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MEDICAL NECESSITY: WHY ARE CHIROPRACTIC EVALUATION AND MANAGEMENT SERVICES NECESSARY FOR A WHIPLASHED PATIENT?

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ABSTRACT

Objective: This paper defines chiropractic necessity and demonstrates a chiropractic evaluation, management, and documentation process, that supports the need for chiropractic care for patients experiencing acute whiplash associated disorders.

Discussion: Whiplash is the most common injury associated with motor vehicle accidents. It is also a common cause of chronic disability. Due to injury of the spinal ligaments and muscles and the resulting spinal joint dysfunction, whiplashed patients benefit from chiropractic services. Chiropractic physicians should gain informed consent to provide both evidence-based and patient-centered care for these injured patients. Evidence-based chiropractic care requires a thorough history of the present illness/injury and a physical examination which identifies the injured tissues and forms a working diagnosis. Chiropractic documentation must demonstrate chiropractic necessity and the patient response to chiropractic care.

Conclusion: It is essential that chiropractic physicians accept the responsibility to treat whiplashed patients and provide evidence-based and patient-centered evaluation and management services supported by accurate and honest documentation. *(J Contemporary Chiropr 2026;9:255-264)*

Key Indexing Terms: Chiropractic; Medical Documentation; Whiplash Injury; Cervical Acceleration-Deceleration Injury

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INTRODUCTION

Crowe first described whiplash as a mechanism of injury to the cervical spine in 1928.[1] According to Barnsley, he defined the whiplash injury as "an acceleration-deceleration mechanism of energy transferred to the neck," usually resulting from rear-end or side-impact motor vehicle collisions.[2] In 1995, the Quebec Task Force described the cervical injury and labeled it as a diagnosis, Whiplash Associated Disorder (WAD).[3] These neuromusculoskeletal disorders are the most common non-hospitalized injury resulting from a motor vehicle crash.[4] Jull et al conclude that the burden of whiplash injuries, the high rate of transition to chronicity, and evidence of limited effects of current management on transition rates demand new directions in evaluation and management.[5] According to Ritchie et al 50% of patients experiencing acute whiplash associated disorder do not resolve and suffer with a chronic, post-traumatic pain syndrome.[6] These authors concluded there are several factors for this progression.

> *Recovery from a whiplash injury is an adaptive process and more than elimination of pain or disability, therefore may be different from common clinical patient reported outcomes. Early identification of patient understandings of pain, expectations of recovery, symptoms and therapy may help merge patient and HCP(health care providers) understandings. Additionally, helping individuals to recognise symptom triggers and develop appropriate strategies to minimize triggers may actively engage patients in their recovery. Finally, acknowledgment and validation of the whiplash injury by HCPs is seen by many as a necessary step in the recovery process.*

Freeman et al estimated that there are approximately 869,000 traffic crash-related cervical spine injuries seen in hospitals in the United States annually, including an estimated 841,000 sprain/strain (whiplash) injuries, 2800 spinal disk injuries, 23,500 fractures, 2800 spinal cord injuries, and 1500 dislocations.[7]

Yadia et al stated that whiplash is the most common injury associated with motor vehicle accidents, affecting up to 83% of patients involved in collisions, and is a common cause of chronic disability.[8] Nearly 50% of whiplashed patients resolve within 3 weeks[9] Ritchie et al reported that over the past few decades, recovery rates have remained unchanged with approximately 50% of individuals experiencing on-going pain and disability.[10]

We must ask why 50% of whiplashed individuals never completely resolve and continue to experience chronic pain and disabilities. Is it due to a lack of access to necessary health care? Is our healthcare system not providing evidence-based and patient-centered healthcare for whiplashed patients? We can't answer those questions, but we will attempt to provide pertinent information that enhances the chiropractic treatment of patients suffering from an acute whiplash injury.

The care of whiplashed patients would improve if the providers embraced Cailliet's wise recommendation regarding the importance of proper care of the whiplashed patient.

> *If characteristic pain can be reproduced by a position or movement and the exact nature of that position or movement is understood, the mechanism of pain production is also understood. A careful, meaningful, and complete history, physical, neurological, and orthopedic examination will reveal the problem clearly. A diagnosis need not be a diagnosis by exclusion. The cause may remain unknown or questionable, but not the pathomechanics. When the physician recognizes which symptoms can be reproduced and which movement and positions reduplicate them, he should have no question as to the diagnosis, and proper therapy.*[11]

The patient's description of when and how differentiates the pain in its static or kinetic nature. A detailed history of the accident as to the direction of impact, the awareness of impending collision, the direction in which the person was facing at the moment of the accident, the severity of the blow, and the resultant movements of the head and neck obviously relate to the mechanism of injury and help to identify the specific tissues involved. This thorough assessment provides valuable insights that guide the diagnostic and therapeutic process, ensuring that treatment is tailored to the unique presentation of each whiplash case.[12]

DISCUSSION

Grading of WAD Injury

The Quebec Task Force classified 4 different grades of WAD based upon signs and symptoms presented by the whiplashed patients which affected the cervical spine.[13]

- Grade 0: No complaints about the neck. No physical sign(s).
- Grade I: Neck complaint of pain, stiffness, or tenderness only. No physical sign(s).
- Grade II: Neck complaint AND musculoskeletal sign(s). Musculoskeletal signs include decreased range of motion and point tenderness.[14]
- Grade III: Neck complaint AND neurological sign(s)
- Neurological signs include decreased or absent tendon reflexes, weakness and sensory deficits
- Grade IV: Neck complaint AND fracture or dislocation.

We believe that chiropractic physicians should grade the WAD prior to determining the chiropractic treatment plan. The severity of the injury impacts the response to chiropractic care and the prognosis. Grades 0 and I should require minimal care while grades II and III may require additional care and are more likely to become post-traumatic chronic pain syndromes.

Referral of patients with grade IV is indicated and chiropractic spinal manipulation to the area of fracture or dislocation is contraindicated. In addition to the WAD grading of the injury, the grades of sprain and strain should be documented in the patient report.

Medical Necessity

It is common for insurance companies to use studies supporting evidence that reduces cost of care by limiting the number of chiropractic treatments based upon medical necessity and documentation. We offer examples from both medical and insurance sources that describe medical necessity.

Hartz claims that doctors do not comprehend medical necessity. We believe the same is true for chiropractic physicians.

> *As physicians, we feel we rarely order things that are not medically necessary, although we know that much of the testing and treatment we do has not been substantiated by evidence-based studies. In fact, many of us do not really know what is medically necessary.*[15]

Insurance companies define medical necessity regarding coverage for the costs of medical care, while chiropractic physicians must demonstrate both subjective and objective data, diagnosis, and a treatment plan that support the need for chiropractic services.

Bare provides an excellent definition of medical necessity that must be shared with chiropractic physicians that evaluate and manage treatment of whiplashed patients.

> *The definition of medical necessity has long been a contentious issue between practicing physicians and physicians who work for health plans or organizations responsible for utilization and quality management. As physicians, we feel we rarely order things that are not medically necessary, although we know that much of the testing and treatment, we do has not been substantiated by evidence-based studies. In fact, many of us do not really know what is medically necessary. Having been on both sides of the aisle has helped me to better understand the complex issues involved but has not brought forward any solution. I want patients to realize that although everything their physician suggests or orders may be medically reasonable and appropriate, it may not be considered medically necessary. However, I do not want to create patient distrust of physicians' recommendations.*[16]

According to Bilhari, medical necessity refers to the determination that a treatment, test, or procedure is essential for maintaining or restoring health or treating a diagnosed medical problem. It is a healthcare policy doctrine that ensures services are reasonable, necessary, and appropriate based on evidence-based clinical standards (best practices).

In practice, it means that healthcare providers prescribe services that follow established medical guidelines to prevent, diagnose, or treat conditions. Ultimately, medical necessity is crucial for ensuring that patients receive relevant and justified healthcare services.[17]

From your doctor or nurse practitioner's perspective, medical necessity refers to any health service or product they prescribe for you that will prevent, diagnose, or treat a condition. These services and products follow medical standards (like published guidelines, for example).[18]

Cigna and Medical Necessity

CIGNA covers chiropractic manipulation and adjunct therapeutic procedures/modalities,

(e.g., mobilization, therapeutic exercise, traction) as medically necessary when ALL of the following conditions are met:

- A neuromusculoskeletal condition is diagnosed that may be relieved by standard chiropractic treatment in order to restore optimal function.
- Chiropractic care is being performed by a licensed doctor of chiropractic who is practicing within the scope of his/her license as defined by state law.
- The individual participates in a treatment program that clearly documents all of the following:
    - A prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time:
    - Symptoms being treated
    - Diagnostic procedures and results
    - Frequency, duration, and results of planned treatment modalities
    - Anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals
    - Demonstrated progress toward significant functional gains and/or improved activity tolerances.[19]

As of 2026, Cigna's chiropractic policies are strictly defined by "medical necessity" and are often administered by a third-party vendor, American Specialty Health (ASH). This guide breaks down the complexities of coverage for Employer, Marketplace (ACA), and Medicare Advantage plans.

Medical Necessity & Exclusions: The "Improvement" Standard

Cigna only pays for "active care." This means the treatment must result in measurable improvement (e.g., "Patient can now bend 45 degrees without pain"). If you reach a plateau where you are stable but not improving, coverage ends.[20] Hence, the medical necessity requires the chiropractic physician to document the patient's diagnosis, treatment plan, and demonstrate that the patient is responding to the prescribed chiropractic treatment.

Chiropractic Necessity

We suggest that chiropractic evaluation and management services are necessary for acute whiplashed patients when there is a strain, sprain, or both of the spinal soft tissues with spinal joint dysfunction. Chiropractic care is provided in order to reduce pain, improve cervical range of motion,[21] enhance spinal joint function, and promote healing. Over-treatment should be avoided in order to reduce disability and harm to the patient. Chiropractic clinicians should practice as evidence-based providers when creating treatment plans. A multimodal approach including manual therapy, self-management advice, and exercise is an effective treatment strategy for both recent-onset and persistent neck pain due to whiplash.[22]

Third-year chiropractic students at the University of Bridgeport are taught differential diagnosis of WAD. The Health Sciences Postgraduate Education department offers postdoctoral WAD classes for practicing chiropractic physicians. The importance of medical necessity and accurate documentation are stressed throughout the training. Attendees are taught that high-quality chiropractic care requires a thorough history of the present illness/injury and a physical examination which identifies the injured tissues and forms an accurate diagnosis. Documentation must demonstrate chiropractic necessity and patient response to chiropractic care. It is taught that radiography and/or specialized imaging are frequently necessary to complete the differential diagnoses process.

Evidence-Based Practice

Sacket et al defined EBM as clinical decision-making that integrates clinical expertise with the best available external clinical evidence from systematic research while respecting a patient's rights and preferences.[23] Hence, the first requirement is clinical expertise. It is our opinion that chiropractic clinical expertise may be enhanced with postdoctoral WAD training. We recommend that chiropractic physicians interested in caring for WAD patients enhance their clinical expertise through postgraduate training and board certification in relevant specialties, such as rehab, neurology, orthopedics, and neuromusculoskeletal medicine. The board-certified chiropractic neuromusculoskeletal medicine specialist may use patient-centered, evidence-based, and outcome-driven treatment strategies, including but not limited to spinal and extremity manipulative therapy and a wide array of physical medicine and non-surgical procedures to achieve optimal outcomes.[24] Chiropractic specialists demonstrate a higher level of clinical expertise and are credentialed as tier 3 specialists by the AMA.[25]

Informed Consent Process

We recommend that prior to performing physical examination and treatment procedures, all chiropractic physicians must provide an informed consent process, which includes the actual written document, discussion regarding the document, and documentation of consent in the patient chart. The patient should be encouraged to ask questions regarding evaluation and management recommendations, alternative treatment options, risks involving treatment, and potential outcome. It is imperative that the chiropractic physician take the time to properly inform the patient and obtain written or verbally informed consent before initiating evaluation and management procedures.

However, there is a legal onus on the practitioner to actually initiate disclosure of all information that might reasonably be considered necessary to make an informed decision. This legal onus does not end after the initial visit. The informed consent process is a continuum, which enables the patient to determine the value of evaluation and management procedures throughout the entire treatment plan. Informed consent must clearly document in the patient chart any notable change in the treatment plan.[26]

The whiplashed patient presents a markedly heterogeneous and complex condition with varied disturbances in motor, sensorimotor and sensory function as well as psychological distress.[27] Hence, chiropractic physicians should consider post-doctoral training and board certification, which might improve quality of care for whiplashed patients. We suggest that the Centers of Medicare Service and the American Medical Association support this claim with their new modified taxonomy levels, which include Board Certified

chiropractic specialists at the tier level of 3. Currently, as of July 2025, the American Medical Association credentials these chiropractic specialists as tier 3 specialists (111NX0800X: Chiropractor — Orthopedic).[28] Licensed chiropractic physicians without a Diplomate status are credentialed at a Level 1 Chiropractic Physician graduated from Council of Chiropractic Education accredited chiropractic college and has completed National Board of Chiropractic Education certification. A Chiropractic Physician can practice under a Level 1 Taxonomy. 111NX0000X. This credentialing process delineates the difference between a chiropractic physician and a chiropractic specialist.

Chiropractic Evaluation and Management of a Whiplashed Patient

Chiropractic physicians should perform a thorough evaluation including history of present injury, physical examination, and then document the diagnoses and the treatment plan.[21] We suggest the use of the SOAP format, which requires documentation of subjective and objective data, which leads to diagnoses and treatment plan. The subjective data should describe the location of the injured tissues and mechanism of injury, determine if this is a new or old condition, detail provocative and palliative activities, describe the quality of pain, determine if the pain is localized, referring, or radiating, and the timing and treatment history. These subjective findings should be presented in a narrative format, which enables the chiropractic physician to create a list of different diagnosis.

Next, the physical examination should provide objective data, which enables the chiropractic physician to rule-in and rule-out diagnoses and conclude with the working diagnoses. Once the working diagnoses are documented, a treatment plan should be completed that is evidence-based and patient-centered. It is essential that the chiropractic physician documents specifically the treatment interventions and the goals of the treatments. Then the outcomes must be listed. The documentation of the outcomes of treatment should enhance the quality of care and demonstrate patient improvement. The chiropractic physician must appreciate the 3 phases of whiplash injury recovery suggested by Leong et al, which include the inflammatory, proliferative, and remodeling phases, and the cells involved in tendon (muscle) and ligament (joint) healing.[29]

We offer an example of subjective and objective data plus the assessment and plan for a whiplashed patient.

Putative Case of an Acute Whiplash Injury

Subjective

This 28-year-old, female patient stated "My neck and arm hurt". When asked where her neck hurt, she pointed to the upper and lower regions of the cervical spine on the right. She claimed that 2 weeks ago, she was at a stop light, and her car was rear-ended by a pickup truck. She was wearing her belt, looking to the right when the truck hit her car. Her right foot was on the brake at the time of impact. She denied loss of consciousness or previous neck injuries. Currently, the dull, aching neck pain increases and shoots down her right arm to the index finger and thumb when she looks up and turns her head to the right. Hot showers and NSAIDS have reduced her neck pain from 8-9/10 to 7-8/10.

She was taken to the ER by ambulance following the accident. An examination included x-rays of her neck and prescription of Ibuprofen. She was told that there were no fractures, but her neck was sprained. The patient stated that she had never been treated by a chiropractor but the PA at the ER suggested she see one. There were no passengers in her automobile.

The differential diagnosis process commences with the patient interview, which enables the chiropractic physician the opportunity to create a list of potential diagnoses. The patient interview should be followed with a physical examination, which includes observation of patient, vital signs, posture and gait, palpation, range of motion of the cervical spine, orthopedic testing, and neurological examination. These evaluation procedures should enable the chiropractic physician to rule-in and rule-out the potential diagnoses.

Unlike the documenting of the subjective data gleaned from the patient interview, the objective data should be listed with bullet points, but it is essential that the outcomes be detailed.

Objective

Vital signs: Height 64 inches, weight 125 pounds, blood pressure 126/80, pulse rate 72 per minute respiration, and 14 per minute

Gait: Steady without limp

Posture: Erect without antalgia, forward head posture of 2 inches with slight head tilt to the left.

Palpation: Pain elicited at C2-3 and C5-6 right paravertebral muscles and ligamentum nuchae.

Hypertonicity and spasms noted in the posterior cervical and upper trapezius muscles bilaterally.

Cervical active range of motion was full and without pain with flexion and left rotation reduced with pain upon extension right rotation, right lateral and left lateral flexion. Pain was located at C2-3 and C5-6 right paravertebral muscles.

O'Donoghue's Maneuvers

Cervical active range of motion was full and without pain upon flexion and left rotation. Cervical active range of motion was reduced with pain upon extension, right rotation, right lateral and left lateral flexion. The kinetic pain was located at C2-3 and C5-6 right paravertebral muscles.

Maximal cervical compression to the right produced radiating pain down the right upper extremity to the index finger and thumb.

Cervical compression in the neutral position increased the C5-6 pain with radiating pain down the right upper extremity to the index finger and thumb.

Cervical distraction produced pain in the paravertebral muscles on the right at C2-3 and C5-6.

There was posterior joint dysfunction at C2-3 and C5-6 with pain upon palpation of the ligamentum nuchae and cervical active and passive range of motion. There was reduced range of motion due to cervical paravertebral hypertonicity and pain.

Neurological Examination

Sensory functions were intact with light touch and pinprick for the upper extremities bilaterally except for hypesthesia in the right C 6 dermatome.

Motor findings were 5/5 bilaterally for the upper extremities.

Deep tendon reflexes were 2 plus bilaterally for the upper extremities.

Hoffmann's sign was absent bilaterally.

Imaging study: The cervical spine radiographic examination included a 7-view (Davis series), which was taken at the hospital on the day of the injury. It did not demonstrate any fractures or dislocations. There was a loss of cervical lordosis, probably due to muscle spasms. There were no findings of disc space narrowing.

Assessment

1. Grade 2 cervical sprain/strain of the cervical spine
2. Grade 3 WAD
3. Post-traumatic cervical radiculopathy

Plan

1. Patient care 2 times per week for 3 weeks.
2. Gentle massage therapy to relax hypertonic muscles prior spinal manipulation.
3. Spinal manipulation of the cervical spine to reduce pain and improve function.
4. Shock wave therapy promotes healing of injured muscles and ligaments.
5. Therapeutic exercises to follow each manipulation to improve range of motion and improve muscle function.
6. Consider an MRI of the cervical spine based upon response to care for radiculopathy.
7. The short-term goals by the end of 3 months include reduction of pain, improved cervical range of motion, healing of the strained and sprained soft tissues.
8. Long-term goals include ability to function without disabilities.

Chiropractic physicians must document the care and demonstrate the outcomes. It is necessary to document a pattern of improvement with treatment in order to demonstrate continuing medical necessity.[21] It is not acceptable to list a treatment and a charge for the treatment without documentation of location, intensity, duration, and response of a physiological therapeutic intervention. We recommend that chiropractic physicians utilize the Whiplash Disability Questionnaire[30] or the Neck Disability Index (NDI)[31] or the Bournemouth Questionnaire[32] to measure the functional limitations that are experienced by whiplashed patients. The neck BQ covers the salient dimensions of the biopsychosocial model of pain, is quick and easy to complete, and has been shown to be reliable, valid, and responsive to clinically significant change in patients with nonspecific neck pain.[33]

Examples:

1. Spinal manipulation of C2-3 and C5-6 was well received by the patient. She claimed the neck pain reduced from 7/10 to 3/10. Her cervical range of motion increased without cervical radicular pain down the right upper extremity.

2. Therapeutic massage of the posterior cervical and upper trapezius muscles was well tolerated with pain reduction and relaxation of the spastic muscles.

Treatment Plan

Evidence-based practice involves clinical expertise, patient needs and wants, and appreciation of the best available published evidence.[34] It is our opinion, based upon review of chiropractic websites and review of hundreds of chiropractic charts that many individual chiropractic physicians claim the number of treatments for an acute whiplash injury depends upon many factors. Unfortunately, others use a similar or exactly the same treatment plan for every whiplashed patient, which is not either evidence-based or patient-centered.

We offer four peer-reviewed articles that indicate fewer chiropractic interventions during the initial stage (acute and sub-acute) of a whiplash injury are beneficial and too many treatments are detrimental for the whiplashed patients.

Cote et al suggest that medical doctors and chiropractors may have the ability to reduce the burden of disability related to whiplash by avoiding overtreatment of patients soon after onset. The type and intensity of clinical care initiated within the first month after the injury is associated with the rate of recovery from whiplash injuries. Their study does not support the hypothesis that early aggressive care promotes faster recovery. This finding may have important implications for prevention because it identifies a narrow period for effective intervention.[35]

Cote et al also conclude that whiplashed patients that visited a general practitioner more than 2 times, visited a chiropractor more than 6 times, received combined care from general practitioners and chiropractors , and consulted general practitioners and specialists had a longer recovery than patients who visited general practitioners once or twice. The observation that intensive health care utilization early after a whiplash injury is associated with slower recovery was reproduced in an independent cohort of patients.

The results add to the body of evidence suggesting that early aggressive treatment of whiplash injuries does not promote faster recovery. In particular, the combination of chiropractic and general practitioner care significantly reduces the rate of recovery.[36]

Whalen et al suggest that treatment for acute neck pain should include an initial trial of care of 6 to 12 visits during the initial 12 weeks, to determine the success or failure of treatment and the possible need for additional diagnostic tests or referral, including multidisciplinary, multimodal care.

Chiropractic physicians should avoid the recommendation of treatment plans based on philosophy, habitual practice procedures, and/or financial considerations. The treatment plan should be based upon the severity of the neck pain, history of injury, subjective and objective findings. Passive treatments should be replaced with active care, such as exercise.[37]

Teasell et al state there is no indication that therapies effective during the acute (Initial 2 weeks) or chronic (greater than 12 weeks) stages of WAD will also be effective when delivered during the subacute phase (2-12 weeks), and vice-versa. As well, most treatment takes place in the subacute phase for whiplash patients. He also states that while a supervised exercise program may be more effective than an unsupervised program over the short term, and earlier therapy appears to be more effective than later therapy, the use of fitness and exercise programs during the subacute stage of WAD may actually be counterproductive. In particular, an aggressive work-hardening type of approach may be detrimental at this stage.[38]

Fiani et al claim that shockwave therapy is both safe and effective with the treatment of spinal pathologies and cervical spondylosis.[39] Chiropractors are using shockwave treatments for whiplashed patients with positive outcomes. It appears that this type of therapy provides a healing action for damaged soft tissues including muscles, tendons, ligaments, and joints. Yet there is the potential for overuse of the therapy, which may cause negative outcomes.

Simplicio et al claim that shockwaves may regenerate injured tissue.

> *Shockwaves can generate interstitial and extracellular responses, producing many beneficial effects such as: pain relief, vascularization, protein biosynthesis, cell proliferation, neuro and*

chondroprotection, and destruction of calcium deposits in musculoskeletal injuries. The combination of these effects can lead to tissue regeneration and significant alleviation of pain, improving functional outcomes in injured tissues. Considering these facts, ESWT shows great potential as a useful regenerative medicine technique for the treatment of numerous musculoskeletal injuries.[40]

The treatment works by delivering pulses of energy to damaged tissue, which helps increase blood flow in the affected area. This stimulates repair and healing and helps reduce pain. Depending on the type, location, and severity of the injury, multiple treatments may be required to achieve desired results. Often, 6 sessions are necessary for a total, with 2 sessions per week for 3 consecutive weeks.[41]

Shockwave therapy works best when sessions are done about 1 week apart, and most injuries require a minimum of 3 sessions, so the ideal is to plan to be available for 3 consecutive weeks without skipping treatment for the best results. It is important that patients do not take nonsteroidal anti-inflammatory drugs (NSAIDs) for 2 weeks before the first session and throughout the treatment, as this may interfere with the effectiveness of the treatment.[42]

CONCLUSION

Chiropractic physicians have a fundamental responsibility to approach the evaluation and management of whiplash patients with an evidence-based/influenced and patient-centered framework. The medical necessity for care is determined through validated assessment tools and thorough, accurate clinical documentation, demonstrating the clinical need and appropriateness of treatment. This process is critical for ensuring appropriate care and optimal outcomes, as well as for supporting insurance coverage and third-party review.

Patients presenting with grades 1, 2, and 3 WAD typically benefit from high-quality chiropractic interventions, provided that treatment plans are tailored to individual needs, regularly reassessed for effectiveness, and supported by clinical evidence of necessity. Over-treatment should be avoided, and care must be taken to adhere strictly to clinical guidelines to prevent unnecessary interventions and ensure that all treatments are medically necessary.

Chiropractic specialists possess advanced training in the diagnosis and management of WAD, positioning them as key providers for these cases. Their training enables them to discern the medical necessity of different therapeutic modalities, including manual therapies and adjunctive treatments.

In addition to standard manual therapies, Shock Wave therapy has shown promise in reducing chronic disability associated with ligamentous laxity and persistent myofascial pain syndromes; its use should be reserved for cases where medical necessity is clearly established by clinical findings. Incorporating this modality, when indicated, may enhance patient recovery and functional outcomes. Ultimately, the integration of current best evidence, clinical expertise, and patient values, alongside a clear demonstration of medical necessity, remains the cornerstone of effective chiropractic care for whiplash-related injuries.

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