Dynamic Chiropractic

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Peer Review & Professional Responsibility

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Once upon a time, chiropractors basked in their glory. Patients came through the door and we billed insurance; we received checks from insurance carriers; patients returned for care; and we billed again. The checks came; the money flowed. It was a golden age.

New graduates can look back in awe at the 1980s - with probable disbelief. Insurance paid 80 percent of the bill; there were unlimited visits and no precertification. ("You could bill for what?")

Yes, it was a time to remember - before reality struck.

Chiropractic and the Need for Quality

It was the dawn of a new era: Insurers began recognizing the impossibility of an open-ended system. They saw that doctors needed to be more accountable for the care they provided, or risk losing the cash flow they so craved. Demands for accountability began, and chiropractic was targeted.

One aspect of this demand for quality was the retrospective review - the so-called "peer review" that doctors have come to dislike. Indeed, the vitriol spewed forth by review opponents and proponents has often rivaled the widest of schisms. Trade journals remain full of authors calling into question the morals of review doctors, questioning their professional (if not personal) ethics. They demand justice for the indiscretion of informed opinion, claiming the deliberate and malicious intent to "backstab" one's own brethren. They point to restrictive determinations as proof of the illegitimacy of the system, going so far as to create Web sites highlighting poorly constructed reviews and publicly flogging overzealous evaluators.

Yet, the system itself was inevitable. Simply put, fraudulent activity among health care providers stains our collective reputation. It permeates the fabric of our profession, and calls into question the very essence of our professional integrity, with unending treatment programs billed to insurance; a half-dozen modalities utilized on each visit; questionable imaging and diagnostic practices; and a seemingly endless list of "gimmick" practice management tools.[1] While some may not wish to acknowledge this exposed underbelly, the list is both real and onerous. It continues with only minor remission, and must be confronted as a significant threat to the continued expansion of our management paradigm. We cannot look away, and we cannot rationalize its existence.

A look at the current health insurance climate quickly reflects the impossibility of having continued along our charted course. A step back from the trenches of clinical practice reveals an insurance system fraught with abuse, overutilization and illegitimacy - not just in our own profession, but within all professional health care. Despite the best intentions of national and state organizations, improved educational standards, and the difficult-but-progressing efforts of clinical guideline creators, utilization management was necessary to stem the tide of unreasonable and unnecessary care. Unfortunately, many chiropractors did not see the big picture, focusing their attention on selective denials and individual reviewers instead of the system as a whole. Many have lost sight of

the forest for the trees.

The Big Lie

Dr. Dave* sees Melissa every week. He is a second-generation chiropractor, brought up on the premise that regular chiropractic care maintains a healthy immune system. Melissa's insurance doesn't cover maintenance chiropractic care, but does reimburse for treatment provided once per month, according to medical necessity. This doesn't bother Dr. Dave, who bills insurance for the monthly visit and accepts only the copayment for the other three visits. The way he figures it, the patient gets the care she needs, and he gets to see her "on his terms."

Dr. Beth deals primarily with personal injury cases. She knows from the outset that an attorney is involved, and that Joe's case will ultimately be paid out of settlement. The unspoken attorney-doctor communication is that a higher bill means a higher settlement. Therefore, Dr. Beth sees Joe three times per week - she gets to bill several therapies per session (amounting to about $200.00 per visit) and Joe sort of likes the massage he's getting from the on-staff "myofascial release therapist." Joe's case has been very complicated, necessitating 252 visits in less than two years. In peer review, Dr. Beth says that Joe is "at nearly maximum medical improvement."

Dr. Bob is a "cash doctor." He doesn't accept insurance - unless the case involves a motor vehicle or workers' compensation injury. "Insurers don't respect chiropractors," Dr. Bob says, "and I don't respect insurers." His routine office visit fee is $30.00, "so it's affordable to everyone," he adds. "Kids pay their ages."

A Look in the Mirror

The peer review system, while flawed, should not be held scapegoat for our profession's ethical shortcomings. It is nothing more than an outside opinion on the reasonableness of the care provided, having little to do with the patient, per se. Severity of the injury or the patient's response to care is secondary to the reasonableness of the treatment provided, and the doctor's ability to convey that reasonableness within the patient file. The circumstances surrounding an individual doctor's inability to follow accepted protocols, even by the most liberal definitions, in no way negates the need for intraprofessional oversight.

Peer review demands such accountability and dictates that certain principles be followed - even if the provider does not agree with the principle. For example, chiropractic parameters dictate, "Records should be maintained in a manner that makes them suitable for utilization review."[2] While many in our profession routinely decry the *Mercy Guidelines*, few would question the appropriateness of maintaining a legible file. We must appreciate the need for conformity to such basic guidelines. We are no longer a fringe profession, looking in from the outside of insurance reimbursement. Rather, we are becoming integral players, burdened with expectations befitting our status.

Detractors of peer review point out the inherent bias of a system predicated on insurance money. Reviewers have too much financial incentive to deny claims, they rightfully argue, and this remains the most substantial hurdle to appropriate peer review. But the baby must not be thrown out with the bathwater. Each health care profession utilizes peer review as a method of policing its own profession. Peer review goes back to the 11th century, when Arab physicians practiced *hisbah* ("quality control"). Even today, hospitals largely bypass the legal system to ensure that problem doctors are dealt with "in-house." For better or for worse, the system is in place.

Yet chiropractors, possibly more than others, cannot see the value of a system of checks and

balances. We turn the other cheek, blindly supporting the wildest of treatment paradigms, boldly insisting, "You can't subject innate intelligence to a randomly controlled trial." This, of course, is a cop-out. We, as professionals, must take stands that occasionally rankle feathers, and it appears that some are more willing to "let sleeping dogs lie," than to "call it like we see it."

Herein lies the rub: In chiropractic, one doctor's guidelines are another doctor's rubbish. This has held true for more than 100 years, and has never been more apparent than today. Guideline creators snarl at each other through keyboards, like two desperate animals protecting their young. Professional associations work in conjunction, then opposition, seemingly for the same, then different objectives. Practitioners look upon each other with disdain, not as peers, but as adversaries, with no mutual understanding and no effort to examine the "bigger picture."

Instead, we must look at our situation with objectivity, and see past the endless rhetoric of fringe voices. We must put our collective foot down and stamp the soil with what constitutes reasonable and necessary care. We must tackle the difficult questions, and face the answers with respect and acceptance. If I can agree that subluxation should be managed, then you can tell me how many visits it takes to manage it. If I can agree on your diagnosis of lumbar sprain, you can agree to an accepted resolution time. Maybe my number is six; maybe your number is sixteen. Maybe this is where we need to start - on determining what treatment should *not* be!

Making it Work

"Physicians and health care institutions have a moral obligation to strive for continuous improvement of services."[3]

There is a way to make peer review work, at least until research bears out the essence of clinical guidelines. Insisting that peer reviewers utilize only the utmost ethical considerations is, of course, the basic tenet of performing review work. It is also somewhat akin to asking politicians to be honest. Instead, I suggest the following:

1. Make peer review a profession-wide tool, utilizing all chiropractors on a random basis. This will ensure a wide-ranging "pool" of doctors, offering a more mainstream representation of chiropractic practice.
2. Dictate a predetermined number of peer reviews an individual doctor may perform over the course of one year's time. This will prohibit doctors from becoming professional reviewers, and keep money from being a source of impartiality.
3. Create a resource of literature from which opinion may be drawn. Demand that reviewers provide adequate representation of their opinions and avoid "selective quoting."

We can no longer remain blind to the need for professional responsibility. Blaming the peer review system does not validate our profession's inadequacies, and we must show the type of maturity implicit in our degree. It is time for us to move into the future of health care - and that future demands accountability.

References

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3. World Medical Association. *Declaration with Guidelines for Continuous Quality Improvement in Health Care*. 49th World Medical Assembly, Hamburg, Germany, November 1997.

- All names have been changed.

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FEBRUARY 2003