


<b>UCLA MEDICAL GROUP / UCLA Santa Monica Bay Physicians – Managed Care Operations</b>		
DEPARTMENT:	Utilization Management	POLICY NUMBER: TBD
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TITLE:	<b>Orthopedic and Sports Medicine Guidelines</b>	ISSUE:03/2019 EFFECTIVE: 04/2021
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- Patients initially evaluated and treated in the **Emergency Room** for fractures may be referred to an Orthopedist without further PCP evaluation in a time period as outlined in the section on Outpatient Fracture Care.
- In general all other problems; It is expected that **the Primary Care Physician will perform a history and physical and initiate treatment prior to referral**. If the diagnosis is unclear, or if the patient does not respond to treatment as expected, or if the referral indications are met a referral should be submitted for an initial consultation. This list covers the more common conditions, but there may be other orthopedic conditions that PCPs can and should initially treat.
- DME – Please see the document “DME Referral Tips” posted on the UCLA Medical Group and Managed Care Operations website (<https://mcoperations.mednet.ucla.edu/>). If you need assistance with any DME item (braces, splints etc.) please call (310) 302-1400.

## 1. Knee Pain (general approach regardless of diagnosis)

### Recommended Evaluation/Treatment:

- History and physical examination of knee (ROM, alignment, stability, effusion, weight bearing status)
- X-ray: Weight bearing AP lateral of both knees and sunrise view of patellae of both knee(s)
- Treatment is dependent upon the specific condition diagnosed.

### Indications for Referral:

- Refer to Orthopedics for painful clicking; knee effusion associated with trauma; mechanical derangement (e.g. locked knee, fixed knee flexion); acute swelling; obvious fracture, or audible tear or “pop” at the time of injury.
- If negative findings on PCP evaluation, consider conservative treatment including NSAIDS and physical therapy. If symptoms do not improve within 6-8 weeks, refer for orthopedic consultation.

## 2. Anterior Knee Pain (Non-traumatic, includes Patello-Femoral Syndrome)

### Evaluation/Treatment:

- Symptoms include pain in front of the knee that is aggravated by stairs, squatting, and prolonged flexion. Evaluate the x-rays as above. If negative, treat with NSAIDs and physical therapy.
- May consider MRI if symptoms have not improved after adequate trial of conservative treatment.

### Indications for Referral:

- Refer to orthopedics if there is a positive finding on an MRI (tendonitis in the patellar tendon, meniscal tear, etc.) or when surgery is a consideration due to failure of conservative treatment (PT, NSAIDs) over the course of 2-3 months.

## 3. Osteoarthritis of the Knee

### Evaluation:

- As per knee pain – please see above

### Recommended Treatment:

- Reduced joint loading (e.g. weight reduction, reduction of activity). For acute exacerbation of known OA, short periods of rest (24-48 hours) and then low impact exercise to strengthen muscles across weight bearing joints.
- Reduction and or elimination of high impact sports.
- Try adequate dose Tylenol and over the counter NSAIDs as clinically indicated.

### Indications for Referral:

- Debilitating pain
- Deformity
- Chronic effusion
- Knee pain persistent after 4-8 weeks of conservative therapy
- In the absence of severe arthritis on x-ray or deformity, consider referral to rheumatology

## 4. Neck Pain and/or Low Back Pain (Recent Onset)

See Back Pain Guidelines. Neck pain is evaluated and treated in a manner similar to back pain.

## 5. Carpal Tunnel Syndrome

### Evaluation:

### History

- There is a history of repetitive motion activity with the subsequent development of acroparesthesia, pain (often at night), impaired hand dexterity and hypoesthesia, and/or numbness in the distribution of the median nerve of the hand.
- Associated conditions include:
  - Hypothyroidism
  - Rheumatoid arthritis
  - Diabetes mellitus
  - Tenosynovitis
  - Bony pathology of the carpal tunnel
  - Prior trauma
  - Direct injury
  - Sprain
  - Fracture
  - Fluid retention
  - Space-occupying lesions
  - Pregnancy and lactation
  - Consider both neck and wrist compression pathology (“double crush neuropathy”), pain may radiate proximally into the forearm and elbow, and rarely to the shoulder or neck.
- Dysesthesia of the common median distribution of the hand. Pain and tingling most often worse at night.
- Rule out simple tendonitis.
- If work related, should be referred to employer for worker’s comp evaluation and treatment.

### Physical findings:

- Pain can be exacerbated by manual activity particularly by extreme extension or flexion of the wrist
- Phalen’s test signs are frequently positive
- Sensory changes usually occur before motor changes and are often subtle.
- Weakness of the thenar muscles is an early sign of motor involvement and is absolute indication for early surgical management even if systemic causes are identified.
- Thenar muscle atrophy is a late sign - however, it usually dictates surgical management.

### Diagnostic Testing to confirm diagnosis:

- Nerve conduction test of median and ulnar nerves
- EMG and NCS (if “double crush neuropathy” is suspected)

**Treatment:**

- Wrist Splint for 6 weeks (especially at night)
- If responds to splinting--splint only at night for 6 weeks
- Anti-inflammatories for 2 weeks then prn
- Physical /Occupational Therapy is generally not indicated in carpal tunnel syndrome due to lack of documented effectiveness.
- In pregnancy always treat carpal tunnel pregnant patients CONSERVATIVELY with night wrist splints, acetaminophen, and patient education. There is almost never a reason to do surgery in pregnancy since the CTS would be expected to resolve on its own 3 months after pregnancy or lactation.

**Indications for Referral:**

**Failure of 6 weeks of conservative treatment.**

- Consider orthopedic consultation for documented, persistent CTS with nerve conduction study showing moderate to severe decrease of median nerve conduction to the wrist
- Hand Team consultation for documented, persistent CTS with negative or mild disease on nerve conduction study

## **6. Shoulder Pain**

**Evaluation:**

**History**

- Usually presents as a pain or dysfunction with movement (especially internal rotation and forward flexion).

**Physical Findings:**

- Pain on passive abduction of the shoulder joint (the gleno-humeral joint). This is the “impingement sign”, a classic examination finding. When present an MRI should be ordered.
- Exam for “dropped shoulder” (inability to actively abduct the gleno-humeral joint). This is an important finding which strongly suggests rotator cuff rupture.
- Painful shoulder crepitation during range of motion may be indicative of shoulder arthritis.

**Clinical Indication for Imaging:**

- Any painful shoulder should be imaged with plain x-rays
- “Impingement sign” or significant shoulder weakness indicates need for MRI.

**Imaging:**

X-ray: Shoulder sports series (AP, Grashey AP, Axillary and Transcapular- Y views) of the affected shoulder.

MRI only when indicated (see above)

**Treatment:**

**In the absence of indications for referral for acute shoulder pain, in the first week:**

Activity modification (avoid activity causing pain), and anti-inflammatories

If not significant improvement, refer for physical therapy

**For chronic shoulder pain:**

Anti-inflammatory medication  
Physical therapy

**Indications for Referral:**

- Marked loss of ROM
- Fractures
- AC separation
- Marked weakness
- Unremitting severe pain
- History of instability i.e. subluxation or dislocation
- Lack of response to initial treatment

**7. Adult Elbow Problems****Epicondylitis (when lateral, aka “Tennis Elbow”)**

Rest; no throwing, racquet or club sports, and no weight lifting

Ice

Forearm elastic band (counterforce brace)

–NSAIDS for at least 2 – 4 weeks

Physical therapy modalities; eccentric strength program and stretching

Ortho referral if conservative therapy fails after 3 months.

**Trauma:**

Obtain x-rays, AP/lateral/oblique.

Non-displaced fracture: posterior splint. Ortho referral in 5- 7 days.

Displaced fractures or dislocations—need URGENT consult.

**Soft Tissue Trauma/Sprain:**

Obtain x-rays to rule out fractures.

Sling for comfort

Ice, rest, and anti-inflammatories

Routine orthopedic referral if symptoms not improved in 7-10 days

**Biceps/Triceps Tear:**

Sling/Splint

X-rays—AP/lateral/oblique

Urgent Ortho consult within at least 5-7 days

**Chronic Instability:**

X-rays—AP/lateral/oblique  
Discuss avoidance of sports/lifting with patient  
Consider physical therapy for elbow motion and strength program  
Routine referral to Ortho if activity modification/therapy fails

**8. Ankle Injuries****Trauma:**

1. Obtain x-rays: AP, lateral and mortise views
2. Grade 1 sprain (patient can still walk on ankle)
  - Can be treated by PCP in the office
3. Grade 2 and 3 sprain (patient cannot walk on ankle)
  - Should be referred to Ortho
4. Non-displaced fractures, fibula: Splint, NWB, orthopedic f/u within 7-10 days.
5. Medial malleolus fractures: Ankle and full-length tibia films, splint, orthopedic, referral within 7-10 days if non-displaced. URGENT referral if displaced or wide mortise
6. Bi/Tri malleolus fractures: Splint, crutches, orthopedic referral within 72 hours if non- or minimally displaced. URGENT consult if displaced
7. Displaced fractures/dislocations: URGENT consult

**• Acute ankle sprains:**

1. X-rays if patient unable to bear weight or bony tenderness
2. Crutches and weight bearing as tolerated (WBAT), air stirrup orthosis (e.g., Air Cast)
3. Ice, elevation, and NSAIDs
4. Functional rehabilitation and proprioceptive exercises
5. Ankle support brace for sports
6. Routine orthopedic referral if unable to return to full function within 4-6 weeks

**• Chronic ankle instability (“chronic ankle sprain”):**

1. Weight bearing foot and ankle x-rays
2. Course of therapy and bracing

3. Routine orthopedic referral
4. Consider MRI prior to referral if recurrent, swelling, mechanical symptoms or instability present

### **General Outpatient Fracture Care**

#### **General principles:**

- Displaced fractures are initially best treated in an ER.
- Most closed fractures that require surgical treatment can be operated on 7-14 days from injury without having a negative outcome due to timing of surgery. Should be evaluated by an orthopedist within 5 days.
- Minimum of two x-ray views is required to evaluate fractures and should image the joint above and below.
- Immobilization, elevation, ice and weight bearing modification are appropriate initial response to most fractures.
- Certain fractures should be discussed individually with an orthopedist: femur, tibia, distal tibia, elbow and hip fractures.
- Open fractures need to be sent to ER.
- Fractures with neurological or vascular injury should be sent to ER.
- DME- If you need assistance to determine the coverage for any DME (braces, splints etc.) please call the managed care office at 302-1400.

#### **Ankle Fractures:**

- 1) Radiographic evaluation included three views AP, lateral, and Mortise.
- 2) Non-displaced fractures need orthopedic f/u within 5 days.
- 3) Posterior splinting and crutches with NWB (Non Weight Bearing) for initial treatment.

#### **Foot fractures:**

- 1) Posterior splint or hard sole fracture shoe, and crutches for initial treatment.
- 2) Arrange orthopedic follow-up within 5 days.

#### **Wrist Fractures:**

- 1) Non-displaced fractures can be splinted and referred to orthopedics within 5 days.  
Can be seen by non-op providers

#### **Proximal Humerus fractures:**

- 1) Consider an axillary view of the shoulder (if patient can tolerate the position) as one of the initial radiographs to rule out gleno-humeral dislocation.
- 2) Non-displaced fractures can be placed in a sling and referred to orthopedics within 5 days.
- 3) Displaced fractures can be placed in a sling but need referral to orthopedics within 48 hours.
- 4) Fracture/dislocations need ER evaluation.

**Clavicle fractures and AC sprains:**

- 1) In addition to clavicle radiographs, shoulder views are needed to r/o a humerus fracture.
- 2) Sling or figure-of-8-splint for initial treatment.
- 3) Orthopedic referral within 5 days.

**Elbow fractures:**

- 1) Non-displaced fractures need a posterior splint, and referral within 5 days.

**Humerus shaft fractures:**

- 1) Need to evaluate shoulder and elbow with radiographs in addition to the humerus.
- 2) Posterior splint and sling for initial management.
- 3) Orthopedics referral within 5 days.

**Hand fractures**

- 1) Non-displaced fractures can be splinted and referred to orthopedics within 5 days.  
Non displaced fractures can be seen by non -op providers
- 2) Displaced fractures need splinting and orthopedic referral within 5 days.
- 3) Fracture/dislocations need urgent evaluation in the ER.