CANADIAN SOCIETY OF CHIROPRACTIC EVALUATORS

the Evaluator

Content

The Canadian Society of Chiropractic Evaluators (CSCE) *strives to promote a high level of quality, expertise and standardization in the performance of independent chiropractic evaluations and in the production of the resultant narrative report.*

CSCE President's Report

November 2014

Subsequent to my last report in May, the following information will provide you with updated activities and financial health of the Society. The Board continues to endeavour to fulfill and promote our mandate to maintain and enhance the quality and visibility of chiropractic expertise in independent assessment. To that end, recent activities have included lobbying policy makers for greater utilization of chiropractic assessment in independent assessment, promoting continuing education for chiropractic experts and other health care providers, and providing input to regulatory issues surrounding licensure of facilities and the minor injury guideline review.

Given the growing backlogs in mediation and arbitration, while at the same time witnessing cost pressures on the dispute resolution system, CSCE continues to advocate with policy makers and regulators for a peer-to-peer process to help reduce disputes. We have advocated for greater stakeholder input and enhanced collaboration. We have advocated for easier access to benefits for persons with injuries that are beyond those included within the definition of a minor injury, but who may not be deemed catastrophic.

In December 2013 CSCE was invited by the Ontario Ministry of Finance to present to Justice Cunningham for the Ontario Automobile Insurance Dispute Resolution System Review. Our input highlighted the current concerns with the DRS, including changes that have resulted in large backlogs to the mediation process, and now arbitration proceedings. Most of the disputes in the system surround medical/rehabilitation benefits. Comments and recommendations focused on the need for greater neutrality in the independent assessment process and return to a peer-to-peer principle in order to help reduce subsequent dispute procedures. In February 2014 Justice Cunningham released his final report. Within it included recommendations that the government should look to ensure that the independent assessment process is fairer.

CSCE has also attended a stakeholder meeting on the Minor Injury Guideline review process led by Dr. Côté. We are expecting a release of information on the review process, and the accompanying article by Dr. Panetta provides some background information on relevant concerns with the existing Guideline.

The Ontario Government has moved forward with licensure of rehabilitation facilities, to be overseen by FSCO. If you have not already registered, and wish to continue to bill auto insurers directly for assessment or treatment of auto accident victims, please register as soon as possible. As I have mentioned previously, licensure will only affect oversight of business practices, and will not have any impact on clinical care.

At our upcoming AGM the financial health of CSCE will be presented. As you are aware, CSCE operates on a limited budget, but income is dependent on membership dues and continuing education programs. The financial health of CSCE remains strong, and your Board endeavours to operate with fiscal restraint, with spending focused on advocacy measures.

CSCE continues to partner with CMCC to offer a certification course on Catastrophic Impairment Rating. Another course is being offered this fall. I would like to thank Dr. Guerriero for his continued efforts in this regard. CSCE also continues to seek opportunities to offer continuing education programs to other jurisdictions in the country, to enhance the profile of chiropractic experts in those jurisdictions.

Your Board of Directors will continue to advocate for greater involvement of chiropractic experts in independent assessment. There is compelling data that the existing dispute resolution system requires reform to create more balance between those entitled to receive benefit and their access to those benefits; and cost stability for ratepayers. .

On behalf of your Board, I thank all of you for your continued involvement and support. Together I am hopeful that can influence change for the better, to the benefit of injured parties and third party payment systems.

Sincerely,

D. Dos Santos, B.Sc.,D.C.,FCCRS(C),FCCO(C)
CSCE President

The MIG-can one size fit all?

CSCE raises its concerns for the MIG review team - by Dr. Lino Panetta, DC, FRCCSS

In light of the soon to be released MIG review, the CSCE takes a closer look at the current Minor Injury Guidelines, We look at some of the benefits the MIG provides and to some of the concerns as it relates to Classification of Neck Pain and Whiplash Disorder, to a comparison of other Guidelines (Australian and UK), and to its impact as a Common Treatment Pathway and Funding Model on the delivery of care.

Classification of Neck Pain & Whiplash Associated Disorder

BACKGROUND

In 1995, the Quebec Task Force on Whiplash Associated Disorders provided the standard for classification of neck pain and whiplash associated disorders which is described briefly by 5 distinct categories:

Grade 0 WAD *is "no complaint about the neck, no physical sign(s)*
Grade 1 WAD *is "neck pain, stiffness, or tenderness, with no physical sign(s)"*
Grade 2 WAD *is "neck pain, stiffness, or tenderness, with musculoskeletal sign(s)"*
Grade 3 WAD *is "neck pain, stiffness, or tenderness, with neurologic sign(s)";*
Grade 4 WAD *is "neck fracture or dislocation."*

Since its publication, a number of revisions to the QTF classification system have been proposed.

The first is outlined in the Clinical Guidelines from the Chartered Society of Physiotherapist UK (2005) which states:

"The Quebec task force classification should be used by physiotherapists for WAD with grade II subdivided into IIa and IIb in order to assist with diagnosis and prognosis.

The second was published by the Neck Pain Task Force (2008) which revised the QTF classification as it is best applied to health care,

Our goal in this endeavor was to produce a severity classification system that encompasses all neck pain syndromes, and that is relevant irrespective of the professional background of the health care provider and the circumstances surrounding the onset of pain (traffic collisions, sports, nontrauma, etc.). Thus, we propose that the assessment of a person with neck pain and associated disorders should distinguish situations which have major management implications.

These are:

- **Grade I neck pain:** *Neck pain and associated disorders with no signs or symptoms suggestive of major structural pathology and no or minor interference with activities of daily living. Major structural pathologies include (but are not limited to): fracture, vertebral dislocation, injury to the spinal cord, infection, neoplasm, or systemic disease including the inflammatory arthropathies.*
- **Grade II neck pain:** *No signs or symptoms of major structural pathology, but major interference with activities of daily living.*
- **Grade III neck pain:** *No signs or symptoms of major structural pathology, but presence of neurologic signs such as decreased deep tendon reflexes, weakness, or sensory deficits.*
- **Grade IV neck pain:** *Signs or symptoms of major structural pathology.*

As we can see, the classification systems for Neck Pain and Whiplash Associated Disorders have evolved significantly over the last 20 years. The UK Guidelines recommends that the QTF Grade II be revised into a in Grade IIa and Grade IIb classification for more appropriate diagnosis and prognosis in clinical practice. In addition, the current concept of pain as a biopsychosocial condition has had a distinct impact on how we approach and assess the patient with neck pain/WAD. In the Neck Task Force classification system emphasis is not only on the signs and symptoms of tissue injury but on assessing the impact of pain on an individual's abilities, function, and behaviour (i.e. impairment and disability).

In contrast, there is concern with the classification system fundamental to the structure of the MIG.

1. The MIG does not distinctly refer to the QTF classification system, but rather defines whiplash associated disorders as follows:

> ***f) whiplash associated disorder*** means a whiplash injury that:
> (i) does not exhibit objective, demonstrable, definable and clinically relevant neurological signs, and
> (ii) does not exhibit a fracture in or dislocation of the spine.

In addition, the MIG applies the term **"minor injury"** which it defines as

> ii.a) **minor injury** means a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and any clinically associated sequelae. This term is to be interpreted to apply where a person sustains any one or more of these injuries.

There is concern that by introducing the general term "minor injury" as a single cohort instead of maintaining separate and distinct classifications as in the original and revised QTF on Whiplash Associated Disorders (i.e. Grade 0, Grade I and Grade IIa and Grade IIb), the MIG may put individual neck pain/WAD patients at risks for inappropriate diagnosis and prognosis for recovery.

2. The MIG does not maintain the QTF/Neck Pain Task Force criteria for Grade III WAD, namely neurological signs **such as decreased deep tendon reflexes, weakness, or sensory deficits.**

> It includes the general term **"clinically associated sequel"** as part of "minor injury" but then excludes **"clinically relevant neurological signs."** There is concern that since these terms critical to classification as part of the MIG are not defined an individual patient may be inappropriately classified which may put the patient at risk for inappropriate diagnosis and prognosis for recovery.

This is of significant concern as the MIG states:

> The SABS and this Guideline are **intended to encourage and promote the broadest use of this Guideline**, recognizing that most persons injured in car accidents in Ontario sustain minor injuries for which the goods and services provided under this Guideline are appropriate.

The MIG, it is a Guideline?

As health care providers, we are familiar with both the terms "guideline" and "clinical practice guideline (CPG)." Often used interchangeably, CPGs have been used for years to promote best practices in the delivery of health care. The Institute of Medicine defines **clinical practice guidelines** as:

> *"…systematically developed statement to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."*

In an effort to ensure transparency and remove bias from the CPG process, the movement in health care has been to establish, guidelines that are evidence-based (EBG):

> *"Evidence-based" implies that the document or recommendation has been created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients…. If adequate evidence is lacking to support a specific recommendation, a consensus statement is developed in a very transparent fashion and under specific rules. All consensus statements are labeled as such in the guidelines.*

Several Clinical Practice Guidelines in the management of neck pain and whiplash associated disorder have been published since the QTF (1995), this includes: CPGs for WAD in Australia (November 2008) and UK (2005, review 2010). While the Australian Guideline utilizes a strict Quebec Task Force classification system, the UK Guideline opts for a revised Quebec Task Force classification system that divides Grade II WAD in Grade IIa and IIb to assist with diagnosis and prognosis.
In addition, the UK Guidelines provides a summary of recommendations it refers to as "best practices" to guide evidence based care but goes on to state that:

> *"…treatment cannot be prescriptive and should always follow individual assessment."*

In contrast, the Australian Guideline outlines both an **Acute and Chronic Pathway of care** for patients presenting with whiplash associated disorder to any primary care practitioner. The Australian Guideline states:

> *Both pathways include a section on the initial assessment of a whiplash patient appropriate for each phase. The development of these pathways, including the proposed review time after injury, were by consensus and aimed to ensure that ineffective treatment is not continued where it could possibly lead to chronicity.*

By comparison, the Minor Injury Guidelines does not represent an evidence based guideline nor is it supported by the recommendations made by a panel of experts following a comprehensive review of the scientific literature. If it is not a Guideline, then what exactly is the MIG?

The MIG: a Common Treatment Pathway and Funding Model

The objectives of this Guideline are to:

a) Speed access to rehabilitation for persons who sustain minor injuries in auto accidents;

b) Improve utilization of health care resources;

c) Provide certainty around cost and payment for insurers and regulated health professionals; and

d) Be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the SABS and set out in Part 2 of this Guideline.

In an effort to *b) improve utilization of health care resources* and *c) provide cost certainty,* the MIG integrates a common treatment pathway with a revised funding model for goods and services in the assessment and treatment of minor injuries.

A common treatment pathway is a management tool used in health care to promote organized and efficient patient care, minimize variability, and improve patient outcomes. As previously detailed, the MIG combines several classifications of Whiplash Associated Disorders into a single cohort it defines as "minor injuries, and then promotes a common treatment pathway for those "minor injuries." There is concern that the single cohort in the MIG is not clearly defined and subsequently the common treatment pathway may provide less than optimal outcomes depending on the individual patient.

In addition, a common treatment pathway can help achieve certainty around cost and payment for insurers and regulated health professionals. The MIG combines a revised funding model with its common treatment pathway which we detail here.

The MIG provides a maximum of $3500 of funding for goods and services in the assessment and treatment of minor injuries in the Acute/Sub-Acute Phases, with a portion of funding available for goods and services beyond 12 weeks (i.e Chronic Phase).

The Acute/Sub-Acute Phase (0-12 weeks)
The funding for Block 1 (Week 1-4) would generally provide a total of 12 therapy sessions (i.e. chiropractic/physiotherapy treatments) in the management of a minor injury.

While treatment 2-3 times per week for Block 1, may be sufficient for management of an uncomplicated Grade II WAD Grade, there is concern that the *MIG provides no additional funding for assessment or treatment of WAD Grade IIa or WAD Grade IIb, which represent musculoskeletal injuries with associated clinical sequelae and complex symptomatology* (i.e. Vertigo, Post-Concussion Syndrome, Sleep disturbances/ Insomnia, Anxiety, Referred Pain, etc.).

For treatment beyond 4 weeks, the MIG provides a maximum of $725 of approved funding over the next 2 months (Blocks 2 and 3). The funding for Block 2 and Block 3 significantly reduces access to therapy and would generally provide a maximum of weekly therapy sessions (chiropractic/physiotherapy) over the last 4 weeks of approved care.
While weekly sessions of therapy in Block 2 and 3, may be sufficient funding for patients who report no relapse or residual complaints with returning to work and full daily activities; there is concern that the MIG provides no additional funding for assessment and treatment of WAD IIa and WAD IIb whose prognosis for return to work and activities of daily living is often delayed.

Chronic Phase (beyond 12 weeks)
In cases where further assessment and treatment is recommended beyond 12 weeks, the MIG provides some funding, however this is not part of the pre-approved format and is conditional upon third party approval. This is not consistent with either the Australian or UK CPGs which both include provisions for immediate access to benefits (assessment/treatment) in the Chronic Phase. Given research which confirms that 40%-of auto accident injuries continue to report complaints beyond 12 weeks.

There is concern that the MIG may be overly prescriptive and may present both financial and administrative barriers which may delay the delivery of appropriate care in particular for the WAD IIa and WAD IIb patients that are at highest risk for chronic pain.

The MIG - a work in progress

It is recognized that the MIG is a work in progress. As a common treatment pathway for most auto accident injuries, the MIG can serve as a valuable tool by ensuring early access to goods and services (i.e. assessment, therapy and rehabilitation benefits). However, there are some fundamental concerns with the current MIG. This includes:

- the criteria for classification of a "minor injury" is poorly defined and may in some cases put individual patients at risk for inappropriate diagnosis and prognosis for care
- the common treatment pathway is overly prescriptive and in some cases may put individual patient at risk for delay in recovery by not providing the appropriate care in a timely fashion
- the funding model may present both financial and administrative barriers for assessment and treatment beyond 12 weeks which may delay the delivery of appropriate care and may place the individual patient at risk for delay in recovery.

The CSCE looks forward to the MIG review and trusts it will provide assistance in resolving some of the concerns that have be highlighted in the article.

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