

DOCTOR NEWSLETTER NO. 1: EFFECTIVE REPORT WRITING INCREASES

SUCCESS RATES IN PERSONAL INJURY CLAIMS

This is the first in a series of articles designed to help chiropractors write effective reports in personal injury claims. It summarizes some of the fundamental aspects of such reports. After successfully handling over 7,000 cases, we know that good results still can be achieved for personal injury clients, and that doctors can be well paid for services provided in those claims. The outcome of these personal injury claims is greatly assisted by the quality of the doctor's reports. Note: Future installments of this article will complete the more basic elements of these reports, and will discuss the incorporation of scientific studies, provide details on the importance of S.O.A.P notes and how they relate to the final report. Upon request, we will make available to you, a sample of a complete, well-written report.

FIRST THINGS FIRST

The reports we are referring to, of course, are final narrative reports prepared after completion of the patient's treatment. They involve patients treated "on a lien basis," in which your bills are due to be paid upon settlement of the patient's personal injury claim. For that reason, you should always work with an attorney who will give you a sound appraisal of the patient's claim before you commit your time and resources. No amount of effective report writing will get you paid if the patient you are treating on a lien basis was at fault for the accident! The attorney should also be glad to assist on other matters related to the protection of your lien and should help you with Med-Pay and other issues.

INITIAL HISTORY OF INJURY

When doing your patient intake, in addition to your routine questions in accident cases, it is helpful to record the patient's position at time of impact. In an automobile accident, this might include, for example, that the patient was seated in the passenger seat, with head turned, at the time of impact. Age and gender should also be recorded since, based on studies, different responses may occur due to these criteria. It is important, also, to record any instance of patient contact with interior surfaces, such as knee hitting a dashboard, or impact with a window. Events that transpired following the accident should also be noted (for example, that the patient felt dazed, or that they went to the local emergency room). On occasion, we see reports that provide voluminous details of how an accident happened, but these accounts, understandably, are never verified, and are sometimes inaccurate. This can, at a minimum, cause delays. It is better to give a general statement of the type of accident, such as a "passenger in a rear-end automobile collision on (date) in Los Angeles, California, with head turned at time of significant impact," rather than being overly-descriptive about directions of travel, speed of the cars involved, weather conditions or the like. Your post-treatment report is after all, a medical report. Avoid stating information in the negative. For instance, pointing out that the patient did not sustain any loss of consciousness, did not strike any object during the accident, or did not seek care immediately after the accident, may serve to give the wrong impression as to the severity of the incident. If, however, any of the foregoing were true of a given incident, it will be helpful to accurately assess the severity of the personal injury incident. The patient's initial complaints should be listed, usually by order of severity.

INITIAL PHYSICAL EXAMINATION

This section alone could take up our entire newsletter (we can better address this section by providing you with a sample report from our office on request). In this section of your report, you should describe what orthopedic tests were performed, and state their results, as well as radiological and/or neurological findings. A nice format to use is one that shows both initial and final exam findings side-by-side for easy comparison. This shows the adjuster or peer reviewer, that your treatment had a therapeutic effect upon the patient. The taking of x-rays has been very useful to our legal handling of claims (but, obviously, not if a case is likely to require only a few treatments, although this is always the doctor's decision). If the radiological findings display objective findings, such as loss of cervical lordosis, these findings should be reported, in order to substantiate the patient's subjective complaints. In this case, it is nice to have a statement to the effect that "objective findings are consistent with subjective complaints." With regard to test results, we have found that listing the results of all tests performed, inclusive of negative results, can lead to argument as to the severity of the injuries reported. This is especially true where, for example, you performed 8 orthopedic tests for the lumbar area and only the straight leg raise was positive. By reporting only the positive findings, you minimize the risk that the adjuster or peer reviewer will get the wrong impression as to the severity of the injury.

PRIOR HISTORY SECTION

Often times, the importance of the Prior History section of a medical narrative report is overlooked. Realize that in personal injury claims, the insurer has access to the National Index Report, a database that tracks all claims made by an individual identified by name, birth date, social security number, and driver's license. If the patient had a personal injury accident before your treatment for this injury, and you report that the patient had no prior history, the credibility of the claim will be compromised. Often times the patient will legitimately forget about minor injuries that resulted in prior claims. Early representation by counsel can assist you in getting paid, by sorting out prior claims with the patient, before a stance is taken in a narrative report that causes credibility concerns. In a related matter, if the patient suffered a prior injury such as a compression fracture; or has a scoliosis condition with installation of Harrington rods, but had been pain free prior to the personal injury incident, this would support an "egg-shell" argument, as the patient is predisposed to injury. The best method of reporting prior history is to state the date, nature and extent of prior injury, and whether or not the complaints were resolved. This will acknowledge but distinguish the prior injury from the current. You should also include if you have treated the patient in the past. Also state other relevant medical conditions (such as diabetes) that might affect the patient's predisposition to injury or lengthen their response to treatment.

DIAGNOSIS

In future articles we will explore some of the myths and realities associated with computerized claims assessment software, such as Colossus. For the purposes of report writing, it is important to recognize that your reports and billing may be put through an Optical Character Recognition system. This is computer automation which will automatically pick out pieces of data for consideration in the claims process, where the adjuster or claims assistant simply feeds written sheets of text into a computer scanner, and the text characters are recognized and assigned a value. This value is used to inform the adjuster which claims should be paid, and which should be rejected. Without providing a written diagnosis, you are virtually guaranteeing that your billing will be returned, unpaid-with an explanation. You will then be forced to expend more labor resources to correct the deficiency and resubmit the claim, and further delay collection of accounts receivable. It is recommended that a narrative diagnosis be used in conjunction with current ICD-9 coding listed in parenthesis.