Health Care Provider Advisory Committee
Meeting Minutes
Webex Conference Meeting
May 5, 2023
DRAFT

Members Present: John Bartell, RN; Theodore Gertel, MD; Richard Goldberg, MD; Steven Peters (Chair); Jennifer Seidl, PT; Kelly Von-Schilling Worth, DC; and Nicole Zavala.

Excused: David Bryce, MD; Andrew Floren, MD; Barbara Janusiak, RN; David Kuester, MD; and Timothy Wakefield, DC.

Staff Present: Jim O'Malley, Kelly McCormick, Laura Przybylo, Frank Salvi, MD, and Sean Spencer.

1. Call to Order/Introductions: Mr. Peters, convened the Health Care Provider Advisory Committee (HCPAC) meeting at approximately 10:05 a.m., in accordance with Wisconsin's open meetings law, and called the roll. A quorum of the members was not present.

2. Acceptance of the January 20, 2023 meeting minutes: Deferred.

3. Future meeting dates: The HCPAC members agreed to schedule the next meeting on August 4, 2023 as a virtual meeting. Tentative meeting dates of October 6, 2023 and January 19, 2024 were also selected.

4. Recap of work on minimum PPD ratings in s. DWD 80.32 of the Wisconsin Administrative Code: Mr. O'Malley and Mr. Peters thanked the members for their time and effort in thoroughly reviewing the minimum permanent partial disability (PPD) ratings and making recommendations to update the current ratings. The Worker's Compensation Advisory Council is considering the recommendations as part of this biennium's Agreed Upon Bill process and may have additional questions for the HCPAC.

5. Review of ch. DWD 81 of the Wisconsin Administrative Code including section covering treatment of lower extremities: The HCPAC members resumed review of ch. DWD 81 with the language proposed to add a section specific to the lower extremity as s. DWD 81.091. The following recommendations were made:

To create s. DWD 81.091 (1) (f):

(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.

To create s. DWD 81.091 (1) (g):

(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
5. Somatosensory evoked potentials and motor evoked potentials.

To create s. DWD 81.091 (1) (h):

(h) 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, or physical or occupational therapy evaluation or treatment. A health care provider may order computerized range of motion or strength measuring tests during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program.

To create s. DWD 81.091 (1) (i):

(i) A health care provider may order psychological 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 in order 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. The health care provider performing the evaluation shall consider all of the following:

1. Is symptom magnification occurring?
2. Does the patient exhibit an emotional reaction to the injury, such as depression, catastrophizing, fear, or anger, that is interfering with recovery?
3. Does the patient have an elevated Adverse Childhood Experiences (ACE) score?
4. Are there other psychological factors or disorders that are interfering with recovery?
5. Does the patient have a substance use disorder?
6. Are there any interpersonal conflicts interfering with recovery?
7. Does the patient have a pain disorder with related psychological factors?
8. In cases in which surgery is an appropriate treatment, are psychological factors likely to interfere with the potential outcomes of the surgery?

To create s. DWD 81.091 (1) (j):

(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).

To create s. DWD 81.091 (1) (k):

(k) Functional capacity evaluation is a comprehensive and objective assessment of a patient’s ability to perform work tasks. The components of a functional capacity 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

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. A functional capacity evaluation is not typically necessary during the period of initial management.
2. A functional capacity evaluation may be appropriate in any of the following circumstances:
a. To delineate the patient's physical capabilities.
b. To provide information about the patient's ability to do a specific job.
3. A functional capacity evaluation is not the appropriate tool to establish baseline performance before treatment.
4. A health care provider may direct only one completed functional capacity evaluation per injury unless one or more of the following exceptions exist at which time another functional capacity evaluation may be appropriate:
a. An exacerbation of the injury occurs.
b. A major change in the patient's health status occurs.
c. The patient undergoes surgery that significantly changes the patient's physical status.
d. If the initial functional capacity evaluation was for a particular job and there is a change in the job to which the patient is returning.
e. Final determination of PPD is necessary.

To create s. DWD 81.091 (1) (L):

(L) Consultations with other health care providers may be initiated at any time by a treating health care provider consistent with accepted medical practice.

To create s. DWD 81.091 (2):

(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.
3. Subsection (13) governs lower extremity nerve syndromes.
4. Subsection (14) governs lower extremity musculoskeletal 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 if the new clinical information is causally related to the initial mechanism of injury. Bases for changing the clinical category include 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 at the same visit, if possible, to all necessary areas.

(d) In general, a course of treatment shall be divided into the following 4 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. To continue initial nonsurgical treatment, it shall result in progressive improvement as specified in subs. (9).

2. Second, for patients with symptoms persisting beyond 6 weeks who are not progressing towards functional restoration, a reassessment shall be performed looking for barriers to recovery. This may include but is not limited to reconsidering the diagnosis and/or evaluating psychosocial issues or motivational factors as specified in sub. (1)(i). The treatment plan shall then be modified accordingly.

3. Third, after consideration of sub 2., patients with persistent symptoms may be considered for 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.

4. Fourth, for those patients who are not candidates for surgery or refuse surgery, or who do not have adequate recovery of function 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.

To create s. DWD 81.091 (3):

(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 a total of 12 weeks of continuous or interrupted treatment 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 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, but only after a documented assessment of response to treatment and ongoing or persistent need.

3. A health care provider documents in the medical record a plan to encourage self-efficacy 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 surgical or chronic pain evaluation required by this chapter.
6. Passive care is not recommended for patients with chronic pain syndrome.
7. An aggravation or exacerbation of the initial injury that limits a patient's function may warrant additional episodes of passive treatment in conjunction with active treatment.

(c) *Adjustment or manipulation of joints*. For purposes of this paragraph, "adjustment or manipulation of joints" includes chiropractic and osteopathic adjustments or manipulations and physical therapy manipulations. All the following guidelines apply to adjustment or manipulation of joints:
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 2 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 of 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 3 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 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, heating pads, ice packs, cold soaks, and other durable medical equipment 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 stimulation.* For purposes of this paragraph, "electrical stimulation" includes galvanic stimulation, transcutaneous electric nerve stimulation, interferential and microcurrent techniques. All the following guidelines apply to electrical stimulation:
1. Electrical stimulation given in a clinical setting:
a. Time for treatment response is 3 to 5 treatments.
b. Maximum treatment frequency is up to 5 times per week for the first one to 3 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 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 3 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 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 3 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 3 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" techniques consist of, but are not limited to connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, dry needling techniques and therapeutic massage. Manual therapy techniques may be applied to one or more regions. All of 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 2 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 2 weeks shall be accompanied by active motion exercises to avoid stiffness of the uninvolved tissues and prolonged disability. 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.

(L) *Photo or laser or light therapy.* Photo or laser or light therapy uses light with specific characteristics, primarily wavelength, power, and delivery mode to provide photons of light to cellular tissue to treat specific medical conditions. The main responses to photo or laser or light therapy are pain reduction, inflammation reduction, and accelerated tissue healing.

To create s. DWD 81.091 (4):

(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 as with passive treatment modalities as long as acceptable reasons, as set forth in s. 81.04 (5), are documented.

(b) Education shall include teaching the patient about pertinent anatomy and physiology as it relates to lower extremity function for the purpose of injury prevention. Patient education includes training on posture, biomechanics, and relaxation. Patient education shall be ongoing and reflected through active treatment modalities.

(c) Posture and work method training shall instruct the patient in the proper performance of job activities based on essential job duties as reported by the employer. Topics include proper positioning of the trunk, neck, and upper and lower extremities, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, exercises, and simulated work tasks. This is an ongoing part of treatment and is reflected through active treatment modalities.

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

(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, aerobic capacity, muscle relaxation, range of motion, kinesthetic sense, balance, coordination, posture, proprioception, self-care, home management, and/or to improve functional performance. Exercise shall, at least in part, be specifically aimed at the musculature that impacts function 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, endurance, range of motion, balance, or functional performance 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 of the following guidelines apply to supervised exercise:

a. Maximum treatment frequency is 5 times per week for the first week, 3 times per week for the next 2 weeks, and decreasing in frequency after the third week until the end of the maximum treatment duration period in subd. 1. b.

b. Maximum duration is 12 weeks.

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

To create s. DWD 81.091 (5):

(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 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.
4. Health care providers shall educate, instruct, and actively encourage patients to utilize myofascial self-care techniques in conjunction with trigger point injections.

(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. Ideally the treatment is administered within the first 6 to 8 weeks.
2. Time for treatment response is within one week.
3. 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.
4. Maximum treatment is 2 injections to any one site over the course of treatment.

To create s. DWD 81.091 (6):

(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. Twelve 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. Eight 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).

To create s. DWD 81.091 (7):

(7) CHRONIC MANAGEMENT. Chronic management of lower extremity disorders shall be provided according to the guidelines in s. DWD 81.13.

To create s. DWD 81.091 (8):

(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, active-assisted range of motion devices, or supports may be necessary as specified in sub. (3) (i).

(c) For patients using an electrical 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 but not limited to, bicycles, treadmills, stair climbers, and weight machines, 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. 'Indications.' 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 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.
3. Magnetic devices.

To create s. DWD 81.091 (9):

(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 par. (c) or (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.

To create s. DWD 81.091 (10):

(10) MEDICATION MANAGEMENT. (a) Prescription of controlled substance medications scheduled under ch. 450, Stats., including opioids, are necessary primarily for the treatment of severe acute pain, when non-narcotic medications and other modalities have failed. Therefore, these medications are not generally recommended in the treatment of patients with lower extremity disorders. When used, they shall be prescribed in accordance with the Wisconsin Examining Board Opioid Prescribing Guideline as authorized in ch. 448, subch. II, Stats. Prescribers shall comply with the requirements stipulated in s. 961.385, Stats., regarding the Prescription Drug Monitoring Program.

(b) A health care provider shall document the rationale for the use of any controlled substances. 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 that ongoing medication is effective treatment for the patient's condition.

(c) Corticosteroids shall be prescribed in a manner consistent with standards of medical practice for the patient's condition.

To create s. DWD 81.091 (11):

(11) ADDITIONAL 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 active, passive, 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 to 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 include active treatment modalities under sub. (4).

2. Initial nonsurgical management shall be provided in the least intensive setting consistent with standards of medical 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 caused by the injury, 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 primary treating physician responsible for the treatment being provided. The 12-week rule as described in s. DWD 81.091 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 s. DWD 81.091 (3) and (4). Further, DWD 81.04 (5) a.-e., 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 health care provider, beyond the 12-week period.

4. The monitoring of home-based treatment modalities by the treating health care provider may continue for up to 4 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 living, 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. If initial nonsurgical management fails, surgery may be indicated.

2. If initial nonsurgical management fails or the patient does not wish to proceed with surgery, or if surgery is not indicated, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

3. Surgical evaluation may include the use of appropriate laboratory testing, electrodiagnostic testing, and diagnostic imaging within the guidelines of sub. (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 in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

4. Surgical evaluation may also include 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 initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition.

6. Medical imaging procedures may 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). Other medical diagnostic imaging may be indicated on a case-by-case basis.

To create a corresponding section on fractures and dislocations in the upper extremity as is proposed in s. DWD 81.091:

1. Create s. DWD 81.09 (2) 7.:

7. Subsection (17) governs fractures and dislocations of the upper extremity.

2. Create s. DWD 81.09 (17):

(17) ADDITIONAL 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 upper extremity practices shall be followed as stated in s. DWD 81.12 (2). Nonsurgical management shall be the first phase of care or treatment.

1. The active, passive, 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 to 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 include active treatment modalities under sub. (4).

2. Initial nonsurgical management shall be provided in the least intensive setting consistent with standards of medical 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 caused by the injury, or the severity of the dislocation. Therefore, the 12-week period will be subject to the day of removal of casting or splinting/ bracing, that is provided by the health care provider or the primary treating physician responsible for the treatment being provided. The 12-week period as described in s. DWD 81.09 for upper 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 s. DWD 81.09 (3) and (4). Further, DWD 81.04 (5) a.-e., 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 health care provider, beyond the 12-week rule.

4. The monitoring of home-based treatment modalities by the treating health care provider may continue for up to 4 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 living, 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. If initial nonsurgical management fails, surgery may be indicated.

2. If initial nonsurgical management fails or the patient does not wish to proceed with surgery, or if surgery is not indicated, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

3. Surgical evaluation may include the use of appropriate laboratory testing, electrodiagnostic testing, and diagnostic imaging within the guidelines of sub. (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 in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

4. Surgical evaluation may also include 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 initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition.

6. Medical imaging procedures may 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).

(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.

To update language in s. DWD 81.09 (11) (b) 1. through 7. to be consistent with proposed language for lower extremity:

1. ~~Surgical evaluation, if necessary, shall begin no later than 12 months after beginning initial nonsurgical management.~~ If initial nonsurgical management fails, surgery may be indicated.

2. If initial nonsurgical management fails or the patient does not wish to proceed with surgery, or if surgery is not indicated, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.

~~2~~3. Surgical evaluation may include the use of appropriate laboratory testing, ~~and~~ electrodiagnostic testing, and diagnostic imaging within the guidelines of sub. (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 in itself would warrant further testing. Failure to improve with therapy does not, by itself, warrant further testing.

~~3. Plain films may be appropriate if there is a history of trauma, infection, or inflammatory disorder and are subject to the general guidelines in s. DWD 81.05 (1). Other medical imaging studies are not 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 initial nonsurgical management. The need for consultation and the choice of consultant will be determined by the diagnostic findings and the patient's condition.

6. Medical imaging procedure may 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).

~~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, then the patient is a candidate for chronic management. An initial recommendation or decision against surgery does not preclude surgery at a later date.~~

Update to add lower extremities references in other sections:

1. In sections DWD 81.06 (4), 81.07 (4), and 81.09 (4) update to:

   (c) Posture and work method training shall instruct the patient in the proper performance of job activities based on essential job duties as reported by the employer. Topics include proper positioning of the trunk, neck and ~~arms~~ upper and lower extremities, 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.~~ This is an ongoing part of treatment and is reflected through active treatment modalities.

2. In s. DWD 81.08(4) update to:

   (c) Posture and work method training shall instruct the patient in the proper performance of job activities based on essential job duties as reported by the employer. Topics include proper positioning of the trunk, back and ~~arms~~ upper and lower extremities, 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.~~ This is an ongoing part of treatment and is reflected through active treatment modalities.

Update newly created language in s. DWD 81.09 (10) (c) for consistency with lower extremity language to:

(c) Corticosteroids shall be prescribed in a manner consistent with standards of medical practice for the patient's condition.

Update language in s. DWD 81.09 (11) (a) 2. to be consistent with proposed language for lower extremity:

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

Update language in s. DWD 81.09 (14) to be consistent with proposed language for lower extremity to:

(b) Surgery is not necessary for the treatment of ~~muscle~~ musculoskeletal pain syndromes where there is no structural pathology.

6. New Business: None.

7. Adjournment: A motion to adjourn was made by Dr. Von-Schilling Worth and seconded by Ms. Seidl. The meeting was adjourned at approximately 12:50 p.m. The next meeting is scheduled for August 4, 2023.