Patrick Mickelsen, DC, DAAMLP

Patient: Injured Patient Claim #: 0123456789-1

To: A**verage Attorney** 1/**1/2019**
Attorney at Law

RE: Independent review performed by Defense Expert for CorVel Corporation

Patient: Injured Patient

DOI: 11/17/2015

Concerning Injuries and Treatment in the Case of Injured Patient

Dear Mr. Attorney:

I recently received a report from Defense Expert, who works for Corvel Corporation, wherein he expressed opinions which he formulated after conducting a paper review of Ms. Patient's case. Expert advocated denial of payment for our services based on his paper review. He contended that Ms. Patient could not have needed the treatment provided for the following reasons:

1. Ms. Patient's complaints while at the ER were not exactly the same as her complaints to her chiropractic physician.

2. Ms. Patient's ER diagnosis was a strain injury, "which is the least of all soft tissue injuries."

3. Ms. Patient's report to the chiropractor did not match her report to the ER.

4. Ms. Patient's pain was not genuine as proven by normal vital signs.

5. Ms. Patient should have made a full recovery within 4 to 5 weeks after treatment started (8 to 10 visits), and she would not have experienced any residual symptoms after that.

Note:
Initially, it was difficult to wrap our heads around Expert's report, and it took a while to figure out why. We deciphered that, in many instances, Expert's exceptionally-confident opinions were based on inaccurate presumptions. Expert expected the reader to take for granted that his underlying assumptions were factual. His logic unraveled when the underlying assumptions were seen for what they are, erroneous.

Point 1:

Expert's Statement:

Ms. Patient's did not complain of midline neck pain, headache, or back pain while at the ER. She only complained of "mild" pain (5/10) over the sternum and in the left neck radiating toward the shoulder.

Underlying Assumption:

If trauma causes an injury, the symptoms appear immediately and do not change over time. In other words, there can be no delay in onset of symptoms, and pain will not change (e.g., location, intensity, frequency, etc…) over time.

Reality:

Delayed onset of symptoms after a trauma is common. Lateralization and spreading of pain is common. Just because Ms. Patient didn't complain of midline neck pain at the ER, it doesn't mean that the pain wouldn't spread to include the middle and right side of her neck over the next few days. Just because Ms. Patient didn't experience moderate pain in her left extremities on the day of the crash, it doesn't mean that the pain wasn't going to worsen over the next day, week, or even a month.

An additional discrepancy in Expert's statement:

- Expert trivialized Ms. Patient's pain by referring to it as mild even though she rated her neck pain at 5/10 on a pain scale. The numerical breakdown between mild, moderate, and severe is seen below:
    - Mild = 1-3/10
    - Moderate = 4-6/10
    - Severe = 7-9/10
    - Extreme = 10/10

A Note About Trivialization:
Expert habitually minimalized Ms. Patient's symptoms throughout his report. Such a practice is indicative of partiality.

Point 2:
Expert's Statement:

"She was given the diagnosis of cervical strain which is the least of all soft tissue injuries. She was not given any other diagnosis."

Underlying Assumptions:

1- Soft tissue injuries are minor in nature, and a strain is the least of all minor injuries.

2- If the ER doctors did not diagnose it, then the injury didn't exist.

Reality 1:

All tissues in the body—except for bone—are soft tissue. Ripping an arm off at the joint constitutes an entirely soft tissue injury if no bones were broken. The skin, fascia, muscles, vessels, nerves, and ligaments are all soft tissues. One would hardly classify tearing an arm off as minor just because it is a soft tissue injury. Soft tissue injuries range from minor to severe. Ligaments are avascular in nature and do not bruise. (I will address the severity of Ms. Patient's soft tissue injuries later in this report.)

A strain is an injury to a musculotendinous unit resulting from violent contraction or excessive, forcible stretch.[1] These injuries are graded by the amount of damage that occurs to the muscle or tendon. The grading system has been produced below:

1. First Degree: minor tearing of the musculotendinous unit characterized by swelling, local tenderness, and minor loss of function.

2. Second Degree: more fibers are torn than in a first-degree sprain but without complete disruption characterized by swelling, ecchymosis, and a more marked loss of strength.

3. Third Degree: the muscle of tendon is completely disrupted with resultant separation of muscle from muscle, tendon from muscle, or tendon from bone.

Strain injuries are not necessarily minor in nature. Oftentimes, a strain is associated with an avulsion fracture. An Achilles tendon rupture is an example of a third-degree strain, which is hardly, "the least of all soft tissue injuries," as Expert put it.

Reality 2:

It is not the function (or the general practice) of the ER physician to investigate injuries beyond their scope of practice. The preface to *Rosen's Emergency Medicine, 7th edition, Volume 1*, establishes the primary scope of the ER physician to be, "the identification and stabilization of patients threatened with loss of life or limb." The preface of *Avoiding Errors in the Emergency Department* further clarifies the duty of an emergency room physician by stating that, "The great

challenge in emergency medicine is to sort through the morass of benign conditions and properly diagnose and treat the deadly ones."

It is not the ER physician's duty to accurately diagnose all conditions that come through their doors. It is not the ER physician's duty to treat individuals injured in motor vehicle crashes unless they are threatened with the "loss of life or limb," and it is not the ER physician's duty to manage patient care outside of the "identification and stabilization of" conditions that threaten life or limb.

They continually sift through the mass of patients looking for the "deadly" conditions and send the rest of the conditions on their way with little investigation.

Below is a list of conditions (some potentially life threatening and most potentially disabling) that we have diagnosed in patients injured in motor vehicle crashes who were treated at the ER prior to coming to our clinic:

- Compression fracture
- Impaction fracture
- Sternum fracture
- Odontoid fracture
- Sprains (throughout the body)
- Ligamentous instability
- Concussion
- Biceps tendon rupture
- SLAP tears
- Double crush syndrome
- Thoracic outlet syndrome (vascular and neurogenic)
- Disc herniation (with and without radiculopathy)
- Annular tearing
- Facet tearing
- and the list goes on.

It was mendacious for Expert to claim that an ER work-up was complete (outside of an ER physician's scope of practice) or to claim that no further diagnostic intervention was necessary because Ms. Patient had already been evaluated at the ER. We believe that Expert is entirely aware of his guile… especially if the following conditions apply to him:

- he is employed—with any regularity—to review medical records, or
- he has ever treated patients who had been evaluated at the ER prior to presenting to his office for a consultation.

An inquiry should be made.

Point 3:

Expert's Statements:

At the ER, Ms. Patient complained of, "Mild pain over the sternum and mild pain on the left side of the neck and radiating toward the shoulder. She rated this discomfort 5/10 on the 0 to 10 scale." In his next sentence, Expert (surprisingly) admitted that it hurt for the physician to touch her neck, and it hurt for her to move her own neck. Neither of those observations suggest a "mild" injury.

At the chiropractic clinic, "Ms. Patient states that, at the time of the accident, she had symptoms to her left bicep, left anterior elbow, left anterior forearm, and left anterior knee."

"Her chief complains were bilateral neck pain 2-7/10. Right lower back pain rated 2-7/10. Right shoulder pain rated 1-5/10. Bilateral temporal headaches rated 1-7/10."

Inference:

Ms. Patient lied to her chiropractic physician (or the ER) about the symptoms she experienced at the time of the crash. She did not name her complaints at the ER, so they were made up between the time she left the ER and the time she presented to the chiropractic clinic.

Reality:

The *Pain Gate Theory*[2] explains the phenomenon and reason why people only feel one location of pain at a time. In addition, trauma injured people usually feel the most intense pain above all other pains. When a pain is low grade, new, and is not a patient's worst pain, then patients expect it to go away like most minor pains do. They may not mention it if they expect it to go away. It would be unexpected for a patient to discover worsening. Patients do not realize there is a problem until pain forces them to take medication or limits their daily activities.

As pointed out earlier in this report, delayed onset of symptoms is common. There are several phases of inflammation.[3] It takes time (days) for inflammation to maximize. It is common for an individual who has suffered tissue damage because of a crash to feel fine immediately after the crash. It is common for pain to lateralize (move from side to side) and spread to include a larger area than initially experienced as the tissues become increasingly inflamed.

It is common for the pain to worsen with time and not respond to medication, including narcotics, muscle relaxers, or anti-inflammatories. It is more and more common for people to avoid medicating because of the opiate epidemic and other adverse effects of medications.

Expert was excessively critical of Ms. Patient's sincerity. Again, this is an indication of partiality. There is no way Expert could know how she felt when she presented to the chiropractic clinic for treatment . He wasn't the one taking the history or observing how much pain Ms. Patient was in two days after the crash, which brings us to the next point.

Point 4:

Expert's Claim:

Expert declared that he was certain Ms. Patient wasn't in pain when she presented to the chiropractic clinic because her vital signs were normal. [I'm assuming he was referring to her blood pressure and respiratory rate, unless Expert believes height and weight reveal some truth as to how much pain a patient is experiencing.]

Rebut:

How ridiculous. While sympathetic distress may be a relevant observation in patients experiencing severe (or extreme), acute pain, it is not a reliable finding in cases of ongoing or chronic pain. Expert's suggestion is unorthodox. There is no compelling reason to believe that a patient is lying about their pain because their blood pressure and respiratory rate are normal.

As far as he stretched it here, Expert cannot be taken seriously. He is obviously bias.

Point 5:

Expert's Statement:

"In my opinion," Ms. Patient should have completely recovered from her injuries in a month or five weeks with 10 or 12 treatments. He also stated that, with his suggested treatment regimen, there would have been no residual symptoms.

Rebuttal:

Physicians learn the fundamentals of tissue repair in an introductory pathology course. Tissue repair time frames have been reproduced below for your convenience:

1- Acute inflammatory stage occurs during the first 3 days after injury
2- Subacute repair stage occurs between 3 days and 14 weeks (3 ½ months)
3- Remodeling stage occurs from 14 weeks to 12 months or more

It must be acknowledged that a patient's recovery time is based on many factors. Severity of the injury, previous damage to the tissues, age, concurrent health conditions (e.g., diabetes), and other complicating circumstances are a few of the factors that affect recovery. It is a good idea to remember that patients are individuals and recover in their own time. Treatment guidelines should reflect that fact by demonstrating some degree of flexibility (like the above timeline of tissue recovery).

To my knowledge, there has only been one set of whiplash treatment guidelines that have been adopted by national and state chiropractic organizations. They are the Croft Guidelines, and they

have been adopted by the Utah Chiropractic Physician's Association. Ms. Patient's treatment fell within those guidelines.

I challenge Expert to produce academic texts, scientific studies, or peer-reviewed treatment guidelines that support his claim that a middle-aged woman injured in a rollover crash will recover from her injuries in a month or 10 to 12 visits. At a frequency of 3 treatments per week, 10 visits would barely get a patient past the three-week mark.

Expert's suggested healing time frame defies the science of tissue repair times. His rigidity reflects partiality.

This spurs another direct question for Expert: have you ever treated a patient injured in a motor vehicle crash more than 10 visits of 3 weeks? If you haven't, then you rarely get people better. There is absolutely no way that such a treatment regimen could cover the spectrum of injury severity and individualized recovery factors. No way!

Additional Report Discrepancies:

Expert censured every objective finding discovered during the chiropractic physician's initial exam. Expert acknowledged that he didn't have the computer measured data in his possession, but he didn't request the data before drawing his conclusions. We know that it wouldn't have mattered if he did have the measured data, Expert would have criticized it - even though computers don't lie. Expert was so critical that he couldn't concede that maybe, just maybe, we got one thing right, out of so many, during Ms. Patient's first visit. It was all wrong.

Expert stated emphatically that he knew the crash was not a rollover because the police report said the crash was a side impact crash. The photographs clearly demonstrate that Ms. Patient's vehicle came to rest on its roof.

Expert claimed that he knew for certain that Ms. Patient was not transported to the hospital via ambulance because the ER record said she wasn't. The bill for the ambulance transport reflects the cost of the service, and the ambulance report is signed by the responders who provided the service.

The truth is that human beings make mistakes. Records are not always accurate, and there is no possible way that every single event that occurs during a patient encounter can be recorded. The Utah Chiropractic Physician Association concluded, for reasons such as these, that paper reviews are unethical.

In addition, so-called independent and impartial reviewers who work for insurance companies are notorious for ignoring facts and being excessively critical. They do what they do because insurance companies pay good for doctors who are willing to impeach themselves on their behalf.

Expert claimed that the shoulder shrug test was a "more aggressive" test that the shoulder depression test. Passive tests are always less aggressive than active tests.

Expert claimed that trigger points were reported in numerous muscles that are not in any areas of complaint made by the patient. That is not true. Also, Expert should realize that we took the time to record the trigger points in the notes, so it's implied that they were active.

Expert's argument about the term muscle spasm was semantic. You say guarding, I say spasm. Semantic arguments are indicative of excessive criticism.

Expert criticized the use of computerized documentation. Most notes are computer generated these days.

Even More Mind Blowing:

Expert was so self-possessed that he submitted a fee recommendation, apparently with the expectation that it should be adopted. Our fees are based on the 2011 Personal Injury Protection (No Fault) Relative Value Study. Expert has no authority to dictate fees.

Expert offered to examine Ms. Patient to understand her condition from a "forensic perspective." Ms. Patient has recovered from her injuries under our treatment. One must question Expert's logic. Was he expecting to derive what objective findings existed on 11/19/2015 by performing a professional "forensic examination" now?

Conclusions and Summary:

Recommending denial for payment was unjustified. We are convinced that Expert was partisan against Ms. Patient throughout his review. The following summary lists our evidence that Expert conducted an unethical and bias record review:

1- Expert repeatedly trivialized Ms. Patient's pain by referring to it as mild even though her recorded pain levels (at multiple facilities) were in the moderate and severe range.

2- Expert disparaged every objective finding recorded by the treating physician.

3- Expert dismissed established, pain-rating practices in favor of an exceptionally unorthodox method, which we have never seen (or heard of) anyone utilizing.

4- Expert's suggested treatment schedule was inflexible and defied fundamental healing time frames. On this point, we maintain our challenge for Expert to produce an authoritative reference to support his opinion.

5- Expert's tone throughout his entire report was arrogant, excessively critical, and absolute even though he was wrong about basic facts, such as this was a rollover crash and Ms.

Patient was transported by ambulance after the crash.

6- Expert, as a reviewer for insurance companies and their representatives, has a financial interest in denying payment on their behalf. By so doing, he increases the potential for repeat business from affluent clients whose interest it is to withhold payment from people they are legally obligated to cover, such as Ms. Patient. There have been so many of these unscrupulous reviews that the Utah Chiropractic Physician's Association has officially deemed paper record reviews as unethical.

I hereby affirm that, to the best of my knowledge, the information contained in this report is true and accurate.

Regards,

X

Patrick Mickelsen, DC, DAAMLP

Bibliography

1. Marx, J. A. (Ed.). (2010). Rosen's Emergency Medicine (7th ed. Vol 1 p482). Philadelphia, PA: Mosby Elsevier.

2. Guyton, A. C., Hall J. E. (2000). Textbook of Medical Physiology (10th ed. p557). Philadelphia, PA: W.B. Saunders Company.

3. Robbins, S. L. (Ed.). (2003). Basic Pathology (7th ed. pp34-37). Philadelphia, PA: Saunders.

Relevant Research

Current Research About Injuries and Pain Resulting from MVCs:

In a study from the *Euopean Spine Journal*, data is provided that indicates, "Fifty percent of the complaints had begun immediately after the accident, a further 26% within the first 6 h, 9% after 6–12 h, 6% after 12–24 h and 8% after more than 24 h. Complaints starting within the first 24 h revealed no significance in regard to the duration of symptoms [meaning that the prognosis was in line with normal clinical expectations]; however, complaints that began after more than 24 h lasted for twice as long as the rest (see Fig. 7). The difference was highly significant."

This study also found that the average duration for complaints reported immediately following the accident was 334 days, whereas the average duration of complaints reported after 24 hours was 595 days. This is important because it is statistically significant, and it shows that pain developing over 24 hours often becomes chronic. In conclusion, the authors stated, "In the analysis of insurance-independent data, it is the accident mechanism that is relevant from a prognostic point of view, not the accident severity."

Reference:

Richter, M.., Otte, D., Pohlemann, T., Krettek, C., & Blauth, M. (2000). Whiplash-type neck distortion in restrained car drivers: Frequency, causes and long-term results. *European Spine Journal*, *9*(2), 109-117.

Chiropractic v. NSAIDS:

Whiplash victims treated medically are almost always given non-steroidal anti-inflammatory drugs (NSAIDs). All such drugs have significant risks associated with their use. The New

England Journal of Medicine reported in 1999 that if NSAIDs were given their own category they would be the 15th most common cause of death in the US, primarily due to gastrointestinal bleeding. (Wolfe, Lichtenstein, and Singh, 01/07/99). The study reported that conservative estimates have found that approximately 16,500 people die per year from NSAID use. Also, the number does not include over-the-counter NSAIDs that caused fatalities. It is certainly reasonable for patients to minimize the use of these medications and instead choose chiropractic.

Prolonged use of NSAID's and narcotic pain medication have shown to have adverse long-term effects of systems in the body and their burden on society is increasing. The number one providers of spinal manipulative therapy (SMT) are chiropractors. Their training and clinical experience with this technique far exceeds other providers. In regards to musculoskeletal care, chiropractic is a critical component in the United States and will continue to modulate pain, reduce costs, and increase function.

Reference:
Coronado, R. A., Gay, C. W., Bialosky, J. E., Carnaby, G. D., Bishop, M. D., & George, S. Z. (2012). Changes in pain sensitivity following spinal manipulation: A systematic review and meta-analysis. Manuscript in preparation. Retrieved from http://www.sciencedirect.com/science/article/pii/S1050641112000065

Concerning Multiple Complaints Following MVC:

Ms. Patient suffered multiple injuries as a result of the accident. A recent study confirmed this observation on a larger scale.

Hincapié et al (2010), in a research paper submitted to the World Congress on Neck Pain, stated that, "The majority of persons involved in MVCs have neck pain; however, this is but one area of pain localization that most commonly involves multiple areas of the body."

They further described the details of the results by stating, "Pain confined to a single body area was rare. Just 0.4% of respondents (28 of 6481) reported pain that was confined to the posterior neck area alone

Finally, they showed overall, 86.2% of respondents reported posterior neck pain, 75% had posterior shoulder pain, 72% reported head pain, 66% had mid-back pain, and 60% reported lumbar pain.

Reference:
Hincapié, C. A., Cassidy, J. D., Côté, P., Carroll, L. J., & Guzmán, J. (2010). Whiplash injury is more than neck pain: A population-based study of pain localization after traffic injury. Journal of Occupational and Environmental Medicine, 52(4), 434-440.

Concerning Ligamentous Damage to the Cervical Spine and Disability:

In a recent study by Leahy et al (2012) the authors stated "*it was found that the ligaments sustain significant initial toe length distension after whiplash-type injuries. The laxity of these injured ligaments provided negligible support to the spine, resulting in nearly-identical kinematic responses to spines with no ligamentous support*. Accordingly, victims of severe ligamentous hyper strain appear to require the same degree of clinical stabilization as patients presenting fully-torn ligaments" This is why patient care may be prolonged and more intense than in cases without ligamentous injury.

Leahy, P. D., & Puttlitz, C. M. (2012). The effects of ligamentous injury in the human lower cervical spine. *Journal of Biomechanics*, *45*(15), 2668-2672.

When whiplash injuries occur, there is a possibility that these injuries do not resolve quickly and that the patient continues to be disabled. In the referenced study in 2009 the authors reported "Research has shown that up to 40% of neck complaints may become chronic and persist for at least a year"

Buitenhuis, J., de Jong, P. J., Jaspers, J. P. C., & Groothoff, J. W. (2009). Work disability after whiplash, A prospective cohort study. Spine, 34(3), 262-267.

Expert states the notes are computerized in a prewritten format. The majority of health records are computerized this was established and required by the federal government to standardize patient care and have health records in an easy to read and understandable format for not only other medical professionals, but the lay person as well.