

TREATMENT GUIDELINES STAKEHOLDER STUDY

Not necessarily the views of the Kentucky Office of Workers Claims - Draft

**REPORT TO THE EXECUTIVE
DIRECTOR OF THE KENTUCKY
OFFICE OF WORKERS CLAIMS
FROM THE TREATMENT
GUIDELINES COMMITTEE OF THE
2006 UTILIZATION REVIEW STUDY**

Frankfort, Kentucky

December 1, 2006

In July of 2006, Hon. William P. Emrick, Executive Director of the Kentucky Office of Workers Claims (OWC), commissioned a study of the utilization review process currently employed by the OWC: the **2006 Utilization Review Study** (URS). The study was conducted by Ms. Sue Barber, Director, Division of Ombudsmen and Specialist Service of the OWC. Ms. Barber formed several committees and staffed the committees with individuals who have both an expertise in the delivery and/or management of medical services in the workers compensation arena as well as a vested interest in the Kentucky workers compensation system. One of those committees formed was the Treatment Guidelines (TG) committee.

The TG committee was staffed by six medical doctors (“physicians”), two doctors of chiropractic (“chiropractors”), two representatives of the insurance community, two attorneys specializing in workers compensation practice and one OWC administrative law judge (ALJ). The doctors are James Bean, M.D., an actively practicing neurosurgeon; Steven Glassman, M.D., an actively practicing orthopedic and spine surgeon; Gregory Gleis, M.D., an orthopedic surgeon and medical evaluator; Timothy R. Kriss, M.D., a neurosurgeon and medical evaluator; Russell Travis, M.D., a neurosurgeon and medical evaluator; and Daniel Wolens, M.D., an occupational and environmental medicine specialist and medical evaluator. The chiropractors are Michael Hillyer, D.C., and Andrew Slavik, D.C. Representing the insurance sector is Ms. Rosemary Sterling, with GAB Robbins, and Ms. Mary Carney, with Cannon Cochran Management Services, Inc. The lawyers are Hon. Bonnie Hoskins, who practices exclusively for the defense in workers compensation and Hon. John E. Anderson, who practices exclusively for plaintiffs in workers compensation. The ALJ and committee chair is J. Landon Overfield.

As the process began, the TG committee was charged by the Executive Director with the responsibility of gathering and studying information relating to and making recommendations concerning 1) the 1996 “Clinical Practice Parameters on Acute Low Back Problems in Adults” adopted by the (then) Department of Workers Claims, 2) existing evidence based studies of treatment of industrial injuries and occupational diseases, 3) weight to be given

treatment guidelines if such were adopted by the Kentucky OWC, 4) the experience of other states in the implementation and application of treatment guidelines in workers compensation, and 5) what is best for Kentucky workers compensation.

The full TG committee met on July 24, 2006 and August 21, 2006 in Lexington, Kentucky and on September 19, 2006 in Frankfort, Kentucky. In addition, the members of the committee have corresponded on a frequent and consistent basis via the Internet and the telephone. The physicians have met together and the chiropractors have met together on multiple occasions. The "legal section" of the committee (the insurance representatives, lawyers and judge) corresponded via the Internet and telephone on a frequent and consistent basis. The intent of this document is to report the consideration given by the committee and its individual members to the issues to be addressed and to deliver the recommendations of the committee to the Executive Director.

The TG committee decided, early on, that the 1996 acute low back treatment parameters have not been effective. The opinion was that this ineffectiveness is due, in large part, to the fact that the parameters addressed an extremely abbreviated time period relative to a workers compensation claim. By the time a claim was ripe for filing, the acute phase of the injury has passed. The TG committee recommends that the 1996 parameters be abandoned. The TG committee also decided that issues relating to pain management should be left to the Pain Management

committee of the URS. The committee also concluded that any recommendation for treatment guidelines, at this point in time, should be limited to treatment of low back conditions. That decision, the committee believed, was necessitated by the brief time span of the URS.

The TG committee, guided by its doctors and chiropractors, investigated many of the existing "evidence based studies". The studies reviewed included the Official Disability Guidelines (ODG) as well as the guidelines of the American College of Occupational and Environmental Medicine (ACOEM), the American Association of Orthopedic Surgeons (AAOS), Intercorp and the McKesson Group. Various interests are undoubtedly to be found in all studies/guidelines and while none of the studies/guidelines appear to be without flaw or criticism, it seemed to most of the TG committee members that the ODG were the most up-to-date treatment guidelines and, in the states adopting treatment guidelines, the most often adopted.

The TG committee members were unanimous concerning what weight should be given treatment guidelines by the OWC. The unanimous opinion by the TG committee members is that the Kentucky workers compensation system NEEDS treatment guidelines. These opinions were expressed not just on a personal basis but after each member had conference with his or her colleagues in their respective fields of expertise. The only expression of any concern was that some members of the plaintiff's bar feared that the adoption of any type of treatment guidelines would

result in their clients experiencing more difficulty in obtaining needed medical treatment.

The consensus of the TG committee is that, if treatment guidelines are adopted by the OWC, there should be regulatory or statutory provisions which would make the guidelines effective. The lawyers and insurance representatives on the TG committee have recommended that, if treatment guidelines are adopted, 803 KAR 25:012 should be amended. The amendment could provide that no medical fee dispute would be required for medical treatment not approved by the guidelines. Conversely, if medical treatment approved by the guidelines were contested, sanctions could be issued if the contesting party did not prevail in the medical fee dispute. Non-recommended medical procedures could still be approved if the requesting party presented evidence which convinced an ALJ that the treatment was reasonably necessary and compensable. A proposed amendment is attached to this document as "Addendum 1".

The TG committee reviewed the current procedure in several other states. Many of our sister states have adopted treatment guidelines and the most adopted guidelines are from the ODG. The states adopting treatment guidelines have reported mixed results. Many claim to have experienced a reduction in medical costs. Some, however, also report confusion and difficulty in effectively applying the adopted guidelines. Studies performed by the International Association of Industrial Accident Boards and Commissions (IAIABC) of states that have adopted

treatment guidelines report that the most successful use of treatment guidelines have been found to be in states which have full-time medical directors in their workers compensation system.

The advisability of the Kentucky OWC having a medical director has been discussed in the TG committee and has met with favor. The general consensus of the TG committee is that the Kentucky OWC would be well served by adding a medical director to its staff. One chiropractor on the TG committee is of the opinion that the Kentucky OWC should also add a chiropractic director to its staff. The other chiropractor believes there could be an assistant medical director who is a chiropractor. It does not appear that these opinions are shared by the remainder of the TG committee members. The consensus of the TG committee is that one medical director will be able to ensure proper application of any adopted guidelines to all providers of health care.

The most important issue to be addressed by the TG committee is: **What is best for Kentucky workers compensation.** Unfortunately the TG committee does not have a unanimous recommendation. Dr. Wolens has prepared a written proposal (which is attached to this document as "Addendum 2") which, in essence, recommends adoption of the ODG as the Kentucky OWC's treatment guidelines for the treatment of low back injuries and diseases. Dr. Wolens' proposal is that there be no exceptions or additions to the ODG as this would allow "provider/discipline specific" guidelines. All but two

members of the TG committee have expressed the opinion that the recommendation to the Executive Director should be that, if low back treatment guidelines are adopted by the OWC, the ODG should be adopted in the manner proposed by Dr. Wolens.

Dr. Hillyer and Dr. Slavik voiced significant opposition to adoption of the ODG. These committee members, both chiropractors, believe that the ODG is unduly restrictive relating to many treatment modalities employed by chiropractors. Drs. Hillyer and Slavik have prepared written proposals (which are attached to this document as "addenda 3A and 3B", both containing the same recommendations and one being an abbreviated version of the original version). These proposals, in essence, recommend adoption of a "chiropractic low back guideline" based on the workers compensation guidelines adopted by the workers compensation systems in the states of Minnesota and Wisconsin. Drs. Hillyer and Slavik are not opposed to the ODG parameters as they relate to treatment modalities administered by doctors in non-chiropractic disciplines. However, they are opposed to the application of the ODG to chiropractic treatment.

Many of the physicians on the TG committee have objected to the chiropractic community having specific guidelines. They note that for treatment modalities that are in common to both the practice of medicine and the practice of chiropractic, what ODG denies of physicians, the chiropractic guidelines allow for chiropractors. It is the position the physicians that the ODG addresses treatment

modalities without regard to the medical discipline using those modalities.

In deference to the committee as a whole, both proposals will be presented to the Executive Director. The question of which proposal was favored by the individual members of the committee was subjected to what, for lack of a better term, can be referred to as an "Internet vote". The "majority" recommendation is that the ODG be adopted as Kentucky's low back treatment guidelines without exceptions or "add-ons". The chiropractor recommendation is that, if the ODG is adopted by the OWC, it should not be applied to chiropractic treatment and a specific "chiropractic low back guideline" should also be adopted. The only votes for that position were from the two TG committee members who are chiropractors. Of the six physicians, five were in favor of the majority recommendation and one did not cast a vote. Both members of the insurance community, both lawyers and the ALJ voted for the majority position.

The full text of the ODG low back treatment guidelines (well in excess of 100 pages) will not be included in this document. The ODG treatment guidelines can be accessed via the Internet. The annual subscription fee quite inexpensive and is well within the budget of any health care provider, insurance carrier, workers compensation practitioner who routinely practices workers compensation law and the OWC. The ODG treatment guidelines are periodically updated and the TG committee recommends

periodic review and amendment by the OWC of any guidelines it adopts.

RECOMMENDATIONS TO THE EXECUTIVE DIRECTOR

The Treatment Guidelines Committee makes the following recommendations:

- 1. Abandonment of the 1996 “Clinical Practice Parameters on Acute Low Back Problems in Adults”.**
- 2. Amendment of 803 KAR 25:012 in order to ensure effectiveness of any adopted low back treatment guidelines.**
- 3. Addition to the staff of the OWC, a full-time medical director.**

The majority of the treatment guidelines committee makes the following recommendation:

Adoption the low back treatment guidelines of the ODG as the low back treatment guidelines of the Kentucky OWC has proposed in Addendum 2.

The minority of the treatment guidelines committee makes the following recommendation:

Adoption of the treatment guidelines as adopted by the workers compensation systems of the sites out of Minnesota and Wisconsin with specific chiropractic low back treatment guidelines proposed in Addenda 3A and 3B.

LOW BACK PROBLEMS: Chiropractic Care

Kentucky OWC Treatment Guidelines Subcommittee
Chiropractic Report
November 15, 2006

Preface

The current trend in the healthcare field is development of “best practices, evidence-based” guidelines. Previous attempts at guidelines as cookbooks or prescriptions for care had disastrous effects in patient management. In general, good guidelines are now considered as data sets to serve as background information to assist the physician in deciding the proper course of care based on the best available evidence and their clinical experience. “Good doctors use both individual clinical expertise and the best available external evidence, and *neither alone is enough* [emphasis added]. Without clinical expertise, practice risks becoming tyrannized by external evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best external evidence, practice risks becoming rapidly out of date, to the detriment of patients (Sackett).”

An attempt to provide the best external evidence and yet retain the simplistic approach of cookbook guidelines is represented by the Official Disability Guidelines (ODG), with their confusing new approach of recommendations of automatically approvable care. We find the ODG to be laudable in its attempt to list the evidence for provider scrutiny, but its cookbook conclusions are particularly problematic and a source of potential misuse and abuse. The medical necessity of care should be based on the documentation of benchmark outcomes found in the patient’s file, not in a guideline document that recommends arbitrary numbers of treatments. The greatest weakness of the ODG is this arbitrary assignment of treatment numbers, with no attempt to differentiate between mild, moderate, and severe conditions. Therefore, any reference to specific numbers of treatments over specific periods of time is inherently inaccurate compared to the actual facts of each injured workers' case. The development of quality for therapeutically necessary care requires a triad of elements; Structure, which leads to Process, which leads to Outcome. Outcomes are universally measured to establish the appropriateness and medical necessity of care, yet are not referenced as benchmarks in the ODG guidelines. Our past experience with the misunderstanding or misuse of cookbook-style guidelines by claims managers, nurse reviewers, and outside peer review consultants gives us great concern that ODG will be used

inappropriately by replacing the effort needed to understand the uniqueness of each patient, with arbitrary hard and fast numbers provided by the ODG easy reference. "Rigid standards and guidelines, which frequently are interpreted rigidly, must be avoided to allow for individual considerations and scientific innovation" (Triano).

ODG Background:

The editorial advisory board of the ODG is comprised of 78 people, including 62 doctors of medicine, 2 doctors of Osteopathy, and 2 doctors of chiropractic. Neither the American Chiropractic Association, representing the largest number of doctors of chiropractic in the world, nor, any of the profession's recognized researchers, were represented on the panel.

The prestigious Rand Institute evaluated ODG and four other guidelines at the request of the state of California, and ODG was not found to be a valid guideline for any of the low back treatment issues evaluated. Rand's conclusion was, "The ODG guideline set was rated comprehensive and valid for both carpal tunnel surgery and shoulder surgery; the other two topics were of 'uncertain validity'. And finally; "Seven of the 11 Rand panelists felt that 'The five selected guidelines [including ODG] are not as valid as everyone would want in a perfect world.; They do not meet or exceed standards; they barely meet standards. [and] California could do a lot better by starting from scratch."

Chiropractic Treatment Guideline Concerns:

While the ODG cites numerous references to support their recommendations; the process is reliant on a medically dominated committee's interpretation of the data. We have no confidence that a committee dominated by 62 medical physicians and only 2 DCs who do not represent the majority of practicing chiropractors or even chiropractic researchers, can produce a credible recommendation for chiropractic care. None of the papers cited in ODG supports the use of their rigid recommendations for the typical injured worker. ODGs "Codes for Automated Approval", assigns procedure codes (CPT) to a diagnosis (ICD9) code with a recommendation for "maximum occurrences", based on the self-admitted "ideal protocol", for use in decisions to approve treatment. These specific "ideal protocol" numbers beg for misuse and abuse by those overseeing care based on the ODG. As previously seen by the outmoded guideline attempts to arbitrarily limit care, the ODG could be interpreted to avoid the much more laborious but appropriate determination of medical necessity by measuring patient progress. We challenge the supporters of ODG to produce credible references suggesting the appropriateness of 10 visits for a cervical disc, 18 for a lumbar disc, or 14-16 visits for post-surgical care. In our opinion, these numbers are overly conservative and will lead to unnecessary specialist referral,

diagnostic imaging, pain relief prescriptions and surgical intervention in the injured worker population; contrary to the stated goals of the Utilization Review Committee.

Again, we return to the Rand Report for support of our objection to the adoption of ODG as the guideline for chiropractic care:

From the Rand report's, "Clinical Evaluation Summary: Panelists' Assessment of Comprehensiveness and Validity", we find that ODG was rated "Appropriate" in only 2 of 6 criteria for Physical Therapy and Chiropractic.

Rand's conclusion on ODG on Lumbar spine physical therapy (passive care) and chiropractic care is found in Table S.5 (Panelists' Assessment of the Comprehensiveness and Validity of Content Addressing the Quantity of Physical Modalities): "Lumbar spine physical therapy = Validity uncertain"; and, "Lumbar spine chiropractic = Validity uncertain". We find guidelines with such weak validity unacceptable for treatment of an entire segment of the injured worker population.

ODG lists all passive modalities as "Not Recommended", even though Rand found their validity, "uncertain"; and ODG omits the literature studying these passive modalities when used as an adjunctive treatment to the chiropractic manipulation. In contrast, however, the CCGPP (Chiropractic Committee on Guidelines and Practice Parameters) Best Practices Document, when studying the research specific to chiropractic practice (94% of manipulation in the USA is provided by chiropractors), found that these passive modalities were "Recommended" in conjunction with spinal manipulation. While ODG accurately states, "Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities.", they distort the phrase, "extensive use of passive modalities" into a conclusion of, "Not Recommended", thereby totally eliminating not just extensive use, but any use, of these resources.

Also of particular concern is the confusion created by differing treatment recommendations found in the Disability Guideline (DG) and the Treatment Guideline (TG), sections of the ODG. The DG section suggests 18 visits over 6-8 weeks for a typical nonradicular lumbar sprain/strain; while the TG section suggests "End manual therapy at 4 weeks" after what appears to be just 3 visits. [page 415 TG] An example provided in the very beginning of the TG section is that of a typical computer screen presumably available to a case manager, that indicates the treatment protocols for low back pain includes only 3 visits over a 4 week period, ending all manual therapy at 4 weeks. More troublesome is the fact that the "radiculopathy" section completely omits chiropractic management and the various conservative spinal manipulative techniques that are supported by the literature, decades of clinical experience

and the chiropractic-specific CCGPP Best Practices Low Back Literature Review. While the chiropractic profession certainly encourages the shift towards active care, the ODG could easily be interpreted to suggest that no chiropractic care is appropriate after 3 visits or 18 visits, no matter the patient's satisfaction and progress.

The chiropractic panelists are also concerned over the potential of ODG to restrict treatment to only limited spinal conditions for a limited course of care. For example, the ODG provides no mention of chiropractic management for the sub-acute, chronic and permanently injured worker.

Lastly, the ODG actually recommends a referral for both high cost diagnostic tests and referral to an orthopedic surgeon without even the benefit of a trial period of chiropractic care; an obvious bias resulting from a medically dominated ODG panel.

The WC system in Kentucky has experienced a dramatic increase in both drug expenditures and hospital based costs. If the ODG guidelines are adopted, especially for chiropractic care, the Commonwealth will likely experience an even greater shift toward increased drug and surgical costs for the most prevalent injuries suffered by workers by forcing those workers into higher cost medical management.

Best practice guidelines should be a source of information to provide the physicians with choices based on the best available medical evidence, but treatment guidelines based on rigid numbers and case averages is a concept already outdated and laden with potential conflict between physicians and case managers; with delays and uncertain care-paths for the injured worker. We have developed guidelines which supplement the data set of the Best Practices Document of the CCGPP, and rely on patient progress measured by outcome benchmarks with parameters for benchmarking that will control unnecessary or inappropriate care.

(The process of extracting, studying, referencing, and researching was limited by the time constraints of the committee process, so the chiropractic members of the subcommittee respectfully request an opportunity to further refine this guideline in consultation with the LRC and the Kentucky State Board of Chiropractic Examiners before its final adoption.)

Respectfully submitted,

Michael R. Hillyer, D.C.
Andrew P. Slavik, D.C.

The Proposed Chiropractic Guidelines

I. Diagnostic procedures for treatment of low back injury.

A chiropractic provider shall determine the nature of the condition before initiating treatment.

A. An appropriate history and physical examination must be performed and documented. Based on the history and physical examination the chiropractic provider must assign the patient at each visit to the appropriate clinical category according to subitems (1) to (4). The diagnosis must be documented in the medical record. For the purposes of subitems (2) and (3), "radicular problems" means pain, or other symptoms, radiating distal to the knee, or pain conforming to a dermatomal distribution and accompanied by anatomically congruent motor weakness or reflex changes. *This part does not apply to fractures of the lumbar spine, or back pain due to an infectious, immunologic, metabolic, endocrine, neurologic, visceral, or neoplastic disease process or any condition outside the scope of practice as defined in KRS 312.*

(1) Regional low back pain, includes referred pain to the leg above the knee unless it conforms to an L2, L3, or L4 dermatomal distribution and is accompanied by anatomically congruent motor weakness or reflex changes. Regional low back problems includes the diagnoses of lumbar, lumbosacral, or sacroiliac: strain, sprain, myofascial syndrome, musculoligamentous injury, soft tissue injury, spondylosis, and other diagnoses for pain believed to originate in the discs, ligaments, muscles, or other soft tissues of the lumbar spine or sacroiliac joints and which effects the lumbosacral region, with or without referral to the buttocks and/or leg above the knee, including, but not limited to, ICD-9-CM codes 720 to 720.9, 721, 721.3, 721.5 to 721.90, 722, 722.3, 722.32, 722.5, 722.51, 722.52, 722.6, 722.9, 722.90, 722.93, 724.2, 724.5, 724.6, 724.8, 724.9, 732.0, 737 to 737.9, 738.4, 738.5, 739.2 to 739.4, 756.1 to 756.19, 847.2 to 847.9, 922.3, 926.1, 926.11, and 926.12.

(2) Radicular pain, with or without regional low back pain, with static or no neurologic deficit. This includes the diagnoses of sciatica; lumbar or lumbosacral radiculopathy, radiculitis or neuritis; displacement or herniation of intervertebral disc with myelopathy, radiculopathy, radiculitis or neuritis; spinal stenosis with myelopathy, radiculopathy, radiculitis or neuritis; and any other diagnoses for pain in the leg below the knee believed to originate with irritation of a nerve root in the lumbar spine, including, but not limited to, the ICD-9-CM codes 721.4, 721.42, 721.91, 722.1, 722.10, 722.2, 722.7, 722.73, 724.0, 724.00, 724.02, 724.09, 724.3, 724.4, and 724.9.

In these cases, neurologic findings on history and physical examination are

either absent or do not show progressive deterioration.

(3) Radicular symptoms, with or without regional low back problems, with progressive neurologic deficit. This includes the same diagnoses as subitem (2), however, this category applies when there is a history of progressive deterioration in the neurologic symptoms and physical findings which include worsening sensory loss, increasing muscle weakness, or progressive reflex changes.

(4) Cauda equina syndrome, which is a syndrome characterized by anesthesia in the buttocks, genitalia, or thigh and accompanied by disturbed bowel and bladder function, ICD-9-CM codes 344.6, 344.60, and 344.61.

B. Laboratory tests are not indicated in the evaluation of a patient with regional low back pain, radicular pain, or cauda equina syndrome, except in any of the following circumstances:

(1) when a patient's history, age, or examination suggests infection, metabolic-endocrinologic disorders, tumorous conditions, systemic musculoskeletal disorders, such as rheumatoid arthritis or ankylosing spondylitis;

(2) to evaluate potential adverse side effects of medications; or (3) as part of a preoperative evaluation. Laboratory tests may be ordered at any time the health care provider suspects any of these conditions, but the health care provider must justify the need for the tests ordered with clear documentation of the indications.

C. Medical imaging evaluation of the lumbosacral spine must be based on the findings of the history and physical examination and cannot be ordered before the chiropractic provider's clinical evaluation of the patient. Medical imaging may not be performed as a routine procedure and must comply with all of the standards in section XII. The health care provider must document the appropriate indications for any medical imaging studies obtained.

D. EMG and nerve conduction studies are inappropriate for regional low back pain as defined in item A, subitem (1). Needle EMG and nerve conduction studies may be an appropriate diagnostic tool for radicular pain and cauda equina syndrome as defined in item A, subitems (2) to (4), after the first three weeks of radicular symptoms. Repeat EMG and nerve conduction studies for radicular pain and cauda equina syndrome are not indicated unless a new neurologic symptom or finding has developed which in itself would warrant electrodiagnostic testing. Failure to improve with treatment is not an indication for repeat testing without clear documentation of the indications.

E. The use of the following procedures or tests is not indicated for the diagnosis

of any of the clinical categories in item A:

- (1) surface electromyography or surface paraspinal electromyography;
- (2) thermography;
- (3) plethysmography;
- (4) electronic X-ray analysis of plain radiographs;
- (5) diagnostic ultrasound of the lumbar spine; or
- (6) somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP).

F. Computerized range of motion or strength measuring tests are not indicated during the period of initial nonsurgical management, but may be indicated during the period of chronic management when used in conjunction with a computerized exercise program, work hardening program, or work conditioning program.

G. Personality or psychosocial screening evaluations may be indicated for evaluating patients who continue to have problems despite appropriate care. The treating chiropractor may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

- (1) Is symptom magnification occurring?
- (2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?
- (3) Are there other personality factors or disorders which are interfering with recovery?
- (4) Is the patient chemically dependent?
- (5) Are there any interpersonal conflicts interfering with recovery?
- (6) Does the patient have a chronic pain syndrome or psychogenic pain?
- (7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

H. Referral for Diagnostic analgesic blocks or injection studies include facet joint injection, facet nerve injection, epidural differential spinal block, nerve block, and nerve root block. [SEE Medical Guidelines]

I. Functional capacity assessment or evaluation is a comprehensive and objective assessment of a patient's ability to perform work tasks. The components of a functional capacity assessment or evaluation include, but are not limited to, neuromusculoskeletal screening, tests of manual material handling, assessment of functional mobility, and measurement of postural

tolerance. A functional capacity assessment or evaluation is an individualized testing process and the component tests and measurements are determined by the patient's condition and the requested information. Functional capacity assessments and evaluations are performed to determine and report a patient's physical capacities in general or to determine work tolerance for a specific job, task, or work activity.

(1) Functional capacity assessment or evaluation is not indicated during the period of initial nonsurgical management.

(2) After the period of initial nonsurgical management functional capacity assessment or evaluation is indicated in either of the following circumstances:

(a) activity restrictions and capabilities must be identified; or

(b) there is a question about the patient's ability to do a specific job.

(3) A functional capacity evaluation is not appropriate to establish baseline performance before treatment, or for subsequent assessments, to evaluate change during or after treatment.

(4) Only one completed functional capacity evaluation is indicated per injury.

J. Consultations with other health care providers can be initiated at any time by the treating health care provider consistent with accepted medical practice.

II. General treatment parameters for low back pain.

A. All chiropractic care for low back pain, appropriately assigned to a clinical category in subpart I, item A, is determined by the clinical category to which the patient has been assigned. Treatment that conforms to that defined in section III. Passive Care; IV. Active Care and IX. Chronic Care sections for the appropriate clinical category and is documented to be effective according to part VII. shall be presumed to be appropriate and medically necessary.

The chiropractor must reassess the appropriateness of the clinical category assigned and reassign the patient if warranted by new clinical information including symptoms, signs, results of diagnostic testing, and opinions and information obtained from consultations with other health care providers. When the clinical category is changed, the treatment plan must be appropriately modified to reflect the new clinical category. However, a change of clinical category does not in itself allow the health care provider to continue a therapy or treatment modality past the maximum duration specified herein, or to repeat a therapy or treatment previously provided for the same injury.

B. In general, a course of treatment is divided into three phases.

(1) First, all patients with low back problems, except patients with progressive neurologic deficit or cauda equina syndrome may be given initial chiropractic management which may include active and passive treatment procedures and modalities. The period of initial chiropractic treatment begins

when the first passive or active procedure or modality is initiated. Initial chiropractic treatment must result in progressive improvement as specified in section VI.

C. A chiropractic provider may refer the employee for a consultation at any time during the course of treatment consistent with accepted medical and chiropractic practice.

III. Passive treatment Procedures and Modalities.

A. Passive modalities are not recommended except when provided as adjunctive or augmentative to the chiropractic spinal manipulation/adjustment. Passive Care must run concurrently with 24 week limit of Active Care. There are no limitations on the use of passive treatment modalities by the employee at home.

B. (1) Additional passive treatments over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to work; or

(b) is permanently disabled and seeking a judgement for ongoing care for cure and relief, and the additional passive treatment must result in progressive improvement in, or support of, functional status achieved during the initial 24 week course of care;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment procedures during this period;

(2) Except as otherwise provided treatment may continue beyond the additional 12 months only after prior approval by the insurer, or Administrative Law Judge based on documentation in the medical record of the effectiveness of passive treatment in maintaining employability; if the employee is permanently disabled, or if the employee is eligible for ongoing medical benefits for the work injury, treatment may continue beyond the additional 12 months only after prior approval by the insurer or Administrative Law Judge based on documentation in the medical record of the effectiveness of passive treatment in maintaining functional status and/or providing relief. (See Supportive Chiropractic Care).

(3) Supportive Chiropractic Care is defined as, Passive and active chiropractic treatment/care for patients having reached maximum therapeutic benefit with a Permanent Impairment and an ALJ judgement for ongoing care for cure and relief from the effects of an injury. Supportive Care is appropriate for patients who clinically deteriorate by failing to sustain their previous functional improvements and pain relief levels if chiropractic treatment is withdrawn. It is appropriate when rehabilitative and/or functional restorative and alternative care

options, including home based self care and lifestyle modifications are being attempted.

(a) Periodic trials of chiropractic treatment withdrawal should be made every 3 months the first year; every 6 months the second year, and annually, thereafter.

(b) The withdrawal should be attempted for a period equal to twice the current treatment interval, unless significant clinical deterioration occurs before.

(c) Documentation of functional and pain deterioration is required to establish the need for continued supportive care. Currently accepted pain scale and functional outcome assessment instruments should be completed on a regular basis to establish the functional and pain relief gains maintained with supportive care; and be completed to document any deterioration due to the withdrawal of care.

(d) The goal of supportive care is to achieve the maximum interval between treatments with patient self care strategies such as activity modification and home exercise.

C. Adjustment or manipulation of joints includes chiropractic adjustments or manipulations:

(1) maximum treatment frequency, up to five times per week for the first one to two weeks with an anticipated decreasing frequency thereafter as patient progress warrants; and

(2) maximum treatment duration, 24 weeks.

D. Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks and infrared. Deep thermal modalities include diathermy, ultrasound, and microwave.

(1) Treatment given in a clinical setting:

(a) Deep thermal modalities only: maximum treatment frequency, up to five times per week for the first one to two weeks with an anticipated decreasing frequency thereafter as patient progress warrants; and

(b) maximum treatment duration, 6 weeks of treatment in a clinical setting and only if given in conjunction with chiropractic adjustment/manipulation; unless provided in conjunction with, and to facilitate the active treatment procedure of supervised exercise in IV. D. 1).

(2) Home use of superficial thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without health care provider assistance. Home use of thermal modalities does not require any special training or

monitoring, other than that usually provided by the health care provider during an office visit.

E. Electrical muscle stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(1) Treatment given in a clinical setting:

(a) maximum treatment frequency, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(b) maximum treatment duration, 6 weeks of treatment in a clinical setting and only if given in conjunction with chiropractic adjustment/manipulation; unless provided in conjunction with, and to facilitate the active treatment procedure of supervised exercise in IV. D. 1).

(2) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

(a) time for patient education and training, one to three sessions; and

(b) patient may use the electrical stimulation device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

F. Mechanical traction:

(1) Treatment given in a clinical setting:

(a) maximum treatment frequency, up to three times per week for the first one to two weeks with an anticipated decreasing frequency thereafter as patient progress warrants; and

(b) maximum treatment duration, 6 weeks in a clinical setting but only if used in conjunction with chiropractic adjustment/manipulation.

(2) Home use of a mechanical traction device may be prescribed as follow-up to use of traction in a clinical setting if it has proven to be effective treatment and is expected to continue to be effective treatment. Initial use of a mechanical traction device must be in a supervised setting in order to ensure proper patient education:

(a) time for patient education and training, one session and one followup; and

(b) patient may use the mechanical traction device for one month, at which time effectiveness of the treatment must be reevaluated by the health care provider before continuing home use of the device.

G. Acupuncture and Non-Acupuncture Dry Needling treatments.

Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure and Dry Needling techniques:

(1) maximum treatment frequency, up to three times per week for one to

two weeks with an anticipated decreasing frequency thereafter as patient progress warrants; and

(2) maximum treatment duration, 12 weeks.

H. Manual therapy includes soft tissue and joint mobilization, therapeutic massage, and manual traction:

(1) maximum treatment frequency, up to five times per week for the first one to two weeks with an anticipated decreasing frequency thereafter as patient progress warrants; and

(2) maximum treatment duration, 24 weeks.

I. Bedrest. Prolonged restriction of activity and immobilization are detrimental to a patient's recovery. Bedrest should not be prescribed for more than 3 days without documentation of unusual complications or co-morbidities.

J. Spinal braces and other movement-restricting appliances. Bracing required for longer than two weeks must be accompanied by active muscle strengthening exercise to avoid deconditioning and prolonged disability:

(1) treatment frequency, limited to intermittent use during times of increased physical stress or prophylactic use at work; and

(2) maximum continuous duration, 6 weeks.

K. Therapeutic Massage:

(1) maximum treatment frequency, up to five times per week for the first one to two weeks with an anticipated decreasing frequency thereafter as patient progress warrants; and

(2) maximum treatment duration, 24 weeks.

IV. Active Treatment Procedures.

Active treatment must be used as set forth in items A to D. Use of the 24 weeks of active treatment may or may not run concurrently with the limitation on passive treatment modalities so long as the maximum duration or number of sessions for the active modality is not exceeded and total treatment duration (Active plus Passive) does not exceed 24 weeks.

A. Education must teach the patient about pertinent anatomy and physiology as it relates to spinal function for the purpose of injury prevention. Education may include training on posture, biomechanics, and relaxation. The maximum number of sessions is 12 visits, which includes an initial education and training session, and eleven follow-up visits. Education should begin within the first week and no later than the second week of chiropractic care.

B. Posture and work method training must instruct the patient in the proper performance of job activities. Topics include proper positioning of the trunk, neck, and arms, use of optimum biomechanics in performing job tasks, and appropriate pacing of activities. Methods include didactic sessions, demonstrations, and simulated work tasks. The maximum number of sessions is six visits.

C. Worksite analysis and modification must examine the patient's work station, tools, and job duties. Recommendations are made for the alteration of the work station, selection of alternate tools, modification of job duties, and provision of adaptive equipment. The maximum number of treatments is six visits.

D. Exercise, (Therapeutic Exercise, Neuromuscular Re-education and Therapeutic Activities) which is important to the success of an initial nonsurgical treatment program and a return to normal activity, must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must, at least in part, be specifically aimed at the musculature of the lumbosacral spine. While aerobic exercise and extremity strengthening may be performed as adjunctive treatment, this shall not be the primary focus of the exercise program. Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, and endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation and monthly thereafter. Subitems (1) and (2) govern supervised and unsupervised exercise.

(1) Supervised exercise. One goal of an exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, three times per week for four weeks, with an anticipated decreasing frequency thereafter as patient progress warrants; and

(b) maximum duration, 24 weeks.

(c) must begin no later than six weeks after initiating Passive Care. If initiated in the sixth week of Passive Care the Active Care may continue for 18 weeks.

(d) Active care may not continue for more than 24 weeks , except as provided for in Section IX.

(2) Unsupervised exercise must be provided in the least intensive setting appropriate to the goals of the exercise program, and may supplement or follow the period of supervised exercise:

(a) maximum treatment frequency, up to 12 visits for instruction and monitoring; and

(b) there is no limit on the duration or frequency of exercise at home.

E. Additional active treatments over an additional 12 months may be provided if all of the following apply:

(a) the employee is released to return to work or is permanently disabled and seeking a judgement for ongoing care for cure and relief, and the additional treatment must be documented every 4 weeks to result in progressive improvement in, or support of, functional status achieved during the initial 24 weeks of care;

(b) the treatment may or may not be given on a regularly scheduled basis;

(c) the health care provider must document in the medical record a plan to encourage the employee's independence and decreased reliance on health care providers;

(d) management of the employee's condition must include active treatment modalities during this period;

V. Chronic management.

Chronic management of low back problems must be provided according to the parameters of section IX. Supportive Chiropractic Care is defined as Passive and active chiropractic treatment/care for the chronic management of patients having reached maximum therapeutic benefit with a Permanent Impairment and an ALJ judgement for ongoing care for cure and relief of the effects of a work related injury. Supportive Care is appropriate for patients who clinically deteriorate by failing to sustain their previous functional improvements and pain relief levels if chiropractic treatment is withdrawn. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home based self care and lifestyle modifications are being attempted.

(a) Periodic trials of chiropractic treatment withdrawal should be made every 3 months the first year; every 6 months the second year, and annually, thereafter.

(b) The withdrawal should be attempted for a period equal to twice the current treatment interval, if tolerated. (i.e., a patient being treated every 4 weeks should attempt an 8 week withdrawal of care.)

(c) Documentation of functional and pain deterioration is required to establish the need for continued supportive care. Currently accepted pain scale and functional outcome assessment instruments should be completed on a regular basis to establish the functional and pain relief gains; and be completed to document any deterioration due to the withdrawal of care.

(d) The goal of supportive care is to achieve the maximum interval between treatments with patient self care strategies such as activity modification and home exercise.

(e) The purpose of Supportive Care chronic management is twofold: the patient should be made as independent as possible of health care providers in the ongoing care of a chronic condition; and the patient should be returned to, or maintain, the highest functional status reasonably possible.

VI. Evaluation of treatment by chiropractic provider.

The health care provider must evaluate whether the treatment is medically necessary, and must evaluate whether chiropractic treatment is resulting in progressive improvement as specified in items A to C; and it must be documented according to the Record Keeping standards of KRS 312 no later than 4 weeks after the initiation of active or passive chiropractic care and at least every 4 weeks thereafter:

A. the employee's subjective complaints are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, duration, use of pain relievers, or intensity of symptoms;

B. the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of the injury; and

C. the employee's daily activity functional status, including vocational activity, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

If there is not progressive improvement in at least two items of items A to C, the current treatment plan must be significantly modified or discontinued, or the provider must reconsider the diagnosis.

D. For therapeutically necessary care, provider behavior is an important component in all performance measures. Management of an injury episode has only three potential courses:

1) the patient progress is similar to expectations;

2) the patient's progress is below expectations and the provider has appropriately initiated diagnostic or therapeutic strategies in response; or

3) the progress of the patient's recovery is below expectations and appropriate action has not been taken.

Appropriate processes of care include documentation of complicating factors, setting realistic treatment and recovery goals and modifying treatment and diagnostics in response to slow progress. Where appropriate process is or has been followed, then provider decision-making should not be questioned.

VII. Specific treatment parameters for radicular pain, with or without regional low back pain, with no or static neurologic deficits.

A. Chiropractic treatment is appropriate for all patients with radicular pain, with or without regional low back pain, with no or static neurologic deficits and

may be the first phase of treatment or may follow any other form of treatment.

B. Surgical evaluation or chronic management is indicated if the patient continues with symptoms and physical findings after the course of initial 24 weeks of chiropractic care, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

C. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered, the patient refused surgical therapy, or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, the patient may be presumed to be a candidate for chiropractic treatment.

VIII. Specific treatment parameters for cauda equina syndrome and for radicular pain, with or without regional low back pain, with progressive neurologic deficits.

A. Patients with cauda equina syndrome or with radicular pain, with or without regional low back pain, with progressive neurologic deficits require immediate or emergency surgical evaluation at any time they become evident during the course of the overall treatment. The decision to proceed with surgical evaluation is made by the chiropractic provider based on the type of neurologic changes observed, the severity of the changes, and the rate of progression of the changes. Referral for surgical evaluation, if indicated, may be made at any time during the course of treatment. Surgical evaluation and surgery shall be provided within the parameters of the ODG Guidelines.

B. If the patient continues with symptoms and objective physical findings after surgical therapy has been rendered or the patient refuses surgical therapy or the patient was not a candidate for surgical therapy, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for a course of passive care, active care and/or chronic management. Any course or program of chronic management for patients with radicular pain, with or without regional back pain, with foot drop or progressive neurologic changes at first presentation must first meet the parameters of the ODG Guidelines.

IX. CHRONIC MANAGEMENT/SUPPORTIVE CHIROPRACTIC CARE.

If a patient continues with symptoms and physical findings after all appropriate initial nonsurgical or surgical treatment has been rendered, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for Supportive Chiropractic Care chronic management. Supportive Chiropractic Care is defined as, Passive and Active chiropractic treatment/care for the chronic management

of patients having reached maximum therapeutic benefit with a Permanent Impairment and an ALJ judgement for ongoing care for cure and relief from the effects of a work related injury. Supportive Care is appropriate for patients who clinically deteriorate by failing to sustain their previous functional improvements and pain relief levels if chiropractic treatment is withdrawn. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home based self care and lifestyle modifications are being attempted.

(a) Periodic trials of chiropractic treatment withdrawal should be made every 3 months the first year; every 6 months the second year, and annually, thereafter.

(b) The withdrawal should be attempted for a period equal to twice the current treatment interval, if tolerated. (i.e., a patient being treated every 4 weeks should attempt an 8 week withdrawal of care.)

(c) Documentation of functional status and pain deterioration is required to establish the need for continued supportive care. Currently accepted pain scale and functional outcome assessment instruments or other documentation should be completed on a regular basis to establish the functional and pain relief gains; and be completed to document any deterioration due to the withdrawal of care.

(d) The goal of supportive care is to achieve the maximum interval between treatments with patient self care strategies such as activity modification and home exercise.

(e) The purpose of Supportive Care chronic management is threefold: the patient should be made as independent as possible of health care providers in the ongoing care of a chronic condition; and the patient should be returned to, or maintain, the highest functional status reasonably possible and treatment should provide relief from the effects of an injury.

A. Personality or psychological evaluation may be indicated for patients who are candidates for chronic management. The treating health care provider may perform this evaluation or may refer the patient for consultation with another health care provider in order to obtain a psychological evaluation. These evaluations may be used to assess the patient for a number of psychological conditions which may interfere with recovery from the injury. Since more than one of these psychological conditions may be present in a given case, the health care provider performing the evaluation must consider all of the following:

- (1) Is symptom magnification occurring?
- (2) Does the patient exhibit an emotional reaction to the injury, such as depression, fear, or anger, which is interfering with recovery?
- (3) Are there other personality factors or disorders which are interfering with recovery?
- (4) Is the patient chemically dependent?
- (5) Are there any interpersonal conflicts interfering with recovery?

(6) Does the patient have a chronic pain syndrome or psychogenic pain?

(7) In cases in which surgery is a possible treatment, are psychological factors likely to interfere with the potential benefit of the surgery?

B. Any of the chronic management modalities may be used singly or in combination as part of a program of chronic management.

C. No further diagnostic evaluation is indicated unless there is the development of symptoms or clinical findings which would in themselves warrant diagnostic evaluation.

X. Departures from parameters.

A departure from a parameter that limits the duration or type of treatment may be appropriate in any one of the circumstances specified in items A to E. The health care provider must provide notification of the departure.

A. Where there is a documented medical complication (see Section XIII).

B. Where previous chiropractic treatment provided by a previous provider did not meet the requirements of this parameter.

C. Where the treatment is necessary to assist the employee in the initial return to work where the employee's work activities place stress on the part of the body affected by the work injury. The health care provider must document in the medical record the specific work activities that place stress on the affected body part, the details of the treatment plan and treatment delivered on each visit, the employee's response to the treatment, and efforts to promote employee independence in the employee's own care to the extent possible so that prolonged or repeated use of health care providers and medical facilities is minimized.

D. Where the treatment continues to meet two of the following three criteria, as documented in the medical record:

(1) the employee's subjective complaints of pain are progressively improving as evidenced by documentation in the medical record of decreased distribution, frequency, or intensity of symptoms;

(2) the employee's objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in physical signs of injury; and

(3) the employee's daily activity functional status including vocational activities, is objectively improving as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

E. Where there is a documented incapacitating exacerbation of the

employee's condition. However, additional treatment for the incapacitating exacerbation may not exceed, and must comply with, the parameters in parts III. and IV.

XI. DEFINITIONS. (To be modified as necessary to conform to current KRS definitions)

The terms used in this chiropractic guideline have the meanings given them in this part.

A. Active treatment. "Active treatment" means treatment specified in part IV. which requires active patient participation in a therapeutic program to increase flexibility, strength, endurance, or awareness of proper body mechanics.

B. Chronic pain syndrome. "Chronic pain syndrome" means any set of verbal or nonverbal behaviors that:

1. involve the complaint of enduring pain;
2. differ significantly from the patient's preinjury behavior;
3. have not responded to previous appropriate treatment;
4. are not consistent with a known organic syndrome which has remained untreated; and
5. interfere with physical, psychological, social, or vocational functioning.

C. Condition. A patient's "condition" means the symptoms, physical signs, clinical findings, and functional status that characterize the complaint, illness, or injury related to a current claim for compensation.

D. Emergency treatment. "Emergency treatment" means treatment that is:

1. required for the immediate diagnosis and treatment of a medical condition that, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death; or
2. immediately necessary to alleviate severe pain. Emergency treatment includes treatment delivered in response to symptoms that may or may not represent an actual emergency but that is necessary to determine whether an emergency exists.

E. Etiology. "Etiology" means the anatomic alteration, physiologic dysfunction, or other biological or psychological abnormality which is considered a cause of the patient's condition.

F. Functional status. "Functional status" means the ability of an individual to engage in activities of daily living and other social, recreational, and vocational activities.

G. Initial chiropractic management or treatment. "Initial chiropractic management or treatment" is . treatment provided after an injury that includes passive treatment, active treatment, and durable medical equipment.

H. Medical imaging procedures. A "medical imaging procedure" is a technique, process, or technology used to create a visual image of the body or its function. Medical imaging includes, but is not limited to: X-rays, tomography, angiography, venography, myelography, computed tomography (CT) scanning, magnetic resonance imaging (MRI) scanning, ultrasound imaging, nuclear isotope imaging, PET scanning, and thermography.

I. Medically necessary treatment. "Medically necessary treatment" means those health services for a compensable injury that are reasonable and necessary for the diagnosis and cure or significant relief of a condition consistent with any applicable treatment parameter, the treatment must be reasonable and necessary for the diagnosis or cure and significant relief of a condition consistent with the current accepted standards of practice within the scope of the chiropractor as defined by KRS 312.

The care is presumed to be medically necessary if it conforms to the care defined in the appropriate clinical category and the treatment is resulting in progressive improvement in at least 2 of the 3 specified subitems (1) to (3):

(1) the employee's subjective complaints of pain or disability are progressively improving, as evidenced by documentation in the medical record of decreased distribution, frequency, duration, or intensity of symptoms;

(2) the objective clinical findings are progressively improving, as evidenced by documentation in the medical record of resolution or objectively measured improvement in clinical signs of injury; and

(3) the employee's functional status, especially vocational activities, is progressively improving, as evidenced by documentation in the medical record, or successive reports of work ability, of less restrictive limitations on activity.

J. Neurologic deficit. "Neurologic deficit" means a loss of function secondary to involvement of the central or peripheral nervous system. This may include, but is not limited to, motor loss; spasticity; loss of reflex; radicular or anatomic sensory loss; loss of bowel, bladder, or erectile function; impairment of special senses, including vision, hearing, taste, or smell; or deficits in cognitive or memory function.

1. "Static neurologic deficit" means any neurologic deficit that has remained the same by history or noted by repeated examination since onset.

2. "Progressive neurologic deficit" means any neurologic deficit that has become worse by history or noted by repeated examination since onset.

K. Passive treatment. "Passive treatment" is any treatment modality specified in

part III. Passive treatment modalities include bedrest; thermal treatment; traction; acupuncture or other needling techniques; electrical muscle stimulation; braces; manual and mechanical therapy; massage; and adjustments.

L. Supportive Chiropractic Care is defined as, Passive and active chiropractic treatment/care for the chronic management of patients having reached maximum therapeutic benefit with a Permanent Impairment and an ALJ judgement for “ongoing care for cure and/or relief of a work related injury”. Supportive Care is appropriate for patients who clinically deteriorate by failing to sustain their previous functional improvements and pain relief levels if chiropractic treatment is withdrawn. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home based self care and lifestyle modifications are being attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care.

(a) Periodic trials of chiropractic treatment withdrawal should be made every 3 months the first year; every 6 months the second year, and annually, thereafter.

(b) The withdrawal should be attempted for a period equal to twice the current treatment interval, if tolerated. (i.e., a patient being treated every 4 weeks should attempt an 8 week withdrawal of care.)

(c) Documentation of functional and pain deterioration is required to establish the need for continued supportive care. Currently accepted pain scale and functional outcome assessment instruments should be completed on a regular basis to establish the functional and pain relief gains; and be completed to document any deterioration due to the withdrawal of care.

(d) The goal of supportive care is to achieve the maximum interval between treatments with patient self care strategies such as activity modification and home exercise.

(e) The purpose of Supportive Care chronic management is threefold: the patient should be made as independent as possible of health care providers in the ongoing care of a chronic condition; and the patient should be returned to, or maintain, the highest functional status reasonably possible and treatment should provide relief from the effects of an injury.

XII. PARAMETERS FOR CHIROPRACTIC IMAGING.

General principles. All imaging must comply with items A to E. Except for emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study.

A. Effective imaging. A health care provider should initially order the single most effective imaging study for diagnosing the suspected etiology of a patient's condition. No concurrent or additional imaging studies should be ordered until the results of the first study are known and reviewed by the treating health care provider. If the first imaging study is negative, no additional imaging is indicated except for repeat and alternative imaging allowed under items D and E.

B. Appropriate imaging. Imaging solely to rule out a diagnosis not seriously being considered as the etiology of the patient's condition is not indicated.

C. Routine imaging. Imaging on a routine basis is not indicated unless the information from the study is necessary to develop a treatment plan.

D. Repeat imaging. Repeat imaging, of the same views of the same body part with the same imaging modality is not indicated except as follows:

- (1) to diagnose a suspected fracture or suspected dislocation;
- (2) to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment; repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment;
- (3) to follow up a surgical procedure;
- (4) to diagnose a change in the patient's condition marked by new or altered physical findings;
- (5) to evaluate a new episode of injury or exacerbation which in itself would warrant an imaging study; or
- (6) when the treating health care provider and a radiologist from a different practice have reviewed a previous imaging study and agree that it is a technically inadequate study.
- (7) When prior imaging studies are not available to the treating chiropractor after reasonable attempts to obtain them have been documented.

E. Alternative imaging.

(1) Persistence of a patient's subjective complaint or failure of the condition to respond to treatment are not legitimate indications for repeat imaging. In this instance an alternative imaging study may be indicated if another etiology of the patient's condition is suspected because of the failure of the condition to improve.

(2) Alternative imaging is not allowed to follow up negative findings unless there has been a change in the suspected etiology and the first imaging study is not an appropriate evaluation for the suspected etiology.

(3) Alternative imaging is allowed to follow up abnormal but inconclusive findings in another imaging study. An inconclusive finding is one that does not provide an adequate basis for accurate diagnosis.

Specific imaging procedures for low back pain. Except for the emergency evaluation of significant trauma, a health care provider must document in the medical record an appropriate history and physical examination, along with a review of any existing medical records and laboratory or imaging studies regarding the patient's condition, before ordering any imaging study of the low back.

A. Computed tomography (CT) scanning is indicated any time that one of the following conditions is met:

- (1) when cauda equina syndrome is suspected;
- (2) for evaluation of progressive neurologic deficit; or
- (3) when bony lesion is suspected on the basis of other tests or imaging procedures.
- (4) When MRI is indicated but unavailable or contraindicated.

Except as specified in subitems (1) to (3), CT scanning is not indicated in the first eight weeks after an injury.

Computed tomography scanning is indicated after eight weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

B. Magnetic resonance imaging (MRI) scanning is indicated any time that one of the following conditions is met:

- (1) when cauda equina syndrome is suspected;
- (2) for evaluation of progressive neurologic deficit;
- (3) when previous spinal surgery has been performed and there is a need to differentiate scar due to previous surgery from disc herniation, tumor, or hemorrhage; or
- (4) suspected discitis.

Except as specified in subitems (1) to (4), MRI scanning is not indicated in the first eight weeks after an injury. Magnetic resonance imaging scanning is indicated after eight weeks if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.

C. Myelography is indicated in the following circumstances:

- (1) may be substituted for otherwise indicated CT scanning or MRI scanning in accordance with items A and B, if those imaging modalities are not locally available;
- (2) in addition to CT scanning or MRI scanning, if there are progressive

neurologic deficits or changes and CT scanning or MRI scanning has been negative; or

(3) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

D. Computed tomography myelography is indicated in the following circumstances:

(1) the patient's condition is predominantly sciatica, and there has been previous spinal surgery, and tumor is suspected;

(2) the patient's condition is predominantly sciatica and there has been previous spinal surgery and MRI scanning is equivocal;

(3) when spinal stenosis is suspected and the CT or MRI scanning is equivocal;

(4) in addition to CT scanning or MRI scanning, if there are progressive neurologic symptoms or changes and CT scanning or MRI scanning has been negative; or

(5) for preoperative evaluation in cases of surgical intervention, but only if CT scanning or MRI scanning have failed to provide a definite preoperative diagnosis.

E. Intravenous enhanced CT scanning is indicated only if there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor, but only if intrathecal contrast for CT-myelography is contraindicated and MRI scanning is not available or is also contraindicated.

F. Gadolinium enhanced MRI scanning is indicated when:

(1) there has been previous spinal surgery, and the imaging study is being used to differentiate scar due to previous surgery from disc herniation or tumor;

(2) hemorrhage is suspected;

(3) tumor or vascular malformation is suspected;

(4) infection or inflammatory disease is suspected; or

(5) unenhanced MRI scanning was equivocal.

G. Discography is indicated when:

(1) all of the following are present:

(a) back pain is the predominant complaint;

(b) the patient has failed to improve with initial nonsurgical management;

(c) other imaging has not established a diagnosis; and

(d) lumbar fusion surgery is being considered as a therapy; or

(2) there has been previous spinal surgery, and pseudoarthrosis, recurrent

disc herniation, annular tear, or internal disc disruption is suspected.

H. Computed tomography discography is indicated when:

- (1) sciatica is the predominant complaint and lateral disc herniation is suspected; or
- (2) if appropriately performed discography is equivocal or paradoxical, with a normal X-ray pattern but a positive pain response, and an annular tear or intra-annular injection is suspected.

I. Nuclear isotope imaging (including technicium, indium, and gallium scans) are not indicated unless tumor, stress fracture, infection, avascular necrosis, or inflammatory lesion is suspected on the basis of history, physical examination findings, laboratory studies, or the results of other imaging studies.

J. Thermography is not indicated for the diagnosis of any of the clinical categories of low back conditions in this guideline.

K. Anterior-posterior (AP) and lateral X-rays of the lumbosacral spine are limited by subitems (1) and (2).

- (1) They are indicated in the following circumstances:
 - (a) when there is a history of significant acute trauma as the precipitating event of the patient's condition, and fracture, dislocation, or fracture dislocation is suspected;
 - (b) when the history, signs, symptoms, or laboratory studies indicate possible tumor, infection, or inflammatory lesion;
 - (c) when the patient is more than 50 years of age;
 - (d) before beginning a course of treatment with spinal adjustment or manipulation; or
 - (e) eight weeks after an injury if the patient continues with symptoms and physical findings after the course of initial nonsurgical care and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities.
- (2) They are not indicated in the following circumstances:
 - (a) to verify progress during initial nonsurgical treatment; or
 - (b) to evaluate a successful initial nonsurgical treatment program.

L. Oblique X-rays of the lumbosacral spine are limited by subitems (1) and (2).

- (1) They are indicated in the following circumstances:
 - (a) to follow up abnormalities detected on anterior-posterior or lateral X-ray;
 - (b) for postoperative follow-up of lumbar fusion surgery; or
 - (c) to follow up spondylolysis or spondylolisthesis not adequately diagnosed by other indicated imaging procedures.
- (2) They are not indicated as part of a package of X-rays including anterior-

posterior and lateral X-rays of the lumbosacral spine.

M. Electronic X-ray analysis of plain radiographs and diagnostic ultrasound of the lumbar spine are not indicated for diagnosis of any of the low back conditions in this guideline.

XIII. COMPLICATIONS

Prior history, traumatic onset, ergonomic and environmental conditions, comorbidities, age, overall fitness and psychosocial factors are among the factors that may influence patient recovery. Documentation of these factors and adapting treatment strategies may help anticipate and prevent slow or incomplete recovery.

Each individual case may be assessed by observation and documentation of complicating factors. Both biomechanical and psychosocial effects are important considerations. Together they identify factors of causation, recurrence and delayed recovery. Caution is necessary, however, in considering risk factors; many patients with significant risk factors respond well to treatment and achieve significant improvement and return to full function. Patients with a significant number of risk factors should be closely monitored.

Some of the confirmed risk factors:

Category	Factor
Personal	
Age	(older)
Gender	(female)
Severity of symptoms	Leg pain > back pain
Increased spine flexibility	
Reduced muscle endurance	
Prior recent injury	(< 6 months) including surgery
Prior surgery	
Asymmetric atrophy of multifidus	up to 5 years later
Abnormal joint motion	with or without abnormal emg function of medial spine extensors
Poor body mechanics	
Falling as mechanism of prior injury	
Biomechanical	
Prolonged static posture	> 20 degrees (odds ratio 5.9)
Poor spinal motor control	
Vehicle operation	> 2 hours per day
Sustained (frequent / continuous) trunk load	> 20 lbs
Materials handling	(Static work postures, frequent bending and twisting, lifting demands, pushing, pulling and repetitive exertion)

Psychosocial

Condition chronicity

Employment history (<5 years same employer)

Employment satisfaction

Lower wage employment

Family / relationship stress

Attorney retention

Low patient expectations of recovery

Attachment 3 B
Chiropractic Treatment Guideline Recommendation

We, the chiropractic physician panelists on the Treatment Guidelines Subcommittee were unable to agree with the medical physicians that the ODG are an acceptable Low Back treatment guideline, especially for the practice of chiropractic in the Commonwealth of Kentucky. The editorial advisory board of the ODG is comprised of 78 people, including 62 doctors of medicine, 2 doctors of osteopathy, and only 2 doctors of chiropractic. Neither the American Chiropractic Association, representing the largest number of chiropractors in the world, nor, any of the profession's recognized researchers, were represented on the panel.

While the ODG cites numerous references to support their recommendations; the process is reliant on a medically dominated committee's selection and interpretation of the data. We have no confidence that a committee dominated by 62 medical physicians and only 2 DCs who do not represent the majority of practicing chiropractors or even chiropractic researchers, can produce a credible recommendation for chiropractic care. None of the papers cited in ODG supports the use of their rigid recommendations for the typical injured worker. Their visit limits for chiropractic patients are established from self-admitted "ideal protocols". These specific "ideal protocol" numbers beg for misuse and abuse by those overseeing care based on the cookbook approach of ODG. In our opinion, ODG's numbers are not only arbitrary, but overly conservative and will lead to unnecessary specialist referral, diagnostic imaging, pain relief prescriptions and surgical intervention in the injured worker population. This is certainly contrary to the stated goals of the Utilization Review Committee.

The prestigious Rand Institute evaluated ODG and four other guidelines at the request of the state of California, and ODG was not found to be a valid guideline for any of the low back treatment issues evaluated. From the Rand report's, "Clinical Evaluation Summary: Panelists' Assessment of Comprehensiveness and Validity", we find that ODG was rated "Appropriate" in only 2 of 6 criteria for both Physical Therapy and Chiropractic.

Rand's conclusion of ODG's recommendations on Lumbar spine physical therapy (passive care) and chiropractic care is found in the Panelists' Assessment of the Comprehensiveness and Validity of Content Addressing the Quantity of Physical Modalities, wherein they find, "Lumbar spine physical therapy = Validity uncertain"; and, "Lumbar spine chiropractic = Validity uncertain". We, the chiropractic panelists find guidelines with such weak validity unacceptable for treatment of an entire segment of the injured worker population.

Rand concluded that, "The ODG guideline set was rated comprehensive and valid for both carpal tunnel surgery and shoulder surgery; the other two topics were of 'uncertain validity' [Note that Low Back was not judged to be "comprehensive and valid"]. And finally: Seven of the 11 Rand panelists felt that "The five selected guidelines [including ODG] 'are not as valid as everyone would want in a perfect world.'; "They do not meet or exceed standards; they barely meet standards." [and] "California could do a lot better by starting from scratch."

We, the chiropractic panelists on the Treatment Guideline Committee, concurred with Rand's conclusion and have serious doubts about the acceptability of the ODG by the citizens of Kentucky and their health care providers. Therefore, we have developed a chiropractic Low Back guideline based on the Workers' Compensation Parameters adopted into law by both Minnesota and Wisconsin. We have labored to update these Parameters with new evidence from the soon to be released nationally recognized Chiropractic Committee on Guidelines and Practice Parameters, Low Back Chapter Literature Review, and to adapt them to the Kentucky statutes and regulations governing chiropractic practice and the Workers' Claims' system. We recommend them for consideration by the Executive Director of the Office of Worker's Claims.

Respectfully submitted,

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