

May 5, 2000

CHIROPRACTIC CARE AND SERVICES

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

2. BACKGROUND

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

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

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

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

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

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

3. POLICY

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

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

4. ACTION

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

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

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

5. REFERENCES

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

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

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

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