Back To Chiropractic Continuing Education Seminars
Ethics The Personal Injury Narrative Report – 2 Hours

Welcome:
This course is approved for 2 Hours of Ethics The Personal Injury Narrative Report for the Chiropractic Board of Examiners for the state of California.

There is no time element to this course, take it at your leisure. If you read slow or fast or if you read it all at once or a little at a time it does not matter.

How it works:

1. **Helpful Hint: Print exam only and read through notes on computer screen and answer as you read.**
2. **Printing notes will use a ton of printer ink, so not advised.**
3. **Read thru course materials.**
4. **Take exam; e-mail letter answers in a NUMBERED vertical column to marcusstrutzdc@gmail.com.**
5. **If you pass exam (70%), I will email you a certificate, within 24 hrs, if you do not pass, you must repeat the exam. If you do not pass the second time then you must retake and pay again.**
6. **If you are taking the course for DC license renewal you must complete the course by the end of your birthday month for it to count towards renewing your license. I strongly advise to take it well before the end of your birthday month so you can send in your renewal form early.**
7. **Upon passing, your Certificate will be e-mailed to you for your records.**
8. **DO NOT send the state board this certificate.**
9. **I will retain a record of all your CE courses. If you get audited and lost your records, I have a copy.**

The Board of Chiropractic Examiners requires that you complete all of your required CE hours BEFORE you submit your chiropractic license renewal form and fee.

NOTE: It is solely your responsibility to complete the course by then, no refunds will be given for lack of completion.

Enjoy,
Marcus Strutz DC
CE Provider

Ethics - The Personal Injury Narrative Report – 2 Hours

Back to Chiropractic CE Seminars

Objective of this seminar –

This seminar specifically focuses on the personal injury narrative report, by teaching and demonstrating the degree of competence necessary to prove a personal injury case to both claims adjusters and in court, avoid negligence, and being able to prove that no insurance fraud has occurred. This material is the game plan for correctly and competently handling personal injury cases. This material is the nuts and bolts of personal injury, presented clearly and concisely. It is a roadmap for showing the doctor the information needed to be obtained from the patient pertaining to the history, physical exam, radiology, management, and treatment of a personal injury case. This seminar is unlike most other personal injury courses and does not focus on the scientific research or justification for doing what is done in these situations. Instead, it is based on courtroom and other experience as a full time practicing personal injury attorney at law in rare combination of practice as a doctor of chiropractic. This seminar explains what needs to be done when handling personal injury cases and excludes what is not necessary.

Complying with the State of California Chiropractic Act and its associated Rules and Regulations generally speaking is not hard to do. More often than not, compliance involves thinking before doing, and having enough common sense to know when to read the Act, Rules, and Regulations when being suspicious that a given course of action might be at issue. Fortunately, most chiropractors are blessed with a high degree of common sense.

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In previous years, the California Board of Chiropractic Examiners posted their mission statement on their website, which was centered around protecting consumers from three main areas of focus - lack of competence, negligence, and insurance fraud. Competence is having and utilizing the degree of knowledge, skill, thoroughness, and training that a reasonable doctor of chiropractic would use in the performance of their professional duties. The board's focus on competence means assuring a minimal level of acceptable competence on the part of the doctor, as well as a lack of competence below a minimum level of acceptable competence. Negligence is conduct that falls below the standard of care that an objective, reasonable doctor of chiropractic would use in their professional practice. Insurance fraud is the intentional misrepresentation of at least one material fact, justifiably relied upon by another (the insurance company), so as to obtain the property of another (the insurance company). Insurance fraud is most easily avoided by not having any bad intent, but it can be extremely helpful to prove that lack of bad intent, and this will be discussed later.

Outline of this seminar -

1st Hour -

- Introduction
- Caution #s 1-4
- Complying with the State Board Rules and Regulations
- The Personal Injury Narrative Report itself -
  - The Beginning
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  - Mechanism of Injury -
    - what to include
    - what not to include
    - example
  - Complaints -
    - 3 general categories of complaints
    - example
  - Diagnoses -
    - rules pertaining to diagnoses
      - list all relevant diagnoses
      - list diagnoses in decreasing order of severity
      - diagnoses are based on the history, exam, and radiology
      - use adjectives to describe time frame and severity
      - specify disc levels
      - use of MRI reports
      - ICD-9 codes
      - ICD-10 codes
      - traumatic versus non-traumatic subluxation diagnoses
    - example
  - Medications Prescribed by Physicians
    - example
  - Previous Accidents
    - example
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2nd Hour -

- Other Health Care Providers Seen for This Accident
  - example
- Radiology
  - necessity and justification
  - obtain plain film x-ray radiographs prior to considering MRIs
  - justification when post -accident films already exist
  - standing, weight bearing condition
  - MRI justification
  - which plain film x-ray views to be obtained
  - MRI STIR view for detection of fractures and edema in bone
  - DACBR interpretation
  - Example

Malingerer tests -
example
Referrals from this Office to Other Health Care Providers
example
Recommendations Throughout Treatment
example
Duties Under Duress
example
Loss of Enjoyment of Life
example
Disability/Restrictions
example
Prognoses
example
Disfigurement -
example
Past/Present Care -
example
Future Care -
example
Susceptibility to Reinjury
example
Explanation for Extended Care
example
Certification Statement
example

Introductory comments -

A History Lesson - Once upon a time, a long, long time ago (prior to 1988), there were the good old days for chiropractic where money was easily obtained when working on automobile accident cases. Although medical payments coverage paid doctors of chiropractic relatively quickly just as it does today, in those good old days the 3rd party insurance routinely paid for garden variety pain and suffering in an amount of three to five times the doctors' bills. It was therefore easy for an attorney to obtain high settlements for routine automobile accident cases, and in turn in was easy to pay the doctor in full.

The reason it was easy to obtain high settlements and pay doctors in full was because the 3rd party insurance companies had a duty of good faith and fair dealing owed to the injured patient. This meant that the same insurance companies were afraid of committing bad faith, which is the opposite of good faith. Good faith is the duty each party to a contract owes each other to get the benefits of their bargain. For example, when a chiropractor agrees to treat a patient in exchange for money, both parties have a duty of good faith to assist the other in getting the benefit of their bargain. If the patient calls and says traffic is slow and requests to be seen as soon as they can get there which is a few minutes after regular closing time, the doctor has a duty of good faith to make themselves available a little bit longer than usual so the patient can get their adjustment (provided the doctor doesn't have a strong reason for being unavailable at that time).

A routine bad faith settlement could result in a very large trial verdict against the offending insurance company, and often an insurance company settles a legitimate bad faith claim for a sizable settlement in the tens of thousands of dollars so that they don't risk losing more at trial. With the potential for a huge extra amount of money to be obtained from the 3rd party insurance company if they were found to be lacking good faith, the insurance companies were motivated to settle cases on a more than fair basis.

Big money for personal injury settlements ended in 1988 with a landmark California Supreme Court case in which there was and continues to be no more duty of good faith and fair dealing owed by a 3rd party insurance company toward an injured victim. Over roughly five years time, the insurance companies realized there was no longer any major threat against them, and this completely changed the entire settlement circumstances. To put it in other words, this major court ruling resulted in a very unlevel playing field strongly in favor of insurance companies.

Settlements were no longer a simple result of multiplying the doctors' bills by a number of often three to five, but in this new and continuing lack of bad faith environment became based on proof of the patient's injuries. On paper and from an ivory tower perspective, basing settlements of sufficient proof sounds fair; however, the reality is that it is far from fair for the injured patient. **The major reason for settlements being so low and unfair is that the vast majority of doctors simply don't properly document a patient's injuries from a personal injury case perspective.** Insurance claims adjusters and jurors assume that if something was not written in the chart notes, then that something didn't happen.

The reasons that many if not most doctors don't properly document their chart notes for a personal injury case include a) not taking enough time with the patient to ask the extra information needed for a personal injury case, b) not documenting all of the necessary information needed in the chart notes, and c) not knowing what to do.

Caution #1 - Be open-minded to learning new information that works well. Many if not most doctors want to assume they know what they are doing in reference to personal injury patients even though at this point in time it is an extremely rare doctor who truly knows what to do. This author readily admits that properly documenting a personal injury case was not taught in chiropractic college, and that 99% of learning this information was learned as a personal injury attorney and litigator. In other words, this information was learned as an attorney and not as a doctor. Doctors are in a position of authority and typically feel they are expected to know everything about being a doctor, including personal injury. Rather than admit they don't know something, some doctors falsely project that they do. Some may feel a patient may lose confidence in a doctor if the doctor admits they don't know everything. A fresh perspective is to say that although they don't know the answer to a given question, they will find the answer. The following material clearly, concisely, and in a very straightforward manner shows the doctor the information needed to prove a personal injury case in the form of a narrative report. A willingness to take the little bit of extra time to obtain and document this information is all else that is needed. Please be open-minded to what works, and especially what works well.

Caution #2 - Many people want to believe what they have previously learned is correct, even if it is not. The more one identifies with a particular speaker, the more they want to believe that what they are hearing is true. For example, people are likely to positively identify with a speaker who has similar traits to their own, even if what is said is not necessarily true. For another example, a doctor who loves the school they attended may want to believe that what was taught there was correct. They unconsciously do this because they like the person (or entity) and want to think well of that person (or entity). The material presented here is well referenced and is enhanced by litigation including trial experience. The approach presented here works well and the vast majority was not taught in chiropractic college, so please be open-minded to what works, and especially what works well.

Caution #3 - **Make sure you write your own narrative reports using your own language, sounding like a doctor**. Do not copy word for word the examples provided here, as this author has a certain way of speaking and writing which is obviously different than most others' way of speaking and writing. Your narrative report should be well organized and well stated, as expected of a doctor. Make sure you use good English, proofread your reports, and make sure you can back up everything stated in your reports with sound reasoning and sound facts (chart notes including your history, exam, radiology, treatment, etc.). The quality of the written report directly reflects upon the doctor. A claims adjuster will have a very good idea as to how a doctor will appear to a jury based on their writing. There is no second chance for a first impression.

Caution #4 - **A quality narrative report is needed when billing third party insurance**. It is usually not needed when not billing third party insurance, such as when there is first party medical payments insurance when the patient themselves is entirely at fault for a given accident. There are some doctors and attorneys who say that a narrative report is not needed from a doctor of chiropractic. This author strongly disagrees with that train of thought because the same information contained in the narrative report is needed regardless of the form presented. Some attorneys may not want to pay for narrative reports. Some attorneys don't want to discourage doctors from sending business their way due to requiring the doctor to spend more of their time obtaining the needed material. These people often encourage doctors to use check the box forms to provide some of the needed information with very little time spent by the doctor. However, the main problem with check the box forms are that the information obtained is too skimpy and lacks the detail needed to prove important facts. A well written narrative shows the insurance claims adjuster how well a doctor will appear to a jury. There is no substitute for quality information presented in a quality format, which is what a quality narrative report does.

Complying with Current State Board Rules and the Initiative Act -

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The Beginning -

Although obvious, make sure you have a title and list the patient's name and their date of injury.

Narrative Report

Patient: Jane Doe
DOI: 4/22/14, motor vehicle accident

Mechanism of Injury -

There are certain important pieces of information to include in the mechanism of injury section, and there is also other information that should not be included in this section. Information to be included are those pieces of information that pertain to doctor type decisions. Examples of information to be included are

a) **the direction of the head and neck of the patient at the moment of impact** - Patients are typically hurt worse when rotation and/or lateral flexion is involved in a whiplash injury as compared to a pure flexion/extension whiplash injury. This is one of many explanations for needing more care than might otherwise be expected. Failure to include this information when appropriate would result in a claims adjuster or jury perhaps not hearing this information and thinking that there might be merit to the argument that the patient should have gotten well quicker than the amount of time actually taken. This information is also important in determining what radiographical films should be taken;

b) **whether the patient was aware or not aware of the impending impact** - Those who are aware of an impending impact tense their muscles due to fear and are typically hurt worse than those who did not tense their muscles from not being aware of an impending impact. A claims adjuster will assume that the patient was not hurt as badly as reality if this information is not clearly stated when appropriate;

c) **the location of the hands and feet at the moment of impact** - This information can explain why certain body parts are injured. For example, it is possible that a person holding the steering wheel with only their left hand could have complaints associated with any joint involved with their upper left extremity, such as their left shoulder. A person could have lumbopelvic pain caused by transmission of the force imparted on their lower right extremity due to their right foot having been on the brake pedal at the moment of impact;

d) **what part of the patient's head struck the headrest** (if there was one) - Based on spinal anatomy, a person's head and neck will move as allowed by their joints, bones, and soft tissues as affected by the direction of the physical forces on the area of impact. Ideally, a headrest on top of a seat is designed to limit head and neck extension by having a properly adjusted headrest such that the center of the back of a person's head strikes the headrest. An improperly positioned headrest results in a different physical vector of force causing the head and neck to move a manner more likely to cause harm to a person as compared to a properly adjusted headrest;

e) **whether their head struck any object as a result of the impact** - A person's head can strike objects in their vehicle in front of them as well as the headrest or seat behind them. Although there are scientific papers that conclude traumatic brain injury does occur even without direct head trauma, it is helpful to document direct head trauma. Common objects that a person's head strikes in a vehicle are the steering wheel, windows, and dashboard. Claims adjusters often wrongfully argue that there could not be traumatic brain injury without direct head trauma. This is a common issue raised in litigation;

f) **the direction of the two vehicles at the moment of impact** - This information is important not only to the treating doctors, but also to accident reconstruction experts. Sometimes cars strike each other in a straight line (head on or rear-ender impacts), sometimes at a 90 degree angle, and other times there are different angles involved. A person may have started a left turn and been only partially in the midst of that turn when an impact occurred. This information can directly explain the force imparted on a patient, as well as infer lateral flexion involvement in a whiplash injury. This information also is important in determining what radiographical films should be taken;

g) **an approximation of the speed (not the exact speed) of each of the vehicles in language that affords flexibility (e.g. low, moderate, high speed, etc.)** - Most people have had little experience with being involved in collisions, and therefore tend to overestimate the speed of each of the vehicles involved in an accident. A defense attorney at a trial will try to do anything to discredit a witness including patients and doctors. Rarely do people look at their speedometer just prior to impact. It is therefore ideal to use language that reasonable describes a situation such that there is room for flexibility. For example, instead of documenting that your patient was moving about 25 mph. at the time of impact, it is better to document that they were moving at a moderate speed. Use of the word "moderate" allows for a range of speed. Asking the patient whether their vehicle was moving at a low, moderate, or high speed at the time of impact is much better than asking how fast their vehicle was moving. If there is any problem with the speed involved as stated by the patient, a defense attorney will also try to discredit the doctor for stating an inaccurate fact; and

h) **the total number of impacts suffered in the accident** - Sometimes there are chain collision accidents involving multiple vehicles with multiple impacts. The most impact aspect of this situation is the number of impacts suffered by your patient. One example is where your patient is rear-ended (one impact) that forces their vehicle to again crash into another vehicle (a second impact). Another example is where your patient in car #1 is rear-ended by car #2 (one impact), and subsequently car #3 collides with car #2 which forces car #2 to again impact your patient's vehicle (a second impact). Generally, a person can be expected to be injured worse in direct correlation with the number of impacts.

Information NOT to be included in this section is information not needed as a doctor as well as disputable facts. For example, the color of the traffic light as seen by your patient is not important from a doctor perspective, as it has no bearing on the diagnosis or treatment rendered to a patient. As such, it should not be included in chart notes. Worse yet, a patient's credibility can be undermined if they said the traffic light was one color at the time of the accident, and a witness says that same traffic signal light was a different color which is different than what is stated in your chart notes. As previously stated, the defense attorney will typically attempt to degrade the doctor's credibility for stating an incorrect fact in their chart notes.

Example:

Mechanism of Injury -

The patient was the driver of a 2011 Honda Accord wearing her seat belt and shoulder harness, stopped due to traffic conditions. Just prior to impact, she was looking up at her central rear view mirror with extension, right rotation, and also possible right lateral flexion of her neck. Both hands were on the steering wheel and her right foot was on the brake pedal, when she was suddenly rear-ended with a moderate speed impact. She was aware of the impending impact, as she stated she felt horrified and in fear when viewing the fast approaching vehicle that struck her car in her rear view mirror.

Complaints -

Way back in chiropractic college, what was usually taught in regards to taking a patient history was to ask for a chief complaint and additionally other complaints. Although that is appropriate for most situations, it is inadequate for a personal injury patient.

A personal injury patient needs to clearly state whether each complaint belongs in one of **three categories** -

a) pre-existing to the given accident and not worsened by the given accident,
b) pre-existing to the given accident and worsened by the given accident, or
c) a new complaint caused solely by the given accident.

In order to place each complaint in the proper of these three categories, the doctor needs to first ask "When did this complaint start?" Sometimes patients need some assistance to understand your intention. They may interpret the question "When did this complaint start?" to mean when did it start FOLLOWING this accident (despite the doctor not asking that question). The doctor may need to ask "Did you have this complaint in the 12 months before this accident?" If the patient did have a given complaint in the 12 months prior to the given accident, the doctor needs to ask one more question - "Did this complaint become worse anytime after this accident?" Upon having these one or two questions answered, the doctor can then place each given complaint in the appropriate category from the three possibilities.

Frequency, duration, and severity need to be clearly stated for each complaint, always comparing PRIOR to with AFTER the given accident. Frequency, duration, and severity also need to be clearly stated for each complaint that are new just as for pre-existing complaints. Let the patient know that ranges can be stated instead of one specific number (e.g.15-30 minutes instead of 20 minutes, 6-8/10 instead of 7). As to frequency, start by asking whether the given complaint is present all the time (constant) or whether it comes and goes (intermittent). Constant during waking hours is different than constant and interfering with sleep, so add the appropriate descriptor. If a complaint is intermittent, ask how many times the complaint occurs per a given time period (e.g. neck pain occurs intermittently about 3-4 times per day ...). Then ask how long each episode typically lasts (e.g. ... with each episode lasting about 30-60 minutes ...). Finally, ask how bad is their complaint on a 0-10 scale with 0 being none and 10 being the most. You may want to remind patients that they should be careful about using 10 to describe the intensity, because that number is hard to believe. If they describe something as a 10, you might ask them if they ever experienced anything more intense than the given complaint. They will soon get the idea that few things are truly the most intense that can ever be experienced.

Defense attorneys typically try to persuade a jury that a given complaint was not caused by a particular accident because the same complaint was present prior to this particular accident. This illogical conclusion is thwarted by a clear, concise, and accurate description of a complaint both before and after a particular accident. Any of the frequency, duration, and severity can be different when comparing before and after the accident. If the doctor doesn't properly document all of this information, the defense attorney will make the most of the opportunity.

The doctor will save time by telling the patient that they need short, clear answers to the following questions for each complaint:

a) Did you have this complaint in the 12 months prior to this accident?
b) When did this complaint start (or, how soon after the accident did you first feel it?)?
c) Is the complaint present all the time, or does it come and go?
d) If intermittent, how long does the complaint typically last each time it is present?
e) How intense is the complaint from 0-10, with 0 being none and 10 being the most?

f) Does this complaint interfere with sleep?

Interference with sleep is a separate complaint with two distinct components - a) delay in falling asleep, and b) being awoken from sleep. Be sure to document any other complaints as being a cause to sleep interference when describing those other complaints (e.g. Neck pain - ... constant neck pain that interferes with sleep ...). Ask the patient how long their sleep is typically delayed once they lie down and attempt to sleep. Then ask how often they are awoken from their sleep due to their accident related complaints, and then how much time is typically required to resume sleeping after being awoken from sleep.

Update the frequency, duration, and severity of each complaint with each significant change as to any of their frequency, duration, and/or severity. It is reasonable to assume that continued care is based on improvement of symptoms, and these changes need to be properly documented. Conversely, there are serious problems with continued treatment when there is no improvement of symptoms for more than a reasonable amount of time.

Continue to update these complaints as the patient improves over time. Just as with interferences with activities of daily living , these updates need to be noted relative to significant changes for each given complaint. Do not update in robotic fashion with fixed intervals for time, as there may not yet be a significant change for a given complaint.

By describing a patient's complaints with the clarity shown here, a claims adjuster and defense attorney will know that the reporting doctor is credible (believable). They will also know that a jury will likely view that doctor in a highly favorable manner. Credibility is of utmost importance in the courtroom, is proven by one's actions, and there is no substitute for it.

Example:

Complaints -

a) **Pre-existing complaints NOT worsened** by this accident -

Right shoulder pain - Prior to this accident, my patient had constant right shoulder pain during waking hours since approximately 2002 at an intensity of about 7/10. Nine days following this accident when first seen by this doctor, his right shoulder pain remains unchanged.

b) **Pre-existing complaints WORSENED** by this accident -

Low back pain - Prior to this accident, my patient experienced low back pain about once every 4-6 months lasting for several hours per episode at an intensity of about 2/10. Almost immediately following this accident, she felt low back pain on a constant basis at an intensity of about 8-9/10. This was a major contributor to her sleep interference. It remained constant for about 2 months, at which time it became intermittent, occurring about 3 times per week lasting about several hours per episode at an intensity of about 5/10. About 3 months following this accident, her low back pain occurred about once weekly lasting for about several hours per episode at an intensity of about 2/10. Her low back pain improved fairly steadily from that point in time such that she no longer experienced low back pain as of middle to late January 2014.

c) **New complaints** resulting from this accident -

Sleep interference - My patient did not have any problem with sleep interference for at least 12 months prior to this accident. She first experienced sleep interference as a result of this accident on the

second night after it occurred. Her sleep interference involved both delay of onset of sleep and being awoken from sleep. Both of these aspects of sleep interference occurred every night for about one month, and was caused primarily by low back pain, shoulder pain, and neck pain. She would typically awake once or twice nightly, and would typically require 20-30 minutes to resume sleeping. She no longer had sleep interference approximately one month following this accident.

Diagnoses -

All pertinent diagnoses need to be listed in a personal injury case when third party insurance is involved. In general, this is because it is assumed that something (a given fact) didn't happen when it is not expressly stated. Even when two given diagnoses are partially redundant, it is much better to state both as compared to just one of those diagnoses. Providing less information than the whole picture conveys the idea that a patient is not injured as badly as they actually are.

Diagnoses should be listed with the **most severe diagnosis listed first, and then the remaining diagnoses listed in descending order of severity**. Additionally and consistent with listing them in descending order, diagnoses should also be listed in the following **hierarchy**:

1) traumatic diagnoses listed first,
2) neurological diagnoses listed next,
3) symptoms other than neurological symptoms listed next, and finally
4) underlying conditions listed lastly.

There can be but does not need to be a space provided between each of the four hierarchies of diagnoses.

Diagnoses are based on the history, examination, and radiology obtained on a given patient. They are not guesses. For example, a patient with numbness and tingling in their left 1st, 2nd, and 3rd fingers has differential diagnoses of cervical radiculopathy, cervicobrachial syndrome, and carpal tunnel syndrome among others. It is only appropriate to make definitive diagnoses based on the history, examination, and/or radiology for this given patient. A positive left foraminal compression orthopedic test resulting in an increased severity of symptoms in the left hand would merit a diagnosis of cervical radiculopathy, as would a radiographical finding of left C5/C6 foraminal stenosis. A positive Eden's test would justify a diagnosis of cervicobrachial syndrome. Similarly, a positive Tinel's test on the median nerve at the left wrist would merit a diagnosis of carpal tunnel syndrome.

Diagnoses need to include appropriate adjectives to describe each of the **time frame** as well as **severity**. Acute, subacute, and chronic all describe different stages of healing for trauma. Severity is typically described with the use of one or a combination of two of the following adjectives: minimal, mild, moderate, advanced, and severe. It is not appropriate to fail to use adjectives when necessary. For example, a diagnosis of acute moderate to advanced cervical strain/sprain may be appropriate, whereas cervical strain/sprain is not appropriate.

With plain film radiology, diagnoses pertaining to **discs** need to **include the specific disc level(s)** in addition to a description of their **severity**. Severity here does not mean the intensity of symptoms, but instead means the degree of loss of disc height as compared to a healthy disc above an unhealthy one. For example an appropriate diagnosis could be cervical mild C5 and mild to moderate C7 intervertebral disc degeneration. A diagnosis of C5 disc degeneration is inappropriate and is too vague to convey a clear description of the actual degree of damage.

When a MRI report is available that states the direction and distance of a prolapse or protrusion, the diagnoses based on radiography should include the s**pecific disc level(s), direction of the prolapse or protrusion, distance in millimeters of that prolapse or protrusion, and distance in millimeters of the amount of decreased height**. For example, an appropriate diagnoses of an unhealthy disc when a MRI report is available with sufficient information could be cervical C5 intervertebral disc degeneration with a left 3 mm. paracentral protrusion impinging upon the thecal sac and 2 mm. decreased disc height.

ICD-9 diagnoses are used for personal injury and all other purposes as of the time of this writing. The implementation of ICD-10 has been delayed by federal law until Oct. 1, 2015 and could be further delayed or never implemented. There is strong reason to believe that ICD-10 will never be implemented because ICD-11 scheduled to be implemented in 2017.

The 739 subluxation (segmental dysfunction) diagnosis codes should usually not be used for personal injury because they are non-traumatic subluxations by definition, and automobile accidents are obviously traumatic. Instead, the **839 subluxation diagnosis codes are usually appropriate for automobile accidents because by definition they are traumatic**. The inappropriate use of a 739 diagnosis code with an automobile accident tells the adjuster and a jury that subluxations were present that were not caused by the given automobile accident. Many check the box diagnosis forms have only 739 but not 839 subluxation codes. In those circumstances and when used, the doctor will need to write in additional pertinent diagnosis codes not listed on the form. This author recommends not using check the box forms.

Example -

The following diagnoses pertain to this patient only as a result of this accident unless otherwise stated:

1) 805.05 Cervical C5 fracture
2) 728.4 Ligament laxity
3) 720.1 Spinal enthesopathy
4) 784.3 Edema
5) 847.0 Acute moderate to advanced traumatic cervical strain/sprain
6) 847.1 Acute moderate to advanced traumatic thoracic strain/sprain
7) 847.2 Acute moderate traumatic lumbar strain/sprain
8) 846.0 Acute moderate traumatic lumbosacral strain/sprain
9) 846.9 Acute moderate traumatic sacroiliac strain/sprain
10) 310.02 Traumatic brain injury/post-concussion syndrome
11) 839.08 Multiple traumatic cervical subluxations
12) 839.21 Traumatic thoracic subluxations
13) 839.20 Traumatic lumbar subluxations
14) 839.42 Traumatic sacral subluxations
15) 839.69 Traumatic pelvic subluxations
16) 338.11 Acute new pains due to trauma
17) 338.21 Exacerbation of chronic pains due to trauma
18) 339.21 Acute post-traumatic headaches
19) E812.0 Driver of a motor vehicle impacted by another motor vehicle
20) 728.4 Cervical C2/C3 and C5/C6 ligament laxity
21) 722.4 Cervical mild C5 and moderate C7 intervertebral disc degeneration
22) 722.10 Lumbar mild to moderate L5 intervertebral disc degeneration without myelopathy

23) 723.3 Cervicobrachial syndrome
24) 723.4 Brachial neuritis
25) 353.0 Brachial plexus lesion

26) 784.0 Headaches
27) 719.41 Left shoulder pain
28) 719.42 Left arm and forearm pain
29) 719.45 Left and right hip pain
30) 723.1 Cervicalgia
31) 729.1 Myalgia
32) 728.85 Muscle spasms/trigger points
33) 300.4 Anxiety, depression
34) 780.50 Insomnia with sleep disturbance, unspecified

35) 729.1 Fibromyalgia (underlying pre-existing condition)
36) 737.30 Scoliosis (underlying pre-existing condition)
37) 756.12 Spondylolisthesis

ICD-10 –

Overview -

The ICD-10 diagnosis codes have been implemented and are now in force and apply only for Oct. 1, 2015 and thereafter dates of service. ICD-9 diagnosis codes remain in use for all dates of service prior to and including Sept. 30, 2015. In California, the statute of limitations for written contracts is four years, which means that unless shortened by other law (such as Medicare) or contract, providers will be able to bill dates of service prior to and including September 30, 2015 up to four years later. For example, unless shortened by other law or contract, a doctor can bill for services rendered on Sept. 18, 2015 until Sept. 18, 2019. Medicare is the most obvious example of other law that shortens the time period to bill for chiropractic services, which are generally required to be billed within ONE year from the date of service. Contracts with a doctor and an insurance company or other entity can also reduced to the time allowed for billing, and many such contracts limit the time to one year following the given date of service. **With personal injury in regard to billing first party medical payments of automobile insurance, the contract between the insurance company and the insured can also limit the time period for both the dates of service rendered eligible for payment as well as the total length of time after the date of service for submission of bills.** Therefore, **do not discard information pertaining to ICD-9, since it potentially can be used until Sept. 30, 2019**, and even longer with personal injury as to those automobile insurers that will still allow and/or insist on ICD -9 diagnosis codes being used. ICD-11 is already is already being designed and is scheduled for implementation in the year 2017 (as of the time of this writing).

Do not mix ICD-9 dates of service and/or codes with ICD-10 dates of service and/or codes on the same billing sheet. Instead, use ICD-9 diagnosis codes with dates of service prior to and including Sept. 30, 2015 on a given billing sheet, and use ICD-10 diagnosis codes with dates of service Oct. 1, 2015 and thereafter on a different billing sheet. Mixing the information inappropriately will result in rejection of the claim.

All of the diagnosis codes for each of these ICD series pertain only to diagnoses, and do not pertain to procedures. A great website to learn about continuously updated issues concerning ICD-10 is www.icd10monitor.com, and another is that of the world health organization (WHO) at www.who.int. Some but not all of the ICD-9 codes covert easily to ICD-10 codes, and some do not. Conversation

information is available from a number of sources. A thorough understanding of ICD-10 for most people will involve attendance at a seminar dedicating a significant amount of time to the subject, as many people learn new material easier at an in person seminar. An ICD-10 code book will need to be purchased by most doctors. This online course in part provides a clear, concise overview of the subject, but obviously does not provide the benefits of learning in the presence of a teacher.

Legal Authority -

Our United States Congress is the entity that writes the laws pertaining to the ICD diagnosis series, and it is Congress that can change written laws at any time. Congress' proposed laws become the law of the land once our President signs Congress' proposed laws. The law concerning ICD-10 is an addition to existing laws pertaining to federal HIPAA confidentiality. Congress did change the written law which would have implemented ICD-10 as of Oct. 1, 2014, and it was our United States President that signed Congress' proposed law which made it a reality. ICD-10 codes could not be used prior to its implementation, which occurred on Oct. 1, 2015. Any bills submitted with ICD-10 diagnosis codes prior to implementation resulted in rejection of those bills.

To Whom Will/Does ICD-10 Apply? -

ICD-10 laws are part of Federal HIPAA laws, which pertain only to "covered entities," which is the legal term for those doctors who bill electronically or hire a billing firm that files bills electronically.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. This is federal law, and is applicable in addition to state confidentiality laws only if a health care provider, facility, health plan, or billing agency is a "covered entity." Covered entities are those health care providers, facilities, health plans, and billing agencies that transmit health care information electronically, those that use such an electronic transmitter, those contracted to provide private healthcare information electronically, and all doctors who are in states with state laws that mandate HIPAA compliance. Electronically generally means that patient health information is being transmitted by use of computers. This includes accessing websites to verify patient eligibility, sending bills by computer, receiving explanations of benefits by computer, etc. There are two types of fax (facsimile) machines - computer and conventional telephone. Faxing from a conventional telephonic fax machine does not constitute a HIPAA electronic transaction, but doing so via use of a computer does.

Determining whether you are or are not subject to HIPAA laws is discussed elsewhere. If you do not care to be subject to HIPAA laws, simply mail your bills by regular United States Postal Service 1st class mail, do not bill electronically, do not use a billing service that bills electronically, do not enter into any contracts requiring you to bill electronically or be HIPAA compliant, do not obtain or transmit any patient healthcare information by computer, and do not practice in a state that requires HIPAA compliance. At this point in time, California does not require HIPAA compliance for doctors of chiropractic.

As far as ICD-10 is concerned, from a technical standpoint ICD-10 only applies to "covered entities." Realistically, the vast majority of doctors offices are "covered entities" and the effect is likely to be that many if not most insurance companies are likely to insist on ICD-10 being used in order for payment to be made (because consistency makes their business more efficient). Therefore, it is likely that ICD-10 will become universal.

Personal Injury - There is confusion occurring as to payment of personal injury claims with the use of both ICD-9 and ICD-10 being used for appropriate dates of service. Many insurance companies are choosing their own method of operation in regard to both ICD-9 and ICD-10, despite a number

wrongly doing so. Even though "covered entities" (doctors and billing services hired by doctors any of which bill electronically) are required to use ICD-10 diagnosis codes when billing for dates of service Oct. 1, 2015 and forward, a number of automobile insurance companies are wrongfully setting their own policy in regard to the use of ICD-9 and ICD-10 in defiance of the new federal law. For example, at the time ICD-10 was implemented, State Farm processed insurance claims with both ICD-9 and ICD-10, and for an indefinite period of time as to ICD-9 claims regardless of the date of service. In contrast, Progressive Ins. Co. rejects claims for dates of service Oct. 1, 2015 and thereafter using ICD-9. Even though it might be easier to call the given claims adjuster and ask what they will accept, the correct procedure for "covered entities" is to use ICD-10 for claims with dates of service Oct. 1, 2015 and thereafter, and to use ICD-9 with claims of service Sept. 30, 2015 and prior to that date. Doctors who are not "covered entities" (most of those doctors who do not bill electronically) are not required to use ICD-10 by federal law because the mandatory use of ICD-10 for "covered entities" has been added as an attachment to federal HIPAA law. However, doctors who are not "covered entities" are a minority and will probably discover that insurance companies eventually will insist upon all doctors using ICD-10 for dates of service Oct. 1, 2015 and thereafter in order to be paid.

When an insurance company including automobile insurers wrongfully insists upon the "covered entity" doctor using ICD-9 and/or ICD-10 incorrectly (in conjunction with the given date of service), the doctor should keep in mind that doing so would be illegal. Doctors like anyone else as well as business entities must abide by all laws. Using ICD-9 and/or ICD-10 incorrectly in regard to dates of service would be illegal as to "covered entities." Federal laws become the law of the land when the president of the United States signs a bill authored by Congress. Congress' most powerful ability to make laws is based on the Commerce Clause of the United States Constitution. No person nor business entity can interfere with any law. Even though ICD-10 and HIPAA law pertain only to "covered entities," automobile insurance companies cannot rightfully insist in operating in violation of any law, and cannot force others to violate laws. "Covered entity" doctors should only use ICD-9 and ICD-10 properly with claims. If an insurance company does not pay bills, the solution is for the patient to sue the insurance company for breach of contract. In California small claims court, assignees (third party beneficiaries such as doctors) are not allowed to file a claim. Therefore, it is the patient who must file suit against the insurance company.

Medications prescribed by physicians -

In a personal injury situation, it is important to list medications prescribed for the given accident. Generally speaking, a person who was prescribed medication is hurt worse than a patient not prescribed medication. Additionally, stronger medications are usually indicative of injuries being worse to a patient. For example, a patient given a prescription for vicodin is usually hurt worse than another patient merely prescribed motrin. Listing this information can be helpful to partially explain why a given patient may need more treatment than would otherwise be expected. Chart notes from other health care providers the patient has seen for a given automobile accident should be promptly requested and obtained. Furthermore, listing this information shows that the treating doctor of chiropractic performed a competent history as is expected.

Example -

This patient has been prescribed naproxin 50 mg. b.i.d., flexoril 80 mg. t.i.d., and ibuprofen 200 mg. p.r.n. by Dr. John Doe, M.D. for this accident.

This patient has also been prescribed atenolol for high blood pressure, and simvastatin to reduce cholesterol, which were not prescribed for this accident.

Previous Accidents -

A personal injury patient should be asked to list previous traumatic accidents with a short description of any injuries, and the resolution of those injuries (if any). Injuries include more than automobile accidents, such as traumatic sports injuries, workers' compensation injuries, and others. Automobile insurance companies communicate with each other, and are well aware of other injuries. Asking and clearly stating previous injuries shows that both the doctor and patient are honest and truthful, important qualities of any witness at trial.

Example:

In 2008, this patient was involved in a fender bender minor impact automobile accident which resulted in no injuries.

Subsequent Accident(s) - (if this happens, comparison of EACH complaint must made PRIOR to and AFTER EACH accident in the previous section).

Similar to the just mentioned section of previous accident, subsequent accidents also need to be listed. Insurance companies become almost immediately aware of subsequent accidents while a given claim is pending. Furthermore, a claims adjuster with a pending claim will routinely check to see if a claimant (your patient) has incurred any subsequent accidents in an effort to minimize the money paid out for that claim. Listing any subsequent accidents shows both the doctor and patient to be both honest and truthful.

A re-examination needs to promptly performed with subsequent accidents provided a claim is still pending on another, previous accident. Most of the information contained in this format for a narrative needs to again be obtained from the perspectives of both just prior to and after the given subsequent accident. Hopefully, the doctor has been performing periodical re-examinations to document the patient's progress with chiropractic care. Doing so is a standard of competence and assures that there is a relatively close in time re-examination soon before an unpredictable subsequent accident occurs. When there is an existing accident claim pending, the information obtained pertaining to prior to the subsequent accident is of course in the short time frame just before the subsequent accident (not in the roughly 12 months prior to the subsequent accident).

Example -

On May 23, 2014, this patient was involved in a moderate impact automobile accident that resulted primarily in headaches, neck pain, middle back pain, and low back pain. Please see the attached re-examination form.

Other Health Care Providers Seen for this Accident -

It is extremely important to obtain chart notes from other health care providers that a patient has seen for a personal injury accident. The doctor needs to be aware of any potential problems in additional to other possible issues. These chart notes from other providers may shed light on other aspects of care and the narrative report, such as diagnoses. This is also further proof of a doctor performing their duties in a competent manner.

Additionally, there is a realistic need to have a chiropractic patient evaluated by a medical doctor so as to document the need for continued chiropractic care in some situations. These situations usually arise when a patient has more extensive injuries than would otherwise be expected as well as when there

are possible medical concerns outside the scope of chiropractic. Although this is no slight against chiropractic, the third party insurance adjusters are always evaluating a claim based on how an average jury would perceive a trial. The vast majority of people have never been treated by a chiropractor, and those people often have a biases against chiropractic and in favor of medicine. In situations where a patient has sustained injuries beyond garden variety accident symptoms (such as additionally having symptoms of traumatic brain injury), they should be evaluated by a medical doctor for possible medical treatment in addition to chiropractic (make sure to explain to your patient that they still need chiropractic if so, but that they possibly may also need additional care). When the bill for chiropractic care becomes higher than expected, a medical doctor's documentation as to the continued need for chiropractic care (or at least continuing unresolved accident injuries) will usually dispel an unfair assumption of no further need for chiropractic. Many times the best medical doctor for this purpose is the patient's own established medical doctor, because there can be no insinuation of an invalid medical opinion since the doctor of chiropractic did not choose the medical doctor.

Example -

ABC Ambulance Service for transportation to hospital emergency room.
Dr. Jane Doe, D.O., John Muir Hosp. emergency room, Concord, CA (925)-555-1234.
Dr. John Doe, M.D., neurologist, 123 Any St., Walnut Creek, CA 94596, (925)-555-1111.

Radiology -

Plain film x-ray radiographs are almost usually needed and justified for personal injury purposes. The justification boils down to the need for assessing anatomical disruption. Radiology provides information impossible to be obtained from the history and physical exam. **A picture is worth a thousand words**. The absence of a radiological report tells the claims adjuster that there are no pictures to show a jury, and this is harmful to a case.

There is almost always sufficient justification for a doctor to feel they need plain film x-ray radiographs. In a personal injury case, the primary reason to need radiographs is to **assess anatomical disruption**. Plain film x-ray radiographs provide an inside perspective that a standard physical exam will not provide. For example, interruptions in George's line (or the equivalent of a George's line) of at least 1 mm. indicate significant tearing of ligaments. As to muscles, tendons, and ligaments, ligaments are stronger than both muscles and tendons (which is why ligaments are the primary stabilizer of joints with both muscles and tendons being secondary stabilizers of joints). Interruptions in George's line can only be established with radiology. Furthermore, the very strong diagnosis of ligament laxity is conclusively proven on radiographs, whereas it is only inferred with a standard physical exam. Additionally, certain radiographical findings can explain the need for extended care, such as a tropism involving two vertebrae (because this situation causes a proclivity to produce subluxations and retard the beneficial effects of chiropractic care).

Plain film x-ray radiographs can be justified when there are already post-accident films in existence. This can be due to several different reasons. The typical reasons for needing new films is that the existing ones or the associated written report are not readily obtainable, especially when treatment is needed and should not be delayed. Even though some facilities send films and their reports that arrive as soon as perhaps four days following a valid request, a four day lack of treatment can and often is detrimental to a patient. Another reason for new films can be that the previously taken films are of insufficient quality.

Plain film x-ray radiographs should be taken prior to even considering the possible need for a MRI. Plain film radiographs are much less expensive than MRIs. Often, standard plain film

radiographs provide sufficient information, at least for the time being. Claims adjusters will often think that the purpose of obtaining MRIs without plain film x-ray radiographs having first been obtained is merely to rack up a bill. Some attorneys want doctors to obtain MRIs regardless of sufficient doctor justification because usually something adverse appears on the images and this creates a strong bias against the defense in a trial. However, it is important to have sufficient justification from a doctor perspective to do anything, including obtaining MRI images.

MRIs are justified when there is a continued need to assess anatomical disruption after having first obtained plain film x-ray radiographs. MRIs provide much greater detail for soft tissues as compared to plain film x-ray radiographs. As we doctors of chiropractic know, plain film radiographs show only a mostly non-interpretable shadow of soft tissue structures (and in particular that of discs). The detail shown on MRI films and images can show the number of millimeters of disc prolapse or protrusion, whether there is effacement or impingement on the spinal cord, etc. MRI can also show greater detail of hard tissue (bone) as compared to plain film x-ray radiographs, such as whether or not edema is present within bone (thus indicating a new fracture).

Plain film x-ray radiographs and MRIs should ideally both be obtained with the patient in a standing, weight-bearing position. Doctors of chiropractic know very well that gravity not only highlights the full effects of injuries, but people are always under the full effect of gravity in their lives. Conversely, people normally are in a horizontal position 1/3 of their time (when sleeping) with 2/3 of their lives being in an upright position. Images produced with the patient in a standing, weight-bearing position are realistic. The reason that medical facilities typically take images in a horizontal position is because they have to treat some patients who are unconscious or otherwise unable to stand. The number of MRI facilities with upright technology will increase as time goes forward. At the time of this writing, there are currently two upright MRI facilities in the Bay Area of California (Hayward and San Jose).

Which plain film radiology views should be obtained? In the simplest terms, as many views that are needed to assess anatomical disruption should be obtained. Using the cervical region as an example, start with the first three basic views - AP, APOM, and neutral lateral. The AP and APOM views should be taken with two separate images instead of combining the two on one image, because the mandible and teeth obscure structure needed to be visualized. The oblique views are justified usually when the patient has upper extremity neurological symptoms so as to assess the patency (or lack of patency) of the neural foraminae.

Flexion and extension views are justified when there was a forceful impact with a significant anterior to posterior (or vice versa) directional component. When the directional component of force is from a sideways (90 degree) angle relative to your patient's head and neck at the time of impact, two specialized views of anterior to posterior with each of left and right lateral flexion should be taken, even though these views were probably not taught in school. The flexion and extension views along with the neutral lateral view are assessed for a break in George's line. Analogously, the two specialized lateral flexion views are assessed for a break in the equivalent of a George's line. An interruption of 1 mm. to 3.5 mm. on these views of George's line or the equivalent of George's line is conclusive evidence of ligament laxity, which is caused by traumatic tearing of ligaments. Since ligaments are stronger than both muscles and tendons, both muscles and tendons will be torn when ligaments are torn. An interruption of greater than 3.5 mm. is conclusive of ligament instability, and a referral to an orthopedic surgeon is warranted.

It must be remembered that there is not always a pure A to P or P to A directional impact force or a pure sideways force. For example, when your patient's vehicle and another vehicle are approaching each other from opposite directions on the same road, and your patient was subsequently in the midst of a

left hand turn and was struck by that other vehicle that ran a red light, there were most likely both anterior to posterior as well as sideways direction components of force.

Short tau inversion recovery (STIR) MRI view - This MRI perspective is the golden standard for detection of edema in bone, and therefore confirmation of a fracture being new as caused by recent trauma. This view is used after having first obtained standard MRI views that show a previously undetected fracture where those views do not resolve the issue as to whether the fracture is an old or new one. Edema is produced not only with soft tissues when injured, but also by bone when fractured. Greater amounts of edema are produced in direct correlation with the degree of trauma to the given structure. Therefore, there is less edema produced with hairline fractures as compared to a much greater amount of edema produced with larger, more pronounced fractures. Edema in bone disappears within 6-12 months time depending upon the original amount of edema present. Requesting a STIR view could be very important from a chiropractic ethics standpoint, because it is unethical for a California licensed doctor of chiropractic to adjust a bone with an active (not fully healed) fracture.

Interpretation by a radiologist - There are times when a radiologist is needed to interpret films. In this author's opinion, the radiologist should be a California licensed doctor of chiropractic who is a D.A.C.B.R. and also geographically located in California when your patient was involved in a California based automobile accident. D.A.C.B.R. radiological reports are routinely written with an excellent degree of detail, whereas medical radiological reports usually have too little detail (because those radiologists usually have too many images to read and not enough time to do the job). The reason that a California based radiologist should be used is so that they can be available to testify in a deposition or at trial. A claims adjuster who sees a radiology report written by an out of state radiologist knows that the radiologist is not likely to be available to testify locally.

Example -

Please see the attached radiology report.

Malingerer tests -

Of the various malingerer tests, Mankopf's test is the most important malingerer test because it is objective. To this author's knowledge, Mankopf's test is the only objective malingerer test. Being an objective test, it is considerably more reliable than subjective tests. Mankopf's test is performed by first determining the patient's heart rate, and then again determining their heart rate when assertively pressing on an area of the patient's body that the patient has stated is painful. The patient's heart rate will quickly increase by at least 10 beats per minute with assertive palpation on a painful area of their body. This is due to an autonomic neurological reflex arc that involves an involuntary response to a painful stimulus. This test confirms that a given area of the patient's body truly is painful, although it does not provide any information as to the cause of the pain.

Example -

This patient tested negative on the superficial palpation test (no pain upon very light palpation) and positive on Mankopf's test (heart rate increased by at least 10 beats per minute upon significant palpation of an area where the patient complains of pain), which is indicative of this patient's complaints being genuine.

Referrals from this office made to other health care providers -

This section is for the most part self-explanatory, and provides proof of the doctor performing their duties in a competent manner as necessary.

Additionally and as previously stated, there is a realistic need to have a chiropractic patient evaluated by a medical doctor so as to document the need for continued chiropractic care in some situations. These situations usually arise when a patient has more extensive injuries than would otherwise be expected as well as when there are possible medical concerns outside the scope of chiropractic. Although this is no slight against chiropractic, the third party insurance adjusters are always evaluating a claim based on how an average jury would perceive a trial. The vast majority of people have never been treated by a chiropractor, and those people often have a biases against chiropractic and in favor of medicine. In situations where a patient has sustained injuries beyond garden variety accident symptoms (such as additionally having symptoms of traumatic brain injury), they should be evaluated by a medical doctor for possible medical treatment in addition to chiropractic (make sure to explain to your patient that they still need chiropractic if so, but that they possibly may also need additional care). When the bill for chiropractic care becomes higher than expected, a medical doctor's documentation as to the continued need for chiropractic care (or at least continuing unresolved accident injuries) will usually dispel an unfair assumption of no further need for chiropractic. Many times the best medical doctor for this purpose is the patient's own established medical doctor, because there can be no insinuation of an invalid medical opinion since the doctor of chiropractic did not choose the medical doctor.

Example -

This patient has been referred to Dr. ABC, a neurologist for consultation concerning her traumatic brain injury with resultant neurological effects.

This patient has also been referred to XYZ MRI, Inc. to obtain a cervical MRI with flexion and extension views.

Recommendations throughout treatment -

The purposes of both recommendations throughout treatment as well as restrictions placed upon a patient are to speed the healing process and minimize the risk of exacerbating conditions. Listing this information is not only one aspect of competence, but also shows the claims adjuster or a jury that the doctor is taking action expected of a professional and that the given doctor will present well at a deposition or trial. It is also proof of the good intentions of a doctor to have their patient become well as quickly as possible.

Example -

no work from 5/24/14 through 5/27/14
no lifting or carrying over 10 pounds from 5/27/14 through 6/20/14
no lifting or carrying 5-10 pounds from 5/27/14 through 6/20/14
ice from 5/24/14 through 5/26/14
gentle stretching of the cervical, thoracic, and lumbar spine as well as lower extremities through all ranges of motion, with cervical flexion being deemphasized starting 5/27/14
cervical extension gravity traction building up to 20 minutes per day as tolerated
passive range of motion exercise of the entire body from two to four weeks post-accident
complete active exercise program to tolerance, building up intensity and endurance over time starting at 30 days post-accident

Duties Under Duress -

Interference with activities of daily living is another area of compensable damage to an injured person, and it includes both a) duties under duress and b) loss of enjoyment of life. The two subcategories are best understood when considered at the same time with each other, but need to be detailed in separate sections. Unless the doctor takes the time to document this information, the result will be a recovery for less money than there should be.

Duties under duress are those activities that the patient can still perform despite the detrimental effects of their injuries. Loss of enjoyment of life are those activities that the patient cannot perform at all, whether the length of time they cannot perform a given activity is temporary or permanent.

It is imperative to always compare each given interference of activities of daily living both prior to as well as after a given accident. Just as with detailing complaints, comparison of the frequency, duration, and severity of each interference with activities of daily living need to be made both prior to and after a given accident. The reason for needing this degree of detail is that the burden of proving a case is that of the injured person, and the civil standard of proof is that each fact must be shown to be more probable than not that it is true. This standard of proof means that each fact must be at least a smidgen more than 50% probable that it is true. For example, merely stating that the patient had difficulty mowing their lawn is insufficient. However, comparing the frequency, duration, and severity both prior to and after a given accident as shown in the following example clearly qualifies as being more probable than not of being true, and the result is that the entire fact is accepted as true.

Continue to update these interferences with activities of daily living as the patient improves over time. Just as with complaints, these updates need to be noted relative to significant changes for each given activity. Do not update in robotic fashion with fixed intervals for time, as there may not yet be a significant change for a given activity.

Some interferences with activities of daily living involve both a duty under duress as well as a loss of enjoyment of life component, and must therefore be listed and detailed separately in each section. It is okay to detail both components in a single paragraph for a given activity, and to then copy and paste the exact same paragraph such that it appears exactly the same in both sections. It is better to clearly state the whole situation rather than mistakenly forgetting to include something important. Effectiveness is of paramount importance, and as the saying goes substance (is far more important) over form.

Example -

This patient has difficulty performing the following activities as a result of this accident:

Mowing the yard - Prior to this accident this patient had no difficulty mowing her entire yard when took approximately 20-25 minutes, but after this accident could not do so at all for the first 2 1/2 weeks, and then from 2 1/2 weeks until 10 1/2 weeks she had to mow the lawn for approximately 10 minutes, then rest for about 5 minutes, then continuing mowing, etc. due to intermittent low back pain which generally persisted for about 5 minutes per episode when doing this activity at an intensity of about 2-4/10.

Lifting her children - Prior to this accident she had no difficulty lifting her children who weighed 22 and 35 lbs. at the time of the accident, but after the accident for the first 8 weeks she could not lift her children at all, and then from 8 weeks until 14 weeks after the accident, she could only lift her children

with intermittent pain in her low back occurring only when lifting objects of significant weight which generally persisted for about 15-30 minutes per episode at an intensity of about 3-7/10.

Loss of Enjoyment of Life -

The same discussion as with the preceding section of duties under duress applies here and is incorporated by reference.

Example -

This patient could not or cannot do the following activities as a result of this accident:

Mowing the yard - Prior to this accident this patient had no difficulty mowing her entire yard when took approximately 20-25 minutes, but after this accident could not do so at all for the first 2 1/2 weeks, and then from 2 1/2 weeks until 10 1/2 weeks she had to mow the lawn for approximately 10 minutes, then rest for about 5 minutes, then continuing mowing, etc. due to intermittent low back pain which generally persisted for about 5 minutes per episode when doing this activity at an intensity of about 2-4/10.

Lifting her children - Prior to this accident she had no difficulty lifting her children who weighed 22 and 35 lbs. at the time of the accident, but after the accident for the first 8 weeks she could not lift her children at all, and then from 8 weeks until 14 weeks after the accident, she could only lift her children with intermittent pain in her low back occurring only when lifting objects of significant weight which generally persisted for about 15-30 minutes per episode at an intensity of about 3-7/10.

Disability/Restrictions -

The purposes of both recommendations throughout treatment as well as restrictions placed upon a patient are to speed the healing process and minimize the risk of exacerbating conditions. Listing this information is not only one aspect of competence, but also shows the claims adjuster or a jury that the doctor is taking action expected of a professional and that the given doctor will present well at a deposition or trial. It is also proof of the good intentions of a doctor to have their patient become well as quickly as possible.

The restrictions that are simultaneously also disabilities need to be listed in this separate section, even though they will be redundant to and included in the larger set of recommendations throughout treatment. The reason they should also be listed here is for the purpose of clearly detailing another area of legal recovery of damages for your patient.

At the time of this writing and for workers' compensation purposes specifically, permanent disability is assessed with the AMA Guides to the Evaluation of Permanent Impairment, 5th edition. Even though it is specific to workers' compensation only, it can be used to provide information if the doctor is familiar with it. This book and its methods for evaluation of permanent disability are not required for personal injury purposes, but may be used to express detail on this subject.

The most important point to make is to list the critical information one way or another in clearly stated terms that the reader can understand.

Example -

a) **Temporary** Disability -

no work for 3 weeks from 8/1/14 - 8/21/14
no lifting or carrying more than 10 lbs. from 8/22/14 through 9/27/14
no lifting or carrying more than 15 lbs. from 9/28/14 through 11/30/14
no lifting or carrying more than 25 lbs. from 11/31/14 and continuing

b) **Permanent** Disability -

no lifting or carrying more than 25 pounds from 11/31/14 and indefinitely from that time and forward

Per the AMA Guides to the Evaluation of Permanent Impairment, 5th edition, as a result of this accident this patient is rated with a 5-8% neck and upper extremity impairment rating, and a total 7-12% impairment rating.

Prognoses -

Prognoses are statements of the approximate percentage of improvement of a given diagnosis based on residual symptoms related to that diagnosis and the likelihood of any expected improvement. The percentage improvement is best express as a reasonable range of the remaining frequency, duration, and severity as compared to the post-accident worst of each of frequency, duration, and severity. Residual symptoms are best expressed in terms of frequency, duration, and severity. The likelihood of future improvement is a reasonable extrapolation of future expected improvement based on the rate of improvement at the time the prognosis is made. For example, a person whose given complaint has plateaued with no consistent change of frequency, duration, and severity in the short term can be expected to have permanent affects of that complaint with no reasonable expectation of improvement. On the other hand, short term minimal improvement can have an expectation of only slightly more improvement over time.

Theoretically, there would be one prognosis for each and every diagnosis. Realistically, this approach is too cumbersome. The solution is to do a limited number of prognoses based on logical groups of diagnoses. As examples, one prognosis can be made for a group of diagnoses that pertain to traumatic brain injury. Another prognosis can be made for a group of diagnoses that pertain to whiplash. Another prognosis can be made for a group of diagnoses pertaining to lumbopelvic symptoms.

Example -

This patient's traumatic brain injury/post-concussion symptoms are approximately 80-90% improved but with residual symptoms of short term memory loss, difficulty with concentration, and headaches still occurring on a fairly regular basis, although to a mild but significant degree. It is likely that these symptoms will continue at least 6 months to one year, but with the distinct possibility of occurring indefinitely based on the persistent presence of these symptoms and the very slow rate of improvement at the time of this writing.

Diagnoses 1-5 and 7-14 listed above are approximately 70-80% resolved with residual headaches occurring approximately one to two times every two weeks lasting for 30-60 minutes per episode, neck stiffness with decreased range of motion occurring two to four times per week worse in the morning and better as the day progresses and in warmth lasting several hours per episode, and muscle spasms and trigger points occurring two to four times per week lasting for several hours per episode. These symptoms are likely to occur indefinitely due to the incomplete healing of torn ligaments, muscles, and

tendons (perhaps only approximately 60% as strong as compared to this patient's pre-injury status) with the resultant greater proclivity for the occurrence of subluxations as compared to a typical person.

Diagnoses 16-21 listed above (including C5 and C7 disc degeneration, ligament laxity, spinal enthesopathy, etc.) are approximately 50-60% resolved based on recurrent subluxations, neck pain, and other related symptoms occurring two to three times per week lasting about 20 to 60 minutes per episode (and subluxations lasting until being adjusted). They are likely to occur for the remainder of this patient's life since discs do not generally improve. Furthermore, this patient can expect their disc related symptoms to last long and be present with more intensity over time as the discs worsen, which is a certainty.

Diagnoses 22-24 and 26-27 listed above are apparently nearly totally resolved on the basis of infrequent symptoms of shoulder, arm, and forearm pain and tingling only when this patient lifts anything over 50 lbs. The patient has been advised not to lift anything over 30 lbs. and to obtain help when necessary so as to avoid exacerbations of these diagnoses.

Diagnoses 25, 29-31, and 33 are approximately 85-95% resolved based on infrequent mild headaches and neck pain occurring together, lasting 30-60 minutes per episode and relieved with chiropractic adjustments. These symptoms are likely to occur for at least the next several years as a result of this accident due to incomplete healing of the soft tissues of the neck and head, which leaves this patient with a proclivity towards the occurrence of subluxations.

Diagnosis 28 (left and right hip pain) is approximately 70-80% resolved based on the occurrence of pain in both left and right hips when this patient exerts themselves beyond their now limited capabilities, such as exercise. The patient has been instructed to walk, swim, and perform light weight resistive muscle strengthening and range of motion exercise, but to carefully be aware of and not exceed their physical capabilities.

Diagnoses 32 and 33 are apparently completely resolved since approximately two months after this accident as the patient has not reported any anxiety, depression, or sleep disturbances since that point in time.

Diagnoses 35-37 are longstanding pre-existing conditions which are not likely to ever resolve, and are also likely to predispose this patient to exacerbations of their symptoms. Since this patient is an adult with scoliosis, this condition is not likely to change beyond a significant degree, however they have a radiological scoliosis study performed on them every six months for the next year to assess any decline in this condition as related to their pertinent automobile accident.

Disfigurement -

Disfigurements are injuries such as bruises and scars. They need to be documented with pictures as well as being included in written chart notes. Pictures need to be taken periodically throughout the healing process with the current day's newspaper and its date showing in the picture next to what needs to be photographed. As known to this author, the newspaper with the largest and therefore the most visible date is USA Today. The doctor should have a camera in their office just for this purpose, and these pictures need to be included in their chart notes because they pertain to diagnosis and/or treatment of injuries. A doctor cannot rely on a patient to obtain these pictures.

Example -

As a result of this accident, this patient suffered a 1 1/2" scar from being cut by a piece of glass on her forehead which required 5 months to heal, apparently becoming as good as it will get. There is a remaining visible scar in this location as shown in pictures included in this patient's chart.

Past/Present Care -

Past care is all of the care related to an accident that has already occurred up to the present point in time. Bills should be produced for care already rendered, and their total should be stated. Additionally, the amount of money received from all sources toward the total amount billed should be stated, as should the outstanding balanced owed.

Referrals to other doctors should also be listed but without any dollar amounts, because care by those professionals are also important.

Example -

As a result of this accident, this patient required chiropractic care for approximately five months at a cost of $3,220.00, of which $2,720.00 has been received, leaving a balanced owed of $500.00.

I referred this patient to Dr. XYZ, a neurologist, for consultation and possible treatment for symptoms related to traumatic brain injury. Additionally, I referred her to Dr. RST, an orthopedic surgeon, for consultation and possible treatment for her cervical and lumbar disc injuries. She was also referred to a psychologist due to her fears when driving. The cost for each type of care would be known by those doctors.

Future Care -

Future care is an estimate of the care needed in the future that is necessary and reasonable due to a given accident. The cost of this care is based on the full amounts billed to an accident case without any discounts.

Example -

As a result of this accident, this patient is expected to need approximately 2-4 visits per month in order to keep her symptoms at a pre-injury level, plus approximately 6-10 visits per flare up of her symptoms. The cost of this treatment is $120.00 per visit.

Since this patient is an adult with scoliosis, this condition is not likely to change beyond a significant degree, however standards of care require a radiological scoliosis study be performed every six months to assess any decline in this condition. The cost of this treatment is $200.00 per scoliosis study.

Susceptibility to Reinjury -

Susceptibility to reinjury is a statement explaining why the patient is prone to being injured worse than their present condition if injured in a subsequent accident. This information needs to be provided for conditions that are generally out of the ordinary (although disc injuries could be considered to be somewhat more common than other conditions that occur less commonly).

Susceptibility to reinjury is another area of legal damages recovery, but will not occur unless properly documented by the doctor.

Example -

As a result of this accident, this patient's brain is significantly more susceptible to reinjury than a typical person because they have now suffered traumatic brain injury with lasting symptoms of memory loss, difficulty concentrating, and balance problems. Extensive research has shown that each subsequent traumatic brain injury is worse than those previously incurred, and that the effects of multiple traumatic brain injuries are cumulative and greater than the sum of the individual effects of separate such traumatic injuries.

Additionally, this patient is also significantly more susceptible to reinjury of their already injured C5, C7, and L5 discs as compared to a typical person, which have been shown to be symptomatic because a disc does not ever totally heal once injured, and is prone to worse injury once it is again injured as compared to prior to a given injury, and eventually can reasonably be expected to require surgery when the benefits of surgery outweigh its risks in light of the significant interference with this patient's life.

Explanation for Extended Care -

This section is necessary only when the length of time and/or the amount of the bill for care rendered to a patient is greater than would typically be expected. This section is only expected to be needed on a limited percentage of patients, as most patients typically improve within a reasonable time frame. Of course, care should generally be rendered for the most part if the patient's conditions are improving. A valid explanation may appease a claims adjuster or jury.

Example -

This patient needed considerable more care than a typical patient because she is elderly, previously suffered a previous traumatic brain injury worsened by this accident, has a L5 tropism as shown on plain film radiographs, and had other pre-existing injuries made worse by the present accident.

Certification Statement -

A signed and dated statement such as the one shown in the following example shows a that the doctor stands behind their words, and also conveys a sense of reasonableness on the part of the doctor.

Example -

All procedures performed on this patient and the bills incurred were reasonable and necessary to diagnose and treat injuries sustained directly as a result of the automobile accident that occurred on Aug. 22, 2014, and they were performed by myself or at my direction of my staff.

Sincerely,

/s/

Dr. XYZ Date:

About the Author -

Dr. David H. Hofheimer, D.C., Esq. is committed to the empowerment and service to others by actively and enthusiastically practicing personal injury and trial litigation law, continuing to practice chiropractic after more than 24 years of service and personal injury as an attorney at law for more than 5 years of service, and teaching continuing education relicensing seminars as an attorney to fellow chiropractors. With his major emphasis as an active personal injury and trial litigation attorney, he is at the present time the only active plaintiff personal injury attorney in all of northern California who is concurrently licensed in the state of California as both a doctor of chiropractic and an attorney at law. Dr. Hofheimer has as his purpose as a practicing lawyer the intention to empower the chiropractic profession and to maximize and protect peoples' legal rights, including those of fellow chiropractors and their patients. He has as his purpose as a practicing chiropractor the intention to have patients be well naturally through chiropractic. He makes himself available to all good chiropractors for anything related to chiropractic and law, as he would much rather have doctors of chiropractic prevent problems than have to deal with them. Feel free to contact Dr. Hofheimer at (707)-745-9700.