Dynamic Chiropractic

The Inherent Deceitfulness of Insurance In Today's World

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The insurance carrier use of paid "paper review" consultants or paid "independent examiners," as practiced in today's world, besides being a contradiction of terms, is deceitful from the outset. Neither follows a purpose consistent with the business of insurance, which is providing its policyholders protection from loss. Each of these is to protect the carrier from loss.

Both are thinly disguised systems designed for carriers to escape obligations. The "paper review" consultant, for example, can affirm there was never a medically necessary need; and the "IME" will rarely find anything wrong with the patient, no matter the degree of injury. Their biased reports will then allow the carrier to legally withhold benefits, cutting claims with wild abandon.

As a practical matter, does it work in such a manner? Yes, it does. Are there exceptions? Yes. But to perform as an exception assures little use by the carriers.

The two procedures, when used in tandem with a peer review system sympathetic with the carrier point of view, are also a method to contain (perhaps eventually to eliminate) the chiropractic profession.

The attending doctor who performed the necessary treatment, over whose loud objections the claim is cut, is generally regarded as an insignificant doctor who knows much less than the reviewer who is cutting fees---when actually that is rarely the case.

Essentials of the Issue

However, when boiled to essentials, "medical necessity" can only be determined by attending or examining doctors who can be held accountable for their opinions. Insurance IME's are responsible only to the carrier; the patient cannot sue them. For someone who has never seen the patient and who has no responsibility toward the patient, to second-guess at some later date is a legitimate thought only in the unfortunate psyche of an I.Q. of 36 and should be confined to institutions dedicated to caretaking crippled ideas and warped minds.

The Latest Game

One of the latest ploys is to issue policies which define key words as the insurance carrier would like to have them defined for its advantage. Some have gone so far as to place in their policies that "medical necessity" and other such terms are to be determined by the carrier.

This defies the imagination and explodes the credibility of the regulating boards allowing such maneuvers. Even as a practical matter, how can a corporation make human judgements? Any corporate officer who allows mercy and kindness to stand in the way of profitability will soon be an ex-employee.

On his way to work he might personally pay the expenses of a needy person and be commended for

it, but, at work, for him to allow a policy to be construed so as to provide the same needy person with money at the expense of the stockholders would cost him his job.

No New Deal

This corruption of definition issue is not new. Mark Twain's colorful characters invented a "five-legged dog" by voting to call the dog's tail a leg; then charged neighborhood kids admission fees to see this "most wonderful freak of nature." Eventually the sheriff demanded refunds. But in the insurance story the authorities are still allowing the public to be forced to pay admission fees to see themselves being hounded into submission. Let it not be said that much progress has been made.

Insurance carriers do have the right to examine patients, but not to determine "medical necessity" if the disorder is covered by the carrier.

A Doctor's Training

Medical necessity is a concept to be solely decided by the treating doctor. That is what he is trained for. On that issue stands all his responsibilities. Whoever heard of an insurance carrier graduating from professional school? Whoever heard of a carrier being troubled by the patient who won't respond---except cost-wise? Are carriers sued for malpractice? Whoever heard of a patient seeking treatment from an insurance company?---until lately.

The Causation Issue

The patient's expenses are not subjecting carriers to be helpless payors for all things "carte blanche" simply because the attending doctor renders treatment; there is a "causation" issue.

The loss must be a direct result of the injury or disorder for which the carrier is contractually liable. The carrier has the right to dispute liability.

But, if no dispute of liability exists they are obligated to pay "medically necessary" expenses as determined by the attending doctor. Doctors have licenses; doctors have responsibilities to the patient; doctors have examining boards to hold their excesses in check; and, finally, the insurance carrier can call the doctor to account for fraud or engage him in a civil tort action on their own initiative---but, expenses are to be paid first. All the remedies come later. And that is how it should be.

The Carrier's Responsibility

The insurance carriers' responsibility to the patient is singular: to protect him from loss. If that offends, another line of work should be considered because that is the essential business of insurance: to protect against loss. They are not qualified for other purposes, and to fail this function means they are broken and can't be relied on. That carrier is now a drain, a parasite on society.

Neither have they any business judging treatment in quality or quantity, therefore the concept of the "independent medical examiner" is without foundation. Unless there is a dispute over liability, the carriers' resistance is without privilege.

Independent medical examiners do have a place in determining handicap, the need for vocational retraining, the need for vocational rehabilitation, the qualifying for medicare and other benefits---but these do not relate to the dispute of medical necessity rendered by a qualified treating doctor

treating a covered disorder.

Hired For An Unsavory Job

Besides, such examiners are rarely independent. If so, they are usually temporary. Some are employed by the carrier; most obligate themselves to color findings in favor of the carrier because of desires for future business; some have been selected by the carrier because of the examiners' predictable ignorance, their known biases, their chauvinism, their indoctrination by the insurance industry, or, perhaps other factors. But the fact remains: their use is rarely intended to serve the interests of the injured.

Therefore, their routine use is a blatant prostitution of the purpose of insurance, being designed and promulgated for purposes of case-confusion, delay or avoidance of legitimate payments, destruction of doctor-patient relationships, and routine reduction of claims, which arbitrarily reduces the value of the contract held by their insureds. When they are irreverantly referred to as whores, there are good reasons for the terminology. Canada refers to them as Juke Box Doctors; the theory being that the tune they play is dependent on who gets his quarter to the machine first.

The Side Issues Involved

Their widespread use unsurps the authority vested in the various boards of examiners, peer review systems, the legislatures of the states granting licensure, the attorneys' general opinions, and ultimately, the courts.

Eventually, if left unchecked, they will destroy the value of licensing by violating the spirit, if not the statutes, of anti-trust legislation because, through economic power, they determine which doctors prosper and which will not.

A First Solution

The real mistake of legislators in dealing with insurance carriers is not often seen. Carriers are required to maintain a certain profitability to protect their policyholders by being able to meet their contractual obligations, but, they fail to limit their profitability, thus allowing the carrier to enter a ceaseless quest for more money. To this end, the carriers play word games where deception and delusion and hassles enter a never-ending sport of seeing how much money they can make, with no thought of the complications to other parties.

One basic solution is very simple: limit their profitability so they can do business in a manner befitting a public trust, which they are legally held to be.

Any accident victim who has been told he must settle his health care claim before the company will pay for repairs to his automobile will recognize a perfect example of the "squeeze play." Is there deception, delusion and hassling in this? Oh, yes. Then there are the 10,000 other examples. Why? Maximum profit. That's why.

Exercising the Logic Gland

It is easy to become entangled in the arguments pro and con, but the simple solution is to step back, mentally and emotionally, and address the issues with barbed questions:

1. Who is more qualified to determine medical necessity or utilization issues than the attending doctor at the time of need?

2. Do patients go to their insurance carriers for treatment? Or do carriers pay the bills to

protect against loss?

3. If it is malpractice for a doctor to render irresponsible treatment, then what is it called when an insurance carrier refuses to meet their responsibilities? (Try bad faith insurance claims practices.)

4. What possible justification could be convincing to people who are hired to cut claims? Surely we do not expect a truthful recitation of patient needs to overcome a claim cutter's personal desire to prosper.

5. Can proper treatment be given, followed by an error-filled write-up? Or is it all one procedure?

6. What are the basic differences between witch doctors, faith healers and independent medical examiners?

7. And the most mysterious question of all: Why do we stand still for such absurdities?

Bring The Farce To An End

Here are a few suggestions regarding how the chiropractic profession can effectively resist these practices:

1. Determine if any elected leader, officer, member of boards of examiners, boards of reagents, or boards of directors of any local, state or national organization act as "paper review consultants" or "independent medical examiners" for the insurance industry. If so, ask them to resign, vote them out of office or charge them with a conflict of interest along with publicizing their identities.

   Your chiropractic organizations can never be effective instruments in protecting your interest as long as their leaders suck milk from your professional enemies.
2. Join a class action litigation if one is active in your state or look for one of the bountiful bad faith insurance claims from your own practice and file litigation yourself. Judgments from bad faith insurance claims practices are based on the worth of the carrier and have no relationship to the actual value of the claim itself.

3. Get straight in your head the following things:
    1. The position of the treating doctor.

    2. The "job of the paper review consultant, that is, what he must do to stay in the good graces of his employer, the insurance carrier?

    3. The role expected of the carrier-hired "independent" medical examiner.

    4. Now, what is the patient actually entitled to because of his contract with the carrier?

    5. What are the obligations of the insurance carrier?
4. Stop thinking of the "paper review consultants" as saviors of the chiropractic profession who perform unpleasant but necessary duties on behalf of the profession. Don't flatter them in their own eyes.

When they set standards, determine scope of practice, determine utilization, alter treatment programs of the treating doctor and substitute their own, and cut claims indiscriminately or illogically they are three things: (i) presumptuous, (ii) usurpers of proper authorities, and (iii)

servants of your profession's enemies even if they are not smart enough to be aware of it.

Greedy Chiropractors

The horror of the insurance industry has always been said to be the "unleashing" of a few greedy chiropractors. How realistic is that complaint? Well, in Florida, earlier in 1989, a study comparing MDs and DCs in 20,000 closed work-comp cases showed chiropractors to produce what multiple earlier studies also showed: DCs get their patients well in about half the time, at half the cost, with half the residual effects of their medical counterparts---and that with every chiropractic abuse, real and imagined, firmly in place.

The real problem is simple: ten years ago there were 20,200 chiropractors, today there are 45,000. These 45,000 are seeing a lot more patients than ever before. With the continued swing to insurance as opposed to cash practices, it's costly to carriers. There are also 8,300 students now enrolled in chiropractic colleges. (Figures from the Chiropractic Report, David Chapman-Smith, Vol. 3, No. 5. July 1989.) The insurance industry has never figured out that it would be twice as costly for them if every chiropractor disappeared. Amazing is the only word that describes their continued resistance.

Their exemption from anti-trust laws is the major thing making it possible; and bills to revoice their exemption are being introduced in the U.S. Congress.

In Texas the peer review system is being overhauled from the ground up; scientific councils are being established as a wellspring of professional expertise; and the leadership is maturing to the point where spades are called spades.

Several litigations in the U.S. and Canada, some now in progress, some planned, are destined to sharpen the issues. Insurance carriers will not be allowed to continue their roughshod trample. Chiropractors, be of good cheer.

PS: Our name has been changed. To avoid any confusion with existing organizations of consultants or independent medical examiners, we have selected the name Congress of Chiropractic Consultants. These guys wear white hats.

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