

Properly Documenting a File and Forensic Examination of IME Doctors

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Note: *This article makes reference to several addenda forms. Due to space limitations these forms are not included here. However, you may access them by visiting www.acfei.com. (Click "Online CE" and then locate this article. The links to download the forms will be listed directly below the article.)*

Abstract

The independent medical exam (IME) was designed to reel in over-utilization and monitor doctors' billing practices so that fair and equitable payments are made for services rendered. The IME phenomenon has spread from the chiropractic arena to the medical and physical therapy worlds. While this trend is a good and reasonable way to monitor doctors and their billing practices, regrettably, some doctors have gone too far, inhibiting good practices and denying needy patients the care they require. This article describes proven techniques for appropriate file documentation. These techniques, together with several additional strategies, are effective in rebutting and dismantling specious independent examiners (IEs) (for the sake of this article this term includes all examiners, regardless of discipline) and peer review reports (review of case file only). This article also demonstrates how to uncover fraud in an industry that was originally designed to thwart unscrupulous chiropractic and medical practices.

Introduction

The IME phenomena began in New Jersey in 1985. Larry Walther, DC, initiated a plan born of his disgust with nurses and insurance adjusters adjudicating chiropractic bills. The plan, as originally intended, was noble in its simplicity. The independent examiner (IE), in this case a DC, would review a bill to deter-

mine if over-billing was present. The task was to ferret out over-utilization of treatment, supplies, and other specious charges submitted by chiropractors. Who better to understand chiropractic bills than another chiropractor?

Unfortunately, a legion of unscrupulous IEs have sprung up over the years who are far more corrupt, dishonest, and fraudulent than the practitioners they audit. Each of the authors in this article has performed independent exams on patients and/or carried out peer reviews. In Dr. Henry's case, this included reviews of x-rays as well. Everything



mentioned in this article is geared to meet if not exceed the standard of care in any jurisdiction. The standard of care refers to what is reasonably expected of any physician in the clinical office setting. For instance, reasonable standard of care expectations in a doctor's office consist of a good case history, exam, a report of the findings (ROF) to the patient, informed consent (IC), detailed daily note recording, and rendering a written report of these findings with a plan of therapeusis or referral. On the other hand, computed tomography scanning for every patient who comes

through a doctor's door is not an example of meeting the standard of care, as it would be tremendously expensive and time consuming.

Part I: Documenting a Patient File

The most important aspects of patient care are a credible initial case history along with an equally credible initial examination. It is surprising how many clinicians fail to grasp this basic concept, which becomes crucial for a number of reasons. A well-taken case history, barring the bizarre, will tell the treating

doctor what is wrong with the patient or at least give the clinician a reasonably narrowed differential diagnosis. It is important for the doctor to properly guide the patient through his or her history and not let the patient lead the discussion, as patients are notoriously bad informants. It is up to the doctor to control the case history, obtain the salient past, and present and obtain facts in a reasonable order along with properly documented signs and symptoms. As patients may very well exaggerate or embellish their symptoms either subconsciously or intentionally, the doctor



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(DC, DO, MD) must be able to sift through the data being related and document a reasonably accurate history.

The examination that follows must be thorough enough to include vitals, a review of systems, an on-point ortho/neuro examination, and all salient palpatory findings (which in the case of DCs should include an inventory of all pathomechanics located). This should all be recorded in a first day report (FDR). The clinician may or may not take x-rays at his or her facility. Whether the doctor takes x-rays or reads outside films, a detailed report should ensue (see x-ray addendum sample).

As previously stated, the patient comes first, but other factors always come into play. The specter of malpractice accusations and payment for services rendered are ever-present issues. For doctors who interact with insurance companies, documentation becomes an even more critical issue as the insurance companies routinely hire out IEs to review the bills and the documenting data submitted by treating physicians. Therefore, we recommend that the FDR also include a differential diagnosis, diagnosis, and an initial treatment plan with short-, intermediate-, and long-term goals. Very few practitioners currently do this.

Additionally, if a range of motion (ROM) was done on any body part for any reason, a mensuration device must be used according to the *AMA Guides to the Evaluation of Permanent Impairment, 5th Ed.* If the spine is at issue, then the use of an electronic inclinometer is strongly urged by the *Guides*. Doctors should document that the ROM was performed, a measuring device was used, and the ranges were obtained properly; the actual values themselves should be highlighted. Doctors who do not document how they obtained the ROM leave themselves open to attack. If not noted in the FDR, this information can be reported on an addendum (see ROM addendum sample).

Familiarity with the *AMA Guides* is essential when amassing data on a patient, as is remembering to include negative as well as positive findings when documenting the orthopedic and neurological tests performed on the initial exam. Too often doctors fail to document what was normal. Additionally, a practitioner need not perform an excessive number of clinical tests on each patient. For the typical patient, five to seven clinically indicated orthopedic tests are considered the norm. Neurological testing should include basic reflexes

and dermatomes and should determine most of the cranial nerve functions by careful observation of the patient and simple cerebellar testing. Documentation should cover normal and abnormal results. If a more detailed neurological exam is indicated, then this should be performed, and the procedure and results should be fully documented.

Report of Findings and Consent

Regardless of what an exam reveals, the patient must be made aware of the findings and given a chance to consider the doctor's recommendations. Chiropractors are historically excellent at rendering the so-called "report of findings" (ROF) to their patients. What doctors typically forget to do is document that the ROF was actually made. They should include a small blurb in the daily notes along with an addendum (see ROF addendum sample). Furthermore, should the patient be accepted for care, a note to the effect that "the patient has agreed with the treating doctor's recommendations and treatment plan and has agreed to begin care" should be included either in the addenda or the daily note blurb. The ROF and its attendant documentation segue nicely into the IC component of the patient file.

IC is absolutely critical to initiate care on a patient (see IC sample). This means stating clearly that the practitioner has accepted the patient for care, outlining a basic treatment plan with specific treatment inventories, informing the patient of potential risks of care and of alternative treatment options, answering any questions the patient may have, documenting that the patient understood what was said, and finally, obtaining a signed waiver indicating the patient's agreement to let the practicing doctor actually treat and touch the patient in the course of providing professional services in his or her specialty. While some doctors still rely on oral consent, the sagacious path is to get the IC in writing. The only exceptions would be immediate family members in the clinical setting or an ER patient in acute distress. Federal CLAS laws require that the IC be in the patient's native language (Office of Minority Health, 2000).

Legal Issues During an Exam

As a legal aside to this same topic, during an exam typical procedure often includes closing the door to the room for privacy. Practitioners as well as IEs face additional legal challenges from any type of exam. Some of these are assault (acting in a threatening way), battery (unwanted touching), false imprisonment (being enclosed in a room without permission), and possibly sexual harassment. We therefore recommend a signed consent form to examine the patient as well. A simple solution is to develop an exam consent form or use the combined exam/treatment form attached to the IC document and have patients sign it. Should a patient refuse to sign this form, the doctor is urged not to accept the patient. Document in a brief addendum in the file why the patient was not accepted, because, should the patient later elect to sue a doctor for not accepting him or her (as occasionally occurs), proper notation stating that consent could not be obtained from the prospec-

tive patient will be important in a legal challenge.

Daily Notes

With the FDR properly prepared, the ROF stated and documented, and the IC obtained, the practitioner then moves on to treatment and the all-important daily notes documenting the same. There are myriad systems available for documenting patient encounters, such as templates, merge programs, etc. Handwritten notes remain perfectly acceptable, if the handwriting is actually legible and if the note describes the encounter in a basic SOAP (subjective comments, objective findings, assessment of the clinical situation, plan for treatment then and shortly beyond) or DAP (data, a combination of subjective and objective input as seen in the SOAP format; assessment of the clinical situation; plan for treatment that day and shortly beyond) format. Even then, a key explaining the doctor's acronyms and abbreviations must be included.

Doctors should also include language regarding activities of daily living (ADL). Practitioners should have patients comment on simple everyday tasks, such as lifting children, toting groceries, getting in and out of a car, etc., and how the patient feels these activities are affecting his or her pain level. This practice gives the daily notes more originality and diversity. In chiropractic at least, there is a certain redundancy in the day-to-day treatments of patients. By commenting on their ADL, doctors can breathe sensitivity into each encounter and keep the notes looking refreshed. There is the added benefit of documenting what the patient reports on each contact. There will be many encounters bringing forth information regarding exacerbations or additional clinical problems that need to be addressed. By asking pertinent questions and listening to the patients' responses, the doctor will learn what he or she needs to know to document the case file. Many doctors

find it convenient to utilize computer programs to summarize their patient encounters.

Consider the following malpractice claim. The treating doctor (DC) was being sued for causing a disc herniation. Only four treatments were provided and the doctor fully documented in computer-assisted notes how the patient reported constantly adjusting his own back by twisting himself to get the low back "release." The doctor's documentation also included the fact that the patient had been doing the self-twist routine for years. The doctor further cited the fairly blatant positive orthopedic tests on this patient in the first exam encounter. Needless to say, with his documentation in the file, along with the patient's own statement added in the daily notes, a strong defense case was presented that the treating chiropractor did not cause the disc herniation. The doctor also had a key outlining his own acronyms and statements throughout the file that he admonished the patient to not twist his own lower back in this manner. There was a detailed record of quotes indicating that the patient said the doctor's gentle, manipulative techniques had actually made the patient feel better. The malpractice claim was dropped because, without question, the clinician did everything right.

One final caveat on this topic is that every doctor should sign off on every daily SOAP note for every encounter. The note should state something to the effect that "I, (doctor's name), certify that I provided and/or supervised the treatment inventories rendered on this patient today." Check the back of the standard HCFA 1500 forms that are used for billing. There is clear language stating that doctors should sign off on their notes, not just the bills that are submitted. This becomes an issue should bills and notes be investigated. The daily notes need to be certified by the treating doctor or that doctor will be vulnerable to allegations of fraud.

X-rays

Mysteriously, many chiropractic IEs question the use of x-rays under any circumstances. Most IEs who discourage x-rays are following the medical model of daily clinical back-pain treatment; most MDs don't take x-rays for back pain. On the other hand, most current critical literature flatly states that upon ballistic impaction, for example, x-rays in the traumatized area are indicated. Treating physicians should invoke this issue when justifying the use of x-rays. Even in clinical situations involving non-traumatic back pain, judicious use of fast x-ray techniques are widely endorsed in the literature. Incidental findings are numerous and can often add important data to the clinical picture. Even Yokum and Rowe state that plain film x-rays are still the most cost effective imaging available and should be performed if there is the slightest question as to the etiology of a skeletal complaint.

In addition, too often a doctor is sued because he or she did not take (or order) any x-rays on the patient in question. Lack of x-rays is virtually always an issue that is alleged as part of the malpractice problem in a given case. Although it may not turn out to substantiate substandard care, it is a condemning allegation, especially in front of a jury.

Recommendations for Clinical Spinal X-rays. In the cervical spine the so-called Davis Series is considered the norm after an impact. We suggest substituting right-to-left lateral bending views for the right-to-left obliques, as we feel more information is ascertained with lateral motion views. Usually AP/Lat (anterior posterior/lateral) views are adequate for the T-L (thoracic-lumbar) spine should they have suffered traumatic insult. On occasion, lumbar oblique views will be indicated. Remember, the standard rule for taking x-rays is to get at least two views of an area at 90 degrees to each other. For patients with simple back pain the literature is divided as to whether x-rays are absolutely needed (Department of Industrial Rela-

tions—CA, 2005; Walsh, Weinstein, Spratt, Lehmann, Aprill, & Sayre, 1990).

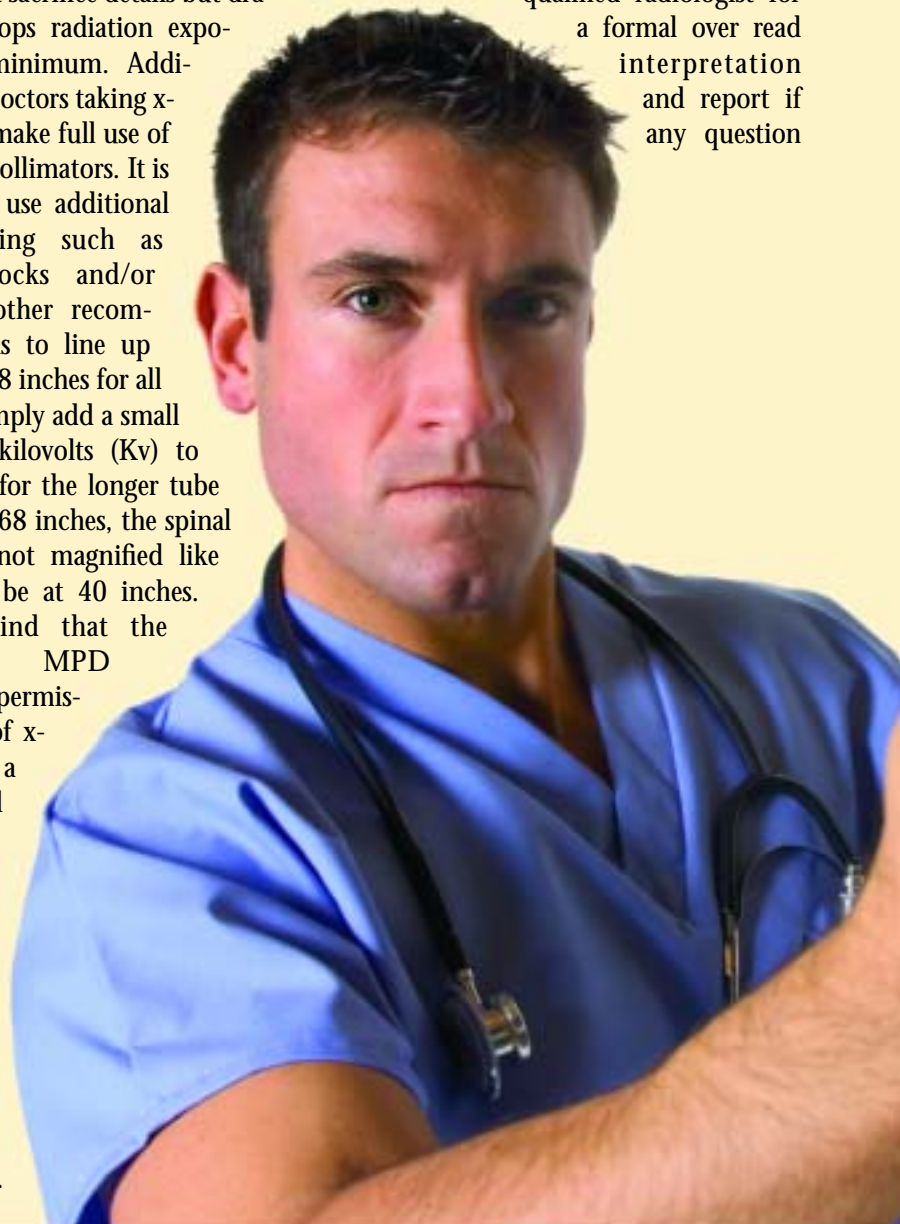
Nevertheless, the judicious use of x-rays in the chiropractic office, even for uncomplicated back pain, is a good idea. This opinion assumes that the following usual contra-indications to x-ray are observed: pregnancy, recent x-ray studies available elsewhere, or an existing patient who has returned due to an exacerbation of the same injury.

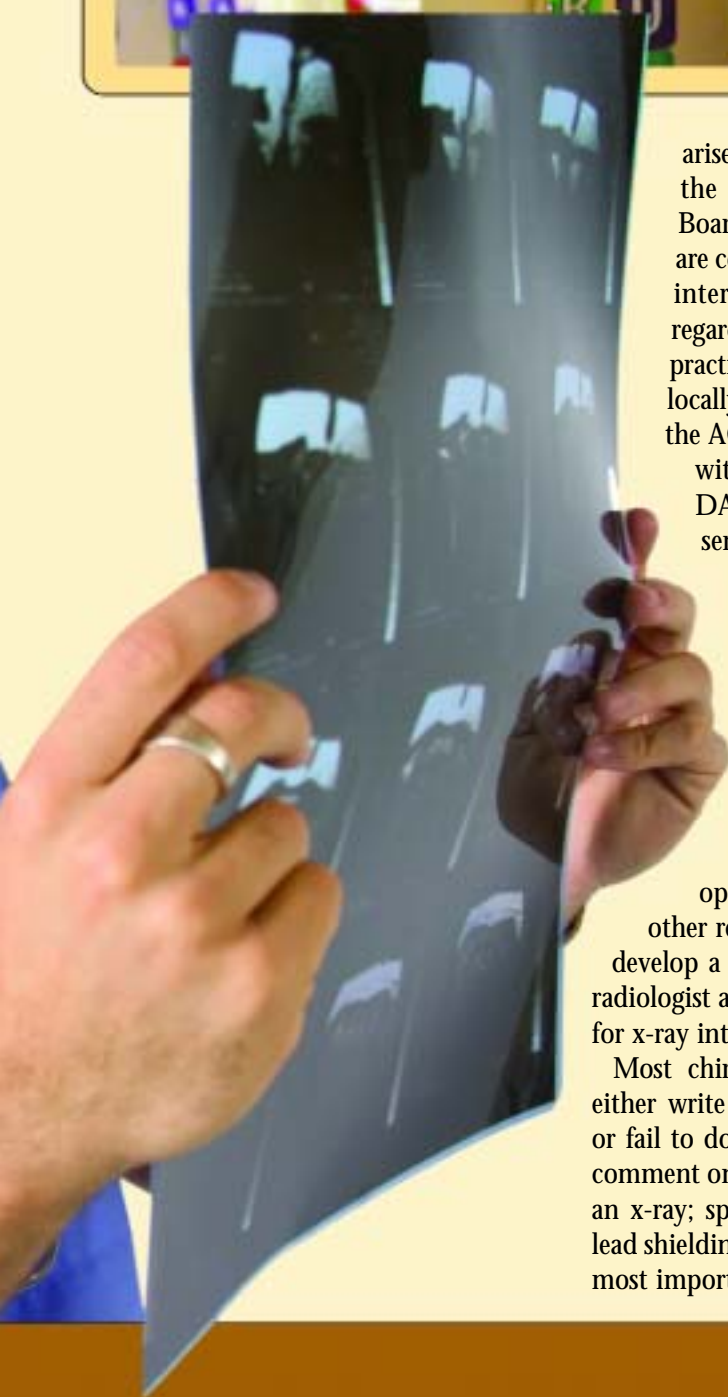
Furthermore, radiation exposure can be mitigated by the use of fast screens and compliant films, such as 800 speed rare earth systems for all views. This is an extremely fast film/screen combination that does not sacrifice details but dramatically drops radiation exposure to a minimum. Additionally, all doctors taking x-rays should make full use of the built in collimators. It is advisable to use additional lead shielding such as gonadal blocks and/or aprons. Another recommendation is to line up the tube at 68 inches for all shots and simply add a small amount of kilovolts (Kv) to compensate for the longer tube distance. At 68 inches, the spinal images are not magnified like they would be at 40 inches. Bear in mind that the established MPD (maximum permissible dose) of x-radiation on a typical patient is 5000 millirad (one thousandth of a unit of an absorbed dose of ionizing radiation) per

year. A normal adult is exposed to 100 millirad per year due to environmental background exposure. The rare earth systems keep exposure at or below the total of 100 millirad per year in a standard set of films.

Chiropractors, by definition, are concerned with the structural integrity of the spine (barring extremity issues that may themselves need to be x-rayed) and must have at least a basic set of x-rays to appreciate the underlying structural positioning of the presenting patient. Using rare earth super-fast systems, patient exposure will be minimal, eliminating the patient's concerns.

Doctors should consult a qualified radiologist for a formal over read interpretation and report if any question





arises on a film. Diplomates of the American Chiropractic Board of Radiology (DACBRs) are considered the very best x-ray interpreters, especially with regard to spinal imaging. If a practitioner is not aware of a locally based DABCR, check out the ACBR website and locate one within reasonable proximity. DACBRs often encourage the sending of films and case histories to their office regardless of geographic location. They will then bill out on the insurance for all charges and return the film, a report of their findings, and the history to the treating doctor. If a DACBR is simply not an option due to geographical or other restrictions, clinicians should develop a relationship with a medical radiologist and utilize his or her services for x-ray interpretation when needed.

Most chiropractors who take x-rays either write a substandard x-ray report or fail to do it entirely. Doctors should comment on why they chose to perform an x-ray; specify the film, screens, and lead shielding used; the views taken; and most importantly, report what the find-

ings were, both normal and abnormal (see the x-ray addendum sample).

Digital X-rays Readers should be made aware of the digital revolution now occurring in plain film radiology. New, smaller digital machines are coming into vogue that will usher in a huge savings to the practitioner in terms of supplies and service. With the new digital machines the tube, tube stand, control panel, and generator remain the same but the screens are all digital. So, where one formerly placed the x-ray film, there will now be a digital screen in place. X-radiation strikes the digital screen such that images are routed directly to a doctor's personal computer or laptop via a wireless radio frequency (RF). The image will then be committed to the hard drive of a doctor's computer and can be pulled up on his or her screen at any time. The clarity of the image can be further enhanced on disc. Copies, if desired, can either be printed, burned onto a CD, or saved to a floppy disc. Should a second opinion be needed, the images can be emailed to a radiologist. With the advent of digital x-ray, the practitioner can say goodbye to the x-ray processor, x-ray film, x-ray envelopes, x-ray chemicals, special plumbing, dark room space, and the cost of processor and chemical servicing. The digital x-ray

will also help reduce the negative environmental impact with the cessation of all the chemicals needed to process film.

Addenda

Hand in hand with clinical documentation is the concept of the addendum. The addendum is a short report that describes a situation too long for a daily note entry but significantly less involved than an FDR. Commonly, patients will suddenly remember something they forgot to tell the treating doctor originally. For example, a patient might suddenly recall recent x-rays taken elsewhere. Because changing the FDR is out of the question and doing an x-ray report is too impractical for daily notes, an addendum, on the doctor's letterhead, is the answer. The heading, "Addendum to Case File," should be in bold font (see Addendum to Case File sample). A series of tabs labeled "Date," "File Name," "File Number," and all other appropriate information identifying the document should be added. At the end of the document the clinician should add "Subscribed and sworn to under the pains and penalties of perjury." Thus, the document becomes a sworn affidavit. In the example above, the introduction to the document stipulates that in fact, the patient did indeed forget to mention these films, which is being noted after the fact via this addendum to preserve the record.

The Doctor's Fees and CPT Coding

Codifying and justifying exactly what treatment decisions the clinician has made and what charges have been billed must be done expertly. The clinician, in our opinion, is ethically obliged to obtain each new annual edition of the *CPT Code Book* and be certain that all staff members are thoroughly up-to-date on charges. Additionally, doctors should obtain a fee guide such as *Ingenix*. This publication sets national and regional standards and means for all services for a given practice. If a practitioner is in line

with national and/or local fee guidelines then he or she has less of a chance of being challenged regarding what he or she charges. The use of a fee guide such as *Ingenix* has the additional benefit of defending doctors against accusations of collusion and/or fee fixing. If a challenge does ensue it can be easily defended by producing a nationally recognized fee standard. The challenged doctor is then urged to rebut by asking why his or her fees were questioned in the first place and what specific concerns prompted the questions.

Obtaining a Second Opinion

There is no catch-22 in noting for the record a suggestion to the patient that he or she should obtain a second opinion. This is good medical/chiropractic practice. However, doctors should go even further. Every treating doctor should develop a mutually mentoring relationship with a practitioner in the same or a related discipline. From time to time, the two should meet to discuss the more unusual cases on which they are working. Questions of diagnosis and/or therapeutics concerning the patient are ideal topics for such meetings. Another possibility is to form a professional "round table" that meets monthly to hold case conferences for the benefit of all the members as well as the patients. In any event, any other opinions obtained and noted in the record will bolster the credibility of patient management decisions. A doctor's own reviewer may be able to make recommendations on treatment protocols that the doctor may not have appreciated originally.

Photographs of the Patient

Simple photographs of the actual patient are helpful for a number of reasons. Use a digital or 35mm camera and obtain 4x6 doubles; each doctor should put one photograph into his or her clinical file and the other into the insurance file (if there is one). This helps the clinician and the insurance clerk better remember

a case at a glance. It is especially helpful for a coverage doctor to see who is who in a clinic full of patients. Supplemental pictures are also recommended if there are visible injuries and/or medical appliances such as neck braces or crutches in use. In addition to visually documenting these items, doctors should add the following language in the report: "See medically documenting photographs." Clinicians should also keep on file a photocopy of a driver's license or other ID to prove the patient's identity. In rare cases, identity theft could snowball into a Board of Registration complaint. If the treating physician can document that he or she took reasonable steps to document that an individual was who he or she purported to be, then the practitioner will be able to withstand even a vigorous fraud challenge.

Compliance

Compliance works hand in glove with HIPAA regulations. All practitioners are now subject to federal regulations and standards together with federal penalties. Most state societies and doctor management organizations are urging their doctors to issue what is called a compliance policy for the office. Basically, this policy calls for a manual given to each staff member to include the essential compliance policy guidelines, a standard office policy, and HIPAA rules. The actual compliance aspect of the package states that a compliance officer be designated to enforce compliance issues.

The primary responsibilities of the compliance officer would be as follows:

- Overseeing and monitoring the implementation of the compliance program by making sure that services provided were clinically indicated, there was no purposeful overbilling or double billing, CPT and ICD-9 coding were correct, and no overt premeditated fraud is being foisted upon third party payers.
- Establishing methods, such as periodic audits, to improve the practice's

efficiency and quality of services and to reduce the practice's vulnerability to fraud and abuse.

- Periodically revising the compliance program in light of changes in the needs of the practice or changes in the law and in the policies and procedures of government and private payer health plans.
- Developing training modules and training materials for the staff and/or leading frequent office meetings to discuss the issues.
- Ensuring that all employees and physicians know and comply with pertinent federal and state statutes, regulations, and standards.
- Investigating any report, allegation, or hint of unethical or improper business practices and remedying the situation if it exists.

This is just a very brief overview. Each doctor should hasten to draft a compliance policy. Essentially, this is a written document that states that the office does not engage in fraud and has a system in place to continually check for errors, and that the designated compliance officer will remedy problems and issues as soon as they arise. For more information on this topic, practitioners should check with their state societies for guidance in setting this system up and properly maintaining it.

Over-Utilization or Not?

Doctors are often taken to task by IEs for the classic allegation of over-utilization. Over-utilization is defined as "Inappropriate or excessive use of medical services that add to health care costs" (Benico, Ltd., 2005). Over-utilization is in the eye of the beholder. Barring outright criminal behavior, what one IE may see as over-utilization is most likely seen by the treating doctor as a concerted clinical trial. The way to deal with this harsh allegation is for doctors to fully document their entire file, including each and every service and why it was selected. This may occasionally

require citing literature as a justification. In chiropractic, for example, intersegmental traction is often singled out as not having been justified in the literature; thus, it is labeled as an unnecessary therapy. However, there is much literature to establish this highly effective mode of therapeutics. Accordingly, a citation from the professional literature placed into the record is a good protective tactic. The practicing clinician should have appropriate literature and citations available to establish efficacy of treatment and treatment parameters. Additionally, outcome-based measures have been considered a fair and reasonable way to monitor the clinical experience with any patient. Disability questionnaires like the "Oswestry" and the "Roland Questionnaire" have worked nicely for clinicians for years. They help document a file and later rebut a challenge if need be.

Patients should complete a patient affidavit with regard to ADL. The doctor should also consider using the simple analog pain scale along with the classic anatomical figurine drawing on which the patient is asked to mark and indicate pain locations. Some doctors utilize this method on re-exams, while others have a patient fill out an analog scale/figurine drawing on every patient encounter.

Part II: Establishing the Credentials of the IE and Rebutting Specious Reports

This section moves forward into the realm of defending a clinical case file in the event that a treating doctor is questioned by third party supplicants such as IEs. These techniques are from a proven, effective methodology to protect a clinician's reputation and case file. Referencing specific literature on this is difficult due to the fact that, to the author's knowledge, this article is the first of its kind in publication. There is a presumption by the authors that a given case file by any practitioner has been ethical and professionally handled and executed.

Curriculum Vitae

After the treating doctor has done all he or she can do to document his or her case file to where it is clinically sound, there will still be the occasional IE who will find fault with the case at hand. The treating doctor must move forward with an aggressive offense aimed at taking the specious IE to task. The first step is to obtain the curriculum vitae (CV) of the insurance doctor. CVs are considered public domain information. Any inquiring party can access them. Inquiries can be made with the company that hires out the IE doctor. Make the request in writing (although a phone call can sometimes get the CV faxed directly to your office), and ask that the CV be faxed as soon as possible. Rarely is the CV request denied. Once the CV is in hand, a careful perusal of the document is urged. Some IEs pad their CVs with false credentialing. To find out what is true and what is not may take some investigative phone calling, but the effort is worthwhile.

In one odd case in Massachusetts, a chiropractic IE claimed to be on staff at a hospital, to have earned two advanced degrees in neurology, to be the director of chiropractic services with an IME company, to have a private practice office in New Hampshire, and to be a forensic consultant at three other facilities. None this was true. When this kind of fabrication is revealed, by extension, any opinion he or she rendered becomes highly suspect and can be attacked in a stinging rebuttal. This type of discovery usually ends the credibility of the examiner right away and thus, any of the treating doctor's services that may formerly have been called into question are usually reimbursed immediately. As a side note, all doctors of every discipline are urged to keep an accurate and up to date CV ready on their hard drive to be used as needed.

In reality, most IEs are not well credentialed from the onset. Their post-graduate training is usually lacking, and

few have been granted a post-graduate degree or certificate. This may be the underlying cause of the falsification of credentials. The practitioner who has been challenged has every right to ascertain the IE's standing to question the care and services the treating doctor has rendered.

Back to IEs and X-rays

Along these lines, the basic forensic investigation of the typical IE needs to start with nothing more than a simple phone call to his or her private office (if he or she even has a practice). It is usually ascertained that the IE does not own an x-ray, nor has he or she ever owned one. It is not unusual to find that the IE doesn't even practice anymore. Rebuttals in this case would consist of commenting on the IE's lack of x-ray skills and equipment and, if applicable, commenting on what you, the practitioner, found on the films you took that had a dispositive bearing on the case.

Rehabilitation Methods

Another example of a forensic challenge to an IE is the justification of isotonic rehab protocols on certain patients. One of the more popular protocols is the Zinovieff-Phase I. Often spectacular results spring from rehab on patients in which manipulative reductions had reached a plateau in effectiveness. Without exception, IE and peer review reports vacate methodology on this aspect of care and indicate that the rehab was not supported by documentation and naturally debarring the bills submitted. Often these reviewers do not have any post-graduate training in rehabilitation methods. Most of the reviewers don't even practice the art of chiropractic. In Massachusetts, the Board of Registration Rules and Regulations states that no chiropractic specialties set any one chiropractor apart from another. While we grudgingly acknowledge this unfortunate regulatory reality, it still does not and should not prevent the

treating doctor from exposing an IE's lack of training in a rebuttal, especially if the treating physician is a well-credentialed specialist in his or her particular field.

Occasionally doctors have had their patients independently examined by very well credentialed orthopedic surgeons. This group of IEs usually renders far more fair and balanced opinions on patients than their chiropractic counterparts. The need to vigorously rebut these doctors is usually diminished to a large degree.

Collecting IE Reports

Practitioners should keep special files on each and every independent exam report they receive and keep a separate file on each IE who has written such a report reviewing their work. The strategy is that over time, a pattern of similarity in the comments, critiques, and financial cutting tendencies will emerge in those reports critiquing the treating doctor's services. This can be extremely helpful should the treating doctor later need to rebut. (Should it be necessary to use this tactic, the practitioner must be careful to redact names of any patients other than the one referenced in the case in chief.)

In one case, the authors of this article brought both the patient and the patient's x-rays with them to a review. The IE (a DC) was nonplussed, yet made his opening statement that there was no doctor/patient relationship between he and the patient. The exam ensued and lasted 9 minutes, including the opening statement and a brief perusal of the x-rays the treating doctors brought with them. The IE's x-ray review was perfunctory at best, akin to merely glancing at them to make sure they were actually x-rays and not vacation photos.

In the IE's report, which came through 2 weeks later, half of the services rendered were disavowed as being unnecessary and undocumented. The report also stated that the patient had no

scoliosis. No mention was made of the IE's "review" of the x-rays that were presented to him. Since the patient in this case has a rather profound scoliosis in the thoraco-lumbar spine, the doctors' rebuttal that followed was scathing. Emphasized in this rebuttal was the fact that this IE always claimed that patients did not have scoliosis and that the IE states this in the same spot between all the other standard macros he uses in his word-processed reports, right along with the standard blurb that the treating doctor's case file was not documented and care was not necessary. Needless to say, there was no defense for this appalling lack of credibility. The bills on this patient were paid in full.

Exam Affidavit

As most practitioners now know, many independent exams are shamefully brief. A proper exam simply cannot be performed in haste. All practitioners should have patients who are forced to attend these independent exams fill out an IE affidavit when they return to the practitioner's office (see the IE affidavit sample). This affidavit, in the form of a questionnaire, asks penetrating questions about the patient's encounter with the IE. Among the questions asked is "How long did the examination take?" Another is, "How much time did the examiner spend talking with you?" It is not uncommon for a patient to indicate that "5 minutes" were spent on the history taking and "5 minutes" for the exam. The patient "subscribes and swears to his/her statement under the pains and penalties of perjury." This becomes a sworn legal statement by the patient, which can be very effective in augmenting a treating doctor's rebuttal of an unfair report. In 5 minutes, an IE cannot possibly sufficiently ascertain a patient's medical/chiropractic status to challenge the careful documentation of an appropriate treatment regime.

Commenting on Pathomechanics and Vitals

This article is limited to neck and back issues. While extremity and internal issues may exist, the bulk of chiropractic complaints remain with the spine. Oddly, in the chiropractic arena, IEs virtually never perform a spinal exam during their assessments. It is incumbent for a chiropractic doctor to perform a spinal exam on a chiropractic patient. In this article, the authors use the term pathomechanics as a somewhat more descriptive term than subluxations, which is the traditional phrase used to describe misaligned vertebrae. The "pathology of mechanics" is exactly what the term pathomechanics means; that is what is appreciated in a properly performed spinal exam. In chiropractic, the majority of patients present for professional services on their spines. How, then, can chiropractic IEs ignore the spine as they do? The treating chiropractor's reports, as well as the daily notes, are replete with data on the patient's spine. Why then do the chiropractic IEs have no interest in examining the patient's back? The chiropractic IE's disinterest is perplexing. With this in mind, the treating doctor should question why the examiner didn't examine or comment on the patient's spinal area of complaint.

In this same vein, IEs regularly fail to perform a truly comprehensive exam and often exclude blood pressure, height, or weight. This alone calls into question the IE's credibility and casts doubt on adherence to state board regulations. These exams are incomplete and flawed and should be challenged. This, together with the usual failure to truly examine the spine for pathomechanics, leaves the IE's report open to attack. Typically, the IE's report speaks of muscle spasm or lack thereof, ROM, and whether the patient was complaining of pain that day. We touched on ROM earlier but it bears repeating again; most commonly the ROM is mentioned, and in the IE's report the ranges are all

miraculously full, ending in 0s or 5s. This means that the ROM was simply eyeballed, which is unacceptable as per the *AMA Guides*. This flaw and others can easily be exploited.

Waddell "Inorganic" Signs

IEs as a group often invoke the so-called Waddell Signs to show that a patient is, at minimum, magnifying his or her symptoms or, at the most, an outright malingerer. The signs came into vogue about 24 years ago and have appeared on a regular basis from a wide gamut of IEs, both chiropractic and medical. To understand what these signs are about, one should understand Gordon Waddell, MD, the man who designed them. The authors of this article have read his book at length, chatted with Waddell online, and have the second edition of his landmark book *The Back Pain Revolution* in our possession. Dr. Waddell is a seasoned veteran of orthopedic surgery who has literally traveled the world researching what he calls a "20th century medical disaster:" back pain. He speaks very highly of chiropractic and physical therapy in his book and goes on to explain the true nature and genesis of the famous signs. In short, Waddell first developed a psychological thesis on behavioral symptoms in his own problem back clinic. The initial aim was to clarify assessment of nerve root problems and decisions about surgery. Next, a psychological approach was developed with regard to behavioral responses to examination. These then are the famous Waddell Signs that have been inappropriately co-opted by the IEs over the years to justify cost containment.

Waddell carried out an exhaustive literature search and performed pilot studies to identify an appropriate group of signs to distinguish a patient's behavior, rather than physical presentations, during an examination. Waddell was interested in the reactions that vary between patients and how people try to convey their condition to an examiner. A so-

called positive sign does not automatically mean the patient is a fraud. Many signs Waddell initially developed were discarded because they were either too unreliable or prone to observer bias. He tells us that even the final seven signs in use today are subject to that bias. This statement is key because the signs are basically completely subjective.

Bear in mind that only IEs call these responses Waddell Signs; Waddell calls them "behavioral responses to examination." Waddell cautions that too many examiners fall into the trap of trying to make judgments rather than dispassionate clinical observations. Waddell's seven signs are as follows:

Tenderness: 1.) superficial, 2.) non-anatomic;

Simulation: 3.) axial loading, 4.) simulated rotation;

Distraction: 5.) SLR;

Regional: 6.) weakness, 7.) sensory disturbance.

Waddell stresses, however, that in the following three situations the behavioral signs cannot be used:

- With patients with possible serious spinal pathology or widespread neurology. Diagnostic triage must be carried out first. The behavioral signs are only inappropriate with regards to mechanical LBP and sciatica.
- With patients over 60 years of age. The behavioral responses are normal for people in this age group.
- With patients from ethnic minorities. There are wide cultural variations in pain behavior. Waddell only standardized his signs on Caucasian patients.

Additionally, Waddell offered the following caveats about observing illness behavior, also known as the signs:

- Again, always carry out diagnostic triage first. As Waddell so well states, diagnosis is the foundation of management and is based on clinical assessment. Thus, diagnostic triage consists of ascertaining the level of back pain in one of the following three cate-

gories: simple backache, nerve root pain, or possible serious spinal pathology.

- Clinical observation of the illness behavior presumes careful technique so to avoid observer bias.
- Isolated behavioral symptoms and signs are meaningless. Many perfectly normal people will display a single "sign." Only multiple findings or several different kinds are significant.

The practicing doctor should obtain a copy of Waddell's book, *The Back Pain Revolution*, study it, and carry out a careful reading of the pertinent text. When confronting a negative IE report based on Waddell's criteria, practitioners should first decide if their patient is part of an ethnic minority group or 60+ years of age. If so, the Waddell signs are rendered meaningless. Next, they should ascertain whether the IE performed diagnostic triage; the chances are slim that this occurred. Then, they should determine how many signs the IE is invoking, remembering that just one or a couple of scattered signs may be meaningless. By understanding these signs and what they were originally intended to reveal, the practicing doctor will easily be able to rebut IE attacks on a case that involves Waddell's research.

Accompanying the Patient to an Independent Exam

The practitioner always has the option of accompanying the patient to the IE. In many jurisdictions there is considerable latitude, such that the patients may have the right to audiotape the exam, have an advocate present, and re-schedule the exam to a more convenient time. Also, family emergencies are always accommodated. For example, in Massachusetts, case law has established the right for a patient to audiotape the exam if English is not the patient's primary language and all parties agree to be taped. There is no known case law on whether a patient "advocate" can be present at an exam. However, the Chiro-

practic Board itself has stated that it is the patient's "right" to have an advocate present during the exam. Statutory law allows for re-scheduling of the exam to a convenient time for the patient and advocate. Thus, the patient doesn't absolutely have to go to the first scheduled IE when it is scheduled.

So, do IEs allow the treating doctors to accompany the patient to an exam? Yes and no; it depends on the personality quirks of the examiner. Some will allow an advocate and some will not. Some will allow audiotaping and some will not. Some will allow the treating doctor to attend and some will not. No IEs will allow the session to be videotaped. Regrettably, there is no case or statutory law that allows for videotaping of the IE encounter. The practicing doctor should reschedule the IE to a convenient time for him or herself and the patient and act as the patient's witness. The following are additional suggestions for the treating doctor "witness":

- Be polite.
- Be respectful.
- Bring a tape recorder, spare batteries, and case law to show an uncooperative examiner.
- Bring pencils and paper to take notes.
- Mark the time you and the patient showed up at the facility and the time the exam started and ended.
- Differentiate the timeline of the exam between history taking and actual hands-on examining.
- Bring x-rays if possible.

Do **not** do the following:

- Say a word other than salutations.
- Correct the examiner if he or she forgets to do part of the exam.
- Correct the examiner if he or she is doing the wrong exam (such as examining the wrong area).
- Correct the examiner if he or she is performing an aspect of the exam improperly.
- Talk with the patient during the

exam (if at all possible).

After the IE has taken place, the doctor should have the patient return to his or her office to fill out the exam affidavit. The treating doctor should compose an unofficial report of what transpired at the insurance exam. The doctor might even dictate such a report en route back to the office from the exam. That report should remain dormant until the treating doctor views the IE's report of the same event.

Almost inevitably, a rebuttal must be prepared. The clinician's contemporaneous, unofficial report on the encounter should then be integrated with a more complete rebuttal composed after the IE report is in hand. For instance, recall our previous example of the IE who looked at some X-rays of a patient he was "examining" and failed to notice the frank dextro scoliosis present. That IE also failed to even mention that he viewed the patient's X-rays in his IE report. This is an excellent example of how what the visiting doctor actually witnessed at the exam, combined with what he read later in the IE's report, was integrated into a well documented, bullet proof rebuttal that completely discredited the sub-standard IE exam and its equally sub-standard report. (Of course, this statement assumes the IE report is not valid.)

Clinicians should not dismiss the fair IEs and reports that can occur. There will be fair and balanced IEs and subsequent reports that may very well support the treatment rendered and even recommend more treatment. In that event, we recommend leaving well enough alone.

Finally, if the practitioner does go to an IE, there may be the occasion in which the IE will refuse to perform the exam. That is not a problem. We recommend that the clinician and the patient simply turn around and leave. We further recommend that when the treating doctor returns to his or her office, he or she should fully document that the patient was present at the appointed

time and place for his or her exam, the IE was present also, and the IE voluntarily refused to perform the exam. Most state law includes language to the effect that if the patient fails to show for an IE more than twice, the entire case file can be disavowed for reimbursement. Make sure that it is documented that the patient did in fact appear for the exam at the appointed time and place, that the IE was there as well, and that the examiner opted not to perform the insurance examination.

Rebuttals

Throughout this article, rebutting the IE attacks on doctors' case files has been discussed. There is a good chance that there will come a time to put all of this information to use. After the treatments rendered, the careful case documentation, the second opinions (if obtained), the collating of data on the IE, and the careful review of an IE report, the rebuttal of an IE attack ensues. Simply put, practitioners should intelligently, cogently, and professionally rebut the attacks that may come against their case files from IEs typically working for a third party payer.

Insurance companies keep track of doctors. If a practitioner gets a reputation as a pushover who does not fight for his or her own bills, he or she will regularly get cut on them. Doctors should state that they have read the IE report and that they want to make a few comments on it. The format each chooses is optional, such as the bulleted sequences, arrowheads, and so forth to draw attention to important points. Sometimes a simple paragraph or two is all that is needed. Bear in mind, if doctors use the techniques and ideas presented in this article, their rebuttals will be easy to read, logically sequenced, and hopefully virtually "bullet-proof."

IE reports occasionally attack practitioners by either exaggerating events, accusing the practitioner of over-utilization, accusing the practitioner of fraud,

accusing the practitioner of making an inappropriate diagnosis, or suggesting that the patient should not have even started treatment with the practitioner. We suggest that the treating physician stand up for his or her case and defend it vigorously. This goes a long way in establishing a respectable, professional name in the community and in supporting the care that is rendered. One final word of advice to clinicians is to keep rebuttals reasonably short. No more than four pages are ever needed. Usually two or three pages will be all it takes for doctors to say what needs to be said.

Conclusion

Meticulously documenting a case file has many advantages: it keeps the file professionally organized for the sake of the patient, the treating doctor, a coverage doctor, or referral doctor; it helps prevent malpractice; it helps make the documents in the file logical and compelling enough for reimbursement; and it provides enough professional documentation to be able to rebut overzealous IE attacks, which in turn also helps get the case reimbursed. Doctors owe it to their patients and to one another to stand up for their discipline, their principles, and their practices. Practitioners now have a highly effective strategy to pull a case file together in a logic-based, outcome-measured format and defend it from virtually any type of challenge.

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Killer Clown Leaves Mass Grave of Skeletal Remains

by Leann Long



In December of 1978, things were going well for John Wayne Gacy. He owned a highly esteemed

construction firm and was well known and respected in the community for his volunteer work. One of Gacy's charitable services was dressing up as Pogo the Clown and visiting the local children's hospital.

If any of the children in the hospital ever shivered at the sight of Pogo's, sinister black eyes, creepy white flesh, and unsettling crimson smile, their spine-chilling fears were not without reason. The eerie dark secrets and murderous habits of the killer clown were about to be exposed.

While Gacy's firm was remodeling a pharmacy, an employee at the pharmacy, 15-year-old Robert Piest, disappeared. Gacy was the last known person to see Piest. Investigators were able to obtain a search warrant after a background check on Gacy revealed he had served prison time for committing sodomy on a teenage boy. During the raid of Gacy's house, investigators found little evidence but did notice a foul smell they believed to be caused by a sewage problem.

However, a couple of items the investigators seized from the house turned out to be extremely valuable. A ring they confiscated belonged to a boy who had disappeared a year earlier, and a receipt for film they found had been given to Piest by a coworker the day of Piest's disappearance.

Before investigators could return to Gacy's house to perform another search, Gacy turned himself in to the authorities, confessing to burying 29 bodies under his house and, due to lack of room in his underground graveyard, dumping 4 bodies in a nearby river. The investigators suddenly realized that the foul smell

coming from Gacy's house was not the smell of sewage, but of decaying dead bodies.

Gacy described his brutal crimes in detail to authorities, explaining how he would often trick his victims into putting on what he told them were fake clown handcuffs. Once they were restrained he frequently tied ropes around his victims' necks to strangle them or stuffed their underwear down their throats to suffocate them and raped them as they died.

Police eventually recovered all 29 bodies buried underneath Gacy's home and the four additional bodies that were dumped in a river. Gacy refused to reveal to authorities the names of any of his victims, so when 14 of the bodies still remained unidentified, well-known forensic anthropologist Clyde Snow took the case.

Many of the bodies were buried on top of each other, so Snow's first task was to separate and arrange the bones to make sure each bone was placed with the correct remains. After all the bones were sorted, Snow was able to confirm that all

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