Stop Treating Your Patients Finances and Insurance and Start Treating Your Patients

These initial words unfortunately are so true in chiropractic today. Everyday in my diagnostic business I listen to doctors under treating spinal injuries and I am not sure what to say. I hear, "well if we go over 24 visits in our state the insurance companies will seriously flag us, or if the case is over $3000.00 our attorneys do not like it." Some other things that I hear are, "my patient does not have a lot of money and their insurance is exhausted, and my patients insurance is exhausted and we are getting killed with low ball settlements, or I am already taking a cut of my bill when the patients attorney calls to reduce my bills." What does any of this have to do with what our patients need? That and only that is what is really important here. No one minds paying for good results!

Now I am going to let you in on a little secret. The medical system does not even give cost a second thought, as it is what does the doctor need? Recently I went into a clinic with racing heart 160-170 bpm resting. I discovered it at two o'clock in the morning as I felt just a bit different and felt my own pulse and could not feel it, which I knew could not be good, but I also knew that I was alive and actually felt okay. I grabbed a BP cuff and slapped the stethoscope to my chest and that is when I heard my racing heart. So I went into the ER at around 3 AM, was given a drug to try to slow it down, which just about killed me as it really slowed my heart down. Revived I was whisked away to another hospital after they got me to baseline 160-170 bpm which is where I started from. The ambulance ride now at 7 AM was an hour ride. When I got to the other hospital I was in intensive care. There, a lot of blood was drawn and a lot of tests were performed. I was told that they were trying to get to the bottom of why my heart was racing so badly.

I then had x-rays and a echocardiogram and was told that my heart function was very weak and my heart was enlarged. I was then lead into a room for cardiac aversion, which means they hit you with a shock to shock the heart signals back into alignment and reduce the heart rate. That is something let me tell you. They then told me that I was to be scheduled for heart cauterization to see if I had blockages of the arteries as I am 44 years old and that could explain the heart weakness, again found on an initial echocardiogram. No blockages found I was told that the future for me was a heart transplant, and this was only my third day in the hospital based on ONE TEST (the echo cardiogram) and one drawn out and very expensive negative testing process. Day three after all testing and the good news (ha ha) I was put on four drugs and told I would have to stay another day in order to monitor for reactions to the drugs, day five I went home. Now I should tell you that the day before my heart raced I put up around 1250 bales of hay in a very hot Wisconsin barn. I never felt weak, tired, feint, lightheaded…nothing…no symptoms… did not make sense to me if my heart was really that bad—this I explained to everyone however that did not seem to matter.

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To make a long story short as there is a lot more, two months later I showed a completely normal heart on a follow-up echocardiogram and am fine. Never felt better. I believe that the first echocardiogram perhaps was misread and that lead them into a whole lot of tests and treatment.

Now mind you though all of this I felt absolutely fine. No symptoms

Now the point I am trying to make here is this…no one once asked me about my insurance which was a higher deductible insurance as my family, nor I are ever sick. No one consulted me and told me what the prices of the various tests were. I did not get a financial consultation to solve my finances in order to receive the care. Now I am not saying that you should not do those, I am simply stating that the only factor that was considered by the doctor was what he needed in order to assess my situation. My job was to figure out the finances. That is where the responsibility ultimately is anyway.

Oh as a side note I got to experience just how expensive things are medically. I believe the whole 5 days cost around $25,000.00. I had at least 6 EKG's performed. They place the pads on and run the EKG for 6 seconds, which is $110.00 and takes less than a minute. Now whenever I go into the cardiologist office I start with a 6 second test for $110.00 and I have not even seen the doctor yet.

The lesson to this was stop thinking about other factors other than what do I need to assess this patient and once determined what is wrong, what do we need to do to get optimal results fixing the problem and do that.

Let the patient figure out the finances, and never assume that they cannot afford it as it is quite a demeaning attitude on your part to do so. Assume they can afford it and then let them tell you if they cannot.

Now let's get back to what the patient needs, not what the insurance company needs or the independent medical evaluator needs, the peer reviewer needs or what the attorney needs right now, or what you think that the patient can afford and lets just focus on what we know, so that we can better assess their needs

In a published Journal Article, "The Fluctuation in Recovery Following Whiplash Injury 7.5 year Perspective Review" published in Injury Volume 36, issue 6, June 2005, pages 758-762; patients who had whiplash accidents were studied and looked at in the first three months, then three months to two years, then two years to 7.5 years. At 7.5 years 29% were asymptomatic, 48% had mild symptoms not interfering with work or leisure, 55% had neck pain, 43% had low back pain and 38% described parasesthesia and headaches.

This article talked about how patients who experienced the most gain in the first three months of care showed the best results, but it also suggested that true assessment of how a patient was going to be could only be gotten after TWO YEARS! Remember Cyriax stated that ligaments take up to 24 months to heal properly, wonder if that correlates as a factor…mmm.

(A copy of this article in on our website in the "links and articles" section)

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In this article review Dr. Dan Murphy one of the most respected experts in the country, suggests and I quote, “I believe that in an effort to reduce chronic pain and disability from whiplash injuries, we should treat the patient daily for two weeks and then three times a week for ten weeks.” Those of you who know that Croft treatment guidelines know that he is talking about a Grade III injury depicting Moderate; Limitation of motion; Some ligamentous injury; Neurological findings may be present. Notice Dr. Murphy never stated any other factor, insurance permitting, if the patient can afford it etc. We are talking above about your ability to get a patient out of a life of persistent pain when we are talking injury treatment. We are talking about taking our patient out of the 55% category!

(For a copy of the Croft treatment Guidelines see our website on Croft Treatment Guidelines)

Now I have been saying this for a very long time. When you start testing with us you are going to find that about 50-60% of your patients will test positive for ratable ligament damage. You could have ten patients in a row test negative and then the next ten will test positive, however many doctors never make it to the tenth test as they lose value in what they are testing for, as I will explain in a minute, they are testing for the wrong reason.

Now if 55% of your whiplash patients have a high probability of ongoing symptoms, and 50%-60% of your patients will test positive for ratable ligament damage—what tissue do you think is injured to cause this 55% to have ongoing pain and discomfort? mmm

Next question how many of your injured patients are you testing for these findings?

Next question if you knew from the onset that a patient had ratable spinal ligament damage do you think it would change the way you manage them—the way that you approach their treatment—what you may be communicating to them? If you do not know what I am talking about please call me and I will give you three or four immediate changes that you can make which will be helpful to getting optimal results with these patients!

When you hear the patient say, “Doctor this just does not seem to be getting any better, or Doctor does it seem like this is taking a long time”—what they are telling you is, Doctor there is a very good chance that you have missed the ligament damage in my neck which is causing retarded results, and we have never gone over this so that I understand and do not have unrealistic expectations with the speed of recovery.

X-ray digitization is really the only recognized spinal ligament testing procedure, besides testing with a MRI for the disc (which is also a ligament).

That being said which injured patient would you not test? Now I also want you to think of any objection that you have to that statement? They go something like this:

1. Doesn’t this just add medical specials to the case? If you did not identify the professional and I was just asked the question and then asked to identify the professional asking it, I would say attorney, yet you would be amazed at how

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many doctors tell me this—I simply say you either do not understand what this test tests for or you are testing for the wrong reasons, which we will get to.

2. Our bills are already up there, how is the insurance company going to like another bill?
3. This one really gets me. Our state has generally low insurance coverage so why would I want to send out our films and chew up the coverage that we could have if we do not test? This one is truly with the best interest of the patient in mind! Another example of not understanding what you are testing for, how it assists you with the patients care and of course testing for the wrong reason.
4. The attorneys we work with do not like additional testing as it raises the costs of the claim. Do I have to comment?
5. Our attorneys like our bills under three thousand dollars—like that would ever enter a medical doctors mind, and what does this have to do with what the patient needs are?
6. Maybe the insurance company will not like this testing?
7. The damage to the car does not correlate to the damage of the patient? Now this would be an accident reconstructionist saying it right? Not you—you are examining THE PATIENT AND PROBABLY NEVER EXAMINED THE CAR—right?

There is no end to what could be said here, just propose to yourself the question, why would I not test my injured patients for ratable spinal ligament damage? See what your mind comes up with—and then see if it really has anything to do with clinical assistance?

What did you come up with?

Now here is testing spinal ligament damage for the wrong reason:

1. If it is positive it will justify my care and I will get paid better? This is true and you will but if it is the primary reason you will never fully implement in, the most powerful clinical aspects of the testing—knowing what the patient has so that you can better manage them.
2. I will do this testing because the impairment rating attached to a positive test makes the medical legal aspect a piece of cake. It does—it has a fantastic medical legal aspect to it—but where the clinical aspect of this — this is primarily a clinical procedure with a side benefit in the medical legal aspect.
3. I will test because I want more attorney referrals? Again no clinical aspect to this and you will fail with good clinical usage of this testing procedure—even though with good clinical usage you will, over time get more attorney referrals.
4. I want to have better patient retention? This one is real close as with good clinical usage and understanding of your testing procedure your retention will go way up—just do not make the numbers the reason, make the procedure usage and optimal results the reason for the improved numbers.
5. At National Injury Diagnostics the reports are signed by a DC and not a DCBR or Medical Radiologist. This one is just a non-understanding of some aspect of the medical legal aspect which is not true, nor should it be the basis for the testing in the first place. Call me if you have this consideration and I will explain.

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There are probably others but my point is this; whenever I hear a rejection to this testing procedure it has never once been because I have replaced it with a better procedure or a more accurate procedure, and it is always for a non-clinical reason. A objection due to a better testing procedure would be acceptable. (To date I am not aware for a better more accurate testing procedure then the one we use at National Injury Diagnostics—if one becomes available I will incorporate it into our service)

I hope this article helps. I also hope that it leads you down the road of what the patient needs as opposed to what they can afford or what anybody else thinks about what they need. Keep the patients needs primary and do a good job clinically and you will be filled with demand for your services by injured people wanting to be your patients.

If you have any questions call Dr. Cronk at 715-833-8533.

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