Dynamic Chiropractic

PAIN RELIEF / PREVENTION

Chiropractic Care for Chronic Pain: A New Model, Part 2

Ronald J. Farabaugh, DC

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Inappropriate Denials - A Change in the Paradigm

To date, most of the denials for chronic care have been based on the wrong filters: "Is care passive?" and/or "Will care improve the condition? Is there a therapeutic benefit?" These criteria used to evaluate care simply are not consistent with current research, clinical experience, reality or the basic design of the HPP system. Consider most of the available treatments for back pain:

- chiropractic or osteopathic manipulation;
- drugs;
- physical therapy (electric stim, ultrasound, ice, heat, etc.);
- massage;
- epidural injections;
- facet injections;
- physical rehabilitation;
- exercises;
- patient education;
- NSAIDs; and
- surgery.

Can any of these treatments, including home management, exercise and NSAIDs, survive the review criteria of "Is care passive?" or "Will treatment improve the condition?" The answer is unequivocally *no*. All the above-mentioned care is passive, with the exception of exercise. But exercise will not improve the condition. The chronic patient already has attained maximal therapeutic benefit with some degree of permanent, soft-tissue residual damage.

As previously noted, research on the effectiveness and compliance with exercise is very limited. The very definition of "chronic" means the patient no longer is capable of improving beyond the level of recovery already attained. Since no treatment, including NSAIDs and exercise, will advance the condition, should the patient be denied all treatment? Again, the answer under the workers' compensation system is *no*.

"What is the new paradigm? What filters - review criteria - should be used to judge the need for care?"

So, how should your MCO review chronic care treatment to assure that it is legitimate? Few would argue that the proper way to review treatment is to focus on function and return to work, not just pain relief.

If a condition has advanced to a chronic pain state, the patient is not likely to reach a higher level of recovery with any treatment. The condition is permanent. The symptoms come and go due to the

weakness created by the original injury, in combination with the physical nature of the job or daily stresses. The issue and goal at that point become twofold: What can be done to maximize function and what can be done to keep this patient employed?

No longer should an MCO or employer ask an IME reviewer to judge a case on the issues of "passive" and "therapeutic gain," for these terms are irrelevant compared to function and employment. It remains the POR's job to determine the treatment, or combination of treatments, that will keep the injured worker "functional" and "employed." If one were to apply those two criteria to determine medical necessity, the entire authorization landscape changes.

In mild, uncomplicated chronic cases, exercise alone may be enough to control the problem and keep the patient employed. At other times, exercise in combination with spinal manipulation and home therapy may be enough. In more extreme cases, periodic injections, rehabilitation or even surgery may become necessary in chronic cases that deteriorate with time.

Bottom line: It is the "treating" doctor's choice, based on the clinical history of the patient, that should be the driver in treatment recommendations. We must begin to think in terms of function and employability, not just pain relief. The POR and case manager should work in "partnership" to resolve any treatment issues.

"Documentation - What does it take to justify ongoing care?"

Clinical evidence suggests most patients do not require ongoing care due to their original injury. However, since moderate to severe injuries may heal with significant residual weakness, it is imperative to determine not only the causality, but also the minimum amount of treatment needed to control the problem. Therefore, the POR should provide a few key elements within the documentation to justify the need for ongoing care. Minimal elements may include (but are not limited to) the following: A statement relating the current pain to the original injury; and evidence/statements that treatment is beneficial in maximizing function and keeping the patient employed.

Other key elements useful in documenting the causality and need for ongoing care may include (but are not limited to) the following:

1. description of the mechanism of injury;
2. description of the injury/allowed conditions in the claim;
3. history of a pain (consistent or episodic) since the original injury;
4. evidence of residual weakness resulting in recurrent pain (instability);
5. complicating factors that interfere with full recovery;
6. periodic examinations to monitor the success or failure of treatment;
7. pain charts, functional disability scores, examination results (subjective and objective findings);
8. second opinion reports;
9. diagnostic testing reports;
10. a brief case summary, which includes a statement of how well the patient functions between appointments/treatments; and
11. nature of employment.

When the HPP program was implemented, it created a huge information gap between the providers and the MCOs. Why? The original file located in the BWC office may be six inches thick with medical and administrative information, but that file was not transferred to the MCOs. As a result, the MCOs usually have in their possession minimal information (many times just a few pages of documentation) on "current" treatment, but they do not have any historical perspective on the

patient or past treatment.

With a lack of historical perspective, a perception is erroneously created that the POR has done a poor job of documentation. In reality, the POR may have submitted dozens of pages of documentation over the past several years. Therefore, the MCOs, PORs and employers must acknowledge this system deficiency and work together in true partnership in an effort to determine the future needs of the patients we serve.

"Are Milliman and Robertson appropriate when determining the needs of a chronic pain patient?"

No! Milliman and Robertson's own publication, *Healthcare Management Guidelines, Questions and Answers,* specifically states in the opening paragraph:

"The Milliman and Robertson Healthcare Management Guidelines (HMGs) are a set of *optimal* clinical practice benchmarks for treating common conditions for patients who have *no complications*" [emphasis added]. It further states that "They are not a prescription, a decision tree, or a set of rules for the practice of medicine. *They show what can be accomplished under the best circumstances* [emphasis added] and are not meant as a substitute for a physician's judgment about an individual patient. As noted, *the goals set are for the uncomplicated patient* (i.e., a patient whose treatment proceeds as anticipated)."

Most important is the following statement by M & R: "Anyone who uses the HMGs as a basis for denying authorization for treatment without proper consideration of the unique characteristics of each patient or as a basis for denying payment for the treatment received is using our guidelines inappropriately."[21]

Clearly M & R is deficient as a tool to judge the treatment appropriateness of chronic pain patients, which by the very definition are complicated cases. Therefore, consultants, MCOs and employers who deny care to chronic pain patients based on M & R simply are wrong. Care should never be denied without considering the complicated nature of chronic pain, and/or the complicated factors with the individual patient.

"What is an appropriate level of chiropractic supportive care for a chronic pain patient?"

The Ohio State Chiropractic Association's *Chiropractic Treatment Guidelines* clearly identify various levels of supportive care. Like M & R, these guidelines should not be used as a "cookbook" for treatment. The individual characteristics of each patient, in combination with the POR's professional recommendations, should always be considered in treatment allowance. In general, the following will serve as a guide only to understand the commonly accepted level of intervention for chronic pain patients:

1. 1-4 visits per month utilizing spinal manipulation and 1-2 therapy modalities (1-2 visits may be the norm; however, in certain well-documented cases, up to 4 visits per month may be necessary, to be re-evaluated every 6 months);
2. home management utilizing exercise, ice/heat, ADL and ergonomic factors;
3. re-evaluation every 6-12 months; and
4. 2-6 visits per mild episode of back pain.[22]

In addition to the above-mentioned services, often a multidisciplinary approach is preferred, utilizing DC, MD, DO and/or PT providers. Often, a combination of treatments is more beneficial than any one singular treatment, especially as it pertains to chronic pain patients.

In summary, it remains my position that to date, the HPP system has unfairly targeted and

terminated chiropractic care for chronic pain patients. The preliminary study reported by Milliman and Robertson (based upon BWC data) at the Atwood Retreat in November 1999, suggests that as the system drastically decreased utilization of chiropractic services, there was a corresponding increase in drug utilization. Meanwhile, the HPP system to date has had negligible impact on return-to- work rates, except for lumbar herniated disc injuries, which actually worsened by 10 percent.[23]

I believe the short-sighted efforts to decrease chiropractic care likely will result in very deleterious effects to injured workers and return-to- work rates, due to the increased utilization of drugs to control pain. The current efforts to minimize chiropractic care in Ohio are diametrically opposed to the scientific literature, the clinical experience of thousands of chiropractic providers, and the satisfaction of injured workers with chiropractic care.

I also believe that the expansion of well-managed chiropractic care will result in decreased overall costs, improved return-to-work rates, decreased reliance on drugs, and improvement of daily function and work productivity while minimizing pain and an increase in the quality of life of injured workers in Ohio. The chiropractic profession in Ohio is ready, willing and able to work in true "partnership," consistent with the original design of HPP.

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