Clinical Practice Guideline: Chiropractic Care for Low Back Pain
Consensus Statements for Public Comment

The consensus statements below are the result of updates to three previously published documents\textsuperscript{a,b,c} as well as an updated systematic review. Consensus was reached by a multidisciplinary Delphi panel of practitioners and academicians, using formal consensus methodology. Permission has been granted by \textit{Journal of Manipulative and Physiological Therapeutics}\textsuperscript{a,b} and \textit{Topics in Integrative Health Care}\textsuperscript{c} to temporarily post this material.

\begin{itemize}
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\textbf{Note: in the document below, superscripted references are not in sequence because this document is excerpted from the full paper, which includes the description of methodology and the systematic review.}

The verbatim evidence-informed consensus-based seed statements, as approved by the Delphi panel, are presented below. The majority of these statements were unchanged from the previous documents\textsuperscript{6,19,20} the new language is indicated with italics.

\textbf{General considerations}

Most acute pain, typically the result of injury (micro-or macrotrauma), responds to a short course of conservative treatment (see Table 3, next page). If effectively treated at this stage, patients often recover with full resolution of pain and function, although recurrences are common. Delayed or inadequate early clinical management may result in increased risk of chronicity and disability. Furthermore, those responding poorly in the acute stage and those with increased risk factors for chronicity must also be identified as early as possible.
Table 3. Frequency and duration for trial(s) of chiropractic treatment

<table>
<thead>
<tr>
<th>Stage</th>
<th>Trials of Care</th>
<th>Re-evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute* and subacute*</td>
<td>2-3 x weekly, 2-4 weeks</td>
<td>2-4 weeks (per trial)</td>
</tr>
<tr>
<td>Recurrent/flare-up</td>
<td>1-3 x weekly, 1-2 weeks</td>
<td>1-2 weeks</td>
</tr>
<tr>
<td>Chronic**</td>
<td>1-3 x weekly, 2-4 weeks</td>
<td>2-4 weeks</td>
</tr>
<tr>
<td>Exacerbation (mild) of chronic**</td>
<td>1-6 visits per episode</td>
<td>At beginning of each episode of care</td>
</tr>
<tr>
<td>Exacerbation (moderate or severe) of chronic**</td>
<td>2-3 x weekly for 2-4 weeks</td>
<td>Every 2-4 weeks, following acute care guidelines</td>
</tr>
<tr>
<td>Scheduled ongoing care for management of chronic pain**</td>
<td>1-4 visits per month</td>
<td>At minimum every 12 visits, or as necessary to document condition changes.</td>
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</table>

* For acute and subacute stages; up to 12 visits per trial of care. If additional trials of care are indicated, supporting documentation should be available for review, including, but not necessarily limited to: documentation of complicating factors and/or comorbidities coupled with evidence of functional gains from earlier trial(s). Efforts towards self-care recommendations should be documented.

** For chronic presentations, exacerbations and scheduled ongoing care for management of chronic pain; additional care must be supported with either evidence of functional improvement or functional optimization. Such presentations may include, but are not limited to: (1) substantial symptom recurrences following treatment withdrawal, (2) minimization/control of pain, (3) maintenance of function and ability to perform common ADLs, (4) minimization of dependence on therapeutic interventions with greater risk(s) of adverse events, and (5) care which maintains or improves capacity to perform work. Efforts towards self-care recommendations should be documented.

Clinicians must continually be vigilant for the appearance of clinical red flags (see clinical red flags section below) that may arise at any point during patient care. In addition, bio-psychosocial factors (also known as clinical yellow flags) should be identified and addressed as early as possible as part of a comprehensive approach to clinical management.

Chiropractic doctors are skilled in multiple approaches of functional assessment and treatment. Depending on the clinical complexity, DCs can work independently or as part of a multidisciplinary team approach to functional restoration of patients with acute and chronic low back pain.

It is the ultimate goal of chiropractic care to improve patients’ functional capacity and educate them to independently accept the responsibility for their own health.

Informed consent

Informed consent is the process of proactive communication between a patient and physician that results in the patient’s authorization or agreement to undergo a specific medical intervention. Informed consent should be obtained from the patient, performed within the local and/or regional standards of practice.
Examination procedures

Thorough history and evidence-informed examination procedures are critical components of chiropractic clinical management. These procedures provide the clinical rationale for appropriate diagnosis and subsequent treatment planning. Assessment should include but is not limited to:

- Health history (e.g., pain characteristics, red flags, review of systems, risk factors for chronicity)
- Specific causes of LBP (e.g., aortic aneurysm, inflammatory disorders)
- Examination (e.g., reflexes, dermatomes, myotomes, orthopedic tests)
- Diagnostic testing (indications) for red flags (e.g., imaging and laboratory tests)

Routine imaging or other diagnostic tests are not recommended for patients with nonspecific low back pain. Imaging and other diagnostic tests are indicated in the presence of severe and/or progressive neurologic deficits or if the history and physical examination cause suspicion of serious underlying pathology. Patients with persistent LBP accompanied by signs or symptoms of radiculopathy or spinal stenosis should be evaluated, preferably, with magnetic resonance imaging or computed tomography. Imaging studies should be considered when patients fail to improve following a reasonable course of conservative care, or when there is suspicion of an underlying anatomical anomaly, such as spondylolisthesis, moderate to severe spondylosis, post-trauma with worsening symptomatology (consider imaging, referral or comanagement) with evidence of persistent or increasing neurological (i.e. reflex, motor & or sensory) compromise or other factors which might alter the treatment approach. Lateral view flexion/extension studies may be warranted to assess for mechanical instability due to excessive intervertebral translation and/or wedging. Imaging studies should be considered only after careful review and correlation of the history and examination.

Severity and Duration of Conditions

Conditions of illness and injury are typically classified by severity and/or duration. Common descriptions of the stages of illness and injuries are acute, subacute, chronic, and recurrent, and further subdivided into mild, moderate, and severe.

- Acute—symptoms persisting for less than 6 weeks.
- Subacute—symptoms persisting between 6 and 12 weeks.
- Chronic—symptoms persisting for at least 12 weeks' duration.
- Recurrent/flare-up—return of symptoms perceived to be similar to those of the original injury at sporadic intervals or as a result of exacerbating factors.

Treatment frequency and duration

Although most patients respond within anticipated time-frames, frequency and duration of treatment may be influenced by individual patient factors or characteristics that present as barriers to recovery (e.g., comorbidities, clinical yellow flags). Depending on
these individualized factors, additional time and treatment may be required to observe a therapeutic response. The therapeutic effects of chiropractic care/treatment should be evaluated by subjective and/or objective assessments after each course of treatment (see Outcome Measurement).

Recommended therapeutic trial ranges are representative of typical care parameters. A typical initial therapeutic trial of chiropractic care consists of 6 to 12 visits over a 2- to 4-week period, with the doctor monitoring the patient’s progress with each visit to ensure that acceptable clinical gains are realized (see Table 3, p. 2).

For acute conditions, fewer treatments may be necessary to observe a therapeutic effect and to obtain complete recovery. Chiropractic management is also recommended for various chronic low back conditions where repeated episodes (or acute exacerbations) are experienced by the patient, particularly when a previous course of care has demonstrated clinical effectiveness and reduced the long-term use of medications.

Initial course of treatments for low back disorders

In order to be consistent with an evidence-based approach, doctors of chiropractic should utilize clinical methods that generally reflect the best available evidence, combined with clinical judgment, experience and patient preference. For example, currently the most robust literature regarding manual therapy for low back pain is based primarily on high-velocity, low-amplitude (HVLA) techniques and mobilization (such as flexion-distraction). Therefore, in the absence of contraindications, these methods are generally recommended. However, best practices for individualized patient care, based on clinical judgment and patient preference, may require alternative clinical strategies for which the evidence of effectiveness may be less robust.

The treatment recommendations that follow, based on clinical experience combined with the best available evidence, are posited for the “typical” patient and do not include risk stratification for complicating factors.

An initial course of chiropractic treatment typically includes 1 or more “passive” (i.e., non-exercise) manual therapeutic procedures (i.e., spinal manipulation or mobilization) and physiotherapeutic modalities for pain reduction, in addition to patient education designed to reassure and instill optimal strategies for independent management. The initial visits allow the doctor to explain that the clinician and the patient must work as a proactive team and to outline the patient’s responsibilities. Although passive care methods for pain or discomfort may be initially emphasized, “active” (i.e., exercise) care should be increasingly lists appropriate frequency and duration ranges for trials of chiropractic treatment for different stages of LBP.

Reevaluation and Reexamination

After an initial course of treatment has been concluded, a detailed or focused reevaluation should be performed. The purpose of this reevaluation is to determine whether the patient has made clinically meaningful improvement. A determination of the
necessity for additional treatment should be based on the response to the initial trial of care and the likelihood that additional gains can be achieved.

As patients begin to plateau in their response to treatment, further care should be tapered or discontinued depending on the presentation. A reevaluation is recommended to confirm that the condition has reached a clinical plateau or has resolved. When a patient reaches complete or partial resolution of their condition and all reasonable treatment and diagnostic studies have been provided, then this should be considered a final plateau (maximal therapeutic benefit). The DC should perform a final examination, typically following a trial of therapeutic withdrawal, to verify that maximum therapeutic benefit has been achieved and provide any necessary patient education and instructions in effective future self-management, and/or the possible need for future chiropractic care to retain the benefits achieved.

**Continuing course of treatment**

If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow-up course of treatment may be indicated. However, one of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. Patients also need to be encouraged to return to usual activity levels, as well as to avoid catastrophizing and overdependence on physicians, including DCs. The frequency of continued treatment generally depends on the severity and duration of the condition. Patients who are interested in wellness care (formerly called “maintenance care”26) should be given those options as well.

When the patient's condition reaches a plateau, or no longer shows ongoing improvement from the therapy, a decision must be made on whether the patient will need to continue treatment. Generally, progressively longer trials of therapeutic withdrawal may be useful in ascertaining whether therapeutic gains can be maintained absent treatment.

In a case where a patient reaches a clinical plateau in their recovery (maximum therapeutic benefit) and has been provided reasonable trials of interdisciplinary treatments, additional chiropractic care may be indicated in cases of exacerbation/flare-up, or when withdrawal of care results in substantial, measurable decline in functional or work status. Additional chiropractic care may be indicated in cases of exacerbation/flare-up in patients who have previously reached MTB, if criteria to support such care (substantive, measurable prior functional gains with recurrence of functional deficits) have been established.
Outcome Measurement

For a trial of care to be considered beneficial, it must be substantive, meaning that a definite improvement in the patient's functional capacity has occurred. Examples of measurable outcomes and activities of daily living and employment include:

1. Pain scales such as the visual analog scale and the numeric rating scale.
2. Pain diagrams that allow the patient to demonstrate the location and character of their symptoms.
3. Validated activities of daily living measures, such as the Revised Oswestry Back Disability Index and the Roland Morris Back Disability Index, RAND 36, Bournemouth Disability Questionnaire.
4. Increases in home and leisure activities, in addition to increases in exercise capacity.
5. Increases in work capacity or decreases in prior work restrictions.
6. Improvement in validated functional capacity testing, such as lifting capacity, strength, flexibility, and endurance.

Spinal range of motion assessment

Range of motion testing may be used as a part of the physical examination to assess for regional mobility, although evidence does not support its reliability in determining functional status.27

Cautions and contraindications

Chiropractic-directed care, including patient education, passive and active care therapy, is a safe and effective form of healthcare for low back disorders. There are certain clinical situations where high-velocity, low-amplitude manipulation or other manual therapies may be contraindicated. It is incumbent upon the treating DC to evaluate the need for care and the risks associated with any treatment to be applied. Many contraindications are considered relative to the location and stage of severity of the morbidity, whether there is co-management with one or more specialists, and the therapeutic methods being used by the chiropractic physician. Table 4 (next page) lists contraindications for high-velocity manipulation to the lumbar spine (red flags); however these do not necessarily prohibit soft tissue, low velocity, low amplitude procedures and mobilization.

Conditions contraindicating certain chiropractic-directed treatments such as spinal manipulation and passive therapy

In some complex cases where biomechanical, neurological or vascular structure or integrity is compromised, the clinician may need to modify or omit the delivery of manipulative procedures. Chiropractic co-management may still be appropriate using a variety of treatments and therapies commonly utilized by doctors of chiropractic. It is
Table 4. Contraindications for high-velocity manipulation to the lumbar spine (red flags).*

- Severe osteoporosis
- Multiple myeloma
- Osteomyelitis
- Local primary bone tumors where osseous integrity is in question
- Local metastatic bone tumors
- Paget's disease

**Neurologic conditions**
- Progressive or sudden (i.e. cauda equine syndrome) neurologic deficit
- Spinal cord tumors that clinically demonstrate neurological compromise or require specialty referral.

In cases where the neoplasm has been properly assessed and is considered to be clinically quiescent and/or perhaps distant to therapeutic target site, then chiropractic manipulative therapy may be utilized.

**Inflammatory conditions**
- Rheumatoid arthritis in the active systemic, stage, or locally in the presence of inflammation or atlantoaxial instability.
- Inflammatory phase of ankylosing spondylitis
- Inflammatory phase of psoriatic arthritis
- Reactive arthritis (Reiter's syndrome)

**Bleeding disorder**
- Unstable congenital bleeding disorders, typically requiring specialty co-management
- Unstable acquired bleeding disorders, typically requiring specialty co-management
- Unstable abdominal aortic aneurysm

**Other**
- Structural instability (e.g., unstable spondylolisthesis)
- Inadequate physical examination
- Inadequate manipulative training and skills

*In some cases, soft tissue, low velocity, low amplitude or mobilization procedures may still be clinically reasonable and safe.

During the course of ongoing chronic pain management of spine related conditions, the provider must remain alert to the emergence of well-known and established “red flags” that could indicate the presence of serious pathology. Patients presenting with “red flag” signs and/or symptoms require prompt diagnostic workup which can include imaging, laboratory studies, and/or referral to another provider. Ignoring these “red flag” indicators increases the likelihood of patient harm. Table 4 (above) summarizes red flags that present contraindications to ongoing high velocity, low amplitude spinal manipulation.

**Management of chronic low back pain**

*Definition of “chronic pain patients.”* NOTE: Maximum therapeutic benefit (MTB) is defined as the point at which a patient’s condition has plateaued and is unlikely to improve further. Chronic pain patients are those for whom ongoing supervised treatment/care has demonstrated clinically meaningful improvement with a course of
Table 5. Conditions contraindicating certain chiropractic-directed treatments such as spinal manipulation and passive therapy

<table>
<thead>
<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>Generally the procedure or therapy is contraindicated over the relevant anatomy and not necessarily contra-indicated for other areas:</td>
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<tr>
<td>• Local open wound or burn</td>
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<tr>
<td>• Prolonged bleeding time/hemophilia</td>
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<tr>
<td>• Pacemaker (contraindicated modality—electrotherapy)</td>
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<tr>
<td>• Joint infection</td>
</tr>
<tr>
<td>• Tumors/cancer</td>
</tr>
<tr>
<td>• Recent/healing fracture</td>
</tr>
<tr>
<td>• Increasing neurologic deficit</td>
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</tbody>
</table>
| • In cases of spinal internal fixation (i.e. fusion) or artificial joint implants, high velocity, low amplitude manipulation is contraindicated at the implant joint level (or levels in case of multi-level implantation), although soft tissue manipulation or other manual techniques may be used. (Source: World Health Organization. WHO Guidelines on Basic Training and Safety in Chiropractic. Geneva: WHO, 2005.)

Conditions requiring co-management

• Cancer pain
• Postoperative surgical pain

Conditions requiring referral

Patients should be referred to another specialty health care practitioner or to emergency care in certain instances, such as the following:

• The patient's condition is not responding to the treatment rendered, when all reasonable alternative chiropractic methods have been exhausted.
• The patient's condition is worsening with treatment.
• The patient has a serious and/or progressive infectious condition.
• The patient experiences a medical emergency (eg, myocardial infarct, cerebrovascular accident, severe laceration, pneumothorax).
• Increasing neurologic deficits (ie, cauda equine syndrome).

management and have reached MTB, but in whom significant residual deficits in activity performance remain or recur upon withdrawal of treatment. The management for chronic pain patients ranges from home-directed self-care to episodic care to scheduled ongoing care. Patients who require provider-assisted ongoing care are those for whom self-care measures, while necessary, are not sufficient to sustain previously achieved therapeutic gains; these patients may be expected to progressively deteriorate as demonstrated by previous treatment withdrawals.

Chronic care goals

• Minimize lost time on the job
• Support patient's current level of function/ADL
• Pain control/relief to tolerance
• Minimize further disability
• Minimize exacerbation frequency and severity
• Maximize patient satisfaction
• Reduce and/or minimize reliance on medication
Application of chronic pain management

Chronic pain management occurs after the appropriate application of active and passive care including lifestyle modifications. It may be appropriate when rehabilitative and/or functional restorative and other care options, such as psychosocial issues, home-based self-care and lifestyle modifications, have been considered and/or attempted, yet treatment fails to sustain prior therapeutic gains and withdrawal/reduction results in the exacerbation of the patient's condition and/or adversely affects their activities of daily living (ADLs).

Ongoing care may be inappropriate when it interferes with other appropriate care or when the risk of supportive care outweighs its benefits, that is, physician dependence, somatization, illness behavior, or secondary gain. However, when the benefits outweigh the risks, ongoing care may be both medically necessary and appropriate.

Appropriate chronic pain management of spine-related conditions includes addressing the issues of physician dependence, somatization, illness behavior, and secondary gain. Those conditions that require ongoing supervised treatment after having first achieved MTB should have appropriate documentation that clearly describes them as persistent or recurrent conditions. Once documented as persistent or recurrent, these chronic presentations should not be categorized as “acute” or uncomplicated.

Factors affecting the necessity for chronic pain management of low back pain

Prognostic factors that may provide a partial basis for the necessity for chronic pain management of LBP after MTB has been achieved include:

- Older age (pain and disability)
- History of prior episodes (pain, activity limitation, disability)
- Duration of current episode >1 month (activity limitation, disability)
- Leg pain [for patients having LBP] (pain, activity limitation, disability)
- Psychosocial factors [depression (pain); high fear-avoidance beliefs, poor coping skills (activity limitation); expectations of recovery]
- High pain intensity (activity limitation; disability)
- Occupational factors [higher job physical or psychological demands (disability)]

The list above is not all-inclusive and is provided to represent prognostic factors most commonly seen in the literature. Other factors or comorbidities not listed above may adversely affect a given patient’s prognosis and management. These should be documented in the clinical record and considered on a case-by-case basis.

Each of the following factors may complicate the patient’s condition, extend recovery time, and result in the necessity of ongoing care:

- Nature of employment/work activities or ergonomics: The nature and psychosocial aspects of a patient's employment must be considered when evaluating the need for ongoing care (e.g. prolonged standing posture, high loads, and extended muscle activity).
• Impairment/disability: The patient who has reached MTB, but has failed to reach pre-
injury status has an impairment/disability even if the injured patient has not yet
received a permanent impairment/disability award.
• Medical history: Concurrent condition(s) and/or use of certain medications may affect
outcomes.
• History of prior treatment: Initial and subsequent care (type and duration), as well as
patient compliance and response to care, can assist the physician in developing
appropriate treatment planning. Delays in the initiation of appropriate care may
complicate the patient’s condition and extend recovery time.
• Lifestyle habits: Lifestyle habits may impact the magnitude of treatment response,
including outcomes at MTB.
• Psychological factors: A history of depression, anxiety, somatoform disorder or other
psychopathology may complicate treatment and/or recovery.

Treatment withdrawal fails to sustain MTB
Documented flare-ups/exacerbations (that is, increased pain and/or associated
symptoms, which may or may not be related to specific incidents), superimposed on a
recurrent or chronic course, may be an indication of chronicity and/or need for ongoing
care.

Complicating/risk factors for failure to sustain MTB
Table 6 (next page) lists complicating factors that may document the necessity of
ongoing care for chronic spine-related conditions. Such lists of complicating/risk factors
are not all-inclusive. Individual factors from this list may adequately explain the
condition chronicity, complexity and instability in some cases. However, most chronic
cases that require ongoing care are characterized by multiple complicating factors.
These factors should be carefully identified and documented in the patient's file to
support the characterization of a condition as chronic.
Table 6 summarizes complicating factors.

Table 6. Complicating factors that may document the necessity of ongoing care for chronic conditions:

- Severity of symptoms and objective findings
- Patient compliance and/or non-compliance factors
- Factors related to age
- Severity of initial mechanism of injury
- Number of previous injuries (>3 episodes)
- Number and/or severity of exacerbations
- Psycho-social factors (pre-existing or arising during care)
- Pre-existing pathology or surgical alteration
- Waiting >7 days before seeking some form of treatment
- Ongoing symptoms despite prior treatment
- Nature of employment / work activities or ergonomics
- History of lost time
- History of prior treatment
- Lifestyle habits
- Congenital anomalies
- Treatment withdrawal fails to sustain MTB

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>Injury characteristics</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older age</td>
<td>Severe initial injury</td>
<td>Pre-existing pathology/surgery</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>&gt; 3 previous episodes</td>
<td>History of lost time</td>
</tr>
<tr>
<td>Psychosocial factors</td>
<td>Severe signs and symptoms</td>
<td>History of prior treatment</td>
</tr>
<tr>
<td>Delay treatment &gt;7 days</td>
<td>Number/severity previous exacerbations</td>
<td>Congenital anomalies</td>
</tr>
<tr>
<td></td>
<td>Treatment withdrawal fails to sustain MTI</td>
<td>Symptoms persist despite previous treatment</td>
</tr>
</tbody>
</table>

* This list is not all-inclusive. Source: Farabaugh RJ, Dehen MD, Hawk C. Management of chronic spine-related conditions: Consensus recommendations of a multidisciplinary panel. J Manipulative Physiol Ther 2010; 33(7): 484-492.


Risk factors for the transition of acute/subacute spine-related conditions to chronicity (yellow flags)

A number of prognostic variables have been identified as increasing the risk of transition from acute/subacute to chronic nonspecific spine-related pain. However, their independent prognostic value is low. A multi-dimensional model, that is, a number of clinical, demographic, psychological and social factors are considered simultaneously, has been recommended. This model emphasizes the interaction among these factors, as well as the possible overlap between variables such as pain beliefs and pain behaviors.

Chronicity may be described in terms of pain, and/or activity limitation (function), and/or work disability. Risk factors for chronicity have been categorized by similar domains:
Factors directly associated with the clinician/patient encounter may influence the transition to chronicity:

- Treatment expectations: patients with high expectations for a specific treatment may contribute to better functional outcomes if they receive that treatment.
- Significant others' support: patients' risk of chronicity may be reduced when family members encourage their participation in social and recreational activities.

**Diagnosis of chronic LBP**
The diagnosis should never be used exclusively to determine need for care (or lack thereof). The diagnosis must be considered with the remainder of case documentation to assist the physician or reviewer in developing a comprehensive clinical picture of the condition/patient under treatment.

**Clinical re-evaluation Information**
Clinical information obtained during re-evaluation that may be used to document the necessity of chronic pain management for persistent or recurrent spine-related conditions includes, but is not limited to:

- Response to date of care management for the current and previous episodes.
- Response to therapeutic withdrawal (either gradual or complete withdrawal) or absence of care.
- MTB has been reached and documented.
- Patient-centered outcome assessment instruments.
- Analgesic use patterns.
- Other health care services used.

**Clinical re-evaluation Information to document necessity for ongoing care of chronic LBP**
In addition to standard documentation elements (i.e., date, history, physical evaluation, diagnosis and treatment plan, the clinical information typically relied upon to document the necessity of ongoing chronic pain management includes:

- Documentation of having achieved a clinically meaningful favorable response to initial treatment, or documentation that the plan of care is to be amended
- Documentation the patient has reached MTB
- Significant residual deficits in activity limitations are present at MTB
- Documented attempts of transition to primary self-care
- Documented attempts and/or consideration of alternative treatment approaches
- Documentation of those factors influencing the likelihood that self-care alone will be insufficient to sustain or restore MTB

Once the need for additional care has been documented, findings of diagnostic/assessment procedures that may influence treatment selection include:

- neurological/provocative testing (standard neurological testing, orthopedic tests, manual muscle testing);
- diagnostic imaging (x-ray, computed tomography, magnetic resonance imaging);
- electrodiagnostics;
• functional movement/assessment (e.g., ambulatory assessment/limp, etc.);
• chiropractic analysis procedures;
• biomechanical analysis (pain, asymmetry, range of motion, tissue tone changes);
• palpation (static, motion);
• nutritional/dietary assessment with respect to factors related to pain management (such as vitamin D intake).

This list is provided for guidance only and is not all-inclusive. All items are not required to justify the need for ongoing care. Each item of clinical information should be documented in the case file to describe the patient's clinical status, present and past.

In the absence of documented flare-up/exacerbation the ongoing treatment of persistent or recurrent spine-related disorders is not expected to result in any clinically meaningful change. In the event of a flare-up or exacerbation, a patient may require additional supervised treatment to facilitate return to MTB status. Individual circumstances including patient preferences and previous response to specific interventions guide the appropriate services to be used in each case.

Chronic pain management components in physician-directed case management

An active care plan for chronic pain management may include, but is not restricted to, the following:

Procedures
• Spinal manipulation and/or mobilization
• Physical modalities
• Acupuncture
• Bracing/orthoses

Behavioral and exercise recommendations
• Supervised rehabilitative/therapeutic exercise
• General and/or specific exercise programs
• Mind/body programs (e.g., yoga, Tai Chi, etc.)
• Multi-disciplinary rehabilitation
• Cognitive behavioral programs

Counseling recommendations
• ADL recommendations
• Co-management/coordination of care with other physicians/healthcare providers
• Ergonomic recommendations
• Exercise recommendations and instruction
• Home care recommendations
• Lifestyle modifications/counseling
• Pain management recommendations
• Psychosocial counseling/behavioral modification/risk avoidance counseling
• Monitoring patient compliance with self-care recommendations
Chronic pain management treatment planning

A variety of functional and physiological changes may occur in chronic conditions. Therefore, a variety of treatment procedures, modalities, and recommendations may be applied to benefit the patient. The necessity for ongoing chronic pain management of spine-related conditions for individual patients is established when there is a return of pain and/or other symptoms and/or pain-related difficulty performing tasks and actions equivalent to the appropriate minimal clinically important change value for more than 24 hours, for example, change in numeric rating scale of more than 2 points for chronic LBP.

Although the visit frequency and duration of supervised treatment vary, and are influenced by the rate of recovery toward MTB values and the individual's ability to self-manage the recurrence of complaints, a reasonable therapeutic trial for managing patients requiring ongoing care is up to 4 visits after a therapeutic withdrawal. If re-evaluation indicates further care, this may be delivered at up to 4 visits per month. Clinicians should routinely monitor a patient's change in pain/function to determine appropriateness of continued care. An appropriate re-evaluation should be completed at minimum every 12 visits. Re-evaluation may be indicated more frequently in the event a patient reports a significant or unanticipated change in symptoms and/or there is a basis for determining the need for change in the treatment plan/goals.

Scheduled ongoing chronic pain management treatment planning

When pain and/or ADL dysfunction exceeds the patient's ability to self-manage, the medical necessity of care should be documented and the chronic care treatment plan altered appropriately.

Patient recovery patterns vary depending on degrees of exacerbations. Mild exacerbation episodes may be manageable with 1-6 office visits within a chronic care treatment plan. There is not a linear effect between the intensity of exacerbation and time to recovery.

Moderate and severe exacerbation episodes within a chronic care treatment plan require acute care recommendations and case management.12
General Algorithm

Patient presents with spine related pain.

This is a new patient.
Perform New Patient Evaluation.¹
Go to Acute Care

This is an established patient with a new condition or a moderate-severe exacerbation of a pre-existing condition.
Perform Established Patient Evaluation.¹
Go to Acute Care

This is an established patient with a mild episode of a previously treated (usually chronic) condition.
Perform Evaluation¹ (Often condition focused rather than general)
Go to Chronic Care Algorithm.

¹Evaluation components
- History
- Examination
  - Imaging if warranted
- Possible Outcomes Assessment Tools—choice based on clinician’s judgment.
  - Pain intensity scales
  - Pain diagrams
  - Pain and disability questionnaires
  - Functional outcomes questionnaires
  - General health questionnaires
  - Psychological profiles
Patient presents with acute spine related pain.

- Refer to appropriate provider/facility.

Is condition outside scope of practice or skill set?

- Yes: Refer to appropriate provider/facility.
- No: Is co-management required?

- Yes: Consult with/refer to appropriate provider/facility.
- No: Assess for improvement at mid-point of trial using any of the accepted measurement tools.

Is improvement evident at midpoint?

- Yes: Begin therapeutic trial of up to 12 visits within 4 weeks.
- No: Consider:
  - Modifying treatment methods
  - Additional diagnostic procedures
  - Referral or co-management

Symptoms resolved?

- Yes: Perform reassessment evaluation
- No: Continue trial

- Refer to appropriate provider/facility

Continue on next page
MTB achieved?¹

Yes

Do significant symptoms and/or functional deficits remain?

No

Is condition stable or resolved?

Yes

Release with home care instructions or transition to wellness care.

No

No/not sure

Consider co-management

Trial withdrawal desired?²

Yes

Provide home care instructions and initiate trial withdrawal.

No

Refer

Reassess condition status.

Has condition deteriorated?

No

Go to Chronic Care Algorithm

Yes

Other treatment options available in this facility?

Yes

Additional improvement likely?

Yes

Continues up to 12 visits within 4 weeks.

No

No

No/Not Sure

Functional/symptom improvements?

Yes

No

Refer

¹ MTB = maximum therapeutic benefit
² Trial withdrawal may be necessary once a patient reaches maximum therapeutic improvement. This helps to determine if the condition recovery is stable. If the condition has deteriorated after the trial, then chronic or ongoing care may be necessary to maintain function and minimize symptoms. The therapeutic withdrawal can be gradual, where the patient’s care is tapered off. It can also be abrupt, with the patient instructed to return if the symptoms recur; or the patient can be scheduled for an evaluation at a later date to determine if there is any regression.
Chronic Care Algorithm

Patient presents with chronic/recurrent spine related pain.

Do the benefits of chronic pain management outweigh the risks?

Red flags present? (See red flag list.)

Refer to appropriate provider/facility or provide home management instructions.

No or yes but appropriately

This is a scheduled visit for ongoing/recurrent care for a patient expected to progressively deteriorate based on previous treatment withdrawals.

Treat according to ongoing/recurrent care plan (up to 4 visits per month). Re-evaluate every 12 visits at minimum.

This is a symptom flare for a known chronic condition or recurrence of acute condition.

Traumatic cause of exacerbation?

Yes

Consider Imaging.

Mild exacerbation?

No

Moderate to severe exacerbations follow Acute Care Algorithm.

No

Continue on next page

Yes

Refer to appropriate provider/facility.

Yes

Red flags present?

This visit follows a trial withdrawal and there is a recurrence or worsening of symptoms.

Yellow Flags present?

Yes

Refer to appropriate provider/facility.

Yes

No or yes but appropriately

This is a scheduled visit for ongoing/recurrent care for a patient expected to progressively deteriorate based on previous treatment withdrawals.

Treat according to ongoing/recurrent care plan (up to 4 visits per month). Re-evaluate every 12 visits at minimum.

Red Flags

- Progressive neurological disorders
- Cauda equina syndrome
- Bone weakening disorders; ie; acute spinal fracture, spinal infection, spinal/extra-vertebral bony malignancies
- Tumor
- Articular derangements indicating instability; i.e., active avascular necrosis in weight-bearing joints
Continued from previous page

Treat for up to 6 visits.

- Has patient returned to pre-episode status?
  - No Continue to next question.
  - Yes Continue to next question.

- Does condition worsen upon repeated attempts to withdraw care? See rationale for ongoing care.
  - No Continue to next question.
  - Yes Release patient; provide home management recommendations if appropriate.

- Consider further diagnostic
  - Yes Consider ongoing/recurrent care plan of up to 4 visits per month. Re-evaluate at least every 12 visits.
  - No Continue to next question.

- Red flags present or other conditions outside of scope or skill set?
  - Yes Refer to appropriate provider/facility.
  - No Continue to next question.

- Symptoms improved?!/Are chronic care goals being met?
  - Yes MTB
  - No Discontinue care and refer to appropriate provider/facility for opinion/management.

- Other treatment options available at this facility?
  - No Continue to next question.
  - Yes Treat for up to 6 visits. Consider multimodal, multidisciplinary care.

2. Documentation of necessity of ongoing care (in addition to standard documentation): *
- Clinically meaningful response to initial treatment
- Maximum therapeutic benefit (MTB)
- Significant residual activity limitations
- Attempts to transition to self-care
- Consideration of alternative treatment approaches
- Factors affecting likelihood that self-care alone will sustain MTI (see Complicating Factors)
References


