Dynamic Chiropractic

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Running Amok

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We have a problem in this profession with file reviewers who have run amok. You all know what I'm talking about: the DC who makes a hefty chunk of change in the employ of insurance companies and MCOs cutting and slashing the fees of hard working field practitioners. In a recent previous edition of DC, I discussed a related case in which an RN was used to deny the DC's medical bills. The present editorial looks at the problem of DCs hamstringing other DCs for fun and profit.

In theory, peer review of patient medical records helps to guard against physician overutilization and fraud. I don't believe I have ever heard that protection of patients' welfare is the chief goal, but it seems improbable that insurance companies would spend the money necessary merely to protect patients from the relatively small risk posed by excessive or unnecessary chiropractic treatment. The conclusion to be drawn from this is that the insurers order file reviews in an attempt to curb expenses. Recent court decisions punishing insurers for unfair practices against DCs in California and Missouri are evidence of this prevalent activity.

And, to put things in perspective, the insurance industry annually spends about $19.1 billion for soft tissue injury claims. State Farm Insurance Company reports a per-claim average of about $3,300 for bodily injury liability, $4,000 for personal injury protection (no-fault), and $2,600 for medical payments coverage. The National Safety Council reported that the total cost of motor vehicle accidents in 1993 exceeded $167 billion. In addition to the cost of motor vehicle accidents, work injuries cost Americans $111.9 billion, home injuries cost $86.5 billion, and public nonmotor vehicle injuries cost $58.9 billion, bringing the grand total to $407.5 billion. For the motor vehicle accidents, the costs are shared primarily by just a handful of insurance companies -- no small wonder then that they take these claims very seriously.

I've read that the insurance industry generally reports fraud to account for about 10 percent of their costs. If this figure is accurate we might expect the rate of file review to be somewhat higher -- say 20 percent. On the surface then, file reviews, if conducted fairly and reasonably, might serve to pull the reins in on those who abuse the system.

The question then becomes, "What is fair and reasonable?" A file review ordered after 12 weeks of care might seem reasonable if you subscribed to the 6-12 week recovery myth. Of course, almost 50 percent of patients will still be symptomatic at this point,1 and many patients will still require ongoing treatment at that time. But, if the reviews are performed by reasonable doctors, they should not, theoretically, present a serious roadblock to the access to health care by the patient. File reviews ordered within the first few treatments, on the other hand, might suggest that either the doctor is perceived as a frequent offender by the insurance company, or the process of review is random and disorganized, or the company is disingenuous in its motives and the file reviews are prescribed capriciously or for the purpose of harassment.

A question that should be addressed, I believe, is the depth or extent of opinion that can reasonably be provided by our "reasonable file reviewer." Typically, reviewers are provided with only scant information, such as initial reports, billing records, and intake forms. Radiographs are not usually reviewed. Frequently the treating doctor's examination form or SOAP notes are not seen by

reviewers either. And the reviewer, of course, rarely has any direct contact with the patient.

Payers may argue that this is merely a practice of convenience and practicality. After all, they already have these records and don't have to request additional information from the treating doctor. And besides, file reviews themselves become even more expensive when reviewers have to look at additional data. The argument, however, fails to skirt the problem encountered with long distance assessment of the reasonableness of care which is made, in some cases, in a virtual information vacuum. In my own experience, file reviewers typically come to the full breadth of opinion(s) regardless of the amount of information provided to them, suggesting that, to some at least, patient records and clinical data are not primary determinants of their findings.

Many reviewers are now in the habit of simply marking the injury date on a calendar, counting forward exactly 12 weeks, and recommending termination of chiropractic care at that time. This practice is to be condemned in the most severe way. To begin with, there is no evidence that most persons recover in that time, or do not require care at the 12 week postinjury point. None. And I will buy anyone a case of champagne that shows me any valid contravening scientific evidence. And, although evidence showing that most people are in need of care at that point is also lacking, we do know that most are still symptomatic at that time. Moreover, anyone with any clinical experience can testify to the fact that some significant percentage of whiplash patients require care beyond 12 weeks. The calendar method is based on nothing more than fallacy. For an educated health care professional, who has at least some training in statistics and epidemiology, to engage in such fatuous and unscientific activity is simply shameful and unethical.

However, the practice of "calendar reviewing" also suggests that basing treatment decisions on statistics and probabilities has become an accepted form of clinical decision making. This is not quite the way things work. The science of informatics will allow us to use statistics, epidemiology, and evidence-based clinical science to determine the best forms of treatment for various conditions and how much treatment is necessary. But these can only be stated in probabilistic terms. For example, suppose a certain surgical procedure in an otherwise healthy adult will require an mean of 2.5 inpatient hospital days. For an elderly patient, the inpatient time will average 3.5 days. Statistics such as this are helpful in a number of ways: for health care planning, to allow hospitals to evaluate their efficiency, for studying special at-risk populations, and even for scientific research (comparing, for example, a new postsurgical nursing procedure to the normal procedure and measuring the total inpatient time as an outcome measure).

However, with the advent of new information come new ethical concerns. Guidelines and protocols are developed to improve health care, not ration it. If the elderly patient after the above surgical procedure develops a deep vein thrombosis and life threatening pulmonary complications on day three, will we send her home tomorrow to fend for herself based coldly on the statistical average 3.5 day hospital stay? Certainly not. The 3.5 days figure is merely a statistic. Complications are unforeseeable and are, in fact, factored into that statistic. It would be more reasonable to look at the hospital's yearly statistics for its geriatric surgical population undergoing that procedure, and then compare the average hospital stay to the 3.5 gold standard. It may well be that the hospital's average is lower than 3.5 days, despite a few complicated cases that exceeded seven days.

So, turning back to our "calendar review," it becomes clear that all persons are being held to a fallacious statistic without consideration of complicating circumstances. But just like our elderly patient with postsurgical complications, whiplash victims also have complications. They collectively suffer from a very broad range of lesions, a broad range of comorbid conditions, and a broad range of injury severities. Statistically, as many as half may have long-term complaints; about 10 percent become disabled from whiplash injury. It would seem to me that a more clinically insightful and compassionate method might be applied -- one that would account not only for the known risk

factors and special complications, but also for the patient's subjective and objective status at the time of file review. Cutting treatment based solely on calendar dates does not follow any accepted form of peer review, is naive at best, and perhaps also unethical.

As a philosophical counterargument, we physicians could be accused of hiding behind the Hippocratean school philosophy as a means to evade some of the problems imposed by today's vexing new problems of health care cost containment. It is easy to say that all we shall be concerned with is the oath we took in chiropractic school: salus aegroti suprema lex (the welfare of the sick is the supreme law). We thus feel entitled to be reviled by cost containment that curtails the patient's access to health care, particularly at our clinics. But we will have to walk from beneath the umbrella of this ancient credo and accept our share of the responsibility for developing new practice guidelines that, one hopes, will eliminate much of the current polemics in peer review.

Solutions?

In the meantime, because I firmly believe that any system requires a set of checks and balances to operate efficiently and fairly, I am providing the following suggestions in the hope that readers who are politically inclined will take them to heart and start the ball rolling.

In my opinion, some limit should be placed on the minimum necessary documentation that should be made available to file reviewers before they are permitted to express opinions in a peer review fashion. Standards of reviewer competency should be developed and adopted. Reviewers who are qualified should pass a written examination and become certified. Some of the following might be considerations for the qualification of file reviewers:

1. Reviewing doctors should be members of the same profession as the treating doctor.

2. Reviewing doctors should have equal specialty training to the reviewed doctor, e.g., only a DABCO may review the records of a DABCO.

3. Review doctors should have at least 5 years of full time clinical practice experience before becoming certified as a file reviewer. [Currently, many reviewers are 1st year graduates who have apparently solved the problems of the "clinical practice lean years syndrome" by arrogantly telling veteran clinicians how to practice.]

4. File reviewers should be licensed to practice in the same state as that of the treating doctor.

5. File reviewers should currently have an active treating practice that contributes at least half of their total professional income. [Many file reviewers conveniently operate out of their homes and have no clinical practice and only limited clinical experience.]

6. The names of the file reviewers should be made available to the treating doctor.

7. A grievance committee for arbitrating disputed reviews should be established. This committee should also have the authority to take administrative action against file reviewers

found to be lacking in sound clinical judgment, engaging in unethical practices, or who no longer satisfy the requirements established for file reviewer status.

8. File reviewers should be required to review, at minimum: the treating doctor's intake and history form(s); the physical examination form(s); all supplemental examination forms and reports; all SOAP notes; radiographic reports or hard copies of films; and all relevant records from other practitioners involved in the current co-management of the patient. When data are missing, a telephone conversation between the treating doctor and file review doctor might suffice.

9. File reviewers should be held professionally accountable in cases where their reports are relied upon by a payor and reimbursement for treatment is subsequently terminated by that payor against the advice of the treating doctor. As a direct result, the patient suffers significant harm. Thus, professional liability insurance should also be mandated. [In a recent editorial by Sigler2 it was noted that the courts have been willing to hold third party payers accountable when injury results from termination of care against the advice of the treating physician. However, one case was overturned on appeal because the treating doctor signed the release order: his remonstrations were not strong enough.]

In the absence of actual direct patient contact (with interview and physical examination), the file reviewers' comments should further be limited to issues pertaining to established clinical guidelines and protocols (which, of course, are still being developed). In other words, the reviewer is not in a position to make diagnostic or treatment decisions, but might comment that care is excessive, based on the patient's age, gender, and the presence or absence of known complicating factors and specific risk factors. These comments should be based only on the balance of evidence in the literature, not merely on the reviewer's personal bias or literature that confuses clinical recovery with return to work, as the Quebec Task Force did.

What Are Your Current Remedies?

Meanwhile, what can you do when a file reviewer makes unreasonable or unqualified recommendations? Here are some ideas. Some states have a statute that requires the insurance company to disclose the name of the file reviewer. If you are unfamiliar with the laws in your state, ask the insurance liaison officer of your state association or call the state insurance commissioner's office. If you do have access to the reviewer, call him/her and volunteer to supply any additional data that might assist the reviewer in better analyzing the case.

Some states also have requirements that reviewers possess a license to practice in the same state, or that they be in active practice, or have a specified number of years of clinical experience. Any rebuttal will be enhanced by showing that the reviewer is not so-qualified. I recall a chiropractor who began performing DMEs here in San Diego immediately upon graduation from chiropractic school, questioning the diagnostic skills and clinical acumen of myself and my colleagues with many years of clinical experience and, in some cases, extensive specialty training.

Write a rebuttal. In the rebuttal, which must always be professional and unemotional, base your arguments on the balance of scientific literature, on your professional and any postgraduate training, and on your clinical experience. If the reviewer has relied on faulty literature, point that out. Selective or inaccurate literature citation by reviewers is quite common, as noted in my previous editorial. Focus on the key issues only. Discuss your reasons for disagreement based on new literature, on known risk factors, and on specific complications/co-morbid conditions in the

particular case. Send along some articles that support your arguments.

What about the Serious Abuser?

If the reviewer's comments are libelous, unprofessional, or clinically or scientifically unsound, and you are unable to resolve the problem by direct contact with the reviewer or insurer, you might consider filing a complaint with the state board of chiropractic examiners. However, such grievances should not be made out of anger or merely for punitive purposes.

In my experience, the comments of file reviewers frequently do transgress the bounds of honor and good taste. For example, it is one thing to suggest that the care and treatment appear not to be supported by the documentation available (a convenient back door used by some reviewers who have only sketchy data from which to base their comments). It is quite another thing for reviewers to suggest that the treating doctor is purposely or fraudulently bilking the system, behaving unethically, or practicing outside the standard of care or below minimal standards of competency. Unfortunately, such derisive writings are fairly common. In the last two years I have been referred to by file reviewers as a "plaintiff-oriented entrepreneur who just teaches attorneys and doctors how to win big settlements," and someone who is "...out of touch with clinical reality and who uses literature, selectively, to support his opinions."

These individuals, aside from abandoning all appearances of objectivity, clearly stepped beyond the boundaries of file review. Their comments are libelous and defamatory. Since they were directed to an insurance carrier that I have done business with, I could easily argue a basis for damages. To the field practitioner, the damages might be based on the insurance carrier's increased harassment of the doctor and the doctor's patients--a practice that, in fact, is not uncommon.

In addition to direct discussion with the file reviewer and filing a grievance with the state board of chiropractic examiners, you can hire an attorney to write a letter to the file reviewer ordering him/her to cease and desist the libelous and defamatory activity under threat of legal action. Ask the attorney whether it would be advisable to send a copy to the carrier as well. That will usually get their attention very quickly.

When a carrier terminates payment of bills based on the reviewer's report or their own interpretations of literature, and they are not willing to allow additional care based on your rebuttal, you can file a complaint with the state insurance commissioner's office. Your patient can also write to the carrier explaining why they believe further care is warranted. The patient can also file a complaint with the insurance commissioner's office. These complaints are not innocuous. Indemnity companies with a high number of such complaints receive lower ratings and insurance brokers make decisions based on these ratings, favoring companies with the highest ratings. Brokers are in business too, and want to keep their clients happy. Selling the client a policy from a company with a low rating is simply not good business. Accordingly, carriers are very much concerned with these ratings.

Finally, for file reviewers who are notorious and intransigent in this activity, and whose opinions are clearly unreasonable, I have an idea. Try having them officially censored by the local chiropractic society. That's right, censored. This is a serious action and must be approached with care and with legal aid. It is not recommended merely as a method for railroading or retaliating against unpopular file reviewers, but as an earnest last resort in dealing with reviewers whose opinions are clearly outside of the standards of care and accepted protocols in the local community and who have not been approachable through other channels.

An official document can be drafted and sent to all insurance claims adjustors and defense lawyers

involved in the local personal injury arena informing them of the censorship. The effect of reading the official censorship letter to an arbitrator or in a courtroom proceeding will be devastating to the credibility of the file reviewer. Defense attorneys will not want to take any chances with this potential impeachment of their key experts and will quickly replace this person with another file reviewer or defense doctor with better standing in the community. Adios, unreasonable file reviewer.

References

1. Radanov BP, Sturzenegger M, Stefano GD: Long-term outcome after whiplash injury: a two-year follow-up considering features of injury mechanism and somatic, radiologic, and psychosocial factors. Medicine 74(5):281-297, 1995.

2. Sigler DC: Chiropractic liability within managed health care -- implications for managed-care organizations. J Manipulative Physiol Ther 19(5):350-356, 1996.

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