

Clinical Resource Group, Inc.



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CLINICAL TREATMENT GUIDELINES

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PART A:

CLINICAL REQUIREMENTS AND CARE MODEL

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Clinical Resource Group, Inc. (CRG) distinguishes itself by its emphasis on a community standard based clinical approach to providing effective chiropractic patient care. Our practitioners utilize patient treatment methods that conform to all applicable state, local, and federal laws, blending proven postural techniques, exercises, education and effective therapies with chiropractic mobilization and manipulation. CRG reimburses Practitioners for approved medically necessary services only, as defined in this document and referenced in the CRG Provider Participation Agreement. CRG will not reimburse a Practitioner for non-covered or excluded services.

A. Chiropractic treatment emphasizes:

- The need for patients to understand the cause of their symptoms in order to actively participate in the treatment of their condition
- Treatment that incorporates realistic lifestyle changes, including home exercise and workplace activities patients can follow

B. Clinical Requirements:

1. CRG clinical treatment guidelines are intended to assist the clinician in decision making based on the expectations of outcome for the typical case. They are not intended to be prescriptive toward a specific course or frequency of treatment for any specific case. They are a network benchmark by which determination of medically necessary care will be based and as such, should be taken under advisement in the provision of services to CRG Members.
2. Practitioners agree to provide CRG eligible Members (enrollees and subscribers or dependents) with chiropractic treatment for covered neuromuskuloskeletal (NMS) conditions. In doing so, practitioners agree to abide by CRG clinical and administrative policies and procedures as outlined in the Clinical Treatment Guidelines and the CRG Provider Manual.
3. The treating practitioner uses his/her best clinical judgment regarding the propriety of any specific procedure in light of the circumstances presented by the patient. The clinical course of care

provided is subject to retrospective clinical review of the appropriateness of that care.

4. Acute disorders and uncomplicated cases typically respond within 30 days with 4 to 6 treatments. CRG guidelines do not support daily treatment of patients and a plan to do so must be authorized in advance by CRG. The patient medical record will clearly document progressive improvement within this timeframe as described in the CRG documentation standards. Practitioners agree to refer Members, if requested or indicated, to other health care professionals for evaluation and treatment of conditions that are not neuromuskuloskeletal (NMS) as well for as NMS conditions that have not responded to chiropractic care within the above timeframe.
5. Chronic disorders and complicated cases will typically respond within 16 weeks or will need re-assessment or referral. Specific length of treatment will be discussed between the provider and CRG clinical management personnel. Practitioners agree to refer Members if requested or indicated, to other health care professionals for evaluation and treatment of conditions that are not neuromuskuloskeletal (NMS) as well for as NMS conditions that have not responded to chiropractic care within the above timeframe.
6. Maximum care for patients within the first 30 days of the initial treatment is typically 6 visits for adults, 4 visits for patients age birth through 4, and 5 visits for patients age 5 through 17.
7. Practitioners will utilize differential diagnosis to rule out conditions that are non-mechanical or non-NMS. These conditions, when identified, require medical referral or concurrent care.

C. The clinical care model incorporates assessment, examination, diagnosis and treatment into a clinical treatment model as follows:

Step 1: *Assessment* entails a thorough patient interview and review of the patient's medical records to understand the patient's:

- current history
- past history
- family history
- previous treatment and imaging studies
- laboratory results

Step 2: *Examination* is completed utilizing appropriate vital sign testing, repetitive spinal movements, orthopedic, neurological and chiropractic evaluation to:

- identify the origin of the patient's symptoms; and
- formulate a treatment plan to relieve the patient's reported symptoms and observed signs.

Step 3: *Diagnosis* is a conclusion arrived at after the assessment and examination determine if the patient is amenable to chiropractic care and if the patient should be referred to another health care provider.

Step 4: *Treatment* of the patient consists of both passive and active care:

First, an in-office treatment plan is developed. The patient is educated as to the cause of his/her

symptoms and the behavioral factors contributing to the symptoms. A treatment plan is formulated for the patient including active and passive care. In-office treatment consists of stretching/exercise, deep tissue work, appropriate therapies, spinal and extremity mobilization and manipulation.

Secondly, a self-care plan is developed for each patient, including:

- 1) patient follow through with the home exercise program the patient perfected during the course of the in-office treatment phase and
- 2) the ongoing self-monitoring of postural correctness while sitting, standing and walking, along with the adoption of proper bending and lifting techniques.
- 3) Instruction of avoidance of aggravating factors and ADL.

PART B:

DEFINITION OF TERMS

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Scope: *The terms used in the CRG Clinical Treatment Guidelines will have the following meanings given them.*

1. **Active treatment.** “Active treatment” means treatment which requires active patient participation in a therapeutic program to increase flexibility, strength, endurance, or awareness of proper body mechanics.
2. **Chronic pain syndrome.** “Chronic pain syndrome” means any set of verbal or nonverbal behaviors that:
 - a. involves the complaint of enduring pain;
 - b. differ significantly from the patient’s pre-injury or onset of symptoms behavior;
 - c. has not responded to previous appropriate treatment;
 - d. is not consistent with a known organic syndrome which has remained untreated; and
 - e. interferes with physical, psychological, social, or vocational functioning.
3. **Condition.** A patient’s “condition” means the symptoms, physical signs, clinical findings, and functional status that characterize the complaint, illness, or injury presented by the patient.
4. **Emergency treatment.** “Emergency treatment” means treatment that is:
 - a. required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death; or
 - b. immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.
5. **Etiology.** “Etiology” means the anatomic alteration, physiologic dysfunction, or other biological or psychological abnormality which is considered a cause of the patient’s condition.
6. **Functional status.** “Functional status” means the ability of an individual to engage in activities of daily living and other social, recreational, and vocational activities.
7. **Initial non-surgical management or treatment.** “Initial non-surgical management or treatment” is initial treatment provided after an injury that includes passive treatment, active treatment, injections, and durable medical equipment.

- 8. Medical imaging procedures.** A “medical imaging procedure” is a technique, process, or technology used to create a visual image of the body or its function. Medical imaging includes, but is not limited to: X-rays, tomography, angiography, venography, myelography, computed tomography (CT) scanning, magnetic resonance imaging (MRI) scanning, ultrasound imaging, nuclear isotope imaging, PET scanning, and thermography.
- 9. Medically necessary treatment.** “Medically necessary treatment” means those health services that is reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment guideline. The treatment must be reasonable and necessary for the diagnosis or cure and significant relief of a condition consistent with the current accepted standards of practice within the scope of the provider’s license.
- 10. Neurologic deficit.** “Neurologic deficit” means a loss of function secondary to involvement of the central or peripheral nervous system. This may include, but is not limited to, motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder, or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.
 - a. “Static neurologic deficit” means any neurologic deficit that has remained the same by history or noted by repeated examination since onset.
 - b. “Progressive neurologic deficit” means any neurologic deficit that has become worse by history or noted by repeated examination since onset.
- 11. Passive treatment.** “Passive treatment” modalities include bed rest; thermal treatment; traction; acupuncture; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments.

PART C:

GENERAL TREATMENT GUIDELINES

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1. Documentation Standards.

A health care provider must maintain an appropriate record of all examinations and treatment provided to a patient. The minimum standard within a state is defined by statute and by the rules of the State Board of Chiropractic Examiners. Patient records must be legible, express coherent ideas and describe the services provided to a unique patient. Documentation methods that require a key to interpret are discouraged. The standards of the CRG Network incorporate the following elements:

- A. A description of past conditions and trauma, past treatment received, current treatment received from other health care providers, and a description of the patient's current condition including onset and description of trauma if trauma occurred.
- B. Examinations performed to determine a preliminary diagnosis based on indicated diagnostic tests, with an indication of all findings of each test performed.
- C. A diagnosis supported by documented subjective and objective findings or clearly qualified as an opinion.
- D. A treatment plan that describes the procedures and treatment used for the conditions identified, including approximate frequency of care.
- E. Daily notes documenting current subjective complaints as described by the patient, any change in objective findings if noted during that visit, a listing of all procedures provided during that visit and information that is exchanged and will affect that patient's treatment.
- F. A description by the chiropractor or written by the patient each time an incident occurs that results in an aggravation of the patient's condition or a new developing condition.
- G. Results of reexaminations that are performed to evaluate significant changes in a patient's condition, including tests that were positive or deviated from results used to indicate normal findings.
- H. When symbols or abbreviations are used, a key that explains their meanings must accompany each file when requested in writing by the patient or a third part.
- I. Documentation that family history has been evaluated.

CRG has adopted the **PARTS** concept as a minimal acceptable level of documentation for supporting medically necessary care as follows:

P^{AIN}

Subjective:

- Presentation and History
- Location and Quality

Objective:

- Observation
- Palpation
- Percussion
- Provocative maneuvers

A^{SYMMETRY}

- Observation of postural deviations
- Palpatory malposition
- Radiographic malposition
- Presence of neurological deficits

R^{ANGE OF MOTION}

- Active and passive range of motion abnormalities
- Segmental motion palpation
- Stress or motion radiography

T^{ONE, TEXTURE and TEMPERATURE}

- Observation of body contours
- Soft tissue palpation characteristics
- Instrumentation techniques
- Neurological examination

S^{PECIAL TEST and CONSIDERATIONS}

- Orthopedic tests and prevocational maneuvers
- Symptoms (particularly visceral) that may related to particular areas of neurological dysfunction

2. Medically Necessary Treatment

All treatment must be medically necessary. Medically Necessary Treatment is defined as those health services that are reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment guideline. The treatment must be reasonable and necessary for the diagnosis or cure and significant relief of a condition consistent with the current accepted standards of practice within the scope of the provider's license. The health care provider must evaluate the medical necessity of all treatment on an ongoing basis.

CRG's Treatment Guidelines do not require or permit more frequent examinations than would typically be required for the condition being treated, but do require ongoing evaluation of the patient that is medically necessary, consistent with accepted medical practice.

3. Criteria for Progressive Improvement

The health care provider must evaluate at each visit whether the therapeutic treatment is effective according to the criteria for progressive improvement as listed below:

- a. the patient's subjective complaints are progressively improved, as evidenced in the medical record by documentation of decreased distribution, frequency, or intensity of symptoms;
- b. the objective clinical findings are progressively improving, as evidenced in the medical record by documentation of resolution or objectively measured improvement in the patient's condition; and
- c. the patient's functional status, at home, at work, and/or at leisure activities, is progressively improving, as evidenced by documentation in the medical record.

If there is not progressive improvement in at least two of these areas, a. to c., the treatment should be either discontinued or significantly modified. In such cases the provider should reconsider the diagnosis and treatment plan. The evaluation of the effectiveness of the treatment modality remains the ultimate responsibility of the treating health care provider who prescribed the treatment. If further treatment is not indicated, the provider should assist the patient with a referral to another appropriate health care provider for further evaluation.

4. Treatment Plan Expectations

The health care provider should use the most conservative treatment plan appropriate. The provider should educate and inform the patient with regard to all aspects of the treatment being provided as well as the probable cause of the patient's condition, what the patient can do to augment the treatment being provided; such as home exercise or restrictions of exacerbating activities. The provider should clearly explain the expectations for improvement in the patient's condition as a result of the plan of treatment.

5. Chemical dependency and domestic abuse

The health care provider shall maintain diligence to detect chemical dependency and/or domestic abuse issues involving the patient. The health care provider shall counsel the patient to seek appropriate evaluation and treatment of the chemical dependency. Issues concerning suspected domestic abuse must be reported to authorities in accordance with applicable state and/or federal statutes.

PART D:

MEDICAL IMAGING GUIDELINES

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1. General principles

All medical imaging must comply with items a. to d. Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study.

- a. Appropriate Imaging.** X-Rays are indicated in cases where trauma has occurred or there is suspicion of the presence of sinister pathology, including but not limited to tumor, pathological fracture, infection, or congenital anomaly. X-Rays are also indicated in cases where the patient has not responded to a reasonable course of chiropractic treatment. A health care provider should order the most appropriate imaging study for diagnosing the suspected etiology of a patient's condition. No concurrent or additional imaging studies should be ordered until the results of the first study are known and reviewed by the treating health care provider. If the first imaging study is negative, no additional imaging is indicated except for repeat and alternative imaging allowed under item f.

X-Rays are indicated in the following cases:

- 1) Where trauma has occurred to rule out a dislocation or fracture. The trauma must have occurred within four weeks prior to the visit.
- 2) Unexplained or unintended weight loss or the reasonable suspicion of some other sinister pathology including but not limited to tumor, pathological fracture, infection, bone weakening disorder, or congenital anomaly.
- 3) In cases where the patient has not responded to a reasonable course of conservative therapy within the first 30 days and there are significant clinical findings suggesting the presence of underlying pathology.
- 4) In cases where examination findings are confirmed by pertinent orthopedic and neurological exams that warrant X-rays to rule out pathology prior to treatment, such as to differentiate between a disc herniation and other lesions that could occupy the same space.
- 5) In cases with a history of spinal surgery or other surgery in the area that is to be treated
- 6) In cases where the symptoms are unremitting and have become progressively more severe and/or are of a severity to cause the patient to awake at night. The symptoms must have been present for at least 30 days,

- b. **Imaging solely to rule out a diagnosis** not seriously being considered as the etiology of the patient's condition is not indicated.
- c. **X-rays for a simple sprain/strain or confirmation of a diagnosis of subluxation are not indicated.** Spinal pain alone is not an indicator of a clinical need for spinal X-rays. If the need for treatment is the result of such things as bending, lifting, exercise, sleeping wrong or waking up with pain, this is not considered to be trauma but rather a strain/sprain postural injury. Such complaints do not by themselves meet the criteria of significant trauma.
- d. **Routine imaging.** Imaging on a routine basis is not indicated.
- e. **Complete regional, cervical, thoracic, and lumbar X-Rays** are rarely indicated and should be reserved for cases of significant trauma.
- f. **Repeat imaging.** Repeat imaging, of the same views of the same area of the body with the same imaging modality is not indicated except to diagnose a suspected fracture, dislocation, or to monitor scoliosis in an adolescent patient.
 - (1) Repeat imaging is not appropriate solely to determine the efficacy of chiropractic treatment.
 - (2) Persistence of a patient's subjective complaint or failure of the condition to respond to treatment are not indications for repeat imaging, but rather indications that a referral to an appropriate health care practitioner should be made to evaluate the patient's condition and further course of treatment.

PART E:

CERVICAL PAIN GUIDELINES

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Section 1: Diagnostic procedures for treatment of cervical pain

A health care provider shall determine the nature of the condition before initiating treatment.

- a. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to items (1) to (4) listed below. The diagnosis must be documented in the medical record. For the purposes of items (2) and (3), “radicular pain” means pain radiating distal to the shoulder. This Part does not apply to fractures of the cervical spine or cervical pain due to an infectious, immunologic, metabolic, endocrine, visceral, or neoplastic disease process.
 - 1) Regional neck pain includes referred pain to the shoulder and upper back. Regional neck pain includes the diagnoses of cervical strain, sprain, myofascial syndrome, musculoligamentous condition, soft tissue condition, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the cervical spine and which affects the cervical region, with or without referral to the upper back or shoulder
 - 2) Radicular pain, with or without regional neck pain, with no static neurologic deficit. This includes the diagnoses of brachialgia; cervical radiculopathy, radiculitis, or neuritis; displacement or herniation of intervertebral disc with radiculopathy, radiculitis, or neuritis; spinal stenosis with radiculopathy, radiculitis, or neuritis; and other diagnoses for pain in the arm distal to the shoulder believed to originate with irritation of the spinal cord or a nerve root in the cervical spine. In these cases neurologic findings on history and examination are either absent or do not show progressive deterioration.
 - 3) Radicular pain, with or without regional neck pain, with progressive neurologic deficit, which includes the same diagnoses as item (2); however, in these cases there is a history of progressive deterioration in the neurologic symptoms and physical findings, including worsening sensory loss, increasing muscle weakness, and progressive reflex changes.
 - 4) Cervical compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both arms and/or legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.

- b. Laboratory tests are not indicated in the evaluation of a patient with regional neck pain, or radicular pain. If the treating chiropractor suspects infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis a referral should be made to an appropriate health care professional.
- c. Medical imaging evaluation of the cervical spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider's clinical evaluation of the patient. Medical imaging should not be performed as a routine procedure and must comply with CRG's guidelines for imaging. The health care provider must document the appropriate indications for any medical imaging studies obtained.

Section 2: General treatment parameters for neck pain

- a. a. All medical care for neck pain appropriately assigned to a clinical category in section 1, item a, is determined by the diagnosis and clinical category in section 1, item a, to which the patient has been assigned. General parameters for treatment modalities are set forth in sections 3 to 6.
- b. The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the recommended duration specified in sections 3 to 6, or to repeat a therapy or treatment provided for the same patient's condition or complaint.

A course of treatment is divided into three phases.

- 1) Patients with neck problems, except patients with radicular pain with progressive neurological deficit, or myelopathy under section 1, item A, sections (3) and (4), should be given initial chiropractic care which may include both active and passive treatment modalities.
 - 2) Patients with radicular pain with progressive neurological deficit, or myelopathy may require immediate surgery. If the chiropractor's findings suggest surgery may be necessary, a referral should be made to an appropriate health care provider.
 - 3) For those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated. A chronic management program must be approved by the CRG chiropractic director.
- c. A treating health care provider may refer the patient for a consultation at any time during the course of treatment consistent with accepted medical practice.

Section 3: Passive treatment modalities

- a. The general guideline for frequency of visits involving passive treatment of the patient in a clinical setting shall be as follows:
 - **Adults age 18 years and over:** 6 visits, decreasing in frequency of visits and/or intensity of services over the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.
 - **Children ages 5 through 17 years of age:** 5 visits within the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.
 - **Children ages birth through 4 years of age:** 1-4 visits within the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.
 - All care provided beyond the first 30 days must be supported by documentation of progressive improvement of the patient's condition.
 - Coverage for services is governed by the individual health plan fee schedule and the patient's chiropractic benefit as described in the patient's insurance certificate of coverage.
 - 1) The health care provider must document in the medical record a plan to encourage the patient's independence and decreased reliance on continued passive treatment.
 - 2) Management of the patient's condition must include active treatment modalities during this period.
- b. Chiropractic adjustment or manipulation of joints:
 - 1) time for treatment response, three to five treatments;
 - 2) maximum treatment frequency:
 - up to three visits in the first week of treatment.
 - **Patients 18 years and over:** 6 visits over the first 30 days.
 - **Patients 5 Years through 17 years of age:** 5 visits over the first 30 days
 - **Patients ages Birth through 4 years of age:** 4 visits over the first 30 days.
- c. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, cool laser light therapy and microwave.
 - 1) Treatment given in a clinical setting in conjunction with chiropractic manipulation:
 - time for treatment response, two to four treatments.

- 2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.
- d. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and micro-current techniques.
 - 1) Treatment given in a clinical setting:
 - (a) time for treatment response, two to four treatments;
 - e. Mechanical traction:
 - 1) Treatment given in a clinical setting:
 - (a) time for treatment response, two to four treatments;
 - 2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education.
 - f. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and manual traction:
 - 1) time for treatment response, two to four treatments;
 - g. Bed rest. Prolonged restriction of activity and immobilization is detrimental to a patient's recovery. Bed rest should not be prescribed for more than 3-4 days.

Section 4: Active treatment modalities

The treating chiropractor should provide education for the patient that includes training on posture, biomechanics, and relaxation. Appropriate exercise instruction should be provided to actively engage the patient in the treatment program and make them less reliant on passive care provided in the clinic setting.

Section 5: Chronic management

Chronic management of neck pain must be approved by CRG. A plan for chronic management must be discussed and approved in advance by CRG's clinical management staff.

Section 6: Evaluation of treatment by health care provider

The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial chiropractic treatment is effective according to items a to c that follow. The health care provider must continually evaluate whether the passive or active treatment modality is resulting in progressive improvement as specified in the following items a through c:

- a. the patient's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;
- b. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs; and
- c. the patient's functional status, especially is progressively improving, as evidenced by documentation in the medical record of less restrictive limitations on activity.

If there is not progressive improvement in at least two of these areas (a to c), the treatment must be discontinued or significantly modified, or a referral made to another appropriate health care provider. The evaluation of the effectiveness of the treatment modality is the ultimate responsibility of the treating health care provider.

PART F:

THORACIC BACK PAIN GUIDELINES

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Section 1: Diagnostic procedures for treatment of thoracic back injury

A health care provider shall determine the nature of the condition before initiating treatment.

- a. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the consistency appropriate clinical category according to items (1) to (3) listed below. The diagnosis must be documented in the medical record. For the purposes of items (2) and (3), “radicular pain” means pain radiating in a dermatomal distribution. This Part does not apply to fractures of the thoracic spine or thoracic back pain due to an infectious, immunologic, metabolic, endocrine, visceral, or neoplastic disease process.
 - 1) Regional thoracic back pain includes the diagnoses of thoracic strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, and any other diagnosis for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the thoracic spine and which affects the thoracic region
 - 2) Radicular pain, with or without regional thoracic back pain, includes the diagnoses of thoracic radiculopathy, or radiculitis; displacement or herniation of intervertebral disc with radiculopathy, or radiculitis; spinal stenosis with radiculopathy, or radiculitis; and any other diagnoses for pain believed to originate with irritation of a nerve root in the thoracic spine.
 - 3) Thoracic compressive myelopathy, with or without radicular pain, is a condition characterized by weakness and spasticity in one or both legs and associated with any of the following: exaggerated reflexes, an extensor plantar response, bowel or bladder dysfunction, sensory ataxia, or bilateral sensory changes.
- b. Laboratory tests are not initially indicated in the evaluation of a patient with regional thoracic back pain, or radicular pain. If the treating provider suspects infection, metabolic-endocrinologic disorders, tumorous conditions, or systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis, a referral to an appropriate health care provider should be made for co-management.
- c. Medical imaging evaluation of the thoracic spine must be based on the findings of the history and physical examination and cannot be ordered prior to the health care provider’s clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure. The health care provider must document the appropriate indications for any medical imaging studies obtained.

- d. Personality or psychological evaluations should be considered for patients who continue to have problems despite appropriate care. The treating provider should arrange for referral to an appropriate health care provider.

Section 2: General treatment parameters for thoracic back pain

- a. All medical care for thoracic back pain, appropriately assigned to a clinical category in Section 1, item a, is determined by the clinical category to which the patient has been assigned. General parameters for treatment modalities are set forth in sections 3 to 6.

The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified in Sections 3 to 6, or to repeat a therapy or treatment previously provided for the same condition or complaint.

- b. A course of treatment is divided into three phases.
 - 1) First, all patients with thoracic back problems, except patients with myelopathy under Section 1, a, item (3), must be given initial non-surgical management which may include active and passive treatment modalities. These modalities and parameters are described in Sections 3, 4, 5, and 6.
 - 2) Second, for patients with persistent symptoms, initial non-surgical management is followed by a period of surgical evaluation. The treating practitioner should make an expeditious referral to an appropriate health care provider when these findings are encountered.
 - (a) Patients with myelopathy may require immediate surgical intervention.
 - (b) Any patient who has had surgery may require postoperative therapy with active and passive treatment modalities. This therapy may be in addition to any received during the period of initial non-surgical care.
 - 3) Third, for those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated.
- c. Consultations. A treating health care provider may refer the patient for a consultation at any time during the course of treatment consistent with accepted medical practice.

Section 3: Passive treatment modalities

- a. The general guideline for frequency of visits involving passive treatment of the patient in a clinical setting shall be as follows:
 - **Adults age 18 years and over: 6 - 8 visits, decreasing in frequency of visits and/or intensity of services over the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.**

- **Children ages 5 through 17 years of age: 5 visits within the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.**
 - **Children ages birth through 4 years of age: 4 visits within the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.**
 - **All care provided beyond the first 30 days must be supported by documentation of progressive improvement in the patient's condition.**
 - **Coverage for services is governed by the individual patient's health plan's certificate of coverage and the CRG fee schedule.**
- b. Chiropractic adjustment or manipulation of joints:
- 1) time for treatment response, two to four treatments;
 - 2) maximum treatment frequency:
 - up to three visits in the first week of treatment
 - Patients 18 years and over: 6 visits over the first 30 days
 - Patients 5 Years through 17 years of age: 5 visits over the first 30 days
 - Patients ages Birth through 4 years of age: 4 visits over the first 30 days
- c. Thermal treatment includes all superficial and deep heating modalities and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, cool laser light therapy and microwave.
- (1) Treatment given in a clinical setting in conjunction with chiropractic manipulation:
- (a) time for treatment response, two to four treatments;
 - (2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.
- d. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and micro-current techniques.
- (1) Treatment given in a clinical setting:
- (a) time for treatment response, two to four treatments;
- e. Mechanical traction:
- (1) Treatment given in a clinical setting:
- (a) time for treatment response, two to four treatments;

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education.

- f. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and manual traction:

(1) time for treatment response, two to four treatments;

Bed rest. Prolonged restriction of activity and immobilizations are detrimental to a patient's recovery. Bed rest should not be prescribed for more than seven days.

Section 4: Active treatment modalities

The treating chiropractor should provide education for the patient that includes training on posture, biomechanics, and relaxation. Appropriate exercise instruction should be provided to actively engage the patient in the treatment program and make them less reliant on passive care provided in the clinic setting.

Section 5: Chronic management

Chronic management of thoracic back pain must be approved by CRG. A plan for chronic management must be discussed with and approved in advance by CRG's clinical management staff.

Section 6: Evaluation of treatment by health care provider

The health care provider must evaluate at each visit whether the treatment is medically necessary, and must evaluate whether initial chiropractic treatment is effective according to items a to c that follow. The health care provider must continually evaluate whether the passive or active treatment modality is resulting in progressive improvement as specified in the following items a to c:

- a. the patient's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;
- b. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and
- c. the patient's functional status, is progressively improving, as evidenced by documentation in the medical record, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items of items a to c, the modality must be discontinued or significantly modified, or a referral made to an appropriate health care provider. The evaluation of the effectiveness of the treatment modality is the ultimate responsibility of the treating health care provider.

PART G:

LOW BACK PAIN GUIDELINES

Date Approved: February 20, 2003

Effective Date: March 1, 2003

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Section 1: Diagnostic procedures for treatment of low back pain

A health care provider shall determine the nature of the condition before initiating treatment.

- a. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the health care provider must assign the patient at each visit to the appropriate clinical category according to items (1) to (3) listed below. The diagnosis must be documented in the medical record. For the purposes of items (2) and (3), “radicular pain” means pain radiating from the lumbar spine proximal and/or distal to the knee, or pain conforming to a dermatomal distribution and possibly accompanied by anatomically congruent motor weakness or reflex changes. This Part does not apply to fractures of the lumbar spine, or back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process.
 - 1) Regional low back pain, includes referred pain into the buttocks region unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back pain includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and which affects the lumbosacral region, with or without referral to the buttocks region.
 - 2) Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the buttocks region believed to originate with irritation of a nerve root in the lumbar spine. In these cases, neurologic findings on history and physical examination are either absent or do not show progressive deterioration.
 - 3) Radicular pain, with or without regional low back pain, with progressive neurologic deficit. This includes the same diagnoses as item (2), however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness, or progressive reflex changes.
- b. Laboratory tests are not initially indicated in the evaluation of a patient with regional low back pain, or radicular pain. If the treating provider suspects infection, metabolic-endocrinologic

- disorders, tumorous conditions, or systemic musculoskeletal disorders, a referral to an appropriate health care provider should be made for co-management.
- c. Medical imaging evaluation of the lumbosacral spine must be based on the findings of the history and physical examination and cannot be ordered before the health care provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure. The health care provider must document the appropriate indications for any medical imaging studies obtained.
 - d. Psychological evaluation should be considered for patients who continue to have problems despite appropriate care. The treating provider should arrange for referral to an appropriate health care provider.

Section 2: General treatment parameters for low back pain

- a. All medical care for low back pain, appropriately assigned to a clinical category in Section 1, item a, is determined by the clinical category to which the patient has been assigned. General parameters for treatment modalities are set forth in Sections 3 to 6. The health care provider must, at each visit, reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the recommended duration specified in sections 3 to 6, or to repeat a therapy or treatment previously provided for the same patient's condition or complaint.
- b. A course of treatment is divided into three phases. (1) First, all patients with low back problems, except patients with progressive neurologic deficit under Section 1, a, item (3), must be given initial non-surgical management which may include active treatment modalities and passive treatment modalities. These modalities and parameters are described in Section 3. (a) Patients with radicular pain with progressive neurological deficit may require immediate surgical intervention. The treating practitioner should make an expeditious referral to an appropriate health care provider when these findings are encountered. (b) Any patient who has had surgery may require postoperative therapy in a clinical setting with active and passive treatment modalities. (2) For those patients who are not candidates for or refuse surgical therapy, or who do not have complete resolution of their symptoms with surgery, a period of chronic management may be indicated.
- c. Regarding referral for consultation, a treating health care provider may refer the patient for a consultation at any time during the course of treatment consistent with accepted medical practice.

Section 3: Passive treatment modalities

- a. The general guideline for frequency of visits involving passive treatment of the patient in a clinical setting shall be as follows:
 - **Adults age 18 years and over:** 6-8 visits, decreasing in frequency of visits and/or intensity of services over the first 30 days of treatment. Consistent and progressive improvement in

the patient's condition must be evident from the daily patient treatment records.

- **Children ages 5 through 17 years of age:** 5 visits within the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.
 - **Children ages birth through 4 years of age:** 4 visits within the first 30 days of treatment. Consistent and progressive improvement in the patient's condition must be evident from the daily patient treatment records.
 - All care provided beyond the first 30 days must be supported by documentation of progressive improvement in the patient's condition.
 - Coverage for services is governed by the individual health plan fee schedule and the patient's chiropractic benefit.
 - 1) The health care provider must document in the medical record a plan to encourage the patient's independence and decreased reliance on continued passive treatment.
 - 2) Management of the patient's condition must include active treatment modalities during this period.
- b. Chiropractic adjustment or manipulation of joints:
- 1) time for treatment response, three to five treatments;
 - 2) maximum treatment frequency:
 - up to three visits in the first week of treatment
 - Patients 18 years and over: 8 visits over the first 30 days
 - Patients 5 Years through 17 years of age: 6 visits over the first 30 days
 - Patients ages Birth through 4 years of age: 4 visits over the first 30 days
- c. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, cool laser light therapy and microwave.
- 1) Treatment given in a clinical setting in conjunction with chiropractic manipulation:
 - time for treatment response, two to four treatments.
 - 2) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.
- d. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and micro-current techniques.
- 1) Treatment given in a clinical setting:
 - time for treatment response, two to four treatments;

- e. Mechanical traction:
 - 1) Treatment given in a clinical setting:
 - time for treatment response, two to four treatments;
 - 2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education.
- f. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and manual traction:
 - 1) time for treatment response, two to four treatments;
- g. Bed rest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bed rest should not be prescribed for more than seven days.

Section 4: Active treatment modalities

The treating chiropractor should provide education for the patient that includes training on posture, biomechanics, and relaxation. Appropriate exercise instruction should be provided to actively engage the patient in the treatment program and make them less reliant on passive care provided in the clinic setting.

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- a. the patient's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;
- b. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs; and
- c. the patient's functional status is progressively improving, as evidenced by documentation in the medical record of less restrictive limitations on activity.

If there is not progressive improvement in at least two of these areas (a to c), the modality must be discontinued or significantly modified, or a referral made to another appropriate health care provider. The evaluation of the effectiveness of the treatment modality is the ultimate responsibility of the treating health care provider.