

# Hawaii State Chiropractic Association



## **STANDARDS OF DOCUMENTATION, CHIROPRACTIC GUIDELINES FOR SPECIFIC CONDITIONS, AND UTILIZATION OF DIAGNOSTIC IMAGING**

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**STANDARDS FOR  
CHIROPRACTIC DOCUMENTATION**

**General information:** The following elements of chiropractic documentation are presented to the participating member doctors of the HSCA. The purpose of these guidelines are:

1. To serve as an informational source to doctors. These guidelines represent well-accepted, contemporary views on documentation issues.
2. To serve as a voluntary standard for chiropractors to utilize when developing documentation systems for their offices.
3. To serve as an internal benchmark for gauging the quality assurance and quality improvement of participating chiropractor of the HSCA.

The HSCA recognizes that the management of each and every and every individual patient is unique. Documentation performed within the parameters of the HSCA guidelines need not be rigid and inflexible, but may be adapted to the needs of a particular case and used to communicate the uniqueness of the individual patient. These guidelines are intended to provide a common framework for patient records which allows for a more consistent reporting and improvement in communication within the health care delivery system.

**Format:** A SOAP format must be used, in some form. The advantages of a SOAP-style format is that information is recorded in a predictable, repetitive manner. Proprietary systems of documentation are, by definition, difficult or impossible for a reviewer to understand and should be avoided. The doctor may complete the documentation process through the use of a narrative-style writing or may choose to utilize pre-prepared forms which include the crucial elements of case documentation.

**Legibility:** Documentation must be legible. It is preferred that the chiropractor's notes be typed and in narrative report form, especially for key portions of the record such as the initial evaluation, interim reexamination / progress report, exacerbation reports and final reports. If the patient records are hand written the records must be legible.

## **General Considerations for Recordkeeping:**

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
  - the reason for the encounter and relevant history, physical exam findings and prior diagnostic test results.
  - the physician's assessment of the patient's condition, clinical impressions or diagnoses
  - a plan for care i.e. treatment plan
  - the date and legible identity of observer i.e. physician, therapist,
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and /or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to treatment and changes in the treatment or diagnosis should be recorded.
7. The CPT and ICD-9-CM codes reported and billed should be supported by the documentation in the medical record.

**Documentation of Patient Consent:** Doctors should review their responsibilities to obtain written proof of the patient's consent in the following critical areas:

- general consent to examine and treat: many doctors will have the patient complete this written consent as part of their initial patient questionnaire.
- informed consent: if any proposed treatment procedure poses a meaningful risk to the patient, the doctor is required to disclose that risk to the patient and to obtain written consent prior to proceeding with the proposed treatment.
- parental consent to examine and treat minor children: required in order to institute treatment for any child under age 18.

**Initial New Patient History:** This section forms the subjective area of the documentation. Recommended elements of the subjective portion of the patient records may include the following:

History of the Present Illness: (HPI)

- history of trauma
- description of the chief complaint(s)
- onset of symptomatology
- palliative and provocative factors
- quality of pain i.e. burning, numbness, tingling, stabbing, dull ache
- radiation of pain
- severity of pain
- frequency or timing of complaint
- previous episodes of chief complaint

Past History:

- prior major illness and injuries
- prior operations
- prior hospitalizations
- current medications
- allergies i.e. food, drugs
- age appropriate feeding / dietary / nutritional status

Social History:

- current employment
- occupational history
- use of drugs (recreational and prescription), alcohol and / or tobacco
- other relevant social factors

## Review of Systems: (ROS)

- constitutional symptoms i.e. fever, weight gain or loss, fatigue, etc.
- eyes
- ears, nose and throat
- cardiovascular
- respiratory
- gastrointestinal
- genitourinary
- musculoskeletal
- integumentary i.e. skin, breast
- neurologic
- psychiatric
- endocrine
- hematologic / lymphatic
- allergic / immunologic

## **Initial New Patient Physical Examination:**

Purpose: To evaluate a new patient or new condition with the following objectives;

- Determine diagnosis
- Set treatment plan
- Determine prognosis
- Refer to other practitioners, as necessary

This information provides the objective area of the documentation. Recommended elements of the objective portion of the patient records may include:

- Vital signs
  - Height
  - Weight

- Blood pressure (required at initial exam, follow-up, as needed, depending on patient's condition)
- Respiration (if symptoms indicate)
- Temperature (if indicated by febrile symptoms)
- observation / visualization
- palpation
- range of motion (AROM, PROM)
- Reflexes
  - Deep tendon
  - Superficial (if indicated by symptoms)
  - Pathologic (if indicated by symptoms)
- Vascular examination (if indicated by symptoms)
- Orthopedics
- Neurologic testing
  - Cranial nerves
  - Station, gait and balance
  - Sensory testing
  - Muscle strength testing
- Auscultation
- Percussion

**Initial New Patient Assessment:**

- Diagnostic impression in narrative report format
- Assessment of risk factors

**Initial New Patient Plan:**

- Diagnostic treatment plan: describe need for further tests, etc.
- Therapeutic treatment plan: describe in-office therapies and modalities, to include frequency and duration

- Educational treatment plan: home exercises modification of activities of daily living and / or work and recreational activities
- Short and long goals
- Coordination of care with other health care professionals, to include nature and extent of proposed referrals / consultations

**Interim or Progress Notes:** The committee has agreed on the following guidelines for the chiropractor's daily notes;

**(S) SUBJECTIVE FINDINGS: Must be included in each daily note**

- Description by the patient of changes in symptomatology, including pain location, frequency, character or intensity
- intensity or quantity of symptomatology (by use of analog pain scale [1-10] or verbal pain scale [mild, moderate, severe]).
- Subjective entries should have an emphasis on function, activities of daily living, inability to perform certain activities, etc.

**(O) OBJECTIVE FINDINGS: Most doctors will include 3 or 4 pertinent objective findings from the possibilities listed below. Of course, the daily note should list any and all objective changes noted in the patient's presentation on that day:**

- Observations: antalgia, edema, postural irregularities
- Palpation: muscle spasm, fixation, hypermobility trigger points, etc.
- Range of motion testing
- Provocative orthopedic tests
- Neurologic tests
- Findings from any supplemental tests, such as radiographs, imaging studies, thermographic studies, etc.
- Other measurable findings (blood pressure, algometry, special tests, etc.

**(A) ASSESSMENT:** The assessment should note any changes in the doctor's impression of the case. Possible entries might include:

- Change in the diagnostic impression
- Subluxation levels
- Opinion regarding the patient's progress
- Opinion regarding how well the patient tolerated various treatments
- Opinion regarding the patient's level of compliance with the treatment plan
- A referral to a prior, more lengthy assessment (usually at the most recent examination) if there is not a change in the assessment for that day.

**(P) PLAN:** The plan section of the daily notes should contain any comments or changes in the doctor's treatment plan of the case. Possible entries might include:

- Date of return for treatment
- Changes in initial treatment plan
- Changes in adjusting techniques
- Spinal levels of adjustment levels
- Therapies performed, including type of therapy, location applied, intensity and duration.
- Recommended exercises
- Ergonomic changes needed for the patient to maximize the recovery
- Imaging or special diagnostic studies which are needed
- Referral to a prior, more lengthy plan (usually at the most recent examination or reexamination) if there is not change in the assessment for that day.

**Reevaluation/Interim Examination Frequency:** It is acknowledge that the chiropractor may reassess and Established Patient at any time during the course of treatment (CPT 99211-99213), especially if the condition changes. The Committee has formulated the following chart which describes the recommended minimum frequency of a reevaluation / interim examination for Established patients (CPT 99214-99215):

**Purpose:** To evaluate an established patient or condition with the following objectives;

- Confirm or alter diagnosis
- Confirm or alter treatment plan
- Evaluate progress
- Determine prognosis

**GUIDELINES FOR FREQUENCY OF EXAMINATIONS**

<b>PATIENT TYPE</b>	<b>DEFINITION</b>	<b>TYPICAL TREATMENT PATTERN</b>	<b>RECOMMENDED MINIMUM FREQUENCY</b>
Acute	Symptomatology is present less than six weeks, or acute exacerbation of a chronic or recurring condition	Variable, depends on severity	30 days or 12 visits
Chronic	Symptomatology present more than 18 weeks	Once to twice per week	3 months or 18 visits
Supportive	Symptomatology present due to a known, permanent deficit; a full recovery is not expected.	Twice per month	Once or twice per year
Maintenance	No active symptomatology	Once per month	No formal re-exam required

In addition to the periodically performed reevaluation/interim examinations for an Established Patient, the need for more frequent examinations should be determined by the clinician, as patient progress warrants, the medical history changes or when one or more of the following conditions exists or occurs:

- a patient presents with a new injury / incident
- a patient presents with a new chief complaint (s)
- a patient presents with a new, distinct episode / exacerbation of a recurring condition
- a patient has an unexpected response to treatment
- an anticipated change in activity level (i.e. return to work)
- a patient is being dismissed from care
- a patient has not received a treatment for ninety (90) days or more
- other significant changes in medical history

Roetgenographic documentation should be included with the **OBJECTIVE FINDINGS** on the day the film was read/billed. These findings may be in the form of a formal report, or may be condensed to the major findings.

**STANDARDS FOR CHIROPRACTIC TREATMENT  
AND TREATMENT GUIDELINES  
FOR SPECIFIC CONDITIONS**

## Disclaimer

Specific parameters of care appropriate for each individual case are impossible to define. Each case must be evaluated with complicating factors, concomitant and all extenuating circumstances taken into consideration in order to assure the patient maximum benefit through conservative chiropractic care.

The following guidelines should serve only as a general guide for parameters of care. Furthermore, these guidelines are **not** meant to provide cut-off points for treatment, but rather to assist the analyst in determining when a request for additional information may be appropriate.

Patients may progress at a rate not anticipated in these guidelines. Exacerbation(s) secondary to physical activity may prolong normal rate of recovery. Complicating conditions wherein the patients recovery, because of one or more identifiable factors, may be slow, regressive or retarded in comparison with expectation. On the other hand, patients sometimes respond more quickly than expected. The need for documentation, as outlined above, is paramount to good communication between the physician and the insurance company and / or employer. Treatment is an essential part of diagnosis. An admitting diagnosis may be given initially until patient response to treatment confirms or alters the diagnosis, category of condition and its degree of severity. The responsibility of upgrading or downgrading a patient's diagnosis and prognosis rests with the treating physician.

## **THE VERTEBRAL SUBLUXATION COMPLEX**

### **SUBLUXATION COMPLEX DEFINED**

The chiropractic subluxation is defined as any alteration of the biomechanical and physiological dynamics of contiguous spinal and paraspinal structures. These biomedical alterations are important because they can cause neurological disturbances.

In its simplest form, a subluxation is an alteration in position and/or motion of spinal segments and joints of the body, which affects the nervous system, thereby creating dysfunction in the tissues innervated by those nerves involved.

The dysfunction may take place at the site of the subluxation or anywhere along the course of the involved nerve(s). In its most severe form, many surrounding tissues are involved and may be permanently damaged or destroyed.

The chiropractic subluxation, as a complex spinal and paraspinal entity, may be divided into five following components.

### **COMPONENTS OF THE VERTEBRAL SUBLUXATION COMPLEX**

#### **1. Kinesiopathology (aberrant mobility, etc.)**

- a. Hypomobility
- b. Hypermobility
- c. Compensation
- d. Loss of joint play
- e. Change in axis of motion
- f. Positional dyskinesia

#### **2. Neuropathophysiology**

- a. Irritation  
Friction, tugging, torsional tension, traction, etc., producing the “facilitated segment”.
- b. Compression  
Direct or indirect – vertebral discogenic, degenerative joint disease, positional dyskinesia, hypertrophic arthritis, etc.

#### **3. Myopathology**

- a. From facilitation – (hyperactivity) spasm, contracture, myofibrositis, etc.
- b. From compression – (hypoactivity) flaccidity, atrophy, myofibrositis.

#### **4. Histopathology**

- a. local inflammatory process.
- b. edema: decreased lymphatic drainage.
- c. vascular aberrations.

#### **5. Biochemical and bioelectrical abnormalities**

- a. Local biochemical changes in response to local tissue damage (inflammation and vascular insufficiency). One example is the degeneration of the myelin sheath producing proteinous toxins affecting all the nerves in the surrounding area and possibly causing local degeneration of the spinal supportive tissues. Another example is the increased deposition of calcium salts in areas of bony stress (kinesiopathology).
- b. Peripheral biochemical and bioelectrical changes in response to ortho and retrograde axoplasmic circulation of protein toxins from spinal lesion. Peripheral biochemical changes are also seen as the general adaptive syndromes (G.A.S.) with an increase in the stress hormones such as: ACTH, histamines, prostaglandanines, kinines, etc. prediposing body to stress reactions, inflammatory reactions, allergic reactions, and elevated cardiovascular functions.

### **DIAGNOSTIC EXAMPLES WITH RELATED SUBLUXATION COMPLEX AND COMPONENTS**

For the purpose of illustration, the following three examples are specific to “subluxation-involved” diagnosis and ICD\*9\*CM coding. Chiropractic physicians also treat conditions that do not involves subluxations.

- A. Cervico-cranial Syndrome (723.2)  
Related Subluxation C1-2 (Facilitative lesion)  
(739.1)
  - 1.) Kinesiopathology: Aberrant motion of C1.  
(718.9)
  - 2.) Neuropathology: Occipital neuralgia (headaches) .  
(784.0)
  - 3.) Myopathology: Cervical myospasm.  
(728.85)
  - 4.) Histopathology: Swelling and palpable tenderness.  
(782.3)
  - 5.) Pathophysiology: Osteophytosis (spurring) C2.  
(726.91)
- B. Thoracic Radiculitis (724.4)  
Related Subluxation T5-6 (Facilitative lesion)

(739.2)

- 1.) Kinesiotherapy: Mid-thoracic fixation/hypomobility  
(739.2)
- 2.) Neurotherapy: Neuogenic gastritis, biliary dyskinesia.  
(535.5)
- 3.) Myopathy: Fibrositis.  
(729.0)
- 4.) Histopathology: Palpable tenderness and tissue  
inflammation.(782.3)
- 5.) Pathophysiology: Thoracic scoliosis.  
(727.39)

C. Lumbar Disc Syndrome (722.73)  
Related Subluxation L5-S1 (Compressions lesion)  
(739.2)

- 1.) Kinesiotherapy: Altered range of motion.  
(780.9)
- 2.) Neurotherapy: Sciatic neuralgia.  
(724.3)
- 3.) Myopathy: Atrophy of gastrocnemius muscle.  
(728.2)
- 4.) Histopathology: Tissue swelling and palpable tenderness.  
(782.3)
- 5.) Pathophysiology: Discogenic spondylosis (L5).  
(756.11)

The vertebral subluxation complex may be composed of one or more of the above components, depending upon the severity of the condition. The examples given above describe moderate to severe subluxation complexes in order to give examples containing all five components. Improvement or reduction of these components of the vertebral subluxation complex is an indication of effective treatment.

**THE IMPORTANCE OF THE VERTEBRAL SUBLUXATION COMPLEX**

The importance of a vertebral subluxation complex is dependent upon its clinical features and whether this lesion and its neurogenic responses are affecting the total health of the individual to a significant degree. Minor mechanical errors in position and motion occur in all of us. Consequently, neurological irritations occur. We are all subject to environmental irritations and respond to these in a manner that creates errors in musculoskeletal symmetry in our body; therefore errors in position and mechanics of our anatomical structure occur. These in turn cause or perpetuate neurological aberrations of motor reflexes. These motor responses, however, may be of a temporary nature, for the body is capable of correcting mechanical faults within its structure provided they are of minimal nature.

On the other hand, certain forms of lesions cannot be corrected without proper professional attention. The subluxation's significance is determined by how it affects the total economy of the body and how involved it is in the production of aberrant neurological responses and the creation of a state of disease. These effects may be determined by a proper chiropractic analysis and diagnosis.

## **THE CAUSE OF SUBLUXATION / SEGMENTAL DYSFUNCTION**

The immediate causes of subluxation may be divided into two major categories: the unequal or asymmetrical musculature efforts upon the joint structures, and the inequality in the supporting tissues or a particular joint, such as the cartilage, intervertebral disc, ligaments, etc.

### **Inequality in Muscular Balance**

Inequality in muscular balance may be initiated by many things such as:

- 1.) Trauma
  - A. Acute macrotrauma may cause inflammation, degeneration, etc., and particularly the muscular splinting or spasm reaction that the musculature makes when its surrounding tissues are injured and therefore alter the position and motion of the structural tissues that are related.
  - B. Microtrauma, though of a less acute nature, may cause a slow continual irritation and may eventually create degenerative pathological changes which similarly alter muscular reaction.
  
- 2.) Postural Distortion Phenomena

Postural compensations for either mechanical activity or for structural changes in the skeleton itself. These changes, as well as other causes of subluxation, often result in a series or combinations of minor mechanical errors which together may be termed scoliosis, kyphosis, lordosis, distortion, or similar terms.

3.) Biochemical Reactions

The acute or chronic hypo or hypertonicities of musculature may be due to various biochemical changes within these tissues.

4.) Psychomotor Reactions

The reaction of the musculature to emotional effects on the nervous activity of the body as it depicts its psychological stresses.

5.) Paralytic Affects

Primary disease of the neuromuscular system itself such as polio or other paralytic diseases which affect the balance of the musculoskeletal tone or strength and therefore positional quality of motion.

6.) Somatic and Visceral Responses

The secondary reaction of the muscular system to somatic or visceral sensory irritation which may develop elsewhere in a given neurological segment.

### Abnormal Structural Support

Mechanical errors in position or motion may also be brought about by structural alterations in the supporting tissues of the joint itself. These in turn may be brought about by:

- 1.) Developmental abnormalities causing asymmetry of the vertebra, cartilage, muscular structure, etc.
- 2.) Various acquired disease processes within the joint such as arthritic degeneration, avascular necrosis or a neuropathic process that causes the cartilage, bone, ligaments, or musculature to be structurally altered.
- 3.) The resolution of macro or microtraumas or of other primary pathology may cause fibrosis, degeneration, or other retrograde changes of a structural nature within the joints themselves.

These same various processes, as mentioned, not only develop within the vertebral column and its paravertebral tissues, but also in the musculoskeletal tissues of the appendicular skeleton, and similar lesions may therein exist which perpetuate neuropathic responses by their presence. Within the structures of the vertebral column, the effects of these subluxations are more evident because of the close anatomical proximities and the functional importance of normal motor motion or mechanical integrity to the various components of the nervous system.

## **SUBLUXATION CLASSIFICATIONS BY RADIOGRAPHIC FINDINGS WHEN RADIOGRAPHIC EVIDENCE EXISTS**

### Static

- 1.) Flexion malposition
- 2.) Extension malposition
- 3.) Lateral flexion malposition (left or right)
- 4.) Rotation malposition (left or right) (anterior or posterior)
- 5.) Anterolisthesis-spondylolisthesis
- 6.) Retrolisthesis
- 7.) Lateral listhesis (left or right)
- 8.) Interosseous spacing
  - a. decreased
  - b. increased
- 9.) Osseous foraminal encroachment

### Kinetic

- 1.) Hypomobility-fixation
- 2.) Hypermobility
- 3.) Aberrant motion

### Sectional Subluxations

- 1.) Scoliosis and/or alteration or curves secondary to musculature imbalance.
- 2.) Scoliosis and/or alteration of curves secondary to structural asymmetries.
- 3.) Decomposition of adaptational curvatures.
- 4.) Abnormalities of motion.

### Paravertebral Subluxations

- 1.) Costovertebral and costotransverse disrelationships.
- 2.) Sacroiliac subluxations.

## LEVEL OF CHIROPRACTIC CARE

There are two basic levels of chiropractic care, classified as **Active Care** and **Preventative/Maintenance Care**. The type of care the patient is to receive is directly dependent upon the classification of his/her condition.

**Active Care:** Patient management directed toward returning the patient to pre-clinical status following injury or illness.

1. **Relief Care:** Patient management directed toward reducing symptoms and improving function to a tolerable level.
2. **Therapeutic Care:** Patient management directed to further reduce symptomatology and improve function. This level of care should enable a patient to perform most normal daily activities without frequent exacerbation symptoms.
3. **Rehabilitative Care:** Patient management directed toward improved function by restoring optimal strength and flexibility to the musculoskeletal system. The goal of this phase is to return the patient to pre-clinical status through education and therapy.
4. **Supportive care:** Patient management directed toward support of an unstable condition which includes periodic monitoring and treatment to reduce the frequency and severity of anticipated exacerbations. The need for supportive care is seen in cases where patients having reached maximum therapeutic benefit, in whom periodic trials of therapeutic withdrawal has failed to sustain previous therapeutic gains, would otherwise progressively deteriorate. Or where the injury or illness results in permanent, unstable conditions or disabilities and the patient is therefore unable to return to pre-clinical status.

**PREVENTATIVE/MAINTENANCE CARE:** Patient management directed toward maintaining optimal body function and health. This is management of the asymptomatic patient who has reached pre-clinical status or maximum therapeutic benefit where the condition is resolved or stable and is provided to reduce the incidence or prevalence of illness, impairment and risk factors.

## Categories of Conditions Treated, Nomenclature and Operational Definitions

**Acute** – Sharp, poignant; having a short and relatively severe course. Acute in this instance is meant to designate the new condition of less than 6 weeks duration.

1. **Mild:** By nature this condition is uncomplicated and usually does not require rehabilitative or supportive care. This category of condition does require relief care and may require therapeutic care. The patient with a mild condition would normally require further care only in the event of significant re-injury or acute exacerbation.

An example of mild, acute condition: Strain of the lower back or neck, no major joint involvement, recent onset, no past history of similar complaints and no complicating factors readily apparent.

2. **Moderate:** This condition commonly requires rehabilitation care but may not require supportive care in the mild-to-moderate case.

An example of moderate, acute condition: Mild-to –moderate lumbosacral sprain/strain injury or cervical hyperflexion/hyperextension injury, recent onset with significant trauma, complicated by concomitant or related conditions such as headaches, nausea, cervicobrachial syndrome.

3. **Severe:** This condition is complicated and usually requires all four levels of care to regain maximum function, which may be maximum therapeutic (chiropractic) benefit without obtaining pre-existing or pre-clinical status.

An example of severe, acute condition: Joint, muscle, ligament, and/or nerve damage, such as lumbar and cervical disc syndromes or moderate complicated sprain/strain injuries.

**Subacute** – May be used to describe a condition between acute and chronic with some acute features.

**Chronic** – Persisting over a long period of time. Chronic in this instance is meant to designate the long-standing, recurring condition of more than 18 weeks duration.

1. **Mild:** Without acute exacerbation, this condition may require little or not intensive relief care, but may require therapeutic, rehabilitative and supportive care.

Example: Chronic muscle strain from aberrant biomechanics, myofascitis/fibromyositis, without major complicating factors.

2. **Moderate:** With acute exacerbation, this condition may require all four levels of care.

Example: Degenerative joint disease, muscle weakness, ligamentous instability, disc degeneration, with numerous complications and concomitant conditions.

3. **Severe:** With serious, acute exacerbation, this condition requires extended periods of all four levels of treatment.

Example: Disc, joint and neurologic involvement, post laminectomy syndrome, history of serious and/or numerous traumatic events, numerous complicating factors notes as well as related conditions and concomitant complaints.

**Acute exacerbation** – May be used to describe a sharp or severe exacerbation of symptoms or an increase in the severity of a condition.

**Maximum Therapeutic Benefit** – Maximum therapeutic benefit (MTB) is considered to have been reached when the patient's symptomatology and/or disability has remained unchanged for two (2) months or longer while under active care. Validation of MTB is to be considered documented when there is a lack of significant measurable improvement or reduction in disability on two-(2) consecutive monthly evaluations. Significant residual symptoms, diminished functional capacity and/or disability may still be present, but no further measurable improvement or reduction in disability is anticipated with continued active care.

**Significant Residual Symptoms** – Residual symptoms are considered significant when they are severe enough to prevent normal work activities, activities of daily living or an improvement in functional capacity.

**PRN Treatment (as needed/supportive care)** – PRN treatment or supportive care is defined as treatment for patients who have reached MTB, but continue to experience significant residual symptoms, that are not adequately controlled with home based self-care and/or lifestyle modifications. PRN treatment should be diagnostically based and administered at a low enough frequency to reduce the chance of physician dependence, somatization, illness behavior or secondary gain.

A treating physician may contend that PRN treatment is, by definition, as needed treatment and in moderate to severe cases ongoing weekly treatment is beneficial even after MTB has been achieved. In an attempt to mitigate the appearance of overutilization and avoid the chance of physician dependence, somatization, illness behavior or secondary gain, weekly chiropractic treatment, for purposes of these treatment utilization guidelines, shall be considered "active" treatment. Once MTB has been reached "active" treatment is appropriate in only very unique circumstances, which are justified by and objective clinically documented condition or state that elevates the patient to an appropriate Diagnostic Related Group.

## **GUIDELINES FOR CHIROPRACTIC MANAGEMENT**

The following charts shall serve as a general guideline for the treatment of acute and chronic conditions. It is important to note that with proper documentation additional treatment or alteration of treatment schedules may be warranted for the categories of conditions and levels of care listed herein.

### **ACUTE CONDITIONS**

Definition: New condition, most frequently related to an injury of less than 18 weeks duration.

<b>TYPES OF CONDITIONS</b>	<b>LEVELS OF CARE</b>	<b>FREQUENCY OF TREATMENT</b>	<b>DURATION OF TREATMENT</b>
Mild	Relief	Daily to 3x's/wk	1-15 days
	Therapeutic	3x's/wk to 1x/wk	0-30 days
	Rehabilitative	None	None
	Supportive	None	None
Moderate	Relief	Daily to 3x's/wk	7-21 days
	Therapeutic	3x's/wk to 1x/wk	30-60 days
	Rehabilitative	1x/wk to 2x's/wk	30-60 days
	Supportive	2x's/wk to 1x/wk	0-3 months
Severe	Relief	Daily to 3x's/wk	21-45 days
	Therapeutic	3x's/wk to 1x/wk	30-90 days
	Rehabilitative	1x/wk to 2x's/mo	45-90 days
	Supportive	2x's/mo to 1x/mo	3-5 days

### **CHRONIC CONDITIONS**

Definition: Old condition; arbitrarily set at greater than 18 weeks duration with long-standing or recurring symptomatology. May be history trauma or microtrauma.

<b>TYPES OF CONDITIONS</b>	<b>LEVELS OF CARE</b>	<b>FREQUENCY OF TREATMENT</b>	<b>DURATION OF TREATMENT</b>
Mild	Relief	None	None
	Therapeutic	3x's/wk to 2x's/wk	14-45 days
	Rehabilitative	2x's/wk to 2x's/mo	45-90 days
	Supportive	2x's/mo to 1x/mo	3-6 months
Moderate	Relief	Daily to 3x's/wk	14-45 days
	Therapeutic	3x's/wk to 2x's/wk	45-90 days
	Rehabilitative	2x's/wk to 2x's/mo	90-180 days
	Supportive	2x's/mo to 1x/mo	6-12 months
Severe	Relief	Daily to 3x's/wk	30-60 days
	Therapeutic	3x's/wk to 2x's/mo	60-120 days
	Rehabilitative	2x's/wk to 2x's/mo	90-180 days
	Supportive	2x's/mo to 1x/3mo	6-18 months



## CHIROPRACTIC TREATMENT GUIDELINES FOR SPECIFIC CONDITIONS

<u>DIAGNOSIS</u>	<u>ICD*9*CM</u>	<u>TREATMENT RANGES</u> <u>TIME/VISITS</u>
Acute, spinal sprain/strain (cervical, thoracic, lumbar, lumbo-sacral, sacroiliac): with or without vertebral	847.0	
	847.1	
	847.2	
	846.0-.9	
	839.0-.9	
	839.21	
	839.20	
	839.42	
	739.0	
	739.1	
	739.2-.5	
mild		2-4 wks / 6-12 visits
moderate		5-8 wks / 18-24 visits
severe		MAY REQUIRE SURGERY
Chronic, spinal sprain/strain (cervico-thoracic, lumbosacral, sacroiliac)	847.0	6-12 wks / 12-20 visits
	847.1	
	847.2	
	846.0-.9	
Cervical / Thoracic disc syndrome displacement		
protrusion	722.0	
herniation	722.0	
mild		6-8 wks / 8-12 visits
moderate		12-14 wks / 24-30 visits
severe		18-24 wks / 32-40 visits
Lumbar disc syndrome/ displacement		
protrusion	722.1	
herniation	722.1	
mild		8-10 wks / 18-24 visits
moderate		14-16 wks / 30-36 visits
severe		18-24 wks / 36-42 visits
Torticollis	723.5	
mild	33.83	2-3 wks/ 2-6 visits
moderate		3-5 wks / 6-10 visits
severe		6-12 wks / 10-20 visits
Cervical-occipital neuralgia	729.2	5-8 wks / 12-20 visits
Cervicocranial syndrome	723.2	2-8 wks/ 6-20 visits

<u>DIAGNOSIS</u>	<u>ICD*9*CM</u>	<u>TREATMENT RANGES</u> <u>TIME/VISITS</u>
Cervicalgia	723.1	3-5 wks / 8-10 visits
Cervicobrachial syndrome	723.1	
cervical neuralgia/brachial neuralgia	729.2	6-12 wks / 15-20 visits
Brachial neuritis or radiculitis	723.4	6-12 wks / 24-28 visits
Intercostal neuralgia	353.8	
	729.2	4-7 wks / 6-14 visits
Intercostal neuritis	353.8	
	724.4	
	729.2	7-9 wks / 18-24 visits
Neurovascular headache	784.0	
acute	307.81	2-4 wks / 6-8 visits
chronic	346.0	8-10 wks / 18-24 visits
severe		12-14 wks / 24-28 visits
Spinal myofasciitis		
acute	729.1	2-4 wks / 3-6 visits
chronic	729.8	6-12 wks / 12-20 visits
Lumbar plexus lesion	353.1	6-8 wks / 15-20 visits
Lumbar facet syndrome	724.8	6-8 wks / 15-20 visits
Lumbar trophism	724.8	4-6 wks / 12-14 visits
Lumbar canal stenosis	724.02	5-7 wks / 16-18 visits
Spondylolisthesis	756.12	
Grade I	738.4	6-8 wks / 14-16 visits
Grade II, III		8-10 wks / 20-24 visits
Grade IV		USUALLY REQUIRES SURGICAL STABILIZATION
Spinal enthesopathy (cervical, thoracic, lumbosacral)	720.1	4-6 wks / 8-12 visits
Scoliosis (treatment of patients under 20 years of age)	737.0-737.9	
	754.2	
mild		4-6 wks / 12-14 visits
moderate		8-10 wks / 18-24 visits
severe		12-14 wks / 24-30 visits
Lumbago / lumbalgia	724.2	6-8 wks / 14-16 visits

<u>Diagnosis</u>	<u>ICD*9*CM</u>	<u>TREATMENT RANGES TIME / VISITS</u>
Lumbosacral or Sciatic neuritis	724.4 724.3 722.10	12- 14 wks / 24-30 visits
Sciatic neuralgia	724.3	8-12 wks / 6-24 visits
TMJ syndrome	524.6	6-8 wks / 16-18 visits
Cervical / lumbar Hypo discopathy Degenerative joint Disease / spondylosis	722.4, 722.52 722.52, 721.90 715.09, 715.9 721.0, 721.2, 721.3	
Mild		4-8 wks / 4-8 visits
Moderate		8-12 wks / 8-12 visits
Severe		12-20 wks / 12-30 visits
Post-laminectomy Syndrome / failed back Surgical syndrome	722.8 966.4	12-24 wks / 12-24 visits
Ligamentous laxity / Hypermobility syndrome	728.4 728.5	4-8 wks / 4-8 visits
*Osteoarthritis / osteoarthritis	715.9 721.90	8-16 wks / 8-16 visits
*Osteoporosis	733.1	8-16 wks / 8-16 visits
*Compression fractures	733.1 805 806	6-12 wks / 6-12 visits
*Congenital abnormalities (i.e. hemivertebra, block vertebra, lumbarization, sacralization)	756.19 756.10	6-12 wks / 6-12 visits
*Spondylolisthesis (usually Grade I is listed as a complicating factor)	756.12 738.4	6-8 wks / 14-16 visits

\* These factors complicate degenerative structural spinal instability upon which other conditions are superimposed and increase the probability of non-resolution. Even after maximum therapeutic benefit, exacerbations may occur that require periods of scheduled therapeutic care and periodic non-scheduled care which, if stopped, could result in deteriorations. Treatment of these chronic complicated cases requires proper case documentation for justification of treatment beyond the recommended guidelines.

<u>DIAGNOSIS</u>	<u>ICD*9*CM</u>	<u>TREATMENT RANGES</u> <u>TIME / VISITS</u>
Shoulder and upper arm Sprain / strain		
Acromioclavicular (joint / ligament)	840.0	
Coroclavicular ligament	840.1	
Coracohumeral ligament	840.2	
Infraspinatus (muscle / ligament)	840.3	
Rotator cuff (capsule)	840.4	
Subscapularis (muscle)	840.5	
Supraspinatus (muscle/ tendon)	840.6	
Other specified sites	840.8	
Unspecified site	840.9	
mild		6-9 wks / 12-16 visits
moderate		10-12 wks / 17-22 visits
severe		MAY REQUIRE SURGERY
elbow and forearm sprain/strain		
Radiohumeral (joint)	841.2	
Ulnohumeral	841.3	
mild		6-8 wks / 10-14 visits
moderate		9-12 wks / 15-18 visits
severe		MAY REQUIRE SURGERY
Wrist sprain/strain		
Unspecified site	842.0	
Carpal (joint)	842.01	
Radiocarpal (joint / ligament)	842.02	
Other (radioulnar joint, distal)		
mild		6-8 wks / 8-10 visits
moderate		10-14 visits
severe		MAY REQUIRE SURGERY

<u>DIAGNOSIS</u>	<u>ICD*9*CM</u>	<u>TREATMENT RANGES</u> <u>TIME / VISITS</u>
Hand sprain/strain		
Unspecified site	842.10	
Carpometacarpal (joint)	842.11	
Metacarpophalangeal (joint)	842.12	
Interphalangeal (joint)	842.13	
Other (midcarpal joint)	842.19	
mild		6-8 wks / 6-9 visits
moderate		9-12 wks / 10-12 visits
severe		MAY REQUIRE SURGERY
Hip and thigh sprain/strain	843.9	
mild		6-9 wks / 12-16 visits
moderate		10-12 wks / 17-22 visits
severe		MAY REQUIRE SURGERY
Knee and leg sprain/strain		
Lateral collateral ligament	844.0	
Medial collateral ligament	844.1	
Cruciate ligament	844.2	
Tibiofibular (joint / ligament)	844.3	
Other specified sites	844.8	
Unspecified site	844.9	
mild		6-9 wks / 12-16 visits
moderate		10-12 wks / 17-22 visits
severe		MAY REQUIRE SURGERY
Ankle sprain/strain		
Unspecified site	845.00	
mild		6-8 wks / 8-10 visits
moderate		9-12 wks / 10-14 visits
severe		MAY REQUIRE SURGERY

<u>DIAGNOSIS</u>	<u>ICD*9*CM</u>	<u>TREATMENT RANGES</u> <u>TIME / VISITS</u>
Foot sprain/strain	845.10 845.19	
Unspecified site	845.10	
Interphalangeal (joint)	845.13	
mild		6-8 wks / 8-10 visits
moderate		9-12 wks / 10-14 visits
severe		MAY REQUIRE SURGERY
<b>Bursitis</b>		
Ankle		
calcaneal	726.79	
Shoulder		
scapulohumeral	726.19	
subacromial	726.19	
subcoracoid	726.19	
subdeltoid	726.19	
Elbow	726.33	
Hand	726.4	
Hip		
ischioogluteal	726.5	
trochanteric area	726.5	
Knee		
infrapatellar	726.69	
prepatellar	726.65	
subpatellar	726.69	
pes anserinus	726.61	
mild		4-8 wks / 8-10 visits
moderate		9-12 wks / 11-15- visits
severe		13-15 wks / 16-22 visits
		MAY REQUIRE SURGERY
Carpal Tunnel Syndrome	354.0	13-16 wks / 12-25 visits
Shoulder Impingement Syndrome		13-16 wks / 23-35 visits
		MAY REQUIRE SURGICAL DECOMPRESSION

## **COMPLICATING CONDITIONS/FACTORS**

Definition: Where the patient, because of one or more identifiable factors, exhibits regression of retarded recovery in comparison with expectations from the natural history.<sup>1</sup>

Complicating conditions, which may retard the patient's return to pre-clinical status or maximum therapeutic benefit include, but are not limited to, the following;

### History:

- Trauma
- Multiple trauma
- Severity of trauma/injuries
- Post-traumatic loss of consciousness
- Major illness or injuries
- Duration of symptoms
- Age
- Employment
- Lifestyle

### Radiographic:

- Vertebral subluxation complex
- Loss of normal spinal biomechanical alignment
- Degenerative joint disease
- Congenital abnormalities
- Loss of motion segment integrity as documented by radiographs or videofluoroscopy

### Physical Examination:

- Deconditioning
- Instability

### Neurological:

- Loss of relevant reflexes
- Measured muscular weakness compared to the contralateral side
- Measured unilateral atrophy
- Altered dermatomal sensitivity
- Neurological impairment verified by electrodiagnostic studies

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<sup>1</sup> Haldeman, Scott, D.C., M.D., Ph.D., et.al., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference, Aspen Publication, Gaithersburg, Maryland, 1993

**STANDARDS FOR  
UTILIZATION OF DIAGNOSTIC IMAGING**

## **STANDARDS FOR UTILIZATION OF DIAGNOSTIC IMAGING IN CHIROPRACTIC**

The fundamental purpose of diagnostic imaging is to gain diagnostic information regarding the patient in terms of diagnosis, prognosis and therapy planning. Studies are performed at the request of a practitioner with the informed consent of the patient. The basic directive of the practitioner is to use radiology to confirm or contribute to the clinical picture. Each study is performed in a reasonable manner and a formal report is generated. Only the written radiology report effectively communicates the information gained from each study.

Diagnostic imaging, especially plain film radiographs, continue to be a mainstay in the assessment of chiropractic patients. There are four (4) required standards that must be met with each imaging study:

- 1.) The study must be obtained based on clinical need.
- 2.) The study must be of sufficient diagnostic quality.
- 3.) There must be interpretation of the study to reach diagnostic conclusions about the study.
- 4.) The information from the study must be correlated with patient management.

### **Decision Making for Patient Selection**

The clinician must select the study which will give the required information with sufficient reliability at a minimal risk to the patient. The value of the information gained from the procedure must be worth the possible detrimental effects. Likewise the dangers inherent in not using the study may be outweighed by the risks. The risk and benefits analysis must always be considered before selection of a patient for radiographic examination. This selection process must be based on the following guidelines.

- 1.) The need for radiographic examination is based on history and
- 2.) The potential diagnostic benefits of the radiographic examination are judged to outweigh the risks.
- 3.) Radiography is used to assist the practitioner in diagnosis of pathology, identify contraindications to chiropractic care, identify bone and joint morphology, and acquire postural, kinematical and biomechanical information.
- 4.) Routine radiography of patients as a screening procedure is not appropriate practice except under public health guidelines.

## Patient Safety

The HSCA recognizes the role of radiography as a major diagnostic tool in the healing sciences, however harmful effects of ionizing radiation are also well documented and practitioner discretion and patient safety are essential considerations in determining when and if to use radiography for diagnostic purposes. The HSCA position is as follows:

- 1.) Routine radiography of any patient should not be performed without due regard for clinical need.
- 2.) Any offer or advertising of x-rays to actual or potential patients shall be accompanied by a statement that, to avoid needless health hazards associated with ionizing radiation, no x-rays will be taken unless there is a prior observable clinical need for it.
- 3.) Avoidance which compensate for tissue thickness by altering the screens or the light emission from the screens, such as the occluding of one of the screens of the cassette, is recommended.
- 4.) Repeat radiographic evaluation of the patient should not be undertaken without significant observable clinical indication, as determined by the treating chiropractor.
- 5.) Pregnant females should not be radiographed unless the patient's symptoms are of such significance that the proper treatment of the patient might be jeopardized without the use of such radiographs.
- 6.) Radiographic procedures should not be undertaken without the use of appropriate compensating filters and gonad shielding, except where such gonad shielding would exclude an area from examination which is clinically necessary to examine.
- 7.) Females with reproductive potential, or where the possibility of pregnancy exists, should be radiographed only where clinically necessary and preferably, during the first ten days following onset of menses.

These guidelines are consistent with the rules of conduct when employing radiographic procedures common throughout the health care community and are consistent with those recommended by the Center for Devices and Radiological Health, Food, & Drug Administration of the U.S. Department of Health & Human Services and the Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health & Human Services.

# APPENDICES

## APPENDIX A

### HSCA Documentation Guidelines

The following is an example of a case record which would receive a perfect score under the HSCA Documentation Guidelines. It is provided as a model for informational purposes. The diction from an initial examination is shown, along with daily note from the next office visit. Please note the following features of the record:

- \* The record allows a reviewer to have a clear summary of the patient's condition and response to treatment, as well as the doctor's diagnostic impression and treatment plan.
- \* The complete initial SOAP workup allows for subsequent daily notes to be abbreviated.
- \* The essential subcomponents of the subjective and objective portions of the SOAP notes are shown in bold type.
- \* Each patient is unique. Each patient record should relate the most pertinent information to that case, but should ideally follow the SOAP format for organization of the information.

01/30/96    **SUBJECTIVE:**    Joe Frobazz, a 45 year old white male, presents to our clinic for evaluation and treatment. His **chief complaint** is of lower back pain over the lower lumbar area, especially at the midline. He rates his pain at 2 out of 10 possible when at rest, and at 7/10 upon movement. The onset of his pain occurred three days prior when he was twisting and lifting a 50# bag of rice. He states that the pain is made worse with most movements, and with prolonged sitting or standing. The pain is somewhat relieved with the use of ice and aspirin. The pain is characterized as usually dull but is sharp with movement. There is no leg pain or numbness, and bowel/bladder symptomatology is denied. The pain is worse in the morning and at night with some mild relief in the middle of the day. The patient denies previous episodes of lower back pain. **Past medical history** includes five years of mild hypertension with successful management with Lopressor, and running 20 minutes three times per week. **Past family, social history** includes an occupation as a pineapple worker for the past 15 years. The patient denies the use of alcohol or tobacco. There is no history of familial diseases which would be pertinent to the current chief complaint. **Past injuries** include a 1992 motor vehicle accident which resulted in mild symptomatology with no treatment or residuals. Past surgical history is negative. **Review of systems** is otherwise negative for the following systems; constitutional, EENT, CV, respiratory, GI, GU, NMS, skin, psychiatric, endocrine, hematologic, allergic.

**OBJECTIVE:** Vitals include BP=132/86. Pulse=74bpm. Upon observation, patient demonstrated a right lumbar antalgia of approximately 20 degrees to the right, with pronounced spasm of the paraspinal musculature bilaterally. Upon palpation, the spinous process of L4-5 were extremely tender to the touch; sacroiliac, hips and sciatic notch were nontender. **Sensory examination** indicated a mild loss of light touch and sharp sensation of the left lateral thigh to the knee. Vibratory sensation is within normal limits. **Motor strength** of the lower extremity is 5/5; trunk strength tests produced too much pain to accurately test. **DTR's** are =2/5 at patella and Achilles bilaterally. Lumbar **range of motion** is limited in flexion, extension, lateral bending. Positive **orthopedic tests:** Kemp's, DSLR at 80 degrees, minor's antalgia. The patient completed a pain drawing, which was in agreement with the patient's verbal description and our objective findings. An Oswestry questionnaire was completed, with a rating of 28%. AP, lateral and Ferguson radiographs displayed an elevated left hemipelvis, spinal bifida occulta at L5-S1, anterior weightbearing due to diminished lumbar lordosis with disc spaces relatively intact.

**ASSESSMENT:** 1. Acute, moderate lumbar facet joint syndrome. 2. Rule out disc pathology.

**PLAN:** With the patient's consent, interferential current (IFC) was applied at 80-150 Hz, 22mA for 15 minutes to the lower back region and spinal manipulative therapy (SMT) using Gonstead technique to L5-S1. Treatment was well tolerated. Treatment plan will consist of spinal manipulative therapy and interferential therapy at three (3) times per week for a period of two (2) weeks, with a reevaluation at that time. The patient is provided with an excuse from work activities for one (1) week and also with lumbar extension exercises to be performed two (2) times per day to patient tolerance. **Short term goals** include reduction of pain at rest, and an increased ability to stand erect and ambulate without significant pain. **Long term goals** include restoration of full lumbar range of motion, increased lower back strength and flexibility. Patient has been provided with instructions for the home use of ice. An MRI and/or orthopedic referral will be considered if symptoms do not significantly improve within the next four (4) weeks.

## **Appendix B**

The following checklist is to be used as a quick test to see how well your records compare to the standards of the HSCA.

- \* Is the record legible?
- \* Is there a completed problem list?
- \* Is there an appropriated past medical history in the record?
- \* Is there a pertinent history and physical exam?
- \* Are lab and other studies ordered as appropriate?
- \* Are working diagnoses consistent with findings?
- \* Are plans of action/treatment consistent with diagnoses?
- \* Is there a date of return visit or other follow-up plan for each encounter?
- \* Is there a continuity and coordination of care between primary and specialty physicians?

02/02/96

S: The patient is having diminished lower back pain, now 1/10 at rest and 3-4/10 upon movement. Walking is slightly less painful and he is able to stand more erect. Patient denies leg pain and/or numbness. Sleeping fairly comfortably and using ice as recommended.

O: Diminished severity of antalgia, now approximately 10 degrees. Fixation L5-S1. +Kemp's, +Dejerines triad.

A: See 01/30/95.

P: See 01/30/95; SMT to L5 area; IFC to lower back 15 min, 80-150 Hz, 22 Ma; increase frequency of stretching exercises to 4x/day, continue home ice therapy.

## APPENDIX C

### DIAGNOSTIC RELATED GROUPS

#### Category I

- \* The patient has not significant clinical findings.
- \* No muscle guarding or history of guarding.
- \* No documentable neurologic impairment.
- \* No significant loss of structural integrity on lateral flexion and extension roentgenograms.
- \* No indication of impairment related to injury or illness.

#### Category II

- \* The clinical history and examination findings are compatible with a specific injury or illness. Findings may include;
- \* Significant intermittent or continuous muscle guarding which is observable by the physician.
- \* Nonuniform loss of range of motion, as measured by Goniometer.
- \* Nonverifiable radicular complaints.
- \* No objective sign of radiculopathy.
- \* No loss of structural integrity.

#### Category III

- \* Patient presents with significant signs of radiculopathy such as;
- \* Loss of relevant reflex (es) or
- \* Measured unilateral atrophy compared to the contralateral side at the same location.
- \* Neurological impairment may be verified by electrodiagnostic findings.

Diagnostic Related groups  
page 2

Category IV

- \* Loss of motion segment integrity or structural integrity of at least 5mm of translations of one vertebra on another, or angular motion greater than 11 degrees of and adjacent motion segment.
- \* Documented history of muscle guarding and pain is present.
- \* Neurologic abnormalities need not be present.

Category V

- \* The patient meets the criteria of **Category III and IV i.e.**
- \* Loss of motion segment integrity and
- \* Radiculopathy is present.
- \* Significant lower-extremity impairment is indicated by:
  - atrophy or
  - loss of reflex(es)
  - numbness with an anatomic basis and/or
  - electromyographic findings

Category VI

Cauda Equina-syndrome with

- \* Objectively demonstrated permanent, partial loss of extremity function
- \* May or may not have loss of motion segment integrity
- \* Do not have objectively documented bowel or bladder impairment.