Dynamic Chiropractic

DIAGNOSIS & DIAGNOSTIC EQUIP

Functional Capacity Testing

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The reality of health care in this day and age is that everything has to be clearly documented. Taking a moment to capture a few "golden nuggets" can make all the difference in your ability to treat your patient and document it properly. Functional capacity testing helps fill this need.

Functional capacity testing is exactly what it sounds like – measuring aspects of a patient's functional capacity within a work or ADL situation. (*Note*: *Functional capacity testing* is the term usually used in the realm of injury care and rehabilitation; *physical capacity testing* is basically the same, but used in a non-injury case.)

VAS – the Visual Analog Scale

This is about where everyone starts: "How is your pain today on a scale of 1 to 10?" This is a good tool and a valid measure, but just documenting that the patient's pain score improves over time has little to do with functional capacity testing. How a patient feels varies as much with the injury as it does with changes in weather, barometer, medications (legal or otherwise), activity and secondary gain. It is also well-known that some patients will embellish their pain score ... not to be misleading, but to convey that they legitimately have a pain problem.

Orthopedic Testing

As with the VAS, these should be performed as a baseline in your initial assessment. As care progresses, you should re-perform these tests, either in regular intervals (e.g., every 10-12 visits) or even individual tests noted in the daily record.

Consider a test like the straight-leg raise: initially positive at 20 degrees with a positive Braggard's, but four visits later Braggard's is negative with SLR up to 45 degrees and the patient is able to flex the hip to past 70 degrees with no pain. All that shows a good functional improvement – but only if it is clearly documented along the care path.

It is also important to note that just saying "SLR is positive" is a meaningless statement that carries no clinical merit. Testing is only valid when clarified. For example, "SLR is positive at 45 degrees with pain radiating down the path of the sciatic to the knee."

Outcomes Assessment

The Oswestry and Neck Disability Index – these tests should be used all the time. If you treat Medicare patients, then you already know to use these forms. It is important to understand that these forms, in and of themselves, *are not* measures of disability – they are objective tools you can use to define a *patient's level of perceived disability* based on their complaints and how they affect ADLs.

Again, a baseline should show a level of irritation. Follow-ups should show improved pain levels, less

limitation / less limiting discomfort and an improvement in scoring.

Consider a lower back pain patient with an Oswestry of 47 who has improved their score to 26 after 10 visits – this shows that the patient's level of pain is affecting their ability to pursue their ADLs less, and that they are improving with your care. However, do not fall into the trap of saying "Oswestry testing shows a 47 percent disability" – this statement is not correct.

Range of Motion

ROM testing is another great tool for patient assessment. Again, having a baseline measure is key, as you can compare your follow-up studies to show progressive improvement. While it is OK to document that the patient has a restriction of motion, such as limited lumbar flexion, *do not* give solid numbers unless you have used a measurement tool. Eyeballing and approximating ROM scores is not a credible or reliable patient measure.

I have had patients with scoliosis spinal fusions and a completely fused lumbar spine – but they could flex over and touch their toes. This does not show 90 degree of lumbar flexion; it shows hip motion. If you only view ROM, you can only comment generally on the patient's status: "Lumbar flexion is limited by spasm in the lower back."

Computerized dual inclinometry testing is currently the standard for ROM testing. You have to show at least three repetitions within 5 degrees or 10 percent for validity. But taking the time to do this testing will provide clear, objective, credible data of a patient's limited motion. Follow-up testing will also yield credible measures of the patient's improvement with your care.

Observation

One final thought is with regards to *observation*. Be alert and watch your patient throughout the scope of their visit. If a patient indicates sharp back pain with the SLR and grossly limited ROM, but is able to hop up and bend over to look through magazines in your waiting room, take note of the discrepancy. You should be paying attention to the patient at all times to observe the signs that allow you to make an appropriate determination of their pain complaints and objective status.

Tools for Your Clinical Toolbox

There are a number of other testing options that can and should be included in this list – muscle testing, reflexes, imaging studies, algometry and sensory testing are a few. You need to make sure you can clearly, objectively show how your care is providing measured benefit to the patient. Again, "feels good" is a great note, but it carries little weight beyond suggesting palliative relief (and patients can get that with medications).

Find what tools are relevant to the patient's care and clearly document how your care is progressively improving the patient's condition. It's well-worth the time spent.

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