

PROJECT ACCESS SAN DIEGO/ SPECIALTY CARE ACCESS INITIATIVE

Referral Guidelines

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GENERAL RECOMMENDATIONS AND DISCLAIMER

The guidelines included in this document are for the sole purpose of providing guidance for the best use of the relatively scarce resource of Project Access San Diego volunteer diagnostic and specialty care, and specialty care arranged through the grant-funded Specialty Care Access Initiative. These are not intended to be prohibitive or restrictive guidelines and in no case are designed or intended to supplant a physician's recommendation for diagnostic services or specialty care. There is no implied or intended patient-specific medical decision-making in these guidelines. The guidelines are developed with the following principles:

1. There is no implied or intended interference with the patient-physician relationship; the ultimate decision about appropriateness and level of care and referral remains with the physician and patient involved.
2. If a referral cannot be provided through PASD or the SCAI, it is not implied or intended to prevent or preclude this referral from occurring- it is solely a decision based on these guidelines in conjunction with resourced available at the time the referral is requested. If a referral cannot be covered through PASD or SCAI, there is no implied statement regarding the appropriateness or medical necessity of the referral.
3. These guidelines are developed with the purpose of promoting the following:
 - a. Stewardship of scarce specialty and primary care resources
 - b. Facilitating volunteerism among specialists by reducing barriers to care from language, transportation, cultural, and regulatory issues
4. The general principle of PASD and the SCAI is to provide additional specialty support to indigent patients and their primary care physicians. Specialty referrals are not intended to transfer care of the patient to the specialist or to make the specialist the primary care provider for that patient. Referrals will be coordinated with the expectation that the intent of the referral is one of the following:
 - a. To provide assistance in making a definitive diagnosis
 - b. To outline a treatment plan to be carried out by the primary care physician
 - c. To perform a specific procedure and its immediate after care
5. These guidelines are not intended to act in a similar fashion to insurance or managed care guidelines; they are designed to maximize the appropriate use of scarce specialty resources, ensure primary care-level workup is completed before referral, and may vary in content or application depending not on medical 'merit' but on the relative availability of the specialty in question.

ACUTE LOW BACK PAIN

http://www.mamc.amedd.army.mil/referral/guidelines/ortho_low_back_pain.htm

(Excerpted from Madigan Army Medical referral guidelines)

History/Physical

- Elicitation of history and performance of physical examination.
- Special attention to presence or absence of "red flags" to include:
 - age <18 or >55
 - history of malignancy
 - steroid use
 - HIV positivity
 - constitutional symptoms (fevers, chills, unintended weight loss)
 - structural deformity
 - anal or urethral sphincter disturbance
 - saddle anesthesia
 - gait disturbance
 - or widespread neurologic deficit
- If red flags are present, diagnostic testing needs to include plain radiographs (AP, Lateral, and Spot Views); CBC with differential; ESR; C-Reactive Protein. Consider bone scan; CT scan or MRI scan and electrodiagnostics as indicated. Generally MRI would be preferred.
- If red flags are absent a diagnostic workup is generally not necessary.
- Initial treatment for the first 4-6 weeks consists of:
 - reassurance that most episodes resolve uneventfully within 6 weeks
 - encouragement to maintain as close to normal activity as is tolerable
 - prescribing a limited number of back exercises and stretches
 - avoidance of bed rest greater than 24 hours
 - NSAIDs (unless contraindicated)
 - muscle relaxants for up to one week
 - acetaminophen as needed
 - steroid taper if symptoms of radiculopathy present
 - weak opiates (codeine; hydrocodone) unless contraindicated
 - passive modalities (e.g. ice, heat) for symptomatic relief

Indications for referral:

- Low Back Pain unresponsive to conservative management without radiculopathy should be referred to Physical Therapy for additional nonsurgical, treatment modalities. A referral to Physical Medicine and Rehabilitation should be considered only for patients who have maximized the benefit of physical therapy and are still symptomatic.
- Focal neurologic signs (muscle weakness, loss of reflexes) with supporting abnormal MRI findings (disk herniation, tumor, deformity) (urgent consult if worsening) - Neurosurgery or Orthopedics referral.
- Focal neurologic signs with abnormal imaging studies (urgent consult if worsening) - Neurosurgery or Orthopedics referral. MRI prior to referral (without contrast unless tumor suspected).
- Focal neurologic signs with normal imaging studies (urgent if worsening) - Neurology referral.
- Incapacitating radiculopathy unresponsive to therapy with supporting abnormal MRI Findings - Neurosurgery or Orthopedic referral.
- Abnormal plain radiographs associated with red flags - Neurosurgery or Orthopedics referral. MRI of lumbar spine prior to referral (without contrast usually).
- Loss of bladder or bowel control, Saddle Anesthesia – If symptoms acute (less than 72 hours), send patient to Emergency Room for expedited evaluation. If symptoms subacute or chronic and supporting

abnormal MRI findings present, Neurosurgery or Orthopedic referral. If supporting abnormal MRI findings are not present, consider referral to urology or gastroenterology.

ALLERGY – ALLERGIC RHINITIS AND SINUSITIS

Treatment or referral is covered only for disease which interferes with the ability to function and work.

Criteria for Referral and possible Desensitization (allergy shots)

Patient History (two of three must be present)

1. Chronic symptoms, at least 3 days per week
2. Facial pain
3. Chronic purulent discharge

Physical Exam (one of three must be present)

1. Facial tenderness
2. Green/yellow discharge
3. Swelling and polypoid changes in the nose

Medication failure (all three)

1. Decongestants and/or antihistamines
2. Antibiotics for 6 weeks if sinusitis
3. Nasal steroids and/or nasal Cromolyn Sodium

X-Rays (for sinusitis)

Sinus imaging (plain films or CT scan) showing evidence of infection

ALLERGY – BEE STING

PASD will consider paying for Bee Sting Allergy kits for a history of definite systemic allergic reaction to bee stings. Referral for consultation and desensitization is based on the following criteria.

Criteria for Referral and possible Desensitization: Patient History (all three)

1. Respiratory distress, acute urticaria and/or hypotension after a bee sting (history of anaphylaxis)
2. Reaction of bee sting is remote from the local reaction, at least 6 inches from sting
3. Personal risk at work or at home for bee sting exposure

Physical Exam (not required if history is clear or reaction documented by past medical records)

Evidence of allergic reaction remote from the site of the sting, including hives (urticaria), respiratory distress or hypotension

ARTHRITIS — OSTEOARTHRITIS- ORTHOPEDIC SURGERY REFERRAL

Criteria for referral to Orthopedic Surgery and/or Physical Therapy

Referral to Orthopedic Surgery may be arranged if the patient requires surgery to function at work or with daily activities. Physical therapy or Occupational therapy may be arranged for home exercise training or for a short course in the event of an acute exacerbation.

Patient History (three of four)

- Restriction of daily activities
- Interferes with current work or preventing employment
- Failure to respond to oral medications – 3-6 month trial
- Failure to respond to physical therapy, if available **AND**

Physical Exam (two of four)

- Pain with movement
- Decreased range of motion
- Muscle wasting
- Deformity **AND**

Imaging

- Evidence of moderate to severe joint changes **AND**

For **Knees**: Fails to respond to intra-articular steroids or has had multiple (≥ 3) intra-articular steroid injections at the primary care level

ASTHMA- ALLERGIST REFERRAL

Mild intermittent, mild persistent and moderate persistent asthma are managed at the primary care level. Severe persistent asthma, defined as requiring continuous systemic steroid therapy and a history of hospitalization, may be referred to an allergy or pulmonary specialist. Desensitization is not paid for with PASD funds.

Criteria for Referral and Possible Desensitization

Patient History (at least one)

1. Life threatening
2. Asthma not responding to maximum medical therapy (see treatment failure below)
3. Multiple ER visits, > 2 per year, or hospitalizations > 2 per year

Treatment failure (failed at least two agents)

1. B-Agonists, including long acting
2. Cromolyn Sodium
3. Inhalation corticosteroids for 3 or more months

Tests (optional)

Pulmonary function testing which shows severe reversible disease

BACK PAIN

Initial Dx/Management:

- Elicitation of history and performance of physical examination. Special attention to presence or absence of "red flags" to include:
 - age <18 or >55;
 - history of malignancy, steroid use, or HIV positivity;
 - weight loss or constitutional symptoms;
 - structural deformity;
 - anal or urethral sphincter disturbance;
 - saddle anesthesia;
 - gait disturbance; or
 - widespread neurologic deficit.
- If red flags are present, diagnostic testing may include:
 - plain radiographs;
 - CBC; ESR;
 - bone scan;
 - CT scan and/or MRI scan and
 - electrodiagnosis as indicated.
 - MRI generally preferred.
- If red flags are absent a diagnostic workup is generally not necessary.
- Initial treatment for the first 2 weeks consists of:
 - reassurance that most episodes resolve uneventfully within 6 weeks;
 - encouragement to maintain as close to normal activity as is tolerable;
 - avoidance of bed rest greater than 24 hours;
 - NSAIDS (unless contraindicated);
 - muscle relaxants for up to one week;
 - acetaminophen as needed;
 - weak opiates (codeine; hydrocodone) unless contraindicated;
 - passive modalities (e.g. ice, heat) for symptomatic relief,
 - work restrictions.

Indications for referral:

- Focal neurologic signs with abnormal imaging studies (urgent consult if worsening) - Neurosurgery or Orthopedics referral with xrays done. Consider MRI prior to referral (without contrast unless tumor suspected).
- Focal neurologic signs with normal imaging studies (urgent if worsening) Neurology referral.
- Incapacitating radiculopathy unresponsive to therapy - Neurosurgery or Orthopedic referral. MRI of lumbar spine prior to referral (without contrast usually).
- Abnormal plain radiographs associated with red flags - Neurosurgery or Orthopedics referral. MRI of lumbar spine prior to referral (without contrast usually).
- Loss of bladder or bowel control - (urgent) Neurosurgery referral.
- Extra-spinal conditions such as, Urologic, GI, Gynecologic, Vascular, Neurologic, Rheumatologic, or Systemic - referral to subspecialty appropriate to affected organ system.

BONE GROWTH STIMULATOR

Bone growth stimulator implantation is not within the scope of PASD

BONE MINERAL DENSITY (BMD) TESTING

BMD testing is not within the scope of Project Access.

SCAI will, when available, arrange for available BMD testing in the presence of major osteoporosis risk factors:

- Vertebral abnormalities as demonstrated by X-ray to be indicative of osteoporosis, low bone mass (osteopenia), or vertebral fracture.
- Glucocorticoid therapy equivalent of 7.5 mg of prednisone or greater per day for 3 months or longer, or the equivalent of 5 mg of prednisone or greater for 6 months or longer.
- Hyperparathyroidism.

Monitoring to assess the response to or efficacy of an FDA approved osteoporosis drug therapy (every 2 years)

BREAST CANCER - DIAGNOSIS AND TREATMENT

PASD/SCAI will attempt to identify resources for breast imaging, diagnosis, and treatment. Currently-available resources outside of PASD and SCAI include:

Patients \geq 40 y/o: BCEDP/CDP programs (through Community Health Centers in affiliation with the CDC). If the patient has a breast cancer diagnosis, the patient will be enrolled in MediCal for the duration of their treatment and beyond according to the specifications of the program.

Patients $<$ 40 y/o: Susan Komen Foundation

Patients $<$ 40 y/o: Scripps Breast Cancer program (through the Council of Community Clinics)

Patients should routinely be referred for screening, diagnosis, and treatment to the closest Community Health Center doing BCEDP/CDP. Only if all of the above resources are exhausted will PASD/SCAI arrange for imaging or referral.

BREAST RECONSTRUCTION

PASD/SCAI helps arrange for breast reconstruction only in relation to breast cancer treatment, following breast cancer surgery, only when available and not covered under the BCEDP or CDP program, Komen, or Scripps/CCC programs.

In rare instances, breast reconstruction may be approved for removal of a prosthesis if it is extruding and interferes with the ability to work.

Criteria for assistance:

- Following or concordant with breast cancer surgery
- Treatment-associated abnormalities or deformities
- Removal of prosthesis from fibrosis or extrusion (significant pain or work history required)
- Replacement of prosthesis if mastectomy due to breast cancer
- Nipple reconstruction (for breast cancer)

BUNIONS

Criteria for referral to Podiatry or Orthopedics for surgery Patient History

Symptomatic bunions which interfere with daily function or work.

AND

Physical Exam

- Marked deformity is present **AND**

Radiology

- X-ray confirmation of severe deformity
- HV angle greater than 40 degree **AND**

Work History

CARDIAC STRESS TESTING

Referral for Cardiac Stress Testing is based on a clear risk for coronary artery disease. Low-risk screening Cardiac Stress Testing will not be provided through the PASD program. The patient must have two or more cardiac risk factors (male sex, age over 40, positive family history, smoking, hypertension, hyperlipidemia, diabetes, and obesity) and chest pain and/or dyspnea on exertion or other symptoms suspicious for angina variant. Exercise Cardiac Stress Testing (non-medication treadmill) is done on all patients except those unable to exercise on the treadmill or on those with abnormal resting EKGs. Medicated Cardiac Stress Testing (Adenosine, Dipyridamole nuclear studies or Dobutamine echocardiogram) will be arranged when available based on the following:

Criteria for 'Medicated' Cardiac Stress Testing

History:

Cardiac symptoms: chest pain, atypical chest pain, dyspnea on exertion

Incapable of exercising on a treadmill

Difficulty maintaining balance

Excessive obesity

Gait problems (post CVA, severe OA, etc.)

Reactive airway disease — risk of bronchospasm

Frail and elderly

OR

Abnormal ST segments or T waves , or Bundle Branch Block on resting EKG

OR

Female >45 y/o or menopause equivalent and with symptoms

Unstable angina/acute coronary syndrome is not within the scope of PASD and strong consideration should be given to immediate hospitalization.

CARPAL TUNNEL SYNDROME

Most patients with carpal tunnel syndrome improve and recover in the primary care setting. For many patients, carpal tunnel syndrome is an overuse injury and a change in work position and rest resolve the problem. For patients with persistent carpal tunnel syndrome despite rest and wrist splinting, referral to an orthopedic or hand surgeon for injection or surgery may be necessary. Referral to Neurology or other entity for nerve conduction study is unnecessary unless the diagnosis is uncertain.

Referral Criteria

Patient must NOT have a work-related reason for CTS (if so, pt should be referred by the PCP back to their employer; accessing the work comp system for work-related injuries, work-related repetitive motion injuries, or chronic conditions exacerbated by work is required under the state workers compensation laws).

Patient History (one of two required)

- Failed three months of conservative management
 - Regular use of NSAIDs and night splints
 - Trial of changed work positioning
 - Rest
 - Specific CTS exercises
- Interferes with A.D.L

AND

Physical Exam (one of three required)

- Positive Tinnel and/or Phalen test
- Atrophy or weakness of the thenar muscles
- Documented nerve impairment on Nerve Conduction Velocity testing (done only if the physical exam is uncertain)

AND

Work History (a procedure will help the patient continue or begin or return to work)

CHOLECYSTITIS AND CHOLELITHIASIS

Criteria for Surgery — PASD will help arrange for available cholecystectomy only for the removable of symptomatic gallstones causing recurrent pain necessitating Emergency Room visits or frequent office visits. The PASD program will not arrange for surgery for asymptomatic gallstones

History (any one of 2)

History of Jaundice

Two or more documented episodes of abdominal colic or severe RUQ pain

(The presence of nausea/vomiting, chills and fever, leukocytosis (if evidence of infection, consider immediate hospitalization outside the purview of PASD))

AND

Diagnostic Tests

Ultrasound or CT scan documenting the presence of gallstones

CHRONIC FATIGUE SYNDROME

The ongoing management of CFS and Fibromyalgia should be undertaken in the primary care setting. It is beyond the scope of PASD to arrange for specialty consult for CFS or Fibromyalgia except in unusual circumstances- e.g., if diagnosis is in question. SCAI may be able to coordinate an alternative referral type for these patients when needed (e.g., e-consult).

Criteria for Referral/Fibromyalgia

History (All must be present)

- Severe unexplained fatigue for > 6 months
- Functionally impaired
- Has a date of onset and unrelated to psychological stress

AND

Symptoms (at least three are present)

- Memory or concentration complaints
- Sore throat
- Tender lymph nodes
- Muscle pain
- Multijoint pain
- New pattern of headaches
- Unrefreshing sleep
- Postexertional malaise lasting more than 24 hours

AND

Treatment (all of these have been met)

- Judicious use of medication to ameliorate symptoms
- Graded exercise or rehabilitation measures
- Hypothyroidism has been ruled out
- Depression has been ruled out or treated

COLONOSCOPY

Criteria for Referral: PASD will not arrange for low risk screening colonoscopy.

Any one of the following indications must be met.

History (at least one present)

- Unexplained iron deficiency anemia
- Acute diarrhea - following recent antibiotic therapy, not responding to C. Diff treatment
- Melena with normal UGI endoscopy (colonoscopy may be approved provisionally to be done immediately following a non-diagnostic colonoscopy)
- Rectal bleeding, unexplained
- Abnormal x-ray findings, mass, lesion or ulceration
- Chronic diarrhea
- Ulcerative colitis or Crohn's Disease

O R

Therapeutic (at least one present)

- Excision of polyps
- Removal of foreign body
- Dilatation of stricture
- Control active bleeding

O R

Surveillance (at least one present)

- With colon polyps - every 3-5 years, if large (greater than 2 cm), may repeat in 3-6 months, if multiple adenomas, repeat at 1 and 4 years.
- History of familial polyposis in primary relative
- Following polypectomy - 1-3 year intervals per gastroenterologist recommendations
- Following removal of colon cancer, 6 months, 1 year, q 2-3 years
- Ulcerative colitis - q 1-2 years after 8th year when stable
- Left sided colitis - q 1-2 years after 15th year when stable
- Family history of colon cancer
 - Three 1° relatives - q 3-5 years from age 20
 - One or 2 1° relatives - q 3-5 years from age 40

COLPOSCOPY - CERVICAL

Criteria for Referral or Performing the Procedure in the Clinic:

Colposcopy is performed to evaluate abnormal Pap Smears and to allow for guided cervical biopsies. Not all atypical Pap smears require Colposcopy, and Colposcopy should not be routinely repeated if the cervical abnormalities are minor. Repeat Pap smears are an acceptable way to monitor mild cervical pathology, especially if HPV testing is negative. Refer to the current ASCCP protocols. (www.asccp.org)

In general, colposcopy should be performed at the primary care level when possible and is typically covered under either the FPACT/SOFP/HAP program (fertile women) or under the Cancer Detection Program (CDP/BCEDP/CCTP) through the Community Health Centers in conjunction with the CDC. Patients should first be screened for eligibility for these programs before accessing Project Access resources.

Colposcopy is indicated for cervical cytology demonstrating:

Atypical Squamous Cells of Undetermined Significance (ASCUS) with HRHPV if >20 y/o.

AGUS

HSIL

CIS

Suspicious cervical or vaginal lesion

Maternal DES use suspected or documented

CT OR MRI OF SPINE

Criteria for Performing Advancing Imaging of the Cervical, Thoracic or

Lumbar Spine: Advanced imaging of the spine should be performed for specific indications and not simply because of pain. In the presence of chronic pain, advanced imaging is done only if there are symptoms of neurologic impairment or suspicion of a lesion in the bone. CT is done to evaluate the bone tissue, and MRI is preferred for looking at the spinal cord and nerves. Advanced imaging will be arranged when available for any of the following:

- Suspected fractures and dislocations (not clear by plain x-rays) (CT)
- Metastatic workup (with signs or symptoms consistent with spinal involvement)
- Disk herniations causing neurologic signs or symptoms (MRI)
- Previously documented spinal stenosis (MRI)
- Previous spinal surgery and demonstration of non-union on X-ray or positive Bone Scan (CT)
- Significant trial of conservative therapy including anti-inflammatory medications and physician supervised home exercise/physical therapy (MRI)
- Chronic pain in a patient at risk for cancer (CT)
- Localized tenderness of a vertebral body suggesting osteomyelitis (CT)

DENTAL

At this time, dental diagnosis and procedures are not within the scope of PASD.

DERMATOLOGY

(incorporated UCSD referral criteria of 2009)

Criteria for Referral and Procedures

Referral and office biopsy can be arranged when available for the following; consideration should be given to doing these in the primary care office for smaller lesions and lesions in non-critical areas (trunk, extremities)

- Possible Melanoma (consider general or plastic surgery also)
- Basal Cell Cancer (BCC)
- Squamous Cell Cancer
- Other Malignant neoplasm
- Dysplastic nevi
- Bullous Pemphigoid
- Pemphigus Vulgaris
- Lupus Erythematosus
- Mycosis Fungoides
- Leprosy
- Epidermolysis Bullosa
- For Biopsy of a lesion on the face, eyelid, or other area difficult to access
- Skin Malignancy

Discussion of referral for Certain Conditions:

Pruritis (Itching): Most itching in primary care is due either to excessive use of soap (dry skin) or neurodermatitis. The primary care physician is able to evaluate and treat most causes of pruritis, including primary and secondary conditions. Referral is approved to Dermatology only after a thorough primary care evaluation is done and the cause is uncertain or the treatment is ineffective. The patient history, physical findings and previous treatments must be well documented.

Rash: Most skin rashes are diagnosed and treated in primary care. Referral to Dermatology is approved when the diagnosis and treatment remain uncertain. The patient history, physical findings and previous treatments must be well documented.

Acne: PASD will help arrange for the evaluation and treatment of moderate to severe cystic acne refractory to topical benzoyl peroxide, antibiotics, and retinoids and oral antibiotics. The patient history, physical findings and previous treatments must be well documented.

Psoriasis: Referral to Dermatology will be assisted only for psoriasis in multiple areas which is actively inflammatory and unstable. The patient history, physical findings and previous treatments must be well documented. Treatments for psoriasis with PUVA or expensive topical agents will be arranged when available and within formulary limitations.

Actinic Keratosis: Most Actinic Keratosis is managed by primary care. Referral to Dermatology will be arranged when available for extensive disease on exposed areas refractory to topical

topical agents. The patient history, physical findings and previous treatments must be well documented.

Dermatology patients might have, but are not required to have, the following labs/diagnostics in the 3 months prior to scheduling an appointment: CBC _ESR_VDRL_RPR

Diagnoses generally within the scope of primary care: (and not Dermatology Clinic): (This list is not intended to be a complete list, but examples of common conditions that should not be referred to Dermatology unless the patient has failed multiple treatments by Primary Care)

- Acne
- Warts
- Eczema
- Psoriasis
- Folliculitis
- Scars
- Total Body Checks
- Biopsy of a potentially malignant lesion (non-facial)

DILATATION & CURETTAGE OF THE UTERUS (D&C)

Criteria for Referral: D & C is performed less commonly today with better procedures for evaluating the tissue in the uterus. For diagnostic purposes, endometrial biopsy, hysteroscopy and ultrasound are most often used.

Patient History (either one of these present)

- Excessive bleeding with a suspicion of tissue present
- Post-menopausal bleeding to evaluate for endometrial cancer
- Recurrent post-menopausal bleeding (for treatment, other tests are performed for diagnosis)

Addendum:

- There is no indication for performing a D&C in an adolescent
- Heavy bleeding is usually better treated with hormones
- Office endometrial biopsy or ultrasound is usually the first step to evaluate for endometrial dysplasia or cancer, and hysteroscopy is preferable to a D & C as the second test
- Bleeding associated with pregnancy should generally be covered under Pregnancy MediCal and evaluation should not be arranged by PASD.

DUPUYTREN'S CONTRACTURE

Criteria for Referral and Surgical Treatment: Referral for this condition is only arranged in cases in which the disease interferes with work or activities of daily living.

Patient History (both must be present)

- Involvement of the palmar and digital fascia
- Flexion deformity of the fingers

AND

Physical Exam (both must be present)

- Characteristic nodule or cord in the palmar fascia
- Metacarpophalangeal joint contracture
>30 degrees

AND

Work History

Endocrinology

(incorporated are UCSD referral guidelines 2009)

Criteria for Referral:

Endocrinology patients must have the following labs/diagnostics prior to scheduling an appointment for the following diagnosis treated in the UCSD Clinic; these would generally apply for other endocrine referrals.

Consider use of virtual consult when available.

Diabetes: labs within 3 months

Logbook Record

Diabetes Education Certificate/Diabetes Mgmt Note

Nutritional Consult Completed (if available)

Lab: CMP, Lipid/Cholesterol Panel, Urine Microalbumin/Creatinine Ratio, HbA1c, Blood Sugar High/Low

Hyperthyroid: labs within 3 months: CMP, CBC, Lipid Panel, TSH, Free T4, Total T3 (required if TSH abnormal)

Hypothyroid: generally should be managed at the primary care level; labs within 3 months: CMP, CBC, Lipid Panel, TSH, Free T4, Total T3 (required if TSH abnormal)

Thyroid Nodules: labs within 3 months: CMP, CBC, Lipid Panel, TSH, Free T4 (if TSH abnormal), Total T3 (if TSH abnormal), Thyroid Uptake/Scan, US, and/or Biopsy Report (if available)

Thyroid Cancer: Records of prior treatments/studies, Surgical Pathology Report, Thyroid Operative Report, Thyroid Whole Body Scan, Post-Op Neck US, Chest CT and/or PET Scan, Thyroglobulin, Thyroglobulin Antibodies

Parathyroid: labs within 3 months: BMP, Ca, PTH

Hypercalcemia/Hyperparathyroid: labs within 3 months: CMP, CBC, PTH, Ca

Hypocalcemia: labs within 3 months: CMP, PTH, CBC, Ca

Pituitary (Adenoma/Mass/Tumor): labs within 6 months: BMP, TSH, Free T4, Prolactin, LH, FSH, 8am Cortisol, 8am Testosterone (if male), IGF-1, 24 hour Urine Creatinine, 24 hour Urine Free Cortisol, Brain/Pituitary CT or MRI Report

Adrenal (Mass/Tumor/Incidentaloma): labs within 6 months: BMP; 24 hour Urines: Creatinine, Free Cortisol, Metanephrine, Catecholamine; Plasma Aldosterone; Plasma Renin Activity; Abdominal CT or MRI (if available)

Adrenal Insufficiency: labs within 3 months: BMP, 8am Cortisol

Osteoporosis: labs within 6 months: CMP, CBC, 25-Hydroxy Vitamin D, Bone Density Scan

Hypogonadism: labs within 6 months: CMP, CBC , 8am Testosterone, LH (if not taking Testosterone), PSA

Gynecomastia: labs within 6 months:, CMP, 8am Testosterone, Prolactin, TSH

Galactorrhea: labs within 6 months: BMP, Prolactin, TSH, CT/MRI Reports (if available)

Hirsutism: labs within 3 months: DHEA-Sulfate (DHEAS), 17-Hydroxy Progesterone, Androstenedione, Testosterone (random), CMP

Pheochromocytoma: labs within 6 months: BMP; 24 hour Urine: Metanephrines,Creatinine, Catecholamine (This is a post op follow up)

Amenorrhea: labs within 3 months: Pregnancy Test, CMP, Prolactin, Estradiol, FSH, LH, Testosterone, 17-Hydroxy Progesterone

SIADH: labs within 3 months: CMP, Lipid Panel, TSH, Free T4, Urine Osmol, Urine Na, Serum Osmol, Cortisol

ENDOMETRIAL ABLATION

Criteria for Referral and the Procedure: Endometrial ablation is an alternative to hysterectomy for women with persistent excessive vaginal bleeding. It is also used for women with hypertrophy or polyps of the endometrial tissue. It has the advantage over hysterectomy in that it does not require major surgery and preserves the uterus.

Patient History (all should be present)

- Excessive vaginal bleeding in a woman who has completed their childbearing
 - profuse bleeding or repetitive periods OR
 - anemia due to acute or chronic blood loss
- No uterine or cervical pathology that would require hysterectomy (normal exam and pap, normal or failed endometrial biopsy)
- No finding of remedial cause by hysteroscopy
- Failure of hormone treatment

EPIDURAL STEROID INJECTION

Criteria for Referral for this Procedure: Epidural steroid injection is indicated for chronic neck or back pain with radiculopathy. It is an alternative to surgery, and may reduce the need for pain medications. When done, these should be arranged in a set of three injections.

Patient History

Chronic neck or back pain with radicular symptoms present for at least 3 months.
Conservative pain management has been used for at least 6 weeks without benefit

Physical Exam

Evidence of neurologic signs (numbness, weakness or reflex changes)

Addendum: Injections limited to three in a given year.

EPILEPSY (SEIZURE DISORDER)- VAGUS NERVE STIMULATOR

It is beyond the scope of PASD to arrange referral for and implantation of Vagal Nerve Stimulators

ERYTHROPOIETIN (RECOMBINANT GROWTH FACTOR) EPOGEN, PROCRIT

Criteria for Approval of this Medication Therapy: The use of these medications has recently come under criticism for their failure to improve patient outcomes and their great expense. Medicare and other health insurance plans are increasing their restrictions on these medications. Erythropoietin will be provided only for patients with severe anemia due to chronic kidney disease or cancer therapy to avoid blood transfusions and should be accessed through patient assistance programs when possible. In general, EPO for CKD and cancer treatment/chemo management is beyond the scope of PASD due to its cost and need for indefinite use.

Patient History (anemia criteria must be met for either condition)

- Recurring chemotherapy expected to cause bone marrow suppression

- Chronic kidney disease

- Anemia with hemoglobin (Hgb) less than 10 gm/dl or hematocrit (Hct) less than 30%

Addendum:

Dosages are approved for one month at a time, and are continued only if anemia criteria are still present

Continuation of therapy for more than 6-8 weeks is not beneficial in the absence of response (e.g. >1 to 2 gm/dl rise in Hb). Longer term use of the medications will not be approved in the absence of a response or if this jeopardizes other patients access to PASD.

ESOPHAGASTRODUODENOSCOPY (EGD)

Criteria for GI referral for this procedure: EGD is also known as Upper GI Endoscopy and is performed when direct visualization of the upper GI tract is necessary. Biopsy of the esophagus, stomach and duodenum can also be done by EGD.

Patient History

- Persistent symptoms of heartburn or GERD despite 2 months of PPI therapy.
- Age of onset of GERD age 50 or later.
- Extrasophageal symptoms, e.g., hoarseness, chest pain, wheezing
- Complicated GERD, e.g. dysphagia or iron deficiency anemia
- Symptoms of five years duration in patient > 50 years of age
- Failure of lifestyle modifications such as no smoking, caffeine, aspirin, alcohol and spices, and positioning
- Melena
- Chronic unexplained anemia (reflexively done at same session after negative colonoscopy)

Repeat EGD (may be done in 8-12 weeks)

Erosive or Transitional cells present on initial biopsy

FRACTURE CARE

PASD: In general, acute fracture care is beyond the scope of PASD due to the urgency of referral.

SCAI: Acute fracture care may be contemplated as a part of the SCAI given certain capabilities (access to specialists, availability of online imaging access by primary care and orthopedics at many imaging centers, clinics, and hospitals, access to email or virtual consults with same day or 1-2 day turnaround time, etc.)

GANGLION CYST

Criteria for Referral for Surgical Removal: Most ganglion cysts are painless and do not interfere with work or living activities. Approval for referral for surgery is limited to those patients that have a critically medical indication for surgery. This diagnosis may be best managed using specific Kaiser surgery days when available.

Patient History

- Pain which causes interference with work or essential activities
- Weakness or altered range of motion
- Unresponsive to, or recurrence after, aspiration and steroid injection (or attempt unsuccessful)

Physical Exam

- Cyst or mass of dorsal or volar wrist
- Cyst or mass in other location causing a limitation of function

Addendum:

- 50% of ganglion cysts disappear without therapy.
- Regardless of therapy, recurrence is common.

GASTROENTEROLOGY

(see also colonoscopy guidelines)

In general, most current GI guidelines can be found at the following site:

<http://www.acg.gi.org/physicians/clinicalupdates.asp#guidelines>

Specific guidelines can be found as follows:

- [Diagnosis and Management of Achalasia](#) (December 1999)
- [Diagnosis, Surveillance and Therapy of Barrett's Esophagus](#) (March 2008)
- [Colorectal Cancer Screening](#) (March 2009)
- [Diagnosis, Treatment and Surveillance for Patients with Colorectal Polyps](#) (November 2000)
- [Management of Crohn's Disease in Adults](#) (February 2009)
- [Diagnosis and Management of C. difficile-Associated Diarrhea and Colitis](#) (May 1997)
- [Acute Infectious Diarrhea in Adults](#) (November 1997)
- [Diagnosis and Management of Diverticular Disease of the Colon in Adults](#) (November 1999)
- [Management of Dyspepsia](#) (October 2005)
- [Esophageal Cancer](#) (December 1999)
- [Esophageal Reflux Testing](#) (March 2007)
- [Diagnosis and Management of Fecal Incontinence](#) (2004)
- [Diagnosis and Treatment of Gastroesophageal Reflux Disease](#) (January 2005)
- [Management of the Adult Patient with Acute Lower Gastrointestinal Bleeding](#) (August 1998)
- [Management of *Helicobacter pylori* Infection](#)(August 2007)
- [Hepatic Encephalopathy](#) (July 2001)
- [Liver Disease in the Pregnant Patient](#) (July 1999)
- [Alcoholic Liver Disease](#) (November 1998)
- [Prevention of NSAID-Related Ulcer Complications](#) (March 2009)
- [Acute Pancreatitis](#) (October 2006)
- [Ulcerative Colitis in Adults](#) (July 2004)

GASTROENTEROLOGY-HEPATITIS C

April 2009 ACG Hep C guidelines paper:

http://www.acg.gi.org/physicians/pdfs/Diagnosis_of_HEP_C_Update.pdf

Patients with Hepatitis C should have a liver biopsy to determine need for antiviral treatment. Prior to GI referral, the following tests should have been completed:

Patient factors: (see contraindications below- should have none of these)

Lab: Comprehensive metabolic panel, CBC, Hep C viral RNA (quantitative) and genotype, (AFP), ANA, RA

Imaging: liver UTZ

Treatment: ideally should be PEG interferon and Ribavirin. Seek PAP supply.

Characteristics of Persons for Whom Therapy Is Widely Accepted

- Age 18 years or older, and
- HCV RNA positive in serum, and
- Liver biopsy showing chronic hepatitis with significant fibrosis (bridging fibrosis or higher), and
- Compensated liver disease (total serum bilirubin \leq 1.5 g/dL; INR \leq 1.5; serum albumin \geq 3.4, platelet count \geq 75,000/mm³ and no evidence of hepatic decompensation (hepatic encephalopathy or ascites), and
- Acceptable hematological and biochemical indices (Hemoglobin \geq 13 g/dL for men and \geq 12 g/dL for women; neutrophil count \geq 1500 /mm³ and serum creatinine \leq 1.5 mg/dL, and
- Willing to be treated and to adhere to treatment requirements, and
- No contraindications (Table 12)

Characteristics of Persons for Whom Therapy Is Currently Contraindicated

- Major uncontrolled depressive illness
- Solid organ transplant (renal, heart, or lung)
- Autoimmune hepatitis or other autoimmune condition known to be exacerbated by peginterferon and ribavirin
- Untreated thyroid disease
- Pregnant or unwilling to comply with adequate contraception
- Severe concurrent medical disease such as severe hypertension, heart failure, significant coronary heart disease, poorly controlled diabetes, chronic obstructive pulmonary disease
- Age less than 2 years
- Known hypersensitivity to drugs used to treat HCV

This link covers the current CDC fact sheet and recommended Clinical Guidelines for the Diagnosis and Treatment of Hepatitis C: <http://www.cdc.gov/hepatitis/HCV/Management.htm#section1>

Gynecology/Pelvic Masses

(incorporated are referral guidelines from UCSD 2009, ACOG 2008 recommendations:

<http://www.aafp.org/afp/2008/0501/p1320.html>)

Criteria for Referral: in general, the following will be considered for GYN or GYN-Oncology referral:

1. *Diagnosed Untreated/Potential Cancer:*

- a. Cervical Cancer (primary access should be through the Breast and Cervical Cancer Treatment Program, BCCTP).
- b. Ovarian and Fallopian Tube malignancy.
- c. Post menopausal patients with pelvic mass, and/or CA-125 >35, ascites, evidence of distant metastases, or first degree relative with breast or ovarian cancer.
- d. All patients with masses >8 cm regardless of age. (CA 125 is helpful, but not required)
- if mass less than 8 cm, consider referral for premenopausal women if ascites, CA-125 >200, evidence of distant metastases, or first degree relative with either breast or ovarian cancer
- for premenopausal women, in the absence of the above cancer risk factors, consider repeat imaging by UTZ after 2-3 menstrual cycles to check for resolution or decrease in size before considering referral
- e. Uterine, endometrial and sarcoma cancer.
- f. Vaginal/ Vulvar Melanoma.

2. *Suspected / Undiagnosed Cancer (pre-cancer)*

- a. Dysplasia: high grade CIN 2-3 or CIS.
- b. Cyst and Lesions: high grade VIN 2-3.

3. *Previously Treated or Recurring Cancer*

- a. Must have had treatment or active disease within the last 5 years.

Gyn-Onc patients must have the following labs/diagnostics prior to scheduling an appointment (as appropriate):

All diagnoses must be confirmed by pathological findings documented in a pathology report.
Prior chemotherapy, operative and pathology reports as appropriate.

Diagnoses generally within the scope of primary care: (This list is not intended to be a complete list, but examples of common conditions that should NOT be referred to Gyn-Onc unless the patient has failed multiple treatments in the Primary Care setting.)

- Low or Moderate grade Cervical pathology: LSIL, CIN 1-2.
- Pre menopausal females with Ovarian and Fallopian tube masses need imaging to determine size of mass.
- Low grade VAIN 1-2.

Placenta Percreta, a condition in which the placenta grows outside the uterus, should be referred to UCSD Perinatology.

GYNECOMASTIA

Abnormal enlargement of the breast in a male is usually due to hormonal imbalance or medications, especially anabolic steroids. The management of Gynecomastia is usually medical and a referral to endocrinology is indicated if the cause is unclear in the primary care setting. The basic work-up should be done in primary care, such as a carefully medication history and hormone levels. If the patient, especially a male, is in puberty, a small degree of temporary gynecomastia is normal and is referred to as thelarche. PASD will help arrange for surgery for gynecomastia if there is a suspicion of malignancy or if volunteer Plastic Surgery and associated facilities are available without threatening access of patients with more medically-necessary diagnoses.

Patient History (required to consider referral)

- Duration of gynecomastia
- Medication History
- Use of alcohol
- Mammogram report (if done)
- Significant weight gain
- History of Liver disease
- Onset of puberty

AND

Physical Exam

- Unilateral or bilateral
- Increased breast (not adipose) tissue

HEADACHE

Most patients with headache are managed by primary care, including migraine. The following are criteria which may lead to arrangement for a referral to a neurologist or other headache specialist. Advanced imaging (CT or MRI) is only indicated for headache when there are neurologic signs, usually an abnormal neurologic exam. CT is generally done in the emergency setting to r/o hemorrhage or mass lesion. MRI is preferred to evaluate for brain tumors and other intracranial lesions.

Note: A separate medical policy follows for Migraine Patient

Neurology referral for headache will be arranged when

available when the following criteria are

met

History

Sudden onset of new severe headache or
Progressively worsening headaches or
Onset with exertion, coughing, straining, and/or sexual activity or
Associated symptoms such as:
 Drowsiness, confusion, memory loss
 Chronic malaise, myalgia, arthralgia
 Fever
 Progressive visual disturbances
 Weakness, clumsiness, loss of balance
 Onset of first headache after the age of 50 years
 Failed usual primary care treatment efforts (NSAIDS, etc.)

OR

Physical Exam

Abnormal vital signs, especially fever (consider hospitalization) or high blood pressure
Altered consciousness or cognition (consider hospitalization)
Meningeal irritation ('stiff neck') (STAT hospitalization)
Papilloedema or fundal hemorrhage) (consider hospitalization)
Pupils unequal and/or poorly reactive (STAT hospitalization)
Weakness or sensory loss in face or limbs (consider hospitalization)
Reflex asymmetry or abnormal plantar response
Clumsiness or loss of balance (consider hospitalization)
Tender temporal arteries with diminished pulse (consider STAT ophthalmology referral as well)

HEADACHES - MIGRAINES

Criteria for Referral: The PCP is able to evaluate and manage most patients with migraines. Referral to a neurologist will be arranged only for a failure to respond to treatment or for abnormal neurologic findings.

Patient History

Dissimilar headache (One item)

- Decreased alertness
- First headache after age 50
- "Worst headache ever"
- Headache with exertion

Failure of adequate trial of management (Two of five)

- Nonsteroidal anti-inflammatories
- Isometheptine
- Ergotamine
- Butalbital
- Triptans (see below)

Physical Exam

- Neurologic exam performed: any focal abnormality
- Nuchal rigidity
- Abnormal vital signs

Criteria for the approval of a triptan medication (e.g. Imitrex)

- Failed a non-steroidal medication, and
- Failed at least one other generic anti-migraine medication

Access \$4 med lists first, then PAPs where available

HEARING LOSS

The PASD program will arrange for referral, testing and treatment by an ENT MD for hearing loss which impairs a person's ability to work and handle activities of daily living. Hearing Aids are not provided by PASD at this time.

Criteria for Referral:

Physical Exam (At least one of these is present)

Otoscope Exam

no presence of blood, pus, cerumen plug, or foreign objects (all of which are treated in primary care)

Abnormal findings of the tympanic membrane or middle ear which suggest a permanent or chronic problem

Tests

Audiogram shows evidence of more than a 30 decibel deficit

Criteria for Hearing Aids (Unilateral): (only if available through donated products)

To correct significant disability with work or ADL

Replacement or repair-1x per 12 month period

Bi-aural hearing aids require visual acuity justification

HEMORRHOIDECTOMY

Criteria for Referral: Most thrombosed external hemorrhoids resolve with warm baths, topical creams, fiber in the diet, and incision and drainage in the primary care setting.. PASD will not arrange for referral for treatment of external hemorrhoids unless the following criteria are met. Internal hemorrhoids that have recurrent bleeding and/or prolapse may warrant a procedure if they interfere with work or daily activities.

Patient History (any one of these present)

- Repeated or persistent prolapse or thrombosis with severe pain (internal hemorrhoids)
- Recurrent bleeding unresponsive to conservative treatment (either external or internal hemorrhoids)
- Thrombosis with severe pain not responsive to warm baths or medications over 3 days

Physical Exam

Acute irreducible prolapse of internal hemorrhoids

Surgical treatment for symptomatic chronic recurrent internal hemorrhoids may be considered as an ideal use of Kaiser surgery days when available.

HEPATITIS C

These links cover the current CDC fact sheet and recommended Clinical Guidelines for the Diagnosis and Treatment of Hepatitis C:

<http://www.cdc.gov/ncidod/diseases/hepatitis/c/fact.htm>

_____ <http://www.aasid.org/web/docs/hepatitis.cdf>

HEPATOLOGY

(incorporates UCSD referral criteria 2009)

Criteria for Referral: Diagnoses treated at the Hepatology Clinic: (this list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Hepatology)

Autoimmune Liver Disease (Requires Immunologic Studies)
Cirrhosis
Fatty Liver
Hemochromatosis
Liver Mass /Cancer (confirmed diagnosis by imaging/biopsy)
Transaminitis
Viral Hepatitis

Hepatology patients must have the following labs/diagnostics prior to scheduling an appointment with UCSD Hepatology:

- Labs within the last 3 months (CMP, Liver panel, CBC with Diff, PT/INR, PTT)
- Serology within the last 6 months:
 - HIV
 - HBsAb
 - HBsAG (and if positive)
 - HBV DNA PCR
 - HBcAb (IgM / IgG)
 - HAV Ab (IgM / IgG)
 - HCV Ab (and if positive)
 - HCV RNA PCR
 - HCV Genotype
- Immunologic Studies:
 - Qualitative Immunoglobulin Panel
 - Immunoglobulin Panel
 - ANA
 - ASMA
 - ALKM-1
 - RF
- Diagnostic Studies (if done): (If studies were done outside UCSD please have patient bring copy of the studies, or a CD of the studies, to their appointment.)
 - CT
 - MRI
 - US
 - EGD/Colonoscopy
 - Liver Biopsy with Pathology report

HERNIAS - Surgical Correction

Criteria for Referral: PASD will help arrange for elective surgery for hernia repair in the following cases. Current clinical guidelines support "watchful waiting" for hernias in patient who are not at high risk for incarceration. The elderly and those persons doing heavy manual labor are at risk.

Inguinal Hernia • Incisional Hernia • Ventral or Periumbilical Hernia

Patient History (both must be present)

Pain of significant duration
Affects employability

or

Physical Exam (one of two)

Difficulty reducing hernia
Incarcerated hernia (surgical emergency, should be hospitalized)

AND

Work History

For laparoscopic repair, BMI<35

HIRSUTISM

Criteria for Referral: Hirsutism is the excessive growth of hair in women. A family and cultural history are important to be sure that the hair growth is not normal. People from Mediterranean countries often have excessive hair growth including some masculinization of women. Hirsutism is triggered by androgen production, and the work-up focuses on hormonal causes. The work-up can usually be done in primary care, but based on the criteria below, a referral to an endocrinologist, or a gynecologist may be appropriate.

Patient History (all are present)

Symptoms suggestive of Polycystic Ovarian Disease or Adrenal Hyperplasia,
Hyperandrogenic, insulin-resistant, acanthosis nigricans syndrome and Androgen secreting
tumors

Absent familial predilection for hirsutism

Evaluation of patient's medications

AND

Physical Exam (both are done)

Confirmation of hirsutism

Pelvic ultrasound

HORMONE THERAPY

Criteria for use of specific agents:

Lupron

Prescribed only as recommended by a gynecologist

- Fibroids
- Endometriosis
- Limited to 3 mg (1x per month)

HYDROCELE

Criteria for Referral and Surgery: Hydrocele is rarely a significant health problem PASD will arrange for evaluation and treatment in the following cases (when available):

Patient History

- Painless mass
- Vague, gradual symptoms may occur with enlargement

Physical Exam

- Mass or focal swelling
- Cystic
- Freely movable
- Non-tender
- Transilluminates
- There may be testicular atrophy
- Usually left-sided

Diagnosis

Based on transillumination with a lack of any mass or solid tissue. Ultrasound may be performed if exam is uncertain and should be done in almost every case of scrotal mass

Management

- Observe for spontaneous resolution or if any change
- No treatment necessary if stable
- Aspiration may be performed if enlarging, causing discomfort or interfering with work
- Criteria for surgical removal
 - persistent pain, or
 - interferes with work

Surgical treatment may be considered as part of the Kaiser surgery days when available

HYPERPARATHYROIDISM

(Causing hypercalcemia)

Criteria for Referral and Surgery: Patient History and

Laboratory Findings:

Occurrence of renal stones or
Progressive bone loss (by Dexa Scan) or
Serum CA > 11.5 mg/d or simultaneous elevation of serum PTH and Calcium
indicating hyperparathyroidism

HYSTERECTOMY

Criteria for Referral and Surgery: The PASD program does not arrange for elective hysterectomy. The procedure is only approved when critically necessary for the woman's health. Abdominal, vaginal or laparoscopic hysterectomy is only approved when clinically necessary. Less invasive procedures, such as uterine ablation therapy should always be considered.

Patient History

- Cancer or pre-cancer of the uterus, cervix or ovary (if cancer, may be beyond the scope of PASD)
- Recurrent endometrial hyperplasia after adequate treatment with curettage and progestin therapy
- Rapid growth of fibroids which are causing health problems such as persistent heavy vaginal bleeding
- Progressive dysmenorrhea or menorrhagia unresponsive to D&C, hysteroscopy and hormone therapy
- Refractory menorrhagia for 3-6 months despite adequate hormone therapy. There must be a clinically significant drop in Hb or Hct.
- Failure of endometrial ablation, when appropriate
- Severe uterine prolapse

Physical Exam

For fibroids, as above with the presence of uterine fibroids > 16 wks gestational size

HYSTEROSCOPY

Criteria for Referral and the Procedure: Hysteroscopy is an outpatient procedure allowing the physician to visualize the inside of the uterus. Hysteroscopy is superior to D&C for diagnosis of intrauterine pathology. Endometrial biopsies and endometrial ablation may be done as part of Hysteroscopy.

Patient History

- Postmenopausal bleeding
- Failure to find cervical or uterine pathology that would cause abnormal bleeding
- History of excessive uterine bleeding evidenced by profuse bleeding, repetitive periods lasting more than 8 days, or frequent periods at less than 21-day intervals
- Failure of appropriate medical therapy

AND

Physical exam and Diagnostics

- Pelvic exam
- Obtain cervical cytology
- Obtain endometrial sampling (usually EMB)

INCONTINENCE

Criteria for Referral and Surgical Correction: Most urinary incontinence in women is managed by primary care with pelvic exercises and medication. Referral for surgical correction is only approved if critically necessary for employment or daily activities.

Patient History

- Duration of symptoms
- Thoroughly evaluated and treated with behavioral techniques and medication
- Patient has previously followed a mandatory voiding schedule with specific fluid intake, i.e. no caffeinated beverages
- Compliance with a pelvic exercise program (Kegels) of 6 months' duration
- Trial of medications for incontinence
- Alternative use of pessary offered to patient- considered, not required

AND

Physical Exam

- Assessment of estrogen status (evidence of atrophy).
- Adequate pelvic exam to R/O diverticula and fistulas; description of prolapse.
- Urine culture

INSULIN PUMP

Criteria for approval

Request from Endocrinologist

Patient must have **frequent** and **severe** glycemic excursions requiring visits to Physician, ER or Hospital.

Significant ketosis history

Insulin reactions and/or ketoacidosis

Blood glucose levels greater than 140 mg/dL preprandially and/or greater than 200 mg/dL fasting ("Dawn phenomenon")

Glycosylated hemoglobin (HbA1c) greater than 8 percent

Chronic renal failure or ongoing dialysis

Intermittent insulin injection not a practical option for the patient

Insulin pump placement under PASD should be considered a one-time event as a bridge while awaiting alternative coverage. The patient should have resources to cover ongoing supplies. Strong consideration should be given to an attempt at intensive diabetes management through a team approach such as Project Dulce.

KNEE PAIN (ANTERIOR)

Knee pain localized to the anterior portion of the knee, either retropatellar or peripatellar. Usually a gradual, non-traumatic onset aggravated with increased activity, running, squatting, stair climbing or prolonged sitting. Symptoms normally decrease with rest.

Initial Dx and management:

- History and physical examination
- Plain films not generally required unless acute injury
- NSAIDs
- Avoidance of aggravating activities
- Strengthening exercises for quadriceps, stretching exercises for quads, hamstrings and calf muscle
- Ice PRN after activities

Ongoing Management:

- Expect resolution or decreasing symptoms in three to four weeks
- If no resolution:
 - Trial of alternate NSAID
 - Trial of neoprene sleeve with patella opening
 - Obtain plain films with sunrise views
 - Do not order an MRI. Ortho will order, or recommend, if patient meets criteria

Indications for Referral:

- History of joint locking and giving way
- Question of underlying instability, especially with subjective report of immediate/significant effusion following onset of symptoms
- Prolonged effusion >14 days
- R/O fractures, septic joints, rheumatoid arthritis, crystal disease, etc. after appropriate primary care workup.
- Refer to Physical Therapy if none of the above but progression of atrophy or persistent symptoms despite initial management, if available.
- Completed full course of rehabilitation and have any of the following concerning symptoms: catching, locking, effusions, instability, warmth or erythema; these symptoms should affect employment or employability or ability to perform ADLs.

LAMINECTOMY (SPINE SURGERY)

Criteria for Referral and Surgery: Surgery to the spine, cervical, thoracic or lumbar, is done for nerve impingement not responsive to conservative measures. Physical therapy, medication and sometimes epidural steroid injections should be tried first in most cases.

Patient History

- Radiating pain from spine down leg or arm
- Numbness of leg , foot, or hand
- Low back or cervical pain
- Bowel or bladder dysfunction
- Weakness of extremity (bowel or bladder dysfunction and weakness suggest need for surgery more than pain or numbness)

AND

Physical Exam

- Decreased sensation
- + contra lateral straight leg raising (lumbar)
- Decreased or unequal DTR (Deep Tendon Reflexes)
- Decreased muscle strength
- Change in gait

AND

Diagnostics

MRI is the imaging of choice. A CT scan may be adequate if already done

- Should demonstrate disc protrusion
- with spinal stenosis, cord compression, or significant nerve root compression with corresponding neurological symptoms and signs

LAPAROSCOPY (GYNECOLOGY)

Criteria for Surgery

- Chronic pelvic pain with no cause identified
- Abnormal ovarian findings (mass or complex cyst on UTZ)
- Failure of conservative management of pelvic pain (OCs, progesterone)
- Failure of GnRH Agonist (endometriosis)

MAMMOGRAPHY

Criteria for Imaging: PASD does not arrange for routine low-risk screening mammography. A diagnostic mammogram is only approved when critically necessary to evaluate some abnormality suggesting possible breast cancer.

If the woman is 40 or more, refer to the Breast and Cervical Cancer Early Detection Program (BCCEDP) through a Community Health Center

If less than age 40: try to access Komen or Scripps/CCC program through CHCs.

Palpable mass: consider UTZ first

Bloody discharge: consider UTZ and/or ductogram and/or MRI- in these cases, consult with general or breast surgeon may be appropriate prior to imaging to determine the preferred imaging technique

Screening high risk patients (strong primary family history of breast cancer, BRCA positive): if no resources via BCCEDP, Komen, or Scripps/CCC, consider MRI in <40 y/o or mammogram in >= 40 y/o

MRI OF KNEE

Criteria for Imaging: An MRI of the knee should only be performed if the diagnosis or extent of the disease is unknown. Plain x-rays of the knees are done first, and if common osteoarthritis is found, an MRI is not necessary. A careful knee exam should also be performed before consideration is given for an MRI. An MRI of the knee should be performed before an Orthopedic consultation for most knee problems.

Patient History

- Aid in the diagnosis of meniscal tear if surgery contemplated
- Aid in the diagnosis of an internal ligament tear (ACL, PCL)
- Detection, staging, post-treatment evaluation of tumor of the knee
- Suspected osteochondritis dessicans if the clinical picture and plain x-rays are not confirmatory
- Suspected osteonecrosis if the clinical picture and plain x-rays are not confirmatory
- Persistent knee pain/swelling and/or instability (gives way) after an injury which has not responded to conservative management (ice, rest, elevation, medication, non-weight bearing, physical therapy), plain x-rays have failed to demonstrate a fracture or loose body, and the clinical picture is unclear.
- Persistent knee/pain swelling and/or instability (gives way) not associated with an injury after a 3-6 week trial of conservative treatment
- If specifically requested by a consulting physician (orthopedist or rheumatologist)

Addendum: An MRI is not indicated for:

- Diagnosis of osteoarthritis or rheumatoid arthritis
- Diagnosis of torn meniscus, loose body, or osteochondritis dessicans when the clinical examination and x-rays are diagnostic. If there is a true "locking" of the knee in flexion rather than "catching" in extension, this is indicative of loose body or torn meniscus
- When the MRI results will not alter the treatment plan of an anticipated surgical procedure
- (i.e., if degree of symptoms do not warrant surgery or if the pt is not a surgical candidate)

NEPHROLOGY

(Incorporates UCSD referral guidelines 2009)

Criteria for Nephrology referral: (This list is not intended to be a complete list, but examples of conditions that are appropriate for referral to Nephrology)

Serum Creatinine of 2.0 or higher in the last 3 months

eGFR of 30 or lower in the last 3 months

Nephrology patients must have the following labs/diagnostics in the 3 months prior to scheduling an appointment:

1. CBC
2. CMP, including serum BUN/ Cr, eGFR; Urinalysis (with Micro), Microalbumin
3. HgA1c (if diabetic)
4. Renal Ultrasound (if warranted)
5. 24 hour urine for Creatinine and Protein or Spot Urine Protein and Creatinine
6. Blood Pressure measurement

Diagnoses generally within the scope of primary care: (this list is not intended to be a complete list, but examples of common conditions that should not be referred to Nephrology unless the patient has failed multiple treatments in the Primary Care Clinic.)

Diabetic or Hypertensive patients with normal microalbumin, serum Cr, and eGFR

NEUROLOGY

(incorporates UCSD referral criteria 2009)

Criteria for Authorization: The following diagnoses/symptom complexes may be considered for referral to neurology:

1. Acute low back pain with red flag symptoms
 - Focal neurologic signs (muscle weakness, loss of reflexes) with supporting abnormal MRI findings (disk herniation, tumor, deformity) – (or consider Neurosurgery referral)
 - Focal neurologic signs with abnormal imaging studies (or consider Neurosurgery referral. Obtain MRI prior to referral (without contrast unless tumor suspected).
 - Focal neurologic signs with normal imaging studies
 - Incapacitating radiculopathy unresponsive to therapy with supporting and corresponding abnormal MRI Findings – consider Neurosurgery or Orthopedic referral.
 - Abnormal plain radiographs associated with red flags – consider Neurosurgery or Orthopedics referral. MRI of lumbar spine prior to referral
 - Loss of bladder or bowel control, Saddle Anesthesia – If symptoms acute (less than 72 hours), patient warrants **immediate** evaluation (consider Emergency Department). If symptoms subacute or chronic and supporting abnormal MRI findings present, consider Neurosurgery or Orthopedic referral. If supporting abnormal MRI findings are not present, consider referral to urology or gastroenterology.
 - **Red Flags** for Acute Low Back Pain include:
 - age <18 or >55
 - history of malignancy
 - steroid use
 - HIV positivity
 - constitutional symptoms (fevers, chills, unintended weight loss)
 - structural deformity
 - anal or urethral sphincter disturbance
 - saddle anesthesia
 - gait disturbance
 - or widespread neurologic deficit
2. CVA
 - New neurologic deficits, recurring symptoms while on antiplatelet therapy, and/or uncertain diagnosis; if acute, consider ER evaluation/admission.
3. Migraine headache
 - If diagnosis in doubt, if focal neurological symptoms or signs, and/or if patient has failed at least two trials of appropriate oral therapies.
4. Transient Impairment of Consciousness
 - History suspicious for seizure disorder, abnormal neurological exam (in which case head imaging should be added to pre-referral test list), and/or abnormal EEG.

5. Tremor

- Uncertain diagnosis.

Neurology (cont'd)

- Asymmetric neurological exam, weakness or coordination difficulties present.
- Patient diagnosed with essential tremor, who has failed trials of appropriate medications.

For UCSD referrals: Neurology patients must have the following labs/diagnostics prior to scheduling an appointment (as appropriate):

- History with particular attention to medications, history of prior strokes, age of onset of symptoms, alcohol consumption and family history of similar symptoms
- Complete Neurological Exam on physical exam.
- Acute Low Back pain with red flags warrant: plain radiographs (AP, Lateral, and Spot Views); CBC with differential; ESR; C-Reactive Protein. Consider bone scan; CT scan or MRI scan and electrodiagnostics as indicated. Generally MRI would be preferred. (If red flags are absent a diagnostic workup is generally not necessary.)
- Labs (Glucose, TSH, etc.)
- Neurology diagnostic test results (EMG, NCV) when indicated
- Radiology studies as needed (CT, MRI)

In general, the following scenarios are within the scope of primary care:

- Acute low back pain without red flag signs
- CVA
 - Management of stable patients who receive the following treatment:
 - Any patient with a new neurologic deficit concerning for stroke should be evaluated in the ER. Time is critical as certain stroke medications may be used only in the first three hours after a stroke.
 - Acute stroke management should include a detailed neurologic history and physical, imaging with head CT with CT angiogram initially, and MRI +/- MRA brain, carotid & vertebral U/S or MRA neck, Echo and lab work up (CBC, Chem 10, Coagulation studies, ESR or CRP, RPR and Lipids).
 - If the patient had onset of stroke symptoms > 5 days prior and is stable, the above workup may be performed as an outpatient. It should be expedited (in 1 week or less).
 - Stroke in person <50yo: consider bubble study (echo). If positive, consider trans-esophageal echocardiogram (TEE).
- Migraine headache, stable pattern without neurologic signs
 - MR/CT imaging indicated if focal neurological signs/symptoms, headache pattern is changing, or history suggests seizure disorder.
 - PCP focus: Identify and reduce triggers, educational behavioral therapies, lifestyle evaluation (cessation of smoking, discussion of contraceptive methods, regular exercise).
 - Determine headache frequency:
 - Weekly or less frequently: generally only abortive therapy required unless severe impact on patient's life, unresponsive to abortive agents, etc.

- Weekly or more frequently: emphasis must be on prophylaxis. Abortive agents can be regularly used no more than 2x per week to avoid risk for rebound.
-
- Neurology (cont'd)
 - Prophylactic therapy: Reduces frequency and/or intensity by at least 50%. Appropriate agents include tricyclics, beta-blockers, valproic acid, calcium channel blockers, or topiramate.
 - Abortive therapy: Reduce severity of attacks. Appropriate abortive agents include isometheptene, non-steroidal anti-inflammatory agents, ergotamine, triptans.
- Transient Impairment of Consciousness
 - Work up for a credible history of impairment or loss of consciousness with complete return to mental status baseline in 24 hours or less includes:
 - History and physical examination, including neurologic, cardiologic and a supervised period of at least 3 minutes of hyperventilation.
 - Electrocardiogram, serum glucose, electroencephalogram (EEG), thyroid screen and Holter if clinically indicated.
- Tremor
 - History by PCP with particular attention to medications, history of prior strokes, age of onset, suppression of tremor with alcohol consumption and family history of similar symptoms.
 - Physical exam should define tremor as resting, coarse or fine, postural or intention tremor. Also, physical exam should look for evidence of cerebellar involvement, weakness or loss of proprioception.
 - With no other physical findings: Fine tremor with no other physical findings is likely physiologic and requires no treatment. Coarse postural tremor in patient on lithium or depakote is likely an effect of the medication. Coarse postural tremor with positive family history (familial essential tremor) in young patient suppressed by alcohol (essential tremor), or in elderly patient (senile tremor) can be given trial of medication if there are no contraindications. Usual agents are propranolol or primidone. Resting tremor with associated features (or without in early stages)-consider Parkinson's Disease in the differential diagnosis.
 - In patients with isolated tremor, the goal of therapeutic intervention is the reduction in the tremor to the point where it does not affect the functioning of the patient (i.e., their ability to write, eat or work) without the patient experiencing side-effects from the medications being used as treatment.

OCULAR DISEASE

Referral for Vision Loss or Eye Pain

Criteria — The PASD program does not at this time arrange for routine eye care, including refractions. The program will cover critical eye services necessary to allow a patient to work and to relieve pain. Referral for refractions is covered only for patients experiencing vision loss to the extent that it interferes with work and basic life functions. All conjunctivitis is treated by primary care.

Patient History (one of these 6 must be present)

- Decreased visual acuity (provide visual acuity)
- Ocular pain
- Persistent photophobia
- Corneal Ulcer
- Red Eye (not conjunctivitis)
- Foreign body

Physical Exam (one of these 4 must be present)

- Injection of vessels around the cornea
- Corneal ulcer opacification
- Pupil abnormalities
- Foreign body

Refer to Ophthalmologist

OPHTHALMOLOGY - CATARACTS

Criteria for Surgical Removal

History (both required)

Functional Impairment - employment or ADLs or driving affected

Failure of vision to improve with prescription changes and other corrective measures

AND

Physical Exam

Visual Acuity in best eye must be worse than 20/50 with corrective lenses. (Covered for both eyes)

Addendum: A cataract may be removed at any level of acuity if it precludes diagnosis or treatment of another ocular disease, such as diabetes or **natural** disease.

OPHTHALMOLOGY- GENERAL

Criteria — Ophthalmology referral can be arranged by PASD for the following conditions and circumstances

Annual diabetic retinal exam (can be done by telemedicine when available)

Chalazion (a cyst in the eyelid that is caused by inflammation of the meibomian gland)

The primary treatment is application of warm compresses for 10 - 20 minutes at least 4 times a day. This may soften the hardened oils blocking the duct and promote drainage and healing.

Topical antibiotic drops or ointment are sometimes used for the initial acute infection, but are otherwise of little value in treating a chalazion. Chalazia will often disappear without further treatment within a few months and virtually all will resorb within two years.

If they continue to enlarge or fail to settle within a few months, then a referral to an Ophthalmologist is appropriate. Smaller lesions may be injected with a corticosteroid or larger one may be surgically removed using local anesthesia.

Criteria for referral to Ophthalmology

Patient History

Persistent Lesion (by the 3rd month or longer)

Failure of Treatment (one of two)

Conservative therapy with antibiotic and warm compresses times two months

Local injection of a corticosteroid

Blepharitis (inflammation of the eyelids)

Many forms of treatment will improve blepharitis, including both antibiotic or steroid eye drops, and certain oral antibiotics. Unfortunately it may recur when any treatment is ceased. Recommend a regime of daily eyelid cleaning which is both effective and can be continued safely long-term. Simply cleaning the eyelids with a face cloth during every bath or shower may be a good system for a patient.

Criteria for referral to Ophthalmology

Patient History – Failure of improvement despite treatment

Physical Exam – Persistent Inflammation of the lid margins

inflammation.

MACULAR DEGENERATION – every 1-12 months depending on severity and progression of the disease

MACULAR HOLE – every 1-3 months

OPACIFICATION OF POSTERIOR CAPSULE – once a year

OPTIC NEURITIS – as often as needed

PSEUDOPHAKIA – once a year

RETINAL DETACHMENT – as often as needed before or after surgery

RETINAL VEIN OCCLUSION (Central or Branch) - Every month for 3 months, then every 3 months until stable, then every 6 months as needed

RETINITIS PIGMENTOSA – once a year

STEROID EYE DROP USE – once a year

_____ STEROID SYSTEMIC MEDICATION – once a year

TAMOXIFEN RETINOPATHY – every 12 months, including Visual Field

VISUAL FIELD DEFECT – once a year

VITREOUS DETACHMENT OR FLOATER – with symptoms such as flashes of light, every 3-6 months, otherwise once a year

VITREOUS HEMORRAGE – every 1-3 weeks, ultrasound as needed

OPHTHALMOLOGY - GLAUCOMA

Criteria for referral to Ophthalmology

Patient History

- Loss of the mid-peripheral visual field
- Elevated intraocular pressure
- Advanced age
- Being black
- Family history of glaucoma
- Other risk factors
 - Myopia
 - Diabetes mellitus
 - Migraine
 - Hypertension
 - Long-Term corticosteroid use
 - Previous eye injury

Physical Exam

With or without suspicious looking optic nerve

Addendum: According to A.A.O. (American Academy of Ophthalmology)(Schultz to crosscheck)

>60 years

exam every 2 years > 40 years in blacks

20-39 years in blacks — exam every 3-5 years

OPHTHALMOLOGY - PTERYGIUM

Criteria for Referral and Surgery: Pterygium is fibrous material that forms in the eye and covers part of the cornea. This benign condition often occurs in persons chronically exposed to dust and outdoor conditions. Referral for surgery is only necessary when vision is impaired.

Patient History

Visual interference (provide documentation)

AND

Physical Exam

Extension onto or over cornea to the extent that vision is impaired

OPTOMETRY

Coverage for Glasses

The scope of PASD does not provide for coverage of glasses or routine refraction; in the future if resources are available, refraction and glasses might be arranged under the following conditions:

Vision defect by Snellen testing of equal to or $> 20/50$ or change in any meridian by at least 1.0 Diopter from the previous prescription
Correction required for employment

Changes in Prescription:

Any meridian change by at least 1.0 diopter

Astigmatic correction of .5 diopters or more

Replacement:

Replacement of glasses – 1 time in 12 months if broken, lost, or stolen

Not in scope of Project Access

Reading glasses

Routine refractions without any noticeable change in vision

ORTHOPEDICS

General and Miscellaneous Orthopedic Guidelines

Madigan Army Medical Center has published an excellent set of general orthopedic guidelines at: http://www.mamc.amedd.army.mil/referral/guidelines/ortho_main.htm these have been reviewed and modified to be applicable to PASD and SCAI

OTITIS MEDIA

Criteria for Referral to ENT: Acute otitis media resolves most of the time in 2-8 weeks. Treatment is done in primary care. Chronic serous otitis media refers to a persistent collection of fluid in the middle ear. This usually resolves spontaneously. The following criteria are used for referrals to ENT:

Patient History (one present)

- Three or more episodes of acute otitis media in 6 months
- Persistent pain and pressure in the middle ear longer than 3 months

Physical exam (one present)

- Visualization of the tympanic membrane shows bulging, retraction or fluid layer
- Inflammation of the tympanic membrane
- Reduced mobility testing of the tympanic membrane by:
 - tympanometry
 - acoustic reflectometry
 - insufflation

Decreased hearing by audiometry

PAIN MANAGEMENT

Criteria for Referral to a Pain Specialist: Most patients with chronic pain are managed by primary care. Referral to a Pain Specialist is appropriate if the diagnosis of chronic pain is uncertain despite a work-up by primary care, if a procedure such as an epidural injection is indicated, or if limited consultation by specialist is needed to help develop a treatment plan to be carried out by the PCP.

Patient History (most of the following is present in the clinical record)

- Failure of adequate medication trial: NSAIDS, opiates, neuropathic pain meds if appropriate
- Failure of an individualized proactive pain control plan
- Failure of a home exercise program
- Patient in agreement and cooperating with pain management plan
- No presence of psychotic disorders or current substance abuse
- Use of pain and functional scales by PCP
- Failure of therapeutic modalities: heat, cold, physical therapy
- Previous surgeries are listed

AND

Physical Exam

- Restriction of movement
- Sites of tenderness
- Neurologic signs with neck or back pain, especially radiculopathy

AND

Tests results done in primary care (Imaging and/or other studies) available

PEPTIC ULCER DISEASE

Criteria for Referral to GI or Surgery: Peptic ulcer refers to gastric and duodenal ulcers. The most common causes are chronic H. pylori infection and the use of NSAIDs or alcohol. Gastric ulcers carry an increased risk of cancer. Medical management by primary care is usually sufficient to treat peptic ulcers. Referral to GI is done for endoscopy (EGD). Because of the effectiveness of modern medical management, surgery for peptic ulcer disease is rarely necessary.

Patient History

- Intractable and recurrent epigastric pain
- Adequate trial of a PPI medication (at least 2 months therapy)
- Treatment for H. pylori done if indicated and symptoms persist

AND

Physical Exam

- Epigastric tenderness may be present.

AND

Labs

- H. pylori testing
- Fecal occult blood If indicated

PET SCAN (POSITRON — EMISSION TOMOGRAPHY)

Criteria for the Procedure: A PET scan differs from a CT or MRI by imaging cellular function of tissue. It is most useful in cancer diagnosis and follow-up. PET scanning is now being applied to other organ systems such as the heart. PASD will request and arrange for PET scanning when it is critically necessary and no other modality will give the information, and only after discussion with the facility radiologist. Indications include

Diagnosis, staging and restaging or the following clinical conditions:

- Lung cancer (non-small-cell)
- Esophageal cancer
- Colorectal cancer
- Lymphoma
- Melanoma
- Head and neck malignancy
- Brain malignancy
- Thyroid cancer
- Breast cancer
- Cervical cancer

To determine appropriate treatment, surgery v. chemotherapy

To determine if a tumor has been completely eradicated, post treatment.

In general, PASD is unable to provide comprehensive cancer care; however, in the initial workup of certain masses (e.g. lung mass), PET scan may be arranged to help determine physiologic activity of the lesion and thereby the need for a biopsy.

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY

Criteria for Referral and Treatment: PT, OT and ST are approved only for clinical conditions which require them for return to function. In general, an evaluation and 2-5 follow-up treatments are approved initially, unless the condition dictates longer therapy (such PT in a long bone fracture or OT/ST post stroke).

Ordered by the PCP when office education is not sufficient

Ordered by specialist

Post-op surgery

Must include aggressive patient education and home exercise

Chronic low back pain – unresponsive to medication management- emphasize home exercise program, limit visits to 3-6

Patient History must include a description of limitations

Physical Exam must include deficits or impairment

Request should include functional goals

Patient Responsibility

Motivation to follow exercise program

Addendum: Extension of therapy requests must be accompanied by original evaluation and comparative documentation showing improvement in function.

PLANTAR FASCIITIS

Criteria for Referral to a Podiatrist or Orthopedist: Most patients with plantar fasciitis are managed by primary care. All patients should have their feet and shoes evaluated. Initial treatment includes heel lifts or shoe inserts. Decreased activity, stretching and weight loss are part of conservative treatment. Only for persistent and severe cases will referral be arranged.

Patient History

Plantar Heel Pain:

- Increased upon awaking or first standing
- Located just anterior to the heel (distal calcaneus)

AND

Failure to respond to conservative management

- Modify activity
- Limit weight bearing
- Oral anti-inflammatory medications
- Heel pads (OTC products)
- Hot soaks with no symptomatic relief
- Exercises to strengthen lower leg muscles and to increase flexibility of the Achilles tendon and Hamstrings.
- Steroid injection by primary care

AND

Physical Exam

- Pain to palpitation at plantar aspect of the distal calcaneus
- May have positive heel squeeze test
- Often associated with pes cavus or pes planus

PODIATRY

Referral to an Orthopedist for foot problems may be arranged by PASD for conditions which are critically necessary for work and/or activities of daily living. Most common foot problems, such as plantar fasciitis and skin conditions, are managed by primary care. Proper shoes and the use of inserts treat most foot problems, along with weight loss and stretching. Routine foot examinations, including the annual diabetic foot exam, are done by primary care. Podiatry referral is not within the scope of PASD.

Management of toenail fungus infestation (tinea unguum) is done at the primary care level.

Criteria for Referral to a Podiatrist (outside of PASD) or an Orthopedist

Major foot deformity, including a bunion which is causing pain and inability to work or perform ADLs (see bunion guideline)

Failure of conservative care provided by PCP

Heel Spurs — failure to respond to conservative care and requiring an injection; in general, injections should be done by the PCP

PROSTATECTOMY

Criteria for Referral and Surgery: There are now multiple options for treating prostate disease other than surgery. Medications are very effective for benign prostatic hypertrophy (BPH). Surgery is only one of many options for treating prostate cancer. The decision to remove the prostate requires a specialist in Urology or Urologic Oncology.

Referral for BPH:

Patient History (one of four)

- History of urinary retention despite treatment with medications
- Presence of incontinence
- Recurrent urinary infections
- Nocturia – more than twice/night despite treatment with medications

AND

Physical Exam (one of three)

- Enlarged prostate or with exam showing nodules
- > 20 ml post-voiding residual despite medications
- Persistent Hematuria

AND

Diagnostic (one of four)

- IVP - obstructing prostate
- UTZ - hydronephrosis
- Positive needle biopsy for cancer
- Abnormal creatinine level, or decreased creatinine clearance

Referral for Prostate Cancer:

Exam or imaging showing nodules OR

PSA >4 or increasing rapidly AND no terminal illness present

RHEUMATOLOGY - RHEUMATOID ARTHRITIS

Criteria for Referral: Referral to Rheumatology must have evidence of active collagen vascular (autoimmune) disease. A thorough history, musculoskeletal exam and laboratory studies below must be done. The treatment of Rheumatoid Arthritis has changed to the early use of disease modifying medications (DMARDS) to prevent further disability. An accurate diagnosis of the condition should occur at the primary care level.

Patient History (three of six)

- Chronic pain
- Reduction of joint function
- Limitation of self-care (Noticeable joint inflammation, stiffness, deformity)
- Morning stiffness, warmth, redness, swelling, and deformity
- Any loss of finger function
- Generalized illness

ACR — Diagnostic Criteria (three of seven)

- Morning stiffness of at least 60 minutes duration
- Arthritis of three or more joints
- Arthritis of hand joints
- Symmetric arthritis - Present for six weeks
- Rheumatoid nodules
- Serum Rheumatoid Factor elevated
- Radiographic changes

Physical Exam

- Fusiform swelling of small joints, especially the hands

Laboratory (the first four must be provided)

- ANA (Antinuclear antibodies)
- Rheumatoid Factor
- ESR (Erythrocyte Sedimentation Rate)
- CBC, electrolytes, creatinine, liver function tests, UA
- Synovial fluid analysis

RHEUMATOLOGY – GENERAL REFERRAL GUIDELINES

Source:

<http://www.rheumatology.org/publications/guidelines/refer/refer.asp#Introduction>

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Guidelines for Rheumatology Referral

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2. Patients with a Presumed or Confirmed Diagnosis

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Appendix 1: Rheumatologist's Role in Patient Care

Introduction

There are over one hundred different rheumatic diseases. While the diagnosis and management of some rheumatic diseases does not always require specialized care, there are numerous rheumatic diseases which are systemic, complex and life-threatening. There are many others which involve the risk of deformity or disability and require immediate and aggressive therapy, often with agents which may have significant toxicity. Even where there is an established diagnosis, management of patients with rheumatic diseases is often difficult. The referral of a patient to a rheumatologist for a consultation is often prompted by one or more of the following factors:

- Diagnostic uncertainty
- Uncontrolled symptoms
- Increasing disability or deformity
- Disease complications
- Management uncertainty
- Consideration of immunosuppressive therapy
- Proposed surgical intervention
- Medication complications
- Patient request for specialist opinion

The objective of a rheumatology consultation is to make or confirm a diagnosis and to provide a prognosis and treatment recommendations.

Since findings on physical examination may take precedence over laboratory findings in the establishment of a diagnosis and a treatment plan, the importance of a skilled examination cannot be overemphasized.

Establishing a prognosis and recommending treatment require experience in assessing the severity, activity and progression of disease. This process may involve one or more visits following the consultation.

Long term management of the rheumatic patient not only involves monitoring and treating disease and medication complications but also counseling skills and the ability to work with, and often coordinate, a team of health care providers, including physical therapists, occupational therapists, nurses, mental health professionals and other physicians.

The goal of the Guidelines for Rheumatology Referral is to help physicians provide quality medical services. The Guidelines are intended to provide a general understanding of the reasons for involving a rheumatologist in patient care and to identify some circumstances when a referral to a rheumatologist is appropriate.

The Guidelines were developed by the authors with input from primary care providers, internists, orthopedists and patient groups. Multiple preliminary drafts and the final product were reviewed by primary care physicians, patient groups and rheumatologists from across the country. There is no evidence-based data available regarding appropriate rheumatology referral, and the Guidelines were based upon consensus of the above physicians and patient groups. The physicians involved in the writing and editing of the Guidelines represent academic, private practice, research and managed care settings.

The Guidelines are directed to two sets of users. The first set of users is of course those physicians who desire to refer a patient to a rheumatologist. The Guidelines will hopefully identify when it is appropriate to refer a patient to a rheumatologist and simplify and expedite the referral process.

The second set of users includes those who, prospectively or retrospectively, review physician decisions to refer care to rheumatologists. The Guidelines should help these users evaluate the medical necessity of specialist care and help them promptly elicit any additional information which may be required to conclude a review.

The patients who are referred to rheumatologists fall into two broad categories - those whose diagnosis is uncertain but a rheumatic disease is a possible cause - and those who carry a diagnosis or presumed diagnosis.

For patients with an uncertain diagnosis, the Guidelines offer a brief list of signs or symptoms which suggest the need for a rheumatology referral.

For patients with a diagnosis or presumed diagnosis, the reasons for a rheumatology referral have been consolidated into five categories:

- Diagnosis
- Uncontrolled Disease
- Disease Complications
- Medication Complications
- Management

Some reasons for referral falling within the category are listed below the category. The Guidelines are not intended to be exclusive. All diseases and all appropriate reasons for a referral are not listed.

The rheumatologist's role in patient care is not solely consultative. (See Appendix 1, The Rheumatologist's Role in Patient Care).

Rheumatologists provide exclusive or concurrent care for many of their patients' rheumatic diseases, including monitoring of disease status, assessing results of treatment and monitoring for potential treatment side effects. The reasons for referral may also justify returning care of a previously stable patient to a rheumatologist for reconsultation and ongoing care; e.g., a patient experiences a disease flare, disease complications or medication complications.

The Guidelines are respectfully submitted to physicians and others in health care with the belief that they promote quality health care for our patients.

Guidelines

1. Patients with Uncertain Diagnosis

- Normal laboratory findings but local or generalized pain and swelling.
- Abnormal laboratory findings but symptoms and/or examination do not fit criteria for any specific rheumatic disease.
- Patient's complaints are out of proportion to findings on laboratory or physical examination.
- Unexplained symptoms/physical findings such as rash, fever, arthritis, anemia, weakness, weight loss, fatigue or anorexia.

2. Patients with a Presumed or Confirmed Diagnosis

A. Inflammatory Arthritis

714.0 Rheumatoid arthritis
 714.3 Juvenile rheumatoid arthritis (adults with hx of)
 99.3 Reactive arthritis (including Reiter's syndrome)
 696.0 Psoriatic arthritis
 718. Arthritis assoc with inflammatory bowel disease
 720.0 Ankylosing spondylitis
 88.81 Lyme disease
 711. Infectious arthritis

Diagnosis

Establish or confirm diagnosis; e.g., differentiate erosive osteoarthritis and inflammatory arthritis, differentiate crystal induced arthropathy and seronegative spondyloarthropathy.

Uncontrolled Disease

- Disease onset with significant pain, stiffness or swelling requiring immediate/aggressive therapy.
- Pain, stiffness or swelling which **does not respond** to NSAID therapy **within 3-4 months** after disease onset.
- Previously stable disease becomes active.
- **Erosions** appear or progress on x-ray at any time in the course of the disease.
- **Functional** deterioration affecting quality of life.
- **Rapid disease progression** (physical signs of) e.g., nodules, new onset of deformities, subluxation or loss of motion in one or more

joints.

Disease Complications

- **Cardiac** involvement causing chest pain and/or pericardial effusions.
- **Eye** involvement presenting as dry, red and/or painful eyes, especially if unilateral.
- **Renal** disease presenting as pedal edema, proteinuria.
- **Pulmonary** involvement causing SOB, cough, nodules on chest x-ray or pleural effusions/infiltrates.
- **Vasculitis, cutaneous or systemic**, causing rash, skin ulcerations, neuropathy.

Medication Complications

Treatment is effective but drug toxicity or intolerance occurs: e.g., steroid myopathy, osteoporosis, multiple recurrent infections, pneumonitis, bone marrow suppression.

Management

- **Corticosteroid** therapy (chronic) is required to control disease.
- **Immunosuppressive** drug therapy is considered to control disease or to taper corticosteroids.
- **Joint injections**, particularly when prior joint injections have not provided sufficient relief or an injection of a small or difficult to access joint is involved, e.g., finger, wrist, elbow, ankle.
- **Long-term treatment** plan/goals for patients with chronic, long-standing disease must be established.
- **Physical/occupational therapy** recommendations, including appropriate use and duration of PT/OT.
- **Pre/Post surgery medication** modifications/coordination.
- **Surgical opinion** - opinion/second opinion regarding the timing of and need for surgical intervention.

B. Connective Tissue Disease

710.0 Lupus
 710.1 Scleroderma
 710.2 Sjögren's syndrome
 710.3 Dermatomyositis
 710.4 Polymyositis
 710.8 Mixed connective tissue disease (MCTD)
 710.9 Unspecified connective tissue disease (UCTD)
 725. Polymyalgia rheumatica
 279.8 Antiphospholipid antibody syndrome

Diagnosis

- Establish or confirm diagnosis.
- Differentiate **sicca** syndrome and **Sjögren's** syndrome.
- Evaluate recurrent **fetal losses** or unexplained **thromboses**.
- Interpret serologic laboratory tests.

Uncontrolled Disease

- Previously stable disease becomes active.
- **Elevated CPK, ESR** on corticosteroid therapy.
- **Normal ESR** but symptoms persist.
- **Pleurisy or arthritis** not controlled by NSAIDs.
- **Skin** tightening, rash, not controlled by topical therapy.
- **Signs/symptoms** (other) persist despite therapy, e.g., Raynaud's, digital ulcers, muscle weakness, dry eyes and/or mouth.

Uncontrolled Disease

Persistent rheumatic symptoms, sleep disturbance, fatigue, pain, despite therapy including anti-depressants and exercise.

Medication Complications

Treatment is effective but drug toxicity or intolerance occurs.

Management

- Establish a treatment plan.
- **Family/patient counseling**, including reassurance that condition is not life-threatening.
- **Pain management program** recommendations.

- **Physical/occupational therapy** recommendations, including appropriate use and duration of PT/OT.

Disease Complications

- **Ankylosis** causing loss of motion.
- **Cardiac** involvement causing pericarditis/myocarditis, pericardial effusion.
- **Hematologic** involvement causing anemia, neutropenia, thrombocytopenia, ITP.
- **Eye** disease with recurrent corneal ulcerations or change in vision.
- **Fetal** losses or thromboses occur while on therapy such as ASA or anticoagulation.
- **GI** involvement causing motility disorders or abdominal pain.
- **Lung** involvement causing shortness of breath, cough.
- **Lymph** node involvement causing lymphadenopathy, lymphoma or pseudolymphoma.
- **Malignant hypertension** (scleroderma and others).
- **Peripheral/central nervous system** disease; e.g., confusion, disorientation, neuropathy, paresthesias, seizures, TIAs, CVAs.
- **Renal** insufficiency/nephrotic syndrome/ glomerulonephritis/renal tubular acidosis causing fluid retention, decreased urine output.
- **Vasculitis**, cutaneous or systemic.

Medication Complications

Treatment is effective but drug toxicity or intolerance occurs; e.g., steroid myopathy, osteoporosis, multiple recurrent infections.

Management

- Establish a treatment plan.
- **Anticoagulation** therapy, e.g., ASA, heparin or Coumadin in presence of antiphospholipid antibodies.
- **Corticosteroid** therapy (chronic) is required to control disease.
- **Immunosuppressive** drug therapy is considered to control disease or to taper corticosteroids.
- Apheresis, IV immunoglobulin or other non-DMARD therapy is considered.
- **Physical/occupational therapy** recommendations, including appropriate use and duration of PT/OT.
- **Pre/Post surgery medication** modifications/coordination.

C. Systemic Vasculitis

287.0 Henoch Schonlein purpura
 446.0 Polyarteritis nodosa (PAN)
 446.4 Wegener's granulomatosis
 446.5 Giant cell arteritis
 446.7 Takayasu arteritis
 287.0 Churg-Strauss syndrome
 273.2 Cryoglobulinemia
 711.2 Behcet's syndrome
 446.20 Hypersensitivity vasculitis

Diagnosis

Establish or confirm diagnosis; presenting symptoms may include fever, weight loss, malaise, rash, arthritis, renal insufficiency, chronic sinusitis, unilateral headache, cough and/or SOB.

Uncontrolled Disease

Progressive systemic involvement despite therapy.

Disease Complications

- **Eye** involvement, e.g., iritis, uveitis.
- **Lung** involvement causing shortness of breath, cough, pulmonary hemorrhage, infiltrates, nodules or cavities.
- **Mesenteric** infarction/perforation causing abdominal pain, distention.
- **Renal** insufficiency/glomerulonephritis.
- **Peripheral/central nervous system** disease; e.g., confusion, disorientation, paresthesias, seizures, TIAs, CVAs.

Medication Complications

Treatment is effective but drug toxicity or intolerance occurs; e.g., bone marrow suppression, opportunistic infections, hemorrhagic cystitis (cyclophosphamide induced), steroid myopathy, osteoporosis.

Management

- Establish a treatment plan.
- Apheresis, IV immunoglobulin or other non-DMARD therapy is considered.
- **Corticosteroid** therapy (chronic) is required to control disease.
- **Immunosuppressive** drug therapy is considered to control disease or to taper corticosteroids.

- These diseases should in almost all instances be managed by subspecialists (e.g., rheumatologists, nephrologists, pulmonologists); concurrent care may be provided by other physicians.

D. Uncommon Rheumatic Diseases

277.3 Amyloidosis
275.0 Hemochromatosis
733.99 Relapsing polychondritis
713.7 Sarcoidosis

Diagnosis

- Establish or confirm diagnosis; e.g., differentiate between infectious arthritis and sarcoidosis.
- Interpret laboratory tests; e.g., angiotensin converting enzyme.
- Determine need for tissue biopsy.

Uncontrolled Disease

- Previously stable disease becomes active.
- Signs/symptoms persist despite therapy; e.g., dry eyes and/or mouth, rash, arthritis.

Disease Complications

- **Cardiac** involvement causing cardiomyopathy, pericarditis.
- **Eye** involvement with uveitis.
- **Hematologic** involvement causing hyperviscosity, bone marrow suppression.
- **Lung** involvement causing shortness of breath, cough, nodules, cavities or infiltrates.
- **Lymph node** involvement causing lymphadenopathy.
- **Peripheral/central nervous system disease**: e.g., entrapment neuropathy, paresthesias, vasomotor instability.
- **Renal** insufficiency/nephrotic syndrome causing peripheral edema, decreased urine output.
- **Vasculitis**, cutaneous or systemic.

Medication Complications

Treatment is effective but drug toxicity or intolerance occurs; e.g., steroid myopathy, osteoporosis, opportunistic infections.

Management

- Establish a treatment plan.
- Apheresis, IV immunoglobulin or other non-DMARD therapy is considered.
- **Corticosteroid** therapy (chronic) is required to control disease.
- **Immunosuppressive** drug therapy is considered to control disease or to taper corticosteroids.

E. Osteoarthritis

Diagnosis

Establish or confirm diagnosis; e.g., differentiate erosive osteoarthritis and inflammatory arthritis, differentiate osteoarthritis and crystal induced arthropathy.

Uncontrolled Disease

Single or multiple joint involvement which does not respond to NSAID therapy.

Medication Complications

NSAID treatment is effective but drug toxicity or intolerance occurs.

Management

- **Joint injections**, particularly when prior joint injections have not provided sufficient relief or an injection of a small or difficult to access joint is involved, e.g., finger, wrist, elbow, ankle.
- **Physical/occupational therapy** recommendations, including appropriate use and duration of PT/OT.
- **Pre/Post surgery medication** modifications/coordination.

- **Surgical opinion** - opinion/second opinion regarding the timing of and need for surgical intervention.

F. Regional Musculoskeletal Disorders

722.xx Degenerative disk disease
Radiculopathy
Spinal stenosis
726.xx Bursitis/tendinitis
727.xx Tenosynovitis
728.5 Hypermobility syndrome
Regional pain syndromes
Repetitive use syndromes

Diagnosis

Differentiate between a regional musculoskeletal problem and a generalized systemic disorder.

Uncontrolled Disease

Functionally compromising or unresponsive to primary treatment.

Medication Complications

NSAID treatment is effective but drug toxicity or intolerance occurs.

Management

- **Periarticular injections**, particularly when prior joint injections have not provided sufficient relief.
- **Physical/occupational therapy** recommendations, including appropriate use and duration of PT/OT.
- **Surgical opinion** - opinion/second opinion regarding the timing of and need for surgical intervention.

G. Fibromyalgia/Myofascial Pain

Diagnosis

Differentiate articular disease, soft tissue rheumatism and systemic inflammatory disease (e.g., rule out lupus in patients with positive ANA and lacking other diagnostic criteria).

H. Metabolic Bone Disease

733.xx Osteoporosis
731.0 Paget's disease
713.0 Endocrine arthropathy
733.7 Reflex sympathetic dystrophy (RSDS)
588.0 Renal osteodystrophy
268.2 Osteomalacia

Diagnosis

- Establish or confirm diagnosis.
- Interpret metabolic laboratory tests.
- Evaluate bone density studies and nuclear medicine bone scans.
- Determine need for bone biopsy.

Uncontrolled Disease

- Corticosteroid therapy (chronic) is necessary to control life threatening or disabling primary disease.
- Elevated alkaline phosphatase in Paget's disease despite therapy.
- Functional deterioration affects quality of life.
- Osteopenia despite hormone replacement therapy (HRT) or other therapy.
- Osteopenia when HRT contraindicated or not desired.
- Persistent pain and/or swelling despite therapy in RSDS.

Disease Complications

- Chronic pain.

- Fractures.

Medication Complications

Treatment is effective but drug toxicity or intolerance occurs.

Management

- Establish a treatment plan.
- Evaluate and treat fractures caused by these diseases.

I. Crystal Induced Arthropathy

274.9 Gout
712.2 CPPD disease
712.8 Hydroxyapatite deposition disease
271.8 Calcium oxalate deposition disease

Diagnosis

- Differentiate polyarticular crystal disease and inflammatory arthritis.
- Establish diagnosis by joint aspiration and crystal identification.
- Interpretation of abnormal laboratory values (calcium, uric acid, phosphorus).

Uncontrolled Disease

- Recurrent episodes despite appropriate therapy.
- Pain, stiffness and swelling which does not respond to NSAID therapy.

Disease Complications

- Polyarticular gout.
- Tophaceous gout.

Medication Complications

Treatment is effective but drug toxicity or intolerance occurs.

Management

Hypouricemic drug therapy is considered.

J. Children With Rheumatic Diseases

Diagnosis, treatment recommendations and concurrent care with pediatrician or family practitioner.

K. Pregnant Women with Rheumatic Diseases

Diagnosis, treatment recommendations and concurrent care with obstetrician or family practitioner during pregnancy and three months post partum.

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The Guidelines are not an exclusive list of circumstances in which a referral is appropriate. At the same time, the Guidelines do not require a referral in each of the circumstances indicated. The decision to refer is left to the judgment of the primary care physician or

other health care provider.

It is hoped that those who use the Guidelines will offer comments and suggestions. It is also hoped that those organizations which adopt the Guidelines will notify the authors of their adoption and make an effort to evaluate their usefulness.

1Dieppe, P. and Paine, T., Referral Guidelines for General Practitioners - Which Patients with Limb Joint Arthritis Should be Sent to a Rheumatologist?, Reports on Rheumatic Diseases, Jan 1994 No. 1, Arthritis and Rheumatism Council (UK). The reasons for referring patients to a rheumatologist are essentially those identified by Drs. Dieppe and Paine.

Appendix 1: Rheumatologist's Role in Patient Care

The objective of a rheumatology consultation is to make or confirm a diagnosis and, in those cases as well as where a diagnosis has been previously established, to provide a prognosis and treatment recommendations. This process may involve one or more visits following the consultation. Subsequently, the rheumatologist acting as a specialist with respect to the rheumatic disease might provide ongoing care, concurrent care, periodic re-evaluation, PRN care (such as for flare intervention) or no care at all, as described below. Rheumatologists are almost all trained as internists, though a small number of rheumatologists, who treat exclusively children, are trained as pediatricians. Some rheumatologists and pediatric rheumatologists may offer their patients primary care services in addition to providing necessary rheumatology specialty care.

Diagnosis: Make the diagnosis or confirm the diagnosis of the referring physician.

Prognosis and Treatment: Establish a prognosis, make treatment recommendations, initiate treatment and educate the patient.

Consultation Only: Return care to the referring physician who will continue care and will be responsible for monitoring the effectiveness and toxicity of the treatment.

Ongoing Care: Assume primary care for the treatment of the rheumatic disorder and be responsible for monitoring the effectiveness and toxicity of the treatment.

Concurrent Care: Share care for the rheumatic disease with the referring physician. The rheumatologist and the referring physician see the patient at mutually agreeable intervals. Each will monitor the effectiveness and toxicity of the treatments at their respective visits. They will determine whether laboratory tests arising from monitoring by the referring physician will be provided to the rheumatologist.

PRN Care: See the patient on an "as needed" basis, such as for exacerbation (e.g., a flare) in disease activity.

Follow-up Consultation: See the patient for re-evaluation after a given period of time; the rheumatologist will not monitor the patient during the interim.

Joint Injections/Aspirations: The rheumatologist may be requested to inject/aspirate a joint.

Nonarticular Injections: The rheumatologist may be requested to inject tendons, bursae or trigger points.

Pregnancy: The rheumatologist may be consulted in the case of pregnancy of a patient with a rheumatic disease to coordinate any necessary modification in patient medications.

Surgery: The rheumatologist may be consulted prior to and after any surgery to coordinate any necessary modification in patient medications, e.g., NSAIDs, corticosteroids, immunosuppressive therapy.

Surgical Opinions: The rheumatologist may be consulted prior to any orthopedic/neurosurgical procedure on a patient with rheumatic disease regarding the timing of and necessity for the surgery as well as to coordinate any necessary modification in patient medications.

SEPTOPLASTY

Criteria for Referral and Surgery: PASD will arrange for referral and surgery (when available) when the abnormality markedly interferes with work or daily function.

Patient History (one of two)

Documented nasal trauma of recent origin with causes significant nasal obstruction
Persistent serous otitis media due to nasal obstruction and poor Eustachian tube
dysfunction, OR
Recurrent sinusitis on the ipsilateral side

AND

Physical Exam

Dislocation of septal cartilage causing complete or near complete obstruction of the nasal cavity

SHOULDER PAIN

Shoulder pain, with or without symptoms of instability, stiffness, weakness, catching, crepitus, deformity, or paresthesias, not associated with acute fracture, in the absence of cervical spine or non-skeletal etiologies (such as cardiac or neurogenic).

Initial Dx and Management:

- History and physical exam, to include a careful neurological exam of the upper extremities.
- AP and axillary x-ray views of the shoulder are sometimes indicated as part of the initial diagnostic work up.
- MRI/CT/arthrogram not indicated as part of initial diagnostic work up.
- Diagnostic or therapeutic injection of local anesthetic and steroid, documenting site of injection (e.g. AC, subacromial, bicipital groove), type and amount of Rx.
- Sling and swathe (limited to maximum of 7 days).
- NSAIDs, appropriate use of light narcotic Rx for no more than 7 days in acute injuries.
- Activity modifications as required.
- Physical Therapy, with a home exercise regimen, can be a key component in the treatment of shoulder pain and should not be overlooked. In shoulder pain more so than other orthopedic conditions, the course of PT may be prolonged.

Ongoing Management:

- With the above plan, resolution is expected in 3-4 weeks. A specific diagnosis can be treated as above for 3-4 months, as long as slow improvement is occurring. Light narcotics only indicated for a short period after an acute injury or re-injury.
- If no improvement has occurred within 4-8 weeks, referral to specialty care is indicated. Adjunctive studies other than x-rays are most appropriately ordered by the specialty care provider or after phone consultation recommendation.

Indications for referral:

- Abnormal x-ray and exam suggestive of tumor, infection, fracture, residual dislocation, or congenital deformity.
- No response to treatment within 4-8 weeks.
- Incomplete response to treatment within 3 months with initial slow improvement.
- Physical therapy as required for maintenance of ROM, strength, and for instruction in a self-therapy program.

SINUSITIS – ACUTE AND CHRONIC

Criteria for Referral: Most acute and chronic sinusitis is managed by primary care. Underlying causes such as allergy and infection are determined and treated by primary care. Referral is only necessary for persistent disease that markedly interferes with work or daily function.

Patient History

Persistent obstruction beyond two months which interferes with function.
Failure to respond to 2-3 courses of antibiotic therapy and topical nasal steroids

Physical Exam

Nasal exam - documenting purulent discharge
Palpable sinus tenderness

Treatment (all tried)

First and Second line antibiotics used for up to 6 weeks
Decongestant therapy for up to 6 weeks (optional)
Nasal corticosteroids used for up to 6 weeks without benefit

Diagnostic

Sinus x-rays or CT scan confirm infection

SLEEP APNEA STUDY

Criteria for Referral: Sleep Apnea is common among obese people and people with upper airway obstruction. PASD will arrange for sleep studies when available. In general, an in-home split night sleep study with CPAP titration should be done in most cases.

Patient History: (two of first four)

- Chronic Loud Snoring
- Gasping or choking episodes
- Excessive daytime sleepiness
- Cognitive difficulties

Physical Exam:

- Obesity, including nuchal obesity
- Hypertension
- Nasopharyngeal narrowing
- BMI > 35

Stable home situation. (required)

Willingness to use C-PAP machine if recommended (required)

TENS UNIT

Criteria for Approval: May be indicated for patients with chronic pain disorders who are refractory or have responded to the modalities and who have demonstrable relief from a TENS trial. TENS units will only be provided on a donated rental basis. No TENS rental or donation will be authorized without a trial.

Refer patient to PT for TENS trial with two visits.

PT to report results to CMO

Addendum: TENS rental may be approved for 3 months at a time, providing the patient remains eligible.

THYROID DISEASE

Criteria for Referral: Hypothyroidism is evaluated and treated at the primary care level. Referral to Endocrinology would only be arranged for severe cases or when the primary care physician is unable to control the patient. Most patients with **Hyperthyroidism** should be referred to Endocrinology to be evaluated and to explore treatment options. (Hyperthyroidism secondary to taking excessive thyroid medication is managed by primary care). **Thyroid nodules** or other thyroid masses are referred to Endocrinology and possibly to either Interventional Radiology or General Surgery for biopsy or other surgery. Occasionally, referral to Endocrinology is needed to evaluate and recommend treatment for severely ill or cardiac patients.

Patient History (Indications for Referral)

- For fine needle aspiration of solitary nodules
- For treatment of thyroid cancer
- To confirm the diagnosis and treatment plan for hyperthyroid patients*
- For radioactive iodine therapy
- When lab values are ambiguous, especially in sick or elderly patients*

*consideration should be given to doing virtual or e-consult in these cases

THYROIDECTOMY

Criteria for Referral and Surgery

Patient History (one of two)

- Family history of thyroid cancer
- Recurrent cystic lesions

AND

Physical (one of three)

- Presence of a thyroid nodule or mass
- Lymphadenopathy or metastasis
- Cystic lesion > 4cm

AND

Diagnostic (one of four)

- Fine needle aspiration, positive for cancer
- I-131, scan-positive
- Chronic thyroiditis by microsomal antibodies
- Increased calcitonin levels

TMJ - TEMPOROMANDIBULAR JOINT DISORDER

Criteria for Referral and Any Procedure such as Arthroplasty: TMJ syndrome refers to persistent pain and other symptoms such as clicking in the temporomandibular joint of the jaw, just in front of the ear. This common problem has many causes: arthritis, dental problems, and stress causing grinding or clenching the teeth (bruxism). TMJ is initially evaluated by primary care to determine the most likely cause. Dental referral should be done before a medical specialist if there is evidence of malocclusion or other dental problems. Other possible referrals include counseling, physical therapy and ENT, which are approved based on these criteria:

Patient History (two of four)

- Pain or difficulty opening mouth
- Jaw locking
- Clicking, popping or crepitus sound
- Past history of rheumatoid or osteoarthritis

AND

Physical Exam (one of three)

- Presence of facial asymmetry
- Limited movement of the jaw (or recurrent locking)
- Tenderness and/or crepitation over TMJ joint on palpation

Dental evaluation should be done on most patients, with a trial of a bite guard for at least 2-3 months

Past Treatment (two of three, one of which must be bite guard/splint)

- Muscle relaxants
- Anti-inflammatory agents
- Splint/oral appliance

TONSILLECTOMY AND ADENOIDECTOMY (T & A)

Criteria for Referral for Surgery: T & A was once an almost universal procedure in America. Upon the realization the tonsils and adenoids are lymph nodes and part of the upper respiratory immune system, their removal has become uncommon. Chronic persistent infection unresponsive to antibiotics and chronic obstruction are the common reasons for referral to ENT and removal of the glands.

Patient History (one of these)

- Repeated episodes of acute tonsillitis (four or more) in past year with failure of resolution despite antibiotic therapy
- Persistent obstruction of breathing and swallowing
- Recurrent otitis media with persistence of fluid pressure secondary to enlarged adenoids causing obstruction to the Eustachian tubes

Physical Exam (one of these)

- Markedly enlarged and chronically infected tonsils
- Tonsils causing oral obstruction
- Peritonsillar abscess
- Adenoid obstruction of the Eustachian tubes (by imaging)

Adenoidectomy alone (one of these)

- Nasal obstruction resulting in sleep apnea
- Chronic otitis media with effusion secondary to adenoids

TRIGGER FINGER

Criteria for Referral and Surgical Correction: Trigger finger, or stenosing tenosynovitis, is a condition in which one or more fingers (including the thumb) is/are caught in a bent position. This finger may straighten with a snap, like a trigger being pulled and released. The finger remains in a bent and locked position in more severe cases. Referral and surgery will be arranged by PASD when correction of the trigger finger is necessary for work or daily function. In general, an attempt at corticosteroid injection should be attempted by primary care before referral.

Patient History (one of first two)

- Pain at the interphalangeal joint of forefinger or thumb
- Failure of injectable steroids
- Affecting work (obtain work history) - required

A N D

Physical Exam (one of two)

- Nodular thickening at or just proximal to the M.C.P. joint
- Catching or locking of the P.I.P. joint with extension of finger

TYMPANOPLASTY

Criteria for Referral: Tympanoplasty is repair of the tympanic membrane, or eardrum. The procedure is done for persistent perforations of the eardrum.

Patient History (two of three)

- Recurrent infection of the middle ear
- Chronic hearing loss interfering with work or daily function
- Previous antibiotic therapy and observation fails to result in healing of the perforation.

A N D

Physical Exam and Testing

- Perforation of Tympanic Membrane (large or persistent)
- Hearing loss of > 40 db by audiometry

TYMPANOTOMY

Criteria for Referral: Tympanotomy, also known as myringotomy, is a surgical incision of the tympanic membrane, or eardrum. The procedure is done to perform surgery in the middle ear, or more commonly to insert drainage tubes because of persistent fluid in the middle ear.

Patient History or Medical Records documenting one of the following:

- Cholesteotoma (collection of tissue in the middle ear)

- For insertion of typanostomy tubes (documented need by consult)

- To explore the middle ear for hearing loss (> 40 db) or other pathology

UROLOGY

(incorporates UCSD referral guidelines 2009)

Criteria for Referral: Generally the following diagnosis would be considered for specialty referral:

1. Diagnosed Untreated Cancer /suspected cancer (confirmed by Imaging Studies)
 - Positive Prostate Biopsy
 - Renal Mass
 - Bladder Tumor
 - Testicular Mass
2. Suspected/Undiagnosed Cancer
 - Gross Hematuria
 - Elevated PSA
3. Acute Stone (confirmed by Imaging Studies)
4. Urinary Retention, ER follow up
5. Previously Treated Prostate or Bladder Cancer Follow up for cystoscopy, or when PSA elevated or increasing following prostate cancer treatment
6. Spinal Cord Injured patients for catheter change, retained stents
7. Complicated Urinary Tract Infections: 5 or more infections within the last 12 months
8. Microhematuria, more than one analysis
 - >5 (greater than five RBC on microscopic urinalysis)
 - Consider trial of antibiotics before referral
 - Ensure no other source (e.g., UA done during menstruation)

Diagnoses generally within the scope of Primary Care:

1. Erectile Dysfunction
2. Urinary Tract Infections (uncomplicated)
3. Family Planning / Infertility (NCB under CMS)

Patients generally should have the following studies done prior to referral, when appropriate per the working diagnosis:

- Urinalysis (microscopic), Urine Culture
- PSA, CBC, BUN/Cr
- Pathology reports
- Radiology studies as needed (US, IVP, etc.)

Uterine Bleeding (AUB, DUB)

(http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=10889 ;
<http://emedicine.medscape.com/article/795587-overview>)

Guideline applies to: (both must be present)

- Reproductive aged women who are not pregnant
 - Abnormal uterine bleeding that is one or a combination of the following
 - Irregular, metrorrhagia, menorrhagia, or both
 - Bleeding between predictable periods ("metrorrhagia")

General Investigation of Reproductive Aged Women with Chronic Abnormal Uterine Bleeding (AUB)

- All patients with chronic AUB should be considered for a complete blood count (CBC), Pregnancy Test, coagulation measures (PT/INR, PTT), and TSH before referral

Uterine Cavity Assessment

- Evaluation of the Endometrium
 - When endometrial sampling is indicated in premenopausal women with AUB, outpatient endometrial biopsy with pipelle catheter techniques should be considered the first line approach.
 - When there is an increased risk of endometrial hyperplasia or neoplasia, endometrial sampling should be performed. Such circumstances include the following:
 - Over the age of 40.
 - Women less than forty with risk factors judged sufficient to warrant biopsy. These include features suggestive of chronic anovulation (irregular menses, infertility); and weight greater than 90 Kg.
 - Patients with a family history of hereditary nonpolyposis colorectal cancer syndrome (Lynch Syndrome)
 - If the endometrial biopsy is indicated and cannot be obtained or is inadequate, repeat sampling should be attempted, if necessary with Dilation and Curettage (D&C) by Gynecology. Patients taken to the operating room should have hysteroscopic evaluation prior to endometrial sampling and it is preferable that the surgeon be prepared to remove identified lesions under hysteroscopic guidance.
 - If chronic AUB continues despite normal and satisfactory endometrial sampling, the patient should be considered for further evaluation with ultrasound, saline infusion sonography (SIS), an/ or hysteroscopy.
- Transvaginal Sonography (TVS)
 - Routine ultrasonography is generally unnecessary for initial visits but should be considered in any individual with persisting symptoms and especially those who fail initial medical therapy.
 - There is no consensus on the upper limit of endometrial thickness in premenopausal women, in part because the thickness varies with the normal systemic variation in ovarian gonadal steroids; in general an endometrial stripe of > 12mm should be evaluated by pipelle biopsy
- Evaluation of Endometrial Cavity Structure
 - Evaluation for structural causes of AUB is most reliably determined by hysteroscopy and/or diagnostic imaging techniques (e.g., transvaginal ultrasonography or saline infusion sonography).
 - Transvaginal ultrasound is a good screening test
 - Irregular thickening of the endometrium (as seen by ultrasound) suggests the presence of one or more focal lesions. When such irregularity exists, when the endometrial cavity cannot

be identified in its entirety or, if for any other reason polyps or fibroids involving the endometrial cavity are suspected, further evaluation should include either saline infusion sonography (SIS) or hysteroscopy.

Treatment of Reproductive Aged Women with Chronic AUB

- All women with excessive bleeding secondary to chronic AUB should be offered oral iron therapy.
- Ovulatory DUB (cyclical heavy bleeding unrelated to structural abnormalities): Medical therapy options. (Note: women with DUB may have asymptomatic lesions such as intramural or subserosal fibroids)
 - Nonsteroidal anti-inflammatory agents.
 - Combination oral contraceptives
 - Oral progestins either continuously or nearly continuously.
 - Local progestins as administered via a progestin secreting intrauterine contraceptive device. (Mirena)
 - Depot GnRH agonists (for limited duration). **(Recommend start by GYN)**
 - Danazol, oral or transvaginal. **(Recommend start by GYN)**
- Anovulatory DUB (irregular and unpredictable bleeding unrelated to structural abnormalities): Medical therapy options: (Note: women with DUB may have asymptomatic lesions such as intramural or subserosal fibroids)
 - Lifestyle issues including stress reduction and weight loss may be important in the management of AUB associated with an anovulatory state.
 - Progestins administered cyclically or continuously
 - Combination oral contraceptive
 - GnRH agonists may have a role in the management of selected women with chronic anovulatory AUB. **(Recommend start by GYN)**
- Persistent AUB: If AUB persists after a negative endometrial biopsy and appropriate medical therapy, the endometrial cavity should be assessed if not previously evaluated.
- Surgical therapy for women with chronic DUB is currently reserved for women not interested in future fertility.
 - Endometrial ablation is frequently effective for chronic DUB and can be performed by outpatient resectoscopic or non-resectoscopic techniques.
 - Hysterectomy is a surgical option for women with chronic DUB.
- Surgical Options for Women with Chronic AUB Associated with Leiomyomas and Polyps
 - Hysteroscopic resection
 - Endometrial Ablation
 - Abdominal myomectomy
 - Uterine Artery Embolization/Occlusion
 - Radiologic uterine artery occlusion may be offered to women with chronic AUB associated with uterine leiomyomata.
 - Hysterectomy
- Indications for referral (see above for details)- Patients requiring any of the following:
 - GnRH agonists or Danazol therapy
 - Uterine ablation or surgery (after failing medical treatments as outlines above)
 - D&C

VARICOSE VEINS

Criteria for Referral and Surgery: Varicose veins are veins that become enlarged or twisted. Usually these occur in superficial veins of the leg, especially in women during and after pregnancy. Most varicose veins cause no significant medical problems and treatment is not necessary. PASD will arrange for referral and surgery for varicose veins that cause major problems with work or daily function, and not for cosmetic purposes.

Patient History (both present)

Associated with severe, constant pain and/or stasis ulceration, or recurrent severe bleeding
Prescription compression stockings have failed after at least a six-month trial.

Physical Exam (one of these present)

Recurrent superficial phlebitis (two or more occasions)
Stasis ulcer that is recurrent (three or more occasions) or not responding to conservative therapy after six weeks.

Contraindication:

Occlusive arterial disease (moderate to severe)
Recent deep vein thrombophlebitis
Pregnancy
Congenital abnormalities of deep veins

VERTIGO

Criteria for Referral: Vertigo is dizziness associated with a feeling of movement, such as the room spinning. Vertigo is usually caused by a problem with the inner ear balance mechanism (vestibular system), or in the brain. The most common cause of vertigo is benign positional vertigo (BPV), a temporary condition common in middle age and the elderly. Temporary vertigo is also caused by inner ear infections, usually a virus, called labyrinthitis. Other more serious causes include toxicity with medications, ischemia to the brain (TIA or stroke) or brain or cranial nerve tumors. If the vertigo is caused by an inner ear problem, it is referred to as peripheral vertigo. If the cause is in the brain, it is referred to as central vertigo. The initial assessment of vertigo, including maneuvers to determine if it is peripheral or central, is done by primary care. Referrals for peripheral vertigo usually go to ENT, while central vertigo is referred to Neurology.

Patient History

True rotatory vertigo elicited by a rapid head movement in a non-axial plane, e.g. rolling over in bed

If other neurologic symptoms are present, such as weakness, severe headache or hearing loss, early referral is indicated

Failure of Treatment for BPV including:

Medications

Epley Maneuvers: Assume position of Dix-Hallpike with the affected ear down then slowly rotate head in the opposite direction. Then, rotate head and whole body another 90 degrees, resume sitting.

AND

Physical Exam

Dix-Hallpike maneuver

Patient moves from a sitting to a supine position with the head hanging over the edge of the bed or table and rotated 45 degrees; ear down. Bi-lateral testing

Affected ear facing ground -> vertigo and rotating movement of eyes or nystagmus indicated peripheral vertigo and most likely BPV.

If this is negative, a central cause of vertigo is considered and neurologic testing is indicated.

Diagnostic Testing

Audiometry should be done to document hearing loss

An MRI (for acoustic neuroma, brain tumor or mass) may be requested by primary care

WOUND MANAGEMENT

Criteria for Referral to a Specialist or to a Wound Care Clinic: Patients with diminished circulation or low oxygen in the blood may have chronic wounds that if not treated aggressively become more complicated. Most wound management is done by primary care, but complicated wounds may require the evaluation and management recommendations of a wound care specialist or clinic. PASD would arrange for such a referral and treatment procedures if critically necessary for wound healing.

Patient History (all must be present)

- Chronic ulcers-not healed within 45-60 days of occurrence.
- Failure of standard wound therapy.
- No measurable signs of healing.

Physical Exam

Chronic stage 3 & 4 pressure ulcers, arterial ulcers, diabetic ulcers and venous stasis.