



Paul E. Okamoto, D.C.

# Back Talk

## Paper Review and Independent Medical Evaluation (Part One - Preparation)

In order to be prepared for the case that will either have a paper review, IME, or even a malpractice suit, the doctor must have a pro-active attitude. He/she must realize that preparation starts on day one. The DC should approach each patient with the understanding that the case might be the one that may require justification for treatment or even go to court. Although a potential motor vehicle accident or worker's compensation injury may alert that you be detailed, no doctor can be assured that a cash or major medical insurance case will not require detailed chart notes. I am confident that each of us who has practiced even a couple of years can state that we had cases that the doctor was not aware of all of the facts until later. A patient can tell us several days or weeks into care that the problem was caused by a car accident or on-the-job injury. Additionally, it is fairly common that a patient will start care and then have an accident. The doctor then is required to contrast findings before and after the accident and come to a conclusive assessment of causal liability. If you try to prepare midway into care or after the fact, it is very difficult, if not impossible, for you to justify ongoing treatment.

The first factor that is essential is that an accurate and detailed history and examination be performed. The doctor should mention every symptom that the patient experiences, no matter how insignificant. Even contusions and abrasions should be noted and diagnosed. If a symptom or body part is not initially noted and then worsens as time progresses, it creates more problems to relate or tie that problem back to the original accident. If there is a causal relationship between the accident and the body area injured (as there typically is in a 3rd party claim), that relationship must be noted and explained. Additionally, the history should state not only the cause, location, and duration of pain, but also state how that problem adversely affects activities of daily living, recreational hobbies, alterations in work activities, etc. Various pain and functional rating scales are helpful. Past health history should include prior accidents, surgeries, past similar symptoms, and treatment.

The examination should be thorough with regard to the involved body part(s). Concerning musculo-skeletal injuries, two items carry great weight in determination of injury and need for treatment - range of motion loss and muscle spasm/hypertonicity. Limited range of motion should be noted. Generally speaking, the more technically advanced the equipment used, the more validity that information carries. Thus visual range of motion is least accurate, goniometry next, and dual inclinometry the most accurate. If spasm or muscle hypertonicity is found, be sure to note that. Both range of motion loss and muscle tone changes are important factors to justify that recent trauma has occurred. Both of these can also help paint the picture to justify continuing treatment. I have found that orthopedic testing, reflex changes, and even osseous restrictions/subluxations carry very little weight with regard to paper review or IME.

Although each of us has witnessed the amazing benefits of chiropractic care, research demonstrates that active exercise is important in both

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accelerating recovery, as well as limiting dependency upon passive modalities and adjustments. Passive modalities, such as ultrasound, EMS, and traction are called passive, because the patient does not actively participate in treatment. In the early stages of healing, passive modalities are helpful to reduce pain, edema, and spasm. However, as time progresses, transition must occur from passive to active care. Active care is differentiated from passive in that it utilizes patient involvement. Thus the doctor must think about the best way to encourage and transition to active care. This involves both a home exercise program, as well as exercise either in the office or in an outside facility. Once the patient is out of acute pain, active care transition is mandatory. Having the patient come in for continuing treatment without active care involvement cannot be justified and will result in denied charges.

I would also like to state that insurance companies, whether major medical or third party, base ongoing treatment upon functional limitations, rather than pain. In the past, the typical chiropractic mindset related to justification for ongoing treatment was centered around pain, i.e. the patient's pain continues to be less severe and less frequent with continuing care. However, this type of justification is a thing of the past. Thus the doctor must find out what functional limitations the patient has, not only related to range of motion loss, but also restrictions in activities of daily living, recreation, work duties, etc. As a result, it is much easier to justify continuing care when it can be shown that the patient notes functional restrictions, but ongoing treatment diminishes those restrictions.

For example, a patient of mine was a runner and regularly ran 5 miles/day. After her accident, she was only able to run 1 mile. I was able to get her out of pain within a reasonable timeframe. However, whenever she ran, she was unable to run her normal distance and speed. On each updated exam, I was able to show that her running endurance was restricted, but continued to improve. After a certain time period, a paper review denied care, but I found it necessary to treat her 3 additional months until she was functionally normal. I wrote an appeal, and my justification for that additional time was based upon her recreational limitation. As a result, the insurance company overturned the denial and paid my services. Another common example is a homemaker who cannot perform all home activities after the accident and either avoids certain tasks, makes modifications, or may need someone to assist.

With regard to pain and disability questionnaires, there are a number of different ones that a patient can fill out that will indicate limitations, as well as track improvement. Some of the more common include Visual Analogue Pain scale, Oswestry low back pain index, and Roland-Morris Pain and Disability. Concerning visit-to-visit tracking, it is easy to note a number on the visual analogue scale with each visit. The patient can fill out other forms of your choosing with each updated exam.

In order to show continuing improvement, there must be regular updated examinations. With major medical care, it is good to perform an updated exam every 10-15 visits. With 3rd party claims (MVA & WC), the standard protocol is every 30 days. As long as you can show that the progress continues to be made on subsequent examinations, you are on fairly solid ground. However, if updated exams do not show continued improvement, you must consider a change in treatment. There are several things that you can consider: 1) Perform additional testing 2) Change your type of treatment 3) Continue to treat the patient, but add another type of treatment, i.e. physical therapy, pain management, etc. 4) Refer the patient out for a 2nd opinion to an MD 5) Transfer the patient to another doctor. In the past, I have done each of these procedures, dependent upon the given situation.

The next article will address complications that may be involved in the paper review or IME case. Have a blessed day!

## Welcome New CCA Members

Welcome to those who have recently joined the CCA:

### January 2014

- Christopher TJ Chianese  
Pennington, NJ (student)
- Gregory Sheppard, D.C.  
Austin, TX

### February 2014

- Wm. Todd Fisher, D.C.  
Chantilly, VA
- Lisa Kline, D.C.  
Beavertown, PA
- Jasmine Perez, D.C.  
Port Orange, FL