Dynamic Chiropractic

YOUR PRACTICE / BUSINESS

Parameters of Chiropractic Treatment -- Part I

Gerald T. Andreoli, DC

The debate continues at a high pace between chiropractors and insurance companies regarding the necessity of treatment. Not a day goes by when a chiropractic office does not receive a denial of insurance coverage based on the question of medical necessity of ongoing chiropractic treatment.

It is becoming increasingly difficult to communicate the status of a patient under chiropractic care. Chiropractors appear to be unable to convince insurance companies that continued care is necessary. On the other hand, insurance companies appear to be finding it more difficult to understand and to accept the determination by a practicing chiropractor that additional treatment of a patient is necessary.

Within the chiropractic profession there are a myriad of techniques and analytical determinations utilized to indicate a need for chiropractic adjustments. Insurance companies conveniently disregard the doctor's statement that his analysis of the patient indicates that additional treatment of the patient is required. The insurance company persistently asks for additional information to be submitted documenting the necessity of care. Chiropractors consistently repeat the presence of vertebral subluxations or other analytically determined findings to justify additional care. These daily occurrences in a busy chiropractic office are beginning to look like incomprehensible communication between two parties speaking different languages. The insurance adjuster cannot understand the language of the chiropractic physician and, likewise, the DC cannot understand the insurance company's reasoning for denying a claim.

It could be stated that the insurance company and the doctor are natural enemies because each is pushing towards opposite ends of the spectrum of patient health care. The insurance company traditionally strives to reduce the amount of care given to patients and therefore reduce the amount of reimbursement they are required to provide. The doctor on the other hand strives to give the most complete and comprehensive care necessary to help the patient to the maximum possible level. The two entities, doctor and insurance company, may never see eye to eye under the current health care system in this country. Despite this long-term opposition of purpose, there should be some common ground on which both entities can agree.

During this current health care crisis, any agreement between the insurance company and health provider comes from a forced approach. What this means is that the insurance company will try to get by with the least amount of reimbursement possible with disregard for the patient's health status. Likewise, the doctor attempts to force the greatest amount of care that the insurance company would possibly pay for as a result of this continuous conflict. Litigation or threatened litigation often occurs as a method of additional coercion for the other party to agree. The doctor, as well as the third-party payer, both resort to extreme means in order to substantiate their viewpoints.

Insurance companies have come upon the idea of utilizing paid consultants in a scam to justify their denial of reimbursement. Chiropractors are beginning to find that insurance companies can be sued

successfully in order to force the reimbursement of necessary care.

This system has become one of the "dog eat dog." As a result of this increased animosity, both the insurance company as well as the doctor are moving further to the extreme end of their continuum. This system is developing more and more animosity among all parties. The patient is obviously placed in the middle of this battle and has the most to lose. The patient also has the fewest resources with which to fight this battle.

At the present time, most insurance companies have rather unlimited resources and assets with which to maintain their position. In general, doctors have a more difficult time fighting for their position because this fight is not a doctor's primary occupational responsibility. Most doctors need and want to spend most of their time and effort treating patients. Insurance companies, on the other hand, find that it is very lucrative to expend a minor amount of money and effort to reject claims. Insurance companies have even been known to brag across the media about the millions of dollars they have saved by preventing health fraud and overutilization. What the public doesn't realize is that actual health fraud is very small and that overutilization in the eyes of the insurance company may not really be overutilization but may really be excellent complete care of a patient.

As the health care crisis in this country becomes analyzed, dissected, and diagnosed, these conflicts between insurance companies and doctors will most likely be resolved in some manner; however, we have no guarantee as to what manner the solution may come. If the solution comes in terms of managed care as the trend appears to be going, then there probably will be some group of people determining what is or what is not acceptable medical care. It is important that the gatekeepers of managed care not be the insurance companies and also not consistent totally of physicians. It would appear that the best combination would consist of partly insurance personnel, physicians, scientists, and patient advocates.

Interim Actions

While this health care crisis is being sorted out, it would be wise for all physicians, especially chiropractors, to take their proper positions in this current health care arrangement. This would require a strong positioning on the part of chiropractic organizations to place chiropractic treatment in the proper light. As a major part of this positioning, chiropractic organizations as well as individual practitioners should agree upon guidelines and criteria for the necessity of chiropractic care. The myriad of chiropractic techniques and analytical determinations should be boiled down to some basic measures to demonstrate the need for chiropractic care. Upon determination of basic criteria as indicators of the need for chiropractic care, individual practitioners and chiropractic associations should demand that these criteria be accepted by third-party payers.

The determination of criteria should avoid the reliance upon specific narrow-minded viewpoints. For example, a chiropractor's objective findings on a patient should not focus upon one variable. Objective findings should be demonstrated by the presence of as many criteria as possible. Most chiropractors agree that determination of medical necessity should not be based solely on the presence or absence of pain. To expand this concept further, determination of medical necessity should not be based solely on the presence of a subluxation either, in most cases. There may be, however, exceptions to the above two statements. If pain is of a significant nature or level, then it may be used as a sole criterion. Likewise, if a subluxation is to such a severe degree, then it alone may be utilized as a single criterion to justify the necessity of ongoing care.

Following is an example to demonstrate the above concepts. We can use as an example a patient with right cervical pain, right brachial neuralgia, and numbness of the right hand. This hypothetical case has disc degeneration at C5-C6 with minor foraminal encroachment on the right. The right brachial neuroradiculitis symptoms are intermittent. This patient exhibits subluxations of C5, T1, and T4. The subluxations may consist of physical misalignment, fixation or hypermobility. Additional findings consist of muscle spasm and tenderness along the right cervicodorsal area, along with the presence of various trigger points. X-rays exhibit a flattening of the normal cervical lordosis. This hypothetical condition resulted from a fall three years previous. The patient underwent initial intensive chiropractic care consisting of CMT three times per week for one month, gradually improving subjective and objective findings allowing the systematic lengthening of intervals between treatments over the following few months to a point where the patient now requires treatment approximately every three weeks. The subluxations or segmental dysfunctions have improved significantly, however not 100 percent. Muscle spasm, tenderness, and trigger points have significantly decreased and are absent for two to three weeks following an adjustment. The patient experiences intermittent right cervical pain and intermittent tingling or numbness of the right hand. Sleep is occasionally disturbed because of tingling in the upper extremity. The majority of the patient's normal activities are undisturbed. Occasionally a right cock-up splint of the right wrist is utilized during the night when sleep is disturbed. Symptoms are generally alleviated following CMT and the patient's good period extends between two to four weeks.

This condition is considered chronic. The patient has reached an apparent position of plateau; however, it is a position of unstable plateau. This patient may choose to schedule an appointment for CMT once every three weeks or once every four weeks on a routine basis to control the gradually escalating symptomatology following CMT. At this time, she can predict that within three to four weeks her symptoms will be elevated to a level of interference with normal daily activities or sleep so that CMT is required. Following CMT the patient then becomes asymptomatic or nearly asymptomatic which extends for another three to four weeks. This is a typical type of case that many DCs see daily in their offices. This patient is undergoing therapeutic care for a chronic condition, just as if a cardiac case or a diabetic undergoes therapeutic medical care on an ongoing basis. This type of case will undoubtedly stimulate dispute among the three interrelated parties -- the insurance company, the doctor, and the patient. This type of case is frequently denied reimbursement by most insurance companies based on the comments by the insurance company that the patient is undergoing maintenance care or there are not significant findings to justify the need for ongoing therapeutic care. Most chiropractors would disagree with this determination. The patient's agreement or disagreement with this determination is usually based upon his aggressiveness towards receiving what is rightfully his.

Many patients as well as many chiropractors are intimidated by the insurance company's denial based upon lack of objective evidence indicating a need for ongoing therapeutic care. The usual scenario would be the patient drops out of care and resorts to analgesic medication or visits to the family MD (which are normally paid by the insurance company) or the patient decides to pay for chiropractic treatment every three to four weeks out of his own pocket. The more aggressive stance is for the patient to object to the insurance company for the premature withholding of benefits and enlist the doctor to write reports in an attempt to justify the ongoing care. Usually these are feeble attempts and produce no change in the insurance company's position. The patient and the doctor become exhausted by the volume of paperwork required to fight one case out of many. As the fight is dropped, the insurance company wins and chalks this up as another success in controlling health fraud or overutilization.

This case typifies many cases handled daily in most chiropractic offices. These cases appear common partly because chiropractic is an excellent and cost-effective, efficient, and indicated treatment for these types of cases. The patient usually has nowhere else to turn. These cases are typically non-surgical and do not respond adequately to the usual anti-inflammatory, analgesic, and muscle relaxer medications. A physical treatment for a physical disorder is a natural. The problem exists when the insurance company systematically and successfully classifies the chiropractic treatment of these cases as medically unnecessary. The old term which the insurance companies have latched upon, that of maintenance care, gives them their out. As proof and backing for this determination, there is always the availability of a chiropractic consultant who is eager to come to the aid of the insurance company -- for a fee. Therefore, the evidence becomes overwhelming against the patient, and the doctor and the conflict exists.

Watch for Part II of this article in the October 23, 1992 issue of Dynamic Chiropractic.

Gerald T. Andreoli, D.C.
Arlington Heights, Illinois

SEPTEMBER 1992