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INTRODUCTION

The Oregon Chiropractic Practice and Utilization Guidelines (OCPUG)

This document was first published in 1991 by the Oregon Board of Chiropractic Examiners (OBCE or Board) with the goal of outlining a healthcare resource for Oregon chiropractic physicians. This document has undergone several iterations to reflect emerging research and clinical experience in the hopes that it would continue to become a more useful tool for practitioners. The OBCE will continue to review and update this document for this purpose. This resource is not designed to cover the complete scope of chiropractic practice in Oregon, nor is it directed at any other individual or group besides Oregon licensed chiropractic physicians and those who practice under their supervision.

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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 to accomplish their associated objectives.

I. Therapeutic Relationship

A. GOAL: Establish a professional doctor-patient relationship with the individual seeking care and appropriately triage their health issue(s) as well as their complaint(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 and/or oral means and provide a permanent record of findings with due regard for a patient's ethnic, cultural, or linguistic background.

4. Include within each case history, chief complaint, present health and relevant past health, including history of injury, disability, and cognitive assessment.

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, as indicated by clinical relevance.

B. OBJECTIVES:

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

2. Perform such examination and diagnostic procedures within statutory scope of practice and clinic capabilities, 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 clinical relevance and justification for additional testing to the patient.

6. Assess historical and physical data to identify relative or absolute contraindications for chiropractic care.

7. If referring to another health care provider, include relevant information pertaining to the referral and document such referral made.

8. Accurately record examination findings in the patient's case file consistent with universal health standards, administrative rules, and statutes.

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 determine the relevance of the presenting complaint(s).

2. Determine subsequent evaluation procedures appropriate to the continued investigation of the patient's condition and establish a clinical impression or diagnosis.

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

4. Record objectively supported differential diagnoses or clinical impressions, complicating factors and/or concomitant conditions using scientifically and/or clinically sound diagnostic procedures and language.

IV. Prognosis and Decision to Treat and/or Refer

A. GOAL:

1. Provide patient with PARQ.

2. Arrive at an initial prognosis and determine whether to accept the patient for chiropractic care and/or refer to another health care provider.

B. OBJECTIVES:

1. Determine the patient's initial prognosis.

2. Determine whether the condition is amenable to chiropractic care and is within the scope of chiropractic practice. Provide patient with report of findings.

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, forwarding any diagnostic tests or relevant information in an expedient manner. Document the referral.

V. Treatment Plan

A. GOAL: Generate an appropriate treatment plan with recommended re-evaluation dates.

B. OBJECTIVES:

1. Provide a treatment plan including procedures and modalities consistent with accepted standards of practice.

2. Record and date the treatment plan, including expected length and intensity of treatment, and projected re-evaluation dates.

3. If there are any general or specific considerations or contraindications for care, note them in the case file, modify the plan appropriately, and/or refer the patient to another provider.

4. Provide the patient with report of findings and with a PARQ. Obtain and record informed consent from the patient.

5. Records should be in a format that permits interpretation by other health care providers.

VI. Monitoring

A. GOAL: Assess the effectiveness of the treatment and make appropriate amendments to the treatment plan to provide efficacious care for the presenting complaint(s).

B. OBJECTIVES:

1. Perform ongoing assessment of both subjective and objective findings, documenting them in the patient record.

2. Initiate an appropriate re-evaluation to account for exacerbations, aggravations, waxing or waning of a chronic condition, or re-injury.

3. Evaluate new objective findings, integrating them with historical data, modify diagnoses and treatment appropriately, including a potential referral to a different discipline to provide timely, efficacious, and continuous care.

4. Generate reports of the patient's current condition that include information in a format a third-party representative will be able to clearly understand. Include clinical impression and treatment or modified treatment plan so that decision-making on authorization of services will be appropriate and timely.

VII. Discharge

A. GOAL: Decide on the appropriate discontinuation of care 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 curative care:

   a. At the request of the patient;
   b. Patient non-compliance;
   c. When the objectives of the treatment plan have been achieved; or

d. When patient has achieved maximum medical improvement.

2. Document the necessity of follow-up care and inform the patient and any necessary ancillary personnel.

CHAPTER II

CHIROPRACTIC CLINICAL APPLICATION, DIAGNOSIS, AND TREATMENT PROCEDURES

SEQUENCE OF CLINICAL APPLICATION

The methods for appropriate clinical decision-making must be consistent with primary health care provisions and portal of entry procedures and standards. Each step taken in reaching a clinical impression provides an opportunity for the chiropractic physician to decide to continue further, refer the patient to another provider, or obtain a second opinion. 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 of Patient

- A. History of presenting illness
- B. Past medical history
- C. Family medical history
- D. Personal, social, and socio-economic history

II. Examination and Diagnostic Procedures

- A. Physical examination
  1. General
  2. Specific to the presenting complaint(s)
  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 (if indicated)

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 medical history
   1. Accidents and injuries
   2. Previous illnesses
   3. Surgeries
   4. Medications

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

D. Personal, social, and socio-economic history
   1. Description of job
   2. Exercise
   3. Diet
   4. Habits/hobbies

II. Examination and Diagnostic Procedures

A. Psycho-social assessment

B. Physical examination shall include:
   1. Vitals, including but not limited to height, weight, blood pressure, and pulse
   2. Examination specific to presenting complaint(s)

C. Physical examination, when clinically indicated, may also include, but not be limited to:
   1. Heart, lungs, and abdomen
   2. EENT
   3. Integumentary examination
   4. Orthopedic and neurological tests
   5. Static and motion palpation of the spine and/or extremities
   6. Postural analysis
   7. Muscle testing including dynamic, isokinetic, static, and/or manual analysis

D. Laboratory examination

   1. Clinical laboratory testing may be necessary when the history and/or other examination findings indicate, including but not limited to blood, urine, saliva, hair, mucus, or stool.

   2. Biopsies of superficial structures may also be performed with additional Oregon minor surgery certification.

E. Diagnostic imaging

While diagnostic imaging procedures may be vital to diagnosis and case management, the decision to use any diagnostic imaging procedure should be based on clinical necessity following an adequate case history and physical examination.

F. Special examinations/evaluations

1. Gynecological examination
2. Proctological examination
3. Obstetrical examination
4. Minor surgical evaluation
5. Electrodiagnostic evaluation
6. Vascular evaluation
7. Laboratory evaluation
8. Diagnostic imaging evaluation

G. Other clinically indicated examination/evaluation 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. Concomitant conditions

IV. Prognosis and decision to treat and/or refer

The decision to treat and/or refer is made after appropriate examination and a differential diagnosis has been established. Consideration of the contraindications to the proposed 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 referral to a different healthcare provider or discipline is appropriate when clinically indicated.

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
8. Bracing and taping

C. Nutritional supplementation, recommendations, and/or over the counter medications

D. Counseling within chiropractic scope of practice

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

V. Re-evaluation and assessment

VI. Conclusion of Treatment

CHAPTER III

RECORD KEEPING AND REPORT WRITING

The quality of a physician's ability to provide efficacious health care is dependent on their 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 medical 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 any medical/healthcare provider. 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 another medical/healthcare provider 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, or any significant event since the last visit with provider.

B. Objective findings

Changes in the objective 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 amendments 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’s condition changes and treatment is altered accordingly. Changes in procedures should be noted.

E. Procedures

Daily recording of procedures performed should include descriptions of therapeutic procedures performed, soft tissue techniques, modalities used, exercises prescribed, nutritional supplementation, over the counter medications, or prescribed diet and activity instructions. Patient response to therapies, and who provided those therapies, should be noted.

III. Written Reports

A. History
   1. Presenting complaints
   2. Past medical history
   3. Family health history
   4. Patient's personal, social, and socio-economic 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 log, dialogue with specialists and/or providers co-managing case or concomitant conditions that may have effect on presenting complaint, and family or friends of the patient, etc.)

CHAPTER IV

CHIROPRACTIC CARE AND MANAGEMENT

Based upon clinical circumstances and other considerations, patient individuality may influence frequency and duration of care. Clinical judgment and decision-making may require peer review and further consultation.

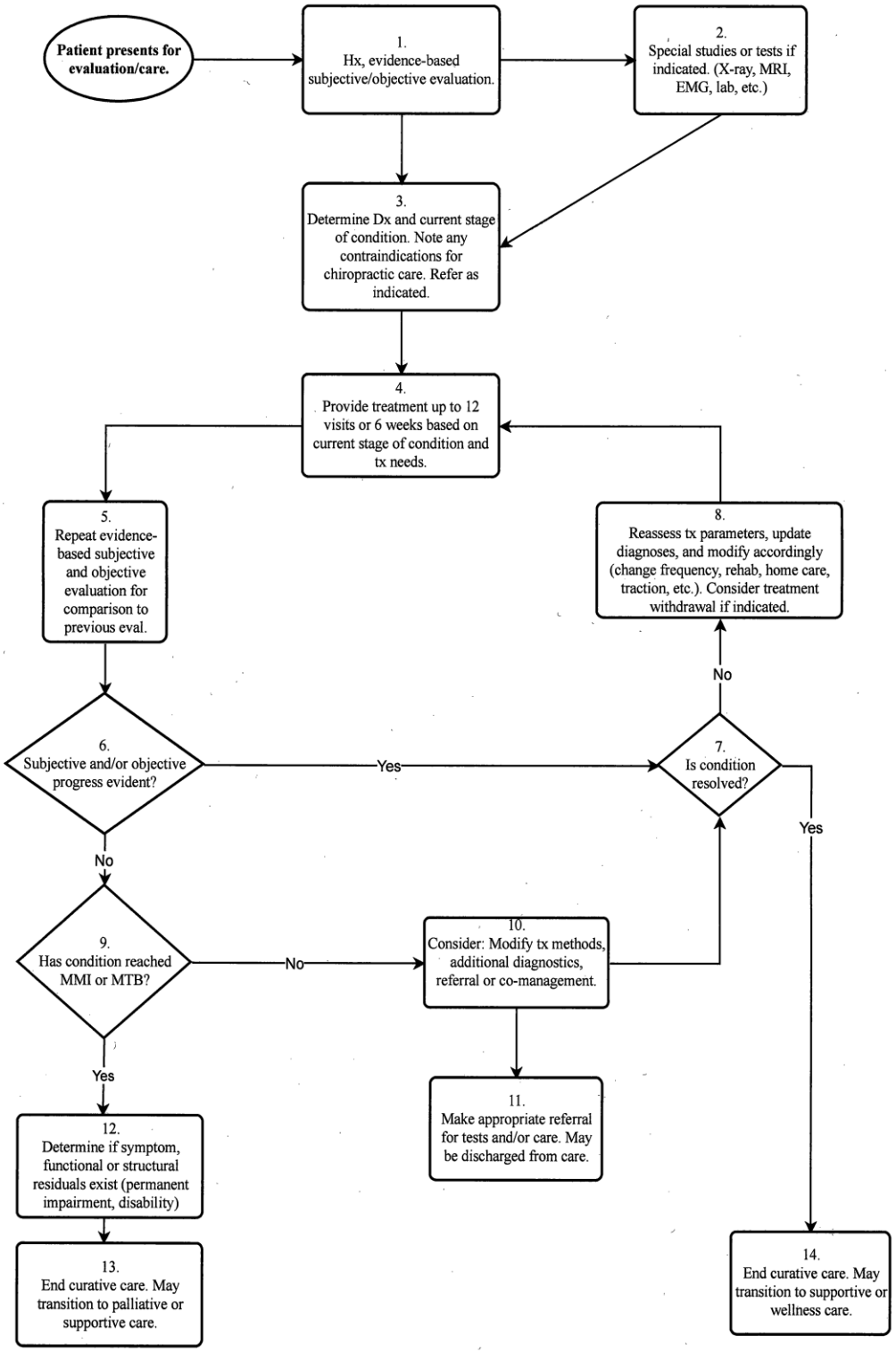
The following curative care algorithm presents a clinical management path for the chiropractic physician to facilitate efficient patient recovery. The emphasis is on management of the patient, not on a specific pathophysiology.

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 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?
Yes
No
7. Is condition resolved?
No
Yes
8. Reassess tx parameters, update diagnoses, and modify accordingly (change frequency, rehab, home care, traction, etc.). Consider treatment withdrawal if indicated.
9. Has condition reached MMI or MTB?
No
Yes
10. Consider: Modify tx methods, additional diagnostics, referral or co-management.
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.

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 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 5) 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 and ACA 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 (MMI). **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 chiropractor 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 to determine the patient response to daily living without care prior to the next evaluation.
Box 9: Has Condition Reached Maximum Medical Improvement or Therapeutic Benefit?	If the patient is not showing progress with care, then the chiropractor should determine whether the patient has reached 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/MTB, 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. Chiropractic care may be suspended or terminated at this time, while the patient's condition may benefit from transfer of care to a different care provider. 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.
Box 13: End Curative Care with Residuals.	Curative care should be terminated after MMI or MTB has been determined and residuals (if any) are documented. The patient may be transitioned into supportive or palliative care if indicated.

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

Nothing in the existing laws or rules of the Board defines a separate standard of care for "curative care," "maintenance care," "palliative care," "supportive care," or "wellness care." All require that the patient is entitled to an appropriate physical examination, a report of findings following the examination, including a clinical impression, and recommendations for care, followed by a PARQ, to obtain informed consent from the patient prior to rendering therapeutics.

Curative Care:

The term "curative care" refers to treatment with an intent to resolve the presenting complaint(s) without a guaranteed curative outcome.

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.

Palliative Care:

Palliative care is treatment to temporarily improve a patient's quality of life without anticipation of overall improvement. Palliative care may be inappropriate when it interferes with other therapeutic protocols.

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. Supportive care may be inappropriate when it interferes with other therapeutic protocols.

Wellness Care:

Wellness care is intended 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.

CHAPTER V

GLOSSARY OF CHIROPRACTIC MEDICAL TERMS

Acute - a condition of sudden onset; any condition with a short (<4 weeks) clinical course.

Algorithm - a step-by-step method of solving a problem.

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.

Chiropractic - is defined pursuant to ORS 684.010.

Chronic - long standing (>12 weeks).

Diagnosis - the act of distinguishing one disease from another.

Clinical diagnosis - based on signs, symptoms, and/or history and clinical presentation, in the absence of objective findings.

Differential diagnosis - generating a list of possible disorders that could be causing symptoms.

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

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

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

Manual Therapy - therapeutic application of manual force including such procedures as massage, active relaxation, passive stretch, exercises, joint mobilization, thrust manipulation, immobilization, and stabilization.

Manipulation - passive maneuver in which specifically directed manual forces are applied to spinal and extra-spinal articulations of the body, with the object of restoring mobility to restricted areas.

Massage - the therapeutic application of friction, stroking, and kneading of the muscles and tissues of the body.

Mobilization - a form of manual therapy applied within the physiological passive range of joint motion, characterized by non-thrust passive joint manipulation.

Neurophysiological 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; c) trophic activity of both the peripheral and autonomic nervous system.

Objective - relating to or being an indicator of disease such as a physical sign, lab test, or x-ray, that can be observed or verified by someone other than the person being evaluated.

Palpation - the application of clinical touch during a physical exam.

Motion palpation - palpatory diagnosis of passive and active segmental joint range of motion.

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

Prognosis - the likely outcome or course of a disease; the chance of recovery or reoccurrence.

Restriction - limitation to movement.

Sign - any objective evidence of a disease, as opposed to a symptom.

Subacute - between the acute and chronic phases of a condition (4-12 weeks).

Subjective - pertaining to or perceived only by the affected individual, not observable by others.

Symptom - any subjective evidence of a disease, as opposed to a sign.

Technique - physical or mechanical procedures used in the treatment of patients.