

Pediatric Chiropractic: Are You "Experimenting" on Kids?

THIRD-PARTY PAYERS SEEM TO THINK SO

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Has a patient of yours ever received an Explanation of Benefits (EOB) or a letter from a third-party payer stating you used techniques that are "experimental and investigational"? I have heard of cases in which parents were enraged when told by an insurer that a DC was "experimenting" on their children. Such terminology conjures up images of Dr. Frankenstein or the [Tuskegee syphilis study](#).

I was mortified when I first heard that some third-party payers are refusing to cover chiropractic services for children under age 12 or care for nonmusculoskeletal conditions in children (and adults) of any age. I have yet to find any literature support, of high or low quality, to support the 12-year-old benchmark.

Doctors of chiropractic have been adjusting children for more than 100 years, and such care has not been limited to the episodic treatment of musculoskeletal pain syndromes. So, who makes the determination of what constitutes an experimental or investigational procedure? The third-party payer. For example, one carrier's definition states, in part, "Treatments, procedures, equipment, drugs, devices, or supplies (hereinafter called services) which are, in our judgment, experimental or investigational for the diagnosis of the enrollee being treated are excluded." Yep. They decide. It's in the contract.

An examination of the current state of conventional medical pediatric practice will show that a double standard is being applied. The off-label use of drugs in children is the rule, not the exception. Benjamin, et al., report that three-fourths of the prescription drugs on the market [do not have labeling indications for children](#), leaving their use in children to physicians' discretion.¹ Furthermore, almost 80 percent of hospitalized children get drugs that are not approved for pediatric use.

What are the consequences of this? According to Shah, et al., "Using drugs that have been insufficiently studied in children has [contributed to adverse outcomes](#), which have been documented in the medical literature."² This leads to a guessing game that can most kindly be characterized as "experimental," if not downright reckless. As Nightingale states, "Physicians who treat children often prescribe drugs for off-label uses because [little information is available](#) from well-controlled studies on dosage, formulation, effectiveness and safety in children."³

The clinical implications of off-label prescribing are significant. Seventy-three percent of off-label uses lack evidence of clinical efficacy. The [greatest disparity](#) between supported and unsupported off-label uses is found among prescriptions for psychiatric uses (4 percent strong support vs. 96 percent limited or no support) and allergies (11 percent strong support vs. 89 percent limited or no support).⁴

Adverse drug reactions (ADRs) are a serious problem in pediatric medicine. The incidence of preventable ADRs in children is similar to that found in adult literature. [More than half](#) of the reported ADRs resulted in treatment intervention and/or temporary patient harm.⁵ A study found that in-hospital medical errors are responsible for the [deaths of nearly 4,500 children](#) in the United States every year.⁶ "The bottom line is that [none of these events should have happened](#)," said Dr. Marlene R. Miller, the study's lead author and director of quality and safety initiatives at the [Johns Hopkins Children's Center](#) in Baltimore.⁷

There were [3.8 million children](#) under the age of 19 hospitalized in the United States in 1997. This means that in one year, there are 79,000 children (2 percent of 3.8 million children) admitted to the hospital because of ADRs, and 31,000 of these children suffer life-threatening adverse reactions.⁸

If these figures seem shocking, says clinical pharmacologist Alastair J.J. Wood, an associate dean at Vanderbilt Medical School in Nashville, consider that some studies suggest the [FDA Adverse Events Reporting System](#) database may capture [only up to 10 percent](#) of drug-induced side effects and deaths; "maybe even less than 1 percent."⁹ That's right. The numbers previously cited may be one or two orders of magnitude too low.

In the interest of intellectual honesty, let's look at what has been reported in the literature concerning the adverse effects purportedly associated with chiropractic care. A review of literature by Vohra, et al., found [14 reported cases](#) of "direct" adverse effects attributed to spinal manipulation.¹⁰ Ten of these were associated with chiropractors. That's it. Ten was all they found in eight databases, each searched since their inception.

The authors correctly noted that causation and incidence cannot be inferred, and that more research is needed. They also stated: "Given the large numbers of children who have received spinal manipulation during the decades assessed by our search strategy, adverse events resulting from spinal manipulation are either remarkably rare or under-reported." Furthermore, no distinction was made between spinal manipulation and specific chiropractic adjustments. The authors also reported 20 reports of "indirect" harm due to such things as delayed diagnosis. No mention was made of cases of delayed diagnosis in medical practice.

The take-home message is simple. We must aggressively counter allegations that suggest chiropractic care for children is dangerous or inappropriate. To do so, we need the intellectual ammunition to show we have a classic case of the pot calling the kettle black. This article will give you a few rounds. While you're at it, review some of the resources supporting pediatric chiropractic.¹¹⁻¹⁴

References

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To learn more about recent actions by media and third-party payers challenging pediatric chiropractic, read "[Pediatric Chiropractic in the Spotlight](#)" (March 12 DC) and "[Nightline in the Dark About Chiropractic?](#)" (April 22 DC).

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