

CHIROPRACTIC SERVICES IN THE DEPARTMENT OF VETERANS AFFAIRS

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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CHIROPRACTIC SERVICES IN THE DEPARTMENT OF VETERANS AFFAIRS

TUESDAY, OCTOBER 3, 2000

**U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
*Washington, DC.***

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stearns, Moran, Baker, Gutierrez, Peterson, Snyder, Rodriguez, and Shows.

Ex officio present: Representative Evans.

Also present: Representative Filner.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The House Subcommittee on Veterans' Affairs will come to order. I am pleased that we are able to hold this hearing today to consider the matter of chiropractic care in the veterans health care system.

I appreciate the attendance of all the witnesses who are here this morning to testify on a very important topic for the subcommittee, a type of care that is very popular today in this country. But for reasons about which we will learn today, chiropractic care does not seem to be totally available to veterans who choose it to meet their health care needs.

We have had an opportunity to review in more depth a proposal that is being advanced by a variety of chiropractic professional organizations. The proposal is modeled after legislative language that is under consideration in the House and Senate Armed Services conference.

One of the purposes of today's hearing is to learn whether this proposal is a good model for consideration in VA care. Chiropractic care has been in existence for over 100 years. Today, millions of Americans—including many thousands, if not millions, of veterans—rely on this care to meet at least some of their health care needs. Congress, as early as 1978, authorized VA to provide chiropractic services to eligible veterans. But over the period of its existence VA has never employed its first chiropractor as a VA staff practitioner in this professional field, has never developed, without some prodding from Congress, any meaningful policy on chiropractic care, and until this hearing has never had to defend its position to severely restrict, or limit, chiropractic care to veterans.

VA's May 5, 2000 Issue of Policy has been criticized as having had the effect of reducing, rather than increasing, the availability of chiropractic services, just the opposite of what we intended in mandating in Section 303 of Public Law 106-117, which was the Millennium Health Care Bill, that VA institute a formal policy.

So I think, my colleagues, it is reasonable to conclude that VA does not want to implement what we tried to suggest through the statutory process. They don't seem to want to expand chiropractic care for veterans and to make these services generally available to all of our American veterans.

If a health care service is licensed and fully legitimized in all 50 States and abroad, if millions of Americans are willingly paying for this service every day, if health insurers and even the federal Medicare program approve reimbursement for the service as a routine activity of doing business, and if health services research cannot establish that chiropractic care is flawed in a way that it presents dangers to the unsuspecting public, then VA needs to better articulate what their policy is for those veterans who are eligible. And in this chairman's opinion, we just haven't gotten that from the Department of Veterans Affairs, so that is why we are having the hearing.

With nearly 200,000 health care employees and staff, operating with an annual budget of more than \$20 billion, deployed in over 600 sites, surely somewhere in the VA there must have been a need for a VA chiropractor. Yet VA maintains it can get along using the occasional fee basis or contract chiropractor and that veterans are completely satisfied with this process and this response.

The subcommittee needs more information on VA's policy in order to make an informed judgment on how to proceed. So I hope that hearing today from our witnesses may help us better understand the difference of view on chiropractic services for veterans, and I appreciate my colleagues and the witnesses today.

I am pleased that the full committee member, Mr. Evans, is here and I would ask the indulgence of the subcommittee to allow him to go first. I understand that he has duties on the House floor momentarily, and so I want to welcome Mr. Evans and offer him an opportunity to have an opening statement.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I thank you for allowing me to participate on this abbreviated schedule that we have. Unfortunately, I am unable to stay, because our committee has two bills on the floor this morning coming right up at 10:00.

The history of chiropractic providers' attempts to gain entry into the health care system dates back longer than the 18 years I have been a member of this body. At this point, the VA is the only federal payer or provider that has effectively sealed the laws to routine chiropractic care.

My involvement with this issue of chiropractic care in the VA has been extensive. Most recently, I worked to ensure that the Veterans Millennium Health Care Act contained a provision that directed the VA to develop a policy to address access to chiropractic

care for lower back pain services. The result of this policy was the continuation of a longstanding non-policy that nudges VA providers towards the conclusion that chiropractic services are only negligibly efficient and no more so than care delivered by other providers for uncomplicated low back pain. Chiropractors actually view this new policy as more restrictive than the previously undefined policy.

Chiropractors, like other practitioners, wish to provide care with the full scope of practice licensed by the State. They want to resolve the issue of veterans' lack of routine access to their services. The VA is the last barrier in the federal sector.

I look forward to continue working with my friends to ensure that we improve veterans' access to effective chiropractic care.

Thank you, Mr. Chairman, for allowing me to participate in this hearing.

[The prepared statement of Congressman Evans appears on p. 82.]

Mr. STEARNS. Thank you, Mr. Evans. Dr. Filner, you are recognized for an opening statement.

OPENING STATEMENT OF HON. BOB FILNER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FILNER. Thank you, Mr. Chairman. You did not say how pleased you are to have me.

Mr. STEARNS. How pleased I am to see you, yes.

Mr. FILNER. Thank you. And I am very pleased to be here. And, Mr. Chairman, I thank you for your leadership on this issue, for holding this hearing, for working on this issue for a long period of time. And I was amazed at your restraint in your opening statement. Your words I think called out for a little bit more heat, although you are the chairman, so you want to be dignified, I know. But I don't have to be that way. What you said, Mr. Chairman, as I understood you, is that after the hard work of people like yourself and Mr. Evans, there was a provision in this important bill that we passed last year, the Veterans Millennium Health Care Benefits Act, which said that the VA ought to establish a policy and implement, I take it, the use of chiropractic treatment for the care of veterans. And as I understood what you said, this did not happen. And we are not the oversight committee of this subcommittee, of this full committee, but I think we should probe and find out why a legislative mandate by this Congress and signed into law by the President was not met by the VA administration.

I will tell you, Mr. Chairman, when we were having problems when the 120 days passed that they were supposed to have acted, I met in my office with the leaders of the various chiropractic organizations with the—what do we call it, the assistant administrator of health and other of his staff for the purpose of trying to get that policy back on track. I was very dismayed by that meeting. What I saw was basically what you described, in a very restrained manner—a bureaucracy unwilling to accept this legislative mandate, unwilling to change, lots of preconceptions and misconceptions, fear, it looked to me, of a loss of turf or whatever we may say. But a refusal to accept the fact that chiropractic care, as you stated very eloquently, is in common practice and is demanded by our veterans, not to say other people of our society.

I read through briefly the statement that Dr. Murphy will have for us this morning, and I couldn't find the explanation, aside from there are some policy differences on the way the chiropractic community might view their role in the VA. But it looks like they said, "Well, because the chiropractor organizations couldn't agree on a definition, that is why we didn't do anything." That is how I read their statement. And I find that at least disheartening, at most very condescending, and I think covers up really the major reasons for why the VA has not acted.

In any case, as Mr. Evans and the chairman have pointed out, this is a well-established approach to medicine. Roughly 27 million patients are under chiropractic care in this country, including this Member of Congress. And we have recognized as a Congress chiropractic care in areas such as Medicare, Medicaid, Federal Workers Compensation, and somehow VA does not want to move on this.

Chiropractic happens to be the fastest-growing, second largest primary health care profession. They are highly trained and licensed. And I think it is time to put VA health care on a par with other government health care programs and to recognize chiropractic as a vital component of the VA health care system.

So we will look forward to the testimony, Mr. Chairman. You have acted very quickly. You have acted very responsibly. And I think we have to insist on the legislative mandate here. And if the VA health division is not willing to accept that mandate, we will either have to take actions with regard to that personnel or change the structure or whatever we can do, but we are going to insist that our veterans have the best care available to them, and this is just one part of that.

And I thank you again for your leadership.

Mr. STEARNS. I thank Dr. Filner. Dr. Filner is not a member of the subcommittee. He had asked that he could come and have an opening statement. I am very pleased that he did take the time. He has been one of the individuals instrumental in pushing this along, so I appreciate his comments.

Mr. Rodriguez from Texas, you are recognized for an opening statement.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. Let me first of all thank you also for allowing us to have this opportunity. And it is unfortunate that we even have to have this hearing. But I think, at least I recognize the value of the work that they provide, and I think it is just something that we need to move on as quickly as possible.

I have always been frustrated with the bureaucratic system in terms of not only the VA but throughout, and somehow we need to make it more flexible and allow it to become more responsive in terms of the veterans that are out there, and I would hope that we can move on this as quickly as possible.

Mr. STEARNS. I thank my colleague; and then we are pleased to have as a member of the subcommittee, Dr. Snyder, who is an M.D., so we appreciate his comments, too.

Dr. SNYDER. I don't have an opening statement.

Mr. STEARNS. All right, with that, we will have the first panel, if they would come forward and take their seats. Our first panel consists of a VA witness in response to my invitation, Dr. Frances Murphy, the VA's acting deputy under secretary for health. Dr. Murphy is accompanied by Dr. Thomas Holohan, the chief consultant of VA Patient Care Services. I understand that Dr. Holohan's office is the source of what we now know as VA's current VA policy on chiropractic services.

My colleagues, without objection, I want to enter into the record of today's hearing VA's internal policy memo dated May 5, 2000 entitled, "Chiropractic Care and Services," VA Directive 2000-014. By unanimous consent, so ordered.

(See p. 57.)

Mr. STEARNS. Our second panel represents a number of views from chiropractic professional organizations. Present today are Dr. Rick McMichael of the American Chiropractic Association, Dr. Michael McLean of the International Chiropractic Association, and Dr. George Goodman of the Association of Chiropractic Colleges, accompanied by Dr. Reed Phillips.

So let us start with our first panel and let me thank you so much for you folks coming, and we appreciate your attendance. And, Dr. Murphy, would you like to start? You are recognized for 5 minutes.

STATEMENT OF FRANCES M. MURPHY, ACTING DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY THOMAS V. HOLOHAN, CHIEF PATIENT CARE SERVICES OFFICER, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Dr. MURPHY. I would like to enter the full text of my statement into the record; I will give a briefer statement this morning.

Mr. STEARNS. By unanimous consent, so ordered.

Dr. MURPHY. Mr. Chairman and members of the subcommittee, I am here today to discuss the VHA policy on provision of chiropractic services for veterans. As you mentioned, Dr. Holohan is here accompanying me this morning.

As you know, the Millennium Health Care Act required the Under Secretary for Health to consult with chiropractors and to establish a VA-wide policy regarding the use of chiropractic treatments in the care of veterans. This Act limited chiropractic treatment to manual manipulation of the spine for treatment of such musculoskeletal conditions as the Secretary considers appropriate.

VHA met with representatives of eight chiropractic organizations in February of 2000. The organizations submitted written positions and recommendations for VA review.

In sum, the general common elements of the various chiropractic organization recommendations were for; first, full-time or contract employment of chiropractors in VA medical centers and satellite clinics; second, direct access of patients to chiropractors without referral requirements; third, a very broad scope of practice; and fourth, clinical privileges, including primary evaluations which include history and physical examinations, ordering and interpreting the wide variety of diagnostic tests and routine check-ups and functioning as "primary care providers."

However, there were differing opinions among these organizations concerning both direct access to care, and the definition of primary care. The general use of the term 'primary care', did not seem to be consistent with the definition provided by the Institute of Medicine for primary care in the general health community.

VHA policy, however, allows medical centers and clinics to utilize chiropractic spinal manipulation therapy for musculoskeletal problems of the spine following a referral from a VA clinician. This policy was adopted following prolonged and detailed discussions, which thoroughly considered a wide number of factors, including requests and submitted materials of the chiropractic organizations and review of the available scientific evidence for use of chiropractic therapy.

In summary, there was insufficient data to conclude that spinal manipulation or chiropractic care is efficacious for non-musculoskeletal conditions. There was limited data to support the efficacy of spinal manipulation as therapy for patients with neck pain. But there was sufficient evidence in the form of randomized clinical trials to conclude that spinal manipulation is efficacious for therapy of patients with uncomplicated low back pain.

These data include clinical trials where manipulation was provided by both physical therapists, osteopaths, and chiropractors and were not limited to chiropractic care. However, there were no clinical trial data to support the position that spinal manipulation delivered by chiropractors is more effective or less risky than spinal manipulation delivered by any other type of practitioner.

The VA remains opposed to allowing chiropractors to act as referring primary care physicians. Available evidence in conjunction with commentary and written materials provided by chiropractors at the joint meeting did not afford confidence that chiropractors have demonstrated that they function as primary providers in the sense of the term that is used in the general health care community. Primary care providers in the VA typically treat patients with hypertension, heart disease, diabetes, pulmonary disease, depression, and a whole host of other complicated medical conditions. They are expected to diagnose and to treat conditions from upper respiratory infections to myocardial infarctions. The diagnosis, treatment, and ongoing management of these problems are not a part of chiropractic training and practice.

The policy requirement for referral to chiropractic care was adopted because virtually all non-primary care provided in VA is accomplished through referrals. This is not unique to chiropractic care. VA does not typically provide for direct access to other types of consultants or contract providers. That is an important point. This is consistent with our overall policy of non-primary care.

Our national policy on chiropractic care was published in May of 2000 and local plans are now being put in place. We are collecting those plans and will review them to ensure consistency with national policy.

The policy establishes a mechanism to monitor cost, quality, and utilization rates of chiropractic care. We will identify and collect data related to the provision of chiropractic services. And we believe that VA has taken a responsible and reasonable approach to the introduction of chiropractic care. Our policy was based on con-

sideration of the views of various chiropractic organizations. And a careful review of the highest quality available published evidence.

VA does not currently have data that allow us to address the magnitude or geographical distribution of appropriate chiropractic care within our system and our current policy will collect that information.

The VISNs are beginning to implement the national chiropractic policy and we believe that this will allow us over the next year to learn more about the use of chiropractic services within VHA and to make assessments about our policy and the level of chiropractic services that veterans need and deserve.

This concludes my statement, and I am glad to respond to any questions.

[The prepared statement of Dr. Murphy appears on p. 84.]

Mr. STEARNS. Thank you. Dr. Holohan, do you have an opening statement?

Dr. HOLOHAN. No, sir.

Mr. STEARNS. Okay, let me start, Dr. Murphy. I think we understood that what you are saying is you don't feel at the moment that you want to implement what has been statutorily outlined in the Millennium Health Care bill and that you want to consider—to study it. Would that be a good characterization of what your position is?

Dr. MURPHY. Actually, we had interpreted——

Mr. STEARNS. Your interpretation, okay.

Dr. MURPHY. We had interpreted that we had implemented the legislation, which requires us to consult with chiropractors and establish a policy. And after having collected the information from the chiropractic associations and reviewing the scientific literature, we feel that the current policy will allow referrals for chiropractic services.

Mr. STEARNS. Okay.

Dr. MURPHY. And allow us to address veterans' health care needs.

Mr. STEARNS. Have you or Dr. Garthwaite met personally with the chiropractors to discuss what your program is and your interpretation? And after meeting with them, did you make changes to your policy statement as a result of these meetings? What changes were they? If not, why not?

Do you mind just pulling the microphone just a little closer, if you don't mind?

Dr. MURPHY. Yes.

Mr. STEARNS. Yes.

Dr. MURPHY. The Under Secretary for Health did meet with the chiropractic organizations, and maybe I can ask Dr. Holohan, who was present today, to address that question.

Mr. STEARNS. Okay, certainly, go ahead.

Dr. HOLOHAN. I was with Dr. Garthwaite. We met with representatives of I think four or five chiropractic organizations in Congressman Filner's office.

Mr. STEARNS. The question wasn't whether you met with a Member of Congress but whether you initiated, from the VA office, reached out to the chiropractors, talked to them as the VA, separate from the prodding by Members of Congress. Just yes or no.

Dr. HOLOHAN. Yes.

Mr. STEARNS. You did?

Dr. HOLOHAN. Yes, sir.

Mr. STEARNS. And did you have meetings with them—

Dr. HOLOHAN. We had a meeting with them—

Mr. STEARNS (continuing). In the VA, where did you have the meetings?

Dr. HOLOHAN. VA headquarters.

Mr. STEARNS. VA headquarters, okay. And as a result of those meetings, what did that tell you?

Dr. HOLOHAN. I am not sure how to answer the question.

Mr. STEARNS. Did you make any policy changes?

Dr. HOLOHAN. That was before the policy was written.

Mr. STEARNS. Oh, I see. So after the legislation passed, you have had no meetings with the chiropractors?

Dr. HOLOHAN. No, that is incorrect, sir.

Mr. STEARNS. Okay.

Dr. HOLOHAN. The legislation required us to develop a policy for chiropractic following consultation with chiropractic organizations. We met with the chiropractic organizations for about 3½ hours.

Mr. STEARNS. At the Veterans' Administration, here in Washington?

Dr. HOLOHAN. Yes, sir.

Mr. STEARNS. Okay.

Dr. HOLOHAN. And following that, we reviewed the available literature, re-reviewed the written material and the oral testimony of the chiropractic organizations that were present, and then developed the policy.

Mr. STEARNS. Okay, so you met with them just once, would that be fair to say?

Dr. HOLOHAN. That is correct.

Mr. STEARNS. Okay. Dr. Murphy, you mentioned osteopathic physicians. Do they have full parity in the VA? In other words, are they in the hospitals today?

Dr. MURPHY. We do have doctors of osteopathy who are VA employees.

Mr. STEARNS. Okay, so osteopathic physicians are given full employment and access by veterans in our veterans' hospitals today?

Dr. MURPHY. Yes, they are.

Mr. STEARNS. Okay.

Dr. MURPHY. And the reason is that their training, the medical education and their postgraduate training, is comparable to that of an M.D.

Mr. STEARNS. Okay, take me—in your estimation, maybe this is what I am not clear on—in your estimation, what is the difference between an M.D., like Dr. Snyder, and a chiropractic physician in terms of education, college, postgraduate work and in terms of their internship, in your estimation? We will certainly get it from the chiropractors, too. But what I see, it appears to me is that you have given osteopathic physicians full privileges and yet you have not given them to chiropractors and you sort of indicate that they haven't demonstrated the right to have primary provider status because you say it is not efficacious, what they are doing, except for spinal manipulation. So you have categorized into one thing.

So I have got two sort of broad questions. One, give me educationalwise what you are talking about and then give me therapeuticwise, because they say they can do a lot more than just what you are indicating, and how you came to that conclusion? Does that make sense? Okay.

Dr. MURPHY. Without going into great detail, M.D.s go through a 4-year medical school training program to obtain their Doctor of Medicine degree. That curriculum covers a wide range of anatomy, physiology, pharmacology for every organ system in the body. And during the last 2 years of training, they rotate through all of the sub-specialty and specialty areas within medicine. So their undergraduate training covers the broad scope of human disease and medical conditions.

Then, in addition to that, every physician must undergo an internship for a year after medical school before they would be licensed to practice clinical medicine. Many physicians then go on and do subspecialty training or advanced training in general medicine.

Osteopaths have a similar background for their medical education, but in addition are taught spinal manipulation techniques. So they have that added qualification that M.D.s don't get during their routine training. They then can apply not only to the D.O. graduate—they can apply both to the Doctor of Osteopathy graduate medical education programs and often are accepted into the routine graduate medical education programs. And they are licensed within every State to provide a broad range of medical care.

Mr. STEARNS. You have given us a physician and you have given us the osteopathic physician; are you giving us the chiropractic, was that included in there, what you just talked about?

Dr. MURPHY. The chiropractors don't have that full range of training that we are talking about.

Mr. STEARNS. Do you know what they have? In other words, are you familiar with what they have?

Dr. MURPHY. To a limited degree, yes.

Mr. STEARNS. Okay, you seem to understand the physician and the osteopathic physician, but you don't understand what training the chiropractic physician has. Am I correct in saying you don't understand their full training?

Dr. MURPHY. I have not experienced the chiropractic training the way I have personally experienced the M.D. training, but I do understand that they do not have training that allows them to address the full range of medical conditions, provide diagnosis and medical treatment for that broad range of illnesses and medical conditions.

Mr. STEARNS. My time has expired, but, Dr. Murphy, I would just say in all deference to you, if you are coming up here to make your case, you certainly should know what the other side's capability is. I think it would behoove you to fully understand it and make the comparison.

Dr. MURPHY. And I believe I have done that for you this morning.

Mr. STEARNS. If you are establishing policy and you don't know what their education and their backgrounds are, I am not sure that you could establish policy. That is just my observation.

Okay, let's see, the ranking member is here. Mr. Gutierrez is recognized for questions for 5 minutes.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman. I would ask that my opening statement—unanimous consent that it be introduced into the record.

Mr. STEARNS. By unanimous consent, so ordered.

[The prepared statement of Congressman Gutierrez follows:]

PREPARED STATEMENT OF CONGRESSMAN GUTIERREZ

Thank you Mr. Chairman. I want to thank you for holding this timely and important hearing. I also want to thank my good friend from Illinois, the ranking member of the Full Committee, Congressman Lane Evans, for taking the time from what will certainly be a busy floor day for him to share his legislative experience and vast knowledge regarding the chiropractic care providers and the many attempts that they have made to ensure entry into the VA health care system. In fact, this issue dates back decades its solution is certainly long overdue.

I had hoped that with the passage of the Veterans Millennium Health Care Act and its requirement that the VA develop a policy with regard to chiropractic care in the VA health care system, a new AND effective VHA policy would have been established regarding the role of chiropractic care for veterans. Unfortunately, this has not been the case and I do not believe that many are pleased with the outcome and with the DVA chiropractic policy that was issued in May, 2000. In fact, there are serious questions as to whether or not the policy is the most appropriate or adequately ensures access to chiropractic care.

On the other hand, a successful pilot program within the Department of Defense has helped in clarifying DOD's relationship with chiropractors. The results of this program seem very encouraging.

I believe that there is a very common understanding of a very basic premise: chiropractors continue to fight for the ability to provide their services to veterans in this country.

I am pleased that our our invited guests will be able to address the current situation and make specific recommendations regarding the best way to reach of solution to this long standing and unresolved situation.

Mr. Chairman, again thank you for holding this hearing today.

Mr. GUTIERREZ. Thank you. I had hoped that with the passage of the Veterans Millennium Health Care Act and its requirement that the VA develop a policy with regard to chiropractic care in the VA health care system, a new and effective VHA policy would have been established regarding the role of chiropractic care for veterans. Unfortunately, this has not been the case, and I do not believe that many are pleased with the outcome and with the DVA policy that was issued in May of 2000. In fact, there are serious questions as to whether or not the policy is most appropriate or adequately ensures access to chiropractic care.

Dr. Murphy, I am discouraged with your statement, and it seems to leave the VA in the same place in terms of chiropractic care as it has been all along, that is, that it will be an extremely limited service, made available to perhaps a few local veterans or vocal veterans. Explain why we should have any expectation that this policy will yield different results than those we had before the Millennium Act was passed?

Dr. Murphy?

Dr. MURPHY. The policy allows for referral to chiropractic care, either on a contract basis, which is appropriate at this time, or use of a purchase order. At present, since we do not know what the utilization will be within the veterans community for chiropractic

services, we did not feel that it was appropriate at this time to hire chiropractors as VA employees.

Mr. GUTIERREZ. Well, how are chiropractic services going to be enhanced?

Dr. MURPHY. The policy lays out the procedure by which referrals can be made to chiropractors and gives a mandate to the local facilities to make information available to their clinicians on the appropriate use of referrals to chiropractors and provides for educational efforts as necessary.

Mr. GUTIERREZ. For some time, Dr. Murphy, the VA has used State licenses to define scope of practice. This has recently been a matter of some debate, particularly in regards to which VA mid-level practitioners, such as physician assistants, nurse practitioners, and optometrists have authority to prescribe medications. Some VA officials have argued that VA does not need to get into the licensing business and VA ought to conform to the licenses for professions in the States in which its facilities are located. Why would you create a different kind of policy guidance for VA use of chiropractors?

Dr. MURPHY. We are not. We are simply complying with the law that was passed, which says that the Secretary should set up a VA-wide policy for chiropractic treatments, to include manual manipulation of the spine for such medical conditions as the Secretary considers appropriate.

Mr. GUTIERREZ. And that is it? That is the only reason anybody would ever visit a chiropractor? Is it?

Dr. MURPHY. We established the policy that the law described.

Mr. GUTIERREZ. You established a policy. So you did limit—you don't limit your doctors, do you? You don't say a physician, an M.D. can only do "X?" You don't say an optometrist can only do "X?" A nurse practitioner can only do "X?" But when it comes to chiropractors, you do limit the scope of their activity, don't you?

Dr. MURPHY. State license defines the scope of practice.

Mr. GUTIERREZ. State license allows chiropractors to do a lot more than spinal manipulation.

Dr. MURPHY. Well, but every practitioner within the VA has their credentials checked and their privileges granted.

Mr. GUTIERREZ. That goes back to my question then, Dr. Murphy; if there is a State license and they are licensing them for what they can do within a State, is that what the State says they can do and only that? You just said that you didn't have a different policy for chiropractors but then you quickly added—and I have heard you repeat it on several occasions here this morning—that the only thing that the policy establishes in the VA—and correct me if I am wrong—is to allow them for spinal manipulation.

Dr. MURPHY. Which is actually what the law said and what the scientific literature can support as their scope of practice.

Mr. GUTIERREZ. Again, so you are defining differently chiropractors from other licensed medical technicians and medical personnel in general? You don't limit other people, do you?

Dr. HOLOHAN. Yes, sir, we do.

Mr. GUTIERREZ. Tell me about it?

Dr. HOLOHAN. We do not permit optometrists to do laser surgery on the eyeball in the VA, despite the fact that the State of Oklahoma license permits optometrists to do that.

Mr. GUTIERREZ. That is a pretty smart policy, isn't it?

Dr. HOLOHAN. We think it is reasonable and based on the evidence.

Mr. GUTIERREZ. I agree with you.

Dr. HOLOHAN. We do not—

Mr. GUTIERREZ. Now, that is one procedure that you don't allow optometrists to perform because ophthalmologists should perform that, and then agree with you, at least that is the reason you are saying that. But to go from there to say that chiropractors, one thing, spinal manipulation, and that is it, I think there is a huge difference between one and the other and how it is you use licensing of State requirements.

Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague. We are going to go first to the members of the subcommittee in order of their attendance and then, Dr. Filner, we will get to you, and then I think Dr. Snyder—Mr. Rodriguez was next. You are recognized.

Mr. RODRIGUEZ. What I gather is that you took it very—you were just instructed to establish a policy and that is all you have. You are not providing any service in that area, is that correct?

Dr. MURPHY. No, sir, that is not true. The policy provides guidance for how the chiropractic services are to be provided.

Mr. RODRIGUEZ. Okay, let me go beyond the policy. Have you done any service?

Dr. MURPHY. Yes, sir, we have.

Mr. RODRIGUEZ. You have. Is this wide throughout the system?

Dr. MURPHY. In fiscal year 2000 we provided a total of over 9,500 visits to chiropractors, totaling \$300,000.

Mr. RODRIGUEZ. I also sense that an ingrained bias that exists, that you might have in terms of the chiropractors. It seems like you have a very limited view in terms of what you see their role is, and I want to ask you specifically why did you decide not to hire them in the hospitals, for example?

Dr. MURPHY. I take exception to your statement that we are biased.

Mr. RODRIGUEZ. Okay, but I take exception to the fact that you haven't been responsive, either. But go ahead.

Dr. MURPHY. We, in fact, have established a policy and have provided a mechanism for providing chiropractic services to veterans through contract or purchase order.

Mr. RODRIGUEZ. But you also said that you had not hired—the decision for not hiring, what was that based on?

Dr. MURPHY. It was based on the fact that there isn't information available at this point that would suggest there is a need for the kind of volume to hire a chiropractor in the medical centers.

Mr. RODRIGUEZ. So you decided not—and I gather that you just looked at the legislation and you keep indicating we were instructed to establish a policy, so I gather we have to put some additional language that you also have to implement that policy to a greater extent and we have to add additional language?

Dr. MURPHY. No, sir, the policy has been implemented. The plans are in place. And I have just reported to you that care is being delivered.

Mr. RODRIGUEZ. So that from your perspective there is no problem then? Do you have any idea as to why we are having this hearing?

Dr. MURPHY. I assume that you wanted an update on the progress that VHA has made in providing chiropractic services.

Mr. FILNER. Would you yield to me for a moment?

Mr. RODRIGUEZ. Yes, I yield.

Mr. FILNER. This is a conversation and a dialogue and a hearing which we would like to understand, and it doesn't seem like you are going to provide questions—or answers, so we are going to have to make our own statements. But Mr. Rodriguez asked you do you have any idea why this hearing was held. And you got a sense from opening statements and what we have said already that we are very unhappy with the way you have supposedly implemented this policy. Has that gotten through to you? But you are still unclear why this hearing was held?

Dr. MURPHY. I didn't say I was unclear, I said that I thought you wanted to review our progress.

Mr. FILNER. You said we wanted an update. We don't want an update. We want to know what you are going to do to make sure that chiropractic services are available to our veterans.

Dr. MURPHY. And they are.

Mr. FILNER. That is what I want to know, and we haven't had any of that. I will read your statement to you. You say, "We don't have any knowledge yet. We see disagreement amongst the professionals. We have asked the VISNs for their opinions." I get here that you don't have a policy, by the way, because you said you have asked your regional networks to provide their local plans within 120 days. They just have come back to you, this is a year after the bill. So from the way I read this statement, there is no policy in place. Is that untrue or is it true?

Dr. MURPHY. There is a national policy in place and there are local policies that are either in draft or have been developed and implemented.

Mr. FILNER. And these 9,500 referrals are a result of this policy?

Dr. MURPHY. I can only tell you that those were the number of referrals that have been completed this year.

Mr. FILNER. In this year?

Dr. MURPHY. This past fiscal year.

Mr. FILNER. And you paid \$300,000 for that? That is \$30 a visit, is that—where does that money go, to the chiropractor?

Dr. MURPHY. Yes, sir.

Mr. FILNER. And you are paying them all of \$30 a visit, is that what I read? Am I right or wrong? I just divided the 9,500 into \$300,000, is that wrong?

Dr. MURPHY. Those are the figures that I have.

Mr. FILNER. So am I wrong in what you have paid any individual chiropractor?

Dr. MURPHY. We paid the bills for the services that were delivered.

Mr. FILNER. There is no limit—you pay whatever they bill?

Dr. MURPHY. Well, we pay reasonable charges, which is what our policy is for payment for purchase orders or contract care.

Mr. FILNER. I will have my turn again. I am sorry, Mr. Rodriguez. I appreciate the yielding. I don't see a policy. I don't see any aggressiveness in implementing it. I don't see any understanding of it. I don't see any proactive stance by the administration. I'm sorry, I yield back.

Mr. RODRIGUEZ. I reclaim my time, and I don't have any time, and I will close. We didn't ask for a pilot program. We didn't ask for your opinions. We asked for you to establish a specific policy and implement the program.

Mr. STEARNS. The gentleman's time has expired. Dr. Snyder is recognized for 5 minutes.

Dr. SNYDER. Thank you, Mr. Chairman. I wanted to, being part of the profession, I always get apprehensive when we have these divisions between different groups of providers or seeing any conflicts, because ultimately I think who wins is insurance companies and not providers or patients. But we have dealt with these things before at the state level, so we will have to deal with them.

I think we have a difference of opinion here. Mr. Chairman, I will be frank, I don't think this is as great as maybe it seems. I want to be sure—the ranking member left, but when we start talking about the scope of chiropractic care that we expect the VA to establish a policy on, the statutory language put great restrictions on what they can do. As I read the statute, it would be illegal for Dr. Holohan and Dr. Murphy to establish a policy to let chiropractors do anything more than spinal manipulation. The language of the statute, this is from—I assume the staff gave me the correct version, this is from the Public Act 106–117, and the language, it is very short, it says, “Not later than 120 days shall establish a policy for the Veterans Health Care Administration regarding the role of chiropractic treatment in the care of veterans.” And then it defines, “For purposes of this section the term 'chiropractic treatment' means the manual manipulation of the spine performed by a chiropractor for the treatment of such musculoskeletal conditions as the Secretary considers appropriate.”

Now, that is what you were trying to respond to Mr. Gutierrez. When you talk about it in the law, and he was saying you had limited it to only what the statute did. So, if I understand your perspective, you were not authorized to—or maybe this is an overstatement, if a person saw a chiropractor for anything other than spinal manipulation, that was not to be part of this policy, is that correct?

Dr. MURPHY. We interpreted the language as being specific, because that was Congress' intent. We limited the policy to that because of the way the law was written.

Dr. SNYDER. Right.

Dr. MURPHY. VA in good faith implemented the legislation that we were given.

Dr. SNYDER. We may bear some of the—this may not have done as much as our friend in the chiropractic community wanted to do but it may not be your problem, it may be our problem, the way this was drafted. And maybe this isn't the correct drafting.

The issue of primary care, and I don't have a feel, I think primary—when people say primary care physician, I think that can mean a variety of different things, but by the statutory language here, there is no way a chiropractic physician could function as “a primary care physician” with any meaning of the word that people have, because they can only deal with, according to this, musculoskeletal conditions, and the only treatment that they can provide is spinal manipulation. It seems like a much more limited role, more in line with a physical therapist than a primary care physician. Is that a fair statement?

Dr. MURPHY. That is a fair statement. And, in addition, before treatment is indicated, there would be a full diagnostic work-up, taking into account the entire patient history and a physical examination. And at that point, a treatment physician gets noted after the diagnostic work-up.

Dr. SNYDER. You mean after the diagnostic work-up and it is concluded that the patient has a musculoskeletal condition, chiropractic care can be appropriated for then.

I am running out of time. Assuming we get passed this business about who limited what chiropractic treatment means, my experience as a family practitioner was that there are clearly patients who prefer, that like to have chiropractic treatment, and that there are insurance plans that cover chiropractic treatment, but they sometimes—often—will require a referral. They don't always do, but they sometimes did. I don't know what the situation is now because I am a bit removed from it. But I always thought I had a good relationship, if a patient came in and said, “I am having this problem, I would like a referral to my chiropractic physician,” that I didn't have any problem, we would refer them and they would sometimes share their x rays with me, that kind of relationship.

It seems that one of the problems that we have here is if you have like 9,000 visits or something, that that patient choice option isn't coming out very well under the policy as adopted. What do you foresee happening over the next year or two? Do you see foresee that throughout the United States that we will come up with policies where if a patient goes in, has a back problem or a neck problem, perhaps a chronic thing that they have on the outside world paid for chiropractic services, that they would be able to say to their VA primary care doctor, “This thing has flared up again,” or call up, “This thing has flared up again, could I get a referral to the chiropractor that you all contract with,” do you foresee that that is the kind of thing that will occur? Or is it going to be so restricted and so limited as not at all to get close to what the advocates on this committee and in the chiropractic community, more importantly veterans who prefer chiropractic care, would like to have? What do you see coming down the line?

Dr. MURPHY. We have opened the option for any physician within the VA to refer to a chiropractor for spinal manipulation for musculoskeletal conditions. And that would be based on a frank discussion about the patient's preferences and the need, based on the individual veteran's diagnosis. This is not a restrictive policy. In fact, it is a very open policy that allows referral to a chiropractor for appropriate care.

The other thing that will occur over the next year that will increase the number of referrals to chiropractors is VHA's mandate that information and education be provided to our health care providers that will allow them to understand when a chiropractic referral might be appropriate and to facilitate inclusion of chiropractic into their treatment regimens.

Dr. SNYDER. Okay. Thank you, Mr. Chairman.

Dr. HOLOHAN. Mr. Chairman, can I add something to the response?

Mr. STEARNS. Sure. Sure, go ahead.

Dr. HOLOHAN. I think if you carefully read the background statement that went with this policy, you will see that the VA panel that reviewed all this believed that there is good quality, objective evidence that manipulation is a useful technique in some cases of spine—certainly, low back, possibly neck—musculoskeletal conditions. I can make this available, if you wish. The International Journal of Technology Assessment just published a 4-year study by the Swedish Institute for Technology Assessment, done in conjunction with the Karolinska Institute, where they reviewed 25,000 published papers on the treatment of back pain and concluded that for chronic back pain, certainly spinal manipulation, although not specifically chiropractic, spinal manipulation as a general term is a useful technique and is supported by the evidence.

(A summary of the International Journal report follows:)

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of most importance to the health service. A list of the entire series to date, together with the full text and full executive summaries, is available on the Internet at <http://www.ncchta.org>.

REPORTS FROM THE SWEDISH COUNCIL ON TECHNOLOGY ASSESSMENT IN HEALTH CARE

Back Pain

Pain is a signal that something is wrong. Regardless of its location, pain should be investigated to confirm or eliminate its association with a specific cause or serious disorder.

Although pain in the low back or neck affects most people at some time during their lives, it is seldom a sign of serious illness. In some people, the effects are more severe and more frequent, but most experience mild effects and only occasionally. Few experience constant, persistent pain.

Research seldom explains why or how pain in the low back or neck originates, or how long it will last, i.e., whether it is acute and temporary or will remain a chronic problem. It can result from different, but perhaps associated, factors. The relationship of these factors often remains unknown. Although it is not always possible to cure back pain, treatment methods are available that can effectively relieve pain in most people.

Numerous studies have analyzed whether factors related to the individual, e.g., gender, age, body length, weight, anatomic changes in the spine, and smoking, correlate in any way with back pain. The data currently available do not reveal any specific individual risk factors for back pain. Most studies find no differences in the risk for back pain, neither between men and women nor among individuals of different height, weight, etc. The only exception would be sciatica resulting from herniated discs, a disorder that appears more frequently in people aged 40 to 45 years.

Heavy physical labor and poor working environments are often cited as reasons for back pain. Many studies also report a clear correlation between reported low back problems and heavy lifting or working positions in which the back is bent or twisted repeatedly and over a longer period of time. This also includes "shaky" vehicles such as forklifts, trucks, and tractors. As regards neck problems, studies have found a clear association between repetitive, monotonous work and fixed working positions. Neck and low back problems are also associated with poor psychosocial conditions in private life and the workplace, including poor work satisfaction.

Pain in the neck or low back can influence functional capacity and cause worry, anxiety, and depression. It has been known for some time that this, in turn, can amplify the perception of pain, but only recently have psychological factors been viewed as a link in the causal chain underlying the occurrence and persistence of neck and low back problems. There is well-documented scientific evidence that numerous psychological factors can influence the development and persistence of acute and chronic pain in the neck and low back. These problems occur because mental state, feelings, and behavior are partly dependent on factors such as work demands, time pressure, monotonous work, a low level of influence over the situation, poor social support, experienced pain, stress, worry, and anxiety.

Despite the insight on the important roles of these factors, research has contributed little by way of studies to assess preventive interventions against back pain. The studies that have been conducted in the field have focused primarily on rather narrowly defined preventive

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measures such as ergonomic methods, physical exercise, education on back anatomy, various supportive devices for the lumbar spine, and interventions to influence smoking, obesity, and certain psychosocial factors. The results of these studies are discouraging in the sense that most of the preventive measures studied are shown to be ineffective. The only exception is moderate but regular physical training or exercise, where the results of several studies show good effects.

There are many different methods to treat back and neck pain. Naturally, for both the caregiver and the person with pain, it is important to know which methods can help and which methods have been shown by scientific studies to have no effect. Far from all methods have been studied scientifically in terms of patient outcomes. This review presents what we know and what we do not know about the effects of different treatment methods, based on comparative studies found in the international scientific literature.

PROJECT

During the late 1980s, the Swedish Council on Technology Assessment in Health Care (SBU) initiated a project on the diagnosis and treatment of back pain. The project report, published in 1991, was well received.

Since then, the body of scientific literature on back pain has expanded greatly. For example, when the previous report was published, the project group had identified around 6,000 studies, whereof approximately 100 were randomized controlled studies. Today, approximately 25,000 studies on back and neck pain have been identified, whereof approximately 1,000 are randomized and/or controlled studies. Methods for searching and classifying scientific literature and methods for assessing the weight of the evidence presented have also advanced and have improved substantially during the past decade.

Approximately 4 years ago, SBU appointed an international project group of 13 people who were charged with complementing the previous report with results from scientific studies published during the 1990s. Approximately 80% of the studies referenced in this report have been published since the previous report was completed. The current SBU report consists of two volumes.

The first volume addresses how the work situation and social, psychological, and individual factors can influence back pain. It also discusses what is known about the origins of pain, the potential for preventing back pain, and how often it appears in different populations and age groups.

The second volume presents scientific facts on the results of conservative, surgical, and psychological treatment methods and the cost-effectiveness of various treatment methods. Volume 2 also presents an estimate of the total socioeconomic costs for neck and low back pain and a comparison of different social insurance systems.

THE SCIENTIFIC LITERATURE

Many of the studies available present only descriptions, perspectives, and opinions about the causes of the problem and discuss what can be done by way of cure, relief, and rehabilitation. Others present data from comparative studies on the outcomes of different treatment methods.

The group working with this review selected around 2,000 studies that they found to present relatively strong scientific evidence on different issues concerning back pain. Each chapter of the report describes how the literature was selected for that chapter.

In most chapters on treatment methods, the studies selected were limited to randomized controlled studies, i.e., studies where patients were randomly allocated to different types of treatment to analyze whether the treatment had effects, and if so, which treatment yielded the

best results. This methodology is the most reliable for assessing the outcome of treatment, even if it is not completely objective and may somewhat limit the conclusions.

All studies that use this methodology are, however, not equally strong scientifically. Therefore, each study was graded according to the strength of the scientific evidence. This was done as objectively as possible with the help of different protocols for grading the quality of the scientific assessments. However, in all chapters it was not possible to follow exactly the same procedure to grade the evidence of studies. As a rule, however, the studies were classified into groups that reflect: a) strong scientific evidence; b) moderate evidence; c) limited evidence; and d) no scientific evidence.

Studies classified into group A offer strong scientific evidence that a particular treatment has good effects or strong scientific evidence that a particular treatment in randomized controlled studies is shown to be ineffective and has no positive effects on a patient's back problems. The same applies to studies in groups B and C, i.e., that moderate or limited evidence is available to show the effectiveness or ineffectiveness of a particular treatment. Finally, placement in group D means that no studies are available that meet the standards for good scientific quality.

A summary of the results from the literature search is presented below.

DIAGNOSING PAIN IN THE NECK AND LOW BACK

Thorough, systematic anamnesis and physical examination are a good foundation for diagnosing back pain, according to many studies reflecting moderate evidence (B). Furthermore, many studies show that the caregiver's involvement and ability to listen to the patient's concerns—not only about pain and its localization but also about the consequences of pain and how it is dealt with—are essential to good diagnosis. Along with the anamnesis and physical examination, listening and talking allow the patient and caregiver to reach agreement on the best treatment. In most cases, this is a sufficient basis for developing a treatment strategy. It is also sufficient for identifying the few cases that must be referred for further investigation when a specific cause or serious disease may be responsible for the pain.

If pain persists for 3 to 4 weeks, further investigation should be carried out using one of the validated questionnaires that are available, which can identify other relevant problems, e.g., in the work environment or the psychosocial situation in general (B).

Basic x-ray examination seldom provides guidance in diagnoses, except in cases where specific trauma or serious disease is suspected. As a rule, computed tomography (CT) and magnetic resonance imaging (MRI) studies do not identify where pain is located, except in patients where specific disease is suspected. A herniated disk pressing on a nerve root can cause severe sciatica. This condition can be visualized and confirmed by CT or MRI.

The advantage of CT examination is that the procedure is noninvasive, and MRI examination does not involve a radiation risk. However, false positive findings are a risk associated with this type of study. This risk is substantial, both regarding herniated disks and changes in disks resulting from aging or constriction in the spinal and root canals, which appear in approximately 40% to 50% of symptom-free individuals.

Only limited evidence is available for many other diagnostic methods and their benefits (C). This applies to measurement of range of motion, muscle strength and condition, facet joint or nerve root blockades, spectrometry, diskography, electromyography or neurophysiology studies, and radiographic measurement of segmental movements and various spinal diameters.

Moderate evidence (B) suggests that tomography and ultrasound studies do not contribute information toward establishing a diagnosis.

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CONSERVATIVE TREATMENT OF ACUTE AND CHRONIC LOW BACK PAIN

Conservative treatment refers basically to all nonsurgical treatment methods, excluding psychological treatment (discussed separately below). Conservative treatment methods include drugs, acupuncture, injections of various types, back exercises, back school, manual treatment, manipulation, physical methods, traction, corsets, transcutaneous electrical nerve stimulation (TENS), behavioral therapy, multidisciplinary treatment, biofeedback, rest, and activation. Appendix 1 to this summary presents an overview of the effects of various treatment methods. Here, the only conclusions presented on conservative treatment methods are those supported by strong evidence (A). However, the treatment methods graded as B-level evidence are also supported by relatively good scientific documentation (Appendix 1).

For acute low back pain, there is strong evidence (A) that:

- Continuing with normal activities results in faster recovery and fewer chronic functional disorders;
- Anti-inflammatory and muscle relaxant drugs offer effective pain relief for uncomplicated, acute, low back pain (however, these drugs have some side effects);
- Bed rest is not effective treatment for acute low back pain; and
- Exercises involving bending, traction, aerobics, and stretching do not effectively cure acute low back pain.

For chronic low back pain, there is strong evidence (A) that:

- Manual treatment/manipulation, back training, and multidisciplinary treatment are effective in relieving pain; and
- Intensive treatment at a health resort reduces pain in the short term for elderly patients (over 60 years of age) with chronic low back problems.

CONSERVATIVE TREATMENT OF ACUTE AND CHRONIC NECK PAIN

Conventional treatment methods that are normally used to treat neck pain are largely similar to those used to treat low back problems. The treatment methods reviewed in this report include drugs, physical training, manual treatment, massage, body exercises, muscle training, heat packs, ergonomic counseling, traction, acupuncture, TENS, electromagnetic treatment, magnet therapy, patient education, behavioral therapy, steroid injections, and treatment involving neck collars, infrared light, ultrasound, lasers, cooling spray, and stretching.

Only a few studies in this field are of high scientific quality. In summary, only moderate or limited evidence is available to show that any of the treatment methods are effective in treating acute or chronic neck pain. However, there is strong evidence to show that acupuncture is not an effective method in treating chronic neck pain (A).

SURGICAL TREATMENT

When assessing the results of surgical treatment, the importance of weighing the risks and benefits of intervention increases.

Low Back Pain

Surgery for low back pain usually involves treating herniated disks in patients with sciatica, reducing pressure on painful nerve roots, or treating degenerative disk disease (which is a

common age-related syndrome) where surgery is used to reduce pressure and/or stabilize vertebrae through fusion. Numerous surgical methods are used to treat herniated disks, e.g., with or without the help of lasers or microscopes, or through minimally invasive surgery. There is no scientific evidence to show that these surgical methods would yield better results or fewer serious complications than conventional surgery (D).

The reviewed studies reveal many methodologic deficiencies, mainly the studies on surgery for degenerative disk disorders aimed at measuring outcomes (which were often based on rough estimates by either the surgeons themselves or by patients who underwent surgery).

There is limited evidence on the outcome of surgery for herniated disks, but there is strong indirect evidence on its effectiveness. The randomized studies that were reviewed showed herniated disk surgery to be more effective than chemonucleolysis (A), which, in turn, was shown to be more effective than placebo (A). Chemonucleolysis is an alternative to surgery and involves using the chymopapain enzyme to chemically dissolve the soft nucleus of the disk. The results of surgery are inferior to those from chemonucleolysis.

Several surgical fusion methods are available to treat degenerative disk disorders or spinal stenosis, but there is no consensus on the definition and importance of spinal "instability." No randomized controlled studies compare the effects of fusion with conventional treatment, placebo, or with the natural course of degenerative disk disease. There is no scientific evidence on the results from this type of surgery (D).

Neck Pain

The studies reviewed address the surgical treatment of chronic pain resulting from whiplash injuries, herniated disks, or spondylosis.

Only one randomized controlled study was found on surgery for spondylosis, with or without herniated disk involvement. This study reported no advantages from surgery (B). Regarding whiplash injuries, there is no evidence that surgery is superior to conservative treatment.

PSYCHOLOGICAL TREATMENT METHODS

Psychological treatment methods are used to complement other treatment and are often included as part of the increasingly common multidimensional pain treatment programs. Cognitive behavioral therapy focuses on managing the problems, feelings, thoughts, and behaviors that pain and functional disabilities may cause.

Many randomized controlled studies have addressed cognitive behavioral therapy. Although it is difficult to assess the specific impact of cognitive behavioral therapy in multidimensional programs, studies show that programs that include this type of treatment achieve better results than other types of treatment in patients with chronic back problems (A). This particularly applies to treatment effects on anxiety, physical function, and medication use.

INFLUENCE OF SOCIAL FACTORS

Social factors that have been reviewed include: the role of culture and family; the influence of unemployment on the consequences of back pain, its intensity, and duration; the role of access to social welfare payments and early pensions; and the importance of relations with work colleagues and the degree of work satisfaction in this context.

Neck and back pain occur in all societies, but cultural groups differ in how they perceive symptoms and react to them. No scientific evidence shows that genetic factors play a role in the occurrence of back pain, except possibly in disk aging.

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Many studies show that poor social conditions are closely associated with poor general health status, including back pain. Regarding back problems as a risk factor for unemployment and early retirement, several studies clearly show conflicting results without a clear cause-and-effect relationship. Rather, it appears that age, psychological factors, and access to insurance are important explanatory variables in this context.

Several studies show that neck and back pain are not always isolated clinical problems but are often associated with other pain, other diseases, stress-related symptoms, and work-related or other social problems. Scientific evidence shows, for example, that negative psychosocial aspects in working life, such as poor work satisfaction and poor relationships with others, are associated with higher reporting of neck and back problems. There are no confirmed biological mechanisms that can explain how psychosocial factors would cause back pain, nor any evidence of a direct causal relationship.

In summary, there is extensive but scientifically weak evidence that social factors can influence the tendency to recognize back pain and that they can influence attitudes toward pain, functional disabilities, absenteeism, and early retirement. Some of these factors can be rather powerful and, at least in some situations, may have a greater impact on the back or neck than physical problems.

HEALTH ECONOMIC ASPECTS

The total socioeconomic costs associated with back pain in 1995 were 29.4 billion Swedish kronors (SEK). Most of these costs, SEK 27 billion, were costs for sick leave and early retirement attributed to back pain. The remaining sum of SEK 2.4 billion represents the direct costs to health services, including physician visits, diagnostic studies, drugs, surgery, hospitalization, etc.

The direct cost to health care increased by 35% from 1987 to 1995. The overwhelming share of the increases in these direct costs can be attributed to a doubling of the costs for physiotherapy from 1987 to 1995. In fixed prices, these costs increased from SEK 435 million in 1987 to SEK 950 million in 1995.

Studies on the cost-effectiveness of various treatment methods were reviewed in developing this report. These studies addressed, for example, preventive programs involving physiotherapy, education, back school, workplace adaptation, early activation, manipulation, exercises, and various types of surgery. The review shows it is not possible to draw reliable conclusions on the cost-effectiveness of any treatment method.

ROLE OF PRIMARY CARE

Many earlier reviews from different countries have led to evidence-based guidelines for care of patients with back pain. These have focused on primary care.

The scientific studies currently available show that the interventions provided within primary care are the only ones needed by most patients with back problems. These studies also show that a primary care physician's most important task is not to intervene unnecessarily. Subjecting a patient to ineffective examinations and treatments carries the risk that the patient's back problem can develop into a chronic, lifelong disorder.

In primary care, the consultation itself offers a major opportunity to influence both the acute and the more long-term course of back problems. An essential aspect of the consultation is the involvement of the caregiver and the ability to work with and listen to the patient's perceptions on back pain, mainly how it impacts on daily life. The opportunity for the physician and the patient to arrive at a common understanding about the nature and course of back pain is of major importance for the prognosis and is highly dependent on a good patient-doctor relationship.

CONCLUSIONS

- Pain in the low back and neck is common. Low back pain affects up to 80% of all people at some time during life, and neck pain affects up to 50% of the population. In the overwhelming majority of people, back pain does not signal a serious disease or suggest that one should avoid normal daily activities. On the contrary, scientific studies show that healing is promoted by staying active, returning to work, and exercising at an appropriate and increasing intensity.
- A thorough anamnesis and physical examination is important for relieving anxiety about the consequences of pain and sufficient for identifying the patients who should be referred to another specialist for examination and treatment (e.g., due to severe infection, specific rheumatic disease, suspected cancer, or other serious conditions).
- For most people with back pain, the interventions that can be offered in primary care are the only ones needed. The physician's attitude and ability to listen to and express empathy with the patient is important for achieving a common understanding with the patient concerning which treatment strategies would be effective. This also has importance for the future course of back pain and compliance with treatment advice.
- Back pain and its consequences are not isolated physical problems but are associated with other conditions such as social, psychological, and workplace-related factors. These factors (e.g., stress, worry, and anxiety)—along with the patient's own perceptions on and ability to manage the problem—can have a decisive impact on the transition from acute to more chronic pain. The obvious role of psychosocial factors in this respect suggests that such factors should be considered an integral part of back pain in relation to preventive efforts, in the initial phase of treatment and later during rehabilitation.
- Knowledge on how to prevent back pain is not directly deficient, but has been applied and assessed to a surprisingly small degree. The knowledge currently available should be applied and thoroughly assessed.
- The relatively large resources that have been invested locally, regionally, and nationally to prevent and rehabilitate back problems, including interventions to improve the work environment, should be subject to systematic assessment based on current knowledge about the effects of various interventions. The sporadic research on prevention and rehabilitation of back problems should also be assessed in terms of its relevance and scientific quality.
- Many treatment methods are currently used, but there is little scientific evidence on their benefits. Some treatment methods are used despite scientific evidence showing that they do not benefit the patient. The appropriateness of subsidizing ineffective treatments with public funds should be investigated.
- The primary focus concerning back pain should be on the pain itself and on the human suffering it involves. Furthermore, back pain has an extensive economic impact on the individual and society. The direct healthcare costs and the costs resulting from sick leave and early retirement due to back pain reach an annual sum that is over three times higher than the corresponding costs for all cancer diseases. Against this background, it is remarkable that research on back pain, particularly research related to prevention, pain relief, and rehabilitation, is relatively limited in scope. Agencies that have responsibility for and interest in effectively managing back problems should take initiatives to stimulate and focus research in this field and disseminate information that is currently available, such as in this report.

APPENDIX 1

Treatment Methods: An Overview of the Results

Level A: *Strong evidence*—findings concur in several, randomized, controlled studies of high quality.

Level B: *Moderate evidence*—findings concur in one randomized, controlled study of high quality and one or more randomized, controlled studies of low quality, or findings concur in several studies of low quality.

Technology assessment reports

Level C: *Limited evidence*—based on one randomized controlled study (of high quality or low quality) or contradictory findings in several studies.

Level D: *No evidence*—no randomized controlled studies or other types of studies of satisfactory scientific quality.

CONSERVATIVE TREATMENT METHODS FOR LOW BACK PAIN

Medication

Strong scientific evidence shows that muscle relaxants, (e.g., benzodiazepines) and anti-inflammatory drugs (NSAIDs) relieve pain in patients with acute and subacute low back problems, i.e., problems that have existed up to 3 weeks or up to 12 weeks (A). However, anti-inflammatory drugs can have serious side effects, particularly in elderly people, and muscle relaxants can cause tiredness and dependency, even after short-term use. Furthermore, there is moderate scientific evidence that paracetamol is effective in relieving acute low back pain (B).

Limited scientific evidence suggests that these drugs are effective in treating chronic low back pain (C). For example, only one study was found that compared the effects of muscle relaxants with the effects of placebo (i.e., no active treatment), but no such studies address analgesics and NSAIDs in people with chronic low back problems.

There are no studies on the effects of antidepressants in treating acute low back problems (D). However, moderate evidence suggests that these drugs do not have any effect on pain and mobility in patients with chronic low back disorders (B).

Studies show that only limited evidence supports the treatment effects of colchicine (medication for gout) and cortisone in tablet form (system steroids) on acute low back pain (C). Serious side effects have been reported for colchicine, but for system steroids such side effects accompany only long-term use.

Injections

Several different types of injections are used at times to treat both acute and chronic back problems. The injections reviewed were epidural steroid injections (i.e., injections in the spinal cord canal), injections in trigger points and ligaments, and injections in facet joints (small joints in the vertebral column).

Limited evidence suggests that epidural steroid injections are more effective than placebo for acute and chronic low back problems involving nerve root pain (C). There are no studies addressing the effects of these injections on acute low back problems without nerve root pain (D). However, moderate evidence suggests that these injections do not have any effects on chronic low back pain without root symptoms (B).

There is no evidence on the effects of injections in trigger points, ligaments, or facet joints (D).

Back School

There is limited evidence on the effects of back school on chronic and acute low back problems (C).

Transcutaneous Electrical Nerve Stimulation

There is limited evidence on the effects of TENS on acute and chronic low back problems (C).

Traction

Limited evidence suggests that traction is effective in treating acute low back problems (C). However, strong evidence shows that it is not effective in treating chronic low back problems (A).

Acupuncture

There is no evidence on the effects of acupuncture in treating acute low back pain (D). However, limited evidence suggests that acupuncture is effective in treating chronic low back pain (C).

Physical Treatment Methods

There is no evidence on the effects of cold, heat, short-wave diathermy, massage, or ultrasound in treating acute low back problems (D).

Low Back Corsets and Other Supportive Devices

There is no evidence on the effects of different types of supportive devices in treating acute low back problems (D), and limited evidence regarding their effects on chronic low back problems (C).

Back Exercises/Back Training

Strong evidence shows that back training is effective treatment for chronic low back pain (A). There is also strong evidence that most types of specific back exercises (e.g., bending, traction, aerobic training, strength training, and stretching) are not more effective than other interventions in treating acute low back pain (A).

Manual Therapy (Manipulation and Mobilization)

Strong evidence shows that manipulation provides short-term pain relief for chronic low back problems (A) and moderate evidence that it has corresponding effects on acute low back pain (B). There is also moderate evidence that manipulation provides better short-term relief from chronic low back pain compared to routine care from a general practitioner, bed rest, analgesics, or massage (B). Limited evidence suggests that manipulation is more effective than physiotherapy or drugs in relieving acute low back pain (C). The long-term effects of manipulation are supported only by limited evidence (C). There is a small but serious risk for neurologic complications from manipulation therapy in patients with progressive neurologic deficit.

Behavioral Therapy

There is limited evidence that behavioral therapy is effective in treating acute low back pain (C), but moderate evidence concerning its effects on chronic low back pain (B).

Multidisciplinary Treatment

Strong evidence shows that multidisciplinary treatment is effective in pain relief and functional improvement for patients with long-term and severe chronic low back pain (A).

Biofeedback

Moderate evidence suggests that EMG-based biofeedback is not effective in treating chronic low back problems (B).

Health Resorts

Strong evidence shows that intensive treatment at a health resort reduces short-term pain in elderly patients with chronic low back problems (A).

Bed Rest

Strong scientific evidence shows that bed rest is not an effective way to treat acute low back pain (A). The previous perception that 1 to 2 days of bed rest is effective in treating uncomplicated, acute low back pain has been rejected in scientific studies. Extended bed rest may cause complications such as joint stiffness, muscle atrophy, osteoporosis, pressure sores, and thromboembolism.

Continued Activity

Strong scientific evidence shows that a gradual reactivation of patients suffering from subacute low back pain, in combination with treatment of pain behavior, helps reduce chronic functional problems and sick leave from work (A).

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CONSERVATIVE TREATMENT METHODS FOR NECK PAIN

Laser Treatment

There is limited evidence on the effects of laser treatment for acute and chronic neck pain (C).

Infrared Light

There is only limited evidence that infrared light has any effect at all on acute neck pain (C).

Electromagnetic Therapy

There is only limited evidence supporting the effectiveness of electromagnetic therapy in treating acute neck pain (C).

TENS

There is only limited evidence on the effects of TENS in treating acute neck pain (C).

Steroid Injections

Limited evidence suggests that steroid injections are not effective in treating neck pain (C).

Acupuncture

There is no evidence on the effects of acupuncture in treating acute neck pain (D). However, strong evidence shows that acupuncture is not effective treatment for chronic neck pain (A).

Traction

Limited evidence suggests that traction is not effective in treating acute neck pain (C), and moderate evidence suggests that it is not effective in chronic neck pain (B).

Cooling Spray and Stretching

Only one controlled study on patients with acute neck pain addressed the effects of cooling spray combined with passive stretching—a common treatment method in sports medicine. The study is of low scientific quality and showed no differences in outcome between active treatment and placebo (C).

Neck Support

Limited evidence suggests that a neck collar is not effective in treating acute or chronic neck pain (C).

Manual Therapy

There is only limited evidence on the effects of separate manual therapy for acute neck pain (C), but moderate evidence on its effects when manual therapy is applied as one of several methods in a treatment program for acute neck problems (B). Regarding chronic neck pain, strong evidence shows that manipulation is not more effective than physiotherapy methods (A), and moderate evidence suggests that manipulation is not effective treatment for chronic neck pain (B).

Other Types of Physiotherapy (Massage, Body Movements, and Instruction)

Strong evidence shows that these physiotherapy methods are not more effective in treating chronic neck pain than are alternative forms of treatment (e.g., group exercises, manual therapy, and routine care from a general practitioner) (A).

Patient Education

Limited evidence suggests that various types of instruction help reduce acute neck pain (C).

Behavioral Therapy

Limited evidence suggests that behavioral therapy is effective in treating chronic neck pain (C).

Medication

There is limited evidence on the effects of pain-relieving drugs in treating acute neck pain (C) and limited evidence that muscle relaxants are effective in treating chronic neck pain (C).

Physical Training

Moderate evidence suggests that active training is more effective than passive methods (e.g., massage, heat therapy, and stretching) in treating acute neck pain (B).

SURGICAL METHODS

Strong indirect evidence shows that surgical resection of herniated discs in patients with several weeks of pronounced lumbar root pain is effective (more effective than chemonucleolysis, which in turn is more effective than placebo) (A). However, moderate evidence suggests that corresponding surgery is not effective in treating neck problems (B). There is no evidence concerning the effects of fusion surgery in treating chronic pain in the low back or neck (D).

PSYCHOLOGICAL TREATMENT METHODS

Strong evidence shows that cognitive behavioral therapy (CBT) reduces problems in patients with chronic back pain (A). The effects mainly involve psychological and physiological functions, pain, and medication use. Limited evidence suggests that CBT influences the patient's return to work (C). There is no evidence on the effects of CBT in treating acute back or neck problems (D).

Advanced Home Health Care

Advanced home health care was introduced in Sweden 20 years ago as an alternative to hospitalization. The basic intent behind advanced home health care is to offer patients and family an alternative to hospitalization, which would enhance the quality of care for all parties. Naturally, many patients prefer care at home where they can retain their integrity and be close to family, particularly during the severe stages of disease near the end of life. A survey by the Federation of Swedish County Councils in 1998 showed that a large majority of the interviewees preferred to receive care at home.

The percentage of elderly in the population has increased steadily during the final decades of the 1900s. As the risk for disease increases with age, so does the number of individuals in the population with health disorders. Furthermore, less invasive methods have enabled providers to offer a wider range of technological and medical interventions, even to those in the higher age groups. Healthcare finances have become increasingly strained, which has led to a reduction in the number of inpatient beds. To compensate for bed reductions, home health care has been extended as a less expensive alternative to hospitalization.

Given the situation described above, there is a risk that the original concepts underlying home health care, i.e., free choice and quality care, will be overshadowed. There is a risk that patients will be referred to home health services without freely choosing this alternative and without being assured of quality care. Family members may feel overloaded and anxious. Furthermore, there is concern that even advanced long-term care, e.g., for advanced dementia

Dr. HOLOHAN. And our approach, not just for chiropractic but for all care—cardiology, oncology, et cetera—is that we should provide care that is supported by good quality evidence. And we think we have done so.

Dr. SNYDER. May I follow up, Mr. Chairman?

Mr. STEARNS. Say again?

Dr. SNYDER. May I follow up?

Mr. STEARNS. Sure. Are you asking unanimous consent for an additional minute?

Dr. SNYDER. Okay, I do.

Mr. STEARNS. So done, sure.

Dr. SNYDER. But you make the point that I think would concern those veterans who want care, that—you acknowledge that it may have an appropriate role—

Dr. HOLOHAN. Yes, sir.

Dr. SNYDER (continuing). There is nothing off the wall about a patient coming in and requesting chiropractic care. I think part of the burden is going to be, though, if you are waiting for all your VA M.D.s and D.O.'s to come to the point that, yes, we are now ready to write a prescription for chiropractic care, I don't think it is going to happen. I think the way it comes about is the patient comes in and says, "I want to see a chiropractor." And there is going to need to be an understanding that, well, there is tension between these professions but that for this particular purpose, there is nothing off the wall about a patient making that request and that the VA I assume is moving towards being accommodating on that.

I am more patient, I guess, than some members of the committee, Dr. Murphy, on a new policy with the language you were given. But I would hope—my guess is 9,000 in the last year does not reflect the potential demand out there amongst veterans who have chronic neck and back conditions.

Thank you, Mr. Chairman.

Dr. HOLOHAN. Well, that is one of the reasons we are providing educational material to both practitioners and patients, and that educational material was provided by chiropractic organizations, not by VA clinicians.

Dr. SNYDER. Thank you.

Mr. STEARNS. The gentleman's time has expired. The gentleman from Mississippi, Mr. Shows, is recognized.

Mr. SHOWS. I don't have any questions.

Mr. STEARNS. Okay. Mr. Moran?

Mr. MORAN. No questions.

Mr. STEARNS. Okay. Mr. Peterson? Dr. Filner is recognized for 5 minutes.

Mr. FILNER. Thank you. I think Dr. Snyder rightfully pointed to a problem in the drafting that probably should be corrected. My only response, though, on behalf of the veterans is that if the VA was sincerely interested in providing this kind of service and came back to us and said, "You know, you have given us something that was badly drafted, it is so limiting, therefore, why don't you change the language a little bit?" And we have a correction. That is, rather than saying to us, "Well, you have limited us by your language, and therefore, we are just going to adopt whatever you said." In a

true dialogue and discussion and commitment of people, they would say, "You know, there is something wrong with this definition, and let's change it," and then work together to provide services.

So I see that as a problem that we can correct. But I also see it as evidence of resistance. That is, rather than say, "We could do a better job if we had a better definition," nobody came to us to say that. In fact, as I understand your testimony, and correct me if I am wrong, you had one meeting with chiropractor organizations before the meeting I requested?

Dr. HOLOHAN. Subsequent to that meeting.

Mr. FILNER. So you didn't meet before I asked you to meet?

Dr. HOLOHAN. No, sir.

Mr. FILNER. This is a prima facie case here of what the problem is. You were directed—even if, let's not even argue about the definition, let's not argue about implementation versus whatever, you were directed to come up with a policy in consultation with groups within 120 days. It was only at my request because I heard that such meetings were not held within the 120 days or coming up, that I asked for one. And you reluctantly—were you at that meeting?

Dr. HOLOHAN. I was.

Mr. FILNER. You reluctantly, it looked to me, you guys looked like you were dragged into it kicking and screaming. You had this—you kept quoting me this one sentence, either from the law or from somebody's definition that you are only going to deal with back pain. It was clear that nobody in the VA at the highest levels, and I had Dr. Garthwaite in the office, wanted to implement this policy. And only because I requested the meeting did you even have one, which the law directed you to have way before that, in my opinion. So I don't sense a cooperative effort here.

Dr. MURPHY, do you have a regard for chiropractic care? Do you think it is a valuable service for our veterans, in your personal opinion?

Dr. MURPHY. Maybe I can answer that from my personal background. I am a neurologist, and I have treated a lot of patients with neck and back pain. And I do have a regard for spinal manipulation and its appropriate use in treatment of musculoskeletal conditions. I have prescribed manipulation that myself on a number of occasions and have referred some of my own patients to chiropractors, osteopathic physicians or physician therapists.

Mr. FILNER. Well, notwithstanding, what sounds to me like legal advice on how you keep defining chiropractic, you never say it without saying that sentence after it, which to me limits very greatly, and we will hear from the chiropractors later, limits—so limits the situations where you can actually prescribe chiropractic care. It sounds to me like a lawyer has told you to say, "Every time you say 'chiropractor,' say 'spinal manipulation,'" whatever you said in that sentence. It is so narrow that you couldn't do anything.

But if you have this regard for chiropractors, why wouldn't you be aggressive and tell us, "We need more authority, we need more resources about providing this kind of care?" You are sort of reacting to a law. You said, "Well, we were limited by the law to do this, and we are working within the law." Why not be aggressive, as we are trying to be here, I think. We want to help our veterans with

their health problems. We want to provide services that have been proven in practice and in the literature to be effective.

And, as Dr. Snyder said, by the way, part of what is effective is also what patients think is effective. And if a lot of people think it is, then we know from our study of medicine that the patient's attitude toward treatment is also very helpful in that treatment.

But why don't you aggressively—we are a year down the line, and you come to us with a statement that says, yes, your VISNs are coming back with a policy. And you say, "We don't have any experience with chiropractic"—it is a chicken and egg here. You don't have any experience, so you are not going to do anything. And if you don't do anything, you don't get any experience. So I don't know where you are ever going to break out of that unless we somehow order you to do it.

But I don't sense that dialogue, of sitting down with the chiropractic groups, if you disagree with their definition of primary care or their—sit down with them and work it out. This has been a year since we have done this, and you haven't taken any aggressive steps, only when prodded, only when asked, only when—to do anything. And I don't see any other conclusion. Why don't you aggressively meet with them and figure out how you are going to provide this care?

Dr. MURPHY. We think that we have the authority that we need to provide appropriate care to veterans. We believe that the meetings that we had with chiropractic associations and the follow-up written comments that we got from them were very helpful in drafting the policy. And that we have, in fact, issued the appropriate policy statement to our centers, and they are in the process of implementing that and are already providing chiropractic care.

We expect that the quantity of care provided by chiropractic will increase in the Veterans Health Administration over the next year, and we intend to monitor that.

Responding to your statement about primary care, I think there is a disagreement there. And the basic disagreement is over what constitutes primary care. The Institute of Medicine—

Mr. FILNER. I read that and, look, I am not arguing that there is no disagreement. I am saying these are not insurmountable disagreements if you want to accomplish an end. You sit down and figure out how to do it. If you have given me the authority, I will sit down with anybody in the room and we will come out with something at the end of 2 hours or 8 hours or 12 hours, whatever it takes to come up with something. And, yes, you disagree, but we are telling you that the legislative mandate is to do more, and you come back and say, "Well, we just disagree."

Well, we may have to order, Mr. Chairman, a division of chiropractic or something and staff it ourselves if that is what it takes.

What is your just and reasonable reimbursement for chiropractic, do you have the schedule here or something?

Dr. HOLOHAN. I don't.

Dr. MURPHY. I don't.

Mr. FILNER. You don't know what it is?

Dr. HOLOHAN. We routinely pay Medicare.

Dr. MURPHY. We use Medicare rates.

Mr. FILNER. Do you folks mind providing a record to us, send us under separate cover an established payment schedule? I am not sure how you work on these things but if you are paying 30 bucks for a visit to a health care professional, that in itself is not going to allow very much usage of the health care system. Nobody could provide service for nothing.

(Subsequently, the Department of Veterans Affairs provided the following information:)

VA Payment rates for Non-VA Chiropractic services are the lesser of the amount billed or the amount calculated using Medicare's participating physician fee schedule (RBRVS). RBRVS payments are the product of three factors: a national uniform relative value for the service; a geographic adjustment factor for each physician fee schedule area; and a national uniform conversion factor for the service.

If the amount cannot be calculated under RBRVS, payment is the lesser of the amount billed (usual and customary) or the amount calculated using the 75th percentile methodology. The 75th percentile methodology is determined for each VA medical facility by ranking all occurrences (with a minimum of eight occurrences) under the Current Procedural Terminology (CPT) code with charges ranked from the highest to the lowest rate billed. The charge falling at the 75th percentile is the maximum amount paid.

VA makes payments for the four recognized Chiropractic national (CPT) codes, which are:

- 98940 Chiropractic manipulation; spinal, one to two regions
- 98941 Chiropractic manipulation; spinal, three to four regions
- 98942 Chiropractic manipulation; spinal, five regions
- 98943 Chiropractic manipulation; extraspinal, one or more regions

The following represents Non-VA Chiropractic payment rates in four geographical areas:

Denver		Tampa, FL	
98940	\$26.50	98940	\$26.68
98941	\$34.73	98941	\$35.15
98942	\$44.03	98942	\$44.71
98943	75 th percentile or usual and customary	98943	75 th percentile or usual and customary
San Diego, CA		Charleston, SC	
98940	\$22.21	98940	\$25.44
98941	\$30.99	98941	\$33.35
98942	\$40.51	98942	\$42.30
98943	75 th percentile or usual and customary	98943	75 th percentile or usual and customary

Aggregate Non-VA Chiropractic payments/cost for FY 2000 were as follows:

FY 2000 CHIROPRACTIC TOTAL OUTPATIENT MEDICAL PAYMENTS			
CHIROPRACTIC CPT CODE	AMOUNT	VISITS	AVERAGE COST
98940	\$ 133,385.56	4894	\$ 27.25
98941	\$ 138,157.71	4105	\$ 33.65
98942	\$ 23,450.98	662	\$ 35.42
98943	\$ 2,209.51	97	\$ 22.78
TOTAL	\$ 297,203.76	9758	

Mr. STEARNS. The gentleman's time has expired. I want to thank Dr. Murphy and Dr. Holohan for your coming this morning. And I would like to call up the second panel of witnesses. Dr. Rick McMichael of the American Chiropractic Association, Dr. Michael McLean of the International Chiropractic Association, and Dr. George Goodman from the Association of Colleges of Chiropractic, accompanied by Dr. Reed Phillips.

We appreciate your responsiveness to our invitation, and we look forward to your opening statements. I understand from our staff that the three organizations here today will each limit your statements to 4 minutes so that a fourth witness, Dr. Phillips, can testify for 3 minutes.

Would the committee clerk please set the clock accordingly then so that the fourth witness, Dr. Phillips, can testify for 3 minutes.

Let us proceed in order with the American Chiropractic Association, the International Organization, and then representatives of the chiropractic schools.

You may proceed.

STATEMENTS OF RICK A. McMICHAEL, ACA DELEGATES MEMBER, DOD OVERSIGHT ADVISORY COMMITTEE, AMERICAN CHIROPRACTIC ASSOCIATION; MICHAEL S. McLEAN, CHAIRPERSON, ICA LEGISLATIVE COMMITTEE, ICA BOARD OF DIRECTORS, INTERNATIONAL CHIROPRACTORS ASSOCIATION, ACCOMPANIED BY RONALD M. HENDRICKSON, EXECUTIVE DIRECTOR, INTERNATIONAL CHIROPRACTORS ASSOCIATION; AND GEORGE GOODMAN, PRESIDENT, LOGAN COLLEGE OF CHIROPRACTIC, DOD OVERSIGHT ADVISORY COMMITTEE, IMMEDIATE PAST PRESIDENT, ASSOCIATION OF CHIROPRACTIC COLLEGES, ACCOMPANIED BY REED PHILLIPS, PRESIDENT, LOS ANGELES COLLEGE OF CHIROPRACTIC, DOD OVERSIGHT ADVISORY COMMITTEE, PAST PRESIDENT, ASSOCIATION OF CHIROPRACTIC COLLEGES

STATEMENT OF RICK A. McMICHAEL

Dr. McMICHAEL. Yes, Mr. Chairman, good morning.

Mr. STEARNS. Good morning.

Dr. McMICHAEL. Good morning to the ranking member and members of the subcommittee. My name is Dr. Rick McMichael. I am a practicing doctor of chiropractic with 26 years experience. I am the Ohio delegate to the American Chiropractic Association and served on the Oversight Advisory Committee for the Department of Defense Chiropractic Health Care Demonstration Projection.

I would like to share with you some brief information from my experience as a member of the Oversight Committee. Not only did a large number of military personnel choose chiropractic services for care but those who sought chiropractic care reported significantly higher satisfaction and outcomes. In addition, doctors of chiropractic work well with other military health care providers.

I believe that the overall outcome of the Chiropractic Demonstration Project shows that chiropractic is a valuable service, needed and desired by many military personnel. Our veterans deserve this positive new service.

As you are aware, the Veterans Millennium Health Care Act included a provision requiring the Department of Veterans Affairs to develop a policy with regard to chiropractic care in the DVA health care system. In response to this provision, the ACA and the Association of Chiropractic Colleges provided to the agency recommendations to serve as a basis of its chiropractic policy.

On February 24, 2000, I had the opportunity to join representatives of ACA, ACC, and other chiropractic organizations for a meeting with VHA officials to discuss implementation of chiropractic policy. The ACA and ACC representatives' main objective was to seek direct access to a full scope of chiropractic services. Despite these efforts, the DVA ignored the input of the chiropractic profession and Members of the Congress and ultimately developed a policy on chiropractic care that is totally inadequate, not mandating chiropractic services, and requiring medical physician referral.

Despite the exclusion of recommendations, we are now asked by DVA to believe that their chiropractic policy is adequate and that it will ensure that eligible veterans in need of chiropractic care will have access to it. Insofar as the ACA is aware, there is no DVA program or organized effort that exists to ensure that chiropractic services are made available to our nation's veterans. Clearly, the agency did not expect significant referrals to doctors of chiropractic to occur as a result of this policy.

How could they expect this policy to work? Are they not aware that medical doctors receive no education or formal training regarding chiropractic care or when a referral to a doctor of chiropractic is warranted? Are they unaware of their own indifference regarding chiropractic care and of the agencies failure over the past half century to initiate any effort to encourage the use of chiropractic care?

Because of the well-documented record of prejudice and neglect toward chiropractic, the ACA requests that the House Committee on Veterans' Affairs advance legislation to require the DVA at a minimum to make available chiropractic care on a direct access basis and allow doctors of chiropractic to provide the full scope of their services as enacted under applicable State law.

As you may know, a similar chiropractic provision was recently included in the House-passed version of the Fiscal Year 2001 Defense Authorization Act.

The ACA stands ready and willing to work with the committee and the DVA to develop legislative language and to devise and implement an acceptable plan to provide for chiropractic care.

Mr. Chairman, we have before us an historic opportunity to take decisive steps to ensure that our nation's veterans are afforded access to the benefits of chiropractic care in an appropriate and effective manner. We are hopeful that the DVA will not further resist this positive new way of serving our nation's veterans. I believe we have much to offer to the DVA and if its representatives will work with the chiropractic profession, there is much we can achieve together to enhance health care for our nation's veterans.

We wish to be clear, however, that in our judgment it will be necessary for Congress to firmly establish in statute desired policy goals and objectives to ensure that a full scope of chiropractic services are made available to our eligible veterans on a direct access

basis. Once Congress establishes firm statutory directives, the chiropractic profession looks forward to working with the DVA to develop an effective chiropractic policy that will benefit the health of our nation's veterans.

This concludes my brief remarks. I will be happy to answer any questions committee members may have.

[The prepared statement of Dr. McMichael, with attachment, appears on p. 89.]

Mr. STEARNS. Thank you very much, and thank you for staying within the time. Dr. McLean.

STATEMENT OF MICHAEL S. McLEAN

Mr. McLEAN. Thank you very much, Mr. Chairman and members of the committee. I am Dr. Michael McLean, chairperson of the legislative committee of the International Chiropractors Association. I also serve as a member of the board of directors of that organization and we at the ICA appreciate the opportunity to present our organization's perspective.

ICA has submitted extensive comments on this body of issues and would like to summarize the key points of that submission this morning and ask that the complete statement be made part of the hearing record.

Mr. STEARNS. By unanimous consent, so ordered.

Mr. McLEAN. This is an issue that has been of major importance to us for a very long time. In fact, the first legislative initiative to provide chiropractic benefits to our nation's military was introduced at the request of the ICA in 1936.

The steps that Congress must take to provide for reasonable access to chiropractic services for America's veterans are clear. What is also unfortunately clear is that unless Congress enacts a series of very specific mandates with a designated timetable for action, the U.S. Department of Veterans Affairs will not make any significant effort to provide access to chiropractic services on anything other than a token basis. In fact, the obvious context of this hearing is the failure of that agency to provide for meaningful chiropractic access.

I respectfully refer the committee to the presentation made by the ICA to the Department of Veteran's Affairs on February 24, 2000.

ICA believes the following elements should be enacted at a minimum to ensure America's veterans have available to them the same chiropractic options that are presently available in most other health benefit programs.

One, the establishment of statutory authority to employ doctors of chiropractic as professional care-givers within the DVA. We specifically ask that Title 38, Section 7401 be amended by inserting the words "doctors of chiropractic" after "optometrists." We also ask Section 7402 be amended by the insertion of a new subsection after the current subsection two, dentists, identifying doctors of chiropractic in the sequence of professionals. Such criteria are comparable to those provided for in the section for dentists, podiatrists, et cetera. Authority to hire doctors of chiropractic should be accompanied by instructions to act on that authority and a timetable to deploy an initial group of doctors of chiropractic.

The establishment of a Division of Chiropractic Services headed by a doctor of chiropractic would be our second request within the VA Health Administration to oversee and facilitate the effective integration of chiropractic services.

Three, the statutory establishment of direct access to chiropractic services as a care pathway choice for eligible veterans without the requirement of a referral from another professional as is presently required.

Four, the statutory establishment of a Chiropractic Advisory Committee comprised of representatives of the chiropractic profession to assist senior VHA officials in addressing program and policy questions.

And, five, the enactment of a specific congressional directive to the VHA to develop within a reasonable period of time a plan for making chiropractic services routinely available on an outpatient basis for those program beneficiaries outside geographic range.

In practical terms, there are no real barriers to the effective integration of chiropractic services and the doctor of chiropractic into the primary care system now in place other than a reluctance to do so on the part of the policy-makers directing those programs. The administrative qualification process that determines the eligibility of a veteran would not change.

The intake and general evaluation process of every patient ought to include a chiropractic evaluation of every patient given the prevalence of spinal problems in the United States. At a minimum, qualified beneficiaries should have a right to choose a chiropractic program of care for chiropractic conditions rather than to be limited or indeed forced to accept only a medical pathway.

ICA rejects as obstructionist and unreasonable the arguments that direct access is incompatible with the primary care system now in place at the VHA and believes the initial phase of any direct access program will rapidly demonstrate this.

In conclusion, I want to emphasize the fundamental issue in this discussion is and should be recognized by all parties as one of fairness to our nation's military veterans.

Mr. Chairman, I want to thank you, the committee, and the staff for the serious attention this body of issues is receiving. I urge the committee to move forward to do the right thing. Thank you, sir.

[The prepared statement of Mr. McLean appears on p. 143.]

Mr. STEARNS. Thank you. Dr. Goodman, we look forward to your opening statement.

STATEMENT OF GEORGE GOODMAN

Dr. GOODMAN. Thank you, my name is Dr. George Goodman.

Mr. STEARNS. Could you pull the microphone a little closer to you, Dr. Goodman. Thank you.

Dr. GOODMAN. My name is Dr. George Goodman. I am president of Logan College of Chiropractic in St. Louis, MO.

Mr. Chairman, Ranking Member, and members of the subcommittee, on behalf of the Association of Chiropractic Colleges, I am honored to be at this important hearing to discuss our proposal for establishing direct access, full scope of practice chiropractic health care services for our nation's veterans through the Department of Veterans Affairs.

This subcommittee is to be commended for its support for enhancing chiropractic care to the Department of Veterans Affairs and for its willingness to put this issue on your agenda for next session of Congress.

Mr. Chairman, I have prepared a more detailed statement with attachments regarding our proposal. But in the interest of time, I would ask that the full text of that longer statement be included in the hearing record. I would also request your consent to have the minority views of the major chiropractic organizations of the Department of Defense Chiropractic Health Care Demonstration Program be included into the record as well.

(Retained in Committee files.)

Dr. GOODMAN. Thank you, Mr. Chairman, and other members of the subcommittee. I know that I only have a few moments, and I will attempt to make the case succinct for moving forward a direct access chiropractic health care benefit for our veterans who are eligible for care within the Department of Veterans Affairs.

First, chiropractic care is effective. It improves patient outcomes. It has been universally accepted as mainstream health care that is licensed in all 50 States and utilized by well over 10 percent of the population every year and constitutes over 192 million patient visits per year.

The research literature cited by your own committee last year in the historic Veterans Millennium Act—Millennium Care Act reconfirms that the century-long debate over chiropractic efficacy has long been over. In short, chiropractic is effective and should be available to our nation's veterans as it is to the rest of American citizens.

Second, the recently completed 5-year Department of Defense Health Care Demonstration Program reconfirmed within the military health system what we already knew in the private sector: chiropractic is effective. It improves patient outcomes, has a high-level of patient satisfaction, enhances the ability of patients to return to their normal lives faster and in better health.

The Chiropractic Demonstration Project was carried out at 13 military sites around the country and by any measure was overwhelmingly positive in how it helped the men and women of the armed forces to address acute and chronic back care conditions. By the Department of Defense's own admission and from their own data, the three charts that we have brought with us today show beyond any doubt that patient outcomes were superior to those derived from so-called traditional medical doctors. Patient satisfaction with chiropractic care was dramatically higher than with traditional medical care. And the average patient who experienced back pain in the military missed fewer days with chiropractic care.

The House has recently passed a provision that would begin planning for the implementation of direct access, full scope of practice for chiropractic health care in the military. Our proposal is based in large part on this military health care system.

Finally, Mr. Chairman, our proposal purposely is very specific about what we believe to be the key components of any chiropractic care to the Department of VA. The VA policy does not allow for direct access and limits the scope of practice that would be available to our veterans. Our proposal calls for full scope of practice under

each State law governing chiropractic care. The Department of Veterans Affairs ignores your requirement on rural and medically under-served areas while our proposal will address those important issues.

In closing, Mr. Chairman, our proposal has precedent in the House. It is the right thing to do for our veterans. And in the aftermath of the Department of Defense Demonstration Program, it will dramatically improve patient outcomes and health care services to those who have served this country so well.

I welcome the opportunity to respond to any particular questions.

Mr. STEARNS. Thank you, Dr. Goodman. And, Dr. Phillips, you are recognized for 3 minutes.

STATEMENT OF REED PHILLIPS

Dr. PHILLIPS. Thank you, Mr. Chairman and members of the committee, for this unexpected opportunity to speak. I come to you as a holder of a Doctor of Chiropractic degree. I also hold a master's degree in community medicine from the University of Utah School of Medicine and a Ph.D. in medical sociology, also from the University of Utah. Also, I have participated in and completed a 2-year residency program in radiology as part of my chiropractic training.

I have served as president of the Los Angeles College of Chiropractic for the last 10 years. It has now just changed its name to the Southern California University of Health Sciences. We are accredited by the Western Association of Schools and Colleges, the same regional accrediting agency that accredits USC, Stanford, and other schools in that region. I also serve as the vice president for the Council on Chiropractic Education, the chiropractic accrediting agency recognized by the U.S. Office of Education. And in our standards, I can tell you very clearly there is an emphasis on the importance of all schools teaching their graduates to be proficient and capable in conducting an appropriate diagnosis.

I have also served on the DOD Oversight Committee. And I also have a son who practices as an ophthalmologist and another son who is now a student in chiropractic education. So I have had a great opportunity to compare those two educational experiences.

Let me just speak briefly about education, since it was a subject that came up in previous testimony. Our educational program is 4 years, equal to that of medical school. Applicants coming into chiropractic education are required to have a minimum of 3 years, or 90 hours, of credit to obtain admission into chiropractic education. Our last entering class had 80 percent of them holding bachelor degrees. Our curriculum includes all the basic and clinical sciences that you would find in medical education. However, we do not teach surgery in our programs, but our students are well acquainted and well trained in the area of clinical, physical and laboratory diagnosis.

Also, in our basic science curriculum, we have a full year of human dissection, full body dissection, which isn't I don't believe done in many of the medical school programs today. We have clinical rotations in places where there is multi-disciplinary care being provided. We have health clinics that are medical clinics that our

interns practice and provide services in. We have continuing post-graduate residency training programs in a multiple of specialties.

And we feel that it is extremely important for any practitioner to have the ability to participate and complete a diagnosis that far exceeds their ability to treat. Diagnosis is a key factor here for a primary care provider, and I know that if a medical intern was to diagnose a cardiac condition, he would be responsible to work with a cardiologist on a referral basis just as a chiropractor would be required if he was to diagnose a similar condition.

Let me conclude by reading a statement out of a paper that was published in the British Medical Journal in August of 1995 where there was a study comparing care for back pain in hospitals as compared to chiropractors outside of hospitals. And the statement reads as follows: "At three years, the results confirmed the findings of an earlier report that when chiropractic or hospital therapists treat patients with low back pain, as they would in day to day practice, those treated by a chiropractor derive more benefit and long-term satisfaction than those treated by hospitals."

Thank you, Mr. Chairman.

[The prepared statement of Dr. Phillips appears on p. 152.]

Mr. STEARNS. Thank you, Dr. Phillips. Maybe just as a general start for myself, you probably heard me ask Dr. Murphy, maybe this is appropriate for Dr. McMichael to answer or Dr. Phillips, or any one of you, just review for us, for the committee, what is the basic standard training for a chiropractor? She outlined what an osteopathic physician's training was and what an M.D.'s was, but would one of you just give—I mean, Dr. Phillips, I think you have an extraordinary background and you are probably very well qualified, if not over-qualified. But I admire your tenacity and your interest in continuing education. So, if one of you would take a moment and just outline for the record what the training is, that would be helpful.

Dr. MCMICHAEL. I think one of our college presidents would be most appropriate to do that, Mr. Chairman.

Mr. STEARNS. Okay.

Dr. PHILLIPS. I would be happy to, and I appreciate your confidence. My children think I am a professional student.

Coming into chiropractic college with 90 units prerequisite requires that the students have the same science background, chemistry, physics, as they would in any other health profession. So the incoming requirements are very similar to any other health profession.

When they enter into the chiropractic program——

Mr. STEARNS. Dr. Phillips, so let's say my son wants to be a chiropractic physician. And let's say he enters the University of Florida, or he enters college, does he need a 4 year degree?

Dr. PHILLIPS. To get in my school, yes. To get into——

Mr. STEARNS. But in general?

Dr. PHILLIPS. But generally he has to have at least 3 years.

Mr. STEARNS. At least 3 years is a prerequisite, okay.

Dr. PHILLIPS. That third year consisting of upper graduate credits.

Mr. STEARNS. Okay, does he need a 4 year college degree? It sounds like you are saying he needs 2 years of college plus this third year?

Dr. PHILLIPS. He needs 3 years of college, 90 units.

Mr. STEARNS. Okay.

Dr. PHILLIPS. And that is a minimum that he needs to get in.

Mr. STEARNS. To get into the chiropractic college?

Dr. PHILLIPS. To get into chiropractic college.

Mr. STEARNS. Okay, and then how many years at the chiropractic college?

Dr. PHILLIPS. Chiropractic college is a 4 year curriculum.

Mr. STEARNS. Okay, and in these 3 years, would my son be taking chiropractic courses or it would be the standard pre-med?

Dr. PHILLIPS. Standard pre-med program. He would have to get his general education requirements. He would have to get all of his sciences, chemistry, physics, biology.

Mr. STEARNS. So he or she would take organic chemistry?

Dr. PHILLIPS. Yes, absolutely.

Mr. STEARNS. Okay, and so they would take all the things that a pre-med student would take for the first 3 years?

Dr. PHILLIPS. Absolutely.

Mr. STEARNS. And then they would leave that college to go to the 4 year chiropractic college?

Dr. PHILLIPS. Yes, so it would be a minimum of 7 years to graduate with their doctor of chiropractic degree.

Mr. STEARNS. So then they get that, okay. Why wouldn't most people just finish their 4 year degrees and then go to the chiropractic school? Why would they leave?

Dr. PHILLIPS. Most of them are doing that now.

Mr. STEARNS. So they would have a 4 year, most of them are having a 4 year degree, then they go to the 4 year chiropractic college?

Dr. PHILLIPS. Correct.

Mr. STEARNS. And what is the leading chiropractic college, the 4 year school named today, give me two or three of the outstanding ones. (Laughter.)

Dr. PHILLIPS. Well, my school, of course.

Mr. STEARNS. The name of your school is?

Dr. PHILLIPS. It is now the Southern California University of Health Sciences. It was previously known as the Los Angeles College of Chiropractic.

Mr. STEARNS. Okay, and that is located in L.A.?

Dr. PHILLIPS. In Whittier, actually.

Mr. STEARNS. Okay. And give me a couple of others?

Dr. PHILLIPS. Well, Dr. Goodman is going to kick me under the table if I don't mention the Logan College of Chiropractic in St. Louis, MO.

Mr. STEARNS. Okay, and how big a school is that? Yours, how big a school is yours, how many students?

Dr. GOODMAN. 850 students.

Mr. STEARNS. 850 students. So my son would probably get a 4 year degree and then he would go to your school of 850 students and he would go for 4 years of training there?

Dr. GOODMAN. Yes.

Mr. STEARNS. Okay. And after his fourth year, can he then start practicing chiropractic—as a chiropractic physician after 4 years there?

Dr. GOODMAN. Well, it is required for licensure in each State, today an individual could take the National Board of Examination, the Chiropractic Board of Examination, and that is covered in 44 States universally. Or if they choose to go to these other six States, they take their State boards. Also, I represent all of the chiropractic colleges here today.

Mr. STEARNS. I see, okay. That's good.

Dr. GOODMAN. As part of the Association of Chiropractic Colleges.

Mr. STEARNS. So what I see is the only thing different, it appears to me, and Dr. Snyder can correct me, but there is not an internship after the 4 years at the chiropractic college. If you got a 4 year degree and then you have the 4 years at a chiropractic college, then you pass the exam, you are ready to go, whereas for a physician, he or she has to have an internship. Or if it is an attorney—well, anyway an internship, is that correct?

Dr. GOODMAN. Well, we have our internship.

Mr. STEARNS. Or a residency, I guess is a better term.

Dr. GOODMAN. Yes, there are residencies available in chiropractic in areas such as radiology, orthopedics, neurology, and family practice. But the general chiropractic student utilizes their internship the last three semesters that they are in school.

Mr. STEARNS. I am just a little puzzled why Dr. Murphy didn't understand this when I asked her. To your knowledge, any of you gentleman, have any VA representatives been sent out to the chiropractic colleges or made any effort to reach across to understand your training and background?

Dr. GOODMAN. At the hearing that we had, we invited the VA to visit, as part of my testimony, to visit any of the Association members, which is all of the chiropractic colleges in the United States.

Mr. STEARNS. And have they followed up on this?

Dr. GOODMAN. Not to my knowledge.

Mr. STEARNS. Okay, let me divert a bit. I understand from staff that, Dr. Goodman, you were one of six chiropractors who wrote a letter to RADM Thomas Carrato, chief operating officer of the TRICARE Management Activity, on February 23, 2000. And I guess there are some chiropractors here on the panel today that had expressed concern regarding the preparation of the Birch and Davis Report on DOD's Chiropractic Demonstration. The staff says there were a number of negative observations. Is that true?

Dr. GOODMAN. Yes.

Mr. STEARNS. And there was also some positive aspects to that report—demonstration—too, weren't they? Were they included in the report?

Dr. GOODMAN. Yes, they were.

Mr. STEARNS. Can you just tell me some of the positive and negative, just briefly? Is that possible, just for the edification of my colleagues?

Dr. GOODMAN. This is outlined in the material that we—

Mr. STEARNS. Submitted.

Dr. GOODMAN (continuing). Submitted.

Mr. STEARNS. I know.

Dr. GOODMAN. We also have some charts that are available for viewing. The first indicates that patients show greater improvement with chiropractic care than with traditional medicine. And we can see proportion of patients with improvement in the disability score and proportion of patients with improvement in the pain score. We also see patients expressed greater satisfaction with chiropractic care, chiropractic versus traditional medicine. The last one is the average patient who experienced back pain and the fewer days under chiropractic care, which is remarkable.

(See pp. 160 to 162.)

Mr. STEARNS. What are the negative aspects in the Birch and Davis Report, maybe just two or three that you differ with?

Dr. MCMICHAEL. If I could respond, Mr. Chairman?

Mr. STEARNS. Yes.

Dr. MCMICHAEL. I believe that that letter to RADM Carrato was in part in relation to the fact that we felt that we were not having opportunity to have enough face-to-face meetings to have the discussions that we feel we should have also been having with the Veterans' Affairs Committee so that we could, in fact, make certain that that data collected was evaluated appropriately, comprehensively, and fairly. And that we could have a very integral part in assisting in writing that particular report.

Our last Oversight Advisory Committee, face to face, was held I believe in July of 1998 and it was more than a year-and-a-half later when the final report was sent back to Congress. And in the interim, we had a couple of phone calls. But, frankly, with an issue of this import and at times this controversy or lack of understanding, if you will, we felt that it very much necessitated face-to-face meetings. So I believe in that letter, we pointed out some inadequacies to what was going on and our inability to address those at the table.

(See p. 72.)

Mr. STEARNS. I thank you. My time has expired. Dr. Snyder?

Dr. SNYDER. I wanted to ask about the Millennium Health Care Act itself, would you all have—if we reach a point that instead of 9,000 chiropractic visits a year, we have—I don't know what a magic number would be, 800,000 chiropractic visits a year, will you all be satisfied if a veteran can walk into a hospital, see a primary care doctor and say, "I tried that Motrin. My back flared up. Can you refer me to a chiropractor?" Will you all be satisfied, Dr. McMichael?

Dr. MCMICHAEL. Yes, Congressman. The importance of primary access to the doctor of chiropractic, which mirrors the private sector, is that the patient when our care is most appropriate, and that is early, aggressive care, largely for those neuro-musculoskeletal conditions and neurologic problems that may be related to those segmental dysfunction problems as well, we need to see that patient as early on as possible to help them as much as we can.

One thing that happened in the DOD study is that some patients referred by traditional providers were being medicated before they sent them to the chiropractic clinic. The problem with that was we didn't get a very good comparison at times, because they had both forms of treatment.

But when we compared the two treatments——

Dr. SNYDER. That is real world stuff, too, right?

Dr. MCMICHAEL. Pardon me?

Dr. SNYDER. That is real world stuff, though, patients self-medicate before they—I mean that is just the real world.

Dr. MCMICHAEL. Yes, it is the real world that patients may medicate themselves. It is also real world that some patients cannot tolerate medication.

Dr. SNYDER. Right.

Dr. MCMICHAEL. That some choose not to employ medication for their health. And chiropractic is best employed as an early intervention, although we have recent studies to show that it is very valuable for chronic care as well.

Dr. SNYDER. Now, is—I don't think you actually got—I am trying to get a sense of what you all are looking for. We have got a system right, I mean I attended an oversight hearing a month ago or so, and we have a real problem getting hepatomologists, liver experts, into VA hospitals and we know we have a big problem with Hepatitis-C. We have got a real money crunch here. I am trying to figure out what is the real world. I don't think we are going to have a system where we are going to have two or three chiropractors in every VA hospital in the country. I don't think that is going happen. I just don't think financially it can.

The issue is what would you all be satisfied with? You obviously are not happy with the way this policy has been implemented, but I am trying to get a feel if a veteran could walk in, if me as a veteran could walk in in an acute situation and the doctor says, "Well, here is some Motrin, some physical therapy." And the veteran says, "Well, my preference would be if I could see the chiropractor or a chiropractor today," and they get a referral that day, will you all be satisfied with that?

Mr. MCLEAN. Congressman, might I address that?

Dr. SNYDER. Sure.

Mr. MCLEAN. I think you have two questions actually and they are both good questions. The first one is what would be the appropriate thing to do in the circumstances with chiropractic integrated? And the second is do we have enough money to pay for this if we integrate chiropractic? And they are both questions.

As to the first one, I would have to say why should he have to take Motrin first? If a patient had a toothache, would you require him to take some painkillers before he saw a dentist?

Dr. SNYDER. Let's not get hung up on that. I said if a patient comes in and says, "I don't care what they say, I would like to see a chiropractor."

Mr. MCLEAN. Right. Your suggestion was they take the Motrin first, though.

Dr. SNYDER. No, I am not suggesting that at all.

Mr. MCLEAN. Oh, okay. All right, fine.

Dr. SNYDER. I am trying to present a real world case to you and if you don't understand that patients actually take medicines over the counter before they call in, whether it is chiropractor or physical therapists or doctors, that is the reality. But, okay, we will take your pure patient who, he immediately goes from the soccer field to the VA hospital, completely medicine-free——

Mr. MCLEAN. Says he would like to go to a chiropractor.

Dr. SNYDER (continuing). And says, "You are my primary care doctor, but my preference would be to see a chiropractor," and they arrange for that referral, would you all be satisfied with that kind of system at VA?

Mr. MCLEAN. If were a thing where we could trust all of the medical practitioners to go ahead and make appropriate referrals, if they were aware of the sorts of problems that chiropractors deal with and when it is appropriate to refer, that would probably be appropriate. But I don't believe that that is a real world situation, either.

Dr. SNYDER. That is what I tried to get at in my previous panel, which is I think that if we—I think it has to be the patient's choice.

Mr. MCLEAN. We believe the patient needs——

Dr. SNYDER. I think the real world is out there that just by the nature of our training and whatever it is, you are not going to find many M.D. primary care physicians anywhere when a patient walks in and is going to say, "My first choice at therapy is a chiropractor." But I think that you all have a following over decades, if not centuries, of people who are going to say, "Well, I prefer a chiropractor." To me, the issue is how will the VA system respond when a patient expresses a preference for chiropractic care. And I am trying to get a sense of if a patient makes that request and the VA accommodates it, would you all be satisfied with that?

Mr. MCLEAN. Let me make one brief comment. In the Medicare world, a patient doesn't have to go to see a medical doctor first. They simply self-select. I don't see any problem with that.

Dr. SNYDER. I don't think that answered my question.

Dr. MCMICHAEL. Congressman, if I could respond further. I hope that I will answer your question more directly. I don't think we are looking for a magic number of visits. I think we are looking for the veteran to have a freedom of choice.

Dr. SNYDER. Right.

Dr. MCMICHAEL. If they have heard about this chiropractic care, and hopefully they will receive some education within the VA to its benefits, and they choose those services, that they would not be restricted from seeing a doctor of chiropractic to receive those services. We are here to represent the freedom of choice for veterans and that our D.C.s have an opportunity to serve them across the country.

And, frankly, we believe that this will not be expensive. The initial cost outlay may certainly involve some expense to get these established. Within the DOD, I think it was a very reasonable amount per clinic. What they found was that you can't just look at the expense of rendering the service. You must also look at expenses averted by outcomes and satisfaction when that service is rendered. And, frankly, we believe that there will be savings for the Veterans Administration or a nominal expense for incorporating this new service for our veterans.

Mr. STEARNS. The gentleman's time has expired. Mr. Moran?

Mr. MORAN. Mr. Chairman, thank you. Doctors, thank you for joining us. Would you compare for me the coverage allowed, the policy of the Veterans Department as compared to other private

and public programs or policies as far as your success in getting coverage for DC's?

Dr. MCMICHAEL. I would be happy to begin, Mr. Moran. Our coverage generally through the health care system has been very broad relative to State law and insurance equality laws. The doctor of chiropractic can practice within that scope and render evaluation and management services, which are examination services done and coded per any physician. They may perform x rays and interpret those x rays. They may do laboratory testing. They do a broad range of skilled manipulation, be that osseous or soft tissue, particularly the chiropractic adjustment.

Mr. MORAN. That being the only part that currently is allowed for veterans is the manipulation?

Dr. MCMICHAEL. That is the way we read the policy.

Mr. MORAN. You are giving me the list, the last one that you mentioned is the only one at the moment that is covered by the Department's policy?

Dr. MCMICHAEL. I am giving you the list that I have been able to practice under in Ohio for the full 26 years that I have been in practice.

Mr. MORAN. And those services, that longer list of services that you provided are covered by private insurance, other federal programs as far as reimbursement?

Dr. MCMICHAEL. Yes, largely. We do, of course, have an ongoing battle at times with some managed care entities, as other providers have as well. I think the only real restricted coverage that we have and we are working on getting changes to that is the Medicare system.

Mr. MORAN. So in the world of providing medical services, we are down, as far as the doctors of chiropractic care, we really are struggling with two programs that provide those services, Medicare and Veterans?

Dr. MCMICHAEL. I believe that would—well, and also our military personnel within the DOD.

Mr. MCLEAN. And also workers' comp, federal workers' comp does cover chiropractic and all the Federal Employee Health Care benefit programs.

Mr. MORAN. I served for 8 years in the State legislature and now 4 years in Congress and it does seem to me that over those—my time in trying to develop public policy that doctors of chiropractic care have had to kind of fight and claw their way into having their services covered, something that I have never understood. I don't understand why it is so difficult for doctors of chiropractic care to have those services covered by federal, state, or private insurance coverage, particularly in light of patient satisfaction, cost-effective care, the desire of patient choice, and the satisfaction that I think generally follows chiropractic care, the satisfaction of the patient.

Is there a way to explain to me, at least either my perception is wrong, that you are fighting and clawing your way into having your services covered, or to tell me why that is, at least based upon my impression of the things I just mentioned, satisfaction, cost-effectiveness, patient flexibility. Why is this such a struggle?

Mr. HENDRICKSON. Competition for the health care dollar is intense. To a very large degree, these are issues of market share. As

members of the committee may be aware, about 14 years ago, representatives of the chiropractic profession filed an antitrust suit against the American Medical Association and 13 other medical organizations in the United States. The finding of the federal courts, all the way through the appeals and to the Supreme Court, was that those medical organizations for anti-competitive reasons, motivated solely to maintain their economic primacy in the health care marketplace, had instituted anti-competitive programs that violated those antitrust laws. And those organizations now are the subject of a permanent injunction upheld by the United States Supreme Court.

I think added to that is a lack of understanding. I think added to that are decades, if you will, of the indoctrination on the part of medical organizations about the chiropractic profession, much of which is based on myth, incorrect assumptions, very willfully and also very skillfully, circulated through the medical education process, through the medical organizations and through the media.

And so this is a situation where this committee in the Congress needs to be proactive, needs to recognize that decades of discrimination for economic advantage have disadvantaged the doctor of chiropractic and the chiropractic beneficiary. And this is a matter of record. This is not a matter of opinion.

Mr. MORAN. So, Mr. Hendrickson, it is an issue of economics, of one aspect of—one section of medical providers fighting another set of providers?

Mr. HENDRICKSON. Yes, and the issues of fairness that stem from that. And I think the ability of an eligible beneficiary for any program to make an informed choice and to have a care pathway closed to them in spite of their wishes, in spite of the appropriateness of that care is bad public policy.

Mr. MORAN. My time is going to expire. And I understand your explanation, although the part of this question that I still don't understand is why those who seek to provide services at the lowest cost would not find chiropractic care desirable. It is not the doctors but physicians, the M.D.s who are making choices about whether or not chiropractic care is provided or allowed under a policy. It is a business person who owns an insurance company or a federal administrator making a decision about what is covered and if chiropractic care can be provided with good outcomes in a cost effective manner, I have never understood why those individuals making "business decision" would not find chiropractic care advisable.

Mr. HENDRICKSON. I think very briefly, Congressman, those individuals are not making business decisions. That is the long and short of the situation that we are in. As long ago as the 1960s, the then Department of Health, Education, and Welfare were publishing papers about physician-dominance of the Blues and the skewing effect that that professional-centric, if you will, view that medical doctors who ran those organizations took about anything that competed with the core of their economic self-interest. And I think, again, these decisions oftentimes are not business decisions.

And, Mr. Chairman, if I could have 90 more seconds?

Mr. STEARNS. If you could just wrap up. The gentleman's time has expired.

Mr. HENDRICKSON. I think that, in fact, the 30 to 40 million Americans who routinely pay out of their own pocket for chiropractic services at some point when other services are available at no charge or a limited amount of money is exactly that kind of a validation, that the private sector has validated chiropractic on a scale that is just monumental.

Mr. STEARNS. The gentleman's time has expired. Mr. Peterson is recognized.

Mr. PETERSON. Thank you, Mr. Chairman. Following Dr. Snyder's question, what I understand is that in a perfect world, you would like to see chiropractors on staff at the VA so when somebody comes in, a chiropractor would be there just like a medical doctor. Is that what you see as the ultimate goal?

Dr. GOODMAN. Yes, there is a history within the demonstration project or 5 years in the Department of Defense. And we were within the hospitals of the military medical system and that has worked well. And it has provided for good care for our men and women of the military.

Dr. MCMICHAEL. I would add, Congressman, that we certainly would like to see D.C.s integrated at every level within the DVA into a Division of Chiropractic, if you will, to oversee chiropractic services so that the chiropractic perspective is there. As employees, so they are there every day with other employees of the VA. Perhaps on an outpatient basis where there is not a facility close for veterans to receive chiropractic care. In the DOD project, our doctors of chiropractic were involved on committees in the hospital. They were involved in educational programs at many different—

Mr. PETERSON. I figured that that was your position and I have no problem with that. When I was in the State legislature, I helped to put your profession on an equal playing field in Minnesota, and I believe what you are saying here. The problem is that my VISN, is facing a \$51 million funding deficiency. They are going to ask us for \$51 million more on an emergency basis because they are that short of money. If they don't get the money, as I understand it, they are going to lay off 50 or 50 nurses in the Minneapolis VA. The waiting period already is a year, sometimes 2 years. We have got in Fargo one whole wing shut down because we don't have people in there to man it even though we have got waiting lines and people can't get in.

I think the problem that nobody has talked about, is how are we going to get the money to do this given what is going on? And it would be hard for me to say that we are going to mandate that they put doctors of chiropractic in every hospital when we can't put the nurses in there, and we can't put the doctors in there. We need to see the patients that are already showing up. And I don't disagree that probably if we had doctors of chiropractic there, it might be cheaper. It might make outcomes better, but how do we ever get in a budget situation so we can do this in the first place?

Dr. GOODMAN. Sir?

Mr. PETERSON. And I think the real problem the VA is having with this internally is that they can't take care of things now. And, frankly, even though we are doing a better job with the budget this year, we aren't doing our job here. We aren't putting the money out there to make this thing work.

And, lastly, I am not getting calls from my veterans complaining that they can't see chiropractors. I am getting calls complaining they can't get into the hospital and they have to wait for a year.

So I would also say to you that if you want to make this happen, you better get folks calling Members of Congress saying that this is something that is a priority because that is not what I am hearing out there. Maybe once in a while, but that is a minor problem compared to all the other problems that we have got.

Dr. GOODMAN. One of the things that we have attempted to propose in our plan that has been presented is an appropriate time process for the doctor of chiropractic to work with the VA to implement this process over a time period so that the VA and the chiropractic profession can integrate itself appropriately. And that certainly does not have a large price tag to implement care and to work on the implementation stages. And so we feel that we have adequately asked the committee to look at this proposal.

Mr. PETERSON. And I think that is a good approach but I still, just from my time around this place, haven't got a lot of confidence that we are going to put the money into this that we need, and we are going to create a problem down the road. We have done this in Medicare. We have got our head in the sand on Medicare. We have got our head in the sand on social security. And in politics, everybody is looking at the short term. If they can figure out a way to make it work in the budget the next few years, everybody ignores what is going to happen 20 years from now. And I don't have a lot of confidence from what we have been doing here the last few years that we are going to put the money into the system that needs to be put in to get at some of these basic problems.

So what I am saying is I don't have any problem with what you are trying to do, but I don't know where we are going to come up with the money to make it happen.

Mr. STEARNS. The gentleman's time has expired. The gentleman, Dr. Filner, is recognized for questions.

Mr. FILNER. I thank the chairman. Is Dr. Murphy or Dr. Holohan here? Anybody from the VA here? Can you tell me who you represent or what division?

Mr. STEARNS. The only thing, I caution my good colleague that these people, if you are going to answer some questions, probably might not be qualified to do so.

Mr. FILNER. I am not going to ask them a question, I just want to know who is here.

Mr. STEARNS. Okay, you just want to know who is here. Sir, you are a physician?

Dr. STANTON. Yes, I am Mark Stanton.

Mr. STEARNS. And who is the other person, just the title? I'm sorry? Bill Ramsey, okay, from the VA. And your name is?

Dr. STANTON. Mark Stanton, primary care chief consultant.

Mr. STEARNS. Okay, Mark Stanton, primary care chief. And we thank you for coming.

Mr. FILNER. Well, I am disappointed that the people who testified did not stay to hear what other people had to say about what we consider a very important issue. We have seen that time and time again. On the Benefits Subcommittee, we tried to schedule the VA people last so they have to listen to the other folks. But if I

were in order, Mr. Chairman, I would ask for a contempt of Congress citation against Dr. Murphy and Dr. Holohan. We spent their whole time here talking about lack of dialogue and trying to understand the issue, and then they take off. For the record, I just want to say that Dr. Murphy and Dr. Holohan are not here to listen to the panels of experts that came before the Congress.

On a more substantive note, what I think I read in Dr. Murphy's testimony and when we heard about their complaints about the original proposal, every time you say "direct access," they read "primary care."

[Telephone rings.]

Mr. FILNER. That is Dr. Murphy now. (Laughter.)

There seems to be a confusion here. You are not asking to be the primary care physician, is that correct? You are asking for direct access; that is a different thing.

Dr. MCMICHAEL. We are asking to be portal of entry, primary contact doctors, which is the way we practice in the civilian world.

Mr. FILNER. But the criticism that Dr. Murphy made that there is this whole range of diagnoses that I think you would admit you are not claiming any qualification. You are not saying that that should be your function anyway?

Dr. MCMICHAEL. No, two things that doctors of chiropractic do not employ are medication or surgery, which PCP perhaps may not be a surgeon but at least would employ the use of medication. However, many PCPs don't employ spinal manipulation, which is a very necessary and important care for a large number of citizens in our country that have back problems.

Mr. FILNER. Now, I would just say to our staff and our committee the problems that they brought up, they kept saying they had problems, that is direct access, they kept reading primary care. And that is not what is being asked for, and we should make sure that that—they sort of have brainwashed us into saying—that is the way I read direct access before this hearing. So I think that is an important point.

On the scope of service, that is another point of issue here, I think we severely limited the situation with our language in the Millennium bill and we need to change that myself. Although, I would also—every time the VA read that line in the meeting that I had in my office with them, and some of you were there, they kept reading back pain. Every time, Mr. Chairman, Dr. Garthwaite or Dr. Holohan or whoever was there said what the scope was that we mandated, what they see is back pain. That is all they thought that the scope of service was authorized for. And I think we have to make that very clear in legislation, another definition, that goes beyond some narrow thing and allows this very bureaucratic restrictions that you heard here today.

Anyone want to comment on that? Do you agree with me on that?

Dr. MCMICHAEL. My understanding was, Representative Filner, that in fact in the meetings you had with Veterans Administration officials and doctors of chiropractic that you very much encouraged them to broaden their perspective on that language. But perhaps you are correct, we do need to go back and—

Mr. FILNER. We need to write the language.

Dr. McMICHAEL (continuing). Draft stronger language.

Mr. FILNER. I think the root of the issue, as Mr. Hendrickson described, is economics but economics has a way of influencing psychology and philosophy and practice, and I don't think any of these doctors in VA would say they are trying to expand their market services but they have what has become a stereotype, which has ramifications in the economic world, but they have prejudices and stereotypes. I think there are two issues, you would be arrested for driving while chiropractic in their view. I mean they have this vision that you don't have the slightest idea of what you are doing, you haven't any training, you are different than a doctor and, therefore, why the hell should we deal with you?

Mr. MCLEAN. Essentially, that is it.

Mr. FILNER. If we have to mandate a change, Mr. Chairman, somehow because those doctors are not going to change the way they think, most of them unless some personal experience may end up doing that.

What point was the doctor trying to make with the 9,500 referrals and the cost of \$300,000? I thought that, one, as Dr. Snyder pointed out, was very low anyway. But, two, showed very, I don't know, low reimbursement rate that would probably not encourage anybody to be fully integrated with this service in the VA system. Did you read that the same way I did or am I missing something there?

Mr. MCLEAN. That is exactly correct. And I see VA patients on a fee basis in my office in Virginia Beach. And I have one who is in a wheelchair. He is paralyzed. He has no sensation whatsoever in his lower back. He is not coming in to see me for low back pain, but he has a misalignment in his lower back because he is in a wheelchair all the time and it does affect his function and it affects the rest of his spine as well. And precisely because he is in a wheelchair, the doctors at the VA did not think to send him off to a doctor of chiropractic. They assumed he could never benefit from chiropractic care because he has had a spinal fracture and the cord has been completely severed.

Mr. FILNER. Now, are you reimbursed by the VA?

Mr. MCLEAN. I saw him 3 years pro bono and now finally he has been worked through the system and the VA is reimbursing me on him.

Mr. FILNER. I calculate that \$30 a visit. Is that?

Mr. MCLEAN. I would like to get \$30.

Mr. FILNER. You are not getting \$30?

Mr. MCLEAN. Not where I am.

Mr. FILNER. Okay.

Mr. STEARNS. The gentleman's time has expired. I want to thank the second panel for their attendance and their willingness to wait, and we appreciate your attendance. We will now call up the third panel.

Mr. MCLEAN. Thank you so much.

Mr. STEARNS. Now for our third panel, but certainly not the least important. As I indicated earlier, DOD has had ongoing chiropractic services in military hospitals and clinics for a number of years. So this experience in a federal health care facility can be very instructive to the VA, the subcommittee and to Congress in general.

We have RADM Michael Cowan of the Office of the Assistant Secretary for Health Affairs at the Pentagon. He is representing DOD, accompanied by Dr. Richard Guerin. And I welcome our witnesses today. If you would be so kind as to realize your full statement is already part of the record, but you may proceed for 5 minutes. So we will start with you, Admiral. Thank you very much for coming and your patience for waiting.

STATEMENT OF REAR ADM. MICHAEL L. COWAN, U.S.N., DEPUTY EXECUTIVE DIRECTOR AND CHIEF OPERATING OFFICER, TRICARE MANAGEMENT ACTIVITY, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE; ACCOMPANIED BY RICHARD D. GUERIN, DIRECTOR, HEALTH PROGRAM ANALYSIS AND EDUCATION, TRICARE MANAGEMENT ACTIVITY, OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Admiral COWAN. Thank you, Mr. Chairman. If I could ask for your indulgence to make one small correction on the witness list. I was listed as the deputy executive director and chief executive officer. While I appreciate the thought, I am the chief operating officer, and that will be easier to explain that to my boss when I return.

Mr. STEARNS. That correction will be made.

Admiral COWAN. Thank you, sir.

Mr. Chairman and distinguished members of the committee, good morning, and thanks for the opportunity to share with you the Department of Defense's experience with this chiropractic services demonstration. As you know, the Department of Defense provides health care services to about 3.5 million active-duty personnel and their dependents, as well as two million retirees and their dependents.

The chiropractic demonstration authorized by Congress in 1995 gave the Department the opportunity to evaluate both the feasibility and the advisability of furnishing chiropractic services to military medical facilities. The provision authorized in the demonstration required the Department to provide these services at 10 facilities. It also required an Oversight Advisory Committee to provide guidance and program development and implementation.

In 1998, the Congress directed the Department to expand that demonstration into three additional facilities for a total of 13, and we added three control sites for comparison. Seven of these sites were managed under a primary care management principal, six used a patient choice model, and the three control sites I just mentioned.

Over the course of the study, data was collected at each site, in the patient choice and comparison sites, the data was collected using patient satisfaction survey forms at the initial visit and at a 4-week follow-up survey and at the primary care sites the data was collected using patient satisfaction surveys, as well as the encounter data.

The Oversight Advisory Committee, which included six chiropractors and three service members provided assistance to us in the development of guidelines, policies, and procedures throughout

the demonstration. They also provided regular input and feedback on issues such as program methodology, site selection, data collection, and operations and influenced several key decisions that formed the framework for implementing and then evaluating the demonstration.

As directed in the statute, the demonstration program ended on 30 September 1999. However, the services continue. The evaluation was completed and the final report was sent to Congress in March of this year. The bottom line analysis of the data concluded that without sufficient funding of this expanded benefit, it was not advisable to establish chiropractic services throughout the military health system, and I will elaborate on that finding.

All participating facilities succeeded in setting up chiropractic clinics with adequate space, equipment, and qualified personnel. The start-up costs ranged from \$20,000 to \$90,000 per site, depending on the availability of adequate clinic space and construction modification requirements. In sum, we showed that it was feasible.

Both patients and providers indicate that chiropractic care complemented and augmented traditional medical care and it was well received by the patient population, as has been described previously. Additionally, provider attitudes towards doctors of chiropractic changed positively over time and the appropriateness of spinal manipulation to treat certain clinical conditions was judged favorably by traditional providers in our system.

While patients who saw doctors of chiropractic were more likely to show self-reported improvement in health, the expected health and economic benefit are not judged sufficient to offset the adverse effects on other aspects of the military health system if chiropractic services are implemented without adequate funding. The Defense health program would have to divert resources from other health care delivery requirements to fund this program.

Full implementation of chiropractic services—that is, implementation for all of our beneficiaries—is estimated to cost the Department of Defense about \$70 million annually. On the other hand, the potential economic benefit from chiropractic care is estimated at about \$26 million. This partly in increased patient satisfaction and productivity, partly in displacing of costs from physical therapy and other modalities of treatment. There is also a potential value associated with a projected increase in the availability of active-duty members receiving chiropractic care, putting soldiers back to work. However, the changes in economic value did not translate and do not translate directly back into DHP dollars in the form of budgetary offsets.

Mr. Chairman, this concludes my statement. Chiropractic services continue to be provided at the demonstration sites pending guidance from the Fiscal Year 2001 Defense Authorization Bill. We understood that both the House and the Senate versions will include a provision for permanently implementing a chiropractic benefit at DOD.

I thank you again for the opportunity to share our experience with you, and I welcome any questions.

[The prepared statement of Admiral Cowan appears on p. 164.]

Mr. STEARNS. Thank you, Admiral. And, Dr. Richard Guerin, do you have an opening statement?

Mr. GUERIN. I do not.

Mr. STEARNS. All right. Let me start with just an observation, Admiral. In your cost analysis and whether chiropractic was a value, I don't know how you did an analysis saying that chiropractic services did not prove—I think in your words “cost value”—I don't know how you did that, but did you take into account the value of patient satisfaction?

Admiral COWAN. I will try to elaborate. And Dr. Guerin can elaborate further because he was directly involved in the study. He is from our program analysis shop.

Mr. STEARNS. Okay.

Admiral COWAN. We felt that the medical care benefits that directly related back to putting soldiers, sailors, airmen, and marines to duty sooner because we saw that what happened was about \$7 million a year. There were offsets of about \$19 million a year that would not be spent on physical therapy, occupational therapy, other modalities of treatment, whose function would be supplanted by chiropractic care. The quality of life and the value from freedom of pain are difficult to estimate economically, frankly. We recognize those, acknowledge those but cannot put those into an economic package.

I was privileged—personal observation, I was privileged to be the commanding officer of a naval hospital at Camp LeJeune, NC where there was one of the original demonstration sites. It was a bit of a battle to start up. There was a bit of resistance from my orthopedic surgeons, and that changed over the course of the demonstration. The orthopedic surgeons became great fans of the program and our patients were very happy to receive the therapy. During that period of time I was battling for dollars to keep my operating rooms open, so it was simply a matter of prioritization to me at that time where our finances go.

Not so terribly much has changed. Last year, the Department of Defense medical treatment system had to have an emergency supplemental of some fairly large sum of money to fund already existing programs. So it is problematic to add new programs, even those of demonstrated value, at this time.

Mr. STEARNS. Setting up this chiropractic model and this demonstration, you said you had some trouble with it and now the primary people who complained were the orthopedic surgeons and you are saying now that they are on board and there is no trouble then?

Admiral COWAN. Yes, sir, my anecdotal experience at my facility matched the statistics and analysis that was done system-wide. We have seen a steady increase in the appreciation for and the acceptance of chiropractic modalities among our traditional providers.

Mr. STEARNS. Okay, so is your argument today that if the money were available, you would institute across the Department of Defense medical treatment facilities a chiropractic program, yes or no?

Admiral COWAN. We are right now in a waiting mode for the legislation to come out to guide us. I have direction from—

Mr. STEARNS. Yes, but the question would be, sir, is if you had the money, in your personal opinion, do you think it merits putting

across the Department of Defense in every medical treatment facility a chiropractic service?

Admiral COWAN. I will be happy to answer that in my personal opinion, because we do not have a departmental position as—

Mr. STEARNS. Okay.

Admiral COWAN (continuing). We are waiting for the congressional—

Mr. STEARNS. I don't want to put you on the spot, but in your personal opinion?

Admiral COWAN. No, sir, my personal position is that if I could afford it, I would want chiropractors at my facility as a very important part of the range of services that we provide.

Mr. STEARNS. Okay.

Admiral COWAN. Semicolon, and I believe, where appropriate, we would move those out through the—

Mr. STEARNS. Okay, so if I came into the medical treatment facility and I was a young airman, would I go first to the primary physician in your model?

Admiral COWAN. Our system is called Force Health Protection. It includes primary care managers, so that you have a doctor that you go to and, where appropriate, that physician would refer you to chiropractor, as he would refer you to a neurosurgeon or any other specialist.

Mr. STEARNS. And he also refers him to an osteopathic physician, too?

Admiral COWAN. Sir, many of them are osteopathic physicians.

Mr. STEARNS. Oh, you mean the chiropractors?

Admiral COWAN. No, no, many of our primary care providers are osteopathic.

Mr. STEARNS. Okay, I'm with you, okay. So the model you would envision is I would come in, meet with the primary doctor and in-house would be a chiropractic physician which I could be referred to?

Admiral COWAN. Or by contract or by—we build business practices with local providers. In many cases, where appropriate, a larger facility might find it a good business case to hire full-time chiropractors.

Mr. STEARNS. Okay.

Admiral COWAN. A smaller hospital might simply contract with local providers for some percentage of their care or a percentage of their cost.

Mr. STEARNS. Let's say I came in and I talked to my father and he said, "Go to a chiropractic physician," could I as an airman come in, under your model, go to one at my own choice or would I have to go through the gatekeeper of the physician?

Admiral COWAN. No, sir, you would go through the gatekeeper physician.

Mr. STEARNS. Okay, and that would be your preference?

Admiral COWAN. Yes, sir.

Mr. STEARNS. But to establish what you are saying is if the money were available, you would have your model in all the medical treatment facilities in the Department of Defense?

Admiral COWAN. I would be an advocate for that, yes, sir.

Mr. STEARNS. Okay, thank you. Dr. Filner?

Mr. FILNER. Just briefly, I guess I at some point I would like to see the basis of all those calculations, but it seems to me, Mr. Chairman, that in the marketplace where these decisions are made, HMO's and others have said it was cost effective to institute the chiropractic benefit. And these are the folks that we always accuse of putting the bottom line ahead of everything else. But in their words, the bottom line—or in their experience, the bottom line seems to have paid off. So I don't know the difference between what the military does and what the private sector does. And I would like to see some time the basis of these extrapolated figures that you did.

Just in conclusion, Mr. Chairman, I want to thank you again for having this hearing. I think it was very important. I think we have a prima facie case of more direct congressional action. I think the VA through the folks who were testifying here, just taking off is symbolic of their refusal to participate in a real process that would have an outcome that would help our veterans. And the misunderstanding of what chiropractic services are, the training shows that we cannot rely on their advice when we write this legislation.

We had a bill, I think the chairman supported it. We held back really I think, if I recall, correct me if I am wrong, on the basis of VA objections. I would say their objections—they have not made the case for their objections today, and we should go forward. And if they don't want to participate in a real dialogue, then we will have to go on with what we have determined on our own and through this hearing.

So I did learn a lot, and I appreciate the Defense Department also being here. Admiral, you have us somewhat of an objective stance here. But I think we ought to look at those figures in more depth. And I thank all the folks who came today and who stayed around to hear the other side's testimony as well.

So, again, thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague. And by unanimous consent, I wish to put four letters in part of the record. One is a letter dated September 28, 2000 from the American Osteopathic Association. The second is a letter dated October 2, 2000 from the American Physical Therapy Association. The third letter is a letter dated September—excuse me, October 3, 2000 from the World Chiropractic Alliance. And the fourth letter is a letter dated October 3, 2000 from the American Medical Association.

By unanimous consent, so ordered.

(See pp. 61 to 70.)

Mr. STEARNS. I want to thank the third panel for attending and waiting. I would point out to my colleagues and everyone that part of the report language, we talked about what we had in the Millennium Health Care bill but in every bill there is report language in the back, and the report language defines—uses a term to include “rehabilitative services and other unspecified services that the Secretary determines to be reasonable and necessary under a fee basis arrangement or within.” So that there is report language that the administration could use as a guide, not just quoting what is in the bill itself.

Let me just in a personal note say this is my last hearing as subcommittee chairman. It has been an honor and an education for

me. And I appreciate the opportunity to do it. I thank Mr. Stump, our chairman, for allowing me to be the chairman of this great subcommittee and, of course, working with the ranking member, Mr. Evans, and also Mr. Gutierrez, who has been a fine and able ranking member on the subcommittee. And I look forward to working with these individuals in the next Congress.

And with that——

Mr. FILNER. Mr. Chairman?

Mr. STEARNS. Yes?

Mr. FILNER. And I thank you for your leadership. Six years already?

Mr. STEARNS. Yes, 6 years already.

Mr. FILNER. And I think you can look back as saying that you had some real impact for improving the health care of all our veterans, and I think that is what we all want to try to do. So I appreciate your efforts.

Mr. STEARNS. Thanks, Dr. Filner. And the subcommittee is adjourned.

[Whereupon, at 12:10 p.m., the subcommittee was adjourned.]

APPENDIX

Department of Veterans Affairs
 Veterans Health Administration
 Washington, D.C., 20420

VHA DIRECTIVE 2000-014

May 5, 2000

CHIROPRACTIC CARE AND SERVICES

1. **PURPOSE:** This Veterans Health Administration (VHA) directive establishes policy and guidance related to VHA chiropractic care and services.

2. BACKGROUND

a. On November 30, 1999, Public Law (Pub. L.) 106-117, the Veterans' Millennium Health Care and Benefits Act (the Millennium Act) was signed into law. Section 303 of the Millennium Act requires the Under Secretary for Health, within 120 days from the date of enactment, and after consultation with chiropractors, to establish a VHA-wide policy regarding the use of chiropractic treatment in the care of veterans. The statutory language establishes no parameters with respect to such policy, except for the consultation requirement. Subsection (b) of section 303 limits the definition of the term "chiropractic treatment" to the manual manipulation of the spine for the treatment of "such musculoskeletal conditions as the Secretary considers appropriate." The law defines "chiropractor" as an individual "who is licensed to practice chiropractic in the State in which the individual performs chiropractic services; and holds the degree of doctor of chiropractic from a chiropractic college accredited by the Council on Chiropractic Education." A group of VHA officials met with representatives of the leading chiropractic organizations on February 24, 2000, for purposes of consultation as specified in Pub. L. 106-117.

b. When considering the scientific evidence concerning chiropractors, it is important to keep in mind two related, but distinct, concepts. Spinal manipulation is a form of manual therapy that is used by chiropractors, physical therapists, osteopaths, and some medical doctors. Chiropractic treatment frequently involves spinal manipulation, but may also include other non-thrust manual therapies, such as mobilization and massage, as well as advice about exercises, nutrition, and proper diet. Prior studies estimate that 70 to 90 percent of patients presenting to chiropractors will be treated with spinal manipulation.

c. There is sufficient evidence in the form of randomized clinical trials to conclude that spinal manipulation is a modestly efficacious form of therapy for some patients with uncomplicated low-back pain. These data include clinical trials where the manipulations were provided by physical therapists, osteopaths, and chiropractors. There are no clinical trial data to support a position that spinal manipulation delivered by chiropractors is more effective or less risky than spinal manipulation delivered by any other type of practitioner.

d. What is not established is the effectiveness of either spinal manipulation or chiropractic care relative to other forms of care for patients with low-back pain. For example, a recent high-quality randomized clinical trial published in the *New England Journal of Medicine* (November 1999, Vol. 341) compared chiropractic care to physical therapy care or self-care. Both the chiropractic group and the physical therapy group had small benefits compared to the patients receiving self-care, but there were no differences between the chiropractic group and the physical therapy group. Furthermore, both chiropractic care and physical therapy care cost more per patient than self-care.

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e. The cost-effectiveness of chiropractic care is uncertain. Observational studies based on claims data or workmen's compensation data tend to suggest that chiropractic care is of lower cost, while scientific and rigorous randomized clinical trial data report chiropractic care is more expensive.

f. Health Care Financing Administration (HCFA) regulations regarding reimbursement of chiropractic care are clearly delineated in Section 2251 of the HCFA Carriers Manual. Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation. Chiropractic care is, therefore, limited to the treatment of spinal subluxation that is documented by either physical examination or by x-ray. *NOTE: Full details related to chiropractic care coverage and limitations as defined by HCFA can be found in the HCFA Carriers Manual Section 2251.*

3. POLICY

a. It is VHA policy that VHA medical centers and clinics may offer chiropractic spinal manipulative therapy for musculoskeletal problems of the spine. Following a referral from a Department of Veterans Affairs (VA) clinician, chiropractic services may be authorized consistent with Title 38 United States Code (U.S.C.) 1703(a)(2)(B). *NOTE: Title 38 U.S.C. authorizes VA to contract for non-VA medical services for veterans receiving VA care and who require additional care to complete their treatment. It is recommended that when such services are authorized under this authority, payments for non-VA outpatient chiropractic care should be set up as an individual authorization and paid through the Fee-basis payment process in the Veterans Health Integrated Systems and Technology Architecture (VisA). Facilities may procure local contracts for chiropractic services when it is determined that the need for such services is sufficient to support the contract action.*

b. VHA will collect information on the utilization of chiropractic consultation and services by VA staff. VHA has not developed a body of experience on the type and amount of chiropractic services VA facilities will require or utilize, and there are neither current established authorization for appointment nor credentialing requirements for chiropractors in Title 38.

4. ACTION

a. The determination of the level of necessary chiropractic services is best made at the facility or the Veterans Integrated Services Network (VISN) level. *NOTE: The need for chiropractic services is likely to be affected by many local or regional factors, such as the burden of illness, availability and access to alternative services, (e.g., physical therapy), urban versus rural environments, patient preferences, etc. Delineating a nationally uniform requirement for the frequency, intensity and duration of chiropractic services, without regard to local exigencies, would be inefficient and inappropriate.*

b. VISNs and/or medical centers will develop a local policy for chiropractic care and services within 120 days of the publication of this policy. The VISN or local policy must address the following:

- (1) The provision of provider and patient information and education related to chiropractic services.
- (2) The identification and collection of data related to the provision of chiropractic services that can be collected and analyzed nationally. At a minimum, VISNs and/or facilities must ensure that the following will be captured in existing Fee Payment Package (Vista) files and/or the medical record; the:
- (a) Reason for referral,
 - (b) Applicable International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) code,
 - (c) Current Procedural Terminology (CPT)-4 code,
 - (d) Number of treatments provided,
 - (e) Cost per visit, and
 - (f) Results of treatment.
- (3) The mechanism(s) and process (es) that will be utilized to authorize, provide, and evaluate the appropriateness and effectiveness of chiropractic services.
- (4) Delineate how chiropractic care will be incorporated into the existing local quality reviews, local utilization management policies, and local credentialing and privileging policies (in accordance with VHA Handbook 1100.19) in a manner that assures an appropriate level of oversight.
- c. Medical centers and VISNs must ensure that chiropractic services are provided only by individuals who are licensed to practice chiropractic in the State in which the individual performs chiropractic services; and who hold the degree of Doctor of Chiropractic from a chiropractic college accredited by the Council on Chiropractic Education."

5. REFERENCES

- a. Public Law 106-117, Section 303 of the Veterans' Millennium Health Care and Benefits Act.
- b. Title 38 United States Code 7402(b)(10).
- c. VHA Handbook 1100.19, Credentialing and Privileging.

6. FOLLOW-UP RESPONSIBILITY: The Chief Patient Care Services Officer (11) is responsible for the contents of this Directive. *NOTE: Questions may be directed to the Office of Primary and Ambulatory Care at (202) 273-8558.*

VHA DIRECTIVE 2000-014
May 5, 2000

7. RESCISSION: This VHA Directive expires May 5, 2005.

S/ Frances Murphy, M.D. for
Thomas L. Garthwaite, M.D.
Deputy Under Secretary for Health

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AMERICAN OSTEOPATHIC ASSOCIATION

1090 VERMONT AVE., N.W., SUITE 510, WASHINGTON, D.C. 20005 • 800-962-9008 • 202-414-0140 • FAX 202-544-3525

September 28, 2000

The Honorable Cliff Stearns
 Chairman, Veterans Affairs Subcommittee on Health
 U.S. House of Representatives
 338 Cannon House Office Building
 Washington, DC 20515

Dear Chairman Stearns:

As President of the American Osteopathic Association (AOA), which represents the nation's 44,000 osteopathic physicians, I would like to thank you for this opportunity to submit comments on proposed changes in the Department of Veterans Affairs Chiropractic Policy.

Background

Osteopathic medicine is one of two distinct branches of medical practice in the United States. Osteopathic physicians are licensed in all 50 states. They practice in over 23 specialties and subspecialties, in hospitals and clinics around the country and in several foreign nations. While allopathic physicians (M.D.) comprise the majority of the nation's physician workforce, osteopathic physicians (D.O.) comprise more than five percent of the physicians practicing in the United States and a significant percentage of physicians serving in the armed services. Significantly, D.O.s represent more than 15 percent of the physicians practicing in communities of less than 10,000 and 18 percent of physicians serving communities of 2,500 or less.

We also feel that it is important to outline the education that each osteopathic physician receives and the process that enables a student to obtain the doctor of osteopathic medicine degree, complete post-graduate training and eventually obtain a license to practice. Prior to entering a college of osteopathic medicine, students must complete their undergraduate education. Although the requirements for admission to osteopathic medical schools vary from college to college, there are basic academic standards that must be met. These requirements include an exceptional academic record and achievement of a satisfactory score on a required admission exam. Applicants must demonstrate personal characteristics that reflect the ability to achieve in the rigors of osteopathic medical education and eventually the practice of medicine.

During the first two years of osteopathic medical education, each student must participate and show proficiency in classes that focus on the basic sciences, clinical sciences and social sciences. The third and fourth years of osteopathic medical education focus on the clinical training of student doctors. This clinical training consist of clerkships performed in hospitals, clinics and private offices in the primary care specialties (internal medicine, family medicine,

<http://www.aoa-net.org>
 e-mail: info@aoa-net.org

pediatrics) as well as many other specialties and subspecialties (surgery, cardiology, neurology, obstetrics and emergency medicine).

An additional and distinct difference between osteopathic physicians and their allopathic colleagues is the training in osteopathic manipulative medicine (OMM). Each physician that graduates from a college of osteopathic medicine has received didactical and clinical training in OMM. I would like to stress to you that the education of osteopathic medical school students in OMM is not optional, it is a requirement. This training in OMM allows our students to enter the practice of medicine with an additional skill unique to osteopathic physicians. These skills allow D.O.'s to better diagnose and treat patients with musculoskeletal symptoms or illnesses related to musculoskeletal dysfunction. This unique set of skills was a fundamental reason the osteopathic profession was established in 1892.

Upon completion of the four year curriculum, a student receives the doctor of osteopathic medicine degree, and begins post-graduate training in the chosen specialty. Graduate medical education is required for each osteopathic physician.

AOA Position

Mr. Chairman, the AOA is a strong supporter of the Department of Veterans Affairs and the Veterans Affairs Health Care system. We strongly support the Department's efforts to provide quality health care to our nation's veterans. However, we must oppose the proposed language designed to implement the Veterans Health Administration Chiropractic Policy Directive of May 5, 2000.

The AOA supports veterans' access to chiropractic services, but remain concerned about efforts made by chiropractors to expand their scope of practice beyond the bounds of their education and training. The issue of chiropractor scope of practice is heavily debated in the individual states. The AOA remains opposed to any legislation that would allow chiropractors to provide services for which they are not trained. We offer the following responses to the proposed legislative language.

- **Direct Access (without requirement for a referral) to doctors of chiropractic at all medical facilities of the Department of Veterans Affairs.**

The AOA feels that access to chiropractic services should be governed by the same regulations that apply to all other services such as physical therapy, occupational therapy and speech therapy. By allowing direct access to chiropractic therapy, you would eliminate the important process of physical examination and medical history by an osteopathic or allopathic physician. Any patient seeking care, regardless of symptoms, should first be examined by a physician. This allows for an overall evaluation of the patient's condition, diagnosis and formulation of a treatment plan.

We also are concerned about direct access based upon our belief that chiropractic therapy should be part of a treatment plan for a particular patient, not the sole treatment plan. Many patients may also require pharmaceutical treatment in conjunction with physical, occupational

or chiropractic therapy. Hence, the AOA believes that patients receiving any type of therapeutic treatment should remain under the supervision of the primary care physician. This allows for continuity of care that is constantly evaluated by the patient and physician.

- **Full scope of practice of chiropractic health services, to include as an absolute minimum, care for neuromusculoskeletal conditions typical of those affecting all age groups within the eligible veterans populations serviced by the Department of Veteran Affairs.**

Chiropractors are not fully licensed physicians. Therefore the AOA challenges this proposal because we believe that chiropractors lack the proper education and training to be given "full scope of practice" in the care of musculoskeletal or neurological conditions. Many medical and neurological conditions often present as musculoskeletal disease and should not be treated with manipulation. These serious medical conditions, that often present with musculoskeletal symptoms, require an understanding of complicated medical information not generally obtainable from chiropractors.

The AOA believes that doctors of chiropractic do not have the necessary medical knowledge or clinical training to be given a "full scope of practice" in the care of musculoskeletal and neurological conditions. Although many conditions are treatable via osteopathic manipulation or chiropractic treatment, this course of treatment should be prescribed by an osteopathic or allopathic physician after the patient has been thoroughly examined and evaluated.

- **Allowance for doctors of chiropractic to act as referring primary care physicians in the Department of Veterans Affairs medical facilities that are in areas designated as medically underserved.**

The AOA adamantly opposes chiropractors being classified as "primary care physicians" under any circumstances. Again, we point out that doctors of chiropractic do not receive training equivalent to osteopathic and allopathic physicians. The AOA strongly challenges their classification as physicians.

We share in the desire of the Department of Veterans Affairs to provide access for veterans in underserved areas to physicians. However, we do not support the concept of access to inappropriate care. The American public has standards and expectations for their "primary care physician." It is our view that chiropractors are unable to meet these public standards and expectations. Again, we base this opinion on the education and clinical training of chiropractors versus osteopathic and allopathic physicians. Furthermore, we feel that the classification of chiropractors as primary care physicians, would constitute a misrepresentation of their qualifications to the public. It would be inappropriate for the Veterans Administration to establish a lower standard of care for those who live in rural or underserved areas.

Summary

In closing, the AOA thanks you for the opportunity to submit comments to this distinguished committee. The AOA does not oppose veterans access to chiropractic services, but we cannot support several proposals that the American Chiropractic Association has submitted. Our opposition is based upon the belief that the expansion of scope for non-physician providers, including chiropractors, prevents patients from receiving the quality of care that they expect and deserve.

We strongly oppose expansion of the scope of practice for non-physician providers and defend this position on the basis of the stark differences in education and post-graduate training that exist between chiropractors and osteopathic and allopathic physicians. Under no stretch of the imagination do doctors of chiropractic receive an equivalent education to osteopathic or allopathic physicians. Their education and clinical training is limited to, and strictly focuses on, chiropractic techniques and treatments. We are unaware of any sufficiently substantiated evidence that establishes the chiropractic community has met the necessary standards to expand their scope of practice.

In contrast, D.O.'s receive an extensive and expansive education in the basic and clinical sciences. They complete two years of clerkships focused on all areas of medical practice followed by a minimum of three post-graduate training years in a field of their choice. This difference in education and training historically has differentiated physicians from non-physician providers. We believe these differences should be the basis of terminating the proposal before the committee.

Again, thank you for the opportunity to share our positions with you. Our Department of Government Relations, located in Washington, D.C., is available to respond to any questions you or your staff may have.

Sincerely,



Donald A. Krpan, D.O.
President

- C: Members, Veterans' Affairs Health Subcommittee
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 AOA Board of Trustees
 AOA Council on Federal Health Programs (COFHP)
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Chief Executive Officer

Francis J. Mallon, Esq.

Combined Sections Meeting
 February 14-18, 2001
 San Antonio, TX

PT 2001:
 The Annual Conference:
 A Exposition of the
 American Physical Therapy
 Association
 June 21-25, 2001
 Anaheim, CA

October 2, 2000

The Honorable Cliff Stearns
 Chairman, Health Subcommittee
 House of Representatives Veterans' Affairs Committee
 335 Cannon House Office Building
 Washington, DC 20515

Dear Chairman Stearns:

Thank you for the opportunity to provide comment with regard to the Committee's consideration of direct access to chiropractic care and services within the Veterans' Health Administration (VHA). APTA supports all Veterans having direct access to appropriate health care services. Improved access to health care will encourage preventative care, reduce long-term health care needs, and provide improved health outcomes for Veterans.

While APTA has no formal position with regard to direct access to chiropractic care and services within the VHA, the Section on Veteran Affairs of APTA is concerned that VHA beneficiaries may not be appropriate candidates for spinal manipulation given that they are largely a geriatric population. It is also apparent that comparable services are presently available to beneficiaries who require such care. These findings are also supported by the VHA's May 2000 policy directive relating to chiropractic care and services:

"Subsection (b) of section 303 limits the definition of the term "chiropractic treatment" to the manual manipulation of the spine in treatment of "such musculoskeletal conditions" as the Secretary considers appropriate."

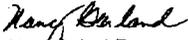
"Spinal manipulation is a form of manual therapy that is used by chiropractors, physical therapists, osteopaths, and some medical doctors."

"There are no clinical trial data to support a position that spinal manipulation delivered by chiropractors is more effective or less risky than spinal manipulation delivered by any other type of practitioner."

APTA does, however, support the right of an individual to obtain treatment from a licensed health professional qualified to provide the health care service where and when he or she may choose. Thus, APTA urges the Committee to consider the military model of unrestricted access to care with respect to rehabilitation services as it considers providing greater access to care for beneficiaries.

Thank you for the opportunity to comment in regard to the Committee's consideration of direct access to chiropractic services. The American Physical Therapy Association (APTA) represents over 65,000 members and its goal is to foster advancement in physical therapy practice, education, and research.

Sincerely,

A handwritten signature in cursive script that reads "Nancy Garland".

Nancy Garland, Esq.
Director, Government Affairs



World Chiropractic Alliance

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TESTIMONY

Submitted by:

Dr. Terry A. Rondberg
 President, World Chiropractic Alliance
 2950 N. Dobson Rd. Suite 1
 Chandler, AZ 85224

TO:

Committee on Veterans Affairs
 Subcommittee on Health
 Hearing on Chiropractic Service in the Veterans Administration
 Tuesday, October 3, 2000
 10:00 a.m.

My name is Dr. Terry Rondberg. I am a doctor of chiropractic and president of the World Chiropractic Alliance (WCA), 2950 N. Dobson Rd., Chandler, AZ 85224. I am also the publisher of *The Chiropractic Journal*, the voice of the World Chiropractic Alliance. It is a monthly publication which reaches more than 50,000 chiropractors in the United States and thousands of additional chiropractors worldwide. WCA is the only national organization which reaches all doctors of chiropractic every month with every issue.

The World Chiropractic Alliance is a non-profit organization of doctors of chiropractic, with members in every state in the United States and in numerous nations around the world. I appreciate this opportunity to submit my comments for the record of the Subcommittee.

The WCA would first like to thank the Congress for its efforts to incorporate chiropractic into the Veterans Affairs Health Services. Time and again, scientific research has shown that chiropractic can be effective in improving health and wellness in a wide range of patients. It provides a unique and drug-free service which can reduce health care costs in many instances.

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 For: Committee on Veterans Affairs Subcommittee on Health
 Hearing on Chiropractic Service in the Veterans Administration
 Tuesday, October 3, 2000 -- 10:00 a.m.

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In addition, by supporting direct access to chiropractic by any patient wishing such care -- without referral by a medical doctor -- Congress is protecting patients' right to choose the health care method best suited to them and their individual health care needs.

However, the World Chiropractic Alliance is very concerned with the description of chiropractic services included in HR 5909. The current wording specifies that the VA plan for chiropractic shall include "care for neuromusculoskeletal conditions typical of those affecting all age groups within the eligible veterans population..."

This terminology has the effect of defining chiropractic as a treatment for neuromusculoskeletal conditions, which is inaccurate. For many, if not most, chiropractors, chiropractic is not a form of medical treatment but rather a unique health care discipline dealing with the correction of vertebral subluxation.

For more than 25 years, chiropractic has been covered as a Medicare benefit in 42 USC 1395x (5), which limits chiropractic services to manual correction of spinal subluxations. The Medicare benefit does not include physical therapy services. The only "condition" covered is spinal subluxation.

The diagnosis and correction of vertebral subluxation is also the purpose which defines chiropractic in most state licensing laws and is the definition supported by the Council on Chiropractic Practice Clinical Practice Guideline, Number 1, "Vertebral Subluxation in Chiropractic Practice," which has been endorsed and adopted by numerous state, regional, and national chiropractic associations.

Finally, it is the definition used by the World Chiropractic Alliance, in its role as an NGO with the United Nations Department of Public Information, when working with other health care officials worldwide and during its discussions with the World Health Organization.

To understand the controversy raised by this bill, it is important to realize that there are two major schools of thought in the chiropractic profession.

The first is committed to positioning chiropractic as a separate and distinct discipline in the healing arts, which does not duplicate existing medical services. It is directed toward the correction of vertebral subluxations, which interfere with the function of the nervous system.

The second school of thought considers chiropractic to be a limited medical specialty for the treatment of certain musculoskeletal disorders. Proponents of this position embrace a broad array of therapeutic interventions including manipulation and physical therapy modalities. This

Testimony by the World Chiropractic Alliance
For Committee on Veterans Affairs Subcommittee on Health
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necessarily encroaches on the practice of medicine and physical therapy.

By failing to define chiropractic as the analysis and correction of vertebral subluxation, the current wording in HR 5909 excludes an entire category of chiropractic. If passed with this wording, thousands of licensed, capable doctors of chiropractic would be virtually barred from providing subluxation-correction services through the VA system.

The WCA and the thousands of doctors of chiropractic it represents cannot support any legislation that excludes a large portion of the profession. In order to win support, any proposal involving chiropractic services within the VA system needs to cover the following:

1. Chiropractic examination and adjustment to correct vertebral subluxations -- Physical therapy and rehabilitation services are already available within the VA system; chiropractic examination and adjustment to correct vertebral subluxations are not. This provides consistency with the other existing Federal program, is the more cost-effective approach, and satisfies legislative intent.
2. Direct access to chiropractic care -- Only a chiropractor is qualified to determine the appropriateness of chiropractic care. Direct access would also eliminate the costs associated with a screening process by other providers.
3. Adoption of Council on Chiropractic Practice Clinical Practice Guideline Number 1, "Vertebral Subluxation in Chiropractic Practice" -- This evidence-based guideline is current and was distributed to U.S. chiropractors in 1999. It was produced by an interdisciplinary expert panel, and underwent peer review by 195 chiropractors in 12 countries. The Guideline was the first to be included in the AHCPR National Guideline Clearinghouse.

The World Chiropractic Alliance and the thousands of subluxation-based chiropractors it represents throughout the world stand ready to work with Congress as it moves toward a full and comprehensive role for chiropractic in the VA.

I thank the members of the Veterans Affairs Committee for their efforts on behalf of chiropractic and for considering the World Chiropractic Alliance perspective on this matter.

American Medical Association

Physicians dedicated to the health of America



E. Ratzliffe Anderson, Jr., MD 515 North State Street 312 464-5000
 Executive Vice President, CEO Chicago, Illinois 60610 312 464 4184 Fax

October 3, 2000

The Honorable Cliff Stearns
 Chairman
 Subcommittee on Health
 Committee on Veterans Affairs
 U.S. House of Representatives
 338 Cannon House Office Building
 Washington, DC 20515

Dear Chairman Stearns:

On behalf of the American Medical Association's (AMA) 300,000 physician and medical student members, I strongly urge you and the members of the Veterans Affairs Subcommittee on Health not to pass legislation that would expand the scope of chiropractic privileges beyond VHA DIRECTIVE 2000-014.

As you know, Section 303 of the Veterans' Millenium Health Care and Benefits Act (P.L. 106-117), which was considered and passed out of this Subcommittee, included a provision that requires the Department of Veterans Affairs (DVA) to establish a policy regarding the role of chiropractic treatment for veterans. This policy was effectively established under VHA DIRECTIVE 2000-014, which allows VHA facilities to offer chiropractic spinal manipulative therapy for musculoskeletal problems of the spine following a referral from a VA clinician. Further, DVA appropriately provided the regional VHA networks with the flexibility to determine the level of necessity for chiropractic services at the local level.

The AMA believes that expanding current statutory authority regarding the role of chiropractic services could lead to a substantial decline in the quality of health care provided to VA patients. We would especially take exception to any legislation that would allow chiropractors to serve as primary care physicians in VHA facilities. Chiropractors simply do not possess the years of specialized medical education and training of physicians necessary to engage in the practice of medicine. In addition, such a departure from the traditional patient-physician relationship is, at the very least, a significant public policy shift and could be in conflict with state health care licensing laws and regulations.

For the same reasons, we believe that this Subcommittee should not provide chiropractors with a special exception for direct access to VA patients without a referral. Not only could this result in underlying medical conditions going undiagnosed, it could preclude other more appropriate courses of treatment from being considered by the patient and the physician. In addition, forcing VHA facilities to provide direct access to chiropractors

could undermine other more appropriate therapy programs already established within such facilities. A better approach is to continue to allow VHA facilities to determine the level of necessity for chiropractic services at the local level.

I appreciate having the opportunity to comment on these issues that could adversely impact the quality of care being provided to our nations' veterans. The AMA stands ready to work with you at any time on this or any other matter.

Respectfully,

A handwritten signature in black ink, appearing to read "E. Ratcliffe Anderson, Jr., MD". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

E. Ratcliffe Anderson, Jr., MD

cc: Members of the Subcommittee on Health

February 23, 2000

Thomas F. Carrato, RADM, USPHS
 Chief Operating Officer
 TRICARE Management Activity
 OASD - HA
 Skyline Five, Suite 810
 5111 Leesburg Pike
 Falls Church, VA 22041-3206

Dear Admiral Carrato:

As the chiropractic representatives on the Oversight Advisory Committee (OAC), we have reviewed the February 10, 2000 Birch & Davis version of the Chiropractic Health Care Demonstration Program (CHCDP) Final Report. We received copies of the document on February 16, 2000 and were granted just seven days to review and submit our comments. This is glaringly insufficient time to review and comment on a report in excess of 650 pages with numerous tables and statistical analyses. Our comments on the initial Birch & Davis draft were conveyed to you in our letter of December 1, 1999. Birch & Davis took almost three months to revise their preliminary report. We are, therefore, complying with this arbitrary deadline, but do so under protest and object to the inordinately short amount of time provided to us for review.

In the course of our review, we have identified numerous shortcomings and inconsistencies that need to be corrected prior to the report being submitted to the Congress. As members of the OAC, we do not approve or endorse certain portions of the Birch & Davis report, in their current form. Clearly, the report attests to the feasibility of providing chiropractic services in the Military Health System (MHS). However, we strongly disagree with the assertions against the advisability of integrating chiropractic care into the MHS since an analysis we are in the process of completing clearly shows significant savings. It is our professional opinion that if these concerns are adequately addressed, the report will clearly conclude that integrating chiropractic care into the MHS is fully advisable.

Our concerns are listed below. They include the issues that were articulated in our December 1, 1999 letter but were not addressed and new concerns based on our review of the revised Birch & Davis report.

1. On page x of the Birch & Davis revised report, the discussion of OAC involvement in all steps related to the development of programs, policies, and procedures is not factual. It sharply contradicts the lack of input that we were afforded. Instead, there was a clear pattern of holding the chiropractic members of the OAC at arm's length from the analysis and editing process, thereby preventing our input until the final stages of report preparation, providing

insufficient opportunity for review and comment, and offering no timely feedback on whether or how our suggestions were incorporated into subsequent edits. Only one chiropractic member of the OAC was provided direct access to information regarding the data analysis, review of findings, and writing of the final report. This individual was required to sign a confidentiality agreement in February 1999 and was instructed not to inform, communicate, or divulge information relative to the final evaluation plan of the CHCDP to any other members of the OAC in spite of the statutory requirement in Section 702 of the National Defense Authorization Act that the OAC actively participate in the implementation plan. This contradicts the Birch & Davis statement that "The OAC was instrumental in several key decisions that formed the framework for implementing and evaluating the demonstration." Although our input was occasionally solicited, we did not have involvement in and did not approve many aspects of the analytical approach and the final report.

2. The entire tone of the Executive Summary has been changed between the initial Birch & Davis draft and the February 2000 document. The text of the Executive Summary appears to have been altered from an evenhanded summary to one which clearly emphasizes negative viewpoints. For example, on page x of the initial draft version of the Executive Summary it states that "In addition, the data support the acceptance by traditional MTF health care providers regarding integrating chiropractic services and treatment modalities within the MTF as evidenced by their willingness to refer patients to chiropractic services." (Emphasis added) This sentence was edited out of the revised document and a new sentence added to the feasibility discussion (page xi) that ends with the negative statement "...but the majority of traditional clinicians perceptions remained negative." (Emphasis added) This would indicate that an entirely new interpretation of CHCDP results was created between the initial and current versions of the report. In fact, MTF clinicians had more positive opinions about Doctors of Chiropractic and their abilities on the follow-up survey. Birch & Davis conclude that, among traditional providers, chiropractic care was judged more favorably over the course of the CHCDP.
3. The Birch & Davis final report tries to downplay the savings attributable to chiropractic care by emphasizing budgetary "scoring" issues. For example, the report correctly concludes that chiropractic services reduce the need for inpatient hospitalizations and recognizes a physical therapy cost offset, but minimizes these savings by claiming that they do not directly accrue to the MTF. Essentially, the report tries to obscure the clear savings shown for chiropractic services by retreating behind Congressional scoring issues.
4. The data upon which the cost analysis and advisability recommendation are based are limited to only medical encounters where general lower back pain is the primary diagnosis. Cost data on medical encounters for the comparison and intervention groups for related conditions are missing from the data base.

Therefore, the costs estimated for all groups in the study, particularly the comparison group, are significantly underestimated. For example, costs for a person in the comparison group with an initial diagnosis of lower back pain who later has another diagnosis that leads to back surgery are not in the data base. Birch & Davis did not address this issue in their revisions.

5. A recommendation that future utilization of chiropractic services should not include artificial limitations on the scope of practice or clinical privileges of chiropractors, as the Demonstration did, should be incorporated into Chapter 3. We voiced our concerns on this issue in our December 1, 1999 letter, but Birch & Davis failed to act on them.
6. The conclusion in Chapter 5 on the advisability of including chiropractic services in the MHS is principally based on the cost analysis contained in earlier chapters. For the reasons outlined in this letter, we strongly believe that a properly conducted cost analysis would support a full advisability recommendation for inclusion of chiropractic services in the MHS.
7. The entire demonstration data analysis was arbitrarily limited to lower back pain by the DoD. This arbitrary limitation does not reflect the scope of practice of Doctors of Chiropractic in the civilian population. Hence, the data abstraction should not have been arbitrarily limited to lower back pain.
8. A major chapter missing from the report is one focusing on the effect or outcomes of chiropractic treatment on military retention. Chapter 2, section 4.2 does not include directly relevant questions that should and could have been addressed by the evaluation. The extent to which providing chiropractic care increases retention of military personnel has not been examined. Additionally, we believe that the findings on military readiness should be strengthened.
9. Primary care physicians write orders for physical therapy. They also order radiology workups which are an integral part of physical therapy treatment for back injury patients. The methodology contained in Exhibit IV-4 does not reflect that reality. For example, the table shows no costs for radiology for physical therapists but, instead, assigns them to primary care. Therefore, the costs of physical therapy are not properly allocated and are underestimated.
10. The recommendation for contracting support on page III-3 should be modified to recommend that Commissioned Doctors of Chiropractic be involved in the contracting support process as well as in implementation and ongoing operation of the chiropractic service.
11. We reiterate that the description of Chiropractic contained in Chapter 1, Section 1.2 is not recognized by the chiropractic representatives on the OAC. The Birch & Davis revised text does not adequately address our concerns. As was included

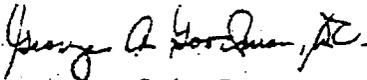
in our December 1, 1999 comments, a profession-wide consensus definition/description is contained in Attachment A.

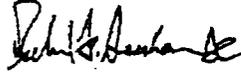
12. Page IV-57 suggests that clinical guidelines exist that recommend a "wait and see" approach for back problems. We do not agree with this interpretation.
13. The references in the Birch & Davis report comparing chiropractic and medical costs ignore a major portion of the relevant literature (see Attachment B). By taking greater pains to present matched conditions and define episodes more correctly, the references included in Attachment B demonstrate significant cost savings for chiropractic care. Some of the studies liberally discussed throughout the Birch & Davis report have been critiqued elsewhere. A recent review of all cost effectiveness studies by Branson¹ concludes that the bulk of evidence demonstrates cost savings when low back care is administered by Doctors of Chiropractic.
14. Repeated references to perceptions of inappropriateness of "treatment of thoracic and cervical conditions," in base line traditional care questionnaires, are considered highly objectionable in that they only represent preconceived opinions. These opinions give the reader an inaccurate impression regarding Doctors of Chiropractic and their accepted scope of practice.
15. ICD-9 bubble sheets varied across intervention sites. We are concerned, therefore, that the data extraction on ICD-9 codes has resulted in inconsistencies across sites and types of providers.
16. Chapter IV addresses the evaluation of advisability but line 21 on page IV-1 states that "The results of the feasibility study are summarized below." While this is probably just an oversight, it does demonstrate that the final report needs to be carefully re-read before it is released.

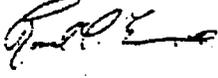
We appreciate the opportunity to be part of the process of improving the provision of health care services to our military personnel. However, as stated in this letter, we have concerns about what we perceive to be serious shortcomings and inconsistencies, especially as they relate to cost issues, in the Birch & Davis final report that must be corrected before the report is released. As OAC members who have repeatedly requested greater involvement, we stand ready to assist in addressing these concerns.

Sincerely,

¹Branson, R. Cost comparison of chiropractic and medical treatment of common musculoskeletal disorders: A review of the literature after 1980, *Topics in Clinical Chiropractic*, 1999, 6(2): 57-68.

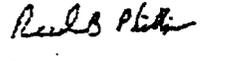

George A. Goodman, D.C.


Richard Beacham, D.C.


Ronald Evans, D.C.


Peter Ferguson, D.C.


Rick McMichael, D.C.


Reed B. Phillips, Ph.D., D.C.

Attachment A
Accepted Definition/Description
of Chiropractic

Attachment A

**Accepted Definition/Description
of Chiropractic**

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.

The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how the relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.

The practice of chiropractic includes:

- establishing a diagnosis;
- facilitating neurological and biomechanical integrity through appropriate chiropractic case management; and
- promoting health.

Attachment B

References

Attachment B

References

1. Shekelle P, Adams AH, Chassin MR, Hurwitz EL, Phillips RB, Brock RH. The appropriateness of spinal manipulation for low-back pain: Project overview and literature review. RAND: Santa Monica, CA, 1991. Monograph No. R-4025/1-CCR-FCER.
2. Freeman KB, Bernstein J. The adequacy of medical school education in musculoskeletal medicine. Journal of Bone and Joint Surgery Am 1998; 80-A: 1421-1427.
3. Jarvis KB, Phillips RB, Morris EK. Cost per case comparison of back injury claims of chiropractic versus medical management for conditions with identical diagnostic codes. Journal of Occupational Medicine 1991; 33(8): 847-852.
4. Nylendo J, Lamm L. Disability low back Oregon workers' compensation of claims, Part I: Methodology and clinical categorization of chiropractic and medical cases. Journal of Manipulative and Physiological Therapeutics 1991; 14(3): 177-184.
5. Nylendo J. Disability low back Oregon workers' compensation of claims. Part II: Time loss. Journal of Manipulative and Physiological Therapeutics 1991; 14(4): 231-239.
6. Nylendo J. Disability low back region workers' compensation of claims. Part III: Diagnostic and treatment procedures and associated costs. Journal of Manipulative and Physiological Therapeutics 1991; 14(5): 287-297.
7. Johnson MR. A comparison of chiropractic, medical and osteopathic care for work-related sprains/strains. Journal of Manipulative and Physiological Therapeutics 1989; 12(5): 335-344.
8. Wolk S. An analysis of Florida workers' compensation medical claims for back-related injuries. Journal of the American Chiropractic Association 1988; 27(7): 50-59.
9. Dean H, Schmidt R. A comparison of the cost of chiropractors versus alternative medical practitioners. Richmond, VA: Virginia Chiropractic Association, 1992.
10. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Park RE, Phillips RB, Brook RH. The appropriateness of spinal manipulation for low back pain: indications and ratings by a multidisciplinary expert panel. R RAND: Santa Monica, CA, 1991, Monograph No. R-4025/2-CCR/FCER.

11. Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Park RE, Phillips RB, Brook RH. The appropriateness of spinal manipulation for low back pain: indications and ratings by an all-chiropractic expert panel. RAND: Santa Monica, CA, 1991, Monograph No. R-4025/3-CCR/FCER.
12. Cherkin DC, Deyo RA, Wheeler K, Ciol MA. Physician views about treating low back pain: The results of a national survey. Spine 1995; 20(1): 1-10.
13. Ernst E, Pittler MH. Experts' opinions on complementary/alternative therapies for low back pain. Journal of Manipulative and Physiological Therapeutics 1999; 22(2): 87-90.
14. Stano M, Smith M. Chiropractic and medical costs of low back care. Medical Care 34(3): 191-204.
15. Smith M, Stano M. Costs and recurrences of chiropractic and medical episodes of low-back care. Journal of Manipulative and Physiological Therapeutics 1997; 20(1): 5-12.
16. Manga P, Angus D, Papadopoulos C, Swan W. The Effectiveness and Cost-Effectiveness of Chiropractic Management of Low-Back Pain. Richmond Hill, Ontario: Kenilworth Publishing, 1993.
17. Manga P. Enhanced chiropractic coverage under OHIP as a means for reducing health care costs, attaining better health outcomes and achieving equitable access to health services. Report to the Ontario Ministry of Health, 1998.
18. Shekelle PG, Markovich M, Louie R. Comparing the costs between provider types of episodes of back care. Spine 1995; 20(2): 221-227.
19. Cherkin DC, Deyo RA, Battle M, Street J, Barlow W. Comparison of physical therapy, chiropractic manipulation, and provision of an educational booklet for the treatment of patients with low back pain. New England Journal of Medicine 1998; 339(14): 1021-1029.
20. Rosner A. Letter to the editor. Spine 1995; 20(23): 2595-2598.
21. Branson RA. Cost comparison of chiropractic and medical treatment of common musculoskeletal disorders: A review of the literature after 1980. Topics In Clinical Chiropractic 1999; 6(2): 57-68.

STATEMENT BY

LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS
HEALTH SUBCOMMITTEE
HEARING ON CHIROPRACTIC CARE IN THE DEPARTMENT OF
VETERANS AFFAIRS
OCTOBER 3, 2000

Thank you Mr. Chairman. I want to commend you for holding this long-overdue hearing. I also want to thank you and your staff for accommodating my schedule and allowing me to briefly attend this hearing. Unfortunately, I will be unable to stay because the Committee on Veterans Affairs has two bills on the floor this morning.

The history of the chiropractic providers attempts to gain entry into the VA health care system date back longer than the 18 years I have been a Member of this body. At this point, VA is the only federal payer or provider that has effectively sealed the walls to routine chiropractic care. Medicare and Medicaid finance chiropractic care. As we'll hear momentarily, DOD has just completed a successful demonstration that will undoubtedly result in its additional use of chiropractic care.

My own involvement with the issue of chiropractic care in VA has been extensive. In 1983, I was an original cosponsor of a bill introduced by this Committee's current Vice-Chair, Chris Smith, which would have authorized VA to reimburse reasonable charges for chiropractic services for certain veterans. In 1985, I worked successfully with Rep. Bob Edgar on a bill that authorized VA to operate a pilot project in five geographic areas to assess the cost-effectiveness of chiropractic care. The study of this pilot assessed only chronic, recurrent, unresolved lower back pain demonstrated that:

- (1) veterans who were eligible to participate chose to select chiropractic care; more than 75% (154/204) of veterans elected chiropractic care as opposed to traditional VA medical services;
- (2) Outcomes for veterans who participated with chiropractors were the same as for those who received traditional VA medical services.
- (3) Veterans used more chiropractic care services resulting in somewhat higher costs than those who received traditional medical services.

Despite the caveat of study authors that this was a limited and non-experimental study, VA has used this experience as a basis upon which to bar the doors to chiropractors. While chiropractors are not explicitly barred from practicing within the agency, VA has never hired a chiropractor, nor have they reimbursed contracted chiropractic services in any meaningful fashion. Chiropractors have continued, rightfully, to insist that VA give veterans real access to their services.

In the last Congress, I introduced H.R. 4421 that would have authorized the Veterans Health Administration to create a division of chiropractic care and to hire chiropractors. Last year, that bill was the starting point for negotiations on a provision included in the Veterans Millennium Health Care and Benefits Act which later became part of PL 106-117.

VA was directed to develop a policy to address access to chiropractic care for musculoskeletal services. The result of this "policy" was the continuation of long-standing "non-policy" that nudges VA providers toward the conclusion that chiropractic services are only negligibly effective (and no more so than care delivered by other providers) for "uncomplicated low-back pain".

Chiropractors actually view this new "policy" as more restrictive than the previously undefined policy because it limits VHA medical centers and clinics to offering "chiropractic spinal manipulative therapy" for "musculoskeletal problems of the spine".

Chiropractors, like other practitioners, wish to provide care within the full scope of practice licensed by the state. Because the law required consultation with chiropractors VA did eventually meet once with a broad coalition of chiropractors which included representatives of the continuum of chiropractic practice. American Chiropractors Association, the International Chiropractors Association, and the American Association of Chiropractic Schools who represent the vast majority of chiropractic practitioners and who have longstanding involvement with VA in past assessments attended this meeting. Some attendees reported that they believed that they had secured VA's commitment to this scope prior to the issuance of VA's policy this May.

A successful pilot within the Department of Defense and reported progress in clarifying DOD's relationship with chiropractors in the DOD Authorization Act of 2001 have understandably emboldened mainstream chiropractors. They want to resolve this issue. VA is the last barrier in the federal sector. This should not be the case. Veterans should also have this treatment available to them on a routine basis.

Mr. Chairman, again thank you for holding this hearing today.

Statement of
Frances M. Murphy M.D., M.P.H.
Acting Deputy Under Secretary for Health
Veterans Health Administration
Department of Veterans' Affairs
Before the
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

October 3, 2000

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Mr. Chairman and Members of the Subcommittee,

I am here today to discuss the Veterans Health Administration's (VHA) policy on provision of chiropractic services for veterans.

Background

On November 30, 1999, Public Law 106-117, the Veterans' Millennium Health Care and Benefits Act (Millennium Act) was signed into law. Section 303 of the Millennium Act required the Under Secretary for Health, within 120 days from the date of enactment, and after consultation with chiropractors, to establish a VA-wide policy regarding the use of chiropractic treatment in the care of veterans. The Millennium Act limits the definition of the term "chiropractic treatment" to the manual manipulation of the spine for the treatment of "such musculoskeletal conditions as the Secretary considers appropriate."

On February 24, 2000, a meeting was held between representatives of VHA and eight chiropractic organizations. Six of the chiropractic organizations represented at the meeting submitted written positions and/or recommendations for VA review. These included: 1) The Foundation for Chiropractic Education and Research (FCER), 2) The International Chiropractors Association (ICA), 3&4) The American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC) provided a joint document, 5) The World Chiropractic Alliance (WCA), and 6) The National Association for Chiropractic Medicine (NACM). Other Chiropractic Organizations present included: 7) The Federation of Chiropractic Licensing Boards and 8) The American College of Chiropractic Orthopedists.

In sum, the generally common elements of the various chiropractic organizations' recommendations for VHA policy for use of chiropractic included:

- 1) full-time and contract employment of chiropractors, in both VA medical centers and satellite clinics;
- 2) "direct access" of patients to chiropractors, without referral requirements;

- 3) a very broad scope of practice, including diagnosis and treatment of a wide spectrum of non-musculoskeletal conditions, diseases, or disorders; and
- 4) clinical privileges to include primary evaluations, including history and physical examinations, ordering and interpretation of a wide range of diagnostic tests, "routine checkups", and functioning as "primary care providers".

However, there were discrepant opinions concerning the definitions of direct access, "primary care services," and "first contact provider," as well as many other issues. Disagreements included, but were not limited to, topics such as the precise scope of practice, and the utility of chiropractic to treat non-musculoskeletal conditions. For example, one organization asserted that chiropractic subluxation is without basis and fact and has never been proven to exist and further that the only conditions which should be considered amenable to chiropractic treatment would be mechanical back/neck pain.

Clarification of the role proposed for chiropractors as providers of primary care was not completely successful, in part because most representatives of chiropractic organizations did not seem to use the term "primary care" in the same sense as it has been employed by the Institute of Medicine (IOM) and the general healthcare community. Consequently, the consultation with chiropractic organizations raised several issues that affected the development of the VHA policy directive.

VHA Policy Development

The current VHA policy allows medical centers and clinics to offer chiropractic spinal manipulative therapy for musculoskeletal problems of the spine, following a referral from a VA clinician. This policy was adopted following prolonged and detailed discussion thoroughly considering a number of factors, including the requests and submitted written materials of the chiropractic organizations and a review of the available scientific evidence.

When considering the scientific evidence concerning chiropractic care, it is important to keep in mind two related, but distinct, concepts. First, spinal manipulation is a form of manual therapy that is used by chiropractors, physical therapists, osteopaths, and some medical doctors. The second concept is that chiropractic treatment frequently involves spinal manipulation, but may also include other non-thrust manual therapies, such as mobilization and massage, as well as advice about exercises, nutrition, and proper diet. Published studies estimate that 70 to 90 percent of patients presenting to chiropractors will be treated with spinal manipulation.

There are insufficient scientific data to conclude that either spinal manipulation or chiropractic care is efficacious for any non-musculoskeletal medical condition (e.g., asthma). The effectiveness of either spinal manipulation

or chiropractic care as compared to other forms of care for patients with low back pain is also not established. For example, a recent high-quality randomized clinical trial funded by the Agency for Health Research and Quality, and published in the *New England Journal of Medicine*, compared chiropractic care to physical therapy care or self-care. (Cherkin DC et al. *NEJM* 1998;339:1021-9.) Both the chiropractic group and the physical therapy group had small benefits compared to the patients receiving self-care, but there were no differences between the chiropractic group and the physical therapy group. Both chiropractic care and physical therapy care cost more per patient than self-care.

There are limited data to support the efficacy of spinal manipulation as therapy for some patients with neck pain. This currently falls short of conclusive proof, but in one consensus process that included medical experts, spinal manipulation was judged as effective for certain neck pain syndromes. (Shekelle PG et al. *J Spinal Disorders* 1997;10(3):223-228.)

There is sufficient evidence in the form of randomized clinical trials to conclude that spinal manipulation is a modestly efficacious form of therapy for some patients with uncomplicated low-back pain. These data include clinical trials where the manipulations were provided by physical therapists, osteopaths, and chiropractors. However, there are no clinical trial data to support a position that spinal manipulation delivered by chiropractors is more effective or less risky than spinal manipulation delivered by any other type of practitioner.

VA is opposed to allowing chiropractors to act as "referring primary care physicians", as it is not possible to develop a precise definition of chiropractors as primary care providers. Available evidence in conjunction with commentary and written materials provided by chiropractors at the joint meeting do not afford confidence that chiropractors have demonstrated that they function as primary providers in the sense that term is defined by the IOM of the National Academy of Sciences, and is commonly used in the healthcare community.

The Institute of Medicine defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." Primary care providers in VA typically treat patients with hypertension, heart disease, diabetes, pulmonary diseases, depression, and a host of other conditions. They are expected to diagnose and to treat conditions from upper respiratory infections to myocardial infarctions. The diagnosis, treatment and ongoing management of these problems are not part of chiropractic practice. We believe that VA has an obligation to assure that any primary medical care provided to our veteran patients meets or exceeds the standards in the best of the private sector within the parameters defined by the IOM.

The policy requirement for a referral to chiropractic care was adopted because virtually all non- primary care provided in VA is accomplished through referrals, and VA does not typically allow direct access to other types of consultants or contract providers. In addition, referrals are required for those VA providers that offer specialized types of services, e.g., cardiologists. Formal referral and consultation ensures that the patient, the primary care clinician, and the consultant are working together, and are aware of the reasons for, and expected results from, the consultation.

We determined that it would not be appropriate to hire chiropractors at this time for several reasons. VA has not developed a body of experience in the type and amount of chiropractic services that VA facilities may need for enrolled veterans. Neither do we have information addressing the regional variation in need for and availability of chiropractic services in VA.

Our national policy on chiropractic care in VA was published in May 2000. Veterans Integrated Service Networks (VISNs) and/or medical centers were required to develop local plans for chiropractic care and services within 120 days of the publication of the national policy. Such plans, at least in draft form, have been received from all VISNs and are currently being reviewed. It is expected that publication of local procedures will eliminate confusion about eligibility for, and availability of, chiropractic as a treatment modality. We are preparing provider and patient information and education related to chiropractic services. Educational materials for patients are in draft and are currently being tested for readability and understanding with groups of patients and it is expected that a patient education brochure template will be released within the next 60 days. Much of the treatment information contained in the draft brochure was adapted from material provided by a chiropractic group. VISNs are developing their own provider education materials.

Our policy establishes mechanisms to monitor the cost, quality and utilization rates of chiropractic care. We will identify and collect data related to the provision of chiropractic services that can be analyzed from a national perspective. Currently, VA's databases do not include chiropractic services, thus it is not possible to accurately determine how many patients have seen chiropractors or to determine the number of visits or the dollars spent on chiropractic. This lack of information about utilization of chiropractic services is addressed in the policy by its requirements to collect certain data elements related to chiropractic care, which will be collated nationally. These changes are expected to be completed by November 30, 2000.

Summary

We believe that VA has taken a responsible and reasonable approach to the introduction of chiropractic care. Our policy is based upon consideration of the views of various chiropractic organizations and a careful review of the highest

quality available published evidence. VA does not currently have data that address the magnitude and geographical distribution of appropriate chiropractic care within our system. Our current policy provides for collecting that information.

VISNs are just now beginning to implement the new National Chiropractic Policy and the work on databases that is required to collect necessary information about chiropractic utilization and the cost will be completed later this year. We need time to implement the policy and to gain experience in the provision of chiropractic care before making assessments about our policy or the level of chiropractic services that veterans need.

This concludes my statement, I will be glad to respond to any questions you may have.

WRITTEN TESTIMONY

PRESENTED BY DR. RICK MCMICHAEL

**ON BEHALF OF THE AMERICAN
CHIROPRACTIC ASSOCIATION**

**TO THE HOUSE VETERANS' AFFAIR
SUBCOMMITTEE ON HEALTH**

OCTOBER 3, 2000

Good morning Chairman Sterns and members of the subcommittee. My name is Dr. Rick McMichael, I am a practicing doctor of chiropractic with 26 years of experience. I currently practice in Canton, Ohio, and serve as the Ohio delegate to the American Chiropractic Association (ACA). I served as a member of the Department of Defense Chiropractic Health Care Demonstration Project Oversight Advisory Committee (CHCDP OAC), representing the Congress of Chiropractic State Associations. Currently, I serve as the president of the Ohio State Chiropractic Licensing Board.

This morning, I would like to share with you the eye-opening experience I had as a member of the DOD CHCDP Oversight Committee, and how this relates to providing chiropractic services to our nation's veterans. Not only did a large number of military personnel independently choose chiropractic services for care, but those who sought chiropractic care also reported significantly higher satisfaction and outcomes. There were no significant difficulties in opening chiropractic clinics, and doctors of chiropractic worked well with the other military health care providers. I believe that the CHCDP experience, the DOD's final report on the demonstration project, and the CHCDP minority report all show that chiropractic is a valuable service, needed and desired by many military personnel.

The CHCDP and accompanying reports showed that chiropractic care: reduced disability; return to duty; saved approximately 199,000 work days per year; improved patient satisfaction; decreased physical therapy and related cost savings; and produced an inpatient cost savings. I believe the benefits of chiropractic care will continue to be proven with the addition of chiropractic services in the military health care system. Our military personnel deserve the ready availability of these much-needed and much-desired services, and our nation's veterans deserve no less.

As you are aware, the Veterans Millennium Health Care Act included a provision requiring the Department of Veteran's Affairs to develop a policy with regard to chiropractic care in the DVA

health care system. More specifically, Section 303 of the Act required that within 120 days after enactment of the Act, the DVA Under Secretary of Health, after consultation with chiropractors, would establish a policy for VHA regarding the role of chiropractic care for veterans.

In response to the enactment of this provision, the ACA and Association of Chiropractic Colleges (ACC) provided to the DVA a set of policy recommendations to serve as the basis of the agency's new policy on chiropractic. The recommendations included, a full scope of practice and hospital privileges for doctors of chiropractic, direct access for patients, availability of chiropractic care at all DVA treatment facilities, and other substantive pro-chiropractic recommendations. A copy of this report is respectfully submitted for the committee record.

On February 24, 2000, I had the opportunity to join representatives of the ACA, ACC and other chiropractic organizations for a meeting with officials of the Veterans Health Administration to discuss implementation of chiropractic care into the VHA. The ACA/ACC representatives' main objective was to seek direct patient access to a full scope of chiropractic services. Despite these efforts, the DVA ignored the input of the chiropractic profession and Members of Congress and ultimately developed a policy on chiropractic care that is totally inadequate. This poorly developed policy states that: "It is the VHA policy that VHA medical centers and clinics may offer chiropractic spinal manipulative therapy for musculoskeletal problems of the spine." As you are well aware, Mr. Chairman, the use of the word "may" in the policy statement means that the DVA is not mandating individual medical facilities provide chiropractic care to their patients.

Despite the exclusion of any recommendations put forth by the chiropractic profession, we are now asked by the Department of Veterans Affairs (DVA) to believe that the chiropractic policy they issued on May 5, 2000, is adequate, and will ensure that eligible veterans in need of chiropractic care will have access to it. Insofar as the ACA is aware, however, there is no DVA program or organized effort, of any type, that exists to ensure that chiropractic services are in fact made available within the DVA health care system. It is clear that the current DVA bureaucracy is quite satisfied with merely having issued a so-called chiropractic "policy"-- and now that the

policy has been issued, they could care little whether the policy is appropriate or ensures adequate access to chiropractic care. Certainly, no substantive activity is currently taking place within the DVA to encourage the use of chiropractic care. The bureaucracy's contentment with their chiropractic policy most likely stems from the fact that they know, or suspect, that their policy will probably prove both inconsequential and ineffective -- and as such, will have no significant impact in the way they conduct business today. Clearly, they do not expect significant referrals to doctors of chiropractic to occur as a result of this policy. This may mean that American veterans will be denied fair access to care they want and deserve just like every other American citizen.

How do they expect the policy to work? Are they not aware of past, unlawful efforts on behalf of organized medicine to contain and destroy the chiropractic profession and the lingering effects this discrimination has had against doctors of chiropractic and their patients? Are they not aware that in some quarters biased attitudes towards the chiropractic profession still exists? Are they not aware that medical doctors receive no education or formal training of any sort regarding chiropractic care, nor are they trained or educated as to when a referral to doctor of chiropractic is warranted? So even when bias is not present, there may likely remain little knowledge on behalf of DVA medical doctors as to when it is appropriate to refer to a doctor of chiropractic. Are they unaware of their own indifference regarding chiropractic care and of the Agency's failure -- over the past half century -- to initiate, of its' own accord, any effort to encourage the use of chiropractic care within the DVA health delivery system? Not one pro-active step in five decades...!

When examining the DVA track record regarding chiropractic care in its' totality, one is forced to conclude that the DVA bureaucracy today, either remains biased against the chiropractic, is woefully ignorant about the benefits of chiropractic care -- or both. If either of these is true, it reflects poorly on stewardship of the DVA health care program. At a bare minimum, it must be said that the Agency has engaged in a pattern of long-term neglect with respect to the provisioning of chiropractic care.

Because of the well-documented record of prejudice and neglect towards chiropractic, the ACA recommends that the House Committee on Veterans Affairs move forward, at the first opportunity, to advance legislation that would require the DVA at a minimum to make available chiropractic care on a "direct access" basis and allow doctors of chiropractic practicing within or furnishing services to the DVA health care system to provide the full-scope of their services as enacted under applicable state law. As you may know, a similar chiropractic provision applicable to the Department of Defense health care system was recently included in the House-passed version of the FY2001 Defense Authorization Act (H.R. 4205), which was voted on and approved by the full U.S. House of Representatives.

With respect to direct access, I would like to clarify that an eligible veteran could self-select to be examined and treated by a doctor of chiropractic, without first having to receive a referral from a medical doctor or other health care provider. Ensuring direct access to doctors of chiropractic is extremely important to the proper utilization of chiropractic care. Patients often experience difficulty accessing chiropractic care when a referral from a medical doctor or nurse is required. AHCPR recognized this problem in a report entitled "Chiropractic in the United States: Training, Practice and Research". In this report, AHCPR stated: "Given that medical practitioners have little exposure to chiropractic training or practice, a case can be made for not requiring medical referral." A direct access system within the DVA would expand an eligible veteran's "choice" of care and "choice" of provider within the DVA health care system, and it would go far towards ensuring that artificial barriers would not be erected in an effort to discourage access to chiropractic care.

It should be noted that doctors of chiropractic are licensed and regulated in all fifty states as independently practicing health care professionals. All of these jurisdictions recognize chiropractors' rights and responsibilities to serve as first-contact, portal-of-entry providers. As such, doctors of chiropractic possess the diagnostic skills necessary to differentiate health conditions that are amenable to their management from those conditions that require referral or

co-management with another professional. Doctors of chiropractic recognize the value of working in cooperation with other health care practitioners and acknowledge their responsibility to do so in the best interest of their patients.

An additional benefit of direct access should also be noted. Such a system within the DVA would encourage the use of chiropractic care -- a low cost, non-surgical and non-pharmaceutical form of care. This may help avoid unnecessary surgeries and pharmacological interventions within the DVA health care system -- and would help emphasize the benefits of the chiropractic profession's natural, "wellness" approach to health care that includes advice on diet/nutrition and exercise/rehabilitation. As added benefit is, that to the extent that some surgical and pharmacological interventions could be eliminated, the risk of life-threatening medical mistakes and/or adverse drug reactions could be lessened within the DVA health care system -- a laudable goal in and of itself.

The other component of any viable chiropractic benefit within the DVA is a doctor of chiropractic's ability to provide the full scope of their services (as determined by state law) to veterans seeking chiropractic care. The practice and procedures that may be employed by doctors of chiropractic are based on the academic and clinical training received in and through accredited chiropractic colleges. These include, but are not limited to, the use of diagnostics and therapeutics. Such procedures include the adjustment and manipulation of the articulations and adjacent tissues of the human body, particularly of the spinal column. Included is the treatment of intersegmental disorders for alleviation of related functional disorders. Patient care is conducted with due regard for environmental, nutritional, psychotherapeutic factors as well as first aid, hygiene, sanitation, rehabilitation, and physiological therapeutic procedures designed to assist in the restoration, and maintenance of neurological integrity and homeostatic balance.

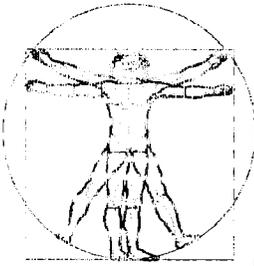
We request that the Committee ensure that the "direct access" and "full scope" provisions comprise the core provisions of any legislative initiative aimed at ensuring access to chiropractic care for our nation's eligible veterans. The ACA stands ready and willing to work with the

Committee to ensure the adoption of an appropriate legislative provision and is anxious to assist in the development of specific legislative language to address our concerns. The American Chiropractic Association also stands willing and able to work with the DVA to devise and implement an acceptable plan to provide for chiropractic care, as envisioned by the statutory provisions we propose. We are confident that a detailed, workable plan can be developed and implemented, provided the DVA is mandated to do so by Congress and acts in good faith to accomplish the legislative requirements.

Mr. Chairman, we have before us an historic opportunity to take decisive steps to ensure that our nation's veterans are afforded access to the benefits of chiropractic care by advancing legislation that would establish a framework within the DVA that would ensure the delivery of chiropractic services in an appropriate and effective manner. Undoubtedly this will require the DVA to make some modifications to the way they currently conduct business today. Change, of course, can often be unsettling to any government agency – however, in this case I am hopeful that DVA will not further resist a better way of serving our nation's veterans. I believe we have much to offer to the DVA, and if its representatives will work with the chiropractic profession in good faith to enhance health care for our nation's veterans, there is much we can achieve together.

We wish to be clear, however, that in our judgment it will be necessary for Congress to firmly establish in statute, desired policy goals and objectives to ensure that a full scope of chiropractic services are made available to our eligible veterans on a direct-access basis, without the imposition of unnecessary barriers to that care. Once Congress establishes those firm statutory directives, the chiropractic profession looks forward to working through our current differences with the DVA and in good faith develop an effective chiropractic policy that will benefit the health of our nation's veterans.

This concludes my brief remarks, and I will be happy answer any questions the Committee may have regarding this testimony.



INTEGRATING CHIROPRACTIC CARE

INTO THE

VETERANS HEALTH CARE SYSTEM



*Preliminary Recommendations
of the
American Chiropractic Association
and the
Association of Chiropractic Colleges*

*January, 2000
Submitted Pursuant to P.L. 106-117*





PREFACE

This report is provided to the Department of Veterans Affairs (DVA) pursuant to Section 303 of P.L. 106-117 by the following:

The **American Chiropractic Association (ACA)** is a professional organization representing doctors of chiropractic. Its mission is to preserve, protect, improve and promote the chiropractic profession and the services of doctors of chiropractic for the *benefit of patients* they serve and the general public. The ACA provides leadership and a positive vision for the profession in its conservative and natural approach to health and wellness. One way to accomplish this mission is to promote high standards of quality in patient treatment and management, and to advocate safe and effective care by expertly trained doctors of chiropractic.

The **Association of Chiropractic Colleges (ACC)** provides worldwide leadership in chiropractic education, research, and service. The Association of Chiropractic Colleges includes and represents all Council on Chiropractic Education (CCE)-accredited colleges and those programs that serve the institutions and their students, the profession and its patients, and the public by advancing chiropractic education, research and service.

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SECTION I

A REVIEW OF THE LEGISLATIVE HISTORY



LEGISLATIVE HISTORY: SECTION 303 OF VETERANS' MILLENNIUM HEALTHCARE ACT OF 1999 (PUBLIC LAW 106-117)

For the past year, the American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC) have worked together with Congress to reintroduce the idea of assimilating chiropractic healthcare services into the Department of Veterans Affairs (DVA) healthcare system. This legislative effort began on behalf of veterans in need of chiropractic services—those who are eligible for medical care benefits under Chapter 17 of Title 38, United States Code (U.S.C.).

The Veterans' Millennium Healthcare Act was signed into law by President Clinton on November 30, 1999 (Public Law 106-117). Among other things, it included a provision requiring the Department of Veterans Affairs to develop a policy with regard to chiropractic care in the DVA healthcare system. More specifically, Section 303 of the Act requires that "Within 120 days after the enactment of this Act, the Under Secretary of Health, after consultation with chiropractors, shall establish a policy for VHA regarding the role of chiropractic treatment in the care of veterans under Chapter 17, Title 38 U.S.C."

The Committee Report accompanying the House version of the Veterans' Millennium Healthcare Act (House Report 106-237) clarifies the committee's intent in carrying out Section 303, which was ultimately modified and agreed to in conference with the Senate. The language strongly supports chiropractic healthcare services for veterans, citing both scientific journals and studies that demonstrate the benefits of chiropractic. The Report cites an earlier effort by the former Veterans Administration to study chiropractic in the VA as too restrictive in the scope of chiropractic methods applied to veterans. It also states that the program reached too few of the veterans for which it was designed. The chiropractic healthcare profession concurs with the thrust of the Report language that the policy established under the new legislation will be sufficiently broad in both scope of practice and outreach to veterans around the country, particularly in rural and medically underserved areas.

Finally, the Report states, and the chiropractic healthcare profession agrees, that doctors of chiropractic should be fully engaged and integrated into primary physician status with the Veterans Health Administration to work with DVA physicians and other medical personnel in the development and implementation of the chiropractic treatment policy that will be set forth under Section 303.



SECTION II

INTRODUCTION AND BACKGROUND RESEARCH ON CHIROPRACTIC CARE



INTRODUCTION

Within the past 100 years, chiropractic has become the third-largest profession of healthcare delivery in the world. The American Chiropractic Association defines chiropractic as, "a branch of the healing arts that is concerned with human health and disease processes. Doctors of chiropractic are physicians who consider man as an integrated being, but give special attention to spinal mechanics, neuromusculoskeletal, neurological, vascular, nutritional, and environmental relationships." (ACA Master Plan, ratified by the House of Delegates June 1964, amended June 1979.)¹

According to the Association of Chiropractic Colleges, chiropractic is defined as "a healthcare discipline that emphasizes the inherent recuperative ability of the body to heal itself without the use of drugs or surgery." In practice, chiropractic "focuses on the relationship of structure [primarily the spine] and function [as coordinated by the nervous system] and how that relationship affects the preservation and restoration of health."²

Chiropractic's focus on the principles of holism have gained it a wide public following among alternative medical procedures (with utilization rates ranging between 11%³ and 15.7%⁴ of the U.S. population). Interest in less-invasive interventions and natural healing is demonstrated by the rapidly growing number of Americans visiting alternative health providers, rather than allopathic physicians.^{1,3}

Chiropractic is recognized and licensed in every state and province in North America, as well as in 76 nations representing the European, Asian, Latin American, Caribbean, Eastern Mediterranean, and Pacific domains.⁶ The increasing acceptance of chiropractic as mainstream healthcare is clear, an acceptance that has grown in tandem with greater emphasis on research by professional organizations and colleges. It also stems from rigorous standards for accrediting and review of educational curricula at chiropractic colleges around the world, 16 of which are accredited in the United States by the Council for Chiropractic Education (CCE). The CCE has had accrediting agency status with the U.S. Department of Education since 1974, and with the Council on Postsecondary Accreditation since 1976. The minimum number of hours required for CCE accreditation is 4,200, ranging from 4,400 to 5,220 hours at colleges nationwide.⁵ In fact, the didactic basic science and clinical science hours among chiropractic colleges around the United States is nearly the same as the corresponding averages obtained from medical schools nationwide.⁷

With more than 65,000 licensed practitioners in the United States, chiropractic is the foremost profession through which spinal manipulation/adjustment is administered—largely in the treatment of back pain but increasingly for other neuromusculoskeletal disorders and conditions, such as neck pain, headache, cumulative trauma disorders in the extremities, infantile colic, enuresis, otitis



media, asthma, and GI dysfunctions. It has been estimated that the total number of chiropractic office visits nationwide each year is 250 million,⁸ with 94% of all spinal manipulations/adjustments administered by doctors of chiropractic.⁹

PATIENT OUTCOMES

Over 40 randomized clinical trials have been published comparing spinal manipulation/adjustment with other treatments for low-back pain. The better-quality clinical trials have indicated that spinal manipulation/adjustment is superior to other types of intervention (corsets, massage, mobilization, back education, physiotherapy, acupuncture) or at least as effective as NSAIDs—¹⁰⁻¹⁹ but without the side effects of NSAIDs, which have been shown to affect no fewer than seven organ systems (gastrointestinal, hepatic, renal, hematologic, cutaneous, respiratory, and central nervous system), sometimes fatally.^{20,21} These findings have been given additional weight by at least two meta-analyses published in peer-reviewed medical journals, unequivocally supporting the effectiveness of spinal manipulation/adjustment in treating acute low-back pain in the absence of radiculopathy.^{22,23}

PATIENT SATISFACTION AND COST-EFFECTIVENESS

In addition to improved patient outcomes, an integral part of evaluating the use of any healthcare modality is its cost. Chiropractic has been found to be a superior treatment option and demonstrates lower costs.²⁴ This pattern is consistently observed from the perspectives of workers' compensation studies,²⁵⁻³⁰ databases from insurers,³¹⁻³³ and other health economists.^{34,35} Some studies have suggested the opposite [that chiropractic services are more expensive than medical services],^{36,37,38} but these studies contain significant refuted flaws.^{28,38}

The cost advantages for chiropractic for matched conditions appear to be so dramatic that Pran Manga, a prominent Canadian health economist, has concluded in a study commissioned by the Canadian National Government (Ontario Ministry of Health) that **doubling the utilization of chiropractic services from 10% to 20% may realize savings as much as \$770 million in direct costs and \$3.8 billion in indirect costs.**³⁵ Furthermore, in no cost studies to date have either iatrogenic or legal burdens been calculated, which suggests advantages for chiropractic health care.

Patient satisfaction with chiropractic treatment has also invariably been shown to be abundantly greater than that found with conventional management.^{39,40} Satisfied patients are far more likely to be compliant in their treatment,⁴¹ giving doctors of chiropractic yet another advantage over other professionals in terms of improved patient outcomes.



APPROPRIATENESS AND GUIDELINES

Spinal manipulation/adjustment has also excelled in experimental designs bearing great clinical significance beyond randomized trials. Panels convened by the RAND Corporation,^{42,43} as well as field practitioners' utilization studies,⁴⁴ have provided additional clinical support to that found in randomized clinical trials of spinal manipulation/adjustment for the management of low-back pain.

In addition, the Mercy Conference guidelines, plus relevant literature, formed the basis of the clinical practice guidelines on low-back pain released in December 1994 by the Agency for Healthcare Policy and Research (AHCPR).⁴⁵ These guidelines rank spinal manipulation/adjustment in the *top tier* of clinical options available for treatment of low-back pain.

EARLY CHIROPRACTIC INTERVENTION

The AHCPR guidelines specifically state that "manipulation can be helpful for patients with low-back problems without radiculopathy when used within the first month of symptoms." These conclusions were arrived at after extensive peer review of the literature, on-site clinical evaluations (pilot reviews), and the hearing of testimony by a 23-member multidisciplinary panel of experts, including consumer representatives. Both strengths and weaknesses in the scientific base were identified, so that it was possible to rank each type of clinical intervention on the effectiveness of its outcome (positive or negative) and the strength of its foundation as published in peer-reviewed literature.

Perhaps the most distinguishing characteristic of this study is that, among 23 options for the therapeutic intervention for relieving back pain, spinal manipulation and the use of nonsteroidal antiinflammatory agents remain sole strategies expected to have the most beneficial effect. All the remaining options (the use of acetaminophen, muscle relaxants, opioid analgesics, antidepressants, colchicine, oral steroids, shoe insoles, physical agents [including hot and cold packs], or lumbar corsets and back belts; trigger point, facet point, ligamentous or epidural injections; bio-feedback; traction; transcutaneous electrical stimulation; acupuncture; activity modification; bed rest; or mild exercise) either have fewer documented effects or are contraindicated.⁴⁵ Similar guidelines developed within Great Britain have come to essentially the same conclusions.⁴⁶

Clearly these findings indicate that *early chiropractic intervention is the most effective and drugless intervention for most cases of low-back pain without sciatica*. Scientific research is the driving force that has enabled all these treatment options to be evaluated and ranked. Since only 15% of *all medical procedures have been documented by research*,⁴⁷ and only 1% have been shown to have any scientific value,⁴⁸ the research that has led to the high ranking of chiropractic intervention takes on even greater significance.



Chiropractic has received little research funding, but has used its resources to produce a premier status in scientific research circles, such as AHCPR.⁴⁸

The strong educational and research bases of chiropractic, in addition to painstaking efforts to adopt standards and achieve consensus, have led to its increasing inclusion in reimbursement systems in public and private payer systems. In both the United States and Canada, chiropractic has been included in Medicare, the majority of private insurance programs, workers' compensation, and personal injury reimbursement systems. Increasing numbers of health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other managed healthcare systems are routinely including chiropractic services, as well.

CHRONIC PAIN CONSIDERATIONS

The belief that low-back pain is benign and will usually disappear after six weeks with no intervention has been significantly refuted by the recent literature. One study in the British Medical Journal demonstrated that, in a cohort of 170 patients, **60% still complained of pain and disability after one year.** Indeed, the author of this study was forced to conclude that low-back pain **"should be viewed as a chronic problem with an untidy pattern of grumbling symptoms and periods of relative freedom from pain and disability interspersed with acute episodes."**⁵⁰ A second study published within the past year was largely in agreement.⁵¹ From these studies, it is reasonable to conclude that all cases of low-back pain have the potential to become chronic if left untreated. Therefore, such cases require immediate and appropriate intervention.

TREATMENT OF CONDITIONS OTHER THAN LOW-BACK PAIN

The process of validation of spinal manipulation/adjustment for the management of low-back pain has been more recently repeated for the cervical region and the treatment of neck pain and headache. In the past decade, clinical trials, prospective series and case studies have provided a strong evidence base for the management of these conditions by spinal manipulation/adjustment.⁵²⁻⁶⁶ The types of headache that have been documented in this research include tension-type, migraine and cervicogenic.

Space does not permit an expanded discussion of other conditions in which the literature has suggested responsiveness to chiropractic intervention; however, the most promising documented clinical areas beyond low-back pain include:

1. Upper extremity disorders: carpal tunnel syndrome⁶⁷⁻⁷⁰
2. Obstetric/gynecologic disorders:
 - a. Dysmenorrhea⁷¹⁻⁷³



- b. Premenstrual syndrome⁷⁴⁻⁷⁶
 3. Conditions of infants, children and adolescents:
 - a. Scoliosis^{77,78}
 - b. Otitis media⁷⁹⁻⁸¹
 - c. Colic^{82,83}
 - d. Enuresis⁸⁴
 4. Pulmonary and circulatory disorders:
 - a. Asthma⁸⁵⁻⁸⁸
 5. GI dysfunctions⁸⁹⁻⁹¹
 6. Primary contact or care services^{92,93}

CHIROPRACTIC EXAMINATION

Chiropractic, by definition, is a conservative and drugless means of intervention. As such, it does not encompass the use of medications or immunizations, the directed use of which would necessarily be referred to a medical doctor. For the sake of parity, however, it is certainly within reason to ask a similar question of medical physicians; i.e., are they capable of performing *complete neuromusculoskeletal* examinations as first-contact healthcare providers? From the results of a recent study of first-year orthopedic residents at the University of Pennsylvania, the answer would appear to be a resounding *no*. In this particular investigation, 82% of the 85 first-year residents failed to demonstrate basic competency in an examination in neuromusculoskeletal medicine which had been validated by 157 chairpersons of orthopedic residency programs in the United States.⁹⁴ With orthopedic residents having failed this examination, one would expect all other medical doctors to do no better and probably worse. By extrapolating this finding, a conclusion can be made that the patient examined by only a medical doctor may deprive the patient of a major, essential portion of the physical examination and its findings.

Furthermore, other direct experience suggests that programs that include the study of laboratory tests involving blood, urine and other bodily fluids taught at most of the chiropractic colleges far exceed those offered at Harvard Medical School and perhaps other M.D.-granting institutions. A similar argument could be made for programs of nutrition. Far too little attention is devoted to nutritional programs of instruction at medical institutions. Any argument that suggests that medical doctors are more equipped to manage prevention programs simply because they are capable of administering immunizations and medications is flawed if evaluation of neuromusculoskeletal conditions, issues of nutrition, and the early detection of disorders from clinical chemistry determinations are addressed. It would appear from both experience and training that doctors of chiropractic should have parity with medical doctors.



SECTION II

REFERENCES



- [1] American Chiropractic Association. Chiropractic Definition, Policies on Public Health and Related Matters 1998-1999. p. 8.
- [2] Position Paper. Association of Chiropractic Colleges, 1998.
- [3] Eisenberg DM, Davis RB, Ebsen SL, Appel S, Wilkey S, van Rompay M, Kessler RC. Trends in alternative medicine use in the United States, 1990-1997. *Journal of the American Medical Association* 1998; 280(16): 1599-1575.
- [4] Atain JA. Why patients use alternative medicine. *Journal of the American Medical Association* 1998; 278(19): 1548-1553.
- [5] Eisenberg DM, Kessler RC, Foster C, Norlock FE, Ciftaris DR, Daltabaco TL. Unconventional medicine in the United States: Prevalence, costs, and patterns of use. *New England Journal of Medicine* 1993; 328(4): 246-252.
- [6] Chapman-Smith D. The Chiropractic Profession. West Des Moines, IA: NCMIC Group Inc., 2000.
- [7] Coulter I, Adams A, Coggan P, Wilkes M, Gonyea M. A comparative study of chiropractic and medical education. *Alternative Therapies in Health and Medicine* 1998; 4(5): 64-75.
- [8] Haldeman S, Kohlbeck FJ, McGregor M. Risk factors and precipitating neck movements causing vertebral-basilar artery dissection after cervical trauma and spinal manipulation. *Spine* 1998; 24(6): 785-794.
- [9] Shekelle P, Adams AH, Chassin MR, Hurwitz EL, Phillips RB, Brook RH. The Appropriateness of Spinal Manipulation for Low-Back Pain: Project Overview and Literature Review. RAND: Santa Monica, CA, 1991. Monograph No. R-4025/1-COR-FCER.
- [10] Meade TW, Dyer S, Browne W, Townsend J, Frank AO. Low back pain of mechanical origin: Randomized comparison of chiropractic and hospital outpatient treatment. *British Medical Journal* 1990; 300: 1431-1437.
- [11] Meade TW, Dyer S, Browne W, Townsend J, Frank AO. Randomized comparison of chiropractic and hospital outpatient management for low back pain: Results from extended follow-up. *British Medical Journal* 1995; 311: 349-351.
- [12] Koes BW, Bouler LM, DVAn Marmeren H, Eskers AHBA, Verelagen GM Jr, Hofhuizen DM, Houben JP, Knipschild PG. The effectiveness of manual therapy, physiotherapy, and treatment by the general practitioner for nonspecific neck and back complaints: A randomized clinical trial. *Spine* 1992; 17(1): 28-35.
- [13] Triano J, McGregor M, Handras MA, Brennan PC. Manipulative therapy versus education programs in chronic low back pain. *Spine* 1995; 20(6): 848-855.
- [14] Giese LGF, Jaulter R. Chronic spinal pain syndromes: A clinical pilot trial comparing acupuncture, a non-steroidal anti-inflammatory drug, and spinal manipulation. *Journal of Manipulative and Physiological Therapeutics* 1999; 22(6): 378-381.
- [15] Brenfort G, Goldstein C, Nelson CF, Boline PD, Anderson AV. Trunk exercise combined with spinal manipulative or NSAID therapy for chronic low back pain: A randomized, observer-blinded clinical trial. *Journal of Manipulative and Physiological Therapeutics* 1998; 19(9): 570-582.
- [16] Kirkubly-Wills WH, Cassidy JD. Spinal manipulation in the treatment of low-back pain. *Canadian Family Physician* 1985; 31: 535-540.
- [17] Pope MH, Phillips RB, Haugh LD et al.: A prospective randomized three-week trial of spinal manipulation, transcutaneous muscle stimulation, massage and control in the treatment of subacute low back pain. *Spine* 1994; 19(22): 2871-2877.
- [18] Blomberg S, Versudd K, Milderberger F: A controlled multicenter trial of manual therapy in low back pain: Initial status, sick leave and pain score during follow-up. *Journal of Orthopaedic Medicine* 1994; 16(1): 2-8.
- [19] Berquist-Ulman M, Larsson U. Acute low back pain in industry: A controlled prospective study with special reference to therapy and confounding factors. *Acta Orthopaedica Scandinavica* 1977; 170(suppl): 1-117.
- [20] Brooks PM. NSAIDs. In: Kipper JH, Dieppe PA [eds.]. *Rheumatology, 2nd edition*. St. Louis, MO: Mosby Year Book, 1988, pp. 3.5.1-3.5.6.
- [21] Debbes V, Lasunski WE. A risk assessment of cervical manipulation vs. NSAIDs for the treatment of neck pain. *Journal of Manipulative and Physiological Therapeutics* 1995; 18(6): 530-536.
- [22] Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Brook RH. Spinal manipulation for low-back pain. *Annals of Internal Medicine* 1992; 117(9): 590-598.
- [23] Anderson R, Meeker WC, Wrick BE, Mootz RD, Kirk DH, Adams A. A meta-analysis of clinical trials of spinal manipulation. *Journal of Manipulative and Physiological Therapeutics* 1992; 15(3): 181-194.



- [24] Branson RA. Cost comparison of chiropractic and medical treatment of common neuromusculoskeletal disorders: A review of the literature after 1990. *Toxics in Clinical Chiropractic* 1999; 9(2): 67-68.
- [25] Jarvis KB, Phillips RB, Morris BK. Cost per case: comparison of back injury claims of chiropractic versus medical management for conditions with identical diagnostic codes. *Journal of Occupational Medicine* 1991; 33(8): 847-852.
- [26] Nyiendo J, Lamm L. Disability low back Oregon workers' compensation of claims. Part I: Methodology and clinical categorization of chiropractic and medical cases. *Journal of Manipulative and Physiological Therapeutics* 1991; 14(3): 177-184.
- [27] Nyiendo J. Disability low back Oregon workers' compensation of claims. Part II: Time loss. *Journal of Manipulative and Physiological Therapeutics* 1991; 14(4): 231-238.
- [28] Nyiendo J. Disability low back Oregon workers' compensation of claims. Part III: Diagnostic and treatment procedures and associated costs. *Journal of Manipulative and Physiological Therapeutics* 1991; 14(5): 287-297.
- [29] Johnson MR. A comparison of chiropractic, medical and osteopathic care for work-related sprains/strains. *Journal of Manipulative and Physiological Therapeutics* 1989; 12(8): 335-344.
- [30] Wolf G. An analysis of Florida workers' compensation medical claims for back-related injuries. *Journal of the American Chiropractic Association* 1988; 77(7): 50-56.
- [31] Dean H, Schmidt R. A Comparison of the Cost of Chiropractors versus Alternative Medical Practitioners. Richmond, VA: Virginia Chiropractic Association, 1982.
- [32] Stano M, Smith M. Chiropractic and medical costs of low back care. *Medical Care* 34(3): 191-204.
- [33] Smith M, Stano M. Costs and resources of chiropractic and medical episodes of low back care. *Journal of Manipulative and Physiological Therapeutics* 1997; 20(1): 5-12.
- [34] Menga P, Angus D, Papadopoulos C, Swan W. The Effectiveness and Cost: Effectiveness of Chiropractic Management of Low-Back Pain. Richmond Hill, Ontario: Kenilworth Publishing, 1983.
- [35] Menga P. Enhanced Chiropractic Coverage under OHP as a Means for Reducing Healthcare Costs, Attaining Better Health Outcomes and Achieving Equitable Access to Health Services. Report to the Ontario Ministry of Health, 1988.
- [36] Shekelle PG, Markovitch M, Louis R. Comparing the costs between provider types of episodes of back care. *Spine* 1995; 20(2): 221-227.
- [37] Chenkin DC, Deyo RA, Battie M, Street J, Galloway W. Comparison of physical therapy, chiropractic manipulation, and provision of an educational booklet for the treatment of patients with low back pain. *New England Journal of Medicine* 1986; 339(14): 1021-1028.
- [38] Rosner A. Letter to the editor. *Spine* 1995; 20(23): 2595-2598.
- [39] Carey TB, Gerrell J, Jackman A, McLaughlin C, Fryer J, Bruckner DR. North Carolina Back Pain Project. The outcomes and costs for acute low back pain among patients seen by primary care practitioners, chiropractors, and orthopedic surgeons. *New England Journal of Medicine* 1986; 333(14): 915-917.
- [40] Chenkin DC, MacConick FA. Patient evaluations of low back pain care from family physicians and chiropractors. *Western Journal of Medicine* 1989; 150: 351-355.
- [41] Williams B. Patient satisfaction: A valid concept? *Social Science and Medicine* 1994; 39: 509-516.
- [42] Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Park RE, Phillips RB, Brook RH. The Appropriateness of Spinal Manipulation for Low Back Pain: Indications and Ratings by a Multidisciplinary Expert Panel. RAND: Santa Monica, CA, 1991, Monograph No. R-40282-CORFCER.
- [43] Shekelle PG, Adams AH, Chassin MR, Hurwitz EL, Park RE, Phillips RB, Brook RH. The Appropriateness of Spinal Manipulation for Low Back Pain: Indications and Ratings by an All-Chiropractic Expert Panel. RAND: Santa Monica, CA, 1991, Monograph No. R-40254-CORFCER.
- [44] Shekelle PG, Hurwitz EL, Coulter J, Adams A, Genovese B, Brook RH. The appropriateness of chiropractic spinal manipulation for low back pain: A pilot study. *Journal of Manipulative and Physiological Therapeutics* 1995; 18(5): 265-270.
- [45] Bigos S, Bowyer O, Briten G, et al. Acute Low Back Pain in Adults. Clinical practice guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Healthcare Policy and Research, Public Health Service, U.S. Department of Health and Human Services, December 1994.
- [46] Rosen M. Back pain. Report of a Clinical Standards Advisory Group Committee on back pain. May 1994, London: HMSO.
- [47] Smith, R. "Where is the wisdom: The poverty of medical evidence." *British Medical Journal* 1991; 303: 786-789, quoting David Eddy, M.D., Professor of Health Policy and Management, Duke University, NC.
- [48] Rachi, N. and Kucshner C. Second Opinion: What's Wrong with Canada's Healthcare System and How to Fix It. Collins, Toronto (1988).
- [49] Corporate Health Policies Group. A Valuation of Federal Funding Policies and Programs and their Relationship to the Chiropractic.



Profession, Arlington, DVA: Foundation for Chiropractic Education and Research, 1991.

[50] Crull PR, Macdonald GA, Popagongkol AC, Thomas E, Sikes AJ. Outcome of low back pain in general practice: A prospective study. *British Medical Journal* 1989; 310: 1288-1292.

[51] Reis S, Hansen D, Beaton JM, Blotman A, Tabinick C, Cost A. A new look at low back complaints in primary care: A FANBIAM Israeli family practice research network study. *Journal of Family Practice* 1999; 49(4): 290-300.

[52] Beloff P, Kestak K, Bessell G, Nelson C, Anderson AV. Spinal manipulation vs. amitriptyline for the treatment of chronic tension-type headaches: A randomized clinical trial. *Journal of Manipulation and Physiological Therapeutics* 1996; 19(2): 140-154.

[53] Blaud J, Graf F, Robert F, et al. Zur wirksamkeit der manuelletherapeutischen behandlung des spannungstypen kopfschmerz [Efficacy effects for the treatment of chiropractic treatment of episodic headaches]. *Manuelle* 1977; 42: 250-252.

[54] Hoyt WM, Shelton P, Reed DA, Strasser JB, Blankenship GD, Gray JH, Hudson WT, Hughes LC. Osteopathy manipulation in the treatment of muscle contraction headache. *Journal of the American Osteopathic Association* 1979; 79: 522-528.

[55] Nelson N. A randomized controlled trial of the effect of spinal manipulation in the treatment of cervicogenic headache. *Journal of Manipulation and Physiological Therapeutics* 1998; 19(7): 435-442.

[56] Fisher G, Tugling H, Pryor D. A controlled trial of cervical manipulation for migraine. *Acupuncture and Bone Zangne Journal of Acupuncture* 1979; 2: 889-893.

[57] Jensen IK, Mathan PF, Vassar L. An open study comparing manual therapy with the use of cold packs in the treatment of post-traumatic headache. *Chiropractic* 1990; 10: 263-250.

[58] Nelson C, Bessell G, Evans R, Sojka P, Galtmanth C, Anderson AV. The efficacy of spinal manipulation, amitriptyline, and the combination of both therapies for the prophylaxis of migraine headache. *Journal of Manipulation and Physiological Therapeutics* 1999; 21(8): 511-518.

[59] Whitehagen W, Ellis WB, Mijayose TP. The effect of manipulation (legge nico) for headaches with upper cervical joint dysfunction: a pilot study. *Journal of Manipulation and Physiological Therapeutics* 1994; 17(8): 360-375.

[60] Massey RD, Dames NSR, Hess JA, Coon RD, Scharr DB. Chiropractic treatment of chronic episodic tension-type headache in male subjects: a case series analysis. *Journal of the Canadian Chiropractic Association* 1994; 38(2): 153-158.

[61] Drex JM, Graf F. Occipital headache: Statistical results in the treatment of vestibrogenic headache. *Annals of the Swiss Chiropractic Association* 1986; 9: 127-136.

[62] Weston HT. Spinal manipulation and headaches of cervical origin. *Journal of Manipulation and Physiological Therapeutics* 1982; 5(2): 100-112.

[63] Wright JR. Migraine: A statistical analysis of chiropractic treatment. *Chiropractic Journal* 1979; 12: 300-307.

[64] Stuckley J, Christensen H. Manual therapy in the treatment of patients with cervical migraines. *Manual Medicine* 1989; 4: 40-51.

[65] Turk Z, Rulloff C. Mobilization of the cervical spine in chronic headaches. *Manual Medicine* 1987; 3:15-17.

[66] Burns G, Nelson N. Spinal manipulation in the treatment of episodic tension-type headache. *Journal of the American Medical Association* 1990; 263(12): 1579-1579.

[67] Risher BM. Polypharyngeal and manipulative management of carpal tunnel syndrome. *Journal of the American Osteopathic Association* 1994; 94(5): 647-652.

[68] Reed BM, Kuehler ML. Osteopathic manipulation for patients with confirmed mild, moderate and moderate carpal tunnel syndrome. *Journal of the American Osteopathic Association* 1994; 94(5): 673.

[69] Davis PT, Hubert JR, Kestak KM, Meyer JL. Comparative efficacy of conservative medical and chiropractic treatments for carpal tunnel syndrome: A randomized clinical trial. *Journal of Manipulation and Physiological Therapeutics* 1999; 21(5): 317-328.

[70] Risher G, McCarthy K. Conservative chiropractic approaches to carpal tunnel syndrome. *Journal of Clinical Chiropractic* 1998; 9(4): 63-72.

[71] Ulett NA, Butler LM. A chiropractic approach to the treatment of dyspareunia. *Journal of Manipulation and Physiological Therapeutics* 1982; 13(2): 101-105.

[72] Bostler D, Wimmer M, Alpen A, Florschütz EP, Kitzmann MA. Efficacy of high-velocity low-amplitude manipulative techniques in subjects with low back pain during menstrual cramping. *Journal of the American Osteopathic Association* 1982; 82(2): 200-214.

[73] Kojima K, Bohndel DM, Tama JJ, Brennan PC. The effect of spinal manipulation on pain and prostaglandin levels in women with primary dysmenorrhea. *Journal of Manipulation and Physiological Therapeutics* 1992; 15(2): 279-285.



- [74] Slude DE. The management of symptoms associated with premenstrual syndrome. *Journal of Manipulative and Physiological Therapeutics* 1991; 14(3): 209-216.
- [75] Walsh MJ, Chandranaj S, Polus BI. The efficacy of chiropractic therapy on premenstrual syndrome: a case series study. *Chiropractic Journal of Australia* 1994; 24(4): 122-126.
- [76] Walsh MJ, Polus BI. A randomized, placebo-controlled clinical trial on the efficacy of chiropractic therapy on premenstrual syndrome. *Journal of Manipulative and Physiological Therapeutics* 1999; 22(9): 542-545.
- [77] Plaugher G, Gramata EE, Phillips R. A retrospective consecutive case analysis of pretreatment and comparative static radiological parameters following chiropractic adjustments. *Journal of Manipulative and Physiological Therapeutics* 1980; 13(9): 498-508.
- [78] Tarola GA. Manipulation for the control of back pain and curve progression in patients with skeletal mature idiopathic scoliosis: two case studies. *Journal of Manipulative and Physiological Therapeutics* 1994; 17(4): 253-257.
- [79] Froehle RM. Ear infection. A retrospective study examining improvement from chiropractic care and analyzing for influencing factors. *Journal of Manipulative and Physiological Therapeutics* 1986; 19(3): 166-177.
- [80] Fallon J. The role of chiropractic adjustment in the care and treatment of 332 children with otitis media. *Journal of Clinical Chiropractic Pediatrics* 1997; 2(2): 167-183.
- [81] Degenhardt BF, Kuchera ML. Efficacy of osteopathic evaluation and manipulative treatment in reducing the morbidity of otitis media in children. *Journal of the American Osteopathic Association* 1994; 94(8): 673.
- [82] Krogard N, Nilsson N, Jacobsen J. Infantile colic treated by chiropractors: a prospective study of 318 cases. *Journal of Manipulative and Physiological Therapeutics* 1989; 12(4): 281-288.
- [83] Vrbeg JMM, Nordstam J, Nilsson N. The short-term effect of spinal manipulation in the treatment of infantile colic: A randomized controlled trial with a blinded observer. *Journal of Manipulative and Physiological Therapeutics* 1990; 22(8): 517-522.
- [84] Reed WR, Beevers S, Raddy SK, Kern G. Chiropractic management of primary nocturnal enuresis. *Journal of Manipulative and Physiological Therapeutics* 1994; 17(8): 590-600.
- [85] Gamble A. Alternative medical approaches to the treatment of asthma. *Alternative and Complementary Therapies* 1995; 11(2): 81-85.
- [86] Jamison JR, McEwen AP, Thomas SJ. Chiropractic adjustment in the management of visceral conditions: a critical appraisal. *Journal of Manipulative and Physiological Therapeutics* 1992; 15(3): 171-180.
- [87] Lines DH. A holistic approach to the treatment of bronchial asthma in a chiropractic practice. *Chiropractic Journal of Australia* 1993; 23(1): 4-8.
- [88] Blum CL. Chiropractic and sacro-occipital technique in asthma treatment. *Chiropractic Technique* 1999; 11(4): 174-179.
- [89] Falk JW. Bowel and bladder dysfunction secondary to lumbar dysfunction syndrome. *Chiropractic Technique* 1990; 2(2): 45-48.
- [90] Wagner T, Owen J, Malone E, Mann K. Irritable bowel syndrome and spinal manipulation: a case report. *Chiropractic Technique* 2000; 12(1): 136-140, 1995.
- [91] Pihalev A, Khartn VV. Use of spinal manipulative therapy in the treatment of duodenal ulcer: A pilot study. *Journal of Manipulative and Physiological Therapeutics* 1994; 17(3): 310-313.
- [92] Bowers JL, Meoltz R. The nature of primary care: The chiropractor's role. *Toxics in Clinical Chiropractic* 1995; 2(1): 66-84.
- [93] Hawk C, Duro M. A survey of 462 chiropractors on primary care and prevention-related issues. *Journal of Manipulative and Physiological Therapeutics* 1995; 8(2): 57-64.
- [94] Freeman KB, Barnstein J. The adequacy of medical school education in neuromusculoskeletal medicine. *Journal of Bone and Joint Surgery Am* 1968; 80-A: 1421-1427.



SECTION III

RECOMMENDATIONS BY THE AMERICAN CHIROPRACTIC ASSOCIATION AND THE ASSOCIATION OF CHIROPRACTIC COLLEGES

- 1. Ensuring Access to Chiropractic Services in the DVA Healthcare System**
- 2. Scope of Practice of Doctors of Chiropractic within the DVA Healthcare System**
- 3. Employment Status of Doctors of Chiropractic**
- 4. The Role of Doctors of Chiropractic in Rural and Medically Under-Served Areas**
- 5. Hospital Privileges and Credentialing of Doctors of Chiropractic**
- 6. The Enhanced Role of Doctors of Chiropractic in the Treatment of Chronic Pain**
- 7. Developing a Chiropractic Educational Campaign for Current and Future DVA Healthcare Personnel**
- 8. Establishing a DVA Liaison to the Chiropractic Profession**



Recommendation 1. Ensuring Access to Chiropractic Services in the DVA Healthcare System

The key to developing an effective policy on chiropractic care in the Veterans healthcare system is the guarantee of reasonable beneficiary access to the services provided by doctors of chiropractic, and the accessibility of such services in all areas served by the DVA healthcare system. Accordingly, this report recommends that the policy on chiropractic care should ensure the availability of chiropractic care at each DVA treatment facility, including all DVA hospitals and satellite clinics. When, due to geographic location, access to a DVA treatment facility is not reasonably available, chiropractic care should be provided on a local basis by doctors of chiropractic who have been pre-qualified and authorized to provide services to DVA beneficiaries. In fact, this was a key issue when the House Veterans' Affairs Committee considered the Veterans' Millennium Healthcare Act (P.L. 106-117). In the committee report (106-237) that accompanied the statutory language, the committee stated that, "in recognition of evolving medical practice, Section 304 of the reported bill *would require the VA to establish a policy that would permit greater access to chiropractic care, particularly in rural and medically underserved areas.*"¹

DIRECT ACCESS

Additionally, in both DVA hospitals and other locations, the availability of chiropractic services should be on a *direct access* basis. In the United States, the governments of all states license and regulate doctors of chiropractic as independently practicing healthcare professionals. All of these jurisdictions recognize chiropractors' rights and responsibility to serve as a first-contact, portal of entry provider.² As such, doctors of chiropractic possess the diagnostic skills necessary to differentiate health conditions that are amenable to their management from those conditions that require referral or co-management with other professionals. Doctors of chiropractic recognize the value of working in cooperation with other healthcare practitioners, and acknowledge their responsibility to do so in the best interest of the patient.

Ensuring *direct access* to doctors of chiropractic is extremely important to the proper utilization of chiropractic care. Patients often experience difficulty accessing chiropractic care when a referral from a medical doctor or nurse is required. Although they are skilled and trained professionals, medical doctors and nurses typically receive no professional training during their formal education relating to when it is appropriate to refer to doctors of chiropractic. Accordingly, it is not surprising that medical referrals are small in number, because the traditional medical personnel simply do not know when it is appropriate or desirable to refer for chiropractic treatment. AHCPR recognized this problem in a report entitled "Chiropractic in the United States: Training, Practice & Research." In this report, AHCPR stated, "Given that medical



practitioners have little exposure to chiropractic training or practice, a case can be made for not requiring medical referral.”³

Additionally, some biases against the chiropractic profession, including a perceived threat of competition, remain within some segments of organized medicine, and work against the concept of informed and professional referral. These biases may be a holdover effect dating from previous efforts by some elements of organized medicine to boycott and contain the profession in violation of the nation's anti-trust laws (*Wilk v. AMA*).⁴

A referral process that restricts access to chiropractic care, as provided by a doctor of chiropractic, can have an adverse effect on overall healthcare cost. Various studies have found that expanded access to chiropractic care can reduce healthcare costs while increasing patient outcomes and satisfaction. The Ontario Ministry of Health concluded that “chiropractic management of low-back pain is more cost-effective than medical management” and recommended that any economic disincentives to chiropractic care should be removed.⁵ A report by the College of William and Mary and Medical College of Virginia entitled Mandated Health Insurance Coverage for Chiropractic Treatment: An Economic Assessment, with Implications for the Commonwealth of Virginia stated that, “The low cost impact of chiropractic is due not to its low rate of use, but to its apparently offsetting impacts on costs in the face of high rates of utilization.”⁶



Recommendation 2. Scope of Practice of Doctors of Chiropractic within the DVA Healthcare System

RECOMMENDED SCOPE OF SERVICES FOR DOCTORS OF CHIROPRACTIC

Doctors of chiropractic are trained and educated at chiropractic colleges accredited by the Council on Chiropractic Education (recognized as an accrediting agency for chiropractic education by the U.S. Department of Education). Their scope of practice extends well beyond treatment and incorporates broad patient evaluation and diagnostic components, as well as the following services:

- Primary contact or care services.
- Diagnostic testing and imaging, including differential diagnosis, with the accompanying ability to perform and/or order as well as interpret diagnostic tests, including venipuncture.
- Taking and interpretation of diagnostic imaging, electro-diagnostic testing, and laboratory analysis.
- Manipulation/adjustment services and a range of other manual and physical therapeutic procedures including daily living instructions, ergonomics, and exercise/rehabilitation and counseling.
- Nutritional counseling including advice on vitamins and food supplements.

- Prescriptive drugs and surgery, however, are outside a chiropractor's scope of professional practice.⁷

It is the recommendation of the ACA and ACC that the above services form the basis for the scope of practice of doctors of chiropractic within the DVA health care system. Please refer to state-level examples on following pages.

SPECIFIC STATE SCOPE OF SERVICES/EXCERPTS FROM FLORIDA, PENNSYLVANIA, AND CALIFORNIA STATUTES

The following excerpts from state law reflect the basic scope of professional services listed above. They are intended to exemplify how these concepts are delineated under state law.



Florida

- a. 'Practice of chiropractic' means a noncombative principle and practice consisting of the science, philosophy, and art of the adjustment, manipulation, and treatment of the human body using specific chiropractic adjustment or manipulation techniques taught in chiropractic colleges accredited by the Council on Chiropractic Education.
- b. Any chiropractic physician who has complied with the provisions of this chapter may examine, analyze, and diagnose the human living body and its diseases by the use of any physical, chemical, electrical, or thermal method; use the x-ray for diagnosing; phlebotomize; and use any other general method of examination for diagnosis and analysis taught in any school of chiropractic.
- c. Chiropractic physicians may adjust, manipulate, or treat the human body by manual, mechanical, electrical, or natural methods; by the use of physical means or physiotherapy, including light, heat, water, or exercise; by the use of acupuncture; or by the administration of foods, food concentrates, food extracts, and items for which a prescription is not required and may apply first aid and hygiene, but chiropractic physicians are expressly prohibited from prescribing or administering to any person any legend drug except as authorized under subparagraph 2., from performing any surgery except as stated herein, or from practicing obstetrics.
- d. Chiropractic physicians shall have the privileges of services from the department's laboratories. The term 'chiropractic,' 'doctor of chiropractic,' or 'chiropractor' shall be synonymous with 'chiropractic physician,' and each term shall be construed to mean a practitioner of chiropractic as the same has been defined herein. Chiropractic physicians may analyze and diagnose the physical conditions of the human body to determine the abnormal functions of the human organism and to determine such functions as are abnormally expressed and the cause of such abnormal expression.⁸



Pennsylvania

"CHIROPRACTIC" A branch of the healing arts dealing with the relationship between the articulations of the vertebral column, as well as other articulations, and the neuro-musculo-skeletal system and the role of these relationships in the restoration and maintenance of health. The term shall include systems of locating misaligned or displaced vertebrae of the human spine and other articulations; the examination preparatory to the adjustment or manipulation of such misaligned or displaced vertebrae and other articulations; the adjustment or manipulation of such misaligned or displaced vertebrae and other articulations; the furnishing of necessary patient care for the restoration and maintenance of health; and the use of board-approved scientific instruments of analysis, including x-ray. The term shall also include diagnosis, provided that such diagnosis is necessary to determine the nature and appropriateness of chiropractic treatment; the use of adjunctive procedures in treating misaligned or dislocated vertebrae or articulations and related conditions of the nervous system, provided that, after January 1, 1988, the licensee must be certified in accordance with this act to use adjunctive procedures; and nutritional counseling, provided that nothing herein shall be construed to require licensure as a chiropractor in order to engage in nutritional counseling. The term shall not include the practice of obstetrics or gynecology, the reduction of fractures or major dislocations, or the use of drugs or surgery."⁹

California

- (1) A duly licensed chiropractor may manipulate and adjust the spinal column and other joints of the human body and in the process thereof a chiropractor may manipulate the muscle and connective tissue related thereto.
- (2) As part of a course of chiropractic treatment, a duly licensed chiropractor may use all necessary mechanical, hygienic, and sanitary measures incident to the care of the body, including, but not limited to, air, cold, diet, exercise, heat, light, massage, physical culture, rest, ultrasound, water, and physical therapy techniques in the course of chiropractic manipulations and/or adjustments.
- (3) Other than as explicitly set forth in section 10(b) of the Act, a duly licensed chiropractor may treat any condition, disease, or injury in any patient, including a pregnant woman, and may diagnose, so long as such treatment or diagnosis is done in a manner consistent with chiropractic methods and techniques



and so long as such methods and treatment do not constitute the practice of medicine by exceeding the legal scope of chiropractic practice as set forth in this section.

(4) A chiropractic license issued in the State of California does not authorize the holder thereof:

- (A) to practice surgery or to sever or penetrate tissues of human beings, including, but not limited to severing the umbilical cord;
- (B) to deliver a human child or practice obstetrics;
- (C) to practice dentistry;
- (D) to practice optometry;
- (E) to use any drug or medicine included in materia medica;
- (F) to use a lithotripter;
- (G) to use ultrasound on a fetus for either diagnostic or treatment purposes; or
- (H) to perform a mammography.

(5) A duly licensed chiropractor may employ the use of vitamins, food supplements, foods for special dietary use, or proprietary medicines, if the above substances are also included in section 4052 of the Business and Professions Code, so long as such substances are not included in materia medica as defined in section 13 of the Business and Professions Code.

The use of such substances by a licensed chiropractor in the treatment of illness or injury must be within the scope of the practice of chiropractic as defined in section 7 of the Act.

(6) Except as specifically provided in section 302(a)(4), a duly licensed chiropractor may make use of x-ray and thermography equipment for the purposes of diagnosis but not for the purposes of treatment. A duly licensed chiropractor may make use of diagnostic ultrasound equipment for the purposes of neuromuscular skeletal diagnosis.

(7) A duly licensed chiropractor may only practice or attempt to practice or hold him or herself out as practicing a system of



chiropractic. A duly licensed chiropractor may also advertise the use of the modalities authorized by this section as a part of a course of chiropractic treatment, but is not required to use all of the diagnostic and treatment modalities set forth in this section. A chiropractor may not hold him or herself out as being licensed as anything other than a chiropractor or as holding any other healing arts license or as practicing physical therapy or use the term "physical therapy" in advertising unless he or she holds another such license.¹⁰

CONDITIONS TREATED BY CHIROPRACTORS

In general, "various studies, which include national surveys in the U.S., Canada, Australia, and Europe, indicate that 95% of chiropractic patients have neuromusculoskeletal pain (NMS disorders), and fully 65-70% have back pain. The breakdown of all patient complaints seen in chiropractic practice, also illustrated in Figure 1, is:

Figure 1

Back pain		70%
	Low back pain	65%
	Mid-back pain	5%
Other NMS pain		25%
	Head/neck pain	15%
	Extremity pain (Shoulder, arm, leg, etc.)	10%
Non-NMS pain	e.g. allergies, asthma, digestive disorders, menstrual problems, visual/hearing/balance disorders, etc.	5%
Total		100%

"These figures need to be interpreted with some caution for several reasons. First, third-party payment policies influence what chiropractors record in their patient charts. For example, in the U.S., Medicare and some private insurers require chiropractors to report neuromusculoskeletal diagnosis as a condition of coverage.

"Second, the realities of practice mean that many of the non-neuromusculoskeletal complaints managed by chiropractors are secondary to neuromusculoskeletal pain.

"Third, in many cases it is quite unclear whether the primary problem is neuromusculoskeletal or non-neuromusculoskeletal. As an example, chiropractors experience cases where a patient has a medical diagnosis of a cardiac problem but also has pronounced spinal dysfunction. Each condition may influence or aggravate the other, and it is unclear which is of primary importance. Manual treatments to relieve the spinal dysfunction may



"completely resolve the pain being treated by the cardiologist as a pure cardiac disorder. A chiropractor, in these circumstances, feels it is more appropriate to record this in chiropractic clinical records as a case of joint and muscle dysfunction in the thoracic spine (mid-back), rather than a case of cardiac or chest pain.

"Fourth, whatever the patient's condition, chiropractors fundamentally see themselves as diagnosing and treating the underlying joint and soft tissue dysfunction. This will have reflex effects in the nervous system that may influence various conditions and general health, not just the patient's primary complaint. To illustrate this point:

"Chiropractors report clinical success in treating children with chronic ear infections (otitis media). It seems that some children have joint and muscle restrictions in the cervical spine, that correction of these may have a related effect on the function of the Eustachian tubes (probably their diameter and inclination), and that this improves drainage of the tubes and helps prevent future infections. The child's mother or father sees this as treating otitis media. A chiropractor generally describes this as treating joint and soft tissue dysfunction.

"Bearing in mind all these considerations it remains clear, however, that the management of conditions thought by patients to be non-neuromusculoskeletal is a relatively small part of chiropractic practice—about 5%. This percentage can be expected to gradually increase now that the areas of back and neck pain have given medical and chiropractic doctors a secure basis for working together. This means that many more medical physicians will be exposed to patients who experience non-neuromusculoskeletal health benefits, and will then provide the patients for interdisciplinary clinical research to more fully investigate and understand the contribution of spinal dysfunction to problems such as cardiac disorders, respiratory disorders, dysmenorrhea and chronic constipation."¹¹

A specific listing of diagnostic codes for conditions commonly treated by chiropractors is attached. Please see Addendum, Section IV.



Recommendation 3. Employment Status of Doctors of Chiropractic

Doctors of chiropractic can and should be retained as full-time employees, part-time employees, and outside contractors to fit the needs and circumstances of the Veterans Administration and its patients.

Doctors of chiropractic should be core members of the interdisciplinary team that is part of the DVA's healthcare delivery system. Patients should have direct access to doctors of chiropractic. They are portal-of-entry providers into the healthcare delivery system and will add a substantial cost-effective resource to the DVA's healthcare team.

The hiring practices currently in place for other professional personnel should be applied to chiropractic. Doctors of chiropractic graduate with a four-year clinical doctorate degree and are a legally and independently licensed profession in all states. Physician status should be included in Title 38 U.S.C., Section 7404, along with doctors of medicine, osteopathy, dentistry, optometry, and podiatry.

PERSONNEL POLICIES

Minimum qualifications for appointment as a DVA doctor of chiropractic are:

- U.S. citizenship (non-citizens may be appointed when qualified citizens are not available).
- Degree of Doctor of Chiropractic from an institution approved by the Council on Chiropractic Education (CCE) for the year in which the degree was granted. Chiropractors graduating prior to CCE accreditation in 1974 must be fully licensed and meet state licensure requirements.
- Current, full, active, and unrestricted license to practice chiropractic in any state, territory, or commonwealth (e.g. Puerto Rico) of the United States or the District of Columbia.
- Successful professional record for experienced doctors of chiropractic.
- Personal interviews by a doctor of chiropractic may include questions on clinical competency.
- English language proficiency.

OPTIONAL QUALIFICATIONS:

The following qualifications for DVA employment as a doctor of chiropractic are optional and should be considered, **without being exclusionary**, in the selection of candidates who have satisfied all of the minimal qualifications stated above:



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- Prior successful professional private practice experience.
 - Board-eligible or diplomate status in an appropriate state licensing board-approved or accredited board program.
 - Formal hospital staff privileges or evidence of providing chiropractic care in a multidisciplinary outpatient clinic.
 - Additional healthcare degrees, registrations, or certifications (e.g. DACBR, DABCO, RN, PT, MD, DO, etc.).
 - Academic teaching appointments.
 - Special awards, citations, or recognitions.



Recommendation 4. The Role of Doctors of Chiropractic in Rural and Medically Underserved Areas

Doctors of chiropractic should be integrated into the DVA in such a way that they are able to serve veterans living in rural and medically underserved areas.

Ongoing surveys and area analyses suggest that chiropractic practices located near primary care shortage areas exhibit higher practice volume, and that doctors of chiropractic render a significant amount of care to underserved populations.

Doctors of chiropractic are uniquely situated to meet the needs of veterans living in underserved areas. There is some evidence to suggest that the extent, scope and scale of chiropractic practice is expanded in rural and medically underserved areas. Doctors of chiropractic are well trained to perform the complete history and examination procedures required of a first contact provider. They are able to make appropriate referrals to other healthcare providers when needed¹² and high levels of patient satisfaction are found with doctors of chiropractic practicing in Health Professional Shortage Areas¹³.



Recommendation 5. Hospital Privileges and Credentialing of Doctors of Chiropractic

PRIVILEGES

Practice privileges for doctors of chiropractic are defined as “minimum practice privileges” and “additional practice privileges,” as listed below, are recommended. The minimum practice privileges should be granted to all doctors of chiropractic determined to be qualified through the hiring process. At the option of an appointed medical liaison, additional privileges should be granted upon request if the mandatory qualifications for such a request can be satisfactorily demonstrated.

The following is the minimum set of privileges that should be granted to all doctors of chiropractic in the DVA healthcare system:

- Performance of patient history and complete physical examinations, including specialized chiropractic examinations.
- Ordering of and interpretation of diagnostic imaging to include, but not be limited to, plain radiography, diagnostic ultrasound, MRI, CT scans, and nuclear studies.
- Ordering of and interpretation of standard diagnostic laboratory tests.
- Ordering of and interpretation of certain electro-diagnostic procedures.
- Performance of standard approved osseous and soft-tissue procedures consistent with chiropractic care, as commonly taught in the core curriculum of the Council on Chiropractic Education-accredited chiropractic colleges.
- Referral of patients to specialty services when clinically appropriate.
- Provision of physiotherapeutic modalities consistent with chiropractic care, as commonly taught in the core curriculum of the Council on Chiropractic Education-accredited colleges, e.g., heat, cold, electrical stimulation, therapeutic ultrasound, etc.
- Provision of patient instructions and recommendations in all matters pertaining to hygiene, nutrition, exercise, sanitary measures, lifestyle changes, and modifications of ergonomic factors.
- Ordering of orthotics, heel lifts, cervical collars, braces/supports, durable medical equipment (i.e. TENS units), etc.



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- Opportunity to serve on appropriate hospital or clinic committees, and participate in educational functions, such as grand rounds, journal club, case reviews, etc.
 - Additional privileges may be granted as appropriate.

CREDENTIALING

Note: "Credentialing" is referred to as "Qualifications" in the DVA literature for "all" healthcare occupations: Advanced Practice Nurse, CNRA, Dentist, Expanded-Function Dental Auxiliary, LPN, OT, OD, Pharmacist, PT, Physician, PA, DPM, RN, and Respiratory Therapist. Doctors of Chiropractic should be included in this list.



Recommendation 6. The Enhanced Role of Doctors of Chiropractic in the Treatment of Chronic Pain

The American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC) are proposing the establishment of a collaborative interdisciplinary chronic pain management initiative with the Department of Veterans Affairs, as part of the new partnership envisioned by the Congress between the chiropractic healthcare profession and the DVA.

NATIONAL FOCUS

Over the past decade, Congress has expressed its support for greater focus among the Federal research and development agencies on addressing the issue of enhanced research and medical treatment for those suffering from chronic pain. In 1996, Congress authorized the establishment of a Pain Research Consortium at the National Institutes of Health—an initiative that ultimately led to the creation of a Center for Chiropractic Research within the then-Office of Alternative Medicine at NIH. Therefore, the concept of an Interdisciplinary Chronic Pain Management Program at the Department of Veterans Affairs is not a new one. However, in light of the Congressional mandate in Section 303 of Public Law 106-117 for the Department of Veterans Affairs to establish a policy for providing chiropractic healthcare services to address, among other things, lower-back pain for veterans healthcare beneficiaries, the ACA and the ACC are recommending that the Department, in partnership with the chiropractic healthcare profession, embark upon an expanded partnership to address the issue of chronic pain management on a *national scale* through the Department of Veterans Affairs.

COLLABORATIVE EFFORTS TOWARD CHRONIC PAIN MANAGEMENT

The ACA and the ACC are aware of the important chronic pain management efforts at the Department of Veterans Affairs, including chronic pain rehabilitation programs at Tampa, Florida; Salt Lake City, Utah; Gainesville, Florida and other venues. However, we firmly believe that the Congressional mandate for a chiropractic healthcare policy in the DVA presents an historic opportunity to bring together the so-called traditional medical healthcare providers in the DVA and doctors of chiropractic to co-chair a national veterans' healthcare program in the area of chronic pain management. The Congress continues to give chronic pain management a high priority and the ACA and the ACC believe that an interdisciplinary, collaborative chronic pain management program for our veterans is long overdue.



PLAN PROPOSAL

The ACA and the ACC propose that the chiropractic healthcare profession and the Veterans Health Administration co-chair a national chronic pain management program at the Department of Veterans Affairs that would, among other things,

- Carry out demonstration projects at DVA healthcare facilities in at least four regions of the United States, building upon the successful chronic pain management program in Tampa and other DVA locations; and
- Engage medical schools, chiropractic colleges and universities, and the Center for Chiropractic Research located at Palmer Chiropractic College in Davenport, Iowa, to form the nucleus of the proposed Interdisciplinary Chronic Pain Management Initiative at the Department of Veterans Affairs.

The ACA and the ACC welcome the opportunity to prepare a more detailed proposal for the design, conduct, and implementation of an interdisciplinary chronic pain management program with the Department of Veterans Affairs. We look forward to developing such a proposal with input from practicing doctors of chiropractic, physicians within the Department of Veterans Affairs medical care system, and officials from DVA headquarters, in response to the mandates contained in the Veterans' Millennium legislation.



Recommendation 7. Developing a Chiropractic Educational Campaign for Current and Future DVA Healthcare Personnel

The ACA and ACC recommend the development and implementation of training and educational programs that encompass the entire spectrum of DVA facilities to enhance the smooth integration of chiropractic services. These programs would result in professional interaction and appropriate referrals that benefit the patient. They should be sustained as an ongoing DVA training and education initiative. The ACA and the ACC are prepared to play a leading role in assisting the DVA in the development and implementation of these programs.

All levels of staff who decide policy and implement chiropractic benefits should have a full understanding of the integration of chiropractic benefits and how and when a doctor of chiropractic can be helpful in patient care. Recommended audiences include:

- DVA administrators, policymakers and medical directors
- Senior management working with primary care programs
- Clinical managers
- Hospital and healthcare system managers
- Professional personnel of the Veterans Administration

To facilitate the above, senior DVA personnel should make site visits to chiropractic colleges to familiarize themselves with chiropractic care. The ACC and the ACA offer their assistance to facilitate such scheduled events. Senior staff should also be educated and trained about chiropractic.

Education and training should include information about the education of doctors of chiropractic, their practice routines and protocols, hospital staff privileges, and routine patient visit practices. Programs should provide forums for question-and-answer sessions. The ACC and the ACA can provide assistance in this area, providing educators and practicing doctors of chiropractic to help lead presentations.

College campus visits are recommended to help initiate the chiropractic integration process. A training module could be developed for use at medical staff meetings, at orientations given to primary care planning committees, for residents' trainings, and as a resource document for DVA strategic planning.



**Recommendation 8. Establishing a DVA Liaison to the
Chiropractic Profession**

In order to assist the DVA with the development and implementation of an effective policy regarding chiropractic care, the ACA and ACC recommend that an ongoing dialog be established between DVA and ACA/ACC and that a senior-level DVA official be designated as a liaison for this purpose. This individual would serve as the primary DVA point of contact and would help organize and facilitate future meetings, communications, etc., between DVA and ACA/ACC for the purposes of helping to develop, implement, and monitor DVA's new policy on chiropractic care.



SECTION III

REFERENCES

- [1] House Veterans' Affairs Committee Report (106-237) accompanying the Millennium Health Care Act (P.L. 106-117).
- [2] American Chiropractic Association, *Chiropractic State of the Art*, Spring 1998
- [3] AHCPR, *Chiropractic in the United States: Training, Practice & Research*, 1997
- [4] Wilk v. American Medical Association, 671 F. Supp. 1495 (N.D. Ill. 1987), 895 F.2d 352 (7th Cir 1990), cert. denied, 498 U.S. 982 (1990)
- [5] Manga, Pran, et al., "Chiropractic Management of Low-Back Pain," Pran Manga and Assoc., Ontario, Canada, 1993
- [6] Shifrin, LG, Mandated Health Insurance Coverage for Chiropractic Treatment: An Economic Assessment, with Implications for the Commonwealth of Virginia. The College of William and Mary and Medical College of Virginia, January 1992.
- [7] Chapman-Smith D., *The Chiropractic Profession: Its Education, Practice, Research and Future Direction*. NCMIC Group Inc. 2000, p. C5, for discussion of Legal Scope of Practice.
- [8] Title XXXII, Regulation of Professions and Occupations, Chapter 460. Chiropractic; section 460.403(8), Florida Statutes Ann.
- [9] 63 P.S. § 624.102 (1999).
- [10] 16 CCR § 302 (1999).
- [11] Ibid Chapman-Smith D., p. 70-71.
- [12] Callahan D. and Cianciulli A., The Chiropractor As A Primary Health Care Provider in Rural, Health Professional Shortage Areas of the U.S.: An Exploratory Analysis. FCER, Arlington, Virginia, March 1994.
- [13] Research Dimensions, The Chiropractic Patient In Rural, Health Professional Shortage Areas of the United States: An Exploratory Analysis. Richmond, Virginia, December 1994.



SECTION IV

ADDENDUM

ICD-9-CM CODES

International Classification of Diseases, 9th Revision, Clinical Modification Codes (ICD-9-CM Codes) are designed to classify illnesses, injuries, and patient-health care provider encounters for services.

NOTE: This is not an all-inclusive list of ICD-9 codes, and is provided simply as a list of commonly used codes by DCs.

ICD-9-CM Codes

ICD CODES – NUMERIC CATEGORY LISTING

<i>CODE</i>	<i>DESCRIPTION</i>
290-319	Mental Disorders
307	SPECIAL SYMPTOMS OR SYNDROMES, NOT ELSEWHERE CLASSIFIED
307.6	ENURESIS, PSYCHOGENIC, NONORGANIC, HABIT DISTURBANCE
307.81	TENSION HEADACHE
307.89	COLIC, PSYCHOGENIC ABDOMINAL
320-389.1.1	Diseases of the Nervous System and Sense Organs
333.83	SPASMODIC TORTICOLLIS
346	MIGRAINE
346.0	CLASSIC MIGRAINE
346.1	COMMON MIGRAINE
346.2	VARIANTS OF MIGRAINE
346.8	OTHER FORMS OF MIGRAINE
346.9	MIGRAINE, UNSPECIFIED
350.1	TRIGEMINAL NEURALGIA
350.2	ATYPICAL FACE PAIN
351	FACIAL NERVE DISORDER
351.0	BELL'S Palsy
352	DISORDERS OF OTHER CRANIAL NERVES
352.3	DISORDERS OF PNEUMOGASTRIC (10TH) NERVE
352.9	UNSPECIFIED DISORDER OF CRANIAL NERVES
353	NERVE ROOT AND PLEXUS DISORDERS
353.0	BRACHIAL PLEXUS LESIONS
353.1	LUMBOSACRAL PLEXUS LESIONS
353.2	CERVICAL ROOT LESIONS, NOT ELSEWHERE CLASSIFIED



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- 353.3 THORACIC ROOT LESIONS, NOT ELSEWHERE
CLASSIFIED
- 353.4 LUMBOSACRAL ROOT LESIONS, NOT ELSEWHERE
CLASSIFIED
- 353.8 OTHER NERVE ROOT AND PLEXUS DISORDERS
- 353.9 UNSPECIFIED NERVE ROOT AND PLEXUS DISORDER
- 354 MONONEURITIS UPPER LIMB
- 354.0 CARPAL TUNNEL SYNDROME
- 354.1 OTHER LESION OF MEDIAN NERVE
- 354.2 LESION OF ULNAR NERVE
- 354.3 LESION OF RADIAL NERVE
- 354.4 CAUSALGIA OF UPPER LIMB
- 354.5 MONONEURITIS MULTIPLEX
- 354.8 OTHER MONONEURITIS OF UPPER LIMB
- 354.9 MONONEURITIS OF UPPER LIMB, UNSPECIFIED
- 355 MONONEURITIS LEG
- 355.0 LESION OF SCIATIC NERVE
- 355.1 MERALGIA PARESTHETICA
- 355.4 LESION OF MEDIAL POPLITEAL NERVE
- 355.5 TARSAL TUNNEL SYNDROME
- 381.4 NONSUPPURATIVE OTITIS MEDIA, NOT SPECIFIED AS
ACUTE OR CHRONIC
- 386 VERTIGINOUS SYNDROME
- 386.0 MENIERE'S DISEASE
- 386.3 LABYRINTHITIS, UNSPECIFIED
- 386.9 UNSPECIFIED VERTIGINOUS SYNDROMES AND
LABYRINTHINE DISORDERS
- 390-459 Diseases of the Circulatory System**
- 401.9 UNSPECIFIED ESSENTIAL HYPERTENSION
- 520-579 Diseases of the Digestive System**
- 524.6 TEMPOROMANDIBULAR JOINT DISORDERS,
UNSPECIFIED
- 630-677 Complications of Pregnancy, Childbirth, and Puerperium**
- 648.7.1.1.1.1 BONE AND JOINT DISORDERS OF BACK, PELVIS, AND
LOWER LIMBS OF MOTHER, COMPLICATING
PREGNANCY, CHILDBIRTH, OR THE PUERPERIUM
- 710-739 Diseases of the Neuromusculoskeletal System and
Connective Tissue**
- 710.4 POLYMYOSITIS
- 714.3 CHRONIC OR UNSPECIFIED POLYARTICULAR JUVENILE
RHEUMATOID ARTHRITIS
- 715 OSTEOARTHROSIS, GENERALIZED
- 715.0 OSTEOARTHROSIS AND ALLIED DISORDERS
- 715.00 OSTEOARTHROSIS, GENERALIZED, INVOLVING
UNSPECIFIED SITE



715.04	OSTEOARTHRISIS, GENERALIZED, INVOLVING HAND
715.09	OSTEOARTHRISIS, GENERALIZED, INVOLVING MULTIPLE SITES
715.1	OSTEOARTHRISIS, LOCALIZED, PRIMARY
715.11	OSTEOARTHRISIS, LOCALIZED, PRIMARY, INVOLVING SHOULDER REGION
715.15	OSTEOARTHRISIS, LOCALIZED, PRIMARY, INVOLVING PELVIC REGION AND THIGH
715.18	OSTEOARTHRISIS, LOCALIZED, PRIMARY, INVOLVING OTHER SPECIFIED SITES
715.2	OSTEOARTHRISIS, LOCALIZED, SECONDARY
715.3	OSTEOARTHRISIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY
715.30	OSTEOARTHRISIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, UNSPECIFIED
715.38	OSTEOARTHRISIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, INVOLVING OTHER SPECIFIED SITES
715.8	OSTEOARTHRISIS INVOLVING OR WITH MENTION OF MORE THAN ONE SITE, BUT NOT SPECIFIED AS GENERALIZED
715.80	OSTEOARTHRISIS INVOLVING OR WITH MENTION OF MORE THAN ONE SITE, BUT NOT SPECIFIED AS GENERALIZED, AND INVOLVING UNSPECIFIED SITE, UNSPECIFIED
715.89	OSTEOARTHRISIS INVOLVING OR WITH MENTION OF MULTIPLE SITES, BUT NOT SPECIFIED AS GENERALIZED
715.9	OSTEOARTHRISIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING UNSPECIFIED SITE
715.90	OSTEOARTHRISIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, UNSPECIFIED
715.96	OSTEOARTHRISIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING LOWER LEG
715.98	OSTEOARTHRISIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING OTHER SPECIFIED SITES
716.1	TRAUMATIC ARTHROPATHY
716.66	UNSPECIFIED MONOARTHRITIS INVOLVING LOWER LEG
716.9	UNSPECIFIED ARTHROPATHY
716.90	UNSPECIFIED ARTHROPATHY, SITE UNSPECIFIED, UNSPECIFIED
716.91	UNSPECIFIED ARTHROPATHY INVOLVING SHOULDER REGION
716.95	UNSPECIFIED ARTHROPATHY INVOLVING PELVIC REGION AND THIGH
716.96	UNSPECIFIED ARTHROPATHY INVOLVING LOWER LEG
716.97	UNSPECIFIED ARTHROPATHY INVOLVING ANKLE AND FOOT



716.99	UNSPECIFIED ARTHROPATHY INVOLVING MULTIPLE SITES
717	INTERNAL DERANGEMENT OF KNEE
717.5	DERANGEMENT OF MENISCUS, NOT ELSEWHERE CLASSIFIED
717.7	CHONDROMALACIA OF PATELLA
717.8	OTHER INTERNAL DERANGEMENT OF KNEE
717.9	UNSPECIFIED INTERNAL DERANGEMENT OF KNEE
718	OTHER DERANGEMENT OF JOINT
718.0	ARTICULAR CARTILAGE DISORDER
718.00	ARTICULAR CARTILAGE DISORDER, UNSPECIFIED
718.4	CONTRACTURE OF JOINT
718.5	ANKYLOSIS OF JOINT
718.50	ANKYLOSIS OF JOINT, UNSPECIFIED
718.55	ANKYLOSIS OF JOINT, PELVIS
718.85	OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED
718.88	OTHER JOINT DERANGEMENT, NOT ELSEWHERE CLASSIFIED, INVOLVING OTHER SPECIFIED SITES
718.98	UNSPECIFIED DERANGEMENT OF JOINT OF OTHER SPECIFIED SITES
719.4	PAIN IN JOINT
719.40	PAIN IN JOINT, UNSPECIFIED
719.41	PAIN IN JOINT INVOLVING SHOULDER REGION
719.42	PAIN IN JOINT INVOLVING UPPER ARM
719.43	PAIN IN JOINT INVOLVING FOREARM
719.44	PAIN IN JOINT INVOLVING HAND
719.45	PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
719.46	PAIN IN JOINT INVOLVING LOWER LEG
719.47	PAIN IN JOINT INVOLVING ANKLE AND FOOT
719.48	PAIN IN JOINT INVOLVING OTHER SPECIFIED SITES
719.49	PAIN IN JOINT INVOLVING MULTIPLE SITES
719.5	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED
719.50	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, UNSPECIFIED
719.51	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING SHOULDER REGION
719.55	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING UNSPECIFIED SITE
719.58	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING OTHER SPECIFIED SITES
719.59	STIFFNESS OF JOINT, NOT ELSEWHERE CLASSIFIED, INVOLVING MULTIPLE SITES
719.6	OTHER SYMPTOMS REFERABLE TO JOINT
719.60	OTHER SYMPTOMS REFERABLE TO JOINT, UNSPECIFIED
719.65	OTHER SYMPTOMS REFERABLE TO JOINT, PELVIS
719.68	OTHER SYMPTOMS REFERABLE TO JOINT, INVOLVING OTHER SPECIFIED SITES



719.69	OTHER SYMPTOMS REFERABLE TO JOINT, INVOLVING MULTIPLE SITES
719.7	DIFFICULTY IN WALKING
719.70	DIFFICULTY IN WALKING, UNSPECIFIED
719.75	DIFFICULTY IN WALKING, PELVIS
719.8	OTHER SPECIFIED DISORDERS OF JOINT, INVOLVING OTHER SPECIFIED SITE
719.80	OTHER SPECIFIED DISORDERS OF JOINT, INVOLVING OTHER SPECIFIED SITE, UNSPECIFIED
719.85	OTHER SPECIFIED DISORDERS OF JOINT, INVOLVING OTHER SPECIFIED SITE, PELVIS
719.88	OTHER SPECIFIED DISORDERS OF JOINT, INVOLVING OTHER SPECIFIED SITES
719.89	OTHER SPECIFIED DISORDERS OF JOINT, INVOLVING MULTIPLE SITES
719.9	UNSPECIFIED DISORDER OF JOINT
719.90	UNSPECIFIED DISORDER OF JOINT, UNSPECIFIED
719.95	UNSPECIFIED DISORDER OF JOINT, PELVIS
719.98	UNSPECIFIED DISORDER OF JOINT
719.99	UNSPECIFIED DISORDER OF JOINT
720	ANKYLOSING SPONDYLITIS AND OTHER INFLAMMATORY SPONDYLOPATHIES
720.0	ANKYLOSING SPONDYLITIS
720.1	SPINAL ENTHESOPATHY
720.2	SACROILIITIS, NOT ELSEWHERE CLASSIFIED
720.8	OTHER INFLAMMATORY SPONDYLOPATHIES
720.81	INFLAMMATORY SPONDYLOPATHIES IN DISEASES CLASSIFIED ELSEWHERE
720.9	UNSPECIFIED INFLAMMATORY SPONDYLOPATHY
721	SPONDYLOSIS AND ALLIED DISORDERS
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.4	THORACIC OR LUMBAR SPONDYLOSIS WITH MYELOPATHY
721.41	SPONDYLOSIS WITH MYELOPATHY, THORACIC REGION
721.42	SPONDYLOSIS WITH MYELOPATHY, LUMBAR REGION
721.5	KISSING SPINE
721.6	ANKYLOSING VERTEBRAL HYPEROSTOSIS
721.7	TRAUMATIC SPONDYLOPATHY
721.8	OTHER ALLIED DISORDERS OF SPINE
721.9	SPONDYLOSIS OF UNSPECIFIED SITE
721.90	SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MENTION OF MYELOPATHY
721.91	SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
722	INTERVERTEBRAL DISC DISORDERS



722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.1	DISPLACEMENT OF THORACIC OR LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.2	DISPLACEMENT OF INTERVERTEBRAL DISC, SITE UNSPECIFIED, WITHOUT MYELOPATHY
722.3	SCHMORL'S NODES
722.30	SCHMORL'S NODES, UNSPECIFIED
722.31	SCHMORL'S NODES OF THORACIC REGION
722.32	SCHMORL'S NODES OF LUMBAR REGION
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.5	DEGENERATION OF THORACIC OR LUMBAR INTERVERTEBRAL DISC
722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.6	DEGENERATION OF INTERVERTEBRAL DISC, SITE UNSPECIFIED
722.7	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY
722.71	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY, CERVICAL REGION
722.72	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY, THORACIC REGION
722.73	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY, LUMBAR REGION
722.8	POSTLAMINECTOMY SYNDROME
722.80	POSTLAMINECTOMY SYNDROME, UNSPECIFIED
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
722.9	OTHER AND UNSPECIFIED DISC DISORDER
722.90	OTHER AND UNSPECIFIED DISC DISORDER OF UNSPECIFIED REGION
722.91	OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION
722.92	OTHER AND UNSPECIFIED DISC DISORDER OF THORACIC REGION
722.93	OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
723	OTHER DISORDERS OF CERVICAL REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
723.1	CERVICALGIA
723.2	CERVICOCRANIAL SYNDROME
723.3	CERVICOBRACHIAL SYNDROME (DIFFUSE)



723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
723.5	TORTICOLLIS, UNSPECIFIED
723.6	PANNICULITIS SPECIFIED AS AFFECTING NECK
723.7	OSSIFICATION OF POSTERIOR LONGITUDINAL LIGAMENT IN CERVICAL REGION
723.8	OTHER SYNDROMES AFFECTING CERVICAL REGION
723.9	UNSPECIFIED NEUROMUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK
724	OTHER AND UNSPECIFIED DISORDERS OF BACK
724.0	SPINAL STENOSIS, OTHER THAN CERVICAL
724.00	SPINAL STENOSIS OF UNSPECIFIED REGION
724.01	SPINAL STENOSIS OF THORACIC REGION
724.02	SPINAL STENOSIS OF LUMBAR REGION
724.09	SPINAL STENOSIS OF OTHER REGION
724.1	PAIN IN THORACIC SPINE
724.2	LUMBAGO
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS, UNSPECIFIED
724.5	BACKACHE, UNSPECIFIED
724.6	DISORDERS OF SACRUM
724.7	DISORDERS OF COCCYX
724.70	UNSPECIFIED DISORDERS OF COCCYX
724.79	OTHER DISORDERS OF COCCYX
724.8	OTHER SYMPTOMS REFERABLE TO BACK
724.9	OTHER UNSPECIFIED BACK DISORDERS
726	PERIPHERAL ENTHESOPATHIES AND ALLIED SYNDROMES
726.0	ADHESIVE CAPSULITIS OF SHOULDER
726.1	DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION, UNSPECIFIED
726.10	ROTATOR CUFF SYNDROME OF SHOULDER AND ALLIED DISORDERS
726.11	CALCIFYING TENDINITIS OF SHOULDER
726.2	OTHER AFFECTIONS OF SHOULDER REGION, NOT ELSEWHERE CLASSIFIED
726.32	LATERAL EPICONDYLITIS
726.91	EXOSTOSIS OF UNSPECIFIED SITE
727	OTHER DISORDERS OF SYNOVIUM, TENDON, AND BURSA
727.0	SYNOVITIS AND TENOSYNOVITIS
727.00	SYNOVITIS NOS
727.01	SYNOVITIS AND TENOSYNOVITIS IN DISEASES CLASSIFIED ELSEWHERE
727.04	RADIAL STYLOID TENOSYNOVITIS
727.05	OTHER TENOSYNOVITIS OF HAND AND WRIST
727.06	TENOSYNOVITIS OF FOOT AND ANKLE
727.09	OTHER SYNOVITIS AND TENOSYNOVITIS



727.2	SPECIFIC BURSTITIDES OFTEN OF OCCUPATIONAL ORIGIN
727.3	OTHER BURSTITIS DISORDERS
727.9	UNSPECIFIED DISORDER OF SYNOVIUM, TENDON, AND BURSA
728.1	MUSCULAR CALCIFICATION AND OSSIFICATION
728.10	CALCIFICATION AND OSSIFICATION, UNSPECIFIED
728.12	TRAUMATIC MYOSITIS OSSIFICANS
728.4	LAXITY OF LIGAMENT
728.5	HYPERMOBILITY SYNDROME
728.6	CONTRACTURE OF PALMAR FASCIA
728.7	OTHER FIBROMATOSES OF MUSCLE, LIGAMENT, AND FASCIA
728.8	OTHER DISORDERS OF MUSCLE, LIGAMENT, AND FASCIA
728.81	INTERSTITIAL MYOSITIS
728.85	SPASM OF MUSCLE
728.9	UNSPECIFIED DISORDER OF MUSCLE, LIGAMENT, AND FASCIA
729	OTHER DISORDERS OF SOFT TISSUES
729.0	RHEUMATISM, UNSPECIFIED AND FIBROSITIS
729.1	MYALGIA AND MYOSITIS, UNSPECIFIED
729.2	NEURALGIA, NEURITIS, AND RADICULITIS, UNSPECIFIED
729.3	PANNICULITIS, UNSPECIFIED
729.30	PANNICULITIS
729.4	FASCIITIS, UNSPECIFIED
729.5	PAIN IN LIMB
729.8	OTHER NEUROMUSCULOSKELETAL SYMPTOMS REFERABLE TO LIMBS
729.81	SWELLING OF LIMB
729.9	OTHER AND UNSPECIFIED DISORDERS OF SOFT TISSUE
734	PES PLANUS
736.81	UNEQUAL LEG LENGTH (ACQUIRED)
737.0	ADOLESCENT POSTURAL KYPHOSIS
737.1	KYPHOSIS
737.10	KYPHOSIS (ACQUIRED) (POSTURAL)
737.12	KYPHOSIS, POSTLAMINECTOMY
737.19	KYPHOSIS (ACQUIRED) OTHER
737.2	LORDOSIS (ACQUIRED)
737.20	LORDOSIS (ACQUIRED) (POSTURAL)
737.21	LORDOSIS, POSTLAMINECTOMY
737.22	OTHER POSTSURGICAL LORDOSIS
737.29	LORDOSIS (ACQUIRED) OTHER
737.3	SCOLIOSIS (AND KYPHOSCOLIOSIS), IDIOPATHIC
737.30	KYPHOSCOLIOSIS AND SCOLIOSIS
737.31	RESOLVING INFANTILE IDIOPATHIC SCOLIOSIS
737.32	PROGRESSIVE INFANTILE IDIOPATHIC SCOLIOSIS
737.34	THORACOGENIC SCOLIOSIS
737.39	KYPHOSCOLIOSIS AND SCOLIOSIS OTHER



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- 737.4 CURVATURE OF SPINE ASSOCIATED WITH OTHER CONDITIONS
 - 737.40 CURVATURE OF SPINE, UNSPECIFIED
 - 737.41 KYPHOSIS ASSOCIATED WITH OTHER CONDITIONS
 - 737.42 LORDOSIS ASSOCIATED WITH OTHER CONDITIONS
 - 737.43 SCOLIOSIS ASSOCIATED WITH OTHER CONDITIONS
 - 737.8 OTHER CURVATURES OF SPINE ASSOCIATED WITH OTHER CONDITIONS
 - 738 OTHER ACQUIRED NEUROMUSCULOSKELETAL DEFORMITY
 - 738.2 ACQUIRED DEFORMITY OF NECK
 - 738.3 ACQUIRED DEFORMITY OF CHEST AND RIB
 - 738.4 ACQUIRED SPONDYLOLISTHESIS
 - 738.5 OTHER ACQUIRED DEFORMITY OF BACK OR SPINE
 - 738.6 ACQUIRED DEFORMITY OF PELVIS
 - 738.9 ACQUIRED NEUROMUSCULOSKELETAL DEFORMITY OF UNSPECIFIED SITE
 - 739 NONALLOPATHIC LESIONS, NOT ELSEWHERE CLASSIFIED
 - 739.0 NONALLOPATHIC LESIONS OF HEAD REGION, NOT ELSEWHERE CLASSIFIED
 - 739.1 NONALLOPATHIC LESIONS OF CERVICAL REGION, NOT ELSEWHERE CLASSIFIED
 - 739.2 NONALLOPATHIC LESIONS OF THORACIC REGION, NOT ELSEWHERE CLASSIFIED
 - 739.3 NONALLOPATHIC LESIONS OF LUMBAR REGION, NOT ELSEWHERE CLASSIFIED
 - 739.4 NONALLOPATHIC LESIONS OF SACRAL REGION, NOT ELSEWHERE CLASSIFIED
 - 739.5 NONALLOPATHIC LESIONS OF PELVIC REGION, NOT ELSEWHERE CLASSIFIED
 - 739.6 NONALLOPATHIC LESIONS OF LOWER EXTREMITIES, NOT ELSEWHERE CLASSIFIED
 - 739.7 NONALLOPATHIC LESIONS OF UPPER EXTREMITIES, NOT ELSEWHERE CLASSIFIED
 - 739.8 NONALLOPATHIC LESIONS OF RIB CAGE, NOT ELSEWHERE CLASSIFIED
 - 740-759.1.1 Congenital Anomalies**
 - 754.2 CONGENITAL NEUROMUSCULOSKELETAL DEFORMITIES OF SPINE
 - 755.69 OTHER CONGENITAL ANOMALIES OF LOWER LIMB, INCLUDING PELVIC GIRDLE
 - 756.1 CONGENITAL ANOMALIES OF SPINE
 - 756.11 CONGENITAL SPONDYLOLYSIS, LUMBOSACRAL REGION
 - 756.12 SPONDYLOLISTHESIS, CONGENITAL
 - 756.13 ABSENCE OF VERTEBRA, CONGENITAL
 - 756.14 HEMIVERTEBRA
 - 756.15 FUSION OF SPINE (VERTEBRA), CONGENITAL



756.16	KLIPPEL-FEIL SYNDROME
756.17	SPINA BIFIDA OCCULTA
756.19	OTHER CONGENITAL ANOMALIES OF SPINE
756.2	CERVICAL RIB
780-799	Symptoms, Signs, and Ill-Defined Conditions
780.4	DIZZINESS AND GIDDINESS
780.7	MALaise AND FATIGUE
780.8	HYPERHIDROSIS
780.9	OTHER GENERAL SYMPTOMS
781	OTHER SYMPTOMS INVOLVING NERVOUS AND NEUROMUSCULOSKELETAL SYSTEMS
781.0	ABNORMAL INVOLUNTARY MOVEMENTS
781.9	OTHER SYMPTOMS INVOLVING NERVOUS AND NEUROMUSCULOSKELETAL SYSTEMS
784	SYMPTOMS INVOLVING HEAD AND NECK
784.0	HEADACHE
784.1	THROAT PAIN
786.5	CHEST PAIN
786.50	UNSPECIFIED CHEST PAIN
788.3	ENURESIS, NOCTURNAL
789.0	COLIC, INFANTILE, ABDOMINAL, INTESTINAL, SPASMODIC
800-999	Injury
839	DISLOCATION, NOT ELSEWHERE CLASSIFIED
839.0	DISLOCATION, CERVICAL VERTEBRA
839.00	DISLOCATION, CERVICAL VERTEBRA, CLOSED
839.01	DISLOCATION FIRST CERVICAL VERTEBRA, CLOSED
839.02	DISLOCATION SECOND CERVICAL VERTEBRA, CLOSED
839.03	DISLOCATION THIRD CERVICAL VERTEBRA, CLOSED
839.04	DISLOCATION FOURTH CERVICAL VERTEBRA, CLOSED
839.05	DISLOCATION FIFTH CERVICAL VERTEBRA, CLOSED
839.06	DISLOCATION SIXTH CERVICAL VERTEBRA, CLOSED
839.07	DISLOCATION SEVENTH CERVICAL VERTEBRA, CLOSED
839.08	DISLOCATION MULTIPLE CERVICAL VERTEBRAE, CLOSED
839.2	CLOSED DISLOCATION, THORACIC AND LUMBAR VERTEBRA
839.20	CLOSED DISLOCATION, LUMBAR VERTEBRA
839.21	CLOSED DISLOCATION, THORACIC VERTEBRA
840	SPRAINS AND STRAINS OF SHOULDER AND UPPER ARM
840.0	ACROMIOCLAVICULAR (JOINT) (LIGAMENT) SPRAIN
840.1	CORACOCLAVICULAR (LIGAMENT) SPRAIN
840.2	CORACOHUMERAL (LIGAMENT) SPRAIN
840.3	INFRASPINATUS (MUSCLE) (TENDON) SPRAIN
840.4	ROTATOR CUFF (CAPSULE) SPRAIN
840.5	SUBSCAPULARIS (MUSCLE) SPRAIN
840.6	SUPRASPINATUS (MUSCLE) (TENDON) SPRAIN



840.8	SPRAIN OF OTHER SPECIFIED SITES OF SHOULDER AND UPPER ARM
840.9	SPRAIN OF UNSPECIFIED SITE OF SHOULDER AND UPPER ARM
841	SPRAINS AND STRAINS OF ELBOW AND FOREARM
841.0	RADIAL COLLATERAL LIGAMENT SPRAIN
841.1	ULNAR COLLATERAL LIGAMENT SPRAIN
841.2	RADIOHUMERAL
841.3	ULNOHUMERAL (JOINT) SPRAIN
841.8	SPRAIN OF OTHER SPECIFIED SITES OF ELBOW AND FOREARM
841.9	SPRAIN OF UNSPECIFIED SITE OF ELBOW AND FOREARM
842	SPRAINS AND STRAINS OF WRIST AND HAND
842.0	WRIST SPRAIN
842.00	SPRAIN OF UNSPECIFIED SITE OF WRIST
842.01	SPRAIN OF CARPAL (JOINT) OF WRIST
842.02	SPRAIN OF RADIOCARPAL (JOINT) (LIGAMENT) OF WRIST
842.09	OTHER WRIST SPRAIN
842.1	HAND SPRAIN
842.10	SPRAIN OF UNSPECIFIED SITE OF HAND
842.11	SPRAIN OF CARPOMETACARPAL (JOINT) OF HAND
842.12	SPRAIN OF METACARPOPHALANGEAL (JOINT) OF HAND
842.13	SPRAIN OF INTERPHALANGEAL (JOINT) OF HAND
842.19	OTHER HAND SPRAIN
843	SPRAINS AND STRAINS OF HIP AND THIGH
843.0	ILIOFEMORAL (LIGAMENT) SPRAIN
843.8	SPRAIN OF OTHER SPECIFIED SITES OF HIP AND THIGH
843.9	SPRAIN OF UNSPECIFIED SITE OF HIP AND THIGH
844	SPRAINS AND STRAINS OF KNEE AND LEG
844.0	SPRAIN OF LATERAL COLLATERAL LIGAMENT OF KNEE
844.1	SPRAIN OF MEDIAL COLLATERAL LIGAMENT OF KNEE
844.2	SPRAIN OF CRUCIATE LIGAMENT OF KNEE
844.3	SPRAIN OF TIBIOFIBULAR (JOINT) (LIGAMENT) SUPERIOR, OF KNEE
844.8	SPRAIN OF OTHER SPECIFIED SITES OF KNEE AND LEG
844.9	SPRAIN OF UNSPECIFIED SITE OF KNEE AND LEG
845	SPRAINS AND STRAINS OF ANKLE AND FOOT
845.0	ANKLE SPRAIN
845.00	UNSPECIFIED SITE OF ANKLE SPRAIN
845.01	DELTOID (LIGAMENT), ANKLE SPRAIN
845.02	CALCANEOFIBULAR (LIGAMENT) ANKLE SPRAIN
845.03	TIBIOFIBULAR (LIGAMENT) SPRAIN, DISTAL
845.09	OTHER ANKLE SPRAIN
845.1	FOOT SPRAIN
845.10	UNSPECIFIED SITE OF FOOT SPRAIN
845.11	TARSOMETATARSAL (JOINT) (LIGAMENT) SPRAIN
845.12	METATARSOPHALANGEAL (JOINT) SPRAIN
845.13	INTERPHALANGEAL (JOINT), TOE SPRAIN
845.19	OTHER FOOT SPRAIN



846	SPRAINS AND STRAINS OF SACROILIAC REGION
846.0	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN
846.1	SACROILIAC (LIGAMENT) SPRAIN
846.2	SACROSPINATUS (LIGAMENT) SPRAIN
846.3	SACROTUBEROUS
846.8	OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
846.9	UNSPECIFIED SITE OF SACROILIAC REGION SPRAIN
847	SPRAINS AND STRAINS OF OTHER AND UNSPECIFIED PARTS OF BACK
847.0	NECK SPRAIN
847.1	THORACIC SPRAIN
847.2	LUMBAR SPRAIN
847.3	SPRAIN OF SACRUM
847.4	SPRAIN OF COCCYX
847.9	SPRAIN OF UNSPECIFIED SITE OF BACK
848	OTHER AND ILL-DEFINED SPRAINS AND STRAINS
848.1	JAW SPRAIN
848.2	THYROID REGION SPRAIN
848.3	SPRAIN OF RIBS
848.4	STERNUM SPRAIN
848.42	CHONDROSTERNAL (JOINT) SPRAIN
848.5	PELVIC SPRAIN
848.8	OTHER SPECIFIED SITES OF SPRAINS AND STRAINS
848.9	UNSPECIFIED SITE OF SPRAIN AND STRAIN
850.9	CONCUSSION, UNSPECIFIED
905.7	LATE EFFECT OF SPRAIN AND STRAIN WITHOUT MENTION OF TENDON INJURY
905.8	LATE EFFECT OF TENDON INJURY
907.3	LATE EFFECT OF INJURY TO NERVE ROOT(S), SPINAL PLEXUS(ES), AND OTHER NERVES OF TRUNK
953.0	INJURY TO CERVICAL NERVE ROOT
953.1	INJURY TO DORSAL NERVE ROOT
953.2	INJURY TO LUMBAR NERVE ROOT
953.3	INJURY TO SACRAL NERVE ROOT
953.4	INJURY TO BRACHIAL PLEXUS
953.5	INJURY TO LUMBOSACRAL PLEXUS
954	INJURY TO CERVICAL SYMPATHETIC NERVE, EXCLUDING SHOULDER AND PELVIC GIRDLES
956	INJURY TO SCIATIC NERVE
959.2	OTHER AND UNSPECIFIED INJURY TO SHOULDER AND UPPER ARM
959.6	OTHER AND UNSPECIFIED INJURY TO HIP AND THIGH
959.7	OTHER AND UNSPECIFIED INJURY TO KNEE, LEG, ANKLE, AND FOOT



STATEMENT
on behalf of the
INTERNATIONAL CHIROPRACTORS ASSOCIATION
on
CHIROPRACTIC SERVICES FOR AMERICA'S VETERANS
presented by
Dr. Michael S. McLean
before the
SUBCOMMITTEE ON HEALTH
of the
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
October 3, 2000

I am Dr. Michael McLean, Chairperson of the Legislative Committee of the International Chiropractors Association (ICA). I also serve as a member of the Board of Directors of that organization. We at the ICA appreciate the opportunity to present our organization's perspective on the very important matter of chiropractic services for our nation's veterans. This is an issue that has been of major importance to us for a very long time. In fact, the first legislative initiative to provide chiropractic benefits for our nation's military veterans was introduced at the request of the ICA in 1936. We also understand that our concerns and objectives are shared by all of the other major chiropractic organizations in the United States and we are here on a collective basis to ask the Committee for action on a matter that is long overdue.

The steps that Congress must take to provide for reasonable access to chiropractic services for America's veterans are clear. What is also unfortunately clear is that unless the Congress enacts a series of very specific mandates, with a designated timetable for action, the U.S. Department of Veterans Affairs (DVA) will not make any significant effort to provide access to chiropractic services on anything other than a token basis. In fact, the obvious context of this hearing is the failure of that agency to provide for meaningful chiropractic access, despite the periodic legislative encouragement from Congress and the decades of opportunity the Department of Veterans Affairs has been given to develop a reasonable chiropractic program from within.

The status of chiropractic science and the chiropractic profession today is well understood in the greater health care community and has been embraced by and is, indeed, the product of enthusiastic consumer support and confidence. In a highly competitive marketplace, chiropractic has validated itself in the most profound and emphatic manner possible, through millions of individuals in the private sector willing to pay out of their own pocket for chiropractic care, when standard medical care was available to them at little or no cost through public or private insurance programs. I do not, however, wish to focus my time today on these details even though this information is important to the full understanding of the role chiropractic can and should play in all public health care programs. Instead, I would refer the Committee to the presentation made by the International Chiropractors Association to the U.S. Department of Veterans Affairs on February 24, 2000, *Chiropractic in the Veterans Health Care System*. Copies of this extensive document have been made available through the Committee staff and its full text is available on ICA's website at www.chiropractic.org. I urge every Member of Congress to review this extensively referenced and well-researched document for a full discussion of the definitions and authorities under which the chiropractic profession operates and the basic clinical elements that distinguish and define the science and practice of chiropractic as a unique approach to health and health care.



ICA does wish to frankly address the elements of public policy that need to be enacted in order to provide for reasonable access to chiropractic services through the DVA. These elements have been the subject of intensive discussions in recent weeks between representatives of the major chiropractic organizations, Members of Congress and the staff of this Committee. ICA respects and appreciates the good faith efforts of all parties to these discussions but feels that the time for specific, decisive action has come, and we are looking to the Committee for insightful and innovative leadership in this area to expand and enhance the health care choices of our nation's veterans to include chiropractic services.

ICA believes that the following elements should be enacted to insure that America's veterans have available to them the same chiropractic options and resources that are presently available in most other health benefits programs:

1. The establishment of statutory authority to employ doctors of chiropractic as professional care givers within the DVA. We specifically ask that Title 38, Section 7401 be amended by inserting the words "doctors of chiropractic" after "optometrists". We also ask that Section 7402 be amended by the insertion of a new sub-section after the current sub-section (2) dentists, identifying "doctors of chiropractic" in the sequence of professionals specifically authorized to be employed under that section. The employment criteria for doctors of chiropractic in such a new provision should include the requirement that any such chiropractic professional be the graduate of an institution accredited by an agency recognized by the U.S. Department of Education for such purposes, and hold a valid chiropractic license in a State. Such criteria are comparable to those provided for in this section for dentists, podiatrists, etc. Authority to hire doctors of chiropractic should be accompanied by instructions to act on that authority and a timetable to deploy an initial group of doctors of chiropractic within VHA facilities.
2. The establishment of a Division of Chiropractic Services, headed by a doctor of chiropractic, within the Veterans Health Administration to oversee and facilitate the effective integration of chiropractic services into the systems in place at that agency. The statutory establishment of such a division would serve to insure that appropriate means would be available on an on-going basis to address operational and procedural questions, peer review issues and to serve as a focal point for the distribution of accurate and relevant information about chiropractic services and the role of the chiropractic professional. Such a step would also signal the resolve of Congress to secure a meaningful and on-going program of chiropractic care and would serve as an important guarantee of fairness, efficiency and quality of care.
3. The statutory establishment of direct access to chiropractic services as a care pathway choice for eligible veterans, without the requirement of a referral from another professional as is presently required under current policy.
4. The statutory establishment of a chiropractic advisory committee comprised of representatives of the chiropractic profession to assist senior VHA officials in addressing program and policy questions and in developing innovative service and research initiatives to maximize the quality, timeliness and availability of chiropractic care. The establishment of such a committee would be consistent with provisions already passed by the House for chiropractic programs in the U.S. Department of Defense.
5. The enactment of a specific Congressional directive to the Veterans Health Administration to develop within a reasonable period of time a plan for making chiropractic services routinely available on an outpatient basis for those program beneficiaries outside the geographic range of VHA clinical facilities.



These five basic elements would provide the foundation for a clinically appropriate, reasonable and cost-effective chiropractic program within the Department of Veterans Affairs. Each of these elements are also firmly grounded in the clinical abilities and experience of the doctor of chiropractic, our experience in cooperative care in inter-professional settings, and the realities of contemporary health care science and administration. We are also aware, however, of concerns brought forward by members of the Committee staff regarding these proposed initiatives and I wish to specifically address a number of those points in detail.

The first of these issues is the employment of doctors of chiropractic and the integration of chiropractic professionals into the VHA system and VHA facilities. Concern has been expressed about the role doctors of chiropractic would play in the primary care system in place in that agency and the delineation of authorities and responsibilities under that system. The International Chiropractors Association believes that the employment of doctors of chiropractic in VHA hospitals and clinic facilities is an obvious and highly practical point at which to launch the integration of chiropractic services into the VHA system. Such inclusion would provide for the maximum coordination of care for program beneficiaries, facilitate professional understanding, utilize the efficiencies and economies of scale inherent in the pre-existing resources and facilities, administrative, diagnostic and professional, and provide maximum convenience and access to the greatest number of beneficiaries.

The experience of chiropractic professionals in the hospital and multi-disciplinary setting over the past several decades has established a record of cooperation and service that should serve as a positive model for the VHA. Doctors of chiropractic serve in hundreds of hospitals in the United States in a wide variety of settings and contexts. Clarity of roles and authority is well established in such settings and the team approach to health care delivery that such situations facilitate provides for the highest level of patient care. Each professional serves to address the needs of patients within their professional competence. Cooperative and concurrent care between chiropractic providers and other professionals widens the options available to patients, enhances quality and efficiency, as well as cost-effectiveness.

I would also refer the Committee to the testimony presented today on behalf of the Association of Chiropractic Colleges for an extensive report on the very positive hospital/clinical experience in the Department of Defense chiropractic project. This project demonstrates the potential for inter-professional cooperation in government programs and strongly validates the position presented by the ICA on this question.

In practical terms, there are no real barriers to the effective integration of chiropractic services and the doctor of chiropractic into the primary care system now in place at the VHA other than a reluctance to do so on the part of the policy makers directing those programs. The administrative qualification process that determines the eligibility of a veteran for care would not change. The basic intake process would remain unchanged in that the general evaluation of the patient would proceed along current lines and the primary care personnel now attending to beneficiary needs would continue their relationship with and involvement in patient care. What is different would be the existence of a clearly identified care option open to qualified beneficiaries which they would be free to seek, without the requirement of a referral from another health care professional.

The intake and general evaluation process of every patient ought to include a chiropractic evaluation, given the prevalence of spinal problems in all segments of the population of the United States. Along with the health history, baseline laboratory tests, vital signs and other standard evaluation processes, a chiropractic examination should be part of this initial evaluation process because of the unique training, skills and clinical experience the doctor of chiropractic brings to the diagnostic process. The practicality and cost effectiveness of this goal ought to be explored. At a minimum, qualified beneficiaries should have the right to choose a chiropractic program of care for chiropractic conditions rather than be limited



to, indeed, forced to accept one medical pathway. This in no way removes or alters the role of other providers in the care of conditions that fall within their specific expertise. Once again, the team approach and a fully cooperative model of patient care is the goal.

In considering these issues, it is helpful to understand the exact nature of chiropractic science and practice and the separate and distinct approach to health and health care taken by the doctor of chiropractic. Chiropractic is a very specific health care science applied by doctors of chiropractic who practice under an extensive body of authorities. These authorities have evolved over more than a century of legislative and judicial development, educational growth, practical experience and professional consensus. Like other first professional degree holders, the doctor of chiropractic is a carefully regulated professional who must qualify on a number of levels to obtain the right to practice.

Chiropractic science is an approach to human health that was developed through extensive anatomical study in which the elements of the human system, particularly the spine and nervous system continue to be examined in an effort to understand the relationship between the state of those anatomical elements and optimal human health. The basic premise of chiropractic science is that abnormalities and misalignments of the spine, defined as subluxation(s) in chiropractic science, can and do distort and interrupt the normal function of the nervous system and may create serious negative health consequences. The correction and/or reduction of subluxation(s) through the adjustment of spinal structures can remove nervous system interference and restore the optimal function of the body. Essential to basic chiropractic theory is the concept of the inherent ability of the human body to effectively maintain optimal health, comprehend the environment and function in a normal manner. This concept is important since chiropractic perceives spinal subluxation(s) as barriers to normal function and obstacles to the body's innate intelligence.

A strong consensus exists within the chiropractic profession on such self-defining issues. This consensus is best depicted by the unanimous adoption of a paradigm statement by the Association of Chiropractic Colleges, International Chiropractors Association, American Chiropractic Association, Federation of Chiropractic Licensing Boards, Council on Chiropractic Education, the National Board of Chiropractic Examiners and the Congress of Chiropractic State Associations. This paradigm statement reads as follows:

"Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.

The practice of chiropractic focuses on the relationship between the structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.



THE CHIROPRACTIC PARADIGM

Purpose

The purpose of chiropractic is to optimize health.

Principle

The body's innate recuperative power is affected by and integrated through the nervous system.

Practice

The practice of chiropractic includes:

- establishing a diagnosis;
- facilitating neurological and biomechanical integrity through appropriate chiropractic case management; and
- promoting health.

Foundation

The foundation of chiropractic includes philosophy, science, art, knowledge, and clinical experience.

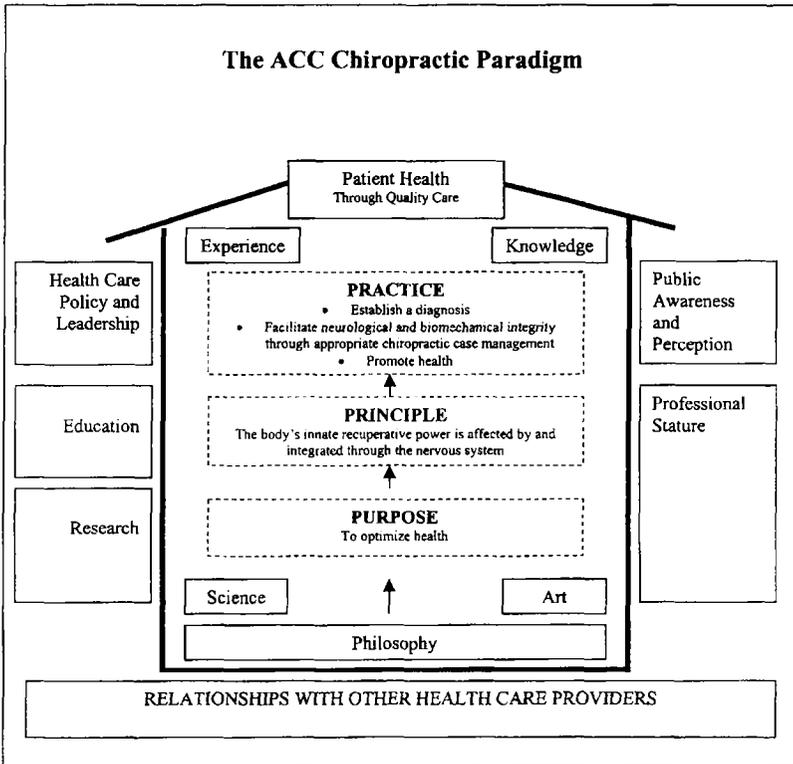
Impacts

The chiropractic paradigm directly influences the following:

- education;
- research;
- health care policy and leadership;
- relationships with other health care providers;
- professional stature;
- public awareness and perceptions; and
- patient health through quality care.

The Subluxation

Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation. A subluxation is a complex of functional and/or pathological articular changes that compromise the neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.



A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health. A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence."

This professional consensus is well reflected in the statutes establishing and authorizing chiropractic practice and in the chiropractic professional education process. The doctor of chiropractic is a primary care, direct access, first professional degree level provider who serves as a *portal-of-entry* into the health care system. ICA understands the term *primary care provider* to be defined as: Any health care provider capable of providing first level contact and intake into the health delivery system, any health care provider licensed to receive patient contact in the absence of physician referral. All laws and regulations in the United States allow any citizen to seek the services of the doctor of chiropractic without referral from any other provider. Individuals are free to seek basic essential care on the same individual initiative basis that applies to other direct access providers.

Only the doctor of chiropractic is professionally competent to evaluate the chiropractic needs of a patient and to determine the level of service appropriate to meet those needs.



In order to assist the Committee in understanding the nature and flow of chiropractic patient evaluation and care, the following chiropractic patient evaluation and care pathway model is offered. This model for the patient presenting in a chiropractic clinical setting is based on the doctor of chiropractic's competence to evaluate the general health status and needs of each patient and determine the appropriateness of chiropractic care and/or the need for referral to other provider(s) for urgent care, additional diagnostic evaluation in the context of another branch of the healing arts, concurrent care, or no care at all, etc. It also recognizes that the majority of patients making the decision to seek the services of any health care professional do so on the basis of some self-perceived symptom, problem or health concern, or at the behest of a parent or guardian.

1. Routine Checkup and Prevention/Wellness Care

2. Initial Presentation--Is Emergency Care Needed?

Upon presentation of each new patient, the doctor of chiropractic determines whether there is any condition, element or crisis that requires the immediate referral for emergency life-saving care or urgent care.

The attending doctor of chiropractic is competent to determine, on the basis of immediate findings whether the patient is in immediate need of emergency intervention.

3. Initial Presentation--Is the Care of Another Provider Needed?

In the course of this evaluation, the attending doctor determines whether there are findings that indicate the need for referral to another provider.

If indications for immediate referral are not present, the patient proceeds along the care pathway to the next level. If such a referral is necessary it does not preclude concurrent chiropractic care.

4. Determining Appropriate Chiropractic Care - Are There Potential Restrictions On Chiropractic Care?

The elimination of imperatives to refer having been undertaken, the next step on the chiropractic care pathway centers on the development of an appropriate course of adjustive care, if needed. In that process, the patient's needs and circumstances are evaluated to determine whether there is a need, and if so whether there are any restrictions on the delivery of adjustive care. This evaluation process will direct the attending doctor to employ specific chiropractic techniques that are appropriate to the status of the patient.

5. Care Delivery

Having carefully worked through the evaluation process eliminating potential red flags to standard care and techniques, the doctor of chiropractic next outlines and delivers a program of adjustive care and other wellness advice, etc., according to the individual needs of the patient, based on the presenting factors.

6. Re-Evaluation for New Condition(s) and/or Re-Injury

On each encounter, the doctor of chiropractic determines whether new conditions and/or injuries might require alterations in the care plan. If there are no such indications, the program of care previously devised will continue.



7. Progress Evaluation

After a reasonable period of care, the patient's progress is evaluated by the chiropractic clinician to determine the effectiveness of the chosen course of care and to determine whether alterations in that program are indicated, as determined by the clinician.

It is also important for the Committees to understand the Doctor of chiropractic recognizes professional boundaries and willing to fully cooperate with and seek the consultation and/or concurrent involvement of other health professionals when the needs of the patient so indicate.

Referral is a professional obligation that is present throughout all phases and aspects of the chiropractic practice. The primary obligation of doctors of chiropractic is to provide the highest quality of care to each patient within the confines of their education and their legal authority. It is the position of the International Chiropractors Association that this primary obligation includes recognizing when the limits of skill and authority are reached. At that point, it is the ICA's position that doctors in all fields of practice are ethically and morally bound to make patient referrals to practitioners in their own and/or other fields of healing when such referrals are necessary to provide the highest quality of patient care.

Doctors of chiropractic are also obligated to receive referrals from other health care providers, applying to those patients the same considerations for quality and appropriateness of care as with any other patient. It is the position of the ICA that the professional obligation to the patient includes honest, full and straightforward communication with the referring provider for optimal patient care.

SUMMARY

The International Chiropractors Association urges the Committee to develop a comprehensive access program that begins with the employment of doctors of chiropractic as professional care-givers in DVA facilities. The DVA should be instructed by Congress to promptly take such steps as are required to provide for reasonable and timely access to chiropractic services at DVA treatment facilities, including hospitals and clinics.

ICA recognizes that facility-based care is impractical in many instances because of demographic and other reasons. In such instances, the DVA should be instructed to establish a plan for out-patient care according to agreed protocols, especially in remote and underserved areas of the nation, and be given a timetable for its implementation.

In accessing chiropractic care, the determination of the need to seek chiropractic care should be at the discretion of the patient. All other federal programs such as Medicare and FEHBP programs provide for such direct access. The unique nature of chiropractic science and practice make it difficult for non-chiropractic doctors to easily recognize the need for and appropriateness of chiropractic care. Thus, direct access provides for an effective means of access that will not delay, confuse or otherwise prevent a beneficiary's access to the care of first choice, while waiting for a referral that may never come. This does not compromise or minimize the procedures and primary care structure presently in place in the VHA, but obligates that agency to expand the decision options available to eligible beneficiaries. This is entirely consistent with procedures in place in a wide range of other clinical and administrative settings. ICA rejects as obstructionist and unreasonable the arguments that direct access is incompatible with the primary care system now in place at the VHA and believes that the initial phase of any direct access program will rapidly demonstrate the ease and practicality of this status.



DVA should undertake to fully orient existing personnel and regularly review procedures to insure that the system understands the potential of chiropractic care and works to facilitate, not obstruct a smooth implementation of a chiropractic benefits program. To this end, the establishment of a permanent chiropractic department, on par with other divisions, through which policies and procedures can be fully and effectively developed and implemented, is indicated.

ICA urges the Congress to require the DVA to maintain an open and objective dialogue with chiropractic professional organizations and educational and research institutions. Such a dialogue should be broad based and inclusive, yet focused on the established organizations and institutions that have a demonstrated record of service to the chiropractic profession and the public. The International Chiropractors Association would seek to participate in such an on-going dialogue and believes that the program, beneficiaries and the profession would benefit by such an effort.

In conclusion, I want to emphasize that the fundamental issue in this discussion is and should be recognized by all parties, as one of fairness to our nation's military veterans. Chiropractic has a powerful, non-invasive, drugless contribution to make to the health of our veterans and the time has come to offer this very special segment of our population the respect, dignity and participation that comes from giving them the choice to seek chiropractic care if they wish. Furthermore, the research and outcomes record clearly shows that chiropractic services represent a significant cost-savings potential, rather than added costs, because of the non-surgical, natural approach to health and healing that chiropractic represents. ICA urges the Committee to objectively examine both clinical outcomes and cost data to understand this impressive record.

I want to thank the Committee and the staff for the serious attention that this body of issues is receiving and to urge the Committee to move forward to do the right thing and enact a meaningful program of chiropractic services for America's veterans. I will certainly be happy to answer any questions any member of the Committee or Staff may have on these topics and the ICA stands ready to provide any additional documentation, clinical perspective or other materials the Committee may wish as all parties work to resolve this important question. Thank you once again for your attention and consideration.

xxxx

STATEMENT OF DR. REED PHILLIPS, PRESIDENT, LOS ANGELES
CHIROPRACTIC COLLEGE, AND DR. GEORGE GOODMAN, PRESIDENT,
LOGAN CHIROPRACTIC COLLEGE

ON BEHALF OF

THE ASSOCIATION OF CHIROPRACTIC COLLEGES

BEFORE THE

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
TUESDAY, OCTOBER 3, 2000
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MR. CHAIRMAN, REPRESENTATIVE GUTIERREZ, MEMBERS OF THE SUBCOMMITTEE, on behalf of the Association of Chiropractic Colleges (ACC) we thank you for calling this hearing to discuss, among other things, our proposal for establishing direct access, 'full scope of practice' chiropractic health care services for our Nation's veterans through the Department of Veterans Affairs (DVA). Your leadership last year to include a directive in the Veterans' Millennium Health Care Act (Public Law 106-117) for the DVA to establish a chiropractic health care policy, further demonstrates your commitment and the Committee's commitment to chiropractic health care for veterans. We also thank you and the Members of the full Committee on Veterans' Affairs for your strong support over the years for chiropractic health care generally, and for our profession in particular.

MR. CHAIRMAN, this Subcommittee, perhaps more so than any other panel in the entire Congress, faces the humbling challenge of authorizing vital health care programs for our Nation's veterans and making sure that they have access to the same high quality care that most Americans already enjoy. By any measure, this Subcommittee has met this challenge and done so in a way that was fair to our veterans and to the taxpayers who support veterans programs.

MR. CHAIRMAN, the chiropractic health care profession is seeking the same health care 'opportunity' for our veterans that is available in the private

sector; all fifty States; and soon, within the Department of Defense. More specifically, we want our Nation's veterans to have the same direct access, 'full scope of practice' chiropractic health care that is authorized under State law, and available to the millions of Americans who utilize chiropractic care every year to address a whole host of neuromusculoskeletal and related health care problems. According to data from the NIH Consortial Center for Chiropractic Research, a center located at Palmer College of Chiropractic and established under the auspices of the National Center for Complementary and Alternative Medicine, chiropractic is used by approximately ten percent of the population annually, representing about 192 million patient visits per year. We want our Nation's veterans to have direct access to this fastest growing segment of the so-called complementary and alternative medicine practice in the United States.

Furthermore, the legislative proposal that we have prepared and which was addressed briefly in your September 13th full Committee markup on H.R. 5109, is modeled after the chiropractic health care development plan that was contained in Section 737 of the National Defense Authorization bill for fiscal year 2001—a plan that passed the full House and which we believe will be approved in conference.

Here is what the major chiropractic health care profession organizations are proposing to be included in the next available veterans health care bill.

Our legislative proposal for chiropractic in the DVA is modeled after the well-vetted, well-crafted provision that was approved by the House Armed Services Committee and by the full House as part of the fiscal year 2001 National Defense Authorization bill, H.R. 4205. More specifically, our proposal calls for the development of a plan by the Secretary of Veterans Affairs to provide chiropractic health care services as permanent part of the DVA health care system, beginning at the end of calendar year 2001. Our proposal would require that the plan include two critical components that have also been addressed in the DoD chiropractic plan proposal: direct access to chiropractic care, without requirement for a medical doctor gatekeeper; and full scope of practice of chiropractic health care services to our veterans. The plan would also call for an examination of projected costs of fully integrating chiropractic into the DVA health care system and a review of facilities; in-house v.s. 'contract' doctors of chiropractic; and the personnel structure required to effectively carry out this new health care program within the DVA.

Our plan also calls for making the appropriate statutory changes to address the issue of pay for chiropractors who become employees of the DVA and calls for the establishment of an advisory oversight committee, analogous to the one utilized by the Department of Defense, to ensure that the Secretary has the requisite outside assistance with which to fully comply with the statutory guidelines and carry out the proposed plan for integrating chiropractic into the DVA.

Again, this proposal mirrors the proposal that was marked up in the Senate Armed Services Committee and approved by the full House of Representatives this year, and in our view, is the most effective way to allow the Department to phase in the development and implementation of a direct access, full scope of practice chiropractic health care benefit for our Nation's veterans.

In short, MR. CHAIRMAN, we believe that our proposal is good health care policy for our veterans, as the House obviously felt it was for our active duty military personnel, and we believe that it will make a significant contribution to improving the health and well-being of our Nation's veterans who deserve the very best.

MR. CHAIRMAN, we wish that the Department of Veterans Affairs and the Department of Defense were in full agreement with us on both the need and the methodology for implementing a new, comprehensive chiropractic health care benefit in the two Departments. Unfortunately, new health care policy changes for our veterans and our armed forces are often met with resistance by the bureaucrats and proponents of the status quo in those Departments. Therefore, let me attempt to briefly outline why the ACC is offering its unqualified support to the joint ACA-ICA-ACC legislative proposal for direct access, full scope of practice chiropractic care for our veterans and why we firmly believe that it constitutes a good health care policy change for the country.

First, and perhaps of paramount importance, chiropractic health care has been shown to be efficacious in addressing the \$40-50 billion per year back pain problem that confronts the Nation, and, with the support of the Congress and Executive Branch health care agencies, has moved into the so-called 'mainstream' of the health care arena. Doctors of Chiropractic are the product of one of the most

rigorous academic, medical, and clinical education and training formats in the entire health care arena and their success with their patients is impressive. Each of the 19 chiropractic training institutions in North America are accredited by the Council on Chiropractic Education, an agency certified by the U.S. Department of Education since 1974. Most importantly, each college requires at least three years of intense undergraduate medical training and education, plus an additional four years at an accredited college of chiropractic, before students can qualify for licensure examinations conducted by the National Board of Chiropractic Examiners. Chiropractic is licensed in all 50 states in the U.S. and has been established in 70 other countries around the world.

Your own Committee, in last year's Committee Report on the Veterans' Millennium Health Care Act (H. Rept. 106-237; pp. 54-55) cited a 1997 Agency for Health Care Policy Research study that said: "There is as much or more evidence for the effectiveness of spinal manipulation as for other non-surgical treatments for back pain", and a New England Journal of Medicine report that the effectiveness of spinal manipulation for certain types of acute pain maladies is no longer in dispute. Your report goes on to cite studies indicating that 'patient satisfaction in the relief of low back pain is as great or greater with chiropractic than with other approaches, even when volunteer patients are randomly assigned to a treatment approach.' Finally, the Committee report laments that, despite the positive results of research on chiropractic, the Department of Veterans Affairs has made only the most limited use of chiropractic care.

MR. CHAIRMAN, we could spend this entire hearing going over the myriad of research studies, randomized clinical trials, and analyses that have been carried out on the effectiveness of chiropractic over the past century. For example, the results of the largest randomized clinical trial ever conducted on chiropractic, confirmed, among other things, that 'when chiropractic or hospital therapists treat patients with low back pain as they would in day to day practice, those treated by chiropractic derive more benefit and long term satisfaction than those treated by hospitals' (T.W. Meade, Director, Medical Research Council Epidemiology and Medical Care Unit, Wolfson Institute of preventive Medicine, medical College of St. Bartholomew's Hospital, London, England, 1995). But I hope that we can all agree that the age-long debate over the efficacy of chiropractic is over; that it is universally accepted as 'mainstream' health care for our citizens; and that it should be available to our Nation's veterans through the Department of Veterans Affairs as it is to the rest of us outside of the DVA.

In this regard, MR. CHAIRMAN, the second compelling reason why our proposed chiropractic health care policy plan should be approved and included in the next available veterans health care bill, is based on the overwhelming success of the recently completed Department of Defense Chiropractic Health Care Demonstration Project. After a five-year pilot program at thirteen military health care facilities across the country and in the Washington, D.C. metropolitan area, the Department of Defense reported its findings to the Congress—findings that, by DoD's own admission, were overwhelmingly positive.

The DoD reported that the problem of spinal maladies among our Armed Forces was major and that the military health care system was not adequately addressing this health care problem. The Department concluded that military personnel who used chiropractic care for the treatment of lower back pain experienced superior outcomes *in every one of five different measures of health status*, compared to patients who received care from so-called traditional medical providers. MR. CHAIRMAN, I have prepared a chart for the consideration of the Subcommittee, that reflects the patient outcomes results of the Chiropractic Health Care Demonstration Program. (Chart A).

Furthermore, a higher proportion of chiropractic patients in the military reported that they felt better, had less pain, and had fewer restrictions/physical limitations than patients receiving traditional medical care, and reported fewer days away from work or on restricted duty due to their condition. Chart B reflects workdays saved as a result of chiropractic care being provided to our military men and women during the CHCDP.

The report went on to quantify that chiropractic patients were more satisfied with their care than patients who received traditional medical treatments and a higher proportion of patients seen by Doctors of Chiropractic reported greater satisfaction with their improvement *and their providers*, than patients treated by traditional medical providers. Chart C reflects patient satisfaction results of the CHCDP and has been prepared for your review and consideration.

And finally, the DoD's own report, acknowledged that integrating chiropractic care into the military health care system will result in improved access to health care services for military personnel and will lead to the recovery of between 111,000 and 331,000 additional duty days per year.

In short, MR. CHAIRMAN, the Department of Defense, in perhaps the most comprehensive demonstration of chiropractic health care services in the history of the country, found that chiropractic improved patient outcomes; had overwhelming patient satisfaction; and improved readiness among those men and women of the Armed Forces who sought the care of a Doctor of Chiropractic. By any measure, the DoD Chiropractic Health Care Demonstration Program proved beyond any doubt that chiropractic works for our military and we believe it will work equally well for our Nation's veterans who are eligible for DVA health care benefits.

The plan that we are proposing takes the lessons learned from the comprehensive DoD chiropractic health care demonstration program and the legislative response contained in Section 737 of H.R. 4205 as passed the House, and provides the Committee with a proven 'model' that should be used to begin the process of integrating a comprehensive, direct access, full scope of practice chiropractic health care benefit into the DVA health care system. It worked for DoD and it will work for the DVA.

Finally, MR. CHAIRMAN, the reason that we are actively seeking your support for our proposal is because of the inadequate response of the Department of Veterans Affairs to your legislative directive contained in Section 303 of the Veterans' Millennium Health Care Act. Although technically, the Department did respond in accordance to the instructions contained in Section 303, their proposed policy was woefully inadequate in several key respects.

First, aside from one meeting in February with representatives of the chiropractic organizations, there was no other substantive input sought by the DVA from our organization or any of the other groups that are testifying before you today. Language contained in House Report 106-237 made it crystal clear that the VA should consult with Doctors of Chiropractic to assist the VHA in the development and implementation of its chiropractic treatment policy'. Again, after February 24th, there was essentially no role whatsoever played by any of our organizations or our Members in the development or implementation of the flawed DVA policy presented to the Congress on May 5, 2000.

Second, the clear message in your Committee report accompanying the Veterans' Millennium Health Care Act was that chiropractic was efficacious and

the time had come to develop a comprehensive chiropractic health care/treatment policy for our veterans that was different and better than the inadequate existing policy at the DVA. Unfortunately, the DVA spent the first half of its written policy document debating the efficacy of chiropractic rather than proposing a real, substantive policy that would enhance—not retract—chiropractic health care treatment for our Nation's veterans whom are eligible for VA health care.

Third, the proposed policy itself completely ignores the prospect of a direct access chiropractic health care benefit that is available elsewhere in health care plans and merely dusts off it's existing 'referral only' approach to providing medical gatekeepers to screen whether or not a veteran should have the opportunity to see a Doctor of Chiropractic. In a health care setting where chiropractic health care services lay dormant and where DVA health care providers are biased against chiropractic, a gatekeeper/ referral system would effectively shut most veterans out from obtaining this valuable health care treatment at DVA facilities or anywhere else.

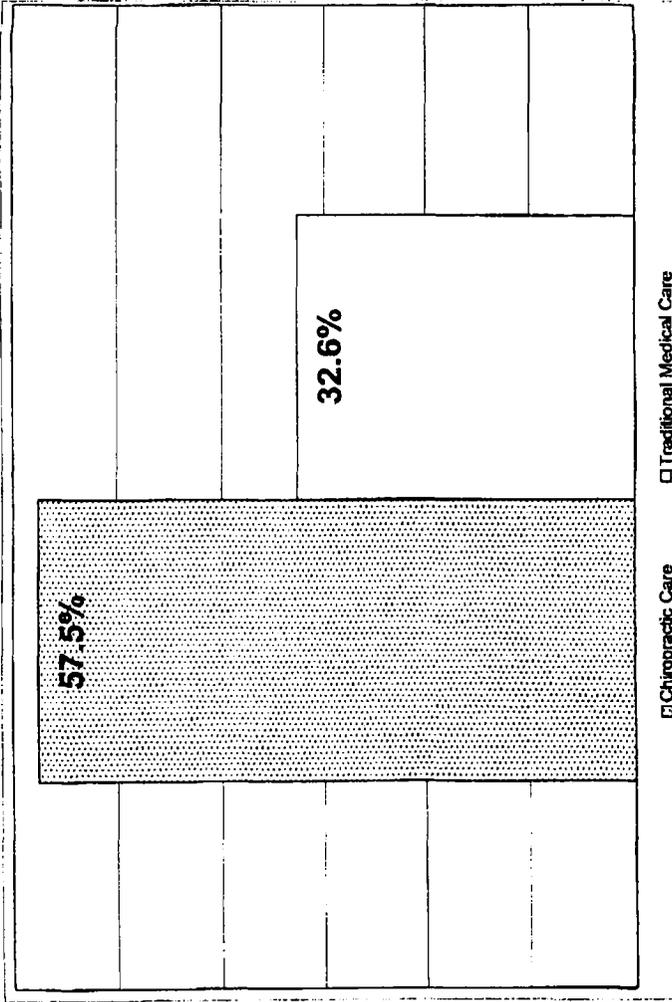
Fourth, the Committee clearly stated that it wanted the DVA to give great weight to a policy that would provide greater access to chiropractic care in rural and medically underserved areas. Nothing that we can find in the May 5, 2000 DVA policy document addresses providing access to chiropractic care for veterans residing in rural or medically underserved areas. Our legislative proposal will address the role of Doctors of Chiropractic in rural and medically under-served areas.

Finally, the flawed DVA policy clearly makes chiropractic health care available at the discretion of individual DVA medical doctors and significantly limits the scope of practice for Doctors of Chiropractic whom would be providing services to our veterans. Again, we believe that a full scope of practice as authorized under State law, should be the minimum criteria utilized in providing chiropractic health care to our veterans at DVA facilities. We also believe that the clear intent of the Committee on Veterans Affairs and ultimately the House-Senate conferees was that the policy of providing chiropractic health care services to veterans was to be 'mandatory' and not subject to the individual whim or discretion of existing DVA doctors who largely oppose chiropractic in the DVA.

For these reasons, MR. CHAIRMAN, we would hope that the Subcommittee would revisit our proposal for the development and implementation

of a chiropractic health care plan as one of the first agenda items for the Committee next year. Chiropractic care is good for our active duty forces in the military and it is good for our Nation's veterans who deserve the very best in health care services. Chiropractic is effective and should be available to our veterans as it is to most every other American. We hope that you concur and will support our reasoned approach to providing quality chiropractic health care services to our Nation's veterans, beginning in the 107th Congress.

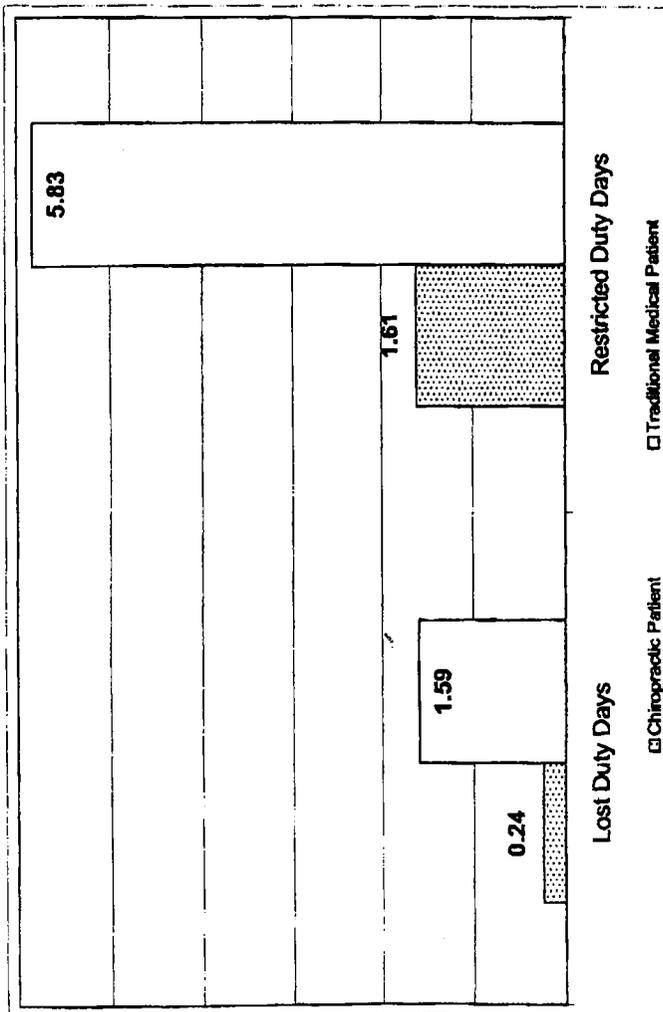
Patients Express Greater Satisfaction With Chiropractic Care Than With Traditional Medicine



Source: Department of Defense, Chiropractic Health Care Demonstration Project Final Report, February, 2000.

CHART B:

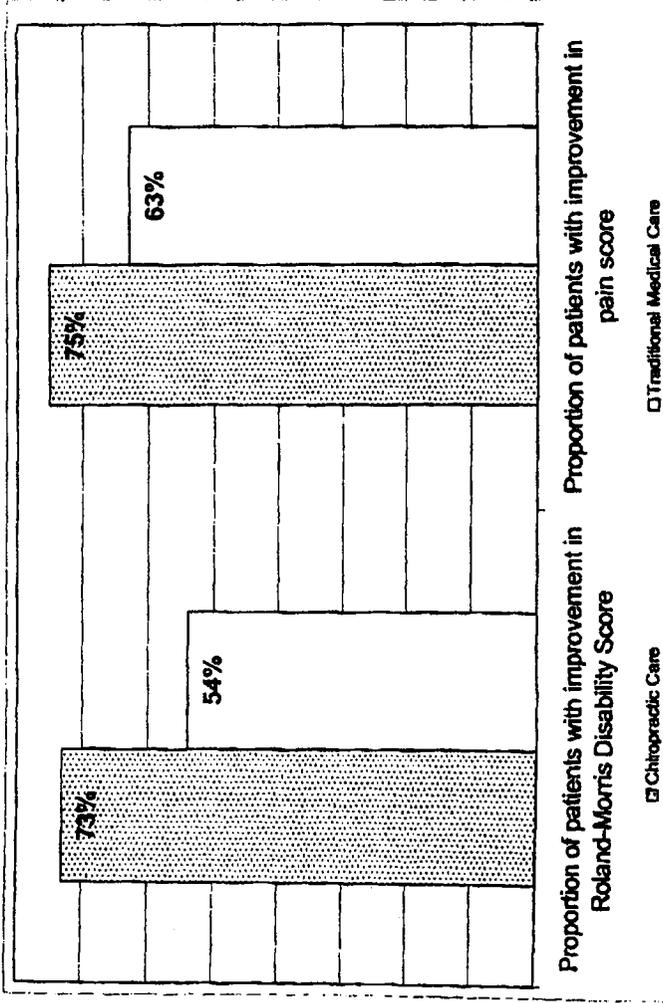
The Average Patient Who Experiences Back Pain Misses Fewer Days Of Duty With Chiropractic Care Than With Traditional Medicine



Source: Department of Defense: Chiropractic Health Care Demonstration Project Final Report, February, 2000.

USARI, A:

**Patients Show Greater Improvement With
Chiropractic Care Than With Traditional Medicine**



Source: Department of Defense, Chiropractic Health Care Demonstration Project Final Report, February, 2000.

Non-Governmental Witnesses:

Dr. Reed Phillips, nor his Collage have received any Federal grant or contract money relevant to the subject matter of his testimony. Dr. Phillips has received expense money from the Department of Defense regarding his role on the DOD Oversight Advisory Committee on the Department of Defense Chiropractic Health Care Demonstration Program.

Dr. George Goodman, nor his Collage have received any Federal grant or contract money relevant to the subject matter of his testimony. Dr. Goodman has received expense money from the Department of Defense regarding his role on the DOD Oversight Advisory Committee on the Department of Defense Chiropractic Health Care Demonstration Program.

CHIROPRACTIC CARE IN THE DEPARTMENT OF VETERANS' AFFAIRS

STATEMENT

By

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TRICARE MANAGEMENT ACTIVITY

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR
HEALTH AFFAIRS

Before the

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Mr. Chairman, I am RADM Michael Cowan, Deputy Executive Director and Chief Operating Officer, TRICARE Management Activity, Office of the Assistant Secretary of Defense (Health Affairs) and I am pleased to be invited here today to share with you and the members of the Subcommittee, the Department of Defense's experience with its Chiropractic Services Demonstration.

As you may know Mr. Chairman, health care services in the Department of Defense are provided to approximately 3.5 million active duty personnel and their dependents and 2 million retirees and their dependents through TRICARE, the Department's managed care program. Before the Chiropractic Demonstration Project, chiropractic care was not offered at any of the health care facilities within the Military Health System (MHS). Individuals seeking chiropractic treatment visited a civilian chiropractor and paid for their care out-of-pocket. Neither the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) nor other DoD funding covered chiropractic care.

The Chiropractic Demonstration was mandated by the National Defense Authorization Act for Fiscal Year 1995. The Act directed the Secretary of Defense to evaluate the feasibility and advisability of offering chiropractic health care at military treatment facilities (MTFs). The Act specifically required the Department to provide chiropractic health care services at no fewer than 10 military treatment facilities. It also required the Department to establish an Oversight Advisory Committee to provide guidance in program development and implementation. Finally, we were required to submit plans for evaluating the program and produce a final report at the end of the demonstration period.

Under that requirement, DoD established chiropractic demonstration programs at ten military clinics: Fort Benning, GA; Fort Carson, CO; Fort Jackson, SC; Fort Sill, OK; Jacksonville Naval Base, FL; Camp Lejeune, NC; Camp Pendleton, CA; Scott AFB, IL; Travis AFB, CA; and Offutt AFB, NE. Also, three comparison (or control) sites Pensacola Naval Air Station, Pensacola, FL; Fort Stewart, GA; and Andrews AFB, MD collected data on patients being treated by traditional providers.

Subsequently, the National Defense Authorization Act for Fiscal Year 1998 directed the Secretary of Defense to expand the Chiropractic Health Care Demonstration Program into at least three new treatment facilities: Walter Reed Army Medical Center, Bethesda National Naval Medical Center, and one other facility to be chosen by the Air Force. The Air Force selected Wilford Hall Medical Center as the third expansion facility. So, there were a total of thirteen demonstration sites along with three control sites. Seven sites were under primary care management principles. Six sites used a patient choice model. The three control sites used traditional treatment.

Data was collected at all of the sites in the chiropractic demonstration. Each Patient Choice and Comparison demonstration site had a site coordinator. The coordinators were originally hired on a part-time basis to assist with data collection and submission, but the positions were upgraded to full-time in order to provide additional resources to the data collection efforts. At the Patient Choice and Comparison sites, the data was collected using patient satisfaction survey forms at the initial visit and at a four-week follow-up survey. At the Primary Care sites, the data was collected using patient satisfaction surveys as well as encounter data retrieved from the Ambulatory Data System.

I mentioned earlier that an Oversight Advisory Committee was created. The committee membership included the Chief Operating Officer of the TRICARE Management Activity, six chiropractors, three Service members, one member from GAO and one from the Military Coalition. Throughout the demonstration, the Oversight Advisory Committee provided assistance to the DoD in the development of program guidelines, policies, and procedures. The committee provided regular input and feedback to the DoD on issues such as program methodology, site selection, data collection, program operations and review of congressional interim and final reports. Two of the Chiropractic representatives were also included as members of the program evaluation team, which was responsible for data analysis and drafting of the final report. The Oversight Advisory Committee influenced several key decisions that formed the framework for implementing and evaluating the demonstration. Those decisions were to:

Restrict the patient population for the demonstration to individuals with spine-related, neuromusculoskeletal conditions, staffing of each of the chiropractic clinics with no more than two doctors of chiropractic and two chiropractic assistants

Focus on acute episodes of care for comparison to account for the transient nature of the military population

Select comparison sites to assess changes that would have taken place without the advent of the demonstration project

Select measurable performance outcomes

The Chiropractic Demonstration Program ended on 30 September 1999, the evaluation was completed and the final report was sent to the Congress in March 2000. The demonstration program report included evaluations as to feasibility and advisability. In the area of feasibility, analysis of the data concluded that it was feasible to establish chiropractic services within the DoD. MTFs participating in the CHCDP succeeded in setting up chiropractic clinics with adequate space, equipment, and qualified personnel. At each of the selected sites, chiropractic health care services were not constrained by contracting issues, physical space, or ability to procure appropriate equipment. Start-up costs ranged from \$20,571 to \$90,350 at each site and included expenses for facility modifications and equipment loans, leases, and purchases, with an average cost of \$67,835. In addition, the data support the fact that doctors of chiropractic were judged more favorably after their integration into the MHS, but the majority of traditional clinicians' perceptions did not change dramatically.

Data also showed that traditional providers judged using spinal manipulation to treat indications with no neurological findings as appropriate. They responded more favorably over time to spinal manipulation as a technique to treat this set of conditions. In contrast, less than a majority of traditional providers at the MTFs were likely to view the use of spinal manipulation to treat indications related to acute or chronic cervical or thoracic pain with radiating pain or numbness, or indications of muscle contraction weakness, as appropriate.

The integration of doctors of chiropractic into the Military Health System is seen as feasible, but further attention must be given to scope of practice issues among providers and whether spinal manipulation as a technique is appropriate for certain medical conditions.

Results from the empirical models indicated that patients who saw doctors of chiropractic were significantly more likely to show self-reported improvement in health over the four-week survey period than patients who saw traditional providers. Patients were also more likely to give their provider excellent marks (a perfect score) if they were seen by a chiropractor.

With respect to advisability, a statistical profile of care methodology was used to determine the per patient cost for treating low back pain. The quantitative results achieved through this methodology were integral factors in determining the advisability of adopting chiropractic care within the MHS.

The introduction of a system-wide chiropractic benefit would increase the cost of outpatient care. The extent of this cost increase would depend on the type of benefit offered (restricted or open to all beneficiaries) and how well the Military Health System could capture potential cost savings in physical therapy and inpatient services.

The estimated gross cost of providing a chiropractic benefit similar to that offered in the demonstration program model would be approximately \$55 million, while the estimated gross cost of providing a chiropractic benefit without restriction to non-active duty beneficiaries would be at least \$70 million. Overall, the addition of any chiropractic benefit within the MHS would have a direct increase on operational costs.

The demonstration program has shown that, as a result of chiropractic care, there appears to be a reduction in the number of physical therapy visits among patients with low back pain. The estimated value of an extrapolated reduction in physical therapy services is approximately

\$19 million. To realize these savings, however, physical therapy staff at facilities would have to be reduced to account for lessened demand, thereby restricting access to physical therapy for other patients presenting with non-back related conditions. The study also showed that chiropractic care may be associated with a reduction in the rate of inpatient admissions among patients with at least one chiropractic visit. The estimated value of reduced admissions for back-related inpatient diagnoses is approximately \$6.7 million. Again, to realize the extent of these savings, back-related inpatient admissions within the MHS would have to be reduced, thereby allowing savings to be passed back to the MHS and personnel authorizations for health care staff to treat patients with back-related conditions would have to be reduced.

The total value of these potential economic benefits is \$26 million. This amount is not sufficient to fully offset the projected increase in outpatient costs as a result of initiating chiropractic care services.

Another potential resource impact, although difficult to value, is derived from the improved return to duty rates of active duty members after receiving chiropractic care. Self-reported survey measures of reductions in lost and restricted duty days (time that Service members are not fully present for duty), extrapolated to the DoD population, indicate a potential to gain 199,000 labor days per year. This represents about a 0.04 percent increase on an annual basis in duty status among all service members. Currently, there is no mechanism within the DoD to realize cost savings resulting from improved return to duty rates. However, improvements in training availability, deployment readiness, and reporting requirements, would be anticipated as a result of higher present for duty ratings.

The conclusion of our evaluation was that chiropractic services could be implemented within the DoD and is feasible. Analysis of data collected from patients and providers indicates that chiropractic care was well received by the patient population. As a result, chiropractic service appears to have complemented and augmented traditional medical care. Further, the CHCDP analysis did not find any negative patient perceptions that would contraindicate the feasibility of offering chiropractic care to DoD beneficiaries throughout the MHS. The study results indicated that clinics were established and fully operational within 60 to 90 days. Policies and procedures were established and later modified during the demonstration as new issues were identified. Start-up costs ranged from approximately \$20,000 to \$90,000 depending on the availability of adequate clinic space and construction modification requirements. No insurmountable issues delayed or prevented the establishment of chiropractic services at the 13 demonstration sites.

Also provider attitudes toward doctors of chiropractic changed positively over time. Perceptions and attitudes about the acceptance of doctors of chiropractic and the appropriateness of spinal manipulation to treat certain clinical conditions were judged to be favorable by traditional providers.

However, the demonstration program imposed several patient access limitations. If these patient access limitations were removed, the *unconstrained demand of implementing chiropractic care within the MHS* could cost at least \$70 million annually. Full implementation of chiropractic care services for the DoD beneficiary population at this time would most likely require reducing or eliminating existing medical programs that are already competing for limited Defense Health Program dollars.

The conclusion, based on the demonstration, was that incorporation of chiropractic care into the DoD health care delivery model was not advisable. Factors contributing to this conclusion were that:

- Chiropractic care is more expensive on a statistical profile of care basis and more expensive even if cost savings associated with substitution of chiropractic care for other traditional care can be realized. This is true even though the cost analysis portrayed chiropractic care, when compared with traditional medical care for back pain, as less expensive on a per visit basis.
- *Utilizing a staffing model similar to the demonstration*, which used restrictive guidelines limiting patient access to the demonstration program, i.e., active duty patients received

priority for appointments at some locations, will result in a cost estimate of approximately \$55 million annually to implement chiropractic care within the DoD direct care system.

- Any potential economic benefit of improved outcomes (estimated at \$26 million) would not translate directly back to the MHS in the form of budgetary savings. This includes reduced inpatient admissions and reduced physical therapy visits for low back pain.
- Any potential resource savings from a projected increase in availability of active duty members receiving care would not accrue directly to the defense medical budget. No mechanism currently exists to pass these changes in economic value back to the military health system in the form of budgetary savings.

The status of the Department's Chiropractic program is that while the original Chiropractic Demonstration Program ended on 30 September 1999, chiropractic services continue to be provided at the current MTFs pending completion of the Fiscal Year 2001 National Defense Authorization Act. Mr. Chairman, that completes my statement, I will be happy to answer any questions.