Dynamic Chiropractic

Managed Care in the Workers' Compensation Environment -- Part III

MY OBSERVATIONS OF INSURANCE COMPENSATION

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Workers' compensation, and especially chiropractic services under workers' compensation, is the last bastion of unmanaged care. There is a tremendous misconception on the part of chiropractors regarding being questioned in necessity of care. We feel that we are the only ones being "picked on." This is simply not true. Chiropractors are the new players in the game. In 1985 we represented 1-2 percent of the total workers' compensation pie.[14] In 1989 we represented 10-12 percent. I have the privilege of sitting in on many high-level insurance meetings. The hospitals, primary medical care doctors, and the specialty MDs all get "picked on." And they have been "picked on" for some time, not only in the workers' compensation arena but also in the group health arena.

Over the past decade, escalation in group health medical benefits has been relentless, nearly doubling every five years. In August 1985, a "Harvard Business Review" article noted that, "Expenses for health care costs are rising at such a fast rate that, if unchecked, in eight years they could eliminate all profits for the average Fortune 500 company and the largest 250 non-industrials." In 1986, the medical cost component of the Consumer Price Index (CPI) surpassed the overall CPI by a margin of seven to one -- the largest gap between the two indexes ever recorded.

In response to such problems, group health insurers rapidly introduced, throughout the 1980s, new concepts in medical cost containment. Having both the control and discretion to quickly dictate changes in medical benefit levels, programs such as "precertification" of hospital admissions, as a prerequisite for receiving full benefits, are now quite common. Further, PPOs have rapidly been incorporated within group health plans, with employers offering increased benefits to employees if they seek care from discounted "preferred providers."

In 1984, 15 percent of all group health insurers monitored employee of programs such as hospital precertification. By 1987, only three years later, approximately 60 percent of all group health insurers had incorporated such programs as basic elements of health insurance plans (source: The Wyatt Company). Now in 1990, it is an accepted fact of life that managed care is part of group health. The federal government has imposed strict guidelines (Diagnostic Related Groups or DRGs) on hospitals and MDs for a number of years. We are "picked on" no more and no less than any other provider. It may seem like more simply because chiropractic is attracting more patients and insurance companies have started to look at all areas of profitabilty.

The misunderstanding and questioning stem from the fact that our profession does not fit the medical model. Under the parameters of workers' compensation, we are only able to render care for the pathophysiological injury/illness that relates to subluxation. We are not able or supposed to correct the subluxation to the point of permanent and stationary. Once the pathophysiological injury/illness is

resolved, our job, under workers' compensation parameters, is over. Workers' compensation is a crisis care phenomena. Wholistic or wellness care is outside the intent of the workers' compensation system. The chest beating and saber rattling I see in some of our chiropractic journals may act to vent our frustrations, but it does little good except to inflame the situation. The solution lies in education and communication. We must educate ourselves regarding the rules of the game and not necessarily by way of practice management people. Some of them have shown that they do not have the best interests of the profession as primary concern.

We need to have our national organizations learn these rules and have them (or known insurance experts) disseminate to the profession the proper, ethical rules of reporting.

Differences in Length of Care

In my years as an insurance consultant, I have seen many cases of gross overutilization of chiropractic care in workers' compensation cases. The problem exists because of 100 percent coverage from day one and the fact that the laws are skewed in favor of the attending physician. I don't question the skewed advantage, but I do question the evidenced abuse of the system. When I call chiropractors for explanations of notes and billings they ask me, "Why are you questioning me, it's only workers' compensation?" as if it were a bottomless pit. I had one chiropractor tell me that workers' compensation and practice insurance (PI) was how he met his overhead. Amazing, isn't it? Ask yourself the question -- what would your bill look like if an injured worker came into your office with no workers' compensation insurance? How about the length of care? Frequency?

Documentation

My reviews of claims over the years have revealed that, in many cases, the history and physical, chiropractic, orthopedic, and neurological examinations were poorly documented or not documented at all. This made it difficult to confirm the diagnosis and the necessity of treatment. If there is little or no documented initial workup and no timely follow-ups, there are only marginal or no reasons at all to treat a patient. Beyond the marginal indications for treatment is the issue of effectiveness of care. If you don't understand or identify what you're treating, how do you know if you're effective in treating it? Further documentation regarding SOAP notes, lab, and x-ray reports, is sorely lacking. I know that these are time-consuming and a drudgery, but they are important in establishing the need for care.

Technical Pyramiding

Another phenomenon I have noticed as being especially prevalent in 100 percent pay policies is "technical pyramiding." A number of new imaging techniques have become available in the last few years that diagnose disorders of the spine and nerve roots. Computerized Axial Tomography (CAT) scans and Magnetic Resonance Imaging (MRI) were marketed as replacements for myelography. Videofluoroscopy and thermorgraphy allegedly give us new insight into aberrant motion (the subluxation?) and pain (soft tissue damage?). In workers' compensation cases, it is not uncommon to see two, three, or four of these different imaging procedures performed. This doubles, triples, or quadruples the expense. It also multiplies the chances that a false positive will be found, resulting in potentially unnecessary or prolonged treatment.

Multiple tests are done for a number of reasons.[15] What is often overlooked is that there must be logical reasons for ordering an advanced imaging procedure and it must be ordered in a timely

manner. This is often not the case. It seems that access to the procedure is reason enough to order the test. The reasons for ordering these tests are beyond the scope of this paper. I refer the reader to the proper imaging authorities (ACA Council on Diagnostic Imaging, International Thermography Society, Post-graduate Training) for background information. Another reason for ordering multiple tests is the whole issue of "sins of omission." You are only guilty of omission if there is substantial clinical reason to investigate an area further, and you do not do so. Another reason for ordering multiple tests is that we chiropractors want to know the best localization of the subluxation/lesion. This is very understandable, especially since MRI and CAT scans have a greater specificity and sensitivity than do flat plate x-rays (the issue of videofluoroscopy (VF) and, to a lesser extent, thermography, are still an open question in the scientific community.)[16]

Unfortunately, additional tests also increase the chances of misdiagnosis. Suppose there is an 85 percent chance that a person with a positive test actually has a problem. If the specificity is the same for each of three tests, the total specificity for all three tests combined is $(0.85)^3$ or 61 percent. These aren't very good odds.

Yet another reason for multiple tests is the "search for the enigmatic subluxation." In a number of cases with minimal historical and physical findings, imaging tests were ordered. This despite the fact that imaging should be used to confirm a physical finding or diagnosis, not to look for one.

When a positive finding is discovered it is used as an attempted justification for continuation of care. Unfortunately, up to 40 percent of the population over the age of 40 has some abnormality of the intervertebral discs, for example, without symptoms or other clinical findings.[17,18,19,20] Treating these "innocent" people under workers' compensation guidelines would bankrupt the system and, quite possibly, the employers.

Is Workers' Compensation Related Chiropractic Care Different?

The above treatment patterns led me to the conclusion that a different group of physicians are treating workers' compensation and personal injury protection (PIP) patients. By comparing names and tax ID numbers of physicians/chiropractors who are treating back and neck problems for group health cases to those physicians/chiropractors treating workers' compensation and PIP patients in the same geographic area, I came up with two very distinct lists. There was very little overlap. It seems there are workers' compensation and PIP doctors, and there are group health doctors. Admittedly, I have seen only a small fraction of the claims sent to insurance companies, but there should have been much more overlap, especially in some of the smaller towns in the Southeast where much of the early work was done, and there are not that many doctors.

Lack of Closure

I am frequently called upon to help resolve a case that seems to be dragging on forever. In most instances, the chiropractor admits that there is little or no clinical objective data or the data has not changed in months (or years). The patient is still complaining, usually of pain. The chiropractor is not trained to diagnose intrapsychic problems or labor relations problems, yet will not release the patient. Often, the patient is not physically impaired and does not have a permanent impairment. It is often overlooked that the patient may have sustained a soft tissue injury and may never be ache-free all the time, regardless of work. You cannot justify keeping a claim open or a patient off of work because they don't feel 100 percent well all of the time.

You must also realize that chiropractic may not be the only approach to resolving a patient's problems. If after a reasonable time under care a patient's symptom complex doesn't change, it is likely that they have reached maximum therapeutic benefit. A physician's first allegiance is to the patient. This may lead to unquestioning acceptance of symptoms on the physician's part or the desire to be off from work on the patient's part, but it creates a problem for employers and may ultimately be a disservice to the patient. Physicians may be tolerant of cases which go on and on or which have no definite diagnosis, ascribing to the course of nature. On the other hand, they try to limit ambiguity by more and more testing.[21]

Non-Related Treatment

I have seen more and more cases in which all manner of unrelated complaints are worked up during workers' compensation visits. Workers' compensation is a regional phenomenon. If a worker injures his lower back, the chiropractor has no right, under the workers' compensation system, to treat the patient's neck, mid-back, elbows, shoulders, or knees (my apologies to the upper cervical practitioners). Diabetes, obesity, and hypertension are common, unrelated problems that are seen in workers' compensation cases, but chiropractors and physicians commonly treat these conditions as if they were primarily causally related and treatment is aggressively pursued without clear connection.

Attorney Driven Care

There are two treatment related observations that I have made when an attorney is involved in workers' compensation or a PIP case. First, adjustors seem very reluctant to challenge any procedure provided when an attorney is involved. Apparently, the adjustor believes that the insurer can be perceived as denying access to needed care. There are many instances I have seen in which marginal needs turn into long, drawn-out cases simply because the chiropractor said that the patient needed care and the attorney's presence in the case created an environment wherein the adjustor refused to challenge the care. For no clinically supportable reason, medical recovery is significantly longer when claimants engage an attorney. Many more claimants never return to work.[22,23] The probability of returning to work has been shown in many cases to be directly related to the length of time away from work.[24,25] Rehabilitation outcome is negatively impacted by litigation as well.[26]

Second, there seems to be a rush to prolonged treatment with temporary disabilities, technical pyramiding, and increased utilization of ancillary procedures when there is an attorney involved, even with relatively minor injuries or little objective indication. It is as if the treatment validated the "injury" and the claimant can then say , "I was obviously seriously injured, just look at all the treatment I received and all the testing that was done to find my problem," (not to mention the cost of the prolonged treatment and extra testing). It seems to me that having an attorney on the case creates additional testing and treatment. The attorneys are asking for and/or demanding "objective" data to "prove" their client's injuries. Some of the "objective" machinary in the marketplace isn't so objective and it often doesn't prove anything. It does increase the cost and often prolongs treatment. When the attorney suggests, recommends, or expects various testing procedures, the chiropractor is no longer driving the medical aspects of the case, the attorney is. It is the chiropractor's job to communicate the patient's objective findings to the attorney. If the chiropractor identifies a need for further testing, it should be done, and it should be objective. It should not be done to "help the case" or to provide the attorney with "whistles and bells." On the other hand, attorneys can provide a vital function in certain instances. I refer the reader to the book Payment Refused by William M. Shernoff.

Indemnity Consequences of Workers' Compensation Treatment Patterns

The consequences of the indemnity side of workers' compensation become very obvious. Inappropriate treatment leads to a great deal more lost time, or temporary total disablity (TTD). There is also a greater chance of a higher permanent partial impairment (PPI) rating. In addition, the overutilization of services, diagnostics, and prolonged treatment only adds to the weight of the "seriousness" of the case.[27] As a result, the final settlement will be much higher.

The situations described above can be unwittingly compounded by the closure mindset. Some people in the insurance industry define a quality physician as one who is cooperative. Unfortunately, a cooperative physician may make the adjustor's daily life easier but they may not be rendering to the patient proper needed care. Some people believe that cooperation and conservative, objective judgement are one and the same. They are not. A patient's care cannot be negotiated over the phone. That system does not make for a winning situation. A patient needs the amount of care they need, no more and no less. The chiropractor needs to be the objective scientist and determine exactly what the patient needs and not let some practice management guru, attorney, the patient or the insurance company tell him what to do. It sounds trite, but the chiropractor must understand the system in which he is working and then deliver exactly what his patient needs. The adversarial nature of the compensation system, as it has evolved, has created a strange phenomenon. Just as there are plaintiff attorneys and defense attorneys, so are there plaintiff doctors and defense doctors. What is needed is clear, objective judgement, not treatment slanted by an ulterior goal.

References will be included in Part IV of this series.

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FEBRUARY 1991