

DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIRS
Office of Workers' Compensation
Statutory Authority: 19 Delaware Code, Section 2322C (19 Del.C. §§2322C)
19 DE Admin. Code 1342

FINAL

ORDER

1342 Health Care Practice Guidelines

A public meeting was held on July 29, 2013, by the Department of Labor to receive public comments relating to revised sections of the Fee Schedule Instructions and Guidelines ("Fee Schedule Instructions"), Forms, Provider Certification, and Utilization Review, as well as revise the Health Care Practice Guidelines to reduce the frequency of some treatment, services, or procedures and clean up language inadvertently left in the original guidelines. In this final version, technical revisions were added to the anesthesia methodology and revenue neutral language. These changes align the regulations with the mandates in HB 175. The members of the Health Care Advisory Panel ("HCAP"), signed below, recommend that the Secretary of Labor adopt this proposal as it was published in the *Register of Regulations*, Volume 17, Issue 1 (July 2013).

SUMMARY OF THE EVIDENCE AND INFORMATION SUBMITTED

Exhibits Admitted Prior to and During the Public Meeting:

- Exhibit 1-News Journal, Affidavit of publication of notice of public meeting.
- Exhibit 2 -Delaware State News, Affidavit of publication of notice of public meeting.
- Exhibit 3 -State of Delaware Public Meeting Calendar electronic posting of today's meeting.
- Exhibit 4 - Written public comments from Rebecca Byrd, The Byrd Group, LLC, on behalf of AHCS (Automated HealthCare Solutions).
- Exhibit 5 -Written talking points from public comments given by Bob Byrd, The Byrd Group, LLC, on behalf of AHCS (Automated Healthcare Solutions)
- Exhibit 6- Written talking points from public comments given by Jayne Cannava, Esquire, Director of Government Affairs, Injured Workers' Pharmacy (IWP).

After the Panel concluded with their introductions, the public was invited to share their comments.

The following comments were made during the public meeting.

- Fee Schedule Instructions: First, Bob Byrd, of The Byrd Group, representing Automated Healthcare Solutions, provided comments about the complete prohibition of physician dispensing medications; the elimination of the physician dispensing fee; the use of more than one pricing index; and the repackaging reimbursement. Second, Jayne Cannava, Esquire, Director of Government Affairs, Injured Workers' Pharmacy, provided comments about the use of New York State as the pharmacy pricing model; the increased risk to payment in an environment when compensability is a frequent back and forth decision; low fees and blocked access-to-care; brand versus generic medications as a cost driver; the use of one pricing index -Medispan, because it more frequently updates fees; and payer response time to the new justification form; recommended AWP + 5% + \$4 dispensing. IWP may choose to stop serving Delaware injured workers given the new pay structure.
- Forms: No Public Comment
- Provider Certification: No Public Comment Utilization Review: No Public Comment
- Health Care Practice Guidelines: No Public Comment

The HCAP agreed to submit and recommend for adoption by the Delaware Department of Labor the revisions to the Fee Schedule Instructions and Guidelines ("Fee Schedule Instructions"), Forms, Provider Certification, and Utilization Review, as well as the revisions to the Health Care Practice Guidelines.

RECOMMENDED FINDINGS OF FACT WITH RESPECT TO THE EVIDENCE AND INFORMATION

The HCAP is persuaded that the proposals are consistent with administering the statutory directives in the workers' compensation law. In 2013, the Administrative Procedures Act changed to extend the public comment period 15 days past the date of the public meeting, which is August 13, 2013. Any further public comment received between July 29, 2013 and August 13, 2013, is included in the attached addendum, along with an e-mail reaffirmation from each Panel member

present at the July 29, 2013, public meeting. If no further public comment was received, no addendum will exist.

RECOMMENDATION

The proposals are respectfully submitted to the Secretary of Labor for consideration with a recommendation for adoption this 29th day of July, 2013.

ADDENDUM TO JULY 29, 2013, RECOMMENDATION

A public meeting was held on July 29, 2013, by the Department of Labor to receive public comments relating to revised sections of the Fee Schedule Instructions and Guidelines ("Fee Schedule Instructions"), Forms, Provider Certification, and Utilization Review, as well as revise the Health Care Practice Guidelines to reduce the frequency of some treatment, services, or procedures and clean up language inadvertently left in the original guidelines. Pursuant to 29 **Del.C.** §10118(a), August 13, 2013, marks the deadline (15 days after the public meeting) to receive written public comments on the above revisions. This addendum lists the additional public comments received. The members of the Health Care Advisory Panel (HCAP) members present at the July 29, 2013, and whose electronic signatures appear below, reaffirm their recommendation that the Secretary of Labor adopt this proposal as it was published in the *Register of Regulations*, Volume 17, Issue 1 (July 2013), with the properly noted subsequent technical revisions to the anesthesia methodology and revenue neutral language.

SUMMARY OF THE ADDITIONAL EVIDENCE AND INFORMATION SUBMITTED

Additional Exhibits Admitted:

- Exhibit 7 -Written comments submitted by Kevin C. Tribout, Executive Director of Government Affairs, PMSI
- Exhibit 8 - Written comments submitted by Sandy Shtab, Senior Manager, Government Relations, Healthesystems, which include a letter, two sample claim forms, and a copy of a publication from the National Council for Prescription Drug Programs (NCPDP) titled "Guidance for the Workers' Compensation Industry."
- Exhibit 9 -Written comments submitted by Todd Wilder, Executive Director, Americans for Patients Rights.
- Exhibit 10-Written comments submitted via e-mail by Melissa J. Petro, JD, MPH, Regional Director, State Government Affairs, Purdue Pharma, L.P. on behalf of J. David Haddox, Vice President, Health Policy, Purdue Pharma L.P.
- Exhibit 11 -Written Comments submitted by Phil Pierson, Associate Counsel, American Insurance Association, which include a letter, "Suggested Language Concerning Compound Drug Pre-Authorization for Workers' Compensation Claimants," a copy of CWCI Research

Notes: "Current Trends in Compound Drug Utilization and Cost in the California Workers' Compensation System," and a copy of a preliminary report by the Texas Department of Insurance titled "Impact of the Texas Pharmacy Closed Formulary."

ADDITIONAL RECOMMENDED FINDINGS OF FACT WITH RESPECT TO THE EVIDENCE AND INFORMATION

The HCAP received electronic copies of all the Exhibits 7-11, which were submitted after the July 29, 2013, and before the August 13, 2013, deadline to receive public comments. For each exhibit, a majority of the Panel reaffirmed their yes vote in favor of moving forward with the regulation changes. In light of the additional written public comments, the HCAP is still persuaded that these additional proposals are consistent with administering the statutory directives in the workers' compensation law.

RECOMMENDATION

This addendum is respectfully included in the submission to the Secretary of Labor for consideration with a recommendation for adoption this 13th day of August, 2013.

HEALTH CARE ADVISORY PANEL

G. B. Heckler, Jr. Chair
Harry Gravell
Joseph Straight
James E. Downing

Bruce Rudin Vice Chair
Joseph J. Rhoades
Douglas Briggs
Theodore W. Becker, Jr.

A. Richard Heffron
Dave Hollen
Barry Bakst D.O.

Wayne A. Smith
Mrs. Theresa A. Smith

DECISION AND EFFECTIVE DATE

Having reviewed and considered the record and recommendations of members of the Health Care Advisory Panel to adopt revisions of the Fee Schedule Instructions and Guidelines ("Fee Schedule Instructions"), Forms, Provider Certification, Utilization Review, and Health Care Practice Guidelines. The Fee Schedule Instructions and Guidelines ("Fee Schedule Instructions"), Forms, Provider Certification, Utilization Review, Health Care Practice guidelines are hereby adopted by the Delaware Department of Labor and made effective September 11, 2013.

TEXT AND CITATION

The proposed Fee Schedule Instructions and Guidelines; Forms; Provider Certification, Utilization Review; and Health Care Practice Guidelines notice appeared in the *Register of Regulations*, Volume 17, Issue 1 (July 1, 2013). The Fee Schedule Instructions and Guidelines ("Fee Schedule Instructions"), Forms, Provider Certification, Utilization Review, and Health Care Practice Guidelines are available from the Department of Labor, Division of Industrial Affairs, Office of Workers' Compensation or on the department's website: www.delawareworks.com.

John McMahon, Secretary of Labor

1342 Health Care Practice Guidelines

PART E Shoulder Treatment Guidelines

1.0 Introduction

Pursuant to 19 **Del.C.** §2322C, health care practice guidelines have been adopted and recommended by the Health Care Advisory Panel to guide utilization of health care treatments in workers' compensation including, but not limited to, care provided for the treatment of employees by or under the supervision of a licensed health care provider, prescription drug utilization, inpatient hospitalization and length of stay, diagnostic testing, physical therapy, chiropractic care and palliative care. The health care practice guidelines apply to all treatments provided after the effective date of the regulation adopted by the Department of Labor, May 23, 2008, and regardless of the date of injury.

The guidelines are, to the extent permitted by the most current medical science or applicable science, based on well-documented scientific research concerning efficacious treatment for injuries and occupational disease. To the extent that well-documented scientific research regarding the above is not available at the time of adoption of the guidelines, or is not available at the time of any revision to the guidelines, the guidelines have been and will be based upon the best available information concerning national consensus regarding best health care practices in the relevant health care community.

The guidelines, to the extent practical and consistent with the Act, address treatment of those physical conditions which occur with the greatest frequency, or which require the most expensive treatments, for work-related injuries based upon currently available Delaware data.

Services rendered by any health care provider certified pursuant to 19 **Del.C.** §2322D(a) to provide treatment or services for injured employees shall be presumed, in the absence of contrary evidence, to be reasonable and necessary if such treatment and/or services conform to the most current version of the Delaware health care practice guidelines.

Services rendered outside the Guidelines and/or variation in treatment recommendations from the Guidelines may represent acceptable medical care, be considered reasonable and necessary treatment and, therefore, determined to be compensable, absent evidence to the contrary, and may be payable in accordance with the Fee Schedule and Statute, accordingly.

Services provided by any health care provider that is not certified pursuant to 19 **Del.C.** §2322D(a) shall not be presumed reasonable and necessary unless such services are pre-authorized by the employer or insurance carrier, subject to the exception set forth in 19 **Del.C.** §2322D(b).

Treatment of conditions unrelated to the injuries sustained in an industrial accident may be denied as unauthorized if the treatment is directed toward the non-industrial condition, unless the treatment of the unrelated injury is rendered necessary as a result of the industrial accident.

The Health Care Advisory Panel and Department of Labor recognized that acceptable medical practice may include deviations from these Guidelines, as individual cases dictate. Therefore, these Guidelines are not relevant as evidence of a provider's legal standard of professional care.

In accordance with the requirements of the Act, the development of the health care guidelines has been directed by a predominantly medical or other health professional panel, with recommendations then made to the Health Care Advisory Panel.

2.0 General Guideline Principles

The principles summarized in this section are key to the intended implementation of these guidelines and critical to the reader's application of the guidelines in this document.

- 2.1 **EDUCATION** of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of upper extremity pain and disability. Currently, practitioners often think of education last, after medications, manual therapy and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.
- 2.2 **TREATMENT PARAMETER DURATION** Time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, comorbidities and availability of services. Clinical judgment may substantiate the need to modify the total number of visits discussed in this document. The majority of injured workers with Shoulder Disorders often will achieve resolution of their condition within 6 to 36 visits (Guide to Physical Therapy Practice – Second Edition). It is anticipated that most injured workers will not require the maximum number of visits described in these guidelines. They are designed to be a ceiling and care extending beyond the maximum allowed visits may warrant utilization review.
- 2.3 **ACTIVE INTERVENTIONS** emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains. All rehabilitation programs must incorporate "Active Interventions" no later than three weeks after the onset of treatment. Reimbursement for passive modalities only after the first three weeks of treatment without clear evidence of Active Interventions will require supportive documentation.
- 2.4 **ACTIVE THERAPEUTIC EXERCISE PROGRAM** Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.
- 2.5 **POSITIVE PATIENT RESPONSE** Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living, cognition, and efficiency/velocity measures which can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.
- 2.6 **RE-EVALUATE TREATMENT EVERY 3-4 WEEKS** If a given treatment or modality is not producing positive results within 3-4 weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.
- 2.7 **SURGICAL INTERVENTIONS** Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s).
- 2.8 **SIX-MONTH TIME FRAME** Since the prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months, the emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries which do not involve work-time loss or are not occupationally related.
- 2.9 **RETURN-TO-WORK** Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. Return-to-work may be therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must write detailed restrictions when returning a patient to limited duty. The

following functions should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. The patient should never be released to "sedentary or light duty" without specific physical limitations. The practitioner must understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties.

- 2.10 **DELAYED RECOVERY** The Department recognizes that not all industrially injured patients will not recover within the time lines outlined in this document despite optimal care. Such individuals may require treatments beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

The remainder of this document should be interpreted within the parameters of these guideline principles which will hopefully lead to more optimal medical and functional outcomes for injured workers.

3.0 Introduction to Shoulder Injury

This section addresses the shoulder and the ten most common work-related injuries/syndromes/disorders to or involving the shoulder complex. The following format was developed to reduce repetitive text:

- 3.1 **HISTORY TAKING AND PHYSICAL EXAMINATION** provides information common to all injuries through a discussion of provider procedures which should be applied to each patient, regardless of the injury and diagnosis (this subsection is standard to all Division medical treatment guidelines).

- 3.2 **SPECIFIC DIAGNOSIS, TESTING AND TREATMENT PROCEDURES** provides information unique to each of the following work-related injuries/syndromes/disorders:

3.2.1 Acromioclavicular (AC) Joint Sprains/Dislocations

3.2.2 Adhesive Capsulitis/Frozen Shoulder Disorders

3.2.3 Bicipital Tendon Disorders

3.2.4 Brachial Plexus Injuries

3.2.4.1 Brachial Plexus

3.2.4.2 Axillary Nerve

3.2.4.3 Long Thoracic Nerve

3.2.4.4 Musculocutaneous Nerve

3.2.4.5 Spinal Accessory Nerve

3.2.4.6 Suprascapular Nerve

3.2.5 Bursitis of the Shoulder

3.2.6 Impingement Syndrome

3.2.7 Rotator Cuff Tears

3.2.8 Rotator Cuff Tendinitis

3.2.9 Shoulder Fractures

3.2.9.1 Clavicular Fracture

3.2.9.2 Proximal Humeral Fracture

3.2.9.3 Humeral Shaft Fracture

3.2.9.4 Scapular Fracture

3.2.9.5 Sternoclavicular Dislocation/Fracture

3.2.10 Shoulder Instability

Each diagnosis is presented in the following format:

3.2.10.1 A definition of the injury/disorder/syndrome;

3.2.10.2 Discussion of relevant physical findings;

3.2.10.3 Applicable testing and diagnostic procedures;

3.2.10.4 Diagnosis-based, non-operative therapeutic treatment procedures;

3.2.10.5 Options for operative/surgical treatment; and

3.2.10.6 Options for post-operative rehabilitation/treatment procedures.

- 3.3 **MEDICATION** provides information common to all injuries through detailed discussions of referenced medications with indications for expected time to produce effect, frequency, and optimum and maximum durations.

- 3.4 **NON-OPERATIVE TREATMENT PROCEDURES** provides information common to all injuries through detailed discussions of referenced therapeutic procedures with indications for expected time to produce effect, frequency, and optimum and maximum durations.

As shoulder injuries frequently involve a complex of problems, it is always necessary to consider the possible interaction of the various parts of the shoulder mechanism when proceeding with a diagnostic workup and a therapeutic treatment plan. Injuries to the shoulder may require the provider to reference and/or use the other Division medical treatment guidelines (i.e., Thoracic Outlet Syndrome Cumulative Trauma Disorder, and/or Complex Regional Pain Syndrome/Reflex Sympathetic Dystrophy).

4.0 History Taking and Physical Examination (HX & PE)

There are two standard procedures that should be utilized when initially diagnosing work-related shoulder instability. These procedures are generally accepted, well-established and widely used procedures that establish the foundation/basis for and dictate all other following stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not complementing each other, the objective clinical findings should have preference.

- 4.1 **HISTORY TAKING** should address at least the following for each shoulder injury diagnosis:

- 4.1.1 Occupational relationship, and
- 4.1.2 History of non-occupational injury and avocational pursuits need to be specifically documented.

- 4.2 **PHYSICAL FINDINGS** are specific to and addressed within each shoulder injury diagnosis noted in this section. Given the complexity of the shoulder mechanism, an evaluation for concomitant injury should be considered.

5.0 Specific Diagnosis, Testing and Treatment Procedures

- 5.1 **ACROMIOCLAVICULAR JOINT SPRAINS/DISLOCATIONS** An acute acromioclavicular (AC) joint injury is frequently referred to as a shoulder separation. There are six classifications of an AC joint separation which are based upon the extent of ligament damage and bony displacement:

- Type I Partial disruption of the AC ligament and capsule.
- Type II Sprains consisting of a ruptured AC ligament and capsule with incomplete injury to the coracoclavicular (CC) ligament, resulting in minimal AC joint subluxation.
- Type III Separation or complete tearing of the AC ligament and/or CC ligaments, possible deltoid trapezius fascial injury, and dislocation of the AC joint.
- Type IV Dislocation consisting of a displaced clavicle that penetrates posteriorly through or into the trapezius muscle.
- Type V Dislocation consisting of complete separation of the AC and CC ligaments and dislocation of the acromioclavicular joint with a large coracoclavicular interval.
- Type VI Dislocation consisting of a displaced clavicle that penetrates inferior to the coracoid.

Types I-III are common, while Types IV-VI are not and, when found, require surgical consultation. For AC joint degeneration from repetitive motion that is found to be work-related, see section 5.4.8, Impingement Syndrome.

- 5.1.1 **History and Initial Diagnostic Procedures (AC Joint Sprains/Dislocations):**

- Occupational Relationship - generally, workers sustain an AC joint injury when they land on the point of the shoulder, driving the acromion downward, or fall on an outstretched hand or elbow, creating a backward and outward force on the shoulder. It is important to rule out other sources of shoulder pain from an acute injury, including rotator cuff tear, fracture and nerve injury.

- 5.1.2 **Physical Findings (AC Joint Sprains/Dislocations) may include:**

- 5.1.2.1 Tenderness at the AC joint with, at times, contusions and/or abrasions at the joint area; prominence/asymmetry of the shoulder can be seen; and/or
- 5.1.2.2 One finds decreased shoulder motion and with palpation, the distal end of the clavicle is painful; there may be increased clavicular translation; cross-body adduction can cause exquisite pain.

- 5.1.3 **Laboratory Tests (AC Joint Sprains/Dislocations):** are not indicated unless a systemic illness or disease is suspected.

- 5.1.4 **Testing Procedures (AC Joint Sprains/Dislocations):**

- 5.1.4.1 Plain x-rays may include:
 - 5.1.4.1.1 AP view;
 - 5.1.4.1.2 AP radiograph of the shoulder with the beam angled 10 cephalad (Zanca view);
 - 5.1.4.1.3 Axillary lateral views; and

5.1.4.1.4 Y-view also called a Stryker notch view;

5.1.4.1.5 Stress view; side-to-side comparison with 10-15 lbs. of weight in each hand.

5.1.4.2 Adjunctive testing, such as standard radiographic techniques (sonography, arthrography or MRI), should be considered when shoulder pain is refractory to 4-6 weeks of non-operative conservative treatment and the diagnosis is not readily identified by a good history and clinical examination.

5.1.5 **Non-operative Treatment Procedures (AC Joint Sprains/Dislocations):** may include:

5.1.5.1 Procedures outlined in this Section 5.3.5 such as thermal treatment and immobilization (up-to-6 weeks for Type I-III AC joint separations). Immobilization treatments for Type III injuries are controversial and may range from a sling to surgery.

5.1.5.2 Medication, such as nonsteroidal anti-inflammatories and analgesics, would be indicated; narcotics are not normally indicated but may be needed after an acute injury. In the face of chronic acromioclavicular joint pain, a series of injections with or without cortisone, may be injected 6-8 times per year.

5.1.5.3 Physical medicine interventions, as outlined in Section 5.3.5, should emphasize a progressive increase in range of motion without exacerbation of the AC joint injury. With increasing motion and pain control, a strengthening program should be instituted and return to modified/limited duty would be considered at this time. By 8-11 weeks, with restoration of full motion, return to full duty should be anticipated.

5.1.6 **Operative Procedures (AC Joint Sprains/Dislocations):**

5.1.6.1 With a Type III AC joint injury, an appropriate orthopedic consultation should be considered initially, but must be considered when conservative care fails to increase function.

5.1.6.2 With a Type IV-VI AC joint injury, an orthopedic surgical consultation is recommended initially.

5.1.7 **Post-Operative Procedures (AC Joint Sprains/Dislocations):** should be coordinated by the orthopedic physician working with the interdisciplinary team. Keeping with the therapeutic and rehabilitation procedures found in this Section 5.3.5. Non-operative Treatment Procedures, the patient could be immobilized for 2-3 weeks, restricted in activities, both work-related and avocational for 8-12 weeks while undergoing rehabilitation, and be expected to progress to return to full duty based upon the his/her response to rehabilitation and the demands of the job.

5.2 **ADHESIVE CAPSULITIS/FROZEN SHOULDER DISORDERS** Adhesive capsulitis of the shoulder, also known as frozen shoulder disorder, is a soft tissue lesion of the glenohumeral joint resulting in restrictions of passive and active range of motion. Occupational adhesive capsulitis arises secondarily to any chest or upper extremity trauma. Primary adhesive capsulitis is rarely occupational in origin. The disorder goes through stages, specifically:

- Stage 1 Consists of acute pain with some limitation in range of motion; generally lasting 2-9 months.
- Stage 2 Characterized by progressive stiffness, loss of range-of-motion, and muscular atrophy; it may last an additional 4-12 months beyond Stage 1.
- Stage 3 Characterized by partial or complete resolution of symptoms and restoration of range-of-motion and strength; it usually takes an additional 6-9 months beyond Stage 2.

5.2.1 **History and Initial Diagnostic Procedures (Adhesive Capsulitis/Frozen Shoulder Disorder):**

5.2.1.1 Occupational Relationship - There should be some history of work related injury. Often adhesive capsulitis is seen with impingement syndrome or other shoulder disorders; refer to appropriate subsection of this guideline.

5.2.1.2 Patient will usually complain of pain in the sub-deltoid region, but occasionally over the long head of the biceps or radiating down the lateral aspect of the arm to the forearm. Pain is often worse at night with difficulty sleeping on the involved side. Motion is restricted and painful.

5.2.2 **Physical Findings (Adhesive Capsulitis/Frozen Shoulder Disorder):** Restricted active and passive glenohumeral range of motion is the primary physical finding. It may be useful for the examiner to inject the glenohumeral joint with lidocaine and then repeat range of motion to rule out other shoulder pathology; lack of range of motion confirms the diagnosis. Postural changes and secondary trigger points along with atrophy of the deltoid and supraspinatus muscles may be seen.

5.2.3 **Laboratory Tests (Adhesive Capsulitis/Frozen Shoulder Disorder):** are not indicated unless systemic illness or disease is suspected.

5.2.4 **Testing Procedures (Adhesive Capsulitis/Frozen Shoulder Disorder):**

5.2.4.1 Plain x-rays are generally not helpful except to rule out concomitant pathology.

- 5.2.4.2 Adjunctive testing, such as standard radiographic techniques (sonography, arthrography or MRI), to rule out concomitant pathology should be considered when shoulder pain is refractory to 4-6 weeks of non-operative conservative treatment and the diagnosis is not readily identified by a good history and clinical examination.
- 5.2.4.3 Arthrography may be helpful in ruling out other pathology. Arthrography can also be therapeutic as steroids and/or anesthetics may be injected and a brisement or distension arthrogram can be done at the same time (refer to the next subsection on non-operative treatment procedures for further discussion).

5.2.5 Non-operative Treatment (Adhesive Capsulitis/Frozen Shoulder Disorder): address the goal to restore and maintain function and may include:

- 5.2.5.1 A home exercise program either alone or in conjunction with a supervised rehabilitation program is the mainstay of treatment. Additional interventions may include thermal treatment, ultrasound, TENS, manual therapy, and passive and active range-of-motion exercises; as the patient progresses, strengthening exercises should be included in the exercise regimen; refer to Section 5.3.5, Non-operative Treatment Procedures.
- 5.2.5.2 Medications, such as NSAIDs and analgesics, may be helpful. Rarely, the use of oral steroids is indicated to decrease acute inflammation. Narcotics can be used for short-term pain control; narcotics are indicated for post-manipulation or post-operative cases; refer to this Section 6.0, Medications.
- 5.2.5.3 Occasionally, subacromial bursal and/or glenohumeral steroid injections can decrease inflammation and allow the therapist to progress functional exercise and range of motion. Injections should be limited to two injections to any one site, given at least one month apart.
- 5.2.5.4 In cases that are refractory to conservative therapy lasting at least 3-6 months and in whom range of motion remains significantly restricted (abduction less than 90°), the following more aggressive treatment may be considered:
 - 5.2.5.4.1 Distension arthrography or "brisement" in which saline, an anesthetic and usually a steroid are forcefully injected into the shoulder joint causing disruption of the capsule. Early and aggressive physical medicine to maintain range of motion and restore strength and function should follow distension arthrography or manipulation under anesthesia; return to work with restrictions should be expected within one week of the procedure; return to full duty is expected within 4-6 weeks.

5.2.6 Operative Procedures (Adhesive Capsulitis/Frozen Shoulder Disorder): For cases failing conservative therapy of at least 3-6 months duration and which are significantly limited in range-of-motion (abduction less than 90°), the following operative procedures may be considered:

- 5.2.6.1 Manipulation under anesthesia which may be done in combination with steroid injection(s) or distension arthrography; and
- 5.2.6.2 In rare cases, refractory to conservative treatment and in which manipulation under anesthesia is contraindicated, an open capsular release or arthroscopy with resection of the coracohumeral and/or coracoacromial ligaments may be done; other disorders, such as impingement syndrome, may also be treated at the same time.

5.2.7 Post-Operative Procedures (Adhesive Capsulitis/Frozen Shoulder Disorder): would include an individualized rehabilitation program based upon communication between the surgeon and the therapist.

- Early, aggressive and frequent physical medicine interventions are recommended to maintain range of motion and progress strengthening; return to work with restrictions after surgery should be discussed with the treating provider; patient should be approaching MMI within 8-12 weeks post-operative, however, coexistence of other pathology should be taken into consideration.

5.3 BICIPITAL TENDON DISORDERS Disorders may include 1) primary bicipital tendinitis which is exceedingly rare; 2) secondary bicipital tendinitis which is generally associated with rotator cuff tendinitis or impingement syndrome (see appropriate diagnosis subsections); 3) subluxation of the biceps tendon which occurs with dysfunction of the transverse intertubercular ligament and massive rotator cuff tears; and 4) acute disruption of the tendon which can result from an acute distractive force or transection of the tendon from direct trauma.

5.3.1 History and Initial Diagnostic Procedures (Bicipital Tendon Disorders):

- 5.3.1.1 Occupational Relationship - bicipital tendon disorders may include symptoms of pain and/or achiness that occur after repetitive use of the shoulder and/or blunt trauma to the shoulder. Secondary bicipital tendinitis may be associated with prolonged above-the-shoulder activities,

and/or repeated shoulder flexion, external rotation and abduction. Acute trauma to the biceps tendon of the shoulder girdle may also give rise to occupational injury of the biceps tendon.

5.3.1.2 Occupational disorders of the biceps tendon may accompany scapulothoracic dyskinesia, rotator cuff injury, AC joint separation, subdeltoid bursitis, shoulder instability or other shoulder pathology. Symptoms should be exacerbated or provoked by work that activated the biceps muscle. Symptoms may be exacerbated by other activities that are not necessarily work related.

5.3.1.3 Symptoms may include aching, burning and/or stabbing pain in the shoulder, usually involving the anterior medial portion of the shoulder girdle. The symptoms are exacerbated with above-the-shoulder activities and those specifically engaging the biceps (flexion at the shoulder, flexion at the elbow and supination of the forearm). Relief occurs with rest. Patients may report nocturnal symptoms which interfere with sleep during the acute stages of inflammation; pain and weakness in shoulder during activities; repeated snapping phenomenon with a subluxing tendon; immediate sharp pain and tenderness along the course of the long head of the biceps following a sudden trauma which would raise suspicions of acute disruption of the tendon; and/or with predominant pain at the shoulder referral patterns which may extend pain into the cervical or distal structures, including the arm, elbow, forearm and wrist.

5.3.2 Physical Findings (Bicipital Tendon Disorders): may include:

5.3.2.1 If continuity of the tendon has been lost (biceps tendon rupture), inspection of the shoulder would reveal deformity (biceps bunching);

5.3.2.2 Palpation demonstrates tenderness along the course of the bicipital tendon;

5.3.2.3 Pain at end range of flexion and abduction as well as biceps tendon activation; and/or

5.3.2.4 Provocative testing may include:

5.3.2.4.1 Yergason's sign - pain with resisted supination of forearm;

5.3.2.4.2 Speed's Test - pain with resisted flexion of the shoulder (elbow extended and forearm supinated); or

5.3.2.4.3 Ludington's Test - pain with contraction of the biceps (hands are placed behind the head placing the shoulders in abduction and external rotation).

5.3.3 Laboratory Tests (Bicipital Tendon Disorders): are not indicated unless a systemic illness or disease is suspected.

5.3.4 Testing Procedures (Bicipital Tendon Disorders):

5.3.4.1 Plain x-rays include:

5.3.4.1.1 Anterior/Posterior (AP) view visualizes elevation of the humeral head, indicative of absence of the rotator cuff due to a tear;

5.3.4.1.2 Lateral view in the plane of the scapula and/or an axillary view determine if there is anterior or posterior dislocation or the presence of a defect in the humeral head (a Hill-Sachs lesion);

5.3.4.1.3 30° caudally angulated AP view determines if there is a spur on the anterior/inferior surface of the acromion and/or the far end of the clavicle; and

5.3.4.1.4 Outlet view determines if there is a downwardly tipped acromion.

5.3.4.2 Adjunctive testing, such as sonography, MRI or arthrography, should be considered when shoulder pain is refractory to 4-6 weeks of nonoperative conservative treatment and the diagnosis is not readily identified by standard radiographic techniques. These tests may be occasionally performed immediately after an injury if tendon injury is suspected based on history and physical examination.

5.3.5 Non-operative Treatment Procedures (Bicipital Tendon Disorders):

5.3.5.1 Benefit may be achieved through procedures outlined in Section 5.3.5. Non-operative Treatment Procedures, such as thermal therapy, immobilization, alteration of occupation and/or work station, manual therapy and biofeedback.

5.3.5.2 Medication, such as nonsteroidal anti-inflammatories and analgesics, would be indicated; narcotics are not normally indicated but may be needed in the acute phase. Refer to Section 5.3.5. Non-operative Treatment Procedures for further discussions.

5.3.5.3 Physical medicine and rehabilitation interventions, as outlined in Section 5.3.5. Non-operative Treatment Procedures, should emphasize a progressive increase in range of motion. With increasing motion and pain control, a strengthening program should be instituted and return to modified/limited duty would be considered at this time. By 8-11 weeks, with restoration of full motion, return to full duty should be anticipated.

- 5.3.5.4 Biceps tendon injections may be therapeutic if the patient responds positively to an injection of an anesthetic. Injection of the corticosteroids directly into the tendon should be avoided due to possible tendon breakdown and degeneration, limited to 3 injections per year at the same site, and avoided in patients under 30 years of age.

5.3.6 Operative Procedures (Bicipital Tendon Disorders):

- 5.3.6.1 Bicipital Tendinitis: Conservative care prior to potential surgery must address flexibility and strength imbalances. Surgical remedies would be considered after 12 weeks of appropriate conservative care has failed. Since impingement of the biceps tendon could cause continued irritation, an acromioplasty may be necessary, especially when the presence of an obstructing osteophyte is demonstrated on plain x-rays.
- 5.3.6.2 Subluxing Bicipital Tendon: The decision to surgically stabilize the bicipital tendon is not commonly indicated. In the vast majority of cases, optimal outcome is achieved through successful rehabilitation procedures and appropriate conservative measures should be maximized prior to surgical intervention.
- 5.3.6.3 Acute Disruption of the Bicipital Tendon: Surgical treatment shows variable responses. Conservative care should be the mainstay of treatment with particular attention given to the patient's age, work description and motivation. Rarely surgery is needed to address chronic mechanical symptoms which can occur from the intra articular residual biceps tendon stump or to stabilize severe biceps bunching.

- 5.3.7 **Post-Operative Procedures (Bicipital Tendon Disorders):** would include an individualized rehabilitation program either self-directed or in a supervised setting. Rehabilitation, lasting 6-12 weeks, is often necessary. Rehabilitation procedures discussed in Section 5.3.5, Non-operative Treatment Procedures should be referenced and used.

- 5.4 **BRACHIAL PLEXUS INJURIES** to the nerves and shoulder girdle region resulting in loss of motor and sensory function, pain and instability of the shoulder. Signs and symptoms vary with the degree of mechanism of injury. The two modes of injury are: 1) acute direct trauma, and 2) repetitive motion or overuse. Transient compression, stretch or traction (neuropraxia) causes sensory and motor signs lasting days to weeks. Damage to the axon (axonemesis) without disruption of the nerve framework may cause similar symptoms. The recovery time is delayed and depends upon axon regrowth distally from the site of injury. Laceration or disruption of the entire nerve with complete loss of framework (neuromesis) is the most severe form of nerve injury. Return of function is dependent upon regrowth of the nerve distal to the injury site.

Electromyography (EMG) is the most commonly used diagnostic modality to analyze nerve injuries. Electrophysiologic studies, such as electromyography and nerve conduction studies, are generally accepted, well-established and widely used for localizing the source of neurological symptoms. These studies should be utilized as an extension of the history and clinical examination.

Slowing of motor nerve conduction velocities due to demyelination localizes regions of entrapment and injury. Denervation demonstrated on the electromyographic portion is indicative of motor axonal or anterior horn cell loss. Studies should be performed 3-4 weeks following injury or description of symptoms. If the symptoms have been present for longer than 3-4 weeks, studies may be performed immediately after the initial evaluation. Serial studies may be indicated if initial studies are negative and may also be useful for gauging prognosis. Limb temperature should be controlled at 30-40° centigrade. There are six relatively common nerve injuries to the shoulder girdle; each type will be addressed separately.

- 5.4.1 **Brachial Plexus:** is formed by the nerve roots of C5-C8 and T1; these nerve roots exit the cervical spine and pass through the scalene musculature; after leaving the scalene musculature, at the level of the clavicle, they form trunks, divisions and chords which ultimately form the peripheral nerves of the arm.

5.4.1.1 History and Initial Diagnostic Procedures (Brachial Plexus)

- 5.4.1.1.1 Occupational Relationship - direct injury to brachial plexus results in widespread sensory and motor loss. Direct trauma, subluxation to shoulder, clavicular fractures, shoulder depression, head deviation away to the arm may result in variable brachial plexus lesions. It is important to differentiate injuries to the brachial plexus from the acquired (nonwork-related) syndrome of brachial plexus neuritis, Parsonage-Turner Syndrome and/or neuralgia demyotrophy.

5.4.1.2 Physical Findings (Brachial Plexus) may include:

- 5.4.1.1.2 Inspection for evidence of trauma or deformity;
- 5.4.1.1.3 Identification of sensory loss and demonstration of weakness which relates to the severity and anatomy of the injury to the brachial plexus; and/or
- 5.4.1.1.4 Pain with recreation of the motions during the mechanism of injury.

- 5.4.1.3 Laboratory Tests (Brachial Plexus) are not indicated unless a systemic illness or disease is suspected.
- 5.4.1.4 Testing Procedures (Brachial Plexus) would include EMG and Nerve Conduction Studies. If they do not localize and give sufficient information, then additional information may be obtained from MRI and/or myelography. These studies are employed to differentiate root avulsion from severe brachial plexus injuries.
- 5.4.1.5 Non-operative Treatment Procedures (Brachial Plexus)
 - 5.4.1.5.1 In closed injuries, observation is favored; repeat electro physiologic studies may be helpful to follow recovery.
 - 5.4.1.5.2 Rehabilitation can be utilized using procedures set forth in this Section 5.3.5, Non-operative Treatment Procedures. However, utilization of ultrasound, cold and heat should be discussed with the Physician since these modalities can aggravate nerve injury.
 - 5.4.1.5.3 Medications, such as analgesics, nonsteroidal anti-inflammatories and anti-convulsants, are indicated; steroids may be prescribed to help diminish the inflammatory response, and narcotics may be indicated acutely; all medications should be prescribed as seen in this Section 6.0, Medications.
- 5.4.1.6 Operative Procedures (Brachial Plexus): In open injuries, exploration may be worthwhile if there is poor progression of recovery from a conservative approach; in closed injuries, if progressive weakness and loss of function is documented after 4-6 months of conservative care, then exploration is also warranted.
- 5.4.1.7 Post-Operative Procedures (Brachial Plexus) would include an individualized rehabilitation program based upon communication between the surgeon and the therapist. This program would begin with 4-6 weeks of rest followed by progressive increase in motion and strength.
- 5.4.2 **Axillary Nerve:** is derived from the 5th and 6th cervical roots; it passes around the shoulder and supplies motor branches to the teres minor and the three heads of the deltoid; it gives sensation to the top of the shoulder at the level of the deltoid.
 - 5.4.2.1 History and Initial Diagnostic Procedures (Axillary Nerve):

Occupational Relationship - direct injury and penetrating wounds to the shoulder and upward pressure on the axilla can cause injury to the axillary nerve; abnormalities of the nerve can also be seen with fractures of the surgical neck of the humerus and dislocation of the shoulder; finally, axillary nerve injury can be seen with shoulder surgery in and of itself.
 - 5.4.2.2 Physical Findings (Axillary Nerve) may include:
 - 5.4.2.2.1 Weakness and atrophy of the deltoid muscle;
 - 5.4.2.2.2 Strength is lost in abduction, flexion and extension of the shoulder; and/or
 - 5.4.2.2.3 Sensory loss can be seen over the upper arm.
 - 5.4.2.3 Laboratory Tests (Axillary Nerve) are not indicated unless a systemic illness or disease is suspected.
 - 5.4.2.4 Testing Procedures (Axillary Nerve) would include EMG and Nerve Conduction Studies.
 - 5.4.2.5 Nonoperative Treatment Procedures (Axillary Nerve)
 - 5.4.2.5.1 Rehabilitation can be utilized using procedures set forth in this Section 5.3.5. Non-operative Treatment Procedures. Utilization of ultrasound, cold and heat should be discussed with the Physician since these modalities can aggravate the nerve injury.
 - 5.4.2.5.2 Medications such as analgesics, nonsteroidal anti-inflammatories and anti-convulsants are indicated and narcotics may be indicated acutely; all medications should be prescribed as seen in this Section 6.0. Medications.
 - 5.4.2.6 Operative Procedures (Axillary Nerve) are usually not necessary, since most injuries to the axillary nerve are due to stretch and/or traction. One may consider surgery after 4-6 months with EMG/ NCV documentation of ongoing denervation and loss of function.
 - 5.4.2.7 Post-Operative Procedures (Axillary Nerve) would include an individualized rehabilitation program based upon communication between the surgeon and the therapist. This program would begin with 4-6 weeks of rest followed by progressive increase in motion and strength.
- 5.4.3 **Long Thoracic Nerve:** is formed by the cervical fifth, sixth, and seventh roots; it crosses the border of the first rib and descends along the posterior surface of the thoracic wall to the serratus anterior.
 - 5.4.3.1 History and Initial Diagnostic Procedures (Long Thoracic Nerve)

- 5.4.3.1.1 Occupational Relationship - injury can occur by direct trauma to the posterior triangle of the neck or trauma may be the result of chronically repeated or forceful shoulder depression. Repeated forward motion of the arms as well as stretch or compression of the nerve with the arms abducted can lead to long thoracic nerve dysfunction.
- 5.4.3.2 Physical Findings (Long Thoracic Nerve) may include:
 - 5.4.3.2.1 Dull ache in the region of the shoulder without sensory loss;
 - 5.4.3.2.2 Scapular deformity and/or winging may be described by patient or family; and/or
 - 5.4.3.2.3 Serratus Anterior (scapular winging) may be demonstrated by asking the patient to extend and lean on his arms, such as against a wall and/or the examiner resisting protraction.
- 5.4.3.3 Laboratory Tests (Long Thoracic Nerve) are not indicated unless a systemic illness or disease is suspected
- 5.4.3.4 Testing Procedures (Long Thoracic Nerve) EMG and Nerve Conduction Studies are used to define the anatomy and severity of the injury; side-to-side comparisons of the nerve can be helpful to confirm the diagnosis; studies may also exclude more widespread brachial plexus involvement.
- 5.4.3.5 Non-operative Treatment (Long Thoracic Nerve)
 - 5.4.3.5.1 Rehabilitation can be utilized using procedures set forth in Section 5.3.5 Non-operative Treatment Procedures. Utilization of ultrasound, cold, and heat should be discussed with the Physician since these modalities can aggravate nerve injury.
 - 5.4.3.5.2 Medications, such as analgesics, nonsteroidal anti-inflammatories and anti-convulsants, are indicated and narcotics may be indicated acutely; all medications should be prescribed as seen in this Section 6.0 Medications.
- 5.4.3.6 Operative Procedures (Long Thoracic Nerve) such as scapular fixation, may be recommended but only in the most severe cases where there is documented significant loss of function.
- 5.4.3.7 Post-Operative Procedures (Long Thoracic Nerve) should include an individualized rehabilitation program based upon communication between the surgeon and the therapist. This program would begin with 8-10 weeks of rest followed by progressive increase in motion and strength.
- 5.4.4 **Musculocutaneous Nerve:** is derived from the fifth and sixth cervical roots; it innervates the coracobrachialis, biceps and brachioradialis muscles and also provides sensation to the lateral aspect of the forearm; trauma (including surgery) or penetrating wound to the brachial plexus, coracobrachialis, and shoulder often can cause nerve injury.
 - 5.4.4.1 History and Initial Diagnostic Procedures (Musculocutaneous Nerve)
 - 5.4.4.1.1 Occupational Relationship - most commonly a stretch/traction injury due to forceful extension of the elbow induces nerve dysfunction; trauma can be seen to the sensory component (lateral antebrachial cutaneous nerve) which delineates loss of sensation to the forearm.
 - 5.4.4.2 Physical Findings (Musculocutaneous Nerve) may include:
 - Pain in the arm;
 - Weakness and atrophy in the biceps and brachialis; and/or
 - Sensory loss over the lateral aspect of the forearm; however, is not always seen.
 - 5.4.4.3 Laboratory Tests (Musculocutaneous Nerve) are not indicated unless a systemic illness or disease is suspected.
 - 5.4.4.4 Testing Procedures (Musculocutaneous Nerve) include EMG and nerve conduction studies; side-to-side comparisons of the motor and sensory components of the nerve may be useful since standard norms are not always reliable.
 - 5.4.4.5 Non-operative Treatment Procedures (Musculocutaneous Nerve)
 - 5.4.4.5.1 Rehabilitation can be utilized using procedures set forth in this Section 5.3.5. Non-operative Treatment Procedures. Utilization of ultrasound, cold, and heat should be discussed with the Physician, since these modalities can aggravate nerve injury.
 - 5.4.4.5.2 Medications, such as analgesics, nonsteroidal anti-inflammatories and anticonvulsants, are indicated and narcotics may be indicated; all medications should be prescribed as seen in this Section 6.5 Medications.
 - 5.4.4.6 Operative Procedures (Musculocutaneous Nerve) are usually not necessary unless there has been increasing loss of function over 4-6 months and/or a laceration to the nerve has been identified.
 - 5.4.4.7 Post-Operative Procedures (Musculocutaneous Nerve) would include an individualized rehabilitation program based upon communication between the surgeon and the therapist. This

program would begin with 8-10 weeks of rest followed by progressive increase in motion and strength.

5.4.5 **Spinal Accessory Nerve:** is the eleventh cranial nerve; the nerve innervates the ipsilateral sternocleidomastoid and trapezius muscles which are extremely important for scapular control and ultimately shoulder function.

5.4.5.1 History and Initial Diagnostic Procedures (Spinal Accessory Nerve)

5.4.5.1.1 Occupational Relationship - direct trauma to the posterior neck, forceful compression of the shoulder downward and/or deviation of the head away from the traumatized shoulder can lead to injury to this nerve; surgical resection of the posterior neck can disrupt the nerve.

5.4.5.2 Physical Findings (Spinal Accessory Nerve) may include:

- Pain in the shoulder;
- Weakness or paralysis of the trapezius which is seen as winging with the arms out to the side (abduction); and/or
- Drooping of the shoulder.

5.4.5.3 Laboratory Tests (Spinal Accessory Nerve) are not indicated unless a systemic illness or disease is suspected.

5.4.5.4 Testing Procedures (Spinal Accessory Nerve) include EMG and Nerve Conduction Studies are used to define the anatomy and severity of the injury; side-to-side comparisons of the nerve can be helpful to confirm the diagnosis; radiographic procedures may be necessary to exclude lesion at the base of the brain or upper cervical spine.

5.4.5.5 Non-operative Treatment Procedures (Spinal Accessory Nerve)

5.4.5.5.1 Rehabilitation can be utilized using procedures set forth in Section 5.3.5. Non-operative Treatment Procedures. Utilization of ultrasound, cold, and heat should be discussed with the Physician, since these modalities can aggravate nerve injury.

5.4.5.5.2 Medications, such as analgesics, nonsteroidal anti-inflammatories and anticonvulsants, are indicated and narcotics may be indicated acutely; all medications should be prescribed as seen in Section 6.5 Medications.

5.4.5.6 Operative Procedures (Spinal Accessory Nerve) are usually not necessary unless increased loss of function over 4-6 months has been documented and/or a laceration to the nerve has been identified.

5.4.5.7 Post-Operative Procedures (Spinal Accessory Nerve) would include an individualized rehabilitation program based upon communications between the surgeon and the therapist. This program would begin with 8-10 weeks of rest followed by progressive increase in motion and strength.

5.4.6 **Suprascapular Nerve:** is derived from the fifth and sixth cervical root, superior trunk of the brachial plexus, and it innervates the supraspinatus and infraspinatus muscles of the rotator cuff.

5.4.6.1 History and Initial Diagnostic Procedures (Suprascapular Nerve)

5.4.6.1.1 Occupational Relationship - supraclavicular trauma, stretch, and friction through the suprascapular notch or against the transverse ligament at the notch can cause injury to the nerve; repetitive use of the arm has been shown on occasion to cause traction to the nerve.

5.4.6.2 Physical Findings (Suprascapular Nerve) may include:

- Pain at the shoulder;
- Wasting at the supraspinatus and/or infraspinatus muscles with weakness; and/or
- Tinel's can help to elicit a provocative pain response.

5.4.6.3 Laboratory Tests (Suprascapular Nerve) are not indicated unless a systemic illness or disease is suspected.

5.4.6.4 Testing Procedures (Suprascapular Nerve) include EMG and nerve conduction studies; side-to-side comparisons may be useful since standard norms are not always reliable. If one suspects a mass lesion at the suprascapular notch, then an MRI may be indicated.

5.4.6.5 Non-operative Treatment Procedures (Suprascapular Nerve)

5.4.6.5.1 Rehabilitation can be utilized using procedures set forth in Section 5.3.5. Non-operative Treatment Procedures. Utilization of ultrasound, cold, and heat should be discussed with the Physician, since these modalities can aggravate nerve injury.

5.4.6.5.2 Medications, such as analgesics, nonsteroidal anti-inflammatories and anti-convulsants, are indicated and narcotics may be indicated acutely; all medications should be prescribed as seen in this Section 6.5 Medications.

- 5.4.6.6 Operative Treatment Procedures (Suprascapular Nerve) involving surgical release at the suprascapular notch or spinoglenoid region is warranted depending upon the results of the electrophysiologic studies and/or absence of improvement with conservative management.
- 5.4.6.7 Post-Operative Procedures (Suprascapular Nerve) would include an individualized rehabilitation program based upon communication between the surgeon and the therapist. This program would begin with 8-10 weeks of rest followed by progressive increase in motion and strength.

5.5 **BURSITIS OF THE SHOULDER** Acute or chronic inflammation of the bursa (a potential fluid filled sac) that may be caused by trauma, chronic overuse, inflammatory arthritis, and acute or chronic infection that generally presents with localized pain and tenderness of the shoulder.

5.5.1 **History and Initial Diagnostic Procedures (Bursitis of the Shoulder):**

- Occupational Relationship - onset of symptoms, date, mechanism of onset, and occupational history and current requirements should be correlated with the intensity, character, duration and frequency of associated pain and discomfort.
- History may include nocturnal pain, pain with over-the-shoulder activities, feeling of shoulder weakness, prior treatment for presenting complaint(s), specific limitations of movement and pertinent familial history.

5.5.2 **Physical Findings (Bursitis of the Shoulder):** may include:

- Palpation elicits localized tenderness over the particular bursa or inflamed tendon; loss of motion during activity;
- Painful arc may be seen between 40-120° and/or
- Bursitis may be associated with other shoulder injury diagnoses such as impingement, rotator cuff instability, tendonitis, etc.; refer to applicable diagnosis subsections for additional guidelines.

5.5.3 **Laboratory Tests (Bursitis of the Shoulder):** may be used to rule out systemic illness or disease when proper clinical presentation indicates the necessity for such testing. Testing could include sedimentation rate, rheumatoid profile, complete blood count (CBC) with differential, serum uric acid level, routine screening of other medical disorders may be necessary, as well as bursal aspiration with fluid analysis.

5.5.4 **Testing Procedures (Bursitis of the Shoulder):**

5.5.4.1 Plain x-rays include:

- 5.5.4.1.1 AP view visualizes elevation of the humeral head, indicative of absence of the rotator cuff due to a tear;
- 5.5.4.1.2 Lateral view in the plane of the scapula or an axillary view determines if there is anterior or posterior dislocation or the presence of a defect in the humeral head (a Hill-Sachs lesion);
- 5.5.4.1.3 30° caudally angulated AP view determines if there is a spur on the anterior/anterior surface of the acromion and/or the far end of the clavicle; and
- 5.5.4.1.4 Outlet view determines if there is a downwardly tipped acromion.

5.5.4.2 Adjunctive testing, such as standard radiographic techniques (sonography, arthrography or MRI), should be considered when shoulder pain is refractory to 4-6 weeks of non-operative conservative treatment and the diagnosis is not readily identified by a good history and clinical examination.

5.5.5 **Non-operative Treatment Procedures (Bursitis of the Shoulder):**

- 5.5.5.1 Benefits may be achieved through procedures outlined in Section 5.3.5. Non-operative Treatment Procedures, such as immobilization, therapeutic exercise, alteration of occupation and work station, thermal therapy, TENS unit, and ultrasound.
- 5.5.5.2 May return to work without overhead activities and lifting with involved arm until cleared by physician for those and heavier activities.
- 5.5.5.3 Additional modalities/treatment procedures may include biofeedback; physical medicine and rehabilitation including instruction in therapeutic exercise, proper work technique and manual therapy; vocational rehabilitation, vocational assessment and interdisciplinary team approach.
- 5.5.5.4 Medications such as nonsteroidal anti-inflammatories and analgesics. Subacromial space injection may be therapeutic but should be limited to 3 injections per year in the same location. Injection of the corticosteroids directly into the tendons should be avoided due to possible tendon breakdown and degeneration. There are rare occasions where intratendinous injections may be cautiously considered if calcific tendonitis is present.

Rarely are injections used in patients under 30 years of age.

5.5.6 **Operative Procedures (Bursitis of the Shoulder):** are not commonly indicated for pure bursitis; refer to other appropriate diagnoses in Section 5.0. Specific Diagnosis, Testing and Treatment Procedures.

5.6 **IMPINGEMENT SYNDROME** A collection of symptoms, not a pathologic diagnosis. The symptoms result from the encroachment of the acromion, coracoacromial ligament, coracoid process, and/or the AC joint of the rotator cuff mechanism that passes beneath them as the shoulder is moved. The cuff mechanism is intimately related to the coracoacromial arch. Separated only by the thin lubricating surfaces of the bursa, compression and friction can be minimized by several factors, such as

- Shape of the coracoacromial arch that allows passage of the subjacent rotator cuff;
- Normal undersurface of the AC Joint;
- Normal bursa;
- Normal capsular laxity; and
- Coordinated scapulothoracic function.

The impingement syndrome may be associated with AC joint arthritis, both partial- and full-thickness rotator cuff tears, adhesive capsulitis/frozen shoulder and bursitis. Normal function of the rotator cuff mechanism and biceps tendon assist to diminish impingement syndrome.

5.6.1 **History and Initial Diagnostic Procedures (Impingement Syndrome):**

5.6.1.1 Occupational Relationship - established repetitive overuse of the upper extremity; many times this is seen with constant overhead motion.

5.6.1.2 History may include:

- 5.6.1.2.1 Delayed presentation; since the syndrome is usually not an acute problem; patients will access care if their symptoms have not resolved with rest, time and "trying to work it out";
- 5.6.1.2.2 Complaints of functional losses due to pain, stiffness, weakness and catching when the arm is flexed and internally rotated; and
- 5.6.1.2.3 Poor sleep is common and pain is often felt down the lateral aspect of the upper arm near the deltoid insertion or over the anterior proximal humerus.

5.6.2 **Physical Findings (Impingement Syndrome):** may include:

- 5.6.2.1 Inspection of the shoulder may reveal deltoid and rotator cuff atrophy;
- 5.6.2.2 Range of motion is limited particularly in internal rotation and in cross-body adduction;
- 5.6.2.3 Passive motion through the 60-90° arc of flexion may be accompanied by pain and crepitus; this is accentuated as the shoulder is moved in-and-out of internal rotation;
- 5.6.2.4 Active elevation of the shoulder is usually more uncomfortable than passive elevation;
- 5.6.2.5 Pain on maximum active forward flexion is frequently seen with impingement syndrome, but is not specific for diagnosis;
- 5.6.2.6 Strength testing may reveal weakness of flexion and external rotation in the scapular plane; this weakness may be the result of disuse, tendon damage, or poor scapulothoracic mechanics;
- 5.6.2.7 Pain on resisted abduction or external rotation may also indicate that the integrity of the rotator cuff tendons may be compromised; and/or
- 5.6.2.8 Weakness of the posterior scapular stabilizers can also be seen as a contributing factor to impingement syndrome by altering the mechanics of the glenohumeral joint.

5.6.3 **Laboratory Tests (Impingement Syndrome):** are not indicated unless a systemic illness or disease is suspected.

5.6.4 **Testing Procedures (Impingement Syndrome):**

5.6.4.1 Plain x-rays include:

- 5.6.4.1.1 AP view visualizes elevation of the humeral head, indicative of rotator cuff fiber failure with diminished space at the subacromial area;
- 5.6.4.1.2 Lateral view in the plane of the scapula or an axillary view can help to determine aspects of instability which can give symptoms similar to impingement syndrome;
- 5.6.4.1.3 30° caudally angulated AP view can assess for a spur on the anterior/inferior surface of the acromion and/or the distal end of the clavicle which can lead to encroachment on the rotator cuff mechanism with motion; and
- 5.6.4.1.4 Outlet view determines if there is a downwardly tipped acromion.

5.6.4.2 Adjunctive testing, such as standard radiographic techniques (sonography, arthrography or MRI), should be considered when shoulder pain is refractory to 4-6 weeks of non-operative conservative treatment and the diagnosis is not readily identified by a good history and clinical examination.

5.6.5 **Non-operative Treatment Procedures (Impingement Syndrome)** may include:

5.6.5.1 Medications, such as nonsteroidal anti-inflammatories and analgesics, should be prescribed as seen in Section 6.5 Medications. Subacromial space injection may be therapeutic. Injections of

corticosteroids into the subacromial space should be limited to 3 injections per year at the same site, and rarely used in patients less than 30 years.

5.6.5.2 In order to have the most favorable outcome from a conservative approach, an aggressive attempt should be made to define the contributing factors which are driving the syndrome, such as shoulder stiffness, humeral head depressor weakness (rotator cuff fiber failure), and subacromial crowding AC Joint arthritis.

5.6.5.3 Procedures outlined in Section 5.3.5. Non-operative Treatment Procedures should be considered, such as relative rest, immobilization, thermal treatment, ultrasound, therapeutic exercise and physical medicine and rehabilitation.

5.6.6 **Operative Procedures (Impingement Syndrome):** should restore functional anatomy by reducing the potential for repeated impingement; procedures might include distal clavicular resection, coracoacromial ligament release, and/or acromioplasty.

5.6.7 **Post-Operative Procedures (Impingement Syndrome):** would include an individualized rehabilitation program based upon communication between the surgeon and the therapist.

5.6.7.1 Individualized rehabilitation programs might include:

5.6.7.1.1 Sling or abduction splint;

5.6.7.1.2 Gentle pendulum exercise, passive glenohumeral range of motion and aggressive posterior scapular stabilizing training can be instituted;

5.6.7.1.3 At 4 weeks post-operative, begin isometrics and ADL involvement; and/or

5.6.7.1.4 Depending upon the patient's functional response, at 4 weeks post-operative consider beginning light resistive exercise; concomitantly, return to a light modified duty may be plausible given the ability to accommodate "no repetitive overhead activities."

5.6.7.2 Progressive resistive exercise from 2 months with gradual returning to full activity at 5-7 months; all active non-operative procedures listed in this Section 5.3.5. Non-operative Treatment Procedures should be considered.

5.6.7.3 Work restrictions should be evaluated every 4-6 weeks during post-operative recovery and rehabilitation with appropriate written communications to both the patient and the employer. Should progress plateau, the provider should reevaluate the patient's condition and make appropriate adjustments to the treatment plan.

5.7 **ROTATOR CUFF TEAR** Partial- or full-thickness tears of the rotator cuff tendons, most often the supraspinatus can be caused by vascular, traumatic or degenerative factors or a combination. Further tear classification includes: a small tear is less than 1cm; medium tear is 1-3cm; large tear is 3-5cm; and massive tear is greater than 5cm, usually with retraction.

5.7.1 **History and Initial Diagnostic Procedures (Rotator Cuff Tear):**

5.7.1.1 Occupational Relationship - established with sudden trauma to the shoulder or chronic over-use with repetitive overhead motion with internal or external rotation.

5.7.1.2 History may include:

5.7.1.2.1 Partial-thickness cuff tears usually occur in age groups older than 30. Full-thickness tears can occur in younger age groups.

5.7.1.2.2 Complaints of pain along anterior, lateral or posterior glenohumeral joint.

5.7.2 **Physical Findings (Rotator Cuff Tear)** may include:

5.7.2.1 Partial-Thickness Tear

5.7.2.1.1 There will be pain at the end of range of motion with full passive range-of-motion for abduction, elevation, external rotation; internal rotation is attainable;

5.7.2.1.2 Active range of motion will be limited and painful for abduction and external rotation, as well as internal rotation and forward flexion;

5.7.2.1.3 A painful arc may be present with active elevation;

5.7.2.1.4 Pain will be positive for resisted tests (abduction, flexion, external rotation, internal rotation, abduction/internal rotation at 90°, and abduction/external rotation at 45°; and/or

5.7.2.1.5 If there are positive impingement signs, see this Section 5.4.8, Impingement Syndrome.

5.7.2.2 Full-Thickness Tears

5.7.2.2.1 Passive and resisted findings are similar to those for partial-thickness tears; and/or

5.7.2.2.2 Active elevation will be severely limited with substitution of scapular rotation being evident.

5.7.3 **Laboratory Tests (Rotator Cuff Tear):** are not indicated unless a systemic illness or disease is suspected.

5.7.4 **Testing Procedures (Rotator Cuff Tear):**

5.7.4.1 Plain x-rays include:

- 5.7.4.1.1 AP view visualizes elevation of the humeral head, indicative of absence of the rotator cuff due to a tear;
- 5.7.4.1.2 Lateral view in the plane of the scapula and/or an axillary view determines if there is anterior or posterior dislocation or the presence of a defect in the humeral head (a Hill-Sachs lesion);
- 5.7.4.1.3 30° caudally angulated AP view determines if there is a spur on the anterior inferior surface of the acromion and/or the far end of the clavicle; and
- 5.7.4.1.4 Outlet view determines if there is a downwardly tipped acromion.

5.7.4.2 Adjunctive testing should be considered when shoulder pain is refractory to 4-6 weeks of non-operative conservative treatment and the diagnosis is not readily identified by standard radiographic techniques, then sonography, arthrography or MRI may be indicated. These tests may be occasionally performed immediately after an injury if rotator cuff tear is suspected based on history and physical exam.

5.7.5 **Non-operative Treatment Procedures (Rotator Cuff Tear):**

5.7.5.1 Medications, such as nonsteroidal anti-inflammatories and analgesics, would be indicated; acute rotator cuff tear could indicate the need for limited narcotics use.

5.7.5.2 Relative rest and procedures outlined in Section 5.3.5. Non-operative Treatment Procedures, such as immobilization, therapeutic exercise, alteration of occupation/work station, thermal treatment, TENS unit, therapeutic ultrasound, return-to-work, biofeedback and physical medicine and rehabilitation. If no increase in function for a partial- or full-thickness tear is observed after 6-8 weeks, a surgical consultation is indicated. Early surgical intervention produces better surgical outcome due to healthier tissues and often less limitation of movement prior to and after surgery.

5.7.6 **Operative Procedures (Rotator Cuff Tear):** options would include arthroscopic repair or an open debridement and repair. Goals of surgical intervention are to restore functional anatomy by reestablishing continuity of the rotator cuff, and to reduce the potential for repeated impingement by the performance of procedures such as distal clavicular resection, coracoacromial ligament release, and/or anterior acromioplasty (subacromial decompression).

5.7.7 **Post-Operative Procedures (Rotator Cuff Tear):** would include an individualized rehabilitation program either home based or in conjunction with supervised therapy.

5.7.7.1 Individualized rehabilitation program might include:

- Sling or abduction splint;
- Gentle pendulum exercise, passive glenohumeral range of motion in flexion and external rotation to prevent adhesions and maintain mobilization with or without the assistance of a pulley;
- At 4 to 6 weeks post-operative begin isometrics and ADL involvement;
- Active assisted range-of-motion in supine with progression to sitting;
- At 6-8 weeks, depending on quality of tissue, begin light resistive exercise;
- Pool exercise, manual resistive exercise to 90°, scapula mobilization exercise with glenohumeral stabilization; and
- Scapular plane exercise.

5.7.7.2 Progressive resistive exercise from 3-6 months, with gradual returning to full activity at 6-9 months. All active non-operative procedures listed in this Section 5.3.5. Non-operative Treatment Procedures should be considered.

5.7.7.3 Work restrictions should be evaluated every 4-6 weeks during post-operative recovery and rehabilitation with appropriate written communications to both the patient and employer. Should progress plateau, the provider should reevaluate the patient's condition and make appropriate adjustments to the treatment plan.

5.8 **ROTATOR CUFF TENDINITIS** Inflammation of one or more of the four musculotendinous structures which arise from the scapula and insert on the lesser or greater tuberosity of the humerus. These structures include one internal rotator (subscapularis), and two external rotators (infraspinatus and teres minor), and the supraspinatus which assists in abduction.

5.8.1 **History and Initial Diagnostic Procedures (Rotator Cuff Tendinitis):**

- Occupational Relationship - may include symptoms of pain and/or achiness that occur after repetitive use of the shoulder and/or blunt trauma to the shoulder.

5.8.2 **Physical Findings (Rotator Cuff Tendinitis)** may include:

- 5.8.2.1 Pain with palpation to the shoulder with active or passive abduction and external rotation of the shoulder (painful arc);
- 5.8.2.2 Pain with impingement signs; and/or
- 5.8.2.3 Pain with specific activation of the involved muscles.
- 5.8.3 **Laboratory Tests (Rotator Cuff Tendinitis):** are not indicated unless a systemic illness or disease is suspected.
- 5.8.4 **Testing Procedures (Rotator Cuff Tendinitis)** may include:
 - 5.8.4.1 Plain x-ray films including AP lateral, axillary, 30° caudally angulated AP, and Outlet view.
 - 5.8.4.2 If shoulder pain is refractory to 4-6 weeks of non-operative care and the diagnosis is not readily identified by standard radiographic techniques, then adjunctive testing, such as MRI, sonography or arthrography, may be indicated.
 - 5.8.4.3 Subacromial space injection can be used as a diagnostic procedure by injecting an anesthesia, such as sensorcaine or xylocaine solutions, into the space. If the pain is alleviated with the injection the diagnosis is confirmed.
- 5.8.5 **Non-operative Treatment Procedures (Rotator Cuff Tendinitis)** may include:
 - 5.8.5.1 Medications, such as nonsteroidal anti-inflammatories and analgesics: Subacromial space injection may be therapeutic. Injections of corticosteroids into the subacromial space should be limited to 3 injections per year, rarely used in patients less than 30 years, and generally not injected into the tendon. Autologous blood product injections into areas of tendinopathy are an evolving treatment and may rarely be considered.
 - 5.8.5.2 Procedures outlined in Section 5.3.5. Non-operative Treatment Procedures such as relative rest, immobilization, thermal treatment, ultrasound, therapeutic exercise, physical medicine and rehabilitation.
- 5.8.6 **Operative Procedures (Rotator Cuff Tendinitis):** are indicated after failure of conservative care. Surgical treatment and post operative care are similar to the surgical treatment of shoulder bursitis and impingement syndrome. See Sections 5.4.7 and 5.4.8.
- 5.9 **SHOULDER FRACTURES** There are five common types of shoulder fractures; each type will be addressed separately and in the order of most frequent occurrence.
 - 5.9.1 **Clavicular Fracture:**
 - 5.9.1.1 **History and Initial Diagnostic Procedures (Clavicular Fracture)**
 - Occupational Relationship - can result from direct blows or axial loads applied to the upper limb; commonly associated injuries include rib fractures, long-bone fractures of the ipsilateral limb and scapulothoracic dislocations.
 - 5.9.1.2 **Physical Findings (Clavicular Fracture)** may include:
 - 5.9.1.2.1 Pain in the clavicle;
 - 5.9.1.2.2 Abrasions on the chest wall, clavicle and shoulder can be seen;
 - 5.9.1.2.3 Deformities can be seen in the above regions; and/or
 - 5.9.1.2.4 Pain with palpation and motion at the shoulder joint area.
 - 5.9.1.3 **Laboratory Tests (Clavicular Fracture)** are not indicated unless a systemic illness or disease is suspected.
 - 5.9.1.4 **Testing Procedures (Clavicular Fracture)** could include routine chest x-rays. Alternatively x-rays centered on the clavicle, both straight AP and 20 degree cephalad AP views, would be indicated. Serial x-rays should be performed to document healing.
 - 5.9.1.5 **Non-operative Treatment Procedures (Clavicular Fracture)**
 - 5.9.1.5.1 Most are adequately managed by closed techniques and do not require surgery. The arm is immobilized in a sling (figure-8 bracing shows limited success and should be used rarely). Shoulder rehabilitation is begun with pendulum exercises 10-14 days after injury. Subsequently, with pain control, the therapy program can be progressed with therapeutic approaches as seen in this Section 5.3.5. Non-operative Treatment Procedures.
 - 5.9.1.5.2 Medication, such as analgesics and nonsteroidal anti-inflammatories, would be indicated; narcotics may be indicated acutely for fracture and should be prescribed as indicated use is indicated in Section 6.5 Medications.
 - 5.9.1.6 **Operative Procedures (Clavicular Fracture)** would be indicated for open fractures, significantly displaced fractures, vascular or neural injuries requiring repair, bilateral fractures, ipsilateral scapular or glenoid neck fractures, scapulothoracic dislocations, flail chest and nonunion

displaced-closed fractures that show no evidence of union after 4-6 months. Also a Type II fracture/dislocation at the AC joint where the distal clavicular fragment remains with the acromion and the coracoid, and the large proximal fragment is displaced upwards.

- 5.9.1.7 Post-Operative Procedures (Clavicular Fracture) would include an individualized rehabilitation program. This program would begin with 2-4 weeks of rest with a shoulder immobilizer or sling while encouraging isometric deltoid strengthening; pendulum exercises with progression to assisted forward flexion and external rotation would follow; strengthening exercises should be started at 10-12 weeks as seen in Section 5.3.5. Non-operative Treatment Procedures.

5.9.2 Proximal Humeral Fractures:

5.9.2.1 History and Initial Diagnostic Procedures (Proximal Humeral Fractures)

- 5.9.2.1.1 Occupational Relationship - may be caused by a fall onto an abducted arm; may also be caused by high-energy (velocity or crush) trauma with an abducted or non-abducted arm; associated injuries are common, such as glenohumeral dislocation, stretch injuries to the axillary, musculocutaneous, and radial nerves; axillary artery injuries with high energy accident.

5.9.2.1.2 Physical Findings (Proximal Humeral Fractures) may include:

- 5.9.2.1.2.1 Pain in the upper arm;
- 5.9.2.1.2.2 Swelling and bruising in the upper arm, shoulder and chest wall;
- 5.9.2.1.2.3 Abrasions about the shoulder; and/or
- 5.9.2.1.2.4 Pain with any attempted passive or active shoulder motion.

- 5.9.2.1.3 Laboratory Tests (Proximal Humeral Fractures) are not indicated unless a systemic illness or disease is suspected.

5.9.2.1.4 Testing Procedures (Proximal Humeral Fracture)

- 5.9.2.1.4.1 X-ray trauma series (3 views) are needed; AP view, axillary view and a lateral view in the plane of the scapula. Additionally, AP view may be done in externally rotation and also internal rotation

- 5.9.2.1.4.2 Vascular studies are obtained emergently if the radial and brachial pulses are absent.

- 5.9.2.1.4.3 Diagnostic testing including CT Scan or MRI to further evaluate the fracture and surrounding structures may be appropriate depending on the fracture configuration and need for pre-operative planning.

5.9.2.1.5 Non-operative Treatment Procedures (Proximal Humeral Fractures)

- 5.9.2.1.5.1 Impacted or minimally displaced fractures of the humeral neck or greater tuberosity are generally managed non-operatively.

- 5.9.2.1.5.2 Isolated and minimally displaced (less than 1cm) fractures are treated non operatively.

- 5.9.2.1.5.3 Anterior or posterior dislocation associated with minimally displaced fractures can usually be reduced by closed means, but an anesthetic is needed.

- 5.9.2.1.5.4 Immobilization is provided with a sling, to support the elbow, and/or an abduction immobilizer if appropriate for the fracture configuration.

- 5.9.2.1.5.5 Immobilization is continued for 4-6 weeks

- 5.9.2.1.5.6 Shoulder rehabilitation is begun with pendulum exercises 10-14 days after injury. Subsequently, with pain control, the therapy program can be progressed with therapeutic approaches as seen in Section 5.3.5. Non-operative Treatment Procedures.

5.9.2.1.6 Operative Procedures (Proximal Humeral Fractures)

- 5.9.2.1.6.1 Indications for operative treatment would include:

- 5.9.2.1.6.1.1 Unstable surgical neck fractures (no contact between the fracture fragments).

- 5.9.2.1.6.1.2 Partially unstable fractures (only partial contact) with associated same upper extremity injuries.

- 5.9.2.1.6.1.3 Displaced 3- and 4-part fractures may be managed by internal fixation or a prosthetic hemiarthroplasty and reattachment of the tuberosities.

- 5.9.2.1.7 Post-Operative Procedures (Proximal Humeral Fractures) would include an individualized rehabilitation program.

- 5.9.2.1.7.1 See this Section 5.4.11, Shoulder Fracture, Non-operative Treatment Procedures.

5.9.3 Humeral Shaft Fractures:

5.9.3.1 History and Initial Diagnostic Procedures (Humeral Shaft Fractures)

- Occupational Relationship - a direct blow can fracture the humeral shaft at the junction of its

middle and distal thirds; twisting injuries to the arm will cause a spiral humeral shaft fracture; high energy (velocity or crush) will cause a comminuted humeral shaft fracture.

5.9.3.2 Physical Findings (Humeral Shaft Fractures) may include:

- 5.9.3.2.1 Deformity of the arm;
- 5.9.3.2.2 Bruising and swelling; and/or
- 5.9.3.2.3 Possible sensory and/or motor dysfunction of the radial nerve.

5.9.3.3 Laboratory Tests (Humeral Shaft Fractures) are not indicated unless a systemic illness or disease is suspected.

5.9.3.4 Testing Procedures (Humeral Shaft Fractures)

- 5.9.3.4.1 Plain x-rays including AP view and lateral of the entire humeral shaft.
- 5.9.3.4.2 Vascular studies if the radial pulse is absent.
- 5.9.3.4.3 Compartment pressure measurements if the surrounding muscles are swollen, tense and painful and particularly if the fracture resulted from a crush injury.

5.9.3.5 Non-operative Treatment Procedures (Humeral Shaft Fractures)

- 5.9.3.5.1 Most isolated humeral shaft fractures can be managed non-operatively.
- 5.9.3.5.2 A coaptation splint may be applied. The splint is started in the axilla, extended around the elbow and brought up to the level of the acromion. It is held in place with large elastic bandages.
- 5.9.3.5.3 At 2-3 weeks after injury, a humeral fracture orthosis may be used to allow for full elbow motion.

5.9.3.6 Operative Treatment (Humeral Shaft Fractures)

5.9.3.6.1 Indications for operative care would include:

- Open fracture;
- Associated forearm or elbow fracture (i.e., the floating elbow injury);
- Burned upper extremity;
- Associated paraplegia;
- Multiple injuries (polytrauma);
- A radial nerve palsy which came on after closed reduction; and/or
- Pathologic fracture related to an occupational injury.
- Some instable or significantly displaced fractures

5.9.3.6.2 Accepted methods of internal fixation include:

- 5.9.3.6.2.1 A broad plate and screws; and/or
- 5.9.3.6.2.2 Intramedullary rodding with or without cross-locking screws.

5.9.3.7 Post-Operative Procedures (Humeral Shaft Fractures) would include an individualized rehabilitation program. Following rigid internal fixation, therapy may be started to obtain passive and later active shoulder motion using appropriate therapeutic approaches as seen in Section 5.3.5. Non-operative Treatment Procedures. Active elbow and wrist motion may be started immediately.

5.9.4 Scapular Fractures:

5.9.4.1 History and Initial Diagnostic Procedures (Scapular Fractures)

- Occupational Relationship - these are the least common of the fractures about the shoulder and include acromial, glenoid, glenoid neck and scapular body fractures. With the exception of anterior glenoid lip fractures caused by an anterior shoulder dislocation, all other scapular fractures are due to a high energy injury.

5.9.4.2 Physical Findings (Scapular Fractures) may include:

- 5.9.4.2.1 Pain about the shoulder and thorax;
- 5.9.4.2.2 Bruising and abrasions;
- 5.9.4.2.3 Possibility of associated humeral or rib fractures; and/or
- 5.9.4.2.4 Vascular problems (pulse evaluation and Doppler examination).

5.9.4.3 Laboratory Tests (Scapular Fractures), because of the association of high energy trauma, may include a complete blood count, urinalysis and chest x-ray are warranted.

5.9.4.4 Testing Procedures (Scapular Fractures)

- 5.9.4.4.1 Trauma x-ray series - AP view, axillary view and a lateral view in the plane of the scapula.
- 5.9.4.4.2 Arteriography if a vascular injury is suspected.

- 5.9.4.4.3 Electromyographic exam if nerve injuries are noted.
- 5.9.4.4.4 Diagnostic testing including CT Scan or MRI to evaluate fracture and surrounding structures.
- 5.9.4.5 Non-operative Treatment Procedures (Scapular Fractures)
 - 5.9.4.5.1 Non-displaced acromial, coracoid, glenoid, glenoid neck and scapular body fractures may all be treated with the use of a shoulder immobilizer.
 - 5.9.4.5.2 Pendulum exercises may be started within the first week.
 - 5.9.4.5.3 Progress to assisted range of motion exercises at 3-4 weeks using appropriate therapeutic procedures as seen in this Section 5.3.5. Non-operative Treatment Procedures.
- 5.9.4.6 Operative Treatment (Scapular Fractures)
 - 5.9.4.6.1 Acromial fractures which are displaced should be internally fixed to prevent a nonunion. These fractures may be fixed with lag screws and/or a superiorly placed plate to neutralize the muscular forces.
 - 5.9.4.6.2 Glenoid fractures which are displaced greater than 2-3 mm should be fixed internally. The approach is determined by studying the results of a CT scan.
 - 5.9.4.6.3 Scapular body fractures require internal fixation if the lateral or medial borders are displaced to such a degree as to interfere with scapulothoracic motion.
 - 5.9.4.6.4 Displaced fractures of the scapular neck and the ipsilateral clavicle require internal fixation of the clavicle to reduce the scapular neck fracture.
- 5.9.4.7 Post-Operative Treatment (Scapular Fractures) would include an individualized rehabilitation program. Non-operative Treatment Procedures, a shoulder immobilizer is utilized, pendulum exercises at one week, deltoid isometric exercises are started early, and, at 4-6 weeks, active range of motion is commenced.
- 5.9.5 **Sternoclavicular Dislocation/Fracture:**
 - 5.9.5.1 History and Initial Diagnostic Procedures (Sternoclavicular Dislocation/Fracture)
 - Occupational Relationship - established with sudden trauma to the shoulder/ anterior chest wall; anterior dislocations of the sternoclavicular joint usually do not require active treatment; however, symptomatic posterior dislocations will require reduction.
 - 5.9.5.2 Physical Findings (Sternoclavicular Dislocation/Fracture) may include:
 - 5.9.5.2.1 Pain at the sternoclavicular area;
 - 5.9.5.2.2 Abrasions on the chest wall, clavicle and shoulder can be seen;
 - 5.9.5.2.3 Deformities can be seen in the above regions; and/or
 - 5.9.5.2.4 Pain with palpation and motion at the sternoclavicular joint area.
 - 5.9.5.3 Laboratory Tests (Sternoclavicular Dislocation/Fracture) are not indicated unless a systemic illness or disease is suspected.
 - 5.9.5.4 Testing Procedures (Sternoclavicular Dislocation/Fracture)
 - 5.9.5.4.1 Plain x-rays of the sternoclavicular joint are routinely done. When indicated, comparative views of the contralateral limb may be necessary.
 - 5.9.5.4.2 X-rays of other shoulder areas and chest wall may be done if clinically indicated.
 - 5.9.5.4.3 Vascular studies should be considered if the history and clinical examination indicate extensive injury.
 - 5.9.5.4.4 Diagnostic tests such as CT Scan or MRI may be required to fully delineate the nature of injury and assist in treatment plan.
 - 5.9.5.5 Non-operative Treatment Procedures (Sternoclavicular Dislocation /Fracture)
 - 5.9.5.5.1 Symptomatic posterior dislocations should be reduced in the operating room under general anesthesia.
 - 5.9.5.5.2 Immobilize with a sling for 3-4 weeks. Subsequently, further rehabilitation may be utilized using procedures set forth in Section 5.3.5. Non-operative Treatment Procedures.
 - 5.9.5.5.3 Medications, such as analgesics and nonsteroidal anti-inflammatories, would be indicated; narcotics may be indicated acutely for fracture and should be prescribed as indicated use is indicated in this Section 6.5 Medications.
 - 5.9.5.6 Operative Procedures (Sternoclavicular Dislocation/Fracture) would be warranted following failure of reduction by manipulation with pointed reduction forceps. Caution should be utilized when pins or screws are used for stabilization secondary to migration.
 - 5.9.5.7 Post-Operative Procedures (Sternoclavicular Dislocation/Fracture) would include an individualized rehabilitation program. This program would begin with 4-6 weeks of rest with a shoulder

immobilizer and be followed by pendulum exercises with progression to assisted forward flexion and external rotation. Strengthening exercises should be started at 8-10 weeks.

5.10 **SHOULDER INSTABILITY** Subluxation (partial dislocation) or dislocation of the glenohumeral joint in either an anterior, interior, posterior or multidirectional position.

5.10.1 **History and Initial Diagnostic Procedures (Shoulder Instability):**

5.10.1.1 Occupational Relationship - instability should be apparent following a direct traumatic blow to the shoulder, or indirectly by falling on an outstretched arm, or while applying significant traction to the arm, or may also develop with a cumulative trauma to the shoulder. Symptoms should be exacerbated or provoked by work and initially alleviated with a period of rest. Symptoms may be exacerbated by other activities that are not necessarily work related (e.g., driving a car).

5.10.1.2 History may include:

5.10.1.2.1 A slipping sensation in the arm;

5.10.1.2.2 Severe pain with inability to move the arm;

5.10.1.2.3 Abduction and external rotation produce a feeling that the shoulder might "come out"; or

5.10.1.2.4 Feeling of shoulder weakness.

5.10.1.3 In subacute and/or chronic instabilities, age of onset of instability is important in the history. Older age group (over age 40) has a propensity not to re-dislocate. Younger age groups (under age 30) need a more aggressive treatment plan.

5.10.1.4 Avoid any aggressive treatment in patients with history of voluntary subluxation or dislocation. These patients may need a psychiatric evaluation.

5.10.2 **Physical Findings (Shoulder Instability)** may include:

5.10.2.1 Anterior dislocations would likely include loss of normal shoulder contour; a fullness in the axilla; pain over the shoulder with any motion and often the patient holding the extremity in a very still position;

5.10.2.2 Posterior dislocations usually occur with a direct fall on the shoulder or outstretched arm resulting in posteriorly directed forces to the humeral head. These patients present with inability to externally rotate the shoulder;

5.10.2.3 Neurologic examination could reveal most commonly axillary nerve injuries, but occasionally musculocutaneous nerve injuries are seen; and/or

5.10.2.4 Abduction and external rotation positioning will produce pain in those who have anterior instability. Direct posterior stress in a supine position will produce pain in those with posterior instability. Longitudinal traction will produce a "sulcus sign" (a large dimple on the lateral side of the shoulder) when there is inferior instability.

5.10.3 **Laboratory Tests (Shoulder Instability):** are not indicated unless a systemic illness or disease is suspected.

5.10.4 **Testing Procedures (Shoulder Instability):**

5.10.4.1 Plain x-rays to rule out bony deficit on the glenoid, including AP, axillary view, lateral in the plane of the scapula and possibly the West Point view. Axillary view to identify larger Hill-Sachs lesion of humeral head.

5.10.4.2 On more difficult diagnostic cases with subtle history and physical findings suggesting instability, MRI, or a CT assisted arthrogram or MRI assisted arthrogram may be ordered for lateral detachment after 4-8 weeks of therapy. (This is done only after other conservative therapies have failed.)

5.10.4.3 An MRI is indicated to rule out acute rotator cuff injury after shoulder dislocation in patients over age 45.

5.10.5 **Non-operative Treatment Procedures (Shoulder Instability):**

5.10.5.1 First-Time Acute Involvement:

5.10.5.1.1 Therapeutic Procedures

5.10.5.1.1.1 Immobilization

5.10.5.1.1.2 Therapeutic Exercise

5.10.5.1.1.3 Alteration of Occupation & Work Station

5.10.5.1.1.4 Thermal Treatment

5.10.5.1.1.5 TENS Unit

5.10.5.1.1.6 Ultrasound

- 5.10.5.1.2 May not return to work with overhead activity or lifting with involved arm until cleared by physician for heavier activities.
 - 5.10.5.1.3 Additional modalities may include:
 - 5.10.5.1.3.1 Biofeedback
 - 5.10.5.1.3.2 Physical Medicine and Rehabilitation
 - 5.10.5.1.3.2.1 Instruction in Therapeutic Exercise and Proper Work Techniques
 - 5.10.5.1.3.2.2 Manual Therapy Techniques
 - 5.10.5.1.3.2.3 Work Conditioning
 - 5.10.5.1.3.2.3.1 Vocational Rehabilitation
 - 5.10.5.1.3.2.3.2 Vocational Assessment
 - 5.10.5.1.3.2.3.3 Interdisciplinary Team Approach
 - 5.10.5.1.3.2.3.3.1 Work Hardening
 - 5.10.5.1.3.2.3.3.2 Functional Restoration Programs
 - 5.10.5.1.3.2.3.3.3 Pain Clinics
 - 5.10.5.1.4 Medications - medication discussions are in Section 6.5 Medications
 - 5.10.5.1.4.1 Analgesics
 - 5.10.5.1.4.2 Anti-inflammatories
- 5.10.5.2 Acute or chronic dislocations with large fracture fragments contributing to instability;
 - 5.10.5.2.1 Attempt to treat with immobilization if in acceptable position, otherwise repair surgically
 - 5.10.5.2.2 Return-to-work may be directly related to time it takes for the fracture to heal
- 5.10.5.3 Subacute and/or chronic instability:
 - 5.10.5.3.1 Provocative dislocation should first be treated similarly to acute dislocation.
 - 5.10.5.3.2 If acute treatment is unsuccessful, and still having findings of instability, would consider operative repair.
- 5.10.6 **Operative Procedures (Shoulder Instability):**
 - 5.10.6.1 Identify causative agent for the instability (i.e., labral detachment, bony lesion, or multidirectional instability), then proceed with:
 - 5.10.6.1.1 Bony block transfer;
 - 5.10.6.1.2 Capsular tightening; or
 - 5.10.6.1.3 Bankart lesion repair.
- 5.10.7 **Post-Operative Procedures (Shoulder Instability):** would include an individualized rehabilitation program. Depending upon the type of surgery, the patient will be immobilized for 3-6 weeks. As soon as it is safe to proceed without damaging the repair, progressive therapy, either home based or with consultation involving an occupational and/or physical therapist should begin with therapeutic exercise, physical medicine and rehabilitation (refer to Section 5.3.5. Non-operative Treatment Procedures). During this period of time, the patient could resume working when:
 - 5.10.7.1 A job assessment results in the treating physician's identification of needed modifications and restrictions;
 - 5.10.7.2 The patient has attained a general level of comfort;
 - 5.10.7.3 Medications which would predispose to injury are no longer being prescribed or used; and
 - 5.10.7.4 The treating physician has cleared the patient for the specific vocational activities.

MMI can be expected 6-9 months after operative intervention. Further job assessment and adjusted work restrictions may be needed prior to the patients return to full duty.

6.0 Therapeutic Procedures – Non-Operative

Before initiation of any therapeutic procedure, the authorized treating provider, employer and insurer must consider these important issues in the care of the injured worker.

First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time. Refer to "Return-to-Work" in this section for detailed information.

Second, cessation and/or review of treatment modalities should be undertaken when no further significant subjective or objective improvement in the patient's condition is noted. If patients are not responding within the recommended duration periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued.

Third, providers should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

In cases where a patient is unable to attend an outpatient center, home therapy may be necessary. Home therapy may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone. Home therapy is usually of short duration and continues until the patient is able to tolerate coming to an outpatient center.

The following procedures are listed in alphabetical order.

- 6.1 **ACUPUNCTURE** is an accepted and widely used procedure for the relief of pain and inflammation. There is some scientific evidence to support its use. The exact mode of action is only partially understood. Western medicine studies suggest that acupuncture stimulates the nervous system at the level of the brain, promotes deep relaxation, and affects the release of neurotransmitters. Acupuncture is commonly used as an alternative or in addition to traditional Western pharmaceuticals. While it is commonly used when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten the return of functional activity. Acupuncture should be performed by MD, DO[, or] DC with appropriate training[; or a licensed acupuncturist].

- 6.1.1 **Acupuncture:** is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated and retained for a period of time. Acupuncture can be used to reduce pain and inflammation, and to increase blood flow to an area and increase range of motion. Indications include joint pain, joint stiffness, soft tissue pain and inflammation, paresthesia, post-surgical pain relief, muscle spasm, and scar tissue pain.

- Time to produce effect: 3 to 6 treatments
- Frequency: 1 to 3 times per week
- Course duration: 14 treatments

- 6.1.2 **Acupuncture with Electrical Stimulation:** is the use of electrical current (micro- amperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation.

It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

- Time to produce effect: 3 to 6 treatments
- Frequency: 1 to 3 times per week
- Course duration: 14 treatments

- 6.1.3 **Other Acupuncture Modalities:** Acupuncture treatment is based on individual patient needs and therefore treatment may include a combination of procedures to enhance treatment effect. Other procedures may include the use of heat, soft tissue manipulation/massage, and exercise.

- Time to produce effect: 3 to 6 treatments
- Frequency: 1 to 3 times per week
- Course duration: 14 treatments

Any of the above acupuncture treatments may extend longer if objective functional gains can be documented or when symptomatic benefits facilitate progression in the patient's treatment program.

Treatment beyond 14 sessions (1 course) may be documented with respect to need and ability to facilitate positive symptomatic or functional gains.

- 6.2 **BIOFEEDBACK** is a form of behavioral medicine that helps patients learn self-awareness and self-regulation skills for the purpose of gaining greater control of their physiology, such as muscle activity, brain waves, and measures of autonomic nervous system activity. Electronic instrumentation is used to monitor the targeted physiology and then displayed or fed back to the patient visually, auditorially, or tactilely, with coaching by a biofeedback specialist. Biofeedback is provided by clinicians certified in biofeedback and/or who have documented specialized education, advanced training, or direct or supervised experience qualifying them to provide the specialized treatment needed (e.g., surface EMG, EEG, or other).

Treatment is individualized to the patient's work-related diagnosis and needs. Home practice of skills is required for mastery and may be facilitated by the use of home training tapes. The ultimate goal in biofeedback treatment is normalizing the physiology to the pre-injury status to the extent possible and involves transfer of learned skills to the workplace and daily life. Candidates for biofeedback therapy or training must be motivated to learn and practice biofeedback and self-regulation techniques.

Indications for biofeedback include individuals who are suffering from musculoskeletal injury where muscle dysfunction or other physiological indicators of excessive or prolonged stress response affects and/or delays recovery. Other applications include training to improve self-management of emotional stress/pain responses such as anxiety, depression, anger, sleep disturbance, and other central and autonomic nervous system imbalances. Biofeedback is often utilized along with other treatment modalities.

- Time to produce effect: 3 to 4 sessions
- Frequency: 1 to 2 times per week
- Maximum duration: 10 to 12 sessions. Treatment beyond 12 sessions must be documented with respect to need, expectation, and ability to facilitate positive symptomatic or functional gains.

6.3 **INJECTIONS – THERAPEUTIC** are generally accepted, well-established procedures that may play a significant role in the treatment of patients with upper extremity pain or pathology. Therapeutic injections involve the delivery of anesthetic and/or anti-inflammatory medications to the painful structure. Therapeutic injections have many potential benefits. Ideally, a therapeutic injection will: (a) reduce inflammation in a specific target area; (b) relieve secondary muscle spasm; and (c) diminish pain and support therapy directed to functional recovery. Diagnostic and therapeutic injections should be used early and selectively to establish a diagnosis and support rehabilitation. If injections are overused or used outside the context of a monitored rehabilitation program, they may be of significantly less value.

6.3.1 **Steroid Injections:** may provide both diagnostic and therapeutic value in treating a variety of shoulder disorders. These include biceps tendonitis, bursitis, rotator cuff tendonitis and impingement syndrome.

Steroid injections provide a potent anti-inflammatory effect, which is usually short term in duration, lasting weeks or months. Injections should always be used as an adjunctive treatment in the context of a physical exercise and rehabilitation program.

When performing tendon injections, the risk of tendon rupture should be discussed with the patient and the need for temporary restricted duty emphasized. *

Contraindications: General contraindications include local or systemic infection, bleeding disorders, and allergy to medications used.

Local Steroid Injections:

- Time to produce effect: 3 days
- Frequency: monthly
- Maximum duration: 3 injections

6.3.2 **Trigger Point Injections:** are generally accepted, although used infrequently in uncomplicated cases. They may, however, be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas, and as an adjunctive treatment in combination with other treatment modalities, such as functional restoration programs, including stretching therapeutic exercise. Trigger point injections should be utilized primarily for the purpose of facilitating functional progress. The Division does not recommend their routine use in the treatment of upper extremity injuries.

- Time to produce effect: Local anesthetic 30 minutes; 24 to 48 hours for no anesthesia.
- Frequency: Weekly. Suggest no more than 4 injection sites per session per week to avoid significant post-injection soreness.
- Maximum duration: 8 weeks. Occasional patients may require 2 to 4 repetitions of trigger point injection series over a 1 to 2 year period.

6.4 **JOB SITE ALTERATION** Early evaluation and training of body mechanics and other ergonomic factors are essential for every injured worker and should be done by a qualified individual. In some cases, this requires a job site evaluation. Some evidence supports alteration of the work site in the early treatment of non-traumatic Shoulder Disorders. There is no single factor or combination of factors that is proven to prevent or ameliorate Shoulder Disorders, but a combination of ergonomic are generally considered to be important. Physical factors that may be considered include use of force, repetition, awkward positions, upper extremity vibration, cold environment, and contact pressure on the nerve.

The job analysis and modification should include input from the employee, employer, and ergonomist or other professional familiar with work place evaluation. The employee must be observed performing all job functions in order for the job site analysis to be valid. Periodic follow-up is recommended to evaluate effectiveness of the intervention and need for additional ergonomic changes.

6.5 **MEDICATIONS**

For shoulder disorders, medications play a secondary role and should never be the sole modality of treatment. If a patient's symptoms resolve quickly with medications or any other passive modality, the practitioner should still consider prescribing a brief course in shoulder and upper extremity education and safety. When required, a wide range of medication is available. Modalities in this group are generally accepted, established and widely

used. All narcotics and habituating medications should be prescribed with strict time, quantity and duration guidelines with a definite cessation parameter. Prescribing these drugs on an as-needed basis (PRN) should almost always be avoided.

- 6.5.1 **NONSTEROIDAL ANTI-INFLAMMATORY DRUGS (NSAIDs)** are probably the most useful medications in acute and chronic shoulder injury. In mild cases, they may be the only drug required for analgesia. There are several classes of NSAIDs and the response of the individual patient to a specific medication is unpredictable. For this reason, a range of anti-inflammatory medications may be tried in each case with the most effective preparation being continued.

For prolonged use of NSAIDs greater than 1-3 months, patients should be monitored for adverse reactions. Appropriate intervals for metabolic screening are dependent upon the patient's age, general health status and should be within parameters listed for each specific medication.

- 6.5.2 **ANALGESICS** (acetaminophen and aspirin are the common choice for non-narcotic analgesia.

- 6.5.3 **PSYCHOTROPIC MEDICATION** may be used in patients with a high level of anxiety or depression. A variety of psychotropic drugs may be used. In acute or subacute shoulder injury, these medications are generally unnecessary except for the use of tricyclic antidepressants as substitutes for hypnotics and/or analgesics. In most cases, major tranquilizers, anxiolytics and antidepressants are reserved for chronic pain disorders. Patients, whose chief complaint is shoulder injury, but require use of major tranquilizers or anxiolytics for greater than two weeks. In particular, benzodiazepams are almost always contraindicated in patients with shoulder injury unless a severe anxiety state exist requiring psychiatric supervision or in cases of extremely severe, objectively visualized acute muscle spasm. In this type of acute scenario, the maximum duration for benzodiazepam administration should be limited to less than five days.

- 6.5.4 **HYPNOTICS** may be given to shoulder injury sufferers because of a chief complaint of "inability to sleep." Such medication must be used with caution because of their dependence-producing capabilities. The Division recommends consideration of sedating tricyclic antidepressants as an alternative when necessary. Physical methods of restoring a normal sleep pattern can usually be employed as an alternative to medication.

- 6.5.5 **NARCOTICS** should be primarily reserved for the treatment of acute shoulder injury or the treatment of patients with objectively documented acute exacerbations. The action of these drugs is central, affecting the patient's perception of pain rather than the pain process itself.

Narcotics are rarely indicated in the treatment of patients with pure shoulder injury without fracture. In mild to moderate cases of upper extremity pain, narcotic medication should not be used at all. Adverse effects include respiratory depression and the development of physical and psychological dependence.

- 6.5.6 **MINOR TRANQUILIZERS/MUSCLE RELAXANTS** should be primarily reserved for the treatment of acute shoulder with muscle spasm or the treatment of patients with objectively documented acute exacerbations. Muscle relaxants may have a significant effect on the early phases of acute shoulder disorders. Their action is central and with no effect on the neuromuscular junction of the muscles themselves. Purported peripheral effects are difficult to separate from the anxiolytic central action.

6.6 **OCCUPATIONAL REHABILITATION PROGRAMS**

- 6.6.1 **Non-Interdisciplinary:** These programs are work-related, outcome-focused, individualized treatment programs. Objectives of the program include, but are not limited to, improvement of cardiopulmonary and neuromusculoskeletal functions (strength, endurance, movement, flexibility, stability, and motor control functions), patient education, and symptom relief. The goal is for patients to gain full or optimal function and return-to-work. The service may include the time-limited use of passive modalities with progression to achieve treatment and/or simulated/real work.

6.6.1.1 **WORK CONDITIONING/SIMULATION**

This program may begin once a patient is out of the acute phase of injury and will be able to tolerate this program.

These programs are usually initiated after the acute phase has been completed and offered at any time throughout the recovery phase. Work conditioning should be initiated when imminent return of a patient to modified or full duty is not an option, but the prognosis for returning the patient to work at completion of the program is at least fair to good.

The need for work place simulation should be based upon the results of a Functional Capacity Evaluation and/or Jobsite Analysis.

- Length of visit: 1 to 4 hours per day.
- Frequency: 2 to 5 visits per week
- Maximum Duration: 8 WEEKS. Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or

functional gains.

6.6.2 **WORK HARDENING**

Work Hardening is an interdisciplinary program addressing a patient's employability and return to work. It includes a progressive increase in the number of hours per day that a patient completes work simulation tasks until the patient can tolerate a full workday. This is accomplished by addressing the medical, behavioral, physical, functional, and vocational components of employability and return-to-work.

This can include a highly structured program involving a team approach or can involve any of the components thereof. The interdisciplinary team should, at a minimum, be comprised of a qualified medical director who is board certified with documented training in occupational rehabilitation; team physicians having experience in occupational rehabilitation; occupational therapist; physical therapist; case manager; and psychologist. As appropriate, the team may also include: chiropractor, RN, vocational specialist or Certified Biofeedback Therapist.

- Length of visit: up to 8 hours/day
- Frequency: 2 to 5 visits per week
- Maximum duration: 8 weeks. Participation in a program beyond six weeks must be documented with respect to need and the ability to facilitate positive symptomatic or functional gains.

6.7 **PATIENT EDUCATION** No treatment plan is complete without addressing issues of individual patient and/or group education as a means of prolonging the beneficial effects of treatment, as well as facilitating self-management of symptoms and injury prevention. The patient should take an active role in the establishment of functional outcome goals, and should be educated on his or her specific injury, assessment findings, and plan of treatment. Education and instruction in proper body mechanics and posture, positions to avoid task/tool adaptation, self-care for exacerbation of symptoms, and home exercise/task adaptation should also be addressed.

- Time to produce effect: Varies with individual patient.
- Frequency: Should occur at every visit.

6.8 **RETURN-TO-WORK** is therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must provide specific physical limitations per the Physician's Form. The following physical limitations should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. The practitioner should understand all of the physical demands of the patient's job position before returning the patient to full duty and should receive clarification of the patient's job duties.

6.9 **SLEEP DISTURBANCES** are a common secondary symptom of CTD. Although primary insomnia may accompany pain as an independent co-morbid condition, it more commonly occurs, secondary to the pain condition itself. Exacerbations of pain often are accompanied by exacerbations of insomnia; the reverse can also occur. Sleep laboratory studies have shown disturbances of sleep architecture in pain patients. Loss of deep slow-wave sleep and increase in light sleep occur and sleep efficiency, the proportion of time in bed spent asleep, is decreased. These changes are associated with patient reports of non-restorative sleep.

Many affected patients develop behavioral habits that exacerbate and maintain sleep disturbances. Excessive time in bed, irregular sleep routine, napping, low activity, and worrying in bed are all maladaptive responses that can arise in the absence of any psychopathology. There is some evidence that behavioral modification, such as patient education and group or individual counseling, can be effective in reversing the effects of insomnia. Behavioral modifications are easily implemented and can include:

- 6.9.1 Maintaining a regular sleep schedule, retiring and rising at approximately the same time on weekdays and weekends.
- 6.9.2 Avoiding daytime napping.
- 6.9.3 Avoiding caffeinated beverages after lunchtime
- 6.9.4 Making the bedroom quiet and comfortable, eliminating disruptive lights, sounds, television sets, and keeping a bedroom temperature of about 65°F.
- 6.9.5 Avoiding alcohol or nicotine within two hours of bedtime.
- 6.9.6 Avoiding large meals within two hours of bedtime.
- 6.9.7 Exercising vigorously during the day, but not within two hours of bedtime, since this may raise core temperature and activate the nervous system.
- 6.9.8 Associating the bed with sleep and sexual activity only, using other parts of the home for television, reading and talking on the telephone.

- 6.9.9 Leaving the bedroom when unable to sleep for more than 20 minutes, returning to the bedroom when ready to sleep again.

These modifications should be undertaken before sleeping medication is prescribed for long term use.

- 6.10 **THERAPY-PASSIVE** includes those treatment modalities that do not require energy expenditure on the part of the patient. They are principally effective during the early phases of treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They should be used in adjunct with active therapies to help control swelling, pain and inflammation during the rehabilitation process. They may be used intermittently as a therapist deems appropriate or regularly if there are specific goals with objectively measured functional improvements during treatment.

- 6.10.1 **Electrical Stimulation (Unattended and Attended):** once applied, requires minimal on-site supervision by the physician or non-physician provider. Indications include pain, inflammation, muscle spasm, atrophy, and decreased circulation.

- Time to produce effect: 2 to 4 treatments
- Frequency: Varies, depending upon indication, between 2 to 3 times/day to 1 time/week. Provide home unit if frequent use.
- Maximum duration: 24 visits

- 6.10.2 **Extracorporeal shock wave treatment:** Consists of the application of pulses of high pressure sound to soft tissues, similar to lithotriptors. It has been investigated for its effectiveness in the treatment of Calcific Tendonitis. It has not been shown to have an advantage over other conservative treatments and remains investigational. It is not recommended.

- 6.10.3 **Iontophoresis:** is the transfer of medication, including, but not limited to, steroidal anti-inflammatories and anesthetics, through the use of electrical stimulation. Indications include pain (Lidocaine), inflammation (hydrocortisone, salicylate), edema (mecholy, hyaluronidase, salicylate), ischemia (magnesium, mecholy, iodine), muscle spasm (magnesium, calcium), calcific deposits (acetate), scars and keloids (chlorine, iodine, acetate).

- Time to produce effect: 1 to 4 treatments
- Frequency: 2-3 times per week with at least 48 hours between treatments.
- Maximum duration: 8 treatments per region

- 6.10.4 **Laser irradiation:** Consists of the external application of an array of visible and infrared wavelengths to soft tissues. Frequency and duration are dependent on severity and chronicity of problem.

- 6.10.5 **Manual Therapy Techniques:** are passive interventions in which the providers use his or her hands to administer skilled movements designed to modulate pain; increase joint range of motion; reduce/eliminate soft tissue swelling, inflammation, or restriction; induce relaxation; and improve contractile and non-contractile tissue extensibility. These techniques are applied only after a thorough examination is performed to identify those for whom manual therapy would be contraindicated or for whom manual therapy must be applied with caution.

- 6.10.5.1 **MANIPULATION:** is generally accepted, well-established and widely used therapeutic intervention for low back pain. Manipulative Treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease, and has associated clinical significance.

High velocity, low amplitude (HVLA) technique, chiropractic manipulation, osteopathic manipulation, muscle energy techniques, counter strain, and non-force techniques are all types of manipulative treatment. This may be applied by osteopathic physicians (D.O.), chiropractors (D.C.), properly trained physical therapists (P.T.), or properly trained medical physicians. Under these different types of manipulation exist many subsets of different techniques that can be described as a) direct- a forceful engagement of a restrictive/pathologic barrier, b) indirect- a gentle/non-forceful disengagement of a restrictive/pathologic barrier, c) the patient actively assists in the treatment and d) the patient relaxing, allowing the practitioner to move the body tissues. When the proper diagnosis is made and coupled with the appropriate technique, manipulation has no contraindications and can be applied to all tissues of the body. Pre-treatment assessment should be performed as part of each manipulative treatment visit to ensure that the correct diagnosis and correct treatment is employed.

High velocity, low amplitude (HVLA) manipulation is performed by taking a joint to its end range of motion and moving the articulation into the zone of accessory joint movement, well within the limits of anatomical integrity. Indications for manipulation include joint pain, decreased joint motion, and joint adhesions. Contraindications to HVLA manipulation include joint instability, fractures, severe

osteoporosis, infection, metastatic cancer, active inflammatory arthritides, aortic aneurysm, and signs of progressive neurologic deficits.

Time to produce effect for all types of manipulative treatment: 1 to 6 treatments.

- Frequency: Up to 3 times per week for the first 4 weeks as indicated by the severity of involvement and the desired effect, then up to 2 treatments per week for the next 4 weeks. For further treatments, twice per week or less to maintain function.
- Maximum duration: 30 visits. Extended durations of care beyond what is considered “maximum” may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Refer to the Chronic Pain Guidelines for care beyond 6 months.

The combination of 97140 plus either CMT or OMT code is equal to one visit when performed on the same day. Any combination of manual therapeutic intervention exceeding 30 visits (not units) needs to go to UR.

6.10.5.2 **MOBILIZATION (Joint) /Manipulation**

Mobilization is passive movement involving oscillatory motions to the involved joints. The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed of the maneuver. It may include skilled manual joint tissue stretching. Indications include the need to improve joint play, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement.

- Time to produce effect: 4 to 6 treatments
- Frequency: 2 to 3 times per week
- Maximum duration: 30 visits (CPT codes 97124 and 97140 cannot exceed 30 visits in combination).

6.10.5.3 **MOBILIZATION (Soft Tissue)**

Mobilization of soft tissue is the skilled application of manual techniques designed to normalize movement patterns through the reduction of soft tissue pain and restrictions. Indications include muscle spasm around a joint, trigger points, adhesions, and neural compression.

Nerve Gliding: consist of a series of flexion and extension movements of the hand, wrist, elbow, shoulder, and neck that produce tension and longitudinal movement along the length of the median and other nerves of the upper extremity. These exercises are based on the principle that the tissues of the peripheral nervous system are designed for movement, and that tension and glide (excursion) of nerves may have an effect on neurophysiology through alterations in vascular and axoplasmic flow. Biomechanical principles have been more thoroughly studied than clinical outcomes. Nerve gliding performed on a patient by the clinician should be reinforced by patient performance of similar techniques as part of a home exercise program at least twice per day.

- Time to produce effect: 4 to 6 treatments
- Frequency: 2 to 3 times per week
- Maximum duration: 30 visits (CPT codes 97124 and 97140 cannot exceed 30 visits in combination).

6.10.6 **Massage:** Manual or Mechanical - Massage is manipulation of soft tissue with broad ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by or with the practitioner's hands. Indications include edema, muscle spasm, adhesions, the need to improve peripheral circulation and range of motion, or to increase muscle relaxation and flexibility prior to exercise.

- Time to produce effect: Immediate.
- Frequency: 1 to 3 times per week
- Maximum duration: 12 visits (CPT codes 97124 and 97140 cannot exceed 30 visits in combination).

6.10.7 **Orthotics/Immobilization with Splinting:** is a generally accepted, well-established and widely used therapeutic procedure. Splints may be effective when worn at night or during portions of the day, depending on activities. Splints should be loose and soft enough to maintain comfort while supporting the involved joint in a relatively neutral position. Splint comfort is critical and may affect compliance. Although off-the-shelf splints are usually sufficient, custom thermoplastic splints may provide better fit for certain patients.

Splints may be effective when worn at night or during portions of the day, depending on activities; however, splint use is rarely mandatory. Providers should be aware that over-usage is counterproductive,

and counsel patients to minimize daytime splint use in order avoid detrimental effects, such as, stiffness and dependency over time.

- Time to produce effect: 1-4 weeks
- Frequency: Daytime intermittent or night use, depending on symptoms and activities.
- Maximum duration: 2 to 4 months. If symptoms persist, consideration should be given to further diagnostic studies or to other treatment options.

6.10.8 **Superficial Heat and Cold Therapy:** are thermal agents applied in various manners that lowers or raises the body tissue temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. Includes application of heat just above the surface of the skin at acupuncture points. Indications include acute pain, edema and hemorrhage, need to increase pain threshold, reduce muscle spasm and promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

- Time to produce effect: Immediate
- Frequency: 2 to 5 times per week (clinic). Home treatment as needed.
- Maximum duration: ~~48~~ 12 visits, with maximum visits 1 per day. If symptoms persist, consideration should be given to further diagnostic studies or other treatment options.

6.10.9 **Ultrasound:** uses sonic generators to deliver acoustic energy for therapeutic thermal and/or nonthermal soft tissue effects. Indications include scar tissue, adhesions, collagen fiber and muscle spasm, and to improve muscle tissue extensibility and soft tissue healing. Ultrasound with electrical stimulation is concurrent delivery of electrical energy that involves dispersive electrode placement. Indications include muscle spasm, scar tissue, pain modulation and muscle facilitation. Phonophoresis is the transfer of medication to the target tissue to control inflammation and pain through the use of sonic generators. These topical medications include, but are not limited to, steroidal anti-inflammatory and anesthetics.

- Time to produce effect: 4 to 8 treatments
- Frequency: 2-3 times per week
- Maximum duration: 18 visits

6.11 **THERAPY–ACTIVE** therapies are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and alleviating discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task, and thus assists in developing skills promoting independence to allow self-care after discharge. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual, and/or tactile instructions. At times a provider may help stabilize the patient or guide the movement pattern but the energy required to complete the task is predominately executed by the patient.

Patients should be instructed to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices.

Interventions are selected based on the complexity of the presenting dysfunction with ongoing examination, evaluation and modification of the plan of care as improvement or lack thereof occurs. Change and/or discontinuation of an intervention should occur if there is attainment of expected goals/outcome, lack of progress, lack of tolerance and/or lack of motivation. Passive interventions/modalities may only be used as adjuncts to the active program.

6.11.1 **Activities of Daily Living:** Supervised instruction, active-assisted training, and/or adaptation of activities or equipment to improve a person's capacity in normal daily living activities such as self-care, work re-integration training, homemaking, and driving.

- Time to produce effect: 4 to 5 treatments
- Maximum of 10 sessions

6.11.2 **Aquatic Therapy:** is a well-accepted treatment which consists of the therapeutic use of aquatic immersion for therapeutic exercise to promote strengthening, core stabilization, endurance, range of motion, flexibility, body mechanics, and pain management. Aquatic therapy includes the implementation of active therapeutic procedures in a swimming or therapeutic pool. The water provides a buoyancy force that lessens the amount of force gravity applies to the body. The decreased gravity effect allows the patient to have a mechanical advantage and more likely have a successful trial of therapeutic exercise. The therapy may be indicated for individuals who:

- cannot tolerate active land-based or full-weight bearing therapeutic procedures
- require increased support in the presence of proprioceptive deficit;
- are at risk of compression fracture due to decreased bone density;
- have symptoms that are exacerbated in a dry environment;
- would have a higher probability of meeting active therapeutic goals than in a land-based

environment.

The pool should be large enough to allow full extremity range of motion and fully erect posture. Aquatic vests, belts and other devices can be used to provide stability, balance, buoyancy, and resistance.

- Time to produce effect: 4 to 5 treatments
- Frequency: 3 to 5 times per week
- Maximum duration: 24 visits

A self-directed program is recommended after the supervised aquatics program has been established, or, alternatively a transition to a land-based environment exercise program.

6.11.3 **Functional Activities:** are the use of therapeutic activity to enhance mobility, body mechanics, employability, coordination, and sensory motor integration.

- Time to produce effect: 4 to 5 treatments
- Frequency: 3 to 5 times per week
- Maximum duration: 24 visits

Total number of visit 97110 and 97530 should not exceed 36 visits without pre-authorization

6.11.4 **Neuromuscular Re-education:** is the skilled application of exercise with manual, mechanical, or electrical facilitation to enhance strength, movement patterns, neuromuscular response, proprioception, kinesthetic sense, coordination education of movement, balance, and posture. Indications include the need to promote neuromuscular responses through carefully timed proprioceptive stimuli, to elicit and improve motor activity in patterns similar to normal neurologically developed sequences, and improve neuromotor response with independent control.

- Time to produce effect: 2 to 6 treatments
- Frequency: 3-5 times per week
- Maximum duration: 24 visits

6.11.5 **Proper Work Techniques:** Please refer to the "Job Site Evaluation" and "Job Site Alteration" sections of these guidelines.

6.11.6 **Therapeutic Exercise:** with or without mechanical assistance or resistance may include isoinertial, isotonic, isometric and isokinetic types of exercises. Indications include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, increased range of motion, and are used to promote normal movement patterns. Can also include complimentary/alternative exercise movement therapy.

- Time to produce effect: 2 to 6 treatments
- Frequency: 3 to 5 times per week
- Maximum duration: 36 visits

Total number of visit 97110 and 97530 should not exceed 36 visits without pre authorization

6.12 **RESTRICTION OF ACTIVITIES** Continuation of normal daily activities is the recommendation for most Shoulder Disorders with or without neurologic symptoms. Complete work cessation should be avoided, if possible, since it often further aggravates the pain presentation. Modified return-to-work is almost always more efficacious and rarely contraindicated in the vast majority of injured workers with Shoulder Disorders.

6.13 **VOCATIONAL REHABILITATION** is a generally accepted intervention. Initiation of vocational rehabilitation requires adequate evaluation of patients for quantification of highest functional level, motivation, and achievement of maximum medical improvement. Vocational rehabilitation may be as simple as returning to the original job or as complicated as being retrained for a new occupation.

11 DE Reg. 1661 (06/01/08)

12 DE Reg. 67 (07/01/08)

17 DE Reg. 322 (09/01/13) (Final)