

# Why aren't chiropractic physicians treating more children with complex diagnoses? A commentary on documenting P.A.R.T. for diagnosing and treating special needs children

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## ABSTRACT

According to the Centers for Medicare and Medicaid Services (CMS) guidelines, chiropractors are deemed physicians in the Medicare system and for consistency throughout the term chiropractic physician will encompass chiropractor, chiropractic doctor, doctor of chiropractic and chiropractic physician. Chiropractic physicians must document subluxation of the spine through x-ray or physical examination. The documentation of subluxation of the spine through physical examination includes the identification of two out of four criteria including: Pain/tenderness, Asymmetry/misalignment, Range of motion abnormality, Tissue tone, texture, and temperature abnormality (P.A.R.T.) with at least one of the two criteria being either A or R. Since special needs children often have difficulty expressing pain, and/or experiencing pain the way a typical child can, it is necessary to understand approaches to the special needs child that allow the doctor to evaluate and treat the child, as well as comply with insurance mandates to establish medical necessity. The purpose of this paper is to help the doctor understand approaches to document the diagnosis/diagnoses and procedures utilized for the medically necessary care of special needs children to while remaining in compliance with the billing to 3rd party payers. A case report follows to illustrate these challenges.

**Keywords:** Special needs children, autism, Down syndrome, insurance compliance, Medicare, medical necessity, pediatrics, chiropractic, chiropractic physician, chiropractor.

## Introduction

Chiropractic philosophy and practice teach us that all dysfunction has a neurologic component.<sup>1</sup> By far, the greatest growth of neurologic dysfunction in children is the increasing presence of autism spectrum disorders (ASD).<sup>2</sup> ASD includes autism, ADD/ADHD, Rett's Syndrome, Asperger's Syndrome, Pervasive Developmental Delay and Childhood Disintegrative Disorder, among others.<sup>3</sup> Commonly, these children lack communication skills, perceive pain differently than non-spectrum children, and present with uncommon signs and symptoms not frequently seen in a chiropractic office.

As chiropractic physicians, we are comfortable with back pain, neck pain and headaches, but when a patient presents with self-stimulatory behaviors, self-injurious behaviors, digestive challenges and abnormal preferred postures, the chiropractic physician may become intimidated and decline to treat these children.

The quality of life of children challenged with these issues may be enhanced by chiropractic care.<sup>4</sup> Chiropractic physicians, as they often provide family care, are encouraged to expand their knowledge and practice to include these chil-

dren. By providing competent chiropractic care, we demonstrate to our patients and their families and other providers that chiropractic is not limited to pain management. At Kentuckiana Children's Center, we observe physiologic, behavioral and social improvements with the addition of chiropractic and complementary care.

This article serves to demonstrate how to comply with insurance mandates to identify Pain/tenderness, Asymmetry/misalignment, Range of motion abnormality, Tissue tone, texture, and temperature abnormality (P.A.R.T.) changes in the absence of ability to question the patient. A case report is also provided.

A common behavioral feature of autistic spectrum disorder (ASD) children is self-stimulatory activity. This activity can manifest as hand-flapping, head-banging, spinning, self-injurious behaviors, and physical attacks.<sup>5</sup> All of these activities have the potential of disturbing normal biomechanical function, and therefore, can cause vertebral subluxation complex (VSC). It is evident, then, that spectrum children should be regularly evaluated and treated by a chiropractic physician. It becomes necessary for the doctor to investigate and/or re-investigate palpation and observational analysis

methods in the special needs population to effectively identify the presence of VSC and then develop the skill set to deliver an appropriate and effective adjustment.

Medicare guidelines require the presence of two of the four P.A.R.T. features to be present to demonstrate medical necessity. At least one of the features must be A and/or R.<sup>6</sup> This makes the job of the chiropractic physician easier since spectrum children cannot communicate pain in the way a non-spectrum individual can.

At Kentuckiana Children's Center, the majority of our patients are ASD children. We also have a wide variety of children with genetic syndromes, like Down Syndrome, and other complex diagnoses that present with varying levels of function. Optimally, after an examination and differential diagnosis and treatment plan are in place, a patient is adjusted. This could happen on the first visit in an acute case or second office visit after a report of findings. We have observed when working with spectrum children, it may take several visits to establish trust so that hands-on work can be accomplished. The treatment environment must be soothing, as non-clinical as possible and quiet. Loud, bright environments are more likely to stimulate unwanted behaviors and make the treatment of the child impossible.

If the parent is accustomed to using them, the use of "social stories" before initial and subsequent visits may facilitate the child's willingness to be treated. Social stories are pictures, videos and discussions of the steps it takes to get through an event, procedure or a day.<sup>7</sup> Use of these tools allows the child time to process a new experience. Once the child is accustomed to the experience, office visits become easier to manage.

It is also important to note that most spectrum children are unable to tolerate light touch. Activator checks, Total Body Modification (TBM) analysis and other techniques that involve analysis via brushing or lightly touching a body part could provoke an unwanted, and possibly violent, reaction. As much as possible, firm, intentional touch is preferred and can have a calming effect.

Once tolerance of the environment and hands-on contact is established, it is not difficult for a competent chiropractic physician to identify Asymmetry/misalignment, Range of motion abnormalities and Tissue tone, texture, and temperature abnormality. We commonly find a short leg (asymmetry), retracted scapula (asymmetry, tone), forward head carriage (asymmetry, tone), heel-to-buttock restrictions (asymmetry, tone) and limited spinal ranges-of-motion. Adjusting the ASD child, then, may be accomplished by any number of methods. We often find that children who are high functioning will tolerate Activator Method, but low functioning children will not allow this technique. Drop

table adjustment mechanisms are effective, but can be very alarming. The most frequently used techniques include Diversified, Gonstead and sustained deep pressure.

Documentation is a vital component of the care of the patient as well as the Centers for Medicare and Medicaid Services (CMS) and insurance compliance. In the case of the special needs child, many aspects of the examination may not be able to be accomplished and documented. A child's weight, height or blood pressure, for example, are often a part of the routine examination. If the record indicates that these examination features have been attempted, and an explanation of why they were not accomplished is noted, then the chiropractic physician should be well in compliance.

Ultimately, once the chiropractic physician has established rapport with the child, has a clear understanding of the case, establishes a treatment plan and obtains an informed consent from the child (if appropriate) and their parents/guardians, it is not difficult to comply with insurance mandates.

Table 1, below, compares analysis methods for the adult, the child and the special needs child. Note that since asymmetry, range-of-motion and tension/tone can be easily assessed without patient participation, there is little difference identifying these features regardless of the individual. Modifications of range-of-motion and tension/tone analysis refer to meeting the special needs child where they are at time of presentation. Behavior often dictates how much touch a child will allow. Usually, over time, even the most reluctant special needs child will allow touch.

Comparisons for documentation of P.A.R.T. in adults, children and special needs children				
	P	A	R	T
Adult	<ul style="list-style-type: none"> <li>Ask</li> <li>Visual analogue scale</li> <li>Apprehension test</li> <li>Palpate heart rate before and after palpation. Pain should cause HR elevation</li> </ul>	<ul style="list-style-type: none"> <li>Observation and Palpation for Asymmetry</li> <li>Observe patient posture and movements</li> <li>Palpation can be static, dynamic/shallow, moderate and deep</li> </ul>	<ul style="list-style-type: none"> <li>ROM testing for Abnormal Motion</li> <li>Observe patient movements/behaviors</li> <li>Observe/Palpate Active, Passive, Resisted ROM's</li> <li>Instrument applied Active, Passive, Resisted ROM's</li> </ul>	<ul style="list-style-type: none"> <li>Palpation for Tissue Tone and Tenderness</li> <li>Soft tissue light, moderate and deep palpation</li> <li>Joint tissue light, moderate and deep static and motion palpation</li> </ul>
Child	<ul style="list-style-type: none"> <li>Ask</li> <li>Visual analogue/modified visual analogue scales</li> <li>Apprehension test</li> <li>Palpate heart rate as above</li> </ul>	<ul style="list-style-type: none"> <li>Observation and Palpation for Asymmetry</li> <li>Observe patient posture and movements</li> <li>Palpation can be static, dynamic/shallow, moderate and deep</li> </ul>	<ul style="list-style-type: none"> <li>ROM testing for Abnormal Motion</li> <li>Observe patient movements/behaviors</li> <li>Observe/Palpate Active, Passive, Resisted ROM's</li> <li>Instrument applied Active, Passive, Resisted ROM's</li> </ul>	<ul style="list-style-type: none"> <li>Palpation for Tissue Tone and Tenderness</li> <li>Soft tissue light, moderate and deep palpation</li> <li>Joint tissue light, moderate and deep static and motion palpation</li> </ul>
Special Needs Child	<ul style="list-style-type: none"> <li>Parental assistance: "I know my child."</li> <li>Observation of behavior</li> <li>Palpate heart rate as above</li> <li>Reflexive withdrawal</li> <li>Report of change in activity levels</li> <li>Sleep disturbances</li> <li>Elimination disturbances</li> </ul>	<ul style="list-style-type: none"> <li>Observation and Palpation for Asymmetry</li> <li>Observe patient posture and movements</li> <li>Palpation can be static, dynamic/shallow, moderate and deep</li> </ul>	<ul style="list-style-type: none"> <li>ROM testing for Abnormal Motions (modified for patient tolerance and ability)</li> <li>Observe/Palpate Active, Passive, Resisted ROM's</li> <li>Instrument applied Active, Passive, Resisted ROM's</li> </ul>	<ul style="list-style-type: none"> <li>Palpation for Tissue Tone and Tenderness (modified for patient tolerance)</li> <li>Soft tissue firm, intentional palpation</li> <li>Joint tissue firm, intentional static and motion palpation</li> </ul>

### Case Report

A recent case illustrates these challenges when working with a special needs child with a complex diagnosis:

A.S. is a 15 year old boy who has both Down Syndrome and Dandy-Walker Syndrome. Both conditions present with communication challenges as well as pronounced physical manifestations.<sup>8,9</sup> A.S. is high functioning (cognitive and motor), at about the level of an 8-9 year old. According to his parents, he has a very high pain tolerance. Dandy-Walker is a congenital malformation of the cerebellum with attendant hydrocephalus. Typically, individuals with Dandy-Walker Syndrome have positive cerebellar findings (inability to perform cross body activities, difficult toe walking, awkward finger-to-nose, etc.). Throughout much of his life, A.S. has suffered restless leg syndrome (RLS) to some degree, and it has been thought that this was a manifestation of Dandy-Walker. When afraid, A.S. will often sleep with his parents, and they report that his legs will wrap around them and continue to move throughout the night. He does not like to walk for long periods of time. When faced with new activities or environments, A.S. has difficulty with transitions such as moving from the waiting room to the treatment room, or from one table to another. He requires encouragement and coaching to make these transitions, but once he has become accustomed to the ritual, working with him becomes easier.

Recently, A.S. started complaining of pain in his lower back. His parents noted that his RLS increased and that he would moan in his sleep. It was believed that these experiences were simply secondary to his congenital abnormalities, but when the symptoms increased, A.S. was taken to an orthopedic surgeon recommended by his neurologist.

Because of the malformation of the brain, A.S. had had prior MRI studies of his head, neck, thoracic spine and lumbar spine, and a lumbar MRI was performed recently and compared to one obtained in 2011. A.S. had hyperlordosis of the lumbar spine. The 2011 study revealed a well-hydrated L5-S1 intervertebral disc with very minimal (less than 3mm) anterolisthesis of L5 on S1. The follow-up study performed in 2015 demonstrated no structural change except disc dehydration. The anterolisthesis was unchanged. The orthopedic surgeon recommended complex surgery that would result in fusion of the joint.

A.S. consulted with KCC and extensive orthopedic, neurologic and chiropractic analyses were performed. Findings included a positive Gillet's test, extreme tension of the lumbar paraspinal muscles, spasm of the right piriformis (no radicular signs were present or reported), diminished internal femoral rotation and subluxation at the right sacroiliac joint, L3, L4, L5 and at C7. A.S. could not walk on his toes (though heel walk was normal), cross body was very difficult and finger-to-nose was awkward. Patellar and Achille's reflexes were normal. L1-S1 myotomes were normal. Given the fact that the anterolisthesis was stable, a course of chiropractic rehabilitation was prescribed.

Treatment included specific chiropractic adjusting using diversified and Gonstead methods, ultrasound therapy (3mHz, .5w/cm<sup>2</sup> at 20% output for 5 minutes), kinesiotape (star pattern). When capable, strategies were discussed to accomplish neuromuscular reeducation. Because it was a challenge getting A.S. to understand core exercises it was determined that since Biering-Sorensen's posture<sup>10</sup> evaluates core muscle stability by challenging these muscles, we could use the posture as an exercise. A.S. was advised to perform Sorensen's at least once per day with the help of his brother. A.S. would lie face down on his bed with his upper body extended off the bed at just below the waist. His brother would sit on or hold his legs down. He would try to keep his upper body parallel to the floor with his arms folded against his chest for as long as he could with a goal of building his endurance and maintaining the horizontal position for two minutes. Rebounding on a physio ball was also advised for a minimum of 20 minutes each day to provoke imbibition of the intervertebral discs.

After the first visit, RLS was reduced. Piriformis spasm was absent though lumbar paraspinal muscle tension persisted. A.S. reported having no pain. His parents were delighted that he was walking longer distances, something he had never done in the past. A.S. never put his shoes on while standing, always preferring to sit. At the end of the second session, his mother noticed he was standing to put on shoes, something he had never done. He was not coming in to his parents' room at night with the frequency to which the family had become accustomed. By the fifth visit, A.S. required adjusting only at the level of L5 and lumbar paraspinal tension had reduced somewhat. Ultrasound was discontinued and exercise time was increased. By the ninth session, A.S. was sleeping soundly through the night. He had a slight left heel-to-buttock restriction and subluxation at L5 only. A.S. currently has no reported lower back pain. His RLS is greatly reduced and he is walking longer distances.

### Discussion

A.S.'s case suggests that the frequency and intensity of his RLS combined with his dislike of walking any distance and his inability to put on his shoes while standing represented pain, which he only verbalized recently. Effects that were believed to be exclusively secondary to congenital brain malformation were also secondary to pain that A.S. could not express the way someone without these challenges would be able to do. Increased tolerance of walking and changes in dressing suggest that the way he did these things in the past was accomplished to avoid pain. Working with this kind of patient places greater responsibility on the chiropractic physician to investigate presentations that can appear to be unrelated to other pathologies.

Broadening the chiropractic physician's knowledge base can be accomplished through continuing postgraduate

education as well as the wealth of information available through special interest groups, research and government sites. The list of sites is ever expanding and additional or diagnosis specific sites as well as past and current research are easily accessed through routine search engines.

Parents are also a wealth of information when it comes to understanding the diagnosis and needs of their child as most have exhaustively researched this information themselves and talked extensively with many health care providers in many fields who are participating in their child's health care program. Interdisciplinary communication is also a source of information and support as all parties should be working towards the child's optimum health and function and understanding the role of each practitioner will ultimately be in the child's best interest. Chiropractic physicians need to be persistent in their communication to assure the safety and well being of the child especially if there are complicating factors that could alter the technique, frequency or force

of the adjustments (as in an unstable atlantoaxial junction in a child with Down Syndrome<sup>11</sup>). For reasons such as this, ongoing education and communication are vital when providing chiropractic care for the special needs child.

### Conclusion

It has been the clinical experience of chiropractic physicians and other health care professionals at Kentuckiana Children's Center that many of the neuromusculoskeletal manifestations of the challenged child can be well managed and functional improvement attained when delivered in conjunction with many of the other rehabilitative services (occupational therapy, physical therapy, speech therapy, feeding therapies, etc). It is imperative that chiropractic physicians understand the value of their services to this population and seek the support and education to establish a comfort level with these patients and their care. Appropriate examination and documentation procedures will also assure appropriate reimbursement for services.

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