5221.6300 UPPER EXTREMITY DISORDERS.

Subpart 1. **Diagnostic procedures for treatment of upper extremity disorders (UED).** A health care provider shall determine the nature of an upper extremity disorder 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 at each visit assign the patient to the appropriate clinical category according to subitems (1) to (6). The diagnosis must be documented in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This part 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. 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) Epicondylitis. This clinical category includes medial epicondylitis and lateral epicondylitis, 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, but not limited to, the diagnoses of tendonitis, tenosynovitis, tendovaginitis, peritendinitis, extensor tendinitis, de Quervain's syndrome, intersection syndrome, flexor tendinitis, and trigger digit, including, but not limited to, ICD-9-CM codes 726.4, 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04, 727.05, 727.09, 727.2, 727.3, 727.4 to 727.49, 727.8 to 727.82, 727.89, and 727.9.

(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, but not limited to, 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, but not limited to, 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, but not limited to, the diagnoses of chronic nontraumatic muscle strain, repetitive strain injury, cervicobrachial syndrome, tension neck syndrome, overuse syndrome,

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myofascial pain syndrome, myofasciitis, nonspecific myalgia, fibrositis, fibromyalgia, and fibromyositis, including, but not limited to, 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, but not limited to, the diagnoses of impingement syndrome, supraspinatus tendonitis, infraspinatus tendonitis, calcific tendonitis, bicipital tendonitis, subacromial bursitis, subcoracoid bursitis, subdeltoid bursitis, and rotator cuff tendinitis, including, but not limited to, ICD-9-CM codes 726.1 to 726.2, 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, and 840.6 to 840.9.

(6) Traumatic sprains or strains of the upper extremity. This clinical category encompasses an instantaneous or acute injury, as a result of a single precipitating event to the ligaments or the muscles of the upper extremity including, without limitation, 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 subitem (4). Injuries with complete tissue disruption are not subject to this parameter.

B. Certain laboratory tests may be indicated 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 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 upper extremity disorders must be based on the findings of the history and physical examination and cannot be ordered before 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 only appropriate for nerve entrapment disorders and recurrent nerve entrapment after surgery.

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

(1) surface electromyography;

(2) thermography; or

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(3) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. The following diagnostic procedures or tests are considered adjuncts to the physical examination and are not reimbursed separately from the office visit:

(1) vibrometry;

(2) neurometry;

(3) Semmes-Weinstein monofilament testing; or

(4) algometry.

G. 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 are not reimbursed separately from an office visit with a physician, chiropractic evaluation or treatment, or physical or occupational therapy evaluation or treatment.

H. Personality or psychosocial evaluations may be a useful tool for evaluating patients who continue to have problems despite appropriate initial nonsurgical 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 likely to interfere with the potential benefit of the surgery?

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I. Diagnostic analgesic blocks or injection studies.

(1) These procedures are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management.

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

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

J. 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, 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.

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

Subp. 2. **General treatment parameters for upper extremity disorders.**

A. All medical care for upper extremity disorders, appropriately assigned to a category of 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

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modalities are set forth in subparts 3 to 10. Specific treatment parameters for each clinical category are set forth in subparts 11 to 16 as follows:

(1) subpart 11 governs epicondylitis;

(2) subpart 12 governs tendonitis of the forearm, wrist, and hand;

(3) subpart 13 governs upper extremity nerve entrapment syndromes;

(4) subpart 14 governs upper extremity muscle pain syndromes;

(5) subpart 15 governs shoulder impingement syndromes; and

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

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 and these changes must be recorded in the medical record. 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, unless the treatment or therapy is subsequently delivered to a different part of the body.

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

B. In general, a course of treatment must be divided into three phases:

(1) First, all patients with an upper extremity disorder must 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 subparts 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 must result in progressive improvement as specified in subpart 9.

(2) Second, for patients with persistent symptoms, initial nonsurgical management 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 16, and part

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

(b) Surgery must follow the parameters in subparts 6 and 11 to 16, and part 5221.6500.

(c) 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 surgery or refuse surgery, 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 is 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 H is not indicated beyond 12 calendar weeks after any of the passive modalities in item C to H 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.

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(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 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 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.

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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 unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

F. Acupuncture treatments:

(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.

G. Phoresis includes phonopheresis and iontophoresis:

(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 is nine 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 includes manual traction, myofascial release, joint mobilization and manipulation, manual lymphatic drainage, soft-tissue mobilization and manipulation, trigger point therapy, acupressure, muscle stimulation - manual (nonelectrical), and any form of massage:

(1) time for treatment response, three to five treatments;

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(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. Splints, braces, and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active motion exercises to avoid stiffness and prolonged disability:

(1) time for treatment response, ten days;

(2) maximum treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(3) maximum continuous duration, eight 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 should not be prescribed for more than two weeks, unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints should begin no later than two weeks after application of the immobilization.

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 treatment for the active treatment modality is not exceeded.

A. Education must 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 three visits, which include 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 a nonsurgical treatment program and a return to normal activity, must include active patient participation in

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activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the upper extremity. While aerobic exercise may be performed as adjunctive treatment this 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, or 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 testing 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, up to three times per week for three weeks. Should decrease with time thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

Subp. 5. **Therapeutic injections.** Therapeutic injections include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. Therapeutic injections can only be given in conjunction with active treatment modalities directed to the same anatomical site. Use of injections may extend past the 12-week limitation on passive modalities, so long as the maximum treatment for injections in items A to C is not exceeded.

A. Trigger point injections:

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

(2) maximum treatment frequency, once per week to any one site 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. No more than three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, four injections to any one site over the course of treatment.

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B. Soft tissue injections include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion:

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

(2) maximum treatment frequency, once per month to any one site 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 three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, three injections to any one site over the course of treatment.

C. Injections for median nerve entrapment at the carpal tunnel:

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

(2) maximum treatment frequency, can repeat injection in one month if a positive response to the first injection. Only three injections to different sites are reimbursable per patient visit; and

(3) maximum treatment, two injections to any one site over the course of treatment.

Subp. 6. **Surgery.** Surgery may only be performed if it meets applicable parameters in subparts 11 to 16 and part 5221.6500.

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 initiation of the first passive modality used, except bedrest or bracing, is as follows:

(1) for rotator cuff repair, acromioclavicular ligament repair, or any surgery for a clinical category in this part which requires joint reconstruction, 16 weeks; or

(2) for all other surgery for clinical categories in this part, eight weeks.

The health care provider must provide the insurer with prior notification of nonemergency inpatient surgery according to part 5221.6050, subpart 9.

B. Repeat surgery must also meet the parameters of subparts 11 to 16 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.

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

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

A. Splints, braces, straps, or supports may be indicated as specified in subpart 3, item I.

B. For patients using an electrical stimulation device at home, the device and any required supplies are indicated within the parameters of subpart 3, item E. Prior notification of the insurer is required for purchase of the device or for use longer than one month. The insurer may provide the 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 nonsurgical care or during reevaluation and surgical therapy. Prior notification of the insurer is required for the purchase of home exercise equipment. The insurer may decide which brand of a prescribed type of 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 use of that facility instead of authorizing purchase of the 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 the upper extremity disorders 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 whether initial nonsurgical treatment 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,

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active, injection, or medication treatment modality is resulting 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 in 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 directly providing the treatment, 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 epicondylitis.**

A. Initial nonsurgical management is appropriate for all patients with epicondylitis and must be the first phase of treatment.

(1) The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified 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. After the first week of treatment, initial nonsurgical care must at all times include active treatment modalities according to subpart 4.

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

(3) Except as provided in subpart 3, 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 indicated.

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(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 indicated. The purpose and goal of surgical evaluation is to determine whether surgery is indicated for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

(1) Surgical evaluation, if indicated, must 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 parameters of subpart 1, if not already obtained during the initial evaluation. Repeat testing is not indicated unless there has been an objective change in the patient's condition which in itself would warrant further testing. 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 parameters in part 5221.6100, subpart 1. Other medical imaging studies are not indicated.

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

(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. Consultation is governed by part 5221.6050, subpart 6.

(6) If surgery is indicated, it may not be performed until 12 months after initial nonsurgical management was begun except in a patient who has had resolution of symptoms with appropriate treatment followed by a recurrence with intractable pain. In this instance, a second surgical opinion must confirm the need for surgery sooner than 12 months after initial nonsurgical management was begun.

(7) If surgery is not indicated, 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

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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 tendonitis of forearm, wrist, and hand.**

A. Except as provided in item B, subitem (3), initial nonsurgical management is appropriate for all patients with tendonitis and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item 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 indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) For patients with a specific diagnosis of de Quervain's syndrome, surgical evaluation and surgical therapy, if indicated, may begin after only two 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 indicated 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 must meet all of the parameters of part 5221.6600.

Subp. 13. **Specific treatment parameters for nerve entrapment syndromes.**

A. Initial nonsurgical management is appropriate for all patients with nerve entrapment syndromes, except as specified in subitem (2), and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item 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 indicated.

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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 indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

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

(2) Surgery is indicated if an EMG confirms the diagnosis, or if there has been temporary resolution of symptoms lasting at least seven days with local injection.

(3) If there is neither a confirming EMG or appropriate response to local injection, or if surgery has been previously performed at the same site, surgery is not indicated unless a second opinion confirms the need for surgery.

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 must meet all of the parameters of part 5221.6600.

Subp. 14. **Specific treatment parameters for muscle pain syndromes.**

A. Initial nonsurgical management is appropriate for all patients with muscle pain syndromes and must be the first phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A.

B. Surgery is not indicated for the treatment of muscle pain syndrome.

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 syndrome must meet all of the parameters of part 5221.6600.

Subp. 15. **Specific treatment parameters for shoulder impingement syndromes.**

A. Initial nonsurgical management is appropriate for all patients with shoulder impingement syndromes without clinical evidence of rotator cuff tear and must be the first

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phase of treatment. Any course or program of initial nonsurgical management must meet all of the parameters of subpart 11, item A, except as follows:

(1) continued nonsurgical management may be inappropriate, and early surgical evaluation may be indicated, for patients with:

(a) clinical findings of rotator cuff tear; or

(b) acute rupture of the proximal biceps tendon;

(2) use of home-based treatment modalities with monitoring by the health care provider may continue for up to six 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 six 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 indicated. Surgical evaluation and surgical therapy must meet all of the parameters of subpart 11, item B, with the modifications in subitems (1) to (3).

(1) Surgical evaluation must begin no later than six months after beginning initial nonsurgical management.

(2) Diagnostic injection, arthrography, CT-arthrography, or MRI scanning may be indicated as part of the surgical evaluation.

(3) The only surgical procedures indicated for patients with shoulder impingement syndrome 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 must meet the parameters of part 5221.6500, subpart 3.

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 syndrome must meet the parameters of part 5221.6600.

Subp. 16. **Specific treatment parameters for traumatic sprains and strains of the upper extremity.**

A. Initial nonsurgical management must be 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 must meet all of the parameters of subpart 11.

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B. Surgery is not indicated 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 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; 40 SR 328*

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