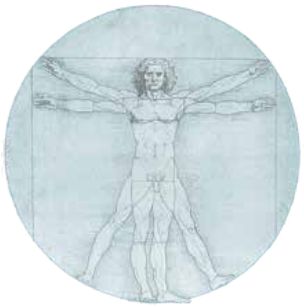
Peer Review: Why You Are Losing Care



By Dr. David Drier, Chiropractic Physician

It is annoying to most chiropractors, myself included, when we find ourselves facing an insurance carrier determining whether some aspect of our patient care is appropriate, effective – and most important – a covered and paid service. We go into this profession partly because of the autonomy and independence it offers us, as solo practitioners and small business people of all stripes. "How dare they decide what is best for my patient!"

I have been performing peer and utilization reviews for a multitude of carriers for many years now, and I can tell you that, first off, it is not personal. It is policy. Insurance companies need some way to "manage care", and utilization reviews are a part of that management. They need to know if a bill is their responsibility or not. Is the treatment for an acute spell of care? An exacerbation? Is it effective, or just going on and on with no end in sight? Are there other, more effective means of treating the presenting condition?

It might seem surprising but, at least in my years of experience, the carriers I work with do not tell me to "cut off" every claim I review, nor do they stop giving me work if I do, indeed, recommend more treatment in some cases. I am asked only to review the office notes provided, and render an opinion based on usual, customary and reasonable practices, as to whether a particular patient is getting care that is medically necessary or not.

As it happens, in ways that are all too familiar from working on malpractice cases, the biggest problem is not actually the treatment rendered, but the office notes, which are usually of sub-standard quality, and which do not adequately document the patient's chief complaints, examination findings, diagnoses and treatment plan or follow-up care. In fact, the documentation is often very poor. Notes are illegible, imprecise, lacking in details and lacking a cohesive plan of treatment, and all too often, an incomplete plan. Many offices do not even bother with an initial examination that includes a full orthopedic/neurological/chiropractic test screen. Findings are likely to include "spasm, tenderness and reduced ranges of motion, with subluxation", with no other details at all. Notes like that are just asking to be ignored, and an office with notes of that lackluster character will usually find their peer reviews finding a lack of medical necessity for care or testing.

Very few offices include ongoing disability scoring, such as Oswestry or Roland-Morris scoring, even though most carriers now expect this along with ongoing patient self-ratings of pain. This kind of ongoing scoring is not only helpful to your notes, in case of review of for claim purposes. It is a great device for showing your patient that they are improving, in a quantifiable way. That is key when a patient feels discouraged or impatient to see more results, and fast! In any case, I can only go on what is in the notes I review, so if it is not there, it did not happen!

Handwritten treatment notes do not help you at all. Most of the time, they are illegible, and this goes back to a twist on "if it is not there, it did not happen". Namely, if I cannot read it, then I cannot use it! The patient's file is his or her medical story. It needs to be legible, sensible and easy to understand. If I do not understand the patient's story, then I cannot follow the treating doctor's thought process. Chief complaints, with notes about duration, causes, treatments rendered in the past, and all the usual details of radiation, timing, setting, provocative and palliative

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factors, so that I can understand your patient. A linear sense of the condition, the exam findings, diagnoses and treatment choices makes my job easier, and also makes it a lot more likely that I will see why you are choosing the treatment you did, or why you made a referral, or tried a new strategy. As a side note, I always look for the home care aspect of treatment, as well. When I see a home care program of instruction in the use of ice and heat, and a well-documented home rehabilitation and stretching program, I tend to feel the patient is in good hands, and that the treating doctor is taking the care of the patient seriously and professionally, making it more likely that I will recommend further treatment.

If any diagnostic testing has been performed, or referred out, make sure the results are in the patient file. These results are extremely valuable to me as a reviewer, and help to add objective value to your notes about the patient. They add depth to the patient's story. Always inquire about a patient's medical history, especially as it relates to their present complaints. It not only helps you to know what treatments were helpful, and not helpful, it allows me the same insight as I review a file of yours. If the patient had pain injections, medication, acupuncture treatment or, especially, chiropractic treatment, this should be in their file. If they have had prior chiropractic treatment for the presenting problem, get more details, such as what techniques were utilized in the treatment.

The majority of my reviews are for diagnostic testing, such as EMG/NCV and MRI testing. Make sure you have a strong case for referring for such testing. Clear reasoning should be in your notes as well as a letter of medical necessity, stating the condition being treated, the exam findings, results of treatment so far, and the way such a test might change your diagnosis and treatment. If a test is not likely to change your treatment (you use spinal manipulation either way, perhaps), then I am very unlikely to recommend its use as medically necessary. All testing should be part of a differential diagnosis, and not for the convenience of the treating doctor, especially if the doctor performs EMG testing in the office.

Diagnostic testing that is not part of initial triage, such as x-rays, is not usually medically necessary too early in treatment, so make sure it is part of a re-assessment plan, and not an automatic policy of having all patients get an MRI.

Probably the nicest thing about chiropractic is that it works! Most patients see good progress within a few weeks of treatment. When they do not see results in 2-4 weeks' time, it is incumbent upon the treating doctor to seek out why with further inquiry- orthopedic testing, diagnostic testing such as MRI, or referral to another practitioner, such as an orthopedist or neurologist, to get another perspective in the patient's condition and needs. If there is one thing that is the most likely to set me against a treating doctor, it is seeing that they continue with an ineffective treatment protocol, with no home care program, no professional referrals and no diagnostic testing. As a patient myself, I know that I do not have six months to "see how it goes". I never recommend doing more of anything that is not working, and neither should the patient! This is unprofessional, ignores the patient's needs, and gives the impression that all the treating doctor cares about is getting paid. That is what I call "treating the carrier; not the patient", and it is a guarantee of not getting a recommendation of more treatment.

When you do make a referral, put it in the patient's chart, and follow through with the other professionals involved.

As your patients improve, their treatment frequency should be reduced in a timely fashion. Because chiropractors believe patients are responsible for their own health, we are their facilitators in this matter, and educating patients in proper health management, including home care and rehabilitation, is a major part of our mission. In any case, the goal of patient

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is to see the patient improve clinically, and get discharged from active care. At that point, the patient may return if they have an exacerbation of their condition, or come in with a new condition, or come in for true preventive maintenance care, because they were well educated in our offices about the value of ongoing chiropractic treatment. Maintenance care, however, is almost never covered by insurance carriers, even though there are multiple studies showing it to be cost-effective in reducing the need for more acute treatment or even surgeries.

Most carriers will pay for care that is acute, or up to the point where the patient has reached their maximum improvement, even if they are still in pain. This is an important point. A patient may still be in pain, but his or her treatment is only keeping them from getting worse, while not correcting their problem. Such care is certainly beneficial, but is rarely covered under insurance plan guidelines. Peer reviews, like Independent Examinations (IMEs) have to follow each carrier's Plan Guidelines in determining what care is medically necessary. In some cases, if you properly document your care with the patient, and can document how the patient becomes much worse without care, you may be able to justify further treatment when care is begun again, as an exacerbation of the condition they presented with initially.

Take advantage of the carrier guidelines. Their clinical policy bulletins are the primary resource used by utilization reviewers in going over claims for medical necessity. Make sure you are familiar with the Mercy Guidelines, since many chiropractors, including myself, use these as part of their review process. Ditto for the Official Disability Guidelines, and the Council on Chiropractic Practice Clinical Practice Guidelines.

If you have your treatment or a diagnostic test reviewed for medical necessity, and you "lose", you can appeal the findings. Insurance carriers depend on doctors not even trying to appeal their reviews, but also have an appeal process in place. You may be able to speak to the reviewing doctor by phone, or add aspects of the patient's case or treatment you felt were not clearly included in your treatment notes. Some carriers will hold a telephone conference call, including the treating doctor, the patient, and the reviewer. If this happens, make sure the patient is honest, clear and diplomatic in tone, and be the same way yourself. If you are making the case for a test or more care, be prepared to explain the need clearly, and to answer questions about the patient's chief complaint, treatment, clinical progress and any referrals you made. Your goals should be very clear, and how they were met, or not met, and why.

Go over your office policies, and make sure they follow the carrier guidelines, no matter what your personal health care philosophy is. This will make it much less likely that a reviewer cuts down your treatment or diagnostic test referrals. Carrier guidelines may not feel fair to you, but they are making the ultimate decisions, and working with their guidelines helps your patients in the end. In any event, we all lose some reviews, because of simple differences of opinion about what is medically necessary. When this happens, stay grounded, be diplomatic, and keep improving your charts, to make your life, and that of your patients, a little smoother.