Guidelines for the Practice of Chiropractic in North Carolina

Introduction

"North Carolina is a C.C.E. state." This simple statement encapsulates the wide-ranging influence exerted by the Council on Chiropractic Education over nearly every aspect of chiropractic practice in this jurisdiction. Our scope of practice is defined as "the method, thought, and practice of chiropractors, *as taught in recognized chiropractic schools and colleges."* Our credentialing statute provides that only "a graduate of a four-year chiropractic college that is either *accredited by the Council on Chiropractic Education or deemed by the Board to be the equivalent of such a college*" shall be eligible for licensure.

In a similar vein, the statute that defines our standards of acceptable care, although expressly authorizing the Board of Chiropractic Examiners to adopt standards when it deems appropriate, also provides, *"If the Board has not defined a standard of acceptable care by rule, then the standard of acceptable care shall be the usual and customary method as taught in the majority of recognized chiropractic colleges.*" Thus far, the Board has not adopted any of its own standards, so all current legal standards of care are the standards taught by most recognized colleges.

One practical difficulty associated with having standards set by the colleges is that there is no central, easily accessible repository containing the standards. Rather, they are embedded in the texts, treatises, lectures and clinical protocols that comprise a chiropractic education. Recently, a number of interested parties, including the North Carolina Chiropractic Association, the North Carolina Department of Insurance and several insurers and managed care organizations, have suggested that the Board of Examiners address the problem of accessibility by engaging in formal rule-making to create a comprehensive, North Carolina-specific set of standards.

In our judgment, there is no need to attempt such an enormous project. Legally enforceable standards, adequate to protect the public, have been in place since C.C.E.'s inception and continue to be in place today. However, the Board does recognize the need for a convenient summary or distillation of the standards, and so we have compiled the following guidelines, which represent the Board's understanding of the current standards of acceptable care "as taught in the majority of recognized chiropractic colleges." We would like to acknowledge and thank the Oregon Board of Chiropractic Examiners, author of the *Education Manual for Evidence-Based Chiropractic* (2005), and the Canadian Chiropractic Association and Canadian Federation of Chiropractic Regulatory Boards, co-authors of *Chiropractic Clinical Practice Guidelines* (2005). Both of these works inform our own guidelines document.

February 2006 N.C. BOARD OF CHIROPRACTIC EXAMINERS

I. Scope of Practice (added May 2009)

A. Chiropractic is an alternative, conservative form of health care which does not duplicate allopathic medicine and is successful at treating a wide variety of ailments. Chiropractic principles were first discovered in 1895, and chiropractic has been recognized as a learned profession in North Carolina since 1917. North Carolina's licensure laws require that a chiropractic physician possess a four-year baccalaureate degree and a four-year Doctor of Chiropractic degree awarded by a college approved by the Council on Chiropractic Education (CCE), an accrediting agency recognized by the U.S. Department of Education.

B. Doctors of Chiropractic are trained in physical examination, diagnosis, treatment, management, reassessment and referral. The State of North Carolina, through its Board of Chiropractic Examiners, examines licensure applicants for clinical competency and the ability to identify a broad spectrum of illness and injury. Comprehensive training and rigorous licensure standards allow chiropractors to serve as primary care portals of entry into the health care system "Primary care" does not mean full-service care, nor does it necessarily entail performing surgery or prescribing drugs. It means that the physician possesses the training to identify a patient's health problems and either treat or refer as warranted by the diagnosis and any scope of practice considerations.

C. It is within the chiropractic scope of practice to use diagnostic methods including but not limited to blood and urine evaluation, diagnostic imaging, electro-diagnostic studies, orthopedic and neurological examination, meridian procedures and nutritional deficit assessment.

D. It is within the chiropractic scope of practice to use therapeutic procedures including but not limited to spinal manipulation and rehabilitative activity, durable medical equipment, physiological therapeutics, body work, massage, acupuncture and nutritional management. Nutritional supplements and other natural substances are those described in 21 NCAC 10 .0209 and may be administered via the most efficacious and safe method taught by recognized chiropractic colleges and universities, as limited by law.

II. Initial Examination and Evaluation

A. In evaluating a new patient or new condition to determine whether the patient would benefit from chiropractic care, the physician should perform a thorough examination. The examination should include a consultation to ascertain history and such relevant orthopedic, neurological and chiropractic tests as are necessary to establish the extent and severity of the injury or condition. If the patient demonstrates a positive history and clinical findings, diagnostic imaging or other investigatory studies may be indicated to rule out pathology and determine the best method of care.

B. After the examination is complete, if the physician determines that the patient's needs are beyond the scope of chiropractic care, he should refer the patient to the appropriate category of provider. If the physician determines that chiropractic care is justified and

accepts the patient, he should formulate a working diagnosis and develop a treatment plan that is consistent with these guidelines.

C. The patient's complaint should be classified by date of onset. A complaint is considered acute if it occurred within four weeks prior to the patient's seeking treatment. (Treatment of acute conditions typically involves passive care to reduce soft tissue and joint stress and diminish inflammation and swelling. Short-term reduced mobility may be warranted to limit the joint-loading effects of gravity.) A complaint is considered chronic if it has lasted more than four weeks or if there are one or more recurrences of the same symptoms produced by the same cause.

D. The patient should be assessed for complicating factors such as family history, skeletal anomaly, pathology, work environment, home environment, age, obesity, previous episodes and other pertinent considerations. The presence of complicating factors will affect the design and duration of the treatment plan and the patient's prognosis and should be noted in the clinical record.

III. Informed Consent (added July 2008)

A. A chiropractic physician is legally and ethically obligated to obtain informed consent from his patient prior to the start of treatment. Consent cannot be considered informed unless, at a minimum, the physician orally explains the risks associated with the proposed course of treatment, answers any questions the patient may have, and obtains the patient's permission to treat.

B. The physician shall note in the patient's clinical record the date of the informed consent consultation, the matters discussed, and the authorization to treat given by the patient. A standardized form may be used only as a written acknowledgment by the patient that the consultation occurred and that consent was given. A form cannot replace the face-to-face discussion between physician and patient contemplated by this guideline.

C. If the patient is a minor or an incompetent adult, the informed consent consultation shall include the patient's parent or legal guardian.

IV. Treatment Plan

A. Each patient is unique, and each patient's complaints, injuries and circumstances are distinct. It is the physician's responsibility to develop a treatment plan individually tailored to the patient's condition. The goals of the treatment plan should be to restore motion, improve strength and function, and reduce pain.

B. At the outset of treatment, the physician should provide the patient with estimates of the time within which to expect initial improvement and the time within which to expect maximum therapeutic benefit. The physician should adequately explain to the patient the nature of the patient's condition, the goals of treatment, and the treatment strategy. Because the patient's active participation in the treatment plan is essential to success, the

physician should refer or discharge a patient who fails to comply with treatment recommendations.

C. During each office visit, the physician should inquire as to the patient's presenting complaints, perform the treatment called for in the treatment plan, and monitor the patient's clinical picture through the use of objective tests such as range of motion, segmental range of motion, presence or absence of spasm or swelling, presence or absence of positive orthopedic findings, and pain assessment.

D. The physician should re-evaluate the appropriateness of further care after whichever comes first, approximately twelve office treatments or four weeks of care (i.e., one "treatment cycle"). If the patient shows improvement, the physician may recommend another treatment cycle. For as long as improvement can be objectively demonstrated, the patient may continue treatment cycles. However, if re-evaluation fails to demonstrate additional improvement after any two consecutive treatment cycles, the physician should assume that maximum therapeutic benefit has been reached. Patients who have reached maximum therapeutic benefit may be candidates for supportive care, elective care, referral or release.

E. Once the goals of treatment have been realized, the patient may continue to need supportive care in order to prevent deterioration or relapse.

V. Frequency and Duration of Treatment

A. The frequency of treatment should gradually decline until the patient reaches the point of discharge or converts to supportive or elective care. An acute exacerbation may require more frequent care. The treatment time may be extended due to complicating factors.

B. For some patients, the physician may determine, in the exercise of clinical judgment, that a period of trial treatment is warranted. An initial trial period of up to two weeks may be appropriate. If re-evaluation shows no improvement, a second trial period, lasting a maximum of two weeks and utilizing a different method of treatment, may be instituted. If there is still no demonstrable improvement, the physician should refer or discharge the patient.

C. Some patients may require supportive care using passive therapy if efforts to withdraw treatment results in deterioration of clinical status.

VI. Failure to Meet Treatment Goals

A. Healing the sick, injured and infirm is an art, and no health care provider, regardless of professional training or category of license, can guarantee the success of treatment.

B. If a patient's recovery is slower than expected, the physician should search for complicating or extenuating factors by engaging in a reassessment interview with the patient, including a review of the patient's activities of daily living.

C. If a patient with an acute condition shows signs of becoming chronic, the physician should review and consider altering the treatment plan to de-emphasize passive care and focus on active care.

D. If a patient with an uncomplicated condition fails to show initial improvement after two treatment cycles, or a patient who initially showed improvement subsequently fails to show further improvement after one additional treatment cycle, the physician should assume that maximum therapeutic benefit has been achieved. Patients who have reached maximum therapeutic benefit may be candidates for supportive care, elective care, referral or release.

VII. Supportive and Elective Care

A. Supportive care is appropriate for patients who have reached maximum therapeutic benefit and who have failed to sustain therapeutic gains when treatment is withdrawn. Supportive care is also appropriate for patients who display persistent or recurrent signs of illness or impairment.

B. Supportive care should be administered only after rehabilitative, restorative or alternative care options such as home-based self-care and lifestyle modification have been attempted without success. Supportive care should be administered according to the assessment/treatment/re-assessment paradigm and should not exceed one office visit per week, absent exacerbation.

C. Elective care is not medically necessary; it is voluntarily chosen by a patient who perceives an overall health benefit from regular, periodic chiropractic treatment. The frequency of elective care varies from patient to patient. If a patient's stable condition changes, the physician may be required to intervene, reassess the treatment regimen and convert elective care to active or supportive care.

VIII. Typical Treatment Duration for Common Conditions

A. Treatment or coverage limitations imposed by insurance policies or managed care contracts do not relieve the physician of his duty to deliver treatment sufficient to satisfy the minimum standards of acceptable care.

B. A treating physician should not accede to third-party requests for modification of treatment unless the requesting party has first caused the patient to be examined and evaluated by an independent examiner whose credentials meet the requirements of applicable North Carolina law and who has submitted to the treating physician a written professional opinion that the requested modification is justified.

C. A physician's variance from typical treatment periods does not necessarily imply any violation of these guidelines. As stated earlier, the basis of all treatment programs is the paradigm of assessment/treatment/re-assessment during each office visit, followed by re-evaluation after approximately twelve office visits or four weeks of care. Treatment cycles may be repeated for as long as the patient continues to demonstrate objective

progress towards maximum therapeutic benefit or the desired treatment goals. However, the physician's decision to continue treatment must be based on documented, objective findings in all cases.

D. The following examples of neuro-muscular-skeletal conditions routinely treated by chiropractic physicians are grouped according to typical recovery times. **This list is not exhaustive**, and the recovery times are for simple cases devoid of complicating factors that could prolong the need for treatment. The recovery times are averages, and the progress of any individual patient may be faster or slower than the time stated.

CATEGORY ONE: 0-6 WEEKS OF TREATMENT

Mild strain
Mild sprain
Mechanical/joint dysfunction, uncomplicated
Subluxation, uncomplicated
Acute facet syndrome
Contusion
Mild tendonitis, capsulate, bursitis, synovitis
Mild sacroiliac syndrome
Acute myofascial pain syndrome
Mild symptomatic degenerative joint disease
Headaches, vertebrogenic, muscle contraction
Torticollis, acquired

CATEGORY TWO: 2-12 WEEKS OF TREATMENT

Moderate-marked strain
Moderate sprain
Post-traumatic mild-moderate myofibrosis
Post-traumatic periarticular fibrosis and joint dysfunction with marked tendonitis,
bursitis, capsulitis, synovitis
Chronic tendonitis, bursitis, capsulitis, synovitis
Chronic facet syndrome
Moderate sacroiliac syndrome
Chronic sacroiliac syndrome with marked myofascial pain syndrome
Chronic myofascial pain syndrome
Mechanical/joint dysfunction, complicated
Subluxation, complicated
Moderate symptomatic degenerative joint disease
Mild inter-vertebral disc syndrome without myelopathy
Chronic headaches, vertebrogenic, muscle contraction, migraine, vascular
Mild temporomandibular joint dysfunction
Symptomatic spondylolisthesis
Mild clinical joint instability

CATEGORY THREE: 1-6 MONTHS OF TREATMENT

Chronic facet syndrome associated with clinical vertebral instability
Marked strain associated with post-traumatic myofibrosis and/or joint dysfunction
Marked sprain with associated instability/dysfunction
Thoracic outlet syndrome
Moderate inter-vertebral disc syndrome without myelopathy
Moderate-marked temporomandibular joint dysfunction
Adhesive capsulitis
Partial or complete dislocation

CATEGORY FOUR: 2-12 MONTHS OF TREATMENT

Marked inter-vertebral disc syndrome without myelopathy, with or without radiculopathy
Lateral recess syndrome
Intermittent neurogenic claudication
Acceleration/deceleration injuries of the spine with myofascial complications
Cervicobrachial sympathetic syndromes
Sympathetic dystrophies
Severe strain/sprain of the cervical spine with myoligamentous complications

IX. Transcutaneous Electrical Nerve Stimulation (added May 2009)

A. Transcutaneous Electrical Nerve Stimulation (TENS) units or similar devices should be dispensed conservatively and used only as part of a documented treatment plan that defines application parameters and objectives. TENS units are an appropriate component of treatment in the following situations:

- For the relief of pain in chronic pain syndromes, but only after standard management utilizing chiropractic adjustment, physical therapy and in-office modalities has been tried for at least 30 days and has failed to produce adequate results;

- For the relief of acute post-operative pain in the first 90 days following surgery;

- For the temporary relief of pain in acute care cases where the overall treatment plan is consistent with these guidelines and the standards of care taught in accredited chiropractic colleges.

B. Charging excessively for TENS units or dispensing TENS units without clinical justification are violations of the Chiropractic Practice Act and grounds for disciplinary action by the Board.

X. Durable Medical Equipment (added May 2009)

"Durable medical equipment" consists of items that help the patient stabilize a condition or achieve a therapeutic gain. The items of durable medical equipment listed below are commonly dispensed or recommended by chiropractic physicians. This list is not exhaustive; other items may be dispensed or recommended if warranted by clinical findings.

- Orthotics
- Heel lifts
- Heel cups
- Cervical collars
- Lumbar and SI joint supports
- Carpal tunnel braces
- Cervical pillows
- Extremity braces and supports
- Ice packs
- Home traction units
- TENS units
- Home exercise equipment, including therabands, exercise balls, exercise tubing, nexercisers
- Balance or wobble boards
- TMJ night guards
- Seat wedges
- Spine wedges
- Remodeling devices