

# Chiropractic Care for Chronic Pain

## *A New Model that can save you money!*

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Since the inception of HPP, few treatment-related issues have stirred more controversy than chiropractic treatment for chronic pain. Due to the natural history of degeneration some believe that at a certain point in time the obligation of the employer should stop and personal responsibility should begin for treatment of chronic pain. Others believe that since the work injury may have caused permanent damage that resulted in chronic pain, benefits should be paid for life. Both chiropractic and medical consultants have been criticized for improperly applying guidelines and denying necessary care. Field doctors have been criticized for poor documentation. Embedded somewhere in this HPP quagmire is the truth.

So where does chiropractic fit in and how? This paper will suggest that properly managed chiropractic care can often be the treatment of choice for chronic back pain compared to the most commonly recommended alternatives, including drugs (NSAIDs) and exercise. We will identify indications, contraindications, and treatment guidelines for appropriate chiropractic management of chronic pain. Documentation issues (covered in many previous OSCA seminars), while mentioned, will be covered more thoroughly in the next publication.

Commonly assumed statements about chiropractic will serve as our guide through this paper.

### ***"I thought soft tissue injuries healed in 6-12 weeks. Why should we pay for chronic pain?"***

One of the most common myths about back pain is that the majority of pain is "self-limiting" with a short and predictable healing time. While minor acute conditions heal in a timely and uncomplicated fashion, moderate to severe injuries usually heal with enough scar tissue to create residual soft tissue weakness. These cases can be "complicated" and often result in chronic back pain.

A 1998 study in the British Medical Journal found that only 25% of patients consulting about the problem reported full recovery 12 months later. Seventy five percent of acute low back pain patients continue to endure chronic pain much longer than traditionally believed. It further states, "*We should stop characterizing low back pain in terms of multiplicity of acute problems, most of which get better, and a small number of chronic long term problems. Low back pain should be viewed as a chronic problem with an*

*untidy pattern of grumbling symptoms and periods of relative freedom from pain and disability interspersed with acute episodes, exacerbations, and recurrences."*<sup>1</sup>

This research would seem to suggest that 75% of acute low back pain patients continue to endure chronic pain much longer than traditionally believed. Numerous other studies have clearly demonstrated that the belief that all soft tissue injuries/sprain/strains are self-limiting with a healing time of 6-12 weeks is simply erroneous and archaic thinking. One study reported in *Spine* demonstrated that only 27% of patients were completely recovered in three months.<sup>2</sup>

**Why can't the patient take aspirin to control the pain?**  
**Are non-steroidal anti-inflammatory drugs (NSAIDs) safe and effective to adequately control chronic pain?**

Non-steroidal anti-inflammatory drugs (NSAIDs) are still the most common types of substances used by millions who suffer from joint agony. They can certainly offer some relief for chronic pain patients. These drugs, however, are linked to a broad spectrum of uncomfortable and even life-threatening side effects. They are known to induce a wide range of gastrointestinal problems when taken in high quantities and for long periods of time and can harm the liver and cause kidney failure (Theodosakis 1997).<sup>3</sup>

Researchers also discovered that NSAIDs actually ***hasten*** the destruction of joints by inhibiting the synthesis of proteoglycans, vitally important molecules that attract water to cartilage (Theodosakis 1997).

The conclusion of another study on NSAIDs stated: "*Unnecessary NSAID prescribing and suboptimal management of NSAID-related side effects were sufficiently common to raise questions about the appropriateness of NSAID use in the general population.*"<sup>4</sup>

Drugs classified as NSAIDs include aspirin, ibuprofen, and ingredients in Aleve, Naprox, Voltaren, Indocin, and others. In addition to gastrointestinal (GI) bleeding, other side effects include ulceration, perforation, and (less commonly) hepatitis, asthma, and tinnitus. Unfortunately most people do not realize the extent of the danger. An article in *The New England Journal of Medicine* labeled the deaths caused by complications from these drugs a "silent epidemic", killing over 16,000 people annually.<sup>5</sup>

The risks of adverse side-effects as a result of NSAID use increases with prolonged use. Unfortunately, those suffering from chronic pain are also often the ones repeatedly reaching for relief through more and more drugs. While these drugs may be effective at relieving pain, they do not restore mobility and joint function.<sup>6</sup> Given the high incidence of chronic pain experienced by injured workers, no doubt NSAID use, and the associated risks, are even greater in the Ohio Workers' Compensation system.

NSAID use for temporary pain relief becomes a vicious cycle. In the end, both the patient and the employer may lose to deteriorating joint stability and health and poor work performance.

**Will home exercise and/or physical rehabilitation  
prevent the need for ongoing care?**

While exercise is an integral component of a well managed overall treatment plan, it is not the panacea for the prevention or control of chronic pain as many case managers and consultants would suggest. The plain truth is, based on clinical experience, most patients simply do not comply with exercise recommendations. Injured workers are not alone. How often do any of us regularly engage in stretching and strengthening exercise? We all know how important exercise is to maintain health, but the majority of Americans simply do not like exercise.

Every January, most gyms in America are full of well-intentioned "athletes" fulfilling their New Year's resolution. By March, the gym is usually reduced to the same dedicated few who will work out all year long. Injured workers are no different.

Even more important is the fact that some case managers "encourage" the injured worker into physical rehabilitation for a six week program to hopefully "cure" the chronic patient. There is little to no research to support rehabilitation once the case has become chronic. Consider this scenario: within six weeks of spending \$5000-\$10,000 on a rehabilitation program, the majority of patients are likely to settle back into the same old routine, thus eliminating any gains made via rehabilitation. What happens when a person quits exercising? The same type of de-conditioning can be expected when an injured worker ends a rehabilitation program and fails to comply with home exercise.

While the workers' compensation system spends thousands on rehabilitation programs, case managers are reducing chiropractic costs (usually 1-2 visits per month at a cost of less than \$100) by fighting "supportive care" payments for chronic conditions. Does this make sense . . . especially when the patient is on the job working at the same job that caused his or her original injury and subsequent chronic pain? Exercise (home directed or formalized rehabilitation programs), while important, is no long-term "cure".

Current research discovered that the popular McKenzie exercise program did not reduce recurrences or long-term utilization of health care.<sup>7 8</sup> Can chiropractic play a role in the proper management of chronic conditions? And can chiropractic increase revenues of MCOs by keeping injured workers on the job?

**Studies demonstrate that chiropractic care can return a worker back to the work in less time, with fewer costs, and less disability!**

Numerous scientific studies have supported the use of spinal manipulation in the treatment of chronic pain. In addition, studies from across the country have supported the fact that Chiropractic manipulation can return a patient to work in less time, with less cost, and less disability compared to traditional medical care.

An Australian study concluded that, "*Comparison demonstrated that (I) a significant reduction was seen in the number of claimants requiring compensation days when chiropractic care was chosen. (II) fewer compensation days were taken by claimants who chose chiropractic care, (III) more patients progressed to chronic status when medical care was chosen, and (IV) the average payment per claim was greater with medical management.*" The study further encourages increased utilization of chiropractic care and increased early referral of claimants with mechanical back pain by MDs to DCs.<sup>9</sup>

A study published in the Journal of Occupational Medicine found that *(I) chiropractic care was 73% more cost effective per case, (II) the average cost per office visit was 67% less for chiropractic than for a medical office visit, and (III) patients seeing doctors of chiropractic were able to return to work 10 times sooner than those under medical care.*<sup>10</sup> [Emphasis added]

A University of Virginia study concluded that chiropractors see their patients more frequently but have lower overall costs for most of the conditions considered. The researchers stated, "By every test of cost-effectiveness, the general weight of evidence show that chiropractic provides important therapeutic benefits at economical costs."<sup>11</sup>

The MEDSTAT Project concluded that plans which have limited or no chiropractic coverage have the highest total costs per patient. Broader coverage of chiropractic services results in dramatically lower health care costs:

- 35% lower hospital admission rates
- 42% lower inpatient payments
- 23% lower total health care costs<sup>12</sup>

Another study examined 10,652 closed cases of patients with back-related injuries who were covered by Florida's worker's compensation law to compare chiropractic case management with standard medical case management. The results indicated that the duration of temporary total disability was 51.3% shorter for chiropractic patients, the cost of chiropractic service was 58.8% lower, and 52.2% of medical patient claimants were hospitalized compared to only 20.3% of chiropractic patients.<sup>13</sup>

## **“What research supports the use of spinal manipulation for chronic back pain?”**

A British ten year study concluded that chiropractic treatment was significantly more effective, particularly with patients with **chronic and severe pain**.<sup>14</sup> [Emphasis added] A second study appeared in the British Medical Journal in 1992, confirming the results of the first study. It concluded that, *"Manipulative therapy and physiotherapy are better than general practitioner and placebo treatment. Furthermore, manipulative therapy is slightly better than physiotherapy after 12 months."*<sup>15</sup>

Despite exercise failure to cure back pain, exercise is still recommended in a quality treatment program. Current research demonstrates that continuance of exercise was associated with a better outcome along with other treatment options. *"For the management of chronic back pain, trunk exercise in combination with manipulation or NSAIDs seems beneficial and worthwhile."*<sup>16</sup>

Another study compared spinal manipulation, needle acupuncture, and NSAIDs for the treatment of chronic back pain. After 30 days, spinal manipulation was the only intervention to achieve statistically significant improvement. Intervention by way of acupuncture or NSAIDs did not result in significant improvements in any of the outcome measures.<sup>17</sup>

A double blind study of the efficacy of spinal adjustive therapy delivered by chiropractors was designed and implemented at the clinic of a chiropractic college. While the sampling was small, the results were clear, and demonstrated the need for a larger scale study. It found that both subjectively and objectively, chiropractic therapy is more effective at relieving low back pain than a manual placebo treatment.<sup>18</sup>

A systematic review of randomized controlled trials found in *Spine* magazine found, *"strong evidence for the effectiveness of manipulation, back schools, and exercise therapy for chronic low back pain, especially for short term results."* Additionally, the study found that no single therapeutic intervention was demonstrated to be effective in the treatment of chronic LBP.<sup>19</sup>

Another study found in *Spine* supported the use of spinal manipulation for chronic low back pain. The study concluded, *"[T]here appears to be clinical value to treatment according to a defined plan using manipulation even in low back pain exceeding 7 weeks' duration"*.<sup>20</sup>

The benefit of chiropractic manipulation (in addition to exercise) over single intervention treatments like acupuncture, exercise, and NSAIDs for patients with chronic pain syndromes is clear and supported by scientific study. Manipulation is certainly the safest and most effective treatment to keep a spine functional and the chronic pain patient employed.

**Inappropriate denials--A change in the paradigm!**  
**Passive is out. Function is in!**

To date, most of the denials for chronic care have been based on the wrong filters:

***"Is care passive?" and/or, "Will care improve the condition? Is there a therapeutic benefit?"***

These criteria used to evaluate care are simply not consistent with current research, clinical experience or reality, or the basic design of the HPP system. Consider most of the available treatments for back pain:

- ◆ Chiropractic or Osteopathic manipulation
- ◆ Drugs
- ◆ Physical Therapy (electric stim, ultrasound, ice, heat, etc.)
- ◆ Massage
- ◆ Epidural injections
- ◆ Facet Injections
- ◆ Physical Rehabilitation
- ◆ Exercises
- ◆ Patient Education
- ◆ NSAIDs
- ◆ Surgery

Can any of these treatments, including home management, exercise, and NSAIDs survive the review criteria of "Is care passive?" or "Will treatment improve the condition?" The answer is unequivocally: NO. All the above-mentioned care is passive, with the exception of exercise. But exercise will not improve the condition. The chronic patient has already attained maximal therapeutic benefit with some degree of permanent, soft tissue residual damage.

As previously noted, research on the effectiveness and compliance with exercise is very limited. The very definition of "chronic" means the patient no longer is capable of improving beyond the level of recovery already attained. Since no treatment, including NSAIDs and exercise, will advance the condition, should the patient be denied all treatment? Again, the answer under the workers' compensation system is "NO."

**"What is the new paradigm?"**  
**What "filters"- review criteria - should be used to judge**  
**the need for care?"**

So how should your MCO review chronic care treatment to assure that it is legitimate? Few would argue that the proper way to review treatment is to focus on **function and return to work, not just pain relief.**

If a condition has advanced to a chronic pain state, the patient is not likely to reach a higher level of recovery with any treatment. The condition is permanent. The symptoms come and go due to the weakness created by the original injury in combination with the physical nature of the job or daily stresses. The issue and goal at that point becomes twofold:

- (1) *What can be done to maximize function?* and...
- (2) *What can be done to keep this patient employed?*

No longer should an MCO or employer ask an IME reviewer to judge a case on the issues of “passive” and “therapeutic gain,” for these terms are irrelevant compared to function and employment. It remains the POR’s job to determine the treatment, or combination of treatments, that will keep the injured worker “functional” and "employed."

If one were to apply those two criteria to determine medical necessity, the entire authorization landscape changes.

In mild, uncomplicated chronic cases, exercise alone may be enough to control the problem and keep the patient employed. At other times, exercise in combination with spinal manipulation and home therapy may be enough. In more extreme cases, periodic injections, rehabilitation or even surgery may become necessary in chronic cases that deteriorate with time.

Bottom line: It is the “treating” doctor’s choice based on the clinical history of the patient that should be the driver in treatment recommendations. We must begin to think in terms of function and employability, not just pain relief. The POR and case manager should work in "partnership" to resolve any treatment issues.

### **Documentation-What does it take to justify ongoing care?**

Clinical evidence suggests that most patients do not require ongoing care due to their original injury. However, since moderate to severe injuries may heal with significant residual weakness, it is imperative to determine not only the causality, but also the minimum amount of treatment needed to control the problem. Therefore, the POR should provide a few key elements within the documentation to justify the need for ongoing care. Minimal elements may include (but are not limited to) the following:

- 1) A statement relating the current pain to the original injury.
- 2) Evidence/statements that treatment is beneficial in maximizing function and keeping the patient employed.

Other key elements that are useful in documenting the causality and need for ongoing care may include but are not limited to the following:

- 1) Description of the mechanism of injury.
- 2) Description of the injury/allowed conditions in the claim.
- 3) History of a pain (consistent or episodic) since the original injury.
- 4) Evidence of residual weakness resulting in recurrent pain (instability).
- 5) Complicating factors that interfere with full recovery.
- 6) Periodic examinations to monitor the success or failure of treatment.
- 7) Pain charts, functional disability scores, examination results (subjective and objective findings)
- 8) Second opinion reports. Were other treatment options considered?
- 9) Diagnostic testing reports.
- 10) A brief case summary, which includes a statement of how well the patient functions **between** appointments/treatments. How long does a treatment last?
- 11) Nature of employment.

When the HPP program was implemented, it created a huge information gap between the providers and the MCOs. Why? The original file located in the BWC office may be six inches thick with medical and administrative information, but that file was not transferred to the MCOs. As a result, the MCOs usually have in their possession minimal information (many times just a few pages of documentation) on "current" treatment, but they do not have any historical perspective on the patient or past treatment.

With a lack of historical perspective, a perception is erroneously created that the POR has done a poor job of documentation. In reality, the POR may have submitted dozens of pages of documentation over the past several years. Therefore, the MCOs, PORs, and employers must acknowledge this system deficiency and work together in true partnership in an effort to determine the future needs of the patients we serve.

**“Are Milliman and Robertson appropriate  
when determining the needs of a chronic pain patient?”**

NO! Milliman and Robertson's own publication, *Healthcare Management Guidelines, Questions and Answers*, specifically states in the opening paragraph:

"The Milliman and Robertson Healthcare Management Guidelines (HMGs) are a set of **optimal** clinical practice benchmarks for treating common conditions for patients who have **no complications**." (emphasis added). It further states that "They are not a prescription, a decision tree, or a set of rules for the practice of medicine." "***They show what can be accomplished under the best circumstances*** (emphasis added) and are **not** meant as a substitute for a physician's judgement about an individual patient." "***As noted, the goals set are for the uncomplicated patient*** (i.e., a patient whose treatment proceeds as anticipated)." (emphasis added)

Most importantly is the following statement by M & R:

**"Anyone who uses the HMGs as a basis for denying authorization for treatment without proper consideration of the unique characteristics of each patient or as a basis for denying payment for the treatment received is using our guidelines inappropriately."**<sup>21</sup>

Clearly M & R is deficient as a tool to judge the treatment appropriateness of chronic pain patients, which by the very definition are complicated cases. Therefore, consultants, MCOs, and employers who deny care to chronic pain patients based on M & R are simply wrong. Care should never be denied without considering the complicated nature of chronic pain, and/or the complicated factors with the individual patient.

**“What is an appropriate level of chiropractic supportive care  
for a chronic pain patient?”**

The Ohio State Chiropractic Association, "*Chiropractic Treatment Guidelines*," clearly identifies various levels of supportive care. Like M & R, these guidelines should not be used as a “cookbook” for treatment. The individual characteristics of each patient, in combination with the POR's professional recommendations, should always be considered in treatment allowance. In general the following will serve as a guide only to understand the commonly accepted level of intervention for chronic pain patients:

- 1) 1-4 visits per month utilizing spinal manipulation and 1-2 therapy modalities. (1-2 visits may be the norm, however in certain well documented cases up to 4 visits per month may be necessary, to be re-evaluated every 6 months).
- 2) Home management utilizing exercise, ice\heat, ADL, and ergonomic factors.
- 3) Re-evaluation every 6-12 months.
- 4) 2-6 visits per **mild** episode of back pain.<sup>22</sup>

In addition to the above-mentioned services, often a multi-disciplinary approach is preferred, utilizing DC, MD\DO, and/or PT providers. Often a combination of treatment is more beneficial than any one singular treatment, especially as it pertains to chronic pain patients.

In summary, it remains our position that to date, the HPP system has unfairly targeted and terminated chiropractic care for chronic pain patients. The preliminary study reported by Milliman and Robertson (based upon BWC data) at the Atwood Retreat in November 1999 suggests that as the system drastically decreased utilization of chiropractic services, there was a corresponding increase in drug utilization. Meanwhile the HPP system to date has had negligible impact on return to work rates, except for lumbar herniated disc injuries, which actually worsened by 10%.<sup>23</sup>

We believe that the short-sighted efforts to decrease chiropractic care will likely result in very deleterious effects to injured workers, and return to work rates, due to the increase utilization of drugs to control pain. The current efforts to minimize chiropractic care in Ohio are diametrically opposed to the scientific literature, the clinical experience of thousands of chiropractic providers, and the satisfaction of injured workers with chiropractic care.

We believe that the expansion of well managed chiropractic care will result in decrease overall costs, improved return to work rates, decreased reliance on drugs, improvement of daily function and work productivity while minimizing pain, and an increase in the quality of life of injured workers in Ohio. The chiropractic profession in Ohio is ready, willing, and able to work in true "Partnership" consistent with the original design of HPP.

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