for the incapacitating exacerbation shall comply with and may not exceed the guidelines in this chapter.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.05 Guidelines for medical imaging.

(1) GENERAL PRINCIPLES. (a) *Documentation.* Except for emergency evaluation of significant trauma, a health care provider shall document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient’s condition before ordering any imaging study. All medical imaging shall comply with all of the following:

(b) *Effective imaging.* A health care provider shall initially order the single most effective imaging study for diagnosing the suspected etiology of a patient’s condition. No concurrent or additional imaging studies shall be ordered until the results of the first study are known and reviewed by the treating health care provider. If the first imaging study is negative, no additional imaging is necessary except for repeat and alternative imaging allowed under pars. (e) and (f).

(c) *Appropriate imaging.* Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient’s condition is not necessary.

(d) *Routine imaging.* Imaging on a routine basis is not necessary unless the information from the study is necessary to develop a treatment plan.

(e) *Repeat imaging.* Repeat imaging of the same views of the same body part with the same imaging modality is not necessary except for any of the following:

1. To diagnose a suspected fracture or suspected dislocation.
2. To monitor a therapy or treatment that is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment.
3. To follow up a surgical procedure.
4. To diagnose a change in the patient's condition marked by new or altered physical findings.
5. To evaluate a new episode of injury or exacerbation that in itself warrants an imaging study.
6. When the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study.

(f) *Alternative imaging.* 1. Persistence of a patient's subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be necessary if another etiology of the patient's condition is suspected because of the failure of the condition to improve.

2. Alternative imaging may not follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation for the suspected etiology.

3. Alternative imaging may follow up abnormal but inconclusive findings in another imaging study. An inconclusive finding may not provide an adequate basis for accurate diagnosis.

(2) SPECIFIC IMAGING PROCEDURES FOR LOW BACK PAIN. (a) Except for the emergency evaluation of significant trauma, a health care provider shall document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study of the low back.

(b) A health care provider may order computed tomography scanning for any of the following:

1. When cauda equina syndrome is suspected.
2. For evaluation of progressive neurologic deficit.
3. When bony lesion is suspected on the basis of other tests or imaging procedures.

(c) Except as specified in par. (b), a health care provider may not order computed tomography scanning in the first 4 weeks after an injury. Computed tomography scanning is necessary after 4 weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities.

(d) A health care provider may order magnetic resonance imaging scanning for any of the following:

1. When cauda equina syndrome is suspected.
2. For evaluation of progressive neurologic deficit.
3. When previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage.
4. Suspected discitis.

(e) Except as specified in par. (d), a health care provider may not order magnetic resonance imaging scanning in the first 4 weeks after an injury. Magnetic resonance imaging scanning is necessary after 4 weeks if the patient continues with symptoms

and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities.

(f) A health care provider may order myelography for any of the following:

1. Myelography may be substituted for otherwise necessary computed tomography scanning or magnetic resonance imaging scanning in accordance with pars. (b) and (d), if those imaging modalities are not locally available.

2. In addition to computed tomography scanning or magnetic resonance imaging scanning, if there are progressive neurologic deficits or changes and computed tomography scanning or magnetic resonance imaging scanning has been negative.

3. For preoperative evaluation in cases of surgical intervention, but only if computed tomography scanning or magnetic resonance imaging scanning have failed to provide a definite preoperative diagnosis.

(g) A health care provider may order computed tomography myelography for any of the following:

1. The patient's condition is predominantly sciatica, there has been previous spinal surgery, and tumor is suspected.

2. The patient's condition is predominantly sciatica, there has been previous spinal surgery, and magnetic resonance imaging scanning is equivocal.

3. When spinal stenosis is suspected and the computed tomography scanning or magnetic resonance imaging scanning is equivocal.

4. If there are progressive neurologic symptoms or changes and computed tomography scanning or magnetic resonance imaging scanning has been negative.

5. For preoperative evaluation in cases of surgical intervention, but only if computed tomography scanning or magnetic resonance imaging scanning have failed to provide a definite preoperative diagnosis.

(h) A health care provider may order intravenous enhanced computed tomography scanning only if there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor, but only if intrathecal contrast for computed tomography–myelography is contraindicated and magnetic resonance imaging scanning is not available or is also contraindicated.

(i) A health care provider may order enhanced magnetic resonance imaging scanning for any of the following:

1. There has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor.

2. Hemorrhage is suspected.

3. Tumor or vascular malformation is suspected.

4. Infection or inflammatory disease is suspected.

5. Unenhanced magnetic resonance imaging scanning was equivocal.

(j) A health care provider may order discography for any of the following:

1. All of the following are present:

a. Back pain is the predominant complaint.

b. The patient has failed to improve with initial nonsurgical management.

c. Other imaging has not established a diagnosis.

d. Lumbar fusion surgery or other surgical procedures are being considered as a therapy.

2. There has been previous spinal surgery, and pseudoarthrosis, recurrent disc herniation, annular tear, or internal disc disruption is suspected.

(k) A health care provider may order computed tomography discography when it is necessary to view the morphology of a disc.

(L) A health care provider may not order nuclear isotope imaging including technetium, indium, and gallium scans, unless tumor, stress fracture, infection, avascular necrosis, or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies, or the results of other imaging studies.

(m) A health care provider may not order thermography for the diagnosis of any of the clinical categories of low back conditions in s. [DWD 81.06 \(1\) \(b\)](#).

(n) A health care provider may order anterior–posterior and lateral X–rays of the lumbosacral spine for any of the following:

1. When there is a history of significant acute trauma as the precipitating event of the patient's condition, and fracture, dislocation, or fracture dislocation is suspected.
2. When the history, signs, symptoms, or laboratory studies indicate possible tumor, infection, or inflammatory lesion.
3. For postoperative follow–up of lumbar fusion surgery.
4. When the patient is more than 50 years of age.
5. Before beginning a course of treatment with spinal adjustment or manipulation.
6. Eight weeks after an injury if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities.

(o) A health care provider may not order anterior–posterior and lateral X–rays of the lumbosacral spine for any of the following:

1. To verify progress during initial nonsurgical treatment.
2. To evaluate a successful initial nonsurgical treatment program.

(p) A health care provider may order oblique X–rays of the lumbosacral spine for any of the following:

1. To follow up abnormalities detected on anterior–posterior or lateral X–ray.
2. For postoperative follow–up of lumbar fusion surgery.
3. To follow up spondylolysis or spondylolisthesis not adequately diagnosed by other necessary imaging procedures.

(q) A health care provider may not order oblique X–rays of the lumbosacral spine as part of a package of X–rays including anterior–posterior and lateral X–rays of the lumbosacral spine.

(r) A health care provider may not order electronic X–ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine for diagnosis of any of the low back conditions in s. [DWD 81.06 \(1\) \(b\)](#).

History: CR 07–019; cr. Register October 2007 No. 622, eff. 11–1–07.

DWD 81.06 Low back pain. (1) DIAGNOSTIC PROCEDURES FOR THE EVALUATION OF LOW BACK PAIN. (a) A health care provider shall determine the nature of the low back condition before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination the health care provider shall assign the patient at each visit to the appropriate clinical category under subsds. 1. to 4. The health care provider shall document the diagnosis in the medical record. For the purposes of subsds. 2. and 3., “radicular pain” means pain radiating distal to the knee, or pain conforming to a dermatomal distribution, and accompanied by anatomically congruent motor weakness, or reflex changes. This section does not apply to fractures of the lumbar spine, or low back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

1. Regional low back pain, includes referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and that effects the lumbosacral region, with or without referral to the buttocks or leg, or both above the knee, including ICD–9–CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51, 722.52, 722.6, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 847.2 to 847.9, 922.3, 926.1, 926.11, and 926.12.

2. Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis, or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine, including ICD–9–CM codes 721.4, 721.42, 721.91, 722.1, 722.10, 722.2, 722.7, 722.73, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and 724.9. In these cases, neurologic findings on history and physical examination are either absent or do not show progressive deterioration.

3. Radicular pain, with or without regional low back pain, with progressive neurologic deficit. This includes the same diagnoses as subd. 2., except this subdivision applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness, or progressive reflex changes.

4. Cauda equina syndrome, which is a syndrome characterized by anesthesia in the buttocks, genitalia, or thigh and accompanied by disturbed bowel and bladder function, including ICD–9–CM codes 344.6, 344.60, and 344.61.

(c) A health care provider may not order laboratory tests in the evaluation of a patient with regional low back pain, radicular pain, or cauda equina syndrome, except for any of the following:

1. When a patient's history, age, or examination suggests infection, metabolic–endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered any time a health care provider suspects any of the conditions in par. (c), if the health care provider justifies the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the lumbosacral spine shall be based on the findings of the history and physical examination and may not be ordered before a health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and shall comply with all of the guidelines in s. [DWD 81.05 \(1\) and \(2\)](#). A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(f) A health care provider may not order electromyography and nerve conduction studies for regional low back pain as defined in s. [DWD 81.06 \(1\) \(b\) 1](#). A health care provider may order electromyography and nerve conduction studies as a diagnostic tool for radicular pain and cauda equina syndrome as defined in s. [DWD 81.06 \(1\) \(b\) 2](#) to 4, after the first 3 weeks of radicular symptoms. Repeat electromyography and nerve conduction studies for radicular pain and cauda equina syndrome are not necessary unless a new neurologic symptom or progression of

existing finding has developed that in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

(g) A health care provider may not order the use of any of the following procedures or tests for the diagnosis of any of the clinical categories in par. (b) 1. to 4.:

1. Surface electromyography or surface paraspinal electromyography.
2. Thermography.
3. Plethysmography.
4. Electronic X-ray analysis of plain radiographs.
5. Diagnostic ultrasound of the lumbar spine.
6. Somatosensory evoked potentials and motor evoked potentials.

(h) A health care provider may not order computerized range of motion or strength measuring tests during the period of initial nonsurgical management but may order these tests during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider's evaluation or treatment, or physical or occupational therapy evaluation or treatment.

(i) A health care provider may order personality or psychosocial evaluations for evaluating patients who continue to have problems despite appropriate care. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation shall consider all of the following:

1. Is symptom magnification occurring?
2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?
3. Are there other personality factors or disorders that are interfering with recovery?
4. Is the patient chemically dependent?
5. Are there any interpersonal conflicts interfering with recovery?
6. Does the patient have a chronic pain syndrome or psychogenic pain?
7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) All of the following are guidelines for diagnostic analgesic blocks or injection studies and include facet joint injection, facet nerve injection, epidural differential spinal block, nerve block, and nerve root block:

1. These procedures are used to localize the source of pain before surgery and to diagnose conditions that fail to respond to initial nonsurgical management.
2. These injections are invasive and are not necessary when done as diagnostic procedures only, unless noninvasive procedures have failed to establish the diagnosis.
3. Selection of patients, choice of procedure, and localization of the level of injection may be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.
4. These blocks and injections may also be used as therapeutic modalities and are subject to the guidelines of sub. (5).

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

1. A functional capacity assessment or evaluation is not necessary during the period of initial nonsurgical management.

2. A functional capacity assessment or evaluation is necessary in any of the following circumstances:

- a. To identify the patient's activity restrictions and capabilities.
- b. To resolve a question about the patient's ability to do a specific job.

3. A functional capacity evaluation may not establish baseline performance before treatment or for subsequent assessments to evaluate change during or after treatment.

4. A health care provider may direct only one completed functional capacity evaluation per injury.

(L) Consultations with other health care providers may be initiated at any time by the treating health care provider consistent with accepted medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR LOW BACK PAIN. (a) All medical care for low back pain appropriately assigned to a clinical category in sub. (1) (b) is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11), (12), and (13), as follows:

1. Subsection (11) governs regional low back pain.
2. Subsection (12) governs radicular pain with no or static neurologic deficits.
3. Subsection (13) governs cauda equina syndrome and radicular pain with progressive neurologic deficits.

(b) A health care provider shall, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. If the clinical category is changed, the treatment plan shall be appropriately modified to reflect the new clinical category. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury.

(c) In general, a course of treatment for low back problems is divided into the following 3 phases:

1. First, all patients with low back problems, except patients with progressive neurologic deficit or cauda equina syndrome under sub. (1) (b) 3. or 4., shall be given initial nonsurgical management which may include active treatment modalities, passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3), (4), (5), (8), and (10). The period of initial nonsurgical treatment begins with the first active, passive, medication, durable medical equipment, or injection modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner.

Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11), (12), (13), and s. DWD 81.12. A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Patients with radicular pain with progressive neurological deficit or cauda equina syndrome may require immediate surgical therapy.

b. Any patient who has had surgery may require postoperative therapy in a clinical setting with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

c. Surgery shall follow the guidelines in subs. (6), (11), (12), (13), and s. DWD 81.12.

d. A decision against surgery at any particular time does not preclude a decision for surgery at a later date.

3. Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be necessary. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment as described in sub. (8).

(d) A treating health care provider may refer the patient for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES. (a) *General.* Except as set forth in par. (b) and s. DWD 81.04 (5), a health care provider may not direct the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) beyond 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the patient at home.

(b) *Additional passive treatment modalities.* A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months if all of the following apply:

1. The patient is released to work or is permanently totally disabled and the additional passive treatment shall result in progressive improvement in, or maintenance of, the functional status that was achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is not necessary while the patient has chronic pain syndrome.

(c) *Adjustment or manipulation of joints.* For purposes of this paragraph, "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations. All of the following guidelines apply to adjustment or manipulation of joints:

1. Time for treatment response is 3 to 5 treatments.

2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(d) *Thermal treatment.* For purposes of this paragraph, "thermal treatment" includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep

thermal modalities include diathermy, ultrasound, and microwave. All of the following guidelines apply to thermal treatment:

1. Thermal treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks in a clinical setting but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(e) *Electrical muscle stimulation.* For purposes of this paragraph, "electrical muscle stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:

1. Electrical muscle stimulation given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting in order to ensure proper electrode placement and patient education. All of the following guidelines apply to home use of an electrical muscle stimulation device:

a. The time for patient education and training is one to 3 sessions.

b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(f) *Mechanical traction.* All of the following guidelines apply to mechanical traction:

1. Treatment given in a clinical setting:

a. Time for treatment response is 3 treatments.

b. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks in a clinical setting but only if used in conjunction with other therapies.

2. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device shall be in a supervised setting in order to ensure proper patient education. All of the following guidelines apply to home use of a mechanical traction device:

a. Time for patient education and training is one session.

b. Patient may use the mechanical traction device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(g) *Acupuncture treatments.* For purposes of this paragraph, "acupuncture treatments" include endorphin-mediated analgesic

therapy that includes classic acupuncture and acupressure. All of the following guidelines apply to acupuncture treatments:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(h) *Manual therapy*. For purposes of this paragraph, “manual therapy” includes soft tissue and joint mobilization, therapeutic massage, and manual traction. All of the following guidelines apply to manual therapy:

1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(i) *Phoresis*. For purposes of this paragraph, “phoresis” includes iontophoresis and phonophoresis. All of the following guidelines apply to phoresis:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment is 9 sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

(j) *Bedrest*. Prolonged restriction of activity and immobilization are detrimental to a patient’s recovery. Bedrest shall not be prescribed for more than 7 days.

(k) *Spinal braces and other movement restricting appliances*. All of the following guidelines apply to spinal braces and other movement-restricting appliances:

1. Bracing required for longer than 2 weeks shall be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability.
2. Time for treatment response is 3 days.
3. Treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.
4. Maximum continuous duration is 3 weeks unless patient is status postfusion.

(4) ACTIVE TREATMENT MODALITIES. (a) Active treatment modalities shall be used as set forth in pars. (b) to (f). A health care provider’s use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities so long as the maximum durations for the active treatment modalities are not exceeded.

(b) Education shall teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is 3 visits, which include an initial education and training session and 2 follow-up visits.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is 3 visits.

(d) Worksite analysis and modification shall examine the patient’s work station, tools, and job duties. A health care provider’s recommendations may be made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is 3 visits.

(e) Exercise, which is important to the success of an initial non-surgical treatment program and a return to normal activity, shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall, at least in part, be specifically aimed at the musculature of the lumbosacral spine. Aerobic exercise and extremity strengthening may be performed as adjunctive treatment, but may not be the primary focus of the exercise program.

(f) Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subdivisions 1. and 2. govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. ‘Guidelines for supervised exercise.’ One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is 5 times for the first week decreasing to 3 times per week for the next 2 weeks and decreasing in frequency after the third week.

b. Maximum duration is 12 weeks.

2. ‘Guidelines for unsupervised exercise.’ Unsupervised exercise shall be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. All of the following guidelines apply to unsupervised exercise:

a. Maximum treatment frequency is up to 3 visits for instruction and monitoring.

b. There is no limit on the duration or frequency of exercise at home.

(5) THERAPEUTIC INJECTIONS. (a) Injection modalities are necessary as set forth in pars. (b) to (d). A health care provider’s use of injections may extend past the 12-week limit on passive treatment modalities so long as the maximum treatment for injections is not exceeded.

(b) For purposes of this subsection, “therapeutic injections” include injections of trigger points, facet joints, facet nerves, sacroiliac joints, sympathetic nerves, epidurals, nerve roots, and peripheral nerves. Therapeutic injections may only be given in conjunction with active treatment modalities directed to the same anatomical site.

1. All of the following guidelines apply to trigger point injections:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week to any one site if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections shall be redirected to other areas or discontinued. No more than 3 injections to different sites per patient visit may be given.

c. Maximum treatment is 4 injections to any one site.

2. All of the following guidelines apply to sacroiliac joint injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency may permit repeat injection 2 weeks after the previous injection if there is a positive response to the first injection. Only 2 injections per patient visit.

c. Maximum treatment is 2 injections to any one site.

3. All of the following guidelines apply to facet joint or nerve injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks to any one site if there is a positive response to the first injection. If

subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.

- c. Maximum treatment is 3 injections to any one site.
- 4. All of the following guidelines apply to nerve root blocks:
 - a. Time for treatment response is within one week.
 - b. Maximum treatment frequency may permit repeat injection 2 weeks after the previous injection if there is a positive response to the first injection. Only 3 injections to different sites per patient visit.
 - c. Maximum treatment is 2 injections to any one site. Maximum treatment is 2 injections to any one site.
- 5. All of the following guidelines apply to epidural injections:
 - a. Time for treatment response is within one week.
 - b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections should be discontinued. Only one injection per patient visit.
 - c. Maximum treatment is 3 injections.
- (c) For purposes of this paragraph, “lytic or sclerosing injections” include radio frequency denervation of the facet joints. These injections may only be given in conjunction with active treatment modalities directed to the same anatomical site. All of the following guidelines apply to lytic or sclerosing injections:
 - 1. Time for treatment response is up to 6 weeks.
 - 2. Maximum treatment frequency may repeat 4 times per year or once every 3 months for any site.
 - 3. Maximum of 2 injections to any one site.
- (d) Prolotherapy and botulinum toxin injections are not necessary in the treatment of low back problems.

(6) SURGERY, INCLUDING DECOMPRESSION PROCEDURES AND ARTHRODESIS. (a) A health care provider may only perform surgery if it meets the specific guidelines specified in subs. (11), (12), (13), and s. DWD 81.12 (1).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period, the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

- 1. Eight weeks following lumbar decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system.
- 2. Twelve weeks following arthrodesis.

(c) Repeat surgery shall also meet the guidelines of subs. (11), (12), (13), and s. DWD 81.12 (1).

(d) The surgical therapies in subs. 1. and 2. have very limited application and require a personality or psychosocial evaluation that indicates the patient is likely to benefit from the treatment:

- 1. Spinal cord stimulator may be necessary for a patient who has neuropathic pain and has had a favorable response to a trial screening period.
- 2. Intrathecal drug delivery system may be necessary for a patient who has somatic or neuropathic pain and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of low back pain shall be provided according to the guidelines of s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. (a) A health care provider may direct the use of durable medical equipment in any of the following:

- 1. Lumbar braces, corsets, or supports are necessary within the guidelines of sub. (3) (k).

2. For patients using electrical muscle stimulation or mechanical traction devices at home, the device and any required supplies are necessary within the guidelines of sub. (3) (e) and (f).

3. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are necessary only as part of an approved chronic management program. This equipment is not necessary during initial nonsurgical care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

a. ‘Indications.’ The patient is deconditioned and requires reconditioning that may be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

b. ‘Requirements.’ The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(b) All of the following durable medical equipment is not necessary for home use for low back conditions:

- 1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.
- 2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) A health care provider shall evaluate at each visit whether the treatment is medically necessary and shall evaluate whether initial nonsurgical treatment is effective according to pars. (b) to (e). No later than the time for treatment response established for the specific modality in subs. (3) to (5), a health care provider shall evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement in pars. (b) to (e).

(b) The patient’s subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

(c) The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of the injury.

(d) The patient’s functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record or documentation of work ability involving less restrictive limitations on activity.

(e) If there is not progressive improvement in at least 2 criteria specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to another health care provider.

(10) MEDICATION MANAGEMENT. (a) Prescription of controlled substance medications under ch. 450, Stats., including opioids and narcotics, are indicated primarily for the treatment of severe acute pain. These medications are not recommended in the treatment of patients with persistent low back pain.

(b) Patients with radicular pain may require longer periods of treatment.

(c) A health care provider shall document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine that ongoing medication is effective treatment for the patient’s condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL LOW BACK PAIN. (a) A health care provider shall use initial nonsurgical

treatment as the first phase of treatment for all patients with regional low back pain under sub. (1) (b) 1.

1. The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

2. The only therapeutic injections necessary for patients with regional low back pain are trigger point injections, facet joint injections, facet nerve injections, sacroiliac joint injections, and epidural blocks, and their use shall meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical treatment shall at all times contain active treatment modalities according to the guidelines in sub. (4).

4. Initial nonsurgical treatment shall be provided in the least intensive setting consistent with quality health care practices.

5. Except as otherwise specified in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not necessary beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is necessary in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is necessary.

1. Surgical evaluation, if necessary, may begin as soon as 8 weeks after, but shall begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery may not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique shall be chosen on the basis of the suspected etiology of the patient's condition but a health care provider shall follow the guidelines in s. DWD 81.05. Medical imaging studies that do not meet these guidelines are not necessary.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only necessary if their use is consistent with the guidelines of sub. (1) (j).

4. Surgical evaluation may also include personality or psychosocial evaluation, consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks, and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

6. The only surgical procedures necessary for patients with regional low back pain are decompression of a lumbar nerve root or lumbar arthrodesis, with or without instrumentation, which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1). For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary and consistent with sub. (6) (d).

a. If surgery is necessary, it shall be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it shall be performed as expeditiously as possible consistent with sound medical practice.

b. If surgery is not necessary, or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management under the guidelines in s. DWD 81.13.

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient

refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management that shall be provided under the guidelines in s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL LOW BACK PAIN, WITH NO OR STATIC NEUROLOGIC DEFICITS. (a) Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits under sub. (1) (b) 2., and shall be the first phase of treatment. It shall be provided within the guidelines of sub. (11) (a), with the following modifications: Epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections necessary for patients with radicular pain only. If there is a component of regional low back pain, therapeutic facet joint injections, facet nerve injections, trigger point injections, and sacroiliac injections may also be necessary.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional low back pain, with static neurologic deficits shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR CAUDA EQUINA SYNDROME AND FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL LOW BACK PAIN, WITH PROGRESSIVE NEUROLOGIC DEFICITS. (a) Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, with progressive neurologic deficits may require immediate or emergency surgical evaluation at any time during the course of the overall treatment. The decision to proceed with surgical evaluation is made by a health care provider based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any initial nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (11) (b), except that surgical evaluation and surgical therapy may begin at any time.

(b) If a health care provider decides to proceed with a course of initial nonsurgical care for a patient with radicular pain with progressive neurologic changes, it shall follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional low back pain, with foot drop or progressive neurologic changes at first presentation shall be provided under the guidelines of s. DWD 81.13.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.07 Neck pain. (1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF NECK INJURY. (a) A health care provider shall determine the nature of the neck condition before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination the health care provider shall assign the patient at each visit to the appropriate clinical category in subds. 1. to 4. A health care provider shall document the diagnosis in the medical record. For the purposes of subds. 2. and 3., “radicular pain” means pain radiating distal to the shoulder. This section does not apply to fractures of the cervical spine or cervical pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

1. Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and that affects the cervical region, with or without referral to the upper back or shoulder, including ICD–9–CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

2. Radicular pain, with or without regional neck pain, with no or static neurologic deficit includes the diagnoses of brachialgia, cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of a nerve root in the cervical spine, including ICD–9–CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00. In these cases neurologic findings on history and examination are either absent or do not show progressive deterioration.

3. Radicular pain, with or without regional neck pain, with progressive neurologic deficit, includes the same diagnoses as subd. 2., except in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness, and progressive reflex changes.

4. Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

(c) A health care provider may not order laboratory tests in the evaluation of a patient with regional neck pain, or radicular pain, except for any of the following:

1. When a patient’s history, age, or examination suggests infection, metabolic–endocrinologic disorders, tumorous conditions, or systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered at any time a health care provider suspects any of the conditions specified in par. (c), but a health care provider shall justify the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the cervical spine shall be based on the findings of the history and physical examination and may not be ordered prior to a health care provider’s clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and shall comply with the guidelines in s. DWD 81.05. A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(f) Electromyography and nerve conduction studies are always inappropriate for the regional neck pain diagnoses in par. (b) 1. to 4. Electromyography and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and myelopathy diagnoses in par. (b) 2. to 4., after the first 3 weeks of radicular or myelopathy symptoms. Repeat electromyography and nerve conduction studies for radicular pain and myelopathy are not necessary unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing.

(g) A health care provider may not order the use of any of the following procedures or tests for the diagnosis of any of the clinical categories in par. (b) 1. to 4.:

1. Surface electromyography or surface paraspinal electromyography.

2. Thermography.

3. Plethysmography.

4. Electronic X–ray analysis of plain radiographs.

5. Diagnostic ultrasound of the spine.

6. Somatosensory evoked potentials and motor evoked potentials.

(h) A health care provider may not order computerized range of motion or strength measuring tests during the period of initial nonsurgical management, but may order these tests during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider’s evaluation or treatment, or physical or occupational therapy evaluation or treatment.

(i) A health care provider may order personality or psychological evaluations for evaluating patients who continue to have problems despite appropriate care. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, a health care provider performing the evaluation shall consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?

3. Are there other personality factors or disorders that are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) All of the following are guidelines for diagnostic analgesic blocks or injection studies and include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block.

1. These procedures are used to localize the source of pain prior to surgery and to diagnose conditions that fail to respond to initial nonsurgical management.

2. These blocks and injections are invasive and when done as diagnostic procedures are not necessary unless noninvasive procedures have failed to establish the diagnosis.

3. Selection of patients, choice of procedure, and localization of the level of injection shall be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

4. These blocks and injections may also be used as therapeutic modalities and are subject to the guidelines in sub. (5)

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine a patient's physical capacities in general or to determine and report work tolerance for a specific job, task, or work activity.

1. Functional capacity assessment or evaluation is not necessary during the period of initial nonoperative care.

2. Functional capacity assessment or evaluation is necessary in any of the following circumstances:

a. To identify the patient's permanent activity restrictions and capabilities.

b. To assess the patient's ability to do a specific job.

(L) Consultations with other health care providers may be initiated at any time by a treating health care provider consistent with accepted medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR NECK PAIN. (a) All medical care for neck pain appropriately assigned to a clinical category in sub. (1) (b) is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (14) as follows:

1. Subsection (11) governs regional neck pain.

2. Subsection (12) governs radicular pain with no or static neurologic deficits.

3. Subsection (13) governs radicular pain with progressive neurologic deficits.

4. Subsection (14) governs myelopathy.

(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan shall be appropriately modified to reflect the new clinical category. A change of clinical category shall not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury.

(c) In general, a course of treatment is divided into the following 3 phases:

1. First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit or myelopathy under sub. (1) (b) 3. and 4., shall be given initial nonsurgical care that may include both active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3), (4), (5), (8), and (10). The period of initial nonsurgical management begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical

treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonoperative care is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (14), and s. DWD 81.12 (1). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Patients with radicular pain with progressive neurological deficit or myelopathy may require immediate surgical therapy.

b. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

c. Surgery shall follow the guidelines in subs. (6), (11) to (14), and s. DWD 81.12 (1).

d. A decision against surgery at any particular time does not preclude a decision for surgery made at a later date.

3. Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be necessary. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment as described in sub. (8).

(d) A treating health care provider may refer the patient for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES. (a) *General.* Except as set forth in par. (b) or s. DWD 81.04 (5), a health care provider may not direct the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) beyond 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the patient at home.

(b) *Additional passive treatment modalities.* A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months to be provided if all of the following apply:

1. The patient is released to work or is permanently totally disabled and the additional passive treatment shall result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is not necessary while the patient has chronic pain syndrome.

(c) *Adjustment or manipulation of joints.* For purposes of this paragraph "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations. All of the following guidelines apply to adjustment or manipulation of joints:

1. Time for treatment response is 3 to 5 treatments.

2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(d) *Thermal treatment.* For purposes of this paragraph, "thermal treatment" includes all superficial, deep heating modalities,

and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave. All of the following guidelines apply to thermal treatment:

1. Treatment given in a clinical setting:
 - a. Time for treatment response is 2 to 4 treatments.
 - b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
 - c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) *Electrical muscle stimulation.* For purposes of this paragraph, “electrical muscle stimulation” includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:

1. Electrical muscle stimulation given in a clinical setting:
 - a. Time for treatment response is 2 to 4 treatments.
 - b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
 - c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting in order to ensure proper electrode placement and patient education. All of the following guidelines apply to home use of an electronic muscle stimulation device:

- a. Time for patient education and training is one to 3 sessions.
- b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(f) *Mechanical traction.* All of the following guidelines apply to mechanical traction:

1. Treatment given in a clinical setting:
 - a. Time for treatment response is 3 treatments.
 - b. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks and decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
 - c. Maximum treatment duration is 12 weeks in a clinical setting, but only if used in conjunction with other therapies.

2. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device shall be in a supervised setting in order to ensure proper patient education. All of the following guidelines apply to home use of a mechanical traction device:

- a. Time for patient education and training is one session.
- b. A patient may use the mechanical traction device for one month, at which time effectiveness of the treatment shall be

reevaluated by a health care provider before continuing home use of the device.

(g) *Acupuncture treatments.* For purposes of this paragraph, “acupuncture treatments” include endorphin-mediated analgesic therapy that includes classic acupuncture and acupressure. All of the following guidelines apply to acupuncture treatments:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for one to 3 weeks and decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(h) *Manual therapy.* For purposes of this paragraph, “manual therapy” includes soft tissue and joint mobilization, therapeutic massage, and manual traction. All of the following guidelines apply to manual therapy:

1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks and decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(i) *Phoresis.* For purposes of this paragraph, “phoresis” includes iontophoresis and phonophoresis. All of the following guidelines apply to phoresis:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(j) *Bedrest.* Prolonged restriction of activity and immobilization are detrimental to a patient’s recovery. Bedrest shall not be prescribed for more than 7 days.

(k) *Cervical collars, spinal braces, and other movement restricting appliances.* All of the following guidelines apply to cervical collars, spinal braces, and other movement-restricting appliances:

1. Bracing required for longer than 2 weeks shall be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability.
2. Time for treatment response is 3 days.
3. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.
4. Maximum continuous duration is up to 3 weeks unless patient is status postfusion.

(4) **ACTIVE TREATMENT MODALITIES.** (a) Active treatment modalities shall be used as set forth in pars. (b) to (f). A health care provider’s use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

(b) Education shall teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is 3 visits, which include an initial education and training session and 2 follow-up visits.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is 3 visits.

(d) Worksite analysis and modification shall examine the patient’s work station, tools, and job duties. A health care provider may make recommendations for the alteration of the work

station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is 3 visits.

(e) Exercise, which is important to the success of an initial non-surgical treatment program and a return to normal activity, shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall, at least in part, be specifically aimed at the musculature of the cervical spine. Aerobic exercise and extremity strengthening may be performed as adjunctive treatment, but may not be the primary focus of the exercise program.

(f) Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subds. 1. and 2. govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. 'Guidelines for supervised exercise.' One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is 3 times per week for 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks.

2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. All of the following guidelines apply to unsupervised exercise:

a. Maximum treatment frequency is up to 3 visits for instruction and monitoring.

b. There is no limit on the duration or frequency of exercise at home.

(5) THERAPEUTIC INJECTIONS. (a) Injection modalities are necessary as set forth in pars. (b) to (d). A health care provider's use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

(b) For purposes of this paragraph, "therapeutic injections" include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections may only be given in conjunction with active treatment modalities directed to the same anatomical site.

1. All of the following guidelines apply to trigger point injections:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger point injections shall be redirected to other areas or discontinued. Only 3 injections per patient visit.

c. Maximum treatment is 4 injections to any one site.

2. All of the following guidelines apply to facet joint injections or facet nerve blocks:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks shall be discontinued. Only 3 injections or blocks per patient visit.

c. Maximum treatment is 3 injections or blocks to any one site.

3. All of the following guidelines apply to nerve root blocks:

a. Time for treatment response is within one week.

b. Maximum treatment frequency may permit repeat injection no sooner than 2 weeks after the previous injection if there is a positive response to the first injection. No more than 3 blocks per patient visit.

c. Maximum treatment is 2 blocks to any one site.

4. All of the following guidelines apply to epidural injections:

a. Time for treatment response is within one week.

b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only one injection per patient visit.

c. Maximum treatment is 3 injections.

(c) For purposes of this paragraph, "lytic or sclerosing injections" include radio frequency denervation of the facet joints. These injections may only be given in conjunction with active treatment modalities directed to the same anatomical site. All of the following guidelines apply to lytic or sclerosing injections:

1. Time for treatment response is within one week.

2. Maximum treatment frequency, may repeat once for any site.

3. Maximum duration is 2 injections to any one site.

(d) Prolotherapy and botulinum toxin injections are not necessary in the treatment of neck problems.

(6) SURGERY, INCLUDING DECOMPRESSION PROCEDURES AND ARTHRODESIS. (a) A health care provider may perform surgery only if it meets the specific guidelines of subs. (11) to (14) and s. DWD 81.12 (1).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Eight weeks following decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system.

2. Twelve weeks following arthrodesis.

(c) Repeat surgery shall also meet the guidelines of subs. (11) to (14) and s. DWD 81.12 (1).

(d) The surgical therapies in subds. 1. and 2. have very limited application and require a personality or psychosocial evaluation that indicates the patient is likely to benefit from the treatment.

1. Spinal cord stimulator may be necessary for a patient who has neuropathic pain and has had a favorable response to a trial screening period.

2. Intrathecal drug delivery system may be necessary for a patient who has somatic or neuropathic pain and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of neck pain shall be provided according to the guidelines in s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. (a) A health care provider may direct the use of durable medical equipment only as specified in pars. (b) to (e).

(b) Cervical collars, braces or supports, and home cervical traction devices may be necessary within the guidelines of sub. (3) (f) and (k).

(c) For patients using electrical muscle stimulation at home, the device and any required supplies are necessary within the guidelines of sub. (3) (e).

(d) Exercise equipment for home use, including bicycles, treadmills, and stairclimbers are necessary only as part of an approved chronic management program. This equipment is not necessary during initial nonoperative care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

1. 'Indications.' The patient is deconditioned and requires reconditioning that may be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

2. 'Requirements.' The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment is not necessary for home use for neck pain conditions:

1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) A health care provider shall evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical management is effective according to pars. (b) to (e). No later than the time for treatment response established for the specific modality in subs. (3) to (5), a health care provider shall evaluate whether the passive, active, injection, or medication treatment modality has resulted in progressive improvement as specified in pars. (b) to (e).

(b) The patient's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

(c) The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

(d) The patient's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record or documentation of work ability involving less restrictive limitations on activity.

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to another health care provider.

(10) MEDICATION MANAGEMENT. (a) Prescription of controlled substance medications scheduled under ch. 450, Stats., including opioids and narcotics, are indicated primarily for the treatment of severe acute pain. These medications are not recommended in the treatment of patients with persistent regional neck pain.

(b) Patients with radicular pain may require longer periods of treatment.

(c) A health care provider shall document the rationale for the use of any scheduled medication. Treatment with nonnarcotic medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL NECK PAIN. (a) A health care provider shall use initial nonsurgical treatment for the first phase of treatment for all patients with regional neck pain under sub. (1) (b) 1.

1. The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subs. (3),

(4), (5), (8), and (10), may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition.

2. The only therapeutic injections necessary for patients with regional neck pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use must meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical treatment shall at all times contain active treatment modalities according to the guidelines of sub. (4).

4. Initial nonsurgical treatment shall be provided in the least intensive setting consistent with quality health care practices.

5. Except as otherwise provided in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not necessary beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is necessary in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is necessary.

1. Surgical evaluation if necessary may begin as soon as 8 weeks after, but shall begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique shall be chosen on the basis of the suspected etiology of the patient's condition but a health care provider shall follow the guidelines of s. DWD 81.05. Medical imaging studies that do not meet these guidelines are not necessary.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only necessary if their use is consistent with the guidelines of sub. (1) (j).

4. Surgical evaluation may also include personality or psychosocial evaluation, consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks, and injections, if performed, and the patient's ongoing subjective complaints and physical findings.

6. The only surgical procedure necessary for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation, which shall meet the guidelines in sub. (6). For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with the guidelines of sub. (6) (d).

a. If surgery is necessary, it shall be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it shall be performed as expeditiously as possible, consistent with sound medical practice.

b. If surgery is not necessary or if the patient does not wish to proceed with surgical therapy, then the patient is a candidate for chronic management.

(c) If the patient continues with symptoms and objective physical findings after surgery has been rendered or the patient refuses surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management under s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL NECK PAIN, WITH NO OR STATIC NEUROLOGIC DEFICITS. (a) Initial nonsurgical treatment is appropriate for all patients with radicular pain, with or without regional neck pain, with no or static neurologic deficits under sub. (1) (b) 2., and shall be the first phase of treatment. It shall be provided within the guidelines of sub. (11) (a), with the following modifications: Epidural blocks, nerve root, and peripheral nerve blocks are the only therapeutic injections necessary for patients with radicular pain only. If there is a component of regional neck pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be necessary.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b), with the following modifications: The only surgical procedures necessary for patients with radicular pain are decompression of a cervical nerve root which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (c) and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain, with static neurologic changes shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN, WITH OR WITHOUT REGIONAL NECK PAIN, WITH PROGRESSIVE NEUROLOGIC DEFICITS. (a) Patients with radicular pain, with or without regional neck pain, with progressive neurologic deficits may require immediate or emergency evaluation at any time during the course of their overall treatment. A health care provider may make the decision to proceed with surgical evaluation based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (11) (b), with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures necessary for patients with radicular pain are decompression of a cervical nerve root that shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (c), or cervical arthrodesis, with or without instrumentation. For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with the guidelines of sub. (6) (d).

(b) If a health care provider decides to proceed with a course of nonsurgical care for a patient with radicular pain with progressive neurologic changes, it shall follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional neck pain,

with progressive neurologic changes at first presentation shall be provided under the guidelines of s. DWD 81.13.

(14) SPECIFIC TREATMENT GUIDELINES FOR MYELOPATHY. (a) Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. A health care provider may make the decision to proceed with surgical evaluation based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the guidelines of sub. (6) (b), with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures necessary for patients with myelopathy are anterior or posterior decompression of the spinal cord, or cervical arthrodesis with or without instrumentation. For patients with failed back surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with the guidelines of sub. (6) (d).

(b) If a health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it shall follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy shall be provided under the guidelines of s. DWD 81.13.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.08 Thoracic back pain. (1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF THORACIC BACK INJURY. (a) A health care provider shall determine the nature of the thoracic back condition before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination, a health care provider shall assign the patient at each visit to the appropriate clinical category in subds. 1. to 3. A health care provider shall document the diagnosis in the medical record. For the purposes of subds. 2. and 3., "radicular pain" means pain radiating in a dermatomal distribution around the chest or abdomen. This section does not apply to fractures of the thoracic spine or thoracic back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.

1. Regional thoracic back pain includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and that affects the thoracic region, including ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925, and 926.1 to 926.12.

2. Radicular pain, with or without regional thoracic back pain, includes the diagnoses of thoracic radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and any other diagnoses for pain believed to originate with irritation of a nerve root in the thoracic spine, including ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00.

3. Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

(c) A health care provider may not order laboratory tests in the evaluation of a patient with regional thoracic back pain, or radicular pain, except for any of the following:

1. When a patient's history, age, or examination suggests infection, metabolic–endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis.

2. To evaluate potential adverse side effects of medications.

3. As part of a preoperative evaluation.

(d) Laboratory tests may be ordered at any time a health care provider suspects any of the conditions specified in par. (c), but a health care provider shall justify the need for the tests ordered with clear documentation of the indications.

(e) Medical imaging evaluation of the thoracic spine shall be based on the findings of the history and physical examination and may not be ordered prior to a health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and shall comply with the guidelines in s. DWD 81.05. A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(f) A health care provider may not order electromyography and nerve conduction studies for regional thoracic back pain and radicular pain under par. (b) 1. to 3.

(g) A health care provider may not order the use of any of the following procedures or tests for the diagnosis of any of the clinical categories in par. (b) 1. to 3.:

1. Surface electromyography or surface paraspinal electromyography.

2. Thermography.

3. Plethysmography.

4. Electronic X–ray analysis of plain radiographs.

5. Diagnostic ultrasound of the spine.

6. Somatosensory evoked potentials and motor evoked potentials.

(h) A health care provider may not order computerized range of motion or strength measuring tests during the period of initial nonsurgical care, but may order these tests during a period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonoperative care computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider's evaluation or treatment, or physical or occupational therapy evaluation or treatment.

(i) A health care provider may order personality or psychological evaluations for evaluating patients who continue to have problems despite appropriate care. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, a health care provider performing the evaluation shall consider all of the following:

1. Is symptom magnification occurring?

2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?

3. Are there other personality factors or disorders that are interfering with recovery?

4. Is the patient chemically dependent?

5. Are there any interpersonal conflicts interfering with recovery?

6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) All of the following are guidelines for diagnostic analgesic blocks or injection studies and include facet joint injection, facet nerve block, epidural differential spinal block, nerve block, and nerve root block:

1. These procedures are used to localize the source of pain prior to surgery and to diagnose conditions that fail to respond to initial nonoperative care.

2. These blocks and injections are invasive and when done as diagnostic procedures only are not necessary unless noninvasive procedures have failed to establish the diagnosis.

3. Selection of patients, choice of procedure, and localization of the level of injection may be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

4. These blocks and injections may also be used as therapeutic modalities and are subject to the guidelines in sub. (5).

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

1. A functional capacity assessment or evaluation is not necessary during the period of initial nonoperative care.

2. Functional capacity assessment or evaluation is necessary in any of the following circumstances:

a. To identify the patient's permanent activity restrictions and capabilities.

b. To assess the patient's ability to do a specific job.

(L) Consultations with other health care providers may be initiated at any time by a treating health care provider consistent with standard medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR THORACIC BACK PAIN. (a) All medical care for thoracic back pain, appropriately assigned to a category of sub. (1) (b) 1. to 3. is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11), (12), and (13) as follows:

1. Subsection (11) governs regional thoracic back pain.

2. Subsection (12) governs radicular pain.

3. Subsection (13) governs myelopathy.

(b) A health care provider shall, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan shall be appropriately modified to reflect the new clinical category. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in this section or to repeat a therapy or treatment previously provided for the same injury.

(c) In general, a course of treatment is divided into the following 3 phases:

1. First, all patients with thoracic back problems, except patients with myelopathy under sub. (1) (b) 3., shall be given initial nonoperative care that may include active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and guidelines are described in subs. (3), (4), (5), (8), and (10). The period of initial nonsurgical treatment begins with the first clinical passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11), (12), (13), and s. DWD 81.12 (1). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Patients with myelopathy may require immediate surgical therapy.

b. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical care.

c. Surgery shall follow the guidelines in subs. (6), (11), (12), (13), and s. DWD 81.12 (1).

d. A decision against surgery at any particular time does not preclude a decision for surgery made at a later date in light of new clinical information.

3. Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be necessary. Chronic management modalities are described in s. DWD 81.13 and may also include durable medical equipment as described in sub. (8).

(d) A treating health care provider may refer the patient for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES. (a) *General.* Except as set forth in par. (b) or s. DWD 81.04 (5), a health care provider may not direct the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) beyond 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the patient at home.

(b) *Additional passive treatment modalities.* A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months if all of the following apply:

1. The patient is released to work or is permanently totally disabled and the additional passive treatment shall result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is not necessary while the patient has chronic pain syndrome.

(c) *Adjustment or manipulation of joints.* For purposes of this paragraph, "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations. All of the following guidelines apply to adjustment or manipulation of joints:

1. Time for treatment response is 3 to 5 treatments.

2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(d) *Thermal treatment.* For purposes of this paragraph, "thermal treatment" includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave. All of the following guidelines apply to thermal treatment:

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) *Electrical muscle stimulation.* For purposes of this paragraph "electrical muscle stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:

1. Electrical muscle stimulation given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting in order to ensure proper electrode placement and patient education. All of the following guidelines apply to home use of an electrical stimulation device:

a. Maximum time for patient education and training is up to 3 sessions.

b. Patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(f) *Mechanical traction.* All of the following guidelines apply to mechanical traction:

1. Treatment given in a clinical setting:

a. Time for treatment response is 3 treatments.

b. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks in a clinical setting but only if used in conjunction with other therapies.

2. Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device shall be in a supervised setting in order to ensure proper patient education. All of the following guidelines apply to home use of a mechanical traction device:

a. Maximum time for patient education and training is one session.

b. A patient may use the mechanical traction device for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(g) *Acupuncture treatments.* For purposes of this paragraph, “acupuncture treatments” include endorphin-mediated analgesic therapy that includes classic acupuncture and acupressure. All of the following guidelines apply to acupuncture treatments:

1. Time for treatment response is 3 to 5 sessions.

2. Maximum treatment frequency is up to 3 times per week for one to 3 weeks and decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(h) *Manual therapy.* For purposes of this paragraph, “manual therapy” includes soft tissue and joint mobilization, therapeutic massage, and manual traction. All of the following guidelines apply to manual therapy:

1. Time for treatment response is 3 to 5 treatments.

2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(i) *Phoresis.* For purposes of this paragraph, “phoresis” includes iontophoresis and phonophoresis. All of the following guidelines apply to phoresis:

1. Time for treatment response is 3 to 5 sessions.

2. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks and decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(j) *Bedrest.* Prolonged restriction of activity and immobilization are detrimental to a patient’s recovery. Bedrest may not be prescribed for more than 7 days.

(k) *Spinal braces and other movement restricting appliances.* Spinal braces and other movement-restricting appliances required for longer than 2 weeks shall be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability. All of the following guidelines apply to spinal braces and other movement-restricting appliances:

1. Time for treatment response is 3 days.

2. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.

3. Maximum continuous duration is 3 weeks unless patient is status postfusion.

(4) **ACTIVE TREATMENT MODALITIES.** (a) Active treatment modalities shall be used as set forth in pars. (b) to (f). A health care provider’s use of active treatment modalities may extend past the 12-week limit on passive treatment modalities, so long as the maximum durations for the active treatment modalities are not exceeded.

(b) Education shall teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is

3 visits, which include an initial education and training session and 2 follow-up visits.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, back and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods may include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is 3 visits.

(d) Worksite analysis and modification shall examine the patient’s work station, tools, and job duties. A health care provider may make recommendations for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is 3 visits.

(e) Exercise, which is important to the success of an initial non-surgical treatment program and a return to normal activity, shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall, at least in part, be specifically aimed at the musculature of the thoracic spine. Aerobic exercise and extremity strengthening may be performed as adjunctive treatment but may not be the primary focus of the exercise program.

(f) Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subdivisions 1. and 2. govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. ‘Guidelines for supervised exercise.’ One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is 3 times per week for 3 weeks and may decrease with time until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks.

2. ‘Guidelines for unsupervised exercise.’ Unsupervised exercise shall be provided in the least intensive setting appropriate to the goals of the exercise program and may supplement or follow the period of supervised exercise. All of the following guidelines apply to unsupervised exercise:

a. Maximum treatment frequency is one to 3 visits for instruction and monitoring.

b. There is no limit on the duration and frequency of exercise at home.

(5) **THERAPEUTIC INJECTIONS.** (a) Injection modalities are necessary as set forth in pars. (b) to (d). A health care provider’s use of injections may extend past the 12-week limit on passive treatment modalities, so long as the maximum treatment for injections is not exceeded.

(b) For purposes of this subsection, “therapeutic injections” include trigger points injections, facet joint injections, facet nerve blocks, sympathetic nerve blocks, epidurals, nerve root blocks, and peripheral nerve blocks. Therapeutic injections may only be given in conjunction with active treatment modalities directed to the same anatomical site.

1. All of the following guidelines apply to trigger point injections:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency is once per week if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then trigger

point injections shall be redirected to other areas or discontinued. Only 3 injections per patient visit.

- c. Maximum treatment is 4 injections to any one site.
2. All of the following guidelines apply to facet joint injections and facet nerve blocks:
 - a. Time for treatment response is within one week.
 - b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection or block. If subsequent injections or blocks demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections or blocks shall be discontinued. Only 3 injections or blocks per patient visit.
 - c. Maximum treatment is 3 injections or blocks to any one site.
3. All of the following guidelines apply to nerve root blocks:
 - a. Time for treatment response is within one week.
 - b. Maximum treatment frequency may permit repeat injection 2 weeks after the previous injection if there is a positive response to the first block. Only 3 injections per patient visit.
 - c. Maximum treatment is 2 blocks to any one site.
4. All of the following guidelines apply to epidural injections:
 - a. Time for treatment response is within one week.
 - b. Maximum treatment frequency is once every 2 weeks if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only one injection per patient visit.
 - c. Maximum treatment is 3 injections.

(c) For purposes of this paragraph, “lytic or sclerosing injections” include radio frequency denervation of the facet joints. These injections may only be given in conjunction with active treatment modalities directed to the same anatomical site. All of the following guidelines apply to lytic or sclerosing injections:

1. Time for treatment response is within one week.
2. Optimum treatment frequency may repeat once for any site.
3. Maximum duration is 2 injections to any one site.

(d) Prolotherapy and botulinum toxin injections are not necessary in the treatment of thoracic back problems.

(6) SURGERY INCLUDING DECOMPRESSION PROCEDURES. (a) A health care provider may perform surgery only if it meets the specific guidelines of subs. (11), (12), (13), and s. DWD 81.12 (1).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from the initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Eight weeks following decompression or implantation of a spinal cord stimulator or intrathecal drug delivery system.
2. Twelve weeks following arthrodesis.

(c) Repeat surgery shall also meet the guidelines of subs. (11), (12), (13), and s. DWD 81.12 (1).

(d) The surgical therapies in subs. 1. and 2. have very limited application and require a personality or psychosocial evaluation that indicates the patient is likely to benefit from the treatment.

1. Spinal cord stimulator may be necessary for a patient who has neuropathic pain and has had a favorable response to a trial screening period.
2. Intrathecal drug delivery system may be necessary for a patient who has somatic or neuropathic pain and has had a favorable response to a trial screening period.

(7) CHRONIC MANAGEMENT. Chronic management of thoracic back pain shall be provided according to the guidelines of s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. (a) A health care provider may direct the use of durable medical equipment only in certain specific situations as specified in pars. (b) to (e).

(b) Braces or supports may be necessary within the guidelines of sub. (3) (k).

(c) For patients using electrical muscle stimulation or mechanical traction devices at home, the device and any required supplies are necessary within the guidelines of sub. (3) (e) and (f).

(d) Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are necessary only as part of an approved chronic management program. This equipment is not necessary during initial nonoperative care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate the use of that facility instead of authorizing purchase of equipment for home use.

1. ‘Indications.’ The patient is deconditioned and requires reconditioning that may be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

2. ‘Requirements.’ The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment is not necessary for home use for thoracic back pain conditions:

1. Whirlpools, Jacuzzis, hot tubs, or special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, or loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) A health care provider shall evaluate at each visit whether the treatment is medically necessary and shall evaluate whether initial nonsurgical management is effective according to pars. (b) to (e). No later than the time for treatment response established for the specific modality in subs. (3) to (5), a health care provider shall evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement in pars. (b) to (e).

(b) The patient’s subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

(c) The objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

(d) The patient’s functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record or documentation of work ability involving less restrictive limitations on activity.

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to another health care provider.

(10) MEDICATION MANAGEMENT. (a) Prescription of controlled substance medications under ch. 450, Stats., including opioids and narcotics, are indicated primarily for the treatment of severe acute pain. These medications are not recommended in the treatment of patients with persistent thoracic back pain.

(b) Patients with radicular pain may require longer periods of treatment.

(c) A health care provider shall document the rationale for the use of any scheduled medication. Treatment with nonnarcotic

medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR REGIONAL THORACIC BACK PAIN. (a) A health care provider shall use initial nonsurgical treatment for the first phase of treatment for all patients with regional thoracic back pain under sub. (1) (b) 1.

1. The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management, depending on the severity of the condition.

2. The only therapeutic injections necessary for patients with regional thoracic back pain are trigger point injections, facet joint injections, facet nerve blocks, and epidural blocks, and their use shall meet the guidelines of sub. (5).

3. After the first week of treatment, initial nonsurgical management shall at all times contain active treatment modalities according to the guidelines of sub. (4).

4. Initial nonsurgical treatment shall be provided in the least intensive setting consistent with quality health care practices.

5. Except as provided in sub. (3), passive treatment modalities in a clinic setting or requiring attendance by a health care provider are not necessary beyond 12 weeks after any passive modality other than bedrest or bracing is first initiated.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and objective physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. The purpose of surgical evaluation is to determine whether surgery is necessary in the treatment of a patient who has failed to recover with initial nonsurgical care. If the patient is not a surgical candidate, then chronic management is necessary.

1. Surgical evaluation, if necessary, may begin as soon as 8 weeks after, but shall begin no later than 12 weeks after, beginning initial nonsurgical management. An initial recommendation or decision against surgical therapy does not preclude surgery at a later date.

2. Surgical evaluation may include the use of appropriate medical imaging techniques. The imaging technique shall be chosen on the basis of the suspected etiology of the patient's condition, but a health care provider shall follow the guidelines in s. DWD 81.05. Medical imaging studies that do not meet these guidelines are not necessary.

3. Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only necessary if their use is consistent with the guidelines of sub. (1) (j).

4. Surgical evaluation may also include personality or psychosocial evaluation, consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers may be appropriate as part of the surgical evaluation. The need for consultation and the choice of consultant will be determined by the findings on medical imaging, diagnostic analgesic blocks, and injections, if performed, and the patient's ongoing subjective complaints and objective physical findings.

6. The only surgical procedure necessary for patients with regional thoracic back pain only is thoracic arthrodesis with or without instrumentation, which shall meet the guidelines of sub. (6) and s. DWD 81.12 (1) (d). For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

a. If surgery is necessary, it shall be offered to the patient as soon as possible. If the patient agrees to the proposed surgery it shall be performed as expeditiously as possible consistent with sound medical practice.

b. If surgery is not necessary or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management.

(c) If the patient continues with symptoms and objective physical findings after surgery has been rendered, or the patient refuses surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management under s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR RADICULAR PAIN. (a) Initial nonsurgical treatment is appropriate for all patients with radicular pain under sub. (1) (b) 2., and shall be the first phase of treatment. It shall be provided within the guidelines of sub. (11) (a), with the following modifications: Epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections necessary for patients with radicular pain only. If there is a component of regional thoracic back pain, therapeutic facet joint injections, facet nerve blocks, and trigger point injections may also be necessary.

(b) Surgical evaluation or chronic management is necessary if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities. It shall be provided within the guidelines of sub. (11) (b), with the following modifications: The only surgical procedures necessary for patients with radicular pain are decompression or arthrodesis. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refused surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional thoracic back pain shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR MYELOPATHY. (a) Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The health care provider may decide to proceed with surgical evaluation based on the type of neurologic changes observed, the severity of the changes, the rate of progression of the changes, and the response to any nonsurgical treatments. Surgery, if necessary, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be within the guidelines of sub. (11) (b), with the following modifications:

1. Surgical evaluation and surgical therapy may begin at any time.

2. The only surgical procedures necessary for patients with myelopathy are decompression and arthrodesis. For patients with failed surgery, spinal cord stimulators or intrathecal drug delivery systems may be necessary consistent with sub. (6) (d).

(b) If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it shall follow the guidelines of sub. (12) (a).

(c) If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with myelopathy shall be provided under the guidelines of s. DWD 81.13.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.09 Upper extremity disorders. (1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF UPPER EXTREMITY DISORDERS.
 (a) A health care provider shall determine the nature of an upper extremity disorder before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination a health care provider shall at each visit assign the patient to the appropriate clinical category according to subds. 1. to 6. A health care provider shall document the diagnosis in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This section does not apply to upper extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, fractures, lacerations, amputations, or sprains or strains with complete tissue disruption.

1. ‘Epicondylitis.’ This clinical category includes medial epicondylitis and lateral epicondylitis, including ICD–9–CM codes 726.31 and 726.32.

2. ‘Tendonitis of the forearm, wrist, and hand.’ This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the upper extremity at or distal to the elbow due to mechanical injury or irritation, including the diagnoses of tendonitis, tenosynovitis, tendovaginitis, peritendinitis, extensor tendinitis, de Quervain’s syndrome, intersection syndrome, flexor tendinitis, and trigger digit, including ICD–9–CM codes 726.4, 726.5, 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04, 727.05, and 727.2.

3. ‘Nerve entrapment syndromes.’ This clinical category encompasses any compression or entrapment of the radial, ulnar or median nerves, or any of their branches, including carpal tunnel syndrome, pronator syndrome, anterior interosseous syndrome, cubital tunnel syndrome, Guyon’s canal syndrome, radial tunnel syndrome, posterior interosseous syndrome, and Wartenburg’s syndrome, including ICD–9–CM codes 354, 354.0, 354.1, 354.2, 354.3, 354.8, and 354.9.

4. ‘Muscle pain syndromes.’ This clinical category encompasses any painful condition of any of the muscles of the upper extremity, including the muscles responsible for movement of the shoulder and scapula, characterized by pain and stiffness, including the diagnoses of chronic nontraumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome, myofascial pain syndrome, myofasciitis, nonspecific myalgia, fibrositis, fibromyalgia, and fibromyositis, including ICD–9–CM codes 723.3, 729.0, 729.1, 729.5, 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and 842.

5. ‘Shoulder impingement syndromes, including tendonitis, bursitis, and related conditions.’ This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the shoulder due to mechanical injury or irritation, including the diagnoses of impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendinitis, including ICD–9–CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, 840.6, 840.8, and 840.9.

6. ‘Traumatic sprains or strains of the upper extremity.’ This clinical category encompasses an instantaneous or acute injury that occurred as a result of a single precipitating event to the ligaments or the muscles of the upper extremity including ICD–9–CM codes 840 to 842.19. Injuries to muscles as a result of repetitive use, or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes under subd. 4. Injuries with complete tissue disruption are not subject to this section.

(c) A health care provider may order certain laboratory tests in the evaluation of a patient with upper extremity disorder to rule out infection, metabolic–endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications. Laboratory tests may be ordered at any time a health care provider suspects any of these conditions, but a health care provider shall justify the need for the tests ordered with clear documentation of the indications.

(d) Medical imaging evaluation of upper extremity disorders shall be based on the findings of the history and physical examination and may not be ordered before a health care provider’s clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and shall comply with the guidelines in s. DWD 81.05. A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(e) Electromyography and nerve conduction studies are only necessary for nerve entrapment disorders and recurrent nerve entrapment after surgery.

(f) A health care provider may not order the use of any of the following diagnostic procedures or tests for diagnosis of upper extremity disorders:

1. Surface electromyography.
2. Thermography.
3. Somatosensory evoked potentials and motor evoked potentials.

(g) All of the following diagnostic procedures or tests are considered adjuncts to the physical examination and are not necessary separately from the office visit:

1. Vibrometry.
2. Neurometry.
3. Semmes–Weinstein monofilament testing.
4. Algometry.

(h) A health care provider may not order computerized range of motion or strength measuring tests during the period of initial nonsurgical management but may order these tests during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider’s evaluation or treatment.

(i) A health care provider may order personality or psychosocial evaluations for evaluating patients who continue to have problems despite appropriate initial nonsurgical care. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, a health care provider performing the evaluation shall consider all of the following:

1. Is symptom magnification occurring?
2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?
3. Are there other personality factors or disorders that are interfering with recovery?
4. Is the patient chemically dependent?
5. Are there any interpersonal conflicts interfering with recovery?
6. Does the patient have a chronic pain syndrome or psychogenic pain?

7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) Diagnostic analgesic blocks and injection studies are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management. All of the following guidelines apply to diagnostic analgesic blocks and injection studies:

1. Selection of patients, choice of procedure, and localization of the site of injection shall be determined by documented clinical findings indicating possible pathologic conditions and the source of pain symptoms.

2. These blocks and injections may also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5).

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

1. Functional capacity assessment or evaluation is not necessary during the first 12 weeks of initial nonsurgical treatment.

2. Functional capacity assessment or evaluation is necessary after the first 12 weeks of care in any of the following circumstances:

a. To identify the patient's activity restrictions and capabilities.

b. To assess the patient's ability to return to do a specific job.

3. A functional capacity evaluation is not necessary to establish baseline performance before treatment or for subsequent assessments to evaluate change during or after treatment.

4. Only one completed functional capacity evaluation is necessary per injury.

(L) Consultations with other health care providers may be initiated at any time by a treating health care provider consistent with accepted medical practice.

(2) GENERAL TREATMENT GUIDELINES FOR UPPER EXTREMITY DISORDERS. (a) All medical care for upper extremity disorders, appropriately assigned to a category of sub. (1) (b) 1. to 6., is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (16) as follows:

1. Subsection (11) governs epicondylitis.

2. Subsection (12) governs tendonitis of the forearm, wrist, and hand.

3. Subsection (13) governs upper extremity nerve entrapment syndromes.

4. Subsection (14) governs upper extremity muscle pain syndromes.

5. Subsection (15) governs shoulder impingement syndromes.

6. Subsection (16) governs traumatic sprains and strains of the upper extremity.

(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan shall

be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury, unless the treatment or therapy is subsequently delivered to a different part of the body.

(c) When treating more than one clinical category or body part for which the same treatment modality is appropriate, then the treatment modality shall be applied simultaneously, if possible, to all necessary areas.

(d) In general, a course of treatment shall be divided into the following 3 phases:

1. First, all patients with an upper extremity disorder shall be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subs. (3), (4), (5), (8), and (10), appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in sub. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (16), and s. DWD 81.12 (2). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

a. Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial nonsurgical management.

b. Surgery shall follow the guidelines in subs. (6), (11) to (16), and s. DWD 81.12 (2).

c. A decision against surgery at any particular time does not preclude a decision for surgery made at a later date.

3. Third, for those patients who are not candidates for surgery or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be necessary. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment as described in sub. (8).

(e) A treating health care provider may refer the patient for a consultation at any time during the course of treatment consistent with accepted medical practice.

(3) PASSIVE TREATMENT MODALITIES. (a) *General.* Except as set forth in par. (b) or s. DWD 81.04 (5), a health care provider may not direct the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) beyond 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the patient at home.

(b) *Additional passive treatment modalities.* A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months if all of the following apply:

1. The patient is released to work or is permanently totally disabled and the additional passive treatment may result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.

2. The treatment is not given on a regularly scheduled basis.

3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.

4. Management of the patient's condition includes active treatment modalities during this period.

5. The additional 12 visits for passive treatment does not delay the required surgical or chronic pain evaluation required by this chapter.

6. Passive care is not necessary while the patient has chronic pain syndrome.

(c) *Adjustment or manipulation of joints.* For purposes of this paragraph, "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations. All of the following guidelines apply to adjustment or manipulation of joints:

1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(d) *Thermal treatment.* For purposes of this paragraph, "thermal treatment" includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave. All of the following guidelines apply to thermal treatment:

1. Treatment given in a clinical setting:
 - a. Time for treatment response is 2 to 4 treatments.
 - b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
 - c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.
2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) *Electrical muscle stimulation.* For purposes of this paragraph, "electrical muscle stimulation" includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential and microcurrent techniques. All of the following guidelines apply to electrical muscle stimulation:

1. Treatment given in a clinical setting:
 - a. Time for treatment response is 2 to 4 treatments.
 - b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.
 - c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.
2. Home use of an electrical muscle stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting in order to ensure proper electrode placement and patient education. All of the following guidelines apply to home use of an electrical stimulation device:
 - a. Time for patient education and training is one to 3 sessions.
 - b. Patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(f) *Acupuncture treatments.* For purposes of this paragraph, "acupuncture treatments" include endorphin-mediated analgesic

therapy that includes classic acupuncture and acupressure. All of the following guidelines apply to acupuncture treatments:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(g) *Phoresis.* For purposes of this paragraph, "phoresis" includes phonophoresis and iontophoresis. All of the following guidelines apply to phoresis:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 9 sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

(h) *Manual therapy.* For purposes of this paragraph, "manual therapy" includes soft tissue and joint mobilization and therapeutic massage. All of the following guidelines apply to manual therapy:

1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(i) *Splints, braces, and other movement-restricting appliances.* Bracing required for longer than 2 weeks shall be accompanied by active motion exercises to avoid stiffness and prolonged disability. All of the following guidelines apply to splints, braces, and other movement-restricting appliances:

1. Time for treatment response is 10 days.
2. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.
3. Maximum continuous duration is 8 weeks. Prophylactic use is allowed indefinitely.

(j) *Rest.* Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Total restriction of use of an affected body part may not be prescribed for more than 2 weeks, unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints shall begin no later than 2 weeks after application of the immobilization.

(4) ACTIVE TREATMENT MODALITIES. (a) A health care provider shall use active treatment modalities as set forth in pars. (b) to (f). A health care provider's use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded.

(b) Education shall teach the patient about pertinent anatomy and physiology as it relates to upper extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments is 3 visits which include an initial education and training session, and 2 follow-up visits.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is 3 visits.

(d) Worksite analysis and modification shall examine the patient's work station, tools, and job duties. A health care provider may make recommendations for the alteration of the work station, selection of alternate tools, modification of job duties, and

provision of adaptive equipment. The maximum number of treatments is 3 visits.

(e) Exercise, which is important to the success of a nonsurgical treatment program and a return to normal activity, shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall, at least in part, be specifically aimed at the musculature of the upper extremity. While aerobic exercise may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

(f) Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subdivisions 1. and 2. govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. 'Guidelines for supervised exercise.' One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is up to 3 times per week for 3 weeks and shall decrease with time until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks.

2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

(5) THERAPEUTIC INJECTIONS. (a) For purposes of this subsection, "therapeutic injections" include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. A health care provider may only give therapeutic injections in conjunction with active treatment modalities directed to the same anatomical site. A health care provider's use of injections may extend past the 12-week limitation on passive modalities, so long as the maximum treatment for injections in pars. (b) to (d) is not exceeded.

(b) All of the following guidelines apply to trigger point injections:

1. Time for treatment response is within 30 minutes.

2. Maximum treatment frequency is once per week to any one site if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, trigger point injections shall be redirected to other areas or discontinued. Only 3 injections to different sites per patient visit.

3. Maximum treatment is 4 injections to any one site over the course of treatment.

(c) For purposes of this paragraph, "soft tissue injections" include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion. All of the following guidelines apply to soft tissue injections:

1. Time for treatment response is within one week.

2. Maximum treatment frequency is once per month to any one site if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.

3. Maximum treatment is 3 injections to any one site over the course of treatment.

(d) All of the following guidelines apply to injections for median nerve entrapment at the carpal tunnel:

1. Time for treatment response is within one week.

2. Maximum treatment frequency may permit repeat injection in one month if there is a positive response to the first injection. Only 3 injections to different sites per patient visit.

3. Maximum treatment is 2 injections to any one site over the course of treatment.

(6) SURGERY. (a) A health care provider may perform surgery if it meets applicable guidelines in subs. (11) to (16) and s. DWD 81.12 (2).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities may be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing, is as follows:

1. Sixteen weeks for rotator cuff repair, acromioclavicular ligament repair, or any surgery for a clinical category in this section that requires joint reconstruction.

2. Eight weeks for all other surgery for clinical categories in this section.

(c) Repeat surgery shall also meet the guidelines of subs. (11) to (16) and s. DWD 81.12 (2).

(7) CHRONIC MANAGEMENT. Chronic management of upper extremity disorders shall be provided according to the guidelines in s. DWD 81.13.

(8) DURABLE MEDICAL EQUIPMENT. (a) A health care provider may direct the use of durable medical equipment only in the situations specified in pars. (b) to (e).

(b) Splints, braces, straps, or supports may be necessary as specified in sub. (3) (i).

(c) For patients using an electrical muscle stimulation device at home, the device and any required supplies are necessary within the guidelines of sub. (3) (e).

(d) Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are necessary only as part of an approved chronic management program. This equipment is not necessary during initial nonsurgical care or during reevaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment the insurer may mandate use of that facility instead of authorizing purchase of the equipment for home use.

1. 'Indications.' The patient is deconditioned and requires reconditioning that can be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

2. 'Requirements.' The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment is not necessary for home use for the upper extremity disorders specified in subs. (11) to (16):

1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER. (a) A health care provider shall evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical treatment is effective according to pars. (b) to (e). No later than the time for treatment response established for the specific modality in subs. (3) to (5), a health care provider shall evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in pars. (b) to (e).

(b) The patient's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the

medical record of decreased distribution, frequency, or intensity of symptoms.

(c) The objective clinical findings are progressively improving as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

(d) The patient's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record or documentation of work ability involving less restrictive limitations on activity.

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to an allied health professional directly providing the treatment but remains the ultimate responsibility of the treating health care provider.

(10) MEDICATION MANAGEMENT. (a) Prescription of controlled substance medications scheduled under ch. 450, Stats., including opioids and narcotics, are necessary primarily for the treatment of severe acute pain. Therefore, these medications are not generally recommended in the treatment of patients with upper extremity disorders.

(b) A health care provider shall document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine that ongoing medication is effective treatment for the patient's condition.

(11) SPECIFIC TREATMENT GUIDELINES FOR EPICONDYLITIS. (a) A health care provider shall use initial nonsurgical management for all patients with epicondylitis and this shall be the first phase of treatment.

1. The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first week of treatment, initial nonsurgical care shall at all times include active treatment modalities under sub. (4).

2. Initial nonsurgical management shall be provided in the least intensive setting consistent with quality health care practices.

3. Except as provided in sub. (3), the use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period in excess of 12 weeks is not necessary.

4. Use of home-based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. The purpose and goal of surgical evaluation is to determine whether surgery is necessary for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

1. Surgical evaluation, if necessary, shall begin no later than 12 months after beginning initial nonsurgical management.

2. Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the guidelines of sub. (1), if not already obtained during the initial evaluation. Repeat testing is not necessary unless there has been an objective change in the patient's condition that in itself would warrant further test-

ing. Failure to improve with therapy does not, by itself, warrant further testing.

3. Plain films may be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general guidelines in s. DWD 81.05 (1). Other medical imaging studies are not necessary.

4. Surgical evaluation may also include personality or psychological evaluation consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers is an important part of surgical evaluation of a patient who fails to recover with appropriate initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition.

6. If surgery is necessary, it may be performed after initial nonsurgical management fails.

7. If surgery is not necessary or if the patient does not wish to proceed with surgery, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(c) If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management under s. DWD 81.13.

(12) SPECIFIC TREATMENT GUIDELINES FOR TENDINITIS OF FOREARM, WRIST, AND HAND. (a) Except as provided in par. (b) 3., a health care provider shall use initial nonsurgical management for all patients with tendonitis and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11) (a).

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all of the guidelines of sub. (11) (b), with the following modifications:

1. For patients with a specific diagnosis of de Quervain's syndrome, surgical evaluation and surgical therapy, if necessary, may begin after only 2 months of initial nonsurgical management.

2. For patients with a specific diagnosis of trigger finger or trigger thumb, surgical evaluation and potential surgical therapy may begin after only one month of initial nonsurgical management.

3. For patients with a locked finger or thumb, surgery may be necessary immediately without any preceding nonsurgical management.

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with tendonitis shall be provided under the guidelines of s. DWD 81.13.

(13) SPECIFIC TREATMENT GUIDELINES FOR NERVE ENTRAPMENT SYNDROMES. (a) A health care provider shall use initial nonsurgical management for all patients with nerve entrapment syndromes, except as specified in par. (b) 2., and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11) (a), with the following modifications: Nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression, such as abnormal two-point discrimination, motor weakness, or muscle atrophy, or for patients with symptoms

of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be necessary.

(b) If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all of the guidelines of sub. (11) (b), with the following modifications:

1. Surgical evaluation may begin and surgical therapy may be provided, if necessary, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is necessary under par. (a).

2. Surgery is necessary if an electromyography confirms the diagnosis or if there has been temporary resolution of symptoms lasting at least 7 days with local injection.

3. If there is neither a confirming electromyography nor appropriate response to local injection or if surgery has been previously performed at the same site, surgery is not necessary.

(c) If the patient continues with symptoms and objective physical findings after all surgery, or the patient refused surgery therapy, or the patient was not a candidate for surgery therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with nerve entrapment syndromes shall be provided under the guidelines of s. DWD 81.13.

(14) SPECIFIC TREATMENT GUIDELINES FOR MUSCLE PAIN SYNDROMES. (a) A health care provider shall use initial nonsurgical management for all patients with muscle pain syndromes and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11) (a).

(b) Surgery is not necessary for the treatment of muscle pain syndromes.

(c) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with muscle pain syndromes shall be provided under the guidelines of s. DWD 81.13.

(15) SPECIFIC TREATMENT GUIDELINES FOR SHOULDER IMPINGEMENT SYNDROMES. (a) A health care provider shall use initial nonsurgical management for all patients with shoulder impingement syndromes without clinical evidence of rotator cuff tear, and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11) (a), except for the following:

1. Continued nonsurgical management may be inappropriate, and early surgical evaluation may be necessary, for patients with any of the following:

- a. Clinical findings of rotator cuff tear.
- b. Acute rupture of the proximal biceps tendon.

2. Use of home-based treatment modalities with monitoring by a health care provider may continue for up to 6 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as necessary treatment.

(b) If the patient continues with symptoms and objective physical findings after 6 months of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical

evaluation and surgical therapy shall meet all of the guidelines of sub. (11) (b), with any of the following modifications:

1. Surgical evaluation shall begin no later than 6 months after beginning initial nonsurgical management.

2. Diagnostic injection, arthrography, computed tomography–arthrography, or magnetic resonance imaging scanning may be necessary as part of the surgical evaluation.

3. The only surgical procedures necessary for patients with shoulder impingement syndromes and related conditions are rotator cuff repair, acromioplasty, excision of distal clavicle, excision of bursa, removal of adhesion, or repair of proximal biceps tendon, all of which shall meet the guidelines of s. DWD 81.12 (2).

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with shoulder impingement syndromes shall be provided under the guidelines of s. DWD 81.13.

(16) SPECIFIC TREATMENT GUIDELINES FOR TRAUMATIC SPRAINS AND STRAINS OF THE UPPER EXTREMITY. (a) A health care provider shall use initial nonsurgical management for the first phase of treatment for all patients with traumatic sprains and strains of the upper extremity without evidence of complete tissue disruption. Any course or program of initial nonsurgical management shall meet all of the guidelines of sub. (11).

(b) Surgery is not necessary for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

(c) If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with traumatic sprains and strains shall be provided under the guidelines of s. DWD 81.13.

History: CR 07–019; cr. Register October 2007 No. 622, eff. 11–1–07.

DWD 81.10 Complex regional pain syndrome of the upper and lower extremities. (1) SCOPE. (a) Complex regional pain syndrome of the upper and lower extremities encompasses any condition of the upper or lower extremity characterized by findings in all of the following categories:

1. One or more findings reported by the patient in 3 or more of the following categories:

a. Positive sensory abnormalities, which include spontaneous pain, mechanical hyperalgesia, thermal hyperalgesia, and deep somatic hyperalgesia.

b. Vascular abnormalities, which include vasodilation, vasoconstriction, skin temperature asymmetries, and skin color changes.

c. Swelling or sweating abnormalities.

d. Motor and trophic changes, which include motor weakness, tremor, abnormal movements, coordination deficits, nail changes, hair changes, skin atrophy, joint stiffness, and soft tissue changes.

2. One or more findings observed by the health care provider in 2 or more of the following categories:

a. Positive sensory abnormalities, which include spontaneous pain, mechanical hyperalgesia, thermal hyperalgesia, and deep somatic hyperalgesia.

b. Vascular abnormalities, which include vasodilation, vasoconstriction, skin temperature asymmetries, and skin color changes.

c. Edema or sweating abnormalities, which include swelling, hyperhidrosis, and hypohidrosis.

d. Motor and trophic changes, which include motor weakness, tremor, abnormal movements, coordination deficits, nail changes, hair changes, skin atrophy, joint stiffness, and soft tissue changes.

(b) Complex regional pain syndrome of the upper and lower extremities includes the diagnoses of complex regional pain syndrome, reflex sympathetic dystrophy, causalgia, Sudek's atrophy, algoneurodystrophy, shoulder–hand syndrome, including ICD–9–CM codes 337.9, 354.4, and 733.7.

(c) Complex regional pain syndrome occurs as a complication of another preceding injury. The treatment guidelines of this section refer to the treatment of the body part affected by the complex regional pain syndrome. The treatment for any condition not affected by complex regional pain syndrome continues to be subject to whatever treatment guidelines otherwise apply. Any treatment under this section for complex regional pain syndrome may be in addition to treatment received for the original condition.

(d) Thermography may be used in the diagnosis of complex regional pain syndrome and is considered an adjunct to physical examination.

(e) For a patient with continued clinical signs and symptoms of complex regional pain syndrome, further diagnostic testing may be appropriate.

(2) INITIAL NONSURGICAL INVOLVEMENT. (a) A health care provider shall use initial nonsurgical management for all patients with complex regional pain syndrome and this shall be the first phase of treatment. Any course or program of initial nonsurgical management is limited to the modalities specified in pars. (b) to (i).

(b) The only therapeutic injection modalities necessary for complex regional pain syndrome are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

1. Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or sympatholytics shall be used if complex regional pain syndrome has continued for 4 weeks and the patient remains disabled as a result of the complex regional pain syndrome. All of the following guidelines apply to therapeutic injection modalities:

a. Time for treatment response is within 30 minutes.

b. Maximum treatment frequency permits a repeat injection at a site if there was a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.

c. Maximum treatment duration may be continued as long as injections control symptoms and facilitate objective functional gains if the period of improvement is progressively longer with each injection.

2. Epidural block may only be performed in patients who had an incomplete improvement with sympathetic block or intravenous infusion of steroids or sympatholytics.

(c) Only the passive treatment modalities set forth in pars. (d) to (g) are necessary. These passive treatment modalities in a clinical setting or requiring attendance by a health care provider are not necessary beyond 12 weeks from the first modality initiated for treatment of complex regional pain syndrome.

(d) For purposes of this paragraph, “thermal treatment” includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities

include diathermy, ultrasound, and microwave. All of the following guidelines apply to thermal treatment:

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies specified in this subsection.

2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without professional assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) For purposes of this paragraph, “desensitizing procedures” includes stroking or friction massage, stress loading, and contrast baths. All of the following guidelines apply to desensitizing procedures:

1. Time for treatment response is 3 to 5 treatments.

2. Maximum treatment frequency in a clinical setting is up to 5 times per week for the first one to 2 weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration in a clinical setting is 12 weeks. Home use of desensitizing procedures may be prescribed at any time during the course of treatment.

(f) For purposes of this paragraph, “electrical stimulation” includes galvanic stimulation, transcutaneous electrical nerve stimulation, interferential, and microcurrent techniques. All of the following guidelines apply to electrical stimulation treatment:

1. Treatment given in a clinical setting:

a. Time for treatment response is 2 to 4 treatments.

b. Maximum treatment frequency is up to 5 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1. c.

c. Maximum treatment duration is 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

2. Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting in order to ensure proper electrode placement and patient education. All of the following guidelines apply to home use of an electrical stimulation device:

a. Time for patient education and training is one to 3 sessions.

b. Patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment shall be reevaluated by a health care provider before continuing home use of the device.

(g) For purposes of this paragraph, “acupuncture treatments” include endorphin–mediated analgesic therapy that includes classical acupuncture and acupressure. All of the following guidelines apply to acupuncture treatments:

1. Time for treatment response is 3 to 5 sessions.

2. Maximum treatment frequency is up to 3 times per week for the first one to 3 weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.

3. Maximum treatment duration is 12 weeks.

(h) Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management shall include exercise. Exercise is essential for a return to normal activity and shall include active patient participation in activities designed to increase flexibility, strength,

endurance, or muscle relaxation. Exercise shall be specifically aimed at the involved musculature. Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care.

1. 'Guidelines for supervised exercise.' One goal of a supervised exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is up to 5 times per week for 3 weeks and shall decrease in frequency until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks.

2. 'Guidelines for unsupervised exercise.' Unsupervised exercise shall be provided in the least intensive setting and may supplement or follow the period of supervised exercise. Maximum duration is unlimited.

(i) Oral medications may be necessary in accordance with accepted medical practice.

(3) SURGERY. (a) Surgical sympathectomy may only be performed on a patient who had a sustained but incomplete improvement with sympathetic blocks by injection.

(b) There shall be appropriate psychological assessment prior to implantation of a spinal cord stimulator or intrathecal drug delivery system to determine whether the patient is a suitable candidate for this type of treatment.

(4) CHRONIC MANAGEMENT. If the patient continues with symptoms and objective physical findings after surgery, or the patient refuses surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with complex regional pain syndrome shall be provided under the guidelines of s. DWD 81.13.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.11 Inpatient hospitalization guidelines.

(1) GENERAL PRINCIPLES. (a) For purposes of this chapter, hospitalization is characterized as inpatient if the patient spends at least one night in a hospital, except for a patient in outpatient short stay status recovering after surgery for less than 24 hours or a patient in observation status.

(b) Unless a patient's condition requires special care, only ward or semiprivate accommodations are necessary. The admitting health care provider shall document the patient's special care needs.

(c) Admission before the day of surgery is necessary only if it is medically necessary to stabilize the patient before surgery. Admission before the day of surgery to perform any part of a preoperative work-up that could have been completed as an outpatient is not necessary.

(d) Inpatient hospitalization solely for physical therapy, bed-rest, or administration of injectable drugs is necessary only if the treatment is otherwise necessary and the patient's condition makes the patient unable to perform the activities of daily life and participate in the patient's own treatment and self-care.

(e) Discharge from the hospital shall be at the earliest possible date consistent with proper health care.

(2) SPECIFIC GUIDELINES FOR HOSPITAL ADMISSION OF PATIENTS WITH LOW BACK PAIN. (a) A health care provider shall direct hospitalization for low back pain in the circumstances in pars. (b) to (e).

(b) When the patient experiences incapacitating pain as evidenced by inability to mobilize for activities of daily living, for example unable to ambulate to the bathroom, and, in addition, the intensity of service during admission meets any of the following:

1. Physical therapy is necessary at least twice daily for assistance with mobility. Heat, cold, ultrasound, and massage therapy alone do not meet this criterion.

2. Muscle relaxants or narcotic analgesics are necessary intramuscularly or intravenously for a minimum of 3 injections in 24 hours. Need for parenteral analgesics is determined by any of the following:

a. An inability to take oral medications or diet by mouth.

b. An inability to achieve relief with aggressive oral analgesics.

(c) For surgery that is otherwise necessary according to s. DWD 81.12 (1) and is appropriately scheduled as an inpatient procedure.

(d) For evaluation and treatment of cauda equina syndrome according to s. DWD 81.06 (13).

(e) For evaluation and treatment of foot drop or progressive neurologic deficit according to s. DWD 81.06 (13).

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.12 Guidelines for surgical procedures.

(1) SPINAL SURGERY. (a) General. In addition to this section, initial nonsurgical, surgical and chronic management guidelines are also in s. DWD 81.06, relating to low back pain; s. DWD 81.07, relating to neck pain; and s. DWD 81.08, relating to thoracic back pain.

(b) Surgical decompression of lumbar nerve root or roots. Surgical decompression of a lumbar nerve root or roots includes all of the following lumbar procedures: laminectomy, laminotomy, discectomy, microdiscectomy, percutaneous discectomy, or foraminotomy. The procedure at each nerve root is subject independently to the requirements of subds. 1. and 2.

1. A health care provider may perform surgical decompression of a lumbar nerve root for any of the following diagnoses:

a. Intractable and incapacitating regional low back pain with positive nerve root tension signs and an imaging study showing displacement of lumbar intervertebral disc that impinges significantly on a nerve root or the thecal sac, ICD-9-CM code 722.10.

b. Sciatica, ICD-9-CM code 724.3.

c. Lumbosacral radiculopathy or radiculitis, ICD-9-CM code 724.4.

2. Any of the following conditions in this subdivision and any of the conditions in subd. 3. shall be satisfied to indicate that the surgery is reasonably required. For the response to nonsurgical care, the patient's condition includes one of the following:

a. Failure to improve with a minimum of 8 weeks of initial nonsurgical care.

b. Cauda equina syndrome, ICD-9-CM code 344.6, 344.60, or 344.61.

c. Progressive neurological deficits.

3. The patient exhibits one of the clinical findings of subd. 3. a. in combination with the test results of subd. 3. b. or, in the case of diagnosis in subd. 1. a., a decompression of the lumbar nerve root is the appropriate treatment for the patient's condition.

a. Subjective sensory symptoms in a dermatomal distribution that may include radiating pain, burning, numbness, tingling, or paresthesia, or objective clinical findings of nerve root specific motor deficit, including foot drop or quadriceps weakness, reflex changes, or positive electromyography.

b. Medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(c) Surgical decompression of a cervical nerve root. Surgical decompression of a cervical nerve root or roots includes all of the following cervical procedures: laminectomy, laminotomy, discectomy, foraminotomy with, or without, fusion. For decompression of multiple nerve roots, the procedure at each nerve root is subject to the guidelines of subds. 1. and 2.

1. A health care provider may perform surgical decompression of a cervical nerve root for any of the following diagnoses:

a. Displacement of cervical intervertebral disc, ICD-9-CM code 722.0, excluding fracture.

b. Cervical radiculopathy or radiculitis, ICD-9-CM code 723.4, excluding fracture.

2. Any of the requirements in this subdivision and any of the requirements in subd. 3. shall be satisfied to indicate that surgery is reasonably required. For the response to nonsurgical care, the patient's condition includes any of the following:

a. Failure to improve with a minimum of 8 weeks of initial nonsurgical care.

b. Cervical compressive myelopathy.

c. Progressive neurologic deficits.

3. The patient exhibits one of the clinical findings of subd. 3. a. in combination with the test results of subd. 3. b.

a. Subjective sensory symptoms in a dermatomal distribution that may include radiating pain, burning, numbness, tingling or paresthesia, or objective clinical findings of nerve root specific motor deficit, reflex changes, or positive electromyography.

b. Medical imaging test results that correlate with the level of nerve root involvement consistent with both the subjective and objective findings.

(d) *Lumbar arthrodesis with or without instrumentation.* A health care provider may perform surgery for a lumbar arthrodesis when any of the following diagnoses are present to indicate that the surgery is reasonably required:

1. Unstable lumbar vertebral fracture, ICD-9-CM codes 805.4, 805.5, 806.4, and 806.5.

2. For a second or third surgery only, documented reextrusion or redisplacement of lumbar intervertebral disc, ICD-9-CM code 722.10, after previous successful disc surgery at the same level and new lumbar radiculopathy with or without incapacitating back pain, ICD-9-CM code 724.4. Documentation under this subdivision shall include a magnetic resonance imaging scan or computed tomography scan or a myelogram.

3. Traumatic spinal deformity including a history of compression or wedge fracture or fractures, ICD-9-CM code 733.1, and demonstrated acquired kyphosis or scoliosis, ICD-9-CM codes 737.1, 737.10, 737.30, 737.41, and 737.43.

4. Incapacitating low back pain, ICD-9-CM code 724.2, for longer than 3 months, and any of the following conditions involving lumbar segments L-3 and below is present:

a. For the first surgery only, degenerative disc disease, ICD-9-CM code 722.4, 722.5, 722.6, or 722.7, with postoperative documentation of instability created or found at the time of surgery, or positive discogram at one or 2 levels.

b. Pseudoarthrosis, ICD-9-CM code 733.82.

c. For the second or third surgery only, previously operated disc.

d. Spondylolisthesis.

5. A health care provider may not perform a lumbar arthrodesis as the first primary surgical procedure for a new, acute lumbosacral disc herniation with unilateral radiating leg pain in a radicular pattern with or without neurological deficit.

(2) **UPPER EXTREMITY SURGERY.** (a) *General.* Initial nonsurgical, surgical, and chronic management guidelines for upper extremity disorders are set forth in s. DWD 81.09 (1) to (16).

(b) *Rotator cuff repair.* A health care provider may perform rotator cuff surgery for any of the following diagnoses:

1. Rotator cuff syndrome of the shoulder, ICD-9-CM code 726.1, and allied disorders, including unspecified disorders of shoulder bursae and tendons, ICD-9-CM code 726.10; calcifying tendinitis of shoulder, ICD-9-CM code 726.11; bicipital tenosyn-

ovitis, ICD-9-CM code 726.12; and other specified disorders, ICD-9-CM code 726.19.

2. Tear of rotator cuff, ICD-9-CM code 727.61.

(c) *Criteria and indications for rotator cuff repair.* In addition to one of the diagnoses in par. (b), both of the following conditions shall be satisfied to indicate that surgery for rotator cuff repair is necessary:

1. The patient's condition failed to improve in response to nonsurgical care with adequate initial nonsurgical treatment.

2. The patient's clinical findings exhibit any of the following:

a. Severe shoulder pain and inability to elevate the shoulder.

b. Weak or absent abduction and tenderness over rotator cuff or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial.

c. Positive findings in arthrogram, magnetic resonance imaging scan, or ultrasound, or positive findings on previous arthroscopy, if performed.

(d) *Acromioplasty diagnosis.* A health care provider may perform acromioplasty for the diagnosis of acromial impingement syndrome, ICD-9-CM codes 726.0 to 726.2. In addition to the diagnosis in this paragraph, both of the following conditions shall be satisfied to indicate that surgery is necessary:

1. The patient's condition has failed to improve in response to nonsurgical care after adequate initial nonsurgical care.

2. The patient's clinical findings exhibit pain with active elevation from 90 to 130 degrees, pain at night, and a positive impingement test.

(e) *Repair of acromioclavicular or costoclavicular ligaments.* A health care provider may perform surgical repair of acromioclavicular or costoclavicular ligaments for the diagnosis of acromioclavicular separation, ICD-9-CM codes 831.04 to 831.14.

1. In addition to the diagnosis in this paragraph, the guidelines in subds. 2. and 3. shall be satisfied for repair of acromioclavicular or costoclavicular ligaments.

2. The patient's condition or response to nonsurgical care includes any of the following:

a. Failure to improve after at least a one-week trial period in a support brace.

b. Separation cannot be reduced and held in a brace.

c. Grade III separation has occurred.

3. The patient's clinical findings exhibit localized pain at the acromioclavicular joint and prominent distal clavicle and radiographic evidence of separation at the acromioclavicular joint.

(f) *Excision of distal clavicle diagnosis.* A health care provider may perform excision of the distal clavicle for any of the following diagnoses specified in subd. 1. to 3.:

1. Acromioclavicular separation, ICD-9-CM codes 831.01 to 831.14.

2. Osteoarthrosis of the acromioclavicular joint, ICD-9-CM codes 715.11, 715.21, and 715.31.

3. Shoulder impingement syndrome.

(g) *Criteria and indications for excision of distal clavicle.* In addition to one of the diagnosis in par. (f), all of the following conditions shall be satisfied for excision of distal clavicle:

1. The patient's condition failed to improve in response to nonsurgical care with adequate initial nonsurgical care.

2. The patient's clinical findings exhibit any of the following:

a. Pain at the acromioclavicular joint, with aggravation of pain with motion of shoulder or carrying weight.

b. Confirmation that separation of the acromioclavicular joint is unresolved and prominent distal clavicle, or pain relief obtained with an injection of anesthetic for diagnostic or therapeutic trial.

c. Separation at the acromioclavicular joint with weight-bearing films or severe degenerative joint disease at the acromioclavicular joint noted on X-rays.

(h) *Repair of shoulder dislocation or subluxation, any procedure.* 1. A health care provider may perform surgical repair of a shoulder dislocation for any of the following diagnoses:

- a. Recurrent dislocations, ICD-9-CM code 718.31.
- b. Recurrent subluxations.
- c. Persistent instability following traumatic dislocation.

2. In addition to one of the diagnoses in this paragraph, all of the following clinical findings shall exist for repair of a shoulder dislocation:

- a. The patient exhibits a history of multiple dislocations or subluxations that inhibit activities of daily living.
- b. X-ray findings are consistent with multiple dislocations or subluxations.

(i) *Repair of proximal biceps tendon.* 1. A health care provider may perform surgical repair of a proximal biceps tendon for the diagnosis of proximal rupture of the biceps, ICD-9-CM code 727.62 or 840.8.

2. In addition to the diagnosis in subd. 1., both of the following conditions shall be satisfied for repair of proximal biceps tendon:

- a. The procedure may be done alone or in conjunction with another necessary repair of the rotator cuff.
- b. The patient's clinical findings exhibit pain that does not resolve with attempt to use arm and palpation of "bulge" in upper aspect of arm.

(j) *Epicondylitis.* Specific guidelines for surgery for epicondylitis are included in s. DWD 81.09 (11).

(k) *Tendinitis.* Specific guidelines for surgery for tendinitis are included in s. DWD 81.09 (12).

(L) *Nerve entrapment syndromes.* Specific guidelines for nerve entrapment syndromes are included in s. DWD 81.09 (13).

(m) *Muscle pain syndromes.* Surgery is not necessary for muscle pain syndromes.

(n) *Traumatic sprains and strains.* Surgery is not necessary for the treatment of traumatic sprains and strains, unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery.

(3) LOWER EXTREMITY SURGERY. (a) *Anterior cruciate ligament reconstruction.* 1. A health care provider may perform surgical repair of the anterior cruciate ligament, including arthroscopic repair, for any of the following diagnoses:

- a. Old disruption of anterior cruciate ligament, ICD-9-CM code 717.83.
- b. Sprain of cruciate ligament of knee, ICD-9-CM code 844.2.

2. In addition to one of the diagnoses in this paragraph, all of the conditions in subd. 2. a. to c. shall be satisfied for anterior cruciate ligament reconstruction. Pain alone is not an indication.

a. The patient gives a history of instability of the knee described as "buckling or giving way" with significant effusion at time of injury, or description of injury indicates a rotary twisting or hyperextension occurred.

b. There are objective clinical findings of positive Lachman's sign, positive pivot shift, or positive anterior drawer.

c. There are positive diagnostic findings with arthrogram, magnetic resonance imaging scan, or arthroscopy, and there is no evidence of severe compartmental arthritis.

(b) *Patellar tendon realignment.* 1. A health care provider may perform patellar tendon realignment for the diagnosis of dislocation of patellar, open, ICD-9-CM code 836.3; or closed, ICD-9-CM code 836.4; or chronic residuals of dislocation.

2. In addition to the diagnosis in this paragraph, all of the following conditions shall be satisfied for a patellar tendon realignment:

a. The patient gives a history of rest pain as well as pain with patellofemoral movement, and recurrent effusion, or recurrent dislocation.

b. There are objective clinical findings of patellar apprehension, synovitis, lateral tracking, or Q angle greater than 15 degrees.

(c) *Knee joint replacement.* 1. A health care provider may perform a knee joint replacement for degeneration of articular cartilage or meniscus of knee, ICD-9-CM codes 717.1 to 717.4.

2. In addition to the diagnosis in this paragraph, all of the following conditions shall be satisfied for a knee joint replacement:

a. The patient exhibits limited range of motion, night pain in the joint, or pain with weight-bearing, and no significant relief of pain with an adequate course of initial nonsurgical care.

b. The patient's diagnostic findings confirm there is significant loss or erosion of cartilage to the bone, and positive findings of advanced arthritis, and joint destruction with standing films, magnetic resonance imaging scan, or arthroscopy.

(d) *Fusion; ankle, tarsal, metatarsal.* 1. A health care provider may perform an ankle, tarsal, or metatarsal fusion for either of the following diagnoses:

a. Malunion or nonunion of fracture of ankle, tarsal, or metatarsal, ICD-9-CM code 733.81 or 733.82.

b. Traumatic arthritis, arthropathy, ICD-9-CM code 716.17.

2. In addition to one of the diagnoses in this paragraph, the following conditions shall be satisfied for an ankle, tarsal, or metatarsal fusion. For initial nonsurgical care the patient shall have failed to improve with an adequate course of initial nonsurgical care that included any of the following:

a. Immobilization, which may include casting, bracing, shoe modification, or other orthotics.

b. Anti-inflammatory medications.

3. The patient's clinical findings exhibit both of the following and subd. 4.:

a. The patient gives a history of pain which is aggravated by activity and weight-bearing, and relieved by xylocaine injection.

b. There are objective findings on physical examination of malalignment or specific joint line tenderness, and decreased range of motion.

4. The patient's diagnostic findings include medical imaging studies confirming the presence of any of the following:

- a. Loss of articular cartilage and joint space narrowing.
- b. Bone deformity with hypertrophic spurring and sclerosis.
- c. Nonunion or malunion of a fracture.

(e) *Lateral ligament ankle reconstruction.* 1. A health care provider may perform ankle reconstruction surgery involving the lateral ligaments for any of the following diagnoses:

- a. Chronic ankle instability, ICD-9-CM code 718.87.
- b. Grade III sprain, ICD-9-CM codes 845.0 to 845.09.

2. In addition to one of the diagnoses in subd. 1., all of the clinical findings in subd. 3. shall be satisfied for a lateral ligament ankle reconstruction. For initial nonsurgical care, the patient shall have received an adequate course of initial nonsurgical care, including one of the following:

a. Immobilization with support, cast, or ankle brace.

b. A physical rehabilitation program that follows immobilization with support, cast, or ankle brace.

3. The patient's clinical findings shall include all of the following:

- a. The patient gives a history of ankle instability and swelling.
- b. There is a positive anterior drawer sign on examination.

c. There are positive stress X-rays identifying motion at ankle or subtalar joint with at least a 15 degree lateral opening at the ankle joint, or demonstrable subtalar movement, and negative to

minimal arthritic joint changes on X-ray, or ligamentous injury is shown on magnetic resonance imaging scan.

4. Prosthetic ligaments are not necessary for the treatment of lateral ligament ankle reconstruction.

History: CR 07-019; cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.13 Chronic management. (1) SCOPE. This section applies to chronic management of all types of physical injuries, even if the injury is not specifically governed by this chapter. If a patient continues with symptoms and physical findings after all appropriate initial nonsurgical and surgical treatment has been rendered, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. The purpose of chronic management is twofold: the patient should be made independent of health care providers in the ongoing care of a chronic condition; and the patient shall be returned to the highest functional status reasonably possible.

(a) Personality or psychological evaluation may be necessary for patients who are candidates for chronic management. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, a health care provider performing the evaluation shall consider all of the following:

1. Is symptom magnification occurring?
2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, that is interfering with recovery?
3. Are there other personality factors or disorders that are interfering with recovery?
4. Is the patient chemically dependent?
5. Are there any interpersonal conflicts interfering with recovery?
6. Does the patient have a chronic pain syndrome or psychogenic pain?
7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(b) Any of the chronic management modalities of sub. (2) may be used singly or in combination as part of a program of chronic management.

(c) No further passive treatment modalities or therapeutic injections are necessary, except as otherwise provided in ss. [DWD 81.06 \(3\) \(b\)](#), [81.07 \(3\) \(b\)](#), [81.08 \(3\) \(b\)](#), and [81.09 \(3\) \(b\)](#).

(d) No further diagnostic evaluation is necessary unless there is the development of symptoms or physical findings that would in themselves warrant diagnostic evaluation.

(e) A program of chronic management shall include appropriate means by which use of scheduled medications can be discontinued or severely limited.

(2) CHRONIC MANAGEMENT MODALITIES. (a) *Home-based exercise programs.* Home-based exercise programs consist of aerobic conditioning, stretching, and flexibility exercises, and strengthening exercises done by the patient on a regular basis at home without the need for supervision or attendance by a health care provider. Maximum effectiveness may require the use of certain durable medical equipment that may be prescribed within any applicable treatment guidelines in ss. [DWD 81.06](#) to [81.10](#).

1. 'Indications.' Exercise is necessary on a long-term basis to maintain function.

2. 'Guidelines.' The patient shall receive specific instruction and training in the exercise program. Repetitions, durations, and frequencies of exercises shall be specified.

3. 'Treatment.' Treatment period is one to 3 visits for instruction and monitoring.

(b) *Health clubs.* 1. 'Indications.' The patient is deconditioned and requires a structured environment to perform prescribed exercises. A health care provider shall document the reasons why reconditioning may not be accomplished with a home-based program of exercise.

2. 'Guidelines.' The program shall have specific prescribed exercises stated in objective terms, for example "30 minutes riding stationary bicycle three times per week." There shall be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals can be achieved in the prescribed time. There shall be a prescribed frequency of attendance and the patient shall maintain adequate documentation of attendance. There shall be a prescribed duration of attendance.

3. 'Treatment.' Treatment period is 13 weeks. Additional periods of treatment at a health club are not necessary unless there is documentation of attendance and progression in activities during the preceding period of treatment. If the employer has an appropriate exercise facility on its premises the insurer may mandate use of that facility instead of providing a health club membership.

(c) *Computerized exercise programs.* Computerized exercise programs utilize computer-controlled exercise equipment that allows for the isolation of specific muscle groups and the performance of graded exercise designed to increase strength, tone, flexibility, and range of motion. In combination with computerized range of motion or strength measuring tests, these programs allow for quantitative measurement of effort and progress.

1. 'Indications.' The patient is deconditioned and requires a structured environment to accomplish rehabilitation goals. A health care provider shall document the reasons why reconditioning may not be accomplished with a home-based program of exercise.

2. 'Guidelines.' The program shall have specific goals stated in objective terms, for example "improve strength of back extensors 50%." There shall be a specific set of prescribed activities and a specific timetable of progression in those activities, designed so that the goals may be achieved in the prescribed time. There shall be a prescribed frequency and duration of attendance.

3. 'Treatment.' Treatment period is 6 weeks. Additional periods of treatment are not necessary unless there is documentation of attendance and progression in activities during the preceding period of treatment.

(d) *Work conditioning and work hardening programs.* Work conditioning and work hardening programs are intensive, highly structured, job oriented, individualized treatment plans based on an assessment of the patient's work setting or job demands, and designed to maximize the patient's return to work. These programs shall include real or simulated work activities. Work conditioning is designed to restore an individual's neuromusculoskeletal strength, endurance, movement, flexibility, motor control, and cardiopulmonary function. Work conditioning uses physical conditioning and functional activities related to the individual's work. Services may be provided by one discipline of health care provider. Work hardening is designed to restore an individual's physical, behavioral, and vocational functions within an interdisciplinary model. Work hardening addresses the issues of productivity, safety, physical tolerances, and work behaviors. An interdisciplinary team includes professionals qualified to evaluate and treat behavioral, vocational, physical, and functional needs of the individual.

1. 'Indications.' The patient is disabled from usual work and requires reconditioning for specific job tasks or activities and the reconditioning cannot be done on the job. A health care provider shall document the reasons why work hardening cannot be accomplished through a structured return to work program. Work conditioning is necessary when only physical and functional needs are identified. Work hardening is necessary when, in addition to physical and functional needs, behavioral, and vocational needs are also identified that are not otherwise being addressed.

2. 'Guidelines.' The program shall have specific goals stated in terms of work activities, for example "able to type for 30 minutes." There shall be an individualized program of activities and the activities shall be chosen to simulate required work activities or to enable the patient to participate in simulated work activities. There shall be a specific timetable of progression in those activities, designed so that the goals may be achieved in the prescribed time. There shall be a set frequency and hours of attendance and the program shall maintain adequate documentation of attendance. There shall be a set duration of attendance. Activity restrictions shall be identified at completion of the program.

3. 'Treatment.' The treatment period for a work conditioning or work hardening program is 6 weeks. Additional periods of treatment are not necessary unless there is documentation of attendance and progression in activities during the preceding period of treatment or unless there has been a change in the patient's targeted return to work job that necessitates a redesign of the program.

(e) *Chronic pain management programs.* A chronic pain management program consists of a multidisciplinary team who provides coordinated, goal-oriented services to reduce pain, disability, improve functional status, promote return to work, and decrease dependence on the health system of persons with chronic pain syndrome. A pain management program shall provide physical rehabilitation, education on pain, relaxation training, psychosocial counseling, medical evaluation, and, if necessary, chemical dependency evaluation. The program of treatment shall be individualized and based on an organized evaluative process for screening and selecting patients. Treatment may be provided in an inpatient setting, outpatient setting, or both as appropriate.

1. 'Indications.' The patient is diagnosed as having a chronic pain syndrome.

2. 'Guidelines.' An admission evaluation shall be performed by a health care provider. The evaluation shall confirm the diagnosis of chronic pain syndrome and a willingness and ability of the patient to benefit from a pain management program. There shall be a specific set of prescribed activities and treatments and a specific timetable of progression in those activities. There shall be a set frequency and hours of attendance and the program shall maintain adequate documentation of attendance. There shall be a set duration of attendance.

3. 'Treatment.' Treatment period is for initial treatment, a maximum of 20 eight-hour days, though fewer or shorter days may be used, and a maximum duration of 4 weeks no matter how many or how long the days prescribed. For aftercare, a maximum of 12 sessions is allowed. Only one completed pain management program is necessary for an injury.

(f) *Individual or group psychological or psychiatric counseling.* 1. 'Indications.' A personality or psychosocial evaluation has revealed one or more of the problems listed in sub. (1) (a) that interfere with recovery from the physical injury, but the patient does not need or is not a candidate for a pain management program.

2. 'Guidelines.' There shall be a specific set of goals based on the initial personality or psychosocial evaluation and a timetable for achieving those goals within the prescribed number of treatment or therapy sessions. There shall be a prescribed frequency of attendance and a treating health care provider shall maintain adequate documentation of attendance. There shall be a prescribed duration of treatment.

3. 'Treatment.' Treatment period is a maximum of 12 sessions. Only one completed program of individual or group psychological or psychiatric counseling is necessary for an injury.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.

DWD 81.14 Health care provider advisory committee.

(1) The department shall establish a health care services provider committee to advise the department and the council on worker's compensation on modification of the treatment standards under this chapter. The administrator of the worker's compensation division shall serve as chairperson. The committee shall consist of 14 members, including 6 medical doctors of different specialties, 2 chiropractors, 2 hospital representatives, one registered nurse, one physical therapist, and 2 at-large members, all of whom are licensed in and practicing in Wisconsin and provide treatment under s. 102.42, Stats. The appointments to the committee shall be made from a consensus list of 24 names submitted by the Wisconsin Medical Society, Wisconsin Chiropractic Association, and the Wisconsin Hospital Association, except for the 2 at-large members, who shall be selected by the department.

(2) In modifying this chapter, the committee shall consider the following:

(a) Clarifying the description of the guidelines under this chapter.

(b) Updating the guidelines at least every 4 years to include new modalities of treatment, procedures, and treatment options for classes of injuries included in the guidelines.

(c) Expanding the guidelines to cover new types and classes of injuries.

History: CR 07-019: cr. Register October 2007 No. 622, eff. 11-1-07.