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How Do I Justify the Medical Necessity of My Care? Part II: The Roland-Morris Questionnaire

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Introduction

In part one of this series, the topic of medical necessity was discussed (*DC*, May 17, 1999). There are three aspects: identification of the high-risk patient ("yellow flags"); documentation of progress with outcomes; and evidence-based treatments. In previous columns, I have addressed how to identify "yellow flags" in patients on day one (*DC*, Jan. 14, 1997; August 11, 1997; June 29, 1998; and July 27, 1998). I have also dealt with the modes of care and timelines for each based on evidence (*DC*, July 1, 1996).

This paper will address a simple outcome for use in low back pain patients to document progress over time. It is essential to measure and monitor patient progress with robust outcomes so that the value of our care may be judged by an independent third party. Medical necessity is determined or argued for by this simple process. It is neither time consuming nor expensive. However, the knowledge and skills to implement this do require training.

Discussion

According to Deyo et al., the most important domains to assess with outcomes are pain symptoms, function, well being, disability (social role) and satisfaction with care.¹ Pain symptoms are best assessed by visual analog scale (VAS); function, by the Roland-Morris scale or Oswestry questionnaire; well being by the SF-12 or SF-36; disability (social role) by days off work or activity intolerances; and satisfaction with care with a single question regarding overall satisfaction with care.

An outcome tool should be valid, responsive and practical. Validity is demonstrated by a positive association with different but related measures, or what is called construct validity. Responsiveness relates to the tool's ability to detect clinically significant changes over time that are not due to random variability.

Finally, practicality deals with the cost in terms of time to administer and the time and expense of scoring.

The Roland-Morris Questionnaire

One of the most important and useful outcomes is the Roland-Morris form. It is an excellent short functional disability questionnaire. It focuses on activity intolerances related to one's low back problem. It was developed from the Sickness Impact Profile (SIP), a widely used disability questionnaire.² It has been compared to the SIP and found to be simpler, quicker and easier to use.^{3,4} It is well suited to administration by telephone and therefore is invaluable in research when securing followup information efficiently.¹ It is particularly responsive to change in acute back pain populations.^{2,3,5}

When compared with the Oswestry questionnaire, the Roland was found to be simpler, faster and more acceptable to patients.^{6,7} It is a more sensitive measure of activity intolerances in acute and subacute patients.^{6,7} The Oswestry is more sensitive for identifying activity intolerances in chronic patients and therefore may be more appropriate for tertiary care facilities.⁶⁻⁸

A slightly shorter version of the Roland-Morris form with 18 questions instead of 24 has recently been validated.⁹ The original 24-question version is available in eight non-English languages from Dr. Sandra Sinclair (ssinclair@wh.on.ca). The Roland form should be given at the initial patient contact and then every 2-4 weeks thereafter. It is simple to total the score and track a patient's progress over time. Software is available which automatically charts and graphs the patient's improvement over time.¹⁰

Conclusion

Outcomes are invaluable for documenting the response of patients to our care. Such documentation is essential in medicolegal settings. Outcomes are a universal language which makes them ideal for communication with referring doctors, attorneys, adjusters or the patients themselves. They also help in clinical decision making by focusing us on issues which can influence our choice of therapy for our patients. For instance, persistent activity intolerances such as in walking can indicate the need for a biomechanical re-evaluation of the lower extremity kinetic chain.

Finally, outcomes are a means to a crucial goal for chiropractic. They can allow us to document the effectiveness of our care collectively. Groups such as the National Spine Network (*DC*, May 17, 1999) and CareTrak aggregate data from providers and thus are creating large databases which can prove the effectiveness of chiropractic.¹⁰

Low Back Pain and Disability Questionnaire

(Roland-Morris)

Name: _____ Date: _____

Age: _____ Score: _____

When your back hurts, you may find it difficult to do some of the things you normally do.

Mark only the sentences that describe you today.

1. I stay at home most of the time because of my back.
2. I walk more slowly than usual because of my back.
3. Because of my back, I am not doing any jobs that I usually do around the house.
4. Because of my back, I use a handrail to get upstairs.
5. Because of my back, I lie down to rest more often.
6. Because of my back, I have to hold onto something to get out of an easy chair.
7. Because of my back, I try to get other people to do things for me.
8. I get dressed more slowly than usual because of my back.
9. I stand up only for short periods of time because of my back.
10. Because of my back, I try not to bend or kneel down.
11. I find it difficult to get out of a chair because of my back.
12. My back or leg is painful almost all of the time.

13. [] I find it difficult to turn over in bed because of my back.
14. [] I have trouble putting on my socks (or stockings) because of pain in my back.
15. [] I sleep less well because of my back.
16. [] I avoid heavy jobs around the house because of my back.
17. [] Because of back pain, I am more irritable and bad tempered with people than usual.
18. [] Because of my back, I go upstairs more slowly than usual.

References

1. Deyo RA, Battie M, Beurskens AJ, Bombardier C, Croft P, Koes B, et al. Outcome measures for low back pain research. *Spine* 1998;23:2003-2013.
2. Roland M, Morris R. A study of the natural history of back pain: part I: development of a reliable and sensitive measure of disability in low-back pain. *Spine* 1983;8:141-144.
3. Deyo RA. Comparative validity of the sickness impact profile and shorter scales for functional assessment in low back pain. *Spine* 1986;11:951-0954.
4. Jensen MP, Strom SE, Turner JA, Romano JM. Validity of the Sickness Impact Profile Roland scale as a measure of dysfunction in chronic pain patients. *Pain* 1992;50:157-162.
5. Patrick DL, Deyo RA, Atlas SJ, Singer DE, Chapin A, Keller RB. Assessing health related quality of life in patients with sciatica. *Spine* 1995;20:1899-909.

6. Roberts A. The conservative treatment of low back pain. MD thesis, University of Nottingham, 1991.

 7. Waddell G. *The Back Pain Revolution*. Edinburgh: Churchill Livingstone, 1998.

 8. Baker CD, Pynsent PB, Fairbank JCT. The Oswestry Disability Index revisited: its reliability, repeatability and validity, and a comparison with the St. Thomas's Disability Index. In: Roland MO, Jenner JR, eds. *Back Pain: New Approaches to Education and Rehabilitation*. Manchester University Press, 1989:174-86.

 9. Stratford PW, Binkley JM. Measurement properties of the RM 18: a modified version of the Roland-Morris disability scale. *Spine* 1997;22:2416-2421.

 10. CareTrak outcomes software. Grand Rapids, MN; (800) 393-7255, www.caretrak-outcomes.com.
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