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The Well Managed Chiropractic Soft Tissue Injury Case

By Michael J. Stahl, DC and Stephen M. Foreman, DC, DABCO

The "Well Managed Soft Tissue Injury Case" can be a bit misleading as it means different things to different people. The insurance companies or "defense" side, seem to have one set of expectations from the medical and chiropractic communities, while those who treat these injuries have a different set of expectations from the insurance carriers. There are those on the "defense" side who maintain all soft tissue injury patients should be released after several weeks of care and any patient who complains further has a financial motive. The other extreme is typified by our personal experience with a case in which the doctor treated the patient 454 times for an uncomplicated soft tissue injury. Neither point, in our opinion, is rational and both fail to represent a well managed soft tissue injury. The management of these patients should fall under the dual heading of "medical" and "legal" issues as both areas are critical to the case.

Medical

Our experience with these cases comes from clinical practice, file reviews, and contributions to the scientific literature on the subject. With this said, we are in a unique position to see cases at the request of both the plaintiff and defense. There is, despite the apparent contradiction in party philosophy, one area of commonality. Both sides utilize our opinion and both desires to know what, in our opinion, constitutes a well managed soft tissue case. Both sides, it seem, have a strong desire to be reasonable, but the different levels of expectations mentioned earlier make each party feel the other is often being unreasonable.

Legal

The plaintiff side of the issue is represented by the patient’s attorney and we have discovered they are often placed in a position of "pressure" when attempting to justify some of the patient care issues common to the handling of soft tissue cases by the doctor or therapist. We believe anything which allows the claim to pass through the "legal" process easier, will be greatly appreciated by the attorney and will often result in a better long-term working relationship with the attorney. This better relationship often results in greater utilization

of the doctor's services by the attorney.

If, on the other hand, the clinical treatment of the doctor or therapist causes the case to lose value, the possibility of a long-term relationship decreases dramatically. For example, the case we mentioned earlier in which the doctor treated the patient 454 times for an uncomplicated soft tissue injury, makes the case very difficult for the attorney to move the case through the "system" and do justice to their client's interests. This type of behavior makes the claim lose value and results in protracted litigation before settlement.

This discussion is designed to address the soft tissue personal injury case and to offer what we consider are reasonable points of view which are supportable in the literature when possible. In our experience, failure to follow a reasonable approach often leads to close scrutiny of the claim. It is our hope this discussion will bring the two different levels of expectation a bit closer and result in a higher level of cooperation between the two sides. Additionally, if the case you manage as the treating practitioner can pass through the medical/legal system, your relationship with the plaintiff attorney can only flourish. However, if the attorney representing the patient loses a potential award as a result of many of the topics mentioned in this article, how likely could an expanding relationship be?

Scope of Care

Obviously, the correct diagnosis is paramount in treating any patient following trauma. We will assume, for the purposes of this discussion, the case being treated represents an uncomplicated soft tissue injury. Specifically, injuries that are absent fractures neurological deficits, dislocations, disc herniations or vascular complications. Treatment rendered for these injuries should represent the standard of care for the geographic area serviced. The "scope of practice" or treatment rendered should be designed to make passage through the medical/legal system easier. For example, performing reflexology on a patient's feet for cervical spine injuries will draw more attention than the well accepted treatment course of manipulation, moist heat, ice, ultrasound, and other therapies. This is not to say that payment will be denied, but the road to reimbursement and settlement would be much easier if a more traditional approach to care is rendered.

Frequency of Care

It is reasonable to assume the injured tissues will necessitate a higher frequency of care during the initial stages of injury. This is due to the fact that the patient's subjective complaints are often at or near their zenith during the first week after the accident. The injured tissues swell to their greatest degree during this

time; thus, the level of the patient's complaints. As the injuries enter the subacute and chronic stages, it is reasonable to assume the treatment frequency would decrease and correlate with the clinical gains being made.

Since the goal of all treatment is to return the patient to their preinjury status, a well managed case will include decreased treatment frequency while occupational and daily activities are slowly reintroduced. In our experience, we have found a constant treatment frequency maintained from the onset of care can lead to problems for the plaintiff attorney as they have to explain this apparent inconsistency. Consider how they will attempt to explain the following questions: First, how can an accurate prognosis of the patient's future medical/chiropractic condition be measured if the treatment has remained the same? Secondly, how could the patient reach their preinjury status if the normal occupational and daily stressors were not introduced while under treatment? An unreasonable approach to treatment frequency complicates settlement.

Duration of Care

The scientific literature indicates the vast majority of healing will take place during the first three weeks following the traumatic event. In addition, the majority of the injuries seen are limited to muscular injuries and treatment of patients over 90 days, in our experience, often hinders the solving of the legal matters. This is not to say that all soft tissue injuries need 90 days of care. Care, like the patient's injuries, are individual. But, if treatment is longer than 90 days, it should be stressed that the clinical necessity for care should be justified even more. It is the doctors responsibility to prove the care is needed, not the insurance company's responsibility to prove it's not needed. In our experience and opinion, documenting only the patient's subjective complaints, is insufficient criteria for the continuation of care. To support the need for continued care, the documentation within the file should show timely re-examinations which demonstrate objective physical examination findings. In addition, these objective signs would need to be reasonably "weighed" against the clinical potential for further healing.

Orthopedic Supports

The use of orthopedic supports, such as a cervical collar, during the acute states of the injury, is a common clinical practice in both the medical and chiropractic communities. It is, however, a double-edged sword. The most reasonable approach would entail use of these supports during the functional instability phase of injury, followed by removal as prolonged use can lead to dependency. Typically, the support is most beneficial during the ten days following the trauma. Prolonged use would support the need for additional

investigation, which must include consideration of a psychological component.

X-rays

The initial use of x-rays in the well managed soft tissue injury is well supported in the scientific literature. The use of "follow-up" series of x-rays is, however, debated. We have found the use of serial x-ray studies is usually unwarranted, absent the clinical management of clear osseous injuries or delayed instability. The prudent use of x-rays should always consider the potential harm from radiation exposure. This is especially true in patients of child bearing years. The use of repeat plain film radiographs will often bring the case under immediate scrutiny, thus, complicating the settlement process.

Special Tests

The use of special imaging and diagnostic procedures are becoming more popular in the clinical management of patients. Attorneys will be placed in the position of justifying the expense and use of these tests to the claims adjustor or judge. The doctor should consider the following questions before ordering such tests:

1. What is the clinical criteria for performing the test? If based solely on the patient's subjective complaints, this represents a very poor criteria.

2. Is the test both sensitive and specific for the condition? Computerized Axial Tomography (CAT) and Magnetic Resonance Imaging (MRI), for example, represent procedures which are both sensitive and specific. However, their use is often inappropriate in an uncomplicated soft tissue injury. Thermography, in comparison, is very sensitive, yet due to vast testing and interpretation variables, often renders the use of this test questionable.

3. Is the testing procedure well accepted in the scientific literature? For example, the timely use of paraspinal EMGs producing $900 to the incurred bills, in our experience, will bring the settlement process to a halt. The treating doctor may contend that the use of this special procedure was clinically necessary, but the insurance carrier will only reimburse those procedures proven in the clinical and

literary arenas.

4. How will a "positive" or "negative" test alter the form of care rendered? A "positive" paraspinal EMG finding, in our experience, has never produced a change in the type of care rendered. For that matter neither has a "negative" result.

5. Is the test timely? The thermogram, for example, would be expected to be "positive" on the first days following the trauma, thus, negating the clinical criteria for performing said test during the acute stages of injury.

For the above reasons, plus the high fees associated with these procedures, we feel the improper use of these tests often produces prolonged reimbursement to all parties; patients, attorneys, and doctors

Narrative Reports

In our experience, this is far and away the greatest downfall in the well managed soft tissue case. We, as a profession, have become dependent on the computer generated narrative report. In our opinion, and that of the legal community as well, these types of reports often do not represent original thought or an accurate depiction of the patient’s condition. The various legal arenas involved in personal injury suits take a very dim light as to the veracity of these types of reports.

The narrative report must also be an accurate reflection of the treatment rendered. All sections of the report should correlate to eliminate inconsistencies, and above all should represent accurate and original work. Remember, the attorney will use the report as a settlement tool. It should contain answers, not new problems. The quality and accuracy of the narrative report should not be underestimated. It alone represents months of care, the patient’s basis for future medical considerations, prognosis, and most important of all, reimbursement for the services rendered. "He who botches the report, botches the case."

End Points of Care

In our experience, this is often the most debated aspect of the personal injury case. The attorney is again forced to justify the length of his client’s care, and thereby support the amount billed as well. The care

rendered should be reasonable and fall within reasonable guidelines for treatment duration.

In our opinion, when one or more of the following occurs, the patient has reached the maximum point of medical/chiropractic improvement from the type of care rendered.

1. If the patient's condition gets worse under the care rendered.

2. When the patient's subjective complaints have clearly reached the upper and lower limits. An example is when the patient's subjective complaints have reached a point where the treatment rendered only "makes them feel better" for a few days and then they are the same as before the visit. It is clear that the feeling of being "better" for a few days is only temporary and the patient has more than likely reached the clinical limitations of matter from the type of care rendered. This is not to say the patient does not have complaints, or that the care does not make him feel good, only that further treatment will more than likely be of very little clinical benefit. Thus, the criteria for determining the end points of care.

3. When the patient fails to make clinical progress between lengthening dates of service. All care is based on achieving a preinjury status. If the patient fails to make progress between visits over an expected period of time, the clinical potential for further healing is remote.

Treatment, after these points have been achieved, increases the total amount of services rendered and makes a timely settlement more difficult.

Prognosis:

The need for future care and the amount of settlement for that care is based on an accurate prognosis. Due to overuse, the term "guarded" has lost most of it's meaning in the medical/legal world. We contend a more accurate system will benefit the patient, insurance carrier, representing attorney, treating doctor, and most important, the profession as a whole. The prognosis should encompass facts from the history of the accident, physical examination, and the radiographic studies.

Fees:

As one might imagine, this is also a hotly debated subject. We fully believe the doctor has the prerogative to charge any fee he chooses for the level of service rendered. For example, a charge of $5,000/visit can be made and reimbursement can be sought. However, it should be realized an uphill battle for total reimbursement will ensue. In other words, the fees charged may only be paid at the end of expensive litigation and in all likelihood will not be the amount billed.

We strongly suggest the doctors use fees which are both usual and customary to their geographic location. Relative value studies can be a key to determine these fees. Use of these accepted relative value guides is a powerful weapon for the attorney when he argues the reasonableness of the charges as they are able to show the fees fell within an accepted range and do not represent an unreasonable amount on the doctor's part.

The treating practitioner should realize both the legal and insurance communities consider all aspects of the personal injury case to be negotiable. This would certainly include the fees charged by the doctor.

Liability

Even when all aspects of case are well managed, problems for reimbursement can ensue. If the liability for the automobile accident is disputed, the settlement will often be different when compared to an undisputed case. For example, if the treated patient is found to be 20 percent comparatively negligent for not wearing his seat belt, the final award of $10,000 would now total $8,000. This final award now reflects the 20 percent comparative negligence. In our opinion, it is not fair for the doctor to reduce his bill by any amount to compensate the patient for his negligence.

Labor Disability

There are times, most often in severe traumas, when a labor disabling status will be afforded to the patient. To justify this status and the accompanying reimbursement for lost wages, the doctor must document what specific occupational activities are prohibited by the injury. Failure to document the need for temporary disability will cause the patient to lose financial compensation for his loss of earning.

Documentation

This is a broad classification which encompasses all written words concerning this accident. We are of the opinion that "travel cards" and "fill in the blank exam forms" are no longer sufficient in the current medical/legal system. They tell what was done but not the reason. The literature is very clear as to how to

properly document each of the patient’s office visits. The SOAP acronym is most often used: The "S" refers to the patient’s subjective complaints, the "O" refers to the objective evidence for care seen on each office visit, the "A" stands for the doctor’s assessment of the patient’s condition, and the "P" pertains to the treatment plan of that visit. This type of documentation is not only taught in the chiropractic schools, but is also recommended by most malpractice insurance carriers as the proper way to document each of the dates of service.

It should be mentioned that even the best attorneys can not adequately represent their clients interests without proper documentation from the doctor.

We hope this discussion has enlightened and provided a reasonable source of reference for both sides of these issues. The doctor has a heavy burden. He must not only adequately treat the patient, but also assume the responsibility placed upon him by the legal system. The financial and personal rewards for his efforts will be more than adequate for the effort expended.

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Michael J. Stahl, D.C.
Woodland Hills, California

and

Stephen M. Foreman, D.C., D.A.B.C.O.
Sepulveda, California

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