

Chapters 1-3 are final and Ch. 4-6 are still under review.

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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.

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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

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- 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:

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- 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.

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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

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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

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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.)

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CHAPTER IV

CHIROPRACTIC MANAGEMENT ALGORITHM (Rev. 01/2018)

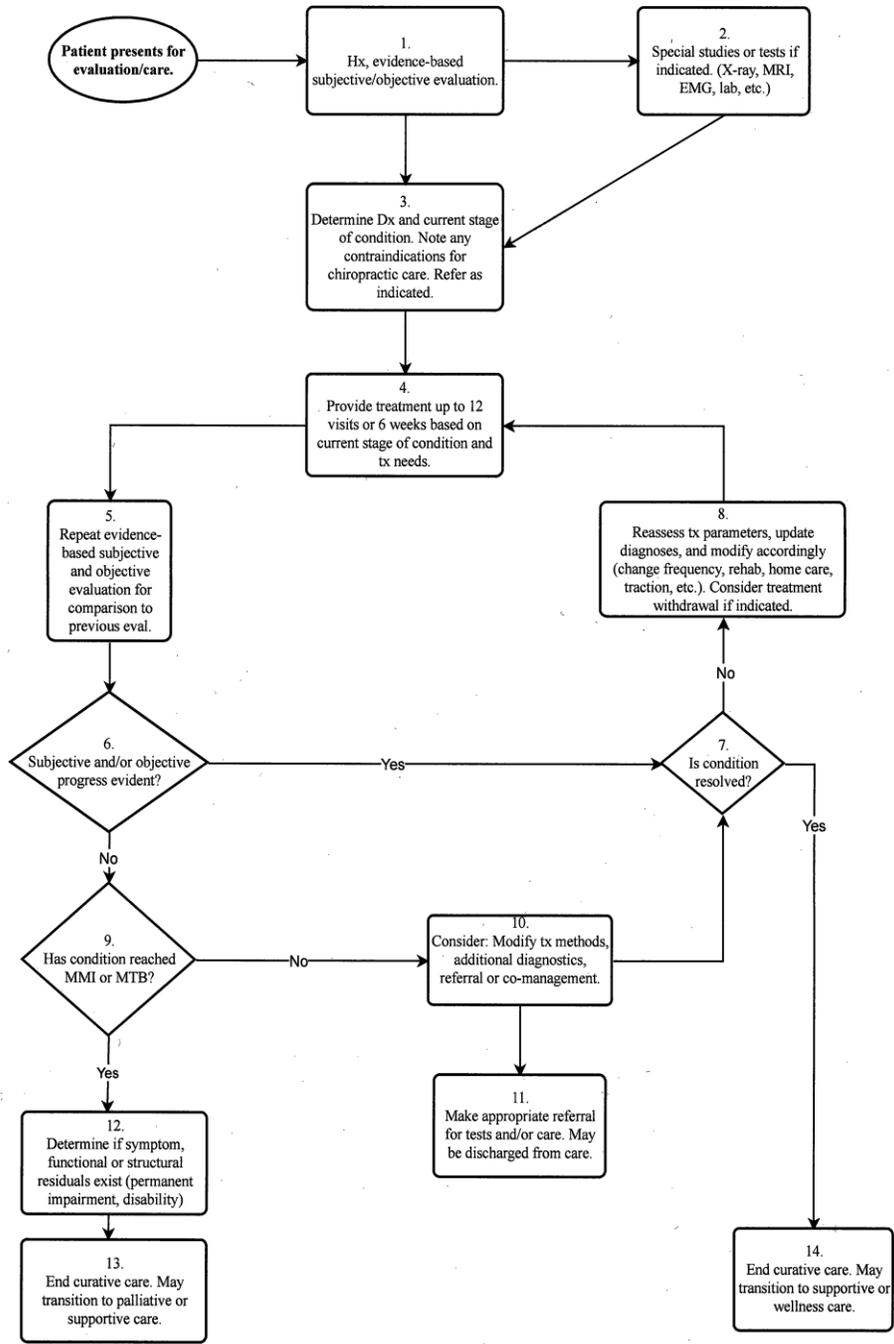
The following curative care algorithm, developed and accepted by a subcommittee of the OBCE (2014-2016), presents a clinical management path for the chiropractic physician to facilitate efficient patient recovery. The emphasis is on management of the patient, not on a specific pathophysiology.

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.



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

<p><u>Box 1:</u> <u>History,</u> <u>Subjective/Objective</u> <u>Evaluation</u></p>	<p><u>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.</u></p> <p><u>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).</u></p>
<p><u>Box 2:</u> <u>Imaging and</u> <u>Special Studies</u></p>	<p><u>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.</u></p> <p><u>Clinical necessity should be reflected in the records including the concerns warranting the study and how the results will influence management.</u></p>
<p><u>Box 3:</u> <u>Determine</u> <u>Diagnosis, Stage of</u> <u>Condition, and any</u> <u>contraindications to</u> <u>care</u></p>	<p><u>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.</u></p> <p><u>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.</u></p>
<p><u>Box 4:</u> <u>Treatment Plan</u></p>	<p><u>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).</u></p> <p><u>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.</u></p>
<p><u>Box 5:</u> <u>Re-Evaluation</u></p>	<p><u>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</u></p>

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	<p><u>should not exceed 12 visits or 6 weeks, depending on the patient's current condition and treatment goals. See above examples.</u></p>
<p><u>Box 6: Determine if progress is shown</u></p>	<p><u>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.)</u> <u>If progress is shown, go to box #7. If no improvement, go to box #9.</u></p>
<p><u>Box 7: Is Condition Resolved?</u></p>	<p><u>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.</u> <u>If resolved, go to box #14. If not resolved, go to box #8.</u></p>
<p><u>Box 8: Modify Treatment if indicated</u></p>	<p><u>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 in order to determine the patient response to daily living without care prior to the next evaluation.</u></p>
<p><u>Box 9: Has condition reached Maximum Medical Improvement or Therapeutic Benefit?</u></p>	<p><u>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.</u> <u>If MMI/MTB, then go to box #12. If not, go to box #10.</u></p>
<p><u>Box 10: Modify Case Management</u></p>	<p><u>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.</u> <u>If referral is indicated, go to box #11. To continue care, go to box #7 (May do both)</u></p>
<p><u>Box 11: Referral and/or Discharge</u></p>	<p><u>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.</u></p>
<p><u>Box 12: Residual Findings/ Permanent Impairment</u></p>	<p><u>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.</u></p>

<u>Box 13:</u> <u>End curative care with residuals.</u>	<u>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.</u>
<u>Box 14:</u> <u>End curative care.</u>	<u>When ending curative care, the patient may be transitioned to supportive or wellness care, if indicated.</u>

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 is 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.

Nothing in the existing laws or rules of the Board announce a separate standard of care for “wellness care,” “maintenance care,” “curative,” or “palliative” 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, in order to obtain informed consent from the patient prior to rendering therapeutics.

Palliative Care:

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

CHIROPRACTIC MANAGEMENT ALGORITHM

This algorithm develops a clinical management path for the chiropractic patient; to facilitate their recovery in the shortest time and the most cost effective manner possible. The algorithm is presented primarily to organize the chiropractic physician's application of diagnostic and therapeutic interventions. The emphasis is on management of the patient and not on management of a particular pathophysiology. This is because any one patient may present with multiple pathophysiologies or their clinical course may progress through multiple pathophysiological states requiring management modification.

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An algorithm provides a visual tool for communication of expected diagnostic and therapeutic applications from the Oregon Board of Chiropractic Examiners to practicing chiropractors, from the individual D.C. to his patient and from the D.C. to third parties involved with any particular patient. Key points are defined for the referral to another physician and/or health care provider and for the reporting of information to patients and to involved third party payors. Concurrent allopathic and/or psychological management is incorporated into this scheme and the algorithm identifies the usual protocol for chiropractic management alternatives of a patient at maximum clinical improvement.

The algorithm is organized into three basic sections: diagnostics, therapeutics and maximum clinical improvement. The diagnostics section includes history, examination, data collection, special studies or examinations ordered by the D.C., allopathic procedures ordered by the D.C. and allopathic procedures ordered by any consulting discipline; including but not limited to, allopathic, osteopathic, psychiatric or psychological. The therapeutic section defines three feedback loops originating with the clinical reevaluation of patients who are showing poor progress, multiple exacerbations or no response to the provisional management plan. The maximum clinical improvement section defines four categories of patients and describes appropriate management alternatives at that juncture.

The sequence of this algorithm begins with consultation, history of present illness, physical examination and collection of data to confirm and analyze the medical history. Based on this information a clinical impression is rendered. This initial impression may be modified by any special studies or examinations ordered as they may identify complicating conditions which will naturally modify the resulting treatment plan or prognosis.

At this point, prior to treatment, the D.C. may desire a medical or surgical consultation. The consultation may result in a referral for medical management or feedback into chiropractic management with concurrent medial treatment. Based on these clinical impressions, a provisional treatment plan is formulated with a time line and goals for expected subjective and objective response. After reporting this to the patient, treatment is initiated.

Treatment response is monitored and documented objectively and subjectively in the patient's records. Appropriate progress to treatment usually confirms the initial clinical impressions and a more accurate prognosis can be formulated and reported to the patient, third party payors and

employers, if indicated. Assuming continued improvement with treatment, the management may be modified based on the patient's stage of recovery until maximum clinical improvement is reached.

For patients making poor progress, patients with multiple exacerbations or patients showing no response to treatment, clinical re-evaluation is indicated. At this point, the D.C. may elect four courses of action: **first**, to redefine the prognosis, goals and time line and continue with treatment; **second**, to modify the patient's management with his consent; **third**, to refer the patient to another physician and/or health care provider; **fourth**, to perform other special studies or examinations as indicated by the re-evaluation. This final option loops into the diagnostic section of the algorithm allowing the clinical impressions to be altered or modified. This resulting modified impression and treatment plan may include additional chiropractic or conservative therapies, concurrent allopathic or psychological treatment or referral to other disciplines. After the patient's consent is obtained, modified treatment is continued.

Usually four groups of patients exist at maximum clinical improvement. Those who are asymptomatic and without objective findings are discharged. Those who are asymptomatic with objective findings may be clinically re-evaluated and their management modified or given an

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appropriate referral. Patients who are still symptomatic and retain objective findings may be referred for impairment rating, work capacity evaluation and/or vocational rehabilitation if it is appropriate. These patients should be instructed in or referred to self help and pain management programs and often require some supportive or maintenance treatment. Patients who are symptomatic but without objective findings may be instructed in or referred to self help or pain management programs, other appropriate health care providers or discharged.

This algorithm was developed utilizing the combined experience of chiropractic physicians and the academic departments at Western States Chiropractic College and is not considered the only approach to chiropractic patient management in the State of Oregon. Further refinement and validation of this scheme is expected. We are not implying that this algorithm actually improves the clinical outcome of any particular patient group progressing through a course of chiropractic treatment. However, it does represent a tool for clinical decision making and stresses three chronological phases in patient management: diagnostics, therapeutics and maximum clinical improvement. It also allows for feedback loops returning to the diagnostic section based on information obtained in the therapeutics section of this model.

ALGORITHM

(insert manually)

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~~ 1st degree/Grade I strains
2. ~~Mild sprain~~ 1st & 2nd degree/Grade I & Grade II sprains
3. ~~Mechanical/joint dysfunction (uncomplicated)~~ Subluxation/mechanical joint dysfunction
4. ~~Subluxation (uncomplicated)~~
- 5.4. ~~Acute~~ & chronic facet syndrome
- 6.5. ~~Contusion~~
- 7.6. ~~Mild-moderate tendinitis, capsulitis, bursitis, synovitis~~
- 8.7. ~~Mild sacroiliac syndrome~~
- 9.8. ~~Acute M~~ myofascial pain syndrome
- 10.9. ~~Mild symptomatic degenerative joint disease~~ Included in mechanical joint dysfunction
- 11.10. Headaches: vertebrogenic, muscle contraction, migraine, ~~vascular~~ acute & chronic or episodic
- 12.11. Torticollis (~~acquired~~) non-congenital

CATEGORY II

2 - 12 WEEKS TREATMENT

1. Moderate-marked strain
2. ~~Moderate sprain~~ 3rd degree/Grade II sprains
3. ~~Post traumatic mild-moderate myofibrosis~~
- 4.3. ~~Post traumatic periarticular fibrosis and joint dysfunction with marked tendinitis, bursitis, capsulitis, synovitis~~
- 5.4. ~~Chronic tendinitis, bursitis, capsulitis, synovitis~~
6. ~~Chronic facet syndrome~~
7. ~~Moderate sacroiliac syndrome~~
- 8.6. ~~Chronic S~~ sacroiliac syndrome with marked myofascial pain syndrome
- 9.7. ~~Chronic M~~ myofascial pain syndrome recurrent
10. ~~Mechanical/joint dysfunction (complicated)~~
11. ~~Subluxation (complicated)~~
8. ~~Subluxation/mechanical joint dysfunction with instability~~
12. ~~Moderate symptomatic degenerative joint disease~~
- 13.9. ~~Mild inter-vertebral disc syndrome w/o myelopathy~~ Disc tear/protrusion without myelopathy

Chapters 1-3 are final and Ch. 4-6 are still under review.

- ~~14. Chronic headaches: vertebrogenic, muscle contraction, migraine, vascular~~
- ~~15.10. Mild temporomandibular joint dysfunction~~
- ~~16.11. Symptomatic spondylolisthesis (must list grade & with or without pars defect)~~
- ~~17. Mild clinical joint instability~~

CATEGORY III

1 - 6 MONTHS TREATMENT

- 1. ~~Chronic~~ Facet syndrome associated with clinical vertebral instability - measurable instability 3mm or more
- 2. Marked strain associated with post traumatic myofibrosis and/or with joint dysfunction
- ~~3. Marked sprain with associated instability/dysfunction~~
- ~~4.3. Thoracic outlet syndromes~~
- ~~5.4. Moderate inter vertebral disc syndrome w/o myelopathy~~ Inter-vertebral disc protrusion with migration but without myelopathy
- ~~6.5. Peripheral neurovascular entrapment syndromes (identify what?)~~
- ~~7.6. Moderate to marked temporomandibular joint dysfunction~~
- ~~8.7. Adhesive capsulitis (frozen joint)~~ Manipulation & rehabilitation of adhesive capsulitis (frozen joint)
- ~~9.8. Partial or complete dislocation~~ - identify what structures – not all require follow up

CATEGORY IV

2 - 12 MONTHS TREATMENT

- 1. Intervertebral disc protrusion without cord compression, with or without radiculopathic symptoms
- ~~1.2. Marked inter-vertebral disc syndrome w/o myelopathy, with or without radiculopathy~~
- ~~2.3. Lateral recess syndrome – needs clarification~~
- ~~3.4. Intermittent neurogenic claudication – needs more precise definition~~
- ~~4.5. Acceleration/deceleration injuries of the spine with myofascial complications (whiplash) with measurable instability~~
- ~~5.6. Cervicobrachial sympathetic syndromes/brachial plexus syndromes~~
- ~~6.7. Sympathetic dystrophies/Complex regional pain syndrome~~
- ~~7.8. Severe strain/sprain of cervical spine with myoligamentous complications~~ Grade III sprains & strains

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.

CHIROPRACTIC CARE

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 life style 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 life style 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.

Commented [CMS1]: How does this section align with the information around the algorithm?

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 – 1. Articulation or line of juncture between two bones; 2. 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 – is defined in Oregon pursuant to ORS 684.010.

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)

Commented [CMS2]: This change was made by the board in March, 2018.

Chapters 1-3 are final and Ch. 4-6 are still under review.

Chronic - long standing (≥ 6 weeks, ~~months or years~~). Symptoms may range from mild to severe. (+)

Compensation - the counterbalancing of any defect of structure or function. (+) - Changes in structural relationships to accommodate for foundation disturbances and maintain balance. (S)

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

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

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

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

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

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

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. (S)

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. (+)

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

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. (+)

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

Hyper - ~~beyond-over or~~ excessive. (+)

Hypo - under or deficient. (+)

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)

Chapters 1-3 are final and Ch. 4-6 are still under review.

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 spinal~~ and ~~extravertebral-extra-spinal~~ 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 pain 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 non-muscular fascial trigger points. Types include active, latent, primary, associated, satellite and secondary. (4)

Myofasciitis - 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; example: "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)

Chapters 1-3 are final and Ch. 4-6 are still under review.

Palpation - a) The act of feeling with the hand. (+)

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. (+)

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

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. (+)

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. (+)

Spondylitis - inflammation of the vertebrae. (+)

Spondyloarthrosis - arthrosis of the synovial joints of the spine. (+0)

Spondylolisthesis - anterior or posterior slippage of a vertebral body on its caudal fellow. (+0)

Spondylolysis - is defined as an interruption in the pars interarticularis which may be unilateral or bilateral. (+0)

Spondylophytes - degenerative spur formation arising from the vertebral end plates and usually projecting somewhat horizontally. (+0)

Spondylosis - degenerative joint disease as it effects the vertebral body end plates. (+0)

Spondylotherapy - 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. (+)

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

Strain - an overstretching and tearing of musculotendinous tissue.

Chapters 1-3 are final and Ch. 4-6 are still under review.

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. (4)

Subacute - less than acute, between acute and chronic. (4)

Subjective - pertaining to or perceived only by the affected individual; may or may not be 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. (46)

Symptom - ~~any subjective evidence of a patient's condition, i.e., such evidence as perceived by the patient. (1) a physical or mental feature which is regarded as indicating a condition of disease, particularly such a feature that is apparent to the patient.~~

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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