Oregon

Chiropractic Practices

and Utilization Guidelines

Last updated Nov 2017

Common
Neuromusculoskeletal
Conditions
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Reference Documents:

Chiropractic Advisory Committee, Department of Labor & Industries, State of Washington

Chiropractic Standards of Practices and Utilization Guidelines in the Care and Treatment of Injured Workers

Council on Chiropractic Education
Clinical Competencies
FOREWORD

By Steven L. Gardner, D.C.
President, Oregon Board of Chiropractic Examiners

The Oregon Board of Chiropractic Examiners is pleased with volume I of this document. It combines the efforts of many fine Chiropractic Physicians with the academic perspective of Western States Chiropractic College. It is the result of research, hard labor, and healthy debate. The Board respectfully acknowledges that research provided both insight and language which was adopted here, however it is by design that this document was written by and for Oregonians.

The Board intends and believes that these guidelines will be helpful to all Oregon Chiropractors. Furthermore, and paramount to the Board, is that this guide will continue to refine the professional care provided to the Chiropractic patients of Oregon.

Future volumes will include other areas that are defined in the Chiropractic Practices Act of Oregon. The next volume of the document will include guidelines for Minor Surgery, Proctology, Obstetrics and Gynecology.

CHALLENGES

Dr. Melvin Turner was a graduate of Palmer Chiropractic College and the first chiropractor in Walla Walla Valley. He opened his office on Cherry Street in 1901. He found the practice of chiropractic very challenging. Every time he treated a patient he was jailed for "practicing medicine without a license". It was reported to have happened five times in one day. Chiropractors were not licensed in his community yet. Neither Dr. Turner nor his patients were discouraged however, each time he went to jail his patients paid the one dollar bail to set him free so he could treat others. You see, Dr. Turner provided an excellent service for his patients and they needed him. In fact, they demanded chiropractic care and although it took years, Dr. Turner was finally licensed. Today, Dr. Turner's son and grandson continue to provide excellent chiropractic care to the people in the Walla Walla Valley.

Ninety years later chiropractic physicians still find their practices very challenging. No matter what challenges are to be faced, chiropractic physicians must always place the welfare of their patients first. After all, it is only because of the patients that chiropractic exists. Practicing chiropractic in Oregon is a blessing and a privilege.
INTRODUCTION

By Michael G. Lang, D.C.
Chairman, Peer Review Committee

In 1989, the Oregon Board of Chiropractic Examiners, in keeping with its licensing and regulatory responsibilities, elected to direct the Peer Review Committee of the OBCE to coordinate the development of a document that would be of assistance to the Chiropractic profession as it pertains to outlining health care guidelines for the chiropractic physician.

To accomplish this objective, the Peer Review Committee in turn formed a 12 member Oregon Chiropractic Practices and Utilization Guidelines Committee. The composition of this group reflects a substantial amount of clinical field experience as well as a strong academic background from Western States Chiropractic College.

It is the desire of the OBCE to help ensure that a desirable level of both clinical competence and quality of care are rendered by each licensed practitioner. This document is an attempt to provide a guideline for assuring that quality and competence.

It should be emphasized that these guidelines are not designed to cover the complete scope of chiropractic practice in Oregon, but rather focus on the care and management of the common neuromusculoskeletal conditions that are encompassed within that scope of practice.

Finally, these guidelines are an expression of clinical experience and related research. As new research is done and additional clinical experience is gained, corresponding modifications will be appropriate to supplement the original consensus process.
CHAPTER I

GOALS AND OBJECTIVES FOR CLINICAL PRACTICE

As a primary health care provider and as a portal of entry to the health delivery system, an Oregon chiropractic physician is led by these goals and accomplishes their associated objectives.

I. Therapeutic Relationship

A. GOAL: Establish a satisfactory relationship with the individual seeking care and determine the nature of health problem(s) being presented.

B. OBJECTIVES:

1. Establish rapport in an atmosphere of physical comfort conducive to information gathering.

2. Provide for the presence of a third party, as required, to assist or observe in recording information, allaying apprehension, or other circumstances.

3. Elicit a thorough case history through written or oral means and provide a permanent record of findings with due regard for a patient's differing ethnic, cultural or linguistic background.

4. Include within each case history, chief complaint, present health pattern and relevant past health, injury or disability factors.

5. Assess the reliability of information presented.

II. Examination

A. GOAL: Provide such examination and diagnostic procedures and/or refer for additional diagnosis and management plan.

B. OBJECTIVES:

1. Specify which examination and diagnostic procedures are pertinent to the patient's complaint and present condition of health.

2. Perform such examination and diagnostic procedures within statutory scope of practice and clinic capabilities and consistent with efficient exploration of the condition presented.

3. Assess the sensitivity, specificity and predictive value of examination procedures selected.

4. Conduct examination and diagnostic procedures in an objective manner, remaining impartial with respect to etiology and extent of condition.

5. If referring for outside examination or diagnostic procedures, explain the rationale for additional testing to the patient.

6. Assess historical and physical data to identify contraindications or non-indications for chiropractic care.

7. If referring to another health care provider, include the courtesy of an appropriate referral report as required.
8. Accurately record examination findings in the patient's case file consistent with common practice.

III. Diagnosis

A. GOAL: Arrive at provisional diagnoses or clinical impressions consistent with the presenting complaint(s) and the results of examination and diagnostic procedures conducted.

B. OBJECTIVES:

1. Gather and interpret the results of all examination and diagnostic procedures, differentiating between normal and abnormal findings and determining the relevance of each of the presenting complaint(s).

2. Select subsequent evaluation procedures that are appropriate to the continued investigation of the patient's condition.

3. Differentiate between clinical entities common to chiropractic practice.

4. Rule in or rule out the pathophysiological processes responsible for the patient's presenting complaint(s).

5. Record objectively supported provisional diagnoses or clinical impressions, complicating factors and/or concomitant conditions using common diagnostic lexicon.

IV. Prognosis and Decision to Treat and/or Refer

A. GOAL: Arrive at a provisional prognosis and determine whether to accept the patient for chiropractic care and/or refer to another health care provider. Consider the risk and cost/benefit ratios incurred.

B. OBJECTIVES:

1. Determine the patient's provisional prognosis.

2. Determine whether the condition is amenable to chiropractic care and is within the scope of chiropractic practice.

3. If any portion of the patient's condition is not treatable within the scope of chiropractic practice, refer to the appropriate health care provider in an expedient and professional manner.

V. Treatment Plan

A. GOAL: Decide upon and initiate an efficient and effective treatment and regimen.

B. OBJECTIVES:

1. Use only those treatment procedures and modalities within the statutory scope of practice and consistent with a fair appraisal of the cost/benefit ratio.

2. Record and date the treatment plan, including expected length and intensity of treatment, in the case file.
3. If there are any general or specific considerations or contraindications for care, note them in the case file and modify the plan appropriately and/or refer the patient to another provider.

4. Educate the patient about his/her condition, diagnosis and rationale for the treatment plan; outlining expectations and significant risks. Obtain consent from the patient.

5. Record the course of treatment in a format that permits interpretation by health care providers.

VI. Monitoring

A. GOAL: Assess the effectiveness of the treatment plan and make appropriate changes in case management as required.

B. OBJECTIVES:

1. Perform ongoing assessment of both subjective and objective findings; noting them in the case file.

2. Identify the need and extent of re-examination necessary to assess significant exacerbations or deviations from planned recovery.

3. Conduct such examinations and refer for consultation to adequately monitor changes in the patient's condition.

4. Evaluate new objective findings, integrating them with historical data, and changing diagnoses and treatment appropriately, including referral to another provider in the best interest of the patient.

5. Provide sufficient information in reports to be authorized by a third party representative of the patient to permit informed understanding of patient progress and intelligent decision making on authorization of services.

VII. Discharge

A. GOAL: Decide on the appropriate termination of services either at the endpoint of treatment or when no further improvement in the patient's condition can reasonably be expected. This responsibility includes the determination of follow-up care when necessary.

B. OBJECTIVES:

1. Release the patient from corrective care:
   a. At the request of the patient, or
   b. When the objectives of the treatment plan have been achieved, or
   c. When no further significant improvement in objective signs can be anticipated due to further chiropractic treatment or to passage of time.

2. Determine necessity of follow-up care and refer or instruct as appropriate.
SEQUENCE OF CLINICAL APPLICATION

The methods for appropriate clinical decision making must be consistent with primary health care provisions and portal of entry procedures. Each step taken in reaching a clinical impression provides an opportunity for the chiropractic physician to decide to continue further without consultation or referral. The following is a general sequence of procedures that is commonly followed by the chiropractic physician. It is intended as a guideline, not as an exhaustive list.

I. Intake Interview
   A. History of presenting illness
   B. Past health history
   C. Family health history
   D. Personal and social history

II. Examination and Diagnostic Procedures
   A. Physical examination
      1. General
      2. Regional area of complaint
      3. Chiropractic examination of spine and extremities
   B. Psycho-social Assessment
   C. Laboratory examination (ordered or performed when clinically indicated)
   D. Diagnostic imaging (ordered or performed when clinically indicated)
   E. Special examinations (ordered or performed when clinically indicated)
      1. Gynecological examination
      2. Proctological examination
      3. Obstetrical examination
      4. Minor surgical examination
      5. Electrodiagnostic evaluation
      6. Vascular evaluation

III. Diagnostic and/or Clinical Impression

IV. Prognosis and Decision to Treat and/or Refer

V. Chiropractic Therapeutic Care and Patient Management

VI. Re-evaluation and Appropriate Modification of the Diagnostic Impression and Treatment Plan

VII. Conclusion of Treatment
CHIROPRACTIC DIAGNOSTIC PROCEDURES

I. History

A necessary component of clinical fact finding through subjective offerings by the patient. The history may include, but is not limited to, the following:

A. Presenting condition
   1. Location
   2. Chronology
   3. Quality
   4. Severity
   5. Setting (circumstances)
   6. Modifying factors
   7. Associated symptoms (review of systems)
   8. Prior treatment(s)

B. Past health history
   1. Accidents and injuries
   2. Previous illnesses
   3. Surgeries
   4. Medications

C. Family health history
   1. Parents
   2. Grandparents
   3. Siblings

D. Personal and social history
   1. Description of job
   2. Exercise
   3. Diet
   4. Habits

II. Examination and Diagnostic Procedures

The examination and diagnostic procedures may include:

A. Physical examination
   1. Vitals
   2. Heart, lungs and abdomen
   3. EENT
   4. Integumentary examination
   5. Orthopedic and neurological tests
   6. Static and motion palpation of the spine and extremities
   7. Postural analysis
   8. Muscle testing including dynamic, isokinetic, static and manual

B. Psycho-social assessment

C. Laboratory examination

   Clinical laboratory testing may be necessary when the history and/or other examination findings indicate.

D. Diagnostic imaging
While diagnostic imaging procedures may be vital to diagnosis and case management, the decision to utilize any diagnostic imaging procedure should be based on a demonstrated need (medical necessity) following an adequate case history and physical examination.

E. Special examinations

1. Gynecological examination
2. Proctological examination
3. Obstetrical examination
4. Minor surgical evaluation
5. Electrodiagnostic evaluation
6. Vascular evaluation

F. Other clinically indicated examination procedures that comply with the OBCE rules.

III. Diagnosis and/or clinical impression

A. Severity
B. Acute vs. chronic
C. Location of lesion and/or disease
D. Etiology
E. Complicating factors
F. Concurrent conditions

IV. Prognosis and decision to treat and/or refer

The decision to treat and/or refer is made after appropriate examination and a working diagnosis has been established. Consideration of the contraindications to the chosen treatment should be taken at this time as well as consideration of consultation and/or acquiring a second opinion.

When possible and/or appropriate a prognosis should be given at the time that a diagnosis is made. The prognosis may change as the condition of the patient and the response to treatment changes. A later referral may also be considered following an appropriate therapeutic trial.

V. Chiropractic Therapeutic Care and Patient Management

A. Manual therapy
1. Adjustment
2. Manipulation
3. Mobilization
4. Soft tissue manipulation

B. Physiological therapeutics
1. Heat and/or cold
2. Hydrotherapy
3. Electrotherapy
4. Phototherapy
5. Mechanotherapy
6. Therapeutic and/or rehabilitation exercise
7. Orthotics
C. Nutritional

D. Counseling

E. Treatment in special areas
   1. Gynecology
   2. Obstetrics
   3. Proctology
   4. Minor surgery

VI. Re-evaluation, etc.

VII. Conclusion of Treatment
CHAPTER III
RECORD KEEPING AND REPORT WRITING

The quality of a physician's health care is dependent on his/her ability to gather, organize, analyze and make decisions on clinical data. Good decisions are the result of accurate and complete facts being retrievable from a patient's records.

Therefore, documentation of the patient's health history, presenting complaint(s), progression of care, diagnosis, prognosis and treatment plan should be reflected in the record keeping and written reports of the patient file. Some aspects of this file have been included in Chapter I. Components of this file should include:

I. Patient History and Examination Records

There is considerable variation in how physicians develop and record a clinical history and examination findings. The reader is referred to Chapter I, Sections I and II for a summary of the suggested guidelines.

II. Chart Notes

Chart notes should be recorded at each visit in a form which may be understood by the chiropractor's peers. While the patient's history indicates their status at the time of the initial visit or at the onset of a new condition, the progress record (often called chart notes) reflects the patient's state of health at subsequent points of time.

The minimum acceptable records should create a story of the patient's response to the physician's management of their case. This story should be legible and clear enough to allow a peer to assume management of the case after an initial review of the chart notes. Full SOAP charting at each visit, while recommended, is not required, but components of the file should include:

A. Subjective complaints

The patient's complaints should be recorded at each visit in the patient's own words when possible) indicating improvement, worsening or no change.

B. Objective findings

Changes in the clinical signs of a condition should be noted at each visit in the doctor's own words.

C. Assessment or diagnosis

It is not necessary to update this category at each visit. However, periodic clinical re-evaluations should be performed and these results included in the daily entries with any alterations in the diagnosis.

D. Plan of management

A provisional plan of management should be recorded initially and further entries should be made as this plan is modified and/or as a patient enters a new phase of treatment. Changes in procedures should be noted.

E. Procedures
Daily recording of procedures performed should include descriptions of manipulations performed, soft tissue techniques, modalities used, exercises prescribed, nutritional supplementation or prescribed diet and activity instructions. Patient response to therapies should be noted.

III. Written Reports

A. History
   1. Presenting complaints
   2. Past health history
   3. Family health history
   4. Personal and/or social history

B. Examination findings
C. Assessment, diagnosis or clinical impression
D. Plan of management and/or response to treatment
E. Prognosis and/or outcome expectations

IV. Ancillary Documentation

A. Correspondence (sent and received)
B. Specialty reports (diagnostic imaging, lab nerve conduction studies, etc.)
C. Communications (telephone conversations, dialogue with family or friends of the patient, etc.)
Chapter IV
Chiropractic Management Algorithm

The following curative care algorithm, developed and accepted by a subcommittee of the OBCIE (2014-2016), presents a clinical management path for the chiropractic physician to facilitate efficient patient recovery. The emphasis is on management of the patient, not on a specific pathophysiology.

Rehabilitation

Rehabilitation is treatment designed to facilitate the process of recovery from injury, illness, or disease. The goal of rehabilitation is to promote recovery, improve function, and to help the patient become self-reliant in management of their health. This generally involves transitioning the patient from passive to active care so as to achieve efficient patient recovery.

Pediatric patients

Pediatric evaluations require age appropriate inquiry and examination to determine treatment plans; this management may need to be modified.
Patient presents for evaluation/care.

1. Hx, evidence-based subjective/objective evaluation.

2. Special studies or tests if indicated. (X-ray, MRI, EMG, lab, etc.)

3. Determine Dx and current stage of condition. Note any contraindications for chiropractic care. Refer as indicated.

4. Provide treatment up to 12 visits or 6 weeks based on current stage of condition and tx needs.

5. Repeat evidence-based subjective and objective evaluation for comparison to previous eval.

6. Subjective and/or objective progress evident?

   7. Is condition resolved?

      No

      9. Has condition reached MMI or MTB?

         Yes

         10. Consider: Modify tx methods, additional diagnostics, referral or co-management.

      No

      8. Reassess tx parameters, update diagnoses, and modify accordingly (change frequency, rehab, home care, traction, etc.). Consider treatment withdrawal if indicated.

         Yes

         11. Make appropriate referral for tests and/or care. May be discharged from care.

      12. Determine if symptom, functional or structural residuals exist (permanent impairment, disability)

      13. End curative care. May transition to palliative or supportive care.

      14. End curative care. May transition to supportive or wellness care.
Chapter IV
Chiropractic Management Algorithm

The following recommendations correlate and refer to the steps in the algorithm:

| Box 1: History, Subjective/Objective Evaluation | Chiropractors should conduct a medical history of the presenting condition and a past medical history including illnesses, hospitalizations, surgeries and prior musculoskeletal conditions. The history should consider red flags and psychosocial risk factors. Subjective-based outcome assessment tools (OATS) of good reliability and validity should be used at this time to establish a baseline for pain, function and/or disability.

Chiropractors should perform a physical examination appropriate to the presenting complaint(s). Procedures should be chosen according to specificity and sensitivity, and have a relatively high likelihood for ruling in or out a specific condition. A physical examination should be neither more nor less than the presenting condition(s) require(s). |
| Box 2: Imaging and Special Studies | Chiropractors should determine the clinical necessity of additional testing that would improve their ability to accurately diagnose and/or provide treatment for the presenting condition(s). This testing can include, but is not limited to: diagnostic imaging, radiographs, laboratory, EMG, functional capacity, etc.

Clinical necessity should be reflected in the records including the concerns warranting the study and how the results will influence management. |
| Box 3: Determine Diagnosis, Stage of Condition and any contraindications to care | Based on history and examination, chiropractors should determine and document a diagnostic impression expressed in generally accepted terminology. The diagnostic impression clarifies the details of the diagnosis, including stage of condition (acute, sub-acute, repair, remodeling, chronic), and contributing and complicating factors.

If any of the patient’s conditions are outside the scope of practice or clinical capacity of the specific chiropractor, or if treatment is contraindicated, then a referral to a different provider should be made and documented. |
| Box 4: Treatment Plan | Chiropractors should formulate a treatment plan appropriate to the diagnostic impression and the patient’s presentation. This should include the frequency and duration of treatment, specific therapies, and goals for each. The treatment plan should not exceed 12 visits or 6 weeks before an updated evaluation for curative care (example: 3x/week for 4 weeks acute, or 2x/week for 6 weeks subacute).

Proposed treatment plan(s) and prognosis should be discussed in the context of the report of findings and PARQ conference. Informed consent shall be documented. |
| Box 5: Re-Evaluation | An updated evaluation of the subjective OATS (outcome assessment tools) and objective/functional examination should be performed at regular intervals, or whenever clinically relevant, to determine patient progress, efficacy of care and necessity of additional treatment. Intervals between re-evaluations should not exceed 12 visits or 6 weeks, depending on the patient’s current condition and treatment goals. See above examples. |
| Box 6: Determine if progress is shown | A comparison of the new evaluation findings (from Box 7) to the previous evaluation findings should be performed to determine progress (OATS, functional, etc.). Patient progress should be determined by comparing previous to current findings and assessed by the physician for clinically meaningful change. (OATS specific, ICA guidelines, etc.)

If progress is shown, go to box #7. If no improvement, go to box #9. |
**Box 7: Is Condition Resolved?**
The chiropractor should determine if the condition has resolved (subjectively, functionally, structurally, etc.). This should be goal-specific. Possible endpoints of care should be when patient is at pre-injury status or maximum medical improvement.  
*If resolved, go to box #14. If not resolved, go to box #8.*

**Box 8: Modify Treatment if indicated.**
As treatment continues, the diagnoses should be amended based on the patient's clinical presentation. If indicated, the doctor should modify treatment, including but not limited to: changing the frequency of visits, modifying modalities, updating home care instruction, etc. If appropriate, treatment frequency may be proportionately decreased in order to determine the patient response to daily living without care prior to the next evaluation.

**Box 9: Has condition reached Maximum Improvement or Therapeutic Benefit?**
If the patient is not showing progress with care, then the chiropractor should determine whether the patient has reached maximum medical improvement (MMI) or maximum therapeutic benefit (MTB). MMI refers to a date from which further recovery or deterioration is not anticipated. MTB refers to when provided care no longer provides benefit, but other options may still exist for improvements.  
*If MMI, then go to box #12. If not, go to box #10.*

**Box 10: Modify Case Management**
If the patient is not progressing and is not considered MMI or MTB, the chiropractor should consider psychosocial factors and other treatment options. Examples of other or additional treatment options include, but are not limited to: referral to another provider, referral for additional testing, adding or removing therapeutic modalities from the treatment plan, etc.  
*If referral is indicated, go to box #11. To continue care, go to box #7 (May do both).*

**Box 11: Referral and/or Discharge**
See box #2 and #3 to determine appropriate referral needs. It is possible that chiropractic care is terminated at this time, even if the patient’s condition can benefit from a different care provider. Any referrals should be documented in the patient records.

**Box 12: Residual Findings/Permanent Impairment**
When a patient's condition has reached MMI or MTB, if any residuals are still evident (subjective, functional, objective, structural, etc.) the chiropractor should determine if a permanent impairment evaluation and/or disability rating is indicated. All residuals should be documented and discussed with the patient. MTB patients may be referred out.

**Box 13: End curative care with residuals.**
Curative care should be ended after MMI or MTB has been determined and residuals (if any) should be documented. The patient may be transitioned into supportive care or palliative care if indicated.

**Box 14: End curative care.**
When ending curative care, the patient may be transitioned to supportive or wellness care, if indicated.

**Maintenance Care:**

The term “maintenance care” is not well-defined at this time in scientific literature and is inherently vague. For purposes of this document, the OBCE will forego its use.

**Supportive Care:**

Supportive care is ongoing treatment/care for patients who have reached MTB but who may fail to sustain these benefits and may progressively deteriorate without treatment. In addition, it is intended to minimize exacerbations and degenerative sequelae. Supportive care sometimes includes the return to curative care for the waxing and waning of chronic conditions. It follows appropriate application of active and passive treatments including rehabilitation and/or lifestyle modifications. It is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other therapeutic protocols.
Wellness Care:

The purpose of chiropractic wellness care to enhance and optimize a patient’s physical well-being and potentially prevent the future onset of symptoms. It is not limited to spinal manipulation but could include any element of the chiropractor’s scope of practice.

Palliative Care:

Palliative care is treatment to temporarily improve a patient’s quality of life without anticipation of overall improvement.
CHAPTER V

TREATMENT PARAMETERS FOR COMMON NMS CONDITIONS

The following treatment parameters are to be used only as guidelines. These are estimates of treatment and/or healing time for commonly encountered categories of neuromusculoskeletal conditions. Disorders outside the NMS system are not addressed by this document. As stated in the preamble, this is an ongoing and dynamic process. These parameters will be amended or modified as new research and expert clinical judgments fill in the inevitable gaps in this process.

The suggested parameters do not reflect the protracted healing time and disability that may result from individual conditions complicated by such factors as previous injuries, congenital or developmental defects, systemic diseases, degenerative disorders, obesity, smoking, psychosocial compromise and others. In such conditions, or if the natural history of an injury is interrupted by aggravations, exacerbations, or flare-ups; applicable treatment guidelines could be modified or extended. However, benefit of care should be supported by subjective and objective documentation.

CATEGORY I
0 - 6 WEEKS TREATMENT

1. Mild-moderate strain
2. Mild sprain
3. Mechanical/joint dysfunction (uncomplicated)
4. Subluxation (uncomplicated)
5. Acute facet syndrome
6. Contusion
7. Mild-moderate tendinitis, capsulitis, bursitis, synovitis
8. Mild sacroiliac syndrome
9. Acute myofascial pain syndrome
10. Mild symptomatic degenerative joint disease
11. Headaches: vertebrogenic, muscle contraction, migraine, vascular
12. Torticollis (acquired)

CATEGORY II
2 - 12 WEEKS TREATMENT

1. Moderate-marked strain
2. Moderate sprain
3. Post traumatic mild-moderate myofibrosis
4. Post traumatic periarticular fibrosis and joint dysfunction with marked tendinitis, bursitis, capsulitis, synovitis
5. Chronic tendinitis, bursitis, capsulitis, synovitis
6. Chronic facet syndrome
7. Moderate sacroiliac syndrome
8. Chronic sacroiliac syndrome with marked myofascial pain syndrome
9. Chronic myofascial pain syndrome
10. Mechanical/joint dysfunction (complicated)
11. Subluxation (complicated)
12. Moderate symptomatic degenerative joint disease
13. Mild inter-vertebral disc syndrome w/o myelopathy
14. Chronic headaches: vertebrogenic, muscle contraction, migraine, vascular
15. Mild temporomandibular joint dysfunction
16. Symptomatic spondylolisthesis
17. Mild clinical joint instability

**CATEGORY III**

1 - 6 MONTHS TREATMENT

1. Chronic facet syndrome associated with clinical vertebral instability
2. Marked strain associated with post traumatic myofibrosis and/or joint dysfunction
3. Marked sprain with associated instability/dysfunction
4. Thoracic outlet syndromes
5. Moderate inter-vertebral disc syndrome w/o myelopathy
6. Peripheral neurovascular entrapment syndromes
7. Moderate to marked temporomandibular joint dysfunction
8. Adhesive capsulitis (frozen joint)
9. Partial or complete dislocation

**CATEGORY IV**

2 - 12 MONTHS TREATMENT

1. Marked inter-vertebral disc syndrome w/o myelopathy, with or without radiculopathy
2. Lateral recess syndrome
3. Intermittent neurogenic claudication
4. Acceleration/deceleration injuries of the spine with myofascial complications (whiplash)
5. Cervicobrachial sympathetic syndromes
6. Sympathetic dystrophies
7. Severe strain/sprain of cervical spine with myoligamentous complications

**RE-ASSESSMENT**

The following circumstances are offered as an indication for reassessment by the treating physician. Clinical evidence or special circumstances may support continued treatment and/or work loss beyond these guidelines.

However, lack of justification for such management would indicate the need for consultation/second opinion and/or special examination.

1. Daily treatment exceeding two consecutive weeks
2. Treatment 3x/week exceeding six consecutive weeks
3. Authorized full time work loss for longer than four consecutive weeks
4. No objective or subjective improvement noted within the guideline parameters as outlined in this chapter.
The previous categories of care pertain to acute care or initial primary therapy. Because chiropractic education and training also includes the application of rehabilitative care and maintenance care, the following provides an appropriate explanation for the administration of these forms of treatment.

REHABILITATIVE CARE: The rehabilitation protocol of Chiropractic Rehabilitation Association are the accepted clinical chiropractic standards for rehabilitative care. These are updated annually and are available in the administrative office of the Oregon Board of Chiropractic Examiners.

MAINTENANCE CARE includes both preventive and supportive care.

Preventive care involves the reduction of the incidence and/or prevalence of illness, impairments, and risk factors, and the maintenance of optimal functions.

Supportive care sustains previous therapeutic gains that might otherwise progressively deteriorate. Supportive care follows appropriate application of acute care and rehabilitation and includes concurrent lifestyle modification efforts. In addition, it is intended to minimize complications and degenerative sequelae.

Appropriateness of Maintenance Care

Preventive care is considered to be appropriate in an outwardly healthy individual who may have no symptoms and in whom signs of illness or impairment may be absent, minimal or subclinical. Preventive care may be inappropriate when it interferes with other appropriate primary care or when the risk of preventive care outweighs the benefits.

Supportive care is appropriate for a patient who has reached maximum therapeutic benefit (maximum medical improvement), and in whom periodic trial of therapeutic withdrawal fail. It is appropriate when rehabilitative and/or functional restorative and alternative care options, including home-based self-care and lifestyle modification, have been considered and attempted. Supportive care is appropriate in patients who display persistent and/or recurrent signs of illness or impairments.

Supportive care may be inappropriate when it interferes with other appropriate primary care or when the risk of supportive care outweighs the benefits, e.g. physician dependence, somatization illness behavior, or secondary gain.

Guidelines for determining frequency and duration of maintenance care should be based upon the definitions provided above, with the understanding that clinical circumstances and other considerations, such as age, occupation, etc., as determined by the attending chiropractic physician, will alter duration and frequency needs and that application of care will result in reasonable differences in patient status. The determination of frequency and duration is subject to clinical judgment and at times may require peer review and further consultation.

Chiropractic doctors commonly recommend monthly visits for the purpose of supportive care. More frequent visits may be clinically justified.

Preventive care is usually applied less frequently, but would rarely be less than once per year.
CHAPTER VI

CHIROPRACTIC GLOSSARY OF COMMONLY USED TERMS

**Acute** - common usage: of recent onset (hours or days); sharp; poignant; having a short and relatively severe course. (1)

**Adhesion** - a fibrous band or structure by which parts adhere abnormally. (1)

**Adjustment** - a chiropractic word of art; as defined by Janse, it is a specific form of direct articular manipulation utilizing either long or short leverage techniques with specific contacts and is characterized by a dynamic thrust of controlled velocity, amplitude and direction. (3)

**Algorithm** - a mechanical procedure for solving a certain kind of mathematical problem; a step-by-step method of solving a problem, as in making a diagnosis. (1)

**Alignment** - the act of aligning; the adjusting of a line. (2)

**Analysis** - separation into component parts; the act of determining the component parts of a substance (1)

**Anomaly** - marked deviation from the normal standard, especially as a result of congenital defects. (1)

**Arthritis** - inflammation of a joint. (1)

**Arthrosis** - degenerative joint disease of the truly movable joints of the spine or extremities. (10)

**Asymmetry** - lack or absence of symmetry of position or motion. Dissimilarity in corresponding parts or organs of opposite sides of the body which are normally alike. (1)

**Barrier** - a boundary of any kind. (2)

  - **Anatomic barrier** - the limit of anatomical integrity; the limit of motion imposed by an anatomic structure. Forcing the movement beyond this barrier would produce tissue damage. (7)

  - **Elastic barrier (physiologic)** - the elastic resistance that is felt at the end of passive range of movement; further motion toward the anatomic barrier may be induced passively. (7)

**Chiropractic**

  - **Chiropractic practice** - chiropractic is a discipline of the scientific healing arts concerned with the pathogenesis, diagnostics, therapeutics and prophylaxis of functional disturbances, pathomechanical states, pain syndromes and neurophysiological effects related to the static and dynamics of the locomotor system, especially of the spine and pelvis. (13)

  - **Chiropractic science** - chiropractic science is concerned with the investigation of the relationship between structure (primarily the spine) and function (primarily the nervous system) of the human body that leads to the restoration and preservation of health. (12)

**Chronic** - long standing (weeks, months or years). Symptoms may range from mild to severe. (1)
Compensation - the counterbalancing of any defect of structure or function. (1) Changes in structural relationships to accommodate for foundation disturbances and maintain balance. (5)

Contraction - a shortening or reduction in size; in connection with muscles, contraction implies shortening and/or development of tension. (1)

Contracture - a condition of fixed high resistance to passive stretch of a muscle resulting from fibrosis of the tissues supporting the muscle or joint. (1)

Diagnosis - the art of distinguishing one disease from another. (1)

Clinical diagnosis - diagnosis based on signs, symptoms and laboratory findings during life. (1)

Physical diagnosis - determination of disease by inspection, palpation, percussion and auscultation. (1)

Discogenic - common usage; caused by derangement of an inter-vertebral disc. (1)

Discopathy - any pathological changes in a disc. (3)

Displacement - removal from the normal position or place (1); as pertaining to vertebral displacement, it refers to a disrelationship of the vertebra to its relative structure. (5)

Facet Syndrome - common usage: back pain and dysfunction caused by a lesion of a posterior facet joint. This may be accompanied by referred pain in the lower extremity.

Fibrosis - the formation of fibrous tissue. (1)

Fibrositis - inflammatory hyperplasia of the white fibrous tissue of the body, especially of the muscle sheaths and fascial layers of the locomotor system. (1)

Fixation - (dynamic fault) - the state whereby articulation has become temporarily immobilized in a position which it may normally occupy during any phase of physiologic movement. The immobilization of an articulation in a position of movement when the joint is at rest, or in a position of rest when the joint is in movement. (8)

Functional - affecting the function but not the structure; said of disturbances with no detectable organic cause; idiopathic. (1)

Health - a state of optimal physical, mental and social well-being and not merely the absence of disease and infirmity. (1)

Hyper - beyond excessive. (1)

Hypo - under or deficient (1)

Instability - quality or condition of being unstable; not firm, fixed or constant. (15)

Ischemic compression - application of progressively stronger painful pressure on a trigger point for the purpose of eliminating the point's tenderness. (4)

Joint dysfunction - joint mechanics showing area disturbances of function without structural change--subtle joint dysfunctions affecting quality and range of joint motion. They are diagnosed with the aid of motion palpation, and stress and motion radiography investigation. (14)
Joint play - discrete, short range movements of a joint independent of the action of voluntary muscles, determined by springing each vertebrae in the neutral position. (5)

Manual Therapy - common usage: therapeutic application of manual force. Includes such procedures as massage, active relaxation, passive stretch, exercises, joint mobilization, thrust manipulation, immobilization and stabilization. (18)

Manipulation - passive maneuver in which specifically directed manual forces are applied to vertebral and extravertebral articulations of the body, with the object of restoring mobility to restricted areas. (17)

Massage - the systematic therapeutical friction, stroking and kneading of the body. (1)

Mobilization - the process of making a fixed part movable. (1) A form of manual therapy applied within the physiological passive range of joint motion and is characterized by non-thrust passive joint manipulation. (17)

Myofascial syndrome - pain and/or autonomic phenomena referred from active myofascial trigger points with associated dysfunction. The specific muscle or muscle group that causes the symptoms should be identified. (4)

Myofascial trigger point - a hyper-irritable spot, usually within a taut band of skeletal muscle or in the muscle's fascia, that is painful on compression and that can give rise to characteristic referred pain, tenderness, and autonomic phenomena. A myofascial trigger point is to be distinguished from cutaneous, ligamentous, periosteal and nonmuscular fascial trigger points. Types include active, latent, primary, associated, satellite and secondary. (4)

Myofascitis - a) Inflammation of a muscle and its fascia, particularly at the fascial insertion of muscle to bone.

b) Pain, tenderness, other referred phenomena, and the dysfunction attributed to myofascial trigger points. (4)

Myofibrosis - replacement of muscle tissue by fibrous tissue. (1)

Nerve interference - a chiropractic term used to refer to the interruption of normal nerve transmission (nerve energy). (5)

Neurogenic - this word is often used to mean originating in nerve tissue; "the cause of the disorder is neurogenic." (11)

Neuropathy - a general term denoting functional disturbances and/or pathological changes in the peripheral nervous system. (1)

Neurophysiologic effects - a general term denoting functional or aberrant disturbances of the peripheral or autonomic nervous systems. The term is used to designate nonspecific effects related to: a) motor and sensory functions of the peripheral nervous system; b) vasomotor activity, secretomotor activity and motor activity of smooth muscle from the autonomic nervous system, e.g., neck, shoulder, arm syndrome (the extremity becomes cool with increased sweating); c) trophic activity of both the peripheral and autonomic nervous system, e.g., muscle atrophy in neck, shoulder, arm syndrome. (15)

Objective - pertaining to those relations and conditions of the body perceived by another, as objective signs of disease. (1)

Osteophyte - a degenerative exostosis secondary to musculotendinous stress. (10)

Palpation - a) The act of feeling with the hand. (1)
Motion palpation - palpatory diagnosis of passive and active segmental joint range of motion. (5)

Static palpation - palpatory diagnosis of somatic structures in a neutral static position. (5)

Prognosis - a forecast as to the probable outcome of an attack of disease; the prospect as to recovery from a disease as indicated by the nature and symptoms of the case. (1)

Referred pain - pain felt in a part other than that in which the cause that produced it is situated. (1)

Restriction - limitation to movement. Describes the direction of limited movement in subluxated and/or dysfunctional joints. (5)

Sacroiliac Syndrome - pain over one sacroiliac joint in the region of the posterior superior iliac spine. This may be accompanied by referred pain in the leg. (9)

Scoliosis - an appreciable lateral deviation in the normally straight vertical line of the spine. (1)

Functional scoliosis - lateral deviation of the spine resulting from poor posture, foundation anomalies, occupational strains, etc., that are still not permanently established. (5)

Structural scoliosis - permanent lateral deviation of the spine; such that the spine cannot return to neutral position. (5)

Short leg - an anatomical, pathological or functional leg deficiency leading to dysfunction. (6)

Sign - an indication of the existence of something; and objective evidence of a disease, i.e. such evidence as is perceptible to the examining physician, as opposed to the subjective sensations (symptoms) of the patient. (1)

Spondylitis - inflammation of the vertebrae. (1)

Spondyloarthritis - arthrosis of the synovial joints of the spine. (10)

Spondylolisthesis - anterior or posterior slippage of a vertebral body on its caudal fellow. (10)

Spondylolysis - is defined as an interruption in the pars interarticularis which may be unilateral or bilateral. (10)

Spondylophytes - degenerative spur formation arising from the vertebral end plates and usually projecting somewhat horizontally. (10)

Spondylosis - degenerative joint disease as it effects the vertebral body end plates. (10)

Spondylotomy - the therapeutic application of percussion or concussion over the vertebrae to elicit reflex responses at the levels of neuromeric innervation to the organ being influenced. (3)

Sprain - joint injury in which some of the fibers of a supporting ligament are ruptured but the continuity of the ligament remains intact. (1)

Spur - a projecting body as from a bone. (1)

Strain - an overstretching and tearing of musculotendinous tissue.

Stress - the sum of the biological reaction to any adverse stimulus, physical, mental or emotional, internal or external that tends to disturb the organism's homeostasis; should these compensating reactions be inadequate or inappropriate, they may lead to disorders. The term is also used to refer to the stimuli that elicit the reactions. (1)
Subacute - less than acute, between acute and chronic. (1)

Subjective - pertaining to or perceived only by the affected individual; not perceptible to the senses of another person.

Subluxation/Vertebral - vertebral subluxation is an aberrant relationship between two adjacent articular structures that alteration in the biomechanical and/or neurophysiological reflections of these articular structures, their proximal structures, and/or body systems that may be directly or indirectly affected by them. (16)

Symptom - any subjective evidence of a patient's condition, i.e., such evidence as perceived by the patient. (1)

Syndesmophyte - inflammatory ossification of a ligament. (19)

Technique - any of a number of physical or mechanical chiropractic procedures used in the treatment of patients. (5)

Trigger point - see myofascial trigger point. (4)
CHAPTER VII
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