WEST VIRGINIA
SECRETARY OF STATE
JOE MANCHIN, III
ADMINISTRATIVE LAW DIVISION

Form #1

Do Not Mark In This Box

FILED

2004 OCT 19 P 3:15

OFFICE WEST VIRGINIA
SECRETARY OF STATE

NOTICE OF A PUBLIC HEARING ON A PROPOSED RULE

AGENCY: Workers' Compensation Commission TITLE NUMBER: 85

RULE TYPE: Exempt Legislative CITE AUTHORITY: W. Va. Code§§23-1-1a(j)(3), 23-4-3b(b)

AMENDMENT TO AN EXISTING RULE: YES X NO ____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 20

TITLE OF RULE BEING AMENDED: MEDICAL MANAGEMENT OF CLAIMS, GUIDELINES FOR IMPAIRMENT EVALUATIONS, EVIDENCE, AND RATINGS, AND RANGES OF PERMANENT PARTIAL DISABILITY AWARDS

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: ____

TITLE OF RULE BEING PROPOSED: ____

DATE OF PUBLIC HEARING: November 19, 2004 TIME: 1:00 p.m.

LOCATION OF PUBLIC HEARING: Rooms 207-209
Charleston Civic Center
Charleston, West Virginia
**Comments will close at the end of the public hearing on this rule. Comments will be limited to the sections of this rule that are proposed to be amended.

COMMENTS LIMITED TO: ORAL ____, WRITTEN ____, BOTH X

COMMENTS MAY ALSO BE MAILED TO THE FOLLOWING ADDRESS:

T. J. Obrokta
Executive Offices
Workers' Compensation Commission
~~4700 MacCorkle Avenue, S.E.~~
Charleston, WV 25304
Fax # (304) 926-5372

The Department requests that persons wishing to make comments at the hearing make an effort to submit written comments in order to facilitate the review of these comments.

The issues to be heard shall be limited to the proposed rule.

ATTACH A **BRIEF** SUMMARY OF YOUR PROPOSAL

Authorized Signature

$20.20

Workers' Compensation Commission
Insuring a Working West Virginia
Gregory A. Burton, Executive Director

Office of General Counsel
4700 MacCorkle Avenue, S. E.
Charleston, West Virginia 25304
Phone Number (304) 926-3423
Fax Number (304) 926-5441

October 19, 2004

The Honorable Joe Manchin III
Secretary of State
State Capitol Complex
Building 1, Room W-157
Charleston, West Virginia 25305

Re: Proposed Rule
Title 85, Series 20
"Medical Management of Claims, Guidelines for Impairment Evaluations, Evidence, and Ratings, and Ranges of Permanent Partial Disability Awards"

Dear Secretary Manchin:

Please consider this letter to be my written approval for the filing of the above-noted proposed Rule.

Pursuant to Senate Bill 2013, Second Extraordinary Session, 2003, the Workers' Compensation Commission is established as a government entity separate from the Bureau of Employment Programs. Pursuant to that same bill, the Board of Managers of the Workers' Compensation Commission have approved the enclosed 85 C.S.R. 20 entitled, "Medical Management of Claims, Guidelines for Impairment Evaluations, Evidence, and Ratings, and Ranges of Permanent Partial Disability Awards," for filing as a proposed rule of the Workers' Compensation Commission.

Thank you very much for your assistance in this matter.

Very truly yours,

Gregory A. Burton
Executive Director

Enclosure

FISCAL NOTE FOR PROPOSED LEGISLATIVE RULES

Rule Title: Title 85 Series 20: Addition of Section 34 - Treatment Guidelines: Functional Capacity Evaluations: Work Conditioning and Work Hardening Rehabilitation Programs & addition of Section 70 - Injured Employees' Responsibilities Concerning Medical Examinations and Treatment

Type of Rule: X Legislative Exempt ___Interpretive ___Procedural

Agency: Workers' Compensation Commission

Address: 4700 MacCorkle Avenue, S.E.

Charleston, WV 25301

1. Effect of Proposed Rule

	Annual		Fiscal Year		
	INCREASE	DECREASE	CURRENT	NEXT	THEREAFTER
ESTIMATED TOTAL COST	Unknown	Unknown	Unknown	Unknown	Unknown
PERSONAL SERVICES	0	0	0	0	0
CURRENT EXPENSE	0	0	0	0	0
REPAIRS & ALTERNATIONS	0	0	0	0	0
EQUIPMENT	0	0	0	0	0
OTHER: Claims expense	Unknown	Unknown	Unknown	Unknown	Unknown

2. Explanation of above estimates:

Implementation of the proposed rule changes will require additional costs to complete the functional capacity evaluations required by the rule for permanent total disability evaluations. However, there should be a reduction in medical treatment costs incurred and disability benefits paid for certain job-related injuries as a result of the determinations made from the functional capacity evaluations. Work hardening and work conditioning programs are designed to return the injured worker to employment as soon as possible. Additional savings may also result from benefits that are suspended due to injured workers refusing medical examination and treatment without good cause. With no historical data readily available to estimate the anticipated costs and savings, it cannot be reasonably determined the annual amount of additional costs that will be incurred for functional capacity evaluations or to estimate the amount of savings in claims related expenses realized from any medical cost efficiencies and reductions in disability awards that result from implementing the proposed rule changes.

Rule Title: Title 85 Series 20: Addition of Section 34 - Treatment Guidelines: Functional Capacity Evaluations: Work Conditioning and Work Hardening Rehabilitation Programs & addition of Section 70 - Injured Employees' Responsibilities Concerning Medical Examinations and Treatment

3. Objectives of this rule:

The additional provisions amend the rule for policies and procedures of the Workers' Compensation Commission for claims related medical treatment and guidelines by adding treatment guidelines for functional capacity evaluations and work conditioning and work hardening rehabilitation programs and establishing the responsibilities of injured employees concerning medical examinations and treatment.

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

This rule should reduce the amount of medical and disability benefits payments incurred on certain claims. It is also expected that this rule will marginally increase the Commission's administrative expenses of tracking functional capacity evaluations and work hardening and work conditioning programs and monitoring the responsibilities of injured employees concerning medical examinations and treatment for the related claims.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

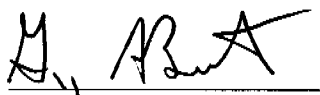
It is expected that employers will benefit from the monitoring and review of medical costs resulting from the addition of functional capacity evaluations and work hardening and work conditioning programs and the required medical examinations and treatments for certain disability claims. Claimants should benefit from better medical utilization resulting from implementation of the prescribed evaluations and treatments of injuries as well as assist in their return to work.

C. Economic Impact on Citizens/Public at Large.

This rule will not have a direct economic impact on the citizens of West Virginia.

Date: October 19, 2004

Signature of Agency Head or Authorized Representative



Gregory A. Burton
Executive Director, Workers' Compensation Commission

SUMMARY OF PROPOSED RULE
STATEMENT OF CIRCUMSTANCES
TITLE 85, SERIES 20

Medical Management of Claims, Guidelines for Impairment Evaluations, Evidence, and Ratings, and Ranges of Permanent Partial Disability Awards

West Virginia Code Section 23-4-3b(b) requires the Workers' Compensation Board of Managers to promulgate a rule establishing the process for the medical management of claims and awards of disability which includes, but is not limited to, reasonable and standardized guidelines and parameters for appropriate treatment, expected period of time to reach maximum medical improvement and range of permanent partial disability awards for common injuries and diseases or, in the alternative, which incorporates by reference the medical and disability management guidelines, plan or program being utilized by the commission for the medical and disability management of claims, with the requirements, standards, parameters and limitations of such guidelines, plan or program having the same force and effect as the rule promulgated in compliance herewith. This Rule satisfies this statutory requirement. See also, West Virginia Code Sections 23-1-1(b); 23-1-1a(j)(2), (3), (9), and 13); 23-1-1a(j)(13); 23-1-1b(g)(25); 23-1-13; 23-4-1(c), (d), (f), and (i); 23-4-1g; 23-4-3; 23-4-1d; 23-4-3c; 23-4-6; 23-4-7; 23-4-7a; 23-4-8; 23-4-8b; 23-4-8c; and 23-4-16.

This proposed rule amends certain provisions of the existing rule that was filed on May 14, 2004, and which became effective on June 14, 2004.

The amendments add three new sections to the rule. The new sections provide rules related to functional capacity evaluations, work hardening and conditioning programs and refusals to attend examinations.

The Commission proposes amendments to this Rule to further comply with the Legislative directive.

85 CSR 20

TITLE 85

EXEMPT LEGISLATIVE RULE

WORKERS' COMPENSATION COMMISSION

SERIES 20
MEDICAL MANAGEMENT OF CLAIMS, GUIDELINES FOR IMPAIRMENT EVALUATIONS, EVIDENCE, AND RATINGS, AND RANGES OF PERMANENT PARTIAL DISABILITY AWARDS

I. INTRODUCTION

§85-20-1. General.

1.1. Scope.— West Virginia Code Section 23-4-3b(b) requires the Workers' Compensation Board of Managers to promulgate a rule establishing the process for the medical management of claims and awards of disability which includes, but is not limited to, reasonable and standardized guidelines and parameters for appropriate treatment, expected period of time to reach maximum medical improvement and range of permanent partial disability awards for common injuries and diseases or, in the alternative, which incorporates by reference the medical and disability management guidelines, plan or program being utilized by the commission for the medical and disability management of claims, with the requirements, standards, parameters and limitations of such guidelines, plan or program having the same force and effect as the rule promulgated in compliance herewith. This Rule satisfies this statutory requirement. See also, West Virginia Code Sections 23-1-1(b); 23-1-1a(j)(2), (3), (9), and 13); 23-1-1a(j)(13); 23-1-1b(g)(25); 23-1-13; 23-4-1(c), (d), (f), and (i); 23-4-1g; 23-4-3; 23-4-1d;23-4-3c; 23-4-6; 23-4-7; 23-4-7a; 23-4-8; 23-4-8b; 23-4-8c; and 23-4-16.

1.2. Authority.— Pursuant to W. Va. Code, §23-1-1a(j)(3), rules adopted by the Workers Compensation Board of Managers are not subject to legislative approval as would otherwise be required under W. Va. Code, § 29A-3-1 et seq. Public notice requirements of that chapter and article, however, must be followed.

1.3. Filing Date - May 14, 2004.

1.4. Effective Date – June 14, 2004.

1.5. Repeal of former rules. – This exempt legislative rule repeals and replaces the following: 1) 85 C.S.R. 13, " Protocals and Procedures for Performing Medical Evaluations in Noise-Induced Hearing Loss Claims," filed in the Secretary of State's Office January 24, 1996 and made effective February 22, 1996; 2) 85 C.S.R. 16, "Guidelines for Permanent Impairment Evaluations, Evidence, and Ratings," filed in the Secretary of State's Office January 24, 1996 and effective February 26, 1996; 3) 85 C.S.R. 20, "Guidelines for the Treatment of Workers'

Compensation Injuries" filed in the Secretary of State's Office August 23, 1995 and effective October 1, 1995; 4) 85 C.S.R. 21, "Guidelines for Controlled Substances," filed in the Secretary of State's Office August 23, 1995 and made effective September 22, 1995; and 5) 85 C.S.R. 1, "Administration of the Workers' Compensation Fund," Sections 11, 14, and 20.

1.6. Filing Date of Amendments –

1.7. Effective Date of Amendments --

§85-20-2. Purpose of Rule.

2.1. The purpose of this rule is to implement the provisions of W. Va. Code. Section 23-4-3b(b) and the other provisions of the Code that are identified in Section 1.1 above.

§85-20-3. Definitions.

As used in these rules, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

3.1. "Code of West Virginia" and "West Virginia Code" means the West Virginia Code of 1931 as amended.

3.2. "Executive Director" means the Executive Director of the West Virginia Workers' Compensation Commission as provided pursuant to the provisions of W.Va. Code §23-1-1b.

3.3. "Commission" means the West Virginia Workers' Compensation Commission as provided for by W. Va. Code §23-1-1, et seq.

3.4. "Health Care Vendor" or "Health Care Provider" refers to health care providers, including providers of rehabilitation services within the meaning of W. Va. Code §23-4-9, both in- and out-of-state who have signed provider agreements with the West Virginia Workers' Compensation Commission to provide health care for injuries or illnesses covered by Chapter 23 of the Code. For this Rule, the terms shall mean any person, firm, corporation, partnership, association, agency, institution, or other legal entity providing any kind of services or equipment. The terms include, but are not limited to, hospitals, medical doctors, dentists, chiropractors, vocational rehabilitation counselors, vocational rehabilitation service providers, qualified rehabilitation professional, osteopathic physicians, pharmacists, podiatrists, physical therapists, occupational therapists, massage therapists, psychologists, naturopathic physicians, and durable medical equipment suppliers.

3.5. "Office of Judges" refers to the Office of Judges, as set forth in W. Va. Code §23-5-8.

3.6. "This rule" means the present exempt legislative rule that is designated in the caption here as title 85, series 20.

3.7. The following will be referred to throughout the rule by the abbreviation indicated.

a. Magnetic resonance imaging - MRI

b. Encephalogram - EEG

c. Computer Assisted Tomogram - CT scan

d. Electromyelogram – EMG

3.8. "Guides Fourth" means the "Guides to the Evaluation of Permanent Impairment," (4th ed. 1993), as published by the American Medical Association.

3.9. "Maximum medical improvement" means a condition that has become static or stabilized during a period of time sufficient to allow optimal recovery, and one that is unlikely to change in spite of further medical or surgical therapy.

3.10. "Permanent impairment" means a permanent alteration of an individual's health status and is assessed by medical means and is a medical issue. An impairment is a deviation from normal in a body part or organ system and its functioning. An injured worker's degree of permanent whole body medical impairment is to be determined in keeping with the determination of whole person permanent impairment as set forth in the applicable Guides. For the purposes of this Rule, the Guides' use of the term "whole person" impairment is the equivalent of the term "whole body" impairment.

3.11. Chart Notes: This type of documentation may also be referred to as "office" or "progress" notes or "narrative report." Providers must maintain charts and records in order to support and justify the services provided. "Chart" means a compendium of medical records on an individual patient. "Record" means dated reports supporting bills submitted to the department or self-insurer for medical services provided in an office, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service shall be entered in a chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible, and shall include, but are not limited to:

a. Date(s) of service;

b. Patient's name and date of birth;

c. Claim number;

d. Name and title of the person performing the service;

e. Chief complaint or reason for each visit;

f. Pertinent medical history;

g. Review of medication

h. Pertinent findings on examination;

i. Medications and/or equipment/supplies prescribed or provided;

j. Description of treatment (when applicable);

k. Recommendations for additional treatments, procedures, or consultations;

l. X rays, tests, and results; and

m. Plan of treatment/care/outcome.

3.12. "Injured worker" means an individual seeking to received benefits available under Chapter 23 of the Code and/or has received and/or is receiving benefits under Chapter 23 of the Code.

§85-20-4. Adoption of Standards and Acceptance of Rules.

4.1. The treatment guidelines, standards, protocols, and limitations thereon provided for the injuries and diseases listed in this section are designed to assist health care providers in the evaluation and treatment of injured workers. The provisions of this Rule are not intended to strictly dictate results and it is recognized that there may be extraordinary cases that require treatments in addition to the treatments set forth in this Rule. However the treatments and limitations on treatments set forth in this Rule are presumed to be medically reasonable and treatments in excess of those set forth in this rule are presumed to be medically unreasonable. A preponderance of evidence, including but not limited to, detailed and documented medical findings, peer reviewed medical studies, and the elimination of causes not directly related to a compensable injury or disease, must be presented to establish that treatments in excess of those provided for in this Rule are medically reasonable. To receive reimbursement from the Commission for treatment in excess of that provided for in this Rule, all providers must thoroughly document and explain the action taken and the basis for the deviation from this Rule and shall receive authorization before providing said treatment.

4.2. Except as provided for in section 5.11 of this Rule, providing treatment to an injured worker, filling prescriptions for an injured worker, and/or acceptance of payment for treatment, devices, or medications provided to an injured worker constitutes acceptance by the medical provider of the Commission's rules and fee schedules.

4.3. Failure of the medical provider to timely submit appropriately completed forms, failure to comply with this Rule or any fee schedule or billing guideline, as may be from time to time amended, and any attempt to seek reimbursement in excess of the levels provided for in this Rule may be considered as an abusive practice for purposes of West Virginia Code Section 23-4-3c and may be considered as evidence of conduct in violation of West Virginia Code Section 61-3-24g. All medical reports and fee bills must be signed by the medical vendor rendering the

services or his authorized representative. If the report or bill is not submitted electronically, the medical vendor's name must be legibly printed or typed beneath the signature.

II. PROVIDERS

§85-20-5. Qualified Providers and Registration

5.1. To receive payment as a health care provider, a provider must be enrolled as an active vendor with the Commission. Providers may be reimbursed only for services actually provided or supervised and for which the vendor is duly licensed. To enroll, the provider must submit the applicable application to the Commission, completed in its entirety, along with all documentation requested by the Commission, including, but not limited to, all professional licenses, board certificates, business licenses, accreditation certificates, and/or operating permits held by the provider in this or any other state. Providers must advise if their license to practice medicine has ever been suspended or terminated by the appropriate authority in West Virginia or any other state and whether the provider has been convicted of any crime in relation to his or her practice, or any felony. Providers with address or telephone number changes must advise the Commission in writing (by mail or facsimile), providing both old and new information and their tax identification number on letterhead.

5.2. Any provider who has had his or her license to practice medicine suspended or terminated by the appropriate authority in West Virginia or any other state, any provider who has been convicted of any crime in relation to his or her practice, or any felony, and/or any provider who has been suspended or terminated by the Commission pursuant to West Virginia Code Section 23-4-3c, or any other provision, may be excluded by the Commission in any managed care plan created by the Commission.

5.3. Providers must submit their usual and customary charges for commonly billed codes when applying for enrollment. If the provider is ultimately enrolled, the provider shall only be permitted to charge the provider's usual and customary charges, and not the maximum amount allowed under the Commission's fee schedule.

5.4. Licensed practitioners are eligible to treat injured workers to the extent of the practitioner's license certification. Providers not independently licensed must practice under direct supervision of a licensed health care professional whose scope of practice and specialty training includes service provided by the paraprofessional.

5.5. Reimbursement for care will only be authorized if the provider has provided documentation of credentialing consistent with the type of care provided.

5.6. A new Application is required if a provider's name or tax identification number changes. The Application must have the original signature of an authorized person and may be faxed initially to the Commission's Provider Registration unit. Activation is not official until a

complete signed application has been received and a confirmation letter is sent at that time. The hard-copy original must be sent to:

Workers' Compensation Commission
ATTN: Provider Registration
P.O. Box 4228
Charleston, WV 25364-4228

5.7. Registration as a Commission provider constitutes an agreement to:

a. Accept the Commission's fee schedule, as amended from time to time by the Commission;

b. Submit reports and to make continuing reports in a timely manner and as otherwise required and on forms required by the Commission, as from time to time amended;

c. Retain medical records, including, but not limited to, general medical records and X-Ray's, for ten (10) years and invoices, electronic or paper, for three years;

d. Timely and fully participate in all physical and vocational rehabilitation efforts of the Commission;

e. Accept all provisions of this Rule, and all policies, procedures, and other requirements adopted from time to time by the Commission; and

f. To remain updated and familiar with all medical billing instructions, and other rules, regulations, and procedures of the Commission.

5.8. Health Care Providers . Certain procedures performed by health care providers are reimbursable by the Commission only when providers have certification in accordance with W. Va. Code §30-16-20. Health care providers must provide evidence of certification if they wish to perform videofluroscopy, diagnostic ultrasound, electromyography, nerve conduction velocity studies, somatosensory testing, neuromuscular junction testing, and any other diagnostic testing identified by the Commission.

5.9. Independent Medical Examiners. Registered providers may apply to be recognized by the Commission as independent medical examiners, who provide independent examinations and recommend impairment ratings of injured workers. A separate application, Independent Medical Examiner Application, must be submitted and approved by the Commission. Approval shall only be granted if the applicant is board certified or board eligible, where such board exists. The Commission reserves the right, in its sole discretion, to direct the examinee to the examiner of its choosing. All independent medical examiners shall comply with all Commission policies and procedures as a pre-requisite to payment.

5.10. Out-of-State Providers. If an injured worker elects or is directed to receive health care services from an out-of-state provider, and that provider does not accept the Commission's fee as payment in full, then the injured worker may be liable for the difference between the Commission's payment and the amount charged by the out-of-state health care provider.

5.11. Given the above, it is essential that all physicians be aware of the injured worker's potential liability when selecting a referral, consulting, surgical, or other provider located in another state. Accordingly, all referrals should be to providers registered with the Commission and referrals to non-registered providers requires pre-authorization from the Commission. Unless the following exceptions apply, referral to an out-of-state provider will put the injured worker at risk for out-of-pocket payment for medical service.

a. Emergencies: Where there is an urgent need for immediate medical attention to prevent death or serious and permanent harm, the injured worker will not be personally liable for the difference between fee schedule and the amount charged by the out-of-state provider. The exception no longer applies when, after emergency admission, the injured worker attains a stable medical condition and can be transferred to either a West Virginia health care provider or an out-of-state health care provider who has agreed to accept the scheduled fee as payment in full. If the injured worker refuses to be transferred, then he or she will be personally liable for the difference in costs between the fee schedule amount and the amount charged by the provider for services after attaining medical stability.

b. No Nearby Qualified Provider: If no health care provider qualified to provide needed medical services and who has agreed to accept the Commission's fee schedule as payment in full is reasonably near to the injured worker's home, the injured worker may request authorization for an out-of-state provider. If the Commission authorizes medical services from the out-of-state provider, the injured worker will not be personally liable for the difference between fee schedule and the amount charged by the out-of-state provider.

III. PROVISION OF SERVICES

§85-20-6. The Role of the Treating Physician

6.1. Each injured worker selects a treating physician of record who will treat the injured worker and be responsible for coordinating all subsequent health care. The treating physician of record may be a medical doctor, osteopath, podiatrist, or chiropractor. Any treating physician who is limited in number of treatments by another provision of this Rule shall, upon exhaustion of that limit, only seek reimbursement as a treating physician for services provided in intervals consistent with those of other treating physicians. The injured worker should not seek care from more than one provider without contacting the Commission, requesting the designation of a different attending physician, and having that request approved. Injured workers whose employer's managed care plans have been approved by the Commission or who are covered by a

managed care plan adopted by the Commission shall chose a treating physician offered under the applicable plan.

6.2. Whenever possible, the treating physician should use the least costly mode of treatment. This generally will require that outpatient services be used in lieu of inpatient care and the avoidance of referring injured workers to hospital emergency rooms for care that can be rendered in the office. The Commission will approve payment for initial use of emergency room facilities and services such as routine dressings, routine tests, routine medications and routine local anesthesia. Subsequent use of the emergency room for services will not be approved without a statement from the physician explaining the necessity for the services rendered. Routine visits to the emergency room shall not be approved or reimbursed by the Commission.

6.3. Treating physicians should request referral of an injured workers who continues to report pain and dysfunction while showing no significant measurable or objective signs of improvement for a Permanent Partial Disability evaluation. Such injured workers may also be discharged or referred to a different, appropriate specialty for evaluation and possible modification of treatment.

6.4. When the treating physician finds the injured worker to be at maximum medical improvement, the treating physician may provide an impairment rating pursuant to applicable *Guidelines* for the injured worker. If the rating exceeds fifteen percent (15%), the Commission may accept or reject the rating and may order an independent evaluation of the injured worker. The treating physician may also report a finding of Maximum Medical Improvement without making an impairment rating, reported on Form WC-219a, "Notice of Maximum Medical Improvement."

6.5. The treating physician of record shall provide a treatment plan for the medical care being considered in narrative form as set forth in section 3.11 of this Rule.

6.6. It is the responsibility of the treating physician to notify the Commission of the injured worker's most accurate and current condition. The initial diagnosis reported when a claim is filed often requires updating based on diagnostic tests and clinical objective findings. Changes, additions and revisions of the injured worker's condition must be reported using the applicable Commission form. All changes related to a diagnosis code shall submitted to the Commission and must be approved by the Commission, unless the new diagnosis is otherwise accepted by the Commission as being causally related to the compensable injury. Bills submitted for treatment that is clearly unrelated to the compensable diagnosis shall be denied and may serve as evidence of abuse under West Virginia Code Section 23-4-3c and/or fraud under West Virginia Code Section 61-3-24g. The Commission may, in its sole discretion, recognize and identify the change, addition, or revision as a compensable condition.

6.7. Injured workers must request authorization from the Commission to change the treating physician of record in their claim. This rule does not apply in the following cases:

a. Care transferred after initial emergency or first aid treatment if done so within 30 days of the date of injury;

b. Care transferred to a specialist by the original treating physician; or

c. Care where an unforeseen emergency develops which requires special facilities and skills are not available to the treating physician or hospital.

6.8. Any change of treating physician that does not require authorization by the Commission will require a detailed explanation to ensure that the change is documented on the claim file. Failure to do so may result in the delay of benefits and will result in the denial of payment for medical services.

6.9. When a change of physician is authorized, the previous treating physician must file a final report of the injured worker's physical status on the effective date of change. The new treating physician of record must file an initial narrative report of his/her findings. It is the responsibility of every provider to make reasonable effort to ascertain whether there was a prior treating physician.

6.10. Except in cases where a consultant, anesthetist or surgical assistant is required, or the necessity for treatment by a specialist is clearly shown, fees not pre-authorized by the Commission will not be approved for treatment by more than one medical vendor for the same condition over the same period of time.

§85-20-7. Initial Reporting of Injury

7.1. It is the responsibility of the injured worker to notify the employer, Commission, and medical provider when there is reason to believe the injury or condition is industrial in nature. Conversely, if the medical provider discovers a condition which he or she believes to be work related or has reason to believe an injury is work related, he or she must so notify the injured worker. Once such a determination is made by either the injured worker or the medical provider, the appropriate form(s) must be immediately submitted. Failure of the medical provider to timely submit the appropriately completed forms may be considered as an abusive practice for purposes of West Virginia Code Section 23-4-3c. Failure of the injured worker to timely submit appropriately completed forms may be considered and given appropriate weight by the Commission in determining compensability or any other matter.

7.2. It is the medical provider's responsibility to ascertain whether he or she is the first attending practitioner. If so, the medical provider will take the following action:

a. Give emergency treatment.

b. Immediately complete and forward the Initial Report of Injury to the Commission and the employer.

c. Instruct and give assistance to the injured worker in completing his or her portion of the report of accident. The Initial report of Injury shall include a narrative report containing the following information so there is no delay in adjudication of the claim or payment of compensation:

1. Complete history of the industrial accident or exposure.

2. Comprehensive description of physical findings and prognosis.

3. Specific diagnosis with ICD-9-CM code(s) and narrative definition relating to the injury.

4. Type of treatment rendered.

5. Known medical, emotional or social conditions which may influence recovery or cause complications.

6. Estimated time loss due to the injury.

d. To the extent the information called for in (c)(1) – (c)(6) is not required on the Initial Report of Injury in use by the Commission on the effective date of this Rule, the medical provider shall complete the appropriate form in its entirety and provide the additional information in the form of a narrative report.

§85-20-8. Additional Reporting Requirements

8.1. Whenever requested by the Commission, and at least every ninety (90) days in situations regarding the continuation of temporary total disability benefits, the medical provider shall report on the condition and treatment of the injured worker. The following information must be included in this type of report.

a. The condition(s) diagnosed including ICD-9-CM codes and the objective and subjective findings.

b. Their relationship, if any, to the industrial injury or exposure.

c. Outline of proposed treatment program, its length, components, and expected prognosis including an estimate of when treatment should be concluded and condition(s) stable. An estimated return to work date should be included. The probability, if any, of permanent partial disability resulting from industrial conditions should be noted.

d. If the worker has not returned to work, the attending doctor should indicate whether a vocational assessment will be necessary to evaluate the worker's ability to return to work and why.

e. If the worker has not returned to work, a doctor's estimate of physical and functional capacities should be included with the report. If further information regarding physical and functional capacities is needed or required, a performance-based functional capacity evaluation can be requested. Functional capacity evaluations shall be conducted by a licensed health care provider approved by the Commission to perform this testing.

8.2. To the extent the information called for in Section 8.1 is not required on Attending Physician's Report in use by the Commission on the effective date of this Rule, the medical provider shall complete the Attending Physician's Report in its entirety and provide any additional information set forth in Rule 8.1 in the form of a narrative report.

8.3. The Commission may request, and the medical provider shall provide all chart notes relating to the evaluation and treatment of an injured worker.

8.4. The Commission, in its sole discretion, may require additional reporting on forms and in intervals as it deems necessary. Medical providers shall comply with the requests of the Commission in this regard. Failure to make reports promptly may result in the delay of payments of benefits to the injured worker and denial of payment to the medical vendors for services rendered.

8.5. By application for benefits, an injured worker irrevocably waives patient-physician confidentiality and agrees that treatment providers may release and discuss the injured worker's medical history and medical reports pertaining to the compensable injury or disease to the injured worker's employer, employer's representative, or representatives of the Commission, assuming such discussions are otherwise permissible under applicable law. Such discussion includes the injured worker's condition, treatment, prognosis, anticipated period of disability and dates when the injured worker will reach maximum medical improvement or be released to return to work. Any prior injury or disease of the injured worker which impacts the alleged injury or treatment is covered by this agreement.

8.6 In any claim where only medical benefits are being paid, the medical provider shall provide the report described in section 8.1 within thirty (30) days of being requested to do so by the Commission.

§85-20-9. Coverage and Billing Provisions

9.1. The Commission will pay for health care services, durable medical and other goods and other supplies and medically related items as may be reasonably required. The Commission will only pay for those services or items that have a direct relationship to the work related injury or disease, as determined in the sole discretion of the Commission.

9.2. A medical coverage decision is a general policy decision to be made in the sole discretion of the Commission, to include or exclude a specific health care service or supply as a covered benefit. These decisions are made to insure quality of care and prompt treatment of workers. Medical coverage decisions include, but are not limited to, decisions on health care services and supplies rendered for the purpose of diagnosis, treatment or prognosis, such as:

a. Ancillary services including, but not limited to, home health care services ambulatory services, specific rehabilitative modalities;

b. Devices;

c. Diagnostic tests;

d. Drugs, biologics, and other therapeutic modalities;

e. Durable medical equipment;

f. Procedures;

g. Prognostic tests;

h. Supplies; and

i. Inpatient hospital stays and associated charges

9.3. The Commission, with some exceptions, uses these nationally-accepted standardized code sets for reporting medical conditions and treatment and may adopt successor code sets without amendment to this rule:

a. Common Procedure Terminology (CPT-4) codes (HCPCS Level I codes), for provider professional services

b. Alpha-numeric codes (HCPCS Level II codes) for supplies, equipment and other medical services

c. Local Codes (HCPCS Level III) for unique Workers'-Compensation-specific services (NOTE: Use of these non-standardized codes is limited as much as possible)

d. International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) for reporting diagnoses of work-related injuries and occupational illnesses

e. Diagnostic related groups (DRG for in-patient hospital services)

f. Revenue codes for outpatient hospital based services

g. National drug codes (NDC) for pharmaceuticals

9.4. CPT-4 Codes (HCPCS Level I).

The Commission updates the vendor bill processing system to accept many of the new codes that are implemented nationally on an annual basis. This coding system, which uses a five-digit numeric code and allows for a two-digit modifier, is used to report most professional services, including Evaluation and Management, surgical intervention, anesthesia services related to surgery, physical medicine and other professional services.

9.5. HCPCS Level II National Alpha-numeric Codes.

The Commission accepts many of the codes developed by CMS for reporting those medical services and supplies not addressed by the CPT-4 code set. This coding system uses a five-digit alpha-numeric code, which consist of one alphabetic character (a letter between and including A and V), followed by four digits. The codes all begin with a single letter and are followed by four-digits. HCPCS codes also use modifiers, either two digits or two letters.

9.6. HCPCS Level III Local Codes.

The Level III codes are assigned and maintained by individual carriers. Like the HCPCS II National Codes, these codes begin with a letter (W through Z) followed by four numeric digits. The most notable difference is that these codes are not common to all carriers. Since 1999, the Commission has been eliminating the use of Local Codes wherever possible; however, there are still some local codes utilized by the Commission for services not normally reported by Medicare carriers.

9.7. ICD-9-CM Diagnosis Codes.

The Commission uses the ICD-9-CM coding system to report injured worker conditions in work-related injuries and occupational illnesses. Standard coding conventions shall be followed in reporting diagnosis. Payment will be denied for diagnosis judged, in the sole discretion of the Commission, to not be causally related to the compensable injury.

9.8. Written descriptions of procedures alone will not be accepted. Billing may be submitted on the CMS-1500 (formerly, HCFA 1500) and the CMS-1450 (formerly, UB-92), or the most current forms utilized by the Commission. Pharmacy charges should be submitted using the on-line Point-of-Sale system, but can also be reported on the Universal Claim Form, or the most current form utilized by the Commission. Certain non-standard services unique to the Commission require Service Invoice, Form WC-400, or the most current form(s) utilized by the Commission.

9.9. Pre-authorization. Written authorization must be obtained from the Commission in advance for the procedures and services listed below, except in emergencies or where the condition of the patient, in the opinion of the medical vendor, is likely to be endangered by delay. Failure to comply with this rule will result in disapproval of the medical vendor's bill. The vendor shall not seek reimbursement from the injured worker if payment is denied under this provision. This rule does not apply in cases involving initial treatment.

9.10. The following services *require* prior review and authorization before services are rendered and reimbursement made:

a. Inpatient hospitalizations subsequent to the Date of Injury (emergency admissions are reviewed on a retrospective basis);

b. Transfers from one hospital to another hospital (emergencies do not require authorization);

c. Reconstructive and restorative surgeries;

d. All surgeries;

e. Purchase of TENS unit above the amount of $50.00;

f. Treatment/supplies used in excess of three (3) months for TENS units;

g. Psychiatric treatment (does not include the initial psychiatric consultation);

h. Physical Medicine treatment in excess of this Rule;

i. Outpatient pain management procedures (epidural steroids, facet injections, etc.);

j. Medication not normally used in injury treatment and medication not listed on the preferred drug list, if applicable;

k. Medication - Controlled Substance (in excess of this Rule);

l. Durable Medical Equipment in excess of $500.00;

m. Brainstem evoked audiometry;

n. Repeat diagnostic studies (Workers' Compensation no longer requires approval for the initial MRI, CAT scan, Myelogram, EMG, and Nerve Conduction Studies);

o. Standard/analog hearing aids;

p. Programmable/digital hearing aids;

q. Replacement hearing aids;

r. Repair of hearing aids over the price of $250.00;

s. Hearing Aid batteries over the allowed quantity of 50 per 6 months;

t. Telephone amplification devices;

u. Hearing aid assistance products (V5299);

v. Non-emergency ambulance transportation;

w. Non-emergency air transportation;

x. All vision services and items associated with vision;

y. All physical and vocational rehabilitative services;

z. Retraining expenses;

aa. All oxygen equipment, supplies, and related services;

bb. All nursing, nursing home, and personal care services;

cc. Home or vehicle modifications;

dd. Work hardening;

ee. Work conditioning; and

ff. Dental procedures.

9.11. Prior-authorization requests shall be made in writing or electronically to the Commission for approval.

9.12. Medical services not specified above do not require prior approval but will be reviewed retrospectively to determine medical necessity. Services provided on an emergency basis are also subject to retrospective review to validate that the service was truly an emergency, and to determine medical necessity and relationship to the compensable injury.

9.13. Disposable/Non-reusable Supplies.

The Commission will reimburse for supplies prescribed by the authorized physician for use by the injured worker in the home setting which are reasonably required, as determined in the sole discretion of the Commission. Supplies include dressings, colostomy supplies, catheters, and other similar items. The injured worker's related diagnosis must be stated on the prescription form.

9.14. Durable Medical Equipment Exceptions.

The following durable medical equipment require prior-authorization, although reimbursed at less than $500:

a. E0585 Nebulizer with compressor;

b. E0607 Home blood glucose monitor;

c. E0610 Pacemaker monitor;

d. E0730 TENS, name brand;

e. E0731 Garment for TENS/neuromuscular;

f. E0745 Neuromuscular stimulator, electronic shock unit; and

g. E0935 Passive motion exercise device.

9.15. The Commission shall deny bills for services rendered in violation of these Rules. Injured workers may not be billed for services denied pursuant to this provision.

9.16. Bills must be itemized on department or self-insurer forms or other forms which have been approved by the Commission. Bills may also be transmitted electronically using Commission file format specifications. Providers using any of the electronic transfer options must follow Commission instructions for electronic billing.

9.17. Bills must specify the date and type of service, the appropriate procedure code, the condition treated, and the charges for each service.

9.18. Bills submitted to the Commission must be completed to include the following:

a. Injured worker's name and address;

b. Injured worker's claim number;

c. Date of injury;

d. Referring doctor's name;

e. Area of body treated, including ICD-9-CM code(s), identification of right or left, as appropriate;

f. Dates of service;

g. Place of service;

h. Type of service;

i. Appropriate code to report services provided (including CPT, DRG, NCD, revenue codes, etc.);

j. Description of service;

k. Charge;

l. Units of service;

m. Tooth number(s);

n. Total bill charge;

o. The name and address of the practitioner rendering the services and the provider account number assigned by the Commission;

p. Date of billing;

q. Submission of supporting documentation required by the Commission.

9.19. Responsibility for the completeness and accuracy of the description of goods and/or services and charges billed rests with the provider rendering the good or service, regardless of who actually completes the bill form.

9.20. Bills must be received within six (6) months of the date of service to be considered for payment. Injured workers cannot be billed for any invoice denied under this provision.

9.21. The following supporting documentation is required to have been received by the Commission before reimbursement for a service is made:

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

d. Office notes;

e. Consultation reports;

f. Special diagnostic study reports; and

g. Special or closing exam reports.

9.22. Requirements for payment of fees.

Fees for examination or treatment are approved only when made by the health care provider duly licensed to make such examination or to render such treatment, and then only when the medical vendor actually sees and examines the patient and actually renders or directly supervises such treatment.

9.23. Additional services and accommodations not reasonably required for treatment of the compensable injury but requested by the injured worker shall be the responsibility of the injured worker.

9.24. Failure on the part of the health care provider or other person, firm or corporation to submit fee bills to the Commission for services rendered within the statutory period prohibits collection thereof from the injured employee, the employer or the Commission.

9.25. Payment for drugs or medicine. The Commission may approve payment for drugs or medicines furnished to the injured worker as part of routine treatment rendered by the medical vendor. If unusual treatment is necessary, or if drugs or medicines are to be used by the injured worker at his home in the absence of the medical vendor, payment for a reasonable quantity of such drugs or medicines may be approved. Application for such payment must be accompanied by a statement of the medical vendor setting forth the necessity and purpose of the use of such drugs or medicines.

9.26. Use of appropriate codes to report services is required and up coding (reporting a higher level of service than can be substantiated or actually was performed) is prohibited. Reimbursement shall not be made for such billing and up coding may be considered evidence of abuse under West Virginia Code Section 23-4-3c and evidence of fraud under West Virginia Code Section 61-3-24g.

9.27. Prosthetics and Orthotics. Upon receipt of the attending medical vendor's report, the Commission may refer the injured worker to a medical vendor or a Rehabilitation Center for evaluation to determine the type of prosthesis most beneficial for the particular injured worker involved and whether the injured worker is in need of training in use of the prosthesis. Upon receipt of the medical recommendations, the Commission shall authorize the fitting of the recommended prosthesis. Payment shall not be approved until the prosthesis is determined to be serviceable and satisfactory. The requirement for prior approval for prosthesis shall not apply when the attending medical vendor utilizes the procedure of immediate amputation prosthetic application.

9.28. A durable medical equipment supplier is required to exercise due diligence to verify that equipment is in use, that supplies are needed, and that a valid request for supplies has been made. Due diligence requires, but is not limited to, a personal contact with the injured worker. Reimbursement shall be denied for failure to exercise this required due diligence and may be evidence of fraud or abuse under Chapters 23 and 61 of the West Virginia Code.

§85-20-10. Supplies.

HCPCS code A4550 (Surgical Trays) is a status B code and is not reimbursable for office procedures. Codes with a status B are bundled services for which no separate payment may be made. Supply costs are included in the global fee allowance for surgical procedures performed in an office setting. Code 99070 continues to be a non-covered, bundled code.

§85-20-11. Vision Care

Ophthalmologists and optometrists may use CPT codes for reporting procedures and professional services. Reimbursement for vision care equipment such as spectacles, contact lenses, etc., should be requested using appropriate HCPCS Level II codes. Repair or replacement

of vision care equipment damaged in an accident will not be approved for payment unless the injured worker suffers a compensable physical injury in the accident.

§85-20-12. Psychiatric/Psychological Services

12.1. Services may be approved to treat psychiatric problems only if they are a direct result of a compensable injury. As a prerequisite to coverage, the treating physician of record must send the injured worker for a consultation with a mental health care professional who shall examine the injured worker to determine 1) if a psychiatric problem exists; 2) whether the problem is directly related to the compensable condition; and 3) if so, the specific facts, circumstances, and other authorities relied upon to determine the causal relationship. The mental health care professional shall provide this information, and all other information required in section 8.1 of this Rule in his or her report. Failure to provide this information shall result in the denial of the additional psychiatric diagnosis. Based on that report, the Commission will make a determination, in its sole discretion, whether the psychiatric condition is a consequence that flows directly from the compensable injury.

12.2. A Diagnosis Update Form WC-214 must be attached to the treating physician's report in order to request the psychiatric condition be added as an approved diagnosis.

§85-20-13. Coverage Medication Checks.

Medication checks may be billed if needed, but should be reported using the appropriate Evaluation and Management or Drug Management procedure codes. Medication checks for psychiatric medication require the use of an ICD-9-CM code to identify the compensable mental health condition.

§85-20-14. Medication/Injections.

Professional services for administering injections to an injured worker in an office setting for the treatment of a compensable injury may be reimbursable. Effective January 1, 2003, the cost of medication administered through other-than-oral method may be billed as a separate line item using appropriate HCPCS II "J" codes. Legend drugs dispensed by physicians will not be reimbursed except in emergency situations.

§85-20-15. Dental Services.

15.1. Standard dental treatment necessary as a result of a compensable injury to the face or head is covered under the Workers' Compensation program. Repair or replacement of dentures and other dental appliances damaged in an accident will not be approved for payment unless the injured worker suffers a compensable physical injury in the accident. Except in cases of emergency, prior authorization must be obtained for any and all dental services provided.

15.2. The Commission will not approve payment for treatment of a preexisting dental deficiency or disease, unless it is clearly established that such preexisting condition is prohibiting treatment of or recovery from an industrial injury. In such cases the Commission must be provided with a complete report of the preexisting condition and authorization granted prior to rendering treatment.

§85-20-16. Experimental Procedures.

16.1. Services investigative or experimental in nature or unsafe and not accepted by the general medical community are not reimbursable by the Commission.

16.2. To be considered for reimbursement by the Commission, medical devices must have gone through FDA pre-market notification submission or pre-market approval application or be exempt for commercial distribution on the national level. Pre-market approval designation is preferred because this designation requires sufficient information to reasonably assure the safety and effectiveness of the device.

§85-20-17. Unusual treatment.

17.1. In cases requiring unusual treatment not contemplated under ordinary circumstances, the medical vendor must inform the Commission immediately of the condition or complications present. If the necessity for additional treatment and its causal relationship with the compensable injury is clearly indicated, authorization for such treatment may be granted by the Commission if it otherwise is deemed to be medically reasonable and additional professional fees may be paid at a rate commensurate with the services rendered in addition to the fee specified by the Commission.

17.2. New or experimental therapies always require prior authorization from the Commission. The Commission will require a detailed, credible and otherwise sufficient explanation of the anticipated outcomes of the proposed therapy. The Commission may authorize a trial of the therapy, for a duration identified by the Commission, prior to acceptance of any modality. Approval of new or experimental therapies is within the sole discretion of the Commission.

§85-20-18. Organ Transplants.

18.1. Transplants are not generally accepted or reimbursed by the Commission; however, requests are reviewed on a case-by-case basis. All transplants must be pre-approved by the Office of Medical Management prior to issuance of authorization.

18.2. Transplants which are needed, in whole or in part, because of an intervening cause, such as long term alcohol consumption, smoking, or other tobacco use shall be declined coverage by the Commission.

§85-20-19. Other Non-Covered Services.

19.1. Diagnostic Studies. No payment is allowed for:

a. Plethysmography;

b. Temperature gradient studies;

c. Fomentation;

d. Thermography;

e. Routine lab studies in back injury claims; or

f. Routine X-rays which the Commission determines, in its sole discretion, are medically unreasonable or medically unsupported as defined under 85 C.S.R. 28.

19.2. Payment to Complete Reports. No payment is allowed for routine status reports, Attending Physician's Report WC-219 Form, other routine reports requested by the Commission relating to care that has already been provided, or for completion of the medical portion of the report of injury. Providers shall not charge injured workers or any others for completion of the WC-219 form.

19.3. Miscellaneous. No payment will be made for the following services:

a. Telephone calls;

b. Telephone consultations by providers;

c. Writing or phoning prescriptions;

d. Education materials;

e. Babysitting;

f. Lost or stolen items;

g. Vitamins;

h. Diet pills;

i. Dietary supplements;

j. Weight loss programs;

k. Physical fitness programs;

l. Acupuncture;

m. Swimming therapy/aquatic therapy (unless under direct supervision of a physical therapist);

n. Homeopathy;

o. Massage therapy, except that up to 3 sessions of massage therapy will be allowed if massage therapy is not the sole means of treatment;

p. Copying or supplying needed records;

q. Costs associated with office audits; and

r. Saunas.

§85-20-20. Payment for appearance at hearings.

A party causing the cancellation of an examination of a medical doctor, osteopath, or chiropractor may be charged a $100 cancellation fee by said provider if forty-eight (48) hours notice of said cancellation is not provided.

§85-20-21. Treatment of unrelated conditions.

The Commission may pay for treatment of a condition which was not caused by the injury only if the Commission determines, in its sole discretion, that the unrelated condition is preventing recovery by aggravating the occupational injury. Any unrelated condition must be reported to the Commission before payment is considered. Pre-existing conditions which prevent recovery but do not aggravate the compensable injury shall not be covered.

§85-20-22. Consultations

22.1. The treating physician may refer an injured worker for a first-time consultation without prior authorization when the need can be clearly documented and has been reported to the Commission. The first-time consultation to a specialist does not require prior authorization; however, should additional consultations in the same specialty field be performed, Commission approval is required.

22.2. The consultant must submit a written report to the Commission after the exam has been carried out. The report shall contain the information required in Rule 8.2 and 8.1 above. Invoices from providers, other than the attending physician, should specify the name of the referring physician. In billing those services, the appropriate consultation procedure code from the Evaluation and Management section of the AMA CPT coding system shall be utilized.

22.3. If a specialist will be providing continuing care, the Commission must be notified so that an approval for a transfer or concurrent care may be considered.

22.4. The Commission reserves the right to arrange a consultation prior to authorizing any services, equipment, or supplies. Requests for treatment will be approved or denied upon review of the entire medical record.

22.5. Consultation Versus Referral. A consultation is considered to include those services rendered by a specialist whose review and opinion of the evaluation and/or treatment of an injured worker's condition is requested by another provider, or an official party in the claim, such as the injured worker's attorney, the employer, the Commission, etc. The consulting provider must submit a written report that becomes part of the Commission's claim record on the

injured worker. When the consulting provider assumes the continuing care of the injured worker, any subsequent services rendered by this provider are no longer considered a consultation.

22.6. A referral is considered to be the transfer of the total or specific care of a patient from one provider to another. If this involves a change of treating physician, an authorization is required from the Commission. A referral for specialty services, such as surgery, requires approval by the Commission.

§85-20-23. Miscellaneous Coverage and reimbursement Issues

23.1. Hernia. The Commission shall not approve payment for conservative treatment of an otherwise compensable hernia condition, except for the initial examination for diagnostic purposes, and except where it is shown that the employee has some chronic disease or is otherwise in such physical condition that it is considered unsafe for him to undergo such operation. Payment for surgical repair of a hernia cannot be considered until all required forms have been filed and the claim determined compensable.

23.2. Amputation reports. In cases involving amputations, the physician must mark the exact line of amputation on the prescribed form (Amputation Chart). To avoid error, the exact point of amputation must also be described in the written report and the Amputation Chart and report must be carefully checked to be certain that they agree.

IV. SPECIFIC TREATMENT GUIDELINES

The following are treatment guidelines for specific conditions. However, the usage of the term "guidelines" should not be interpreted to suggest that the guidelines are to be given any less legal weight than an exempt legislative rule is otherwise given. The provisions of Section 4 of this Rule apply in their entirety to these guidelines.

§85-20-24. Treatment Guidelines: Post Concussion Syndrome.

24.1. Post concussion syndrome is a clinical syndrome characterized by a variety of vague symptoms including a headache, dizziness, memory dysfunction and depression, following head trauma. There is little relationship between the serious nature of the trauma and the severity and duration of the symptoms.

24.2. The diagnostic criteria consists of a persistent dysfunctional state following head trauma without clinical or laboratory sign of serious intracranial or cervical spine disorder.

24.3. The appropriate diagnostic tests and evaluations are as follows:

a. Neurological examination;

b. MRI;

c. EEG;

d. Electronystagmyogram; and

e. Neuropsychological testing if no improvement after four weeks.

24.4. Symptomatic therapy for post concussion syndrome includes:

a. Analgesia;

b. Medication for labyrinthine dysfunction;

c. The use of narcotic medications is not indicated; and

d. Severe dizziness or mental/emotional problems may require hospitalization for acute care rehabilitation.

24.5. While the estimated duration of care is variable, a return to work is anticipated in four weeks or less.

24.6. The anticipated outcome is full recovery. In some cases there may be residual symptomatology such as dizziness or mental/emotional changes. These conditions may be disabling and may be permanent.

§85-20-25. Treatment Guidelines: Corneal Abrasion.

25.1. Corneal abrasion is usually caused by a foreign body striking the eye resulting in a disruption of the corneal epithelium. The foreign body does not remain in the eye.

25.2. The diagnostic criteria consists of complaints of pain and blurred vision. Photophobia may or may not be present.

25.3. Appropriate diagnostic tests and evaluations include a determination of visual acuity, a slit lamp examination and, when indicated, a dilated fundus examination.

25.4. Treatment is administered on an outpatient basis and consists of topical antibiotics, cycloplegics, and a pressure patch. For severe pain analgesics may be indicated.

25.5. The duration of care consists of daily visits up to 72 hours with a return to work within two days unless there are complications.

25.6. The anticipated outcome is full recovery.

§85-20-26. Treatment Guidelines: Corneal Foreign Body.

26.1. Corneal foreign body generally occurs when striking stone; hot metal may perforate the cornea and enter the eye. Contaminated foreign bodies pose a risk for corneal ulcers or systemic toxicological effect.

26.2. The diagnostic criteria consists of pain which occurs either immediately after the injury or within the first twenty-four hours, accompanied by a sensation of something in the eye, and photophobia. The pain is aggravated by blinking or moving the eye. Vision may be affected if the foreign body is in the visual axis.

26.3. The appropriate diagnostic tests and examinations consist of a comprehensive examination, including determination of visual acuity, a slit lamp examination and dilated fundus examination when indicated to rule out intraocular foreign bodies. An orbital x-ray or CT scan may be indicated if there is a suspicion of ocular or orbital penetration.

26.4. Treatment is administered on an outpatient basis and consists of the following:

a. Removal of embedded foreign body;

b. Topical antibiotics, cycloplegics, and pressure patch;

c. Analgesics for the first several days;

d. Daily visits until the cornea is healed; and

e. If a scar remains in the visual axis, corrective lenses or surgery may be required to attain optimal vision.

26.5. In uncomplicated cases the injured worker is expected to return to full work within one to two days.

26.6. Full recovery is expected unless the foreign body leaves a significant scar in the visual axis, in which case decreased visual acuity may be permanent.

§85-20-27. Treatment Guidelines: Hyphema.

27.1. Hyphema is bleeding within the anterior chamber of the eye, typically caused by a severe blunt trauma to the eye rupturing intraocular blood vessels. Hyphema may be associated with disruptions of the trabecular meshwork and lead to angle recession glaucoma. Early complications include elevated intraocular pressure causing blood staining of the cornea, vision loss, and most significantly, rebleeding which will occur in up to 30% of the cases within the third to fifth day. Rebleeding may cause marked elevation of intraocular pressure, corneal blood staining and visual loss. Late complications may include angle - recession glaucoma and cataract. Injured workers at considerable risk for complications include those with sickle cell or other coagulopathy.

27.2. Diagnostic criteria consist of a history of a blunt trauma to the eyes. The physical findings may include red blood cells visible within the anterior chamber, a layered clot filling the entire anterior chamber and/or intraocular pressure elevation.

27.3. The appropriate diagnostic tests and examinations are as follows:

a. Immediate referral to an opthalmologist as this is an ocular emergency;

b. A comprehensive examination by an ophthalmologist including a slit lamp exam, determination of the intraocular pressure, and a dilated fundus examination if possible;

c. Orbital x-rays may be indicated to rule out other orbital injuries; and

d. A platelet count and coagulation study as indicated as well as a sickle prep, and hemoglobin electrophoresis as indicated.

27.4. Appropriate treatment is as follows:

a. Outpatient treatment is indicated if the hyphema is not severe, there are no complications present and the injured worker is reliable. Treatment consists of the following:

1. Strict bed rest for five days;

2. Daily eye examination;

3. Medication, which may include the following: topical cycloplegics, steroids, ocular hypotensive and oral prednisone and/or aminocaproic acid;

4. Hard shield to be worn day and night; and

5. A gonioscopy after 2-3 weeks.

b. Inpatient treatment is indicated for significant hyphema, marked intraocular pressure elevation, complication or unreliable care and consists of the following:

1. Medication as noted for outpatient care;

2. Hospitalization with strict bed rest for five days; and

3. Surgical evacuation of the clot.

27.5. Return to full work is anticipated in three weeks for uncomplicated cases. Evidence of disruption of intraocular structures dictates lifetime monitoring for glaucoma and cataracts.

27.6. The anticipated outcome is resolution of the hyphema with return of visual acuity.

§85-20-28. Treatment Guidelines: Eyelid Laceration.

28.1. Eyelid lacerations may occur from blunt injuries or from laceration by a sharp object. They may involve only skin, eyelid muscles, eyelid margin, and the lacrimal drainage system and may be associated with an orbital foreign body.

28.2. The diagnostic criteria consists of laceration and bleeding, which may be profuse.

28.3. The appropriate diagnostic tests and examinations consist of a comprehensive examination including a visual acuity and a slit lamp examination to rule out an additional injury. A dilated fundus examination may be conducted when indicated.

28.4. Appropriate treatment is as follows:

a. Outpatient treatment is appropriate for uncomplicated lacerations. Sutures are generally removed in one to two weeks and medication may include antibiotics and analgesics.

b. Inpatient treatment is appropriate for injuries involving the lacrimal drainage system or those penetrating the orbit. The surgical repair may or may not require general anesthesia. Intravenous antibiotics are often indicated. Depending on the severity of the injury and overall condition of the injured worker, a one to two day hospital stay may be required. Medications may include topical, oral or parenteral antiobiotics and analgesics.

28.5. In uncomplicated cases the injured worker is expected to return to full work within two weeks with medical follow- up in four weeks. Damage to the eyelid muscles resulting in traumatic ptosis may require six to twelve months to resolve, or may ultimately require surgical repair.

28.6. The anticipated outcome is full recovery.

§85-20-29. Treatment Guidelines: Canalicular Laceration.

29.1. Laceration in the medial eyelid may injure the upper or lower canaliculus or lacrimal sac, resulting in constant tearing or abscess in the lacrimal sac (dacryocystitis). The presence of an infection within the lacrimal system usually requires surgical repair.

29.2. The appropriate diagnostic criteria consists of a laceration in the medial eyelid. Any laceration to the punctum may include canalicular laceration. Tearing or bloody tears and laterally displaced punctum may be present.

29.3. The appropriate diagnostic tests and examinations consist of a comprehensive examination, including visual acuity, slit lamp, examination, dilated fundus examination and probing of the canaliculus. Orbital x-rays or CT scan is appropriate if a fracture or foreign body is suspected.

29.4. Appropriate treatment is as follows:

a. Outpatient treatment is appropriate for simple lacerations and repair. Treatment consists of surgical repair including stent placement and topical drops and oral antibiotics as indicated.

b. Inpatient treatment is appropriate for contaminated or complicated wounds. Treatment consists of the following:

1. Surgical repairing; may include complex reconstruction;

2. Antibiotics and topical medications as indicated; and

3. Lacrimal bypass surgery if repair is unsuccessful.

29.5. The estimated duration of care in uncomplicated cases is two weeks with follow-up in 3 - 6 months.

§85-20-30 Treatment Guidelines: Orbital Contusion.

30.1. An orbital contusion is usually a result of blunt trauma causing swelling and ecchymosis of the orbit not associated with any fractures or significant lacerations.

30.2. The diagnostic criteria consists of a history of a blunt trauma to the ocular area, with progressive swelling of the lids, ptosis, proptosis of the eye and diplopia.

30.3. The appropriate diagnostic tests and examinations consist of:

a. Comprehensive examination, including an assessment of visual acuity, slit lamp examination, and a dilated fundus examination;

b. Orbital x-rays; and

c. CT scan may be indicated.

30.4. The appropriate treatment is as follows:

a. Outpatient treatment is appropriate in injuries without complications. Treatment includes analgesics, ice packs and systemic antibiotics as indicated.

b. Diminished visual acuity or severe pain may indicate a more extensive injury and may warrant inpatient treatment for further evaluation and treatment.

30.5. In uncomplicated cases the estimated return to work is one to two days. Disability may be longer if diplopia or ptosis persists.

30.6. The anticipated outcome is resolution of the swelling and diplopia with return of normal ocular motility.

§85-20-31. Treatment Guidelines: Orbital Fracture.

31.1. Fractures of the orbit may be indirect, resulting in a "blowout" of the orbital floor or medial wall, or direct involving fractures of the orbital rims.

31.2. The appropriate diagnostic criteria consists of a history of blunt trauma to the eye, usually by an object larger then the bony orbital opening. The eye may appear proptosis or enophthalmic. Ocular motility is usually diminished. There is usually numbness over the cheek due to injury to the infraorbital nerve. There may be a palpable fracture of the orbital rim. There may also be a fracture of the zygomatic arch.

31.3. The appropriate diagnostic tests and examinations are as follows:

a. A comprehensive examination by an ophthalmologist is necessary, including a visual acuity, slit lamp examination and dilated fundus examination;

b. X-ray of the orbits; and

c. Coronal CT scans.

31.4. Appropriate treatment is as follows:

a. In uncomplicated cases outpatient treatment is appropriate and consists of the following:

1. Outpatient follow-up for 1 - 2 weeks;

2. Oral antibiotics; and

3. Analgesics may be required.

b. Inpatient treatment is appropriate for severe fractures or other complicated injuries. Treatment consists of the following:

1. Surgical repair;

2. Medications include antibiotics and analgesics; and

3. Hospitalization from 1 - 3 days.

31.5. The estimated duration of care is as follows:

Diplopia may resolve spontaneously within one to two weeks with small fractures not requiring repair. Double vision generally resolves within two to three weeks after surgical repair unless there is intrinsic damage to the extraocular muscles.

Modified work may be required with diplopia resolved. Heavy work can generally be resumed three weeks after injury if surgery is not required, or three weeks after surgical repair.

31.6. The anticipated outcome is resolution of diplopia and normal functioning of the eye. Numbness over the cheek may persist for one year or longer and is not affected by surgical repair.

§85-20-32. Treatment Guidelines: Corneoscleral Lacerations.

32.1. Corneoscleral lacerations are potentially severe injuries resulting from sharp objects making forceful contact with the globe.

32.2. The appropriate diagnostic criteria consists of:

a. A detailed examination by an ophthalmologist including visual acuity, slit lamp exam, intraocular pressure and dilated fundus exam.

b. CT scan of orbits may be required.

32.3. Appropriate treatment is as follows:

a. Small partial thickness lacerations:

1. Follow-up and/or patching; and

2. Bandage contact lens application and follow-up.

b. Full thickness corneal lacerations:

1. Bandage lens application;

2. Cyanoacrylate tissue adhesive and protective shield;

3. Surgical repair under general anesthesia and hospitalization;

4. Cycloplegic, steroid and antibiotic drops; and

5. Hospitalization: 0 - 7 days.

32.4. The estimated duration of care and anticipated outcome:

a. Partial thickness laceration: The injured worker should wear a protective shield for three to six weeks. Modified work may be done after several days. Normal visual function should be restored after six weeks.

b. Full thickness simple corneal lacerations: Treatment lasts from two to four months. Protective shield should be worn for six weeks. Return to full work after suture removal is normally in three to four months if vision is adequate for fusion.

c. Lacerations involving lens, uveal tissue and retina: Six months are normally required to achieve stability after which contact lens correction of the aphakic condition may allow good visual recovery.

§85-20-33. Treatment Guidelines: Chemical Ocular Injuries.

33.1. Chemical injuries may result from an almost infinite variety of agents contacting the ocular surface, with the extent of the injury largely a function of the nature of the substance involved, how much ocular surface is involved, and duration of exposure.

33.2. The appropriate diagnostic criteria is as follows: A detailed examination is performed after copious irrigation (see treatment). It is vitally important to know the chemical causing the injury, its concentration and amount of exposure.

In alkali burns, the Hughes classification (grading or corneal haziness and loss of blood vessels at limbus) is helpful in assessing long term prognosis.

33.3. The appropriate treatment is as follows:

a. Acute phase (0 to 7 days).

1. Immediate copious irrigation using any nontoxic irrigating solution;

2. Detailed ophthalmologic exam, including pH level of eye secretions;

3. Topical steroids, antibiotic drops, topical ascorbate and cycloplegic agents;

4. Follow-up outpatient for 3 weeks;

5. Immediate referral to ophthalmologist for alkaline burns; and

6. Monitoring for systemic effect of toxin.

b. Severe chemical injuries should be hospitalized for treatment for several days.

33.4. The estimated duration of care depends on the extent of the initial injury. Milder injuries may permit return to work after several days. Moderate chemical injuries (if bilateral) may need several weeks to recover. Severe burns (if bilateral) may be blinding. In many cases corneal transplants may be able to restore vision.

§85-20-34. Treatment Guidelines: Functional Capacity Evaluations: Work Conditioning and Work Hardening Rehabilitation Programs. (Effective Date:)

~~By July 1, 2004 the Commission shall introduce to the Board of Managers a Treatment Guideline on functional capacity evaluation standards and procedures, work hardening programs, and other related matters.~~

34.1. Functional capacity evaluations. Functional capacity evaluations measure or quantify the physical abilities of an injured worker identified as essential in performing suitable, gainful employment and/or objectively define an injured worker's functional abilities or limitations in the context of safe and productive work. A functional capacity evaluation does not reflect what an individual should be able to do; but rather, what an individual can do or is willing to do at a given time.

34.2. Functional capacity evaluation providers. Functional capacity evaluations shall be performed by an approved licensed occupational therapist or physical therapist, with the limited exception as described within this subsection. Medical doctors, doctors of osteopathy and chiropractors shall not perform functional capacity evaluations, unless, they are also a licensed occupational therapist or physical therapist and meet the exception described in the section.

a. Functional capacity evaluation provider qualifications. The approved functional capacity evaluation provider shall:

1. Submit specific documented post professional education and training in occupational rehabilitation and rehabilitation and/or training for the model of functional capacity evaluation they are providing, and

2. Have a minimum of one year of supervised patient care experience in an outpatient industrial, orthopedic or sports medicine setting. A minimum of 25% of the provider in training's work experience must be spent working with injured workers.

b. Limited exception. If approved by the commission, nationally certified athletic trainers, nationally certified exercise physiologists, medical doctors, doctors of osteopathy and chiropractors may be allowed to continue to perform functional capacity evaluations.

1. In its sole discretion the commission may grant this limited exception only to those that have demonstrated to the commission the ability to perform high quality functional capacity evaluations for a period exceeding thirteen (13) months prior to the effective date of this rule.

2. Exams performed by commission approved providers under this limited exception shall be supervised by a licensed occupational therapist or physical therapist. All functional capacity evaluations performed by these providers shall be signed by the person performing the exam and by the supervising licensed occupational therapist or physical therapist.

3. Functional capacity evaluations performed by unapproved athletic trainers and exercise physiologists shall have no force and effect for evidentiary purposes, nor shall the commission pay for this service.

c. The commission may perform site inspections and all functional capacity evaluation providers must meet the commission's functional capacity evaluation criteria.

d. The commission shall require each approved provider to successfully complete a number of test cases. An ongoing quality assurance system will monitor the quality of functional capacity evaluation providers after a provider is approved. The commission will establish the quality assurance system.

34.3. Indications for functional capacity evaluations. A functional capacity evaluation is indicated if the medical, physical therapy, work hardening, work conditioning records are unclear in regard to the injured worker's physical and functional abilities to return to suitable gainful employment or proceed with a vocational rehabilitation plan. A functional capacity evaluation is not necessary if the medical, physical therapy, work hardening, work-conditioning records are clear. In the case of a permanent total disability claim, a functional capacity evaluation is required as part of the permanent total disability evaluation.

34.4. Authorizations for functional capacity evaluations. If a treating provider determines a functional capacity evaluation is needed, the initial functional capacity evaluation can be performed without prior authorization, as long as it is a Level 1 examination. All subsequent functional capacity evaluations will require and prior authorization and found to meet the standards of being medically, physically, or vocationally reasonably necessary..

34.5. Purpose. The purpose of the functional capacity evaluation is to enable the provider to:

a. Determine the injured worker's physical and functional status;

b. Determine if the injured worker is able to return to the pre-injury job;

c. Determine the injured worker's physical demand level; and

d. Determine the injured worker's material and non-material handling abilities.

34.6. Types of functional capacity evaluations. The Commission will recognize and reimburse for two (2) levels of functional capacity evaluations, a Level 1, or limited functional capacity evaluation, and Level 2, or comprehensive functional capacity evaluation.

a. A Level 1 functional capacity evaluation will be performed prior to entry into a work hardening or work conditioning program or as a focused physical and functional evaluation prior returning to pre-injury employment or objectively identified vocational rehabilitation goals.

1. The FCE provider generally will perform a Level 1 exam in a one (1) to, two (2) hour timeframe.

b. A Level 2 exam will be a comprehensive evaluation used for the quantification of an injured worker's physical and functional abilities to establish a vocational rehabilitation plan or goal, permanent total disability evaluation or as a physical and functional evaluation prior to entering a job search. In the case of a permanent total disability claim, a functional capacity evaluation is required.

1. The provider will generally perform a Level 2 evaluation in a three (3) to four (4) hour timeframe.

c. Testing is performed under specific test conditions, and addresses issues associated with worker participation and physical effort. Restrictions in the ability to perform, at the level of the whole person, a physical action, task, or activity in an efficient, typically expected, or competent manner may be physiological, bio mechanical or psycho physical in nature.

d. Test components for Level 1 and 2 evaluations include and are not limited to a review of medical records, worker interview, physical examination, and the performance of simulated and real functional tasks addressing the material and non-material handling requirements of work as defined by the US Department of Labor.

1. Unless otherwise specified, requested, or documented to be of limited ability or a safety hazard to the injured worker by the evaluator, material handling test

will include: lifts-12" floor to waist, waist to shoulder, overhead lift, carry, push, pull and maximum lift, and

2. Unless otherwise specified, requested, or documented to be of limited ability or a safety hazard to the injured worker by the evaluator, non-material handling test will include: stair climbing, standing, walking, sitting, balancing, over-head reach, forward bend, repetitive squatting, sustained kneeling, crawling, handling and grasping.

34.7. Functional Capacity Evaluation Report. The functional capacity evaluation report shall contain, as a minimum:

a. A summary of the injured worker's compensable and non-compensable injuries and/or coexistent physical or medical impairments or diagnoses as they relate to specific job demands of the injured worker's pre-injury employment or identified vocational goal;

b. The length of the evaluation and the test components of the evaluation;

c. The injured worker's material handling abilities;

d. The injured worker's non-material handling abilities;

e. The injured worker's demonstrated Physical Demand Level and demonstrated areas of restriction or limitations in the Physical Demand Level as outlined in the United States Department of Labor's Dictionary of Occupational Titles;

f. The reliability of injured worker's reported symptoms including consistencies and inconsistence between injured worker's subjective reports, medical record review, documented physical findings, and test results;

g. The injured worker's level of demonstrated physical effort/cooperation and/or presence of nonorganic signs and symptoms and/or presence of symptom magnification syndrome or chronic pain disorder;

h. The signature of the person performing the test and, if appropriate in accordance with the provisions of 34.2.b. the signature of the individual supervising the test, with their qualifications and/or certifications that testing was performed in accordance with these rules and the established professional standards;

i. Documentation that the injured worker's informed consent was obtained prior to testing; and

j. The evaluator's summary with conclusions and recommendations.

34.8. Work Conditioning and Work Hardening Rehabilitation Programs. Occupational rehabilitation programs, including work conditioning and work hardening, have the goal of assisting the injured worker with unresolved physical, functional, behavioral, and vocational

needs following acute care. The treatment focus of these rehabilitation programs is aimed at restoration of work-related function. Physical and occupational therapists provide the physical and functional components within these programs.

a. A work conditioning program is an intensive, work-related, goal-oriented, conditioning program designated specifically to restore systemic neuromuscular activities, including strength, endurance, movement, flexibility, motor control, and cardiopulmonary functions. The objective of the work conditioning program is to restore or maximize physical ability and function to enable the injured worker to return to work.

b. Work hardening programs are of two types:

1. A general work hardening program is highly structured, goal-oriented, outcome focused, individualized, progressive and supervised treatment program designed to maximize physical abilities and enable the injured worker to return to work. Such a program may be offered at any time throughout the recovery phase. The program focuses on functional restoration and return to work. Goals of the program include, but are not limited to, improvement of cardiopulmonary and neuromuscular functions, including strength, endurance, movement, flexibility, stability, and motor control functions, education, and symptom relief. A general work hardening program may follow and supplement or enhance the goals achieved in work conditioning.

2. A comprehensive work hardening program includes all the components of a general program but is also multidisciplinary in nature. Multidisciplinary functional restoration and return to work (RTW) programs are addressed in the guidelines on Multidisciplinary Pain Management. See section thirty-six of this Rule (Rule 20, §85-20-36) for a description of the services typically associated with these types of programs. All comprehensive work hardening programs and multidisciplinary functional restoration programs require prior authorization from the commission and are handled on a case-by-case basis.

34.8. Work Conditioning and Work Hardening Rehabilitation Programs: Admission Criteria.

To be eligible for these programs, the injured worker must have a return to work goal, a job goal, have stated or demonstrated willingness to participate, and have identified systemic neuromuscular physical and functional deficits that interfere with work. A limited vocational assessment that is job focused and individualized is required prior to entry into a work hardening program. A functional capacity evaluation (FCE) is required prior to entering any work conditioning or work hardening program, unless it is determined and documented to be unnecessary by the program director and/or treating physician.

34.9. Work Conditioning and Work Hardening Rehabilitation Programs: Discharge Criteria. The injured worker shall be discharged from the work conditioning or work hardening program when:

a. The anticipated goals and expected outcomes have been met;

b. It can be documented that the injured worker is unable to continue to progress toward the anticipated goals and expected outcomes;

c. It can be documented that the injured worker declines to continue the program;

d. It can be documented that the injured worker fails to comply with the requirements for participation; or

e. The program director determines the injured worker will no longer benefit from the work conditioning or work hardening program. Upon discharge from the work conditioning or work hardening program, the program director shall notify the claimant's employer, the commission, and/or any other referral source with the following information:

1. Reasons for program termination;

2. Clinical and functional status;

3. Recommendations regarding return to work; and

4. Recommendations for follow-up services.

f. Only the injured workers' treating physician, program director, or the commission shall discharge an injured worker from a work conditioning or work hardening program.

34.10. Referrals to Work Conditioning and Work Hardening Programs.

Referrals to work conditioning and work hardening programs will be received from the commission or treating physicians of record

34.11. Components of an Occupational Rehabilitation Program. An occupational rehabilitation program shall consist of the following components:

a. Providers of work conditioning and work hardening shall have the following qualifications.

1.Providers of work conditioning and work hardening programs will be directed by a licensed occupational therapist or physical therapist who has completed training in a specific industry accepted work conditioning or work hardening training model. The provider will have a minimum of one year of supervised patient care experience in an outpatient, industrial, orthopedic, or sports medicine setting. A minimum of 25% of the provider-in-training's work must be spent with work-related injury care. A licensed health care professional must be "on site" at all times while treatment is being rendered to the injured worker. The daily staff members of the work conditioning and work hardening program will be composed of exercise physiologists, certified athletic trainers, occupational therapists, physical therapists,

certified occupational therapist assistants, and physical therapist assistants. All programs, directors, and supervisors shall be approved by the commission's approval process. Any change in the directorship or supervisory staff must be communicated to the commission. The staff to injured worker ratio in both work conditioning and work hardening programs will not exceed 1:8, at any time. Direct observation by a staff member is required at all times.

2. The director of work conditioning and work hardening programs will be a licensed occupational or physical therapist. The commission acknowledges other providers may be able to provide highly useful services. At the sole discretion of the executive director of the commission, and acting pursuant to the advice of the Health Care Advisory Panel (HCAP), those treating providers who demonstrate their skill in the performance of these services may be allowed to provide these services. These treating providers will be subject to the usual review and quality assurance programs (review of applicants and monitor performance) as designated by the commission, approved by HCAP and under the direction of the commission's office of medical management. Each approved provider will successfully complete a number of test cases. The primary goal of these guidelines is to assure only valid, highly quality exams are rendered to injured workers.

b. Work conditioning and work hardening programs are a form of physical medicine services. These programs are also subject to the treatment services restrictions contained in the physical medicine treatment guidelines. The commission, on a case-by-case basis may approve initiation of such programs when their provision will exceed such guidelines.

c. The duration of occupational rehabilitation programs shall be two (2) to four (4) hours per day for work conditioning programs and four (4) to eight (8) hours per day for work hardening programs. Work conditioning and work hardening programs will be attended five (5) day per week. Program duration will be four (4) weeks; however, the commission, on a case-by-case basis, may approve program extension.

d. Material handling components of the work conditioning and work hardening programs shall be at a minimum: 12" and floor to waist lift, waist to shoulder lift, overhead lift, carry, push, pull, and maximum lift.

e. Non-material handling components of the work conditioning and work hardening programs shall typically include balancing, overhead reach, forward reach, repetitive squatting, sustained kneeling, crawling, stair climbing, walking, standing, and sitting. Both material handling and non-material handling goals shall be consistent with identified functional goals of the individual injured worker.

f. The educational component of the work conditioning/work hardening programs will include prevention of re-injury, benefits of a home exercise program, self-treatment of symptoms, activity control of symptoms, body mechanics, benefits of exercise, nutrition, and healthy living habits.

g. All work conditioning programs shall have a minimum of 1250 square feet of dedicated non-office clinic space. The commission may perform site inspections and all work conditioning and work hardening programs must meet the commission facility criteria.

34.12. Providers of work conditioning or work hardening programs are required to provide the following information in their reports in the timeframe as provided:

a. A brief summary of the injured worker's medical issues and problems as related to specific job demands;

b. Initial and discharge evaluations;

c. Attendance records, including the time spent in each session;

d. Duration of the program;

e. Material handling abilities;

f. Non-material handling abilities;

g. The current physical demand level as outlined in the United States Department of Labor, "Dictionary of Occupational Titles," and consistency with physical demand level of the established vocational goal;

h. Consistency of the injured worker's reported symptoms, including consistencies and inconsistencies between the injured worker's report and test results.

i. Level of demonstrated physical effort, cooperation and/or the presence of symptom magnification;

j. Treatment summary with conclusions, restrictions, limitations, and recommendations;

k. Signature of the program director performing the evaluation with qualifications and/or certifications; and

l. Reports will be bi-weekly, upon exit or discharge from the program and/or as requested by the referral source or the commission.

34.13. If an injury or incident occurs during a work conditioning or work hardening program, a signed and dated incident report must be filed by the treating therapist and submitted to the the commission within three (3) working days of the incident. The incident report shall include as a minimum:

a. Name of the injured worker;

b. Claim number of the injured worker;

c. Date of incident;

d. Description of incident;

e. Description of injury to the injured worker;

f. Name of witnesses;

g. Name of facility and therapist; and

h. Name of facility director or supervisor.

Following an injury or incident, unless in the case of an emergency, the injured worker will be referred by the facility to his treating physician for re-evaluation. The work conditioning/work hardening program may be temporarily suspended. The injured worker's ability to resume the work conditioning/work hardening program will be evaluated on a case-by-case basis and the decision to re-enter the program will be made by the program director in conjunction with the treating physician and the commission.

§85-20-35. Treatment Guidelines: Cervical Musculoligamentous Injury (Sprain/Strain).

35.1. Symptoms are believed to be related to a partial stretching or tearing of the soft tissues (muscles, fascia, ligaments, facet joint capsule, etc.). Neck pain may be accompanied by vague upper extremity complaints. The recovery period is of variable duration, but generally is less than three or four weeks.

35.2. The appropriate diagnostic criteria consists of the following:

a. Pertinent historical and physical findings documenting the mechanism and degree of force and the time sequence before the onset of symptoms is important. The onset of neck pain and paraspinal muscle spasm begins either suddenly after the injury occurs or develops gradually over the next 24 hours. This pain is usually aggravated by motion of the neck and frequently is relieved by rest. It can be accompanied by paresthesia or a sense of weakness in the upper extremities related to the muscle spasm in the neck. Physical findings include tenderness to palpation, spasm of the paravertebral muscles and aggravation of the pain with motion.

35.3. The appropriate diagnostic tests and examinations are as follows:

a. If indicated by examination, anteroposterior, lateral, lateral flexion and extension x-rays of the spine and open mouth view to visualize the odontoid process are appropriate. Other x-rays may be added to the roentgenographic series as indicated. Straightening of the cervical spine is frequently observed on the lateral x-ray.

b. Further imaging may be indicated depending upon clinical course.

35.4. The appropriate treatment is as follows:

a. Outpatient treatment:

1. Nonoperative treatment:

A. Indications: Almost all injured workers with cervical musculoligamentous (sprain/strain) can be treated conservatively. However, disruption of intervertebral ligaments with subluxation is an indication for surgery.

B. Treatment options:

1. Analgesics;

2. Muscle relaxants;

3. Anti-inflammatory drugs, non-steroidal;

4. Physical modalities and/or rehabilitative procedures may be helpful;

5. Occasional trigger point injections may be helpful; and

6. Manual manipulation and mobilization.

b. Inappropriate treatment:

1. Operative treatment is inappropriate for cervical strain;

2. Narcotic medication for prolonged period of time; and

3. Inpatient treatment.

35.5. The estimated duration of care is 1 to 4 weeks; not to exceed 8 weeks.

35.6. A diagnosis of sprain/strain exceeding this 8 week period requires detailed re-evaluation. The Commission may require an IME to verify the diagnosis and will authorize continued treatment/coverage in its sole discretion.

35.7. The anticipated outcome:

a. Resumption of normal activity without residual symptoms in most cases.

35.8. Modifiers (age, and co-morbidity). If the injured worker has not responded to the above-outlined treatments within four weeks, the injured worker must be referred to an appropriate specialist.

§85-20-36. Treatment Guidelines: Acute Herniated Cervical Disc.

36.1. A cervical disc syndrome is a condition in which there is a bulging or rupture of the intervertebral disc. This may be lateral, compressing a root and causing a radiculopathy, or midline, compressing the spinal cord and causing a myelopathy. This most often occurs at the C4-5, C5-6 and the C6-7 disc levels. When the C4-5 disc ruptures there is pressure on the C5 root. This may cause pain over the top of the shoulder in the "epaulet" distribution. Tingling is not common. There may be weakness of the deltoid muscle. Occasionally the biceps reflex is diminished. When the C5-6 disc ruptures there is pressure on the C6 root with pain as well as tingling and decreased sensation over the thumb and index finger, weakness of elbow flexion, and diminution of the biceps and brachial radialis reflexes. When the C6-7 disc ruptures there is pressure on the C7 root with pain and tingling in the index and middle fingers, weakness of elbow extension, and diminution of the triceps reflex. There can be more extensive weakness than noted above, although the description is that of the classic syndrome. There may be changes in other reflexes, and the sensory abnormalities may be somewhat variable. Pain, sensory changes or weakness may predominate because of ill-defined differences in sensibility of the different components of the nerve. Over time the pain may resolve due to permanent damage to pain fibers, leaving the injured worker with motor and sensory dysfunction, which still may merit decompression.

Myelopathic symptoms may occur due to central disc protrusion and cause sensory (particularly posterior column) and motor dysfunction in the arms and legs, and bladder and bowel symptoms.

36.2. The appropriate diagnostic criteria is as follows:

The onset may be sudden or insidious. Neck pain is common, especially at night and with the neck in extension. Neck motions are frequently limited and cause an exacerbation of pain. The hallmark is arm pain and/or paresthesia. The pain is often described as a sharp, shooting pain that radiates from proximal to distal along the anatomic course of the nerve.

The Spurling test (neck extension and tilting the head toward the painful arm followed by axial compression of the cervical spine) is often positive. The neurological exam may be normal if compression is not too severe or there may be weakness, sensory impairment and/or altered reflexes.

36.3. Appropriate diagnostic tests and treatments are as follows:

a. In the face of a typical history and physical examination, plain spine x-rays are indicated since treatment may be altered if there are associated problems such as ostephytes.

b. Non-operative treatment:

1. Cervical traction;

2. Cervical collar may be used; not to exceed one week;

3. Use of analgesics, mild relaxants, and non-steroidal anti-inflammatory drugs;

4. Appropriate physical medicine referral to include physical agents; exercise, and manipulation/mobilization; and

5. Indications for inpatient admission:

A. Inability to control pain; and

B. Progressive neurological deficit.

c. Injured workers with significant neurologic deficit, uncontrollable pain, or who fail to improve after two to four weeks should be referred for consultation to a surgeon who does cervical operations.

d. Neuro-Imaging examinations:

1. Myelography followed by CT scan with contrast medium in place. Myelography with CT scan is the established test for evaluating the presence of nerve root compression. To warrant treatment, abnormalities must relate to the clinical problems of the injured worker. There is no reason to admit an injured worker to a hospital overnight for a myelogram. Persistent post-myelogram syndrome should be treated by hydration, caffeine, and/or blood patch as an outpatient procedure;

2. MRI, although occasionally it may not provide complete information about root compression or bony anatomy; and therefore,

3. EMG and nerve conduction velocity studies may be required to determine exact level of compression and rule out peripheral nerve compression, but should be delayed 21 days from onset of symptoms.

e. Inappropriate diagnostic tests and examinations:

1. Computed tomography without myelographic dye, although this may be helpful for other conditions such as infection or tumor;

2. Myeloscopy;

3. Dermatomal somatosensory evoked potentials;

4. Thermography; and

5. Spinoscopy.

f. Operative treatment:

1. Failure of non-operative treatment to relieve symptoms;

2. Quality of injured worker's life significantly impaired; or

3. Presence of significant or progressive neurologic deficit, either radiculopathy or myelopathy diagnosis confirmed by myelogram with CT scan, or by MRI.

g. Procedure options:

1. Laminectomy with excision of disc or arthritic spur or foraminotomy. Fusion is not indicated for a simple disc. Discharge 2 - 4 days post op. Posterior fusion is not indicated unless approved.

2. Anterior cervical diskectomy, especially in cases where there is medial compression. Discharge 1-3 days post op.

3. Complicated - after wound infection, thrombophlebitis, spinal fluid leak, or other significant complication has been controlled; and

4. Additional physical and/or vocational rehabilitation may be required.

36.4. The estimated duration of care is as follows:

a. Non-operative treatment - if still symptomatic by six weeks, must be referred for surgical consultation; and

b. Operative treatment - depending on degree of neurological impairment and persistent pain. If pain persists over three months after surgery, the injured worker should be referred for multidisciplinary pain management. If a disabling neurological deficit persists more than three months, vocational guidance should be considered. If a fusion has been done, the injured worker may require short and/or long term modified work.

§85-20-37. Treatment Guidelines: Low Back Musculoligamentous Injury (Sprain/Strain).

37.1. Strains and sprains are a common cause of acute low back pain encountered in the general population. These injuries often are the result of the mechanical stresses and functional demands placed on the low back area by everyday activities. Symptoms are believed to be related to a partial stretching or tearing of the soft tissues (muscles, fascia, ligaments, facet joint capsule, etc.) The conditions, for the vast majority of injured workers, are of short duration and complete recovery is the general rule. Most injured workers with a musculoligamentous injury to the low back recover rapidly, with 50% to 60% of injured workers recovering within one week.

37.2. The appropriate diagnostic criteria consist of:

Onset of low back pain and paraspinal muscle spasm begins either suddenly after the injury occurs or develops gradually over the next 24 hours. The pain is usually relieved by rest and aggravated by motion of the back. The pain usually does not radiate below the knee, and the strain is not accompanied by paresthesias or muscle weakness in the legs. Physical findings include low back tenderness to palpation, loss of normal lumbar lordosis, and spasm of the paravertebral muscles. Straight leg raising and other tests that cause spinal motion may

increase low back pain. The injured worker may stand with a list to the side or in a flexed position. The neurological examination and nerve root stretch tests usually are negative.

37.3. Appropriate and inappropriate diagnostic tests and examinations are as follows:

a. Although the diagnosis of a musculoligamentous injury is not based on radiographic criteria, plain x-rays may be indicated based on mechanism of injury (actual trauma, hyperextension, compression), a high index of clinical signs of pathology, or treatment plan for manipulative therapy. Pain, which persists (no improvement) longer than 2-4 weeks or worsens may also be criteria for x-rays.

b. Inappropriate diagnostic tests and examinations during the acute phase of the first four weeks:

1. CT scan;

2. MRI;

3. Bone scans;

4. Myelography;

5. EMG;

6. *Thermogram;

7. *Evoked Potentials;

8. *Myeloscopy; and

9. *Spinoscopy;

*Never appropriate

c. Failure to improve in four weeks warrants an appropriate second opinion.

37.4. Treatment considerations are as follows:

a. Non-operative treatment:

1. Indications: Almost all injured workers with low back musculoligamentous (sprain/strain) can be treated satisfactorily. No indications exist for the use of surgery in the treatment of low back musculoligamentous injuries.

2. Treatment options:

A. Short-term bed rest for approximately 2 days with appropriate positioning;

B. Analgesics;

C. Muscle relaxants as needed;

D. Anti-inflammatory nonsteroidal medication;

E. Referral for physical medicine (PT, OT, DC, DO, and physiatrist);

F. Physical modalities in conjunction with proper body mechanics and flexibility, endurance, and strength reactivation exercises;

G. Manipulation of spine;

H. Occasional trigger point injections; and

I. Lumbosacral corset or brace.

b. Inappropriate treatment:

1. Operative treatment is inappropriate for low back strain;

2. Prolonged bed rest beyond two days;

3. Narcotic medication for prolonged period;

4. Home traction; and

5. Inpatient treatment.

37.5. The estimated duration of care: 0 to 4 weeks; not to exceed 8 weeks.

37.6. A diagnosis of sprain/strain exceeding this 8 week period requires detailed re-evaluation. The Commission may require an IME to verify the diagnosis and will authorize continued treatment/coverage in its sole discretion.

37.7. The anticipated outcome is resumption of normal activity without residual symptoms in most cases. Transitional activities may be required.

37.8. Modifiers (age, and co-morbidity). Co-morbidity (e.g., degenerative disc disease, spondylolisthesis, segmental instability, osteoporosis, spine deformity) may be associated with a higher incidence of persistent symptoms but are not compensable conditions.

§85-20-38. Treatment Guidelines: Herniated Lumbar Disc.

38.1. Injured workers under treatment by their own physician who fail to improve after two to four weeks - refer to a qualified orthopedic surgeon or neurosurgeon for consultation and/or treatment.

Herniations occur most commonly through a posterolateral defect, but midline herniations may occur. Resulting compression of the spinal nerve root causes inflammation and pain, usually along the anatomic course of the nerve. In the lumbar spine, this most often occurs at

the L4 and L5 disc levels, causing pressure on the corresponding L5 and S1 nerve roots. As a result of both mechanical and biochemical changes around the nerve root, the injured worker will experience pain, paresthesia, and possibly weakness in the leg or legs usually below the knee. The rare herniations at the L1, L2 and L3 levels are usually associated with pain, paresthesia, and weakness above the knee. Back pain may or may not be a presenting complaint with any herniated lumbar disc.

38.2. The appropriate diagnostic criteria consist of:

Back pain is usually the first symptom and may or may not abate as the pain and paresthesias begin to radiate down the leg. The leg pain is often described as a sharp, shooting pain that radiates along the anatomic course of the nerve from proximal to distal. The onset may be sudden or insidious. The injured worker often has difficulty getting up from sitting or supine positions and commonly leans or lists to one side or the other. Motion of the spine is limited due to pain and muscle spasm. The neurological examination may be normal if the compressed nerve is still functional, or it may yield objective evidence of impaired nerve function (e.g. atrophy, weakness, sensory alteration or diminished reflex) depending upon the nerve root affected. Signs of nerve root tension (e.g. positive straight leg raising) may also be present.

When the L4 disc herniates, it usually causes pressure on the L5 nerve root resulting in weakness of the great toe extensor or other dorsiflexor muscles of the foot and sensory loss along the medial aspect of the foot to the great toe, but it is usually not associated with reflex abnormality. When the L5 disc herniates, it usually causes pressure on the S1 nerve root, resulting in a sensory deficit in the posterior calf area and lateral aspect of the foot in addition to a diminished Achilles' reflex and occasional weakness of the plantar flexors of the foot.

38.3. Diagnostic test and examination considerations are as follows:

a. Clinical diagnosis is supported by these studies:

1. Plain spine radiographs (and on rare occasions bone scans) to rule out other conditions such as tumor, infection, fracture and congenital anomalies, if not previously done;

2. MRI; and

3. Myelography with CT scans.

b. Inappropriate diagnostic tests and examinations:

1. Myeloscopy;

2. Dermatomal somatosensory evoked potentials;

3. Thermography; and

4. Spinoscopy.

c. Supporting evidence. EMG may be helpful in rare cases. Discography can occasionally be helpful. Selective lumbar nerve block may be helpful for diagnosis.

38.4. The appropriate treatment is as follows:

a. Outpatient treatment:

1. Non-operative treatment:

A. Short period of bed rest, up to 10 days with analgesics, mild relaxants, and non-steroidal anti-inflammatory drugs;

B. Physical medicine and/or rehabilitation; and

C. Orthotics.

The value of periods of bed rest has not been demonstrated. Complete bed rest for prolonged periods may be deleterious to the body and should be closely monitored. A significant number of injured workers will respond to a nonoperative treatment program for herniated lumbar disc. The physician should be aware that those injured workers who have marked, early limitation of straight leg raising and those injured workers who have symptoms or physical findings suggestive of cauda equina syndrome may need early surgery. Close monitoring is indicated in those settings.

b. Inpatient treatment.

1. Non-operative treatment.

A. Indications for admission.

1. Inability to control pain; and

2. Severe or progressive neurologic deficit.

B. Treatment options.

1. Monitored bed rest with parenteral medications.

C. Indications for discharge.

1. Uncomplicated - relief or improvement of leg and/or back pain.

2. Exceptions:

(a) No response to nonoperative treatment options requiring consideration of surgical intervention; and

(b) Spinal headache after myelogram requiring IV fluids or blood patch.

2. Operative treatment:

A. Indications: diagnosis confirmed by myelography with CT scan, or MRI, plus one of the following three.

1. Failure of nonoperative treatment to relieve symptoms;

2. Quality of injured worker's life significantly impaired; and

3. Presence of significant or progressive neurologic deficit.

B. Procedure options:

1. Open removal; and

2. Percutaneous diskectomy by special approval.

C. Indications for discharge:

1. Uncomplicated - One to three days after diskectomy.

2. Complicated - after wound infection, thrombophlebitis, spinal fluid leak, or other significant complication has been controlled.

D. Home health care may be required for a short period.

E. Physical modalities and/or rehabilitative procedures.

1. Some monitoring of the injured worker's activities may be necessary;

2. General fitness, flexibility, and simple spinal muscle strengthening are all important;

3. Injured worker should be instructed in walking program with a gradual increase in physical activities; and

4. Strengthening exercises or work simulation activities may be indicated for some injured workers.

F. Supporting evidence. Diskectomy has been proven to be a safe and effective procedure in some injured workers with herniated disc. Such surgical intervention remains elective (in the absence of a severe neurologic deficit) and the decision is based on the surgeon's clinical judgment and the injured worker's personal assessment of the extent to which quality of life has been impaired.

38.5. The estimated duration of care is as follows:

a. Nonoperative treatment - maximum medical improvement 0 - 12 weeks.

b. Operative treatment - 0 - 12 weeks.

38.6. Modifiers (age, and co-morbidity). Injured workers with symptoms suggestive of cauda equina syndrome will require a different approach to treatment. Cauda equina syndrome is a surgical emergency. Symptoms include low back pain and paralysis with loss of bladder and bowel control. Once this diagnosis is suspected, the injured worker should undergo prompt referral and neurodiagnostic evaluation.

§85-20-39. Treatment Guidelines: Lumbar Fusion.

39.1. Indications of compensable lumbar fusion:

a. Injuries to bone or soft tissue that cause instability;

b. For a second or third time disc surgery, the injured worker must have a second medical opinion and prior approval from the Commission

39.2. Lumbar fusion may also be appropriate treatment for other noncompensable conditions for which treatment will not be authorized:

a. Cancer;

b. Symptomatic spondylolisthesis; and

c. Documented instability for other cause.

d. Degenerative disc disease with pre-operative documentation of instability.

e. Pseudoarthrosis.

39.3. Contraindications for lumbar fusion.

a. Primary surgery for a new, acute disc herniation with unilateral radiation leg pain.

39.4. Surgical procedures.

a. Bony fusion with or without instrumentation. A second concurring surgical opinion must be obtained before surgery unless clear evidence of a medical emergency exist.

§85-20-40. Treatment Guidelines: Shoulder Injury Guidelines.

40.1. The term "shoulder complex" refers to the humerus, clavicle, scapula and the surrounding supporting connective tissue and emphasizes their interdependent relationship. Articulations of the "shoulder complex" are the sternoclavicular, acromioclavicular, scapulothoracic, glenohumeral, and subacromial arch.

Fractures, separations, or subluxations/dislocations of components within the "shoulder complex" result from trauma to the shoulder girdle or upper extremity. Soft tissue strains or sprains may result from either trauma or longstanding accumulative microtrauma. The rotator cuff is particularly vulnerable to overuse pathology.

Treatment of "shoulder complex" injuries is directed to restoring balanced motion in the entire complex. Because of the importance of the soft tissues, physical therapy is very important and can be lengthy. On the other hand, because the shoulder complex is so adaptable, most individuals can find alternative patterns of function in their work, home, or recreational needs while they are undergoing physical rehabilitation.

40.2. The appropriate diagnostic criteria are as follows:

a. History and physical.

1. Mechanism of injury - single episode or repetitive microtrauma.

2. Pain pattern - pain at rest, pain related to work, activities of daily living, or recreational activities, night pain; painful arc of motion; position of comfort; relative position of the pain; relative position of the neck; referred pattern (pain below the elbow suggests a radicular component).

3. Range-of-motion - active glenohumeral and scapulothoracic balance; passive forward flexion, external rotation, internal rotation, and abduction compared to the opposite side.

4. Palpation - point or zone of maximum tenderness.

5. Neurological - motor, sensory, muscle stretch reflexes for C5, C6, C7, C8 and T1 roots.

6. Special tests - apprehension; drop arm; impingement; Yergason; posterior apprehension; sulcus sign; clunk; AC spring; Adson; Awinged scapular; lateral scapular slide.

40.3. The appropriate diagnostic tests are as follows:

a. Routine imaging:

1. Shoulder series - internal, external, and transaxillary or transcapular lateral (a transthoracic lateral is of no benefit except in humeral shaft fractures, posterior dislocations of the shoulder may be missed).

2. Special imaging - requires pre-authorization and specialty referral.

A. CT scan;

B. MRI;

C. Arthrogram; and

D. EMG/NCV.

40.4. The guidelines for appropriate specialty referral are as follows:

a. Failure of improvement or resolution of symptoms with conservative treatment in four weeks;

b. Radiographic evidence of fracture, subluxation, or dislocation;

c. Initial presentation of hemarthrosis;

d. Significant lack of motion compared to opposite side; and

e. Suspected neurologic injury.

40.5. Appropriate treatment is as follows:

a. Fracture - subluxation/dislocation (requires specialty referral).

1. Nonoperative or operative:

A. One to four weeks of immobilization; and

B. Physical therapy beginning in one to four weeks and continuing up to six months.

b. Sternoclavicular or acromioclavicular strain or grade 1 (non-displaced sprain).

1. Non-operative:

A. One to seven days of immobilization;

B. Physical therapy, modalities and range-of-motion, one to six weeks;

C. Duration of care - one to six weeks;

D. Anticipated results - resolution of symptoms and resumption of normal activities. May develop degenerative arthritis at a later date.

2. Operative (specialty referral) - no indication except evidence of degenerative changes after prolonged conservative management.

c. Rotator cuff tendinitis/bursitis.

1. Nonoperative.

A. Local steroid injections at three to six week intervals (not to exceed three);

B. Physical therapy - up to three months at decreasing intervals;

C. Job activity modification if indicated; and

D. NSAIDs.

2. Operative (specialty referral).

A. Indications.

1. Failure of improvement after three to six months of conservative care;

2. Positive impingement sign; and

3. Arthrogram or MRI to determine integrity of rotator cuff.

B. Physical therapy following surgery, three to six months at decreasing intervals.

d. Rotator cuff tear.

1. History - sudden onset of pain and inability to initiate active abduction; passive abduction relatively normal; plain x-rays revealed not acute bony changes.

2. Nonoperative.

A. Physical therapy one to three weeks;

B. Specialty referral if no improvement.

3. Operative (specialty referral).

A. Arthrogram or MRI confirms tear; and

B. Physical therapy following surgery, three to six months at decreasing intervals.

e. Adhesive capsulitis (frozen shoulder).

1. History - insidious pain and loss of motion in the glenohumeral joint.

2. Nonoperative.

A. Physical therapy tried one to six weeks;

B. Glenohumeral joint injection with saline distention using short acting steroids plus Xylocaine - limit two at three week intervals; and

C. Specialty referral if no improvement after six to eight weeks.

3. Operative (specialty referral).

A. Manipulation if no improvement after three months.

4. Other conditions which (require specialty referral).

A. Thoracic outlet syndrome;

B. Brachial plexus injuries; and

C. Ruptured biceps tendon, proximally or distally.

§85-20-41. Treatment Guidelines: Carpal Tunnel Syndrome.

41.1. The purpose of the Carpal Tunnel Syndrome ("CTS") Rule is to provide the treating physician with treatment guidance and treatment parameters so that the treating team can:

a. Determine if the illness is work-related; that is, determine causality.

b. Properly diagnose the illness through a careful history, physical examination and appropriate diagnostic tests and examinations.

c. Initiate timely and proper treatment; and

d. Keep the injured worker in the workplace, through modified or restricted duty if necessary, as much as possible during the treatment plan.

41.2. Background. CTS is one of several nerve compression/entrapment syndromes of the upper extremity. This condition occurs when pressure increases in the canal and disrupts the normal flow of nerve impulses to the hand. The exact cause of this condition is unclear. It is often bilateral. The prevalence of CTS in the general population is approximately 3.1%. Half of CTS cases are idiopathic. Providers considering the diagnosis and compensability of CTS are advised to assess several factors, diagnostic accuracy, confounding conditions, work setting and duration of symptoms in assigning causality.

41.3. Diagnostic Accuracy. Hand symptoms may be produced by tendonitis, arthritis, tumor, interrupted blood flow, trauma or nerve entrapment at levels from the neck to the hand. Symptoms suggesting CTS include numbness and paresthesia (especially at night), weakness, uselessness and pain in a median nerve distribution. Clinical examination findings are frequently difficult to interpret. Tinel's and Phalen's tests have limited sensitivity and specificity. Thenar atrophy is a late sign.

41.4. Confounding Conditions. Medical conditions frequently produce or contribute to CTS. Recognition of these conditions is important for good outcomes. Diabetes mellitus, hypothyroidism, obesity, alcohol abuse, rheumatoid arthritis, postural abnormalities and other conditions can precipitate CTS symptoms. Pregnancy is a well-established risk factor for reversible CTS. Sleep disorders significantly aggravate CTS for some patients. Hobbies and sports activities may contribute to CTS symptoms. A careful look for contributing noncompensable factors may impact causality and response to treatment.

41.5. Work Setting. Occupational groups at high risk for CTS have included grinders, butchers, grocery store workers, frozen food factory workers, manufacturing workers, dental hygienists, platers and workers with high force, high repetitive manual movement. The literature notes a high prevalence of concurrent medical conditions capable of causing CTS in persons with the syndrome, without regard to any particular occupation. Studies have failed to show a relationship between normal clerical activities and CTS. When evaluating CTS in this work setting, a careful search for other contributing factors is essential. Awkward wrist positioning, vibratory tools, significant grip force, and high force of repetitive manual movements have all been shown to contribute to CTS. The Moore-Garg Strain Index is a valuable tool for assessing risk for work-related CTS.

41.6. Duration. Work-related CTS is associated with <u>years</u> of repetitive activity. To find CTS in workers with weeks to months of exposure suggests a pre-existing condition.

41.7. Diagnosis Criteria.

a. Pertinent Historical and Physical Findings

1. Patients usually complain of painful, burning paresthesia or numbness involving the thumb, index, long and occasionally radial aspect of the ring digit or the entire hand.

2. These symptoms are usually worse while lying down or sitting quietly.

3. Activities such as driving, holding a telephone or fixing one's hair often precipitate the paresthesia.

4. The most common complaints usually include nocturnal paresthesia, clumsiness with loss of fine dexterity and dropping things.

5. The patient often feels as if there is a loss of circulation. The paresthesia is often relieved by actively working the fingers, shaking the hand or holding it in a dependent position.

6. Pain is usually present over the palmar wrist area and may radiate proximally as far as the shoulder or neck.

7. Findings are consistent with those of a nerve irritation.

A. Tinel's test may be positive over the medial nerve in the proximal palm or wrist.

B. Numbness in the fingers may be elicited with the wrist in extreme extension or flexion (Phalen's test).

C. There may be decreased sensation distal to the wrist, particularly over the thumb, index and middle fingers, inability to flex or oppose the thumb or abduct it in its own plane and thenar muscle atrophy.

D. There can be significant variations in location of pain and sensory changes.

E. The examiner also needs to evaluate additional or alternate sites of compression that can produce similar symptoms.

b. Appropriate Diagnostic Tests and Examinations

1. Radiographs of the hand and wrist if indicated by history and examination, mainly in patients with history of previous trauma or painful range of motion of the wrist.

2. Nerve conduction studies and electromyograms. (Mild cases wait 6 weeks).

3. Response to conservative measures; splinting of wrist and carpal tunnel steroid injections.

4. Laboratory studies if symptoms suggest an underlying disease such as diabetes mellitus, thyroid dysfunction or rheumatoid arthritis.

5. Radiograph of cervical spine, upper extremity and/or chest if symptoms suggest a more proximal disease process.

c. Specialist Directed Tests and Examinations

1. CT scan and MRI only if indicated by previous plain films and history pace-occupying deformity or mass.

2. Wrist arthrogram if findings suggestive of carpal instability.

d. Supporting Evidence.

1. Since double crush syndrome (entrapment of a nerve at more than one level) and systemic diseases causing carpal tunnel syndrome are not unusual, a thorough evaluation is essential.

2. EMG/NCS is the standard diagnostic modality and has high sensitivity and specificity. Regarding EMG and NCS, there is variability in the skill of the testing physician and diagnostic reference criteria do vary. This should be carefully monitored by the referring physician and by a Quality Assurance mechanism.

41.8. Treatment.

a. Non-operative Treatment

1. Indications

A. Symptoms mild or moderate (but without thenar atrophy).

B. Pregnancy or other systemic problems that may be treated medically.

C. Onset of symptoms associated with work exposure, and plausibly subjective and/or objective findings.

D. Associated with other physical conditions, i.e. cervical radiculopathy.

2. Treatment.

A. Initial Four Weeks—Options

1. Splint wrist in neutral.

2. Nonsteroidal anti-inflammatory drugs.

3. Steroid injections, optional.

4. Eliminate or modify aggravating activities with the cooperation of the employer.

5. Physical medicine.

6. Concurrent treatment of systemic disease until the injury has returned to pre-injury status.

7. Self care: ice, elevation, range of motion, stretching, exercises, postural correction, etc.

3. Referral

A. If there is no substantial improvement by four (4) weeks, the injured worker should be referred for evaluation and possible treatment.

B. Treatment should be by either a physical medicine practitioner or a surgeon (orthopedic, hand, plastic, or neurosurgeon).

1. Physical Medicine.

(a) A physical medicine practitioner shall evaluate for functional anatomical lesions in the neck, shoulder, thorax, elbow and wrist. Physical medicine examiners: Chiropractor (DC), Osteopathic Physician (DO who specializes in manipulation), Physical Medicine and Rehabilitation Specialist (MD/DO, formerly known as "physiatrist"), Physical Therapist (PT), and Occupational Therapist (OT).

(b) If functional anatomical lesions are identified, two to eight (2-8) weeks of treatment with a physical medicine practitioner (DC, DO who specializes in manipulation, MD/DO who is a physical medicine and rehabilitation specialist, PT, OT) should be performed on a decreasing frequency. The referring physician shall be provided progress reports at 2-week intervals. Treatment should cease if two weeks pass without significant documented functional improvement. It is important that the injured worker continue to work and perform his or her activities of daily living during this therapy. Modified duty or work reassignment is appropriate during treatment.

b. Ambulatory Surgery.

1. Indications

A. Unresponsive or progression of symptoms in the face of non-operative treatment; objective signs.

B. Thenar atrophy or objective impairment of sensibility (widened two-point discrimination or diminished light touch).

C. Intolerable numbness and pain.

D. Mass or deformity in carpal tunnel.

2. Treatment Options

A. The operative treatment usually includes minimal invasive type of surgery vs. open type of surgery, and is indicated according to the condition of the patient.

B. In some of the severe CTS cases, the surgeon may wish to seek an examination by another physician in order to determine if the injured worker is an appropriate candidate for recovery and return to work.

3. Home Health Care. When self-care is compromised during the early post-operative period, homemaker services may be required in some instances. Examples: opposite hand amputation or limiting injury.

4. Physical Rehabilitation.

A. Brief post-operative splinting, optional.

B. Finger and wrist range of motion.

C. Scar massage after sutures removed.

D. Grip and pinch strengthening.

E. Range of motion exercises of affected extremity.

F. Progressive activity reintroduction.

G. Physical medicine, if indicated, should be limited to six weeks.

5. Supporting Evidence.

A. Carpal tunnel release relieved pain and paresthesia in up to 90% of patients with correct diagnosis.

B. Significant pre-operative median nerve involvement, concurrent medical conditions and/or inability to modify aggravating exposures may affect post-operative functional recovery.

c. In-Patient Treatment.

1. Inpatient Treatment.

A. Rare.

B. Associated with other trauma or condition, i.e. crush injury, burns, etc.

2. Indications for Admission.

A. Compartment syndrome of forearm.

B. Other serious medical conditions which increase surgical anesthetic risks.

C. Complication at time of operative procedure.

D. Treatment options: same as for ambulatory patient.

E. Indications for discharge: medical condition stabilized.

F. Home health care: same as for ambulatory patient.

G. Rehabilitation: same as for ambulatory patient.

d. Estimated Duration of Care

1. Non-operative Treatment

A. Activity modification may be indicated.

B. Depending on objective findings and past duration of symptoms and as outlined in the Presley Reed Guide referenced in this Rule.

2. Operative Treatment

A. Consistent with global guidelines and as outlined in the Presley Reed Guide referenced in this Rule.

B. Three month follow-up unless there are complicating factors.

e. Anticipated Outcome.

1. Improved sensory and/or motor and/or autonomic function.

2. Elimination of paresthesia.

3. Lessening of pain.

4. In severe carpal tunnel syndrome cases, complete relief of the symptoms is usually not obtained. The surgery is performed to stop progression of the nerve damage or to delay progression of damage already present in the form of nerve fibrosis and vascular changes.

f. Modifiers

1. Pregnant and nursing women usually have decreased or resolved symptoms shortly after delivery or cessation of lactation, but persistent symptoms may require surgical release.

2. Age and gender are not modifiers.

3. Co-existent neurological or systemic disorder, i.e. diabetes, thyroid dysfunction, amyloidosis, etc., may make symptoms more severe and less likely to fully resolve following treatment.

g. Cold laser is an experimental and unproven therapy. The Commission will not pay for such treatment.

41.9. Rehabilitation

a. Keeping Workers on the Job.

1. Workers generally are in a more positive psychosocial, motivational and financial mode when they continue to work. These factors impact significantly on the rehabilitation outcome.

2. Barring a clear medical contraindication, if the employer can provide suitable reasonable accommodations based upon restrictions recommended by the physician due to the compensable medical condition, the injured worker should continue to work during the recovery process and be released to return to such work as soon as possible when temporary disability is unavoidable.

b. The Work Release

1. Return to work may be initiated via two paths, starting with the physician's work release or with a proposal from the employer or a qualified rehabilitation professional.

2. In either case, the release must be as specific as possible so the employer and patient clearly understand what is expected. The physician should address:

A. Physical restrictions, time restrictions (hours per day and/or week and duration of the restriction).

B. Pacing restrictions.

C. Break requirements (frequency and purpose, such as for rest from certain activities, icing, warm-up exercise, self-massage, etc.).

D. Recommended job site accommodations (such as workstation height or set-up) or ergonomic devices (such as anti-vibration tool wraps).

3. When the employer or a qualified rehabilitation professional offers a return to work proposal, the attending physician should expect to be provided:

A. A functional job analysis with which to make an informed decision regarding the work release. The job analysis must thoroughly describe job duties, physical demands (strength and production/work pace), tools used and environment.

B. Assurance that the employer (line supervisors and co-workers, not just human resources personnel) will support the worker in the restricted or alternate duty return to work.

C. A rehabilitation plan signed by the employer, injured worker and a qualified rehabilitation professional when restricted or alternate duty (part-time or full-time) is to be approved. This plan should describe the accommodations being offered and the time frame for which they will be available.

c. Career Changes. Injured workers with significant permanent upper extremity residual impairment will frequently need a permanent change of vocations.

d. The provisions of Section 41.9 may be used to govern the rehabilitation processes of injuries other than carpal tunnel syndrome as appropriate.

§85-20-42. Treatment Guidelines: Injuries to the Knee.

42.1. The vast majority of knee injuries result from direct trauma to the joint or are caused by torsional or angulatory forces. These injuries vary in severity from simple ligamentous strains to complex injuries involving ligamentous disruption with meniscal damage and associated fracture. This guideline is designed to guide the practitioner in the appropriate management of these injuries and to establish a logical sequence for the diagnostic evaluation and treatment of the more complex injuries.In general, knee injuries should be referred for orthopedic consultation and/or treatment under the following circumstances:

a. Failure of a presumed knee sprain to show progressive resolution and respond to appropriate conservative treatment in a period of three (3) weeks;

b. Radiographic evidence of an associated fracture;

c. The initial presence of a tense hemarthrosis or the development of a recurrent hemarthrosis;

d. An acutely locked or an acutely dislocated knee;

e. Clinical evidence of gross ligamentous instability; and

f. A presumed diagnosis of a meniscal injury.

§85-20-43. Treatment Guidelines: Knee Sprains.

43.1. These are common injuries resulting from the application of a torsional or angulatory force to the knee and are characterized by pain, mild swelling, localized tenderness, increased discomfort or weight bearing, negative x-rays, and no clinical evidence of instability.

a. The appropriate diagnostic tests.

1. Plain x-rays.

43.2. The appropriate and inappropriate treatment is as follows:

a. Nonoperative treatment.

1. Medications to include nonnarcotic analgesics and nonsteroidal anti-inflammatory drugs;

2. Application of ice, compression dressings, and temporary partial restriction of weight bearing;

3. Physical modalities and/or rehabilitative procedures;

4. Duration of care - estimated duration of care is three weeks, not to exceed six weeks; and

5. Anticipated result - resolution of symptoms and resumption of normal activities.

b. Inappropriate treatment:

1. Surgery;

2. Inpatient; and

3. Greater than three weeks without consultation.

§85-20-44. Treatment Guidelines: Meniscal Injuries.

44.1. The mechanism of injury is similar to that for knee sprains but symptoms of pain and swelling fail to resolve in the anticipated period of time and the symptoms frequently include a sensation of "catching or giving away" of the joint and a history of locking of the joint may be elicited.

Clinical findings may include joint space tenderness, a mild effusion and restricted range-of-motion and positive McMurray's sign.

44.2. The appropriate diagnostic tests are as follows:

a. Plain x-rays;

b. Arthrocentesis;

c. MRI;

d. Arthrogram; and

e. Diagnostic arthroscopy.

44.3. The appropriate treatment is as follows:

a. Outpatient/nonoperative treatment.

1. Short-term use of nonsteroidal anti-inflammatory drugs in conjunction with an arthrocentesis and short-term immobilization with a period of limited weight bearing;

2. Physical modalities and/or rehabilitative procedures.

b. Outpatient/operative treatment.

1. Options include arthroscopic meniscectomy and/or arthroscopic meniscal repair; and

2. Physical therapy/rehabilitation.

c. Inpatient/nonoperative treatment not indicated.

d. Inpatient operative treatment - The reasons for admission for surgical treatment may include the presence of associated medical conditions, a concomitant knee injury such as a fracture of the tibial plateau or a major ligamentous disruption, or the presence of other injuries which require inpatient treatment.

44.4. The duration of treatment may vary up to three (3) months. The injured worker's age and pre-existence of arthritic changes within the joint will influence the duration of treatment.

44.5. The anticipated outcome is as follows:

a. Improved knee function with minimal residual symptoms; and

b. Possible predisposition to the development of traumatic arthrosis of the knee.

§85-20-45. Treatment Guidelines: Foot and Ankle Injuries.

45.1. Injuries to the foot and ankle usually relate to a specific traumatic event and have a predictable clinical course depending on the severity index of the initial injury. For simplicity, injuries will be discussed relative to the anatomic region of the foot and ankle (ankle, hind foot, midfoot, forefoot or phalanges).

45.2. The appropriate diagnostic criteria is as follows:

a. Pertinent historical and physical findings:

1. Onset of pain and/or swelling is related to a single event, either a twisting injury, fall or direct blunt trauma. The degree of the injury can be judged quickly by determining which one can bear weight and the degree of initial swelling. The more severe injuries will have greater swelling, inability to bear weight, and may have obvious deformity.

45.3. Diagnostic test and examination considerations are as follows:

a. If differentiation between a soft tissue ligamentous injury and a fracture is required, x-rays in several planes are appropriate in all cases;

b. CT scans may be indicated in hind foot injuries to define subtle fractures, tarsal coalitions or the degree of displacement in three planes in acute injuries;

c. Bone scans are occasionally indicated in long standing pain problems to rule out stress fracture or inflammatory causes of foot pain (after four weeks of pain with normal X-rays).

d. MRI rarely indicated - should require specialty consultation; and

e. EMG and vascular studies (non-invasive arterial perfusion or arteriography at the request of the specialist).

f. Inappropriate diagnostic tests:

1. Thermogram.

g. Indications for specialty referral:

1. Displaced fractures;

2. Neurovascular compromise; and

3. Pain and swelling greater than three weeks.

45.4. The appropriate treatment is as follows:

a. Non-operative.

1. Sprains (No fracture seen on x-ray)

A. Rest, ice compression and elevation(RICE);

B. Crutches and splinting (one through three days);

C. Early mobilization as pain allows. This may involve active supervised physical therapy;

D. Usual course - several days to three weeks; and

E. Referral to specialist required if no improvement by three weeks.

2. Fractures.

A. Simple non-displaced:

1. Ankle – Specialty referral -Will require special splinting or casting for three to six weeks and may require an additional two to four weeks of physical therapy rehabilitation.

2. Hind foot - Same as ankle.

3. Midfoot - Same as ankle but course is usually two to four weeks shorter.

4. Forefoot - Specialty referral not required special shoe or cast may be necessary. Usually resolved in three to six weeks.

5. Phalanges - Same as forefoot, simple taping and/or modified shoe usually all that are necessary.

3. Displaced fractures. Specialty referral is mandatory. Non-operative treatment requires casting for three to six weeks followed by up to four weeks of rehabilitation.

b. Operative. All operative decisions require specialty referral.

1. Sprains. Indicated when there is a complete dislocation/ subluxation without a fracture anywhere in the ankle, hindfoot, or midfoot. May be indicated in the forefoot.

2. Fractures.

A. Simple - may be indicated in ankle.

B. Displaced - Usually indicated in ankle, hindfoot, midfoot, and forefoot. Displaced phalange fractures can sometimes be treated non-operatively.

§85-20-46. Treatment Guidelines: Physical Medicine.

46.1. Principles for use of physical medicine:

a. Physical medicine should be initiated as early as the day of injury; indications for and focus of (early) intervention include:

1. Acute management of pain and spasms;

2. Use of passive modalities as adjunct to active treatment;

3. Manual therapy for restoring joint function;

4. Instruction in range of motion and stretching exercises;

5. Assessment of return to work readiness and identifying necessary work modifications;

6. Injured worker education in healing process, body mechanics, proper resting positions, and home treatment program; and

7. Time frames may range from one visit to daily visits in accordance with applicable treatment guidelines.

b. Evaluations and treatments authorized by the Commission must be provided by professionals licensed to perform such activities.

c. Initiation of treatment may not be indicated when:

1. Few objectively measured deficits are found on evaluations;

2. Subjective complaints of pain are the only finding;

3. Pain behaviors are interfering with the return to work process; and

4. Injured worker is not compliant with the treatment plan.

d. Inappropriate and medically unsupported treatment is the exclusive use of passive modalities throughout the course of treatment.

e. Exercise programs are progressively increased to include strengthening and conditioning exercises. Any work simulation activities (also gradually increased) should focus on essential work tasks (pushing, pulling, lifting, etc.). Time frames may range from 1 to 4 hours per day, 3 to 5 days per week in accordance with above treatment guidelines.

f. Progress reports to the referring physician, the Commission, and the employer should identify continuing complaints, progress made, further rehabilitation needs, and level of return to work readiness. An injured worker may continue in therapy, if indicated, after return to work in accordance with applicable treatment guidelines.

46.2. Treatment limitations. Physical medicine treatment shall not exceed 10 visits in the initial 14 days and must decrease in frequency thereafter. In no case shall the treatment exceed 16 visits in the initial 30 days or 12 visits in the second 30 days.

46.3. If physical medicine care continues to the 30th day and the injured worker has not returned to work, the treating physician may arrange a consultation for a second opinion. Reimbursement for care past the 45th day shall be disallowed unless the consulting physician recommends further care.

46.4. If care continues to the 30th day and the injured worker lost no time or is back to work, shows significant documented functional and clinical signs of improvement, and has not reached maximum medical improvement, continued care is appropriate. Such care shall not exceed the 60th day unless otherwise expressly authorized by this Rule.

46.5. Injured workers with complicating factors which have prevented a return to work by the 60th day require active case management by the Commission within the parameters of this Rule. Independent medical evaluator guidance may be requested by the Commission, in its sole discretion.

46.6. Treatment beyond 28 dates of service (within 60 days) is limited to a maximum of 5 treatments over one additional 30-day period and requires Commission authorization. Authorization requires the worker has a history of surgery or fracture in the involved area, and either 1) the worker has returned to work or 2) modified work is not available.

46.7. Workers who have returned to work, reached maximum medical improvement and experience flare-ups of their injuries, due to job-related activities, may be treated a maximum of 4 times over a 2-week period. The Commission will reimburse a maximum of 12 treatments for work related flare-ups within 14 months of the date of injury.

46.8. Reimbursement shall be disallowed for any treatment rendered after the injured worker reaches maximum medical improvement unless otherwise expressly authorized by this Rule.

§85-20-47. Treatment Guidelines, Protocols and Procedures for Performing Audiological Examinations and Evaluations in Workers' Compensation Claims for Noise-Induced Hearing Loss.

47.1. Only audiometric test results obtained by an audiologist having a certificate of clinical competence in audiology (CCC-A) or a West Virginia audiology licensure are acceptable for purposes of awarding compensation. An audiogram performed at the request of any physician may be utilized by the injured worker for the purpose of completing the workers' compensation application form. However, only physicians who are qualified otologists or otolaryngologists may interpret the results of audiograms in assessing the degree of the injured worker's noise-induced hearing loss impairment for the purpose of determining the percentages of the injured worker's whole person impairment, if any.

47.2. A physician examining and evaluating an injured worker in a noise-induced hearing loss claim must consider the injured worker's medical and occupational history, as well as available audiograms, in determining the etiology of the hearing loss. It is not necessary to use a uniform brand and model of audiometer.

For Commission standards, the audiologist shall adopt the ANSI Guidelines and perform an annual exhaustive calibration. The audiologist should also perform a daily listening check.

47.3. Establishing a definitive margin of error: Two audiograms are said to be in acceptable test-retest variability when the total of four frequencies (500, 1000, 2000, 3000 Hz) is 15 decibels or less and the audiometric curves are similar. Because the two audiograms are technically identical and one cannot be chosen over the other, the calculation of whole person impairment will be based on the audiogram that yields the highest degree of impairment for the injured worker.

a. If two audiograms are both rated "good", and differ by more than the established margin of error, the Commission shall arrange for a third independent evaluation by an otologist or otolaryngologist.

b. The two audiograms that are within an acceptable test/retest variability should be used.

47.4. The audiologist shall be required to perform the following specific reliability and validity checks during the course of an audiogram:

a. Speech Reception Threshold (SRT)/Pure Tone Average Comparison: SRT should be within 10 decibels of the best two frequency average for the pure tone thresholds of 500, 1000, 2000 Hz.

b. Both ascending and descending thresholds should be obtained at 1000 Hz for each ear. The difference should be no greater than 5 decibels.

c. Reliability should be rated: good, fair, poor.

d. Certified and/or licensed audiologists must perform the audiogram.

e. The four validity and reliability checks set forth above must be documented on the Workers Compensation form and the examiner must initial his or her findings on the forms.

47.5. The Commission will inform all physicians evaluating noise-induced hearing loss injured workers on the Commission's behalf that standard air conduction and bone conduction testing, speech reception threshold, speech discrimination, tympanometry and acoustic reflex testing must routinely be performed as a part of audiometric evaluation. Other testing, including otoacoustic emission testing, may be required at the discretion of the otologist/otolaryngologist. If the required audiometric tests have not been done, the report is unacceptable and the physician will not be compensated. W. Va. Code §23-4-8.

47.6. When a sensorineural hearing loss is present it may be the result of noise induced hearing loss and/or other disease processes. The medical evaluator should consider all causes of sensorineural hearing loss. When a conductive loss is present, the bone conduction levels will show the purist hearing an injured worker could have as a result of noise induced hearing loss.

47.7. The audiologist shall perform speech discrimination (word recognition) testing using W-22 word lists. Both live voice and recorded presentation methods for testing speech discrimination are acceptable; each method has its advantages. The audiologist should use the method that provides the best representation of the injured worker's true speech discrimination score.

The otologist or otolaryngologist interpreting the speech discrimination results shall use the formula set forth in W. Va. Code §23-4-6b, to calculate the injured worker's impairment rating.

47.8. Occupational noise induced hearing loss (NIHL) typically starts in the high frequencies; usually 3000, 4000 or 6000 Hz. With progression, these frequencies worsen and the hearing loss extends to the lower frequencies; (2000 and 1000 Hz). Even with progression, however, the audiometric pattern remains one that descends from the low frequencies to the high frequencies, sometimes with recovery at 6000 or 8000 Hz. Occupational NIHL does not cause an ascending audiometric pattern (where the low frequencies would be worse than the high frequencies). A flat audiometric curve is also not typical of an etiology of solely occupational NIHL. If an audiogram presents a pattern that is atypical of an occupational NIHL pattern, then the physician interpreting the audiogram should consider causes other than occupational noise exposure in determining the hearing loss etiology. If the otologist/otolaryngologist determines that an injured worker's hearing loss is not all noise

induced hearing loss, he or she should estimate the true noise induced hearing loss thresholds and explain his or her calculations on the basis of medical and audiological findings.

47.9. When an injured worker has been exposed to steady state noise, his or her NIHL will usually be symmetrical between both ears. If the injured worker has a hearing loss that is asymmetric then the evaluating physician should consider all causes for hearing loss, including nonoccupational noise, trauma or disease processes and whether there is more noise exposure on one side than the other.

47.10. If a physician determines that an injured worker's hearing loss is the result of occupational noise exposure, the total hearing loss impairment rating shall be calculated pursuant to the formula set forth in W. Va. Code 23-4-6b.

47.11. The Commission will reimburse for hearing aids when 5% or greater permanent industrial hearing loss impairment has been diagnosed. The recommendation for the hearing aid must be based on the evaluation of an otologist or a otolaryngologist for reimbursement. The Commission shall retain sole discretion to select the hearing aid most appropriate for treatment.

§85-20-48. Treatment Guidelines: Psychiatric Claims

48.1. Treatment of mental conditions to injured workers is to be goal directed, time limited, intensive, and limited to conditions caused or aggravated by the industrial condition. Psychiatric services to workers are limited to those provided by psychiatrists and licensed psychologists, and according to department policy. For purposes of this rule, the term "psychiatric" refers to treatment by psychologists as well as psychiatrists.

48.2. Initial evaluation, and subsequent treatment must be authorized by Commission staff. The report of initial evaluation, including test results, and treatment plan are to be sent to the injured worker's attending provider, as well as the Commission. A copy of sixty-day narrative reports to the Commission is also to be sent to the attending provider. In addition, the following are required: Testing results with scores, scales, and profiles; report of raw data sufficient to allow reassessment by a panel or independent medical examiner. Use of the current Diagnostic and Statistical Manual of the American Psychiatric Association axis format in the initial evaluation and sixty-day narrative reports, and explanation of the numerical scales are required.

48.3. A report to the department will contain, at least, the following elements:

a. Subjective complaints;

b. Objective observations;

c. Assessment of the worker's condition and goals accomplished; and

d. Plan of care.

Failure to provide the required narrative reports as required under this rule shall result in a waiver of the fee due and owing the provider for that sixty (60) day period.

48.4 This Guideline is in addition to the requirements Section 12 of this rule.

48.5 Understanding that psychiatric conditions may arise as a consequence of injury, the Commission recognizes the need to treat these conditions. It is expected that with resolution of the injury, there will be resolution of the psychiatric injury. The Commission is not responsible for the on-going management of chronic or pre-existing psychiatric conditions which it does not view as directly related to the injury.

§85-20-49. Treatment Guidelines: Multi- Disciplinary Pain Management

49.1. It is now well accepted that chronic pain treatment is a complex problem that involves physical, emotional and behavioral components. Chronic pain and treatment therefore, including multidisciplinary interventions, is only compensable if specifically diagnosed as caused by an injury received in the course of and resulting from employment.

49.2. Multidisciplinary treatment for chronic pain and related disability has been more rigorously examined than most other treatments used with chronic pain. There is strong evidence for the importance of the behavioral/psychological component of treatment in making meaningful changes in pain intensity, functional status and emotional distress.

49.3. The best predictors of disability and response to multidisciplinary treatment may not be a function of physical or medical variables; instead, psychological variables may be the best predictors in certain cases. Additionally, assessment of psychosocial "risk factors" for chronic disability done shortly after injury can lead to more effective management by identifying which patients are likely to benefit from multidisciplinary treatment.

49.4. Chronic Pain Syndrome: Chronic Pain Syndrome patients are defined by the following criteria: a) Reports of persistent (i.e., at least four months duration) pain, which may be consistent with or significantly out of proportion to physical findings; b). Demonstrates or has demonstrated a progressive deterioration in ability to function at home, socially and at work; c) Shows or has shown a progressive increase in health care utilization (such as repeated physical evaluations, diagnostic tests, requests for pain medications and/or invasive medical procedures); d) Demonstrates mood disturbance; and e) May exhibit clinically significant anger, frustration and/or hostility.

49.5. Program Guidelines:

a. Program Goal: To address behavioral barriers, which inhibit return to work while increasing physical function in a protocol-based rehabilitation program.

b. If an injured worker is diagnosed with Chronic Pain Syndrome directly related to a compensable injury, any authorized pain management program shall contain the following objectives and guidelines.

1. To successfully return the patient to pre-injury work. If this goal is not realistically obtainable, then the goal is to have the patient demonstrate specific alternative work capabilities.

2. To develop work-related skills with work simulation activities.

3. To develop strength, endurance, movement, flexibility and motor control related to performance of specific vocational and avocational goals.

4. To identify and improve management of psychosocial barriers to facilitate return to work.

5. To demonstrate increased responsibility for their condition through the use of self-management techniques related to pain and associated psychological symptoms. This should be done with minimal ongoing medical intervention (decrease dependence on health care system).

6. To demonstrate understanding safe job performance, injury prevention and physical and psychosocial threats to relapse.

c. Program Direction: Responsibility should be assigned for program direction and for medical direction. The same individual may be responsible for both functions. Program direction need not be provided by a physician. Program Director may be an Allied Health Professional with an advance degree and state licensure appropriate to degree. Program Director must have at least one year's experience in interdisciplinary rehabilitation and participate in annual continuing education in this field. The participating physician must be board certified or eligible with annual continuing education in this field.

d. For an injured worker to be authorized to participate in a pain management program, the injured worker must demonstrate: 1) At least three months of ongoing pain-related temporary total disability or inability to safely return to work; 2) The need for such a program must be related to the compensable injury and subsequent consequences.; 3)The patient should be able to express a vocational goal whether related to return to work or retraining for return to work; and 4) Presence of psychosocial barriers to rehabilitation (such as depression, anxiety, fear/avoidance behaviors, poor coping/adaptation skills, anger).

e. Pain management program shall not be authorized if any of the following factors exist: 1) Presence of concurrent noncompensable health or mental health condition that would prohibit full understanding and participation in the program; 2) Medical instability that may warrant continued medical intervention (such as surgery, etc.); or 3) Presence of a substance addiction/dependence that prohibits safe and effective participation in the program.

f. Scope of Service/Program Organization: CPS patients are best treated in an integrated interdisciplinary program. The program needs to maximize continuity of care by employing a coordinated group of health care professionals (i.e., physicians, psychologists, physical and occupational therapists, vocational evaluators, counselors and specialty consultants) who evaluate and treat the patient as a team.

g. Evaluation: The treatment plan is developed through an interdisciplinary evaluation with a recommendation for either admission into the occupational rehabilitation program (ORP) or appropriate alternative treatment. The evaluation should consist of the following: 1) Review of records; 2) Quantitative evaluation by physical therapist to determine current level of functioning and anticipated outcome; 3) Psychological evaluation by licensed psychologist to identify behavioral barriers to return to work and to determine need for psychological intervention, if necessary; and 4) Medical evaluation by a licensed physician to identify any medical barriers to participation and to clear patient for physical restoration activity.

h. Treatment: Individual treatment plan will address the following:

1. *Frequency and Intensity of the program:* The frequency, intensity and duration of the program should be sufficient to demonstrate improvement in the following areas: work capabilities, strength, stamina and psychosocial barriers to improved functioning (may include fear avoidance, depression, anxiety, coping strategies, anger...) In order to achieve these goals through an interdisciplinary approach and simulate a typical work day, this treatment requires a minimum of five (5) and a maximum of eight (8) hours per day, five (5) days per week. Daily attendance is therefore imperative and integrated into the goals of the program (see section 7). Provision of services will include both daily behavioral/psychological and physical restoration activities. Effective outcome from interdisciplinary treatment is usually accomplished within a maximum of 20 treatment days. Thus, this 20 treatment-day upper limit for intervention with CPS patients is recommended;

2. *Extensions To Treatment:* Occasionally, there may be justifications for extended treatment beyond the 20-day program. Any such extension needs to be documented, time-limited and monitored on a case-by-case basis. The following should apply to potential extension situations: 1) The patient has clearly shown significant and objectively documented progress within the initial 20-day treatment protocol; 2) Further functional gains that increase the patient's likelihood to return to work are likely within the extension period; 3) Extension periods should be time limited and should not exceed 10 treatment days.

. i. Treatment Team Members:1. Services should be provided by a coordinated interdisciplinary team that includes a core team of individuals who are specifically assigned to the program. The following disciplines, and others as may be designated by the program director, shall constitute the *core treatment team:* participating physician, clinical psychologist and physical therapist.2. Dependent on the needs of the patient, the following practitioners may also be involved: case manager (internal or external), psychiatrist, nurse, occupational therapist, vocational specialist.

j. Services Provided: Services shall include, but not be limited to: 1) Medical assessment; 2) Weekly staff meetings that include the core treatment team (or their assigned representatives).; 3) Ongoing reappraisal of each participant's clinical and functional work status; 4) Performance of appropriate medical diagnostic and treatment procedures; 5) Providing information needed to assist participant to return to work; 6) The practice, modification and instruction of component work tasks through real or simulated work; 7) The development of strength and endurance of the participant related to the performance of work tasks; 8) education to teach safe job performance and prevent re-injury; 9) Promotion of self-management strategies; and 10) The development of attitudes and behaviors that will improve the ability of the participant to return to work or benefit from other rehabilitation.

k. Space: Services consistent with the needs of the program shallbe provided in settings as follows: 1) A physical therapy setting that allows for conditioning and strength training. An area that supports a work-related treatment environment, which would include work simulation activities, is also needed; 2) Classroom and conference space is required for individual counseling and educational sessions.; and 3)Theprogram may be provided as a private or group practice, hospital based program or freestanding program. All services provided should ideally be performed at a single campus setting. Services should not be performed at more than two locations within a given treatment day.

l. Documentation:

1. Whenever possible, pain management programs shall offer outpatient rather than inpatient services and clear and convincing documentation proving that outpatient treatment is inappropriate in a particular claim is required before inpatient treatment can be authorized. Documentation of interdisciplinary evaluation prior to admission shall include: a) A quantitative report by a licensed physical therapist that documents current level of functioning and anticipated outcome; b) A psychological report by a licensed psychologist that documents behavioral and/or emotional barriers to return to work and identifies the need for psychological intervention (if necessary); c) Medical report that documents any barriers to participation in the program and gives medical clearance for the patients participation in physical restoration activity; and e) Post-evaluation summary report that documents specific treatment recommendations.

2. Treatment documentation should include at a minimum: a) Daily progress notes; b) Weekly Staffing Summaries which document progress toward goals, current functional status, and newly identified barriers to participation; and c) Discharge Summary which documents progress achieved in functional, work-related goals, work capability at discharge, progress in addressing psychological barriers to improved function, medical status, and recommendations. The Commission will determine the standards by which this will be reported and the timeframe for such reporting.

m. Discharge Criteria: Discharge of a participant from an interdisciplinary rehabilitation program shall be based upon the following: 1) Goals of the program have been achieved; 2) The injured worker has failed to fully participate and/or comply with program

requirements; 3) The physician of record has discontinued the program for the participant; 4) A condition has arisen directly related to the compensable injury requiring further medical or other health care intervention, not present at initiation of the program.; 5) Prior to completion of the program, it is determined by the service provider or attending physician that the client will be unable to accomplish the goals of the program. This determination can be based upon a combination of objective and subjective criteria; and 6) The participant has excessive absences.

§85-20-50. Treatment Guidelines: Interventional Management of Chronic Pain.

Definitions:

As used in this exempt legislative rule, the following terms have the stated meanings unless the context of a specific use clearly indicates another meaning is intended.

50.1. "Acute pain" means pain experienced as the result of injury, disease, or operative procedure. Treatment usually consists of medications, surgical repair, and/or physical medicine therapies. Care may be provided in the office, clinic, or hospital setting.

50.2. "Bier block" means the instillation of medication into the venous system of a limb for anesthetic or therapeutic purposes; venous circulation is occluded with a tourniquet to retain medication in the veins of the limb.

50.3. "Chronic pain" means pain lasting more than three months. The cause of the pain is often unknown and may not be linked to an actual physiological event. Chronic pain complaints are usually accompanied by other psychophysiological disorders such as depression, weight gain or loss, sleep disorder and digestive disorder. A nurse case manager must coordinate care for claimants experiencing chronic pain, including intervention by a pain management specialist early in the treatment process and involvement of other treatment modalities and consultative specialists as needed.

50.4. "Interdisciplinary" means including representation from two or more health care fields.

50.5. "Medical Services Unit" or "Office of Medical Services" means a group of Commission personnel designated to deal with health care issues; such personnel may be supplemented with health care personnel providing services on a contract or other basis.

50.6. "Nerve block" means injection of a local anesthetic medication in proximity to a nerve or nerve plexus to block nerve transmission.

50.7. "Nurse Case Manager" means a duly licensed registered professional nurse authorized by the Commission to coordinate health care and rehabilitative services for injured workers.

50.8. "Pain" refers to a complex unpleasant sensory and emotional experience associated with actual or potential tissue damage or which may just be a subjective experience described in terms of such damage.

50.9. "Pain management specialist" means a licensed physician with specialized training and experience in the diagnosis and/or treatment of chronic pain.

50.10. "Steady dose" refers to the amount and frequency of pain relief medication that is required to maintain optimum pain relief, once the dosage of such medication has become fixed or nearly fixed in amount and frequency.

50.11. "Trigger point injection" means placement of a needle into a myofascial space with or without injection of medication.

General:

50.12. All practitioners who treat chronic pain need to address goals in three major life areas: physical; social; and psychological.

a. Physical goals include: analgesia, early mobility, functional restoration and increased exercise tolerance, strength and range of motion.

b. Social goals include: a positive expectation for recovery from family and support systems; avoiding identification with disabled family prototypes; resistance to the negative reinforcement from interested other parties; and recognition of the deleterious effects of the disability lifestyle.

c. Psychological goals include: dealing with grief and loss over altered function and coping with chronic distress and a changed lifestyle; maintaining a positive attitude toward recovery; focusing motivation; appreciating primary, secondary and tertiary gains; and obtaining diagnosis and treatment for any psychiatric diagnosis.

50.13. Emergency conditions such as Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy) may require immediate consultation with a pain specialist and initiation of treatment without delay.

50.14. In contusion and sprain/strain cases, and in non-surgical disk cases, claimants who are being considered for injections for the treatment of chronic pain, but who have not had a trial of physical medicine, including exercise and/or manipulation, will be required to be evaluated by a physical medicine practitioner or other independent medical evaluator. The physical medicine practitioner or other evaluator will determine whether a 30-day regimen of physical medicine in conjunction with initiation of chronic pain therapy is likely to provide full or partial relief prior to initiating a series of injections.

50.15. When chronic pain patients do not respond to initial specialist-directed efforts, a nurse case manager may be assigned to coordinate the pain management effort. The nurse case

manager's or other case manager's report will include an assessment as to the benefits of chronic pain management, such as the likelihood that the claimant will be able to return to work. A psychiatric or psychological evaluation must be part of the assessment process. Psychiatric conditions must be evaluated and under treatment as indicated before use of long-term narcotics or implantable devices will be authorized by the Workers' Compensation Commission.

50.16. Claimants who have injuries greater than six (6) months old with continued symptoms, and who are not actively being treated for chronic pain may be eligible for an additional six (6) months further treatment or management of pain, only if an independent medical evaluator selected by the injured worker's treating physician agrees that the recommended treatment, including pain management, is reasonable, necessary, related to the compensable injury, and likely to be successful in substantially reducing the injured worker's symptoms.

Injections:

The following criteria must be met before the Commission will authorize the use of injections by the pain management specialist form the treatment plan:

50.17. The Claim file must document objective physical signs and subjective symptoms which support the use of the proposed procedure.

50.18. When performing a "series" of injections, there must be documentation of measurable physical, psychological or vocational improvement before performing the next injection. Treatment of low back pain requires that a complete Commission back form be in the injured worker's file.

50.19. Active, not passive, physical medicine and home exercises prescribed after documented demonstration to the prescribing provider are to be a part of any injection or procedure-based treatment plan. A report from the provider must be sent to the physician and a copy to the claims manager after every fourth visit. If physical medicine is not recommended, the physician must explain why it is not going to be used. Pain management shall be terminated if the injured worker fails to fully cooperate with the required exercise program.

50.20. If a surgical spine lesion exists that shows no immediate neurologic danger, cervical epidural steroids may be considered prior to surgery. The surgeon and the pain management specialists should work collaboratively in such cases. If epidural injections fail to provide relief or if new neurological deficits develop, surgical, evaluation should be scheduled promptly. The treating physician is responsible for referring any suspected surgical lesion promptly to a surgeon.

50.21. The treatments under each of the following categories are deemed appropriate. The order in which the treatments within each category are listed is not controlling of the treatment plan except as indicated.

Head and Neck Pain:

50.22. Peripheral Nerves, including occipital, greater and lesser, auricular, supraorbital, maxillary branch of V, mandibular branch of V, and others.

a. Six (6) blocks over three (3) months in office, or in ambulatory clinic if fluoroscopy is required;

b. Neurolysis/ Denervation by cryotherapy, chemical means, radiofrequency, or surgical intervention if good response not substained.

50.23. Facial Pain Sympathetically maintained

a. Sphenopalatine ganglion block-six (6) blocks over three (3) months;

b. Stellate ganglion block-six (6) blocks over three (3) months

50.24. Intrathecal Opioids- if all other conservative treatments fail

a. A trial is required. Refer to specific guidelines.

b. A second opinion is required before implant.

50.25. Myofascial Pain

a. Trigger point injections, no more than six (6) points or no more than six (6) occasions in three (3) months. If authorization for trigger point injections are requested more than twice in 1 year or 4 cycles total, the claim may be assigned a nurse case manager. Authorization is at the discretion of the Health Care Advisory Panel or its subpanel(s) after review of the case and focus on the claimant's work record.

b. Home exercise and physical medicine is required in combination with trigger point injections.

50.26. Cervical Facet Mediated Pain.

a. No more than 4 injections over six (6) months.

b. Physical medicine is required in combination with injections.

c. Neurolysis/ Denervation by cryotherapy, chemical means, radiofrequency or surgical intervention if good response to anesthetic injections not sustained.

50.27. Cervical Radiculopathy

a. Cervical epidural steroids, no more than four (4) injections in a six (6) month period, if surgery in accordance with the appropriate Workers' Compensation treatment guideline is not a medically viable option or if surgery has been attempted and failed to provide relief;

b. Cervical epidural infusion

c. If physical medicine alone fails in 30 days, suprascapular nerve block should be considered.

d. Spinal cord stimulation if other treatments fail. See specific guidelines.

Shoulder And Upper Extremity:

50.28. Adhesive Capsulitis.

a. Physical medicine alone should be used initially;

b. If physical medicine alone fails, distention by injection or a local nerve block may be performed combined with a follow-up exercise program.

50.29. Subdeltoid Bursitis, Olecranon Bursitis- No more than three (3) injections over six (6) months.

50.30. Epicondylitis - No more than three (3) injections over six (6) months.

50.31. Myofascial Pain

a. Trigger point injections, no more than six (6) points or no more than six (6) occasions in three (3) months;

b. If trigger point injections need to be repeated more than twice in (one) 1 year or for more than four (4) cycles total, a nurse case manager will be assigned to the claim. Authorization is at the discretion of the Commission.

c. Home exercise and physical medicine is required in combination with trigger point injections.

50.32. Phantom pain or stump pain.

a. Stellate ganglion block, up to six (6) times over a three (3) month period;

b. Cervical epidural catheter with infusion, for not more than four (4) weeks;

c. Spinal cord stimulation per specific guidelines if the above therapies fail.

50.33. Complex regional pain syndrome (reflex sympathetic dystrophy)

a. Referral to specialist made immediately upon diagnosis;

b. Cervical epidural infusion in conjunction with a program of physical medicine therapy no more than four (4) weeks duration;

c. Spinal cord stimulation in accordance with specific guidelines;

d. Stellate ganglion block, up to twelve (12) times during a three (3) month period;

e. Bier block, up to six (6) times over a three (3) month period.

50.34. Peripheral nerve injury

a. Nerve block, up to six (6) times over a three (3) month period;

b. Bier blocks up to six (6) times over a three (3) month period;

c. Cervical epidural infusion with physical medicine therapy of no more than four (4) weeks duration;

d. Spinal cord stimulation in accordance with specific guidelines.

50.35. Carpal Tunnel Syndrome

a. Nerve block up to six (6) times over a three (3) month period, if surgery in accordance with Commission treatment guideline is not a medically viable option or if surgery has been attempted and failed to provide relief.

50.36. Other Causes of Extremity Pain

a. Treatment on a case by case basis, subject to review by the Commission.

Thoracic and Chest Wall Pain:

50.37. Thoracic Disc Syndrome

a. Thoracic epidural steroids injection, up to four (4) times over six (6) months, if surgery is not a medically viable option, in the sole discretion of the Commission, or if surgery has been attempted and failed to provide relief.

b. Thoracic epidural infusion, accompanied by physical medicine if epidural steroids fail.

50.38. Intercostal Neuralgia

a. Intercostal nerve block with local steroids, up to four (4) times over six (6) months;

b. Thoracic epidural steroids, up to four (4) times over six (6) months;

c. Neurolytic intercostal injection if good but nonsustained improvement with steroid injections;

d. Spinal cord stimulation as per specific guidelines.

50.39. Costochondritis

a. Injection of joint, up to four (4) times over six (6) months;

b. Concurrent treatment by physical medicine is required.

Abdominal Pain:

50.40. Traumatic pancreatitis

a. Celiac plexus blocks, up to six (6) times over six (6) months;

b. Neurolytic celiac plexus blocks if a good but unsustained response results from celiac plexus blocks with local anesthetic;

c. Intrathecal opioids. See specific guidelines.

50.41. Post Hernia Nerve Entrapment-Injection of involved nerve, up to six (6) times over three (3) month period

50.42. Peripheral nerve involvement

a. Injection of ilioinguinal, genitofemoral, iliohypogastric, or other peripheral nerves, up to six (6) times over (3) months

b. Spinal cord stimulation in accordance with specific guidelines.

50.43. Pelvic/ Rectal/ Penile/ Vulvar pain

a. Superior hypogastric plexus block, up to four (4) times over a three (3) month period;

b. Intrathecal opioids – see specific guidelines

c. Peripheral nerve block as approved by the Commission.

Low back-Lumbar pain:

50.44. Lumbar Facet Joint Syndrome

a. Injections of facets, up to four (4) times over a six (6) month period, with physical medicine or home exercise. If this needs to be repeated more than twice in a one (1) year or for more than four (4) cycles total, a nurse case manager will be assigned to the claim. Authorization for continued treatment is at the discretion of the Commission.

b. Neurolysis/ Denervation by cryotherapy, chemical means , radio-frequency, or surgical intervention if complete pain relief following injections is not sustained.

50.45. Sacroilitis

a. Injection of joint with a local anesthetic and steroid, up to four (4) times over a six (6) month period.

50.46. Piriformis Syndrome

a. Injection of muscle with a local anesthetic and/or steroid, in conjunction with physical medicine. No more than four (4) injections over a six (6) month period.

50.47. Post Laminectomy Syndrome/ Adhesive Arachnoiditis/ Spinal Stenosis/ Failed Fusion/ Intractable Radiculopathy/ Coccydynia.

a. Lumbar or caudal epidural steroids, up to four (4) injections over six (6) months.

b. Spinal cord stimulation as per Commission guidelines;

c. Intrathecal opioids as per Commission guidelines;

d. Trigger point injections, no more than six (6) points or no more than six (6) occasions in three (3) months.

50.48. Myofacial pain

a. Trigger points no more than six (6) points or no more than six (6) occasions in three (3) months.

Lower Extremity:

50.49. Lumbar radiculopathy

a. Lumbar epidural steroids, up to 4 injections over a 6 month period, in conjunction with physical medicine, if surgery in the opinion of the Commission is not a medically viable option or if surgery has been attempted and failed to provide relief. If this needs to be repeated more than twice in 1 year or 4 cylces , a nurse case manager may be assigned to the claim. Authorization for continued treatment is at the sole discretion of the Commission.

b. Documented interval improvement.

c. Spinal cord stimulation as approved by the Commission.

50.50. Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy)

a. Referral to specialist immediately upon diagnosis.

b. Lumbar sympathetic plexus block, up to 12 times over a 3 month period;

c. Lumbar epidural infusion with analgesic agents, in conjunction with physical medicine, for up to 4 weeks;

d. Bier block, up to 6 injections over a 3 month period;

e. Spinal cord stimulation as approved by the Commission.

50.51. Phantom Limb Pain/ Stump Pain

a. Lumbar sympathetic plexus block, up to 6 injections over a 3 month period.

b. Lumbar epidural infusion with analgesic agents, in conjunction with physical medicine therapy, for up to 4 weeks

c. Spinal cord stimulation as approved by the Commission.

50.52. Peripheral Nerve Injury, including saphenouse, femoral or sciatic nerves

a. Nerve block, up to 6 injections over a 3 month period;

b. Bier block, up to 6 injections over a 3 month period;

c. Lumbar epidural infusion with analgesic agents, in conjunction with physical medicine, for up to 4 weeks;

d. Spinal cord stimulation as approved by the Commission.

50.53. Greater Trochanteric Bursitis

a. Up to 3 injections with a local anesthetic and a steroid over a 3 month period.

50.54. Meralgia Paraesthetica

a. Injection of lateral femoral cutaneous nerve with a local anesthetic agent, up to 6 injections over a 3 month period.

50.55. Myofascial Pain

a. Trigger point injections, no more than 6 points or no more than 6 occasions in 3 months.

50.56. Other Causes Of Extremity Pain

a. Treatment will be authorized by the Commission, in it's sole discretion, on a case by case basis.

Cancer Pain:

Injury related causality must be established prior to authorization for pain management. A nurse case manager may be assigned to claims involving treatment of cancer pain. Unlike treatment for other types of pain, intrathecal opioids for treatment of cancer pain will not require psychiatric evaluation or a second opinion.

50.57. Long-Term Opioid Use: the use of long-term oral, rectal, or transdermal opioid therapy in the non-malignant injured worker is complex and should only be considered in selected injured workers, including, but not limited to, injured workers with diagnoses of failed back surgery syndrome, Complex Regional Pain Syndrome (Reflex Sympathetic Dystrophy), inoperable spinal lesions and spinal stenosis, or plexopathies. Other diagnoses will be considered by a case by case basis, but only as a treatment option of last resort. The following factors are to be addressed in writing in any report recommending the use of long-term opioid therapy:

a. If low dose opioid therapy has not provided at least partial analgesia, then long-term opioid therapy is not an option.

b. The goal of long-term opioid therapy is not complete analgesia. The efficacy of long term opioid therapy is measured by improvement in the injured worker's social and physical function.

c. This therapy should be considered only after all other reasonable attempts at analgesia have failed. Opioid therapy should never be a first line treatment.

d. A history of substance abuse in the injured worker or his or her family (alcohol or other drugs), even if remote, should be regarded as a relative contraindication.If a history of substance abuse is obtained and the choice to long-term, opioid therapy is made despite such history, an appropriate consultation and plan to prevent relapse must be in place before prescribing of opioids.

e. Pregnant injured workers are not candidates for long-term opioid therapy. Female injured workers of child-bearing age are to be advised of the risks to a fetus should pregnancy occur during opioid therapy.

50.58. If the decision is made to initiate long-term opioid therapy, the following must be part of the program:

a. Psychiatric – A psychiatric evaluation of the injured worker for psychiatric disorders and potential for substance abuse must precede the decision to carry out long-term opioid therapy, and a copy of the evaluation must be submitted with the request to initiate opioid therapy.

b. A written contract between the injured worker and the pain management specialist must be established at the onset of the long-term drug therapy. The injured worker must agree that (1) a single practitioner will be responsible for prescribing all medication for pain control; (2) the injured worker will not obtain prescriptions from providers other than the pain management specialist; (3) after an initial six month period of initial dose titration, only one dose escalation per three month period will be allowed; and (4) the injured worker will not consume alcohol or other medications except as approved by the pain management specialist. Any material violation discovered may cause immediate drug tapering and discontinuation of opioid maintenance therapy.

c. Initial long-term opioid therapy must be prescribed by a pain management specialist; once therapy has reached the "steady dose" level, the attending physician *may* resume medical management;

d. The injured worker will be monitored by a nurse case manager during the period when a "steady dose" is being established; the pain management specialist or the attending physician must reevaluate the injured worker every 60-90 days after the "steady dose" has been reached.

e. Injured workers must give informed consent before long-term opioid therapy is initiated; consent must include recognition of the risks of psychological dependence, cognitive impairment and long-term physical side-effects.

f. In order for long-term opioid therapy to continue, there must be documentation of improvement in the social and physical functions, as assessed and documented through home visits by a nurse case manager, written documentation must be provided to the attending physician and pain management specialist. Specific assessment tools must be used

such as interview of significant others, pain drawing comparisons, quality of life and social functioning checklist comparisons.

g. Reassessment by a pain management specialist selected by the Commission will be done annually for injured workers maintained on opioids.

h. Every year, the Commission must review the treatment plant to determine the appropriateness of care. The Commission may call for more frequent review if the use of narcotic medication increases.

i. Evidence of acquisition of opioids from other physicians or persons, uncontrolled increases in dose requirements, drug hoarding, abuse of alcohol or other drugs, conviction of a crime related to drug possession or trafficking, or other behaviors in violation of the narcotic contract should be followed by immediate drug tapering and discontinuation of opioid maintenance therapy.

50.59. Implantable Devices: Use of intrathecal pumps and spinal cord stimulators will only be authorized when other treatments of extremity, back or neck pain, such as pharmacological, physical, or psychological therapy, have failed.

a. The procedure is undertaken only after physical and psychiatric or psychological screening. Psychological or psychiatric clearance will be performed to rule out any untreated psychiatric or behavioral problems and to enhance the efficacy of the device.

b. In the absence of a documented physiological problem, authorization for implantable pain control devices is at the discretion of the Commission.

c. An untreated substance abuse problem prior to implementation of the proposed device will be sufficient reason to deny the request for the implantable device, notwithstanding other physical or psychological criteria.

d. An implantable device will not be authorized until a second opinion is given by a physician with credentials to implant similar devices. The second opinion may be based upon a review of the injured worker's file, or by an independent medical evaluation; either evaluation must be documented in writing. The referral of the injured worker or claim file for the second opinion must be arranged through the Office of Medical Management.

50.60. Procedure Guides for Implantable Devices.

a. Implementation of devices will be authorized only at facilities which meet the following criteria: (1) a physician trained in residency of by the "hands-on" continuing medical training will perform the procedure; (2) all technical support, computers, and ancillary personnel, and a "stand-by" surgical specialist deemed necessary for the specific case must be in place before the procedure begins.

b. The implanting physician will be responsible for all management of the implantable device until such time that another physician credentialed in the management of like devices accepts the injured worker.

c. The necessary "in-home" support must be authorized by the Commission and scheduled prior to implantation of the device.

d. Both intrathecal pumps and dorsal column stimulators must have a successful trial period before the permanent device is placed. The trial period for the pump will be no less than two days. The trial period for the stimulator will be no less that three days as an outpatient. There must be at least a 50% reduction in subjective pain rating and objective improvement in ability to engage in functional activities.

50.61. Contraindications for Implantable Devices: The following are contraindications for an implantation:

a. Allergies or hypersensitivity to the drug being used;

b. Life expectancy of less that three (3) months;

c. Body size is insufficient to support weight and bulk of the device;

d. Less than 50% relief is seen with trial stimulation or intrathecal device;

e. The injured worker does not perceive the trial implantation as pleasant, or side effects are intolerable;

f. The injured worker has an active coagulopathy;

g. The injured worker has a localized or disseminated infection;

h. The injured worker has a demand cardiac pacer or may need one relatively soon (for stimulator only);

i. The injured worker has an untreated substance abuse problem;

j. A significant psychological or behavioral contraindication has been identified;

k. The physician requesting the procedure is not adequately trained or experienced in the procedure;

l. Appropriate surgical coverage necessary to handle any complications is not available before beginning the procedure.

50.62. Myeloscopy in Chronic Pain Management – Myeloscopy procedures are to be reviewed on a case by case basis by the Office Medical Management before authorization can be considered.

§85-20-51. Treatment Guidelines: Complex Regional Pain Syndrome

51.1. Background: Complex regional pain syndrome (CRPS) is a descriptive term encompassing a variety of painful conditions following injury, which appear regionally and have a distal predominance of abnormal physical examination findings. This painful condition typically follows a traumatic injury or noxious event to an extremity, with a disproportionate response respective to the original insult. Medical conditions including stroke and myocardial infarction may also be precipitating factors. The pain pattern is not limited to the distribution of a single peripheral nerve, and physical findings include edema, alterations in skin blood flow, abnormal sudomotor activity in the region of pain, allodynia or hyperalgesia. Treatment for CRPS is only compensable if directly caused by an injury received in the course of and resulting from employment.

51.2. CRPS Type I (Reflex Sympathetic Dystrophy).

a. Type 1 CRPS is a syndrome that may develop after an initiating noxious event.

b. Spontaneous pain or allodynia/hyperalgesia occurs, but is not limited to the territory of a single peripheral nerve and is disproportionate to the inciting event.

c. There is or has been evidence of edema, skin blood flow abnormality, or abnormal sudomotor activity in the region of the pain since the inciting event.

d. The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction.

51.3. CRPS Type II (Causalgia).

a. Type II CRPS is a syndrome that develops after a nerve injury. Spontaneous pain or allodynia/hyperalgesia occurs and is not necessarily limited to the territory of the injured nerve.

b. There is or has been evidence of edema, skin blood flow abnormality, or abnormal sudomotor activity in the region of the pain since the inciting event.

c. The diagnosis is excluded by the existence of conditions that would otherwise account for the degree of pain and dysfunction.

51.4. Diagnostic Criteria:

a. History of a noxious event or cause of immobilization.

b. Continued pain, allodynia or hyperalgesia out of proportion to the injury.

c. Physical evidence of edema, trophic skin changes, hair loss, alterations in skin blood flow or abnormal sudomotor activity in the region of pain.

d. The diagnosis is excluded by the existence of conditions that otherwise account for the degree of pain and dysfunction.

51.5. Diagnostic Studies.

a. Surface temperature measurements indicating at least 1 degree Celsius asymmetry between the normal and injured sides. The existence of a skin temperature differential may vary, and repeated measurements are helpful. The injured side may be warmer or cooler.

b. A three-phase radionuclide bone scan may assist in diagnosis. A normal study does not exclude this diagnosis, however.

c. Radiographic studies of the injured extremity may show patchy demineralization in some cases.

51.6. Treatment: Treatment for compensable complex regional pain syndrome type 1 (reflex sympathetic dystrophy) should be directed at providing pain control in an effort to promote participation in a directed physical and/or occupational therapy program to restore use and function of the injured extremity. Treatment options include:

a. Pharmacologic Agents.

1. Nonsteroidal anti-inflammatory drugs.

2. Tricyclic antidepressants.

3. Anticonvulsants.

4. Oral opioids.

5. Oral steroids.

b. Physical Modalities.

1. Range of motion exercises (passive, active assisted, active).

2. Weight-bearing exercises.

3. Edema-control garments (stocking or glove).

c. Injection Techniques.

1. Somatic and sympathetic nerve blocks.

d. Surgical Sympathectomy. Surgical sympathectomy is rarely considered effective in resolution of complex regional pain syndromes. These syndromes, including causalgia and reflex sympathetic dystrophy, are related to receptor supersensitivity, and are not caused by over-activity of the sympathetic nervous system. Most patients undergoing a surgical sympathectomy obtain only transient improvement in pain levels, and may suffer serious or disabling complications from the surgery.

51.7. The assistance of a pain management psychologist or psychiatrist may be helpful in providing motivational support, assessing and treating co-existing conditions such as depression, and may aid in the establishment of realistic treatment goals and objectives.

51.8. This condition may be appropriate for treatment in a multidisciplinary program.

§85-1-52. Procedure in Occupational Pneumoconiosis Cases.

52.1. A properly completed application must be received before the potential claim will be considered by the Commission. A properly completed application must include 1) a completed WC-105 form; 2) a completed WC-205 form; 3) an ILO form properly completed by a certified "B" reader; and 4) a listing of all alleged exposures to harmful dust, including type of dust, and extent and duration of exposure with each named employer.

52.2. If the employer submits credible evidence as part of the application process demonstrating that it has been in compliance with OSHA and/or MSHA permissible exposure levels for the dust alleged by the injured worker, then the Commission shall determine that the dust exposure alleged by the injured worker was not harmful and does not suffice to satisfy the exposure requirement of West Virginia Code Sections 23-4-1(b) and 23-4-15(b) for the period(s) covered by the testing. Periods for which employees can demonstrate by credible evidence that the employer's dust level testing does not accurately reflect changed conditions in the work place may be included by the Commission in the period of dust exposure which the claimant has alleged to be harmful.

52.3. Nonmedical hearing.

Upon receipt of a proper application, employer's reports and investigation (if requested by the Commission), the Commission shall determine the nonmedical questions, and shall notify all interested parties of the decision. A properly completed application must be filed or the application shall be rejected. After the Commission makes or has made a determination, any dissatisfied party may, within thirty (30) days after receipt of written notice of the Commission's decision, file objection thereto in writing, whereupon the Office of Judges will set a time and place for a hearing thereon. These hearings shall be subject to the provisions of the rules promulgated by the Office of Judges (Title 93, Series 1).

Upon completion of the nonmedical hearing, the Office of Judges will enter a final nonmedical ruling and shall notify the injured worker and employer of this decision. The Office of Judge's final nonmedical ruling will be subject to appeal to the Workers' Compensation Board of Review.

52.4. Occupational pneumoconiosis board hearing.

Following issuance by the Commission of a ruling on the nonmedical issues, the Commission shall refer this claim to the Occupational Pneumoconiosis Board: Provided That, the requirements of West Virginia Code section fifteen-b, article four, chapter twenty-three have been satisfied. In the case of such reference, the Commission will notify the injured worker to appear before the Board for an examination and shall state the date, time, and location thereof. The Commission will notify the employer or employers of the date, time and place of the examination. A quorum of the Board will then proceed to hear and determine all medical questions relating to the claim.

At such hearing the injured worker and each employer must produce as evidence all reports of medical and X ray examinations that may be in their respective possession or control showing the past or present condition of the employee.

52.5. Report of Occupational Pneumoconiosis Board.

Upon completion of the hearing the participating members of the Occupational Pneumoconiosis Board shall prepare a written report to the Commission setting forth their findings and decision, and shall prepare a sufficient number of signed copies of report so that the Commission may file one in his office, send one to the injured worker and one to each employer interested in the claim.

52.6. Objections.

Any interested party who objects, in whole or in part, to the findings and conclusions of the Board may, within the statutory period after the mailing to him of the copy of the report, or within such additional time as may be allowed by the Commission for good cause shown, file with the Commission his written objections, specifying the particular statements of the Board's findings and conclusions to which the party objects. Upon receipt of such objection, the Commission shall set a time and place for a hearing thereon and shall notify each interested party and each member of the Board of the time and place of the hearing.

52.7. Hearings on protest.

Hearings held upon protest to the findings of the Occupational Pneumoconiosis Board will be held at the offices of the Commission in Charleston unless the Commission shall otherwise direct. The procedure in protest hearings shall be governed by the provisions of Section 16 of these Rules, except that evidence shall be limited to medical testimony and other competent medical evidence, unless the Board has passed upon non-medical aspects under the

Commission's referral. Cross-examination of the Board shall be limited to those members who examined the injured worker. However, if the Commission, or a duly authorized representative, decides that testimony of other members of the Board is necessary or desirable, the Commission may permit such testimony at the protest hearing.

52.8. Employer's Request For Medical Examination.

An employer's request for medical examination of the injured worker by a physician of its choice, shall be rejected if filed before the findings of the Occupational Pneumoconiosis Board have been transmitted to the injured worker and the employer. Such requests shall be entertained only when filed subsequent to the transmittal of the Occupational Pneumoconiosis Board findings.

52.9. Standards for medical examination.

a. The following standards specify examination and evaluation criteria to guide the Occupational Pneumoconiosis Board in its examination and evaluation of injured workers, and to guide other physicians and medical technicians who conduct examinations and evaluations of injured workers on behalf of such injured workers and their employers. These standards are established for the further purpose of ensuring that uniform procedures are used in administering and interpreting ventilatory function tests and arterial blood gas studies and that the best available medical evidence will be obtained in support of a claim for occupational pneumoconiosis benefits. The physician supervising any such testing and/or the technician administering any such testing will so indicate by signing the reports. Any report of test results submitted to the Occupational Pneumoconiosis Board must affirmatively state, as to each of the standards individually, the fact that the particular test or study was performed in compliance with that standard. In the event that any such report fails to affirmatively show compliance with these standards, the Occupational Pneumoconiosis Board may disregard all or any part of such test or study or give such test or study such weight as the Board believes it deserves.

b. When two (2) or more ventilatory function tests performed in reasonably close proximity in time produce differing but acceptable results, the Commission, at the request of the Occupational Pneumoconiosis Board, may direct the parties to furnish additional evidence and/or order additional testing at the laboratory utilized by the Occupational Pneumoconiosis Board or other laboratories, all for the purpose of determining whether any of the results are unreliable or incorrect or are clearly attributable to some identifiable disease or illness other than occupational pneumoconiosis.

c. When blood gas studies are performed and abnormal values are obtained and thereafter new blood gas studies are performed and normal or significantly higher values are further obtained, the Commission, at the request of the Occupational Pneumoconiosis Board, may direct the parties to furnish additional evidence and/or order additional studies at the laboratory utilized by the Occupational Pneumoconiosis Board or other laboratories, all for the purpose of determining whether any of the values are unreliable or incorrect or are clearly attributable to some identifiable disease or illness other than occupational pneumoconiosis.

d. As used herein, the following terms shall have the meanings indicated:

1. FVC -forced vital capacity -- Volume of air that can be forcefully exhaled from the lungs after a maximal inspiration.

2. FEV_1 -forced expiratory volume in one (1) second -- Volume of air that can be exhaled forcefully from the lungs in one (1) second after a maximal inspiration.

3. FEV_3 -forced expiratory volume in three seconds -- Volume of air that can be exhaled forcefully from the lungs in three (3) seconds after a maximal inspiration.

4. FEV_1FEV -forced expiratory volume (timed) to forced expiratory volume. -- A ratio expressed as a percentage.

5. MVV -maximal voluntary ventilation -- The volume of air that can be exchanged over a unit period of time, usually performed for twelve (12) to fifteen (15) seconds and converted to liters per minute.

6. BTPS -- Body temperature, ambient pressure, saturated with water.

7. Kpm -kilopond meter -- The amount of work required to lift one (1) kilogram one (1) meter.

8. NIOSH -- National Institute for Occupational Safety and Health.

9. BOARD -- West Virginia Occupational Pneumoconiosis Board.

10. NBRC – National Board for Respiratory Care

11. CPFT – Certified Pulmonary Function Technician

12. RPFT – registered Pulmonary Function technologist

13. Raw – Airway resistance

14. DLCO – Carbon monoxide diffusing capacity of the lungs

15. DL/VA – Carbon monoxide diffusing capacity per unit of alveolar volume

16. VA – Alveolar volume (single breath equivalent to TLC)

17. TLC – Total Lung Capacity (measured by plethysmograph, Nitrogen washout, or helium dilution.

e. Ventilatory function tests.

1. Instruments to be used for the administration of ventilatory function tests should conform to the following criteria:

A. The instrument must be accurate within plus (+) fifty (50) ml or within plus (+) three percent (3%) of reading, whichever is greater.

B. The instrument must be capable of measuring vital capacity from zero (0) to seven (7) liters BTPS.

C. The instrument must have a low inertia and offer low resistance to airflow such that the resistance to airflow at twelve (12) liters per second must be less than 1.5 cm H_20/liter/second.

D. The zero time point for the purpose of timing the FEV_1 must be determined by extrapolating the steepest portion of volume-time curve back to the maximal inspiration volume or by an equivalent method.

E. Instruments incorporating measurements of airflow to determine volume must conform to the same volume accuracy stated in Subdivision 52.9.e.1.A of this regulation when present with flow rates from at least zero (0) to twelve (12) liters per second.

F. The instrument or user of the instrument must correct volumes to body temperature saturated with water vapor (BTPS) under conditions of varying ambient spirometer temperatures and barometric pressures.

G. The instrument used must provide tracings of volume versus time during the entire forced expiration. Flow versus volume tracings may be added. If MVV maneuver is performed, the volume versus time tracings must also be provided. Such tracing must be furnished to the Board with the test results. Volume Scale: When a volume – time curve is plotted or displayed, the volume scale must be at least: 10 mm/L (BTPS). Time scale: at least 10 mm/S. No results will be considered by the Board unless they are accompanied by the corresponding (minimum 3) tracings. Tracings are to determine whether the subject has performed the test properly. The tracing must be of sufficient size that hand measurements may be made within the requirement of paragraph 1A above.

H. The instrument must be capable of accumulating volume for a minimum of ten (10) seconds after the onset of exhalation.

I. The forced expiratory volume in one (1) second (FEV_1 measurement must comply with the accuracy requirements stated in Subdivision 52.9.e.1 of

these Regulations; that is, the FEV_1 must be accurately measured to within plus (+) fifty (50) ml or within plus (+) three percent (3%) of reading, whichever is greater.

J. The instrument must be capable of being calibrated in the field with respect to the FVC and time scales. This calibration of the FVC may be done either directly or indirectly through volume and time base measurements. The volume calibration source must provide a volume displacement of at least three (3) liters and must be accurate to within plus (+) thirty (30) ml.

K. For measuring maximum voluntary ventilation (MVV), the instrument must have a response which is flat within plus (+) ten percent (10%) at flow rates up to twelve (12) liters per second over the volume range. The time for exhaled volume integration or recording must be no less than twelve (12) seconds and no more than fifteen (15) seconds. The indicated time must be accurate to within plus (+) three percent (3%). A recording of the spirometer tracing is required, and the volume sensitivity must be such than ten (10) mm or more deflection corresponds to one (1) liter volume.

2. The administration of ventilatory function tests must conform to the following criteria: For ascertainment of the FEV_1 and FVC, a nose clip or alternative must be used. The procedures must be explained in simple terms to the subject who shall be instructed to loosen any tight clothing and sit or stand in front of the apparatus. Although the subject may sit or stand, care should be taken on repeat testing that the same position is used. Sitting position will be considered the preferred method although standing may be utilized for obese patients and notations made as to the position. Particular attention must be given to insure that the subject's chin is slightly elevated with the neck slightly extended. The subject must be instructed to make a full inspiration, either from the spirometer or the open atmosphere, and then blow into the apparatus, without interruption, as hard, fast, and completely as possible.

At least three (3) forced expirations must be carried out. During the maneuvers, the subject must be observed for compliance with instructions. The expirations must be checked visually for reproducibility by examining the flow-volume or volume-time tracings. The effort shall be judged unacceptable and cannot be considered in evaluating pulmonary functional impairment when the subject:

A. The largest and second largest FVC are not within 7% of each other; or

B. The largest and second largest FEV_1 are not within 7% of each other; or

C. Has not continued the expiration for at least six (6) seconds or until an obvious plateau in the volume-time curve has occurred. Exceptions: Young adults and patients with restrictive defects tend to plateau early. Reduced FVC with a normal or high FEV_1/FVC ration is suggestive of restriction, although measurement of TLC is required to confirm restriction,; or

D. Tracings indicate cough prior to the FEV_1 measurement; or

E. Early termination of flow (glottis closure); or

F. Has an unsatisfactory start of expiration, one characterized by excessive hesitation (or false starts), and therefore did not allow back extrapolation of time zero (0) (extrapolated volume on the volume-time tracing must be less than ten percent (10%) of the FVC); or

G. Has an excessive variability between the three (3) acceptable curves. The variation between the two (2) largest FVCs and the two (2) largest FEV_1s should not exceed seven percent (7%) or 100 ml, whichever is greater.

H. Predicted values are derived from Kory's Nomogram (1961).

3. For ascertainment of the MVV, the subject must be instructed before beginning the test that he or she will be asked to breathe as deeply and as rapidly as possible for approximately twelve (12) seconds. Sitting position will be considered the preferred method although standing may be utilized for obese patients and notations made as to the position. Care shall be taken on repeated testing that the same position is used. The test may be performed with the subject in either a sitting or standing position. Care shall be taken on repeat testing that the same position is used. The subject should breathe normally into the mouthpiece of the apparatus for ten (10) to fifteen (15) seconds to become accustomed to the system. The subject should then be instructed to breathe as deeply and as rapidly as possible and shall be continually encouraged during the remainder of the maneuver. The subject shall continue the maneuver for twelve (12) seconds. Only one (1) MVV maneuver is necessary. The effort must be judged unacceptable and cannot be considered in evaluating pulmonary functional impairment when the patient:

A. Has not maintained consistent effort for at least twelve (12) to fifteen (15) seconds; or

B. Has coughed or closed his glottis; or

C. Has an obstructed mouthpiece or a leak around the mouthpiece (obstruction due to tongue being placed in front of mouthpiece, false teeth falling in front of mouthpiece, etc.); or

D. Has an excessive variability between the three (3) satisfactory curves. The variation between the three (3) satisfactory tracings must not exceed ten percent (10%) and should approximate forty (40) times the greatest FEV_1 volume.

4. A calibration check must be performed on the instrument each day before use, using a volume source of at least three (3) liters, accurate to within +one percent

(1%) of full scale. The room air in the syringe must be introduced into the spirometer once with a flow rate of approximately five tenths (5/10) liters per second (six (6) seconds emptying time with a three (3) liter syringe) and once with a higher flow rate of approximately three (3) liters per second (one (1) second emptying time with a three (3) liter syringe). The volume measured by the spirometer must be between two and nine tenths (2.90) and three and one tenth (3.10) liters for both trials. Accuracy of the time measurement used in determining the FEV_1 must be checked using the manufacturer's stated procedure and must be within +three percent (3%) of actual. The procedure described herein must be performed as well as any other procedures suggested by the manufacturer of the spirometer being used.

5. The first step in evaluating a spirogram for the FVC and FEV_1 shall be to determine whether or not the subject has performed the test properly or as described in Subdivision 52.9.e.2 of this regulation and the forced expiratory volume. From the three (3) satisfactory tracings, the forced vital capacity (FVC) and the forced expiratory volume in one (1) second (FEV_1) must be measured and recorded. The largest FVC and the largest FEV_1 must be used in the analysis, corrected to BTPS.

6. Only MVV maneuvers which demonstrate consistent effort for at least twelve (12) seconds shall be considered acceptable. The largest accumulated volume for a twelve (12) second period corrected to BTPS and multiplied by five (5) shall be reported as the MVV.

f. Single Breath Carbon Monoxide Diffusion Capacity

1. For ascertainment of the Single Breath DLCO, the subject must be instructed before beginning the test that he or she will be asked to breath normally through the system for a number of breaths to achieve stable tidal breathing, then exhale to the level of residual volume (RV). At that point, the patient will be instructed to inhale quickly to the level of Total Lung Capacity (TLC) and hold their breath for approximately 10 seconds, then exhale for sample collection in the instruction of the technician administering the test.

2. Single breath carbon monoxide diffusion capacity tests are performed using the Jones-Meade method of measurement.

3. Predicted values are derived from Crapo (1981) nomogram.

4. Total Hemoglobin and Carboxyhemoglobin are to be reported. Subjects with anemia will have results corrected to hemoglobin of 14.6 (males) and 13.4 (females).

5. IVCs from each acceptable maneuver shall be reported.

6. Reports will include DLCO, Alveolar Volume (VA) and DL/VA.

7. At least two (2) maneuvers are to be carried out. During the maneuvers, the subject must be observed for compliance of instructions. The effort(s) shall be

judged unacceptable and cannot be considered in evaluating pulmonary function impairment when the subject:

A. IVCs do not achieve 90% of previously measured vital capacity.

B. Actual DLCO measurements are not within 3 ml or 10% whichever is larger.

C. IVCx (SVCs) are not reported for each acceptable maneuver.

D. Inspiratory time exceeds 2.5 seconds.

E. Breath hold time is less than 9 seconds or exceeds 11 seconds.

F. Sample is not obtained within 4 seconds after breath hold.

G. Carboxyhemoglobin is not reported or value is 3.1% or higher.

g. AIRWAY RESISTANCE (Raw)

1. Airway resistance measurement will be measured using a body plethysmograph. For ascertainment of the Raw, the subject must be instructed before beginning the test that he or she will, after being sealed in the plethysmograph, be asked to breath normally while temperature equilibration occurs and then to hold cheeks with hands and gently pant while open and close shutter measurements are taken.

h. Arterial blood gas studies.

1. In order to ensure comparability of data obtained in arterial blood studies, the following guidelines should be observed:

A. The puncture site should be infiltrated with a local anesthetic to minimize pain and arterial spasm.

B. The barrel of the syringe used to draw the blood sample should contain a coating of lithium heparin. If wetted syringes are used, the excess heparin must be expelled just prior to obtaining the blood sample.

C. The subject should be allowed to rest while breathing room air for fifteen (15) minutes prior to drawing the sample .

D. Resting blood samples should be drawn with the subject in the sitting position. If supine position is necessary, a notation is to be made on the report.

E. On occasions when the subject is unable to be exercised due to physical impairments; i.e., heart disease, artificial leg, etc., a resting sample of arterial blood may be drawn by direct puncture with a twenty-twenty-five (20-25) gauge needle and a heparinized syringe.

F. Blood samples must be discarded if contaminated by an air bubble.

G. All blood samples should be analyzed immediately (less than ten (10) minutes). If not, the sample should be placed in ice water slush for up to 1 hour. If the analysis is not performed within ten (10) minutes, the metabolic activity of the cells in the blood will cause the $p0_2$ to fall and the $pC0_2$ to rise.

H. If an exercise sample is to be obtained, a plastic catheter may be inserted into the radial or brachial artery for both the resting as well as the exercise sample. Single stick exercise samples may also be obtained if drawn during the last 30 seconds of exercise. Any variation should be so noted.

I. Exercise must be accomplished by having the subject pedal the bicycle ergometer at a rate of fifty (50)-sixty (60) revolutions per minute against a resistance of seventy-five (75) Watts or four hundred fifty (450) Kilopond Meters (Kpm) per minute for a period of five (5) minutes. A treadmill may be used, and when used, exercise must be done at two (2) mph and ten percent (10%) grade. During the last twenty (20) seconds of the fifth minute of exercise, the exercise sample must be drawn into a heparinized syringe and the pulse and respiration rates noted. If an added level of exercise is performed, this must be done at one hundred twenty (120) Watts on the bicycle, or on the treadmill at two and five tenths (2 5/10) mph and twelve percent (12%) grade. Exercise testing beyond the level set forth herein shall be considered to be measurements of physical conditioning rather than of blood gas transfer abnormalities due to occupational pneumoconiosis. The EKG leads are then removed and the subject allowed to sit on a chair while the catheter is removed. Pressure must be held at the site of arterial cannulation for five (5) minutes, and if there is no bleeding or hematoma present, a compression bandage must be placed on the radial artery. This bandage must be left in place for four (4) hours. After about fifteen (15) minutes of observation, the subject will be allowed to leave. The arterial blood sample should be drawn while exercise continues, not following cessation of exercise.

J. EKG monitoring with a single lead should take place during exercise to determine the heart rate. It should be noted that this is not an EKG Stress Test.

K. The report should indicate the place, date and time of the study, altitude of the testing site and barometric pressure at the testing site on the day of the testing, name and claim number of the subject, name of any assisting personnel, name and

signature of the supervising physician, duration and type of exercise (if performed), pulse rate and respiration at the time the blood sample was drawn, and whether analysis equipment was calibrated before each test.

2. It is recognized that arterial blood gas studies done in laboratories throughout this state are obtained at different altitudes. Only by "Standardizing" for altitude can an equitable assessment be made of impairment when values of arterial oxygen are being measured at remarkably different altitudes. Therefore, the results reported from laboratories should include the name of the laboratory and the date and time of the testing, altitude of the laboratory and barometric pressure at the laboratory on the day the samples were collected. The Occupational Pneumoconiosis Board will evaluate the arterial blood gas values by converting those values to the average altitude of Charleston, West Virginia. For this purpose, it shall be sufficient to add one (1) mmHg to each arterial oxygen tension for each three hundred (300) feet or fraction thereof that the testing laboratory is located above the average altitude of Charleston, because the relationship of barometric pressure (altitude) and alveolar oxygen is approximately linear up to four thousand (4,000) feet as long as the subject breathes room air.

As an example, Bluefield is located approximately two thousand six hundred (2,600) feet above sea level. Charleston is approximately six hundred (600) feet above sea level. Thus, arterial oxygen values obtained in Bluefield should have 6.67 mmHg added to them before applying the table to them to obtain "percent impairment". The calculations are as follows:

"Bluefield (2,600') minus Charleston (600') equals 2,000' differential

2,000' divided by 300' altitude equals 6.67

6.67 multiplied by 1 mmHg per 300' altitude equals 6.67 mmHg"

i. See the attached Table 85-20A, "Impairment of Pulmonary Function."

52.10 Treatment Issues

The following services may be provided without prior authorization if carried out under the standards referenced and if the service is documented as to its medical necessity.

1. **MEDICAL VISITS:** Office visits will be considered for payment according to the following schedule based on the FEV_1/FVC ratio or upon percent of disability award (where there is a conflict, FEV_1 will be the controlling factor):

FEV_1/FVC*	WCF % OP AWARD	LEVEL OF IMPAIRMENT	MEDICAL VISITS
70-74%	10-15%	I	One intermediate visit per year.
61-69%	20-30%	II	One comprehensive or extended visit per year for medically necessary

			pulmonary follow-up care.
60% or less	40%>	III	One comprehensive or extended visit per year. Up to four limited visits per year for medically necessary pulmonary follow-up care.

*Based on Actual Results rather than Nomograms.

2. **TESTING**: The testing referenced below will only be considered for payment when the medical necessity is documented by the treating physician. Equivalent testing performed in conjunction with the claimant's examination by the OP board shall be considered toward satisfaction of the limits herein referenced. This testing, with the exception of chest X-rays, is not applicable to claimants with Zero Level of Impairment.

   a) Spirometry: Annually in conjunction with a comprehensive, extended or intermediate office visit. This testing must be performed in compliance with the standards outlined in the Commission rules and regulations.

   b) Single Breath Diffusion Study: Once for all eligible claimants. Repeat every two years if less than 60% of predicted. Repeat every four years if 60% of predicted or greater.

   c) Chest X-Ray: Normal – every four years maximum. Positive reading for OP – every two years maximum.

   d) Blood Tests: Theophylline level annually for claimants taking theophylline medication. Additional theophylline testing will be considered when necessary to monitor and stabilize the blood levels during the first year of ingestion.
   Complete blood count and Chemistry – 12 every four years for claimants in Level II.
   Complete blood count and Chemistry – 12 annually for claimants in Level III.
   This testing is not authorized for claimants in Levels 0 and I.

3. **MEDICATIONS:** The following will be considered for payment prescribed for an acute or chronic condition or problem caused or exacerbated by OP and when such has been documented by the treating physician.

- All above 15% PPD –

   a) Bronchodilators for claimants with a 15% or greater improvement in FEV_1 or FVC on a current post bronchodilator study.

b) Other medications on the Medicaid formulary including antibiotics, steroids and diuretics when required for treatment of pulmonary conditions related to OP for up to 14 days of treatment. Longer treatment may be authorized but will require prior authorization based upon a statement of medical necessity from the treating physician and appropriate prescribing practices.

c) Expectorants or mucolytics will not be approved.

d) Pneumococcal vaccine once and annual flu vaccine for all eligible claimants where the physician certifies that the vaccine is consistent with national guidelines of immunization practices regarding health status and age of the patient.

e) Cardiac medications may be authorized when the cardiac problem is a complication of the pneumoconiosis. Authorization will not be granted for treatment of cardiac conditions unrelated to occupational pneumoconiosis, nor for cardiomyopathy, coronary heart disease or coronary bypass surgery.

4. **PULMONARY REHABILITATION:** Pulmonary rehabilitation services are authorized according to the following schedule when such services are provided by a certified pulmonary rehabilitation center approved by the U. S. Department of Labor and provided in accordance with the guidelines of the WV Department of Health.

LEVEL OF IMPAIRMENT	WCF % AWARD	FEV_1/FVC*	AUTHORIZED TREATMENT
A	5%	75% or greater	None
B	10-15%	70-74%	One hour of education focusing on the nature of pulmonary disease and prevention of progression.
C	20-40%	56-69%	Additional four hours of education and training focusing on techniques and dealing with shortness of breath and pulmonary distress management. (5 hours total) Two hours of follow-up education and training one year later.
D	40%>	55% or less	Additional two hours of education training focusing on individualized treatment of severe pulmonary impairment. (7 hours total) Two hours of follow-up education and training one year later.
Homebound claimants (as result of pulmonary impairment)			Seven hours of education and training by home visitation. Two hours of follow-up education and training each subsequent year.

Pulmonary rehabilitation programs coverage includes: Prevention of disease progression, nutrition, hygiene, anatomy, recognition of symptoms, smoking cessation, physical conditional, weight control, breathing techniques, drug evaluation, stress reduction and follow-up.

Pulmonary rehabilitation services must be provided by a registered nurse, licensed practical nurse or respiratory therapist.

The following services require prior authorization and the request for such authorization must be accompanied by a statement of medical necessity from the treating physician.

1. Arterial Blood Gas (Or Oximetry):

a) Administration of arterial blood gases or oximetry shall be restricted to situations where it is necessary to evaluate the need for chronic oxygen therapy consistent with American Thoracic Society Guidelines.

b) Prior authorization is also required to repeat blood gases and is contingent upon the treating physician providing documentation that the claimant's initial study showed a PO_2 over 80 or 02 saturation over 95%. The PO_2 levels listed below will be the determining factor in how frequently the repeat test will be considered for authorization.

PO_2 less than 55 or O_2 less than 90% saturation – repeat no more than annually.
PO_2 55 to 80 or O_2 saturation 90 to 95% - repeat no more than every two years.
PO_2 over 80 or O_2 saturation over 95% - repeat no more than every four years.

2. Durable medical equipment and nursing care:

a) Purchase or rental of durable equipment such as hospital beds, commode chairs and lifts. Authorization of durable medical equipment, including oxygen delivery systems, shall be given in the sole discretion of the Commission.

b) In-home nursing care or home health care for bedridden claimants.

c) Nursing home care in properly licensed and operated facilities.

d) Mechanical nebulizer: Authorization for Mechanical nebulizers shall only be granted upon certification of medical necessity from the treating physician which

indicated why the use of less expensive medication delivery such as hand nebulizers or metered dose devices is not feasible.

3. **Oxygen:** Except when administered for medical emergency, oxygen therapy requires prior authorization and will only then be authorized when in compliance with the guidelines of the American Thoracic Society.

§85-20-53. Long-Term Opioid Therapy Guideline.

53.1. These guidelines are used by the provider in the management of chronic nonmalignant pain. Chronic nonmalignant pain is defined as pain persisting beyond the expected normal healing time for an injury, for which traditional medical approaches have been unsuccessful. These guidelines do not apply to claimants whose pain is the result of a malignant process (cancer), or when the pain therapy is aimed at relieving intractable pain and suffering in the terminally ill when other measures fail, assuming a compensable diagnosis.

53.2. Successful management of intractable chronic non-malignant pain (hereinafter referred to as "chronic pain") usually does not require the use of opioid medications. There are other effective and non-pharmacologic treatment interventions available. Some carefully selected claimants with chronic pain may benefit from opioid maintenance analgesia (OMA). These claimants function better, are sometimes able to resume working, maintain improved pain control with acceptable side effects, and continue to use their medications in a responsible manner.

53.3. In some claimants, long-term OMA fails. Pain control is marginal, function does not improve, side effects prohibit ongoing therapy, or the claimant's ability to use the medication properly is poor or erratic. The key to success in the management of OMA is careful selection of candidates and monitoring.

53.4. Candidates for long –term OMA should:

a. Have an established diagnosis that is consistent with chronic pain.

b. Have not responded to non-opioid treatment.

c. Not be pregnant. Claimants likely to become pregnant during the course of treatment must be advised of the risks to the fetus should pregnancy occur.

d. Not be using illegal drugs or abusing alcohol.

e. Be reliable claimants who are known to the physician and are expected to be compliant with the treatment protocol.

53.5. Long term OMA is **contraindicated** for claimants who have persistent pain out of proportion to physical findings and/or with no demonstrable lesion, and who meet the criteria for the diagnosis of "chronic pain syndrome".

53.6. Documentation recommendations for controlled substances prescribed within the guidelines.

a. A thorough medical history, physical examination, diagnosis and treatment plan should be documented, with particular attention focused on determining the cause(s) of the injured worker's pain, sleeplessness or anxiety.

b. The treatment plan should include the following information:

1. A list of all current medications (with doses), including medications prescribed by other physicians (whenever possible);

2. Therapies and procedures other than medications to manage/relieve pain;

3. Consultations with health care professionals;

4. Further planned diagnostic evaluation; and

5. Follow-up plan to assess progress.

c. The above standards for documentation are being recommended for inclusion in the provider's records. These records should be submitted to the Commission.

53.7. Claimants with a personal history of addiction (*or in their immediate family*) or poor impulse control are at an increased risk of failing to comply with an OMA regimen.

The risk of abuse or adverse outcome is high if any of the following factors are present:

a. History of active use of alcohol or other substance abuse.

b. Co-morbid psychiatric disorders.

c. Poor response to opioids in the past for the same condition.

53.8. All potential candidates for long-term OMA, with a positive history of any of the above risk factors, must undergo a psychiatric or psychological evaluation to determine the appropriateness of long-term OMA to rule out co-morbid psychiatric disorders and the potential for addiction.

53.9. In addition, any claimant who has been on opioids without evidence of improvement must also undergo a psychological evaluation.

53.10. The report of such an evaluation must be provided to the claimant's Workers' Compensation Division Claims Manager as soon as possible after starting the OMA.

53.11. There is no clinical indication for using injectable opioid preparations for claimants with chronic pain. Injectable opioid preparations should only be used in cases of acute pain. They should never be prescribed as a self-medication on an as needed basis.

53.12. Continuation of Long-Term OMA:

a. If low to moderate dose opioid therapy has not provided at least partial analgesia, then long-term OMA is not indicated.

b. **Complete analgesia is not the goal of long-term OMA**. The efficacy of the therapy is measured not only by reduction in pain but also by improvement in physical and social function. Therefore, documentation of pain and function is essential to monitor the success of the therapy. Functional tool: Table 18.3 of the AMA Guides, Fifth Edition, or a comparable tool.

c. Monitoring of the progress of the therapy must be documented on the attached forms every 30 days the first three months and every 60 days the next six months.

d. A specialist experienced in pain management selected by the Workers' Compensation Commission shall evaluate every claimant on long-term OMA annually to determine the need for continuing OMA.

e. A treatment agreement between the patient and the provider is recommended.

53.13. Definitions for this Section:

a. Acute pain is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time-limited and is responsive to opioid therapy among other therapies.

b. Chronic Non-malignant Pain is an evolving pathological process that can be defined as pain persisting beyond the expected reasonable healing time for an injury despite medical treatment.

c. Chronic Pain Syndrome (CPS): Any claimant presenting with persistent pain of at least three months duration, which may be consistent with or significantly out of proportion to physical findings, and who has at least two of the four criteria listed below should be considered a CPS patient.

1. A progressive deterioration in ability to function at home, socially, or at work.

2. A progressive increase in health care utilization (such as repeated physical evaluations, diagnostic tests, requests for pain medications, and/or invasive procedures).

3. Demonstrable mood disturbance.

4. Clinically significant anger.

d. Qualifications of the Pain Management Specialist for evaluating and treating:

1. A pain management specialist must be Board-certified by the American Board of Medical Specialists. At this time, the only such Board is the American Board of Anesthesiology and this board will be available to all pain practitioners in the next year.

2. He/she must be licensed by the State of WV.

3. He/she should have at least three years experience in chronic pain management, behavioral management, and/or addiction

4. The Workers' Compensation Commission will annually provide a list of approved chronic opioid pain management specialists, based on the above criteria and satisfactory objective measures of prior performance.

e. Qualifications of the Psychologist for evaluating and treating:

1. The psychologist must be licensed by the State of WV.

2. He/she should have at least three years experience in chronic pain management, behavioral management, and/or addiction.

3. The Workers' Compensation Commission will annually provide a list of approved chronic opioid pain evaluating psychologists, based on the above criteria and satisfactory objective measures of prior performance.

f. Qualifications of the Psychiatric Addiction Specialist for evaluating and treating:

1. The psychiatrist must be licensed by the State of WV.

2. He/she must be Board-certified in Psychiatry.

3. He should have at least three years experience in treating patients with addictive disorders and have active hospital privileges in the treatment of same.

4. The Workers' Compensation Commission will annually provide a list of approved psychiatric addictive specialists, based on the above criteria and satisfactory objective measures of prior performance.

53.14. Guidelines for the prescription for controlled substances schedules II - IV (refer to Table § 85-20-B for controlled substances schedule)

a. Schedule II drugs should be prescribed on an outpatient basis for no longer than two weeks after initial injury or following a subsequent operative procedure.

b. Schedule III drugs should be prescribed on an outpatient basis for no longer than six weeks after initial injury or following a subsequent operative procedure.

c. Schedule IV opioid drugs should be prescribed on an outpatient basis for no longer than six weeks after initial injury or following a subsequent operative basis.

d. Schedule IV sedative and anxiolytic drugs should be prescribed on an outpatient basis for no longer than six months after initial injury or following a subsequent operative procedure.

e. To prescribe medications beyond the above guidelines, authorization must be obtained from the Commission. Authorization requests must include documentation as described in the Rule. It is recommended that providers utilize less potent medications when continued use is indicated.

53.15. The Commission will not reimburse for treatment in methadone maintenance programs. These programs are specifically intended to manage opiate addiction and the Commission shall not reimburse costs of treatment, medication, or any other expense associated with these programs.

V. SPECIAL RULES ON DRUGS AND MEDICATIONS

§85-20-54. Drugs with Specific Limitations.

54.1. Injectables. Prescriptions for injectable opioids or other analgesics, sedatives, antihistamines, tranquilizers, psychotropics, vitamins, minerals, food supplements, and hormones are not covered.

54.2. Exceptions: The Commission covers injectable medications under the following circumstances.

a. Indicated injectable drugs for the following:

1. Inpatients; or

2. During emergency treatment of a life-threatening condition/injury; or

3. During outpatient treatment of severe soft tissue injuries, burns or fractures when needed for dressing or cast changes; or

4. During the perioperative period and the postoperative period, not to exceed forty-eight hours from the time of discharge.

b. Prescriptions of injectable insulin, heparin and related anticoagulants, anti-migraine medications, or impotency treatment, when proper and necessary.

54.3. Noninjectable scheduled drugs administered by other than the oral route. Nonoral routes of administration of scheduled drugs that result in systemic availability of the drug equivalent to injectable routes will also not be covered.

54.4. Sedative-hypnotics. During the chronic stage of an industrial injury or occupational disease, payment for scheduled sedatives and hypnotics will not be authorized.

54.5. Benzodiazepines. Payment for prescriptions for benzodiazepines is limited to the following types of patients:

a. Hospitalized patients;

b. Injured workers with an accepted psychiatric disorder for which benzodiazepines are indicated;

c. Injured workers with an unrelated psychiatric disorder that is retarding recovery but which the Commission has temporarily authorized treatment and for which benzodiazepines are indicated; and

d. Other outpatients for not more than thirty days for the life of the claim.

54.6. Cancer. When cancer or any other end-stage disease is an accepted compensable condition, the department or self-insurer may authorize payment for any indicated scheduled drug and by any indicated route of administration.

54.7. Spinal cord injuries. When a spinal cord injury is an accepted condition, the Commission or self-insurer may authorize payment for anti-spasticity medications by any indicated route of administration (e.g., some benzodiazepines, Baclofen). Prior authorization is required.

§85-20-55. Drugs and Medications: Actions by the Commission.

55.1. The Commission may take any or all of the following steps when concerned about the amount or appropriateness of drugs the patient is receiving:

a. Notify the attending physician of concerns regarding the medications such as drug interactions, adverse reactions, prescriptions by other providers;

b. Require that the attending physician send a treatment plan addressing the drug concerns;

c. Request a consultation from an appropriate specialist;

d. Request that the attending physician consider reducing the prescription, and provide information on chemical dependency programs;

e. Limit payment for drugs on a claim to one prescribing doctor.

55.2. If the attending physician or worker does not comply with these requests, or if the probability of imminent harm to the worker is high, the Commission may discontinue payment for the drug after adequate prior notification has been given to the worker, pharmacy and physician.

55.3. Physician failure to reduce or terminate prescription of controlled substances, habit forming or addicting medications, or dependency inducing medications, after the Commission request to do so for an injured worker may result in a transfer of the worker to another physician of the worker's choice

§85-20-56. Physician's Records of Medication.

The physician's record must contain the name and reason for the medication, the dosage, quantity prescribed and/or dispensed, the route of administration, the frequency, the starting and stopping dates, the expected outcome of treatment, and any adverse effects that occur. Failure to maintain these records may be considered abuse under West Virginia Code Section 23-4-3c.

§85-20-57. Payment for oral opioid treatment for chronic, noncancer pain.

Chronic, noncancer pain may develop after an acute injury episode. It is defined as pain that typically persists beyond two to four months following the injury. The Commission, in its sole discretion, may pay for oral opioids for the treatment of chronic, noncancer pain caused by an accepted condition when that treatment is reasonably required.

§85-20-58. Required authorization for treatment of chronic, noncancer pain with opioids.

58.1. No later than thirty days after the attending physician begins treating the worker with opioids for chronic, noncancer pain, the attending physician must submit a written report to

the department or self-insurer in order for the Commission to pay for such treatment. The written report must include the following:

a. A treatment plan with time-limited goals, including a time schedule to wean the injured worker from opiod use;

b. A consideration of relevant prior medical history;

c. A summary of conservative care rendered to the worker that focused on reactivation and return to work;

d. A statement on why prior or alternative conservative measures may have failed or are not appropriate as sole treatment;

e. A summary of any consultations that have been obtained, particularly those that have addressed factors that may be barriers to recovery;

f. A statement that the attending physician has conducted appropriate screening for factors that may significantly increase the risk of abuse or adverse outcomes (e.g., a history of alcohol or other substance abuse); and

g. An opioid treatment agreement that has been signed by the worker and the attending physician. This agreement must be renewed every six months. The treatment agreement must outline the risks and benefits of opioid use, the conditions under which opioids will be prescribed, the physician's need to document overall improvement in pain and function, and the worker's responsibilities.

§85-20-59. Required documentation to be submitted for continued coverage of opioids to treat chronic, noncancer pain.

59.1. In addition to the general documentation required by the Commission, the attending physician must submit the following information at least every sixty days when treating with opioids:

a. Documentation of drug screenings, consultations, and all other treatment trials;

b. Documentation of outcomes and responses, including pain intensity and functional levels; and

c. Any modifications to the treatment plan.

The physician must document the patient's improvement in pain intensity and functional levels.

§85-20-60. Duration Commission Will Continue to pay for opioids to treat chronic, noncancer pain.

60.1. The Commission will continue to pay for treatment with opioids if directly related to a compensable condition so long as the physician documents in addition to the information required in Section 58 of this Rule:

a. Substantial reduction of the patient's pain intensity; and

b. Continuing substantial improvement in the patient's function.

Once the worker's condition has reached maximum medical improvement, further treatment with opioids is not payable. Opioid treatment for chronic, noncancer pain past the first three months of such treatment without documentation of substantial and progressive continuing improvement is presumed to be not proper and necessary.

§85-20-61. Denial of payment of opioid medications used to treat chronic, noncancer pain.

61.1. Payment for opioid medications may be denied in any of the following circumstances:

- Absent or inadequate documentation;
- Noncompliance with the treatment plan;
- Pain and functional status have not substantially improved after three months of opioid treatment; or
- Evidence of misuse or abuse of the opioid medication or other drugs, or noncompliance with the attending physician's request for a drug screen.

§85-20-62. Payment for nonopioid medications for the treatment of chronic, noncancer pain; Chelation therapy

62.1. The Commission may pay for nonopioid medication for the treatment of chronic, noncancer pain when it is proper and necessary and directly related to a compensable injury. For example, some drugs such as anti-convulsants, anti-depressants, and others have been demonstrated to be useful in the treatment of chronic pain and may be approved when proper and necessary.

62.2. All chelation therapy (oral and IV) requires prior authorization and consultation with a Board Certified Medical Toxicologist, an occupational medicine specialist, or general internist familiar with principals of toxicology, prior to initiation of the therapy. In the rare incident, in which acute encephalopathy occurs as the result of heavy metal toxicity, a consultation with the Poison Control Center will serve as confirmation of the need for such chelation therapy. The Commission will not reimburse for IV chelation therapy performed in office.

VI. EXPECTED PERIOD OF TIME TO REACH

MAXIMUM MEDICAL IMPROVEMENT

§85-20-63. Expected period of time to reach maximum medical improvement.

Pursuant to West Virginia Code Section 23-4-3b(b), the Commission hereby incorporates by reference the *Medical Disability Advisor, Workplace Guidelines for Disability Duration*, Presley Reed, MD (4th Edition) ("Presley Reed Guide") for purposes of establishing the expected period of time to reach maximum medical improvement and for continued treatment for various injuries and diseases. The requirements, standards, parameters and limitations of the Presley Reed Guide shall have the same force and effect as this Rule. All requirements, standards, parameters and limitations of the Presley Reed Guide are hereby deemed medically reasonable and any requirements, standards, parameters and limitations which exceed those set forth in the Presley Reed Guide are hereby deemed medically unreasonable. A preponderance of evidence, including but not limited to, detailed and documented medical findings, peer reviewed medical studies, and the elimination of causes not directly related to a compensable injury or disease, must be presented to establish that requirements, standards, parameters and limitations in excess of those provided for in the Presley Reed Guide are medically reasonable.

Nothing in this rule shall prohibit employers from using other guidelines for the purpose of establishing the expected period of time and medical treatment protocals necessary to reach maximum medical improvement for various injuries and diseases, as long as such guidelines are part of a managed care plan otherwise approved by the Commission pursuant to West Virginia Code Section 23-4-3(b)(2)(2003).

VII. RANGE OF PARTIAL DISABILITY AWARDS FOR COMMON INJURIES AND DISEASES

§85-20-64. Ranges of partial disability awards for common injuries and diseases.

64.1. Pursuant to West Virginia Code Section 23-4-3b(b), the Commission hereby adopts the following ranges of permanent partial disability for common injuries and diseases. Permanent partial disability assessments shall be determined based upon the range of motion models contained in the *Guides Fourth*. Once an impairment level has been determined by range of motion assessment, that level will be compared with the ranges set forth below. Permanent partial disability assessments in excess of the range provided in the appropriate category as identified by the rating physician shall be reduced to the within the ranges set forth below:

64.2. Lumbar Spine Impairment: The range of motion methodology for assessing permanent impairment shall be used. However, a single injury or cumulative injuries that lead to a permanent impairment to the Lumbar Spine area of one's person shall cause an injured worker to be eligible to receive a permanent partial disability award within the ranges identified in Table §85-20-C. The rating physician must identify the appropriate impairment category and then assign an impairment within the appropriate range designated for that category.

64.3. Thoracic Spine Impairment: A single injury or cumulative injuries that lead to a permanent impairment to the Thoracic Spine area of one's person shall cause an injured worker

to be eligible to receive a permanent partial disability award within the ranges identified in Table §85-20-D. The rating physician must identify the appropriate impairment category and then assign an impairment within the appropriate range designated for that category.

64.4. Cervical Spine Impairment: A single injury or cumulative injuries that lead to a permanent impairment to the Thoracic Spine area of one's person shall cause an injured worker to be eligible to receive a permanent partial disability award within the ranges identified in Table §85-20-E. The rating physician must identify the appropriate impairment category and then assign an impairment within the appropriate range designated for that category.

64.5. Carpal Tunnel Syndrome Impairment: An injured worker who can otherwise show entitlement to a permanent partial disability award for carpal tunnel syndrome shall be eligible to receive a permanent partial disability award of 0%-6% in each affected hand.

64.6. Mental Impairment:_ See 85 CSR 22, which sets forth disability ranges. These ranges, along with all other ranges in this Rule, must be strictly adhered to and ratings in excess of the ranges shall be considered evidence of abuse under West Virginia Code 23-4-3c.

64.7. Arm: The statutory impairment for the amputation of an injured worker's arm is 60%. Accordingly, a single or all cumulative injuries to an individual's arm shall not total more than 60%. As an example, if an injured worker receives a 6% award for unilateral carpal tunnel, a 30% award for a shoulder injury, and a 10% award for an elbow injury, he shall not be entitled to any future award for injuries sustained to his shoulder in excess of 14%. The "bundling" of awards for injuries to the arm shall not exceed the 60% amputation award.

64.8. Leg: The statutory impairment for the amputation of an injured worker's leg is 40%. Accordingly, a single or all cumulative injuries to an individual's leg shall not total more than 40%. As an example, if an injured worker is awarded a 20% award for a permanently impaired hip and then is later awarded a 15% permanent impairment for an injury to his knee, then he shall only be entitled to an additional 5% permanent award in future injuries to his hip, thigh, knee, shin, ankle, foot, or any other part of his leg. The "bundling" of awards for injuries to the leg shall not exceed the 40% amputation award.

§85-20-65. Adoption of Standards.

65.1. Except as provided for in section 66 of this Rule, on and after the effective date of this rule all evaluations, examinations, reports, and opinions with regard to the degree of permanent whole body medical impairment which an injured worker has suffered shall be conducted and composed in accordance with the "Guides to the Evaluation of Permanent Impairment," (4th ed. 1993), as published by the American Medical Association. If in any particular claim, the examiner is of the opinion that the Guides or the section 64 substitutes cannot be appropriately applied or that an impairment guide established by a recognized medical specialty group may be more appropriately applied, then the examiner's report must document and explain the basis for that opinion. Deviations from the requirements of the Guides or the section 6 substitutes shall not be the basis for excluding evidence from consideration. Rather, in any such instance such deviations shall be considered in

determining the weight that will be given to that evidence. An example of an acceptable recognized medical specialty group's own guides is the "Orthopedic Surgeons Manual in Evaluating Permanent Physical Impairment."

65.2. These revised rules are not applicable to any permanent impairment rating examination performed prior to the effective date of these revised rules. Accordingly, the revised rules are not applicable to any reports or opinions based upon those examinations, in whole or in part, which are submitted either before or after the effective date of these revised rules.

65.3. These rules are applicable to examinations and opinions provided to the Commission by an injured worker's treating physician pursuant to W. Va. Code §23-4-7a(c)(1).

§85-20-66. Evidentiary Requirements.

66.1. The evidentiary weight to be given to a report will be determined by how well it demonstrates that the evaluation and examination that it memorializes were conducted in accordance with the applicable Guides and that the opinion with regard to the degree of permanent whole body medical impairment suffered by an injured worker was arrived at and composed in accordance with the requirements of the applicable Guides.

66.2. The report must state the factual findings of all tests, evaluations, and examinations that were conducted and must state the manner in which they were conducted so as to clearly indicate their performance in keeping with the requirements of the Guides. For any evaluation and examination of a compensable back injury, the back examination form previously adopted by the health care advisory panel must be completed and submitted with the narrative report. A copy of the current edition of the back examination form can be obtained from the Commission. A report and opinion submitted regarding the degree of permanent whole body medical impairment as a result of a back injury without a completed back examination form shall be disregarded.

66.3. The opinion stated in the report as to the degree of permanent whole body medical impairment must reflect the process of calculation as stated in the applicable Guides so as to demonstrate how the degree of permanent whole body medical impairment was arrived at and calculated.

66.4. To the extent that factors other than the compensable injury may be affecting the injured worker's whole body medical impairment, the opinion stated in the report must, to the extent medically possible, determine the contribution of those other impairments whether resulting from an occupational or a nonoccupational injury, disease, or any other cause.

66.5. In any claim for occupational pneumoconiosis benefits, for noise induced hearing loss, or for mental and emotional loss, the application of these evidentiary requirements of this section shall be based upon the guidelines referred to below in lieu of the Guides. All of the other requirements of this section shall be accordingly applied.

§85-20-67. Exceptions to the Guides.

The following portions of the applicable Guides or their successor provisions shall not be used in the determination of the degree of permanent impairment that has been suffered by an injured worker for workers' compensation benefits.

67.1. In claims for occupational pneumoconiosis benefits, the provisions of Chapter 5, "The Respiratory System," are exempted from this rule. The provisions of the statute related to occupational pneumoconiosis, rules adopted in accordance with the statute, and policies and procedures adopted by the occupational pneumoconiosis board adequately and separately control the determination of the degree of permanent impairment suffered by such an injured worker. The occupational pneumoconiosis board may, in any given case and in its discretion, utilize the Guides to the extent the board deems appropriate.

67.2. In claims for noise induced hearing loss, the provisions of section 9.1, Chapter 9, "Ear, Nose, Throat, and Related Structures," are exempted from this rule. The applicable exempt legislative rule has been promulgated for such claims.

67.3. In claims for mental and emotional loss, the provisions of chapter 14, "Mental and Behavioral Disorders," are exempted from this rule. The legislative rule styled "Guidelines for Psychiatric Permanent Impairment Evaluations, Evidence and Ratings of Psychiatric Impairment Due to Workers' Compensation Injuries," §85 CSR 22 (1995), shall be utilized.

67.4. In those claims affected by the provisions of W. Va. Code §23-4-6(f), the degree of disability stated there shall be applied.

67.5. In those claims affected by the provisions of W. Va. Code §23-4-6(m), the conclusive presumption of total disability stated there shall be applied.

§85-20-68. Payment for Evaluations.

The Commission shall not make payment to any impairment examiner whose reports, opinions, examinations, or evaluations are not conducted, performed, and composed in accordance with this Rule. In the event payment was made prior to a determination that the report, opinion, examination, or evaluation was not conducted, performed, or composed in accordance with this Rule, then the amount so paid shall be recovered from the examiner either by way of a direct repayment to the Commission or by way of an offset against any future sums that may be owed by the Commission to the examiner for any services rendered for or to the Commission or for or to an injured worker. A later submission or supplement to the report, which demonstrates compliance with these rules, shall serve to permit such payment.

§85-20-69. Violation and Penalties: Without limiting the general nature of various statutes respecting criminal fraud, and by way of illustration and not in limitation, the following are deemed unlawful acts and practices:

a. Billing for services not actually performed;

b. Billing for expenses not actually incurred;

c. Billing services on dates other than the date on which they were actually performed;

d. Offering consideration of any kind, including gifts, services or gratuities to Commission employees in exchange for or as a past reward for referring cases to the provider;

e. Failing to close claims at the earliest practicable date when the injured worker can no longer benefit from such services;

f. Providing false information in any statement to the Commission, or forging or falsifying any record required to be kept by these Rules or any other statute or rule governing providers; and

g. "Rolling in" unreimbursable time or expenses by adding hours for billable time or expenses.

All providers and employers shall retain for five (5) years and provide to the Commission on request and without a subpoena hard copies of the source underlying any bill, invoice, report, etc. submitted to the Fund by electronic or other means.

§85-20-70. Injured Employee's Responsibilities Concerning Medical Examination and Treatment. (Effective Date: -- .)

70.1. Examination and treatment.

The Commission may order an injured employee to report for examination and may further order him to undergo such treatment or hospitalization as is indicated in the particular case. It shall be the duty of the injured employee to comply fully and promptly with any such order issued by the Commission.

70.2. Violation of rule.

a. If violation of any provision of this rule, or refusal to comply with any order of the Commission issued as provided herein, should result in an increase in the duration of temporary disability or in the degree of permanent disability, such violation or refusal will be considered in determining the compensation, if any, to be awarded and no compensation will be awarded for extension or increase of disability caused thereby.

b. The Commission may suspend benefits being paid to a claimant if the claimant refuses, without good cause, to undergo the examinations or needed treatments provided for in West Virginia Code Section 23-4-7a. Good cause shall consist of the following:

1. Compelling evidence that the examination or treatment would have little, if any, positive effect on the claimant's injury;

2. Compelling evidence that no ordinarily prudent and reasonable person would have submitted to the examination or needed treatment;

3. Compelling evidence that the examination or treatment would pose a danger to the life or health of the claimant or require extraordinary suffering;

4. A consensus of medical opinions establishing that the examination or treatment would not effect a cure or would not at least improve the likelihood that the claimant could return to gainful employment; and

5. Compelling evidence that the prognosis for success and recovery were unreasonably low.

c. Failure to attend a single scheduled examination or treatment shall not be grounds to suspend benefits. However, failure to attend two (2) or more consecutively scheduled examinations or treatments without clear justification, regardless if the examinations or treatments were scheduled for a related purpose, may, in the Commission's sole discretion, constitute grounds to suspend benefits. Also, a pattern of failing to attend scheduled examinations or treatments shall constitute grounds for the suspension of benefits.

d. A claimant whose benefits are suspended under this rule shall not be entitled to benefits from the date the relevant examination or treatment was not undergone until such time as the examination or treatment is undergone and notice of such is provided to the Commission. If benefits are re-instated, any overpayment will be deducted from the re-instated benefits at a reasonable rate until the overpayment is recouped. The unpaid balance of the overpayment, if any, will be recovered from any future award to the claimant.

e. The Commission shall enter a protestable order notifying the claimant of the suspension of benefits and shall serve the order on all of the parties to the claim.

§85-20-71. Severability.

If any provision of this Rule or the application thereof to any entity or circumstance shall be held invalid, such invalidity shall not affect the provisions or the applications of this Rule which can be given effect without the invalid provisions or application and to this end the provisions of this rule are declared to be severable.

TABLE 85-20A. Impairment of Pulmonary Function. Page 1 of 3.

a. The following table will be used as an indicator of impairment of pulmonary function if any of the acceptable values appear in the percentage of impairment column:

% IMPAIRMENT:

	0	10	15	20	25	30	40	50	60	TOTAL
FVC % PRED.	80	75	70	67	64	61	58	55	52	50
FEV_1.% PRED.	75	73	70	67	64	61	58	55	52	50
FEV_1./FVC	75	73	70	67	64	61	56	51	48	45
MVV % PRED.	80	75	70	67	64	61	58	55	52	50
$PaCO_2$			$Pa0_2$ Values Equal to or Less Than							
30 or below	85	81	78	75	73	70	68	67	66	65
31	84	80	77	74	72	69	67	66	65	64
32	83	79	76	73	71	68	66	65	64	63
33	82	78	75	72	70	67	65	64	63	62
34	81	77	74	71	69	66	64	63	62	61
35	80	76	73	70	68	65	63	62	61	60
36	79	75	72	69	67	64	62	61	60	59
37	78	74	71	68	66	63	61	60	59	58
38	77	73	70	67	65	62	60	59	58	57
39	76	72	69	66	64	61	59	58	57	56
40 or above	75	71	68	65	63	60	58	57	56	55

Impairment	0%	10-25%	26-50%	51-100%
DL/VA	> or = 80%pred	60-79% pred	41-59% pred	< or = 40%pred

TABLE 85-20A. Impairment of Pulmonary Function. (page 2)

(b) Exercise pO_2 values that rise above the resting pO_2 values will indicate a lesser degree of impairment of pulmonary function, and if they are less than the resting values will indicate a greater degree of impairment of pulmonary function.

(c) The results of any medically acceptable tests or procedures reported by a physician which are not addressed in this table but which tend to demonstrate the presence or absence of pneumoconiosis or sequela of pneumoconiosis or the presence or absence of a respiratory pulmonary impairment may be submitted and given appropriate consideration (Airway Resistance, Oximetry, and A-a gradient, etc.). It is also important that the Occupational Pneumoconiosis Board use all clinical history and physical findings that would enhance or detract from any percentage of impairment in the above table.

(d) Where an employee has a definitely ascertainable impairment which is not resulting from occupational pneumoconiosis, but which is contributing to the employee's over-all pulmonary impairment, such impairment, the effect thereof, and any aggravation thereof will not be taken into consideration in fixing the amount of compensation allowed for occupational pneumoconiosis, and such compensation will be awarded only in the amount that would have been allowable had such other impairment not been present.

(e) The degree of such impairment attributable to a cause that is not occupational pneumoconiosis may be established at any time by competent medical or other evidence. Competent medical or other evidence will include reasoned medical judgment that is based on the medical record in a given claim and on generally accepted medical science.

(f) The method of establishing impairment attributable to a cause that is not occupational pneumoconiosis need not be a matter of exact mathematical or scientific formulation, but should based upon the entirety of the evidentiary record, including but not limited to: 1) a recognition of the magnitude and type of impairment that is typically associated with different types of pneumoconiosis; 2) a recognition of the magnitude and type of impairment typically associated with medical conditions other than pneumoconiosis that cause pulmonary impairment; 3) a recognition of the type, intensity and duration of the physical insults that have given rise to any pneumoconiosis and other causes of pulmonary impairment; and 4) a recognition that where two or more medical conditions likely to cause pulmonary impairment exist in combination, every effort should be made to fairly allocate responsibility for any over-all pulmonary impairment among the several conditions.

(g) Cigarette and cigar smoking are recognized by the medical community as the principal causes of pulmonary impairment and primary lung cancers in the general population. Special attention will be given to assuring that, wherever possible, pulmonary impairment caused by cigarette or cigar smoking is not included in awards for impairment cause by occupational pneumoconiosis.

TABLE §85-20-A. Impairment of Pulmonary Function (page 3)

I. Ventilatory Function Tests

A. FVC – Forced Vital Capacity – Three adequate trials are required for a valid test. The two best curves must be within 7%. The third curve should be of similar shape. The largest FVC is to be reported.

B. FEV_1 – Forced Expiratory Volume in one second – The largest FEV_1 is to be reported. The two best FEV_1 measurements should be within 7%. Extrapolated volume must be less that 10% of the FVC.

C. MVV – Maximum Voluntary Ventilation – Must approximate the FEV_1 X 40 to within 80% to be a valid test.

D. Tracings – The three best curves from the FVC maneuver must be provided. Multiple trials may be illustrated to demonstrate non-reproducibility.

Tracings which reflect non-valid studies should show all trials to indicate multiple attempts to achieve validity.

E. Reports shall indicate the location of test, date and time along with name of technician or other medical personnel performing the test.

Report shall include the patient/claimant's last name, first and middle initial, social security number, current age in years, gender, height measurement to the nearest ¼ inch, and weight in pounds.

F. Test results are to be reported in BTPS.

G. Calibration reports from the date of testing should also be provided.

H. Kory nomogram is to be used for predicted values for spirometry.

I. Facilities providing services for the Commission may be subject to inspection by an appointee of the Commission. Pulmonary Function Laboratories should be staffed with properly trained personnel, have adequate equipment with documented calibration and quality control, and access to related files. Personnel performing spirometry must possess a minimum of a NIOSH training certificate. Personnel performing more complex pulmonary function testing should possess a minimum of CPFT (Certified Pulmonary Function Technician) with an RPFT (Registered Pulmonary Function Technologist) preferred.

II. Arterial Blood Gas

A. Reports shall indicate resting and/or exercise.

B. If resting only, there should be a noted contraindication to exercise.

C. Reports shall indicate the location, altitude, and barometric pressure of testing facility, date and time along with name of technician or other medical personnel performing the test.

D. Facilities performing blood analysis must provide evidence of compliance with CLIA regulations and be subject to inspection by authorized personnel.

III. Chest X-ray

A. Singleview – PA – Upright at full inspiration on a 14 x 17 film is required.

B. Film should be identified with location of testing facility, date, patient name, SSN, and date of birth.

C. Original films should be provided for review.

D. Facilities performing radiographic services must provide evidence of compliance with state and federal laws regulating such facilities and be subject to inspection by authorized personnel.

TABLE §85-20-B. Schedule of Controlled Substances.

a. The Controlled Substances Act of 1970 regulates the manufacturing, distribution and dispensing of drugs that have abuse potential. The Drug Enforcement Administration (DEA) within the US Department of Justice is the chief federal agency responsible for enforcement.

A. DEA Schedules: Drugs under jurisdiction of the Controlled Substances Act are divided into five schedules based on their potential for abuse and physical and psychological dependence. All controlled substances listed in Drug Facts and Comparisons are identified by schedule as follows:

Schedule I (C-I)	High abuse potential and noaccepted medical use (eg, heroin, marijuana, LSD).
Schedule II (C-II)	High abuse potential with severe dependence liability (eg, narcotics, amphetamines, dronabinol, some barbiturates).
Schedule III (C-III)	Less abuse potential than schedule II drugs and moderate dependence liability (eg, nonbarbiturate sedatives, non-amphetamine stimulants, limited amounts of certain narcotics).

Schedule IV (C-IV)	Less abuse potential than schedule III drugs and limited dependence liability (eg, some sedatives, antianxiety agents, non-narcotic analgesics).
Schedule V (C-V)	Limited abuse potential. Primarily small amounts of narcotics (codeine) used as antitussives or antidiarrheals. Under federal law, limited quantities of certain c-v drugs may be purchased without a prescription directly from a pharmacist if allowed under specific state statutes. The purchaser must be at least 18 years of age and must furnish suitable identification. All such transactions must be recorded by the dispensing pharmacist.

TABLE §85-20-C. PPD Ranges for Lumbar Spine Impairments

Criteria for Rating Impairment Due to Lumbar Spine Injury				
Lumbar Category I 0% Impairment of the Whole Person	**Lumbar Category II 5%-8% Impairment of the Whole Person**	**Lumbar Category III 10%-13% Impairment of the Whole Person**	**Lumbar Category IV 20%-23% Impairment of the Whole Person**	**Lumbar Category V 25%-28% Impairment of the Whole Person**
No significant clinical findings, no obseved muscle guarding or spasm, no documentable neurologic impairment, no documented alteration in structural integrity and no other indication of impairment related to injury or illness; no fractures	Clinical history and examination findings are compatible with a specific injury; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion, or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity and no significant radiculopathy **or** individual had a clinically significant radiculopathy and has an imaging study that demonstrates a herniated disk at the level and on the side that would be expected based on the previous radiculopathy, but no longer has the radiculopathy following conservative treatment **or** fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation (not developmental spondylolysis) that has healed without alteration of motion segment integrity; (3) a spinous or transverse process fracture with displacement without a vertebral body fracture, which does not disrupt the spinal canal	Significant signs of radiculopathy, such as dermatormal pain and/or in a dermatomal distribution, sensory loss, loss of relevant reflex(es), loss of muscle strength or measured unilateral atrophy above or below the knee compared to measurements on the contralateral side at the same location; impairment may be verified by electrodiagnostic findings **or** history of a herniated disk at the level and on the side that would be expected from objective clinical findings, associated with radiculopathy, or individuals who had surgery for radiculopathy but are now asymptomatic **or** fractures: (1) 25% to 50% compression of one vertebral body; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases, the fracture has healed without alteration of structural integrity	Loss of motion segment integrity defined from flexion and extension radiographs as at least 4.5 mm of translation of one vertebra on another or angular motion greater than 15° at L1-2, L2-3 and L3-4, greater than 20° at L4-5, and greater than 25° at L5-S1 (Figure 15-3); may have complete or near complete loss of motion of a motion segment due to developmental fusion, or successful or unsuccessful attempt at surgical arthrodesis **or** fractures: (1) greater than 50% compression of one vertebral body without residual neurologic compromise	Meets the criteria of DRE lumbosacral categories III and IV; that is, both radiculopathy and alteration of motion segment integrity are present; significant lower extremity impairment is present as indicated by atrophy or loss of reflex(es), pain and/or sensory changes within an anatomic distribution (Dermatomal), or electromyographic findings as stated in lumbosacral category III and alteration of spine motion segment integrity as defined in lumosacral category IV **or** fractures: (1) greater than 50% compression of one vertebral body with unilateral neurologic compromise

TABLE §85-20-D. PPD Ranges for Thoracic Spine Injury

Criteria for Rating Impairment Due to Thoracic Spine Injury				
Thoracic Category I 0% Impairment of the Whole Person	**Thoracic Category II 5%-8% Impairment of the Whole Person**	**Thoracic Category III 15%-18% Impairment of the Whole Person**	**Thoracic Category IV 20%-23% Impairment of the Whole Person**	**Thoracic Category V 25%-28% Impairment of the Whole Person**
No significant clinical findings, no observed muscle guarding, no documentable neurologic impairment, no documented changes in structural integrity and no other indication of impairment related to injury or illness; no fractures	History and examination findings are compatible with a specific injury or illness; findings may include significant muscle guarding or spasm observed at the time of the examination, asymmetric loss of range of motion (dysmetria), or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of motion segment integrity **or** herniated disk at the level and on the side that would be expected from objective clinical findings, but without radicular signs following conservative treatment **or** fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without alteration of motion segment integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement, but without a vertebral body fracture	Ongoing neurologic impairment of the lower extremity related to a thoracolumbar injury, documented by examination of motor and sensory functions, reflexes or findings of unilateral atrophy above or below the knee related to no other condition; impairment may be verified by electrodiagnostic testing **or** clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side that would be expected from objective clinical findings; history of radiculopathy, which has improved following surgical treatment **or** fractures: (1) 25% to 50% compression fracture of one vertebral body; (2) posterior element fracture with mild displacement disrupting the canal; in both cases the fracture has healed without alteration of structural integrity; differentiation from a congenital or developmental condition should be accomplished, if possible, by examining preinjury roentgenograms, if available, or by a bone scan performed after the onset of the condition	Alteration of motion segment integrity or bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as translation of one vertebra or another of more than 2.5 mm; radiculopathy as defined in thoracic category III need not be present if there is alteration of motion segment integrity; if an individual is to be placed in DRE thoracic category IV due to radiculopathy, the latter must be bilateral or involve more than one level **or** fractures: (1) more than 50% compression of one vertebral body without residual neural compromise	Impairment of the lower extremity as defined in thoracolumbar category III and loss of structural integrity as defined in thoracic category IV **or** fractures: (1) greater than 50% compression of one vertebral body with neural motor compromise but not bilateral involvement that would qualify the individual for corticospinal tract evaluation

TABLE §85-20-E. PPD Ranges for Cervical Disorders

Table 15-5 Criteria for Rating Impairment Due to Cervical Disorders				
Cervical Category I 0% Impairment of the Whole Person	**Cervical Category II 5%-8% Impairment of the Whole Person**	**Cervical Category III 15%-18% Impairment of the Whole Person**	**Thoracic Category IV 25%-28% Impairment of the Whole Person**	**Thoracic Category V 35%-38% Impairment of the Whole Person**
No significant clinical findings, no muscular guarding, no documentable neurologic impairment, no significant loss of motion segment integrity and no other indication of impairment related to injury or illness; no fractures	Clinical history and examination findings are compatible with a specific injury; findings may include muscle guarding or spasm observed at the time of the examination by a physician, asymmetric loss of range of motion or nonverifiable radicular complaints, defined as complaints of radicular pain without objective findings; no alteration of the structural integrity **or** individual had clinically significant radiculopathy and an imaging study that demonstrated a herniated disk at the level and on the side that would be expected based on the radiculopathy, but has improved following nonoperative treatment **or** fractures: (1) less than 25% compression of one vertebral body; (2) posterior element fracture without dislocation that has healed without loss of structural integrity or radiculopathy; (3) a spinous or transverse process fracture with displacement	Significant signs of radiculopathy, such as pain and/or sensory loss in a dermatomal distribution, loss of relevant reflex(es), loss of muscle strength, or unilateral atrophy compared with the unaffected side, measured at the same distance above or below the elbow; the neurologic impairment may be verified by electrodiagnostic findings **or** individual had clinically significant radiculopathy, verified by an imaging study that demonstrates a herniated disk at the level and on the side expected from objective clinical findings with radiculopathy or with improvement of radiculopathy following surgery **or** fractures: (1) 25% to 50% compression of one vertebral bogy; (2) posterior element fracture with displacement disrupting the spinal canal; in both cases the fracture is healed without loss of structural integrity; radiculopathy may or may not be present; differentiation from congenital and developmental conditions may be accomplished, if possible, by examining preinjury roentgenograms or a bone scan performed after the onset of the condition	Alteration of motion segment integrity or bilateral or multilevel radiculopathy; alteration of motion segment integrity is defined from flexion and extension radiographs as at least 3.5 mm of translation of one vertebra on another, or angular motion of more than 11° greater than at each adjacent level (Figures 15-3a and 15-3b); alternatively, the individual may have loss of motion of a motion segment due to a developmental fusion or successful or unsuccessful attempt at surgical arthrodesis; radiculopathy as defined in cervical category III need not be present if there is alteration of motion segment integrity **or** fractures: (1) more than 50% compression of one vertebral body without residual neural compromise	Significant upper extremity impairment requiring the use of upper extremity external functional or adaptive device(s); there may be total neurologic loss at a single level or severe, multilevel neurologic dysfunction **or** fractures: structural compromise of the spinal canal is present with severe upper extremity motor and sensory deficits but without lower extremity involvement