



## Complete Summary

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### GUIDELINE TITLE

Shoulder (acute & chronic).

### BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Shoulder (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2008. 217 p. [226 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Work Loss Data Institute. Shoulder (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jul 5. 191 p.

The *Official Disability Guidelines* product line, including *ODG Treatment in Workers Comp*, is updated annually, as it has been since the first release in 1996.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Work-related shoulder disorders

### GUIDELINE CATEGORY

Diagnosis  
Evaluation

Management  
Treatment

### **CLINICAL SPECIALTY**

Family Practice  
Internal Medicine  
Orthopedic Surgery  
Physical Medicine and Rehabilitation  
Surgery

### **INTENDED USERS**

Advanced Practice Nurses  
Health Care Providers  
Health Plans  
Nurses  
Physician Assistants  
Physicians

### **GUIDELINE OBJECTIVE(S)**

To offer evidence-based step-by-step decision protocols for the assessment and treatment of workers' compensation conditions

### **TARGET POPULATION**

Workers with occupational shoulder disorders

### **INTERVENTIONS AND PRACTICES CONSIDERED**

The following interventions/procedures were considered and recommended as indicated in the original guideline document:

1. Activity restrictions/work modifications
2. Anterior scalene block
3. Arthrography
4. Arthroplasty for selected patients
5. Bone-growth stimulators/ultrasound fracture healing
6. Cardiovascular functional testing
7. Chiropractic/manipulation
8. Cold packs
9. Computed tomography (CT)
10. Continuous-flow cryotherapy
11. Deep friction massage
12. Diagnostic arthroscopy
13. Diagnostic ultrasound
14. Electrodiagnostic testing for thoracic outlet syndrome (TOS)
15. Exercises
16. Extracorporeal shock wave therapy (ESWT)
17. Home health services

18. Impingement tests
19. Low level laser therapy (LLLT)
20. Magnetic resonance imaging (MRI)
21. Myoelectric upper extremity (hand and/or arm) prosthesis
22. Nerve blocks
23. Physical therapy/occupational therapy
24. Prosthesis (artificial limb)
25. Pulsed electromagnetic field
26. Radiography
27. Range of motion (ROM) assessment
28. Return to work (early mobilization)
29. Superior labrum, anterior and posterior (SLAP) lesion diagnosis
30. Static progressive stretch (SPS) therapy for adhesive capsulitis
31. Steroid injections
32. Surgery for impingement syndrome
33. Surgery for pectoralis tendon repair for full tears in younger patients
34. Surgery for rotator cuff repair
35. Surgery for shoulder dislocation
36. Surgery for SLAP lesions (Type II and Type IV if more than 50% of the tendon is involved)
37. Surgery for thoracic outlet syndrome
38. Therapeutic ultrasound
39. Transcutaneous electrical neurostimulation (TENS) post-stroke
40. Work conditioning, work hardening

The following interventions/procedures are under study and are not specifically recommended:

1. Acupuncture
2. Ergonomic interventions
3. Graft, rotator cuff
4. Hydroplasty/hydrodilatation
5. Manipulation under anesthesia (MUA)
6. Massage
7. Postoperative pain pump
8. Surgery for adhesive capsulitis
9. Thermal capsulorrhaphy
10. Thermotherapy
11. Vacuum-assisted closure wound-healing

The following interventions/procedures were considered, but are not recommended:

1. Adson's test (AT) for thoracic outlet syndrome
2. Biofeedback
3. Biopsychosocial rehabilitation
4. Bipolar interferential electrotherapy
5. Clavicle fracture surgery except in rare cases
6. Continuous-passive motion (CPM)
7. Costoclavicular maneuver (CCM)
8. Cutaneous laser treatment
9. Delayed treatment

10. Diathermy
11. Electrical stimulation
12. Elevated arm stress test (EAST)
13. Immobilization as primary treatment
14. Iontophoresis
15. Low level laser wound-healing
16. Mechanical traction
17. Osteochondral autologous transplantation (OATS)
18. Porcine small intestinal submucosal implants
19. Scapula fracture surgery
20. Supraclavicular pressure (SCP)
21. Surgery for acromioclavicular (AC) joint separation
22. Surgery for ruptured biceps tendon (except as indicated in the original guideline document)
23. Transdermal nitroglycerin

### **MAJOR OUTCOMES CONSIDERED**

- Sensitivity, specificity, and accuracy of diagnostic tests
- Effectiveness of treatment in relieving pain and restoring normal function

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Hand-searches of Published Literature (Primary Sources)  
 Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

Work Loss Data Institute (WLDI) conducted a comprehensive medical literature review (now ongoing) with preference given to high quality systematic reviews, meta-analyses, and clinical trials published since 1993, plus existing nationally recognized treatment guidelines from the leading specialty societies. WLDI primarily searched MEDLINE and the Cochrane Library. In addition, WLDI also reviewed other relevant treatment guidelines, including those in the National Guideline Clearinghouse, as well as state guidelines and proprietary guidelines maintained in the WLDI guideline library. These guidelines were also used to suggest references or search terms that may otherwise have been missed. In addition, WLDI also searched other databases, including MD Consult, eMedicine, CINAHL, and conference proceedings in occupational health (i.e., American College of Occupational and Environmental medicine [ACOEM]) and disability evaluation (i.e., American Academy of Disability Evaluating Physicians [AADEP], American Board of Independent Medical Examiners [ABIME]). Search terms and questions were diagnosis, treatment, symptom, sign, and/or body-part driven, generated based on new or previously indexed existing evidence, treatment parameters and experience.

In searching the medical literature, answers to the following questions were sought: (1) If the diagnostic criteria for a given condition have changed since 1993, what are the new diagnostic criteria? (2) What occupational exposures or

activities are associated causally with the condition? (3) What are the most effective methods and approaches for the early identification and diagnosis of the condition? (4) What historical information, clinical examination findings or ancillary test results (such as laboratory or x-ray studies) are of value in determining whether a condition was caused by the patient's employment? (5) What are the most effective methods and approaches for treating the condition? (6) What are the specific indications, if any, for surgery as a means of treating the condition? (7) What are the relative benefits and harms of the various surgical and non-surgical interventions that may be used to treat the condition? (8) What is the relationship, if any, between a patient's age, gender, socioeconomic status and/or racial or ethnic grouping and specific treatment outcomes for the condition? (9) What instruments or techniques, if any, accurately assess functional limitations in an individual with the condition? (10) What is the natural history of the disorder? (11) Prior to treatment, what are the typical functional limitations for an individual with the condition? (12) Following treatment, what are the typical functional limitations for an individual with the condition? (13) Following treatment, what are the most cost-effective methods for preventing the recurrence of signs or symptoms of the condition, and how does this vary depending upon patient-specific matters such as underlying health problems?

### **Criteria for Selecting the Evidence**

Preference was given to evidence that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reports a cohort study, whether prospective or retrospective, or (5) The article reports a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

More information about the selection of evidence is available in "Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument" (see "Availability of Companion Documents" field).

### **NUMBER OF SOURCE DOCUMENTS**

Not stated

### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

#### **Ranking by Type of Evidence**

1. Systematic Review/Meta-Analysis
2. Controlled Trial-Randomized (RCT) or Controlled

3. Cohort Study-Prospective or Retrospective
4. Case Control Series
5. Unstructured Review
6. Nationally Recognized Treatment Guideline (from [www.guideline.gov](http://www.guideline.gov))
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides

### **Ranking by Quality within Type of Evidence**

- a. High Quality
- b. Medium Quality
- c. Low Quality

### **METHODS USED TO ANALYZE THE EVIDENCE**

Review of Published Meta-Analyses  
Systematic Review

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

The Work Loss Data Institute (WLDI) reviewed each article that was relevant to answering the question at issue, with priority given to those that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reported a cohort study, whether prospective or retrospective, or (5) The article reported a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

Especially when articles on a specific topic that met the above criteria were limited in number and quality, WLDI also reviewed other articles that did not meet the above criteria, but all evidence was ranked alphanumerically (see the Rating Scheme of the Strength of Evidence field) so that the quality of evidence could be clearly determined when making decisions about what to recommend in the Guidelines. Articles with a Ranking by Type of Evidence of Case Reports and Case Series were not used in the evidence base for the Guidelines. These articles were not included because of their low quality (i.e., they tend to be anecdotal descriptions of what happened with no attempt to control for variables that might affect outcome). Not all the evidence provided by WLDI was eventually listed in the bibliography of the published Guidelines. Only the higher quality references were listed. The criteria for inclusion was a final ranking of 1a to 4b (the original inclusion criteria suggested the methodology subgroup), or if the Ranking by Type of Evidence was 5 to 10, the quality ranking should be an "a."

### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Not stated

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

The guideline developers reviewed published cost analyses.

## **METHOD OF GUIDELINE VALIDATION**

External Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Prior to publication, select organizations and individuals making up a cross-section of medical specialties and typical end-users externally reviewed the guideline.

# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

### **Initial Diagnosis**

- First visit: with Primary Care Physician MD/DO (100%)
- Initial evaluation should include:
  - Determine the type of trauma (e.g., direct trauma, fall, repetitive motion, twisting incident, etc.)
  - Test the range-of-motion of the joint (normal, mild restriction, severe restriction, or complete restriction)
  - An initial evaluation of the shoulder requires accurate diagnosis of shoulder injuries by careful inspection and palpation of the shoulder area. Although the shoulder is generally swollen, the injury is usually defined by direct tenderness over the injured area.
- **Determine "degenerative changes" versus "acute trauma":**
  - **Degenerative changes** (Go to *Initial Conservative Treatment*)  
Lesions of the rotator cuff are a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Impingement syndrome, shoulder tendonitis, shoulder sprain, and subacromial bursitis are all closely related entities with the same etiology. They involve friction, abrasion, and inflammation of the rotator cuff and the long head of the biceps tendon with the subacromial arch (anterior lip of the acromion, coracoacromial ligament, and acromioclavicular joint). These conditions involve consequences of aging or repetitive use, or a combination thereof, such as:

- Impingement syndrome (age >40 years, weakness, cuff tenderness, painful range of motion [ROM], impingement sign, radiographic findings, night pain, history of catching, or pain with shoulder motion)
- Rotator cuff tendonitis (similar)
- Rotator cuff tear (only Types I and II, partial tear, age >40 yrs)
- Adhesive capsulitis, frozen shoulder (progressive pain and stiffness, diabetes or trauma, decreased passive ROM, normal x-rays, night pain)
- Tendinopathy
- Bicipital tendon disorders
- Bursitis
- **Acute trauma** (*Go directly to Aggressive Treatment*)
  - Acute rotator cuff tear (type III, age <40 yrs)
  - Acromioclavicular (AC) joint strain or separation
    - Types I-III versus Types IV-VI (rare, surgery may be indicated)
- Rule out diagnoses (See other treatment parameters for each of these):
  - Referred neck pain (see the original guideline document for International Classification of Diseases, Ninth Revision [ICD-9] codes for this and other diagnoses)
  - Thoracic outlet syndrome, brachial plexus disorders
  - Fractures (treat clavicular fractures mostly nonoperatively)
  - Laceration
  - Glenohumeral shoulder joint dislocation
  - Arthritis

#### **Mild/Moderate -- Initial Conservative Treatment** (90% of cases)

- Also first visit (day 1):
  - Prescribe alteration of activity (home and work), no overhead work, stretching (gentle range-of-motion exercises), appropriate analgesia (i.e., acetaminophen) and/or anti-inflammatory (i.e., ibuprofen) [*Benchmark cost: \$14*], back to work--modified duty: if condition caused by job, possible ergonomic evaluation of job

#### **Official Disability Guidelines (ODG) Return-To-Work Pathways**

Medical treatment (Grade I or II<sup>1</sup>, impingement, no tear), modified work: 0 days

Medical treatment (impingement, no tear), manual work: 7 days

(See *ODG Capabilities & Activity Modifications for Restricted Work* under "Work" in the Procedure Summary of the original guideline document)

- Second visit (day 8 to 20 – about 2 weeks after first visit or sooner because delayed treatment is not recommended)
  - Document progress
  - If not significantly improved, then prescribe physical therapy (gentle range-of-motion exercises plus exercises that strengthen the rotators and stabilize the scapula); should be started for home exercise training

- [*Benchmark cost: \$250*]: Refer to Physical Therapist (50%) or Occupational Therapist (50%) for 3 visits per week for 2 weeks.
- Third visit (day 21 to 35 - about 1 month after first visit)
    - Document progress
    - Further relaxation and pain control can be achieved by injecting an anesthetic under the acromion (laterally or anteriorly) into the shoulder joint.
    - Corticosteroid injection trial [*Benchmark cost: \$276*]. Should be performed by musculoskeletal-trained physician. Sprains of the rotator cuff cause swelling within a closed space and add an element of chronic impingement which may be slow to resolve. By decreasing swelling, local infiltration of the rotator cuff with corticosteroids may quicken the resolution of this problem. Repeat corticosteroid injection may be necessary, but should not be done any sooner than every two weeks, up to a maximum of three injections. Injection should be avoided in patients under 30 years of age.
    - If prescribe therapy, then continue therapist, change from passive to active modality, up to 2 visits per week, teach home exercises.

#### **ODG Return-To-Work Pathways**

Medical treatment (impingement, no tear), manual overhead work: 28 days

Medical treatment, regular work if cause of disability: 42 days

Medical treatment, heavy manual work: 42 days

- Fourth visit (day 42 - about 6 weeks after first visit)
  - Refer for imaging

#### **Imaging** (30% of cases)

[*Benchmark cost: \$370-\$1,200*]

- Magnetic resonance images (MRIs) are quite accurate in differentiating chronic impingement from tears of the rotator cuff and should be employed when:
  - A surgical approach is being considered
  - The diagnosis is unclear
  - The clinical examination is limited
- MR arthrograms are accurate in diagnosing labral tears.
- X-rays: special views of AC joint, with weights in hand for AC separation
- Diagnostic ultrasound is an option.
- If indicated by imaging, and no improvement from initial conservative therapy, refer for aggressive treatment at three months.

#### **Aggressive Treatment** (10% of cases)

[*Benchmark cost: \$2,621*]

- Include imaging as above
- Dislocation: After reduction, the first and second dislocations of the shoulder are treated nonsurgically except in unusual circumstances. An initial

dislocation should generally be treated with three or more weeks of immobilization in a sling and swathe. This is followed by a progressive exercise program to strengthen the muscles of the shoulder girdle and, thus, reduce the probability of recurrent dislocations. A second dislocation may be treated in a sling until asymptomatic. After a third dislocation, further dislocations may be presumed to be imminent, and orthopedic referral for consideration of a surgical repair is appropriate.

- Arthroscopy, Shoulder, Surgical: Rotator cuff repair, with decompression of subacromial space with partial acromioplasty, with or without coracoacromial release. Performed by Orthopedic Surgeon (90%) or General Surgeon (10%) on an outpatient or 23-hour basis. May be endoscopic. Decompression/acromioplasty alone should be performed after at least six weeks of conservative treatment.
- Labral tears: When the glenoid labrum becomes injured or torn, it is described as a labral tear. These tears may be classified by the position of the tear in relation to the glenoid (which is often called the "shoulder socket"). A Bankart tear is a tear in the labrum located in the front, lower (anterior, inferior) part of the shoulder socket. This type of tear occurs most commonly during a shoulder dislocation. A Bankart tear makes the shoulder more prone to recurrent dislocations. A SLAP tear (Superior Labral tear from Anterior to Posterior) is a tear in the labrum that covers the top part of the shoulder socket from front to back. A SLAP tear occurs at the point where the long head of biceps tendon attaches. This type of tear occurs most commonly during falls on an outstretched arm. Most superior labral tears can be treated with anti-inflammatory medications, activity modification and physical therapy, but if nonoperative treatment fails, surgery may be indicated.
- Clavicle (collarbone) fractures are common injuries, and they can occur different ways. Some patients fall on an outstretched hand, others fall and hit the outside of their shoulder. Treatment of clavicle fractures most commonly involves resting the affected extremity in a sling. It is unusual for a clavicle fracture to require surgery, but surgery is required in some situations when either the skin is broken or the fracture is severely displaced or shortened.
- Post-surgical treatment
  - Physical/Occupational Therapy: A short course *may* be needed; if so then post-surgical treatment (endoscopic): 14 visits over 8 weeks; post-surgical treatment (open): 20 visits over 10 weeks

#### **ODG Return-To-Work Pathways**

Arthroscopic surgical repair/acromioplasty (Grade III<sup>1</sup>), clerical/modified work: 28 to 56 days

Arthroscopic surgical repair/acromioplasty, manual work, non-dominant arm: 56 to 90 days

Arthroscopic surgical repair/acromioplasty, manual work, dominant arm: 70 to 90 days

Open surgery (Grade III<sup>1</sup>), clerical/modified work: 42 to 56 days

Open surgery, manual work, non-dominant arm: 70 to 90 days

Open surgery, manual work, dominant arm: 90 to 106 days

Open surgery, heavy manual work if cause of disability: indefinite

<sup>1</sup>**Definition of Sprain/Strain Severity Grade:** In general, a Grade I or mild sprain/strain is caused by overstretching or slight tearing of the ligament/muscle/tendon with no instability, and a person with a mild sprain usually experiences minimal pain, swelling, and little or no loss of functional ability. Although the injured muscle is tender and painful, it has normal strength. A Grade II sprain/strain is caused by incomplete tearing of the ligament/muscle/tendon and is characterized by bruising, moderate pain, and swelling, and a Grade III sprain/strain means complete tear or rupture of a ligament/muscle/tendon. A sprain is a stretch and/or tear of a ligament (a band of fibrous tissue that connects two or more bones at a joint). A strain is an injury to either a muscle or a tendon (fibrous cords of tissue that connect muscle to bone).

## **CLINICAL ALGORITHM(S)**

None provided

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

During the comprehensive medical literature review, preference was given to high quality systematic reviews, meta-analyses, and clinical trials over the past ten years, plus existing nationally recognized treatment guidelines from the leading specialty societies.

The heart of each Work Loss Data Institute guideline is the Procedure Summary (see the original guideline document), which provides a concise synopsis of effectiveness, if any, of each treatment method based on existing medical evidence. Each summary and subsequent recommendation is hyper-linked into the studies on which they are based, in abstract form, which have been ranked, highlighted and indexed.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

These guidelines unite evidence-based protocols for medical treatment with normative expectations for disability duration. They also bridge the interests of the many professional groups involved in diagnosing and treating work-related shoulder conditions.

### **POTENTIAL HARMS**

Complications related to cryotherapy (i.e., frostbite) are extremely rare but can be devastating.

## CONTRAINDICATIONS

### CONTRAINDICATIONS

- Extracorporeal shock wave therapy (ESWT) is contraindicated in the following:
  - Pregnant women
  - Patients younger than 18 years of age
  - Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage
  - Patients with cardiac pacemakers
  - Patients who had physical or occupational therapy within the past 4 weeks
  - Patients who received a local steroid injection within the past 6 weeks
  - Patients with bilateral pain
  - Patients who had previous surgery for the condition
- Corticosteroid injections should be avoided in patients under 30 years of age.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

The Treatment Planning sections outline the most common pathways to recovery, but there is no single approach that is right for every patient and these protocols do not mention every treatment that may be recommended. See the Procedure Summaries (in the original guideline document) for complete lists of the various options that may be available, along with links to the medical evidence.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

### IMPLEMENTATION TOOLS

Patient Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

## **IOM DOMAIN**

Effectiveness  
Patient-centeredness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

Work Loss Data Institute. Shoulder (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2008. 217 p. [226 references]

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

### **DATE RELEASED**

2003 (revised 2008 May 28)

### **GUIDELINE DEVELOPER(S)**

Work Loss Data Institute - Public For Profit Organization

### **SOURCE(S) OF FUNDING**

Not stated

### **GUIDELINE COMMITTEE**

Not stated

### **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

Editor-in-Chief, Philip L. Denniston, Jr. and Senior Medical Editor, Charles W. Kennedy, Jr., MD, together pilot the group of approximately 80 members. See the ODG *Treatment in Workers Comp* [Editorial Advisory Board](#).

### **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

There are no conflicts of interest among the guideline development members.

### **GUIDELINE STATUS**

This is the current release of the guideline.

This guideline updates a previous version: Work Loss Data Institute. Shoulder (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jul 5. 191 p.

The *Official Disability Guidelines* product line, including *ODG Treatment in Workers Comp*, is updated annually, as it has been since the first release in 1996.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available to subscribers from the [Work Loss Data Institute Web site](#).

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; [www.worklossdata.com](http://www.worklossdata.com).

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- Background information on the development of the Official Disability Guidelines of the Work Loss Data Institute is available from the [Work Loss Data Institute Web site](#).
- Appendix A. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument. Available to subscribers from the [Work Loss Data Institute Web site](#).

## **PATIENT RESOURCES**

The following is available:

- Appendix C. ODG Treatment in Workers' Comp. Patient information resources. 2008.

Electronic copies: Available to subscribers from the [Work Loss Data Institute Web site](#).

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; [www.worklossdata.com](http://www.worklossdata.com).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## **NGC STATUS**

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 13, 2004. This NGC summary was

updated by ECRI Institute on March 29, 2005, January 18, 2006, April 13, 2006, November 13, 2006, April 2, 2007, August 29, 2007, and January 22, 2009.

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