The Croft Whiplash Management Guidelines (R2)

Results of a Preliminary Practice Survey

Arthur C. Croft, D.C., M.Sc., M.P.H., F.A.C.O.
drcroft@srisd.com

Spine Research Institute of San Diego
www.srisd.com

Introduction

Chiropractic physicians who care for cervical acceleration/deceleration (CAD or whiplash) patients with any degree of regularity are often confronted by representatives of third party payers concerning the issue of alleged excessive utilization. The ensuing dispute is typically based on opinion, company policy, or misinformation, rather than the common practice patterns of chiropractic physicians within the community. There is a dearth of information available in the chiropractic literature to give assistance to anyone engaged in one of these disputes. In 1993, however, Croft published a set of management guidelines in the *ACA Journal* (1). These guidelines have also been published in *Whiplash Injuries: the Cervical Acceleration/Deceleration Syndrome,* 2nd edition (2) in 1995 and in a recent Canadian practitioner's guide to whiplash injuries, sanctioned by the Canadian Chiropractic Association (3). (Note: these guidelines also appeared in the 3rd edition of that textbook in 2001.) This paper will endeavor to make a case for the general adoption of the Croft Guidelines by practitioners as well as payers for evaluating the reasonableness of CAD treatment.

Development of Treatment Guidelines

Historically, a number of different methods have been employed in the development of guidelines. The RAND Corporation used the so-called delphi technique in developing cervical manipulation guidelines (2). A panel of experts (including myself) from divergent fields analyzed the evidence for support of treatment by cervical spine manipulation and ranked a large series of potentially treatable conditions accordingly.

Another method of guideline development comprises practice surveys. This method has also been used by RAND and was utilized by the Spine Research Institute of San Diego to develop the Croft Guidelines for the treatment of CAD injuries. A review of 2,000 cases, graded as to severity (i.e., Grades I-V - see Table I), provided the basis for the Croft Guidelines (see Table II). Subsequently, the Insurance Research Council (IRC) reported that the average number of treatments provided by DCs in cases of CAD trauma was 32 (5). Considering that most CAD injuries requiring treatment will be graded either Grade I, II, or III, this serves to validate the guidelines to some degree. In a practitioner survey recently conducted in the state of Washington, the average number of treatments rendered under the general heading "trauma" was reported to be 34 (6). Similarly, we have recently been informed by a representative of the Manitoba auto insurance company that the average number of treatments rendered by DCs for whiplash was 33 (7). Most recently, the grading system originally developed by Croft, and later adopted by the Quebec Task Force on Whiplash Associated Disorders (WAD), was validated in regard to its ability to predict outcome (8). We used the authors' breakdown

of patients into grades of severity (14% grade I; 83% grade II; 3% grade III) and applied the guidelines. Based on maximal guideline allowance, the average number of treatments would again fall in the mid 30s, consistent with other data.

The fact that the average number of treatments is about 32-34, however, doesn't in any way imply that this is the optimal in terms of treatment results. It is quite likely that less than optimal care was provided in many cases, since many DCs—like their medical counterparts—are not well trained in managing these cases. Optimizing treatment methods would very likely result in both reduced treatment duration and improved outcomes. Nevertheless, these numbers do represent current practice standards.

The Croft Guidelines have been a part of our literature now for more than a decade. The Croft Guidelines are applicable independent of disability status, and have now been adopted by several American state chiropractic organizations and associations (AK, UT, OH, CO, NC, SD, KY, WA) and one state board of examiners (OK), as well as in at least one Canadian province. They are the only widely published CAD guidelines and they are based on actual practice patterns of chiropractic physicians, patterns which appear to be consistent throughout North America.

Table I – Grades of Severity of Injury

Grade I	Minimal; No limitation of motion; No ligamentous injury; No neurological findings
Grade II	Slight; Limitation of motion; No ligamentous injury; No neurological findings
Grade III	Moderate; Limitation of motion; Some ligamentous injury; Neurological symptoms
Grade IV	Moderate to Severe; Limitation of motion; Ligamentous instability; Neurological symptoms; Fracture or disc derangement
Grade V	Severe; Requires surgical management/stabilization

Table II – Guidelines for Frequency and Duration of Care in Cervical Acceleration/Deceleration Trauma (2)

	Daily	3x/wk	2x/wk	1x/wk	1x/mo	T_D	T_N
Grade I	1 wk	1-2 wk	2-3 wk	<4 wk	—[1]	<11 wk	<21
Grade II	1 wk	<4 wk	<4 wk	<4 wk	<4 mo	<29 wk	<33
Grade III	1-2 wk	<10 wk	<10 wk	<10 wk	<6 mo	<56 wk	<76