CALIFORNIA CHIROPRACTIC ASSOCIATION

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RESEARCH REVIEW

According to a 2004 article in the Spine Journal, spinal manipulative treatment for both chronic and acute lower back pain was more effective in providing short-term relief than many other types of care, including prescription drugs, physical therapy and home exercise.
Bronfort G , Haas M , Evans R, Bouter L. Efficacy of Spinal Manipulation and Mobilization for Low Back Pain and Neck Pain: A Systematic Review and Best Evidence Synthesis. Spine Journal, 2004.

A 2010 study evaluating data from Blue Cross Blue Shield of Tennessee found that risk-adjusted costs for low back pain episodes of care initiated with a DC were 20 percent less costly than episodes initiated through a medical doctor.
Cost of Care for Common Back Pain Conditions Initiated With Chiropractic Doctor vs. Medical Doctor/Doctor of Osteopathy as First Physician: Experience of One Tennessee-Based General Health Insurer," Journal of Manipulative and Physiological Therapeutics (JMPT) , 2010.

A 2010 study at the University of British Columbia found that guidelines-based care which included spinal manipulation provided by a DC was significantly more effective than "usual care" provided by medical physicians for patients with lower back pain of less than 16 weeks duration.
Bishop PB, Quon JA, Fisher CG, Dvorak MF. The Chiropractic Hospital-based Interventions Research Outcomes study: a randomized controlled trial on the 2010 effectiveness of clinical practice guidelines in the medical and chiropractic management of patients with acute mechanical low back pain.

Seeing a chiropractor first following a work injury to the low back significantly reduced the likelihood of surgery. Approximately 42.7% of workers who first saw a surgeon had surgery, in contrast to only 1.5% of those who saw a chiropractor.
Early Predictors of Lumbar Spine Surgery after Occupational Back Injury: Results from a Prospective Study of Workers in Washington State. Benjamin J. Keeney, PhD, Deborah Fulton-Kehoe, PhD, MPH, Judith A. Turner, PhD, Thomas M. Wickizer, PhD, Kwun Chuen Gary Chan, PhD◊,, and Gary M. Franklin, MD,MPH. Spine (Phila Pa 1976). 2013 May 15; 38(11): 953–964.*

Patients who see a chiropractor first are much less likely to have an expensive MRI study. Having a chiropractor as the initial provider was associated with a reduced likelihood of early MRI. Early MRI may lead to greater subsequent interventions, potentially poorer outcomes, and increased health care expenditures.
Factors Associated With Early Magnetic Resonance Imaging Utilization for Acute Occupational Low Back Pain. A Population-Based Study From Washington State Workers' Compensation. Janessa M. Graves , MPH, PhD , Deborah Fulton-Kehoe , PhD, MPH , Diane P. Martin , MA, PhD , Jeffrey G. Jarvik , MD, MPH , and Gary M. Franklin , MD, MPH. SPINE Volume 37, Number 19, pp 1708–1718, 2012.

Opioids are not the answer to chronic pain. Over 100,000 persons have died, directly or indirectly, from prescribed opioids in the United States since policies changed in the late 1990s. In the highest-risk group (age 35–54 years), these deaths have exceeded mortality from both firearms and motor vehicle accidents. Whereas there is evidence for significant short-term pain relief, there is no substantial evidence for maintenance of pain relief or improved function over long periods of time without incurring serious risk of overdose, dependence, or addiction.
Opioids for chronic noncancer pain: A position paper of the American Academy of Neurology. Gary M. Franklin. Neurology 2014;83;1277-1284.

Spinal manipulative therapy (SMT) is effective for acute, sub-acute, and chronic low back pain (LBP) in adults.
Bronfort G, Haas M, Evans R, Leiniger B, Triano J. Effectiveness of manual therapies: the UK evidence report. Chiropr Osteopat. Feb 25 2010;18 (1):3.
Clar C, Tsertsvadze A, Court R, Hundt GL, Clarke A, Sutcliffe P. Clinical effectiveness of manual therapy for the management of musculoskeletal and non-musculoskeletal conditions: systematic review and update of UK evidence report. Chiropr Man Therap. 2014;22(1):12.

SMT for chronic low back pain in adults is as effective as other treatments. A 2011 Cochrane review finds no clinically important differences between SMT and other treatments for pain and functional improvement for chronic LBP.
Rubinstein SM, van Middelkoop M, Assendelft WJ, de Boer MR, van Tulder MW. Spinal manipulative therapy for chronic low-back pain. Cochrane Database Syst Rev. 2011(2):Cd008112.

Expert consensus recommends the following dosages for chronic spine-related pain: 2-3 visits/week for 2-4 weeks. Mild exacerbation: 1-6 visits; scheduled ongoing care 1-4 visits/month.
Farabaugh RJ, Dehen MD, Hawk C. Management of chronic spine-related conditions: consensus recommendations of a multidisciplinary panel. J Manipulative Physiol Ther. Sep 2010;33(7):484-492.

UTILIZATION REVIEW

According to the California Supreme Court, all treatment must be approved by the carrier or the carrier need not pay for treatment provided.

Q. Is utilization review required in every case?

A. Yes. The California Supreme Court held that utilization review must be used for every medical treatment request in the California workers' compensation system. The court also held that approving requested treatment without physician review is part of utilization review (UR), and only reviewing physicians may decide to delay, deny or modify requested treatment. The UR regulations allow an employer to reduce the cost of physician review in UR by designing a "prior authorization" program within the employer's UR plan. (See below: About prior authorization.)

DWC supports the establishment of UR best practices that allow claims administrators to approve appropriate levels of care for injured workers at the lowest possible levels within the claims organization, without having to send those requests for external physician review.

http://www.dir.ca.gov/dwc/UtilizationReview/UR_FAQ.htm

Q. How is prior authorization different from "retrospective review"?

A. With prior authorization, the treating physician is assured of appropriate reimbursement at the time of providing the treatment and simply needs to submit the bill for treatment, because the treatment meets the conditions described under the UR prior authorization process, meaning that the treating physician does not have to ask permission to provide the treatment.

With retrospective review, the treating physician has already provided treatment that was not approved before hand, and later submits the treatment report with an RFA and bill. In retrospective review the treating physician has no assurance of appropriate reimbursement at the time treatment is provided.

Most often, when a physician sees an injured worker for the first time and submits a doctor's first report of occupational injury or illness, the treating physician is seeking a retrospective review authorization for the treatment already provided in that first visit and may also be requesting authorization for specific treatment described under the treatment plan explained in question number 24 on the form.

Q. Are MPN physicians required to provide RFAs?

A. Yes. Unless the treatment falls within the claims administrator's prior authorization process, MPN physicians need to provide RFAs.

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