

5221.6205 NECK PAIN.

Subpart 1. **Diagnostic procedures for treatment of neck injury.** A health care provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular pain" means pain radiating distal to the shoulder. This part 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. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this item must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes.

(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 which affects the cervical region, with or without referral to the upper back or shoulder, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90, 722.0, 722.2, 722.3 to 722.30, 722.39, 722.4, 722.6, 722.8, 722.80, 722.81, 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, 738.2, 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 847.9, 920, 922.3, 925, and 926.1 to 926.11.

(2) Radicular pain, with or without regional neck pain, with no or static neurologic deficit. This 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, but not limited to, the ICD-9-CM codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71, 722.8, 722.80, 722.81, 723.4, 724, and 724.9. 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, which includes the same diagnoses as subitem (2); however, 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. Cervical compressive myelopathy includes the ICD-9-CM code 336.9.

B. Laboratory tests are not indicated in the evaluation of a patient with regional neck pain, or radicular pain, except:

(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; or

(3) as part of a preoperative evaluation.

Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the cervical spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with the standards in part 5221.6100, subpart 1. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are always inappropriate for the regional neck pain diagnoses in item A, subitem (1). EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and myelopathy diagnoses in item A, subitems (2) to (4), after the first three weeks of radicular or myelopathy symptoms. Repeat EMG and nerve conduction studies for radicular pain and myelopathy are not indicated 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.

E. The use of the following procedures or tests is not indicated for the diagnosis of any of the clinical categories in item A:

(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; or
- (6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated 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 can be performed but must be done in conjunction with and shall not be reimbursed separately from an office visit, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

G. Personality or psychological evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate care. The 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 which 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 must 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, which is interfering with recovery?
- (3) Are there other personality factors or disorders which 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, such as those in subitems (1) to (6), likely to interfere with the potential benefit of the surgery?

H. Diagnostic analgesic blocks or injection studies 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 which fail to respond to initial nonsurgical management.

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

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

(4) These blocks and injections can also be used as therapeutic modalities and as such are subject to the parameters of subpart 5.

I. A comprehensive functional capacity assessment or evaluation (FCE) is an individualized examination and evaluation that objectively measures the patient's current level of function and the ability to perform functional or work-related tasks, and it predicts the potential to sustain these tasks over a defined time frame. The components of a comprehensive FCE include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance.

(1) A comprehensive FCE is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management, a comprehensive FCE is indicated in either of the following circumstances:

- (a) permanent activity restrictions and capabilities must be identified; or
- (b) there is a question about the patient's ability to do a specific job.

(3) A comprehensive FCE is not indicated to establish baseline performance before treatment or to evaluate change in performance during a course of treatment.

(4) Only one completed comprehensive FCE is indicated per injury.

(5) Functional tests or physical performance tests done as part of a work conditioning program or work hardening program as provided in part 5221.6600, subpart 2, item D, or in conjunction with active treatment modalities as provided in subpart 4, are not a comprehensive FCE and are not limited by this item.

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

Subp. 2. **General treatment parameters for neck pain.**

A. All medical care for neck pain appropriately assigned to a clinical category in subpart 1, item A, is determined by the diagnosis and clinical category in subpart 1, item A, to which the patient has been assigned. General parameters for treatment modalities are

set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 14, as follows:

- (1) subpart 11 governs regional neck pain;
- (2) subpart 12 governs radicular pain with static neurologic deficits;
- (3) subpart 13 governs radicular pain with progressive neurologic deficits;

and

- (4) subpart 14 governs myelopathy.

The health care provider must, 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 must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in subparts 3 to 10, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with neck problems, except patients with radicular pain with progressive neurological deficit, or myelopathy under subpart 1, item A, subitems (3) and (4), must be given initial nonsurgical care which may include both active and passive treatment modalities, injections, durable medical equipment, and medications. These modalities and parameters are described in subparts 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 must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonoperative care is followed by a period of surgical evaluation. This evaluation should be completed in a timely manner. Surgery, if indicated, should be performed as expeditiously as possible consistent with sound medical practice, and subparts 6 and 11 to 14, and part 5221.6500. The treating health care provider may do the evaluation, if it is within the provider's scope of practice, or may refer the employee to a consultant.

(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 must follow the parameters in subparts 6 and 11 to 14, and part 5221.6500.

(d) A decision against surgery at this 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 indicated. Chronic management modalities are described in part 5221.6600, and may include durable medical equipment as described in subpart 8.

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

Subp. 3. Passive treatment modalities.

A. Except as set forth in item B or part 5221.6050, subpart 8, the use of passive treatment modalities in a clinical setting as set forth in items C to I is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to I are initiated. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) An additional 12 visits for the use of passive treatment modalities over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work or is permanently totally disabled and the additional passive treatment must result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care;

(b) the treatment must not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

(e) the additional 12 visits for passive treatment must not delay the required surgical or chronic pain evaluation required by this chapter; and

(f) passive care is inappropriate while the employee has chronic pain syndrome.

(2) Except as otherwise provided in part 5221.6050, subpart 8, treatment may continue beyond the additional 12 visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining employability; if the employee is permanently totally disabled, or if upon retirement the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12

visits only after prior approval by the insurer, commissioner, or compensation judge based on documentation in the medical record of the effectiveness of further passive treatment in maintaining functional status.

C. Adjustment or manipulation of joints includes chiropractic and osteopathic adjustments or manipulations:

- (1) time for treatment response, three to five treatments;
- (2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and
- (3) maximum treatment duration, 12 weeks.

D. 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.

- (1) Treatment given in a clinical setting:
 - (a) time for treatment response, two to four treatments;
 - (b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and
 - (c) maximum treatment duration, 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 which 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 includes muscle stimulation, low-volt therapy, sine wave therapy, stimulation of peripheral nerve, galvanic stimulation, TENS, interferential, and microcurrent techniques.

- (1) Treatment given in a clinical setting:
 - (a) time for treatment response, two to four treatments;
 - (b) maximum treatment frequency, up to five times per week for the first one to three weeks decreasing in frequency thereafter; and
 - (c) maximum treatment duration, 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 must be in a supervised setting in order to ensure proper electrode placement and patient education:

- (a) time for patient education and training, one to three sessions; and
- (b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction is the therapeutic use of mechanically induced tension created by a pulling force to produce a combination of distraction and gliding to relieve pain and increase flexibility. Mechanical traction may be continuous, static, intermittent, inversion, gravity, or positional. Examples of mechanical traction include power traction, intersegmental motorized mobilization, vertebral axial decompression, autotraction (active), and 90/90.

- (1) Treatment given in a clinical setting:
 - (a) time for treatment response, three treatments;
 - (b) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and
 - (c) maximum treatment duration, 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 must be in a supervised setting in order to ensure proper patient education:

- (a) time for patient education and training, one session; and
- (b) a patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture treatments:

- (1) time for treatment response, three to five sessions;
- (2) maximum treatment frequency, up to three times per week for one to three weeks decreasing in frequency thereafter; and
- (3) maximum treatment duration, 12 weeks.

H. Manual therapy includes manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic drainage, soft-tissue mobilization

and manipulation, trigger point therapy, acupuncture, muscle stimulation - manual (nonelectrical), and any form of massage:

- (1) time for treatment response, three to five treatments;
- (2) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and
- (3) maximum treatment duration, 12 weeks.

I. Phoresis includes iontophoresis and phonophoresis:

- (1) time for treatment response, three to five sessions;
- (2) maximum treatment frequency, up to three times per week for the first one to three weeks decreasing in frequency thereafter; and
- (3) maximum treatment duration, 12 weeks.

J. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than seven days.

K. Cervical collars, spinal braces, and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

- (1) time for treatment response, three days;
- (2) treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and
- (3) maximum continuous duration, up to three weeks unless patient is status postfusion.

Subp. 4. **Active treatment modalities.** Active treatment modalities must be used as set forth in items A to D. Use of active treatment modalities may extend past the 12-week limitation on passive treatment modalities, so long as the maximum duration for the active modality is not exceeded.

A. Education must 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 three visits, which includes an initial education and training session, and two follow-up visits.

B. Posture and work method training must 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 three visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are 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 three visits.

D. Exercise, which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the cervical spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, it must not be the primary focus of the exercise program.

Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by part 5221.6600.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for three weeks, decreasing in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must 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:

(a) maximum treatment frequency, up to three visits for instruction and monitoring; and

(b) there is no limit on the duration or frequency of exercise at home.

Subp. 5. **Therapeutic injections.** Injection modalities are indicated as set forth in items A to C. 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.

A. 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 can only be given in conjunction with active treatment modalities directed to the same anatomical site.

(1) Trigger point injections:

(a) time for treatment response, within 30 minutes;

(b) maximum treatment frequency, once per week if 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 should be redirected to other areas or discontinued. Only three injections are reimbursable per patient visit; and

(c) maximum treatment, four injections to any one site.

(2) Facet joint injections or facet nerve blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if 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 should be discontinued. Only three injections or blocks are reimbursable per patient visit; and

(c) maximum treatment, three injections or blocks to any one site.

(3) Nerve root blocks:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, can repeat injection no sooner than two weeks after the previous injection if a positive response to the first injection. No more than three blocks are reimbursable per patient visit; and

(c) maximum treatment, two blocks to any one site.

(4) Epidural injections:

(a) time for treatment response, within one week;

(b) maximum treatment frequency, once every two weeks if 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 is reimbursable per patient visit; and

(c) maximum treatment, three injections.

B. Permanent lytic or sclerosing injections, including radio frequency denervation of the facet joints. These injections can only be given in conjunction with active treatment modalities directed to the same anatomical site:

- (1) time for treatment response, within one week;
- (2) maximum treatment frequency, may repeat once for any site; and
- (3) maximum duration, two injections to any one site.

C. Prolotherapy and botulinum toxin injections are not indicated in the treatment of neck problems and are not reimbursable.

Subp. 6. **Surgery, including decompression procedures and arthrodesis.** Surgery may only be performed if it meets the specific parameters of subparts 11 to 14 and part 5221.6500. The health care provider must provide prior notification for nonemergency inpatient surgery according to part 5221.6050, subpart 9.

A. 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; or
- (2) 12 weeks following arthrodesis.

B. Repeat surgery must also meet the parameters of subparts 11 to 14 and part 5221.6500 and is not indicated unless the need for the repeat surgery is confirmed by a second opinion obtained before surgery, if requested by the insurer.

C. Spinal cord stimulators have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of a spinal cord stimulator is indicated because the patient:

- (a) has intractable pain;
- (b) is not a candidate for another surgical therapy; and
- (c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefiting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with a spinal cord stimulator is indicated if the

psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to a spinal cord stimulator.

(3) Long-term use of a spinal cord stimulator is indicated if the treating health care provider documents that there has been at least a 50 percent improvement in pain during a trial screening period of at least three days, compared to the patient's pain level immediately preceding the trial screening period.

D. Intrathecal drug delivery systems have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of an intrathecal drug delivery system is indicated because the patient:

(a) has intractable pain;

(b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefitting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with an intrathecal drug delivery system is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to an intrathecal drug delivery system.

(3) Long-term use of an intrathecal drug delivery system is indicated if the treating health care provider documents that there has been at least a 50 percent improvement in pain during a trial screening period of at least 24 hours, compared to the patient's pain level immediately preceding the trial screening period.

Subp. 7. **Chronic management.** Chronic management of neck disorders must be provided according to the parameters of part 5221.6600.

Subp. 8. **Durable medical equipment.** Durable medical equipment is indicated only as specified in items A to D. The health care provider must provide prior notification as required in items B and C according to part 5221.6050, subpart 9.

A. Cervical collars, braces, or supports and home cervical traction devices may be indicated within the parameters of subpart 3, items F and K.

B. For patients using electrical stimulation at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification must be given for purchase of the device or for use longer than one month. The insurer may provide equipment if it is comparable to that prescribed by the health care provider.

C. Exercise equipment for home use, including bicycles, treadmills, and stairclimbers, are indicated only within the context of a program or plan of an approved chronic management program. This equipment is not indicated during initial nonoperative care or during reevaluation and surgical therapy. Prior notification must be given to the insurer before purchase of the home exercise equipment. The insurer may decide which brand of a prescribed type of exercise equipment is provided to the patient. 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 which can be accomplished only with the use of the prescribed exercise equipment. The health care provider must document specific reasons why the exercise equipment is necessary and cannot be replaced with other activities.

(2) Requirements: the use of the equipment must have specific goals and there must be a specific set of prescribed activities.

D. The following durable medical equipment is not indicated for home use for any of the neck pain conditions described in subpart 1, item A:

(1) whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments;
or

(2) beds, waterbeds, mattresses, chairs, recliners, and loungers.

Subp. 9. **Evaluation of treatment by health care provider.** The health care provider must evaluate at each visit whether the treatment is medically necessary, and shall evaluate whether initial nonsurgical management is effective according to items A to C.

No later than the time for treatment response established for the specific modality as specified in subparts 3, 4, and 5, the health care provider must evaluate whether the passive,

active, injection, or medication treatment modality has resulted in progressive improvement as specified in items A to C:

A. the employee'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;

B. 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; and

C. the employee's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items of items A to C, the modality must be discontinued or significantly modified or the provider must reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality can be delegated to an allied health professional working under the direction of the treating health care provider but remains the ultimate responsibility of the treating health care provider.

Subp. 10. **Scheduled and nonscheduled medication.** The health care provider must document the rationale for the use of any medication. Treatment with medication may be appropriate during any phase of treatment and must comply with all of the applicable parameters in part 5221.6105. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and the most cost-effective regimen is used.

Subp. 11. **Specific treatment parameters for regional neck pain.**

A. Initial nonsurgical treatment must be the first phase of treatment for all patients with regional neck pain under subpart 1, item A, subitem (1).

(1) The active, passive, injection, durable medical equipment, and medication treatment modalities and procedures in subparts 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 indicated 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 parameters of subpart 5.

(3) After the first week of treatment, initial nonsurgical treatment must at all times contain active treatment modalities according to the parameters of subpart 4.

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

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

B. Surgical evaluation or chronic management is indicated 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 indicated 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 indicated.

(1) Surgical evaluation if indicated may begin as soon as eight weeks after, but must 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 must be chosen on the basis of the suspected etiology of the patient's condition but the health care provider must follow the parameters of part 5221.6100, subpart 1.

(3) Surgical evaluation may also include diagnostic blocks and injections. These blocks and injections are only indicated if their use is consistent with the parameters of subpart 1, item H.

(4) Surgical evaluation may also include personality or psychosocial evaluation, consistent with the parameters of subpart 1, item G.

(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 indicated for patients with regional neck pain only is cervical arthrodesis, with or without instrumentation, which must meet the parameters of subpart 6. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

(a) If surgery is indicated, it should be offered to the patient as soon as possible. If the patient agrees to the proposed surgery, it should be performed as expeditiously as possible consistent with sound medical practice, and consistent with any requirements of part 5221.6050, subpart 9, for prior notification of the insurer or second opinions.

(b) If surgery is not indicated 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 according to part 5221.6600.

Subp. 12. Specific treatment parameters 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 subpart 1, item A, subitem (2), and must be the first phase of treatment. It must be provided within the parameters of subpart 11, item A, with the following modifications: epidural blocks and nerve root and peripheral nerve blocks are the only therapeutic injections indicated 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 indicated.

B. Surgical evaluation or chronic management is indicated 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 must be provided within the parameters of subpart 11, item B, with the following modifications: the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, and cervical arthrodesis, with or without instrumentation. For patients with failed surgery, dorsal column stimulators or morphine pumps may be indicated consistent with subpart 6, item C.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, 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 neck pain, with static neurologic changes must meet all of the parameters of part 5221.6600.

Subp. 13. Specific treatment parameters for radicular pain, with or without regional neck pain, with progressive neurologic changes.

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. The decision to proceed with surgical evaluation is made by the 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 nonsurgical treatments. Surgery, if indicated, may be performed at any

time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated for patients with radicular pain are decompression of a cervical nerve root which must meet the parameters of subpart 6 and part 5221.6500, subpart 2, item B, or cervical arthrodesis, with or without instrumentation. For patients with failed back surgery, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with radicular pain with progressive neurologic changes, it must follow the parameters of subpart 12, item 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 must meet all of the parameters of part 5221.6600.

Subp. 14. Specific treatment parameters for myelopathy.

A. Patients with myelopathy may require emergency surgical evaluation at any time during the course of their overall treatment. The decision to proceed with surgical evaluation is made by the 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 nonsurgical treatments. Surgery, if indicated, may be performed at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of subpart 11, item B, with the following modifications:

(1) surgical evaluation and surgical therapy may begin at any time; and

(2) the only surgical procedures indicated 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, dorsal column stimulators or morphine pumps may be indicated consistent with the parameters of subpart 6, item C.

B. If the health care provider decides to proceed with a course of nonsurgical care for a patient with myelopathy, it must follow the parameters of subpart 12, item 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 must meet all of the parameters of part 5221.6600.

Statutory Authority: *MS s 14.386; 176.103; 176.135; 176.83*

History: *19 SR 1412; 35 SR 138; 39 SR 286; 40 SR 328*

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