CRMA PATIENT RESULTS & TREATMENT PLAN Modification

I have created this form in order to very quickly make individual treatment plan modifications bases on my patients CRMA Intersegmental Motion Spinal Ligament Analysis. This is in a check box format in order to make it easy for me to make it patient specific.

Patients Name:_____ Today's Date:_____

CRMA RESULTS

The results show minimal intersegmental abnormalities, low levels of instability that is more consistent with a milder sprain radiographically.

- o This is consistent with what I see clinically with this patient. Though I reserve the right to modify this position as treatment progresses
- o I have gone over the results with my patient
- o This is inconsistent with what I see clinically right now with this patient, however I will monitor progress and if the condition shows good results I will modify my treatment plan accordingly. Right now my patient shows higher than normal pain when the patient is moved through ROM that is assisted---called passive ROM---which indicates that there is a higher level of nociceptive pain coming from the ligaments.
- o This is inconsistent with what I see clinically and does indicate that there may be more muscular damage. The patient has active ROM pain in the area that may be consistent with this scenario.
- o Other:

  _____

  _____

  _____

The results show abnormal levels of ligamentous instability that would be consistent with a more moderate sprain radiographically.

- o This is consistent with what I see clinically with this patient. Though I reserve the right to modify this position as treatment progresses
- o I have gone over the results with my patient and I have explained the importance of their compliance with our care plan for the overall results of our program. I have reiterated that their active care program is going to be very important and that they may need to do it long after their corrective care program. I have also indicated that they are in a higher category for long term residual complaints which may necessitate the need for ongoing supportive care and that their individual situation will become more clear as they are further down their care plan
- o I have looked for and advised on any ADL or work activity that may be problematic for either exacerbation or aggravation potential.

- This is inconsistent with what I currently see clinically. This may indicate pre-existing ligamentous instability from a previous exposure capable of altering it
    - I have ruled out any active pre-existing condition and there are none recorded that I could find through patient consultation, therefore any pre-existing condition would weaken the structure, predispose it to injury and be at worst a aggravation
    - This patient has active pre-existing condition(s) that is being monitored, all care delivered will be to bring the patient back to the previous established baseline, and all care after that will be apportioned appropriately.
- Other:_____
  _____
  _____

This patient has ratable levels of spinal ligament damage being indicated by the CRMA. These findings indicate a more severe spinal sprain injury

- This is consistent with what I see clinically with this patient. Though I reserve the right to modify this position as treatment progresses
- I have gone over the results with my patient and I have explained the importance of their compliance with our care plan for the overall results of our program. I have reiterated that their active care program is going to be very important and that they may need to do it long after their corrective care program. I have also indicated that they are in a higher category for long term residual complaints which may necessitate the need for ongoing supportive care and that their individual situation will become more clear as they are further down their care plan
- I have explained to the patient that their condition is significant enough that it is conserved to be ratable and permanent by the AMA. I explained that our goal remains to have the patient symptom free and that many patients who have this condition can become that way with care.
- I have checked for and advised on "Return to Play Parameters" for contact sports, or for any other ADL or Work Activity that would increase risk during their healing and stabilization period.
- This is inconsistent with what I currently see clinically. This may indicate pre-existing ligamentous instability from a previous exposure capable of altering it
    - I have ruled out any active pre-existing condition and there are none recorded that I could find through patient consultation, therefore any pre-existing condition would weaken the structure, predispose it to injury and be at worst a aggravation
    - This patient has active pre-existing condition(s) that is being monitored, all care delivered will be to bring the patient back to the previous established baseline, and all care after that will be apportioned appropriately.
- Other:_____
  _____
  _____

Change in Spinal Adjusting Procedures

I utilize HLVA and there is no change in my technique required. I am able to manually adjust this patient with no technique change required and the patient tolerates our main technique well.
Based on the results of the CRMA I will monitor on a daily basis and change if the patient clinically necessitates it. I am at this time not worried about this patient not being stable enough to accept manual spinal adjusting. I will of course utilize the lowest force necessary to make the corrections.
I already utilize what are considered to be lower force techniques with this patient so there are no changes needed.
I am switching from HLVA to a lower force technique based on the results of the CRMA
Other:_____
_____
_____

Further Diagnostics

All diagnostics are performed or ordered in or to get a better differential diagnosis, get a clearer picture of my patient condition, so that I may better understand that most affective care plan for this patient.

I have no need for further diagnostics at this point in care, as my weight bearing x-rays and CRMA have established spinal injury that is consistent with the mechanism of injury as well as consistent with the patient clinical presentation.
In the future I may need to refer this patient out for an MRI of the spine. The main areas of interest will be the areas of highest intersegmental motion (highest ligamentous instability) as they may indicate that this spinal disc is also involved. If for any reason I feel that the disc is complicating care, I may choose to have this specific ligament assessed so that a better understanding of my patient condition can be achieved. I may need this at any point in this patients care.
This patient shows a radicular complaint with no altered motion from the CRMA at that level. I am going to refer the patient out for a MRI as it may indicated that the force involved were more compressive in nature and have injured the disc directly.
I have no positive CRMA and have no positive MRI finding to account for the patient radicular complaint, therefore I am referring out for electro-diagnostic study to better determine the anatomical cause of the patient's condition.
Other:_____
_____
_____

Activity of Daily Living Modifications

Based on the CRMA this patient has more moderate sprain findings showing radiographically. During the acute and corrective phase of care I have indicated the importance of trying to stay away from activities that can exacerbate of worse aggravate this patient's condition. We have gone over the ADL's looking for potentially problematic ADL's or work activities and modified it accordingly.

_____

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_____

This patient has ratable levels of ligament damage from their CRMA. I have explained to the patient that in the cervical spine there are published medical guidelines that call for "contraindications to contact sports play" either "absolute" or relative. I have related that this means while the injury is acute and not stable there is a remote chance that they could sustain a more serious injury. I related that I have seen no evidence of such injuries, but none-the-less there are guidelines and it is my professional responsibility to make you aware of them.

_____

_____

_____PT Initial_____

Patient has been put on a graduated program back into contact sports activities.

_____

_____

_____

Other Activities were found and
modified._____

_____

_____

_____

No ADL modification was found to be necessary.

Work Modification Based On the Results of the CRMA Spinal Ligament Analysis

This patient does not seem to be negatively affected by their work in any way so there are no work modifications to suggest at this point in the patient care.
This patient has difficulty working with their present condition so I have recommended that reduce their work schedule to the following:

_____

_____

_____

I have put the following lifting restrictions on this patient_____

_____

_____

This patient is having a problem with their work station and I have recommended that they speak with their human resources office to see if they could get an ergonomic assessment in order to improve the station and reduce the musculoskeletal stress so that they can better help with less complications.

I have recommended that this patient speak with human resources in order to see about improved computer work station set-up that is more ergonomically correct for the patient.

I have recommended that the patient speak with human resources in order to see if they could get a more ergonomically correct chair to sit in, so that they are not constantly irritating the lower back.

Other Work Modifications Recommended_____

_____

_____

Surgical Consultation Referral

This patient has abnormal or ratable levels of CRMA findings that show moderate to severe levels of ligamentous laxity. In rare cases this can cause spinal instability that will not respond to conservative care. This patient does not show emergency need for a spinal stabilization procedure and is on a conservative care plan that has not failed yet. Should conservative care fail we will reserve the option for a surgical consultation at that point.

This patient has seriously high levels of ligamentous laxity and is in severe pain, I am going to send her to a pain management center that also specializes in spinal surgery. She will be sent for a consult and I will continue to co-treat until clinical information becomes available that would dictate other need.

This patient has severe neurological deficits and I am sending them out for a neuro/ortho surgical consult.

This patient has a disc herniation and I am sending them out for a neurosurgical consult.

Other:_____

_____

_____

Frequency of Treatment Guideline Placement

For our patient who experience an auto collision as their mechanism of injury, we will follow the croft treatment guidelines, as indicate in the Croft Treatment Guidelines, ICA Best Practices and the California Whiplash Guidelines

IV.Motor Vehicle Accidents (MVAs)

ICA decided to use the long-established Croft Cervical Acceleration/Deceleration (CAD) Guidelines for its basic Frequency and Duration Programs of Care for MVA victims.

When developing his guidelines, Croft incorporated the stages of tissue repair. The stages of injury repair are defined in Table 14, Chapter 11 of the original guideline document. In MVAs, Croft originated 5 grades of injury during CAD and these Grades have been universally accepted in the literature (see table below):

Croft's Grades of Injury		
Grades	**Severity**	**Anatomical and Clinical Description**
I	Minimal	No limitation of range of motion, no ligamentous injury, no neurological symptoms
II	Slight	Limitation of range of motion, no ligamentous injury, no neurological findings
III	Moderate	Limitation of range of motion, some ligamentous injury, neurological findings present
IV	Moderate to severe	Limitation of range of motion, ligamentous instability, neurological findings present, fracture or disc derangement
V	Severe	Requires surgical treatment and stabilization

Croft Frequency and Duration Table

The table below details the Croft treatment recommendations. In the seventh and eighth right hand columns are the approximate maximum treatment duration and the approximate maximum number of visits expected to be necessary over that period. In the last column, Croft's Frequency and Duration schedules are correlated with the ICA's 6 Programs of Care. Croft stated that patients not at high risk for poor outcome should not require treatment approaching these maxima.

Grade	Daily	3x/wk	2x/wk	1x/wk	1x/mo	Duration	# Visits	ICA Equivalent
Grade I	1 wk	1-2 wk	2-3 wk	> 4 wk	---	> 10 wk	> 21	#1C
Grade II	1 wk	> 4 wk	> 4 wk	> 4 wk	> 4 mo	> 29 wk	> 33	#2C
Grade III	1-2 wk	> 10 wk	> 10 wk	> 10 wk	> 6 mo	> 56 wk	>76	#6C
Grade IV	2-3	> 16	> 12	> 20	**	**	**	

Grade	Daily	3x/wk	2x/wk	1x/wk	1x/mo	Duration	# Visits	ICA Equivalent
	wk	wk	wk	wk				
Grade V	Surgical stabilization necessary — chiropractic care is post surgical							

****May require permanent monthly or permanent palliative care.**

Vi. Croft provided several complicating factors that might influence the frequency and duration of care to be a maximum. Most of Croft's complicating factors for CAD victims are included in the ICA Table 7 (see original guideline document). These Croft complicating factors are listed in Table 17, Chapter 11 of the original guideline.

Open-ended Frequency and Duration for Grade IV Subjects

ICA will adopt/adapt the Croft Guidelines for Frequency and Duration of Care for subjects with injury Grades I, II, and III (see Table 12, Chapter 11 in the original guideline document). However, because of the open-ended extended Frequency and Duration program recommended by Croft for Grade IV CAD injured subjects, ICA has formulated a Program of Care #7 for these Grade IV subjects:

For 6 extra blocks of 12 visits of care in each 4 week period (72 visits in 24 weeks) + 20 weeks at 1 visit per week +12 months at 1 visit per month

7.A. 5 visits per week for 4 weeks + 72 visits for 24 weeks + 1 visit per week for 4 weeks + 1 follow-up exam visit after each 4 week block + 20 visits in 20 weeks + 12 visits in 12 months (which is 142 visits in 2 years), or

7.B. 4 visits per week for 5 weeks + 72 visits for 24 weeks + 1 visit per week for 4 weeks + 1 follow-up exam visit after each 4 week block + 20 visits in 20 weeks + 12 visits in 12 months (which is 142 visits in 2 years), or

7.C. 3 visits per week for 7 weeks + 72 visits for 24 weeks + 1 visit per week for 4 weeks + 1 follow-up exam visit after each 4 week block + 20 visits in 20 weeks + 12 visits in 12 months (which is 142 visits in 2 years)

Note: For Grade IV subjects, an evaluation including numerical pain scale, range of motion, x-ray, and activities of daily living (such as SF36) should be performed periodically (such as every 3 months) in order to document the patient's condition and the need for ongoing open-ended care.

This patient most closely falls into a Grade:

Grade 1: As they show no indication of loss of Global ROM, No ligamentous damage and No Neurological Findings that would associated with trauma.
Grade 2: As they show Limitation of ROM, but no Ligamentous Damage and No Neurological Findings

Grade 3: As they show: Limitation of range of motion and some ligamentous injury, or some limitation of range of motion and some neurological findings present, or ligamentous injury and some neurological findings, or all three

Grade 4: As they show the findings of a grade three, plus either a disc derangement or a spinal fracture----the fracture is not directly treated, but allowed to stabilize and with direction of the care minimizing the negative effects of the fracture.

Functional Outcome Assessment to Determine Care Progress

I will utilize the following procedures to assist me in determining the patient's response to our care and to allow me to continue to monitor progress and alter the patient's care plan as needed:

Re-examinations on a scheduled basis with Ortho and Neuro Testing
Global ROM
Muscle Testing
Pressure Algometry
Surface EMG
Pain Questionnaires
Serial X-ray for Spinal Alignment Progress

Treatment That I May Utilize in the Course of the Patients Care:

All treatment provided is for care that is to assist the patient with their condition and is both reasonable/medically necessary and per the guidelines for utilization. This is right out of the ICA California Whiplash Guidelines and though Doctors of Chiropractic are currently not allowed by scope to intervene with and form of drugs, I have listed this list exactly as stated in these guidelines.

Treatment / Management

Manual treatment - adjustments/mobilization

Exercise therapy

Transcutaneous electrical nerve stimulation (TENS)

Traction

Ultrasound treatment

Laser treatment

Shortwave diathermy

Massage, heat, ice

Acupuncture

Pulsed electromagnetic treatment (PEMT)

Patient education and advice

Combination therapy

Prescribed function or work alteration

Nutritional supplements (omega-3 fatty acids, anti-oxidants, natural anti-inflammatories)

Simple analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs)

Opioid analgesics (for severe pain only)

Psychopharmacologic drugs (not recommended routinely)

Intravenous methylprednisolone (not recommended for acute management)

Manipulation under anesthesia/sedation

Referral to whiplash specialist

Surgery

Regeneration injection therapy

MMI/MCI

I will use the ICA of California Whiplash Management Guidelines for MMI which states the following: Maximum Improvement is achieved when there is no improvement in clinical status for a period of 2 months as assessed with standard measurement outcomes (visual analog scale, Oswestry, Neck Disability Index, SF-36, etc.) If treatment is withdrawn and the patient's clinical status becomes worse, the patient has not achieved Maximum Medical Improvement.

I will utilize the AMA Guides to the Evaluation of Permanent Impairment definition for MMI which states: The point in which a condition has stabilized and is unlikely to change (improve or worsen) substantially in the next year, with or without treatment. I will then objectively test for supportive care needs

Supportive Care Needs

I will utilize the American College of Chiropractic Consultants Policy for Supportive care and test for the need appropriately when the time may come. **Supportive Care** - Bibliography

Long-term treatment/care that is therapeutically necessary. This is treatment for patients who have reached maximum therapeutic benefit, but who fail to sustain benefit and progressively

deteriorate when there are periodic trials of treatment withdrawal. Supportive care follows appropriate application of active and passive care including rehabilitation and/or lifestyle modifications.

Supportive care is appropriate when alternative care options, including home-based self-care or referral have been considered and/or attempted. Supportive care may be inappropriate when it interferes with other appropriate primary care, or when risk of supportive care outweighs its benefit, i.e. physician/treatment dependence, somatization, illness behavior or secondary gain.

NB: Chiropractic physicians should be sure and clearly document treatment withdrawal attempts and the results of those attempts.
- Position Statement of the American College of Chiropractic Consultants - 2006

IMPAIRMENT RATING

I will include a formal impairment rating at MMI at which time all diagnostic test results, (X-ray, CRMA, MRI, Electro-Diagnostics etc) will be utilized for proper placement.
I will perform and Impairment Rating at MMI if asked to do so.
I am not trained of knowledgeable in Impairment Rating and therefore cannot perform one at MMI
If a formal impairment rating is requested I will assist in locating a qualified professional trained in impairment rating to perform it.