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## **Medicolegal Questions and Answers**

By Arthur Croft, DC, MS, MPH, FACO

Readers write in from time to time and inquire about medicolegal difficulties they are having. Although some are particularly strange, many of these questions seem to echo repeatedly. In this editorial I will share a few of the commonly repeating themes plaguing DCs in the province of personal injury.

**Q:** I have been treating the father of one of my CAs for a CAD injury. He's 62 and has a fairly advanced degenerative spondylosis in his neck. The insurance company's chiropractic consultant recommended that 6-12 weeks of care is all that he should need and that any symptoms referable to the neck are probably the result of his spondylosis. They are refusing to pay my bills on the basis of this report. What is my recourse, if any?

**A:** I'm surprised they didn't cite the Mercy Guidelines or the QTF Guidelines. In any case, this is a very common problem. Before I address your question, let me suggest that in the future you refer relatives, coworkers, or relatives of coworkers to another DC when litigation may be involved. The reason for this advice is that you will always be accused of being partial and nonobjective with those patients.

The question you ask is loaded and space will limit my answer. However, your approach might be the following: 1.) Ask for the consultant's name. Some states have a requirement that the insurer provide it. If you get it, call the consultant and find the basis of the opinion. Usually, they have seen only a partial set of records. Frequently consultants have no more to go on than the doctor's bills and diagnostic codes. The reason for this is a purely practical one: The insurer already has these documents in hand and it would require a bit more effort to request the treating doctor's SOAP notes, history and exam forms, and radiographs. Moreover, the consultant would charge the insurer more to review additional documents. We might also cynically suppose that the reviewer's opinions might not be as harsh if these additional records were reviewed. If you can speak with the reviewer, you may be allowed additional treatment time.

Also, check with your state association. Some states require that file reviewers practice in the state. Others require the reviewer to be in active treating practice, i.e, to treat patients as some percentage of their practice, as opposed to earning most of their income performing chiropractic "drive-bys." 2.) Write a rebuttal letter to the carrier. It is common knowledge that spondylosis does not necessarily cause pain, yet the condition is seen in more than 80 percent of the population in your patient's age group. If the carrier or the reviewer has evidence that the patient has indeed had chronic or serious prior neck problems, their argument may have some validity. If not, I'd certainly point that out. Bogdan Radanov and other authors have shown that patients with spondylosis fare worse than those without it in whiplash accidents. In the Module 1 book of my seminar series you'll find ample ammunition regarding outcome, treatment duration, recovery times of published outcome studies, and long-term prognosis to rebut this reviewer's commentary.

I would also ask the reviewer for the reference to the research that shows that 6-12 weeks is the usual healing time for whiplash. I can virtually guarantee that they'll fail to come up with anything scientific, because this is simply a myth popularized by the "flat Earth mentality" reviewers keen to ingratiate themselves with their clients.

3.) Ask your patient to write a letter to the carrier. He can also file a grievance with the state insurance commissioner. That will get their attention. You can also file such a grievance, and should.

Meanwhile, if the patient does not have an attorney, now is the time I'd recommend to retain one. Then continue to treat on a lien. Incidentally, this may constitute bad faith on the part of the insurer. You might check with your state or local society to find out whether any class action suits have been filed against that carrier. These are becoming more common, with one suit prevailing recently in California and another being organized now in Oregon.

Q: After treating my 23-year-old patient for eight weeks, the file was reviewed by an RN who works as a consultant for the insurer. She suggested that care be terminated and based her opinions on the work of the Quebec Task Force and on your textbook on whiplash injuries. How can I rebut this?

A: This is another variation on the same theme. Many companies have full time utilization review staff poring over medical and chiropractic bills. In many cases RNs occupy these positions. This is nothing new. Our medical brethren have been battling UR difficulties for years. In many cases, the UR nurses work side by side with physicians in hospitals, sometimes cancelling orders for expensive tests or procedures when they believe they are not warranted, much to the consternation and dismay of the doctors. These programs

have resulted in great cost savings despite concerns from critics that optimal health care is jeopardized in the process.

Lacking in your particular case, however, is valid evidence-based reason for terminating care at eight weeks. No research has reported that most cases of whiplash injury do not require care at this point in the recovery stage. In fact, until recently, no reliable reports that correlated recovery over time were available. Radanov et al.,<sup>1</sup> in a report published after the inclusion date cut-off of the Quebec Task Force work on whiplash, followed whiplash patients longitudinally. They reported that over 40 percent of the group remained symptomatic after 12 weeks. And, while this does not necessarily indicate that these patients were in need of ongoing care, certainly a significant portion of this group was in fact receiving care at the 12 week point. Gargan and Bannister<sup>2</sup> also published the results of a longitudinal study of whiplash patients, reporting that those with "minor" complaints recovered in eight weeks. Those with "nuisance" complaints were said to "stabilize" after 17 weeks, and those with complaints described as either "intrusive" or "disabling" merely "plateaued" after 20.5 weeks. These two papers tend to cast serious doubt on the notion that most whiplash injuries require no care after eight weeks.

I am in full support of research directed at determining which treatment methods are the most efficacious for whiplash and I certainly do agree that, in some cases, long-term regular care offers little additional benefit for the patient. So it seems reasonable that insurers are concerned with the reasonableness and necessity of care. On the other hand, as a society, we face a serious ethical and moral dilemma when we attempt to ration health care with the chief purpose of saving money. Certainly, it makes no sense to spend tens of thousands of dollars on transplant operations or other heroic measures for the terminally ill, as is currently the practice. But treatment terminations for whiplash patients are much less black and white.

Care cutting methods based strictly on dogmatically inspired calendar mileposts, and which pay no true regard to the patient's current subjective and objective findings, and disregard the relative risk factors present which might increase the need for extended care, fail not only all logical arguments, but cause us to question the wisdom and perhaps also the motivations of health care reform. In its barest form, the deductive argument is this: 1. All whiplash injuries resolve within eight weeks and require no further medical care. 2. This patient has had a whiplash injury. 3. This patient requires no further care because more than eight weeks have evolved. In this syllogism, because the first premise is false, the conclusion, the third premise, will frequently also (but not necessarily) be false. Even if we substitute the word "most" for the word "all" in premise one, the conclusion will still be frequently false. However, there is no evidence that

either modification of premise one is true.

If these insurance companies and their experts are interested in operating on a purely science-based foundation, providing the appropriate literature to them should allow them to develop a more reasonable and meaningful method of analyzing the need for ongoing care. If they prefer to retain their dogmatic myth-based foundation, we can only assume then that their motives are primarily inspired by the corporate bottom line.

Finally, regarding the reference made to my textbook, I can't think of anything that she could be using without taking me out of context. It certainly would not be the first time. I'd ask for a specific citation: textbook edition, page number, and paragraph. As to the Quebec Task Force, the material they reviewed does not support their conclusions that whiplash injuries are self-limited. Their guidelines for ongoing care, with regard to treatment duration, are consensus-based. They recommend only short-term chiropractic care, but the term "short-term" is not defined. Thus, insurers and their experts are likely to supply their own definition of the term. And, as a final note, the QTF found no research either supporting or refuting chiropractic care as an effective treatment for whiplash injury. Thus the recommendation for short-term only care suffers the same uncertainty as a recommendation for long-term care. We simply don't know at the present time.

Meanwhile, until the research is done, as clinicians, we have no choice but to rest our treatment decisions not on a consensus of statisticians or measures of central tendency, but on the patient's current clinical condition, and on the measure of perceived potential for clinical improvement with additional care. Watchful clinicians can determine when a patient has reached a plateau. This empirical-based approach is still the most widely used in medicine and chiropractic and we must never assume that academics have achieved a monopoly on wisdom.

### *References*

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