

1 Department of Labor and Industry

2

3 Adopted Permanent Rules Relating to Workers' Compensation;

4 Treatment Parameters

5

6 Rules as Adopted

7 5221.6010 AUTHORITY.

8 Parts 5221.6010 to 5221.8900 are adopted under the
9 authority of Minnesota Statutes, sections 176.83, subdivisions
10 1, 3, 4, and 5, and 176.103, subdivision 2.

11 5221.6020 PURPOSE AND APPLICATION.

12 Subpart 1. **Purpose.** Parts 5221.6010 to 5221.6600
13 establish parameters for reasonably required treatment of
14 employees with compensable workers' compensation injuries to
15 prevent excessive services under Minnesota Statutes, sections
16 176.135 and 176.136, subdivision 2. Parts 5221.6010 to
17 5221.6600 do not affect any determination of liability for an
18 injury under Minnesota Statutes, chapter 176, and are not
19 intended to expand or restrict a health care provider's scope of
20 practice under any other statute.

21 Subp. 2. **Application.** All treatment must be medically
22 necessary as defined in part 5221.6040, subpart 10. In the
23 absence of a specific parameter, any applicable general
24 parameters govern. A departure from a parameter that limits the
25 duration or type of treatment may be appropriate in any one of
26 the circumstances specified in part 5221.6050, subpart 8. Parts
27 5221.6010 to 5221.6600 apply to all treatment provided after the
28 effective date of parts 5221.6010 to 5221.6600, regardless of
29 the date of injury. All limitations on the duration of a
30 specific treatment modality or type of modality begin with the
31 first time the modality is initiated after the effective date of
32 parts 5221.6050 to 5221.6600. However, consideration may be
33 given to treatment initiated under the emergency rules (parts
34 5221.6050 to 5221.6500 [Emergency]). Parts 5221.6010 to
35 5221.6600 do not apply to treatment of an injury after an

1 insurer has denied liability for the injury. However, in such
2 cases the rules do apply to treatment initiated after liability
3 has been established. References to days and weeks in parts
4 5221.6050 to 5221.6600 mean calendar days and weeks unless
5 specified otherwise.

6 5221.6030 INCORPORATION BY REFERENCE.

7 The ICD-9-CM diagnostic codes referenced in parts 5221.6010
8 to 5221.6600 are contained in the fourth edition of the
9 International Classification of Diseases, Clinical Modification,
10 9th Revision, 1994, and corresponding annual updates. This
11 document is subject to annual revisions and is incorporated by
12 reference. It is published by the United States Department of
13 Health and Human Services, Health Care Financing Administration,
14 and may be purchased through the Superintendent of Documents,
15 United States Government Printing Office, Washington, D.C.
16 20402. It is available through the Minitex interlibrary loan
17 system.

18 5221.6040 DEFINITIONS.

19 Subpart 1. **Scope.** The terms used in parts 5221.6010 to
20 5221.6600 have the meanings given them in this part.

21 Subp. 2. **Active treatment.** "Active treatment" means
22 treatment specified in parts 5221.6200, subpart 4; 5221.6205,
23 subpart 4; 5221.6210, subpart 4; 5221.6300, subpart 4; and
24 5221.6305, subpart 2, item C, which requires active patient
25 participation in a therapeutic program to increase flexibility,
26 strength, endurance, or awareness of proper body mechanics.

27 Subp. 3. **Chronic pain syndrome.** "Chronic pain syndrome"
28 means any set of verbal or nonverbal behaviors that:

- 29 A. involve the complaint of enduring pain;
30 B. differ significantly from the patient's preinjury
31 behavior;
32 C. have not responded to previous appropriate
33 treatment;
34 D. are not consistent with a known organic syndrome
35 which has remained untreated; and

1 E. interfere with physical, psychological, social, or
2 vocational functioning.

3 Subp. 4. **Condition.** A patient's "condition" means the
4 symptoms, physical signs, clinical findings, and functional
5 status that characterize the complaint, illness, or injury
6 related to a current claim for compensation.

7 Subp. 5. **Emergency treatment.** "Emergency treatment" means
8 treatment that is:

9 A. required for the immediate diagnosis and treatment
10 of a medical condition that, if not immediately diagnosed and
11 treated, could lead to serious physical or mental disability or
12 death; or

13 B. immediately necessary to alleviate severe pain.

14 Emergency treatment includes treatment delivered in
15 response to symptoms that may or may not represent an actual
16 emergency but that is necessary to determine whether an
17 emergency exists.

18 Subp. 6. **Etiology.** "Etiology" means the anatomic
19 alteration, physiologic dysfunction, or other biological or
20 psychological abnormality which is considered a cause of the
21 patient's condition.

22 Subp. 7. **Functional status.** "Functional status" means the
23 ability of an individual to engage in activities of daily living
24 and other social, recreational, and vocational activities.

25 Subp. 8. **Initial nonsurgical management or treatment.**
26 "Initial nonsurgical management or treatment" is initial
27 treatment provided after an injury that includes passive
28 treatment, active treatment, injections, and durable medical
29 equipment under parts 5221.6200, subparts 3, 4, 5, and 8;
30 5221.6205, subparts 3, 4, 5, and 8; 5221.6210, subparts 3, 4, 5,
31 and 8; 5221.6300, subparts 3, 4, 5, and 8; and 5221.6305,
32 subpart 2. Scheduled and nonscheduled medication may be a part
33 of initial nonsurgical treatment. Initial nonsurgical
34 management does not include surgery or chronic management
35 modalities under part 5221.6600.

36 Subp. 9. **Medical imaging procedures.** A "medical imaging

1 procedure" is a technique, process, or technology used to create
2 a visual image of the body or its function. Medical imaging
3 includes, but is not limited to: X-rays, tomography,
4 angiography, venography, myelography, computed tomography (CT)
5 scanning, magnetic resonance imaging (MRI) scanning, ultrasound
6 imaging, nuclear isotope imaging, PET scanning, and thermography.

7 Subp. 10. **Medically necessary treatment.** "Medically
8 necessary treatment" means those health services for a
9 compensable injury that are reasonable and necessary for the
10 diagnosis and cure or significant relief of a condition
11 consistent with any applicable treatment parameter in parts
12 5221.6050 to 5221.6600. Where parts 5221.6050 to 5221.6600 do
13 not govern, the treatment must be reasonable and necessary for
14 the diagnosis or cure and significant relief of a condition
15 consistent with the current accepted standards of practice
16 within the scope of the provider's license or certification.

17 Subp. 11. **Neurologic deficit.** "Neurologic deficit" means
18 a loss of function secondary to involvement of the central or
19 peripheral nervous system. This may include, but is not limited
20 to, motor loss; spasticity; loss of reflex; radicular or
21 anatomic sensory loss; loss of bowel, bladder, or erectile
22 function; impairment of special senses, including vision,
23 hearing, taste, or smell; or deficits in cognitive or memory
24 function.

25 A. "Static neurologic deficit" means any neurologic
26 deficit that has remained the same by history or noted by
27 repeated examination since onset.

28 B. "Progressive neurologic deficit" means any
29 neurologic deficit that has become worse by history or noted by
30 repeated examination since onset.

31 Subp. 12. **Passive treatment.** "Passive treatment" is any
32 treatment modality specified in parts 5221.6200, subpart 3;
33 5221.6205, subpart 3; 5221.6210, subpart 3; 5221.6300, subpart
34 3; and 5221.6305, subpart 2, item B. Passive treatment
35 modalities include bedrest; thermal treatment; traction;
36 acupuncture; electrical muscle stimulation; braces; manual and

1 mechanical therapy; massage; and adjustments.

2 Subp. 13. **Therapeutic injection.** "Therapeutic injection"
3 is any injection modality specified in parts 5221.6200, subpart
4 5; 5221.6205, subpart 5; 5221.6210, subpart 5; 5221.6300,
5 subpart 5; and 5221.6305, subpart 2, item A. Therapeutic
6 injections include trigger point injections, sacroiliac
7 injections, facet joint injections, facet nerve blocks, nerve
8 root blocks, epidural injections, soft tissue injections,
9 peripheral nerve blocks, injections for peripheral nerve
10 entrapment, and sympathetic blocks.

11 5221.6050 GENERAL TREATMENT PARAMETERS; EXCESSIVE TREATMENT;
12 PRIOR NOTIFICATION.

13 Subpart 1. **General.**

14 A. All treatment must be medically necessary
15 treatment, as defined in part 5221.6040, subpart 10. The health
16 care provider must evaluate the medical necessity of all
17 treatment under item B on an ongoing basis.

18 Parts 5221.6050 to 5221.6600 do not require or permit any
19 more frequent examinations than would normally be required for
20 the condition being treated, but do require ongoing evaluation
21 of the patient that is medically necessary, consistent with
22 accepted medical practice.

23 B. The health care provider must evaluate at each
24 visit whether initial nonsurgical treatment for the low back,
25 cervical, thoracic, and upper extremity conditions specified in
26 parts 5221.6200, 5221.6205, 5221.6210, and 5221.6300, is
27 effective according to subitems (1) to (3). No later than any
28 applicable treatment response time in parts 5221.6200 to
29 5221.6300, the health care provider must evaluate whether the
30 passive, active, injection, or medication treatment modality is
31 resulting in progressive improvement as specified in subitems
32 (1) to (3):

33 (1) the employee's subjective complaints of pain
34 or disability are progressively improving, as evidenced by
35 documentation in the medical record of decreased distribution,

1 frequency, or intensity of symptoms;

2 (2) the objective clinical findings are
3 progressively improving, as evidenced by documentation in the
4 medical record of resolution or objectively measured improvement
5 in physical signs of injury; and

6 (3) the employee's functional status, especially
7 vocational activities, is progressively improving, as evidenced
8 by documentation in the medical record, or successive reports of
9 work ability, of less restrictive limitations on activity.

10 Except as otherwise provided under parts 5221.6200, subpart
11 3, item B; 5221.6205, subpart 3, item B; 5221.6210, subpart 3,
12 item B; and 5221.6300, subpart 3, item B, if there is not
13 progressive improvement in at least two of subitems (1) to (3),
14 the modality must be discontinued or significantly modified, or
15 the provider must reconsider the diagnosis. The evaluation of
16 the effectiveness of the treatment modality can be delegated to
17 an allied health professional directly providing the treatment,
18 but remains the ultimate responsibility of the treating health
19 care provider who ordered the treatment.

20 C. The health care provider must use the least
21 intensive setting appropriate and must assist the employee in
22 becoming independent in the employee's own care to the extent
23 possible so that prolonged or repeated use of health care
24 providers and medical facilities is minimized.

25 Subp. 2. **Documentation.** A health care provider must
26 maintain an appropriate record, as defined in part 5221.0100,
27 subpart 1a, of any treatment provided to a patient.

28 Subp. 3. **Nonoperative treatment.** Health care providers
29 shall provide a trial of nonoperative treatment before offering
30 or performing surgical treatment unless the treatment for the
31 condition requires immediate surgery ~~or~~, unless an emergency
32 situation exists, or unless the accepted standard of initial
33 treatment for the condition is surgery.

34 Subp. 4. **Chemical dependency.** The health care provider
35 shall maintain diligence to detect incipient or actual chemical
36 dependency to any medication prescribed for treatment of the

1 employee's condition. In cases of incipient or actual
2 dependency, the health care provider shall refer the employee
3 for appropriate evaluation and treatment of the dependency.

4 Subp. 5. Referrals between health care providers. The
5 primary health care provider directing the course of treatment
6 shall make timely and appropriate referrals for consultation for
7 opinion or for the transfer of care if the primary health care
8 provider does not have any reasonable alternative treatment to
9 offer and there is a reasonable likelihood that the consultant
10 may offer or recommend a reasonable alternative treatment plan.
11 This subpart does not prohibit a referral for consultation in
12 other circumstances based on accepted medical practice and the
13 patient's condition.

14 A. Referrals from consulting health care provider.
15 If the consultant has reasonable belief that another
16 consultation is appropriate, that consultant must coordinate
17 further referral with the original treating health care provider
18 unless the consultant has been approved as the employee's
19 treating health care provider. The consultant is under no
20 obligation to provide or recommend treatment or further
21 referral, if in the consultant's opinion, all reasonable and
22 necessary treatment has been rendered. The consultant shall in
23 this situation refer the employee back to the original treating
24 health care provider for further follow-up.

25 B. Information sent to consultant. When a referring
26 health care provider arranges for consultation or transfer of
27 care, except in cases of emergency, the referring health care
28 provider shall, with patient authorization, summarize for the
29 consultant orally or in writing the conditions of injury, the
30 working diagnosis, the treatment to date, the patient's response
31 to treatment, all relevant laboratory and medical imaging
32 studies, return to work considerations, and any other
33 information relevant to the consultation. In addition, the
34 referring health care provider shall make available to the
35 consultant, with patient authorization, a copy of all medical
36 records relevant to the employee's injury.

1 Subp. 6. Communication between health care providers and
2 consideration of prior care.

3 A. Information requested by new health care provider.

4 Upon accepting for treatment a patient with a workers'
5 compensation injury, the health care provider shall ask the
6 patient if treatment has been previously given for the injury by
7 another health care provider. If the patient reports that
8 treatment has been previously given for the injury by another
9 health care provider and if the medical records for the injury
10 have not been transferred, the new health care provider shall
11 request authorization from the employee for relevant medical
12 records. Upon receipt of the employee authorization, the new
13 health care provider shall request relevant medical records from
14 the previous health care providers. Upon receipt of the request
15 for medical records and employee authorization, the previous
16 health care providers shall provide the records within seven
17 working days.

18 B. Treatment by prior health care provider. If the
19 employee has reported that care for an injury has been
20 previously given:

21 (1) Where a previous health care provider has
22 performed diagnostic imaging, a health care provider may not
23 repeat the imaging or perform alternate diagnostic ~~testing~~
24 ~~previously-performed-by-another-health-care-provider~~ imaging for
25 the same condition except as permitted in part 5221.6100.

26 (2) When a therapeutic modality employed by a
27 health care provider was no longer improving the employee's
28 condition under subpart 1, item B, or has been used for the
29 maximum duration allowed under parts 5221.6050 to 5221.6600,
30 another health care provider may not employ the same modality at
31 any time thereafter to treat the same injury except if one of
32 the departures applies under subpart 8, after surgery, or for
33 treatment of reflex sympathetic dystrophy under part 5221.6305.

34 (3) It is also inappropriate for two health care
35 providers to use the same treatment modality concurrently.

36 C. Employee refusal. An employee's refusal to

1 provide authorization for release of medical records does not
2 justify repeat treatment or diagnostic testing. An insurer is
3 not liable for repeat diagnostic testing or other duplicative
4 treatment prohibited by this subpart.

5 Subp. 7. Determinations of excessive treatment; notice of
6 denial to health care providers and employee; expedited
7 processing of medical requests.

8 A. In addition to services deemed excessive under
9 part 5221.0500 and Minnesota Statutes, section 176.136,
10 subdivision 2, treatment is excessive if:

11 (1) the treatment is inconsistent with an
12 applicable parameter or other rule in parts 5221.6050 to
13 5221.6600; or

14 (2) the treatment is consistent with the
15 parameters in parts 5221.6050 to 5221.6600, but is not medically
16 necessary treatment.

17 B. If the insurer denies payment for treatment that
18 departs from a parameter under parts 5221.6050 to 5221.6600, the
19 insurer must provide the employee and health care provider with
20 written notice of the reason for the denial and that the
21 treatment rules permit departure from the parameters in
22 specified circumstances. If the insurer denies authorization
23 for proposed treatment after prior notification has been given
24 under subpart 9, the insurer must provide the employee and
25 health care provider in writing with notice of the reason why
26 the information given by the health care provider does not
27 support the proposed treatment and notice of the right to review
28 of the denial under subpart 9, item C. The insurer may not deny
29 payment for a program of chronic management that the insurer has
30 previously authorized for an employee, either in writing or by
31 routine payment for services, without providing the employee and
32 the employee's health care provider with at least 30 days'
33 notice of intent to apply any of the chronic management
34 parameters in part 5221.6600 to future treatment. The notice
35 must include the specific parameters that will be applied in
36 future determinations of compensability by the insurer.

1 C. If the insurer denies authorization or payment for
2 treatment governed by parts 5221.6050 to 5221.6600, the health
3 care provider or the employee may request a determination from
4 the commissioner or compensation judge by filing a medical
5 request or petition under chapter 5220 and Minnesota Statutes,
6 sections 176.106, 176.2615, and 176.305. The medical request
7 may not be filed before completion of the managed care plan's
8 dispute resolution process, if applicable. If the health care
9 provider has notified the insurer of proposed treatment
10 requiring prior notification under subpart 9, the health care
11 provider or employee must describe or attach a copy of the
12 notification, and any response from the insurer, to the medical
13 request filed with the department. The insurer may, but is not
14 required to, file a medical response where the insurer's
15 response to prior notification under subpart 9 has been attached
16 to the medical request. If the insurer elects to file a medical
17 response in such cases, it must be received within ten working
18 days of the date the medical request was filed with the
19 department. The commissioner or compensation judge may issue a
20 decision based on written submissions no earlier than ten
21 working days after receipt of the medical request, unless a
22 medical response has been filed sooner.

23 D. A determination of the compensability of medical
24 treatment under Minnesota Statutes, chapter 176, must include
25 consideration of the following factors:

26 (1) whether a treatment parameter or other rule
27 in parts 5221.6050 to 5221.6600 applies to the etiology or
28 diagnosis for the condition;

29 (2) if a specific or general parameter applies,
30 whether the treatment is consistent with the treatment parameter
31 and whether the treatment was medically necessary as defined in
32 part 5221.6040, subpart 10; and

33 (3) whether a departure from the applicable
34 parameter is or was necessary because of any of the factors in
35 subpart 8.

36 Subp. 8. Departures from parameters. A departure from a

1 treatment parameter that limits the duration or type of
2 treatment in parts 5221.6050 to 5221.6600 may be appropriate in
3 any one of the circumstances specified in items A to E. The
4 health care provider must provide prior notification of the
5 departure as required by subpart 9.

6 A. Where there is a documented medical complication.

7 B. Where previous treatment did not meet the accepted
8 standard of practice and the requirements of parts 5221.6050 to
9 5221.6600 for the health care provider who ordered the treatment.

10 C. Where the treatment is necessary to assist the
11 employee in the initial return to work where the employee's work
12 activities place stress on the part of the body affected by the
13 work injury. The health care provider must document in the
14 medical record the specific work activities that place stress on
15 the affected body part, the details of the treatment plan and
16 treatment delivered on each visit, the employee's response to
17 the treatment, and efforts to promote employee independence in
18 the employee's own care to the extent possible so that prolonged
19 or repeated use of health care providers and medical facilities
20 is minimized.

21 D. Where the treatment continues to meet two of the
22 following three criteria, as documented in the medical record:

23 (1) the employee's subjective complaints of pain
24 are progressively improving as evidenced by documentation in the
25 medical record of decreased distribution, frequency, or
26 intensity of symptoms;

27 (2) the employee's objective clinical findings
28 are progressively improving, as evidenced by documentation in
29 the medical record of resolution or objectively measured
30 improvement in physical signs of injury; and

31 (3) the employee's functional status, especially
32 vocational activity, is objectively improving as evidenced by
33 documentation in the medical record, or successive reports of
34 work ability, of less restrictive limitations on activity.

35 E. Where there is an incapacitating exacerbation of
36 the employee's condition. However, additional treatment for the

1 incapacitating exacerbation may not exceed, and must comply
2 with, the parameters in parts ~~5221.6100~~ 5221.6050 to 5221.6600.

3 Subp. 9. Prior notification; health care provider and
4 insurer responsibilities. Prior notification is the
5 responsibility of the health care provider who wants to provide
6 the treatment in item A. Prior notification need not be given
7 in any case where emergency treatment is required.

8 A. The health care provider must notify the insurer
9 of proposed treatment in subitems (1) to (4) at least seven
10 working days before the treatment is initiated, except as
11 otherwise provided in subitem (4):

12 (1) for chronic management modalities where prior
13 notification is required under part 5221.6600;

14 (2) for durable medical equipment requiring prior
15 notification in parts 5221.6200, subpart 8; 5221.6205, subpart
16 8; 5221.6210, subpart 8; and 5221.6300, subpart 8;

17 (3) for any nonemergency inpatient
18 hospitalization or nonemergency inpatient surgery. A surgery or
19 hospitalization is considered inpatient if the patient spends at
20 least one night in the facility; and

21 (4) for treatment that departs from a specific
22 parameter limiting the duration or type of treatment in parts
23 ~~5221.6100~~ 5221.6050 to 5221.6600. The health care provider must
24 notify the insurer within two business days after initiation of
25 treatment if the departure from a parameter is for an
26 incapacitating exacerbation or an emergency.

27 B. The health care provider's prior notification
28 required by item A may be made orally, or in writing, and shall
29 provide the following information, when relevant:

30 (1) the diagnosis;

31 (2) when giving prior notification for chronic
32 management modalities, durable medical equipment, or inpatient
33 hospitalization or surgery required by item A, subitems (1) to
34 (3), whether the proposed treatment is consistent with the
35 applicable treatment parameter;

36 (3) when giving prior notification for treatment

1 that departs from a treatment parameter, or notification of
2 treatment for an incapacitating exacerbation or emergency, the
3 basis for departure from any applicable treatment parameter
4 specified in subpart 8; the treatment plan, including the nature
5 and anticipated length of the proposed treatment; and the
6 anticipated effect of treatment on the employee's condition.

7 C. The insurer must provide a toll-free facsimile and
8 telephone number for health care providers to provide prior
9 notification. The insurer must respond orally or in writing
10 to the requesting health care provider's prior notification of
11 proposed treatment in item A within seven working days of
12 receipt of the request. Within the seven days, the insurer must
13 either approve the request, deny authorization, request
14 additional information, request that the employee obtain a
15 second opinion, or request an examination by the employer's
16 physician. A denial must include notice to the employee and
17 health care provider of the reason why the information given by
18 the health care provider in item B does not support the
19 treatment proposed, along with notice of the right to review of
20 the denial under subitem (3).

21 (1) If the health care provider does not receive
22 a response from the insurer within the seven working days,
23 authorization is deemed to have been given.

24 (2) If the insurer authorizes the treatment, the
25 insurer may not later deny payment for the treatment authorized.

26 (3) If the insurer denies authorization, the
27 health care provider or employee may orally or in writing
28 request that the insurer review its denial of authorization.

29 The insurer's review of its denial must be made by a
30 currently licensed registered nurse, medical doctor, doctor of
31 osteopathy, doctor of chiropractic, or a person credentialled by
32 a program approved by the commissioner of Labor and Industry.
33 The insurer may also delegate the review to a certified managed
34 care plan under subpart 10. In lieu of or in addition to the
35 insurer's review under this subitem, the insurer may request an
36 examination of the employee under subitem (4), (5), or (6) and

1 the requirements of those subitems apply to the proposed
2 treatment. Unless an examination of the employee is requested
3 under subitem (4), (5), or (6), the insurer's determination
4 following review must be communicated orally or in writing to
5 the requestor within seven working days of receipt of the
6 request for review.

7 Instead of requesting a review, or if the insurer maintains
8 its denial after the review, the health care provider or the
9 employee may file with the commissioner a medical request or a
10 petition for authorization of the treatment under subpart 7,
11 item C, or except as specified in subitem (4), (5), or (6), may
12 proceed with the proposed treatment subject to a later
13 determination of compensability by the commissioner or
14 compensation judge.

15 (4) If the insurer denies authorization within
16 seven working days, or requests an examination of the employee
17 by the employer's physician, the health care provider may elect
18 to provide the treatment subject to a determination of
19 compensability by the commissioner or compensation judge under
20 subpart 7, item B. However, the health care provider may not
21 provide nonemergency surgery where the insurer has requested an
22 examination for surgery except as provided in subitems ~~(4)~~ (5)
23 and ~~(5)~~ (6), and may not provide continued passive care
24 modalities where prior approval by the insurer, commissioner, or
25 compensation judge is required under parts 5221.6200, subpart 3,
26 item B, subitem (2); 5221.6205, subpart 3, item B, subitem (2);
27 5221.6210, subpart 3, item B, subitem (2); and 5221.6300,
28 subpart 3, item B, subitem (2).

29 ~~(3) If the insurer authorizes the treatment, the~~
30 ~~insurer may not later deny payment for the treatment authorized.~~

31 (4) (5) If prior notification of surgery is
32 required under item A, subitem (3), the insurer may require that
33 the employee obtain a second opinion from a physician of the
34 employee's choice under Minnesota Statutes, section 176.135,
35 subdivision 1a. If within seven working days of the prior
36 notification the insurer notifies the employee and health care

1 provider that a second opinion is required, the health care
2 provider may not perform the nonemergency surgery until the
3 employee provides the second opinion to the insurer. Except as
4 otherwise provided in parts 5221.6200, subpart 6, items B and C;
5 5221.6205, subpart 6, items B and C; 5221.6300, subpart 6, ~~items~~
6 item B and E; and 5221.6305, subpart 3, item B, if the insurer
7 denies authorization within seven working days of receiving the
8 second opinion, the health care provider may elect to perform
9 the surgery, subject to a determination of compensability by the
10 commissioner or compensation judge under subpart 7.

11 ~~(5)~~ (6) In any case where prior notification of
12 proposed surgery is required, the insurer may elect to obtain an
13 examination of the employee by the employer's physician under
14 Minnesota Statutes, section 176.155, sometimes referred to as an
15 "independent medical examination." If the insurer notifies the
16 employee and health care provider of the examination within
17 seven working days of the provider's notification, the proposed
18 nonemergency surgery may not be provided pending the
19 examination. However, after 45 days following the insurer's
20 request for an examination, the health care provider may elect
21 to proceed with the surgery, subject to a determination of
22 compensability by the commissioner or compensation judge under
23 subpart 7.

24 ~~(6)~~ (7) The insurer's request for additional
25 information must be directed to the requesting health care
26 provider and must specify the additional information required
27 that is necessary to respond to the health care provider's
28 notification of proposed treatment. The proposed treatment may
29 not be given until the provider provides reasonable additional
30 information. Once the additional information has been received,
31 the insurer must respond within seven working days according to
32 subitems (1) to ~~(5)~~ (6).

33 Subp. 10. **Certified managed care plans.** The insurer may
34 delegate responsibility for the notices required in subpart 7,
35 item B, and the response to prior notification under subpart 9,
36 to the certified managed care plan with which the insurer has

1 contracted to manage the employee's medical treatment under
 2 Minnesota Statutes, section 176.135, subdivision 1f.
 3 Alternatively, the managed care plan may act as an intermediary
 4 between the treating health care provider and the insurer. In
 5 either case, the notices and time periods in subparts 7, 8, and
 6 9 also apply to the managed care plan. Where the insurer has
 7 delegated responsibility to the managed care plan, the insurer
 8 may not later deny treatment authorized by the plan.

9 Subp. 11. **Outcome studies.** The commissioner shall perform
 10 outcome studies on the treatment modalities in parts 5221.6200
 11 to 5221.6600. The modalities to be studied shall be selected in
 12 consultation with the Workers' Compensation Medical Services
 13 Review Board. The commissioner may require health care
 14 providers who use ~~the~~ these modalities ~~in parts 5221.6200 to~~
 15 ~~5221.6600~~ to prospectively gather and report outcome information
 16 on patients treated, with necessary consent of the employee.
 17 The health care providers shall report the outcome information
 18 on the modalities in parts 5221.6200 to 5221.6600 on a form
 19 prescribed by the commissioner, which may include:

- 20 A. the name of the health care provider;
- 21 B. the name of the patient, date of injury, date of
 22 birth, gender, and, with patient permission, level of education
 23 and social security number;
- 24 C. the name of the workers' compensation insurer and
 25 managed care plan, if any;
- 26 D. the pretreatment and posttreatment employment
 27 status;
- 28 E. the nature of treatment given before and after the
 29 treatment being studied for the same condition; ~~and~~
- 30 F. the diagnosis, symptoms, physical findings, and
 31 functional status before and after the treatment being studied
 32 for the same condition; and
- 33 G. the presence or absence of preexisting or
 34 concurrent conditions.

35 5221.6100 PARAMETERS FOR MEDICAL IMAGING.

1 Subpart 1. **General principles.** All medical imaging must
 2 comply with items A to E. Except for emergency evaluation of
 3 significant trauma, a health care provider must document in the
 4 medical record an appropriate history and physical examination,
 5 along with a review of any existing medical records and
 6 laboratory or imaging studies regarding the patient's condition,
 7 before ordering any imaging study.

8 A. **Effective imaging.** A health care provider should
 9 initially order the single most effective imaging study for
 10 diagnosing the suspected etiology of a patient's condition. No
 11 concurrent or additional imaging studies should be ordered until
 12 the results of the first study are known and reviewed by the
 13 treating health care provider. ~~Additional studies may be~~
 14 ~~obtained if the first imaging study was inconclusive with~~
 15 ~~suggestive findings.~~ If the first imaging study is negative, no
 16 additional imaging is indicated ~~unless:~~

17 ~~(1) there is a change in the suspected etiology~~
 18 ~~based on the results of the first imaging study; or~~

19 ~~(2) there is a change in the patient's condition~~
 20 ~~which would in itself warrant imaging except for repeat and~~
 21 ~~alternative imaging allowed under items D and E.~~

22 B. **Appropriate imaging.** Imaging solely to rule out a
 23 diagnosis not seriously being considered as the etiology of the
 24 patient's condition is not indicated.

25 C. **Routine imaging.** Imaging on a routine basis is
 26 not indicated unless the information from the study is necessary
 27 to develop a treatment plan.

28 D. **Repeat imaging.** Repeat imaging, of the same views
 29 of the same body part with the same imaging modality is not
 30 indicated except as follows:

31 (1) to diagnose a suspected fracture or suspected
 32 dislocation;

33 (2) to monitor a therapy or treatment which is
 34 known to result in a change in imaging findings and imaging of
 35 these changes are necessary to determine the efficacy of the
 36 therapy or treatment; repeat imaging is not appropriate solely

1 to determine the efficacy of physical therapy or chiropractic
2 treatment;

3 (3) to follow up a surgical procedure;

4 (4) to diagnose a change in the patient's
5 condition marked by new or altered physical findings;

6 (5) to evaluate a new episode of injury or
7 exacerbation which in itself would warrant an imaging study; or

8 (6) when the ~~original radiologist and another~~
9 treating health care provider and a radiologist from a different
10 practice have reviewed a previous ~~MRI or CT scan~~ imaging study
11 and agree that it is a technically inadequate study.

12 E. Alternative imaging.

13 (1) Persistence of a patient's subjective
14 complaint or failure of the condition to respond to treatment
15 are not legitimate indications for repeat imaging. In this
16 instance an alternative imaging study may be indicated if
17 another etiology of the patient's condition is suspected because
18 of the failure of the condition to improve.

19 (2) Alternative imaging is not allowed to follow
20 up negative findings unless there has been a change in the
21 suspected etiology and the first imaging study is not an
22 appropriate evaluation for the suspected etiology.

23 (3) Alternative imaging is allowed to follow up
24 abnormal ~~or~~ but inconclusive findings in another imaging study.
25 An inconclusive finding is one that does not provide an adequate
26 basis for accurate diagnosis.

27 Subp. 2. **Specific imaging procedures for low back pain.**

28 Except for the emergency evaluation of significant trauma, a
29 health care provider must document in the medical record an
30 appropriate history and physical examination, along with a
31 review of any existing medical records and laboratory or imaging
32 studies regarding the patient's condition, before ordering any
33 imaging study of the low back.

34 A. Computed tomography (CT) scanning is indicated any
35 time that one of the following conditions is met:

36 (1) when cauda equina syndrome is suspected;

1 (2) for evaluation of progressive neurologic
2 deficit; or

3 (3) when bony lesion is suspected on the basis of
4 other tests or imaging procedures.

5 Except as specified in subitems (1) to (3), CT scanning is
6 not indicated in the first eight weeks after an injury.

7 Computed tomography scanning is indicated after eight weeks
8 if the patient continues with symptoms and physical findings
9 after the course of initial nonsurgical care and if the
10 patient's condition prevents the resumption of the regular
11 activities of daily life including regular vocational activities.

12 B. Magnetic resonance imaging (MRI) scanning is
13 indicated any time that one of the following conditions is met:

14 (1) when cauda equina syndrome is suspected;

15 (2) for evaluation of progressive neurologic
16 deficit;

17 (3) when previous spinal surgery has been
18 performed and there is a need to differentiate scar due to
19 previous surgery from disc herniation, tumor, or hemorrhage; or

20 (4) suspected discitis.

21 Except as specified in subitems (1) to (4), MRI scanning is
22 not indicated in the first eight weeks after an injury.

23 Magnetic resonance imaging scanning is indicated after
24 eight weeks if the patient continues with symptoms and physical
25 findings after the course of initial nonsurgical care and if the
26 patient's condition prevents the resumption of the regular
27 activities of daily life including regular vocational activities.

28 C. Myelography is indicated in the following
29 circumstances:

30 (1) may be substituted for otherwise indicated CT
31 scanning or MRI scanning in accordance with items A and B, if
32 those imaging modalities are not locally available;

33 (2) in addition to CT scanning or MRI scanning,
34 if there are progressive neurologic deficits or changes and CT
35 scanning or MRI scanning has been negative; or

36 (3) for preoperative evaluation in cases of

1 surgical intervention, but only if CT scanning or MRI scanning
2 have failed to provide a definite preoperative diagnosis.

3 D. Computed tomography myelography is indicated in
4 the following circumstances:

5 (1) the patient's condition is predominantly
6 sciatica, and there has been previous spinal surgery, and tumor
7 is suspected;

8 (2) the patient's condition is predominantly
9 sciatica and there has been previous spinal surgery and MRI
10 scanning is equivocal;

11 (3) when spinal stenosis is suspected and the CT
12 or MRI scanning is equivocal;

13 (4) in addition to CT scanning or MRI scanning,
14 if there are progressive neurologic symptoms or changes and CT
15 scanning or MRI scanning has been negative; or

16 (5) for preoperative evaluation in cases of
17 surgical intervention, but only if CT scanning or MRI scanning
18 have failed to provide a definite preoperative diagnosis.

19 E. Intravenous enhanced CT scanning is indicated only
20 if there has been previous spinal surgery, and the imaging study
21 is being used to differentiate scar due to previous surgery from
22 disc herniation or tumor, but only if intrathecal contrast for
23 CT-myelography is contraindicated and MRI scanning is not
24 available or is also contraindicated.

25 F. Gadolinium enhanced MRI scanning is indicated when:

26 (1) there has been previous spinal surgery, and
27 the imaging study is being used to differentiate scar due to
28 previous surgery from disc herniation or tumor;

29 (2) hemorrhage is suspected;

30 (3) tumor or vascular malformation is suspected;

31 (4) infection or inflammatory disease is
32 suspected; or

33 (5) unenhanced MRI scanning was equivocal.

34 G. Discography is indicated when:

35 (1) all of the following are present:

36 (a) back pain is the predominant complaint;

1 (b) the patient has failed to improve with
2 initial nonsurgical management;

3 (c) other imaging has not established a
4 diagnosis; and

5 (d) lumbar fusion surgery is being
6 considered as a therapy; or

7 (2) there has been previous spinal surgery, and
8 pseudoarthrosis, recurrent disc herniation, annular tear, or
9 internal disc disruption is suspected.

10 H. Computed tomography discography is indicated when:

11 (1) sciatica is the predominant complaint and
12 lateral disc herniation is suspected; or

13 (2) if appropriately performed discography is
14 equivocal or paradoxical, with a normal X-ray pattern but a
15 positive pain response, and an annular tear or intra-annular
16 injection is suspected.

17 I. Nuclear isotope imaging (including technicium,
18 indium, and gallium scans) are not indicated unless tumor,
19 stress fracture, infection, avascular necrosis, or inflammatory
20 lesion is suspected on the basis of history, physical
21 examination findings, laboratory studies, or the results of
22 other imaging studies.

23 J. Thermography is not indicated for the diagnosis of
24 any of the clinical categories of low back conditions in part
25 5221.6200, subpart 1, item A.

26 K. Anterior-posterior (AP) and lateral X-rays of the
27 lumbosacral spine are limited by subitems (1) and (2).

28 (1) They are indicated in the following
29 circumstances:

30 (a) when there is a history of significant
31 acute trauma as the precipitating event of the patient's
32 condition, and fracture, dislocation, or fracture dislocation is
33 suspected;

34 (b) when the history, signs, symptoms, **and**
35 or laboratory studies indicate possible tumor, infection, or
36 inflammatory lesion;

1 (c) for postoperative follow-up of lumbar
2 fusion surgery;

3 (d) when the patient is more than 50 years
4 of age; or

5 (e) before beginning a course of treatment
6 with spinal adjustment or manipulation; or

7 (f) eight weeks after an injury if the
8 patient continues with symptoms and physical findings after the
9 course of initial nonsurgical care and if the patient's
10 condition prevents the resumption of the regular activities of
11 daily life including regular vocational activities.

12 (2) They are not indicated in the following
13 circumstances:

14 (a) to verify progress during initial
15 nonsurgical treatment; or

16 (b) to evaluate a successful initial
17 nonsurgical treatment program.

18 L. Oblique X-rays of the lumbosacral spine are
19 limited by subitems (1) and (2).

20 (1) They are indicated in the following
21 circumstances:

22 (a) to follow up abnormalities detected on
23 anterior-posterior or lateral X-ray;

24 (b) for postoperative follow-up of lumbar
25 fusion surgery; or

26 (c) to follow up spondylolysis or
27 spondylolisthesis not adequately diagnosed by other indicated
28 imaging procedures.

29 (2) They are not indicated as part of a package
30 of X-rays including anterior-posterior and lateral X-rays of the
31 lumbosacral spine.

32 M. Electronic X-ray analysis of plain radiographs and
33 diagnostic ultrasound of the lumbar spine are not indicated for
34 diagnosis of any of the low back conditions in part 5221.6200,
35 subpart 1, item A.

1 5221.6200 LOW BACK PAIN.

2 Subpart 1. Diagnostic procedures for treatment of low back
3 injury. A health care provider shall determine the nature of
4 the condition before initiating treatment.

5 A. An appropriate history and physical examination
6 must be performed and documented. Based on the history and
7 physical examination the health care provider must assign the
8 patient at each visit to the appropriate clinical category
9 according to subitems (1) to (4). The diagnosis must be
10 documented in the medical record. For the purposes of subitems
11 (2) and (3), "radicular pain" means pain radiating distal to the
12 knee, or pain conforming to a dermatomal distribution and
13 accompanied by anatomically congruent motor weakness or reflex
14 changes. This part does not apply to fractures of the lumbar
15 spine, or back pain due to an infectious, immunologic,
16 metabolic, endocrine, neurologic, visceral, or neoplastic
17 disease process.

18 (1) Regional low back pain, includes referred
19 pain to the leg above the knee unless it conforms to an L2, L3,
20 or L4 dermatomal distribution and is accompanied by anatomically
21 congruent motor weakness or reflex changes. Regional low back
22 pain includes the diagnoses of lumbar, lumbosacral, or
23 sacroiliac: strain, sprain, myofascial syndrome,
24 musculoligamentous injury, soft tissue injury, spondylosis, and
25 other diagnoses for pain believed to originate in the discs,
26 ligaments, muscles, or other soft tissues of the lumbar spine or
27 sacroiliac joints and which effects the lumbosacral region, with
28 or without referral to the buttocks and/or leg above the knee,
29 including, but not limited to, ICD-9-CM codes 720 to 720.9, 721,
30 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51,
31 722.52, 722.6, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6,
32 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4,
33 756.1 to 756.19, 847.2 to 847.9, 922.3, 926.1, 926.11, and
34 926.12.

35 (2) Radicular pain, with or without regional low
36 back pain, with static or no neurologic deficit. This includes

1 the diagnoses of sciatica; lumbar or lumbosacral radiculopathy,
2 radiculitis or neuritis; displacement or herniation of
3 intervertebral disc with myelopathy, radiculopathy, radiculitis
4 or neuritis; spinal stenosis with myelopathy, radiculopathy,
5 radiculitis or neuritis; and any other diagnoses for pain in the
6 leg below the knee believed to originate with irritation of a
7 nerve root in the lumbar spine, including, but not limited to,
8 the ICD-9-CM codes 721.4, 721.42, 721.91, 722.1, 722.10, 722.2,
9 722.7, 722.73, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and
10 724.9. In these cases, neurologic findings on history and
11 physical examination are either absent or do not show
12 progressive deterioration.

13 (3) Radicular pain, with or without regional low
14 back pain, with progressive neurologic deficit. This includes
15 the same diagnoses as subitem (2), however, this category
16 applies when there is a history of progressive deterioration in
17 the neurologic symptoms and physical findings which include
18 worsening sensory loss, increasing muscle weakness, or
19 progressive reflex changes.

20 (4) Cauda equina syndrome, which is a syndrome
21 characterized by anesthesia in the buttocks, genitalia, or thigh
22 and accompanied by disturbed bowel and bladder function,
23 ICD-9-CM codes 344.6, 344.60, and 344.61.

24 B. Laboratory tests are not indicated in the
25 evaluation of a patient with regional low back pain, radicular
26 pain, or cauda equina syndrome, except in any of the following
27 circumstances:

28 (1) when a patient's history, age, or examination
29 suggests infection, metabolic-endocrinologic disorders, tumorous
30 conditions, systemic musculoskeletal disorders, such as
31 rheumatoid arthritis or ankylosing spondylitis;

32 (2) to evaluate potential adverse side effects of
33 medications; or

34 (3) as part of a preoperative evaluation.

35 Laboratory tests may be ordered at any time the health care
36 provider suspects any of these conditions, but the health care

1 provider must justify the need for the tests ordered with clear
2 documentation of the indications.

3 C. Medical imaging evaluation of the lumbosacral
4 spine must be based on the findings of the history and physical
5 examination and cannot be ordered before the health care
6 provider's clinical evaluation of the patient. Medical imaging
7 may not be performed as a routine procedure and must comply with
8 all of the standards in part 5221.6100, subparts 1 and 2. The
9 health care provider must document the appropriate indications
10 for any medical imaging studies obtained.

11 D. EMG and nerve conduction studies are always
12 inappropriate for regional low back pain as defined in item A,
13 subitem (1). EMG and nerve conduction studies may be an
14 appropriate diagnostic tool for radicular pain and cauda equina
15 syndrome as defined in item A, subitems (2) to (4), after the
16 first three weeks of radicular symptoms. Repeat EMG and nerve
17 conduction studies for radicular pain and cauda equina syndrome
18 are not indicated unless a new neurologic symptom or finding has
19 developed which in itself would warrant electrodiagnostic
20 testing. Failure to improve with treatment is not an indication
21 for repeat testing.

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

25 (1) surface electromyography or surface
26 paraspinal electromyography;

27 (2) thermography;

28 (3) plethysmography;

29 (4) electronic X-ray analysis of plain
30 radiographs;

31 (5) diagnostic ultrasound of the lumbar spine; or

32 (6) somatosensory evoked potentials (SSEP) and
33 motor evoked potentials (MEP).

34 F. Computerized range of motion or strength measuring
35 tests are not indicated during the period of initial nonsurgical
36 management, but may be indicated during the period of chronic

1 management when used in conjunction with a computerized exercise
2 program, work hardening program, or work conditioning program.
3 During the period of initial nonsurgical management,
4 computerized range of motion or strength testing may be
5 performed but must be done in conjunction with and shall not be
6 reimbursed separately from an office visit with a physician,
7 chiropractic evaluation or treatment, or physical or
8 occupational therapy evaluation or treatment.

9 G. Personality or psychosocial evaluations may be
10 indicated for evaluating patients who continue to have problems
11 despite appropriate care. The treating health care provider may
12 perform this evaluation or may refer the patient for
13 consultation with another health care provider in order to
14 obtain a psychological evaluation. These evaluations may be
15 used to assess the patient for a number of psychological
16 conditions which may interfere with recovery from the injury.
17 Since more than one of these psychological conditions may be
18 present in a given case, the health care provider performing the
19 evaluation must consider all of the following:

- 20 (1) Is symptom magnification occurring?
21 (2) Does the patient exhibit an emotional
22 reaction to the injury, such as depression, fear, or anger,
23 which is interfering with recovery?
24 (3) Are there other personality factors or
25 disorders which are interfering with recovery?
26 (4) Is the patient chemically dependent?
27 (5) Are there any interpersonal conflicts
28 interfering with recovery?
29 (6) Does the patient have a chronic pain syndrome
30 or psychogenic pain?
31 (7) In cases in which surgery is a possible
32 treatment, are psychological factors likely to interfere with
33 the potential benefit of the surgery?

34 H. Diagnostic analgesic blocks or injection studies
35 include facet joint injection, facet nerve injection, epidural
36 differential spinal block, nerve block, and nerve root block.

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

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

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

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

14 I. Functional capacity assessment or evaluation is a
15 comprehensive and objective assessment of a patient's ability to
16 perform work tasks. The components of a functional capacity
17 assessment or evaluation include, but are not limited to,
18 neuromusculoskeletal screening, tests of manual material
19 handling, assessment of functional mobility, and measurement of
20 postural tolerance. A functional capacity assessment or
21 evaluation is an individualized testing process and the
22 component tests and measurements are determined by the patient's
23 condition and the requested information. Functional capacity
24 assessments and evaluations are performed to determine and
25 report a patient's physical capacities in general or to
26 determine work tolerance for a specific job, task, or work
27 activity.

28 (1) Functional capacity assessment or evaluation
29 is not indicated during the period of initial nonsurgical
30 management.

31 (2) After the period of initial nonsurgical
32 management functional capacity assessment or evaluation is
33 indicated in either of the following circumstances:

34 (a) activity restrictions and capabilities
35 must be identified; or

36 (b) there is a question about the patient's

1 ability to do a specific job.

2 (3) A functional capacity evaluation is not
3 appropriate to establish baseline performance before treatment,
4 or for subsequent assessments, to evaluate change during or
5 after treatment.

6 (4) Only one completed functional capacity
7 evaluation is indicated per injury.

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

11 Subp. 2. General treatment parameters for low back pain.

12 A. All medical care for low back pain, appropriately
13 assigned to a clinical category in subpart 1, item A, is
14 determined by the clinical category to which the patient has
15 been assigned. General parameters for treatment modalities are
16 set forth in subparts 3 to 10. Specific treatment parameters
17 for each clinical category are set forth in subparts 11 to 13,
18 as follows:

19 (1) subpart 11 governs regional low back pain;

20 (2) subpart 12 governs radicular pain with no or
21 static neurologic deficits; and

22 (3) subpart 13 governs cauda equina syndrome and
23 radicular pain with progressive neurologic deficits.

24 The health care provider must, at each visit, reassess the
25 appropriateness of the clinical category assigned and reassign
26 the patient if warranted by new clinical information including
27 symptoms, signs, results of diagnostic testing, and opinions and
28 information obtained from consultations with other health care
29 providers. When the clinical category is changed, the treatment
30 plan must be appropriately modified to reflect the new clinical
31 category. However, a change of clinical category does not in
32 itself allow the health care provider to continue a therapy or
33 treatment modality past the maximum duration specified in
34 subparts 3 to 10, or to repeat a therapy or treatment previously
35 provided for the same injury.

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

1 three phases.

2 (1) First, all patients with low back problems,
3 except patients with progressive neurologic deficit or cauda
4 equina syndrome under subpart 1, item A, subitems (3) and (4),
5 must be given initial nonsurgical management which may include
6 active treatment modalities, passive treatment modalities,
7 injections, durable medical equipment, and medications. These
8 modalities and parameters are described in subparts 3, 4, 5, 8,
9 and 10. The period of initial nonsurgical treatment begins with
10 the first active, passive, medication, durable medical
11 equipment, or injection modality initiated. Initial nonsurgical
12 treatment must result in progressive improvement as specified in
13 subpart 9.

14 (2) Second, for patients with persistent
15 symptoms, initial nonsurgical management is followed by a period
16 of surgical evaluation. This evaluation should be completed in
17 a timely manner. Surgery, if indicated, should be performed as
18 expeditiously as possible consistent with sound medical practice
19 and subparts 6 and 11 to 13, and part 5221.6500. The treating
20 health care provider may do the evaluation, if it is within the
21 provider's scope of practice, or may refer the employee to a
22 consultant.

23 (a) Patients with radicular pain with
24 progressive neurological deficit, or cauda equina syndrome may
25 require immediate surgical therapy.

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

31 (c) Surgery must follow the parameters in
32 subparts 6 and 11 to 13, and part 5221.6500.

33 (d) A decision against surgery at this time
34 does not preclude a decision for surgery made at a later date.

35 (3) Third, for those patients who are not
36 candidates for or refuse surgical therapy, or who do not have

1 complete resolution of their symptoms with surgery, a period of
2 chronic management may be indicated. Chronic management
3 modalities are described in part 5221.6600, and may include
4 durable medical equipment as described in subpart 8.

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

8 Subp. 3. **Passive treatment modalities.**

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

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

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

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

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

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

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

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

35 (2) Except as otherwise provided in part
36 5221.6050, subpart 8, treatment may continue beyond the

1 additional 12 visits only after prior approval by the insurer,
2 commissioner, or compensation judge based on documentation in
3 the medical record of the effectiveness of further passive
4 treatment in maintaining employability; if the employee is
5 permanently totally disabled, or if upon retirement the employee
6 is eligible for ongoing medical benefits for the work injury,
7 treatment may continue beyond the additional 12 visits only
8 after prior approval by the insurer, commissioner, or
9 compensation judge based on documentation in the medical record
10 of the effectiveness of further passive treatment in maintaining
11 functional status.

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

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

16 (2) maximum treatment frequency, up to five times
17 per week for the first one to two weeks decreasing in frequency
18 thereafter; and

19 (3) maximum treatment duration, 12 weeks.

20 D. Thermal treatment includes all superficial and
21 deep heating and cooling modalities. Superficial thermal
22 modalities include hot packs, hot soaks, hot water bottles,
23 hydrocollators, heating pads, ice packs, cold soaks, infrared,
24 whirlpool, and fluidotherapy. Deep thermal modalities include
25 diathermy, ultrasound, and microwave.

26 (1) Treatment given in a clinical setting:

27 (a) time for treatment response, two to four
28 treatments;

29 (b) maximum treatment frequency, up to five
30 times per week for the first one to three weeks decreasing in
31 frequency thereafter; and

32 (c) maximum treatment duration, 12 weeks of
33 treatment in a clinical setting but only if given in conjunction
34 with other therapies.

35 (2) Home use of thermal modalities may be
36 prescribed at any time during the course of treatment. Home use

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

7 E. Electrical muscle stimulation includes galvanic
8 stimulation, TENS, interferential, and microcurrent techniques.

9 (1) Treatment given in a clinical setting:

10 (a) time for treatment response, two to four
11 treatments;

12 (b) maximum treatment frequency, up to five
13 times per week for the first one to three weeks decreasing in
14 frequency thereafter; and

15 (c) maximum treatment duration, 12 weeks of
16 treatment in a clinical setting but only if given in conjunction
17 with other therapies.

18 (2) Home use of an electrical stimulation device
19 may be prescribed at any time during a course of treatment.
20 Initial use of an electrical stimulation device must be in a
21 supervised setting in order to ensure proper electrode placement
22 and patient education:

23 (a) time for patient education and training,
24 one to three sessions; and

25 (b) patient may use the electrical
26 stimulation device for one month, at which time effectiveness of
27 the treatment must be reevaluated by the health care provider
28 before continuing home use of the device.

29 F. Mechanical traction:

30 (1) Treatment given in a clinical setting:

31 (a) time for treatment response, three
32 treatments;

33 (b) maximum treatment frequency, up to three
34 times per week for the first one to three weeks decreasing in
35 frequency thereafter; and

36 (c) maximum treatment duration, 12 weeks in

1 a clinical setting but only if used in conjunction with other
2 therapies.

3 (2) Home use of a mechanical traction device may
4 be prescribed as follow-up to use of traction in a clinical
5 setting if it has proven to be effective treatment and is
6 expected to continue to be effective treatment. Initial use of
7 a mechanical traction device must be in a supervised setting in
8 order to ensure proper patient education:

9 (a) time for patient education and training,
10 one session; and

11 (b) patient may use the mechanical traction
12 device for one month, at which time effectiveness of the
13 treatment must be reevaluated by the health care provider before
14 continuing home use of the device.

15 G. Acupuncture treatments. Endorphin-mediated
16 analgesic therapy includes classic acupuncture and acupressure:

17 (1) time for treatment response, three to five
18 sessions;

19 (2) maximum treatment frequency, up to three
20 times per week for one to three weeks decreasing in frequency
21 thereafter; and

22 (3) maximum treatment duration, 12 weeks.

23 H. Manual therapy includes soft tissue and joint
24 mobilization, therapeutic massage, and manual traction:

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

27 (2) maximum treatment frequency, up to five times
28 per week for the first one to two weeks decreasing in frequency
29 thereafter; and

30 (3) maximum treatment duration, 12 weeks.

31 I. Phoresis includes iontophoresis and phonophoresis:

32 (1) time for treatment response, three to five
33 sessions;

34 (2) maximum treatment frequency, up to three
35 times per week for the first one to three weeks decreasing in
36 frequency thereafter; and

1 (3) maximum treatment is nine sessions of either
2 iontophoresis or phonophoresis, or combination, to any one site,
3 with a maximum duration of 12 weeks for all treatment.

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

7 K. Spinal braces and other movement-restricting
8 appliances. Bracing required for longer than two weeks must be
9 accompanied by active muscle strengthening exercise to avoid
10 deconditioning and prolonged disability:

11 (1) time for treatment response, three days;

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

15 (3) maximum continuous duration, three weeks
16 unless patient is status postfusion.

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

22 A. Education must teach the patient about pertinent
23 anatomy and physiology as it relates to spinal function for the
24 purpose of injury prevention. Education includes training on
25 posture, biomechanics, and relaxation. The maximum number of
26 treatments is three visits, which includes an initial education
27 and training session, and two follow-up visits.

28 B. Posture and work method training must instruct the
29 patient in the proper performance of job activities. Topics
30 include proper positioning of the trunk, neck, and arms, use of
31 optimum biomechanics in performing job tasks, and appropriate
32 pacing of activities. Methods include didactic sessions,
33 demonstrations, exercises, and simulated work tasks. The
34 maximum number of treatments is three visits.

35 C. Worksite analysis and modification must examine
36 the patient's work station, tools, and job duties.

1 Recommendations are made for the alteration of the work station,
2 selection of alternate tools, modification of job duties, and
3 provision of adaptive equipment. The maximum number of
4 treatments is three visits.

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

14 Exercises must be evaluated to determine if the desired
15 goals are being attained. Strength, flexibility, and endurance
16 must be objectively measured. While the provider may
17 objectively measure the treatment response as often as necessary
18 for optimal care, after the initial evaluation the health care
19 provider may not bill for the tests sooner than two weeks after
20 the initial evaluation and monthly thereafter.

21 Subitems (1) and (2) govern supervised and unsupervised
22 exercise, except for computerized exercise programs and health
23 clubs, which are governed by part 5221.6600.

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

28 (a) maximum treatment frequency, three times
29 per week for three weeks, and should decrease in frequency
30 thereafter; and

31 (b) maximum duration, 12 weeks.

32 (2) Unsupervised exercise must be provided in the
33 least intensive setting appropriate to the goals of the exercise
34 program, and may supplement or follow the period of supervised
35 exercise:

36 (a) maximum treatment frequency, up to three

1 visits for instruction and monitoring; and

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

4 Subp. 5. **Therapeutic injections.** Injection modalities are
5 indicated as set forth in items A to C. Use of injections can
6 extend past the 12-week limit on passive treatment modalities so
7 long as the maximum treatment for injections is not exceeded.

8 A. Therapeutic injections, including injections of
9 trigger points, facet joints, facet nerves, sacroiliac joints,
10 sympathetic nerves, epidurals, nerve roots, and peripheral
11 nerves. Therapeutic injections can only be given in conjunction
12 with active treatment modalities directed to the same anatomical
13 site.

14 (1) Trigger point injections:

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

17 (b) maximum treatment frequency, once per
18 week to any one site if a positive response to the first
19 injection at that site. If subsequent injections at that site
20 demonstrate diminishing control of symptoms or fail to
21 facilitate objective functional gains, then trigger point
22 injections should be redirected to other areas or discontinued.
23 No more than three injections to different sites are
24 reimbursable per patient visit; and

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

27 (2) Sacroiliac joint injections:

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

30 (b) maximum treatment frequency, can repeat
31 injection two weeks after the previous injection if a positive
32 response to the first injection. Only two injections are
33 reimbursable per patient visit; and

34 (c) maximum treatment, two injections to any
35 one site.

36 (3) Facet joint or nerve injections:

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

3 (b) maximum treatment frequency, once every
4 two weeks to any one site if a positive response to the first
5 injection. If subsequent injections demonstrate diminishing
6 control of symptoms or fail to facilitate objective functional
7 gains, then injections should be discontinued. No more than
8 three injections to different sites are reimbursable per patient
9 visit; and

10 (c) maximum treatment, three injections to
11 any one site.

12 (4) Nerve root blocks:

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

15 (b) maximum treatment frequency, can repeat
16 injection two weeks after the previous injection if a positive
17 response to the first injection. Only three injections to
18 different sites are reimbursable per patient visit; and

19 (c) maximum treatment, two injections to any
20 one site.

21 (5) Epidural injections:

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

24 (b) maximum treatment frequency, once every
25 two weeks if a positive response to the first injection. If
26 subsequent injections demonstrate diminishing control of
27 symptoms or fail to facilitate objective functional gains, then
28 injections should be discontinued. Only one injection is
29 reimbursable per patient visit; and

30 (c) maximum treatment, three injections.

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

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

36 (2) maximum treatment frequency, may repeat once

1 for any site; and

2 (3) maximum duration, two injections to any one
3 site.

4 C. Prolotherapy and botulinum toxin injections are
5 not indicated in the treatment of low back problems and are not
6 reimbursable.

7 Subp. 6. **Surgery, including decompression procedures and**
8 **arthrodesis.** Surgery may only be performed if it also meets the
9 specific parameters specified in subparts 11 to 13 and part
10 5221.6500. The health care provider must provide prior
11 notification of nonemergency inpatient surgery according to part
12 5221.6050, subpart 9.

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

21 (1) eight weeks following lumbar decompression or
22 implantation of a dorsal column stimulator or morphine pump; or

23 (2) 12 weeks following arthrodesis.

24 B. Repeat surgery must also meet the parameters of
25 subparts 11 to 13 and part 5221.6500, and is not indicated
26 unless the need for the repeat surgery is confirmed by a second
27 opinion obtained before surgery, if a second opinion is
28 requested by the insurer.

29 C. The following surgical therapies have very limited
30 application and require a second opinion that confirms that the
31 treatment is indicated and within the parameters listed, and a
32 personality or psychosocial evaluation that indicates that the
33 patient is likely to benefit from the treatment.

34 (1) Dorsal column stimulator is indicated for a
35 patient who has neuropathic pain, and is not a candidate for any
36 other surgical therapy, and has had a favorable response to a

1 trial screening period.

2 (2) Morphine pump is indicated for a patient who
3 has somatic pain, and is not a candidate for any other surgical
4 therapy, and has had a favorable response to a trial screening
5 period.

6 Subp. 7. **Chronic management.** Chronic management of low
7 back pain must be provided according to the parameters of part
8 5221.6600.

9 Subp. 8. **Durable medical equipment.** Durable medical
10 equipment is indicated only in the situations specified in items
11 A to D. The health care provider must provide prior
12 notification as required in items B and C according to part
13 5221.6050, subpart 9.

14 A. Lumbar braces, corsets, or supports are indicated
15 as specified in subpart 3, item K.

16 B. For patients using electrical stimulation or
17 mechanical traction devices at home, the device and any required
18 supplies are indicated within the parameters of subpart 3, items
19 E and F. Prior notification must be provided to the insurer for
20 purchase of the device or for use longer than one month. The
21 insurer may provide equipment if it is comparable to that
22 prescribed by the health care provider.

23 C. Exercise equipment for home use, including
24 bicycles, treadmills, and stairclimbers, are indicated only
25 within the context of a program or plan of an approved chronic
26 management program. This equipment is not indicated during
27 initial nonsurgical care or during reevaluation and surgical
28 therapy. Prior notification must be provided to the insurer for
29 the purchase of home exercise equipment. The insurer may decide
30 which brand of a prescribed type of exercise equipment is
31 provided to the patient. If the employer has an appropriate
32 exercise facility on its premises with the prescribed equipment,
33 the insurer may mandate use of that facility instead of
34 authorizing purchase of the equipment for home use.

35 (1) Indications: the patient is deconditioned
36 and requires reconditioning which can be accomplished only with

1 the use of the prescribed exercise equipment. The health care
2 provider must document specific reasons why the exercise
3 equipment is necessary and cannot be replaced with other
4 activities.

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

8 D. The following durable medical equipment is not
9 indicated for home use for low back conditions:

10 (1) whirlpools, Jacuzzi, hot tubs, and special
11 bath or shower attachments; or

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

14 Subp. 9. Evaluation of treatment by health care provider.

15 The health care provider must evaluate at each visit whether the
16 treatment is medically necessary, and must evaluate whether
17 initial nonsurgical treatment is effective according to items A
18 to C. No later than the time for treatment response established
19 for the specific modality as specified in subparts 3, 4, and 5,
20 the health care provider must evaluate whether the passive,
21 active, injection, or medication treatment modality is resulting
22 in progressive improvement as specified in items A to C:

23 A. the employee's subjective complaints of pain or
24 disability are progressively improving, as evidenced by
25 documentation in the medical record of decreased distribution,
26 frequency, or intensity of symptoms;

27 B. the objective clinical findings are progressively
28 improving, as evidenced by documentation in the medical record
29 of resolution or objectively measured improvement in physical
30 signs of the injury; and

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

35 If there is not progressive improvement in at least two
36 items of items A to C, the modality must be discontinued or

1 significantly modified, or the provider must reconsider the
2 diagnosis. The evaluation of the effectiveness of the treatment
3 modality can be delegated to an allied health professional
4 directly providing the treatment, but remains the ultimate
5 responsibility of the treating health care provider.

6 Subp. 10. Scheduled and nonscheduled medication.

7 Prescription of controlled substance medications scheduled under
8 Minnesota Statutes, section 152.02, including without
9 limitation, narcotics, is indicated only for the treatment of
10 severe acute pain. These medications are not indicated in the
11 treatment of patients with regional low back pain after the
12 first two weeks.

13 Patients with radicular pain may require longer periods of
14 treatment.

15 The health care provider must document the rationale for
16 the use of any scheduled medication. Treatment with
17 nonscheduled medication may be appropriate during any phase of
18 treatment and intermittently after all other treatment has been
19 discontinued. The prescribing health care provider must
20 determine that ongoing medication is effective treatment for the
21 patient's condition and that the most cost-effective regimen is
22 used.

23 Subp. 11. Specific treatment parameters for regional low
24 back pain.

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

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

34 (2) The only therapeutic injections indicated for
35 patients with regional back pain are trigger point injections,
36 facet joint injections, facet nerve injections, sacroiliac joint

1 injections, and epidural blocks, and their use must meet the
2 parameters of subpart 5.

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

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

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

14 B. Surgical evaluation or chronic management is
15 indicated if the patient continues with symptoms and physical
16 findings after the course of initial nonsurgical care, and if
17 the patient's condition prevents the resumption of the regular
18 activities of daily life including regular vocational activities.
19 The purpose of surgical evaluation is to determine whether
20 surgery is indicated in the treatment of a patient who has
21 failed to recover with initial nonsurgical care. If the patient
22 is not a surgical candidate, then chronic management is
23 indicated.

24 (1) Surgical evaluation, if indicated, may begin
25 as soon as eight weeks after, but must begin no later than 12
26 weeks after, beginning initial nonsurgical management. An
27 initial recommendation or decision against surgery does not
28 preclude surgery at a later date.

29 (2) Surgical evaluation may include the use of
30 appropriate medical imaging techniques. The imaging technique
31 must be chosen on the basis of the suspected etiology of the
32 patient's condition but the health care provider must follow the
33 parameters of part 5221.6100. Medical imaging studies which do
34 not meet these parameters are not indicated.

35 (3) Surgical evaluation may also include
36 diagnostic blocks and injections. These blocks and injections

1 are only indicated if their use is consistent with the
2 parameters of subpart 1, item H.

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

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

12 (6) The only surgical procedures indicated for
13 patients with regional low back pain only are decompression of a
14 lumbar nerve root or lumbar arthrodesis, with or without
15 instrumentation, which must meet the parameters of subpart 6 and
16 part 5221.6500, subpart 2, items A and C. For patients with
17 failed back surgery, dorsal column stimulators or morphine pumps
18 may be indicated; their use must meet the parameters of subpart
19 6, item C.

20 (a) If surgery is indicated, it should be
21 offered to the patient as soon as possible. If the patient
22 agrees to the proposed surgery, it should be performed as
23 expeditiously as possible consistent with sound medical
24 practice, and consistent with any requirements of part
25 5221.6050, subpart 9, for prior notification of the insurer or
26 second opinions.

27 (b) If surgery is not indicated, or if the
28 patient does not wish to proceed with surgery, then the patient
29 is a candidate for chronic management according to the
30 parameters of part 5221.6600.

31 C. If the patient continues with symptoms and
32 objective physical findings after surgical therapy has been
33 rendered or the patient refuses surgical therapy or the patient
34 was not a candidate for surgical therapy, and if the patient's
35 condition prevents the resumption of the regular activities of
36 daily life including regular vocational activities, then the

1 patient may be a candidate for chronic management which must be
2 provided according to the parameters of part 5221.6600.

3 Subp. 12. Specific treatment parameters for radicular
4 pain, with or without regional low back pain, with no or static
5 neurologic deficits.

6 A. Initial nonsurgical treatment is appropriate for
7 all patients with radicular pain, with or without regional low
8 back pain, with no or static neurologic deficits under subpart
9 1, item A, subitem (2), and must be the first phase of
10 treatment. It must be provided within the parameters of subpart
11 11, item A, with the following modifications: epidural blocks,
12 and nerve root and peripheral nerve blocks are the only
13 therapeutic injections indicated for patients with radicular
14 pain only. If there is a component of regional low back pain,
15 therapeutic facet joint injections, facet nerve injections,
16 trigger point injections, and sacroiliac injections may also be
17 indicated.

18 B. Surgical evaluation or chronic management is
19 indicated if the patient continues with symptoms and physical
20 findings after the course of initial nonsurgical care, and if
21 the patient's condition prevents the resumption of the regular
22 activities of daily life including regular vocational activities.
23 It must be provided within the parameters of subpart 11, item B.

24 C. If the patient continues with symptoms and
25 objective physical findings after surgical therapy has been
26 rendered, the patient refused surgical therapy, or the patient
27 was not a candidate for surgical therapy, and if the patient's
28 condition prevents the resumption of the regular activities of
29 daily life including regular vocational activities, then the
30 patient may be a candidate for chronic management. Any course
31 or program of chronic management for patients with radicular
32 pain, with or without regional back pain, with static neurologic
33 deficits must meet all of the parameters of part 5221.6600.

34 Subp. 13. Specific treatment parameters for cauda equina
35 syndrome and for radicular pain, with or without regional low
36 back pain, with progressive neurologic deficits.

1 A. Patients with cauda equina syndrome or with
2 radicular pain, with or without regional low back pain, with
3 progressive neurologic deficits may require immediate or
4 emergency surgical evaluation at any time during the course of
5 the overall treatment. The decision to proceed with surgical
6 evaluation is made by the health care provider based on the type
7 of neurologic changes observed, the severity of the changes, the
8 rate of progression of the changes, and the response to any
9 initial nonsurgical treatments. Surgery, if indicated, may be
10 performed at any time during the course of treatment. Surgical
11 evaluation and surgery shall be provided within the parameters
12 of subpart 11, item B, except that surgical evaluation and
13 surgical therapy may begin at any time.

14 B. If the health care provider decides to proceed
15 with a course of initial nonsurgical care for a patient with
16 radicular pain with progressive neurologic changes, it must
17 follow the parameters of subpart 12, item A.

18 C. If the patient continues with symptoms and
19 objective physical findings after surgical therapy has been
20 rendered or the patient refuses surgical therapy or the patient
21 was not a candidate for surgical therapy, and if the patient's
22 condition prevents the resumption of the regular activities of
23 daily life including regular vocational activities, then the
24 patient may be a candidate for chronic management. Any course
25 or program of chronic management for patients with radicular
26 pain, with or without regional back pain, with foot drop or
27 progressive neurologic changes at first presentation must meet
28 the parameters of part 5221.6600.

29 5221.6205 NECK PAIN.

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

33 A. An appropriate history and physical examination
34 must be performed and documented. Based on the history and
35 physical examination the health care provider must assign the

1 patient at each visit to the appropriate clinical category
2 according to subitems (1) to (4). The diagnosis must be
3 documented in the medical record. For the purposes of subitems
4 (2) and (3), "radicular pain" means pain radiating distal to the
5 shoulder. This part does not apply to fractures of the cervical
6 spine or cervical pain due to an infectious, immunologic,
7 metabolic, endocrine, neurologic, visceral, or neoplastic
8 disease process.

9 (1) Regional neck pain includes referred pain to
10 the shoulder and upper back. Regional neck pain includes the
11 diagnoses of cervical strain, sprain, myofascial syndrome,
12 musculoligamentous injury, soft tissue injury, and other
13 diagnoses for pain believed to originate in the discs,
14 ligaments, muscles, or other soft tissues of the cervical spine
15 and which affects the cervical region, with or without referral
16 to the upper back or shoulder, including, but not limited to,
17 ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to 721.90,
18 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to 723.3,
19 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9, 738.4,
20 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3, 925,
21 and 926.1 to 926.12.

22 (2) Radicular pain, with or without regional neck
23 pain, with no or static neurologic deficit. This includes the
24 diagnoses of brachialgia; cervical radiculopathy, radiculitis,
25 or neuritis; displacement or herniation of intervertebral disc
26 with radiculopathy, radiculitis, or neuritis; spinal stenosis
27 with radiculopathy, radiculitis, or neuritis; and other
28 diagnoses for pain in the arm distal to the shoulder believed to
29 originate with irritation of a nerve root in the cervical spine,
30 including, but not limited to, the ICD-9-CM codes 721.1, 721.91,
31 722 to 722.0, 722.2, 722.7 to 722.71, 723.4, and 724 to 724.00.
32 In these cases neurologic findings on history and examination
33 are either absent or do not show progressive deterioration.

34 (3) Radicular pain, with or without regional neck
35 pain, with progressive neurologic deficit, which includes the
36 same diagnoses as subitem (2); however, in these cases there is

1 a history of progressive deterioration in the neurologic
2 symptoms and physical findings, including worsening sensory
3 loss, increasing muscle weakness, and progressive reflex changes.

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

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

13 (1) when a patient's history, age, or examination
14 suggests infection, metabolic-endocrinologic disorders, tumorous
15 conditions, systemic musculoskeletal disorders, such as
16 rheumatoid arthritis or ankylosing spondylitis;

17 (2) to evaluate potential adverse side effects of
18 medications; or

19 (3) as part of a preoperative evaluation.

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

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

32 D. EMG and nerve conduction studies are always
33 inappropriate for the regional neck pain diagnoses in item A,
34 subitem (1). EMG and nerve conduction studies may be an
35 appropriate diagnostic tool for radicular pain and myelopathy
36 diagnoses in item A, subitems (2) to (4), after the first three

1 weeks of radicular or myelopathy symptoms. Repeat EMG and nerve
2 conduction studies for radicular pain and myelopathy are not
3 indicated unless a new neurologic symptom or finding has
4 developed which in itself would warrant electrodiagnostic
5 testing. Failure to improve with treatment is not an indication
6 for repeat testing.

7 E. The use of the following procedures or tests ~~shall~~
8 ~~not-be-reimbursed~~ is not indicated for the diagnosis of any of
9 the clinical categories in item A:

10 (1) surface electromyography or surface
11 paraspinal electromyography;

12 (2) thermography;

13 (3) plethysmography;

14 (4) electronic X-ray analysis of plain
15 radiographs;

16 (5) diagnostic ultrasound of the spine; or

17 (6) somatosensory evoked potentials (SSEP) and
18 motor evoked potentials (MEP).

19 F. Computerized range of motion or strength measuring
20 tests are not indicated during the period of initial nonsurgical
21 management, but may be indicated during the period of chronic
22 management when used in conjunction with a computerized exercise
23 program, work hardening program, or work conditioning program.
24 During the period of initial nonsurgical management,
25 computerized range of motion or strength testing can be
26 performed but must be done in conjunction with and shall not be
27 reimbursed separately from an office visit, chiropractic
28 evaluation or treatment, or physical or occupational therapy
29 evaluation or treatment.

30 G. Personality or psychological evaluations may be a
31 useful tool for evaluating patients who continue to have
32 problems despite appropriate care. The treating health care
33 provider may perform this evaluation or may refer the patient
34 for consultation with another health care provider in order to
35 obtain a psychological evaluation. These evaluations may be
36 used to assess the patient for a number of psychological

1 conditions which may interfere with recovery from the injury.
2 Since more than one of these psychological conditions may be
3 present in a given case, the health care provider performing the
4 evaluation must consider all of the following:

5 (1) Is symptom magnification occurring?

6 (2) Does the patient exhibit an emotional
7 reaction to the injury, such as depression, fear, or anger,
8 which is interfering with recovery?

9 (3) Are there other personality factors or
10 disorders which are interfering with recovery?

11 (4) Is the patient chemically dependent?

12 (5) Are there any interpersonal conflicts
13 interfering with recovery?

14 (6) Does the patient have a chronic pain syndrome
15 or psychogenic pain?

16 (7) In cases in which surgery is a possible
17 treatment, are psychological factors, such as those in subitems
18 (1) to (6), likely to interfere with the potential benefit of
19 the surgery?

20 H. Diagnostic analgesic blocks or injection studies
21 include facet joint injection, facet nerve block, epidural
22 differential spinal block, nerve block, and nerve root block.

23 (1) These procedures are used to localize the
24 source of pain prior to surgery and to diagnose conditions which
25 fail to respond to initial nonsurgical management.

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

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

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

1 I. Functional capacity assessment or evaluation is a
2 comprehensive and objective assessment of a patient's ability to
3 perform work tasks. The components of a functional capacity
4 assessment or evaluation include, but are not necessarily
5 limited to, neuromusculoskeletal screening, tests of manual
6 material handling, assessment of functional mobility, and
7 measurement of postural tolerance. A functional capacity
8 assessment or evaluation is an individualized testing process
9 and the component tests and measurements are determined by the
10 patient's condition and the requested information. Functional
11 capacity assessments and evaluations are performed to determine
12 a patient's physical capacities in general or to determine and
13 report work tolerance for a specific job, task, or work activity.

14 (1) Functional capacity assessment or evaluation
15 is not reimbursable during the period of initial nonoperative
16 care.

17 (2) Functional capacity assessment or evaluation
18 is reimbursable in either of the following circumstances:

19 (a) permanent activity restrictions and
20 capabilities must be identified; or

21 (b) there is a question about the patient's
22 ability to do a specific job.

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

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

27 A. All medical care for neck pain appropriately
28 assigned to a clinical category in subpart 1, item A, is
29 determined by the diagnosis and clinical category in subpart 1,
30 item A, to which the patient has been assigned. General
31 parameters for treatment modalities are set forth in subparts 3
32 to 10. Specific treatment parameters for each clinical category
33 are set forth in subparts 11 to 14, as follows:

34 (1) subpart 11 governs regional neck pain;

35 (2) subpart 12 governs radicular pain with static
36 neurologic deficits;

1 (3) subpart 13 governs radicular pain with
2 progressive neurologic deficits; and

3 (4) subpart 14 governs myelopathy.

4 The health care provider must, at each visit, reassess the
5 appropriateness of the clinical category assigned and reassign
6 the patient if warranted by new clinical information including
7 symptoms, signs, results of diagnostic testing, and opinions and
8 information obtained from consultations with other health care
9 providers. When the clinical category is changed the treatment
10 plan must be appropriately modified to reflect the new clinical
11 category. However, a change of clinical category does not in
12 itself allow the health care provider to continue a therapy or
13 treatment modality past the maximum duration specified in
14 subparts 3 to 10, or to repeat a therapy or treatment previously
15 provided for the same injury.

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

18 (1) First, all patients with neck problems,
19 except patients with radicular pain with progressive
20 neurological deficit, or myelopathy under subpart 1, item A,
21 subitems (3) and (4), must be given initial nonsurgical care
22 which may include both active and passive treatment modalities,
23 injections, durable medical equipment, and medications. These
24 modalities and parameters are described in subparts 3, 4, 5, 8,
25 and 10. The period of initial nonsurgical management begins
26 with the first passive, active, injection, durable medical
27 equipment, or medication modality initiated. Initial
28 nonsurgical treatment must result in progressive improvement as
29 specified in subpart 9.

30 (2) Second, for patients with persistent
31 symptoms, initial nonoperative care is followed by a period of
32 surgical evaluation. This evaluation should be completed in a
33 timely manner. Surgery, if indicated, should be performed as
34 expeditiously as possible consistent with sound medical
35 practice, and subparts 6 and 11 to 14, and part 5221.6500. The
36 treating health care provider may do the evaluation, if it is

1 within the provider's scope of practice, or may refer the
2 employee to a consultant.

3 (a) Patients with radicular pain with
4 progressive neurological deficit, or myelopathy may require
5 immediate surgical therapy.

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

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

12 (d) A decision against surgery at this time
13 does not preclude a decision for surgery made at a later date.

14 (3) Third, for those patients who are not
15 candidates for or refuse surgical therapy, or who do not have
16 complete resolution of their symptoms with surgery, a period of
17 chronic management may be indicated. Chronic management
18 modalities are described in part 5221.6600, and may include
19 durable medical equipment as described in subpart 8.

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

23 Subp. 3. **Passive treatment modalities.**

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

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

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

1 weeks of passive care;

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

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

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

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

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

14 (2) Except as otherwise provided in part
15 5221.6050, subpart 8, treatment may continue beyond the
16 additional 12 visits only after prior approval by the insurer,
17 commissioner, or compensation judge based on documentation in
18 the medical record of the effectiveness of further passive
19 treatment in maintaining employability; if the employee is
20 permanently totally disabled, or if upon retirement the employee
21 is eligible for ongoing medical benefits for the work injury,
22 treatment may continue beyond the additional 12 visits only
23 after prior approval by the insurer, commissioner, or
24 compensation judge based on documentation in the medical record
25 of the effectiveness of further passive treatment in maintaining
26 functional status.

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

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

31 (2) maximum treatment frequency, up to five times
32 per week for the first one to two weeks decreasing in frequency
33 thereafter; and

34 (3) maximum treatment duration, 12 weeks.

35 D. Thermal treatment includes all superficial and
36 deep heating modalities and cooling modalities. Superficial

1 thermal modalities include hot packs, hot soaks, hot water
2 bottles, hydrocollators, heating pads, ice packs, cold soaks,
3 infrared, whirlpool, and fluidotherapy. Deep thermal modalities
4 include diathermy, ultrasound, and microwave.

5 (1) Treatment given in a clinical setting:

6 (a) time for treatment response, two to four
7 treatments;

8 (b) maximum treatment frequency, up to five
9 times per week for the first one to three weeks decreasing in
10 frequency thereafter; and

11 (c) maximum treatment duration, 12 weeks of
12 treatment in a clinical setting, but only if given in
13 conjunction with other therapies.

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

22 E. Electrical muscle stimulation includes galvanic
23 stimulation, TENS, interferential, and microcurrent techniques.

24 (1) Treatment given in a clinical setting:

25 (a) time for treatment response, two to four
26 treatments;

27 (b) maximum treatment frequency, up to five
28 times per week for the first one to three weeks decreasing in
29 frequency thereafter; and

30 (c) maximum treatment duration, 12 weeks of
31 treatment in a clinical setting, but only if given in
32 conjunction with other therapies.

33 (3) Home use of an electrical stimulation device
34 may be prescribed at any time during a course of treatment.

35 Initial use of an electrical stimulation device must be in a
36 supervised setting in order to ensure proper electrode placement

1 and patient education:

2 (a) time for patient education and training,
3 one to three sessions; and

4 (b) patient may use the electrical
5 stimulation device for one month, at which time effectiveness of
6 the treatment must be reevaluated by the health care provider
7 before continuing home use of the device.

8 F. Mechanical traction:

9 (1) Treatment given in a clinical setting:

10 (a) time for treatment response, three
11 treatments;

12 (b) maximum treatment frequency, up to three
13 times per week for the first one to three weeks decreasing in
14 frequency thereafter; and

15 (c) maximum treatment duration, 12 weeks in
16 a clinical setting, but only if used in conjunction with other
17 therapies.

18 (2) Home use of a mechanical traction device may
19 be prescribed as follow-up to use of traction in a clinical
20 setting if it has proven to be effective treatment and is
21 expected to continue to be effective treatment. Initial use of
22 a mechanical traction device must be in a supervised setting in
23 order to ensure proper patient education:

24 (a) time for patient education and training,
25 one session; and

26 (b) a patient may use the mechanical
27 traction device for one month, at which time effectiveness of
28 the treatment must be reevaluated by the health care provider
29 before continuing home use of the device.

30 G. Acupuncture treatments. Endorphin-mediated
31 analgesic therapy includes classic acupuncture and acupressure:

32 (1) time for treatment response, three to five
33 sessions;

34 (2) maximum treatment frequency, up to three
35 times per week for one to three weeks decreasing in frequency
36 thereafter; and

1 (3) maximum treatment duration, 12 weeks.

2 H. Manual therapy includes soft tissue and joint
3 mobilization, therapeutic massage, and manual traction:

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

6 (2) maximum treatment frequency, up to five times
7 per week for the first one to two weeks decreasing in frequency
8 thereafter; and

9 (3) maximum treatment duration, 12 weeks.

10 I. Phoresis includes iontophoresis and phonophoresis:

11 (1) time for treatment response, three to five
12 sessions;

13 (2) maximum treatment frequency, up to three
14 times per week for the first one to three weeks decreasing in
15 frequency thereafter; and

16 (3) maximum treatment duration, 12 weeks.

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

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

25 (1) time for treatment response, three days;

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

29 (3) maximum continuous duration, up to three
30 weeks unless patient is status postfusion.

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

36 A. Education must teach the patient about pertinent

1 anatomy and physiology as it relates to spinal function for the
2 purpose of injury prevention. Education includes training on
3 posture, biomechanics, and relaxation. The maximum number of
4 treatments is three visits, which includes an initial education
5 and training session, and two follow-up visits.

6 B. Posture and work method training must instruct the
7 patient in the proper performance of job activities. Topics
8 include proper positioning of the trunk, neck, and arms, use of
9 optimum biomechanics in performing job tasks, and appropriate
10 pacing of activities. Methods include didactic sessions,
11 demonstrations, exercises, and simulated work tasks. The
12 maximum number of treatments is three visits.

13 C. Worksite analysis and modification must examine
14 the patient's work station, tools, and job duties.
15 Recommendations are made for the alteration of the work station,
16 selection of alternate tools, modification of job duties, and
17 provision of adaptive equipment. The maximum number of
18 treatments is three visits.

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

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

1 governed by part 5221.6600.

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

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

9 (b) maximum duration, 12 weeks.

10 (2) Unsupervised exercise must be provided in the
11 least intensive setting appropriate to the goals of the exercise
12 program, and may supplement or follow the period of supervised
13 exercise:

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

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

18 Subp. 5. **Therapeutic injections.** Injection modalities are
19 indicated as set forth in items A to C. Use of injections may
20 extend past the 12-week limit on passive treatment modalities,
21 so long as the maximum treatment for injections is not exceeded.

22 A. Therapeutic injections include trigger points
23 injections, facet joint injections, facet nerve blocks,
24 sympathetic nerve blocks, epidurals, nerve root blocks, and
25 peripheral nerve blocks. Therapeutic injections can only be
26 given in conjunction with active treatment modalities directed
27 to the same anatomical site.

28 (1) Trigger point injections:

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

31 (b) maximum treatment frequency, once per
32 week if a positive response to the first injection at that
33 site. If subsequent injections at that site demonstrate
34 diminishing control of symptoms or fail to facilitate objective
35 functional gains, then trigger point injections should be
36 redirected to other areas or discontinued. Only three

1 injections are reimbursable per patient visit; and

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

4 (2) Facet joint injections or facet nerve blocks:

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

7 (b) maximum treatment frequency, once every
8 two weeks if a positive response to the first injection or
9 block. If subsequent injections or blocks demonstrate
10 diminishing control of symptoms or fail to facilitate objective
11 functional gains, then injections or blocks should be
12 discontinued. Only three injections or blocks are reimbursable
13 per patient visit; and

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

16 (3) Nerve root blocks:

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

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

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

25 (4) Epidural injections:

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

28 (b) maximum treatment frequency, once every
29 two weeks if a positive response to the first injection. If
30 subsequent injections demonstrate diminishing control of
31 symptoms or fail to facilitate objective functional gains, then
32 injections should be discontinued. Only one injection is
33 reimbursable per patient visit; and

34 (c) maximum treatment, three injections.

35 B. Permanent lytic or sclerosing injections,
36 including radio frequency denervation of the facet joints.

1 These injections can only be given in conjunction with active
2 treatment modalities directed to the same anatomical site:

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

4 (2) maximum treatment frequency, may repeat once
5 for any site; and

6 (3) maximum duration, two injections to any one
7 site.

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

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

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

25 (1) eight weeks following decompression or
26 implantation of a dorsal column stimulator or morphine pump; or

27 (2) 12 weeks following arthrodesis.

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

32 C. The following surgical therapies have very limited
33 application and require a second opinion which confirms that the
34 treatment is indicated and within the parameters listed, and a
35 personality or psychosocial evaluation indicates that the
36 patient is likely to benefit from the treatment.

1 (1) Dorsal column stimulator is indicated for a
2 patient who has neuropathic pain, is not a candidate for any
3 other invasive therapy, and has had a favorable response to a
4 trial screening period.

5 (2) Morphine pump is indicated for a patient who
6 has somatic pain, is not a candidate for any other invasive
7 therapy, and has had a favorable response to a trial screening
8 period.

9 Subp. 7. **Chronic management.** Chronic management of neck
10 disorders must be provided according to the parameters of part
11 5221.6600.

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

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

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

25 C. Exercise equipment for home use, including
26 bicycles, treadmills, and stairclimbers, are indicated only
27 within the context of a program or plan of an approved chronic
28 management program. This equipment is not indicated during
29 initial nonoperative care or during reevaluation and surgical
30 therapy. Prior notification must be given to the insurer before
31 purchase of the home exercise equipment. The insurer may decide
32 which brand of a prescribed type of exercise equipment is
33 provided to the patient. If the employer has an appropriate
34 exercise facility on its premises with the prescribed equipment,
35 the insurer may mandate the use of that facility instead of
36 authorizing purchase of equipment for home use.

1 (1) Indications: the patient is deconditioned
2 and requires reconditioning which can be accomplished only with
3 the use of the prescribed exercise equipment. The health care
4 provider must document specific reasons why the exercise
5 equipment is necessary and cannot be replaced with other
6 activities.

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

10 D. The following durable medical equipment is not
11 indicated for home use for neck pain conditions:

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

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

16 Subp. 9. Evaluation of treatment by health care provider.

17 The health care provider must evaluate at each visit whether the
18 treatment is medically necessary, and shall evaluate whether
19 initial nonsurgical management is effective according to items A
20 to C.

21 No later than the time for treatment response established
22 for the specific modality as specified in subparts 3, 4, and 5,
23 the health care provider must evaluate whether the passive,
24 active, injection, or medication treatment modality has resulted
25 in progressive improvement as specified in items A to C:

26 A. the employee's subjective complaints of pain or
27 disability are progressively improving, as evidenced by
28 documentation in the medical record of decreased distribution,
29 frequency, or intensity of symptoms;

30 B. the objective clinical findings are progressively
31 improving, as evidenced by documentation in the medical record
32 of resolution or objectively measured improvement in physical
33 signs of injury; and

34 C. the employee's functional status, especially
35 vocational activity, is progressively improving, as evidenced by
36 documentation in the medical record, or successive reports of

1 work ability, of less restrictive limitations on activity.

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

10 Subp. 10. **Scheduled and nonscheduled medication.**

11 Prescription of controlled substance medications scheduled under
12 Minnesota Statutes, section 152.02, including, without
13 limitation, narcotics, is indicated only for the treatment of
14 severe acute pain. These medications are not indicated in the
15 treatment of patients with regional neck pain after the first
16 two weeks.

17 Patients with radicular pain may require longer periods of
18 treatment.

19 The health care provider must document the rationale for
20 the use of any scheduled medication. Treatment with nonnarcotic
21 medication may be appropriate during any phase of treatment and
22 intermittently after all other treatment has been discontinued.
23 The prescribing health care provider must determine that ongoing
24 medication is effective treatment for the patient's condition
25 and the most cost-effective regimen is used.

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

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

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

1 (2) The only therapeutic injections indicated for
2 patients with regional neck pain are trigger point injections,
3 facet joint injections, facet nerve blocks, and epidural blocks,
4 and their use must meet the parameters of subpart 5.

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

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

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

16 B. Surgical evaluation or chronic management is
17 indicated if the patient continues with symptoms and physical
18 findings after the course of initial nonsurgical management, and
19 if the patient's condition prevents the resumption of the
20 regular activities of daily life including regular vocational
21 activities. The purpose of surgical evaluation is to determine
22 whether surgery is indicated in the treatment of a patient who
23 has failed to recover with initial nonsurgical care. If the
24 patient is not a surgical candidate, then chronic management is
25 indicated.

26 (1) Surgical evaluation if indicated may begin as
27 soon as eight weeks after, but must begin no later than 12 weeks
28 after, beginning initial nonsurgical management. An initial
29 recommendation or decision against surgery does not preclude
30 surgery at a later date.

31 (2) Surgical evaluation may include the use of
32 appropriate medical imaging techniques. The imaging technique
33 must be chosen on the basis of the suspected etiology of the
34 patient's condition but the health care provider must follow the
35 parameters of part 5221.6100, subpart 1.

36 (3) Surgical evaluation may also include

1 diagnostic blocks and injections. These blocks and injections
2 are only indicated if their use is consistent with the
3 parameters of subpart 1, item H.

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

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

13 (6) The only surgical procedure indicated for
14 patients with regional neck pain only is cervical arthrodesis,
15 with or without instrumentation, which must meet the parameters
16 of subpart 6. For patients with failed surgery, dorsal column
17 stimulators or morphine pumps may be indicated consistent with
18 the parameters of subpart 6, item C.

19 (a) If surgery is indicated, it should be
20 offered to the patient as soon as possible. If the patient
21 agrees to the proposed surgery, it should be performed as
22 expeditiously as possible consistent with sound medical
23 practice, and consistent with any requirements of part
24 5221.6050, subpart 9, for prior notification of the insurer or
25 second opinions.

26 (b) If surgery is not indicated or if the
27 patient does not wish to proceed with surgical therapy, then the
28 patient is a candidate for chronic management.

29 C. If the patient continues with symptoms and
30 objective physical findings after surgery has been rendered or
31 the patient refuses surgery or the patient was not a candidate
32 for surgery, and if the patient's condition prevents the
33 resumption of the regular activities of daily life including
34 regular vocational activities, then the patient may be a
35 candidate for chronic management according to part 5221.6600.

36 Subp. 12. Specific treatment parameters for radicular

1 pain, with or without regional neck pain, with no or static
2 neurologic deficits.

3 A. Initial nonsurgical treatment is appropriate for
4 all patients with radicular pain, with or without regional neck
5 pain, with no or static neurologic deficits under subpart 1,
6 item A, subitem (2), and must be the first phase of treatment.
7 It must be provided within the parameters of subpart 11, item A,
8 with the following modifications: epidural blocks and nerve
9 root and peripheral nerve blocks are the only therapeutic
10 injections indicated for patients with radicular pain only. If
11 there is a component of regional neck pain, therapeutic facet
12 joint injections, facet nerve blocks, and trigger point
13 injections may also be indicated.

14 B. Surgical evaluation or chronic management is
15 indicated if the patient continues with symptoms and physical
16 findings after the course of initial nonsurgical care, and if
17 the patient's condition prevents the resumption of the regular
18 activities of daily life including regular vocational
19 activities. It must be provided within the parameters of
20 subpart 11, item B, with the following modifications: the only
21 surgical procedures indicated for patients with radicular pain
22 are decompression of a cervical nerve root which must meet the
23 parameters of subpart 6 and part 5221.6500, subpart 2, item B,
24 and cervical arthrodesis, with or without instrumentation. For
25 patients with failed surgery, dorsal column stimulators or
26 morphine pumps may be indicated consistent with subpart 6, item
27 C.

28 C. If the patient continues with symptoms and
29 objective physical findings after surgical therapy has been
30 rendered, the patient refused surgical therapy, or the patient
31 was not a candidate for surgical therapy, and if the patient's
32 condition prevents the resumption of the regular activities of
33 daily life including regular vocational activities, then the
34 patient may be a candidate for chronic management. Any course
35 or program of chronic management for patients with radicular
36 pain, with or without regional neck pain, with static neurologic

1 changes must meet all of the parameters of part 5221.6600.

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

5 A. Patients with radicular pain, with or without
6 regional neck pain, with progressive neurologic deficits may
7 require immediate or emergency evaluation at any time during the
8 course of their overall treatment. The decision to proceed with
9 surgical evaluation is made by the health care provider based on
10 the type of neurologic changes observed, the severity of the
11 changes, the rate of progression of the changes, and the
12 response to any nonsurgical treatments. Surgery, if indicated,
13 may be performed at any time during the course of treatment.
14 Surgical evaluation and surgery shall be provided within the
15 parameters of subpart 11, item B, with the following
16 modifications:

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

19 (2) the only surgical procedures indicated for
20 patients with radicular pain are decompression of a cervical
21 nerve root which must meet the parameters of subpart 6 and part
22 5221.6500, subpart 2, item B, or cervical arthrodesis, with or
23 without instrumentation. For patients with failed back surgery,
24 dorsal column stimulators or morphine pumps may be indicated
25 consistent with the parameters of subpart 6, item C.

26 B. If the health care provider decides to proceed
27 with a course of nonsurgical care for a patient with radicular
28 pain with progressive neurologic changes, it must follow the
29 parameters of subpart 12, item A.

30 C. If the patient continues with symptoms and
31 objective physical findings after surgical therapy has been
32 rendered or the patient refuses surgical therapy or the patient
33 was not a candidate for surgical therapy, and if the patient's
34 condition prevents the resumption of the regular activities of
35 daily life including regular vocational activities, then the
36 patient may be a candidate for chronic management. Any course

1 or program of chronic management for patients with radicular
2 pain, with or without regional neck pain, with progressive
3 neurologic changes at first presentation must meet all of the
4 parameters of part 5221.6600.

5 Subp. 14. **Specific treatment parameters for myelopathy.**

6 A. Patients with myelopathy may require emergency
7 surgical evaluation at any time during the course of their
8 overall treatment. The decision to proceed with surgical
9 evaluation is made by the health care provider based on the type
10 of neurologic changes observed, the severity of the changes, the
11 rate of progression of the changes, and the response to any
12 nonsurgical treatments. Surgery, if indicated, may be performed
13 at any time during the course of treatment. Surgical evaluation
14 and surgery shall be provided within the parameters of subpart
15 11, item B, with the following modifications:

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

18 (2) the only surgical procedures indicated for
19 patients with myelopathy are anterior or posterior decompression
20 of the spinal cord, or cervical arthrodesis with or without
21 instrumentation. For patients with failed back surgery, dorsal
22 column stimulators or morphine pumps may be indicated consistent
23 with the parameters of subpart 6, item C.

24 B. If the health care provider decides to proceed
25 with a course of nonsurgical care for a patient with myelopathy,
26 it must follow the parameters of subpart 12, item A.

27 C. If the patient continues with symptoms and
28 objective physical findings after surgical therapy has been
29 rendered or the patient refuses surgical therapy or the patient
30 was not a candidate for surgical therapy, and if the patient's
31 condition prevents the resumption of the regular activities of
32 daily life including regular vocational activities, then the
33 patient may be a candidate for chronic management. Any course
34 or program of chronic management for patients with myelopathy
35 must meet all of the parameters of part 5221.6600.

1 5221.6210 THORACIC BACK PAIN.

2 Subpart 1. Diagnostic procedures for treatment of thoracic
3 back injury. A health care provider shall determine the nature
4 of the condition before initiating treatment.

5 A. An appropriate history and physical examination
6 must be performed and documented. Based on the history and
7 physical examination the health care provider must assign the
8 patient at each visit to the consistency appropriate clinical
9 category according to subitems (1) to (4). The diagnosis must
10 be documented in the medical record. For the purposes of
11 subitems (2) and (3), "radicular pain" means pain radiating in a
12 dermatomal distribution around the chest or abdomen. This part
13 does not apply to fractures of the thoracic spine or thoracic
14 back pain due to an infectious, immunologic, metabolic,
15 endocrine, neurologic, visceral, or neoplastic disease process.

16 (1) Regional thoracic back pain includes the
17 diagnoses of thoracic strain, sprain, myofascial syndrome,
18 musculoligamentous injury, soft tissue injury, and any other
19 diagnosis for pain believed to originate in the discs,
20 ligaments, muscles, or other soft tissues of the thoracic spine
21 and which effects the thoracic region, including, but not
22 limited to, ICD-9-CM codes 720 to 720.9, 721 to 721.0, 721.5 to
23 721.90, 722.3 to 722.30, 722.4, 722.6, 722.9 to 722.91, 723 to
24 723.3, 723.5 to 723.9, 724.5, 724.8, 724.9, 732.0, 737 to 737.9,
25 738.4, 738.5, 739.1, 756.1 to 756.19, 847 to 847.0, 920, 922.3,
26 925, and 926.1 to 926.12.

27 (2) Radicular pain, with or without regional
28 thoracic back pain, includes the diagnoses of thoracic
29 radiculopathy, radiculitis, or neuritis; displacement or
30 herniation of intervertebral disc with radiculopathy,
31 radiculitis, or neuritis; spinal stenosis with radiculopathy,
32 radiculitis, or neuritis; and any other diagnoses for pain
33 believed to originate with irritation of a nerve root in the
34 thoracic spine, including, but not limited to, the ICD-9-CM
35 codes 721.1, 721.91, 722 to 722.0, 722.2, 722.7 to 722.71,
36 723.4, and 724 to 724.00.

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

7 B. Laboratory tests are not indicated in the
8 evaluation of a patient with regional thoracic back pain, or
9 radicular pain, except when a patient's history, age, or
10 examination suggests infection, metabolic-endocrinologic
11 disorders, tumorous conditions, systemic musculoskeletal
12 disorders, such as rheumatoid arthritis or ankylosing
13 spondylitis, or side effects of medications. Laboratory tests
14 may be ordered at any time the health care provider suspects any
15 of these conditions, but the health care provider must justify
16 the need for the tests ordered with clear documentation of the
17 indications. Laboratory tests may also be ordered as part of a
18 preoperative evaluation.

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

27 D. EMG and nerve conduction studies are always
28 inappropriate for regional thoracic back pain and radicular pain
29 under item A, subitems (1) to (3).

30 E. The use of the following procedures or tests ~~shall~~
31 ~~not-be-reimbursed~~ is not indicated for the diagnosis of any of
32 the clinical categories in item A:

33 (1) surface electromyography or surface
34 paraspinal EMG;

35 (2) thermography;

36 (3) plethysmography;

1 (4) electronic X-ray analysis of plain
2 radiographs;

3 (5) diagnostic ultrasound of the spine; or

4 (6) somatosensory evoked potentials (SSEP) and
5 motor evoked potentials (MEP).

6 F. Computerized range of motion or strength measuring
7 tests are not reimbursable during the period of initial
8 nonsurgical care, but may be reimbursable during a period of
9 chronic management when used in conjunction with a computerized
10 exercise program, work hardening program, or work conditioning
11 program. During the period of initial nonoperative care
12 computerized range of motion or strength testing can be
13 performed but must be done in conjunction with and shall not be
14 reimbursed separately from an office visit, chiropractic
15 evaluation or treatment, or physical or occupational therapy
16 evaluation or treatment.

17 G. Personality or psychological evaluations may be a
18 useful tool for evaluating patients who continue to have
19 problems despite appropriate care. The treating health care
20 provider may perform this evaluation or may refer the patient
21 for consultation with another health care provider in order to
22 obtain a psychological evaluation. These evaluations may be
23 used to assess the patient for a number of psychological
24 conditions which may interfere with recovery from the injury.
25 Since more than one of these psychological conditions may be
26 present in a given case, the health care provider performing the
27 evaluation must consider all of the following:

28 (1) Is symptom magnification occurring?

29 (2) Does the patient exhibit an emotional
30 reaction to the injury, such as depression, fear, or anger,
31 which is interfering with recovery?

32 (3) Are there other personality factors or
33 disorders which are interfering with recovery?

34 (4) Is the patient chemically dependent?

35 (5) Are there any interpersonal conflicts
36 interfering with recovery?

1 (6) Does the patient have a chronic pain syndrome
2 or psychogenic pain?

3 (7) In cases in which surgery is a possible
4 treatment, are psychological factors, such as those listed in
5 subitems (1) to (6), likely to interfere with the potential
6 benefit of the surgery?

7 H. Diagnostic analgesic blocks or injection studies
8 include facet joint injection, facet nerve block, epidural
9 differential spinal block, nerve block, and nerve root block.

10 (1) These procedures are used to localize the
11 source of pain prior to surgery and to diagnose conditions which
12 fail to respond to initial nonoperative care.

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

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

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

23 I. Functional capacity assessment or evaluation is a
24 comprehensive and objective assessment of a patient's ability to
25 perform work tasks. The components of a functional capacity
26 assessment or evaluation include, but are not limited to,
27 neuromusculoskeletal screening, tests of manual material
28 handling, assessment of functional mobility, and measurement of
29 postural tolerance. A functional capacity assessment or
30 evaluation is an individualized testing process and the
31 component tests and measurements are determined by the patient's
32 condition and the requested information. Functional capacity
33 assessments and evaluations are performed to determine and
34 report a patient's physical capacities in general or to
35 determine work tolerance for a specific job, task, or work
36 activity.

1 (1) Functional capacity assessment or evaluation
2 is not reimbursable during the period of initial nonoperative
3 care.

4 (2) Functional capacity assessment or evaluation
5 is reimbursable in either of the following circumstances:

6 (a) permanent activity restrictions and
7 capabilities must be identified; or

8 (b) there is a question about the patient's
9 ability to do a specific job.

10 J. Consultations with other health care providers can
11 be initiated at any time by the treating health care provider
12 consistent with standard medical practice.

13 Subp. 2. **General treatment parameters for thoracic back**
14 **pain.**

15 A. All medical care for thoracic back pain,
16 appropriately assigned to a category of subpart 1, item A, is
17 determined by the diagnosis and clinical category in subpart 1,
18 item A, to which the patient has been assigned. General
19 parameters for treatment modalities are set forth in subparts 3
20 to 10. Specific treatment parameters for each clinical category
21 are set forth in subparts 11 to 13, as follows:

22 (1) subpart 11 governs regional thoracic back
23 pain;

24 (2) subpart 12 governs radicular pain; and

25 (3) subpart 13 governs myelopathy.

26 The health care provider must, at each visit, reassess the
27 appropriateness of the clinical category assigned and reassign
28 the patient if warranted by new clinical information including
29 symptoms, signs, results of diagnostic testing, and opinions and
30 information obtained from consultations with other health care
31 providers. When the clinical category is changed the treatment
32 plan must be appropriately modified to reflect the new clinical
33 category. However, a change of clinical category does not in
34 itself allow the health care provider to continue a therapy or
35 treatment modality past the maximum duration specified in items
36 C to F, or to repeat a therapy or treatment previously provided

1 for the same injury.

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

4 (1) First, all patients with thoracic back
5 problems, except patients with myelopathy under subpart 1, item
6 A, subitem (3), must be given initial nonoperative care which
7 may include active and passive treatment modalities, injections,
8 durable medical equipment, and medications. These modalities
9 and parameters are described in subparts 3, 4, 5, 8, and 10.
10 The period of initial nonsurgical treatment begins with the
11 first clinical passive, active, injection, durable medical
12 equipment, or medication modality initiated. Initial
13 nonsurgical treatment must result in progressive improvement as
14 specified in subpart 9.

15 (2) Second, for patients with persistent
16 symptoms, initial nonsurgical management is followed by a period
17 of surgical evaluation. This evaluation should be completed in
18 a timely manner. Surgery, if indicated, should be performed as
19 expeditiously as possible consistent with sound medical practice
20 and subparts 6 and 11 to 13, and part 5221.6500. The treating
21 health care provider may do the evaluation, if it is within the
22 provider's scope of practice, or may refer the employee to a
23 consultant.

24 (a) Patients with myelopathy may require
25 immediate surgical therapy.

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

30 (c) Surgery must follow the parameters in
31 subparts 6 and 11 to 13, and part 5221.6500.

32 (d) A decision against surgery at this time
33 does not preclude a decision for surgery made at a later date in
34 light of new clinical information.

35 (3) Third, for those patients who are not
36 candidates for or refuse surgical therapy, or who do not have

1 complete resolution of their symptoms with surgery, a period of
2 chronic management may be indicated. Chronic management
3 modalities are described in part 5221.6600, and may also include
4 durable medical equipment as described in subpart 8.

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

8 Subp. 3. **Passive treatment modalities.**

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

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

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

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

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

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

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

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

35 (2) Except as otherwise provided in part
36 5221.6050, subpart 8, treatment may continue beyond the

1 additional 12 visits only after prior approval by the insurer,
2 commissioner, or compensation judge based on documentation in
3 the medical record of the effectiveness of further passive
4 treatment in maintaining employability; if the employee is
5 permanently totally disabled, or if upon retirement the employee
6 is eligible for ongoing medical benefits for the work injury,
7 treatment may continue beyond the additional 12 visits only
8 after prior approval by the insurer, commissioner, or
9 compensation judge based on documentation in the medical record
10 of the effectiveness of further passive treatment in maintaining
11 functional status.

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

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

16 (2) maximum treatment frequency, up to five times
17 per week for the first one to two weeks decreasing in frequency
18 thereafter; and

19 (3) maximum treatment duration, 12 weeks.

20 D. Thermal treatment includes all superficial and
21 deep heating modalities and cooling modalities. Superficial
22 thermal modalities include hot packs, hot soaks, hot water
23 bottles, hydrocollators, heating pads, ice packs, cold soaks,
24 infrared, whirlpool, and fluidotherapy. Deep thermal modalities
25 include diathermy, ultrasound, and microwave.

26 (1) Treatment given in a clinical setting:

27 (a) time for treatment response, two to four
28 treatments;

29 (b) maximum treatment frequency, up to five
30 times per week for the first one to three weeks decreasing in
31 frequency thereafter; and

32 (c) maximum treatment duration, 12 weeks of
33 treatment in a clinical setting but only if given in conjunction
34 with other therapies.

35 (2) Home use of thermal modalities may be
36 prescribed at any time during the course of treatment. Home use

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

7 E. Electrical muscle stimulation includes galvanic
8 stimulation, TENS, interferential, and microcurrent techniques.

9 (1) Treatment given in a clinical setting:

10 (a) time for treatment response, two to four
11 treatments;

12 (b) maximum treatment frequency, up to five
13 times per week for the first one to three weeks decreasing in
14 frequency thereafter; and

15 (c) maximum treatment duration, 12 weeks of
16 treatment in a clinical setting but only if given in conjunction
17 with other therapies.

18 (2) Home use of an electrical stimulation device
19 may be prescribed at any time during a course of treatment.

20 Initial use of an electrical stimulation device must be in a
21 supervised setting in order to ensure proper electrode placement
22 and patient education:

23 (a) maximum time for patient education and
24 training, up to three sessions; and

25 (b) patient may use the electrical
26 stimulation device for one month, at which time effectiveness of
27 the treatment must be reevaluated by the health care provider
28 before continuing home use of the device.

29 F. Mechanical traction:

30 (1) Treatment given in a clinical setting:

31 (a) time for treatment response, three
32 treatments;

33 (b) maximum treatment frequency, up to three
34 times per week for the first one to three weeks decreasing in
35 frequency thereafter; and

36 (c) maximum treatment duration, 12 weeks in

1 a clinical setting but only if used in conjunction with other
2 therapies.

3 (2) Home use of a mechanical traction device may
4 be prescribed as follow-up to use of traction in a clinical
5 setting if it has proven to be effective treatment and is
6 expected to continue to be effective treatment. Initial use of
7 a mechanical traction device must be in a supervised setting in
8 order to ensure proper patient education:

9 (a) maximum time for patient education and
10 training, one session; and

11 (b) a patient may use the mechanical
12 traction device for one month, at which time effectiveness of
13 the treatment must be reevaluated by the health care provider
14 before continuing home use of the device.

15 G. Acupuncture treatments. Endorphin-mediated
16 analgesic therapy includes classic acupuncture and acupressure:

17 (1) time for treatment response, three to five
18 sessions;

19 (2) maximum treatment frequency, up to three
20 times per week for one to three weeks decreasing in frequency
21 thereafter; and

22 (3) maximum treatment duration, 12 weeks.

23 H. Manual therapy includes soft tissue and joint
24 mobilization, therapeutic massage, and manual traction:

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

27 (2) maximum treatment frequency, up to five times
28 per week for the first one to two weeks decreasing in frequency
29 thereafter; and

30 (3) maximum treatment duration, 12 weeks.

31 I. Phoresis includes iontophoresis and phonophoresis:

32 (1) time for treatment response, three to five
33 sessions;

34 (2) maximum treatment frequency, up to three
35 times per week for the first one to three weeks decreasing in
36 frequency thereafter; and

1 (3) maximum treatment duration, 12 weeks.

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

5 K. Spinal braces and other movement-restricting
6 appliances. Bracing required for longer than two weeks must be
7 accompanied by active muscle strengthening exercise to avoid
8 deconditioning and prolonged disability:

9 (1) time for treatment response, three days;

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

13 (3) maximum continuous duration, three weeks
14 unless patient is status postfusion.

15 Subp. 4. **Active treatment modalities.** Active treatment
16 modalities must be used as set forth in items A to D. Use of
17 active treatment modalities may extend past the 12-week limit on
18 passive treatment modalities, so long as the maximum durations
19 for the active treatment modalities are not exceeded.

20 A. Education must teach the patient about pertinent
21 anatomy and physiology as it relates to spinal function for the
22 purpose of injury prevention. Education includes training on
23 posture, biomechanics, and relaxation. The maximum number of
24 treatments is three visits, which includes an initial education
25 and training session, and two follow-up visits.

26 B. Posture and work method training must instruct the
27 patient in the proper performance of job activities. Topics
28 include proper positioning of the trunk, back, and arms, use of
29 optimum biomechanics in performing job tasks, and appropriate
30 pacing of activities. Methods include didactic sessions,
31 demonstrations, exercises, and simulated work tasks. The
32 maximum number of treatments is three visits.

33 C. Worksite analysis and modification must examine
34 the patient's work station, tools, and job duties.
35 Recommendations are made for the alteration of the work station,
36 selection of alternate tools, modification of job duties, and

1 provision of adaptive equipment. The maximum number of
2 treatments is three visits.

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

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

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

26 (a) maximum treatment frequency, three times
27 per week for three weeks and should decrease with time
28 thereafter; and

29 (b) maximum duration, 12 weeks.

30 (2) Unsupervised exercise must be provided in the
31 least intensive setting appropriate to the goals of the exercise
32 program and may supplement or follow the period of supervised
33 exercise:

34 (a) maximum treatment frequency, one to
35 three visits for instruction and monitoring; and

36 (b) there is no limit on the duration and

1 frequency of exercise at home.

2 Subp. 5. **Therapeutic injections.** Injection modalities are
3 indicated as set forth in items A to C. Use of injections may
4 extend past the 12-week limit on passive treatment modalities,
5 so long as the maximum treatment for injections is not exceeded.

6 A. Therapeutic injections include trigger points
7 injections, facet joint injections, facet nerve blocks,
8 sympathetic nerve blocks, epidurals, nerve root blocks, and
9 peripheral nerve blocks. Therapeutic injections can only be
10 given in conjunction with active treatment modalities directed
11 to the same anatomical site.

12 (1) Trigger point injections:

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

15 (b) maximum treatment frequency, once per
16 week if a positive response to the first injection at that
17 site. If subsequent injections at that site demonstrate
18 diminishing control of symptoms or fail to facilitate objective
19 functional gains, then trigger point injections should be
20 redirected to other areas or discontinued. No more than three
21 injections are reimbursable per patient visit; and

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

24 (2) Facet joint injections or facet nerve blocks:

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

27 (b) maximum treatment frequency, once every
28 two weeks if a positive response to the first injection or
29 block. If subsequent injections or blocks demonstrate
30 diminishing control of symptoms or fail to facilitate objective
31 functional gains, then injections or blocks should be
32 discontinued. Only three injections or blocks are reimbursable
33 per patient visit; and

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

36 (3) Nerve root blocks:

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

3 (b) maximum treatment frequency, can repeat
4 injection two weeks after the previous injection if a positive
5 response to the first block. Only three injections are
6 reimbursable per patient visit; and

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

9 (4) Epidural injections:

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

12 (b) maximum treatment frequency, once every
13 two weeks if a positive response to the first injection. If
14 subsequent injections demonstrate diminishing control of
15 symptoms or fail to facilitate objective functional gains, then
16 injections should be discontinued. Only one injection is
17 reimbursable per patient visit; and

18 (c) maximum treatment, three injections.

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

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

24 (2) optimum treatment frequency, may repeat once
25 for any site; and

26 (3) maximum duration, two injections to any one
27 site.

28 C. Prolotherapy and botulinum toxin injections are
29 not indicated in the treatment of thoracic back problems and are
30 not reimbursable.

31 Subp. 6. **Surgery, including decompression procedures.**

32 Surgery may only be performed if it meets the specific
33 parameters of subparts 11 to 13 and part 5221.6500. The health
34 care provider must provide prior notification of nonemergency
35 inpatient surgery according to part 5221.6050, subpart 9.

36 A. In order to optimize the beneficial effect of

1 surgery, postoperative therapy with active and passive treatment
2 modalities may be provided, even if these modalities had been
3 used in the preoperative treatment of the condition. In the
4 postoperative period the maximum treatment duration with passive
5 treatment modalities in a clinical setting from the initiation
6 of the first passive modality used, except bedrest or bracing,
7 is as follows:

8 (1) eight weeks following decompression or
9 implantation of a dorsal column stimulator or morphine pump; or

10 (2) 12 weeks following arthrodesis.

11 B. Repeat surgery must also meet the parameters of
12 subparts 11 to 13 and part 5221.6500 and is not indicated unless
13 the need for the repeat surgery is confirmed by a second opinion
14 obtained before surgery, if a second opinion is requested by the
15 insurer.

16 C. The surgical therapies in subitems (1) and (2)
17 have very limited application and require a second opinion which
18 confirms that the treatment is indicated and within the
19 parameters listed, and a personality or psychosocial evaluation
20 which indicates that the patient is likely to benefit from the
21 treatment.

22 (1) Dorsal column stimulator is indicated for a
23 patient who has neuropathic pain, and is not a candidate for any
24 other invasive therapy, and has had a favorable response to a
25 trial screening period.

26 (2) Morphine pump is indicated for a patient who
27 has somatic pain, and is not a candidate for any other invasive
28 therapy, and has had a favorable response to a trial screening
29 period.

30 Subp. 7. **Chronic management.** Chronic management of
31 thoracic back pain must be provided according to the parameters
32 of part 5221.6600.

33 Subp. 8. **Durable medical equipment.** Durable medical
34 equipment is indicated only in certain specific situations, as
35 specified in items A to D. The health care provider must
36 provide the insurer with prior notification as required by items

1 B and C, according to part 5221.6050, subpart 9.

2 A. Braces or supports may be indicated within the
3 parameters of subpart 3, item K.

4 B. For patients using electrical stimulation or
5 mechanical traction devices at home, the device and any required
6 supplies are indicated within the parameters of subpart 3, items
7 E and F. Prior notification of the insurer is required for
8 purchase of the device or for use longer than one month. The
9 insurer may provide equipment if it is comparable to that
10 prescribed by the health care provider.

11 C. Exercise equipment for home use, including
12 bicycles, treadmills, and stairclimbers, are indicated only
13 within the context of a program or plan of an approved chronic
14 management program. This equipment is not indicated during
15 initial nonoperative care or during reevaluation and surgical
16 therapy. Prior notification of the insurer is required for the
17 purchase of home exercise equipment. The insurer may decide
18 which brand of a prescribed type of exercise equipment is
19 provided to the patient. If the employer has an appropriate
20 exercise facility on its premises with the prescribed equipment,
21 the insurer may mandate the use of that facility instead of
22 authorizing purchase of equipment for home use.

23 (1) Indications: the patient is deconditioned
24 and requires reconditioning which can be accomplished only with
25 the use of the prescribed exercise equipment. The health care
26 provider must document specific reasons why the exercise
27 equipment is necessary and cannot be replaced with other
28 activities.

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

32 D. The following durable medical equipment is not
33 indicated for home use for thoracic back pain conditions:

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

36 (2) beds, waterbeds, mattresses, chairs,

1 recliners, or loungers.

2 Subp. 9. **Evaluation of treatment by health care provider.**

3 The health care provider must evaluate at each visit whether the
4 treatment is medically necessary, and must evaluate whether
5 initial nonsurgical management is effective according to items A
6 to C. No later than the time for treatment response established
7 for the specific modality as specified in subparts 3, 4, and 5,
8 the health care provider must evaluate whether the passive,
9 active, injection, or medication treatment modality is resulting
10 in progressive improvement as specified in items A to C:

11 A. the employee's subjective complaints of pain or
12 disability are progressively improving, as evidenced by
13 documentation in the medical record of decreased duration,
14 frequency, or intensity of symptoms;

15 B. the objective clinical findings are progressively
16 improving, as evidenced by documentation in the medical record
17 of resolution or objectively measured improvement in physical
18 signs of injury; and

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

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

31 Subp. 10. **Scheduled and nonscheduled medication.**

32 Prescription of controlled substance medications scheduled under
33 Minnesota Statutes, section 152.02, including, without
34 limitation, narcotics, is indicated only for the treatment of
35 severe acute pain. These medications are not indicated in the
36 treatment of patients with regional thoracic back pain after the

1 first two weeks.

2 Patients with radicular pain may require longer periods of
3 treatment.

4 The health care provider must document the rationale for
5 the use of any scheduled medication. Treatment with nonnarcotic
6 medication may be appropriate during any phase of treatment and
7 intermittently after all other treatment has been discontinued.
8 The prescribing health care provider must determine that ongoing
9 medication is effective treatment for the patient's condition
10 and the most cost-effective regimen is used.

11 Subp. 11. **Specific treatment parameters for regional**
12 **thoracic back pain.**

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

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

22 (2) The only therapeutic injections indicated for
23 patients with regional thoracic back pain are trigger point
24 injections, facet joint injections, facet nerve blocks, and
25 epidural blocks, and their use must meet the parameters of
26 subpart 5.

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

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

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

1 first initiated.

2 B. Surgical evaluation or chronic management is
3 indicated if the patient continues with symptoms and objective
4 physical findings after the course of initial nonsurgical care,
5 and if the patient's condition prevents the resumption of the
6 regular activities of daily life including regular vocational
7 activities. The purpose of surgical evaluation is to determine
8 whether surgery is indicated in the treatment of a patient who
9 has failed to recover with initial nonsurgical care. If the
10 patient is not a surgical candidate, then chronic management is
11 indicated.

12 (1) Surgical evaluation may begin as soon as
13 eight weeks after, but must begin no later than 12 weeks after,
14 beginning initial nonsurgical management. An initial
15 recommendation or decision against surgical therapy does not
16 preclude surgery at a later date.

17 (2) Surgical evaluation may include the use of
18 appropriate medical imaging techniques. The imaging technique
19 must be chosen on the basis of the suspected etiology of the
20 patient's condition but the health care provider must follow the
21 parameters of part 5221.6100. Medical imaging studies which do
22 not meet these parameters are not indicated.

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

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

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

36 (6) The only surgical procedure indicated for

1 patients with regional thoracic back pain only is thoracic
2 arthrodesis with or without instrumentation, which must meet the
3 parameters of subpart 6, and part 5221.6500, subpart 2, item C.
4 For patients with failed surgery, dorsal column stimulators or
5 morphine pumps may be indicated consistent with subpart 6, item
6 C.

7 (a) If surgery is indicated, it should be
8 offered to the patient as soon as possible. If the patient
9 agrees to the proposed surgery it should be performed as
10 expeditiously as possible consistent with sound medical
11 practice, and consistent with any requirements of parts
12 5221.6010 to 5221.6500 for prior notification of the insurer or
13 second opinions.

14 (b) If surgery is not indicated or if the
15 patient does not wish to proceed with surgery, then the patient
16 is a candidate for chronic management.

17 C. If the patient continues with symptoms and
18 objective physical findings after surgery has been rendered or
19 the patient refuses surgery or the patient was not a candidate
20 for surgery, and if the patient's condition prevents the
21 resumption of the regular activities of daily life including
22 regular vocational activities, then the patient may be a
23 candidate for chronic management according to the parameters of
24 part 5221.6600.

25 Subp. 12. **Specific treatment parameters for radicular pain.**

26 A. Initial nonsurgical treatment is appropriate for
27 all patients with radicular pain under subpart 1, item A,
28 subitem (2), and must be the first phase of treatment. It must
29 be provided within the parameters of subpart 11, item A, with
30 the following modifications: epidural blocks and nerve root and
31 peripheral nerve blocks are the only therapeutic injections
32 indicated for patients with radicular pain only. If there is a
33 component of regional thoracic back pain, therapeutic facet
34 joint injections, facet nerve blocks, and trigger point
35 injections may also be indicated.

36 B. Surgical evaluation or chronic management is

1 indicated if the patient continues with symptoms and physical
2 findings after the course of initial nonsurgical care, and if
3 the patient's condition prevents the resumption of the regular
4 activities of daily life including regular vocational
5 activities. It shall be provided within the parameters of
6 subpart 11, item B, with the following modifications: the only
7 surgical procedures indicated for patients with radicular pain
8 are decompression or arthrodesis. For patients with failed
9 surgery, dorsal column stimulators or morphine pumps may be
10 indicated consistent with subpart 6, item C.

11 C. If the patient continues with symptoms and
12 objective physical findings after surgical therapy has been
13 rendered or the patient refused surgical therapy or the patient
14 was not a candidate for surgical therapy, and if the patient's
15 condition prevents the resumption of the regular activities of
16 daily life including regular vocational activities, then the
17 patient may be a candidate for chronic management. Any course
18 or program of chronic management for patients with radicular
19 pain, with or without regional thoracic back pain, must meet all
20 of the parameters of part 5221.6600.

21 Subp. 13. **Specific treatment parameters for myelopathy.**

22 A. Patients with myelopathy may require emergency
23 surgical evaluation at any time during the course of their
24 overall treatment. The decision to proceed with surgical
25 evaluation is made by the health care provider based on the type
26 of neurologic changes observed, the severity of the changes, the
27 rate of progression of the changes, and the response to any
28 nonsurgical treatments. Surgery, if indicated, may be performed
29 at any time during the course of treatment. Surgical evaluation
30 and surgery shall be provided within the parameters of subpart
31 11, item B, with the following modifications:

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

34 (2) the only surgical procedures indicated for
35 patients with myelopathy are decompression and arthrodesis. For
36 patients with failed surgery, dorsal column stimulators or

1 morphine pumps may be indicated consistent with subpart 6, item
2 C.

3 B. If the health care provider decides to proceed
4 with a course of nonsurgical care for a patient with myelopathy,
5 it must follow the parameters of subpart 12, item A.

6 C. If the patient continues with symptoms and
7 objective physical findings after surgical therapy has been
8 rendered or the patient refuses surgical therapy or the patient
9 was not a candidate for surgical therapy, and if the patient's
10 condition prevents the resumption of the regular activities of
11 daily life including regular vocational activities, then the
12 patient may be a candidate for chronic management. Any course
13 or program of chronic management for patients with myelopathy
14 must meet all of the parameters of part 5221.6600.

15 5221.6300 UPPER EXTREMITY DISORDERS.

16 Subpart 1. Diagnostic procedures for treatment of upper
17 extremity disorders (UED). A health care provider shall
18 determine the nature of an upper extremity disorder before
19 initiating treatment.

20 A. An appropriate history and physical examination
21 must be performed and documented. Based on the history and
22 physical examination the health care provider must at each visit
23 assign the patient to the appropriate clinical category
24 according to subitems (1) to (6). The diagnosis must be
25 documented in the medical record. Patients may have multiple
26 disorders requiring assignment to more than one clinical
27 category. This part does not apply to upper extremity
28 conditions due to a visceral, vascular, infectious,
29 immunological, metabolic, endocrine, systemic neurologic, or
30 neoplastic disease process, fractures, lacerations, amputations,
31 or sprains or strains with complete tissue disruption.

32 (1) Epicondylitis. This clinical category
33 includes medial epicondylitis and lateral epicondylitis,
34 ICD-9-CM codes 726.31 and 726.32.

35 (2) Tendonitis of the forearm, wrist, and hand.

1 This clinical category encompasses any inflammation, pain,
2 tenderness, or dysfunction or irritation of a tendon, tendon
3 sheath, tendon insertion, or musculotendinous junction in the
4 upper extremity at or distal to the elbow due to mechanical
5 injury or irritation, including, but not limited to, the
6 diagnoses of tendonitis, tenosynovitis, tendovaginitis,
7 peritendinitis, extensor tendinitis, de Quervain's syndrome,
8 intersection syndrome, flexor tendinitis, and trigger digit,
9 including, but not limited to, ICD-9-CM codes 726.4, 726.5,
10 726.8, 726.9, 726.90, 727, 727.0, 727.00, 727.03, 727.04,
11 727.05, and 727.2.

12 (3) Nerve entrapment syndromes. This clinical
13 category encompasses any compression or entrapment of the
14 radial, ulnar, or median nerves, or any of their branches,
15 including, but not limited to, carpal tunnel syndrome, pronator
16 syndrome, anterior interosseous syndrome, cubital tunnel
17 syndrome, Guyon's canal syndrome, radial tunnel syndrome,
18 posterior interosseous syndrome, and Wartenburg's syndrome,
19 including, but not limited to, ICD-9-CM codes 354, 354.0, 354.1,
20 354.2, 354.3, 354.8, and 354.9.

21 (4) Muscle pain syndromes. This clinical
22 category encompasses any painful condition of any of the muscles
23 of the upper extremity, including the muscles responsible for
24 movement of the shoulder and scapula, characterized by pain and
25 stiffness, including, but not limited to, the diagnoses of
26 chronic nontraumatic muscle strain, repetitive strain injury,
27 cervicobrachial syndrome, tension neck syndrome, overuse
28 syndrome, myofascial pain syndrome, myofasciitis, nonspecific
29 myalgia, fibrositis, fibromyalgia, and fibromyositis, including,
30 but not limited to, ICD-9-CM codes 723.3, 729.0, 729.1, 729.5,
31 840, 840.3, 840.5, 840.6, 840.8, 840.9, 841, 841.8, 841.9, and
32 842.

33 (5) Shoulder impingement syndromes, including
34 tendonitis, bursitis, and related conditions. This clinical
35 category encompasses any inflammation, pain, tenderness,
36 dysfunction, or irritation of a tendon, tendon insertion, tendon

1 sheath, musculotendinous junction, or bursa in the shoulder due
2 to mechanical injury or irritation, including, but not limited
3 to, the diagnoses of impingement syndrome, supraspinatus
4 tendonitis, infraspinatus tendonitis, calcific tendonitis,
5 bicipital tendonitis, subacromial bursitis, subcoracoid
6 bursitis, subdeltoid bursitis, and rotator cuff tendinitis,
7 including, but not limited to, ICD-9-CM codes 726.1 to 726.2,
8 726.9, 726.90, 727 to 727.01, 727.2, 727.3, 840, 840.4, 840.6,
9 840.8, and 840.9.

10 (6) Traumatic sprains or strains of the upper
11 extremity. This clinical category encompasses an instantaneous
12 or acute injury, as a result of a single precipitating event to
13 the ligaments or the muscles of the upper extremity including,
14 without limitation, ICD-9-CM codes 840 to 842.19. Injuries to
15 muscles as a result of repetitive use, or occurring gradually
16 over time without a single precipitating trauma, are considered
17 muscle pain syndromes under subitem (4). Injuries with complete
18 tissue disruption are not subject to this parameter.

19 B. Certain laboratory tests may be indicated in the
20 evaluation of a patient with upper extremity disorder to rule
21 out infection, metabolic-endocrinologic disorders, tumorous
22 conditions, systemic musculoskeletal disorders such as
23 rheumatoid arthritis, or side effects of medications.
24 Laboratory tests may be ordered at any time the health care
25 provider suspects any of these conditions, but the health care
26 provider must justify the need for the tests ordered with clear
27 documentation of the indications.

28 C. Medical imaging evaluation of upper extremity
29 disorders must be based on the findings of the history and
30 physical examination and cannot be ordered before the health
31 care provider's clinical evaluation of the patient. Medical
32 imaging may not be performed as a routine procedure and must
33 comply with the standards in part 5221.6100, subpart 1. The
34 health care provider must document the appropriate indications
35 for any medical imaging studies obtained.

36 D. EMG and nerve conduction studies are only

1 appropriate for nerve entrapment disorders and recurrent nerve
2 entrapment after surgery.

3 E. The following diagnostic procedures or tests are
4 not indicated for diagnosis of upper extremity disorders:

- 5 (1) surface electromyography;
- 6 (2) thermography; or
- 7 (3) somatosensory evoked potentials (SSEP) and
8 motor evoked potentials (MEP).

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

- 12 (1) vibrometry;
- 13 (2) neurometry;
- 14 (3) Semmes-Weinstein monofilament testing; or
- 15 (4) algometry.

16 G. Computerized range of motion or strength measuring
17 tests are not indicated during the period of initial nonsurgical
18 management, but may be indicated during the period of chronic
19 management when used in conjunction with a computerized exercise
20 program, work hardening program, or work conditioning program.
21 During the period of initial nonsurgical management,
22 computerized range of motion or strength testing can be
23 performed but must be done in conjunction with and are not
24 reimbursed separately from an office visit with a physician,
25 chiropractic evaluation or treatment, or physical or
26 occupational therapy evaluation or treatment.

27 H. Personality or psychosocial evaluations may be a
28 useful tool for evaluating patients who continue to have
29 problems despite appropriate initial nonsurgical care. The
30 treating health care provider may perform this evaluation or may
31 refer the patient for consultation with another health care
32 provider in order to obtain a psychological evaluation. These
33 evaluations may be used to assess the patient for a number of
34 psychological conditions which may interfere with recovery from
35 the injury. Since more than one of these psychological
36 conditions may be present in a given case, the health care

1 provider performing the evaluation must consider all of the
2 following:

3 (1) Is symptom magnification occurring?

4 (2) Does the patient exhibit an emotional
5 reaction to the injury, such as depression, fear, or anger,
6 which is interfering with recovery?

7 (3) Are there other personality factors or
8 disorders which are interfering with recovery?

9 (4) Is the patient chemically dependent?

10 (5) Are there any interpersonal conflicts
11 interfering with recovery?

12 (6) Does the patient have a chronic pain syndrome
13 or psychogenic pain?

14 (7) In cases in which surgery is a possible
15 treatment, are psychological factors likely to interfere with
16 the potential benefit of the surgery?

17 I. Diagnostic analgesic blocks or injection studies.

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

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

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

28 J. Functional capacity assessment or evaluation is a
29 comprehensive and objective assessment of a patient's ability to
30 perform work tasks. The components of a functional capacity
31 assessment or evaluation include, but are not limited to,
32 neuromusculoskeletal screening, tests of manual material
33 handling, assessment of functional mobility, and measurement of
34 postural tolerance. A functional capacity assessment or
35 evaluation is an individualized testing process and the
36 component tests and measurements are determined by the patient's

1 condition and the required information. Functional capacity
2 assessments and evaluations are performed to determine and
3 report a patient's physical capacities in general or to
4 determine work tolerance for a specific job, task, or work
5 activity.

6 (1) Functional capacity assessment or evaluation
7 is not indicated during the first 12 weeks of initial
8 nonsurgical treatment.

9 (2) Functional capacity assessment or evaluation
10 is indicated after the first 12 weeks of care in either of the
11 following circumstances:

12 (a) activity restrictions and capabilities
13 must be identified; or

14 (b) there is a question about the patient's
15 ability to return to do a specific job.

16 (3) A functional capacity evaluation is not
17 appropriate to establish baseline performance before treatment,
18 or for subsequent assessments, to evaluate change during or
19 after treatment.

20 (4) Only one completed functional capacity
21 evaluation is indicated per injury.

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

25 Subp. 2. General treatment parameters for upper extremity
26 disorders.

27 A. All medical care for upper extremity disorders,
28 appropriately assigned to a category of subpart 1, item A, is
29 determined by the diagnosis and clinical category in subpart 1,
30 item A, to which the patient has been assigned. General
31 parameters for treatment modalities are set forth in subparts 3
32 to 10. Specific treatment parameters for each clinical category
33 are set forth in subparts 11 to 16 as follows:

34 (1) subpart 11 governs epicondylitis;

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

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

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

5 (5) subpart 15 governs shoulder impingement
6 syndromes; and

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

9 The health care provider must at each visit reassess the
10 appropriateness of the clinical category assigned and reassign
11 the patient if warranted by new clinical information including
12 symptoms, signs, results of diagnostic testing and opinions, and
13 information obtained from consultations with other health care
14 providers. When the clinical category is changed the treatment
15 plan must be appropriately modified to reflect the new clinical
16 category and these changes must be recorded in the medical
17 record. However, a change of clinical category does not in
18 itself allow the health care provider to continue a therapy or
19 treatment modality past the maximum duration specified in
20 subparts 3 to 10, or to repeat a therapy or treatment previously
21 provided for the same injury, unless the treatment or therapy is
22 subsequently delivered to a different part of the body.

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

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

29 (1) First, all patients with an upper extremity
30 disorder must be given initial nonsurgical management, unless
31 otherwise specified. Initial nonsurgical management may include
32 any combination of the passive, active, injection, durable
33 medical equipment, and medication treatment modalities listed in
34 subparts 3, 4, 5, 8, and 10, appropriate to the clinical
35 category. The period of initial nonsurgical treatment begins
36 with the first passive, active, injection, durable medical

1 equipment, or medication modality initiated. Initial
2 nonsurgical treatment must result in progressive improvement as
3 specified in subpart 9.

4 (2) Second, for patients with persistent
5 symptoms, initial nonsurgical management is followed by a period
6 of surgical evaluation. This evaluation should be completed in
7 a timely manner. Surgery, if indicated, should be performed as
8 expeditiously as possible consistent with sound medical practice
9 and subparts 6 and 11 to 16, and part 5221.6500. The treating
10 health care provider may do the evaluation, if it is within the
11 provider's scope of practice, or may refer the employee to a
12 consultant.

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

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

19 (c) A decision against surgery at this time
20 does not preclude a decision for surgery made at a later date.

21 (3) Third, for those patients who are not
22 candidates for surgery or refuse surgery, or who do not have
23 complete resolution of their symptoms with surgery, a period of
24 chronic management may be indicated. Chronic management
25 modalities are described in part 5221.6600, and may include
26 durable medical equipment is described in subpart 8.

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

30 Subp. 3. **Passive treatment modalities.**

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

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

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

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

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

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

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

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

21 (2) Except as otherwise provided in part
22 5221.6050, subpart 8, treatment may continue beyond the
23 additional 12 visits only after prior approval by the insurer,
24 commissioner, or compensation judge based on documentation in
25 the medical record of the effectiveness of further passive
26 treatment in maintaining employability; if the employee is
27 permanently totally disabled, or if upon retirement the employee
28 is eligible for ongoing medical benefits for the work injury,
29 treatment may continue beyond the additional 12 visits only
30 after prior approval by the insurer, commissioner, or
31 compensation judge based on documentation in the medical record
32 of the effectiveness of further passive treatment in maintaining
33 functional status.

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

36 (1) time for treatment response, three to five

1 treatments;

2 (2) maximum treatment frequency, up to five times
3 per week the first one to two weeks decreasing in frequency
4 thereafter; and

5 (3) maximum treatment duration, 12 weeks.

6 D. Thermal treatment includes all superficial and
7 deep heating and cooling modalities. Superficial thermal
8 modalities include hot packs, hot soaks, hot water bottles,
9 hydrocollators, heating pads, ice packs, cold soaks, infrared,
10 whirlpool, and fluidotherapy. Deep thermal modalities include
11 diathermy, ultrasound, and microwave.

12 (1) Treatment given in a clinical setting:

13 (a) time for treatment response, two to four
14 treatments;

15 (b) maximum treatment frequency, up to five
16 times per week for the first one to three weeks, decreasing in
17 frequency thereafter; and

18 (c) maximum treatment duration, 12 weeks of
19 treatment in a clinical setting but only if given in conjunction
20 with other therapies.

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

29 E. Electrical muscle stimulation includes galvanic
30 stimulation, TENS, interferential, and microcurrent techniques.

31 (1) Treatment given in a clinical setting:

32 (a) time for treatment response, two to four
33 treatments;

34 (b) maximum treatment frequency, up to five
35 times per week for the first one to three weeks, decreasing in
36 frequency thereafter; and

1 (c) maximum treatment duration, 12 weeks of
2 treatment in a clinical setting but only if given in conjunction
3 with other therapies.

4 (2) Home use of an electrical stimulation device
5 may be prescribed at any time during a course of treatment.
6 Initial use of an electrical stimulation device must be in a
7 supervised setting in order to ensure proper electrode placement
8 and patient education:

9 (a) time for patient education and training,
10 one to three sessions; and

11 (b) patient may use the electrical
12 stimulation device unsupervised for one month, at which time
13 effectiveness of the treatment must be reevaluated by the
14 provider before continuing home use of the device.

15 F. Acupuncture treatments. Endorphin-mediated
16 analgesic therapy includes classic acupuncture and acupressure:

17 (1) time for treatment response, three to five
18 sessions;

19 (2) maximum treatment frequency, up to three
20 times per week for the first one to three weeks, decreasing in
21 frequency thereafter; and

22 (3) maximum treatment duration, 12 weeks.

23 G. Phoresis includes phonophoresis and iontophoresis:

24 (1) time for treatment response, three to five
25 sessions;

26 (2) maximum treatment frequency, up to three
27 times per week for the first one to three weeks, decreasing in
28 frequency thereafter; and

29 (3) maximum treatment duration is nine sessions
30 of either iontophoresis or phonophoresis, or combination, to any
31 one site, with a maximum duration of 12 weeks for all treatment.

32 H. Manual therapy includes soft tissue and joint
33 mobilization, and therapeutic massage, ~~and manual traction~~:

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

36 (2) maximum treatment frequency, up to five times

1 per week for the first one to two weeks decreasing in frequency
2 thereafter; and

3 (3) maximum treatment duration, 12 weeks.

4 I. Splints, braces, ~~casts~~, and other
5 movement-restricting appliances. Bracing required for longer
6 than two weeks must be accompanied by ~~range-of~~ active motion
7 exercises to avoid stiffness and prolonged disability:

8 (1) time for treatment response, ten days;

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

12 (3) maximum continuous duration, eight weeks.
13 Prophylactic use is allowed indefinitely.

14 J. Rest. Prolonged restriction of activity and
15 immobilization are detrimental to a patient's recovery. Total
16 restriction of use of an affected body part should not be
17 prescribed for more than two weeks, unless rigid immobilization
18 is required. In cases of rigid immobilization, active motion
19 exercises at adjacent joints should begin no later than two
20 weeks after application of the immobilization.

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

27 A. Education must teach the patient about pertinent
28 anatomy and physiology as it relates to upper extremity function
29 for the purpose of injury prevention. Education includes
30 training on posture, biomechanics, and relaxation. The maximum
31 number of treatments is three visits, which include an initial
32 education and training session, and two follow-up visits.

33 B. Posture and work method training must instruct the
34 patient in the proper performance of job activities. Topics
35 include proper positioning of the trunk, neck, and arms, use of
36 optimum biomechanics in performing job tasks, and appropriate

1 pacing of activities. Methods include didactic sessions,
2 demonstrations, exercises, and simulated work tasks. The
3 maximum number of treatments is three visits.

4 C. Worksite analysis and modification must examine
5 the patient's work station, tools, and job duties.
6 Recommendations are made for the alteration of the work station,
7 selection of alternate tools, modification of job duties, and
8 provision of adaptive equipment. The maximum number of
9 treatments is three visits.

10 D. Exercise, which is important to the success of a
11 nonsurgical treatment program and a return to normal activity,
12 must include active patient participation in activities designed
13 to increase flexibility, strength, endurance, or muscle
14 relaxation. Exercise must, at least in part, be specifically
15 aimed at the musculature of the upper extremity. While aerobic
16 exercise may be performed as adjunctive treatment this must not
17 be the primary focus of the exercise program.

18 Exercises must be evaluated to determine if the desired
19 goals are being attained. Strength, flexibility, or endurance
20 must be objectively measured. While the provider may
21 objectively measure the treatment response as often as necessary
22 for optimal care, after the initial evaluation the health care
23 provider may not bill for the testing sooner than two weeks
24 after the initial evaluation and monthly thereafter.

25 Subitems (1) and (2) govern supervised and unsupervised
26 exercise, except for computerized exercise programs and health
27 clubs, which are governed by part 5221.6600.

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

32 (a) maximum treatment frequency, up to three
33 times per week for three weeks. Should decrease with time
34 thereafter; and

35 (b) maximum duration, 12 weeks.

36 (2) Unsupervised exercise must be provided in the

1 least intensive setting and may supplement or follow the period
2 of supervised exercise.

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

11 A. Trigger point injections:

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

14 (2) maximum treatment frequency, once per week to
15 any one site if a positive response to the first injection at
16 that site. If subsequent injections at that site demonstrate
17 diminishing control of symptoms or fail to facilitate objective
18 functional gains, then trigger point injections should be
19 redirected to other areas or discontinued. No more than three
20 injections to different sites are reimbursable per patient
21 visit; and

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

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

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

28 (2) maximum treatment frequency, once per month

29 to any one site if a positive response to the first injection.

30 If subsequent injections demonstrate diminishing control of
31 symptoms or fail to facilitate objective functional gains, then
32 injections should be discontinued. Only three injections to
33 different sites are reimbursable per patient visit; and

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

36 C. Injections for ~~peripheral~~ median nerve entrapment

1 ~~include-injections-of~~ at the carpal tunnel, ~~the-pronator-area-of~~
 2 ~~the-forearm, the-radial-tunnel, Guyon's-canal, and the-cubital~~
 3 ~~tunnel-at-the-elbow:~~

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

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

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

11 Subp. 6. **Surgery.** Surgery may only be performed if it
 12 meets applicable parameters in subparts 11 to ~~14~~ 16 and part
 13 5221.6500.

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

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

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

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

30 B. Repeat surgery must also meet the parameters of
 31 subparts 11 to 16 and part 5221.6500 and is not indicated unless
 32 the need for the repeat surgery is confirmed by a second opinion
 33 obtained before surgery, if requested by the insurer.

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

1 Subp. 8. **Durable medical equipment.** Durable medical
2 equipment is indicated only in the situations specified in items
3 A to D. The health care provider must provide the insurer with
4 prior notification as required in items B and C and part
5 5221.6050, subpart 9.

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

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

15 C. Exercise equipment for home use, including
16 bicycles, treadmills, and stairclimbers, are indicated only
17 within the context of a program or plan of an approved chronic
18 management program. This equipment is not indicated during
19 initial nonsurgical care or during reevaluation and surgical
20 therapy. Prior notification of the insurer is required for the
21 purchase of home exercise equipment. The insurer may decide
22 which brand of a prescribed type of equipment is provided to the
23 patient. If the employer has an appropriate exercise facility
24 on its premises with the prescribed equipment the insurer may
25 mandate use of that facility instead of authorizing purchase of
26 the equipment for home use.

27 (1) Indications: the patient is deconditioned
28 and requires reconditioning which can be accomplished only with
29 the use of the prescribed exercise equipment. The health care
30 provider must document specific reasons why the exercise
31 equipment is necessary and cannot be replaced with other
32 activities.

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

36 D. The following durable medical equipment is not

1 indicated for home use for the upper extremity disorders
2 specified in subparts 11 to 16:

3 (1) whirlpools, Jacuzzi, hot tubs, and special
4 bath or shower attachments; or

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

7 **Subp. 9. Evaluation of treatment by health care provider.**

8 The health care provider must evaluate at each visit whether the
9 treatment is medically necessary and whether initial nonsurgical
10 treatment is effective according to items A to C.

11 No later than the time for treatment response established
12 for the specific modality as specified in subparts 3, 4, and 5,
13 the health care provider must evaluate whether the passive,
14 active, injection, or medication treatment modality is resulting
15 in progressive improvement as specified in items A to C:

16 A. the employee's subjective complaints of pain or
17 disability are progressively improving, as evidenced by
18 documentation in the medical record of decreased distribution,
19 frequency, or intensity of symptoms;

20 B. the objective clinical findings are progressively
21 improving as evidenced by documentation in the medical record of
22 resolution or objectively measured improvement in physical signs
23 of injury; and

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

28 If there is not progressive improvement in at least two
29 items in items A to C, the modality must be discontinued or
30 significantly modified or the provider must reconsider the
31 diagnosis. The evaluation of the effectiveness of the treatment
32 modality can be delegated to an allied health professional
33 directly providing the treatment, but remains the ultimate
34 responsibility of the treating health care provider.

35 **Subp. 10. Scheduled and nonscheduled medication.**

36 Prescription of controlled substance medications scheduled under

1 Minnesota Statutes, section 152.02, including, without
2 limitation, narcotics, is indicated only for the treatment of
3 severe acute pain. Therefore, these medications are not
4 routinely indicated in the treatment of patients with upper
5 extremity disorders. The health care provider must document the
6 rationale for the use of any scheduled medication. Treatment
7 with nonscheduled medication may be appropriate during any phase
8 of treatment and intermittently after all other treatment has
9 been discontinued. The prescribing health care provider must
10 determine that ongoing medication is effective treatment for the
11 patient's condition and the most cost-effective regimen is used.

12 Subp. 11. **Specific treatment parameters for epicondylitis.**

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

16 (1) The passive, active, injection, durable
17 medical equipment, and medication treatment modalities and
18 procedures specified in subparts 3, 4, 5, 8, and 10, may be used
19 in sequence or simultaneously during the period of initial
20 nonsurgical management depending on the severity of the
21 condition. After the first week of treatment, initial
22 nonsurgical care must at all times include active treatment
23 modalities according to subpart 4.

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

27 (3) Except as provided in subpart 3, use of
28 passive treatment modalities in a clinic setting or requiring
29 attendance by a health care provider for a period in excess of
30 12 weeks is not indicated.

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

36 B. If the patient continues with symptoms and

1 objective physical findings after initial nonsurgical
2 management, and if the patient's condition prevents the
3 resumption of the regular activities of daily life including
4 regular vocational activities, then surgical evaluation or
5 chronic management is indicated. The purpose and goal of
6 surgical evaluation is to determine whether surgery is indicated
7 for the patient who has failed to recover with appropriate
8 nonsurgical care or chronic management.

9 (1) Surgical evaluation, if indicated, must begin
10 no later than 12 months after beginning initial nonsurgical
11 management.

12 (2) Surgical evaluation may include the use of
13 appropriate laboratory and electrodiagnostic testing within the
14 parameters of subpart 1, if not already obtained during the
15 initial evaluation. Repeat testing is not indicated unless
16 there has been an objective change in the patient's condition
17 which in itself would warrant further testing. Failure to
18 improve with therapy does not, by itself, warrant further
19 testing.

20 (3) Plain films may be appropriate if there is a
21 history of trauma, infection, or inflammatory disorder and are
22 subject to the general parameters in part 5221.6100, subpart 1.
23 Other medical imaging studies are not indicated.

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

27 (5) Consultation with other health care providers
28 is an important part of surgical evaluation of a patient who
29 fails to recover with appropriate initial nonsurgical
30 management. The need for consultation and the choice of
31 consultant will be determined by the diagnostic findings and the
32 patient's condition. Consultation is governed by part
33 5221.6050, subpart 6.

34 (6) If surgery is indicated, it may not be
35 performed until 12 months after initial ~~surgical~~ nonsurgical
36 management was begun except in a patient who has had resolution

1 of symptoms with appropriate treatment followed by a recurrence
2 with intractable pain. In this instance, a second surgical
3 opinion must confirm the need for surgery sooner than 12 months
4 after initial nonsurgical management was begun.

5 (7) If surgery is not indicated, or if the
6 patient does not wish to proceed with surgery, then the patient
7 is a candidate for chronic management. An initial
8 recommendation or decision against surgery does not preclude
9 surgery at a later date.

10 C. If the patient continues with symptoms and
11 objective physical findings after surgery or the patient refused
12 surgery or the patient was not a candidate for surgery, and if
13 the patient's condition prevents the resumption of the regular
14 activities of daily life including regular vocational
15 activities, then the patient may be a candidate for chronic
16 management according to part 5221.6600.

17 Subp. 12. Specific treatment parameters for tendonitis of
18 forearm, wrist, and hand.

19 A. Except as provided in item B, subitem (3), initial
20 nonsurgical management is appropriate for all patients with
21 tendonitis and must be the first phase of treatment. Any course
22 or program of initial nonsurgical management must meet all of
23 the parameters of subpart 11, item A.

24 B. If the patient continues with symptoms and
25 objective physical findings after initial nonsurgical
26 management, and if the patient's condition prevents the
27 resumption of the regular activities of daily life including
28 regular vocational activities, then surgical evaluation or
29 chronic management is indicated. Surgical evaluation and
30 surgical therapy must meet all of the parameters of subpart 11,
31 item B, with the modifications in subitems (1) to (3).

32 (1) For patients with a specific diagnosis of de
33 Quervain's syndrome, surgical evaluation and surgical therapy,
34 if indicated, may begin after only two months of initial
35 nonsurgical management.

36 (2) For patients with a specific diagnosis of

1 trigger finger or trigger thumb, surgical evaluation and
2 potential surgical therapy may begin after only one month of
3 initial nonsurgical management.

4 (3) For patients with a locked finger or thumb,
5 surgery may be indicated immediately without any preceding
6 nonsurgical management.

7 C. If the patient continues with symptoms and
8 objective physical findings after surgery, or the patient
9 refused surgery or the patient was not a candidate for surgery,
10 and if the patient's condition prevents the resumption of the
11 regular activities of daily life including regular vocational
12 activities, then the patient may be a candidate for chronic
13 management. Any course or program of chronic management for
14 patients with tendonitis must meet all of the parameters of part
15 5221.6600.

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

18 A. Initial nonsurgical management is appropriate for
19 all patients with nerve entrapment syndromes, except as
20 specified in subitem (2), and must be the first phase of
21 treatment. Any course or program of initial nonsurgical
22 management must meet all of the parameters of subpart 11, item
23 A, with the following modifications: nonsurgical management may
24 be inappropriate for patients with advanced symptoms and signs
25 of nerve compression, such as abnormal two-point discrimination,
26 motor weakness, or muscle atrophy, or for patients with symptoms
27 of nerve entrapment due to acute trauma. In these cases,
28 immediate surgical evaluation may be indicated.

29 B. If the patient continues with symptoms and
30 objective physical findings after 12 weeks of initial
31 nonsurgical management, and if the patient's condition prevents
32 the resumption of the regular activities of daily life including
33 regular vocational activities, then surgical evaluation or
34 chronic management is indicated. Surgical evaluation and
35 surgical therapy must meet all of the parameters of subpart 11,
36 item B, with the modifications in subitems (1) to (3).

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

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

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

12 C. If the patient continues with symptoms and
13 objective physical findings after all surgery, or the patient
14 refused surgery therapy or the patient was not a candidate for
15 surgery therapy, and if the patient's condition prevents the
16 resumption of the regular activities of daily life including
17 regular vocational activities, then the patient may be a
18 candidate for chronic management. Any course or program of
19 chronic management for patients with nerve entrapment syndromes
20 must meet all of the parameters of part 5221.6600.

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

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

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

30 C. If the patient continues with symptoms and
31 objective physical findings after ~~12-months-of~~ initial
32 nonsurgical management, and if the patient's condition prevents
33 the resumption of the regular activities of daily life including
34 regular vocational activities, then the patient may be a
35 candidate for chronic management. Any course or program of
36 chronic management for patients with muscle pain syndrome must

1 meet all of the parameters of part 5221.6600.

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

4 A. Initial nonsurgical management is appropriate for
5 all patients with shoulder impingement syndromes without
6 clinical evidence of rotator cuff tear and must be the first
7 phase of treatment. Any course or program of initial
8 nonsurgical management must meet all of the parameters of
9 subpart 11, item A, except as follows:

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

- 13 (a) clinical findings of rotator cuff tear;
- 14 or
- 15 (b) acute rupture of the proximal biceps
- 16 tendon;

17 (2) use of home-based treatment modalities with
18 monitoring by the health care provider may continue for up to
19 six months. At any time during this period the patient may be a
20 candidate for chronic management if surgery is ruled out as an
21 appropriate treatment.

22 B. If the patient continues with symptoms and
23 objective physical findings after six months of initial
24 nonsurgical management, and if the patient's condition prevents
25 the resumption of the regular activities of daily life including
26 regular vocational activities, then surgical evaluation or
27 chronic management is indicated. Surgical evaluation and
28 surgical therapy must meet all of the parameters of subpart 11,
29 item B, with the modifications in subitems (1) to (3).

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

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

35 (3) The only surgical procedures indicated for
36 patients with shoulder impingement syndrome and related

1 conditions are rotator cuff repair, acromioplasty, excision of
2 distal clavicle, excision of bursa, removal of adhesion, or
3 repair of proximal biceps tendon, all of which must meet the
4 parameters of part 5221.6500, subpart 3.

5 C. If the patient continues with symptoms and
6 objective physical findings after ~~initial-nonsurgical-management~~
7 surgery, or the patient refused surgery or was not a candidate
8 for surgery, and if the patient's condition prevents the
9 resumption of the regular activities of daily life including
10 regular vocational activities, then the patient may be a
11 candidate for chronic management. Any course or program of
12 chronic management for patients with shoulder impingement
13 syndrome must meet the parameters of part 5221.6600.

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

16 A. Initial nonsurgical management must be the first
17 phase of treatment for all patients with traumatic sprains and
18 strains of the upper extremity without evidence of complete
19 tissue disruption. Any course or program of initial nonsurgical
20 management must meet all of the parameters of subpart 11.

21 B. Surgery is not indicated for the treatment of
22 traumatic sprains and strains, unless there is clinical evidence
23 of complete tissue disruption. Patients with complete tissue
24 disruption may need immediate surgery.

25 C. If the patient continues with symptoms and
26 objective physical findings after 12 weeks of initial
27 nonsurgical management, and if the patient's condition prevents
28 the resumption of the regular activities of daily life,
29 including regular vocational activities, then the patient may be
30 a candidate for chronic management. Any course or program of
31 chronic management must meet all of the parameters of part
32 5221.6600.

33 5221.6305 REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER AND LOWER
34 EXTREMITIES.

35 Subpart 1. **Scope.**

1 A. This clinical category encompasses any condition
2 of the upper or lower extremity characterized by concurrent
3 presence in the involved extremity of five of the following
4 conditions: edema; local skin color change of red or purple;
5 osteoporosis in underlying bony structures demonstrated by
6 radiograph; local dyshidrosis; local abnormality of skin
7 temperature regulation; reduced passive range of motion in
8 contiguous joints; local alteration of skin texture of smooth or
9 shiny; or typical findings of reflex sympathetic dystrophy on
10 bone scan. This clinical category includes, but is not limited
11 to, the diagnoses of reflex sympathetic dystrophy, causalgia,
12 Sudek's atrophy, algoneurodystrophy, and shoulder-hand syndrome,
13 and including, but not limited to, ICD-9-CM codes 337.9, 354.4,
14 and 733.7.

15 B. Reflex sympathetic dystrophy occurs as a
16 complication of another preceding injury. The treatment
17 parameters of this part refer to the treatment of the body part
18 affected by the reflex sympathetic dystrophy. The treatment for
19 any condition not affected by reflex sympathetic dystrophy
20 continues to be subject to whatever treatment parameters
21 otherwise apply. Any treatment under this part for the reflex
22 sympathetic dystrophy may be in addition to treatment received
23 for the original condition.

24 C. Thermography may be used in the diagnosis of
25 reflex sympathetic dystrophy, but is considered an adjunct to
26 physical examination and is not reimbursed separately from the
27 office visit.

28 Subp. 2. **Initial nonsurgical management.** Initial
29 nonsurgical management is appropriate for all patients with
30 reflex sympathetic dystrophy and must be the first phase of
31 treatment. Any course or program of initial nonsurgical
32 management is limited to the modalities specified in items A to
33 D.

34 A. Therapeutic injection modalities. The only
35 ~~injection~~ injections allowed for reflex sympathetic dystrophy ~~is~~
36 are sympathetic block, intravenous infusion of steroids or

1 sympatholytics, or epidural block.

2 (1) Unless medically contraindicated, sympathetic
3 blocks or the intravenous infusion of steroids or sympatholytics
4 must be used if reflex sympathetic dystrophy has continued for
5 four weeks and the employee remains disabled as a result of the
6 reflex sympathetic dystrophy.

7 ~~(1)~~ (a) Time for treatment response: within
8 30 minutes.

9 ~~(2)~~ (b) Maximum treatment frequency: can
10 repeat an injection at a site if there was a positive response
11 to the first injection. If subsequent injections demonstrate
12 diminishing control of symptoms or fail to facilitate objective
13 functional gains, then injections must be discontinued. No more
14 than three injections to different sites are reimbursable per
15 patient visit.

16 ~~(3)~~ (c) Maximum treatment duration: may be
17 continued as long as injections control symptoms and facilitate
18 objective functional gains, if the period of improvement is
19 progressively longer with each injection.

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

23 B. Only the passive treatment modalities set forth in
24 subitems (1) to (4) are indicated. These passive treatment
25 modalities in a clinical setting or requiring attendance by a
26 health care provider are not indicated beyond 12 weeks from the
27 first modality initiated for treatment of the reflex sympathetic
28 dystrophy.

29 (1) Thermal treatment includes all superficial
30 and deep heating and cooling modalities. Superficial thermal
31 modalities include hot packs, hot soaks, hot water bottles,
32 hydrocollators, heating pads, ice packs, cold soaks, infrared,
33 whirlpool, and fluidotherapy. Deep thermal modalities include
34 diathermy, ultrasound, and microwave.

35 (a) Treatment given in a clinical setting:

36 i. time for treatment response, two to

1 four treatments;

2 ii. maximum treatment frequency, up to
3 five times per week for the first one to three weeks, decreasing
4 in frequency thereafter; and

5 iii. maximum treatment duration, 12
6 weeks of treatment in a clinical setting but only if given in
7 conjunction with other therapies specified in this subpart.

8 (b) Home use of thermal modalities may be
9 prescribed at any time during the course of treatment. Home use
10 may only involve hot packs, hot soaks, hot water bottles,
11 hydrocollators, heating pads, ice packs, and cold soaks which
12 can be applied by the patient without professional assistance.
13 Home use of thermal modalities does not require any special
14 training or monitoring, other than that usually provided by the
15 health care provider during an office visit.

16 (2) Desensitizing procedures, such as stroking or
17 friction massage, stress loading, and contrast baths:

18 (a) time for treatment response, three to
19 five treatments;

20 (b) maximum treatment frequency in a
21 clinical setting, up to five times per week for the first one to
22 two weeks decreasing in frequency thereafter; and

23 (c) maximum treatment duration in a clinical
24 setting, 12 weeks. Home use of desensitizing procedures may be
25 prescribed at any time during the course of treatment.

26 (3) Electrical stimulation includes galvanic
27 stimulation, TENS, interferential, and microcurrent techniques.

28 (a) Treatment given in a clinical setting:

29 i. time for treatment response, two to
30 four treatments;

31 ii. maximum treatment frequency, up to
32 five times per week for the first one to three weeks, decreasing
33 in frequency thereafter; and

34 iii. maximum treatment duration, 12
35 weeks of treatment in a clinical setting, but only if given in
36 conjunction with other therapies.

1 (b) Home use of an electrical stimulation
2 device may be prescribed at any time during a course of
3 treatment. Initial use of an electrical stimulation device must
4 be in a supervised setting in order to ensure proper electrode
5 placement and patient education:

6 i. time for patient education and
7 training, one to three sessions; and

8 ii. patient may use the electrical
9 stimulation device unsupervised for one month, at which time
10 effectiveness of the treatment must be reevaluated by the
11 provider before continuing home use of the device.

12 (4) Acupuncture treatments. Endorphin-mediated
13 analgesic therapy includes classic acupuncture and acupressure:

14 (a) time for treatment response, three to
15 five sessions;

16 (b) maximum treatment frequency, up to three
17 times per week for the first one to three weeks, decreasing in
18 frequency thereafter; and

19 (c) maximum treatment duration, 12 weeks.

20 C. Active treatment includes supervised and
21 unsupervised exercise. After the first week of treatment,
22 initial nonsurgical management must include exercise. Exercise
23 is essential for a return to normal activity and must include
24 active patient participation in activities designed to increase
25 flexibility, strength, endurance, or muscle relaxation.
26 Exercise must be specifically aimed at the involved
27 musculature. Exercises must be evaluated to determine if the
28 desired goals are being attained. Strength, flexibility, or
29 endurance must be objectively measured. While the provider may
30 objectively measure the treatment response as often as necessary
31 for optimal care, after the initial evaluation the health care
32 provider may not bill for the tests sooner than two weeks after
33 the initial evaluation, and monthly thereafter.

34 (1) Supervised exercise. One goal of a
35 supervised exercise program must be to teach the patient how to
36 maintain and maximize any gains experienced from exercise.

1 Self-management of the condition must be promoted:

2 (a) maximum treatment frequency, up to five
3 times per week for three weeks. Should decrease in frequency
4 thereafter; and

5 (b) maximum duration, 12 weeks.

6 (2) Unsupervised exercise must be provided in the
7 least intensive setting and may supplement or follow the period
8 of supervised exercise. Maximum duration is unlimited.

9 D. Oral medications may be indicated in accordance
10 with accepted medical practice.

11 Subp. 3. **Surgery.**

12 A. Surgical sympathectomy may only be performed in
13 patients who had a sustained but incomplete improvement with
14 sympathetic blocks by injection.

15 B. Dorsal column stimulator or morphine pump may be
16 indicated for a patient with neuropathic pain unresponsive to
17 all other treatment modalities who is not a candidate for any
18 other therapy and has had a favorable response to a trial
19 screening period. Use of ~~a-dorsal-column-stimulator~~ these
20 devices is indicated only if a second opinion confirms that this
21 treatment is indicated, and a personality or psychosocial
22 evaluation indicates that the patient is likely to benefit from
23 this treatment.

24 Subp. 4. **Chronic management.** If the patient continues
25 with symptoms and objective physical findings after surgery, or
26 the patient refuses surgery, or the patient was not a candidate
27 for surgery, and if the patient's condition prevents the
28 resumption of the regular activities of daily life including
29 regular vocational activities, then the patient may be a
30 candidate for chronic management. Any course or program of
31 chronic management must satisfy all of the treatment parameters
32 of part 5221.6600.

33 5221.6400 INPATIENT HOSPITALIZATION PARAMETERS.

34 Subpart 1. **General principles.**

35 A. The health care provider must provide prior

1 notification of inpatient hospital admission for nonemergency
2 care according to part 5221.6050, subpart 9. Hospitalization is
3 characterized as inpatient if the patient spends at least one
4 night in the hospital.

5 B. Treatment for emergency conditions, including
6 incapacitating pain, should not be delayed to provide the
7 insurer with prior notification. The admitting health care
8 provider should notify the insurer within two business days
9 following an emergency admission, or within two business days
10 after the health care provider learns that it is a workers'
11 compensation injury. The medical necessity for the emergency
12 hospitalization is subject to retrospective review, based on the
13 information available at the time of the emergency
14 hospitalization.

15 C. Unless the patient's condition requires special
16 care, only ward or semiprivate accommodations are indicated.
17 The admitting health care provider must document the special
18 care needs.

19 D. Admissions before the day of surgery are indicated
20 only if they are medically necessary to stabilize the patient
21 before surgery. Admission before the day of surgery to perform
22 any or all of a preoperative work-up which could have been
23 completed as an outpatient is not indicated.

24 E. Inpatient hospitalization solely for physical
25 therapy, bedrest, or administration of injectable drugs is
26 indicated only if the treatment is otherwise indicated and the
27 patient's condition makes the patient unable to perform the
28 activities of daily life and participate in the patient's own
29 treatment and self-care.

30 F. Discharge from the hospital must be at the
31 earliest possible date consistent with proper health care.

32 G. If transfer to a convalescent center or nursing
33 home is indicated, prior notification is required as provided
34 for inpatient hospitalization.

35 Subp. 2. **Specific requirements for hospital admission of**
36 **patients with low back pain.** Hospitalization for low back pain

1 is indicated in the circumstances in items A to D.

2 A. When the patient experiences incapacitating pain
3 as evidenced by inability to mobilize for activities of daily
4 living, for example unable to ambulate to the bathroom, and in
5 addition, the intensity of service during admission meets the
6 criteria in subitems (1) and (2).

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

10 (2) Muscle relaxants or narcotic analgesics are
11 necessary intramuscularly or intravenously for a minimum of
12 three injections in 24 hours. Need for parenteral analgesics is
13 determined by:

14 (a) an inability to take oral medications or
15 diet (N.P.O.); or

16 (b) an inability to achieve relief with
17 aggressive oral analgesics.

18 B. For surgery which is otherwise indicated according
19 to part 5221.6500 and is appropriately scheduled as an inpatient
20 procedure.

21 C. For evaluation and treatment of cauda equina
22 syndrome, according to part 5221.6200, subpart 13.

23 D. For evaluation and treatment of foot drop or
24 progressive neurologic deficit, according to part 5221.6200,
25 subpart 13.

26 5221.6500 PARAMETERS FOR SURGICAL PROCEDURES.

27 Subpart 1. General.

28 A. The health care provider must provide prior
29 notification according to part 5221.6050, subpart 9, before
30 proceeding with any elective inpatient surgery.

31 B. Emergency surgery may proceed without prior
32 notification. The reasonableness and necessity for the
33 emergency surgery is subject to retrospective review based on
34 the information available at the time of the emergency surgery.

35 Subp. 2. Spinal surgery.

1 Initial nonsurgical, surgical, and chronic management
2 parameters are also included in parts 5221.6200, low back pain;
3 5221.6205, neck pain; and 5221.6210, thoracic back pain.

4 A. Surgical decompression of a lumbar nerve root or
5 roots includes, but is not limited to, the following lumbar
6 procedures: laminectomy, laminotomy, discectomy,
7 microdiscectomy, percutaneous discectomy, or foraminotomy. When
8 providing prior notification for decompression of multiple nerve
9 roots, the procedure at each nerve root is subject independently
10 to the requirements of subitems (1) to (3).

11 (1) Diagnoses: surgical decompression of a
12 lumbar nerve root may be performed for the following diagnoses:

13 (a) intractable and incapacitating regional
14 low back pain with positive nerve root tension signs and an
15 imaging study showing displacement of lumbar intervertebral disc
16 which impinges significantly on a nerve root or the thecal sac,
17 ICD-9-CM code 722.10;

18 (b) sciatica, ICD-9-CM code 724.3; or

19 (c) lumbosacral radiculopathy or
20 radiculitis, ICD-9-CM code 724.4.

21 (2) Indications: both of the following
22 conditions in units (a) and (b) must be satisfied to indicate
23 that the surgery is reasonably required.

24 (a) Response to nonsurgical care: the
25 employee's condition includes one of the following:

26 i. failure to improve with a minimum
27 of eight weeks of initial nonsurgical care; or

28 ii. cauda equina syndrome, ICD-9-CM
29 code 344.6, 344.60, or 344.61; or

30 iii. progressive neurological deficits.

31 (b) Clinical findings: the employee
32 exhibits one of the findings of subunit i in combination with
33 the test results of subunit ii or, in the case of diagnosis in
34 subitem (1), unit (a), a second opinion confirms that
35 decompression of the lumbar nerve root is the appropriate
36 treatment for the patient's condition:

1 i. subjective sensory symptoms in a
2 dermatomal distribution which may include radiating pain,
3 burning, numbness, tingling, or paresthesia, or objective
4 clinical findings of nerve root specific motor deficit,
5 including, but not limited to, foot drop or quadriceps weakness,
6 reflex changes, or positive EMG; and

7 ii. medical imaging test results that
8 correlate with the level of nerve root involvement consistent
9 with both the subjective and objective findings.

10 (3) Repeat surgical decompression of a lumbar
11 nerve root is not indicated at the same nerve root unless a
12 second opinion, if requested by the insurer, confirms that
13 surgery is indicated.

14 B. Surgical decompression of a cervical nerve root.
15 Surgical decompression of a cervical nerve root or roots
16 includes, but is not limited to, the following cervical
17 procedures: laminectomy, laminotomy, discectomy, foraminotomy
18 with or without fusion. When providing prior notification for
19 decompression of multiple nerve roots, the procedure at each
20 nerve root is subject independently to the requirements of
21 subitems (1) to (3).

22 (1) Diagnoses: surgical decompression of a
23 cervical nerve root may be performed for the following diagnoses:

24 (a) displacement of cervical intervertebral
25 disc, ICD-9-CM code 722.0, excluding fracture; or

26 (b) cervical radiculopathy or radiculitis,
27 ICD-9-CM code 723.4, excluding fracture.

28 (2) Indications: the requirements in units (a)
29 and (b) must be satisfied to indicate that surgery is reasonably
30 required:

31 (a) response to nonsurgical care, the
32 employee's condition includes one of the following:

33 i. failure to improve with a minimum
34 of eight weeks of initial nonsurgical care;

35 ii. cervical compressive myelopathy;
36 or

1 iii. progressive neurologic deficits;
2 (b) clinical findings: the employee
3 exhibits one of the findings of subunit i, in combination with
4 the test results of subunit ii:

5 i. subjective sensory symptoms in a
6 dermatomal distribution which may include radiating pain,
7 burning, numbness, tingling, or paresthesia, or objective
8 clinical findings of nerve root specific motor deficit, reflex
9 changes, or positive EMG; and

10 ii. medical imaging test results that
11 correlate with the level of nerve root involvement consistent
12 with both the subjective and objective findings.

13 (3) Second opinions: surgical decompression of a
14 cervical nerve root is not indicated for the following
15 conditions, unless a second opinion, if requested by the
16 insurer, confirms that the surgery is indicated:

17 (a) repeat surgery at same level; or

18 (b) request for surgery at the C3-4 level.

19 C. Lumbar arthrodesis with or without instrumentation.

20 (1) Indications: one of the following conditions
21 must be satisfied to indicate that the surgery is reasonably
22 required:

23 (a) unstable lumbar vertebral fracture,
24 ICD-9-CM codes 805.4, 805.5, 806.4, and 806.5; or

25 (b) for a second or third surgery only,
26 documented reextrusion or redisplacement of lumbar
27 intervertebral disc, ICD-9-CM code 722.10, after previous
28 successful disc surgery at the same level and new lumbar
29 radiculopathy with or without incapacitating back pain, ICD-9-CM
30 code 724.4. Documentation under this item must include an MRI
31 or CT scan or a myelogram; or

32 (c) traumatic spinal deformity including a
33 history of compression (wedge) fracture or fractures, ICD-9-CM
34 code 733.1, and demonstrated acquired kyphosis or scoliosis,
35 ICD-9-CM codes 737.1, 737.10, 737.30, 737.41, and 737.43; or

36 (d) incapacitating low back pain, ICD-9-CM

1 code 724.2, for longer than three months, and one of the
 2 following conditions involving lumbar segments L-3 and below is
 3 present:

4 i. for the first surgery only,
 5 degenerative disc disease, ICD-9-CM code 722.4, 722.5, 722.6, or
 6 722.7, with postoperative documentation of instability created
 7 or found at the time of surgery, or positive discogram at one or
 8 two levels; or

9 ii. pseudoarthrosis, ICD-9-CM code
 10 733.82; or

11 iii. for the second or third surgery
 12 only, previously operated disc; or

13 iv. spondylolisthesis.

14 (2) Contraindications: lumbar arthrodesis is not
 15 indicated as the first primary surgical procedure for a new,
 16 acute lumbosacral disc herniation with unilateral radiating leg
 17 pain in a radicular pattern with or without neurological deficit.

18 (3) Retrospective review: when lumbar
 19 arthrodesis is performed to correct instability created during a
 20 decompression, laminectomy, or discectomy, approval for the
 21 arthrodesis will be based on a retrospective review of the
 22 operative report.

23 Subp. 3. **Upper extremity surgery.** Initial nonsurgical,
 24 surgical, and chronic management parameters for upper extremity
 25 disorders are found in part 5221.6300, subparts 1 to 16.

26 A. Rotator cuff repair:

27 (1) Diagnoses: rotator cuff surgery may be
 28 performed for the following diagnoses:

29 (a) rotator cuff syndrome of the shoulder,
 30 ICD-9-CM code 726.1, and allied disorders: unspecified
 31 disorders of shoulder bursae and tendons, ICD-9-CM code 726.10,
 32 calcifying tendinitis of shoulder, ICD-9-CM code 726.11,
 33 bicipital tenosynovitis, ICD-9-CM code 726.12, and other
 34 specified disorders, ICD-9-CM code 726.19; or

35 (b) tear of rotator cuff, ICD-9-CM code
 36 727.61.

1 (2) Criteria and indications: in addition to one
2 of the diagnoses in subitem (1), both of the following
3 conditions must be satisfied to indicate that surgery is
4 reasonably required:

5 (a) response to nonsurgical care: the
6 employee's condition has failed to improve with adequate initial
7 nonsurgical treatment; and

8 (b) clinical findings: the employee
9 exhibits:

10 i. severe shoulder pain and inability
11 to elevate the shoulder; or

12 ii. weak or absent abduction and
13 tenderness over rotator cuff, or pain relief obtained with an
14 injection of anesthetic for diagnostic or therapeutic trial; and

15 iii. positive findings in arthrogram,
16 MRI, or ultrasound, or positive findings on previous
17 arthroscopy, if performed.

18 B. Acromioplasty:

19 (1) Diagnosis: acromioplasty may be performed
20 for acromial impingement syndrome, ICD-9-CM codes 726.0 to 726.2.

21 (2) Criteria and indications: in addition to the
22 diagnosis in subitem (1), both of the following conditions must
23 be satisfied for acromioplasty:

24 (a) response to nonsurgical care: the
25 employee's condition has failed to improve after adequate
26 initial nonsurgical care; and

27 (b) clinical findings: the employee
28 exhibits pain with active elevation from 90 to 130 degrees and
29 pain at night, and a positive impingement test.

30 C. Repair of acromioclavicular or costoclavicular
31 ligaments:

32 (1) Diagnosis: surgical repair of
33 acromioclavicular or costoclavicular ligaments may be performed
34 for acromioclavicular separation, ICD-9-CM codes 831.04 to
35 831.14.

36 (2) Criteria and indications: in addition to the

1 diagnosis in subitem (1), the requirements of units (a) and (b)
2 must be satisfied for repair of acromioclavicular or
3 costoclavicular ligaments:

4 (a) response to nonsurgical care: the
5 employee's condition includes:

6 i. failure to improve after at least a
7 one-week trial period in a support brace; or

8 ii. separation cannot be reduced and
9 held in a brace; or

10 iii. grade III separation has
11 occurred; and

12 (b) clinical findings: the employee
13 exhibits localized pain at the acromioclavicular joint and
14 prominent distal clavicle and radiographic evidence of
15 separation at the acromioclavicular joint.

16 D. Excision of distal clavicle:

17 (1) Diagnosis: excision of the distal clavicle
18 may be performed for the following conditions:

19 (a) acromioclavicular separation, ICD-9-CM
20 codes 831.01 to 831.14;

21 (b) osteoarthritis of the acromioclavicular
22 joint, ICD-9-CM codes 715.11, 715.21, and 715.31; or

23 (c) shoulder impingement syndrome.

24 (2) Criteria and indications: in addition to one
25 of the diagnosis in subitem (1), the following conditions must
26 be satisfied for excision of distal clavicle:

27 (a) response to nonsurgical care: the
28 employee's condition fails to improve with adequate initial
29 nonsurgical care; and

30 (b) clinical findings: the employee
31 exhibits:

32 i. pain at the acromioclavicular
33 joint, with aggravation of pain with motion of shoulder or
34 carrying weight;

35 ii. confirmation that separation of AC
36 joint is unresolved and prominent distal clavicle, or pain

1 relief obtained with an injection of anesthetic for
2 diagnostic/therapeutic trial; and

3 iii. separation at the
4 acromioclavicular joint with weight-bearing films, or severe
5 degenerative joint disease at the acromioclavicular joint noted
6 on X-rays.

7 E. Repair of shoulder dislocation or subluxation (any
8 procedure):

9 (1) Diagnosis: surgical repair of a shoulder
10 dislocation may be performed for the following diagnoses:

11 (a) recurrent dislocations, ICD-9-CM code
12 718.31;

13 (b) recurrent subluxations; or

14 (c) persistent instability following
15 traumatic dislocation.

16 (2) Criteria and indications: in addition to one
17 of the diagnoses in subitem (1), the following clinical findings
18 must exist for repair of a shoulder dislocation:

19 (a) the employee exhibits a history of
20 multiple dislocations or subluxations that inhibit activities of
21 daily living; and

22 (b) ~~X-ray, CT-scan, or MRI-scan~~ findings are
23 consistent with multiple dislocations or subluxations.

24 F. Repair of proximal biceps tendon:

25 (1) Diagnosis: surgical repair of a proximal
26 biceps tendon may be performed for proximal rupture of the
27 biceps, ICD-9-CM code 727.62 or 840.8.

28 (2) Criteria and indications: in addition to the
29 diagnosis in subitem (1), both of the following conditions must
30 be satisfied for repair of proximal biceps tendon:

31 (a) the procedure may be done alone or in
32 conjunction with another indicated repair of the rotator cuff;
33 and

34 (b) clinical findings: the employee
35 exhibits:

36 i. complaint of pain that does not

1 resolve with attempt to use arm; and

2 ii. palpation of "bulge" in upper
3 aspect of arm.

4 G. Epicondylitis. Specific requirements for surgery
5 for epicondylitis are included in part 5221.6300, subpart 11.

6 H. Tendinitis. Specific requirements for surgery for
7 tendinitis are included in part 5221.6300, subpart 12.

8 I. Nerve entrapment syndromes. Specific requirements
9 for nerve entrapment syndromes are included in part 5221.6300,
10 subpart 13.

11 J. Muscle pain syndromes. Surgery is not indicated
12 for muscle pain syndromes.

13 K. Traumatic sprains and strains. Surgery is not
14 indicated for the treatment of traumatic sprains and strains,
15 unless there is clinical evidence of complete tissue
16 disruption. Patients with complete tissue disruption may need
17 immediate surgery.

18 Subp. 4. Lower extremity surgery.

19 A. Anterior cruciate ligament (ACL) reconstruction:

20 (1) Diagnoses: surgical repair of the anterior
21 cruciate ligament, including arthroscopic repair, may be
22 performed for the following diagnoses:

23 (a) old disruption of anterior cruciate
24 ligament, ICD-9-CM code 717.83; or

25 (b) sprain of cruciate ligament of knee,
26 ICD-9-CM code 844.2.

27 (2) Criteria and indications: in addition to one
28 of the diagnoses in subitem (1) the conditions in units (a) to
29 (c) must be satisfied for anterior cruciate ligament
30 reconstruction. Pain alone is not an indication:

31 (a) the employee gives a history of
32 instability of the knee described as "buckling or giving way"
33 with significant effusion at time of injury, or description of
34 injury indicates a rotary twisting or hyperextension occurred;

35 (b) there are objective clinical findings of
36 positive Lachman's sign, positive pivot shift, and/or positive

1 anterior drawer; and

2 (c) there are positive diagnostic findings
3 with arthrogram, MRI, or arthroscopy and there is no evidence of
4 severe compartmental arthritis.

5 B. Patella tendon realignment or Maquet procedure:

6 (1) Diagnosis: patella tendon realignment may be
7 performed for dislocation of patella, open, ICD-9-CM code 836.3,
8 or closed, ICD-9-CM code 836.4, or chronic residuals of
9 dislocation.

10 (2) Criteria and indications: in addition to the
11 diagnosis in subitem (1), all of the following conditions must
12 be satisfied for a patella tendon realignment:

13 (a) the employee gives a history of rest
14 pain as well as pain with patellofemoral movement, and recurrent
15 effusion, or recurrent dislocation; and

16 (b) there are objective clinical findings of
17 patellar apprehension, synovitis, lateral tracking, or Q angle
18 greater than 15 degrees.

19 C. Knee joint replacement:

20 (1) Diagnoses: knee joint replacement may be
21 performed for degeneration of articular cartilage or meniscus of
22 knee, ICD-9-CM codes 717.1 to 717.4.

23 (2) Criteria and indications: in addition to the
24 diagnosis in subitem (1), the following conditions must be
25 satisfied for a knee joint replacement:

26 (a) clinical findings: the employee
27 exhibits limited range of motion, night pain in the joint or
28 pain with weight-bearing, and no significant relief of pain with
29 an adequate course of initial nonsurgical care; and

30 (b) diagnostic findings: there is
31 significant loss or erosion of cartilage to the bone, and
32 positive findings of advanced arthritis and joint destruction
33 with standing films, MRI, or arthroscopy.

34 D. Fusion; ankle, tarsal, metatarsal:

35 (1) Diagnoses: fusion may be performed for the
36 following conditions:

1 (a) malunion or nonunion of fracture of
2 ankle, tarsal, or metatarsal, ICD-9-CM code 733.81 or 733.82; or

3 (b) traumatic arthritis (arthropathy),
4 ICD-9-CM code 716.17.

5 (2) Criteria and indications: in addition to one
6 of the diagnoses in subitem (1), the following conditions must
7 be satisfied for an ankle, tarsal, or metatarsal fusion:

8 (a) initial nonsurgical care: the employee
9 must have failed to improve with an adequate course of initial
10 nonsurgical care which included:

11 i. immobilization which may include
12 casting, bracing, shoe modification, or other orthotics; and

13 ii. anti-inflammatory medications;

14 (b) clinical findings:

15 i. the employee gives a history of
16 pain which is aggravated by activity and weight-bearing, and
17 relieved by xylocaine injection; and

18 ii. there are objective findings on
19 physical examination of malalignment or specific joint line
20 tenderness, and decreased range of motion; and

21 (c) diagnostic findings: there are medical
22 imaging studies confirming the presence of:

23 i. loss of articular cartilage and
24 joint space narrowing;

25 ii. bone deformity with hypertrophic
26 spurring and sclerosis; or

27 iii. nonunion or malunion of a
28 fracture.

29 E. Lateral ligament ankle reconstruction:

30 (1) Diagnoses: ankle reconstruction surgery
31 involving the lateral ligaments may be performed for the
32 following conditions:

33 (a) chronic ankle instability, ICD-9-CM code
34 718.87; or

35 (b) grade III sprain, ICD-9-CM codes 845.0
36 to 845.09.

1 (2) Criteria and indications: in addition to one
2 of the diagnoses in subitem (1), the following conditions must
3 be satisfied for a lateral ligament ankle reconstruction:

4 (a) initial nonsurgical care: the employee
5 must have received an adequate course of initial nonsurgical
6 care including, at least:

7 i. immobilization with support, cast,
8 or ankle brace, followed by

9 ii. a physical rehabilitation program;

10 and

11 (b) clinical findings:

12 i. the employee gives a history of
13 ankle instability and swelling; and

14 ii. there is a positive anterior
15 drawer sign on examination; or

16 iii. there are positive stress X-rays
17 identifying motion at ankle or subtalar joint with at least a 15
18 degree lateral opening at the ankle joint, or demonstrable
19 subtalar movement, and negative to minimal arthritic joint
20 changes on X-ray, or ligamentous injury is shown on MRI scan.

21 (3) Prosthetic ligaments: prosthetic ligaments
22 are not indicated.

23 (4) Implants: requests for any plastic implant
24 must be confirmed by a second opinion.

25 (5) Calcaneus osteotomy: requests for calcaneus
26 osteotomies must be confirmed by a second opinion.

27 5221.6600 CHRONIC MANAGEMENT.

28 Subpart 1. **Scope.** This part applies to chronic management
29 of all types of physical injuries, even if the injury is not
30 specifically governed by parts 5221.6200 to 5221.6500. If a
31 patient continues with symptoms and physical findings after all
32 appropriate initial nonsurgical and surgical treatment has been
33 rendered, and if the patient's condition prevents the resumption
34 of the regular activities of daily life including regular
35 vocational activities, then the patient may be a candidate for

1 chronic management. The purpose of chronic management is
2 twofold: the patient should be made independent of health care
3 providers in the ongoing care of a chronic condition; and the
4 patient should be returned to the highest functional status
5 reasonably possible.

6 A. Personality or psychological evaluation may be
7 indicated for patients who are candidates for chronic
8 management. The treating health care provider may perform this
9 evaluation or may refer the patient for consultation with
10 another health care provider in order to obtain a psychological
11 evaluation. These evaluations may be used to assess the patient
12 for a number of psychological conditions which may interfere
13 with recovery from the injury. Since more than one of these
14 psychological conditions may be present in a given case, the
15 health care provider performing the evaluation must consider all
16 of the following:

17 (1) Is symptom magnification occurring?

18 (2) Does the patient exhibit an emotional
19 reaction to the injury, such as depression, fear, or anger,
20 which is interfering with recovery?

21 (3) Are there other personality factors or
22 disorders which are interfering with recovery?

23 (4) Is the patient chemically dependent?

24 (5) Are there any interpersonal conflicts
25 interfering with recovery?

26 (6) Does the patient have a chronic pain syndrome
27 or psychogenic pain?

28 (7) In cases in which surgery is a possible
29 treatment, are psychological factors likely to interfere with
30 the potential benefit of the surgery?

31 B. Any of the chronic management modalities of
32 subpart 2 may be used singly or in combination as part of a
33 program of chronic management.

34 C. No further passive treatment modalities or
35 therapeutic injections are indicated, except as otherwise
36 provided in parts 5221.6200, subpart 3, item B; 5221.6205,

1 subpart 3, item B; 5221.6210, subpart 3, item B; and 5221.6300,
2 subpart 3, item B.

3 D. No further diagnostic evaluation is indicated
4 unless there is the development of symptoms or physical findings
5 which would in themselves warrant diagnostic evaluation.

6 E. A program of chronic management must include
7 appropriate means by which use of scheduled medications can be
8 discontinued or severely limited.

9 Subp. 2. **Chronic management modalities.** The health care
10 provider must provide prior notification of the chronic
11 management modalities in items B to F according to part
12 5221.6050, subpart 9. Prior notification is not required for
13 home-based exercises in item A, unless durable medical equipment
14 is prescribed for home use. The insurer may not deny payment
15 for a program of chronic management that the insurer has
16 previously authorized for an employee, either in writing or by
17 routine payment for services, without providing the employee and
18 the employee's health care provider with at least 30 days'
19 notice of intent to apply any of the chronic management
20 parameters in part 5221.6600 to future treatment. The notice
21 must include the specific parameters that will be applied in
22 future determinations of compensability by the insurer.

23 A. Home-based exercise programs consist of aerobic
24 conditioning, stretching and flexibility exercises, and
25 strengthening exercises done by the patient on a regular basis
26 at home without the need for supervision or attendance by a
27 health care provider. Maximum effectiveness may require the use
28 of certain durable medical equipment that may be prescribed and
29 reimbursed within any applicable treatment parameters in parts
30 5221.6200 to 5221.6305.

31 (1) Indications: exercise is necessary on a
32 long-term basis to maintain function.

33 (2) Requirements: the patient should receive
34 specific instruction and training in the exercise program.
35 Repetitions, durations, and frequencies of exercises must be
36 specified. Any durable medical equipment needed must be

1 prescribed in advance and the insurer must be given prior
2 notification of proposed purchase.

3 (3) Treatment period, one to three visits for
4 instruction and monitoring.

5 B. Health clubs:

6 (1) Indications: the patient is deconditioned
7 and requires a structured environment to perform prescribed
8 exercises. The health care provider must document the reasons
9 why reconditioning cannot be accomplished with a home-based
10 program of exercise.

11 (2) Requirements: the program must have specific
12 prescribed exercises stated in objective terms, for example "30
13 minutes riding stationary bicycle three times per week." There
14 must be a specific set of prescribed activities and a specific
15 timetable of progression in those activities, designed so that
16 the goals can be achieved in the prescribed time. There must be
17 a prescribed frequency of attendance and the patient must
18 maintain adequate documentation of attendance. There must be a
19 prescribed duration of attendance.

20 (3) Treatment period, 13 weeks. Additional
21 periods of treatment require additional prior notification of
22 the insurer. Additional periods of treatment at a health club
23 are not indicated unless there is documentation of attendance
24 and progression in activities during the preceding period of
25 treatment. If the employer has an appropriate exercise facility
26 on its premises the insurer may mandate use of that facility
27 instead of providing a health club membership.

28 C. Computerized exercise programs utilize computer
29 controlled exercise equipment that allows for the isolation of
30 specific muscle groups and the performance of graded exercise
31 designed to increase strength, tone, flexibility, and range of
32 motion. In combination with computerized range of motion or
33 strength measuring tests, these programs allow for quantitative
34 measurement of effort and progress.

35 (1) Indications: the patient is deconditioned
36 and requires a structured environment to accomplish

1 rehabilitation goals. The health care provider must document
2 the reasons why reconditioning cannot be accomplished with a
3 home-based program of exercise.

4 (2) Requirements: the program must have specific
5 goals stated in objective terms, for example "improve strength
6 of back extensors 50 percent." There must be a specific set of
7 prescribed activities and a specific timetable of progression in
8 those activities, designed so that the goals can be achieved in
9 the prescribed time. There must be a prescribed frequency and
10 duration of attendance.

11 (3) Treatment period, six weeks. Additional
12 periods of treatment require additional prior notification of
13 the insurer. Additional periods of treatment are not indicated
14 unless there is documentation of attendance and progression in
15 activities during the preceding period of treatment.

16 D. Work conditioning and work hardening programs are
17 intensive, highly structured, job oriented, individualized
18 treatment plans based on an assessment of the patient's work
19 setting or job demands, and designed to maximize the patient's
20 return to work. These programs must include real or simulated
21 work activities. Work conditioning is designed to restore an
22 individual's neuromusculoskeletal strength, endurance, movement,
23 flexibility, and motor control, and cardiopulmonary function.
24 Work conditioning uses physical conditioning and functional
25 activities related to the individual's work. Services may be
26 provided by one discipline of health care provider. Work
27 hardening is designed to restore an individual's physical,
28 behavioral, and vocational functions within an interdisciplinary
29 model. Work hardening addresses the issues of productivity,
30 safety, physical tolerances, and work behaviors. An
31 interdisciplinary team includes professionals qualified to
32 evaluate and treat behavioral, vocational, physical, and
33 functional needs of the individual.

34 (1) Indications: the patient is disabled from
35 usual work and requires reconditioning for specific job tasks or
36 activities and the reconditioning cannot be done on the job.

1 The health care provider must document the reasons why work
2 hardening cannot be accomplished through a structured return to
3 work program. Work conditioning is indicated where only
4 physical and functional needs are identified. Work hardening is
5 indicated where, in addition to physical and functional needs,
6 behavioral and vocational needs are also identified that are not
7 otherwise being addressed.

8 (2) Requirements: the program must have specific
9 goals stated in terms of work activities, for example "able to
10 type for 30 minutes." There must be an individualized program
11 of activities and the activities must be chosen to simulate
12 required work activities or to enable the patient to participate
13 in simulated work activities. There must be a specific
14 timetable of progression in those activities, designed so that
15 the goals can be achieved in the prescribed time. There must be
16 a set frequency and hours of attendance and the program must
17 maintain adequate documentation of attendance. There must be a
18 set duration of attendance. Activity restrictions must be
19 identified at completion of the program.

20 (3) Treatment period, six weeks. Additional
21 periods of treatment require prior notification of the insurer.
22 Additional periods of treatment at a work hardening program or
23 work conditioning program are not indicated unless there is
24 documentation of attendance and progression in activities during
25 the preceding period of treatment or unless there has been a
26 change in the patient's targeted return to work job which
27 necessitates a redesign of the program.

28 E. Chronic pain management programs consist of
29 multidisciplinary teams who provide coordinated, goal-oriented
30 services to reduce pain disability, improve functional status,
31 promote return to work, and decrease dependence on the health
32 system of persons with chronic pain syndrome. Pain management
33 programs must provide physical rehabilitation, education on
34 pain, relaxation training, psychosocial counseling, medical
35 evaluation, and, if indicated, chemical dependency evaluation.
36 The program of treatment must be individualized and based on an

1 organized evaluative process for screening and selecting
2 patients. Treatment may be provided in an inpatient setting,
3 outpatient setting, or both as appropriate.

4 (1) Indications: the patient is diagnosed as
5 having a chronic pain syndrome.

6 (2) Requirements: an admission evaluation must
7 be performed by a doctor, and a licensed mental health
8 professional, each with at least two years experience in
9 evaluation of chronic pain patients and chronic pain treatment,
10 or one year of formal training in a pain fellowship program.
11 The evaluation must confirm the diagnosis of chronic pain
12 syndrome and a willingness and ability of the patient to benefit
13 from a pain management program. There must be a specific set of
14 prescribed activities and treatments, and a specific timetable
15 of progression in those activities. There must be a set
16 frequency and hours of attendance and the program must maintain
17 adequate documentation of attendance. There must be a set
18 duration of attendance.

19 (3) Treatment period: for initial treatment, a
20 maximum of 20 eight-hour days, though fewer or shorter days can
21 be used, and a maximum duration of four weeks no matter how many
22 or how long the days prescribed. For aftercare, a maximum of 12
23 sessions is allowed. Only one completed pain management program
24 is indicated for an injury.

25 F. Individual or group psychological or psychiatric
26 counseling.

27 (1) Indications: a personality or psychosocial
28 evaluation has revealed one or more of the problems listed in
29 subpart 1, item A, which interfere with recovery from the
30 physical injury, but the patient does not need or is not a
31 candidate for a pain management program.

32 (2) Requirements: there must be a specific set
33 of goals based on the initial personality or psychosocial
34 evaluation and a timetable for achieving those goals within the
35 prescribed number of treatment or therapy sessions. There must
36 be a prescribed frequency of attendance and the treating health

1 care provider must maintain adequate documentation of
2 attendance. There must be a prescribed duration of treatment.

3 (3) Treatment period: a maximum of 12 sessions.
4 Only one completed program of individual or group psychological
5 or psychiatric counseling is indicated for an injury.

6 5221.8900 DISCIPLINARY ACTION; PENALTIES.

7 Subpart 1. **Discipline.** A health care provider is subject
8 to disciplinary action under Minnesota Statutes, section
9 176.103, for failure to comply with the requirements in parts
10 5221.6010 to 5221.6600 or the violation of any of the provisions
11 of Minnesota Statutes, chapter 176, or other rules or orders
12 issued pursuant thereto.

13 Subp. 2. **Complaints.** Complaints about professional
14 behavior or services of health care providers relating to
15 noncompliance with established workers' compensation laws,
16 rules, or orders shall be made in writing to the commissioner.
17 The commissioner or a designee shall assist a person in filing a
18 complaint, if necessary. A complaint may be submitted by any
19 person who becomes aware of a violation, including designees of
20 the commissioner, administrative law judges, and presiding
21 officials at judicial proceedings.

22 Subp. 3. **Review and investigation.** The commissioner shall
23 investigate all complaints to determine whether there has been a
24 violation of established workers' compensation laws, rules, or
25 orders. The commissioner may refer a matter to another agency
26 that has jurisdiction over the provider's license or conduct, or
27 to an agency that has prosecuting authority in the event of
28 suspected theft or fraud or to a peer review organization for an
29 opinion. Absent suspected theft or fraud, providing treatment
30 outside a parameter set forth in parts 5221.6020 to 5221.6500
31 shall not in itself result in a referral to a prosecuting
32 authority.

33 If an investigation indicates that discipline may be
34 warranted, the commissioner shall determine whether the
35 violation involves inappropriate, unnecessary, or excessive

1 treatment, or whether the violation involves other statutes or
2 rules. The commissioner shall take appropriate action according
3 to subpart 6, 7, or 8.

4 Subp. 4. **Cooperation with disciplinary proceedings.** A
5 health care provider who is the subject of a complaint
6 investigated by the commissioner under Minnesota Statutes,
7 section 176.103, shall cooperate fully with the investigation.
8 Cooperation includes, but is not limited to, responding fully
9 and promptly to any questions raised by the commissioner
10 relating to the subject of the investigation and providing
11 copies of records, reports, logs, data, and cost information as
12 requested by the commissioner to assist in the investigation.
13 The health care provider shall not charge for services ~~or~~ but
14 may charge for the cost of copies of medical records, at the
15 rate set in part 5219.0300, subpart 2, for this investigation.
16 Cooperation includes attending, in person, a meeting scheduled
17 by the commissioner for the purposes of subpart 5. This subpart
18 does not limit the health care provider's right to be
19 represented by an attorney.

20 Subp. 5. **In-person meeting.** When conferring with the
21 parties to a complaint is deemed appropriate, the commissioner
22 shall schedule a meeting for the purpose of clarification of
23 issues, obtaining information, instructing parties to the
24 complaint, or for the purpose of resolving disciplinary issues.

25 Subp. 6. **Resolution by instruction or written agreement.**
26 The commissioner may resolve a complaint through instruction of
27 a provider, or may enter into stipulated consent agreements
28 regarding discipline with a provider in lieu of initiating a
29 contested case or medical services review board proceeding.

30 Subp. 7. **Inappropriate, unnecessary, or excessive**
31 **treatment.**

32 A. Except as otherwise provided in subparts 3 and 6,
33 if the suspected violation involves a treatment standard set
34 forth in parts 5221.6020 to 5221.6500 the commissioner must
35 refer the health care provider to the medical services review
36 board for review under Minnesota Statutes, section 176.103,

1 subdivision 2, if:

2 (1) the situation requires medical expertise in
3 matters beyond the department's general scope;

4 (2) wherever possible under Minnesota Statutes,
5 chapter 176, a final determination has been made by a workers'
6 compensation presiding official, or provider licensing or
7 registration body that the medical treatment in issue was
8 inappropriate, unnecessary, or excessive; and

9 (3) a pattern of consistently providing
10 inappropriate, unnecessary, or excessive services exists for
11 three or more employees.

12 B. Where the medical service review board's report to
13 the commissioner indicates a violation of treatment standards or
14 other inappropriate, unnecessary, or excessive treatment the
15 commissioner shall order a sanction. Sanctions may include, but
16 are not limited to, a warning; a fine of up to \$200 per
17 violation; a restriction on providing treatment; requiring
18 preauthorization by the board, the payor, or the commissioner
19 for a plan of treatment; and suspension from receiving
20 compensation for the provision of treatment.

21 C. Within 30 days of receipt of the order of
22 sanction, the health care provider may request in writing a
23 review by the commissioner of the sanction in accordance with
24 the procedure set forth in Minnesota Statutes, section 176.103,
25 subdivision 2a. Within 30 days following receipt of the
26 compensation judge's decision reviewing the sanction, a provider
27 may petition the workers' compensation court of appeals for
28 review according to the procedures in Minnesota Statutes,
29 section 176.103, subdivision 2a.

30 Subp. 8. **Violations of statutes and rules other than those**
31 **involving inappropriate, unnecessary, or excessive treatment.**
32 If the suspected violation warranting discipline involves a
33 statute or rule other than treatment standards, the commissioner
34 shall initiate a contested case hearing for disciplinary action
35 under Minnesota Statutes, section 176.103, subdivision 3,
36 paragraph (b), and the administrative procedure act in Minnesota

1 Statutes, chapter 14.

2 A. Upon petition of the commissioner and following
3 receipt of the recommendation of the administrative law judge,
4 the medical services review board may issue a fine of up to \$200
5 for each violation, or disqualify or suspend the health care
6 provider from receiving payment for services, according to
7 Minnesota Statutes, section 176.103, subdivision 3, paragraph
8 (b).

9 B. Within 30 days after service of the board's
10 decision, a provider may petition the workers' compensation
11 court of appeals for review according to Minnesota Statutes,
12 section 176.421.

13 Subp. 9. Penalties. In addition to disciplinary action
14 under subparts 1 to 8, the commissioner may assess a penalty
15 under part 5220.2810 if a health care provider fails to release
16 existing written medical data according to Minnesota Statutes,
17 section 176.138. A penalty may also be assessed under part
18 5220.2830 and Minnesota Statutes, section 176.231, subdivision
19 10, if a health care provider fails to provide reports required
20 by part 5221.0410.