

MANAGEMENT OF CHRONIC SPINE-RELATED CONDITIONS: CONSENSUS RECOMMENDATIONS OF A MULTIDISCIPLINARY PANEL

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ABSTRACT

Objective: Chronic spine-related conditions are very problematic in terms of treatment and indemnity costs, diagnostic complexity, and appropriate case management. Currently no chiropractic-directed guideline exists related to chiropractic management of the chronic spine pain patient. The purpose of this project was to develop a broad-based multidisciplinary consensus of medical and chiropractic clinical experts representing mainstream medical and chiropractic practice to produce a document designed to provide standardized parameters of care and documentation.

Methods: Background materials were provided to the panelists prior to the consensus process and served as the basis for the 29 seed statements. Delphi rounds were conducted electronically, and the Nominal Group Panel was conducted via conference call. The RAND/UCLA methodology was used to reach consensus, which was considered present if both the median rating was 7 or higher and at least 80% of panelists rated the statement 7 or higher. Consensus was reached through a combination of Delphi rounds and Nominal Group Panel. Of 29 panelists, 5 were non-doctors of chiropractic.

Results: Specific recommendations regarding treatment, frequency and duration, as well as outcome assessment and contraindications for manipulation, were agreed upon by the panel.

Conclusions: A multidisciplinary panel of experienced practitioners was able to reach a high level (80%) of consensus regarding specific aspects of the chiropractic approach to care for complex patients with chronic spine-related conditions, based on both the scientific evidence and their clinical experience. (*J Manipulative Physiol Ther* 2010;33:484-492)

Key Indexing Terms: *Chiropractic; Chronic Spine Pain; Manipulation*

SCOPE OF THE CHRONIC PAIN PROBLEM

Chronic pain is considered the most underestimated health care problem impacting quality of life. Today, chronic pain is one of the most common reasons for patients to seek medical care; it is estimated that 35% of the US population in general, 25% of children younger than 18 years, and 50% of community-dwelling older adults experience chronic pain.^{1,2} The majority of chronic pain is spine-related.³ Health care costs associated with spine problems, including low back pain (LBP) and neck pain, were estimated at \$102

billion in the United States in 2004.⁴Total estimated expenditures among individuals with spine problems increased 65% (adjusted for inflation) from 1997 to 2005, more rapidly than overall health expenditures.⁵

PHARMACOLOGICAL MANAGEMENT AND ASSOCIATED COSTS

Frequent use of opioids in managing chronic non-cancer pain has been a major issue for health care in the United States, with significant concerns related to adverse effects,

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misuse, abuse, and addiction.³ While these medications serve as powerful pain killers, they have also been implicated for potential drug abuse. A 2006 Centers for Disease Control and Prevention report showed that the rise in drug overdose mortality was due to increasing deaths from prescription drugs, rather than from illicit drugs such as heroin and cocaine.⁶ Furthermore, approximately 21% of people with chronic pain find their care unsatisfactory, and only 30% find that prescription medications adequately address their pain.¹

Most chronic pain sufferers initially try to self-manage their symptoms with over-the-counter analgesic drugs. Perhaps because of their ready availability to the general public, over-the-counter drugs are a significant source of morbidity and mortality in the United States, especially acetaminophen, salicylates, and nonsteroidal anti-inflammatory drugs such as ibuprofen and naproxen.⁷

CHIROPRACTIC MANAGEMENT

Chiropractic practice has long been associated with managing neuromusculoskeletal conditions, predominantly back pain. There is a substantial body of literature to support the effectiveness of this care.⁸ A synthesis of recommendations for acute LBP suggests that clinicians should educate patients about its etiology (eg, unknown and nonspecific), prognosis (eg, likely to improve within weeks with or without care), recurrence (eg, future occurrences are common). They should also recommend that patients stay active despite discomfort and rely mostly on acetaminophen, nonsteroidal anti-inflammatory drugs or spinal manipulative therapy for short-term symptomatic relief. Those recommendations also held true for the management of chronic LBP, with the judicious addition of one or more interventions, such as back exercises, behavioral therapy, acupuncture, yoga, massage therapy, multidisciplinary rehabilitation, and adjunctive or strong opioid analgesics.^{4,9}

There is also moderate quality evidence that spinal manipulation/mobilization combined with exercise is effective for chronic non-specific neck pain.⁸ There is low-quality evidence supporting the clinical benefit of mobilization and manipulation for pain, function and global perceived effect for patients with chronic cervicogenic headache, compared to controls at intermediate and long-term follow-up.¹⁰

In 2007 the American College of Physicians and the American Pain Society released a joint guideline related to the diagnosis and treatment of low back pain. According to their review of the literature, spinal manipulation was recommended for both acute and chronic low back pain.⁹

Due to the scope of chronic pain problem in the United States and the lack of clear guidelines related to chronic pain treatment rendered by chiropractic physicians, the Council on Chiropractic Guidelines and Practice Parameters (CCGPP) conducted a formal consensus process with a multidisciplinary panel of experts to develop rational, appropriate patient-centered treatment guidelines for patients with chronic spine-

related pain who prefer an alternative/complementary management strategy to pharmaceutical use.

METHODS

Background Materials and Seed Documents

Several documents were provided to the panelists prior to the consensus process. These included (1) guidelines on the management of chronic spinal pain through interventional techniques (injections), by the American Society of Interventional Pain Physicians,¹¹ to provide context and comparisons for the current project; (2) “Chiropractic Management of Low Back Disorders,” which reported on a previous consensus project conducted by CCGPP¹²; (3) the introductory article to an issue of *The Spine Journal* dedicated to management of chronic low back pain¹³; (4) “Evidence-Informed Management of Chronic Low Back Pain with Spinal Manipulation and Mobilization;”¹⁴ (5) “Consensus Terminology for Stages of Care: Acute, Chronic Recurrent and Wellness,” an article with consensus definitions of these stages arrived at through another CCGPP project.¹⁵ The core committee, composed of CCGPP Executive Committee members, developed 29 seed statements, based on the background documents.

Consensus Panel

Delphi panelists were solicited through a press release and word of mouth. Every attempt was made to include not only experienced chiropractors but also other health professionals involved in the conservative management of chronic pain.

Conduct of Delphi Rounds

All Delphi rounds were conducted electronically, by e-mail. The panelists’ rating forms were identified only by an ID number, which was only connected to the panelist’s name by the project coordinator, in order to distribute and collect the forms. The panelists did not know one another’s identity until the consensus process was concluded. We used the consensus process methodology established by RAND/UCLA to seek consensus on the seed statements.¹⁶ Statements were rated on an ordinal rating scale of 1 to 9 (highly inappropriate to highly appropriate); as specified by RAND/UCLA, “appropriateness” indicated that the expected health benefit to the patient exceeds the expected negative consequences by a sufficiently wide margin that it is worth doing, exclusive of cost.¹⁶ To score the ratings, we considered ratings of 1 to 3 to indicate “inappropriate;” 4 to 6 to indicate “undecided,” and 7 to 9 to indicate “appropriate.” Inappropriate ratings required that the panelist provide a specific reason and, if possible, a supporting citation from the peer-reviewed literature. The ratings were entered into an SPSS v 17.0 database (SPSS, Chicago, IL). Consensus on a statement’s appropriateness

was considered to be present if both the median rating was 7 or higher and a minimum of 80% of panelists rated the statement 7 or higher. Panelists were allowed to make comments of any length on each statement. The core committee then reviewed all comments and then, based on these comments, revised statements on which consensus was not reached. The revised statements, accompanied by the deidentified comments, were circulated in the next round. Although consensus was reached after 3 rounds, 2 panelists requested that they be allowed to give a minority statement because they strongly disagreed with 2 statements. In order to gain full consensus, we conducted an additional two Delphi rounds, in conjunction with the Nominal Group Panel, at which time all disagreement was resolved.

Composition of the Delphi Panel

Of the 29 panelists, 24 were doctors of chiropractic (DCs); the 5 non-DC panelists consisted of an acupuncturist, massage therapist, medical physician (pain management specialist), physical therapist and massage therapist. Geographically, 2 countries (US and UK) and 14 states (CA, CT, FL, GA, HI, IA, IL, MA, MN, NV, NY, OH, UT, WI) were represented. The mean number of years in practice for the 29 panelists was 24. Of the 23 US DCs, 14 (61%) were members of the American Chiropractic Association; 2 (9%) of the International Chiropractors Association, and the rest did not belong to any national chiropractic organization.

Conduct of Nominal Group Panel

Similarly to Delphi panels, Nominal Group Panels (NGPs) are used for problem solving and also for developing consensus.¹⁷

We conducted the NGP electronically, an innovative method we had used successfully in a previous consensus project.¹⁵ Nominal Group Panel participants self-selected from the Delphi panel. The NGP was used to clarify issues that arose during the Delphi panel that would have been difficult to resolve without real-time participant interactions. There were 12 panelists, all but one DCs; the other panelist was an MD (pain management specialist).

RESULTS

The following statements were the result of the consensus process.

Definition of Maximum Therapeutic Improvement

Maximum therapeutic improvement (MTI) is defined as the point at which a patient's condition has plateaued and is unlikely to improve further.

Definition of "Chronic Pain Patients"

Chronic pain patients are those for whom ongoing supervised treatment/care has demonstrated clinically meaningful improvement with a course of management and have reached MTI, 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. Additional relevant definitions in common use are provided in [Table 1](#).

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 MTI 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.

Prognostic Factors

Prognostic factors that may provide a partial basis for the necessity for chronic pain management of spine-related conditions after MTI 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)

Table 1. Definitions of chronic pain-related terminology

Term	Definition
Acute episode/disorder	...return to pre-episode status: six to eight weeks ¹⁸
Complicated case	A case where the patient, because of one or more identifiable factors, exhibits regression or retarded recovery in comparison with expectations from the natural history. ¹⁸
Chronic episode/disorder	...symptoms have been prolonged beyond 16 weeks ¹⁸
Chronic low back pain	...back related limitations lasting longer than 3 months ¹⁹
Chronicity	Acute: 6-8 weeks Subacute: 8-16 weeks Chronic: >16 weeks ¹⁸
Disability	An umbrella term for activity limitations and/or participation restrictions in an individual with a health condition, disorder or disease. ²⁰
Exacerbation	Temporary worsening of a pre-existing condition. Following a transient increase in symptoms, signs, disability, and/or impairment, the person recovers to his or her baseline status, or what it would have been had the exacerbation never occurred. Given a condition whose natural history is one of progressive worsening, following a prolonged but still temporary worsening, return to pre-exacerbation status would not be expected, despite the absence of permanent residuals from the new cause. ²⁰
Impairment	A significant deviation, loss, or loss of use of any body structure or function in an individual with a health condition, disorder, or disease. ²⁰
Permanent impairment	An impairment extant at the point of maximal medical improvement. ²⁰
Recurrence	Reappearance of the symptoms and/or signs of a disease after a remission (period during which the manifestations were absent or significantly diminished). ²⁰

- 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 MTI, 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 MTI.
- Psychological factors
A history of depression, anxiety, somatoform disorder or other psychopathology may complicate treatment and/or recovery.

Treatment Withdrawal Fails to Sustain MTI

Documented flare-ups/exacerbations, that is, phases of increased pain, 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. A flare-up or exacerbation is characterized by a return of atypical pain and/or other symptoms and/or pain-related difficulty performing tasks and actions equivalent to the appropriate minimal clinically important change value for the outcome of interest.

- 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]

Table 2. *Complicating factors that may document the necessity of ongoing care for chronic conditions*

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- 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 MTI
-

Complicating/Risk Factors for Failure to Sustain MTI

Table 2 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.

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:

- Symptoms
- Psychosocial factors
- Function
- Occupational factors

Factors directly associated with the clinician/patient encounter may influence (increase or decrease the likelihood) the transition toward chronicity:

- Treatment expectations: patients with high expectations for a specific treatment have been shown to

demonstrate better functional outcomes if they received that treatment

- Significant others' support: overprotectiveness and encouraging avoidance may contribute to the risk of chronicity. In contrast, the risk of chronicity may be reduced when significant others encourage participation in social and recreational activities
- Healthcare practitioners' attitudes and beliefs – clinicians' beliefs about activity seem to influence their self-reported practice behaviors

Diagnosis

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.
- MTI has been reached and documented.
- Patient-centered outcome assessment instruments.
- Analgesic use patterns.
- Other health care services used.

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 (eg, 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^{21,22}).

This list is provided for guidance only and is not all-inclusive. All of these items are not required to justify the

Table 3. *Clinical information often relied on to document the necessity of ongoing care for chronic conditions*

In addition to standard documentation elements (ie, date, history, physical evaluation, diagnosis and treatment plan,²³ 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 MTI
- Significant residual deficits in activity limitations are present at MTI
- 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 MTI

need for ongoing care. Each appropriate item of clinical information should be documented in the case file to describe the patient's clinical status, present and past. [Table 3](#) summarizes the clinical information that may be used to document the necessity of ongoing care for patients with chronic conditions.

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 MTI 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

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. These include but are not limited to the items indicated in [Table 4](#).

Chronic pain management treatment planning/dosaging

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.²⁴

Although the visit frequency and duration of supervised treatment vary, and are influenced by the rate of recovery toward MTI values and the individual's ability to self-manage the recurrence of complaints, a reasonable therapeutic trial for managing patients requiring ongoing

Table 4. *Components which may be included in physician-directed case management*

Active Care

- Supervised rehabilitative/therapeutic exercise
 - General exercise programs
 - Specific exercise approaches
 - Mind/body programs, eg, yoga, Tai Chi, etc.
- Multi-disciplinary rehabilitation
- Cognitive behavioral programs

Counseling

- ADL recommendations/counseling
- Co-management/coordination of care with other physicians/healthcare providers
- Ergonomic recommendations/counseling
- Exercise recommendations/counseling and instruction
- Home care recommendations
- Lifestyle modifications/counseling
- Pain management recommendations
- Psycho-social counseling/behavioral modification
- Risk avoidance counseling
- Monitoring patient compliance with self-care recommendations

Passive Care

- Manual therapy procedures
 - Adjustment/manipulation of joint structures
 - Mobilization of joint structures
 - Mobilization of soft-tissue
 - Massage therapy
- Physical modalities
 - Thermal
 - Acoustic
 - Light
 - Mechanical
 - Electrical
- Acupuncture
- Bracing/orthoses

care is up to 4 visits after a therapeutic withdrawal. See [Table 5](#) for a summary of dosaging and re-evaluation recommendations.

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

Table 5. Chronic care dosaging recommendations^a

Stage	Dosaging	Re-evaluation
Mild exacerbation	1-6 visits per episode	At beginning of each episode of care
Scheduled ongoing care	1-4 visits per month	At minimum every 12 visits, or as necessary to document condition changes.
Moderate exacerbation	Follow acute care guidelines ¹²	Every 2-4 weeks, following acute care guidelines ¹²
Severe exacerbation	Follow acute care guidelines ¹²	Every 2-4 weeks, following acute care guidelines ¹²

^a The ultimate goal is providing the least frequent level of direct physician care to maintain the highest level of documented physical functioning. When an individual case warrants it, the clinical necessity to exceed guidelines parameters must be documented adequately.

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.²⁵

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

Chronic Care Goals

Chronic care goals are to:

- 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

Complex cases that require modification of manipulative technique

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 prudent to document the steps taken to minimize the additional risk that these conditions may present.

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

Table 6. Red flags that are contraindications to ongoing high velocity low amplitude (HVLA) spinal manipulation

<ul style="list-style-type: none"> • Progressive neurological disorders • Cauda Equina syndrome • Bone weakening disorders, ie, acute spinal fracture, spinal infection, spinal or extra-vertebral bony malignancies • Tumor • Articular derangements indicating instability, ie, active avascular necrosis in weight-bearing joints

likelihood of patient harm. Table 6 summarizes red flags that present contraindications to ongoing high velocity, low amplitude spinal manipulation.

DISCUSSION

It is important for the reader to recognize that these guidelines are intended to be flexible and may need to be modified. They are not standards of care. Adherence to them is voluntary. Alternative practices are possible and may be preferable under certain clinical conditions. The ultimate judgment regarding the propriety of any specific procedure must be made by the practitioner in light of individual circumstances presented by each patient.¹⁸

There is substantial agreement on the management of acute, and episodic chronic pain related to mild, moderate, and/or severe exacerbations for the typical patient presentation. Relative to low back pain, CCGPP’s project, described in the 2008 publication, “Chiropractic Management of Low Back Disorders: A Consensus Report” has addressed those patients.¹² Therefore, this project focused on the problematic category of patients whose chronic pain is not successfully controlled without ongoing care. Management of this category of patient contributes substantially to overall medico-legal complications and costs. Since no chiropractic guideline currently exists to address this problem, these patients may be inappropriately denied chiropractic care and must therefore turn to more expensive, more invasive, and often less effective therapies.

Although this document may provide some assistance to third party payers in the evaluation of care, it is not by itself a proper basis for evaluation. Many factors must be considered in determining clinical or medical necessity, including the best available scientific evidence, the clinical experience of the involved practitioners and the patient’s personal preferences. Furthermore, guidelines require periodic re-evaluations as additional scientific and clinical information becomes available.

Limitations

The chief limitation of this project was the lack of diversity in the consensus panel, which included only 5 non-DCs and only 2 International Chiropractors Association members. CCGPP had hoped to attract a broader, more multidisciplinary panel. Our inability to do so may

reflect the longstanding isolation of the profession, as well as the factionalism within it. Another limitation may be related to the number of source documents available to provide to the panel as background chronic pain in use throughout the medical and research communities. Additional sources may have been useful for the panel to gain a broader understanding of common medical lexicon. We reviewed only a limited number of terms and perspectives centered on “chronic spine-related conditions.” There may be other terminology, definitions or perspectives which were not considered, although efforts were made to include those most commonly used in the health care arena. Limitations imposed by the Delphi process, as well as the limited diversity of the panel members may also have contributed to a bias in consideration of other definitions or terminology.

CONCLUSION

There is increasing evidence in the scientific literature supporting the long tradition of patients seeking chiropractic care when dealing with chronic spinal pain. As demonstrated above, there is also an obvious need for a safe, low-cost alternative to pharmaceutical chronic pain management. Therefore, it appears the time is right for chiropractic management of chronic pain for spine-related conditions to be embraced by the mainstream health care system.

The CCGPP has endeavored, through this consensus process, to provide a responsible care guide to assist healthcare providers in providing appropriate, evidence based chronic pain management to their patients while recommending appropriate documentation to allow reasonable evaluation by third-party payors.

Practical Applications

- The consensus process utilizing a multidisciplinary panel was successful in developing a set of case management recommendations.
- This document provides a case management compass for an evidence-based and reasonable approach to the chiropractic management of chronic spine pain patients who require ongoing care.
- This is an iterative process and case management recommendations will be updated as new evidence emerges.

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