UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF COLUMBIA

AMERICAN CHIROPRACTIC ASSOCIATION, INC.
Plaintiff,

v.

TOMMY G. THOMPSON,

Defendant.

) **Civil Action No. 98-2762 (JGP)**

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ORDER

For the reasons stated in a separate memorandum order to be filed by the Court, it is hereby

ORDERED that the defendant's motion for summary judgment is GRANTED as to Counts III and V. It is further

ORDERED that the plaintiffs cross-motion for summary judgment is DENIED. It is further

ORDERED that all other pending motions are DENIED as moot.

Date: October 8, 2004
JOHN GARRETT PENN
United States District Court

UNITED STA TIES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN CHIROPRACTIC ASSOCIATION, INC.	)	
Plaintiff,	)	
	)	**Civil Action No. 98-2762 (JGP)**
v.	)	
	)	
TOMMY G. THOMPSON, Secretary of Health and Human Services,	)	
Defendant.	)	

MEMORANDUM OPINION

This case comes before the Court on the parties' cross motions for Summary Judgment pursuant to Federal Rule of Procedure 56(c) and Local Rule 7(h). The plaintiff, American Chiropractic Association, Inc., ("ACA") brought this action against the Secretary of Health and Human Services' (the "Secretary") alleging that the Secretary's interpretation of §1861(r) of the "Medicare Act," codified as 42 U.S.C. §1395x(r) (hereinafter "~1395x(r)") is erroneous because it extends Medicare coverage to manual manipulations of the spine to correct a subluxation performed by medical doctors and osteopaths, as well as chiropractors. ACA alleges that Chiropractors alone are eligible to provide this service and seeks to have thuds allegedly misspent on the services of non-chiropractors designated for future payment of services rendered by chiropractors alone. Upon review of the parties' motions for summary judgment, corresponding memoranda, oppositions and replies thereto, the administrative record, and the relevant law, the Court will deny the plaintiffs motion and grant the defendant's motion as to both of the remaining counts of the amended complaint.

I. BACKGROUND

A. Medicare Statutory Framework Established in 1965 under Title XVIII of the Social Security Act, the Medicare

Program, 42 U.S.C. *§1395 et seq.*, provides government-subsidized health insurance to elderly and disabled individuals. Part A of Title XVIII provides basic coverage for hospital and related post-hospital services. *See* 42 U.S.C. § h395c. Part B of Title XVIII provides supplemental insurance coverage for expenses unrelated to hospitalization that is financed jointly by the federal government and by enrollees who pay premiums. *See Id.* §~h395j, h395k. Under Parts A and B, patients "self-refer" to care givers of their choosing and Medicare pays for covered services on a "fee-for-service" basis. *Am. Chiropractic Ass ½ v.* S/ia/a/a, 108 F. Supp. 2d h, 3 (D.D.C. 2000) (opinion of Judge Harris); Def.'s Mem. Supp. Summ. .1. at 2 n.2, 5.

In addition to the fee-for-service system under Parts A and B, Congress established a managed care system involving health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") in 1982. *See* 42 U.S.C. §h395mm. Under this system, Medicare beneficiaries can receive their benefits through LIMOs and CMPs. *Id.* These organizations provide coverage for all services covered under Parts A and B. *See Id. §1395mm(c)(2)(A).* Medicare then pays the participating organizations a monthly, predetermined amount for each enrollee pursuant to "risk contracts" entered into between the Secretary and the organization. *See Id.* §1395mm(g)(3).

The HMO/CMP program is gradually being phased out in favor of the "Medicare + Choice" ("M+C") program. *See* 42 U.S.C. § 1395mm(k)(h). In 1997, Congress established the M±C program as a new "Pan C" to the Medicare Act. *Id.* §~1395w-2h . 1395w-28. In order to

be eligible for Part C coverage, an individual must be entitled to benefits under Part A and enrolled under Part B. *See* Id. § l395w-21(a)(3). Eligible individuals can elect to receive benefits under an M±C plan from an M+C organization as an alternative to coverage under Parts A and B. *See Id.* § 1395w-21.(a)(l.). Medicare pays a fixed amount to these organizations pursuant to a contract. *See Id.* §~1395w-23, 1395w-27. M+C organizations are then required under Medicare Part C to provide coverage for all services covered under Parts A and B. *See id.* §1395w-22(a).

B. Medicare Coverage for Chiropractic Services

Medicare Part B (and therefore Part C) provides coverage for, among other things, "physician services." *Id.* §1395k(a)(2)(B)(i). When Medicare was originally established, the term "physician" for purposes of "physician services" did not include services provided by a chiropractor. In 1972 however, Congress amended the definition of "physician" to include the services of chiropractors to a limited extent. *See* Pub. L. 92-603, § 273, 86 Stat. 1329 (1972) (adding paragraph *(5)* to §1395x(r)). The term "physician" is now defined as follows:

> The term "physician", when used in connection with the performance of any function or action., mean.s (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1301 (a)(7) of this title), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he perfonims such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(l), and (s) of this section and sections 1.395f(a), 1395k(a)(2)(F)(ii), and *1395n* of this title but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only for purposes of subsection (p)(I) and with respect to the provision of items or services described in subsection (s) of this section which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of

> subsections (s)(1) and (s)(2)(A) of this section and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perfonn by the State or jurisdiction in which such treatment is provided. For the purposes of section 1395y(a)(4) of this title and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previ.ous sentence, legally authorized to practice such art in the country in which the inpati.ent hospital services (referred to in such section 1395y(a)(4) of this title) are furnished.

42 U.S.C. §1395x(rf

In 1990, eighteen years after adding coverage of chiropractic services, Congress passed the Omnibus Budget Reconciliation Act of 1990 ("OBRA"). A provision of this law directed the Secretary to "conduct a study of the extent to which health maintenance organizations with contracts under [the HMO/CMP program] make available to enrollees entitled to benefits under Title XVIII of the [Social Security] Act chiropractic services that are covered under such title." Pub. L. No. 101-508, §4204(0, 104 Stat. 1388, 112 (1990), *as amended by* Pub. L. No. 103-432, § 157, 108 Stat. 4398, 4442 (1994). Section 4204(9 required the Secretary to issue a report on the study to Congress by January 1, 1993, and to include in that report "recommendations with

'As originally enacted in 1972, the amendment that added paragraph 5 to 42 U.S.C. §1395x(r) read as follows:

> a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of subsections (s)(i) and (s)(2)(A) of this section and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

The Balanced Budget Act of 1997 ("BBA") amended this provision however, by removing the requirement that the subluxation be "demonstrated by X-ray to exist." *See* BBA § 45 13(a), Pub. L.No. 105-33, 111 Stat. 251 (Aug. 5,1997).

respect to any legislative and regulatory changes that the Secretary determines are necessary to ensure access to such services." *Id.* The Secretary did not issue the report by the January 1, 1993 deadline. Am. Compl. ¶ 33, Answer ¶ 33.

On December 14, 1994, the Secretary and the Health Care Financing Administration ("HCFA"), now called the Centers for Medicare and Medicaid Services ("CMS"),[2] issued Operational Policy Letter #23 ("OPL#23"), which discusses §1395x(r)(5)). OPL#23 originally read as follows:

> MANUAL MANIPULATION OF THE SPINE - MEDICARE COVERAGE
>
> **Operational Policy Question:**
>
> Which practitioners are authorized by law to perform manual manipulation of the spine as a Medicare-covered service?
>
> **Answer:**
>
> Section 1861(r) [codified as 42 U.S.C. § 1395x(r)] of the Social Security Act provides the definiti.on of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation demonstrated by x-ray. The statute specifically references manual manipulation of the spine to correct a subluxation demonstrated by x-ray as a physician service. Thus, managed care plans may use physicians to perform this service.
>
> Managed care plans contracting with Medicare are not required, however, to offer services of chiropractors, but may use other physicians to perform this service. In addition, managed care plans may offer manual manipulation of the spine as performed by non-physician practitioners, such as physical therapists, if allowed under applicable state law.
>
> Please also note that section 2153.1 of the Medicare HMO/CMP manual states that marketing materials of the managed care plans must clearly state which physician specialties are authorized by the plan to provide manual manipulation of the spine.

[2] The name was changed by announcement of the Secretary effective June 14, 2001..

See Am. Compl atEx. 5; Pl.'sMem. Supp. Sumin. J.Ex. 11 at 1.~

On April. 12, 1999, the Secretary submitted the report required by § 4204(0 of OHRA, over five years after it became due. *See* Pl.'s Statement Of Material Facts ¶ 25; Def.'s Response To Pl.'s Statement Of Material Facts ¶ 25; Pub. L. No. 101-508, ~ 4204(0, 104 Stat. 1388, 112 (1990), as *amended by* Pub. L. No. 103-432, § 157, 108 Stat. 4398, 4442 (1994). The report to Congress entitled "Chiropractic Services In Medicare Managed Care" (the "'99 Report"), appears to have been submitted in response to the filing of this suit, *See Am. Chiropractic Ass 'ii,* 108 F. Supp. 2d at 4 (opinion of Judge Harris).

The '99 Report seeks to determine "the extent to which HMOs make chiropractic services

OPL #23 was updated January 15, 2002, apparently as part of an agreement between the parties that resulted in the dismissal of Count II of the Amended Complaint. *See* Stipulation of Dismissal filed March 1, 2002. OPL #23 now reads as follows:

> Operational Policy Question:
> Which practitioners are authorized by law to perform manual manipulation of the spine to correct a subluxation as a Medicare-covered service?
>
> Answer:
> Section l861(r) [codified as 42 U.S.C. *§l395x(r)]* of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation. (As a standard Medicare Part B benefit, manual manipulation of the spine to correct a subluxation must be made available to enrollees in all Medicare + Choice plans). The statute specifically references manual manipulation of tire spine to correct a subluxation demonstrated by x-ray as a physician service. Thus, Medicare + Choice organizations must use physicians, which include chiropractors, to perform this service. They may not use non-physician physical therapists for manual manipulati.on of the spine to correct a subluxation. Medicare+Choice organizations may continue to use physical therapists to treat enrollees for conditions not requiring physician services as defined in section 86 1(r) of the Social Security Act.

Department of Health and Human Services Operational Policy Letter *available at* http ://www.cms.hhs.gov/healtlìplans/opl/defaulta$_5$p9

available; the arrangements under which the services are made available; and the types of practitioners furnishing the services to Medicare enrollees." '99 Report at Chap. 1. The '99 Report first sets forth the policy of the Secretary regarding provision of chiropractic services though Medicare managed care programs. *Id.* at Chap. 3. The report states:

> the Medicare statute provides that several types of practitioners are qualified to provide chiropractic services: doctors of medicine, doctors of osteopathy, and chiropractors. Regulations reflect these policies in that they provide Medicare risk HMOs with flexibility to use any qualified practitioner to render services. Medicare regulations that applied at the time Congress requested this report at 42 CFR 417.414(b)(4) state:
>
> > If more than one type of practitioner is qualified to perform a particular item or service, the organization may select the type of practitioner to be used.
>
> Thus, there is nothing in the Medicare statute or regulations that precludes M+C organizations (or Medicare HMOs) from utilizing chiropractors to provide covered Medicare services. Similarly, neither the statute nor regulations require M+C organizations (or Medicare lIMOs) to utilize chiropractors or refer enrollees to chiropractors.

fri. The '99 Report then goes on to present the findings of a 1991 survey where nine Medicare-contracting HMOs and CMPs, representing over half of all enrollees in managed care programs, were polled. *Id.* at Chap. 4. The report states that "78 percent of HMOs utilized chiropractors to provide the service of manual manipulation of the spine. None of the plans that utilized chiropractors included them on the staff, group, or panel." *Id.* "Of the plans that use chiropractors, the majority also use other practitioners to provide services" including osteopaths, orthopedists and physical therapists. *Id.* The twenty-two percent of organizations that did not use chiropractors to provide manual manipulation of the spine to treat a subluxation, reported using "physiatrists (physicians who specialize in muscular-skeletal disorders), orthopedists, and physical therapists." *Id.* The organizations surveyed could not provide information about the

numbers of patients diagnosed with a spinal subluxation and the treatment these patients received. *Id.* The report does note however, that HMOs generally require a referral from a patient's primary care physician to obtain treatment from any other physician, *Id.* at Chap. 3, and that fewer than one percent of chiropractic visits are referred from another physician. *Id.* at Chap. 2 *(citing American Journal of Health,* April 1991).

Finally, the '99 Report addresses Congress' request for recommendations regarding legislative and regulatory changes. *Sec* Pub. L. No. 101-508, § 4204(0, 104 Stat. 1388, 11.2. The '99 Report concludes:

> We are not recommending legislative or regulatory changes to ensure access for M+C organization enrollees to Medicare-covered chiropractic services. In support of this perspective, we note that:
>
> - The statute governing the availability of chiropractic services in Medicare is clear that doctors of medicine and doctors of osteopathy are qualified to provide the service of manual manipulation of spine to correct a subluxation.
> - It is important to provide M+C organizations with flexibility to operate efficiently by allowing them to organize the delivery of services using any practitioner legally qualified in the state to render services.
> - M+C organizations may utilize different modalities to treat ailments, such as exercise regimens, physical therapy, drugs, surgery, manual manipulation of the spine, etc.
> - There is an established appeals process to address instances where a beneficiary believes covered services are inappropriately denied.
> - All surveyed Medicare-contracting plans provided the service of manual manipulation of the spine to correct a subluxation demonstrated by an x-ray. Seventy-eight percent of the plans surveyed used chiropractors to provide this service. Plans that did not utilize chiropractors provided the service through doctors of medicine.
>
> We seek to implement policy reflected in the statute. We believe that a statutory change would be required to define Medicare coverage of manual manipulation of the spine to

> correct a subluxation as a service that must only be provided by chiropractors. Therefore, if Congress would like to require that manual manipulation of the spine to correct a subluxation must only be provided by a chiropractor, we believe that Congress must amend the statute such that manual manipulation of the spine to correct a subluxation could only be performed by a chiropractor.

Id. at Chap. 5.

C. Procedural History

ACA filed its five-count amended complaint on May 18, 1999. The amended complaint contains five counts. *See* Am. Compl. On September 2, 1999, the Secretary moved to dismiss this action for lack of subject matter jurisdiction and for failure to state a claim upon which relief could be granted. On July 7, 2000, Judge Stanley Harris, to whom this case was previously assigned, issued an opinion granting the Secretary's motion as to Count I because he found the plaintiff lacked standing. *Am. Chiropractic Ass 'ii,* 108 F. Supp. 2d at 6. Judge Harris also requested supplemental briefing of the parties regarding the plaintiffs ability to pursue administrative remedies to the injuries alleged in Counts II through V of the amended complaint. *See Ed.* On January 22, 2001, Judge Harris issued another opinion, this time granting the Secretary's motion to dismiss as to Count IV of the amended complaint, finding that the court lacked jurisdiction to consider this claim. *Am. Chiropractic Ass 'n v. Shalala,* 131 F. Supp. 174, 177 (D.D.C. 2001). The case was then reassigned to this Court on March 7,2001, with Counts 11, 111 and V still pending. On April 6,2001, the American Physical Therapy Association ("APTA") moved to intervene as a defendant in this action. On March 1, 2002, however, the existing parties to the case filed a Stipulation. of Dismissal Without Prejudice as to Count II, which involves the question of whether physical therapists are authorized to perform a "manual manipulation of the spine (to correct a subluxation)" under 42 U.S.C. §1395x(r). *See* Am.

Compl. at 27, In response, APTA withdrew its motion to intervene on September 30, 2003. Counts Ill and V of the amended complaint remain pending, therefore the Court takes up the parties' motions for summary judgment.

II. COUNT III

Count 111 of the amended complaint challenges the Secretary's interpretation of 42 U.S.C. § I 395x(r). Under the Administrative Procedure Act this Court may review such interpretations and "set aside [those] agency actions, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. 5 USC §706(2). The standard by which agency actions, findings, or conclusions are judged however, varies in accordance with *Chevron US.A. Inc. v. Natural Resources Defense Council,* 467 U.S. 837, 104 S. Ct. 2278 (1984). Under that decision, the first question in reviewing the statutory interpretation of an agency is whether "Congress has directly spoken to the precise question at issue." *Id.* at 842, 104 S. Ct. at 2781. If so, "that is the end of the matter" and the Court "must give effect to the unambiguously expressed intent of Congress." Id. at 842-43, 104 S. Ct. 2781. If however, "the statute is silent or ambiguous with respect to the specific issue," we move to the second step and will defer to the agency's interpretation as long as it is "based on a permissible construction of the statute." 14. at 843, 1048. Ct. at 2782.

A. *Chevron* Step One

In order to determine the proper construction of § 1 395x(r) the Court examines the text of the statute, the stnxcture, the legislative history and purpose. *Pub. Citizen, Inc. v. Dep ‘t qfHealth and Human Serv.,* 357 U.S. App. D.C. 1, 6-7, 8,332 F.3d 654, 659-60, 661 (2003). The first and most important of these is the language of the statute. *Id.* The defendant argues that by adding

paragraph 5 to § 1395x(r) in 1972, Congress "expressly and unequivocally names chiropractors as the exclusive practitioners for providing manual manipulation of the spine to correct a subluxation of the spine under Medicare." P1's Mem. In Opp'n To Deft Mot. For Summ. J. at 11. The Secretary however, contends that "careflul review of this provision leads to the conclusion that Congress has not directly spoken to the precise issue of who may provide manual manipulation of the spine to correct a subluxation to Medicare beneficiaries." Def. 's Mem. Supp. Summ. .J. at 19. Accordingly, the Secretary argues that the Court should move to step two of the *Chevron* analysis and defer to the Secretary's position that the statute "does not.., require that manual manipulation of the spine to correct a subluxation be provided exclusively by chiropractors." *Id; see also* '99 Report at Chap. *5;* OPL #23 dated January 15, 2002, available at http://www.cms.hhs.gov/healthplans/opl/ default.asp?. The Court disagrees with both views and finds that the statute is neither silent nor ambiguous as to the question at hand, but explicitly supports the position of the Secretary as its has been stated in the '99 Report, the revised OPL #23 and in this Litigation.

Medicare Parts B, and therefore Part C, provide coverage for "physician services" 42 U.S.C. §1395k(a)(2)(B)Q). Section 1395x(r) limits the definition of "physician" for purposes of the term "physician services", *see* Section 1395x(q), and thereby limits the coverage of Medicare Parts B and C. These limitations however, are divided into separate paragraphs and ate plainly made to apply to specific types of practitioners. Paragraph 5 by its terms applies to chiropractors. Paragraph 5 limits the physician services that may be provided by a chiropractor to "manual manipulation of the spine (to correct a subluxation)." Paragraph 1 on the other hand, applies to doctors of medicine and osteopaths and limits the types of services for which these practitioners

may seek reimbursement. Unlike paragraph *5* however, paragraph 1 contains no limitation on the types of services to be provided by medical doctors and osteopaths. Paragraph I only limits physician services rendered by these practitioners to those performed in the state where the practitioner is licensed to practice. It therefore appears, based purely on the text, that doctors of medicine and osteopaths may perform any service for Medicare beneficiaries as tong as that service is performed in the state where they are licensed.

ACA argues however, that the phrase "manual manipulation of the spine to correct a subluxation" is a "term, of art unique to the chiropractic profession," and that by using this terminology Congress "demonstrat[ed] a clear intent that chiropractors, not other physicians, were to provide the added service." *See* Pl.'s Mem. In Opp'n To Def's Mem. Supp. Summ. .J. at 1 2. The Court agrees that Congress manifested an intent to allow chiropractors to perform this service; that is very clear from the statute. The Court cannot agree however, that the simple fact that the terminology used by Congress in the statute originated with chiropractors necessarily means that Congress intended to foreclose all other medical practitioners from adopting that language and the procedure it connotes for purposes of Medicare.

The structure of § 1395x(r) also leads the Court to the conclusion that manual manipulations of the spine to correct a subluxation perfonned by a doctor or osteopath are covered by Medicare Parts B and C. To decide otherwise invites an absurd result when other paragraphs of the same subsection are construed in the same manner. In paragraphs 3 and 4 of § 1395x(r), doctors of podiatric medicine and optometry respectively, are defined as physicians "but only with respect to" services or functions "which he is legally authorized to perform." *See* 42 U.S.C. §1395x(r)(3)-(4) This Limitation on the practice of

doctors of podiatric medicine and

optometry is phrased in the very same manner that the limitation on chiropractors is phrased in paragraph 5. It should therefore follow that if paragraph 5 limits the services of doctors and osteopaths in paragraph 1 as ACA claims, then paragraphs 3 and 4 should operate in the very same manner and limit those included in paragraph 1 as well. That would mean that doctors of medicine and osteopaths, including ophthalmologists or orthopedists, would be prevented from rendering any service that a podiatrist or optometrist "is legally authorized to perform." *Id.* That result is untenable given the degree of overlap between the practices of an optometrist and an ophthalmologist and between a doctor of podiatry and an orthopedic surgeon. *See* Def.'s Mern. Supp. Summ. .J. at 12. The Court therefore concludes that both the text and the structure of the statute support the Secretary's construction.

Next the Court takes up the legislative history of the amendment and, contrary to ACA's contentions, finds nothing to convince the Court that Congress intended to exclude doctors and osteopaths from performing manual manipulations of the spine to correct a subluxation. ACA cites to the "Summary of Principal Provisions of the Bill" section of a Senate Finance Committee report which states:

> The Committee on Finance deleted the study of chiropractic services called for in the House bill and substituted a provision providing for the coverage under medicare of services involving treatment by means of manual manipulation of the spine by a licensed chiropractor who meets certain minimum standards established by the Secretary of Health, Education, and Welfare.

S. Rep. No. 92-1230, 92 Cong., 2d Sess. at page 53 (1972). ACA emphasizes the words "licensed chiropractor" in the passage and writes "it would be nearly impossible to state any more clearly or unequivocally that the intention of Congress in passing § 1395x(r)(5) was that the service of manual manipulation of the spine to correct a subluxation is to be delivered by a

chiropractor." P1.'s Mem. Supp. Summ. J. at 21.

ACA's emphasis on the words "licensed chiropractor" is misplaced. The purpose of the amendment was undoubtedly to allow licensed chiropractors, who had previously been prevented from providing any Medicare services at all, to provide manual manipulation of the spine to correct a subluxation. Congress therefore identified chiropractors by name and defined chiropractors as physicians for the particular purpose of rendering manual manipulations of the spine to correct a subluxation. There is however, a difference between allowing a particular set of practitioners to render a service and granting those practitioners an exclusive right to render this service. This language simply does not convince the Court that Congress intended to grant Chiropractors an exclusive right, or that the addition of paragraph $ was intended to impliedly limit the broad language of paragraph 1. *See* §1395x(r)(l). Even if inclusion of the phrase "licensed chiropractor" in the Senate Report were more conclusive, the Court would have difficulty according it controlling weight given because the same phrase is conspicuously absent from the statute itself, despite very similar phrasing.[4]

ACA however, argues that this conclusion ignores the circumstances surrounding the addition of chiropractic services to Medicare coverage through the adoption *§1395x(r)(5).* ACA

Other sections of this Senate Report that discuss the amendment do not contradict this conclusion. A section subsequent to the portion cited by ACA gives the amendment more thorough treatment and shows that Congress' chief concern was with ensuring that chiropractors were properly qualified to render such services. *See* S. Rep. No. 92-1230, 92 Cong., 2d Sess. at page 253-54. It also shows that Congress sought to prevent chiropractors from rendering services (besides manual manipulation of the spine to correct a subluxation) that for purposes of Medicare are rendered by doctors and osteopaths. But it does

not show any intention to prevent doctors or osteopaths from performing traditionally chiropractic services. *Id.* ("Moreover, the committee does not intend that the practice of operative surgery, osteopathy, or administering or prescription of any drug or medicine included in materia medica should be covered by the practice of chiropractic.").

states that doctors of medicine and osteopaths received very little training in treatment of musculoskelatal disorders at the time Congress amended §1395x(r) to add chiropractic services and thus were not qualified to perform a manual manipulation of the spine to correct a subluxation. *See* P1's Mem. Supp. Summ. J. at 22-24; Pl.'s Mem. In Opp'n To Def's Mern. Supp. Sumrn. J. at 15-19. ACA goes on to explain that doctors, and indeed the Department of Health, Education and Welfare, the predecessor agency of the Department of Health and Human Services, did not believe that subluxations existed or that manual manipulation was a scientifically sound method of treatment. *See* Pl's Mem. Supp. Summ. J. at 20; *see generally Rastetter v. Weinberger,* 379 F. Supp. 170 (D. Ariz. 1974). Indeed, ACA points out that the American Medical Association believed that the chiropractic approach to treatment was quackery and deemed it unethical to refer a patient to a chiropractor. *See* P1.'s Mem. Supp. Summ. J. at 23, 24. ACA therefore concludes that "Congress did not have to state [in § 1395x(r)] that doctors of medicine were excluded from engaging in chiropractic treatment because, at the time, Congress could not have imagined that a doctor of medicine would ever acknowledge the validity of, much less engage in the practice of, manual manipulation of the spine to correct a subluxation." *See* P1's Mem. Supp. Summ. J. at 23, 24.

The Court finds this argument insufficient to show that Congress intended Chiropractors to be exclusive providers of manual manipulation of the spine to correct a subluxation for purposes of Medicare. To the contrary, this argument shows, as ACA itself has pointed out, Congress did not consider the question of whether doctors should be allowed to provide this service, should they become willing and able to do so at some point in the future, because Congress "could not have imagined" the issue would

arise. Since Congress did not consider the

question, it is impossible that Congress intended to exclude doctors and osteopaths as ACA contends.

The fact that Congress did not consider whether doctors and osteopaths could provide manual manipulations of the spine to correct a subluxation when it amended the statute to allow chiropractors to perform this services, does not however, prevent the Secretary's interpretation of the statute from being vindicated. This is because the coverage of services provided by doctors and osteopaths is governed not by paragraphs but by paragraph 1. The text of this §1395x(r)(1) makes plain that Congress intended coverage for the services of doctors and osteopaths to be as broad as possible. *See* 42 U.S.C. §1395x(r)(l); H.R. No. 213, 89th Cong., 1st Sess. at 150, 167 (discussing scope of coverage of the original provision). The field of medicine is ever advancing and doctors of medicine and osteopaths tender services now that had not been invented when this statute was first passed, but that can hardly mean that because these services were not anticipated by Congress they are not now covered. The statute is crafted to create broad coverage that embraces the changing realities of modem medical care, and in large part leaves to the agency the task of determining the proper extent of coverage through promulgation of detailed regulations. *Cf Goodman v. Sullivan,* 891 F.2d 449, 451 (2d Cir. 1989) (discussing the Secretary's role in promulgating regulations that allowed for the coverage of MRIs as the technology became broadly accepted). The Court must heed this fact until Congress indicates an intent to the contrary.[5]

The Secretary also argues that allowing M-C organizations participating under Part C the flexibility to choose among qualified practitioners is vital to the organization's ability to control costs. This may make economic sense, but the Secretary has not pointed the Court to anything that indicates Congress sought to enact this policy, other than some of its own regulations that are no longer in effect.

See Def.'s Mem. Supp. Sunim. .1. at 14 n.7; '99 Report at

ACA argues however, that doctors and osteopaths are not currently trained or qualified to provide this service to Medicare beneficiaries. *See* P1's Mem. Supp. Summ. J. at 28; P1's Mem. In Opp'n To Defs Mem. Supp. Summ. J. at 15. This argument seeks to adapt 42 U.S.C. Section 1395x(r) to a purpose for which it is not suited. This section of the statute does not delineate which practitioners are qualified, in terms of their training and credentials, to perform a particular Medicare service, and would be wholly inadequate to perform this function. Moreover, Congress has made it quite clear tat such questions remain the responsibility of authorities such as state licensing boards. *See* 42 U.S.C. § 1395 ("Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided..."); 42 U.S.C. §1301(a)(7) (cross referenced in §1395x(r)(1) and limiting the scope of osteopathic practice by reference to state law); *Pennsylvania Medical Soc. v. Marconis,* 755 F. Supp. 1305, 1308 (W.D. Pa. 1991) ("[F]rom its inception, the Medicare program itself specifically sought to prevent any impact on the state's traditional role in the health care area."). The Secretary's interpretation of *~1395x(r)(5)* takes proper account of this prohibition.

ACA points out however, that at least some states do not allow doctors to perform manual manipulations of the spine to correct a subluxation, *see* Pl.'s Mem. Supp. Summ. J. at 26-28, and further points out that "the Defendant has not come forward with any evidence that non-chiropractors, in fact, provide manual manipulation of the spine to correct a subluxation." .74. at 28. Both of these considerations are irrelevant to the interpretation of §1395x(r). The Court simply holds that if the states choose to allow doctors and osteopaths to perform this function

within the scope of their license, § 1395x(r) extends coverage to this service for purposes of Medicare Parts B and C. C.f. *Diaz v. Sha/ala,* 59 F.3d 307 (2d Cir. *1995)* ("The subsections this definition cross-references discuss reimbursement for a physicians services and supplies. Thus, all this definition tells us is that chiropractors may be reimbursed under Medicare for services and supplies in connection with manual manipulation of the spine.")

ACA however, maintains that a manual manipulation of the spine performed by a non-chiropractor is not the same as a manual manipulation of the spine to correct a subluxation performed by a licensed chiropractor and implies that if coverage is extended to such treatment by a non-chiropractor doctor or osteopath, Medicare beneficiaries would be deprived of covered services. *See* Pl.'s Mcm. Supp. Summ. J. at 17. The Court reiterates that whether a doctor or medicine is licensed to perform this function is not a matter determined by the statute in question and the Court expresses no opinion on the matter. Nor does the Court address the question of whether a deprivation of services occurs if non-chiropractors perform this service. The Court is not now confronted with an allegation that beneficiaries have been deprived of covered services. *See* Am. Compl. at ¶¶ 68-78. The only question for the Court to decide is the proper construction of 42 U.S.C. § 1395x(r).

Finally, the Secretary argues that Congress has acquiesced to the agency's interpretation of the statute. The Secretary argues that the position the agency takes in this litigation was set out in the original version of OPL #23, first published in 1994, yet three years later, when Congress amended § 1395x(r)(5), Congress made no effort to amend the statute to give chiropractors an exclusive right to perform this

service. *See* Def 's Mem. Supp. Summ. J. at 28; BBA. Section 4513(a), Pub. L. No. 105-33, 111 Stat. 251 (Aug. 5, 1997) (removing the requirement

that the subluxation be "demonstrated by X-ray to exist."). Furthermore, the Secretary's position was reiterated when the '99 Report was delivered to Congress and again Congress took no action. *ld.* Finally, the Secretary notes that two resolutions, one in each house of Congress, were introduced in 1999, and neither have been acted upon. *See* Def.'s Mem. Supp. Surnm. J. at 30. These arguments are potentially supportive of the Secretary's position and of the Court's conclusion in this matter, however, the Court will not rely on them. The Supreme Court has indicated that the power of subsequent evidence to elucidate original Congressional intent is subject to serious question. *See Solid Waste Agency of N. Cook County* v. *United States Army Corps of Eng'rs,* 531 U.S. 159, 169-70, 121 S.Ct. 675, 681-82 (2001). Ultimately, it is the text, purpose and structure of the statute that convinces the Court that summary judgment should be granted in favor of the Secretary. The Court need not rely on the first prong of *Chevron* alone however, because even if the language of the statute were found to be ambiguous, the Court would find under the second prong of *Chevron* that the Secretary's interpretation preferable and would grant summary judgment in the Secretary's favor.

B. *Chevron* Step Two

Frequently, the Court's task under step two of *Chevron* is to defer to the agency's interpretation as long as it is "based on a permissible construction of the statute." *Chevron,* 467 U.S. at 843,1.04 S. Ct. at 2782. The Secretary claims deference for the agency's interpretations of the statute at issue here. Def.'s Mem. Supp. Summ. J. at 24. The plaintiff disputes this claim, and for a number of reasons argues that deference to the agency is not warranted. The Court need not decide whether *Chevron* deference is

appropriate however, because even under the less deferential analysis prescribed by *Skidmore v. Swift & Co.*, 323 U.S. 134, 65 S. Ct. 161 (1944),

the Court is persuaded that summary judgment should be granted in favor of the Secretary. *See Mead,* 533 U.S. at 221, 121 5. Ct. at 2168 (holding that the less deferential *Skidmore* standard still applies when *Chevron* deference does not); *Christensen,* 529 U.S. at 587, 120 5. Ct. at 1662-63 (holding That where *Chevron* deference is unwarranted, agency interpretations are still "'entitled to respect' ....but only to the extent those interpretation have the 'power to persuade"' (quoting *Skidmore,* 323 U.S. at 140, 65 S. Ct. at 164). The reasons for this finding need not be set out here, as they have already been discussed above and would not differ. The Court will simply reiterate its conclusion that 42 U.S.C. §1395x(r) does not prevent doctors of medicine and osteopaths from performing a "manual, manipulation of the spine to correct a subluxation." Accordingly, the Court finds that the Secretary is entitled to summary judgment on Count Ill.

Ill. COUNT V

Count V alleges that the agency has misappropriated Medicare funds. ACA reasons that payments are made to M+C organizations by CMS to compensate these organizations for provision of covered services, a portion of which is for provision of manual manipulations of the spine to correct a subluxation. Am. Compl. at ¶ 95. ACA claims that these funds have been "(1) wrongfully paid to [M+C organizations] for providing purported "chiropractic services" through non-chiropractors and/or (2) wrongfully withheld from chiropractors and their patients on the basis that the [MA-C] does not provide the services of chiropractors." Pl.'s Mem. Supp. Summ. J. at 32-33. ACA then requests that the misspent funds be calculated and earmarked for future provision of services performed by chiropractors. Am.

Compl. at ¶ 97.

This claim is derivative of Counts II and Ill of the amended complaint. ACA must have prevailed on at least one of the interpretational issues presented in Counts II and III for this Court

to find that funds have been "wrongfully paid" or "wrongfully withheld" for purposes of Count V. *See* El's Rep. Mem. Supp. Summ. J. at 24 ("If the court grants ACA's Cross Motion For Summary Judgment regarding statutory construction, then the ACA should be permitted to prove-up its damages."); Def.'s Mem. Supp. Summ. J. at 30-3 1. ACA however, has prevailed on neither of these two counts. ACA agreed to a stipulation of dismissal as to Count II and filed if with the Court on March 1, 2002, depriving the Court of the ability to consider the allegations contained in that Count.[6] Count 111 remained pending, but as the Court has outlined above, the Secretary is entitled to a grant of summary judgment. Accordingly, ACA has failed to demonstrate that CMS has misspent, misdirected or misappropriated funds. The Secretary is therefore entitled to an award of summary judgment as to Count V.

IV. CONCLUSION

For the foregoing reasons, the defendant's motion for summary judgment is granted as to Counts Ill and V. The plaintiffs cross-motion for summary judgment is denied. So ordered.

Date: October 14, 2004

JOHN GARRETT PENN
United States District Judge

The Stipulation of Dismissal specifically states that "this stipulation does not constitute an admission of fact or law by either party.