Dynamic Chiropractic

Utilization Review Strategies: Is the Current System Fair to All?

Arthur Croft, DC, MS, MPH, FACO

The fast-paced business of health care today provides numerous opportunities for fraud. Insurers, third parties and other businesses responsible for paying health care bills must be constantly on guard against it. It has many faces coming from totally false claims, such as injuries from motor vehicle collisions that never really occurred, or claims that treatment for pre-existing disorders is actually related to a new industrial or personal injury claim.

Some insurers now use the term *soft fraud* to describe the practices of health care providers who, in the opinion of the insurer and consultants, provided overpriced services that were not medically indicated and not considered generally accepted as being validated; or provided too much service. "Service" in this context could be either diagnostic or treatment in nature. In outright fraud, a clinician can lose their license, pay heavy fines and even land in prison. In soft fraud, the clinician just isn't paid.

A rational and common approach to this process of monitoring or due diligence adopted by insurers and other responsible parties is to send medical bills and other records to utilization-review nurses or physicians. Applying a variety of criteria, these reviewers then decide which bills were reasonable and necessary. Insurers use this recommendation to remonstrate their denial of service and deflect bad-faith complaints. But many practitioners feel their bills are rejected arbitrarily or unfairly. As the Latin expression goes, "*Quis custodiet custodes ipsos?*" Who will watch the watchers?

Insurers and others who pay medical bills have every right to contest claims they feel are unreasonable, but clinicians also have a right to contest these abnegations of payment. This editorial is stimulated by what appears to me to be a gradual decline in checks and balances between insurers and clinicians, and offers some ideas for the re-establishment of these balances. The following are some recent cases in which I had a certain level of involvement.

Case 1

In one Eastern state, the state board of chiropractic examiners confronted a doctor and charged him with providing substandard care based on two complaints. In the first case, the board thought his SOAP notes were not adequate. In the second case, the board took issue with his approach to practice because he manipulated the neck of a patient who had been diagnosed by a radiologist as having a mild cervical compression fracture. The board told this doctor that he could accept a three-month licensure suspension or face a hearing and a possible permanent revocation of his license. He took the suspension.

Although I do not know what the specific letter of the law is in that state in regards to SOAP note contents, or whether this is really spelled out in any statutes. I would mention that two medical

radiologists had given the opinion that this "lesion," which was said to be a mild compression fracture by one radiologist, was not, but in fact, a fracture before the DC treated that patient. In essence, this man lost his license because his SOAP notes failed to pass muster with the board. (In spite of the other radiologists' reports, the board apparently would not relinquish the fracture issue.)

Case 2

In my neck of the woods, a DC was investigated by an insurer's special investigations unit for possible fraud. He had treated two unrelated individuals for injuries allegedly sustained in motor vehicle crashes. In both cases, the treatment was fairly brief. However, the insurer remanded the case to the state board for further investigation. The board passed the case off to one of its investigators, a local DC with specialty certification in rehabilitation, who offered the opinion that the treating DC was guilty of incompetence. The reasoning? He had not recommended exercise to these patients in the first week of care. In fact, it should be noted that the DC did recommend exercise in the fourth week. Also noteworthy is the use of the term *incompetence*. This raised the question beyond a simple act of falling below the standard of care to a criminal level and sent the case to an administrative law judge. Although, this doctor eventually prevailed, it cost him a small fortune in legal fees.

Case 3

In a Midwestern case with which I was involved, the state board contracted with an independent company consisting of a handful of local DCs, some of whom were also board members or ex-board members, who offered their services in peer review. When insurers have a problem with a practitioner, they report them to the board, which then remands the case for review to this peer-review panel. After a certain number of unfavorable reviews, the clinician's license is in jeopardy. In this case, the board had again offered a voluntary license suspension, but the clinician elected to fight the case, even against the advice of his attorney. I reviewed several peer-review opinions and found some of the concerns to be fair and reasonable, as did the treating doctor. Other opinions, however, were somewhat arbitrary and often based on guidelines that were not designed to cover the conditions for which the patient was treated. In the 11th hour, as I was preparing to travel to give testimony, the case was resolved out of court, with no loss of licensure.

Case 4

Most recently, I reviewed the report of a utilization reviewer in the same Eastern state as case #1. The reviewer voiced a number of common criticisms: too long a gap between injury and treatment; prior treatment for the same kind of condition; too many visits overall for the condition; too much passive administration of PT modalities, etc. A *fortiori,* a list of references and selected quotations from these references was appended to every comment. The reviewer's arguments ranged from being somewhat opinionated or even dubious to the absurd. Most began with the statement, "There is no evidence to support." This included treating a person who claimed to have been injured six months ago, using TENS as an adjunct to care, treating a person for whiplash injury more than a certain length of time, and so on.

I would hasten to point out that for the majority of medical interventionism, including even many spinal surgery interventions, there is little or no category-1 level evidence for their support. But lack of proof of effectiveness is not equivalent to proof of lack of effectiveness. Often, the case is simply that no randomized and controlled trials have been undertaken. Judgments of the clinical value of

interventions should be tempered with this truth. When best evidence fails to provide guidance, the next best approach is to rely on standard practices.

When there is no documentation, the reviewer's job is simple enough. Without documentation, the clinician is hard-pressed to argue for reimbursement. As is common in the more egregious of these reviews, this reviewer, faced with actual documentation, switched his angle of attack to the soundness of the findings that were documented. These comments became specious when he broached into arguments against the validity of physical examination, reliance of physical findings, orthopaedic tests, assessment of range of motion, and so on.

Is range of motion a rock-solid, perfectly objective, always consistent finding? No. Interexaminer and even intraexaminer reliability are imperfect, as with most things that are measured by humans. The subject's range of motion is likely to vary from time to time as well. It is an imperfect assessment, no doubt, but certainly not unreliable or pointless. It is a simple enough exercise to collect papers demonstrating these variances for this or other clinical measures. But these are not compelling reasons to cease considering the measures in one's assessment. In fact, range-of-motion assessment is a standard and critical component of disability/impairment assessment and functional capacity evaluations throughout the world. More importantly, these do not provide a rational basis for dismissing the treating doctor's attempts to document injury and response to treatment.

I looked at the references offered by this reviewer in support of his opinions. A number of problems and potential problems are visible. In any such review, the use of supporting literature is admirable and potentially helpful to all. But the misuse, misquoting (as well as taking selected statements out of context), inappropriate extrapolation, and misrepresentation of literature are inexcusable and unethical.

In the following, I provide a few examples that clinicians can consider in their next peer-review experience:

1. The reviewer did not use the proper format for the references, making locating many of them quite a challenge. While there are numerous formats available, common to them all would be: author name, title of citation, book name or journal name, volume number, issue number, year and pages. Failure to provide this basic information suggests the writer is either ignorant of this convention or is purposely obscuring the source to prevent others from checking up on them.
2. Many of the references cited were to low back pain literature, while the subject's injury was to the neck from a mechanically distinct exposure to trauma. This kind of extrapolation generally is not defensible on scientific grounds.
3. Some of the quotations offered by the reviewer were opinions offered by the authors and were not based on their actual findings. This "call to authority" is scientifically disingenuous.
4. In several cases, the reviewer had listed several papers after a statement that would not, in fact, have been supported by all of those papers. Again, a disingenuous appeal to authority.
5. As a general observation, the list of citations was far from balanced, and one easily could add a number of contrapuntal papers which come to contrasting opinions.
6. Cited guidelines are misapplied. For example, the reviewer cited guidelines suggested for physical therapists. Are these generally accepted by the chiropractic profession? Some of the guidelines cited considered low back pain, not cervical spine pain.

The question of discrimination in these cases or fraud investigation, claims review, and board action looms large. In many cases, state boards are required by law to conduct investigations when insurers report suspected fraud, but are some practitioners singled out for this special attention? There is no

way to know whether insurers send out files for review based on a fair randomization method or whether, instead, certain practitioners are specifically targeted by insurers because their bills tend to be higher than most or because they treat more patients, have multiple clinics, etc. Deliberate, nonrandom targeting is discriminatory and illegal.

Conflicts of interest are also reason for concern. One wonders about the rationale of appointing state board members and/or using board-appointed investigators who also obtain a substantial portion of their income as reviewers or examining doctors for the same insurers who request board reviews. Can they be considered truly unbiased and unconflicted?

Are the methods and criteria used by investigators, peer reviewers, and even state boards standardized, systematized, well-defined, clear-cut and evidence-based? In my experience, this is uncommon. Criteria usually are loosely defined and often arbitrarily applied, as evidenced by the common disagreements within the same body or panel and wide swings in board actions from one year to the next.

Ultimately, checks and balances are necessary for health care payers, but they are also necessary for health care providers to guard against discriminatory practices of payers who target selected individuals; and against the unfair and unethical practices of some reviewers who have an obvious, albeit unstated, fiduciary obligation to their patrons to provide recommendations that benefit the company's bottom line.

Conflict of interest and reviewer bias are very difficult to avoid. In my view, the only solution involves the adoption of a systematized and standardized review methodology. Clinicians should then be informed as to what, precisely, is expected of them in terms of documentation and practice. Also, reviewers should operate under clearly defined and standardized methods understood by all parties. This clear approach needs to be adopted by all state boards.

APRIL 2007