



RULE XVII, EXHIBIT B

**Upper Extremity
Medical Treatment Guidelines 1995**

(Revised March 15, 1998)

presented by:

**State of Colorado
Department of Labor and Employment
DIVISION OF WORKERS' COMPENSATION**



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INTRODUCTION

This document has been prepared by the Colorado Department of Labor and Employment, Division of Workers' Compensation (Division) and should be interpreted within the context of guidelines for physicians/providers treating individuals qualifying under Colorado's Workers' Compensation Act as injured workers with upper extremity involvement.

Although the primary purpose of this text is educational, these guidelines are enforceable under the Workers' Compensation Rules of Procedure, 7 CCR 1101-3. The Division recognizes that acceptable medical practice may include deviations from these guidelines. Therefore, these guidelines are not relevant as evidence of a provider's legal standard of professional care.

**To properly utilize this document, the reader
should not skip nor overlook any sections.**

I. GENERAL GUIDELINE PRINCIPLES

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

- A. **APPLICATION OF GUIDELINES:** The Division provides procedures to implement medical treatment guidelines and to foster communication to resolve disputes among the provider, payer and patient through the Workers' Compensation Rules of Procedure, Rule XVII and Rule VIII. In lieu of more costly litigation, parties may wish to seek administrative dispute resolution services through the Division.
- B. **EDUCATION:** Education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of lower extremity pain and disability. Currently, practitioners often think of education last, after medications, manual therapy and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention.
- C. **TREATMENT PARAMETER DURATION:** Time frames for specific interventions commence once treatments have been initiated, not on the date of injury. Obviously, duration will be impacted by patient compliance, as well as availability of services. Clinical judgement may substantiate the need to accelerate or decelerate the time frames discussed in this document.
- D. **ACTIVE INTERVENTIONS:** Interventions emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.
- E. **ACTIVE THERAPEUTIC EXERCISE PROGRAM:** Exercise program goals should incorporate patient strength, endurance, flexibility, coordination, and education. This includes functional application in vocational or community settings.

- F. POSITIVE PATIENT RESPONSE:** Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range-of-motion, strength, endurance, activities of daily living, cognition, psychological behavior, and efficiency/velocity measures which can be quantified. Subjective reports of pain and function should be considered and given relative weight when the pain has anatomic and physiologic correlation. Anatomic correlation must be based on objective findings.
- G. RE-EVALUATE TREATMENT EVERY 3-4 WEEKS:** If a given treatment or modality is not producing positive results within 3-4 weeks, the treatment should be either modified or discontinued. Reconsideration of diagnosis should also occur in the event of poor response to a seemingly rational intervention.
- H. SURGICAL INTERVENTIONS:** Surgery should be contemplated within the context of expected functional outcome and not purely for the purpose of pain relief. The concept of "cure" with respect to surgical treatment by itself is generally a mis-nomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course and diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s).
- I. SIX-MONTH TIME FRAME:** Since the prognosis drops precipitously for returning an injured worker to work once he/she has been temporarily totally disabled for more than six months. The emphasis within these guidelines is to move patients along a continuum of care and return-to-work within a six-month time frame, whenever possible. It is important to note that time frames may not be pertinent to injuries which do not involve work-time loss or are not occupationally related.
- J. RETURN-TO-WORK:** Even if there is residual chronic pain, return-to-work is not necessarily contraindicated. Return-to-work may be therapeutic, assuming the work is not likely to aggravate the basic problem or increase long-term pain. The practitioner must write detailed restrictions when returning a patient to limited duty. The following functions should be considered and modified as recommended: lifting, pushing, pulling, crouching, walking, using stairs, bending at the waist, awkward and/or sustained postures, tolerance for sitting or standing, hot and cold environments, data entry and other repetitive motion tasks, sustained grip, tool usage and vibration factors. The patient should never be released to "sedentary or light duty" without specific physical limitations. The practitioner must understand all of the physical demands of the patient's job position before returning the patient to full duty and should request clarification of the patient's job duties. Clarification should be obtained from the employer or, if necessary, including, but not limited to, an occupational health nurse, occupational therapist, vocational rehabilitation specialist, or an industrial hygienist.

- K. DELAYED RECOVERY:** Strongly consider a psychological evaluation, if not previously provided, as well as initiating inter-disciplinary rehabilitation treatment and vocational goal setting, for those patients who are failing to make expected progress 6-12 weeks after an injury. The Division recognizes that 3-10% of all industrially injured patients will not recover within the timelines outlined in this document despite optimal care. Such individuals may require treatment beyond the limits discussed within this document, but such treatment will require clear documentation by the authorized treating practitioner focusing on objective functional gains afforded by further treatment and impact upon prognosis.

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