

BACK TALK

Advertising Material

September/October 2004

COMMON PITFALLS

by Bruce A. Davis

For 26 years I've been reviewing treatment documentation produced by the numerous medical disciplines that make up the personal injury arena. The records I have examined for nearly three decades could best be described by the title of a well known Clint Eastwood flick. No, not a *Fistfull of Dollars*. Hardly. I was referring to *The Good, The Bad and The Ugly*.

Today, let me share with you some of the common errors made by doctors when they set out to document patient files and/or compose medical reports.

You would be shocked at the number of physicians who don't date their medical reports.

I have also seen reports that are rambling novelettes, that go on and on for pages, but never reference the patient's name once anywhere in or on the report.

Too many doctors fail to number the back pages of their reports and reference multi-page narratives with the patient's name in the top left corner of each back page

numbered. In a pile I recently reviewed, the doctor had produced 6 page reports for each family member injured in the same auto collision. They were a family of five, so about 30 pages of reports altogether. The back pages of the narratives were not reference with a patient name or page numbers. To make matters worse, the doctor's CA had accidentally shuffled the deck at their copy machine before sending it to us. There was no telling which back pages went with which patient's report. I see this error quite often and each time it's like untangling a string of Christmas tree lights.

Another common pitfall is a medical report that lists *headaches, blurred vision, vertigo, dizziness, nausea, vomiting at the scene* and *short term memory loss* in the Patient Complaints segment, but the Diagnoses segment begins with "cervical hyperflexion/hyperextension strain/sprain." Far too many physicians, confirmed experts in paraspinal trauma, write narratives as if the top of the central nervous system started somewhere around C4. With this, they often overlook classic symptoms pointing to a post concussive syndrome. It then gets excluded from

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Compatibility Concerns Between Cars and Sport Utility Vehicles

By Dr. Art Croft, D.C.

The past decade has seen a dramatic shift in the fleet vehicle composition. Light trucks and vans accounted for 20% of the fleet in 1980 and rose to 35% of the fleet by 1997. This disparity change between vehicle mass and characteristics, has resulted in a growing disproportionate crash fatality risk in crashes between disparate vehicle type partners. The growth of the sport utility vehicle (SUV) market, in particular, is astounding, if not

ridiculous. Most automobile manufacturers turn out SUVs, which the owners treat more like a luxury car than the sports vehicle they were designed to be. The problem is, should you find yourself—in your passenger car—on the business end of one of these Goliaths, you are very likely to be the big loser vis-a-vis risk for acute injury and outcome.

A recent paper by Gabler and Hollowell (1) looked into the compatibility of cars, light trucks, and vans (LTVs) involved in traffic crashes. They noted in their abstract, "An analysis of U.S. crash statistics shows that, although LTVs currently account for approximately

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Common Pitfalls *continued from pg. 1*

the Diagnoses. Such obvious oversights will quickly de-power any medical report, every time.

Last week a report crossed my desk that had about 13 Patient Complaints listed and just 2 Diagnoses. The Diagnoses segment was seriously out of balance with the Patient Complaints segment. Furthermore, the Exam Findings segment of the same report had positive findings for each of the listed Patient Complaints. I see this far too often. It came as no surprise that the treating doctor was complaining how poorly the PIP adjuster was paying his bill on a badly injured patient. But, the doctor was merely suffering the ill effects of his own wimpy Diagnoses segment, out of balance with reality. Remember, the Diagnoses drives payments.

“Too many doctors still write their reports as if the recipient of their narrative was another medically trained professional.”

On the issue of Exam Findings, save everyone some time and just list *positive* findings in your report. Even green adjusters know the exam protocol.

When doctors comment on the patient's medical past in a report, they commonly forget to also list the *duration* of care for some pre-accident ailment or injury. The adjuster with the checkbook reviewing the doctor's report will want to know (1) the length and breadth of the prior care and (2) the timeline period of *asymptomatology* thereafter, . . . *before* the subject auto collision. Just listing a prior injury, without the associated time frame of that former care, is a surefire way to roadblock PIP payments from the desk of an inquisitive adjuster with a stingy supervisor breathing down his or her neck.

Last month I slogged through a 12 page medical report that never once stated the injuries being treated were the result of the auto collision that brought the patient to the doctor's door. The doctor who composed that needlessly wordy manuscript was frustrated, angry and seeking our help. It seems that instead of receiving a payment check in the mail, he kept receiving forms to fill out from the auto insurance company.

As you may have already guessed, the first few lines of the blank forms sent to the doctor asked him to state how the injuries he was treating were *related*, or not related, to the subject auto impact. Much time, money and effort is wasted when doctors treating auto victims fail to include a basic *causation* sentence or two appropriately tying the injuries to the accident at the conclusion of their reports.

I continue to see letterhead devoid of clinic phone numbers and fax numbers. I guess that if the adjuster has a question about the billing, these doctors are willing to accept a snail mail inquiry about it and they are happy to wait for their money. I also see a lot of letterhead produced with fonts too small or too oddly cursive to be readable on the other end of a fax machine. The Cs look like Gs, and you can't tell an 8, from a 9 or a 3.

Of course, none of the preceding suggestions will matter if your correspondence to the auto insurance carrier doesn't eventually get to the assigned adjuster with the power to cut checks. I continue to see clinics referencing mail to auto insurance companies using a combination of *patient name, date of birth, social security number, date of onset, and policy number*. None of these work if you wish to square dance with an *auto* carrier. None. With auto companies, it's *claim number, date of loss* and their *insured's name* that will get your stuff to the auto PIP adjuster's desk more consistently.

Too many doctors still write their reports as if the recipient of their narrative was another medically trained professional. In reality, the report's audience is generally some undereducated harried adjuster with no formal medical training whatsoever. Doctors who compose their reports aimed at an adjuster's level get paid far better than those doctors who waste their office time composing pontificating reviews that overworked adjusters don't understand and have even less time to read.

Most PIP adjusters want to know (1) if the doctor has a basic working knowledge of the facts of the auto impact, (2) what's wrong with the patient and (3) were those injuries caused by the subject auto impact? The most effective doctors *never* forget to address these three critical topics in the body of their reports when seeking to *get paid* for treating an auto accident survivor.

Today, the number one dilemma within a chiropractic clinic is the dreaded "paper factor" associated with the excellent care being rendered. I hope this article sheds some light on the fine art of getting paid on today's playing field.

The end.

Cars vs. SUV's *continued from pg. 1*

one-third of registered U.S. passenger vehicles, collisions between cars and LTVs account for over one-half of all fatalities in light vehicle-to-vehicle crashes. In these crashes, 81 percent of the fatally injured are found to be occupants of the car. These statistics suggest that LTVs and passenger cars are incompatible in traffic crashes, and that LTVs are the more aggressive of the two vehicle classes.” They examined crash test results, field crash statistics, and vehicle measurements, in order to evaluate the design imbalances between cars and LTVs, such as mass, stiffness, and geometry, which lead to these severe crash incompatibilities.

It is important to understand some basic definitions before looking any further into this subject, namely aggressivity and crashworthiness. *Aggressivity* refers to the ability of a car to cause damage to the other car or injury to the other car's occupants. It is the opposite of *crashworthiness*, which describes the subject car's ability to deal effectively with other vehicles in a crash and protect the occupants. The method used to measure the former is as follows: Aggressivity equals the fatalities in collision partner divided by the number of crashes of subject vehicle. This equation is referred to as the Aggressivity Metric (AM).

Passenger cars can be categorized as to relative weight as follows: Mini-car weighs less than 2000, Subcompact car 2000-2499, Compact car 2500-2999, Mid-sized car 3000-3499, and Large car approximately 3500.

The ratio of fatally injured drivers in LTV-to-car frontal collisions, based on the Fatality Analysis Reporting System (FARS) and General Estimates System (GES) database from 1992-1996, are illustrated below. Unity would be 1: 1 (i.e., the occupant of the crash partner would be killed as often as in the subject car).

Vehicle type vs. passenger car; Ratio of fatality

Full sized van	1:6.0
Full sized pickup truck	1:5.3
Sport utility vehicle (SUV)	1:4.1
Minivan	1:3.3
Small pickup	1:1.6

As striking as this relationship for frontal crashes is, the relationship between side-crashing partners is more profound. The first number in the ratio is the driver of the striking or bullet car; the second number of the ratio is for the side-struck occupant driver.

Vehicle type vs. passenger car; Ratio of fatality

Passenger car	1:6
Full sized van	1:23

Full sized pickup	1:17
Utility vehicle	1:20
Minivan	1:16
Small pickup	1:11

Thus, if your vehicle is a passenger car, and you are struck on your driver's door by a full sized van, you are 23 times more likely to die in the crash than the driver of the van. Even between two like-sized passenger cars, the side-struck driver is 6 times more likely to die than the bullet car driver.

The reason for the disparity in risk between cars is simply that the side of the car is relatively soft and only about 6-8 inches wide. By the time the front of the bullet vehicle comes into contact with your body, it is still at fairly high relative speed. Your body's change of velocity (**DV**) in that case will be greater than your car's eventual **DV**. In contrast, the bullet driver has more front end to crush, providing them with much more ride down. The reason for the even greater disparity between passenger cars and vans, for example, is two-fold: (1) these vehicle have generally greater mass, and so the conservation of momentum relationship tells us that the smaller vehicle will experience greater change of momentum and a greater **DV**; (2) just as importantly, the longitudinal portions of trucks, vans, and SUVs continue to be constructed as frame rails—as opposed to the more common unibody construction of most cars—and these are generally much higher than the door sills or rocker panels of most passenger cars. These door-sills are the only rigid portion of passenger cars on the side. Moreover, perhaps due to a mandatory bumper requirement on passenger cars, these rocker panels are at relatively uniform height. In contrast, LTVs have no such standard and their bumpers are relatively ornamental and do not necessarily correlate with the level of longitudinal members. They are generally much higher than those of passenger cars. The combined result is that the LTVs greater mass and longitudinal stiffness, coupled with the higher center of mass and location of the longitudinals, gives a greatly enhanced ability of the larger vehicle to intrude into the occupant compartment of the side stuck passenger vehicle.

One final caveat: because LTVs have a higher center of gravity, they are generally less stable on the road than passenger cars, so this component of safety is also worthy of consideration when choosing a new vehicle.

1) Gabler HC, Hollowell WT: The crash compatibility of cars and light trucks . J Crash Prevention and Injury Control 2(1):19-31, 2000. **The end.**

The battles we fight

The following is text from an actual letter we recently received from Allstate. This is just an example of the kind of battles we fight with the insurance companies on a daily basis:

Dear Mr. Larson,

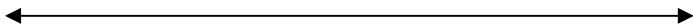
This letter is in response to your request for a clarification on payments made to Dr....., D.C. As supported in the Explanation of Benefits sent to Ms....., and Dr.; Dr.is billing a 98941 CPT code, which is for a manipulation of 3-4 regions of the spine. Yet in the injury diagnosis he is only listing one injury to the spine, a neck strain 847.0 the other two diagnostic codes they have listed are for headache and lumbago, which are not regions of the spine. Therefore, if Dr.....would like us to take a second look at these charges he will either need to list the additional diagnostic codes if Ms.....is injured in 3-4 regions or, correct the CPT code to reflect the injuries listed in the diagnostic codes.....

Sincerely,

Tiffany Magleby

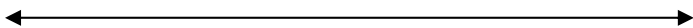
Claim Representative

- keep a disposable camera in the car at all times. It can come in handy)
- 4. Write down statements made by the other driver(s) involved in the collision.
- 5. Do not admit guilt.
- 6. Don't deny that you are injured.
- 7. Complain of pain if you legitimately feel hurt.
- 8. If an ambulance is offered, take it.
- 9. Get checked out in the ER.
- 10. Get the name and location of where your car will be towed to, if your vehicle is drivable, take it to a body shop that is a member of the Auto Body Owners Association of Utah. Seek medical treatment before dealing with your car.
- 11. Call insurance to report accident, do not give a recorded statement until after you retain legal counsel.
- 12. Seek proper medical care from your Chiropractor as soon as possible after the Emergency Room.
- 13. Begin aggressive Chiropractic medical treatment.
- 14. Contact an attorney, as soon after you see your chiropractor as possible.



Looking for a CA?

Call Bryan Larson for someone who may be able to help. (801)446-6464



What to do if you are in a crash

What do you tell your patient's to do if they are in a collision? Here are some good suggestions:

- 1. Call the police and ask that they fill out an accident report.
- 2. Get names, addresses, and phone numbers for all witnesses.
- 3. Take photographs of all vehicles and all the property damage if possible (it is good to

These tips are all valuable for an injured victim of a car crash.

We are extremely grateful for the referrals we get from so many of you. We are grateful to be able to exchange our help for your referrals. We find our job rewarding on many different levels. We encourage you to continue to refer injured and innocent patients to us. We will help each one that we can. We also remind you that have a business to run, and sometimes we will not be able to help those whose cases are not good ones.

Thank you again, and keep up the good work of making people well. *The end.*

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Chiropractic and Children

By Bryan A. Larson

We recently have noticed a pattern with Farmers Insurance Company sending a letter to their insured which states among other things the statement "Please be advised that any time a child receives chiropractic care, we require that a pediatrician examine the child and provide a referral."

Many of you probably wonder can Farmers do this? Is it legal? Both of those questions are not very precise. Farmers can do it because they have done it. It is not illegal for them to set a company standard requiring a pediatric referral before chiropractic care can be paid for. However, that standard goes beyond the statutory requirements under the no-fault law. The no-fault law requires them to pay for all necessary and reasonable care related to the automobile collision. What constitutes necessary and reasonable is ultimately up to a court to decide. This means that a jury could ultimately sit in judgment on the reasonableness and necessity of the care that you give to a child. Even a successful lawsuit for Farmers in one given case would not necessarily set a precedent for other cases. Care that may have been appropriate in one case may simply not be appropriate in another. Unfortunately, some jurors who do not understand chiropractic may not understand the value of chiropractic at all, especially for a child. On

the other hand, I believe that a jury could be persuaded in the right case. I would be willing to pursue such a case against Farmers or any other insurance company for non-payment of no-fault benefits if it was the right case. Such a test case would include a number of variables to make it a good test case. Some of those variables should include the following:

- 1) A case where the total amount of chiropractic care and all other care was less than \$3,000.00 (so the defense couldn't argue that it was merely a run at getting a third party claim.)
- 2) The child should be a somewhat older child between the ages of 8-16.
- 3) The child's case must be well documented including re-examinations demonstrating progress of the child.
- 4) The child needs to be reasonably articulate for his or her age and must think that the chiropractor did a wonderful job in making them feel better.
- 5) An even stronger case would be one in which the child was referred for chiropractic care by his or her pediatrician or other M.D. and Farmers or another insurance company still declined to pay for the chiropractic care.

If you have such a case feel free to give me a call so we can discuss the possibility of using it to help teach Farmers that children are not made of rubber and as the most precious joys in our lives, they should be given the best healthcare possible, including chiropractic when appropriate. *The end.*



Jack Cracker

In 1859, a young Brooklyn chemist, Robert Chesebrough, journeyed to Titusville, Pennsylvania with the intentions of entering into the petroleum business given the recent crude oil discoveries in that locale. While visiting a jobsite his chemist's curiosity was piqued by the pasty, gooey residue that stuck to the drilling rods gumming them into inactivity. The field workers had several names for the goo that clogged their pumps, all of them not printable. The one redeeming quality is that the oil workers told tales of healing qualities of the substance. Rubbed on a wound or a burn and it promoted healing. After months of experimentation with the petroleum waste product, Chesebrough turned out

a clear, smooth substance he called "petroleum jelly". To test the jell's healing properties Chesebrough inflicted numerous burns on himself. All his "tests" healed quickly and without infection. By the turn of the century, Chesebrough's jelly was the staple of home medicine chests in America. It was later sold throughout the western hemisphere. Some amazon natives chose to cook with it and eat it as a treat spread on bread. Chesebrough himself ate a spoonful of it every day and credited his "jelly" for his long life. He died at age 98.

A druggist, Lunsford Richardson, mixed petroleum jelly with menthol while experimenting in his brother-in-law's back room makeshift laboratory. The in-law's names was Dr. Joshua Vick. Richardson's concoction was originally marketed as Pneumonia Cure Salve, but the name was soon changed. Just in time for the flu epidemic of 1918, *Vick's VaporRub* was available as a forehead and chest rub.

At about the same time another version of the stuff started out as an analgesic muscle rub first called Jules Bengue's Balm, but we know it today as Ben-Gay. *The end.*



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