Dynamic Chiropractic

WHIPLASH / NECK PAIN

Medical Necessity of a Whiplash: Post Slip and Fall

Nancy Martin-Molina, DC, QME, MBA, CCSP

I recently called a patient's auto insurance company to see if my returning walk-in patient had any medical pay included in his policy. His car had been rear-ended two weeks prior, and he was quite concerned about his headaches and neck pain. What compelled me to write this column was the result of a conversation I had with the insurance adjuster, which indicated to me either her poor understanding of our profession, or her company's need to establish a chiropractic policy.

When I called the adjuster to confirm the medical pay, the reported date of the accident, and other details, the adjuster asked, "Are you the doctor - or the chiropractor?"

"I am the doctor of chiropractic," I responded.

The insurance adjuster went into what sounded like a rehearsed response:

"Your patient does have med pay, but we will only pay what is medically necessary. All care is subject to medical review requiring submission of documentation to our review board consisting of chiropractors and nurses. We will not pay for any reports you submit. We only pay for care specific to the injury. If you have been treating ..."

I just had to interrupt: "First of all, let me make absolutely certain that neither you nor the company you represent are biased toward DCs. I would like to clarify: When a doctor of chiropractic performs a history and examination procedural service (generally indicated on a claims submission as a CPT code that describes an initial examination and any interim examinations, also known as 'evaluation/management' visits), do you automatically submit these to your review board for medical necessity?

"When our patients have a new complaint, or when a condition worsens, it needs evaluation and management. I am well aware that the 99080 CPT codes have components that need to be satisfied. Commonly, the report is not reimbursable unless a report is requested; furthermore, only the final examination charge is reimbursable. The report then becomes a component of the final EM code: to substantiate the medical /chiropractic necessity of the final examination."

I concluded the call with: "I would like your supervisor's name and extension, not because I will be reporting you - I am certain that you and I have a clear-cut understanding of where each of our responsibilities lie. I am curious, though, as to your company's policy and would like to provide this information to my profession."

I was later relieved to speak to the supervisor who told me: "Doctor, it is a rarity for a chiropractor not to submit adequate documentation; it appears to be a thing of the past."

Ever wonder why certain insurance companies (you know whom I mean) down-code the chiropractor's EM codes and reimburse routinely at a lower cost level? Consider what you need in your documentation. With this in mind, I present an unusual twist in a whiplash case. Recognize

that examination reports need not be exhaustive; the general purpose is to simply provide "medical necessity" information on how you are managing the patient's care. Here is my letter:

August 2, 2002

Travel Accidental Policy Insurance
XXX California Street
Sunshine, California 90000

Chiropractic Physician's (or Doctor of Chiropractic) Examination Report Identification:

Name: John Henry Doe
DOB: date of patient's birth
DOI: date of patient injury
DOE: date of your exam

To Whom It May Concern:
The above named patient was seen in my office on (date of the exam) for a chiropractic evaluation of an accidental injury. Mr. Doe requested chiropractic at the time of initial injury, but your company instead referred to the "All-Medical-Doc-Health-Center," where he was examined by a medical generalist and released with pain prescription medication. He reported being quite hesitant to take any drugs, in view of the nature of his complaints. His girlfriend, a patient of mine, referred him.
History of Present Illness
The patient is a pleasant 19-year-old male that presented as a "walk-in" and asked me to see him primarily for head and neck injuries sustained during airline travel during the holidays. He had slipped and fell, struck the back of his head, and lost consciousness. He now suffers an inability to tolerate prolonged neck-bending (required of a student during study time), and gets frequent headaches. He is also intolerant of rapid changes in head-neck positioning, and on "pain chart drawing," he described the cervical complaint as a "seven-ache" and "sharp spasm over the posterior midline cervical spine."
He describes head pain as typically morning onset, constant during variable visual affect, accompanied by nausea, generally right temple pain that can be often retro-orbital. At times of cephalgia, the cervical complaint is generally regarded as a "clicking and grating" sensation that is sharp at its worst. He regards the cephalgia as chronic duration since his accident.
Limited weightbearing radiographs were obtained of the cervical spine that revealed a sigmoid curve type, whose discs and vertebrae are of normal size, shape and configuration.
Physical Examination
Vital signs: 5' 11," 153 lbs., B/P:100/60, LA R: 16 P: 56.
HEENT: normocephalic, atraumatic, and mucus membrane clear, palpable right maxillary tender.
Neck: nonfixed thyroid gland, diffuse trigger points, right cervical.
Heart/lungs: no murmurs/gallops. Lung sounds clear to auscultation.
Abdomen: no ascites, negative bruits.
Extremities: distal and proximal pulses full, regular, strong.
Orthopedic, Neurological and Chiropractic Evaluation
Pain with photophobia is directed at the suboccipital, right upper trapezium regions and midcervical left lateral flexor group. No signs for dural tension and nuchal rigidity are exhibited. Antalgic carriage head and neck, right occipital list, and myospasm and tenderness are recorded over the posterior cervical facet joints and upper trapezium. Segmental: C4, C2-3, and upper thoracic vertebrae.
Neurological and orthopedic: Cranial nerves are intact. No nystagmus or vertigo reproduced deep tendon and motor reflexes; intact upper and lower extremities with the exception of slight hyporeflexia bilateral C7 with digital palpation pain reported on provocation of posterior deltoid region. No radiculopathy apparent. Vibratory senses, intact upper extremities.
General and specific cerebral function: Intact.
Coordination disturbance (cerebellum vs. posterior columns): Intact.
Cranial nerves: As above. Trigeminal nerve motor testing yielded no clicking of temporal mandibular joints.
Motor and sensory: Muscle strength 5/5 throughout, with the exception of the right scalene and sternocleidomastoid, which are grade four with "breakaway" quality. Cervical compression and Soto-Hall test are positive for pain. Resistive flexion yields C5 dermatomal pain sensation, primarily dominant extremity; right-sided.
Pathological and superficial reflexes: Absent.
Range of motion: goniometric:

Cervical Spine	Finding	Normal
flexion	50	60
extension	50+P right	75
bend right	30+P right	45
bend left	45	45
rotate right	50+P right	80
rotate left	60	80

Impression
1. postconcussive head trauma syndrome
2. cervical, thoracic sprain - chronic myofascial pain syndrome

Discussion
Without a CT scan of the brain it is undetermined if he experienced a cerebral contusion, secondary to the sudden acceleration caused by the slip and the deceleration caused by the fall. This causes a whipping effect of the head and neck region. It is not uncommon for subdural hematomas to manifest in a closed head injury months after the initial injury, and this provides clinical suspicion enough to monitor the patient. The fact that he experiences residual pain of the head and neck suggests a common malady of postconcussive traumatic syndrome (PCTS). Physical findings of tenderness, spasm and impaired range of motion in the cervical and upper thoracic spine indicate that these regions have suffered a sprain-strain-traction injury. Mr. Doe exhibits curve reversal, which is generally seen following an injury of this nature. The curvature change is compensatory to the injured ligaments and adjacent muscles and facet or joints. The headaches are the result of the head injury and paraspinous spasm in the cervical area, which cause pressure on the occipital nerves and postauricular nerves, leading to headaches. The patient has completed four chiropractic care sessions of the head, neck and upper thoracic region, with very good response and significant reduction in headache frequency and duration. If his headaches return, he may require a referral to neurology. I have agreed to continue to address this patient's head and neck complaints, as needed, for any head/neck pain he may experience. His treatment frequency shall be 2-3 times per week for 4-6 weeks. During the interim, I shall prescribe specific exercises to strengthen the opposing extensor cervical musculature, and flexor cervical stretches to alleviate his cervical myospasm.

_____
(signature of DC)

Clinically Important Head Injuries

The following shall serve as a condensed review of the various types and presentations of head injuries for those in my profession. I shall review cervical conditions with my colleagues, some of whom I am certain possess far better clinical judgment than I in these entities.

1. Cerebral Contusion

   When acceleration-deceleration forces are applied to the head, the brain is driven into or over sharp bony outcroppings in the skull. This can produce tissue and vascular damage, resulting in contusions or lacerations of the brain. Depending on where the contusion is, the neurological deficit may be evident. The findings will usually localize the injury near the site of the blow on the head (*coup*) or the opposite hemisphere (*contrecoup*). Frontal and temporal lobes are common sites of *contrecoup* contusions, as the occiput is frequently a site of injury.

2. Concussion

   This traditionally refers to loss of consciousness, however brief at the time of trauma. Concussion has been graded in levels of I-IV. For my chiropractic colleagues, grades I-II are most likely to be encountered in our clinical practices and require brief review:

- Grade I: transient confusion, rapid return to normal state, no amnesia.

- Grade II: increased confusion and some residual posttraumatic amnesia.

1. Chronic Postconcussion Syndrome

   This is a chronic condition of the patient who has developed healed residuals,generally three months postinjury. Postconcussion (or posttraumatic) syndrome refers to persistent headache and associated symptoms usually beginning hours to days after minor head trauma.

   Associated symptoms include: sleep disorders, such as insomnia; personality changes, such as angry outbursts, fatigue, vertigo (difficult to determine because cervical facetal injury may be causative for vertigo as well); and performance inconsistencies such as impaired memory, difficulty handling multiple tasks and reduced attention spans.

   Hematomas

   Traumatic intracranial hematomas can produce such devastating neurological consequences that they must be discussed briefly. I always recommend a neurological referral if a clinical suspicion exists. (This may be dependent entirely on mechanism of trauma - do not wait for objective signs to appear!) I ask that you pay particular attention to the subdural hematoma.

2. Epidural Hematomas

   Bleeding occurs when blood vessels between dura and skull are torn. These hematomas are usually produced by low-velocity blows to the head, such as those that occur in fistfights; by *contrecoup* arterial tears; or by lacerations occurring as the dura is pulled away from the skull by deceleration. Such injuries may or may not be associated with skull fractures. They almost always occur from a tear in the middle meningeal artery. 15-20 percent of these victims die - even with early recognition. An epidural hematoma can create a rapid increase in intracranial pressure. It is unusual that this is presented initially to a doctor of chiropractic's office.
3. Subdural Hematomas

   These differ from epidurals in location, cause and prognosis. They are divided into acute, subacute, and chronic types, and are the result of venous bleeding. This takes place between dura and brain, and frequently is associated with damage to the underlying brain tissue.

   An example of the cause of an acute hematoma is a high-velocity motor vehicle accident. The prognosis for this is grave, because of underlying brain injury, 50-80 percent die, even with early intervention. Subacute hematomas have a slower onset than acute, reflecting less brain damage. Their prognosis is better than grave, with a 25-percent mortality rate.

   Chronic hematomas may present weeks or months after what seems a minor head injury, and may initially present to a doctor of chiropractic's office. Small vessels that bridge the subdural spaces are torn, and blood slowly accumulates in the subdural space or between layers of dura. The initial trauma may go unnoticed. Signs and symptoms include personality changes and persistent headaches. Chronic subdurals have a mortality rate of about 50 percent - almost as high as that for acute.
4. Intracerebral Hematomas

   Hemorrhage can also occur in the brain tissue due to lacerations. Symptoms depend on the area of the brain in which bleeding occurs. Seizures are common. This can occur when decelerating head injuries drag the brain across the bony outcroppings in the skull.

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