Lower Back and Chronic Pain Section/Spinal Manipulation Recommendations

Respectfully submitted by Dr. Ronald Farabaugh and the OSCA BWC Work Comp Committee

Question: Does the literature support a recommendation for scheduled ongoing spinal manipulation for LB chronic pain sufferers who upon withdrawal from care deteriorate beyond the ability to home-manage?

Discussion:

For a small but problematic subpopulation of chronic LB pain patients, scheduled ongoing chronic care may be necessary once a plateau is attained in the acute care recovery, and upon therapeutic withdrawal (either gradual or abrupt) deteriorate functionally or symptomatically, beyond their ability to home-manage. Current guidelines from the Council on Chiropractic Guidelines and Practice Parameters (CCGPP) suggest that up to 1-4 visits per month *, with re-evaluation at a minimum of approximately 12 visits may be appropriate for certain complicated chronic pain patients. This type of care has been shown to reduce pain and disability along with significant reductions in the need for medications. [Senna, Cifuentes, Descaurreaux, Sarnat, CCGPP]. After approximately 12 visits another re-evaluation should be performed to determine the success or failure of treatment and the need for care or ability to discharge from active care. Ongoing care recommendations should include education/instruction on home-based care and other case management strategies.

Chronic care recommendations. The majority of chronic pain patients generally fall into four categories.

1. ***No physician-directed care necessary***. Patient may suffer mild chronic pain and requires very little if any self/home care.
2. ***No physician-directed care necessary***. Patient can manage chronic pain with self/home care such as NSAIDs, exercises, ice, heat.
3. ***Patient requires episodic physician-directed care***. Patient can managed acute flare-ups of chronic pain in short episodic bursts of care, 1-12 visits/episode, followed by release.
4. ***Patient requires scheduled ongoing physician-directed care.*** This patient deteriorates upon gradual or abrupt withdrawal from care, and therefore requires ongoing schedule care/pain management, at a frequency of 1-4 visits per month, to be re-evaluated at a minimum of every 12 visits. *****

General principles:

1. Only a small percentage of chronic pain patients typically require “ongoing scheduled” care, and typically these types of patients often require a multi-disciplinary, multi-modal team approach. These cases represent the most complicated of chronic pain categories.
2. There exists no standard or defined time frame for “therapeutic withdrawal”. The physician cannot predict nor dictate when a patient returns for care.

3. There exists no standard or defined number of therapeutic withdrawals that must be attempted before qualifying for ongoing scheduled care. This issue is case dependent and physician of record and/or IME must consider the response to care, co-morbidities, and complicating factors, etc.

* NOTE: It is rare that a patient would require 4 visits per month to manage even advanced or complicated chronic pain.

Please consider the following:

1. **[Senna 2011]** *"Conclusion: SMT is effective for the treatment of chronic non- specific LBP. To obtain long-term benefit, this study suggests maintenance spinal manipulations after the initial intensive manipulative therapy."* The design of this study included "maintenance spinal manipulation" every two weeks for nine months. Results: the group receiving maintenance spinal manipulation showed more improvement in pain and disability scores at the 10-month evaluation, compared to the other groups.[i]

2. **[Descarreaux]** *"Conclusion: Intensive spinal manipulation is effective for the treatment of chronic low back pain. This experiment suggests that maintenance spinal manipulations after intensive manipulative care may be beneficial to patients to maintain subjective post intensive treatment disability levels."* The design of this study included a group which received 12 treatments in an intensive 1-month period and also received maintenance spinal manipulation every 3 weeks for a 9-month follow-up period. Results: For the disability scores, only the group that was given spinal manipulations during the follow-up period maintained their post-intensive treatment scores.[ii]

3. **[Cifuentes]** *"Conclusion: In work-related nonspecific LBP, the use of health maintenance care provided by physical therapist or physician services was associated with a higher disability recurrence than in chiropractic services or no treatment.* Furthermore the authors found that after controlling for demographics and severity indicators, the likelihood of recurrent disability due to LBP for recipients of services during the health maintenance care period by all other provider groups was consistently worse when compared with recipients of health maintenance care by chiropractors.[iii]

4. **[Sarnat/AMI 2004 and 2007]** Conclusion: *During the past 7 years, and with a larger population than originally reported, the CAM-oriented PCPs using a nonsurgical/non-pharmaceutical approach demonstrated reductions in both clinical and cost utilization when compared with PCPs using conventional medicine alone. Decreased utilization was uniformly achieved by all CAM-oriented PCPs, regardless of their licensure.*

   RESULTS: Clinical and cost utilization based on 70,274 member-months over a 7-year period demonstrated decreases of 60.2% in-hospital admissions, 59.0% hospital days, 62.0% outpatient surgeries and procedures, and 85% pharmaceutical costs when compared with conventional medicine IPA performance for the same health maintenance organization product in the same geography and time frame. NOTE: It was not atypical for new AMI members to have PCP (DC) encounters at an average of twice per month.[iv v]

5. **[Council on Chiropractic Guidelines and Practice Parameters]** *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.* Design: 29 panelists representing a wide cross-section of the chiropractic profession in addition to 5 non-DC panelists, were able to arrive at a recommendation for chronic pain patients, based upon over 80% consensus/agreement. Consensus recommendations included: Scheduled ongoing care: 1-4 visits per month. Re-evaluation: At minimum every 12 visits, or as necessary to document condition changes. [vi]

6. **[American College of Physicians/Chou]** Recommendation 7: For patients who do not improve with self-care options, clinicians should consider the addition of non-pharmacologic therapy with proven benefits—for acute low back pain, spinal manipulation; for **chronic or subacute low back pain**, intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, **spinal manipulation**, yoga, cognitive-behavioral therapy, or progressive relaxation (weak recommendation, moderate-quality evidence).[vii]

Summary: There are six good studies and a medical guideline supporting the recommendation provided above. As with nearly all studies, additional research is needed regarding the proper management of chronic pain sufferers. Additionally, every study has certain limitations. However the weight of the evidence is persuasive enough at this point to provide a reasonable and conservative recommendation to assist providers, payors, and patients dealing with ongoing chronic pain, in regards to spinal manipulation.

Case Management/Documentation Suggestions:

Goals of Care: The general goals of chronic pain management include

(1) minimize/control pain,
(2) maximize ability to engage in common activities of daily living and/or work activity,
(3) reduce reliance on drugs, and
(4) return a patient to work, and/or keep them at work. [CCGPP]

Case management suggestions: (the following list is not all-inclusive, nor prescriptive, nor a standard of care, but does represent quality case management process):

1. The claimant has been determined to be at MMI/Permanent and stable (P&S).

2. The claimant has a documented complex spinal condition (i.e. – s/p laminectomy, s/p fusion, or MRI/CT evidence of spinal stenosis or severe lumbar spondylosis, chronic sprain/strain and/or instability, etc.).

3. The claimant has previously received chiropractic care which has demonstrated to provide clinically meaningful functional and/or symptomatic benefit.

4. The deterioration of the claimant's clinical status has been documented following reasonable trials of therapeutic withdrawal.

5. The claimant may have an ongoing history of prescription medication use or interventional procedures (ESI, MBB, or TP injections) for chronic pain which may be reduced or eliminated by the application of ongoing chiropractic care.

6. Ongoing care should continue to promote active care and further the development of self-efficacy.

7. Psychosocial issues may complicate a claimant's long-term recovery (i.e. anxiety, depression, pain avoidance behavior, etc.) Caution is warranted regarding frequent ongoing passive treatment of all types (ex. spinal manipulation rendered greater than 2x/month per month, narcotics, etc.) which may contribute to prolonged complaints of chronic pain and impairment.

8. See the CCGPP Chronic Pain paper for additional documentation and case management suggestions.

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[i] Senna et al. Does maintained Spinal manipulation therapy for chronic non-specific low back pain result in better long term outcome? Spine (Phila Pa 1976). 2011 Jan 17. [Epub ahead of print]

[ii] Descarreaux et al. Efficacy of preventive spinal manipulation for chronic low-back pain and related disabilities: a preliminary study. J Manipulative Physiol Ther. 2004 Oct;27(8):509-14.

[iii] Cifuentes et al. Health Maintenance Care in Work-Related Low Back Pain and Its Association With Disability Recurrence. JOEM Volume 53, Number 4, April 2011. Pages. 396-404.

[iv] Sarnat et al. Clinical utilization and cost outcomes from an integrative medicine independent physician association: an additional 3-year update. J Manipulative Physiol Ther. 2007 May;30(4):263-9.

[v] Sarnat et al. Clinical and cost outcomes of an integrative medicine IPA. J Manipulative Physiol Ther. 2004 Jun;27(5):336-47.

[vi] Farabaugh et al. Management of Chronic Spine-Related Conditions: Consensus Recommendations of a Multidisciplinary Panel. Journal of Manipulative and Physiological Therapeutics, September 2010. Volume 33, Number 7. Pages 484-492.

[vii] Chou et al. Clinical Efficacy Assessment Subcommittee of the American College of Physicians and the American College of Physicians/American Pain Society Low Back Pain Guidelines Panel. Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society. 2 October 2007 | Volume 147 Issue 7 | Pages 478-491.