

MINUTES

MONTANA HOUSE OF REPRESENTATIVES  
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

Call to Order: By Chairman Stella Jean Hansen, on January 4, 1989, at 3:00 p.m.

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Mary McCue, Legislative Council

Announcements/Discussion: Rules of procedure for members of the committee. (Exhibit 1).

HEARING ON HOUSE BILL 33

Presentation and Opening Statement by Sponsor: Rep.

Pavlovich, District 70, stated that this bill required a Workers' Compensation impairment evaluator to be a chiropractor if the claimant's treating physician is a chiropractor.

List of Testifying Proponents and What Group they Represent:

Michael Pardis, D.C.  
Gary Blom, D.C.  
Lou Sage, D.C.  
Bonnie Tippy, Montana Chiropractor's Association

List of Testifying Opponents and What Group They Represent:

Jerome Loendorf, Montana Medical Association  
John W. McMahon, M.D.  
Hiram Shaw, Montana Department of Labor and Industry  
Oliver Goe, Montana Municipal Insurance Association

Testimony:

Michael Pardis, D.C., indicated his support of this legislation and also said that chiropractors have

always been able to rate impairments for on-the-job workers up until two years ago and that is when the W.C. bill excluded them.

Gary Blom, D.C., stated that he was fully trained to rate impairments and had done this for many years until this privilege was taken from him. Dr. Blom said that it is demeaning to an injured worker not to be able to be rated by a chiropractor if this is the wish of the patient. He feels that it is unconstitutional for both the patient and chiropractor.

Lou Sage, D.C., stated that the State Board of Chiropractors lends its support to this bill. This bill would also extend the authority of the Board to make them responsible for setting up the guidelines for certification.

Bonnie Tippy supports this bill and distributed Exhibit 2.

Jerome Loendorf, an opponent to this legislation, said that no discredit is indicated in his testimony. The page 4 amendment was his concern. If a claimant chooses a chiropractor as his treating physician, the W.C. loses its right to whatever physician W.C. wants as its evaluator. (Exhibit 3).

John W. McMahon, M.D., opposing this bill, discussed specific patients with specific injuries and the ability of the W.C. to hire the best expertise it can to evaluate patients.

Hiram Shaw, in opposition, stated that the bill provided so many conflicts between the definitions of physicians and chiropractors that the basic definitions were amended in the 1987 session to clarify specifically who can do impairment evaluations and that it would be extremely detrimental to the ability of the W.C. to obtain appropriate impairment evaluations. (Exhibit 4).

Oliver Goe said the passage of the bill will not only affect the uniformity of the benefits which are to be provided to the workers but also will unnecessarily expand the persons under W.C. who would be qualified to render the ratings.

Questions From Committee Members: Rep. Whalen asked Oliver Goe if injured workers under W.C. have adopted the Montana Rules of Civil Procedure and the Montana Rules of Evidence. Mr. Goe indicated that they were

applicable. Rep. Whalen also asked Mr. Goe if a worker could receive an independent medical examination and Goe's response was a "yes" to this statement. Rep. Whalen then asked if this would not be evidenced in any disputed litigation and Goe responded "true". Again, Rep. Whalen asked whether chiropractors were competent to give evaluations and Mr. Goe indicated that he did not have the expertise to answer this question.

Rep. Simon asked Hiram Shaw what qualifications physicians have with regard to doing these kinds of evaluations and Mr. Shaw stated that physicians are solicited from the Board of Medical Examiners based on Board eligible certification. Rep. Simon asked if chiropractors were certified to be treating in a particular area and are they certified to be doing impairment ratings. Mr. Shaw said they would be considered certified in that area.

Rep. Blotkamp asked Gary Blom if it was for the good of the patient and to whether that patient is better off by receiving a chiropractors' evaluation or a doctor's evaluation, and Dr. Blom indicated "yes" to this question.

Rep. Good asked Hiram Shaw if there were two evaluations and a tiebreaker, would you object if any of those evaluations were a chiropractor and Mr. Shaw said that he would object.

Rep. Simon asked Michael Pardis if he were solely treating a patient what would the cost of that evaluation be and Dr. Pardis said \$100.00. Rep. Simon then asked Dr. McMahon if a patient had been treated by a chiropractor solely and was then sent to you for an evaluation, what would it cost to take a patient that you had never seen. He said it would be a system evaluation which would be \$40.00-\$60.00, depending on what he did.

Rep. Boharski asked Rep. Pavlovich, who in turn referred the question to Dr. Blom, if a chiropractor is qualified to make a determination of an impairment based upon the whole person when that doctor is trained to deal specifically with injuries related to the spinal cord. Dr. Blom stated that if there were other systems involved, a chiropractic physician would be involved. Rep. Boharski then asked if a medical doctor could ask a medical doctor input while doing an evaluation and Mr. Shaw stated "no".

Closing by Sponsor: Rep. Pavlovich supplied a copy of the Supreme Court decision which is also supplied in

Exhibit 4 plus a Statement of Intent which is supplied as Exhibit 5.

DISPOSITION OF HB 33

Disposition of HB 33 is on hold.

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 37

Presentation and Opening Statement by Sponsor: Rep. Cohen stated that this bill was an act removing the requirement that the director of the Department of Health and Environmental Sciences be a physician.

List of Testifying Proponents and What Group they Represent:

Robert A. Ellerd, Governors Office  
Robert R. Johnson, Montana Public Health Association  
Rose Hughes, Montana Health Care Association  
Kim Wilson, Montana Sierra Club  
Mona Jamison, Rocky Mountain Treatment Center  
George M. Fenner, RES Management Services  
Meg Nelson, Montana Environmental Center

List of Testifying Opponents and What Group They Represent:

Jerome Loendorf, Montana Medical Association  
John W. McMahon, M.D.  
Barbara Booher, Montana Nurses Association

Testimony:

Robert A. Ellerd stated that the Governor felt that the director should be and may be a qualified administrator and still it does not exclude a doctor from serving if so chosen.

Robert R. Johnson, also the director of the City/County Health Department, supports this legislation. He said strong management and strong leadership is primary. The choosing of a strong leader by the Governor, who is not necessarily a doctor, would be the wish of this proponent. The leadership of the director should be more important than for that director to have an M.D. license. (Exhibit

6).

Rose Hughes supported this legislation and stated that on only one occasion in the past nine years did she require the needs of a medical doctor to resolve the problems she had incurred in the Department of Health. She was in turn referred to a non-medical person to resolve this problem.

Kim Wilson supports this bill.

Mona Jamison, an attorney who previously had been employed in the Department of Health, stated that it was the bureau chiefs, the program managers and the division administrators who were involved in the direction of the litigation and contested cases and the rule-making.

George Fenner, past employee of the Department of Health distributed Exhibit 7 as his testimony.

Meg Nelson supported this bill for reasons previously stated and urged a DO PASS recommendation.

Jerome Loendorf an opponent to this bill stated that a general manager can manage much of the work but he still does not have technical expertise in the medical field. The medical facilities which are built in the state of Montana were then discussed. The prevention of the spread of infectious diseases was also discussed and of the inability of a non-medical manager to comprehend this.

John W. McMahon, M.D., opposed this legislation, stated that, if properly solicited, qualified M.D.'s were good managers, were good with people and could guide a total health-care system where available.

Barbara Booher indicated her opposition to the loss of another physician in the Department of Health stating it would not be to the benefit of the state.

Questions From Committee Members: Rep. Blotkamp asked Rep. Cohen if there were three members as M.D.'s on the staff of the Department of Health and the response was "yes".

Rep. Squires asked Dr. McMahon how inspections of health care facilities were done and he indicated that they were done by someone with a medical background.

Rep. Gould asked Rose Hughes if she thought it was important that people in the state departments have experience working with the federal government and her response was "yes".

Rep. Simon asked Dr. McMahon how many practicing physicians there were in the state and he answered that there were between 1400-1600. He also asked him how many doctors did he feel would be willing to work for the salary of \$55,000 annually which was offered and Dr. McMahon indicated that 1% would be available. Rep. Simon then asked Jerome Loendorf if he had indicated that the job of appointing the director of the Department of Health should be left up to the governor and Loendorf stated that by the adoption of the bill the state would give up the right to set the qualifications. Asked what the qualifications for the head of the highways would be, Mr. Loendorf indicated he did not know. Simon then asked Mr. Loendorf if he knew what the qualifications of any of the department heads were and Mr. Loendorf said that he thought the attorney general was required to be an attorney.

Rep. Boharski asked Rep. Cohen if there would be any assurances to the general public that any of the bureau chiefs had any medical training and Rep. Cohen was unable to answer the question.

Closing by Sponsor: Rep. Cohen stated that the most telling evidence was nonverbal today and that we had the executive director of the Montana Medical Association and determined that he was not a physician, but he is an administrator. Cohen indicated that we needed to free our governor of the duty of getting the very best administrator to move forward in the Department of Health administrating this wide range of issues and getting the very best job done for the people of Montana.

#### DISPOSITION OF HOUSE BILL 37

Discussion: HB 37 is put on hold.

Amendments and Votes: None

Recommendation and Vote: None

ADJOURNMENT

Adjournment At: 5:20 p.m.



STELLA JEAN HANSEN, Chairman

SJH/AJS

0307.min

# DAILY ROLL CALL

## HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

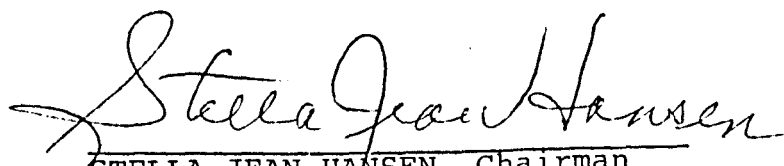
Date January 4, 1989

NAME	PRESENT	ABSENT	EXCUSED
Stella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

RULES OF PROCEDURE  
HOUSE HUMAN SERVICES AND AGING  
51st Legislative Session  
Room 312-2

- (1) All individuals wishing to testify must sign the witness sheet prior to the committee hearing. Your testimony will not be recorded if you do not sign the witness sheet. The witness sheet is located on the desk as you enter the room. Written copies of your testimony should also be submitted if at all possible.
- (2) Proponents will speak first, followed by opponents, the time subject to limitation of the chair.
- (3) The proponents and opponents should try to state new points of testimony. If they wish to agree with points already made, they should simply so state.
- (4) The sponsor of the bill will open and close the presentation.
- (5) All questions will be put forth by the committee. No questions shall be directed between proponents and opponents.
- (6) All discussion will commence at the direction of the chair.
- (7) Questions by committee members shall be directed to proponents and opponents at the close of the presentation unless otherwise authorized by the chair.
- (8) Amendments to measures must be presented to the committee in writing.

EXHIBIT 1  
DATE 1-4-89  
HB                     

  
STELLA JEAN HANSEN, Chairman

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

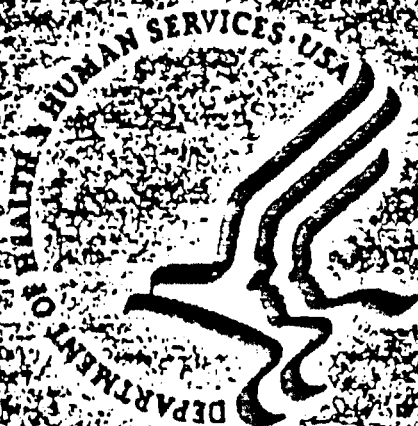
OFFICE OF INSPECTOR GENERAL

DEFENDANT'S  
EXHIBIT  
DX 21051  
ALBANY, N.Y. SUPPLY CO.

LIS  
INSPECTION OF  
CHIROPRACTIC SERVICES UNDER MEDICARE

EXHIBIT 2  
DATE 1-4-89  
HB 33

OFFICE OF  
ANALYSIS AND INSPECTIONS



**INSPECTION OF  
CHIROPRACTIC SERVICES UNDER MEDICARE**

**RICHARD P. KUSSEROW  
INSPECTOR GENERAL**

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**Office of Analysis & Inspections  
Region VII**

**August, 1986**

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## I. Introduction

### Purpose and Objectives

In the period January through May 1985, a national program inspection on Medicare coverage of chiropractic services was conducted by the Region V (Chicago) Office of Analysis and Inspections, Office of the Inspector General, Department of Health and Human Services.

This study was done in response to growing concerns regarding: the rapidly rising cost of chiropractic care under Medicare Part B; the possible implications of previously conducted OIG targeted investigations of chiropractors; an emerging perception that current Medicare legislation and regulations may not be administered in such a way as to provide intended limits on coverage; and a perception by chiropractors and others that the benefit does not adequately cover or reflect current patterns of practice.

The inspection had four general objectives:

- o To develop an understanding of chiropractic as a profession as seen by its practitioners, schools and associations, as well as representatives of mainstream medicine.
- o To explore with the chiropractic community how current Medicare legislation and regulations affect them and their patients, and in particular to discuss with them how they evaluate the x-ray requirement and handle billing.
- o To gather and analyze data on patterns of chiropractic utilization and expenditures under Medicare, Part B.
- o To examine how Medicare Part B carriers process chiropractic claims and to determine the effects of their screens and reviews.

### Methods

In order to achieve these objectives, the inspection had three major segments:

- o On-site discussions were held with 86 organizations and individuals in 13 states and the District of Columbia, selected to provide broad geographic and interest-group participation. Included were representatives of 12 chiropractic colleges, 15 chiropractic associations, 28 medical societies and hospital associations, and 22 third-party payers (Medicare Part B carriers and private payers), as well as representatives of HCFA and other policy experts.
- o Telephone discussions were held with a representative sample of 145 chiropractors in eight states, who were randomly selected from lists of providers with billing numbers, provided by randomly selected Part B carriers.
- o An analysis was made of the billing and payment histories of chiropractors in the telephone sample for claims processed in calendar year 1983, along with other data on Medicare billing and expenditure patterns provided by Part B carriers and HCFA. (See Appendix A for a discussion of sampling methodology for the telephone survey and the provider history review.)

## II. Overview

### What is Chiropractic?

The American Chiropractic Association describes the discipline as follows:

"Chiropractic is a branch of the healing arts which is concerned with the human health and disease process. Doctors of chiropractic are physicians who consider man as an integrated being but gives special attention to spinal mechanics, neurological, vascular, and nutritional relationships...

Chiropractic is built on three related scientific theories and principals...

- 1) Disease may be caused by disturbances of the nervous system ...
- 2) Disturbances of the nervous system may be caused by derangements of the musculoskeletal structure. Off-centerings (subluxations) of vertebral and pelvic segments represent common mechanical clinical findings in man ...
- 3) Disturbances of the nervous system may cause or aggravate disease in various parts or functions of the body ..."  
(American Chiropractic Association, Chiropractic: State of the Art, 1984. pp. 8-9)

### Medicare Coverage of Chiropractic Services

In 1972, PL 92-603 authorized limited Medicare Part B coverage of chiropractic services. In the final legislation, chiropractors were defined as physicians for coverage purposes, but payment was limited to :  
"...treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by x-ray to exist) ...". (Section 1861(r)(5), Social Security Act). There was considerable controversy surrounding the passage of this legislation which was adopted despite the recommendations and concerns about chiropractic as a form of treatment contained in the 1968 HEW report, Independent Practitioners Under Medicare. Almost every mainstream medical group also formally opposed passage.

Educational standards were set for chiropractors and payment could only be made for services provided in states where chiropractors were legally authorized to practice.

The regulations for this benefit further limited coverage to payment "...only for the chiropractor's manual manipulation of the spine to correct a subluxation... which has resulted in a neuromusculoskeletal condition for which manipulation is an appropriate treatment." (42 CFR 405.232b(c)). Not included for coverage were other services that chiropractors were licensed in some states to perform, including: an initial diagnostic visit, adjunctive services (physical therapy), routine laboratory work and, most important, x-rays which are required by the legislation to justify treatment.

#### Utilization of and Expenditure for Chiropractic Services Under Medicare

The national figures on Medicare utilization of chiropractic services show minority but growing demand by the elderly for such care, with a rapid rate of growth for expenditures.

- o In calendar year 1984, total Medicare expenditures for chiropractic services were greater than \$93.6 million, as compared with \$38.2 million in 1979 and \$19.2 million in 1975. The average annual rate of growth in Medicare expenditures for chiropractic services between 1975 and 1984 was 18.7%. (An anticipated 50% growth in the number of chiropractors over the next five years will probably increase this rate of growth.)
- o A report from the National Medical Care and Utilization Survey (published in 1984 by the National Center for Health Statistics) estimates that in 1980, 5.2% of the U.S. population, age 65 and over, received services from a chiropractor. This is greater than the percentage of persons in this age group which received services from a podiatrist (4.4%), and less than received services from an optometrist (9.2%), a nurse (18.1%) or an MD/DO (76.7%).
- o OIG analysis of HCFA's 1983 prevailing charge summary data showed that manual manipulation of the spine was the 9th most frequently billed procedure under Medicare in 1983. This was exceeded only by such routine services as urinalysis, complete blood count, blood sugar, and follow-up hospital and office visits.

### III. Chiropractic Today: A Continuing Paradox

Because heated controversy regarding chiropractic theory and practice continues to exist, it was decided early in the study to examine Medicare issues in the context of how the profession views itself and is viewed by others. On-site and telephone discussions with chiropractors, and their schools and associations, coupled with a review of background materials (many of which were provided by respondents) result in a picture of a profession in transition and containing a number of contradictions.

#### Growth of Acceptance by Patients and Society

Despite historical opposition from organized medicine, there has been a steady growth in the acceptance of chiropractic as a profession. There are now about 24,000 chiropractors in the United States and in 1985, 9847 students were enrolled in 15 chiropractic colleges. About 4% of the total US population receives some services from a chiropractor each year. As the result of law suits and other pressures, the American Medical Association has revised its code of ethics to allow some cooperation between physicians and chiropractors. Similarly, the Joint Commission on the Accreditation of Hospitals has revised accreditation standards to allow hospitals the option of including chiropractors on their staffs.

Chiropractors have been quite successful in obtaining recognition from Federal and State governments, and have been included in many governmental programs. For example:

- o Chiropractors are now licensed in all states, although there is considerable variation in statutory definitions of the profession and of its scope of practice.
- o Chiropractic services have limited coverage under Medicare and under Medicaid programs in about half the states. In all states, chiropractic services are covered under worker's compensation programs.
- o In 20 states, legislation has been passed which mandates either coverage or offering of coverage of chiropractic services under private health insurance policies.
- o Federal financial assistance is available to chiropractic students under the HEAL program. However, chiropractic colleges in general receive no state support.

## Professional Organization and Practice

Chiropractors have organized their professional and educational structure into a format which to some extent mirrors mainstream medicine. There are two major (and competing) national organizations, the American Chiropractic Association and the International Chiropractors Association, state and local societies, specialty boards, a national Board of Chiropractic Examiners and a Council on Chiropractic Education which recommends policy and sets accreditation standards for chiropractic colleges across the United States.

Within the profession, there continues to be a debate between "straight" chiropractors who limit their activity to spinal manipulation therapy and "mixers" who use a variety of therapeutic techniques, most often different forms of physical therapy. It is recognized by many chiropractors that elaborate claims for universal efficacy of chiropractic care have been greatly overstated in the past, but there continues to be some disagreement within the profession regarding which conditions are appropriate for chiropractic care and regarding appropriate parameters for treatment.

During the field visits, chiropractors were asked how they viewed their position within the larger health care delivery system, and their relationship with orthodox medicine. The respondents maintained that, for many patients, the chiropractor can and should serve as a sort of gatekeeper, doing an initial diagnostic work up on patients, referring those for which chiropractic care is inappropriate. It is for this purpose that many chiropractors are seeking greater access to hospital diagnostic resources and physical therapy facilities, and expansion of their scope of practice in states where their activity is limited. However, many also conceded that most patients at an initial visit present such complaints as headaches or lower back pain, and view the chiropractor as a specialist dealing with a limited set of conditions.

Many of the respondents stressed the value of expanded scientific inquiry into the efficacy of chiropractic, and welcomed the continued upgrading of curriculum and admission standards at the colleges. They were eager to point out the increased time the colleges have allocated to teaching the basic sciences and stressed the increased numbers of PhDs on their faculties from such disciplines as chemistry, physiology, nutrition, etc.

## The Problem Side of Chiropractic

Despite the evidence which was presented during the study regarding the increased emphasis on science and

professionalism in the training and practice of chiropractors, there also exist patterns of activity and practice which at best appear as overly-aggressive marketing and, in some cases, seem deliberately aimed at misleading patients and the public regarding the efficacy of chiropractic care. Teaching materials provided by one chiropractic college warn students of "cultists" within the profession which on one side are "anti-diagnosis, anti-therapeutics, pseudo-religious and stress one cause/one cure"; and, on the other extreme, use a "plethora of questionable elixirs, pseudo-medical concepts regarding treatment of specific disorders, and practice a variety of (questionable) healing philosophies."

During the study, discussions were held with reform-minded chiropractors who are in the process of forming a separate professional group of practitioners, the National Association of Chiropractic Medicine, that would set strict standards of ethical conduct and practice, and would actively work in cooperation with consumer groups and others to expose and rid the profession of questionable activities. To date, this group appears to have attracted only a small proportion of the profession. During the discussions, some representatives of schools and associations recognized that there continue to be problems with some of the chiropractors, but emphasized their minority status within the profession.

Examples of problem situations gathered during field visits included:

- o Practice-building courses, popular with many chiropractors, advocate advertising techniques which suggest the universal efficacy of chiropractic treatment for every ailment known to humans. The chiropractor's staff is encouraged to reinforce this message even in regard to a patient's questioning the continued use of medication and other therapies prescribed by other physicians for life-threatening conditions and venereal disease.
- o A newspaper in Iowa published a multi-part story on chiropractic where a reporter visited many chiropractors and got many different conflicting diagnoses and proposed treatment plans.
- o There was testimony regarding patients who, on the basis of a limited examination, had been encouraged to sign contracts for a multi-year course of chiropractic therapy (payable in advance by Mastercharge, Visa or in easy installments).

- o A major television station in Chicago did an expose of cancer scams which heavily involved chiropractors in Illinois.

Prior to the start of this program inspection, OIG regional studies had uncovered problems with chiropractors via a vis federal programs. Independent studies of chiropractic services conducted by the Chicago, Philadelphia and New York regional offices found serious recordkeeping problems. The office records did not support diagnostic information submitted with the claim; frequently, little else was documented beyond the patient's payment record (i.e. no complaint, no examination notes, no treatment notes or progress notes, no documentation for the taking of or evaluation of x-rays, etc.) Treatments billed for spinal ailments were in fact treatments for sinus problems, bed wetting, crossed eyes, sprained wrist. A review of office records showed patients receiving regular treatment, with little or no change, over long periods of time, some going as far back as late 1960s and early 1970s. In addition:

- o For a sample of 21 patients, one New York chiropractor was unable to furnish treatment records for 19 patients, or x-rays for 16 patients.
- o A Pennsylvania chiropractor billed Medicaid for the same-day treatment of a nine-member family, with no documentation of such in the office records.
- o The Atlanta Regional Office has investigated a chiropractor who, using a medical doctor's provider number and signature stamp, billed Medicare for the x-rays and office visits, and also for physical therapy which was provided (if provided at all) by the chiropractor.

Some of these problems are not unique to chiropractors. But, at a time when chiropractors are pursuing greater legitimacy in the competition for limited health care dollars, caution should be exercised before any changes in coverage are considered.

#### IV. Chiropractic Under Medicare

The Social Security Act limits Medicare coverage for chiropractic services to "treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist." Because chiropractic theory regarding illness differed so greatly from mainstream medicine, the x-ray requirement was written into the benefit as an attempt to "control program costs by insuring that a subluxation actually exists" (from a 1978 GAO review of Medicare coverage of chiropractic). The consensus, from the chiropractic community as well as representatives of the health care field, is that the x-ray requirement has not served this purpose. As noted previously, Medicare expenditures for chiropractic services have increased at an annual rate of 18.7% between 1975 and 1984.

The responses in the telephone survey (supported by information gathered during the field visits) brought into question some of the other basic assumptions inherent in the coverage. There was no clear consensus as to what a subluxation is; furthermore, in the telephone survey:

- o The majority (81%) stated that, on an older person's x-ray, more "wear and tear," osteoarthritis and osteoporosis will show up, and not subluxations per se.
- o The majority of respondents (84%) said that there are subluxations that do not show up on x-rays.
- o Nearly half stated that, when billing Medicare, they "could always find something" (by x-ray or physical examination) to justify the diagnosis, or actually "tailored" the diagnosis to obtain reimbursement.
- o Many respondents in the telephone survey, in advocating a change in the benefit, volunteered that the majority of their Medicare patients had chronic conditions that would never be corrected, and were receiving what was essentially palliative or maintenance care for those conditions.

These responses raise serious questions as to the extent that Medicare is paying for conditions that do not meet the original intent of the law.

#### Subluxations and the X-ray Questions

Previous regional studies of selected chiropractors raised serious questions as to whether chiropractors were billing

-only for treatment of subluxations visible on x-rays, as specified by the Medicare benefit. The 1974 ACA guidelines for Medicare claims review (later withdrawn) stated:

"subluxations ... demonstrable by x-ray represent only a relatively small portion of spinal subluxations treated by Chiropractic Physicians. Clinical subluxations not necessarily demonstrable by x-ray, constitute the majority of spinal subluxations successfully treated by Chiropractic Physicians."

In our current study, the on-site discussions with chiropractic schools and associations went even further. As was summarized at one school: subluxations are a minor part of chiropractic practice, the term itself is out-of-date, and the x-ray requirement is a distortion of chiropractic which forces chiropractors to state a subluxation is present on an x-ray even when it is not.

Based on a 1979 New Zealand study of chiropractic praised by chiropractors in its fairness to their profession, chiropractors in the telephone survey were asked whether there were different categories of subluxations (such as "structural" and "functional") and whether there are subluxations that do not show up on x-rays. According to the New Zealand report, "structural" subluxations are generally visible on x-rays; "functional" subluxations may not be evident on x-rays because they relate to the functioning of a joint, as in impaired range of motion. While no clear consensus emerged around the structural/functional distinction itself, 84% of the respondents in this current study said that there are subluxations that are not visible on a standard x-ray, and their descriptions generally related to function (fixations, hyper/hypo-mobility).

Having gotten a consensus that some subluxations are not visible on x-rays, respondents gave a very different set of answers when asked whether chiropractors do anything different in treatment or billing when a Medicare patient's x-ray does not show a subluxation:

- o 29% stated that one could "always find something" on the x-ray to justify the billing, but there was wide divergence as to whether this "something" correlated to the patient's complaint or treatment.
- o 10% indicated that if they determined the subluxation by other means (i.e. physical examination and palpation) they billed it as though it appeared on the x-ray;

- o 6% actually said they "adapted" their diagnosis to "what Medicare wants to hear." As one chiropractor said, "Do we change the diagnosis? I'll find a millimeter out of alignment or rotated on any x-ray ... It's called 'the insurance game'... I don't consider it lying - it's just learning how to function within the system ... [for example,] when you get to the allowed number of treatments, change the subluxation up or down one and give a new date of onset."

Examining the responses about the appropriateness of x-rays in relation to the age of patients helps provide at least an internal logic to the apparent contradictions in these responses. Eighty-one percent of the respondents indicated that the older a person, the greater the likelihood of conditions showing up on x-rays; however 87% of this subgroup specified general degeneration of the spine, osteoarthritis, osteoporosis, and not subluxations per se, as the kinds of things that would show up. The implication is that although there are subluxations that do not show up on x-rays, a chiropractor "can always find something" on an older person's x-ray that for Medicare purposes can be related to, or reinterpreted as, a subluxation.

The cost of an x-ray to justify Medicare reimbursement can often exceed the total reimbursement for the treatments themselves. Almost every chiropractor interviewed complained that this high initial expense was unfair to a patient already on a limited income. However, a great many chiropractors, including those who disagreed with the x-ray requirement, admitted that they would x-ray the Medicare age group anyway, either to rule out inappropriate conditions (e.g., cancer) or to protect themselves from malpractice suits. This becomes an important consideration when looking at the requested coverage changes below.

#### Desire for Expansion of Medicare Coverage.

At the beginning of each telephone interview and again at the end, chiropractors were queried about changes they would like made in the Medicare benefit. Far and away, the biggest response (68%) was for coverage/reimbursement of x-rays. Thirty-one percent felt the x-ray requirement should be changed or eliminated, but many felt the x-ray should be reimbursed even if the requirement were dropped. From the discussion in the previous paragraph, it is unclear whether dropping the x-ray requirement will result in significantly fewer x-rays. Any shifting of x-ray costs from the patient to the program could mean substantial increases in Medicare expenditures.

Thirty-seven percent of the respondents felt that Medicare should expand coverage to include more or all of the chiropractors' scope of practice (i.e. what they had been taught and are licensed to perform). Linked with this group were 17% who specifically wanted coverage for physical therapy by chiropractors, 8% who wanted coverage for the initial examination, and 13% who wanted parity in coverage and/or reimbursement with mainstream medical practitioners. 18% recommended the liberalization or elimination of the limits on the number of allowable visits. The implementation of any of these recommendations would result in significant increases in Medicare payments, with no new effective control over quality or quantity of services.

The chiropractic schools and professional associations voiced support for all of these changes. In addition, many school representatives spoke of the need for federal funding for research, comparable to the research money available to medical schools.

As noted previously, it is unclear to what extent Medicare now pays for treatment of conditions that do not meet the original intent of the law. The chiropractic community seems to sidestep rather than clarify the ambiguities involved in the current program while requesting a major increase in coverage and costs for the Medicare program.

V. Billing and Payment Patterns for Chiropractors in the Sample

The actual pay-out of Medicare dollars for chiropractic services depends on both the volume and variety of claims which are submitted for payment and on how Part B carriers review and process them. There are differences in treatment philosophy and practice between chiropractors (as well as differences in patient preference) which result in a wide variance in both the number of services billed and in the types of covered and non-covered services that are included. As indicated above, there is a significant (but undetermined) volume of billing for correction of subluxations that do not show up on an x-ray.

Carriers have systems in place to deny claims for some non-covered services (e.g. physical therapy) but not others (e.g. manipulation of the spine where the subluxation is not demonstrated by x-ray). They have no common standards to determine the appropriate frequency of covered services and there is little consistency among carriers in the number of covered services per patient that are approved for payment. Less than 6% of all services billed are denied for utilization reasons. Because claims for chiropractic care include many services at small cost, and because the review of claims (beyond determination of completeness, and whether a service is covered) is labor intensive and expensive, carriers seldom review actual x-rays or office records. Denial of claims flagged by utilization screens has relatively little effect on Medicare payout. (See Appendix B for a more detailed discussion of these patterns than is presented below.)

## Billing Patterns

The average number of services billed for a patient in the sample was 13.4 and the average number allowed for payment was 10.4. The average total dollars billed for a patient was \$224, the average allowed was \$131 and the average paid was \$87. The average number of Medicare patients served by a chiropractor in the sample was 39.

These averages, however, mask the diversity across the full range of the scale. At the low end, about 28% of the patients only received between 1 and 5 services in a year that were billed to Medicare. At the high end, however, 19% of the patients received more than 20 services, almost half (47%) of all services billed. In the sample 14.3% of the chiropractors on average billed for more than 20 services for each Medicare patient seen.

## Payment Patterns by Carriers

The Medicare Carriers Manual recognizes the somewhat ambiguous position of chiropractic and states that:

"Implementation of the chiropractic benefit requires an appreciation of the disparate orientation of chiropractic theory and experience and those of traditional Medicine since there are fundamental differences regarding the etiology and theories of the pathogenesis of disease" (Sec. 2250)

The manual presents a system for classifying subluxations, a general discussion of treatment parameters and a schema for relating various symptoms to a particular area of the spine. The manual also lists examples of conditions for which manual manipulation of the spine is not an appropriate treatment. Some critics have suggested that this system has provided a blueprint for some chiropractors to work backward to identify the appropriate location of a subluxation for billing purposes, as opposed to treating and billing for a subluxation which has been identified on an x-ray.

Claims for payment for chiropractic services must include a statement of diagnosis and symptoms, specify the precise level of the spinal subluxation and must indicate that an x-ray film is available for carrier review. The carriers appear to spend a considerable amount of time assuring that the documentation on the claim is complete, but seldom is an actual x-ray or office record reviewed. Most carriers have instituted automated systems which (if the procedure is coded correctly) reject claims for non-covered services such as x-ray or physical therapy. The carriers have set up their own frequency parameters which flag for review the claims of patients whose number of covered services exceeds the carrier's established thresholds for review. There is little consistency nationally, and none at all in the sample carriers, regarding these parameters.

In the sample, 22% of all services submitted for payment were denied by the carriers. Of these, 16.7% were denied more or less automatically because they were duplicate bills or non-covered services, while only 5.3% were denied because they exceeded frequency parameters or failed to meet other utilization review criteria. There was little consistency among carriers in their overall denial rates which ranged in total between 2.7% and 47% of all services. Similarly, denials for non-utilization reasons ranged between 0.3% and 32.2%, and denials for utilization ranged between 0.8% and 14.8%.

An examination of how individual chiropractors fared in relation to the intensity with which they treated patients or billed for services showed only a limited relationship. Chiropractors that on the average billed for more than 20 covered services per patient per year had 20.6% of their covered services denied, but there was little variation in the percent of covered services denied for groups of chiropractors that on the average billed for 20 or fewer services per patient per year.

In order to bring at least partial consistency to frequency screens, HCFA in the fall of 1984 set up a pilot project which would require some carriers to review all claims for chiropractic care for chronic cases that exceeded one treatment per month. However, there was no common definition provided for chronic care. At the time this study was begun, there had been only partial participation in this project and at least one of the participants had modified HCFA's mandated frequency screens because too many cases would have been selected for additional intensive review.

When processing chiropractic claims, the carriers have had to individually impose administrative order on a situation where the standards for evaluating x-ray documentation are ambiguous and there is no consensus regarding the number of services a patient should receive. It seems clear that the x-ray requirement is ignored by some chiropractors. On a benefit/cost basis, the x-ray requirement may be unenforceable. This suggests the need for a change in the benefit which would provide a workable approach to limiting utilization as originally intended by Congress and which would reflect somewhat more clearly the current realities of chiropractic practice.

## VI. Recommendations

- o HCFA and the Department should vigorously oppose any movement to expand the coverage of chiropractic services to include an initial diagnostic visit, x-ray, laboratory services or adjunctive therapy. In the absence of effective utilization controls, the cost of these proposals would more than double the cost of chiropractic care under the Medicare benefit in the next several years (from \$93.6 million in CY 84 to more than \$260 million in CY 87.)

Legislation was introduced in the 98th Congress which would remove the x-ray requirement for justifying chiropractic services and would expand Medicare coverage to payment for an appropriate x-ray, physical examination and related routine lab tests. Chiropractic associations and individual practitioners would also like to see coverage of adjunctive (physical therapy) services.

The financial impact of expansion would be great. A survey done by the American Chiropractic Association indicates that in 1984, the median bill for an initial visit to a chiropractor, including diagnostic tests, x-ray etc, was about \$110. If bills at this amount were submitted for only half of the patients seen by chiropractors in the sample (and paid at 80%), the Medicare expenditures for the sample would increase more than 50%. Coverage of physical therapy would at a minimum increase cost by another 16% (the amount denied by carriers in the sample for non-covered services). Under an expanded program, (and assuming an annual rate of growth in the cost of chiropractic services of 18.7%) it is projected that in CY 87, total annual cost to Medicare for chiropractic services would more than double to \$260 million. Given Medicare history relative to coverage of other physical therapy services, and the 50% expected increase in chiropractors over the next five years, the amount would probably be greater.

- o HCFA and the Department should consider submitting a legislative proposal to Congress which would:
  - Continue to limit Medicare coverage of chiropractic services to manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist.
  - Cap the number of services for which a patient could receive payment at 12 per year. All covered services over 12 visits would be automatically denied. (\$23.9 million savings in CY 87.)

The carriers have in place systems which for the most part routinely deny payment for non-covered services, such as x-ray, laboratory tests or physical therapy, provided by chiropractors. However the requirement that Medicare cover only the treatment of those subluxations demonstrated by x-ray is not well enforced and may be unenforceable. Although the chiropractors in this study admit they sometimes bill for services in cases where the subluxation is not clearly demonstrated by x-ray, the carriers have not found x-ray review to be cost effective. This is because there is little agreement among carriers, chiropractors or others regarding the criteria which should be used to determine which conditions of the spine (shown on an x-ray) are actually subluxations which require treatment. X-ray review is also labor intensive, relatively expensive and often the last step in the process of determining which claims should be paid.

In addition, the carriers indicate that even when an x-ray clearly shows a subluxation, there are no agreed upon standards regarding the appropriate number of services (manipulations) required to treat a given acute or chronic condition. Similarly, neither national chiropractic association has approved or endorsed any utilization review criteria. Given the ineffectiveness of these brakes on costs and utilization, a 12 service per year cap is recommended.

The impact of a 12 service cap on patients would be minimal. It would allow patients with chronic conditions one treatment a month and would encompass the number of services provided to a majority of the patients needing acute care. (Over two thirds of the patients in the sample received less than 12 covered services per year.) Patients who do not respond after 12 treatments would still have the option of seeking additional services in the traditional medical care system. The cap would also provide both patients and chiropractors with a known level of coverage against which treatment decisions could be made. The imposition of a cap would be similar to the dollar limitation which has been imposed on outpatient psychiatric services and on services provided by independent physical therapists.

In December 1985, HCFA mandated all carriers to implement a screen on chiropractic claims set at 12 services per year.

The manual issuance requires that "[m]edical necessity determinations must be made on all claims where the parameters are exceeded." Carriers are required to "[r]eview both those claims which exceed the parameters and those which do not." However there remains the question of what standards should be used to evaluate these claims.

If this screen is implemented with a level of development and review sufficient to deal with the problems raised by this inspection, the burden on the carriers could be quite heavy. We estimate that between 31% and 56% of the Medicare patients receiving chiropractic services will have their claims examined. This is the range between the proportion of patients with 12 or more approved services and the proportion with 12 or more billed services. Some will require more than one review because they will submit claims after the first batch of 12 is examined or because they are treated for more than one acute episode.

If a well developed review (with examination of an x-ray) costs at least \$10, if 5.2% of the 31 million Medicare patients with part B coverage see a chiropractor each year, if 43.5% require review, and if each patient in the sample is reviewed 1.5 times, then the annual cost to the carriers will be \$10.5 million. Since HCFA requires a 5 to 1 return on medical review/utilization review, the carriers would have to reduce total chiropractic pay out almost 50% to meet the standard. It may be argued that some reviews can be done for less than \$10, but these would involve no additional contact with the chiropractor, no x-ray review and no consideration of evidence other than that which is submitted on the face of the claim.

Based on sample data, a 12-visit cap would annually save about 8.6% in Medicare expenditures for chiropractic services. Assuming an 18.7% annual rate of growth of the billings for chiropractic services, this would amount to about \$13.4 million in savings from reduced payment for services in CY 87. To this can be added a reduction of \$10.5 million per year, the estimated additional cost of the HCFA mandated screens, for a total savings of \$23.9 million a year. (See Appendix C for a further discussion of the derivation of the impact of the cap.)

- o The Department should examine the ways in which it can further encourage the submission of scientific research proposals by chiropractic colleges, which meet the standards applied to other projects supported by the National Institutes of Health.

As chiropractors seek access to mainstream resources and look for acceptance by a larger portion of the society, there would be value for all parties in finding a meeting ground where issues could be examined within a common set of ground rules and definitions. Increased access to research funding by chiropractic colleges would provide one point of mutual interaction between chiropractors and other health professions, and would serve to enhance the position of those segments of the profession that seek to improve the quality of chiropractic education and who would work to limit the use of questionable diagnostic and therapeutic techniques used by some chiropractors.

## Appendix A

### Sampling Methodology for Telephone Survey and Review of Provider Histories

In order to obtain a representative sample of carriers, providers and patients for use in the telephone survey and in review of provider histories, the following steps were taken:

- (1) OIG headquarters staff obtained from HCFA a print-out of "Part B Expenditures for Chiropractors by Type of Service, Payment Records Processed 1/83 - 12/83." Each carrier's percentage of total dollars paid was determined and multiplied times 10,000. Each carrier was assigned sequentially a block of numbers equal to its share of 10,000. Eg, carrier #1 was assigned numbers 1-154, carrier #2, numbers 155 - 245, etc.
- (2) Ten numbers from a range of 1 to 10,000 were selected using a random number table, and carriers were selected whose block of numbers encompassed the selected numbers. Because we were sampling with replacement, 6 carriers were selected once and 2 carriers came up twice.
- (3) From each carrier that was selected, a list of current chiropractors with provider numbers was requested. Using a random number table, 20 provider numbers were selected from each of the carriers that came up once and 40 chiropractors were selected from the 2 carriers that came up twice.
- (4) Of the 200 chiropractors selected, telephone discussions were completed with 145.
- (5) A complete provider history for CY 83 was requested for each provider selected. Because the list of provider numbers was current, but the billing histories were over a year old, only 152 provider histories were obtained.

## Appendix B

### Expanded Discussion of Treatment, Billing and Payment Patterns for Chiropractors in the Sample

#### Treatment and Billing Patterns

Of the 200 randomly selected chiropractors, 154 had payment histories indicating services had been billed for one or more Medicare beneficiaries in 1983. The remaining 46 chiropractors had an active Medicare billing number, but no bills had been received for processing because they were not then serving Medicare patients, or had moved, retired or expired. The 154 chiropractors served 5964 patients and provided 79,775 services that were billed to Medicare. The total dollar value of these services billed was \$1,337,604, the amount allowed \$785,349, and the amount paid \$516,499.

- o The average number of services billed for a patient was 13.4 and the average number allowed was 10.4.
- o The average total dollars billed for a patient was \$224, the average allowed \$132, and the average paid \$87.
- o The average number of Medicare patients served by a chiropractor (for which a bill was submitted) was 39.
- o The average total number of services billed by a chiropractor for all patients served was 518, and the average number of services allowed and paid was 404.
- o The average total dollar value of services billed by a chiropractor was \$8686, allowed was, \$5100, and paid \$3354.

But further consideration should be given to patterns at the high and low ends of the treatment scale. Table 1 below presents a breakdown of patients and services by frequency of services billed per patient. Table 2 illustrates treatment patterns in a somewhat different way by grouping chiropractors according to the average number of services billed for all the patients in their practice; and showing the percent of all patients served by each group of chiropractors and the percent of all billed services that were provided.

Table 1

Number, Percent, and Cumulative Percent of Patients and Services Billed by Number of Services Billed Per Patient

Number of Services Billed	Number of Patients	% of Patients	Cumulative % of Patients in Sample	Number of Services Billed	% of All Services Billed	Cumulative % of Services Billed
1-5	1,688	28.3%	28.3%	5,185	6.5%	6.5%
6-10	1,449	24.3	52.6	9,015	11.3	17.8
11-15	1,038	17.4	70.0	16,035	20.1	37.9
16-20	644	10.8	80.8	11,727	14.7	52.6
21 +	1,145	19.2	100%	37,813	47.4	100%
Total	5,964	100%		79,775	100%	

As indicated in Table 1, about half (52.6%) of the patients in the sample received 10 or fewer services that were billed to Medicare. This is fairly evenly divided between the 28.3% of the patients that received between 1 and 5 services and the 24.3% that received between 6 and 10 services. At the other extreme, 19.2% of the patients received more than 20 services and accounted for almost half (47.4%) of all services billed. The distribution of these high-use patients tapers off fairly quickly, but extends far to the right. For example, 11.7% of the patients received between 21-30 services (25% of all services billed), and 4.1% of the patients received between 31-40 services (11.2% of all services billed). The highest user was a patient that had 153 services billed to Medicare in 1983.

**Table 2**

Number, Percent, and Cumulative Percent of Chiropractors, Patients Served and Services Billed by Average Number of Services Billed Per Patient

Average Number of Services Billed Per Patient	Number of Chiropractors	% of all Chiropractors (Cum. %)	Number of Patients Served	% of all Patients Served (Cum. %)	Number of Services Billed	% of all Services Billed (Cum. %)
1-5	19	12.3% (12.3%)	200	3.4% (3.4%)	807	1% (1%)
>5-10	38	24.7 (37)	1,253	21.0 (24.4)	10,213	12.8 (13.8)
>10-15	55	35.7 (72.7)	2,710	45.4 (69.8)	33,626	42.2 (56)
>15-20	20	13.0 (85.7)	1,315	22 (91.8)	23,309	29.2 (85.2)
>20	22	14.3 (100%)	486	8.2 (100%)	11,820	14.8 (100%)
Total	154	100%	5,964	100%	79,775	100%

Table 2 provides a view of the billing and service patterns of chiropractors in the sample broken out by the relative intensity of their practice - the average number of services billed for each Medicare patient they served. The median chiropractor provided on the average between 10 and 15 services that were billed. At the low end 12.3% of the chiropractors (serving 3.4% of the patients) averaged between 1 and 5 services per patient. At the other end, 14.3% of the chiropractors averaged more than 20 services per patient, served 8.2% of all patients in the sample, and accounted for 14.8% of all services billed.

There are a number of explanations for these differences in billing patterns. Although Medicare pays only for manual manipulation of the spine, some chiropractors obviously provide other services such as x-ray and adjunctive services which are included on the bills submitted. In addition, there continue to be differences in treatment philosophy between "straights" and "mixers" which might account for some variation. Chiropractors also have differing views regarding which conditions are appropriate for chiropractic treatment and there are indications that a proportion of the profession advocates regular maintenance and preventive care that may not be specifically related to either an acute episode or a specific, chronic condition. There are no commonly accepted frequency parameters for care which have been agreed upon at the national level by the profession, and standards previously adopted have been withdrawn.

An important reason for the variation in frequency which must be considered is patient preference. The high percentage of patients receiving between 1-5 and 6-10 services, suggests that there are a number of elderly persons who go to a chiropractor seeking relief for a particular acute episode or who may see a chiropractor briefly and discontinue treatment. There are also economic incentives (co-payments and deductibles) which would operate to modify utilization all across the scale.

#### Part B Carrier Processing and Payment of Claims

The actual payment for chiropractic services under Medicare depends on the processing of claims by the Part B carriers. The Medicare Carrier Manual recognizes the somewhat ambiguous position of chiropractic and states that:

"Implementation of the chiropractic benefit requires an appreciation of the disparate orientation of chiropractic theory and experience and those of traditional medicine since there are fundamental differences regarding the etiology and theories of the pathogenesis of disease." (Sec. 2250)

The Medicare Carrier's Manual presents a system for classifying subluxations, a very general discussion of treatment parameters and a schema for relating various symptoms to a particular area of the spine. The manual also lists examples of conditions for which manual manipulation of the spine is not an appropriate treatment, e.g. rheumatoid arthritis, muscular dystrophy, multiple sclerosis, emphysema, etc. Some critics have suggested

that this system provides a blueprint for some chiropractors to work backward to identify the appropriate location of the subluxation based on a complaint, as opposed to treating a subluxation which has been identified on an x-ray or by other means.

Claims for payment of chiropractic services require more documentation than is required for comparable services provided by an MD or DO. In addition to a statement of a diagnosis and symptoms, a claim for chiropractic services must:

"Specify the precise level of spinal subluxation, contain certification on all bills by the treating chiropractor that an x-ray film is available for carrier review demonstrating a subluxation at the specified level of the spine; and include identification of the treatment phase and adjustment - e.g. second, fifth, tenth treatment." (Sect. 4118B)

The carriers appear to spend a considerable amount of time assuring that written documentation is available on the face of the claim submitted. Claims without this documentation should routinely be denied. But only in the most unusual cases is there any review of a chiropractor's actual office records to compare what is written on the claim with what has been recorded in the patient's history. Seldom is an actual x-ray film reviewed. One chiropractor that serves on a carrier professional review committee, interviewed as part of the field study, described the quality of some office records and x-rays that he had reviewed as an embarrassment to the profession.

Most of the carriers have instituted claims processing systems which should (if the procedure is coded correctly) easily and automatically reject all claims for non-covered services such as x-ray, laboratory or physical therapy provided and billed by a chiropractor. As indicated and discussed further below, over 75% of all the rejections of services for payment are on the basis of lack of documentation or for submission for payment of a non-covered service.

Once non-covered services have been eliminated, the covered manual manipulation of the spine services are evaluated for necessity. The carriers have set up their own frequency parameters which flag for review the claims of patients whose number of covered services exceeds the carrier's established limits. There is little consistency nationally, and none at all among the carriers in the sample, regarding these frequency screens.

In order to bring at least partial consistency to these frequency screens, HCFA in the fall of 1984 set up a pilot project, which would require some carriers to review all claims for chiropractic care for chronic cases which exceeded one treatment per month. However, there was no common definition provided for chronic cases. At the time this study was begun, there had been only partial participation in this pilot project, and at least one of the participants had modified HCFA's mandated frequency screens because too many cases would have been selected for additional intensive review.

The extreme variation in dealing with chiropractic claims among carriers in the sample is illustrated in Table 3 below which presents the number and percent of services denied by each carrier in its sample, broken down by "Non-UR" (non-covered services, etc) and UR (Exceeding frequency screens, etc.) reasons.

**Table 3**

**Number of Services Billed and Number and Percentage of Services Denied by Non-Utilization Review and Utilization Review Categories.**

Carrier	Services Billed In Sample	Number and % of Services Denied		
		Non-UR (%)	UR (%)	Total (%)
A	10,972	37 (0.3%)	265 (2.4%)	302 (2.7%)
B	9,979	556 (5.6)	661 (6.6)	1,217 (12.2)
C	4,698	177 (3.8)	247 (5.3)	424 (9.0)
D	10,418	2,280 (21.9)	147 (1.4)	2,427 (23.3)
E	14,430	3,904 (27.1)	122 (0.8)	4,026 (27.9)
F	11,805	1,553 (13.2)	960 (8.1)	2,513 (21.3)
G	10,073	3,245 (32.2)	1,493 (14.8)	4,738 (47.0)
H	7,400	1,600 (21.6)	351 (4.7)	1,951 (26.3)
Total	79,775	13,352 (16.7%)	4,246 (5.3%)	17,598 (22.0%)

As indicated in Table 3, 22% of all billed chiropractic services presented for payment are denied. This ranges among carriers from 2.7% to 47.0%. Denial rates for non-UR reasons range from 0.3% to 32.2%, and averages 16.7%. Denial for UR reasons range from 0.8% to 14.8% and averages 5.3%. Over 75% of all denials are for non-UR reasons; that is, the services were not covered by Medicare. Less than 25% are because the number of services provided exceeded one of the various frequency screens. Given the low dollar amount paid per chiropractic service, low rate of UR denial and the high cost of development, the IG seriously questions the cost effectiveness of edits in controlling chiropractic utilization.

Another way of considering the carrier's handling of claims is to examine the patterns of denials for utilization reasons after claims for non-covered services and duplicate bills have been removed. Table 4 below shows distribution of chiropractors, the number of patients they serve and services they bill arrayed by the relative intensity of covered services (total services billed less non-covered services) which they bill. It also shows the relative denial rates for covered services which were billed.

Table 4

Number and Percent of Chiropractors, Patients Served and Services Billed after Denial for Coverage; and Percent of Services Denied for Utilization Review Reasons by Average Number of Services Billed per Patient after Denial for Non-covered Services

Average Number of Services Billed Per Patient After Denial for Non-covered Services	Number of Chiropractors (%)	Number of Patients Served (%)	Number of Services Billed After Denial for Coverage (%)	Percent of Services Denied for UR
1-5	21 (14%)	284 (4.8%)	1,103 (1.7%)	1.5%
>5-10	56 (38)	2,155 (36.2)	16,769 (25.2)	4.1
>10-15	49 (33)	2,308 (38.7)	28,246 (42.5)	7.7
>15-20	15 (10)	1,117 (18.7)	17,986 (27.1)	5.0
>20	7 (5)	93 (1.6)	2,319 (3.5)	20.6
Total	148 (100%)	5,957 (100%)	66,423 (100%)	6.4%

As indicated in Table 4, over 10% of the chiropractors in the sample (serving 18.7% of the patients) bill for an average of between 15-20 covered services (manual correction of a subluxation) per year. Approximately 5% of the chiropractors (serving about 1.6% of the patients) bill for an average of more than 20 services per year. As would be expected, the carriers rejected for payment only 1.5% of the covered services billed by chiropractors who bill for between 1-5 services per patient. There is relatively little difference in the denial rates for providers who billed between 5-10, 10-15 and 15-20 services per year. The carriers denied 20.6% of covered services for chiropractors that billed for more than 20 services.

Across the board, however, there is no statistical relationship between the average number of covered services billed and the denial rate for services that exceed frequency parameters. That is, knowing the relative intensity with which a chiropractor provides covered services to his patients does not allow one to predict at what rate services will be denied because frequency or other UR screens are exceeded.

## Appendix C

### Estimation of the Effect of a 12 Service Cap

- 1) For the 152 chiropractors in the sample that billed patients for one or more services in CY 83, the following information was gathered: total number of services billed and allowed; total dollars billed, allowed and paid; total number of patients served; total number of services denied for (a) utilization and (b) non-utilization reasons, and total dollar value of services denied for (a) utilization reasons.
- 2) It was assumed that the effect of a cap could only be projected on the basis of a reduction in allowed services and allowed dollars. That is, no credit could be taken for any reduction in billed services that the carriers would have made had there not been a cap in effect.
- 3) The average number of allowed services per patient (total allowed services/total patients served) was determined for each chiropractor. The chiropractors were divided into two groups: (A) chiropractors with an average number of allowed services equal to or less than 12 and (B) chiropractors with an average number of allowed services greater than 12.
- 4) A new variable (total dollars paid after the cap) was created for each chiropractor. For chiropractors in the (3A) group (providers with an average number of services allowed per patient equal to or less than 12):

Total dollars paid after the cap =  
Total dollars paid.

For chiropractors in the (3B) group (providers with an average number of services allowed greater than 12.

Total dollars paid after the cap =  
12 X Total patients served x (Total dollars paid/Total services allowed).

- (5) The Percent of dollars saved under the cap =

$$1 - \left( \frac{\text{Weighted } \Sigma (\text{Total dollars paid after cap})}{\text{Weighted } \Sigma (\text{Total dollars paid})} \right) = .085.$$

(6) Because of the lack of availability of data, we were forced to make the final estimate of savings based on the average number of services billed. We know that some patients served by chiropractors with an average number of services per patient allowed equal to or less than the cap, had allowed services greater than the cap; and that some patients served by chiropractors with an average number of services allowed per patient greater than the cap have an allowed number of services less than the cap. For purposes of computation it is assumed these two groups would balance out.

(7) The projected dollar savings for 1987 assumed a 18.7% annual rate of growth and was computed as follows:

Dollar savings in CY 87 =

1984 Medicare expenditures for chiropractic services x  
Annual rate of growth for three years x  
Percent of dollars saved under the cap =

\$93.6 million x (1.187 x 1.187 x 1.187) x .085 =

\$13.3 million.

## Highlights of "Inspection of Chiropractic Services Under Medicare"

The regulations for this benefit further limited coverage to payment "...only for the chiropractor's manual manipulation of the spine to correct a subluxation... which has resulted in a neuromusculoskeletal condition for which manipulation is an appropriate treatment."

OIG analysis of HCFA's 1983 prevailing charge summary data showed that manual manipulation of the spine was the 9th most frequently billed procedure under Medicare in 1983. This was exceeded only by such routine services as urinalysis, complete blood count, blood sugar, and follow-up hospital and office visits.

Within the profession, there continues to be a debate between "straight" chiropractors who limit their activity to spinal manipulation therapy and "mixers" who use a variety of therapeutic techniques, most often different forms of physical therapy. It is recognized by many chiropractors that elaborate claims for universal efficacy of chiropractic care have been greatly overstated in the past, but there continues to be some disagreement within the profession regarding which conditions are appropriate for chiropractic care and regarding appropriate parameters for treatment.

The respondents maintained that, for many patients, the chiropractor can and should serve as a sort of gatekeeper, doing an initial diagnostic work up on patients, referring those for which chiropractic care is inappropriate.

...many also conceded that most patients at an initial visit present such complaints as headaches or lower back pain, and view the chiropractor as a specialist dealing with a limited set of conditions.

...there also exists patterns of activity and practice which at best appear as overly-aggressive marketing and, in some cases, seem deliberately aimed at misleading patients and the public regarding the efficacy of chiropractic care. Teaching materials provided by one chiropractic college warn students of "cultists" within the profession which on one side are "anti-diagnosis, anti-therapeutics, pseudo-religious and stress one cause/one cure"; and, on the other extreme, use a "plethora of questionable elixirs, pseudo-medical concepts regarding treatment of specific disorders, and practice a variety of (questionable) healing philosophies."

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During the study, discussions were held with reform-minded chiropractors who are in the process of forming a separate professional group of practitioners, the National Association of Chiropractic Medicine, that would set strict standards of ethical conduct and practice, and would actively work in cooperation with consumer groups and others to expose and rid the profession of questionable activities. To date, this group appears to have attracted only a small proportion of the profession.

Practice-building courses, popular with many chiropractors, advocate advertising techniques which suggest the universal efficacy of chiropractic treatment for every ailment known to humans. The chiropractor's staff is encouraged to reinforce this message even in regard to a patient's questioning the continued use of medication and other therapies prescribed by other physicians for life-threatening conditions and venereal disease.

A newspaper in Iowa published a multi-part story on chiropractic where a reporter visited many chiropractors and got many different conflicting diagnoses and proposed treatment plans.

There was testimony regarding patients who, on the basis of a limited examination, had been encouraged to sign contracts for a multi-year course of chiropractic therapy (payable in advance by Mastercharge, Visa or in easy installments).

A major television station in Chicago did an expose of cancer scams which heavily involved chiropractors in Illinois.

The office records did no support diagnostic information submitted with the claim; frequently, little else was documented beyond the patient's payment record (i.e. no complaint, no examination notes, no treatment notes or progress notes, no documentation for the taking of or evaluation of x-rays, etc.) Treatment billed for spinal ailments were in fact treatments for sinus problems, bed wetting, crossed eyes, sprained wrist. A review of office records showed patients receiving regular treatment, with little or no change, over long periods of time, some going as far back as late 1960s and early 1970s.

Some of these problems are not unique to chiropractors. But,, at a time when chiropractors are pursuing greater legitimacy in the competition for limited health care dollars, caution should be exercised before any changes in coverage are considered.

The Social Security Act limits Medicare coverage for chiropractic services to "treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by x-ray to exist." Because chiropractic theory regarding illness differed so greatly from mainstream medicine, the x-ray requirement was written into the benefit as an attempt to "control program costs by insuring that a subluxation actually exists"... The consensus, from the chiropractic community as well as representatives of the health care field, is that the x-ray requirement has not served this purpose.

The majority (81%) stated that, on an older person's x-ray, more "wear and tear," osteoarthritis and osteoporosis will show up, and not subluxations per se.

The majority of respondents (84%) said that there are subluxations that do not show up on x-rays.

Nearly half stated that, when billing Medicare, they "could always find something" (by x-ray or physical examination) to justify the diagnosis, or actually "tailored" the diagnosis to obtain reimbursement.

These responses raise serious questions as to the extent that Medicare is paying for conditions that do not meet the original intent of the law.

"subluxations ... demonstrable by x-ray represent only a relatively small portion of spinal subluxations treated by Chiropractic Physicians. Clinical subluxations not necessarily demonstrable by x-ray, constitute the majority of spinal subluxations successfully treated by Chiropractic Physicians."

29% stated that one could "always find something" on the x-ray to justify the billing, but there was wide divergence as to whether this "something" correlated to the patient's complaint or treatment.

10% indicated that if they determined the subluxation by other means (i.e. physical examination and palpation) they billed it as though it appeared on the x-ray;

6% actually said they "adapted" their diagnosis to "what Medicare wants to hear." As one chiropractor said, "Do we change the diagnosis? I'll find a millimeter out of alignment or rotated on any x-ray... It's called 'the insurance game'... I don't consider it lying - it's just learning how to function within the system ... {for example,} when you get to the allowed number of treatments, change the subluxation up or down one and give a new date of onset."

The implication is that although there are subluxations that do not show up on x-rays, a chiropractor "can always find something" on an older person's x-ray that for Medicare purposes can be related to, or reinterpreted as, a subluxation.

...and 13% who wanted parity in coverage and/or reimbursement with mainstream medical practitioners.

within those limits. We find no abuse of discretion in the sentences imposed on the defendant.

The judgment of the district court is affirmed.

AFFIRMED.



228 Neb. 191

191 Ronald Dean RODGERS, Appellee,

v.

Roger SPARKS, Doing Business as Sparks Concrete, and the Hartford Insurance Company, Third-Party Plaintiff, Appellants;

Cornhusker Casualty Company,  
Third-Party Defendant,  
Appellee.

No. 87-599.

Supreme Court of Nebraska.

April 8, 1988.

In workers' compensation proceeding, the Workers' Compensation Court awarded compensation for total temporary disability, loss of earning power, rehabilitation benefits, chiropractic expenses, and attorney's fee, and employer and its insurer appealed. The Supreme Court, held that: (1) duly licensed and practicing chiropractor is competent to testify as expert witness in workers' compensation case within scope of his knowledge according to his qualifications in field of chiropractic; (2) when record presents nothing more than conflicting medical testimony, appellate court will not substitute its judgment for that of workers' compensation court; and (3) finding with regard to causation of workers compensation injury will not be set aside unless clearly wrong.

Affirmed.

1. Workers' Compensation ⇨1417

In workers compensation cases, unless character of injury is objective such as where injury's nature and effect are plainly apparent, injury is subjective condition, requiring opinion by expert to establish causal relationship between incident and injury as well as any claimed disability consequent to such injury.

2. Workers' Compensation ⇨1417

A workers' compensation claimant must show by competent medical testimony causal connection between alleged injury, employment and disability.

3. Administrative Law and Procedure ⇨461, 792

Workers' Compensation ⇨1396, 1704

Duly licensed and practicing chiropractor is competent to testify as expert witness in workers' compensation hearing within scope of his knowledge according to his qualifications in field of chiropractic, and weight of his testimony is question for fact finder.

4. Workers' Compensation ⇨1396

Chiropractor who treated injured employee was properly permitted to testify in workers' compensation hearing that in his opinion, employee's injury was caused by lifting of heavy pipe and that second incident approximately one year later was exacerbation of original injury, and further, was properly permitted to testify regarding percentage of employee's disability.

5. Workers' Compensation ⇨1939.8

When record presents nothing more than conflicting medical testimony, appellate court will not substitute its judgment for that of workers' compensation court.

6. Workers' Compensation ⇨1939.11(1)

Finding with regard to causation of injury in workers' compensation case will not be set aside unless clearly wrong.

7. Workers' Compensation ⇨1624, 1634, 1637

Competent testimony supported award for temporary total disability, 20% loss of earning power and rehabilitation benefits to workers' compensation claimant despite

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testimony by orthopedic surgeon that claimant had no disability; chiropractor who treated claimant after injury testified as to existence of disability.

### *Syllabus by the Court*

**1. Workers' Compensation: Expert Witnesses.** Unless the character of an injury is objective, that is, an injury's nature and effect are plainly apparent, an injury is a subjective condition, requiring an opinion by an expert to establish the causal relationship between an incident and the injury as well as any claimed disability consequent to such injury.

**2. Workers' Compensation: Expert Witnesses.** The employee must show by competent medical testimony the causal connection between the alleged injury, the employment, and the disability.

**3. Workers' Compensation: Expert Witnesses.** A duly licensed and practicing chiropractor is competent to testify as an expert witness within the scope of his knowledge according to his qualifications in the field of chiropractic, and the weight of his testimony is a question for the fact finder.

**4. Workers' Compensation: Expert Witnesses: Appeal and Error.** When the record presents nothing more than conflicting medical testimony, this court will not substitute its judgment for that of the Workers' Compensation Court.

**5. Workers' Compensation: Appeal and Error.** A finding with regard to causation of an injury will not be set aside unless clearly wrong.

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Francis L. Winner of Winner, Nichols, Douglas, Kelly and Arfmann, Scottsbluff, for third-party plaintiff, appellants.

Robert G. Pahlke of Van Steenberg, Brower, Chaloupka, Mullin & Holyoke, P.C., Scottsbluff, for appellee Ronald D. Rodgers.

Walter E. Zink II of Baylor, Evnen, Curtiss, Grimit & Witt, Lincoln, for third-party defendant, appellee Cornhusker Cas. Co.

1192 BOSLAUGH, CAPORALE, and GRANT, JJ., and RIST and CLARK, District Judges.

### PER CURIAM.

This is an appeal in a proceeding under the Workers' Compensation Act. The plaintiff, Ronald Dean Rodgers, alleged that he was injured on July 25, 1983, while employed as a laborer by the defendant Roger Sparks, doing business as Sparks Concrete.

According to the plaintiff, he was injured while working at a feedlot, pouring a cement slab and putting up steel pipes. Rodgers testified he was attempting to hold up a steel pipe, which weighed approximately 200 pounds, when he developed a sharp stabbing pain in his chest and back and then collapsed and had trouble breathing. At his own request, he was taken to see Dr. Daryl Wills, a licensed chiropractor, that same day.

Dr. Wills' examination consisted of examining Rodgers' thoracic spine with palpation, motion palpation, and ranges of motion. Rodgers refused to have an x ray taken. Dr. Wills diagnosed the injury as an acute moderate to severe traumatic thoracic juxtaposition with associated myalgia, neuralgia, and deep and superficial muscle spasm. Dr. Wills testified that in layman's terms Rodgers had pulled the muscles in his back, which shifted vertebrae, and developed pain, nerve irritation, and muscle spasms. He further testified that this was a cartilaginous injury in which the heavy lifting depressed the shoulder girdle, which depressed the rib cage. The torquing of the ribs brought a strain on the cartilages. There are lighting joints between the cartilages and the sternum in the rib area, which are held by thin ligament structures both anteriorly and posteriorly. When an injury or trauma is experienced, those ligaments are stretched and/or torn.

Dr. Wills' treatment for this condition included therapy to the muscles, chiropractic manipulations, and pulse ultrasound therapy to the thoracic and external or

chest spine. Rodgers was also placed in a rib orthopedic appliance.

After the initial visit on the day of the injury, Dr. Wills treated Rodgers on July 27 and July 29, 1983, for aches, weakness, and pain. Rodgers returned on August 16 and 19 and <sup>1193</sup>October 25, 1983. Rodgers continued to have problems relating to rib irritation and again sought treatment, on November 18, 1983. Rodgers continued to work after the accident until September 29, 1983, doing the same kind of work. He returned to work in April 1984, after the winter layoff, again doing the same type of work.

In June 1984, while still employed by Sparks, Rodgers was injured while pushing a wheelbarrow filled with cement, and which weighed about 300 pounds, through approximately 6 inches of sand. While pushing the wheelbarrow, he experienced a sharp stabbing pain and fell to the ground. In comparing this with the previous injury, Rodgers testified that it felt like the exact same pain. He visited Dr. Wills the next day, June 19, 1984. Dr. Wills diagnosed the injury as acute traumatic costovertebral and costosternal juxtaposition, with associated intercostal myalgia and neuralgia. As compared to the earlier injury, Dr. Wills testified that it involved the same area of the spine and that this diagnosis was consistent with the previous diagnosis.

Rodgers visited Dr. Wills again on June 21, 1984, and on May 13, 1985, he saw Dr. Wills, with complaints that he felt his ribs were out of place. Rodgers continued to visit, with complaints of chest pain, on May 20, June 1, August 5, September 10, and December 18, 1985. On December 18, 1985, x rays were taken for the first time. Dr. Wills testified that the x rays indicated that Rodgers had rotational problems of the vertebrae and a marked subluxation of one of his ribs. He explained that subluxation is an off-centering of the joint fixed within a range of motion so that it cannot move freely.

Dr. Wills again saw Rodgers for chest complaints on January 3, 1986; on February 4, for stiffness of the cervical spine; on February 19, for neck discomfort and chest

pain; and on March 12, for cervical spine stiffness, headache, and chest trouble. He returned for similar problems on April 16, May 1, and August 14, 1986.

Rodgers testified that since the accident on July 25, 1983, he has had pain in his chest and rib area whenever he lifts something heavy.

On August 7, 1986, Rodgers filed a petition in the Workers' <sup>1194</sup>Compensation Court, claiming that he was injured on July 25, 1983, while working for Sparks, who was at that time insured by The Hartford Insurance Company.

Hartford answered, denying liability, and alleging that Rodgers' injury took place on June 18, 1984, during a time when Cornhusker Casualty Company was the employer's insurance carrier.

After a hearing before a single judge, the compensation court found that the second injury on June 18, 1984, caused Rodgers' disability, and dismissed the petition as to Sparks and Hartford. The court also dismissed a third-party complaint against Cornhusker Casualty because the statute of limitations barred recovery for the accident of June 18, 1984.

On rehearing before a three-judge panel, the compensation court found that the accident on July 25, 1983, caused Rodgers' disability and that the second accident on June 18, 1984, only exacerbated the original injury. Two judges awarded compensation for temporary total disability, 20 percent loss of earning power, rehabilitation benefits, chiropractic expenses, and an attorney fee. The third member of the panel found that the plaintiff's loss of earning power did not exceed 5 percent and that rehabilitation benefits should be denied because the plaintiff could return to the work for which he had previous training or experience. The third-party complaint against Cornhusker Casualty was again dismissed.

Sparks and Hartford have appealed.

The appellants' principal assignment of error is that the compensation court erred in relying exclusively on the testimony of a

chiropractor to establish medical standards beyond the scope of chiropractic.

[1,2] In workers' compensation cases,

Unless the character of an injury is objective, that is, an injury's nature and effect are plainly apparent, an injury is a subjective condition, requiring an opinion by an expert to establish the causal relationship between an incident and the injury as well as any claimed disability consequent to such injury.

*Mendoza v. Omaha Meat Processors*, 225 Neb. 771, 785, 408 N.W.2d 280, 289 (1987). See, also, *Hamer v. Henry*, 215 Neb. 1195, 805, 341 N.W.2d 322 (1983); *Mack v. Dale Electronics, Inc.*, 209 Neb. 367, 307 N.W.2d 814 (1981).

[W]here the claimed injuries are of such a character as to require skilled and professional persons to determine the cause and extent thereof, the question is one of science. Such a question must necessarily be determined from testimony of skilled professional persons and cannot be determined from the testimony of unskilled witnesses having no scientific knowledge of such injuries. The employee must show by competent medical testimony the causal connection between the alleged injury, the employment, and the disability.

*Hamer v. Henry*, *supra* 215 Neb. at 809, 341 N.W.2d at 325.

[3] The issue here is whether the testimony of a chiropractor was "competent medical testimony."

Under Neb.Rev.Stat. § 71-177 (Reissue 1986), the practice of chiropractic is defined as being one or a combination of the following, without the use of drugs or surgery:

- (1) The diagnosis and analysis of the living human body for the purpose of detecting ailments, disorders, and disease by the use of diagnostic X-ray of the axial skeleton excluding the skull, physical and clinical examination, and routine procedures including urine analysis; or
- (2) the science and art of treating human ailments, disorders, and disease by locating and removing any interference with the transmission and expression of nerve

energy in the human body by chiropractic adjustment, chiropractic physiotherapy, and the use of exercise, nutrition, dietary guidance, and colonic irrigation.

Although it is clear that a chiropractor is not licensed to engage in the practice of medicine and surgery as defined under Neb.Rev.Stat. § 71-1, 104 (Reissue 1986), the practice of chiropractic is a skilled profession. Neb.Rev.Stat. § 71-179 (Reissue 1986) requires:

Every applicant for a license to practice chiropractic shall (1) present satisfactory evidence that he has completed a four-year course in an accredited high school; (2) present proof of graduation from an accredited college of chiropractic; and (3) pass an examination prescribed by the Board of Examiners in Chiropractic in the subjects of anatomy, adjusting, bacteriology, chemistry, chiropractic physiotherapy, hygiene, pathology, roentgenology, orthopedics, physiology, symptomatology, palpation, principles and practice of chiropractic; *Provided*, that the Board of Examiners in Chiropractic may waive the written examination for an applicant who holds a National Board of Chiropractic Examiners Certificate who meets the requirements of this section and who satisfactorily passes all oral and practical examinations of the Board of Examiners in Chiropractic.

In *Chalupa v. Industrial Commission*, 109 Ariz. 340, 509 P.2d 610 (1973), the court considered the extent to which a licensed chiropractor could testify as an expert in an Industrial Commission hearing. The court granted review to correct an incorrect statement of law contained in the lower court's decision, which had stated in part that "'while a chiropractor or naturopath may give testimony as to observable facts within his realm of knowledge and training, any other testimony he might offer which takes the form of medical conclusions (as to causation or disability, for example) cannot be regarded as expert medical testimony.'" 109 Ariz. at 341, 509 P.2d at 611.

The Arizona court noted that while chiropractors, unlike physicians, were not com-

petent to give expert testimony in the entire medical field, they were competent as expert witnesses in their limited field of practice. The court held that, regardless of chiropractors' limitations,

[W]e do not believe that a statute which allows [a chiropractor] to manipulate or treat by hand articulations of the spinal column denies him the right to diagnose the reasons for that treatment. We believe that he is a competent witness to testify as to causation of any abnormalities of the spine.

109 Ariz. at 341-42, 509 P.2d at 611-12.

In *Fries v. Goldsby*, 163 Neb. 424, 435, 80 N.W.2d 171, 178 (1956), we said that "a duly licensed and practicing chiropractor is competent to testify as an expert witness within the scope of his knowledge according to his qualifications in the field of chiropractics, and the weight of his testimony is a question for <sup>1197</sup>the jury." What must now be determined is whether causation and permanency are within the scope of the field of chiropractic.

Other courts appear to hold, generally, that chiropractors are competent to express an opinion as to the cause of an injury, its probable effects, and its permanency.

In *Miss. Farm Bureau Mut. Ins. Co. v. Garrett*, 487 So.2d 1320 (Miss.1986), the court held that one who is qualified as an expert in chiropractic may state an opinion regarding diagnosis, causation, and prognosis of an injury when the testimony is carefully limited to the field of chiropractic. "The fact that medical doctors ... might even be qualified to give better and more reliable opinions is beside the point." 487 So.2d at 1327. The court stated it is within the discretion of the trial court as to whether a chiropractor's testimony would be helpful.

In *Klingman v. Kruschke*, 115 Wis.2d 124, 339 N.W.2d 603 (1983), a chiropractor was allowed to give his opinion concerning the cause and permanence of the plaintiff's injuries in light of the fact that proper foundation was laid. The chiropractor based his opinion on his examination of the plaintiff and on statements made by the plaintiff during the examination that the

neck stiffness had begun after the accident. The chiropractor diagnosed it as an injury to the cervical spine with associated nerve damage. The court held that the plaintiff's statements regarding neck stiffness provided sufficient foundation for the chiropractor's conclusion that the accident caused the injuries, and noted that it was for the jury to weigh the credibility.

In *Stevens v. Smallman*, 267 Ark. 786, 590 S.W.2d 674 (1979), the court held that a chiropractor could express his opinion as to whether the plaintiff was permanently disabled from an auto collision, where the chiropractor had examined the plaintiff, taken a history of his complaints, and treated him over a period of several months. The chiropractor was permitted to testify that the patient had muscle spasms in the cervical area, misalignment in the vertebral column, limitation of motion in the cervical area, and continuing pain, and that because the muscle spasms and pain had not cleared up during months of treatment, the patient had suffered a 5- to 7-percent permanent disability.

<sup>1198</sup>In *Line v. Nourie*, 298 Minn. 269, 215 N.W.2d 52 (1974), the court allowed a chiropractor to testify that the plaintiff had suffered general spinal sprain and strain and that as a result, some of the muscles had lost their ability to hold the vertebrae in place and, further, that the cause of this condition was an automobile accident and that plaintiff had suffered a 15- to 20-percent permanent partial disability of the mid and upper thoracic spine. The court held it permissible for a chiropractor to render opinions based on reasonable chiropractic certainty as to the probable effects, permanency, and future medical requirements, where proper foundation for such opinion has been laid.

Finally, in *Badke v. Barnett*, 35 A.D.2d 347, 316 N.Y.S.2d 177 (1970), the court rejected an argument that chiropractors should not be permitted to give expert medical testimony on questions of diagnosis, prognosis, and causal connection because they lack the extensive training of a physician. The court held that because chiropractors are extensively trained in the

practice of chiropractic and are qualified to treat patients suffering from chiropractic ailments, a chiropractor should be deemed competent to testify as an expert witness and express his opinion as to the nature of a chiropractic ailment and its probable cause and duration. Hence, it was proper for the chiropractor to testify that, based on his examination of the plaintiff, she suffered from a subluxation, or a slight overriding of one vertebra against the other. This caused nerve roots in the vertebral openings to be pinched, which in turn caused muscle spasms. The chiropractor testified that it was his opinion that the auto accident was the cause and the injuries were permanent. The court rejected the argument that this testimony was beyond the scope of chiropractic and was entering the fields of neurology and orthopedics, because the chiropractor spoke of nerves and bone solely in the context of the subluxation he had detected in the plaintiff's spinal column.

[4] The witness in this case, Dr. Wills, was a qualified expert in chiropractic. He obtained his degree as a doctor of chiropractic in 1973 and has practiced in the profession ever since. During the course of his training he studied anatomy, physiology, microbiology, chemistry, bacteriology, and public health. The 1199 doctor of chiropractic program consists of 2 years of preprofessional study and 5 years of professional study, including clinical work. He averages 50 hours per year of continuing education and is currently president of the Nebraska chiropractic association.

Being qualified as an expert, Dr. Wills was properly permitted to testify that, in his opinion, Rodgers' injury was caused by the lifting of a heavy pipe on July 25, 1983, and that the second incident on June 18, 1984, was an exacerbation of the original injury. He was properly permitted to testify regarding the percentage of Rodgers' disability. Sufficient foundation existed for his opinion regarding disability because of his repeated treatments of Rodgers over the years and because of his education in spinal impairment ratings.

The second and third assignments of error are that the court erred in making an award having no competent evidence to support it and erred in making an award for an injury where the only competent evidence showed a different and separate injury was responsible.

Dr. Bruce Claussen, an orthopedic surgeon, examined Rodgers on December 18, 1986, and found no abnormalities in the costosternal area where the breastbone meets the ribs. There were no abnormalities as to the cervical and thoracic spine, and Rodgers had an acceptable range of motion. Rodgers did have some tenderness in the front of the chest in the area where the breastbone meets the ribs, at about the third rib. Dr. Claussen referred Rodgers to a radiologist for x rays. X rays made of the area of the third rib indicated no abnormalities. Dr. Claussen testified that he could not explain the popping sound Rodgers complained of in his ribs, but stated it possibly could be due to the strain of the muscles and the ligaments. Dr. Claussen was of the opinion that the plaintiff had no disability as a result of either of the incidents, but on a "purely speculative basis" it was possible he might have an impairment of 2 to 3 percent or less.

Dr. Wills testified that the cause of Rodgers' first injury on July 25, 1983, was his lifting of the heavy pipe. In describing the relationship between this injury and the wheelbarrow incident on June 18, 1984, he testified that the pain Rodgers felt as he pushed the wheelbarrow was due to an exacerbation of his first 1200 injury. He explained that the injury Rodgers sustained on July 25, 1983, involved a stretching or tearing of the ligaments, in which case there would be a deformation of the connective tissue, resulting in scar tissue which would not allow healing. The popping sound Rodgers reported hearing in his chest was due to joints that were torn loose and did not heal properly. He stated that Rodgers had never healed properly and when Rodgers returned for treatment in June 1984, he treated his condition as an exacerbation of the original injury.

He further testified that Rodgers' injury is a permanent condition with respect to Rodgers' experiencing pain upon heavy lifting, pushing, or pulling.

As to the extent of disability, Dr. Wills was of the opinion that Rodgers had a 15-percent disability as to his work capacity and a reduction of approximately 25 percent of his preinjury capacity for performing such functions as bending, stooping, lifting, pushing, pulling, climbing, or other comparable physical efforts. He explained that work disability does not correlate directly with impairment, in that a patient can have an impairment rating of a certain percentage and a disability rating of a different percentage based upon the type of work that the patient does.

[5] When the record presents nothing more than conflicting medical testimony, this court will not substitute its judgment for that of the Workers' Compensation Court. *Nice v. IBP, inc.*, 226 Neb. 538, 412 N.W.2d 477 (1987); *Ward v. City of Mitchell*, 224 Neb. 711, 400 N.W.2d 862 (1987).

[6] A finding with regard to causation of an injury will not be set aside unless clearly wrong. *Kingslan v. Jensen Tire Co.*, 227 Neb. 294, 417 N.W.2d 164 (1987). The findings of fact made by the Workers' Compensation Court after rehearing have the same effect as a jury verdict in a civil case and will not be set aside unless clearly wrong. *Kuticka v. University of Nebraska-Lincoln*, 227 Neb. 565, 418 N.W.2d 593 (1988).

[7] Since there was competent testimony to support the award for Rodgers, the judgment of the compensation court is affirmed.

The plaintiff is allowed \$1,000 for the services of his attorney in this court.

AFFIRMED.

228 Neb. 201

1201 STATE of Nebraska, Appellee,

v.

Kim M. BRITT, Appellant.

No. 87-642.

Supreme Court of Nebraska.

April 8, 1988.

Defendant was convicted in the District Court, Douglas County, Donald J. Hamilton, J., of possession of heroin with intent to distribute, deliver, or dispense, and possession of marijuana with intent to distribute, deliver, or dispense, and he appealed. The Supreme Court, Grant, J., held that: (1) evidence was sufficient to support finding that defendant had physical or constructive possession of marijuana and heroin found in car and at residence with knowledge of its presence and its character as controlled substance, and thus supported finding of possession, and (2) circumstantial evidence was sufficient to support determination that marijuana and heroin were possessed by defendant with intent to distribute, deliver, or dispense.

Affirmed.

#### 1. Drugs and Narcotics ⇐116

Evidence was sufficient to support finding that defendant had physical or constructive possession of marijuana and heroin found in car and at residence with knowledge of its presence and its character as controlled substance, and thus supported finding of possession; witness testified at trial that witness did not know that there were drugs in witness' vehicle until defendant tossed heroin at him, that black leather jacket in vehicle containing marijuana belonged to defendant, that witness had previously purchased marijuana from defendant at searched residence and that defendant had supplied marijuana from corn chip cannister in which police found marijuana.



The proposed revision to section 39-71-711 (4), MCA, would, if enacted, be in conflict with the provisions of certain sections of Title 39 (Workers' Compensation) and Title 37 (Professions and Occupations). Also, the language of the revision itself is confusing. First, the term "chiropractic physician" is contradictory, in that a chiropractor is not a physician within the meaning of the laws of the State of Montana (see below). (The language could be clarified by replacing the terms "treating physician" and "chiropractic physician" with the terms "treating chiropractor" and "chiropractic practitioner", respectively.) Second, the revision is ambiguous with respect to a requirement for chiropractors to act as second or third evaluators in the impairment evaluation dispute process. If the claimant's treating provider is a chiropractor, the proposed amendment to 39-71-711 (4) conflicts with 39-71-711 (2), "A claimant . . . may obtain an impairment rating from a physician of the party's choice . . .".

The following specific instances of conflict with existing statute are noted:

- (1) Section 39-71-711 (1)(a) declares that an impairment rating "is a purely medical determination;; however, section 37-12-102 states that the practice of chiropractic is "declared not to be the practice of medicine or surgery within the meaning of the laws of the state of Montana defining the same." The revision would allow a chiropractor (who is not recognized as a practitioner of medicine) to be an impairment evaluator (who must deliver an impairment rating by purely medical determination).
- (2) Section 39-71-711 (1)(b) states that the impairment rating determined by an impairment evaluator "must be based on the current edition of the Guides to the Evaluation of Permanent Impairment published by the American Medical Association." The Glossary contained in this publication defines evaluation or rating of impairment as "an assessment of data collected during a clinical evaluation . . .", and further defines clinical evaluation as "the collection of data by a physician . . .". That is, impairment evaluation requires the assessment of data collected by a physician. However, section 37-12-104 declares that while chiropractors may

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use the prefix "Doctor" as a title, they "shall not in any way imply that they are regular physicians or surgeons.: The revision would allow a chiropractor (who is not recognized as a physician) to perform an impairment evaluation (which requires clinical evaluation by a physician).

- (3) More generally, the revision might be seen to expand chiropractors' scope of practice by allowing them to act as impairment evaluators -a function currently reserved for licensed physicians. This expansion conflicts with Title 37, Chapter 3.

The proposed revision to section 37-12-201, MCA, would present the same problems as those outlined for the revision to 39-71-711 (4).

5890E

## PROPOSED STATEMENT OF INTENT

### HB 33

This bill authorizes the Board of Chiropractors to adopt a rule for the certification of impairment evaluators within their profession. The Board should consider the applicant's experience in treating industrial accidents and any academic training he may have in using the impairment rating guides recognized by the division of worker's compensation.

EXHIBIT 5  
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In Support of HB37

Submitted by Robert R. Johnson, President  
Montana Public Health Association  
316 N. Park  
P. O. Box 1723  
Helena, Montana 59624  
443-1010 ext 357

Montanans want effective and efficient government. The best way, maybe even the only way, this can be accomplished is through the selection of the most effective Department Directors and supervisory staff possible. We need strong leadership that is well trained in their specialty, experienced in management and capable of making the tough decisions necessary to get the job done.

The Institute of Medicine, an arm of the National Academy of Sciences, recently conducted a study of Public Health in America and published a November, 1988<sup>1</sup> report of the findings. The report carried recommendations that call for greater emphasis on managerial and leadership skills in Public Health directors. "Health Department Directors should have management competence as well as technical/professional skills." (pp 155)

The Montana Public Health Association conducted a study of its own during 1987 and 1988 to determine the future of Montana's Public Health. It conducted a series of strategic planning sessions in which participated a broad array of state and local public health professionals. A telephone survey was also conducted which, among other things, asked what was needed to improve Montana's response to her Public Health needs. The overriding response was a call for stronger public health leadership with management training and experience.

The present law precludes this from happening. The going rate for the kind of leader we need, one who must also meet the licensed physician requirement, costs roughly twice the present compensation offered by the State.

We support HB37 because the bill would make it possible for Montana to gain the strong, capable public health leadership it needs without pushing the salary of the State Health Department Director beyond the State's ability to pay.  
Thank you.

Robert R. Johnson  
President  
Montana Public Health Association

EXHIBIT 6  
DATE 1-4-89  
HB 33

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<sup>1</sup>The Future of Public health,  
Washington, D.C., November, 1988

36 South Last Chance Gulch  
Suite A  
Helena, Montana 59601  
Telephone: 406-443-1160



TESTIMONY BEFORE THE HEALTH COMMITTEE

January 4, 1989

My name is George M. Fenner. I appear before you today as a retired state employee.

I appear as a proponent of HB 37, which would remove the requirement that a physician head up the Department of Health and Environmental Sciences as the Director.

I was employed by the Department of Health and Environmental Sciences (DHES) from January of 1969 through June of 1988 in several capacities: I began as a Hospital Consultant, became Bureau Chief for the Health Facilities Bureau, then became Chief of the Hospital and Medical Facilities Division, and in 1983 became Chief of the Health Services Division. The Health Services Division was composed of all of the health delivery programs included in the Licensing and Certification Bureau, Health Planning Bureau, EMS Bureau, Preventative Health Bureau, and the MCH/Family Health Bureau.

EXHIBIT 7  
DATE 1-4-89  
HB 37

This was a position I held when I retired last June. Before being employed in Montana State Government, I worked as a Medical Administrative Office with the Veterans Administration.

Throughout those many years, I have worked closely with physicians and have nothing but the greatest respect for them. In some instances, they were the administrator or top official. During my tenure with the DHES, this was always the case. I served under Dr. John Anderson, Dr. Arthur Knight, and lastly, Dr. John Drynan. They were all fine people, but in every instance they were a doctor first, and administrator second. They were not educated to be administrators or managers and more frequently than not made decisions based on how their peers in the medical community felt about some very important issues. With some exceptions, many decisions were made using the Russian methodology "Commisar".

Many of today's health programs are controversial and require that the administrator of the department be receptive to new ideas and thoughts, be diplomatic when dealing with various advocacy groups, and politically aware as to what is going on at the state and federal levels. It is not enough to say, "if its good for medicine, it is good for health", or, "this is the way we have always done it, and that is good enough." This is not

to say that all lay administrators are experts either, because I have worked with a few of them that were inept. Their training, however, is specialized and totally directed to solving problems in an open or closed arena, as appropriate. They have experience in public management and organization, personnel management, public relations, dealing with the media, community concerns, communication, delegation of authority and responsibility, support staff, speak the truth, have good morals, fiscal responsibility, staff loyalty . They are knowledgeable about setting goals and objectives, and for the most part, are motivators. It helps if they have some experience in dealing with the legislature.

I have a brief description of a manager, and that is to get things done through people and give credit where credit is due. Be firm, understanding, and keep a good sense of humor. Physicians go to medical school, do an internship and residency, and go into practice. They spend very little time taking management and interpersonal relationship training, but in my opinion, are all extremely intelligent.

In my opinion, the department requires appropriate medical staff plus one physician to be medical director who should have Deputy

Director status and who can advise the administrator on technical medical matters and who can serve as a liaison for the Department with the medical community. Very much the same organizational structure found in a hospital. The chief executive officer for a hospital is responsible to the hospital board, and in this instance it would be administrator to the governor, and the chief medical director in a hospital is responsible to the medical staff and chief executive officer, but in this instance, would report to the administrator.

I urge your favorable consideration of House Bill 37.

Thank you for giving me the opportunity to appear before you today.

GEORGE M. FENNER

## VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HB 33

DATE January 4, 1989

SPONSOR Representative Pavlovich

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Oliver Cox - MMTA	23 N 1st Chance Gulch		✓
Ernie Tippy - MCA	350 N Last Chance Gulch	✓	
Margaret Burkhardt MCA	350 N Last Chance Gulch	✓	
Jerome Loendorf	Helena, MT		✓
Gary Blom	Claremont MT	✓	
John W. Tupper Inc	Helena MT		✓
Max Parks II	Helena, MT	✓	
Joe Bork, D.C.	Victor MT	✓	
Graham Ahan	LABOR & INDUSTRY		✓
Steven Shapiro	LABOR & INDUSTRY		✓
John A. Shles	Helena MT		X
John Lawton	Billings		X
Carrie L. Barker	E. Helena / MSU		X

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

## VISITORS' REGISTER

HUMAN SERVICES AND AGING

COMMITTEE

BILL NO. HB 37

DATE January 4, 1989

SPONSOR Representative Cohen

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Robert R Johnson	316 S Park	✓	
Stan Bradshaw	824 9th	✓	
MAXINE HOMER	2031 Lockey, Hlwr	✓	
Robert Kellard	Hawesman Office	✓	
Boe Hughes McHeale Care Assn		✓	
Margaret Sigis	LWMT	✓	
Reg Nelson	MEIC	✓	
Jerome T. Loerdick	Helena, mt.		✓
<del>Gary P. Blom</del>	<del>Cheney MT</del>		
John Tuckman Jr D	Helena		✓
GEORGE OCHENSKI	HELENA	✓	
Kim Wilson	Hickory - Sierra Club	✓	
George M. Finson	Helena	✓	
Dorothy Cooper	MNA Helena	✓	
Keith Boone	MNA, Helena	✓	
<del>John</del>	<del>Cheney MT</del>	✓	
Mona Jamison	Rocky Mtn. Trout Center	✓	
Carrie L. Harber	E. Helena / MSU	✓	

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PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.