Dynamic Chiropractic

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Chiropractic Primary Care: Is There One Chance Left?

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In 1970, as a freshman chiropractic student in the Chiropractic Principles class, I heard an interesting observation from our instructor, Dr. Roy Hildebrandt. The quote, as I remember it, was: "The profession has never been able to agree on what chiropractic practice should be. Chiropractic is what the local chiropractor says it is."

He should have known, I reasoned, as he had taught at both the conservative Palmer College and the broad-scope National College. The statement made sense to me, even though I had grown up knowing the "hands only" approach to chiropractic practice and assumed it was the only approach. But in my teen-age years I had visited a different kind of chiropractic office. This chiropractor called himself "a chiropractic physician." He had a stethoscope, took blood pressure, did lab/blood work in the office, and would put on a rubber glove and palpate a prostate now and then if he thought it necessary. There were shelves filled with herbal and nutritional products, and an old Cameron Heartometer in the corner. I was like a Baptist at the Vatican.

It is no secret to chiropractors that we have different practice behaviors, but it is a secret to almost everyone else. I had a patient ask me recently if I did spinal surgery. The history of differing scopes of practice goes back to the beginning of the profession and is well- documented in numerous texts. However, only chiropractors and a few others have ever read those texts. The romantic and chaotic history of chiropractic, let alone that of the natural healing arts in America, is almost unknown to the public and the rest of the health care world.

Chiropractic scope of practice, however, may be a moot point, as surveys repeatedly indicate that about 90% of what doctors of chiropractic treat are neck and back problems. Although many DCs practice a broader scope of practice, it is unknown to what extent this is recognized by the public, health care plans or any other entity. Despite the efforts of chiropractic researchers, no one is quite sure to what extent DCs practice the more "holistic" or natural medical approach, even though many of us offer nutritional supplements in the office, or may do acupuncture.

Many chiropractic students entered school with the idea that a "holistic" practice was a valid and viable model, only to find out that the "back doctor" image strongly prevailed. Thankfully, we have all been trained to take on the responsibility of treating spinal disorders. But does the "natural medicine" model of practice still have a chance for those doctors who pursue it? It has not been seriously nurtured by many of our schools or professional associations, since they have been busy establishing our credibility in the spinal arena.

I would like to discuss this topic in light of the way the chiropractic profession has delivered its treatments, the battle over the definition of a chiropractor as a procedural or cognitive practitioner, and how the methods of reimbursement from third-party payers have affected the way chiropractic is

practiced. In summary, I will make the case for a responsible and clear differentiation among doctors of chiropractic.

PROCEDURES vs PROCEDURES

Almost from the start, there were serious arguments about what chiropractic treatment should be. The "straight" or "spinal adjustment only" champions could most easily articulate what they did, since the idea of correcting a "bone out of place" is not difficult to understand. But even these practitioners could not agree. Some said the adjustment should be done by "hand only"; that there should be no soft tissue techniques. A spinal adjustment is not "spinal manipulation," even though it might look the same. Adjusting other articulations, such as the shoulder, was not chiropractic, even though D.D. Palmer wrote about adjusting the feet.

Yet of all the arguments, the greatest came from the "mixers" in the profession who advocated the use of other physical therapy modalities (electrotherapy, traction, exercise, etc.) What is interesting about these early arguments was that they were primarily about what chiropractors should do, not what they should know. Doctors of chiropractic were much like dentists and surgeons. They ultimately did clinical procedures, as opposed to cognitive doctors, who were obliged to diagnosis and "manage" a condition with a combination of nostrums and advice. A procedural doctor is paid to do procedures. A cognitive physician is paid to think.

PROCEDURAL vs COGNITIVE CLINICAL PRACTICE

The differentiation and battles of physicians and surgeons in the history of medicine is legendary. Early surgeons were more like barbers or butchers than physicians. They are still called "Mister" in Britain, not "doctor." Physicians, on the other hand, had only one major identifying variable: a general basic science education that allowed them to do differential diagnosis. Today, they are still paid to listen, examine, think and advise, but not necessarily to do anything. Even among specialists, some are more cognitive than procedural, such as rheumatologists.

Our unfortunate history shows that the battle over what chiropractors should do quickly became a battle over what is appropriate, and even crucial, for a chiropractor to know. If any chiropractor followed a broader scope of practice, emphasizing treatment of many disorders using nutrition, herbs, hydrotherapy, etc., it became obvious that a broader knowledge of the basic and diagnostic sciences was necessary. The dissension among the chiropractic colleges about the direction of education was understandable. A holistic practice demanded the training of a cognitive chiropractic physician, but only a few schools agreed. Almost from the beginning of the profession, a schism had developed that would lead to the present continuing debate over how much diagnostic education a doctor of chiropractic show have.

And this is where we should stop for a minute. Let no one be confused. The broad-based or generalist tradition in chiropractic is every bit as valid and strong as the orthodox model. Our recorded history makes this clear. It can be illustrated by the philosophical battle waged between B.J. Palmer at the original Palmer College and Joseph Janse at National College. Yet it is also clear that this protocol of practice is not the most common one today. Why is that?

There is no doubt that the hallmark of chiropractic, the spinal adjustment, is what captures the attention of the public, the media and the other healing arts. But our ability to diagnostically differentiate spinal pain coming from joint fixations, as opposed to systemic pathology, is widely

mistrusted or misunderstood by these same entities. (To paraphrase: "Consult your physician first before seeing a chiropractor to make sure nothing serious is wrong.") Consequently, if our cognitive ability to manage spinal disorders is not universally acknowledged and respected, how can we expect much understanding when some of our colleagues attempt to participate in the conservative management of, for example, cardiovascular or other metabolic conditions?

PERCEPTIONS ARE REALITY TO THIRD-PARTY PAYERS

The world considers chiropractors to be spinal doctors. In terms of our predominant clinical behavior, they are correct. But most of us also treat shoulders. Is this well known? If many people are unaware of what additional services we offer for a more general musculoskeletal array of problems, then they are probably quite fuzzy about the availability of any holistic or natural treatment services. And the concept of services, as I see it, includes diagnostic expertise. The question from any patient then becomes: "If chiropractors are bright enough to diagnose back and shoulder problems, are any of them bright enough to diagnose other stuff?"

This ignorance has always been prevalent in the health insurance industry. We continue to be considered as procedural doctors, with little regard to our diagnostic abilities. This is reflected in the benefit designs of insurance and health care policies that have increasingly limited our services to manipulation and various physiotherapy modalities. Our ability to be reimbursed for blood work or other laboratory tests, even when associated with spinal disorders, is almost nonexistent. Managed care has relegated primary care to the gatekeeper. That of course means that chiropractors (as subspecialists) have found it impossible to get diagnostic tests done without sending the patient back to the primary care provider.

The greatest insult to our cognitive skills and training came with the extraordinary limitations of Medicare in the early 1970s. But why should we have been surprised? Our colleges taught a smorgasbord of curriculums. We all had the same degree, but vastly different educations. As insurance reimbursement became more common for chiropractic, it often sank to the lowest common denominator of services: the spinal adjustment. Even though benefits during that era were sometimes liberal, it was because competitive forces demanded it in some markets. Third-party payers simply paid the bills and raised premiums when necessary.

During my early days in chiropractic practice, I was constantly frustrated by the inconsistent denial of examination codes, especially for established patients. In 1991, I had a unique opportunity to do utilization review for a major national insurance company and learned much about claims payment and computer systems. When the E + M codes (evaluation and management) were established in the early 1990's, reimbursement for examinations became more muddled. Most of the computer systems could not differentiate whether an E+ M code was done by a medical doctor or chiropractic doctor. Many simply did not pay the code, or used a proprietary "mnemonic" code to indicate the exam was done by a chiropractor. Since analysis of the codes was important to the bottom line, most health care systems were annoyed by the ambiguity and paid the E + M codes even more inconsistently. Every company did it differently. Today many only pay these codes for the first and last visits, much as they do for physical therapy assessment codes.

In the reimbursement or health plan world, E + M codes belong to the medical profession, physicians in particular. Now with the new "chiropractic" codes (the 98940 series), the reimbursement problem concerning diagnostic codes is even worse in many cases. Use the exam code more than once or twice,

and be denied payment. The point of this discussion is to underline the fact that chiropractic physicians are equal only to physical therapists in the eyes (or computer systems) of health care insurance companies. We are not cognitive physicians in their eyes. The different and often more liberal reimbursement behavior of personal injury or workers' compensation companies can make it appear that this statement is not entirely correct. But the medicolegal culture and laws are different in these arenas and do not translate well into the commercial or group insurance world. Besides, chiropractic care is sold as a "rider," much like dental care. It is not considered as a "standard" benefit in most commercial health plans unless mandated by law or by the good intentions of self-insured plans.

With all this in mind, I must submit that chiropractic benefits have historically been considered as an annoyance by most health plans. They have never been clear on what to do with us when managing claims. Despite the warm sympathy of individual employees in any particular insurance company, the chances of making significant changes in the information systems of colossal managed care organizations is dismal. With few exceptions, chiropractors are paid to do procedures, not diagnose or manage disorders in any comprehensive manner.

MEDICARE: THREAT OR MENACE?

When chiropractors were paid totally in cash there were no standards of care, no criteria for treatment, and no serious cooperation with the medical profession. We were ignored by the health care industry. But with our inclusion in Medicare in the 1970s, all that changed. As inevitable as it was, we stuck our fingers in the Tar Baby, and now we're waiting for the feathers. We forgot to define ourselves; someone else had to do it. We were hired to do a simple procedure, albeit valuable.

I recently attended the annual Dorsey-Hughes Health Policy conference in the Rocky Mountains. It is for health policy wonks, especially those from Washington, D.C. Speakers included superstars from HCFA, giant HMOs and physician groups. Suffice it to say, third-party payers of all kinds are moving toward payment schemes based on Medicare definitions and policies. That means that chiropractic reimbursement may deteriorate to manipulation only. No third-party payments for reexaminations, modalities, rehab. codes, laboratory, and yes, even x-rays. This has already happened in some markets. Of course this perceived cost-savings are attractive to managed care organizations and health plans who have either lost money or barely skimmed a profit in the last two years. The changes of "cost-shifting" these services to other providers (that results in no real savings) is usually ignored.

WILL WE DIVIDE THE PROFESSION IN ORDER TO DEFINE THE PROFESSION?

I have made the case for a sober realization that the DC degree often means the following: an alternative-type quasi-doctor who treats back problems with the hands. The DC degree is not typically considered equal to the MD degree in regard to spinal disorders or musculoskeletal disorders, as of course it should be. The DC who practices a broader-scope, natural therapeutic approach, is in a "gray area," and that doctors' clinical training can be suspect. That about sums it up.

The outlook for any expansion of this definition soon is not good. Yet it has become clear to me that the solution to this general ignorance concerning our education is simply for us to quit arguing about what it should be. We must credential and identify DCs who differ from one another. We all share the DC degree. But those who choose to be identified as a more broadly trained chiropractic physician, offering an array of natural therapies, must do so in a clear and valid manner. And that requires rational credentialing.

To offer different opportunities to prospective students, the University of Bridgeport is offering the Doctor of Naturopathy degree, (ND). The National College will soon follow. But this degree is recognized only in 11 states, and there are many spurious diploma mills, even today. In the 1950s several chiropractic schools that had previously offered the ND degree "gave it up" because it was so poorly defined and professionally unregulated. Nevertheless, the current training in naturopathy may become the definition of the "nature doctor." The competition for this recognition is heating up rapidly.

Chiropractors have wasted untold years in squabbling, but it is understandable. There has always been a strong urge among practitioners to identify themselves as they choose, without the dictates of a larger professional organization. After all, chiropractic associations have tried to appeal to all chiropractors without offending many. The political leaders of the profession have never relished the notion of working to clarify and divide the profession when there was a bigger threat to chiropractic's existence - that of organized Medicine and their allies.

SO NOW WHAT?

There is no time left to squabble. Medical doctors and naturopathic physicians want to control the "nature doctor" market. Physical therapists, massage therapists, and perhaps oriental medical doctors want to control the manual therapy and "touch" therapy markets, including joint manipulation. Chiropractic can't wait any longer to really define itself.

Presently, there is a movement to form a new professional guild, the Amercian Academy of Chiropractic Physicians (AACP). (*Editor's note:* See "American Academy of Chiropractic Physicians Created," DC Nov. 1, 1999, or the online archives at http://www.chiroweb.com/archives/17/23/01.html .) This effort is backed by the presidents of three prominent chiropractic schools (National, Los Angeles, and Western States), and some members of the Council on Family Practice of the ACA. The mission of this group is "to promote primary care practice" and make it academically sound with postgraduate schooling and credentialing.

Other encouraging happenings are becoming visible. In Illinois, Blue Cross/ Blue Shield is now using DCs as primary care practitioners in their alternative medicine product, via a network (Alternative Medicine, Inc). Chiropractic physicians will be gatekeepers in the system for management of care among complementary and alternative providers (CAM) or for referral to any medical specialist.

No one is trying to equate the primary care training of chiropractic to medical physicians. It is different, but so are primary care definitions internationally. Chiropractors are not giving drugs, for instance. The strategy in this IPA was to use the most qualified DC appeared more appropriate than the MD.

Whether this will make a difference in the health care market remains to be seen. This may be the beginning of different chiropractic degrees, with different paths offered to students seeking different styles of practice. Only this time, the credentials can be certified, valid and acceptable to the health care industry. The degrees could be doctor of chiropractic medicine (DCM) or doctor of chiropractic natural medicine (DCNM). The fact is, new practitioners are not homogenized, and will seek alternative paths in practice. A single chiropractic degree is confusing and archaic when it is meant to define the clinical behavior of all of us.

No one is planning the denigration of the DC degree. I'm proud of my degree, and my musculoskeletal practice. But what are the alternative choices for a broad-based DC seeking recognition within the

profession? Is there going to be room for a DC who wants to counsel patients in nutrition or about the risk factors in heart disease? Or will chiropractic continue to remain "what the local chiropractor says it is"?

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