**NY SURGERY GL**

The following surgery may be appropriate - SURGICAL PROCEDURE:

If the patient has – DIAGNOSIS –

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE –

OBJECTIVE –

IMAGING –

AND this has been done (if recommended) CONSERVATIVE CARE—

**LUMBAR FUSION**

New York State Workers’ Compensation Board

Mid and Low Back Injury Medical Treatment Guidelines

E THERAPEUTIC PROCEDURES: OPERATIVE

E.3 DECOMPRESSIVE SURGERY (LAMINOTOMY/FACETECTOMY, LAMINECTOMY)

Recommendations:

E.3.a.i Decompression surgery is recommended as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management.

E.4 SPINAL FUSION

Lumbar Fusion is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Recommendations:

E.4.a.i Lumbar fusion is recommended as a treatment for spinal stenosis when concomitant instability has been proven. Lumbar fusion is not recommended for spinal stenosis without instability.

Indications: All of the following should be present: 1) neurogenic claudication (leg pain and/or numbness with standing or walking); 2) imaging findings, by MRI, or CT/myelogram that confirm the nerve roots compressed are consistent with the neurological symptoms; 3) lack of responsiveness or unsatisfactory response(s) to adequate conservative treatment over a minimum 6 to 8 week period that may or may not include an epidural steroid injection.

E.4.a.ii Lumbar fusion is recommended as an effective treatment for isthmic spondylolisthesis.

E.4.a.iii Lumbar fusion is recommended as an effective treatment for degenerative spondylolisthesis.

E.4.a.iv There are no scientific studies, but consensus is that if a patient is having the third lumbar discectomy on the same disc, that spine fusion at the time of discectomy is an option.

E.4.a.v Lumbar fusion is not recommended as a treatment for patients with radiculopathy from herniated nucleus pulposus (disc herniation) or for patients with chronic back pain after lumbar discectomy.

E.4.a.vi Lumbar fusion is recommended as a treatment for Degenerative Disc Disease/“Discogenic Back Pain”/“Black Disc Disease” without instability in selected patients for whom non-surgical management has failed to relieve symptoms and improve function (WCB). If available, an intensive Functional Rehabilitation Program should be tried first.

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

Treatment Approaches

A.10 ACTIVE INTERVENTIONS

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 and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.13 SURGICAL INTERVENTIONS

Contemplation of surgery should be within the context of expected functional outcome. 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 imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat severe pain, there should be clear correlation between the pain symptoms and objective evidence of its cause.

**LUMBAR LAMINECTOMY/DISCECTOMY**

New York State Workers’ Compensation Board

Mid and Low Back Injury Medical Treatment Guidelines

E THERAPEUTIC PROCEDURES: OPERATIVE

E.1 Discectomy, Microdiscectomy, Sequestrectomy, Endoscopic Decompression

Recommendations:

E.1.a.i Lumbar discectomy is recommended as an effective operation to speed recovery in patients who have radiculopathy due to ongoing nerve root compression, who continue to have significant pain and functional limitation after 6 to 12 weeks and who have been provided appropriate conservative therapy during which time they experienced no progressive neurological deficits.

E.1.a.ii All of the following should be present: 1) radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness - consistent with a herniated disc at the corresponding level; 2) imaging findings by MRI or CT with/out myelography that confirm persisting nerve root compression at the level and on the side predicted by the history and clinical examination; 3) continued significant pain and functional limitation after 6 to 12 weeks and who have been provided appropriate conservative therapy during which time they experienced no progressive neurological deficits.

Patients who are candidates for discectomy should be informed that (other than for cauda equina syndrome and the rare progressive major neurologic deficit), there is evidence that there is no need to rush surgical decisions, since there is no difference in long-term functional recovery whether surgery is performed early or delayed. Open discectomy, microdiscectomy, and endoscopic discectomy are all potentially appropriate ways to perform discectomy. The decision as to which of these procedures to choose should be left to the surgeon and the patient, until quality evidence becomes available to provide evidence-based guidance.

E.1.a.iii Discectomy is not recommended as treatment of acute, subacute, or chronic back pain without radiculopathy.

E.1.a.iv Percutaneous discectomy (nucleoplasty), laser discectomy, and disc coblation therapy are not recommended as treatment for any back or radicular pain syndrome.

E.3 DECOMPRESSIVE SURGERY (LAMINOTOMY/FACETECTOMY, LAMINECTOMY)

Recommendations:

E.3.a.i Decompression surgery is recommended as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management.

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

Treatment Approaches

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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 and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.13 SURGICAL INTERVENTIONS

Contemplation of surgery should be within the context of expected functional outcome. 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 imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat severe pain, there should be clear correlation between the pain symptoms and objective evidence of its cause.

**SHOULDER**

**IMPINGEMENT**

Table 2: Criteria for Shoulder Surgery – Impingement Syndrome

The following surgery may be appropriate- SURGICAL PROCEDURE- Anterior Acromioplasty

If the patient has – DIAGNOSIS -- Acromial Impingement Syndrome (80% of these patients will get better without surgery)

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE - Pain with active arc motion 90 - 130° AND Pain at night; Tenderness over the greater tuberosity is common in acute cases.

OBJECTIVE - Weak or absent abduction. May also demonstrate atrophy AND Tenderness over rotator cuff or anterior acromial area AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test).

IMAGING - Conventional x-rays , AP, and true lateral or axillary view AND MRI, Ultra-sound or Arthrogram shows positive evidence of deficit in rotator cuff.

AND this has been done (if recommended) CONSERVATIVE CARE-- Recommend 3-6 months: three months is adequate if treatment has been continuous, six months if treatment has been intermittent.

Treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature.

**ROTATOR CUFF TEARS**

Table 3: Criteria for Shoulder Surgery – Rotator Cuff Tear

The following surgery may be appropriate- SURGICAL PROCEDURE-- Rotator Cuff Repair.

If the patient has – DIAGNOSIS -- Full Thickness Rotator Cuff Tear AND Cervical pathology and frozen shoulder syndrome have been ruled out.

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE -- Shoulder pain and inability to elevate the arm; Tenderness over the greater tuberosity is common in acute cases.

OBJECTIVE -- Patient may have weakness with abduction testing; May also demonstrate atrophy of shoulder musculature; Usually has full passive range of motion.

IMAGING -- Conventional x-rays, AP, and true lateral or axillary view AND MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff.

AND this has been done (if recommended) CONSERVATIVE CARE -- Not required

The following surgery may be appropriate- SURGICAL PROCEDURE-- Rotator Cuff Repair OR Anterior Acromioplasty.

If the patient has – DIAGNOSIS -- Partial Thickness Rotator Cuff Tear.

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE -- Pain with active arc motion 90 - 130° AND Pain at night; Tenderness over the greater tuberosity is common in acute cases.

OBJECTIVE -- Weak or absent abduction. May also demonstrate atrophy AND Tenderness over rotator cuff or anterior acromial area AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test).

IMAGING -- Conventional x-rays , AP, and true lateral or axillary view AND MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff.

AND this has been done (if recommended) CONSERVATIVE CARE -- Recommend 3-6 months; three months is adequate if treatment has been continuous, six months if treatment has been intermittent.

Treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature.

F THERAPEUTIC PROCEDURES, OPERATIVE

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). It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions mimicking radiculopathy or instability (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, scleratogenous or sympathetically mediated pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration of elective surgical intervention.

In addition, operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuromusculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention.

Structured rehabilitation interventions should be strongly considered post-operative in any patient not making expected functional progress within three weeks post-operative.

F.2 TOTAL KNEE REPLACEMENT (TKR)

Knee Arthroplasty (Total or Partial Knee Joint Replacement) is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Refer to Table 8.

Table 8: Criteria for Total Knee Replacement

The following surgery may be appropriate - SURGICAL PROCEDURE: Knee Joint Replacement

If only 1 compartment is affected, a unicompartmental or partial replacement if indicated

If 2 of the 3 compartments are affected, a total joint replacement is indicated

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Limited range of motion OR Night time joint pain OR No pain relief with conservative care

OBJECTIVE – Over 50 years of age AND Body Mass Index of less than 35

IMAGING – Osteoarthritis on: Standing x-ray OR Arthroscopy

AND this has been done (if recommended) CONSERVATIVE CARE— Medications OR Viscosupplementation injections OR Steroid injection

**SHOULDER SURGERIES – RCR, SAD, DCR**

New York State Workers’ Compensation Board

Shoulder Injury Medical Treatment Guidelines

D SPECIFIC DIAGNOSES, TESTING AND TREATMENT PROCEDURES

D.1 ACROMIOCLAVICULAR (AC) JOINT SPRAINS/DISLOCATIONS

An acute acromioclavicular (AC) joint injury is frequently referred to as a shoulder separation.

Classification of Injury: The degree of clavicular displacement depends on the severity of injury to the AC and Coracoclavicular (CC) ligaments, the AC joint capsule, and the supporting muscles of the shoulder (trapezius and deltoid) that attach to the clavicle.

The traditional Allman and Tossy classification is a 3-grade classification scheme. Rockwood expanded that classification to 6 types of injury. The Rockwood Type I injury corresponds to the original Allman/Tossy Grade I; Rockwood Type II to the original Allman/Tossy Grade II and Rockwood Types III-VI are in the original Grade III Allman/Tossy category.

The Allman/Tossy classification and the corresponding Rockwood classification are illustrated in Table 1:

Table 1: Allman/Tossy – Rockwood Classification Systems

Allman -Grade I:

Rockwood -Type I: Partial disruption of the AC ligament and capsule.

Allman - Grade II:

Rockwood -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.

Allman - Grade III:

Rockwood - 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. OR

Type IV: Dislocation consisting of a displaced clavicle that penetrates posteriorly through or into the trapezius muscle. OR

Type V: Dislocation consisting of complete separation of the AC and CC ligaments and dislocation of the AC joint with a large CC interval.

OR

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 Impingement Syndrome.

D.1.a History and Mechanism of Injury (AC Joint Sprains/ Dislocations)

D.1.a.i Mechanism of Injury (AC Joint Sprains/Dislocations): generally, patients 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.

D.1.b Physical Findings (AC Joint Sprains/Dislocations)

Physical Findings may include:

D.1.b.i Tenderness at the AC joint, at times with contusions and/or abrasions at the joint area; prominence/asymmetry of the shoulder can be seen; and/or

D.1.b.ii decreased shoulder motion, and tenderness of the distal end of the clavicle on palpation; there may be increased clavicular translation; cross-body adduction can cause exquisite pain.

D.1.c Laboratory Tests (AC Joint Sprains/Dislocations)

Laboratory tests are not indicated unless a systemic illness or disease is suspected.

D.1.d Testing Procedures (AC Joint Sprains/Dislocations)

Plain x-rays may include:

D.1.d.i AP view;

D.1.d.ii AP radiograph of the shoulder with the beam angled 10 cephalad (Zanca view)

D.1.d.iii Axillary lateral views; and

D.1.d.iv Stress view; side-to-side comparison with 10-15 lbs. of weight in each hand.

D.1.f Operative Procedures (AC Joint Sprains/Dislocations)

D.1.f.i With a Type III AC joint injury, an appropriate orthopedic consultation could be considered initially, but should be considered when conservative care fails to increase function.

D.1.f.ii With a Type IV-VI AC joint injury, an orthopedic surgical consultation is recommended.

D.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 on 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 and both partial- and full-thickness rotator cuff tears, as well as adhesive capsulitis/frozen shoulder. Normal function of the rotator cuff mechanism and biceps tendon assist to diminish impingement syndrome.

D.6.a History and Mechanism of Injury (Impingement Syndrome)

D.6.a.i Mechanism of Injury: established repetitive overuse of the upper extremity; many times this is seen with frequently repeated overhead motion.

D.6.a.ii History may include:

(a) 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";

(b) Complaints of functional losses due to pain, stiffness, weakness and catching when the arm is flexed and internally rotated; and

(c) 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.

D.6.b Physical Findings (Impingement Syndrome)

Physical Findings may include:

D.6.b.i Inspection of the shoulder may reveal deltoid and rotator cuff atrophy;

D.6.b.ii Range of motion is limited, particularly in internal rotation and in cross-body adduction;

D.6.b.iii 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;

D.6.b.iv Active elevation of the shoulder is usually more uncomfortable than passive elevation;

D.6.b.v Pain on maximum active forward flexion is frequently seen with impingement syndrome, but is not specific for diagnosis;

D.6.b.vi Strength testing may reveal weakness. This weakness may be the result of pain, disuse, tendon damage, or poor scapulothoracic mechanics;

D.6.b.vii Pain on resisted abduction or external rotation may also indicate that the integrity of the rotator cuff tendons may be compromised; and/or

D.6.b.viii 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.

D.6.c Laboratory Tests (Impingement Syndrome)

Laboratory Tests are not indicated unless a systemic illness or disease is suspected.

D.6.d Testing Procedures (Impingement Syndrome)

D.6.d.i Plain x-rays :

(a) may demonstrate calcification or bone spurs.

D.6.d.ii Subacromial space injection can be used as a diagnostic procedure by injecting an anesthetic, such as sensorcaine or xylocaine solutions, into the space. If the pain is alleviated with the injection, the diagnosis is confirmed.

D.6.d.iii 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.

D.6.f Operative Procedures (Impingement Syndrome)

Anterior Acromioplasty of the Shoulder is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Operative Procedures for impingement syndrome should not be considered prior to an adequate trial of physical rehabilitation that includes direction and supervision by an appropriate, licensed professional and active patient participation. Such a trial should normally last for a minimum of 6 weeks. Refer to Table 2: Criteria for Shoulder Surgery - Impingement Syndrome.

Table 2: Criteria for Shoulder Surgery – Impingement Syndrome

The following surgery may be appropriate- SURGICAL PROCEDURE- Anterior Acromioplasty

If the patient has – DIAGNOSIS -- Acromial Impingement Syndrome (80% of these patients will get better without surgery)

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE - Pain with active arc motion 90 - 130° AND Pain at night; Tenderness over the greater tuberosity is common in acute cases.

OBJECTIVE - Weak or absent abduction. May also demonstrate atrophy AND Tenderness over rotator cuff or anterior acromial area AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test).

IMAGING - Conventional x-rays , AP, and true lateral or axillary view AND MRI, Ultra-sound or Arthrogram shows positive evidence of deficit in rotator cuff.

AND this has been done (if recommended) CONSERVATIVE CARE-- Recommend 3-6 months: three months is adequate if treatment has been continuous, six months if treatment has been intermittent.

Treatment must be directed toward gaining full range of motion, which requires both stretching and strengthening to balance the musculature.

D.7 ROTATOR CUFF TEARS

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 1 cm; medium tear is 1-3 cm; large tear is 3-5 cm; and massive tear is greater than 5 cm, usually with retraction.

D.7.a History and Mechanism of Injury (Rotator Cuff Tear)

D.7.a.i Mechanism of Injury: established with sudden trauma to the shoulder or chronic over-use with repetitive overhead motion with internal or external rotation.

D.7.a.ii History may include:

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

(b) Complaints of pain along anterior, lateral or posterior glenohumeral joint.

D.7.b Physical Findings (Rotator Cuff Tear)

Physical Findings may include:

D.7.b.i Partial-Thickness Tears

(a) 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; (b)

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

(c) A painful arc may be present with active elevation;

(d) 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

(e) If there are positive impingement signs, refer to Section 6, Impingement Syndrome.

D.7.b.ii Full-Thickness Tears

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

(b) Active elevation will be severely limited with substitution of scapular rotation being evident.

D.7.c Laboratory Tests (Rotator Cuff Tear)

Laboratory Tests are not indicated unless a systemic illness or disease is suspected.

D.7.d Testing Procedures (Rotator Cuff Tear)

D.7.d.i Plain x-rays include:

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

(b) 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);

(c) 30 degrees 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

(d) Outlet view determines if there is a downwardly tipped acromion.

D.7.d.ii 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. MRI should be performed sooner (e.g., 1-2 weeks), when there is clinical suspicion of full-thickness rotator cuff tear.

D.7.f Operative Procedures (Rotator Cuff Tear)

Anterior Acromioplasty of the Shoulder is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Refer to Table 3, Criteria for Shoulder Surgery – Rotator Cuff Tear.

Table 3: Criteria for Shoulder Surgery – Rotator Cuff Tear

The following surgery may be appropriate- SURGICAL PROCEDURE-- Rotator Cuff Repair.

If the patient has – DIAGNOSIS -- Full Thickness Rotator Cuff Tear AND Cervical pathology and frozen shoulder syndrome have been ruled out.

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE -- Shoulder pain and inability to elevate the arm; Tenderness over the greater tuberosity is common in acute cases.

OBJECTIVE -- Patient may have weakness with abduction testing; May also demonstrate atrophy of shoulder musculature; Usually has full passive range of motion.

IMAGING -- Conventional x-rays, AP, and true lateral or axillary view AND MRI, Ultrasound, or Arthrogram shows positive evidence of deficit in rotator cuff.

AND this has been done (if recommended) CONSERVATIVE CARE -- Not required

The following surgery may be appropriate- SURGICAL PROCEDURE-- Rotator Cuff Repair OR Anterior Acromioplasty.

If the patient has – DIAGNOSIS -- Partial Thickness Rotator Cuff Tear.

AND the diagnosis is supported by CLINICAL FINDINGS

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

Treatment Approaches

A.10 ACTIVE INTERVENTIONS

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 and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.13 SURGICAL INTERVENTIONS

Contemplation of surgery should be within the context of expected functional outcome. 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 imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat severe pain, there should be clear correlation between the pain symptoms and objective evidence of its cause

New York State Workers’ Compensation Board, Shoulder Injury Medical Treatment Guidelines does not specifically address the request for Arthroscopy and Distal Clavicle Resection.

Official Disability Guidelines Treatment in Workers' Compensation, Online Edition

Chapter: Shoulder

Diagnostic arthroscopy

Recommended as indicated below. Criteria for diagnostic arthroscopy (shoulder arthroscopy for diagnostic purposes): Most orthopedic surgeons can generally determine the diagnosis through examination and imaging studies alone. Diagnostic arthroscopy should be limited to cases where imaging is inconclusive and acute pain or functional limitation continues despite conservative care. Shoulder arthroscopy should be performed in the outpatient setting. If a rotator cuff tear is shown to be present following a diagnostic arthroscopy, follow the guidelines for either a full or partial thickness rotator cuff tear. (Washington, 2002) (de Jager, 2004) (Kaplan, 2004)

Surgery for impingement syndrome

Recommended as indicated below. Surgery for impingement syndrome is usually arthroscopic decompression (acromioplasty). However, this procedure is not indicated for patients with mild symptoms or those who have no limitations of activities. Conservative care, including cortisone injections, should be carried out for at least three to six months prior to considering surgery. Since this diagnosis is on a continuum with other rotator cuff conditions, including rotator cuff syndrome and rotator cuff tendonitis. (Prochazka, 2001) (Ejnisman-Cochrane, 2004) (Grant, 2004) Arthroscopic subacromial decompression does not appear to change the functional outcome after arthroscopic repair of the rotator cuff. (Gartsman, 2004) Operative treatment, including isolated distal clavicle resection or subacromial decompression (with or without rotator cuff repair), may be considered in the treatment of patients whose condition does not improve after 6 months of conservative therapy or of patients younger than 60 years with debilitating symptoms that impair function. The results of conservative treatment vary, ongoing or worsening symptoms being reported by 30-40% patients at follow-up. Patients with more severe symptoms, longer duration of symptoms, and a hook-shaped acromion tend to have worse results than do other patients. (Hambly, 2007)

ODG Indications for Surgery -- Acromioplasty:

Criteria for anterior acromioplasty with diagnosis of acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS

2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night. PLUS

3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS

4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of impingement.

(Washington, 2002)

Surgery for rotator cuff repair

Recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. (Ejnisman-Cochrane, 2004) (Grant, 2004) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. (Cordasco, 2000) Difference between surgery & exercise was not significant. (Brox, 1999)

ODG Indications for Surgery -- Rotator cuff repair:

Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out:

1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS

2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS

3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.)

1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS

2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS

3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS

4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff.

(Washington, 2002)

Partial claviculectomy (Mumford procedure)

ODG Indications for Surgery -- Partial claviculectomy:

Criteria for partial claviculectomy (includes Mumford procedure) with diagnosis of post-traumatic arthritis of AC joint:

1. Conservative Care: At least 6 weeks of care directed toward symptom relief prior to surgery. (Surgery is not indicated before 6 weeks.) PLUS

2. Subjective Clinical Findings: Pain at AC joint; aggravation of pain with shoulder motion or carrying weight. OR Previous Grade I or II AC separation. PLUS

3. Objective Clinical Findings: Tenderness over the AC joint (most symptomatic patients with partial AC joint separation have a positive bone scan). AND/OR Pain relief obtained with an injection of anesthetic for diagnostic therapeutic trial. PLUS

4. Imaging Clinical Findings: Conventional films show either: Post-traumatic changes of AC joint. OR Severe DJD of AC joint. OR Complete or incomplete separation of AC joint. AND Bone scan is positive for AC joint separation.

**KNEE SCOPE+CHONDROPLASTY**

New York State Workers’ Compensation Board

Knee Injury Medical Treatment Guidelines

C DIAGNOSTIC STUDIES

C.1 IMAGING STUDIES

C.1.g Diagnostic Arthroscopy

Refer to Table 1.

Table 1: Criteria for Diagnostic Arthroscopy

The following may be appropriate -- PROCEDURE -- Diagnostic Arthroscopy

IF the diagnosis is supported by --CLINICAL FINDINGS

SUBJECTIVE- Pain and functional limitations continue despite conservative care

OBJECTIVE-

IMAGING – Imaging is inconclusive

AND this has been done (if recommended) -- CONSERVATIVE CARE -- Medications AND/OR Physical therapy

D SPECIFIC KNEE INJURY DIAGNOSES, TESTING, AND TREATMENT

D.1 CHONDRAL DEFECTS (Cartilage or Cartilage and Bone Defects)

D.1.a Description/Definition

Cartilage or cartilage and bone defect at the articular or meniscal surface of a joint.

D.1.b Mechanism of Injury

Usually caused by a traumatic knee injury.

D.1.c Specific Physical Findings

Knee effusion, pain in joint.

D.1.d Diagnostic Testing Procedures

MRI may show bone bruising, osteochondral lesion, or possibly articular cartilage injury. Radiographs and CT may also be used. Following an acute injury an MRI usually shows bone bruising.

D.1.f Surgical Indications/Operative Treatment

Chondroplasty, Osteochondral Autograft and Autologous Chrondrocyte Implantation (ACI) are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Chondroplasty, Osteochondral Autograft (OATS) Procedure and Autologous Chrondrocyte Implantation (ACI). Refer to Table 3.

If a non-operative treatment approach is initially recommended, surgery may be indicated after the failure of conservative management. The patient must continue to exhibit the designated objective findings, subjective symptoms and (where applicable) imaging findings

Table 3: Chondral Defects

The following surgery may be appropriate - SURGICAL PROCEDURE: Chondroplasty

(Shaving or debridement of an articular surface)

If the patient has – DIAGNOSIS – Chondral Defects

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Joint pain AND Swelling

OBJECTIVE – Effusion OR Crepitus OR Limited ROM

IMAGING –

AND this has been done (if recommended) CONSERVATIVE CARE— Medication AND/OR Physical therapy

The following surgery may be appropriate - SURGICAL PROCEDURE: Subchondral drilling OR Micro-Fracture

If the patient has – DIAGNOSIS – Chondral Defects

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Joint pain AND Swelling

OBJECTIVE – Small full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle AND Knee is stable with intact, fully functional menisci and ligaments AND Normal joint space AND Ideal age 45 or younger

IMAGING – Chondral defect on the weight bearing portion of the medial or lateral femoral condyle on:

MRI OR Diagnostic Arthroscopy

AND this has been done (if recommended) CONSERVATIVE CARE— Medication AND/OR Physical therapy

Body Mass Index (BMI): The equation for calculating the BMI = (Weight in pounds ÷ by height in inches divided ÷ by height in inches) x 703. For example, a person weighing 210 pounds and 6 feet tall would have a BMI of 210 pounds ÷ by 72 inches ÷ by 72 inches) x 703=28.5.

D.1.h Post-Operative Therapy

May include restricted weight-bearing, bracing, active and/or passive therapy. Continuous passive movement is suggested after microfracture.

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

Treatment Approaches

A.10 ACTIVE INTERVENTIONS

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 and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.13 SURGICAL INTERVENTIONS

Contemplation of surgery should be within the context of expected functional outcome. 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 imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat severe pain, there should be clear correlation between the pain symptoms and objective evidence of its cause

**ACDF**

New York State Workers’ Compensation Board

Neck Injury Medical Treatment Guidelines

E THERAPEUTIC PROCEDURES: OPERATIVE

All operative interventions should be based on a positive correlation with clinical findings, the natural history of the disease, the clinical course, and diagnostic tests. A comprehensive assimilation of these factors should have led to a specific diagnosis with positive identification of the pathologic condition(s). It is imperative for the clinician to rule out non-physiologic modifiers of pain presentation, or non-operative conditions mimicking radiculopathy or instability (peripheral compressive neuropathy, chronic soft tissue injuries, and psychological conditions), prior to consideration of elective surgical intervention. Early intervention may be required in acute incapacitating pain or in the presence of progressive neurological deficits. Patients who are not candidates for or refuse surgical treatment should be treated with non-operative therapy as indicated.

If a non-operative treatment approach is initially recommended, surgery may be indicated after the failure of conservative management. The patient must continue to exhibit the designated objective findings, subjective symptoms and (where applicable) imaging findings.

Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions. All patients being considered for surgical intervention should first undergo a comprehensive neuromusculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques, or may be refractory to surgical intervention.

In situations requiring the possible need for re-surgery, a second opinion may be necessary. Psychological evaluation is strongly encouraged when surgery is being performed for isolated axial pain to determine if the patient will likely benefit from the treatment.

Interdisciplinary interventions should be strongly considered post-operatively in patients not making functional progress within expected time frames. Return to work activity restrictions should be specific. Most cervical non-fusion surgical patients can return to a limited level of duty between 3 to 6 weeks. Full activity is generally achieved between 6 weeks to 6 months, depending on the procedure and healing of the individual.

E.2 DISC HERNIATION AND OTHER CERVICAL CONDITIONS

Operative treatment is indicated only when the natural history of an operatively treatable problem is better than the natural history of the problem without operative treatment. All patients being considered for surgical intervention should undergo a comprehensive neuromuscular examination to identify pain generators that may respond to nonsurgical techniques or may be refractory to surgical intervention. Timely decision making for operative intervention is critical to avoid deconditioning, and increased disability of the cervical spine.

General Recommendations: There is some evidence to suggest that recovery from cervical radiculopathy in patients without clinical signs of spinal cord compression at one year is similar with one-level fusion, physical therapy, or rigid cervical collar use. For patients with whiplash injury (Quebec Classification Grade Levels I or II), there is no evidence of any beneficial effect of operative treatment.

If cervical fusion is being considered, it is recommended that the patient refrain from smoking for at least six weeks prior to surgery and during the time of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

General Indications for Surgery: Operative intervention should be considered and a consultation obtained when improvement of symptoms has plateaued and the residual symptoms of pain and functional disability are unacceptable at the end of six weeks of treatment, or at the end of longer duration of non-operative intervention for debilitated patients with complex problems. Choice of hardware instrumentation is based on anatomy, the patient’s pathology, and surgeon’s experience and preference.

E.2.a Specific Indications

Specific Indications include:

E.2.a.i For Patients with Myelopathy immediate surgical evaluation and treatment is indicated.

E.2.a.ii For Patients with Cervical Radiculopathy.

Early intervention may be required for acute incapacitating pain or in the presence of progressive neurological deficits.

Persistent or recurrent arm pain with functional limitations, unresponsive to conservative treatment after six weeks; or Progressive functional neurological deficit; or Static neurological deficit associated with significant radicular pain; and confirmatory imaging studies consistent with clinical findings.

E.2.a.iii For Patients with persistent non-radicular cervical Pain: While cervical fusion is appropriate treatment for neck pain due to degeneration with radiculopathy, there is no evidence that cervical fusion for neck pain alone produces results superior to conservative care. In the absence of a radiculopathy, it is recommended that a decisive commitment to surgical or nonsurgical interventions not be made within 4 to 5 months following injury. The effectiveness of cervical vertebral fusion for non-radicular pain has not been established. Therefore, it should not be routinely recommended. In patients with non-radicular cervical pain for whom fusion is being considered, required pre-operative indications include all of the following:

In general, if the program of non-operative treatment fails, operative treatment is indicated when:

-Improvement of the symptoms has plateaued, and the residual symptoms of pain and functional disability are unacceptable at the end of 6 to 12 weeks of active treatment, or at the end of longer duration of non-operative programs for debilitated patients with complex problems; and/or

-Frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence.

-Mere passage of time with poorly guided treatment is not considered an active treatment program.

-All pain generators are adequately defined and treated; and

-All physical medicine and manual therapy interventions are completed; and

-X-ray, MRI, or CT/discography demonstrating disc pathology or spinal instability; and

-Spine pathology limited to two levels; and

-Psychosocial evaluation for confounding issues addressed.

-For any potential surgery, it is recommended that the patient refrain from smoking for at least six weeks prior to surgery and during the period of healing. Because smokers have a higher risk of non-union and higher post-operative costs, it is recommended that insurers cover a smoking cessation program peri-operatively.

E.2.b Surgical Procedures

Surgical Procedures include:

E.2.b.i Cervical Discectomy with or without Fusion:

Description: Procedure to relieve pressure on one or more nerve roots or spinal cord. It may be performed with or without the use of a microscope.

Complications: May include strut graft dislodgment (multi-level decompression), infection, hemorrhage, CSF leak, hematoma, catastrophic spinal cord injury causing varying degrees of paralysis, pseudarthrosis, in-hospital mortality, non-union of fusion, donor site pain (autograft only). Anterior approach: permanent or transient dysphonia, permanent or transitory dysphagia, denervation, esophageal perforation, and airway obstruction.

Surgical Indications: Radiculopathy from ruptured disc or spondylosis, spinal instability, or patients with non-radicular neck pain meeting fusion criteria. There is no evidence that discectomy with fusion versus discectomy without fusion has superior long-term results. Discectomy alone is generally considered in patients with pure radicular symptoms from their herniated disc and who have sufficiently large foramena that disc space collapse is unlikely to further compromise the nerve root. Failure rates increase with disease at more than two levels.

Operative Treatment: Cervical plating may be used to prevent graft dislodgment especially for multi-level disease.

E.2.b.iii Cervical Laminectomy with or without Foraminotomy or Fusion:

Description: Surgical removal of the posterior portion of a vertebra in order to gain access to the spinal cord or nerve roots.

Complications: May include perineural fibrosis, kyphosis in fractures without fusion or with failed fusion, nerve injury, post surgical instability (with foraminotomies), CSF leak, infection, non-union of fusion, donor site pain (autograft only).

Surgical Indications: Neural compression.

Operative Treatment: Laminotomy, partial discectomy, and nerve root decompression.

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

Treatment Approaches

A.10 ACTIVE INTERVENTIONS

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 and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.13 SURGICAL INTERVENTIONS

Contemplation of surgery should be within the context of expected functional outcome. 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 imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat severe pain, there should be clear correlation between the pain symptoms and objective evidence of its cause.

**KNEE ACL REPAIR, MENISCECTOMY, CHONDROPLASTY, DX SCOPE,**

New York State Workers’ Compensation Board

Knee Injury Medical Treatment Guidelines

C DIAGNOSTIC STUDIES

C.1 IMAGING STUDIES

C.1.g Diagnostic Arthroscopy

Refer to Table 1.

Table 1: Criteria for Diagnostic Arthroscopy

The following may be appropriate -- PROCEDURE -- Diagnostic Arthroscopy

IF the diagnosis is supported by --CLINICAL FINDINGS

SUBJECTIVE- Pain and functional limitations continue despite conservative care

OBJECTIVE-

IMAGING – Imaging is inconclusive

AND this has been done (if recommended) -- CONSERVATIVE CARE -- Medications AND/OR Physical therapy

D SPECIFIC KNEE INJURY DIAGNOSES, TESTING, AND TREATMENT

D.1 CHONDRAL DEFECTS (Cartilage or Cartilage and Bone Defects)

D.1.a Description/Definition

Cartilage or cartilage and bone defect at the articular or meniscal surface of a joint.

D.1.b Mechanism of Injury

Usually caused by a traumatic knee injury.

D.1.c Specific Physical Findings

Knee effusion, pain in joint.

D.1.d Diagnostic Testing Procedures

MRI may show bone bruising, osteochondral lesion, or possibly articular cartilage injury. Radiographs and CT may also be used. Following an acute injury an MRI usually shows bone bruising.

D.1.f Surgical Indications/Operative Treatment

Chondroplasty, Osteochondral Autograft and Autologous Chrondrocyte Implantation (ACI) are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Chondroplasty, Osteochondral Autograft (OATS) Procedure and Autologous Chrondrocyte Implantation (ACI). Refer to Table 3.

If a non-operative treatment approach is initially recommended, surgery may be indicated after the failure of conservative management. The patient must continue to exhibit the designated objective findings, subjective symptoms and (where applicable) imaging findings

Table 3: Chondral Defects

The following surgery may be appropriate - SURGICAL PROCEDURE: Chondroplasty

(Shaving or debridement of an articular surface)

If the patient has – DIAGNOSIS – Chondral Defects

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Joint pain AND Swelling

OBJECTIVE – Effusion OR Crepitus OR Limited ROM

IMAGING –

AND this has been done (if recommended) CONSERVATIVE CARE— Medication AND/OR Physical therapy

The following surgery may be appropriate - SURGICAL PROCEDURE: Subchondral drilling OR Micro-Fracture

If the patient has – DIAGNOSIS – Chondral Defects

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Joint pain AND Swelling

OBJECTIVE – Small full thickness chondral defect on the weight bearing portion of the medial or lateral femoral condyle AND Knee is stable with intact, fully functional menisci and ligaments AND Normal joint space AND Ideal age 45 or younger

IMAGING – Chondral defect on the weight bearing portion of the medial or lateral femoral condyle on:

MRI OR Diagnostic Arthroscopy

AND this has been done (if recommended) CONSERVATIVE CARE— Medication AND/OR Physical therapy

Body Mass Index (BMI): The equation for calculating the BMI = (Weight in pounds ÷ by height in inches divided ÷ by height in inches) x 703. For example, a person weighing 210 pounds and 6 feet tall would have a BMI of 210 pounds ÷ by 72 inches ÷ by 72 inches) x 703=28.5.

D.4 ANTERIOR CRUCIATE LIGAMENT (ACL) INJURY

D.4.a Description/Definition

Rupture or partial rupture of the anterior cruciate ligament; may be associated with other internal derangement of the knee.

D.4.c Specific Physical Findings

Findings on physical exam include effusion or hemarthrosis, instability, Lachman’s test, pivot shift test, and anterior drawer test.

D.4.d Diagnostic Testing Procedures

MRI. Radiographs may show avulsed portion of tibial spine but this is a rare finding.

D.4.e Non-Operative Treatment

Active and/or passive therapy, bracing.

D.4.f Surgical Indications/Operative Treatment

If a non-operative treatment approach is initially recommended, surgery may be indicated after the failure of conservative management. The patient must continue to exhibit the designated objective findings, subjective symptoms and (where applicable) imaging findings. Refer to Table 4.

Table 4: Anterior Cruciate Ligament Injury

The following surgery may be appropriate - SURGICAL PROCEDURE: Anterior Cruciate Ligament (ACL) Repair

If the patient has – DIAGNOSIS – Anterior Cruciate Ligament Injury

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Pain alone is not an indication for surgery Instability of the knee, described as “buckling or giving way” OR Significant effusion at the time of injury OR Description of injury indicates rotary twisting or hyperextension incident

OBJECTIVE – Positive Lachman’s sign OR Positive pivot shift OR Positive anterior drawer

IMAGING – (Not required if acute effusion, hemarthrosis, and instability; or documented history of effusion, hemarthrosis and instability) ACL disruption on: MRI OR Arthroscopy OR Arthrogram

AND this has been done (if recommended) CONSERVATIVE CARE— In the presence of a complete tear in a patient for whom surgical repair is contemplated, a course of conservative treatment need not be completed prior to surgery. Physical therapy OR Brace

D.6 MENISCUS INJURY

D.6.a Description/Definition

A tear, disruption, or avulsion of medial or lateral meniscus tissue.

D.6.b Mechanism of Injury

Trauma to the menisci from rotational, shearing, torsion, and/or impact injuries.

D.6.c Specific Physical Findings

Patient describes a popping, tearing, or catching sensation. Findings on physical exam may include joint line tenderness, locked joint, or occasionally, effusion.

D.6.d Diagnostic Testing Procedures

Radiographs including standing Posterior/Anterior (PA), lateral, tunnel, and skyline views. MRI is the definitive imaging test MRI is sensitive and specific for meniscal tear. However, meniscal MRI is frequently abnormal in asymptomatic injuries. Clinical correlation with history and physical exam findings specific for meniscus injury is critically important.

Providers planning treatment should therefore consider the patient's complaints and presence of arthritis on MRI carefully, knowing that not all meniscus tears in the middle aged and older population are related to the patients’ complaints of pain.

MRI arthrograms may be approved to diagnose recurrent meniscal tears particularly after previous surgery

D.6.f Surgical Indications/ Operative Treatment Meniscectomy/Meniscus Repair and Meniscal Allograft Transplantation.

Meniscal Allograft Transplantation is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure. Refer to Table 5.

Table 5: Meniscus Injury

The following surgery may be appropriate - SURGICAL PROCEDURE: Meniscectomy OR Meniscus Repair

If the patient has – DIAGNOSIS – Meniscus Injury

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Joint pain OR Swelling OR Feeling of giving way OR Locking, clicking or popping

OBJECTIVE – Positive Mc Murray’s sign OR Joint line tenderness OR Effusion OR Limited range of motion OR Locking, clicking, or popping OR Crepitus

IMAGING – (Not required for locked knee)

Meniscal tear on MRI (Surgical Repair of Grade I tear is not indicated except in unusual circumstances)

AND this has been done (if recommended) CONSERVATIVE CARE— In the presence of a locked knee, in a patient for whom surgical repair is contemplated, a course of conservative treatment need not be performed prior to surgery Physical therapy OR Medication OR Activity modification

D.8 PATELLAR SUBLUXATION

D.8.a Description/Definition

An incomplete subluxation or dislocation of the patella. Recurrent episodes can lead to subluxation syndrome that can cause frank dislocation of the patella.

D.8.b Mechanism of Injury

Primarily associated with contusion, lateral force direct contact. Secondary causes associated with shearing forces on the patella.

D.8.c Specific Physical Findings

Patient may report buckling sensation. Findings on physical exam may include retinacular weakness, swelling, effusion, marked pain with patellofemoral tracking/compression and glides. In addition, other findings include atrophy of muscles, positive patellar apprehension test, patella alta.

D.8.d Diagnostic Testing Procedures

Radiographs including Merchant views, Q-angle versus congruents.

D.8.f Surgical Indications

Fracture, recurrent subluxation or recurrent effusion, or symptoms not responsive to conservative therapy

D.8.g Operative Treatment

Open reduction internal fixation with fracture. Following a patellar dislocation, surgical consultation no sooner than 4-6 months of conservative therapy. Retinacular release, quadriceps reefing, and patellar tendon transfer should only be considered after a minimum of 4 to 5 months of conservative therapy.

D.9 RETROPATELLAR PAIN SYNDROME (CHONDROMALACIA PATELLA)

D.9.a Description/Definition

A retropatellar pain syndrome lasting over three months. Retropatellar pathologies are associated with resultant weakening instability, and pain of the patellofemoral mechanism. Can include malalignment, persistent quadriceps tendinitis, distal patellar tendinitis, patellofemoral arthrosis, and symptomatic plica syndrome.

D.9.b Mechanism of Injury

May be associated with contusion, repetitive patellar compressive forces, shearing articular injuries associated with subluxation or dislocation of patella, fractures, infection, and connective tissue disease.

D.9.c Specific Physical Findings

Patient complains of pain, instability and tenderness that interfere with daily living and work functions. Findings on physical exam may include retinacular tenderness, pain with patellar compressive ranging, positive patellar glide test, atrophy of quadriceps muscles, positive patellar apprehensive test. Associated anatomical findings may include increased Q angle; rotational lower extremity joints; ligament laxity, and effusion.

D.9.d Diagnostic Testing Procedures

Radiographs including tunnel, Merchant, or Laurin views. MRI rarely identifies pathology. Occasionally CT or bone scan.

D.9.b Mechanism of Injury

May be associated with contusion, repetitive patellar compressive forces, shearing articular injuries associated with subluxation or dislocation of patella, fractures, infection, and connective tissue disease.

D.9.c Specific Physical Findings

Patient complains of pain, instability and tenderness that interfere with daily living and work functions. Findings on physical exam may include retinacular tenderness, pain with patellar compressive ranging, positive patellar glide test, atrophy of quadriceps muscles, positive patellar apprehensive test. Associated anatomical findings may include increased Q angle; rotational lower extremity joints; ligament laxity, and effusion.

D.9.d Diagnostic Testing Procedures

Radiographs including tunnel, Merchant, or Laurin views. MRI rarely identifies pathology. Occasionally CT or bone scan.

The following surgery may be appropriate - SURGICAL PROCEDURE: Lateral Retinacular Release

OR Patellar Tendon Realignment OR Maquet Procedure

If the patient has – DIAGNOSIS – Retropatellar Pain Syndrome (Chondromalacia Patella)

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Knee pain with sitting OR Pain with patellar/femoral movement OR Recurrent dislocations

OBJECTIVE – Lateral tracking of the patella OR Recurrent effusion OR Patellar apprehension OR synovitis with or without crepitus OR Increased Q angle > 15 degrees

IMAGING – Abnormal patellar tilt on: x-ray or MRI

AND this has been done (if recommended) CONSERVATIVE CARE— Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture) OR Medications

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

Treatment Approaches

A.10 ACTIVE INTERVENTIONS

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 and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.13 SURGICAL INTERVENTIONS

Contemplation of surgery should be within the context of expected functional outcome. 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 imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat severe pain, there should be clear correlation between the pain symptoms and objective evidence of its cause

Patient is a 66-year-old male porter who sustained a work-related injury to the left leg when he fell while carrying a table. Patient is diagnosed with lumbar spinal instability with left knee internal derangement. MRI of the left knee by Dr. Peyser dated 3/28/12 showed osteoarthritic change which is severe involving the medial joint space compartment, with foci of osteochondritis involving the medial femoral condyle and medial tibial plateau. Extensive degeneration of the medial meniscus with evidence of tear of the posterior horn and probable displacement of the body anteriorly is noted. There is focal peripheral tear body of the lateral meniscus. Joint effusion is present. Per latest medical report by Dr. Mitamura dated 10/17/2012, patient presents with left knee pain especially on stair climbing. Physical examination of the left knee revealed significant swelling, tenderness of the lateral joint line and medial joint with medial collateral ligament tenderness, quadriceps musculature atrophy and blocked extension at 10 degrees with extension to 95 degrees. Per IME Addendum report by Dr. Cohen dated 5/7/2012, the physical examination done on 3/27/2012 revealed no clear objective findings and was opined that maximum medical improvement has been reached. No further causally related treatment is reasonable or necessary for the low back or left leg. Is the request for 1 Left Knee Arthroscopic Arthroplasty, 1 Left Knee Brace and 18 Post-operative Physical Therapy Visits for the Left Knee between 12/3/2012 and 1/31/2013 medically necessary? C-4 for Preauthorization Request. (Please use NY Medical Treatment Guidelines as primary reference for review.) Medical documents reviewed include MRI of the left knee by Dr. Peyser dated 3/28/12, medical report by Dr. Mitamura dated 10/17/2012 and IME Addendum report by Dr. Cohen dated 5/7/2012.

**Knee Arthroscopic Arthroplasty, Knee Brace and PT**

New York State Workers’ Compensation Board

Knee Injury Medical Treatment Guidelines

D SPECIFIC KNEE INJURY DIAGNOSES, TESTING, AND TREATMENT

D.1 CHONDRAL DEFECTS (Cartilage or Cartilage and Bone Defects)

D.1.f Surgical Indications/Operative Treatment

Chondroplasty, Osteochondral Autograft and Autologous Chrondrocyte Implantation (ACI) are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Chondroplasty, Osteochondral Autograft (OATS) Procedure and Autologous Chrondrocyte Implantation (ACI). Refer to Table 3.

If a non-operative treatment approach is initially recommended, surgery may be indicated after the failure of conservative management. The patient must continue to exhibit the designated objective findings, subjective symptoms and (where applicable) imaging findings.

D.1.h Post-Operative Therapy

May include restricted weight-bearing, bracing, active and/or passive therapy. Continuous passive movement is suggested after microfracture.

D.2 AGGRAVATED OSTEOARTHRITIS

D.2.a Description/Definition

Swelling and/or pain in a joint due to an aggravating activity in a patient with pre-existing degenerative change in a joint.

D.2.f Surgical Indications/Operative Treatment

Symptoms not responsive to conservative therapy.

Debridement with or without removal of loose bodies. Arthroscopic joint lavage is not recommended.

For symptoms not responsive to conservative measures, treatment may involve total joint. Refer to Table 8.

D.2.g Post-Operative Therapy

Active and/or passive therapy.

D.6 MENISCUS INJURY

D.6.a Description/Definition

A tear, disruption, or avulsion of medial or lateral meniscus tissue.

D.6.f Surgical Indications/ Operative Treatment Meniscectomy/Meniscus Repair and Meniscal Allograft Transplantation.

Meniscal Allograft Transplantation is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure. Refer to Table 5.

D.6.g Post-Operative Therapy

Active and/or passive therapy, bracing.

E 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, restricted, or full duty during their rehabilitation at the earliest appropriate time.

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 unusual 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.

E.5 ORTHOTICS AND PROSTHETICS

E.5.a Fabrication/Modification of Orthotics

Fabrication/Modification of Orthotics would be used when there is need to normalize weight-bearing, facilitate better motion response, stabilize a joint with insufficient muscle or proprioceptive/reflex competencies, to protect subacute conditions as needed during movement, and correct biomechanical problems.

-Time to produce effect: 1 to 3 sessions (includes wearing schedule evaluation).

-Frequency: 1 to 2 times per week.

-Optimum/maximum duration: 4 sessions of evaluation, casting, fitting, and re-evaluation.

E.5.c Splints or Adaptive Equipment

Design, fabrication and/or modification indications include the need to control neurological and orthopedic injuries for reduced stress during functional activities and modify tasks through instruction in the use of a device or physical modification of a device, which reduces stress on the injury. Equipment should improve safety and reduce risk of re-injury. This includes high and low technology assistive options such as workplace modifications, computer interface or seating, crutch or walker training, and self-care aids.

-Time to produce effect: Immediate.

-Frequency: 1 to 3 sessions or as indicated to establish independent use.

-Optimum/maximum duration: 1 to 3 sessions.

E.7 THERAPY-ACTIVE

Most of the following active therapies have some evidence and are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy requires supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). At times, the 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.

E.7.e Therapeutic Exercise

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 complementary/ alternative exercise movement therapy.

- Time to produce effect: 2 to 6 treatments.

- Frequency: 3 to 5 times per week.

- Optimum duration: 4 to 8 weeks.

- Maximum duration: 8 weeks.

F THERAPEUTIC PROCEDURES, OPERATIVE

F.2 TOTAL KNEE REPLACEMENT (TKR)

Knee Arthroplasty (Total or Partial Knee Joint Replacement) is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Refer to Table 8.

Table 8: Criteria for Total Knee Replacement

The following surgery may be appropriate - SURGICAL PROCEDURE: Knee Joint Replacement

If only 1 compartment is affected, a unicompartmental or partial replacement if indicated

If 2 of the 3 compartments are affected, a total joint replacement is indicated

If the patient has – DIAGNOSIS –

AND the diagnosis is supported by CLINICAL FINDINGS

SUBJECTIVE – Limited range of motion OR Night time joint pain OR No pain relief with conservative care

OBJECTIVE – Over 50 years of age AND Body Mass Index of less than 35

IMAGING – Osteoarthritis on: Standing x-ray OR Arthroscopy AND this has been done (if recommended) CONSERVATIVE CARE— Medications OR Viscosupplementation injections OR Steroid injection

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

Treatment Approaches

A.10 ACTIVE INTERVENTIONS

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 and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.11 ACTIVE THERAPEUTIC EXERCISE PROGRAM

Active therapeutic exercise program goals should incorporate patient strength, endurance, flexibility, range of motion, coordination, and education. This includes functional application in vocational or community settings.

A.13 SURGICAL INTERVENTIONS

Contemplation of surgery should be within the context of expected functional outcome. 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 imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat severe pain, there should be clear correlation between the pain symptoms and objective evidence of its cause

**ELECTRICAL BONE GROWTH STIMULATORS**

New York State Workers’ Compensation Board

Mid and Low Back Injury Medical Treatment Guidelines

E THERAPEUTIC PROCEDURES: OPERATIVE

E.5 ELECTRICAL BONE GROWTH STIMULATORS

Electrical Bone Growth Stimulators are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Recommendations

E.5.a.i Non invasive Electrical Bone Growth Stimulators (WCB) as an adjunct to spinal fusion surgery for those at high risk for pseudoarthrosis, including one or more of the following fusion failure risk factors:

1) One or more previous failed spinal fusion(s)

2) Grade II or worse spondylolisthesis

3) Fusion to be performed at more than one level

4) Presence of other risk factors that may contribute to non-healing:

-Current smoking

-Diabetes

Renal disease

-Other metabolic diseases where bone healing is likely to be compromised (e.g.: significant osteoporosis)

-Active alcoholism

-Morbid obesity BMI >40

E.5.a.ii Non-invasive Electrical Bone Growth Stimulators (WCB) may be considered as treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of 6 months after the original surgery, as evidenced by serial x-rays over a course of 3 months during the latter portion of the 6 month period.

A GENERAL GUIDELINE PRINCIPLES

Medical Care

A.1 MEDICAL CARE

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient’s daily and work activities and return to work, while striving to restore the patient’s health to its pre-injury status in so far as is feasible.

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Chapter: Low Back - Lumbar & Thoracic

Bone growth stimulators (BGS)

Under study. There is conflicting evidence, so case by case recommendations are necessary (some RCTs with efficacy for high risk cases). Some limited evidence exists for improving the fusion rate of spinal fusion surgery in high risk cases (e.g., revision pseudoarthrosis, instability, smoker). (Mooney, 1990) (Marks, 2000) (Akai, 2002) (Simmons, 2004) There is no consistent medical evidence to support or refute use of these devices for improving patient outcomes; there may be a beneficial effect on fusion rates in patients at "high risk", but this has not been convincingly demonstrated. (Resnick, 2005)

Criteria for use for invasive or non-invasive electrical bone growth stimulators:

Either invasive or noninvasive methods of electrical bone growth stimulation may be considered medically necessary as an adjunct to spinal fusion surgery for patients with any of the following risk factors for failed fusion: (1) One or more previous failed spinal fusion(s); (2) Grade III or worse spondylolisthesis; (3) Fusion to be performed at more than one level; (4) Current smoking habit (Note: Other tobacco use such as chewing tobacco is not considered a risk factor); (5) Diabetes, Renal disease, Alcoholism; or (6) Significant osteoporosis which has been demonstrated on radiographs. (Kucharzyk, 1999) (Rogozinski, 1996) (Hodges, 2003)