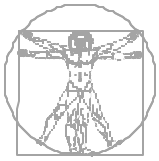

PREFACE

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.

This report was prepared with the assistance of the following:

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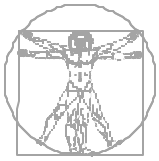

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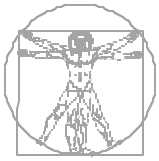
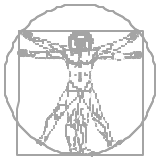


SECTION I

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.).

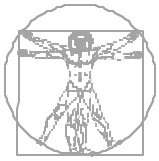
The Veterans' Millennium Healthcare Act was signed into law by President Clinton on November 30, 1999 (Public Law 106-117). Among other things, it included a provision requiring the Department of Veterans Affairs to develop a policy with regard to chiropractic care in the DVA healthcare system. More 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

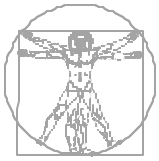
Within the past 100 years, chiropractic has become the third-largest profession of healthcare delivery in the world. The American Chiropractic Association defines chiropractic as, “a branch of the healing arts that is concerned with human health and disease processes. Doctors of chiropractic are physicians 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

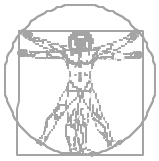
Over 40 randomized clinical trials have been published comparing spinal manipulation/adjustment with other treatments for low-back pain. The better-quality clinical trials have indicated that spinal manipulation/adjustment is superior to other types of intervention (corsets, massage, mobilization, back 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],[36,37,39] 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.

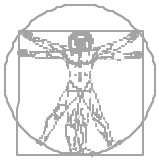
In addition, the Mercy Conference guidelines, plus relevant literature, formed the basis of the clinical practice guidelines on low-back pain released in December 1994 by the Agency for Healthcare Policy and Research (AHCPR).[45] These guidelines rank spinal manipulation/adjustment in the *top tier* 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.[49]

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

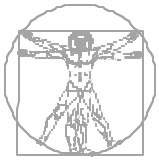
The belief that low-back pain is benign and will usually disappear after six weeks with no intervention has been significantly refuted by the recent literature. One study in the British Medical Journal demonstrated that, in a cohort of 170 patients, ***60%*** *still complained of pain and disability 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 syndrome[67-70]
2. Obstetric/gynecologic disorders:
   - **a.** Dysmenorrhea[71-73]

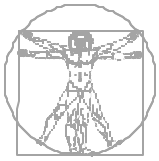


   b. Premenstrual syndrome[74-76]
3. Conditions of infants, children and adolescents:
   a. Scoliosis[77,78]
   b. Otitis media[79-81]
   c. Colic[82,83]
   d. Enuresis[84]
4. Pulmonary and circulatory disorders:
   a. Asthma[85-88]
5. GI dysfunctions[89-91]
6. Primary contact or care services[92,93]

CHIROPRACTIC EXAMINATION

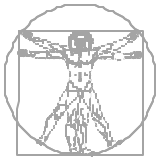
Chiropractic, by definition, is a conservative and drugless means of intervention. As such, it does not encompass the use of medications or immunizations, the directed use of which would necessarily be referred to a medical doctor. For the sake of parity, however, it is certainly within reason to ask 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, 1996.

[3] Eisenberg DM, Davis RB, Ettner 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(18): 1569-1575.

[4] Astin JA. Why patients use alternative medicine. Journal of the American Medical Association 1998; 279(19): 1548-1553.

[5] Eisenberg DM, Kessler RC, Foster C, Norlock FE, Calkins DR, Delbanco 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 vertebro-basilar artery dissection after cervical trauma and spinal manipulation. Spine 1999; 24(8): 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-CCR-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, Bouter LM, DVAn Mameren H, Essers AHM, Verstegen 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, Hondras MA, Brennan PC. Manipulative therapy versus education programs in chronic low back pain. Spine 1995; 20(8): 948-955.

[14] Giles LGF, Muller 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): 376-381.

[15] Bronfort G, Goldsmith 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 1996; 19(9): 570-582.

[16] Kirkaldy-Willis 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 corset in the treatment of subacute low back pain. Spine 1994; 19(22): 2571-2577.

[18] Blomberg S, Varsudd K, Mildenberger F: A controlled multicenter trial of manual therapy in low back pain: Initial status, sick leave and pain score during follow-up. Journal of Orthopedic Medicine 1994; 16(1): 2-8.

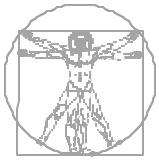
[19] Berquist-Ullman M, Larsson U. Acute low back pain in industry: A controlled prospective study with special reference to therapy and confounding factors. Acta Orthopedica Scandinavia 1977; 170[suppl]: 1-117.

[20] Brooks PM. NSAIDs. In Klipper JH, Dieppe PA [eds.]: Rheumatology. 2nd edition. St. Louis, MO: Mosby Year Book, 1998, pp. 3.5.1-3.5.6.

[21] Dabbs V, Lasuretti WE. A risk assessment of cervical manipulation vs. NSAIDs for the treatment of neck pain. Journal of Manipulative and Physiological Therapeutics 1995; 18(8): 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, Wirick 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 1980. Topics in Clinical Chiropractic 1999; 6(2): 57-68.

[25] 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.

[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): 231-239.

[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(5): 335-344.

[30] 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.

[31] Dean H, Schmidt R. A Comparison of the Cost of Chiropractors versus Alternative Medical Practitioners. Richmond, VA: Virginia Chiropractic Association, 1992.

[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 recurrences of chiropractic and medical episodes of low-back care. Journal of Manipulative and Physiological Therapeutics 1997; 20(1): 5-12.

[34] 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.

[35] Manga P., Enhanced Chiropractic Coverage under OHIP 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, 1998.

[36] Shekelle PG, Markovich M, Louie R. Comparing the costs between provider types of episodes of back care. Spine 1995; 20(2): 221-227.

[37] Cherkin DC, Deyo RA, Battie 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.

[38] Rosner A. Letter to the editor. Spine 1995; 20(23): 2595-2598.

[39] Carey TS, Garrett J, Jackman A, McLaughlin C, Fryer J, Smucker 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 1995; 333(14): 913-917.

[40] Cherkin DC, MacCornack 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; 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-4025/2-CCR/FCER.

[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-4025/3-CCR/FCER.

[44] Shekelle PG, Hurwitz EL, Coulter I, 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.

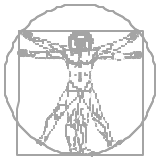
[45] Bigos S, Bowyer O, Braen G, et al. Acute Low Back Pain in Adults. Clinical practice guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Healthcare Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December 1994.

[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: 798-799, quoting David Eddy, M.D., Professor of Health Policy and Management, Duke University, NC.

[48] Rachli, N. and Kuschner C. Second Opinion: What's Wrong with Canada's Healthcare System and How to Fix It. Collins, Toronto [1989].

[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] Croft PR, Macfarlane GJ, Papageorgiou AC, Thomas E, Silman AJ. Outcome of low back pain in general practice: A prospective study. British Medical Journal 1998; 316: 1356-1359.

[51] Reis S, Hermoni D, Borkan JM, Biderman A, Tabenkin C, Orat A. A new look at low back complaints in primary care: A RAMBAM Israeli family practice research network study. Journal of Family Practice 1999; 48(4): 299-303.

[52] Boline P, Kassak K, Bronfort G, Nelson C, Anderson AV. Spinal manipulation vs. amitriptyline for the treatment of chronic tension-type headaches: A randomized clinical trial. Journal of Manipulative and Physiological Therapeutics 1995; 18(3): 148-154.

[53] Bitterli J, Graf F, Robert F, et al. Zur objektivierung der manualtherapeutischen beeinflussbarket des spondylogenen korpschemerzes [Objective criteria for the valuation of chiropractic treatment of spondylotic headache]. Nervenart. 1977; 48: 259-262.

[54] Hoyt WH, Shaffer F, Bard DA, Benesler JS, Blankenhorn GD, Gray JH, Hartman WT, Hughes LC. Osteopathic manipulation in the treatment of muscle contraction headache. Journal of the American Osteopathic Association 1979; 78: 322-325.

[55] Nilsson N. A randomized controlled trial of the effect of spinal manipulation in the treatment of cervicogenic headache. Journal of Manipulative and Physiological Therapeutics 1995; 18(7): 435-440.

[56] Parker G, Tupling H, Pryor D. A controlled trial of cervical manipulation for migraine. Australian and New Zealand Journal of Medicine 1978; 8: 589-593.

[57] Jensen IK, Nielsen FF, Vosmar L. An open study comparing manual therapy with the use of cold packs in the treatment of post-traumatic headache. Cephalalgia 1990; 10: 243-250.

[58] Nelson C, Bronfort G, Evans R, Boline P, Goldsmith C, Anderson AV. The efficacy of spinal manipulation, amitriptyline, and the combination of both therapies for the prophylaxis of migraine headache. Journal of Manipulative and Physiological Therapeutics 1998; 21(8): 511-519.

[59] Whittingham W, Ellis WB, Milyneux TP. The effect of manipulation [toggle recoil] for headaches with upper cervical joint dysfunction: a pilot study. Journal of Manipulative and Physiological Therapeutics 1994; 17(6): 369-375.

[60] Mootz RD, Dhami MSI, Hess JA, Cook RD, Schorr DB. Chiropractic treatment of chronic episodic tension-type headache in male subjects: a case series analysis. Journal of the Canadian Chiropractic Association 1994; 38(3): 152-159.

[61] Droz JM, Crot F. Occipital headaches: Statistical results in the treatment of vertebrogenic headache. Annals of the Swiss Chiropractic Association 1985; 8: 127-136.

[62] Vernon HT. Spinal manipulation and headaches of cervical origin. Journal of Manipulative and Physiological Therapeutics 1982; 5(3): 109-112.

[63] Wight JS. Migraine: A statistical analysis of chiropractic treatment. Chiropractic Journal 1978; 12: 363-367.

[64] Stodolny J, Chmielewski H. Manual therapy in the treatment of patients with cervical migraine. Manual Medicine 1989; 4: 49-51.

[65] Turk Z, Ratkolb O. Mobilization of the cervical spine in chronic headaches. Manual Medicine 1987; 3:15-17.

[66] Bove G, Nilsson N. Spinal manipulation in the treatment of episodic tension-type headache. Journal of the American Medical Association 1998; 280(18): 1576-1579.

[67] Sucher BM. Palpatory diagnosis and manipulative management of carpal tunnel syndrome. Journal of the American Osteopathic Association 1994; 94(8): 647-663.

[68] Strait BW, Kuchera ML. Osteopathic manipulation for patients with confirmed mild, modest and moderate carpal tunnel syndrome. Journal of the American Osteopathic Association 1994; 94(8): 673.

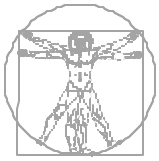
[69] Davis PT, Hulbert JR, Kassak KM, Meyer JJ. Comparative efficacy of conservative medical and chiropractic treatments for carpal tunnel syndrome: A randomized clinical trial. Journal of Manipulative and Physiological Therapeutics 1998; 21(5): 317-326.

[70] Bersten G, McCarthy K. Conservative chiropractic approaches to carpal tunnel syndrome. Topics in Clinical Chiropractic 1999; 6(4): 62-72.

[71] Liebl NA, Butler LM. A chiropractic approach to the treatment of dysmenorrhea. Journal of Manipulative and Physiological Therapeutics 1990; 13(3): 101-106.

[72] Boesler D, Warner M, Alpers A, Finnerty EP, Kilmore MA. Efficacy of high-velocity low-amplitude manipulative technique in subjects with low back pain during menstrual cramping. Journal of the American Osteopathic Association 1993; 93(2): 203-214.

[73] Kokjohn K, Schmid DM, Triano JJ, Brennan PC. The effect of spinal manipulation on pain and prostaglandin levels in women with primary dysmenorrhea. Journal of Manipulative and Physiological Therapeutics 1992; 15(5): 279-285.



[74] Stude DE. The management of symptoms associated with premenstrual syndrom e. Journal of Manipulative and Physiogical Therapeutics 1991; 14(3): 209-216.

[75] Walsh MJ, Chandraraj 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): 582-585.

[77] Plaugher G, Cremata EE, Phillips R. A retrospective consecutive case analysis of pretreatment and comparative static radiological parameters following chiropractic adjustments. Journal of Manipulative and Physiological Therapeutics 1990; 13(9): 498-506.

[78] Tarola GA. Manipulation for the control of back pain and curve progression in patients with skeletally mature idiopathic scoliosis: two case studies. Journal of Manipulative and Physiological Therapeutics 994; 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 1996; 19(3): 169-177.

[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] Klougart N, Nilsson N, Jacobsen J. Infantile colic treated by chiropractors: a prospective study of 316 cases. Journal of Manipulative and Physiological Therapeutics 1989; 12(4): 281-288.

[83] Wiberg JMM, Nordsteen 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 1999; 22(8): 517-522.

[84] Reed WR, Beavers S, Reddy SK, Kern G. Chiropractic management of primary nocturnal enuresis. Journal of Manipulative and Physiological Therapeutics 1994; 17(9): 596-600.

[85] Gamble A. Alternative medic al approaches to the treatment of asthma. Alternative and Complementary Therapies 1995. 11(2): 61-66.

[86] Jamison JR, McEwen AP, Thomas SJ. Chiropractic adjustment in the management of visceral conditions: a critical appraisal. Journal of Manipulative a nd 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 dysfunctional syndrome. Chiropractic Technique 1990; 2(2): 45-48.

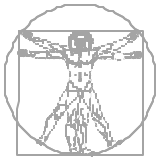
[90] Wagner T, Owen J, Malone E, Mann K. Irritable bowel syndrome and spinal manipulation: a case report. Chiropractic Technique 7(4): 139-140, 1995.

[91] PikalovA, Kharin VV. Use of spinal manipulative therapy in the treatment of duodenal ulcer: A pilot study. Journal of Manipulative and Physiological Therapeutics 1994; 17(5): 310-313.

[92] Bowers JL, MootzR. The nature of primary care: The chiropractor's role. Topics in Clinical Chiropractic 1995; 2(1): 66-84.

[93] Hawk C, Dusio M. Asurvey of 492 chiropractors on primary care and prevention-related issues. Journal of Manipulative and Physiological Therapeutics 1995; 8(2): 57-64.

[94] Freeman KB, Bernstein J. The adequacy of medical school education in neuromusculoskeletal medicine. Journal of Bone and Joint Surgery Am 1998; 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

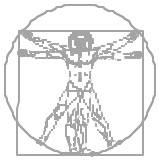
4. The Role of Doctors of Chiropractic in Rural and Medically Under-Served Areas

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



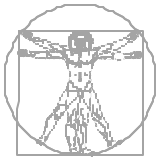
Recommendation 1. Ensuring Access to Chiropractic Services in the DVA Healthcare System

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.

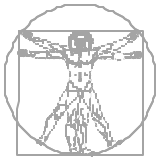
Ensuring *direct access* to doctors of chiropractic is extremely important to the proper utilization of chiropractic care. Patients often experience difficulty accessing chiropractic care when a referral from a medical doctor or nurse is required. Although they are skilled and trained professionals, 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:

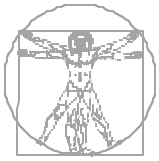
- Primary contact or care services.
- Diagnostic testing and imaging, including differential diagnosis, with the accompanying ability to perform and/or order as well as interpret diagnostic tests, including venipuncture.
- Taking and interpretation of diagnostic imaging, electro-diagnostic testing, and 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.



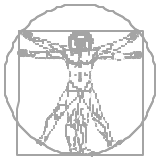
Florida

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

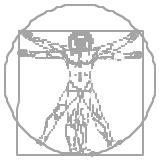
"CHIROPRACTIC" A branch of the healing arts dealing with the relationship between the articulations of the vertebral column, as well as other articulations, and the neuro-musculo-skeletal system and the role of these relationships in the restoration and maintenance of health. The term shall include systems 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

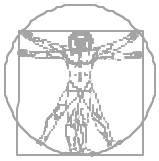
(H) to perform a mammography.

(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:

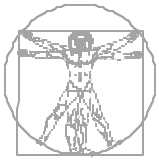
Figure 1

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



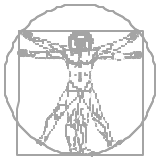
"completely resolve the pain being treated by the cardiologist as a pure cardiac disorder. A chiropractor, in these circumstances, feels it is more appropriate to record this in chiropractic clinical records as a case of joint and muscle dysfunction in the thoracic spine (mid-back), rather than a case 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.

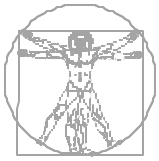
PERSONNEL POLICIES

Minimum qualifications for appointment as a DVA doctor of chiropractic are:

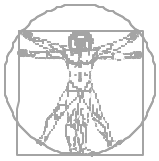
- U.S. citizenship (non-citizens may be appointed when qualified citizens are not available).
- Degree of Doctor of Chiropractic from an institution approved by the Council on Chiropractic Education (CCE) for the year in which the degree was granted. Chiropractors graduating prior to CCE accreditation 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:



- 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.

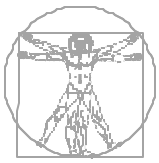


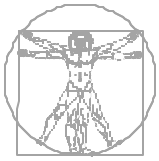
Recommendation 4. The Role of Doctors of Chiropractic in Rural and Medically Underserved Areas

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 needed[12] and high levels of patient satisfaction are found with doctors of chiropractic practicing in Health Professional Shortage Areas[13].





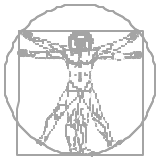
Recommendation 5. Hospital Privileges and Credentialing of Doctors of Chiropractic

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, heal lifts, cervical collars, braces/supports, durable medical equipment (i.e. TENS units), etc.

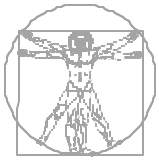


- Opportunity to serve on appropriate hospital or clinic committees, and participate in educational functions, such as grand rounds, journal club, case reviews, etc.

- 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

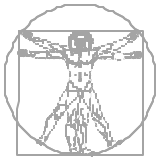
The American Chiropractic Association (ACA) and the Association of Chiropractic Colleges (ACC) are proposing the establishment of a collaborative interdisciplinary chronic pain management initiative with the Department of Veterans Affairs, as part of the new partnership envisioned by the Congress between 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.

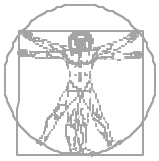


PLAN PROPOSAL

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.

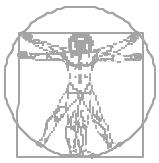
All levels of staff who decide policy and implement chiropractic benefits should have a full understanding of the integration of chiropractic benefits and how and when a doctor of chiropractic can be helpful in patient care. Recommended audiences include:

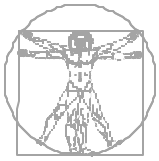
- DVA administrators, policymakers and medical directors
- Senior management working with primary care programs
- Clinical managers
- Hospital and healthcare system managers
- Professional personnel of the Veterans Administration

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.

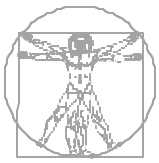
College campus visits are recommended to help initiate the chiropractic integration process. A training module could be developed for use at medical staff meetings, at orientations given to primary care planning committees, for residents' trainings, and as a resource document for DVA strategic planning.

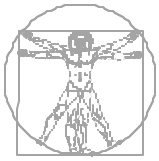




Recommendation 8. Establishing a DVA Liaison to the Chiropractic Profession

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. III. 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.

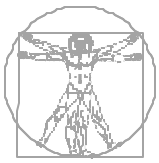
[9] 63 P.S. § 624.102 (1999).

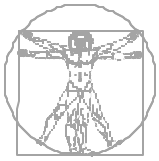
[10] 16 CCR § 302 (1999).

[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

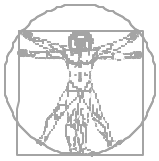
International Classification of Diseases, 9th Revision, Clinical Modification Codes (ICD-9–CM Codes) are designed to classify illnesses, injuries, and patient-health care provider encounters for services.

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.

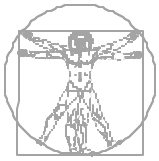
ICD-9-CM Codes

ICD CODES – NUMERIC CATEGORY LISTING

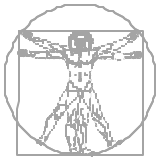
CODE	*DESCRIPTION*
290-319	**Mental Disorders**
307	SPECIAL SYMPTOMS OR SYNDROMES, NOT ELSEWHERE CLASSIFIED
307.6	ENURESIS, PSYCHOGENIC, NONORGANIC, HABIT DISTURBANCE
307.81	TENSION HEADACHE
307.89	COLIC, PSYCHOGENIC ABDOMINAL
320-389.1.1	**Diseases of the Nervous System and Sense Organs**
333.83	SPASMODIC 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



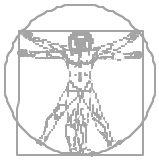
353.3	THORACIC ROOT LESIONS, NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS, NOT ELSEWHERE CLASSIFIED
353.8	OTHER NERVE ROOT AND PLEXUS DISORDERS
353.9	UNSPECIFIED NERVE ROOT AND PLEXUS DISORDER
354	MONONEURITIS UPPER LIMB
354.0	CARPAL TUNNEL SYNDROME
354.1	OTHER LESION OF MEDIAN NERVE
354.2	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



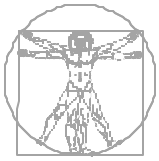
715.04	OSTEOARTHROSIS, GENERALIZED, INVOLVING HAND
715.09	OSTEOARTHROSIS, GENERALIZED, INVOLVING MULTIPLE SITES
715.1	OSTEOARTHROSIS, LOCALIZED, PRIMARY
715.11	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING SHOULDER REGION
715.15	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING PELVIC REGION AND THIGH
715.18	OSTEOARTHROSIS, LOCALIZED, PRIMARY, INVOLVING OTHER SPECIFIED SITES
715.2	OSTEOARTHROSIS, LOCALIZED, SECONDARY
715.3	OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY
715.30	OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, UNSPECIFIED
715.38	OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, INVOLVING OTHER SPECIFIED SITES
715.8	OSTEOARTHROSIS INVOLVING OR WITH MENTION OF MORE THAN ONE SITE, BUT NOT SPECIFIED AS GENERALIZED
715.80	OSTEOARTHROSIS INVOLVING OR WITH MENTION OF MORE THAN ONE SITE, BUT NOT SPECIFIED AS GENERALIZED, AND INVOLVING UNSPECIFIED SITE, UNSPECIFIED
715.89	OSTEOARTHROSIS INVOLVING OR WITH MENTION OF MULTIPLE SITES, BUT NOT SPECIFIED AS GENERALIZED
715.9	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING UNSPECIFIED SITE
715.90	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, UNSPECIFIED
715.96	OSTEOARTHROSIS, UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED, INVOLVING LOWER LEG
715.98	OSTEOARTHROSIS, 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



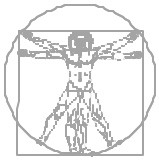
716.99	UNSPECIFIED ARTHROPATHY INVOLVING MULTIPLE SITES
717	INTERNAL DERANGEMENT OF KNEE
717.5	DERANGEMENT OF MENISCUS, NOT ELSEWHERE CLASSIFIED
717.7	CHONDROMALACIA OF PATELLA
717.8	OTHER INTERNAL DERANGEMENT OF KNEE
717.9	UNSPECIFIED INTERNAL DERANGEMENT OF KNEE
718	OTHER DERANGEMENT OF JOINT
718.0	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



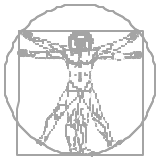
719.69	OTHER SYMPTOMS REFERABLE TO JOINT, INVOLVING MULTIPLE SITES
719.7	DIFFICULTY IN WALKING
719.70	DIFFICULTY IN WALKING, UNSPECIFIED
719.75	DIFFICULTY IN WALKING, PELVIS
719.8	OTHER SPECIFIED DISORDERS OF JOINT, INVOLVING OTHER SPECIFIED SITE
719.80	OTHER SPECIFIED DISORDERS OF JOINT, INVOLVING OTHER 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



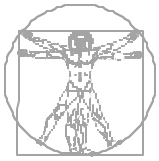
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.1	DISPLACEMENT OF THORACIC OR LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.2	DISPLACEMENT 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



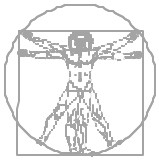
727.2	SPECIFIC BURSITIDES OFTEN OF OCCUPATIONAL ORIGIN
727.3	OTHER BURSITIS DISORDERS
727.9	UNSPECIFIED DISORDER OF SYNOVIUM, TENDON, AND BURSA
728.1	MUSCULAR CALCIFICATION AND OSSIFICATION
728.10	CALCIFICATION AND OSSIFICATION, UNSPECIFIED
728.12	TRAUMATIC MYOSITIS OSSIFICANS
728.4	LAXITY OF LIGAMENT
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



737.4	CURDVATURE 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

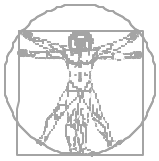
754.2	CONGENITAL NEUROMUSCULOSKELETAL DEFORMITIES OF SPINE
755.69	OTHER CONGENITAL ANOMALIES OF LOWER LIMB, INCLUDING PELVIC GIRDLE
756.1	CONGENITAL ANOMALIES OF SPINE
756.11	CONGENITAL SPONDYLOLYSIS, LUMBOSACRAL REGION
756.12	SPONDYLOLISTHESIS, CONGENITAL
756.13	ABSENCE OF VERTEBRA, CONGENITAL
756.14	HEMIVERTEBRA
756.15	FUSION OF SPINE (VERTEBRA), CONGENITAL



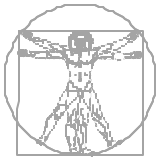
756.16	KLIPPEL-FEIL SYNDROME
756.17	SPINA BIFIDA OCCULTA
756.19	OTHER CONGENITAL ANOMALIES OF SPINE
756.2	CERVICAL RIB

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