

## **DWD 81.09B – LOWER EXTREMITY DISORDERS**

*Definition – By definition, a lower extremity disorder could mean any one or more of the following below\*, at any given time. The lower extremity would consist of the hip, thigh, knee, leg, ankle, foot and any one or more toes, in their entirety.*

Proposed possible disorders could encompass any one or more of the following. This list does not comprise every possible injury or condition that could be related to a work injury. \*(Any and All SPRAINS and STRAINS of the lower limb, including but not limited to hip/ thigh/ knee/ lower leg/ ankle and foot whereby SPRAINS of any one or more joints of the lower limb such as Anterior and Posterior Cruciate Ligaments/ Medial and Lateral Collateral Ligaments/ Supra and Infra-Patellar Ligament injuries of the knee, Deltoid or Medial Ligament or Lateral Ligament injuries of the ankle/ Anterior and Posterior TaloFibular/ Calcaneofibular and Superior and Inferior Peroneal Retinaculum Ligaments/ and STRAINS of the thigh muscles such as quadriceps or hamstring muscle groups or lower leg muscle group, calf, etc. whereby there is objective injury to any one or more muscle groups secondary to trauma. All TRAUMA and/or FRACTURES of any portion of the lower limb including but not limited to, hip/ thigh/ knee/ lower leg/ ankle and foot. All DISLOCATIONS of the lower limb including hip/ knee/ ankle and/or foot. TRAUMATIC AVASCULAR NECROSIS of any one or more tarsal bones. CRUSH INJURIES of the lower limb, including the foot and toes. Any one or more TENDON INJURIES or TENDONITIS such as Achilles Tendon, Any one or more NERVE ENTRAPMENTS or COMPRESSION type disorders or injuries. TOE NAILBED INJURIES or DISORDERS/ deformities. PLANTAR FASCITIS of the foot, MENISCUS INJURY or TRAUMA/ disorders, BAKER's CYST secondary to TRAUMA. All forms of lower extremity CONTUSIONS and finally, All LACERATIONS of the lower extremity.) ETC.

### **(1) DIAGNOSTIC PROCEDURES FOR TREATMENT OF LOWER EXTREMITY DISORDERS.**

(a) A health care provider shall determine the nature of a lower extremity disorder before initiating treatment.

(b) A health care provider shall perform and document an appropriate history and physical examination. Based on the history and physical examination, a health care provider shall at each visit, assign the patient to the appropriate clinical category according to subds. 1. to 6. A health care provider shall document the diagnosis in the medical record. Patients may have multiple disorders requiring assignment to more than one clinical category. This section does not apply to lower extremity conditions due to a visceral, vascular, infectious, immunological, metabolic, endocrine, systemic neurologic, or neoplastic disease process, or systemic rheumatoid arthritis diseases. Instead, applies to any/ all traumatic injuries, cumulative traumatic disorders or disruptions, fractures, dislocations, etc that are work related or determined to be work related or that occurred while on the job and/ or during work hours.

(1) **FRACTURES AND DISLOCATIONS** – This clinical category includes any/ all fractures or dislocations which occur while on the job, or that are work related. This would include any fracture from the hip down to the ankle and foot that is causing secondary pain, swelling, inflammation, disuse atrophy of surrounding lower extremity muscles, numbness and or pain and tendonitis, or gait disturbances from the fracture or dislocation.

(2) TENDONITIS OF THE LOWER LEG/ANKLE/FOOT – This clinical category encompasses any inflammation, pain, tenderness, or dysfunction or irritation of a tendon, tendon sheath, tendon insertion, or musculotendinous junction in the lower extremity at or distal to the knee due to mechanical injury, trauma, or irritation, including the diagnosis of tendonitis, tenosynovitis, or peritendonitis.

(3) NERVE ENTRAPMENT SYNDROMES – This clinical category encompasses any compression or entrapment of the femoral, sciatic, posterior tibial or common peroneal nerve/s and any of their branches, including tarsal tunnel syndrome, Lateral Femoral Cutaneous Nerve, Obturator Nerve, Genitofemoral Nerve, Ilioinguinal Nerve, Iliohypogastric Nerve and so on. Entrapment syndrome for the lower extremity will be known by their painful numbing effect on the patient and can be confirmed by an NCV/EMG study which follows the same protocols for 81.06 (f) and 81.07 (f) for neck and lower back radiculopathies and extremity numbness that is persistent.

(4) MUSCLE PAIN SYNDROMES – This clinical category encompasses any painful condition of any of the muscles of the lower extremity, including the muscles responsible for movement of the hip/ knee and ankle/foot characterized by pain and stiffness, including the diagnosis of acute/ chronic traumatic muscle strain, repetitive strain injury, overuse syndrome for any one or multiple muscle or muscle groups, myofascial pain syndrome, myofascitis, nonspecific myalgia, fibrositis, traumatic fibromyalgia and fibromyositis.

(5) IMPINGEMENT SYNDROMES INCLUDING TENDONITIS and BURSITIS and RELATED CONDITIONS – This clinical category encompasses any inflammation, pain, tenderness, dysfunction, or irritation of a tendon, tendon insertion, tendon sheath, musculotendinous junction, or bursa in the lower extremity due to mechanical injury or irritation, including the diagnosis of impingement syndrome, Iliotibial Band Syndrome, Peroneal Tendonitis, Achilles Tendonitis, Hip Tendonitis, Patellar Tendonitis, Quadriceps Tendonitis, Pes Anserine Bursitis/ Tendinopathy, Hamstring Tendonitis, etc., or any other tendon or bursa that becomes swollen and/or inflamed secondary to a work related injury.

(6) TRAUMATIC SPRAINS and STRAINS OF THE LOWER EXTREMITY – This clinical category encompasses an instantaneous or acute injury that occurred because of a single precipitating event to any one or several of the lower extremity ligaments or muscles of the lower extremity. Injuries to muscles because of repetitive use or occurring gradually over time without a single precipitating trauma, are considered muscle pain syndromes under subd. 4. Injuries with complete tissue disruption are also part of this section and would encompass all necessary avenues for relief from the secondary effects of these type of injuries such as pain, swelling and inflammation, deformation, and dysfunction in total.

(c) A health care provider may order certain laboratory tests in the evaluation of a patient with lower extremity disorders to rule out infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders such as rheumatoid arthritis, or side effects of medications. Laboratory tests may be ordered at any time a health care provider suspects any of these conditions, but a health care provider shall justify the need for the tests ordered with clear documentation of the indications.

(d) Medical imaging evaluation of lower extremity disorders shall be based on the findings of the history and physical examination and may not be ordered before a health care provider's clinical evaluation of the patient. Medical Imaging may not be performed as a routine procedure and shall

comply with the guidelines in s. DWD 81.05. A health care provider shall document the appropriate indications for any medical imaging studies obtained.

(e) Electromyography and nerve conduction studies are only necessary for conditions of the lower extremity that involve ongoing weakness, tingling, numbness or with any nerve entrapment disorders pre or post-surgical.

(f) A health care provider may not order the use of any of the following diagnostic procedures or tests for diagnosis of lower extremity disorders:

1. Surface Electromyography
2. Thermography.
3. Somatosensory evoked potentials and motor evoked potentials.

(g) All of the following diagnostic procedures or tests are considered adjuncts to the physical examination and are not necessary separately from the office visit:

1. Vibrometry
2. Neurometry.
3. Semmes-Weinstein monofilament testing.
4. Algometry.

(h) A health care provider may not order computerized range of motion or strength measuring tests during the period of initial nonsurgical management but may order these tests during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program. During the period of initial nonsurgical management, computerized range of motion or strength testing may be performed but shall be done in conjunction with an office visit with a health care provider's evaluation or treatment.

(i) A health care provider may order personality or psychosocial evaluations for evaluating patients who continue to have problems despite appropriate initial nonsurgical care. A treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions that may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in each case, a health care provider performing the evaluation shall consider all the following:

1. Is symptom magnification occurring?
2. Does the patient exhibit an emotional reaction to the injury, such as depression, fear, anxiety, or anger that is interfering with recovery?
3. Are there other personality factors or disorders that are interfering with recovery?
4. Is the patient chemically dependent?
5. Are there any interpersonal conflicts interfering with recovery?
6. Does the patient have a chronic pain syndrome or any psychogenic pain?
7. In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

(j) Diagnostic analgesic blocks and injection studies are used to localize the source of pain and to diagnose conditions which fail to respond to appropriate initial nonsurgical management. All the following guidelines apply to diagnostic analgesic blocks and injection studies:

1. Selection of patients, choice of procedure, and localization of the site of injection shall be determined by documented clinical findings indicating possible pathological conditions and the source of pain symptoms.
2. These blocks and injections may also be used as therapeutic modalities and as such are subject to the guidelines of sub. (5).

(k) Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural tolerance. A functional capacity assessment or evaluation is an individualized testing process, and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

1. Functional capacity assessment or evaluation is not necessary during the first 12 weeks of initial nonsurgical treatment.
2. Functional capacity assessment or evaluation *is necessary* after the first 12 weeks of care or any time beyond the 12-week mark of acute care when treatment is needed because of extenuating circumstances as stated in DWD 81.04 where care is indeed needed because of surgery or other unforeseen circumstances that bring care beyond the 12-week mark or, in any of the following circumstances:
  - a. To identify the patient's activity restrictions and capabilities.
  - b. To assess the patient's ability to return to do a specific job.
3. A functional capacity evaluation is not necessary to establish baseline performance before treatment or for subsequent assessments to evaluate change during or after treatment.
4. Only one completed functional capacity evaluation is necessary per injury.

(l) Consultation with other health care providers may be initiated at any time by the appointed primary or secondary primary treating health care provider as it stipulates in 102.42 (2)(a).

## **(2) GENERAL TREATMENT GUIDELINES FOR LOWER EXTREMITY DISORDERS**

(a) All medical care for lower extremity disorders, appropriately assigned to a category of sub. (1) (b) 1. to 6., is determined by the diagnosis and clinical category that the patient has been assigned. General guidelines for treatment modalities are set forth in subs. (3) to (10). Specific treatment guidelines for each clinical category are set forth in subs. (11) to (16) as follows:

1. Subsection (11) governs fractures and dislocations.
2. Subsection (12) governs tendonitis of the lower extremity in its entirety.
3. Subsection (13) governs lower extremity nerve entrapment syndromes.
4. Subsection (14) governs lower extremity muscle pain syndromes.
5. Subsection (15) governs lower extremity impingement syndromes.
6. Subsection (16) governs traumatic sprains and strains of the lower extremity.

(b) A health care provider shall at each visit reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing and opinions, and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan shall be appropriately modified to reflect the new clinical category. The health care provider shall record any clinical category and treatment plan changes in the medical record. A change of clinical category may not in itself allow a health care provider to continue a therapy or treatment modality past the maximum duration specified in subs. (3) to (10) or to repeat a therapy or treatment previously provided for the same injury unless the treatment or therapy is subsequently delivered to a different part of the body.

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

(d) In general, a course of treatment shall be divided into the following 3 phases:

1. First, all patients with a lower extremity disorder shall be given initial nonsurgical management, unless otherwise specified. Initial nonsurgical management may include any combination of the passive, active, injection, durable medical equipment, and medication treatment modalities listed in subs. (3), (4), (5), (8), and (10), appropriate to the clinical category. The period of initial nonsurgical treatment begins with the first passive, active, injection, durable medical equipment, or medication modality initiated. Initial nonsurgical treatment shall result in progressive improvement as specified in subs. (9).

2. Second, for patients with persistent symptoms, initial nonsurgical management is followed by a period of surgical evaluation. This evaluation shall be completed in a timely manner. Surgery, if necessary, shall be performed as expeditiously as possible consistent with sound medical practice and subs. (6), (11) to (16), and s. DWD 81.12 (3). A treating health care provider may do the evaluation or may refer the patient to another health care provider.

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

b. Surgery shall follow the guidelines in subs. (6), (11) to (16), and s. DWD 81.12 (3).

c. A decision against surgery at any time does not preclude a decision for surgery made later.

3. Third, for those patients who are not candidates for surgery or refuse surgery, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be necessary. Chronic management modalities are described in s. DWD 81.13 and may include durable medical equipment as described in subs. (8).

(e) A treating health care provider may refer the patient for a consultation at any time during treatment consistent with the accepted medical practice.

### **(3) PASSIVE TREATMENT MODALITIES**

(a) *General* - Except as set forth in par. (b) or s. DWD 81.04 (5), a health care provider may not direct the use of passive treatment modalities in a clinical setting as set forth in pars. (c) to (i) beyond the 12 calendar weeks after any of the passive modalities in pars. (c) to (i) are initiated. There are no limitations on the use of passive treatment modalities by the patient at home.

(b) *Additional Passive Treatment Modalities* - A health care provider may direct an additional 12 visits for the use of passive treatment modalities over an additional 12 months if all the following apply:

1. The patient is released to work or is permanently totally disabled, and the additional passive treatment may result in progressive improvement in, or maintenance of, functional status achieved during the initial 12 weeks of passive care.
2. The treatment is not given on a regularly scheduled basis.
3. A health care provider documents in the medical record a plan to encourage the patient's independence and decreased reliance on health care providers.
4. Management of the patient's condition includes active treatment during this period.
5. The additional 12 visits for passive treatment do not delay the required surgical or chronic pain evaluation required by this chapter.
6. Passive care is not necessary while the patient has chronic pain syndrome.

(c) Adjustment or Manipulation of Joints – For purposes of this paragraph, “adjustment or manipulation of joints” includes chiropractic and osteopathic adjustments or manipulations. All the following guidelines apply to adjustment or manipulation of joint:

1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to two weeks decreasing in frequency until the end of the maximum treatment period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(d) Thermal Treatment – For purposes of this paragraph, “thermal treatment” includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave. All the following guidelines apply to thermal treatment:

1. Treatment given in a clinical setting:
  - a. Time for treatment response is 2 to 4 treatments.
  - b. Maximum treatment frequency is up to 5 times per week for the first one to three weeks decreasing in frequency until the end of the maximum treatment duration period in subs. 1(c).
  - c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies.
2. Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks that can be applied by the patient without health care provider assistance. Home use of thermal modalities may not require any special training or monitoring, other than that usually provided by a health care provider during an office visit.

(e) Electric Muscle Stimulation – For purposes of this paragraph, “electrical muscle stimulation” includes but not limited to, galvanic stimulation, transcutaneous electric nerve stimulation, interferential and microcurrent techniques. All the following guidelines apply to electrical muscle stimulation:

1. Treatment given in a clinical setting:
  - a. Time for treatment response is 2 to 4 treatments.
  - b. Maximum treatment frequency is up to 5 times per week for the first one to three weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 1(c).
  - c. Maximum treatment duration is 12 weeks of treatment in a clinical setting but only given in conjunction with other therapies.

2. Home use of an electrical muscle stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device shall be in a supervised setting to ensure proper electrode placement and patient education. All the following guidelines apply to home use of an electrical stimulation device:

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

(f) Acupuncture Treatments – For purposes of this paragraph, “Acupuncture Treatments” include endorphin-mediated analgesic therapy that includes classic acupuncture and acupressure. All the following guidelines apply to acupuncture treatments:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for the first one to three weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(g) Phoresis – For purposes of this paragraph, “Phoresis” includes phonophoresis and iontophoresis. All of the following guidelines apply to Phoresis:

1. Time for treatment response is 3 to 5 sessions.
2. Maximum treatment frequency is up to 3 times per week for the first one to three weeks, decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 9 sessions of either iontophoresis or phonophoresis, or combination, to any one site, with a maximum duration of 12 weeks for all treatment.

(h) Manual Therapy – For purposes of this paragraph, “Manual Therapy” includes soft tissue and joint mobilization and therapeutic massage. All the following guidelines apply to manual therapy:

1. Time for treatment response is 3 to 5 treatments.
2. Maximum treatment frequency is up to 5 times per week for the first one to two weeks decreasing in frequency until the end of the maximum treatment duration period in subd. 3.
3. Maximum treatment duration is 12 weeks.

(i) Splints, Braces, and other Movement Restricting Appliances – Bracing required for longer than two weeks shall be accompanied by active motion exercises to avoid stiffness and prolonged disability. All the following guidelines apply to splints, braces, and other movement-restricting appliances:

1. Time for treatment response is 10 days.
2. Maximum treatment frequency is limited to intermittent use during times of increased physical stress or prophylactic use at work.
3. Maximum continuous duration is 8 weeks. Prophylactic use is allowed indefinitely.

(j) Rest – Prolonged restriction of activity and immobilization are detrimental to a patient’s recovery. Total restriction of use of an affected body part may not be prescribed for more than 2 weeks unless rigid immobilization is required. In cases of rigid immobilization, active motion exercises at adjacent joints shall begin no later than 2 weeks after application of the immobilization.

#### **(4) ACTIVE TREATMENT MODALITIES**

(a) A health care provider shall use active treatment modalities as set forth in pars. (b) to (f). A health care provider’s use of active treatment modalities may extend past the 12-week limitation on

passive treatment modalities so long as the maximum treatment for the active treatment modality is not exceeded and/or if the patients condition meets or is consistent with s. DWD 81.04 (5) "Departure from Guidelines."

(b) Education shall teach the patient about pertinent anatomy and physiology as it relates to lower extremity function for the purpose of injury prevention. Education includes training on posture, biomechanics, and relaxation. The maximum number of treatments are 3 visits which include an initial education and training session, and 2 follow-up visits.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, low back, and legs, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. The maximum number of treatments is 3 visits.

(d) Worksite analysis and modification shall examine the patient's workstation, tools, and job duties. A health care provider may make recommendations for the alteration of the workstation, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is 3 visits.

(e) Exercise, which is important to the success of a nonsurgical treatment program and a return to normal activity, shall include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise shall, at least in part, be specifically aimed at the musculature of the lower extremity. While aerobic exercise may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program.

(f) Exercises shall be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance shall be objectively measured. A health care provider may objectively measure the treatment response as often as necessary for optimal care after the initial evaluation. Subdivisions 1. and 2. govern supervised and unsupervised exercise, except for computerized exercise programs and health clubs, which are governed by s. DWD 81.13.

1. 'Guidelines for supervised exercise.' – One goal of an exercise program shall be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition shall be promoted. All the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is up to 3 times per week for 3 weeks and shall decrease with time until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks

2. 'Guideline for unsupervised exercise' – Unsupervised exercise shall be provided in the least intensive setting and may supplement or follow the period of supervised exercise.

## **(5) THERAPEUTIC INJECTIONS**

(a) For purposes of this subsection, "Therapeutic Injections" include injections of trigger points, sympathetic nerves, peripheral nerves, and soft tissues. A health care provider may only give therapeutic injections in conjunction with active treatment modalities directed to the same anatomical site. A health care provider's use of injections may extend past the 12-week limitation on passive modalities, so long as the maximum treatment for injections in pars. (b) to (d) is not exceeded.

(b) All of the following guidelines apply to trigger point injections:



1. Time for treatment response is within 30 minutes.
2. Maximum treatment frequency is once per week to any one site if there is a positive week to any one site if there is a positive response to the first injection at that site. If subsequent injections at that site demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, trigger point injections shall be redirected to other areas or discontinued. Only 3 injections to different sites per patient visit.
3. Maximum treatment is 4 injections to any one site over the course of treatment.

(c) For purposes of this paragraph, "Soft Tissue Injections" include injections of a bursa, tendon, tendon sheath, ganglion, tendon insertion, ligament, or ligament insertion. All of the following guidelines apply to soft tissue injections:

1. Time for treatment response is within one week.
2. Maximum treatment frequency is once per month to any one site if there is a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections shall be discontinued. Only 3 injections to different sites per patient visit.
3. Maximum treatment is 3 injections to any one site over the course of treatment.

(d) All of the following guidelines apply to injections for any lower extremity nerve entrapment:

1. Time for treatment response is within one week.
2. Maximum treatment frequency may permit repeat injection in one month if there is a positive response to the first injection. Only 3 injections to different sites per patient visit.
3. Maximum treatment is 2 injections to any one site over the course of treatment.

## **(6) SURGERY**

(a) A health care provider may perform surgery if it meets applicable guidelines in subs. (11) to (16) and s. DWD 81.12 (3).

(b) In order to optimize the beneficial effect of surgery, postoperative therapy with active and passive treatment modalities shall be provided, even if these modalities had been used in the preoperative treatment of the condition. In the postoperative period, the maximum treatment duration with passive treatment modalities in a clinical setting from initiation of the first passive modality used, except bedrest or bracing is as follows:

1. 12 weeks for knee surgery or repair, ligament and/or tendon surgery or repair or any surgery for a clinical category in this section that requires joint reconstruction.
2. 8 weeks minimum for all other surgery for clinical categories in this section.

(c) Repeat surgery shall also meet the guidelines of subs. (11) to (16) and s. DWD 81.12 (3).

## **(7) CHRONIC MANAGEMENT**

Chronic management of lower extremity disorders shall be provided according to the guidelines in s. DWD 81.13.

## **(8) DURABLE MEDICAL EQUIPMENT**

(a) A health care provider may direct the use of durable medical equipment only in the situations specified in pars. (b) to (e).

(b) Splints, braces, straps, or supports, may be necessary as specified in subs. (3) (i).

(c) For patients using an electrical muscle stimulation device at home, the device and any required supplies are necessary within the guidelines of sub. (3) (e).

(d) Exercise equipment for home use, including bicycles, treadmills, and stair climbers, are necessary only as part of an approved chronic management program. This equipment is not necessary during initial non-surgical care during re-evaluation and surgical therapy. If the employer has an appropriate exercise facility on its premises with the prescribed equipment, the insurer may mandate use of that facility on its premises with the prescribed equipment instead of authorizing purchase of the equipment for home use.

1. 'Indication' – The patient is deconditioned and requires reconditioning that can be accomplished only with the use of the prescribed exercise equipment. A health care provider shall document specific reasons why the exercise equipment is necessary and may not be replaced with other activities.

2. 'Requirements' – The use of the equipment shall have specific goals and there shall be a specific set of prescribed activities.

(e) All of the following durable medical equipment listed in (e)(1-2) below, are not necessary for home use for the lower extremity disorders specified in subs. (11) to (16):

1. Whirlpools, Jacuzzis, hot tubs, and special bath or shower attachments.

2. Beds, waterbeds, mattresses, chairs, recliners, and loungers.

#### **(9) EVALUATION OF TREATMENT BY HEALTH CARE PROVIDER**

(a) A health care provider shall evaluate at each visit whether the treatment is medically necessary and whether initial nonsurgical treatment is effective according to pars. (b) to (e). No later than the time for treatment response established for the specific modality in subs. (3) to (5), a health care provider shall evaluate whether the passive, active, injection, or medication treatment modality is resulting in progressive improvement as specified in pars. (b) to (e).

(b) The patient's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms.

(c) The objective clinical findings are progressively improving as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury.

(d) The patient's functional status, especially vocational activity, is progressively improving, as evidenced by documentation in the medical record or documentation of work ability involving less restrictive limitations on activity.

(e) If there is not progressive improvement in at least 2 categories specified in pars. (b) to (d), the modality shall be discontinued or significantly modified, or a health care provider shall reconsider the diagnosis. The evaluation of the effectiveness of the treatment modality may be delegated to an allied health professional directly providing the treatment but remains the ultimate responsibility of the treating health care provider.

#### **(10) MEDICATION MANAGEMENT**

(a) Prescription of controlled substance medication scheduled under ch. 450, Stat., including opioids and narcotics, are necessary primarily for the treatment of severe acute pain. Therefore, these

medications are not generally recommended in the treatment of patients with lower extremity disorders.

(b) A health care provider, appointed primary treating physician or a health care provider in the chain of referral, shall document the rationale for the use of any scheduled medication. Treatment with nonscheduled medication may be appropriate during any phase of treatment and intermittently after all other treatment has been discontinued. The prescribing health care provider shall determine the ongoing medication is effective treatment for the patient's condition.

#### **(11) SPECIFIC TREATMENT GUIDELINES FOR FRACTURES AND DISLOCATIONS**

(a) A health care provider shall use initial nonsurgical management for all patients with any type of fracture or dislocation, provided it is not a surgical case of which, all surgical lower extremity practices shall be followed as stated in DWD 81.12 (3). Nonsurgical management shall be the first phase of care or treatment.

1. The passive, active, injection, durable medical equipment, and medication treatment modalities and procedures specified in subs. (3), (4), (5), (8), and (10) may be used in sequence or simultaneously during the period of initial nonsurgical management depending on the severity of the condition. After the first 6-8 weeks of healing from the fracture and removal of cast or 4 weeks of healing with a dislocation and removal of bracing, initial nonsurgical care shall always include active treatment modalities under sub. (4).

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

3. Except as provided in sub. (3), the use of passive treatment modalities in a clinic setting or requiring attendance by a health care provider for a period more than 12 weeks may be necessary depending on the severity of the fracture, disuse atrophy of surrounding muscle tissue effected by the injury and/or the severity of the dislocation. Therefore, the 12-week rule will be subject to the day of removal of casting or splinting/ bracing, that is provided by the health care provider or the appointed primary treating physician responsible for the treatment being provided. The 12-week rule as described in DWD 81.09 (B) for lower extremities will still be in effect once casting or splinting or bracing is removed, allowing ample time for rehabilitation and use of active and passive modalities as stated in DWD 81.09B (3) and (4). Further, DWD 81.04 (5) (a-e), DEPARTURE FROM GUIDELINES, can or may also apply since the complications of casting a fracture or bracing a dislocation may take longer than 6-8 weeks to heal authorizing active and passive treatment to be applied by the appointed health care provider, beyond the 12-week rule.

4. Use of home-based treatment modalities with monitoring by the treating health care provider may continue for up to 12 months. At any time during this period, the patient may be a candidate for chronic management if surgery is ruled out as an appropriate treatment.

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. The purpose and goal of surgical evaluation is to determine whether surgery is necessary for the patient who has failed to recover with appropriate nonsurgical care or chronic management.

1. Surgical evaluation, if necessary, shall begin no later than 12 months after beginning initial nonsurgical management.

2. Surgical evaluation may include the use of appropriate laboratory and electrodiagnostic testing within the guidelines of subs. (1), if not already obtained during the initial evaluation. Repeat testing is

not necessary unless there has been an objective change in the patient's condition that would warrant further testing. Failure to improve with therapy does not, by itself, warrant further therapy.

3. Plain films would be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general guidelines in s. DWD 81.05 (1). With lower extremity fracture or dislocation, further medical imaging studies may be deemed necessary.

4. Surgical evaluation may also include personality or psychological evaluation consistent with the guidelines of sub. (1) (i).

5. Consultation with other health care providers is an important part of surgical evaluation of a patient who fails to recover with appropriate nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition.

6. If surgery is necessary, it may be performed after initial nonsurgical management fails.

7. If surgery is not necessary or if the patient does not wish to proceed with surgery after the 12-week time period of nonsurgical active and passive care, then the patient is a candidate for chronic management as stated under s. DWD 81.13. An initial recommendation or decision against surgery does not preclude surgery at a later date.

(c) If the patient continues with symptoms and objective physical findings after surgery or the patient refused surgery or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily living including regular vocational activities, then the patient may be a candidate for chronic management under s. DWD 81.13.

#### **(12) SPECIFIC GUIDELINES FOR TENDONITIS OF ANY LOWER EXTREMITY TENDON**

(a) A health care provider shall use initial nonsurgical management for all patients with tendonitis and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a).

(b) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all the guidelines of sub. (11) (b), with the following modifications:

1. For patients with a specific diagnosis of tendonitis in the lower extremity and it has been diagnosed accurately by the health care provider, surgical evaluation, and potential surgical therapy, if necessary, may begin after only 2 months of initial nonsurgical management or in other words, a trial of 8 weeks of traditional active and passive modality care as specified in s. DWD 81.09B (3) and (4).

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery, or the patient was not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with any lower extremity tendonitis shall be provided under the guidelines of s. DWD 81.13.

#### **(13) SPECIFIC TREATMENT GUIDELINES FOR NERVE ENTRAPMENT SYNDROMES**

(a) A health care provider shall use initial nonsurgical management for all patient with nerve entrapment syndromes, except as specified in par. (b) 2., and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a),

with the following modifications: Nonsurgical management may be inappropriate for patients with advanced symptoms and signs of nerve compression in the lower extremities, such as abnormal two-point discrimination, motor weakness, or muscle atrophy, or for patients with symptoms of nerve entrapment due to acute trauma. In these cases, immediate surgical evaluation may be necessary.

(b) If the patient continues with symptoms and objective physical findings after 12 weeks of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all the guidelines of sub. (11) (b), with the following modifications:

1. Surgical evaluation may begin, and surgical therapy may be provided, if necessary, after 12 weeks of initial nonsurgical management, except where immediate surgical evaluation is necessary under par. (a).
2. Surgery is necessary if an electrodiagnostic study, (NCV/EMG), confirms the diagnosis or if there has been temporary resolution of symptoms lasting at least 7 days with local injection.
3. If there is neither a confirming electrodiagnostic study, (NCV/EMG), nor appropriate response to local injection or if surgery has been previously performed at the same site, surgery is not necessary.

(c) If the patient continues with symptoms and objective physical findings after all surgery, or the patient refused surgery therapy, or the patient was not a candidate for surgery therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with nerve entrapment syndromes shall be provided under the guidelines of s. DWD 81.13.

#### **(14) SPECIFIC TREATMENT GUIDELINES FOR MUSCLE PAIN SYNDROME**

(a) A health care provider shall use initial nonsurgical management for all patients with muscle pain syndromes and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a).

(b) Surgery is not necessary for the treatment of muscle pain syndromes.

(c) If the patient continues with symptoms and objective physical findings after initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life or living, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management with patients with muscle pain syndromes shall be provided under the guidelines of s. DWD 81.13.

#### **(15) SPECIFIC TREATMENT GUIDELINES FOR LOWER EXTREMITY IMPINGEMENT SYNDROME**

(a) A health care provider shall use initial nonsurgical management for all patients with lower extremity impingement syndrome without clinical evidence of surrounding tissue damage or tears, and this shall be the first phase of treatment. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11) (a) except for the following:

1. Continued nonsurgical management may be inappropriate, and early surgical evaluation may be necessary, for patients with any of the following:
  - a. Clinical findings of any surrounding tissue tears.
  - b. Acute rupture of any tendon or tendons.

2. Use of home-based treatment modalities with monitoring by a health care provider may continue up to 6 months. At any time during this period the patient may be a candidate for chronic management if surgery is ruled out as necessary treatment.

(b) If the patient continues with symptoms and objective physical findings after 6 months of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life or living, including regular vocational activities, then surgical evaluation or chronic management is necessary. Surgical evaluation and surgical therapy shall meet all the guidelines of sub. (11) (b), with any of the following modifications:

1. Surgical evaluation shall begin no later than 6 months after beginning initial nonsurgical management.
2. Diagnostic injection, arthrography, computed tomography-arthrography, or magnetic resonance imaging scanning may be necessary as part of the surgical evaluation.
3. Any/ all surgical procedures that are appropriate and accepted as part of the medical community relating to impingement surgery or repair including but not limited to, impingement of a tendon, nerve or other, excision of bony protuberance, removal of adhesions or excision of a damaged bursa, all of which meet the guidelines of s. DWD 81.12 (3).

(c) If the patient continues with symptoms and objective physical findings after surgery, or the patient refused surgery or was not a candidate for surgery, and if the patient's condition prevents the resumption of regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with any lower extremity impingement syndrome shall be provided under the guidelines of s. DWD 81.13.

#### **(16) SPECIFIC TREATMENT GUIDELINES FOR TRAUMATIC SPRAINS AND STRAINS OF THE LOWER EXTREMITY**

(a) A health care provider shall use initial nonsurgical management for the first phase of treatment for all patients with traumatic sprains and strains of the lower extremity without evidence of complete tissue disruption. Any course or program of initial nonsurgical management shall meet all the guidelines of sub. (11).

(b) Surgery is not necessary for the treatment of traumatic sprains and strains unless there is clinical evidence of complete tissue disruption. Patients with complete tissue disruption may need immediate surgery and would be warranted if indicated and recommended by the appointed primary treating health care provider or the health care provider assisting within the chain of referral.

(c) If the patient continues with symptoms and objective physical findings after 12-weeks of initial nonsurgical management and if the patient's condition prevents the resumption of the regular activities of daily life or living, including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management for patients with traumatic sprains and strains shall be provided under the guidelines of s. DWD 81.13.