

# Technical Report

## Comparison of the Management Costs for Complicated and Uncomplicated Low Back Pain Among Different Provider Types: Doctors of Chiropractic, Medical Doctors, and Physical Therapists

The North Carolina State Health Plan for Teachers and State Employees,  
2000-2009

Eric L. Hurwitz, DC, PhD

Professor of Epidemiology  
Office of Public Health Studies  
Department of Public Health Sciences  
John A. Burns School of Medicine  
University of Hawaii, Mānoa  
Honolulu, HI 96822

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## Introduction and Methods

This technical report of North Carolina medical claims data analysis focuses on patients with uncomplicated low back pain (ULBP) and patients with complicated low back pain (CLBP) diagnoses reported during years 2000-2009. Each reporting year represents a benefit year starting in July and ending in June. This was done to use the same benefits in a fiscal year. The initial data extraction for this study included the claims for 664,000 covered lives comprising 62% female and 37% male patients. For uncomplicated low back pain, 2,075,866 claims met the inclusion criteria; for complicated low back pain, 1,083,496 claims met the inclusion criteria. Medicare and non-North Carolina residents were excluded.

This report is the first installment in an analysis of some of the most common musculoskeletal conditions seen by health care providers. These conditions include complicated and uncomplicated low back pain, complicated and uncomplicated neck pain and headaches. Following this report, complicated and uncomplicated neck pain and headache will be analyzed and this report will be revised and expanded to include these conditions.

### *Diagnoses*

Patients with uncomplicated low back pain have primary diagnoses falling in the following ICD-9 categories: Lumbago (724.2), lumbar spondylosis (721.3), sprain/strain (847.2), facet syndrome (724.8), muscle spasm (728.85), spondylolisthesis (756.12), facet joint fixation (718.48), and facet joint swelling (719.08).

If a patient's primary diagnosis falls in the categories of degeneration of intervertebral disc (722.52), lumbar stenosis (724.02), compression of spinal nerve root (724.9), disorder of intervertebral disc with myelopathy (722.73), lumbar spondylosis with myelopathy (721.42), neuritis or radiculitis (724.4), numbness or tingling (782), sciatica (724.3), then this patient belongs to the complicated low back pain group.

### *Health-care providers*

The provider type for both uncomplicated and complicated low back pain can be classified into four types: DC, MD, PT, and referral (ref), with each of them defined as DC=Chiropractic; MD=Medical Doctors and Doctors of Osteopathy in General Practice, Internal Medicine, Neurology, Neurosurgery, Obstetrics, Obstetrics-Gynecology, Orthopedic Surgery, Osteopathy, Pediatrics, Physical Medicine Rehab, General Surgery, Family Practice, or Geriatric Medicine; Nurse Practitioner; Podiatry; Public Health; University/College Infirmary; Urgent Care; VA/Military Hospital-Professional Staff; PT=Physical Therapy; and referral=hospitalization, surgery, emergency medicine, diagnostic radiology, durable medical equipment, laboratory, pharmacy, and other specialty referral services and providers.

### *Claim types*

For each fiscal year, the drug claim data is combined with the medical claim data based on each patient's unique ID. There are five major claim types based on the service provided to each patient: "Office Visit", "MRI\_CT", "DX\_RAD", "Physical Therapy", and "Surgical". The five major claim types are defined as follows:

Office Visit: the place of service provided is in office.

MRI\_CT: If the service type belongs to CAT scan, magnetic resonance imaging, computerized axial tomography or similar services, then the claim type is MRI\_CT.

**DX\_RAD:** If the service type belongs to diagnostic X-ray, arthrography, radiologic examination, or similar services, then the claim type is DX\_RAD.

**Physical Therapy:** the provider specialty is physical therapy or the service type belongs to physical therapy.

**Surgical:** surgical services and ancillary services provided by a neurosurgeon, orthopedic surgeon, or general surgeon for patients diagnosed with one or more of the uncomplicated or complicated low back pain diagnoses listed above.

### *Patterns of care*

Based on the utilization of providers, patients were classified into 15 care patterns:

1. MD\_only: Patients who only use MD service
2. DC\_only: Patients who only use Chiropractic service
3. PT\_only: Patients who only use Physical Therapy
4. RE\_only: Patients who only use referred provider
5. MD\_DC: Patients who use both MD and Chiropractic service
6. MD\_PT: Patients who use both MD and Physical Therapy
7. MD\_RE: Patients who use both MD and referred provider
8. PT\_DC: Patients who use both Physical Therapy and Chiropractic
9. DC\_RE: Patients who use both Chiropractic and referred provider
10. PT\_RE: Patients who use both Physical Therapy and referred provider
11. MD\_DC\_PT: Patients who use MD, Chiropractic, and Physical Therapy
12. MD\_DC\_RE: Patients who use MD, Chiropractic, and referred provider
13. RE\_DC\_PT: Patients who use Chiropractic, Physical Therapy, and referred provider
14. MD\_PT\_RE: Patients who use MD, Physical Therapy, and referred provider
15. MD\_DC\_PT\_RE: Patients who use all four providers

Among these 15 care patterns, the PT\_only and RE\_DC\_PT care patterns were not included in tables due to small sample size. Any negative medical or pharmaceutical charges (allowed amount, member liability, and paid amount) were excluded from the analysis. Note: Episodes of care were not used. Episodes of care would have required arbitrary definitions of (a) episode length, (b) time lapse between visits, and (c) time to recurrence.(e.g., reoccur in 1 week, 1 month or 1 year) that have not been validated.

### *Statistical analysis*

SAS 9.2 (Cary, NC) was used for data management and statistical analyses. The demographic variables analyzed are age and gender. Age is calculated as from the patient's birth date as of January 1<sup>st</sup> of the reporting

year. The summary statistics for age were calculated for each care pattern using the proc means procedure in SAS. The frequency distributions of gender and age group ( $\geq 18$  or  $< 18$ ) were calculated by the proc freq procedure in SAS. Proc means and proc freq are the primary procedures in SAS for computing descriptive statistics.

The number of claims for each care pattern was identified by the proc freq procedure in SAS. The number of claims in each provider group for each care pattern was found by the cross tabulation of care pattern and provider type. Within each of those five claim types, the care pattern and provider type were cross-tabulated to identify the number of claims in each provider group for each care pattern by the proc freq procedure in SAS 9.2.

The total and per claim medical, pharmaceutical, and combined expenses were summarized for each patient using the proc means procedure in SAS 9.2. The patient-based and claim-based mean and median of medical, pharmaceutical, and combined medical and pharmaceutical expenses were then summarized for each care pattern by the proc means procedure in SAS 9.2. Pharmaceutical data included only categories for skeletal muscle relaxants, analgesics, antipyretics and anti-inflammatory agents. Pharmacy data were included only on patients that met the diagnostic inclusion criteria.

## Results

Utilization and charges by pattern of care for each year are reported in diagnosis- and year-specific Tables 1 through 4. Table 5 for each year shows age and gender distributions (by care pattern) of patients with at least one claim in that year. Approximately two-thirds of patients in both groups of low back pain (uncomplicated and complicated) are female. Complicated low back pain patients are three to four years older, on average, than uncomplicated low back pain patients. Although patterns of care vary somewhat by age and gender, there are no consistent or significant differences by provider type.

Year-to-year utilization and charges by care pattern are shown in Trend tables 1 through 10 and in the year-to-year trend graphs.

### *Year-specific table contents*

Table 1: Utilization and charges, by patient (n=) and claim (n=).

Table 2: Overall (medical + pharmaceutical) mean and median charges (\$) according to pattern of care, by patient and claim.

Table 3: Charges (\$) per patient and claim, by care pattern and claim type.

Table 4: Overall medical and pharmaceutical charges (\$) per patient and claim, by care pattern and claim type.

Table 5: Age and gender distributions for patients (n=).

### *Trend table contents*

Table 1: Number of patients / number of claims.

Table 2: Mean (median) allowed charges per patient / mean (median) allowed charges per claim.

Table 3: Mean allowed charges for in office claims per patient / mean allowed charges for in office claims per claim.

Table 4: Mean allowed charges for MRI\_CT claims per patient / mean allowed charges for MRI\_CT claims per claim.

Table 5: Mean allowed charges for DX\_RAD claims per patient / mean allowed charges for DX\_RAD claims per claim.

Table 6: Mean allowed charges for PT\_THE claims per patient / mean allowed charges for PT\_THE claims per claim.

Table 7: Mean allowed charges for surgical claims per patient / mean allowed charges for surgical claims per claim.

Table 8: Mean (median) allowed overall medical charges per patient / mean (median) allowed overall medical charges per claim.

Table 9: Mean (median) allowed overall pharmaceutical charges per patient / mean (median) allowed overall pharmaceutical charges per claim.

Table 10: Mean (median) allowed overall medical + pharmaceutical charges per patient / mean (median) allowed overall medical + pharmaceutical charges per claim.

### *Year-to-year trend graphs*

Year-to-year trends in utilization and charges for each care pattern are illustrated in the attached line graphs for each type of low back pain.

### *Uncomplicated low back pain*

Results summary: Reference points of average numbers of claims, average charges per claim and average overall allowed charges per patient were used to analyze costs. Average numbers of claims per patient are two to three times greater for care patterns that included chiropractic compared with patterns involving medical care (e.g., 15.7 vs. 5.3 in 2000; 16.5 vs. 6.3 in 2009); however, charges per medical claim were twice to three times greater on average than chiropractic claims. For all years, care patterns involving multiple types of providers resulted in significantly greater average charges per patient than care patterns involving single providers. In general, care patterns with MDs and referrals resulted in greater average charges per patient than care patterns with non-referral provider types such as DC and PT providers. Charges are generally greatest when referrals are involved. When looking at average overall allowed charges (which differs from individual claim charges), MD-only care, DC-only care, and MD-DC care are consistently the three least expensive patterns of care for uncomplicated low back pain (mean [median] total allowed charges in 2009 of \$978 [\$182], \$1165 [\$277], and \$1667 [\$300], respectively).

Medical care with physical therapy is more expensive than medical care with chiropractic whether or not care includes referral providers. Without referral providers involved, medical care with physical therapy was on average more expensive than medical care with chiropractic. With referral providers, medical care with

physical therapy was on average \$561 (in 2000) to \$2508 (in 2008) more expensive than medical care with chiropractic.

Mean difference in total allowed charges for medical care with physical therapy vs. medical care with chiropractic care for uncomplicated low back pain, by referral status and year.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
No ref	+\$373	+\$423	+\$361	+\$706	+\$723	+\$762	+\$477	+\$269	+\$254	+\$303
W/ref	+\$561	+\$1105	+\$1659	+\$2028	+\$1681	+\$1639	+\$1763	+\$1746	+\$2508	+\$1308

Trends: Number of patients with at least one claim for uncomplicated low back pain increased from 13,534 in 2000 to 31,964 in 2009 (136% increase). Total claims increased from 110,134 in 2000 to 263,112 in 2009 (139% increase). Total allowed charges for the year increased from \$20,232,558 in 2000 to \$69,317,553 in 2009. Total charges increased almost threefold (2.95) from 2000 to 2006, then declined slightly between 2006 and 2007 (from \$59,575,853 to \$59,095,693) before escalating by 17% from 2007 to 2009. Of historical note; on October 1, 2006, a legislative mandate was implemented for the State of North Carolina Employees Health Plan. The mandate required that insurance copays for primary care and chiropractic care be equal. Up until that point, chiropractic copays were equal to higher specialist levels. This mandate was reversed effective October 1, 2007 and chiropractic copays were returned to the higher specialist levels.

Average total charges for all care patterns combined increased from \$1495 in 2000 to \$2396 in 2006 (60% increase), and declined to \$2096 in 2007 (12.5% decrease) before climbing up to \$2220 in 2008 and \$2169 in 2009. Over the decade, average total allowed charges for uncomplicated low back pain increased by 45%.

Sum and mean of total allowed charges for all care patterns combined for uncomplicated low back pain, by year.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Sum	\$20.2M	\$34.1M	\$41.0M	\$47.2M	\$54.3M	\$58.7M	\$59.6M	\$59.1M	\$66.4M	\$69.3M
Mean	\$1495	\$1792	\$1876	\$2116	\$2363	\$2394	\$2396	\$2096	\$2220	\$2169

Numbers of patients and claims in all care patterns increased over the 10-year period; however, gains were greatest among care patterns involving MDs, PTs, and referrals. Numbers of patients in DC-care patterns increased the least amount. Numbers of patients in care patterns with MDs (with or without referral to PT or other providers but without DC care) increased from 7,375 in 2000 to 21,044 in 2009, a gain of 13,669 patients (185% increase), whereas numbers of patients in care patterns with DCs (with or without MDs or referral care but without PT care) increased from 3,390 in 2000 to 5,055 in 2009, a gain of 1665 patients (49% increase). Concomitant medical claims increased from 38,712 in 2000 to 133,435 in 2009, a gain of 94,723 claims (245% increase), whereas concomitant chiropractic claims increased from 53,119 in 2000 to 83,565, a gain of 30,446 (57% increase).

In office allowed and other charges per patient generally increased for most care patterns up to 2006, then declined between 2006 and 2009. With the exception of MD-only care, total allowed charges per patient generally increased up to 2006 and decreased thereafter. Comparing total allowed charges for uncomplicated low back pain in 2000 and 2009, care patterns showing significant increases in means are DC\_RE [from \$2081 to \$2424], MD\_DC\_PT\_RE [from \$4053 to \$6292], MD\_DC\_RE [from \$2823 to \$3807], MD\_RE\_PT [from

\$3384 to \$5115], MD\_RE [from \$2167 to \$3152], MD\_only [from \$608 to \$978], PT\_RE [from \$3272 to \$4033], and RE\_only [from \$1398 to \$2314]. DC\_only mean charges did not increase or decrease, but remained stable. Total allowed charges did not decline significantly for any care pattern.

*Complicated low back pain*

Results summary: Patterns of care involving chiropractic had on average double to triple the number of claims per patient compared to that of medical care (e.g., 19.9 vs. 5.8 in 2000; 20.4 vs. 7.9 in 2009); however, chiropractic claims were on average one-third to one-half the cost of medical claims. For all years, care patterns involving multiple types of providers resulted in greater average charges than care patterns involving single providers. In general, care patterns with MDs resulted in greater average charges than care patterns with non-referral provider types. As with uncomplicated low back pain, charges are generally greatest when referrals are involved, and DC-only care and MD-only care are consistently the least expensive patterns of care (mean [median] total allowed charges in 2009 of \$1394 [\$324] and \$1498 [\$250], respectively).

Medical care with physical therapy is generally less expensive than medical care with chiropractic when care does not include referral providers (mean total allowed charges in 2009 of \$1888 vs. \$2642); however, when referral care is involved, the combination of medical and chiropractic care is generally less expensive than the combination of medical and physical therapy care. Without referral providers involved, medical care with physical therapy was on average \$494 (in 2004) to \$1567 (in 2006) less expensive than medical care with chiropractic. With referral providers, medical care with physical therapy was on average \$1270 (in 2009) to \$3038 (in 2004) more expensive than medical care with chiropractic.

Mean difference in total allowed charges for medical care with physical therapy vs. medical care with chiropractic care for complicated low back pain, by referral status and year.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
No ref	-\$1032	-\$982	-\$627	-\$564	-\$494	-\$1199	-\$1567	-\$928	-\$1504	-\$754
W/ref	+\$1592	+\$1453	+\$2183	+\$2544	+\$3038	+\$1810	+\$2044	+\$1450	+\$1463	+\$1270

Trends: Number of patients with at least one claim for complicated low back pain increased from 5,097 in 2000 to 14,139 in 2009 (177% increase). Total claims increased from 53,705 in 2000 to 151,012 in 2009 (181% increase). Total allowed charges increased from \$15,940,924 in 2000 to \$60,872,188 in 2009. There was a threefold increase in total charges from 2000 to 2006 (\$47,464,445) and a slight decline to \$46,469,859 in 2007. Total charges rose sharply in the last two years, however, to \$52,199,992 in 2008 and \$60,872,188 in 2009 (31% increase from 2007 to 2009). Average total charges for all care patterns combined increased from \$3128 in 2000 to \$4465 in 2006 (43% increase), and declined to \$3768 in 2007 before escalating to \$3977 in 2008 and \$4305 in 2009. Over the decade, average total allowed charges for complicated low back pain increased by 38%.

Sum and mean of total allowed charges for all care patterns combined for complicated low back pain, by year.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Sum	\$15.9M	\$26.2M	\$29.2M	\$33.4M	\$42.6M	\$43.8M	\$47.4M	\$46.5M	\$52.2M	\$60.9M
Mean	\$3128	\$3752	\$3524	\$3988	\$4680	\$4359	\$4465	\$3768	\$3977	\$4305

As with uncomplicated low back pain, numbers of patients and claims in all care patterns increased over the 10-year period; however, gains were greatest among care patterns involving MDs, PTs, and referrals. Numbers of patients in DC-care patterns increased the least amount. Numbers of patients in care patterns with MDs (with or without referral to PT or other providers but without DC care) increased from 2798 in 2000 to 9122 in 2009, a gain of 6,324 patients (226% increase), whereas numbers of patients in care patterns with DCs (with or without MDs or referral care but without PT care) increased from 1427 in 2000 to 2540 in 2009, a gain of 1113 patients (78% increase). Concomitant medical claims increased from 16,315 in 2000 to 71,702 in 2009, a gain of 55,387 claims (339% increase), whereas concomitant chiropractic claims increased from 28,468 in 2000 to 51,778, a gain of 23,310 (82% increase).

On average, in office allowed and other non-pharmaceutical charges per patient increased from 2000 to 2006, and then declined thereafter for most patterns of care. Pharmaceutical charges tended to increase, on average, over the 10-year reporting period. Total allowed charges associated with MD-only care or MD care with referrals tended to increase, on average, whereas charges associated with other care patterns decreased over time. Comparing total allowed charges for complicated low back pain in 2000 and 2009, care patterns showing significant increases in means are MD\_DC\_PT\_RE [from \$4293 to \$10,201], MD\_DC\_PT [from \$1449 to \$2281], MD\_DC\_RE [from \$4678 to \$6455], MD\_RE\_PT [from \$6270 to \$7725], MD\_RE [from \$5125 to \$6224], MD\_only [from \$907 to \$1498], and RE\_only [from \$2443 to \$3913]; total allowed charges decreased significantly in the PT\_DC care pattern [from \$7348 to \$3404]. DC\_only mean charges did not increase or decrease, but remained stable.

## **Discussion and Conclusions**

Utilization (numbers of patients and claims) are greater for uncomplicated low back pain; however, charges are substantially greater for care of complicated low back pain. Mean and median per-patient and per-claim charges associated with both uncomplicated and complicated low back pain varied significantly by pattern of care during the 2000-2009 decade. In general, patterns of care involving multiple providers and referrals incurred the largest charges, while patterns of care involving single or non-referral providers incurred the least charges. Mean charges are substantially higher than median charges for all care patterns, indicating the presence of extremely high-cost cases among the care patterns. Numbers of claims per patient are higher when chiropractic care is involved; however, mean charges per chiropractic claim are significantly less than mean charges per medical claim. Mean charges per physical therapy claim are higher than mean charges per chiropractic claim; however, numbers of physical therapy claims per patient are on average fewer than numbers of chiropractic claims per patient.

Utilization increased for all care patterns over the decade; however, utilization increased most dramatically for care involving MDs, PTs, and referral providers. DC care showed the least gains in patients and claims over the decade. In fact, numbers of claims involving DC care were greater than numbers of claims involving MD care in 2000 (53,119 vs. 38,712 for ULBP; 28,468 vs. 16,315 for CLBP) but not in 2009 (83,565 vs. 133,435 for ULBP; 51,778 vs. 71,702 for CLBP). Charges increased considerably on average for both uncomplicated and complicated low back pain from 2000 to mid-decade and decreased or stabilized, then increased again in 2008 and 2009. This opens the question of the possible impact of policy changes taking place between 2005 and 2007. Complicated low back pain resulted in greater charges than uncomplicated low back pain for all care patterns except for patterns involving PTs, MDs, and DCs together.

For several years, 2006-2009, risk scores were available for analysis. The scores reflect measure of risk of expected health care cost and utilization relative to that of the overall population. For example, a score of 1.00 indicates risk comparable to that of the population used in developing the risk groups, whereas a score of



2.00 indicates 100% greater risk than the average for the population. The risk score tables are included in the table section of this report (see Appendix pages 501-502).

The risk score data revealed: patterns of care with MDs generally have higher risk scores than patterns of care with DCs, but the scores do not appear highly divergent from each other. For example, looking at the uncomplicated low back pain, 2009 medians (which are more stable estimates because of outliers that skew the means), MD only care has a median of 1.25 vs. 1.14 for DC only care (about a 10% difference). Comparing MDs and DCs with and without referral, the difference is about 16%. As expected, the risk scores for complicated low back pain are higher than for uncomplicated low back pain, but the MD vs. DC differences are largely similar and in the same direction, e.g., MD only vs. DC only in 2009 (11% greater median risk for MD only cases), MD with referral vs. DC with referral (9% greater median risk for MD cases).

The question is, are 10-20% differences in risk (or 0.10-0.20 absolute differences) of expected health care cost and utilization clinically important? Using an analogy with blood pressure, a treatment that results in a systolic blood pressure reduction from 140 mmHg to 120 mmHg would be considered important (clinically significant) in comparison to another treatment that results in a reduction from 140 mmHg to 135 mmHg. In contrast, treatments that result in blood pressure reductions of 2 vs. 4 points would probably not be considered clinically meaningful. Though we would like to know if the differences in risk scores between the different patterns are clinically meaningful or not, we are unable to answer that question.

Overall, for uncomplicated low back pain in 2009, care patterns with MDs (with or without referral to PT or other providers but without DC care) incurred average total per patient charges of \$2212.36; and care patterns with DCs (with or without MDs or referral care but without PT care) incurred average total per patient charges of \$1363.01. Therefore, MD care for uncomplicated low back pain in 2009 was on average \$849.35 (or 62.3%) more expensive than DC care. Although pharmaceutical charges account for about one-third of total charges, physical therapy charges are responsible for much of the difference in charges between MD and DC care for uncomplicated low back pain. On average over the decade, the combination of medical and chiropractic care (without additional referral care) incurred \$465 fewer total charges per patient than the combination of medical care with physical therapy (without additional referral care). The combination of medical and chiropractic care with additional referral care incurred \$1600 fewer total charges per patient than the combination of medical and physical therapy care with additional referral care.

Overall, for complicated low back pain in 2009, care patterns with MDs (with or without referral to PT or other providers but without DC care) incurred average total per patient charges of \$4909.10; and care patterns with DCs (with or without MDs or referral care but without PT care) incurred average total per patient charges of \$1745.80. Therefore, MD care for complicated low back pain in 2009 was on average \$3163.30 (or 181.2%) more expensive than DC care. Surgery, advanced imaging, and physical therapy charges are the main drivers of the difference in charges between MD and DC care for complicated low back pain. On average over the decade, the combination of medical and chiropractic care (without additional referral care) incurred \$965 greater total charges per patient than the combination of medical care with physical therapy (without additional referral care). The combination of medical and chiropractic care with additional referral care incurred \$1885 fewer total charges per patient than the combination of medical and physical therapy care with additional referral care.

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