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Saskatchewan's Joint Chiropractic Professional Review Committee

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Saskatchewan's Joint Chiropractic Professional Review Committee functions to ensure that clinically necessary services are provided to patients. The committee which has both government (payer) and professional representation is created by the Medical Care Insurance Act *in Saskatchewan. Examples of committee concerns include frequent visits by individual patients, high number of patients treated per day, poor record keeping, high service per discrete patient value. The article concludes with some suggestions for how to determine if a practitioner's pattern of practice is unusual and how to respond if contacted by the committee. The strengths of this form of review process include: the committee has a majority of chiropractors, patterns of practice are compared to that of peers, evaluation of patterns of practice uses random sampling of files to be analysed, and guidelines for practice are set by peers using a consensus process.*
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KEY WORDS: Joint Chiropractic Professional Review Committee, peer review, services per discrete patient.

Le comité mixte d'étude des professionnels de la chiropraxie de la Saskatchewan est mandaté en vue de s'assurer que les patients reçoivent les services nécessaires sur le plan clinique. Le comité, auquel siège à la fois le gouvernement (payeur) et les représentants de la profession, a été créé par la loi sur l'assurance-maladie de la Saskatchewan. Les préoccupations du comité sont diverses et incluent : les visites fréquentes de certains patients, le nombre élevé de patients soignés par jour, la mauvaise tenue des dossiers, et les soins répétitifs sans résultats significatifs. En conclusion, l'article propose des suggestions sur la façon de déterminer si la conduite professionnelle d'un praticien est inhabituelle et sur la manière de répondre lorsqu'on est contacté par le comité. La crédibilité de ce processus d'évaluation tient au fait que : la majorité des membres du comité sont des chiropraticiens, la conduite professionnelle est comparée à celle des pairs, l'évaluation de la conduite professionnelle repose sur l'analyse d'un échantillon de dossiers choisis au hasard, les règles de déontologie sont fixées par les pairs et adoptées au consensus.
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MOTS-CLES : Comité mixte d'étude des professionnels de la chiropraxie, révision des pairs, soins répétitifs sans résultats significatifs.

Introduction

In this era of third party payers, the practice patterns of health care practitioners have come under scrutiny. To many practitioners, critical analysis of how their patients are managed is unknown or certainly unwelcome. They are simply concerned with the results that they see in their day to day practice. They do not see any place for someone else telling them how to treat their patients.

Evans[1] argues that doctors can control their income to a great degree by deciding just how busy they wish to be. In a fee for service practice, the greater the number of patient visits, the more income is earned. Several studies have traced a direct relationship between the rise in physician population in an area and the cost of health care in that area.[2] The question arises, how much of the patient visitation is clinically necessary? To this end, several committees of the Saskatchewan Department of Health have been established to ensure that the insured services are provided in a cost effective manner. This paper will discuss the Joint Chiropractic Professional Review Committee which is charged with reviewing the practice patterns of Saskatchewan chiropractors.

Patients make the initial decision to consult their doctor for two types of care, for treatment of sickness or injury and for

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preventative maintenance. Once they have seen their doctor, the frequency of visits is determined to a great degree by the health care practitioner. With some variation, patients will follow advice regarding attendance as long as they are in some discomfort or the malady under care is of a serious nature.

The frequency of attendance by patients will vary depending on the type of sickness or injury which caused the patient to seek care. In addition, even for a specific diagnosis, there will be a range of severity of the condition, resulting in variation of treatment attendance. Thus, individual practitioners will have a practice consisting of a "Case Mix" of diagnoses and severity of the conditions. Patient attendance varies depending on several other factors including:

1. Cultural variation of patients;
2. Socio-economic class of the patient;
3. Distance from available health care;
4. Availability of health care personnel; and
5. The method and style of practice of the treating physician.

It is this last factor which the joint review committees are designed to attempt to evaluate.

The Medical Care Insurance Branch (MCIB) is mandated to pay for treatment of individual patients, not salaries for doctors (with some exceptions). Thus, if a duly licensed physician provides a service to a patient, the MCIB must pay for that service.

Composition of the review committees

The Professional Review Committees[3] are created in the legislation governing health in Saskatchewan, the *Medical Care Insurance Act*. They are designed to have a majority of members appointed by each respective profession. Each committee elects a chairman from among its members. The Department of Health provides secretarial assistance and the support of the Director of Professional Review and his Assistant.

The Joint Chiropractic Professional Review Committee (JCPRC) consists of five members which include three (3) members appointed by the Board of the Chiropractors' Association of Saskatchewan and two (2) members appointed by the Minister of Health.

The Joint Optometric Professional Review Committee (JOPRC) has the same structure as the JCPRC. The Joint Medical Professional Review Committee consists of six members, two members are appointed by each of the Council of the College of Physicians and Surgeons, the Board of the Saskatchewan Medical Association and two by the Minister of Health.

Protocol for the review committees

The mandate of the Professional Review Committees is to ensure that the care provided to patients is clinically necessary. Each time a claim is paid, data about the patient and practitioner is entered into the main data base of the Medical Care Insurance Branch. By looking at interpretations of this data, the review committees can begin to isolate individual patients or practices or clinics who deviate significantly from what is the experience for others in their same situation.

For instance, the number of initial assessments per thousand patients in a rural practice may be compared to the average of all rural practitioners.

The Joint Chiropractic Professional Review Committee (JCPRC) has looked at both high cost of care and low cost of care and at practitioners whose numbers are at first glance not unusual. MCIB utilizes a series of audit procedures which turn up unusual situations. For instance, patients are regularly randomly selected to be asked if they attended an office on a certain date. If this or other audit procedures turn up something unusual, further checking may result in a referral to the committee. It should be noted that the Review Committee does not have access to patient names. Patients are identified only by their health care number. Thus, confidentiality of patients is ensured.

Development of guidelines for reasonable standards of care

In 1985, the Chiropractors' Association of Saskatchewan initiated a process which culminated in a consensus meeting attended by more than half of the Saskatchewan chiropractors. This consensus meeting established guidelines about what the "reasonable practitioner" would do. For instance, an agreement was reached about how many patients could be adequately treated per hour. This is based upon the facilities and the number of staff in the chiropractor's office. Discussion resulted in a consensus on what an adequate record should contain. Discussed was the need for referral of non responding cases. These guidelines form the framework for analysis by the review committee. Thus, although there are only three or four chiropractors and a staff person from MCIB at the table at a JCPRC meeting, the basis of the evaluation of files represents the collective opinion of the Saskatchewan Association, applied to the particular situation under review.

The review process

1 Unusual Billing Patterns are referred to the Professional Review Committee by the Director of Professional Review

An unusual billing pattern is referred to the committee by the Director of Professional Review. Note that it is the director who selects unusual billing patterns and refers them to the committee.

2 Written Request for Information

A letter is written to the practitioner to request information about the particular instances. If the practitioner responds and the explanation is found acceptable, no further action is taken.

3 Further Clarification May Be Requested

If the response is not acceptable, the practitioner may be asked to clarify further by letter. At a certain point, it becomes obvious that further written communication will not clarify the

concerns. The practitioner is then requested to come before the review committee for an interview.

4 The Formal Review Hearing

The interview consists generally of questions regarding the practice of the individual practitioner. Often the practitioner is asked to bring a random selection of patient files. This procedure helps to ensure that an unbiased sample of how the practitioner practices is considered.

5 Committee Decision Process

If, in the opinion of the committee, the practice pattern of the practitioner is justified by the case mix of his patient population, the committee thanks the practitioner for his or her time and the matter is ended. Often the committee may have some constructive criticisms about the practitioner's practice and suggestions are made at this time. The general concerns of the committee are given verbally and a written decision is always sent to the practitioner.

If, in the opinion of the committee, the practice pattern of the practitioner can not be justified by the case mix of his patient population, the committee can order a reassessment of the moneys paid to the practitioner for services rendered on individual patients. For instance, in the case of excessive services for a particular group of patients, the committee may decide that instead of 100 cents on the dollar, perhaps 80% of payment for visit services is more appropriate. If the practitioner's behaviour is significantly inappropriate, the committee has the option to fine the practitioner an amount up to $50,000 in addition to the reassessment.

6 Right of Appeal

A practitioner has the right of appeal through the court system. The Court of Queen's Bench looks at the appeal based on standards of due process. The court asks the following question: Was the individual practitioner treated fairly and given all the opportunities afforded to him or her by the legislation? The court does not look at the material examined in the review process except if it reflects on how the practitioner was treated.

Issues Considered by the JCPRC

1. Individual patients treated frequently in a year;
2. High services per discrete patient values;
3. High volume of visit services on an individual day.

1 Individual patients treated frequently in a year

Patients seen very frequently in a year are often reviewed. A calendar of dates of treatment is often provided to show the actual dates in a rather graphic fashion. Typically, the committee is concerned about a calendar that shows visits on Monday, Wednesday and Friday for a whole year without any variation except for holiday Mondays or a two week period in July when a practitioner was out of town. A letter is written to the practitioner or practitioners who treated the patient to inquire about their management of these patients.

2 High services per discrete patient value for the individual and for the office.

The average annual service per discrete patient values for chiropractic patients are listed in Table 1[4]. In the last ten years the value has ranged from 6.18 to 7.10 services.

TABLE 1
Average Services Per Discrete Patient By Year

Fiscal Year	Average Service per Discrete Patient
1984–85	6.18
1985–86	6.77
1986–87	6.89
1987–88	6.70
1988–89	6.89
1989–90	7.10
1990–91	7.02
1991–92	6.89
1992–93	6.33
1993–94	6.18

Some definitions are in order.

Discrete Patient:

– Refers to the number of individual patients on whose behalf a payment was made by MCIB. in the course of the quarter or year. If this patient sees another chiropractor, this patient is counted twice.

Visit service:

– Refers to an attendance at a doctor's office.

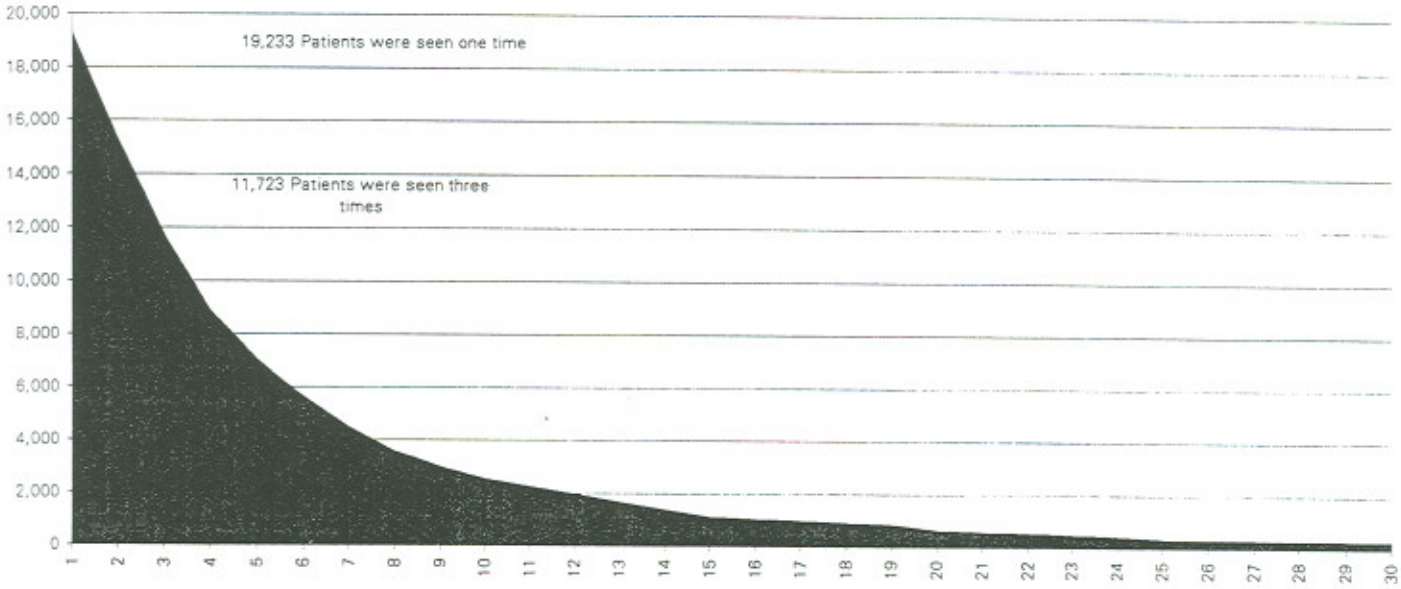
$$\textbf{Services per discrete patient} = \frac{\text{total visit services per year}}{\text{total discrete patients per year}}$$

For example, if the practitioner had 1000 visit services and saw 100 patients, the services per discrete patient value would be 10.

Why is the services per discrete patient value so low?

Chiropractic patients, in particular, often need to be seen for a series of treatments. It may not be uncommon for a patient suffering from an episode of acute back pain to be treated as often as 15–20 times over a period of 3–4 months. How then, ask chiropractors can the average annual services per discrete patient be only 6.2 visits? The answer lies in the large number

FIGURE 1
Patient Visits at Chiropractic Offices 1993–94
Number of Patients vs Number of Times Attending Chiropractic Office



of patients who are seen only a few times. In order to understand why the value is so low, one must understand how Saskatchewan patients visit health care practitioners' offices.

Figure 1 describes the attendance at chiropractic offices by Saskatchewan patients for the fiscal year 1993/94.[5] Of the 100,716 people who saw a chiropractor, 19,233 people saw a chiropractor one time, 15,272 people saw a chiropractor two times, 11,723 people were seen three times and so on. The frequency of attendance diminishes rapidly. Over half (54.8%) were seen four or less times. 80.7% of the patients were seen ten or less times.

The services per discrete patient value is simply an average. Most practices have patients who were seen thirty or fifty times in a year, but the fact remains that most patients were seen one to four times. Since most patients are seen only a few times, the average services per discrete patient value is a smaller number, weighted by the preponderance of patients who were seen infrequently.

Office services per discrete patient:
This is the total patient visits in an office divided by the number of different patients seen in the office. This provides a more accurate reflection of how patients are managed within offices.

Consider the case of Office A and Office B. There are three chiropractors in each office.

Office A – Chiropractor A1 has 10,000 services, 1,000 discrete patients, therefore services per discrete patient equals 10. Chiropractor A2 has 15,000 services, 1,500 discrete patients, therefore services per discrete patient equals 10. Chiropractor A3 has 12,000 services, 1,200 discrete patients, therefore services per discrete patient equals 10.

Office B – Chiropractor B1 has 10,000 services, 1,500 discrete patients, therefore services per discrete patient equals 6.67. Chiropractor B2 has 15,000 services, 2,000 discrete patients, therefore services per discrete patient equals 7.5. Chiropractor B3 has 12,000 services, 2,000 discrete patients, therefore services per discrete patient equals 6.

Office A – Office services per discrete patient
In Office A, 37,000 treatment services were given to 3,500 discrete patients, therefore office services per discrete patient equals 10.57. So in Office A, there was some crossover of patients. 3,500 different people were seen in Office A. If you add up the discrete patients seen by the three chiropractors you will see a total of 3,700 discrete patients. This means that 200 discrete patients were seen by more than one chiropractor. (Well, actually it means that at least 100 patients saw 2 chiropractors in the office.)

You would expect to see some crossover of patients. Patients decide that they like one of the other doctors better, or perhaps

the office hours of another doctor in the office are more suitable for the patient. Also, the doctors cover for each other during holidays.

Office B – Office services per discrete patient
In Office B, 37,000 treatment services were given to 2,100 discrete patients, therefore office services per discrete patient equals 17.62. Here, if you total the discrete patients seen by individual chiropractors in Office B, you will find a total of 5,500 discrete patients. But actually only 2,100 different people were seen in the office in the year.
It would appear that there is some management of office discrete patients in Office B. Certainly, this would warrant further investigation.

3 High volume of services seen on individual days
The following calendar shows the number of patients seen on individual days in a month.

Monday	Tuesday	Wednesday	Thursday	Friday
1 112	2 125	3 95	4 115	5 43
8 124	9 122	10 98	11 133	12 38
15 132	16 115	17 135	18 118	19 42
22 112	23 99	24 97	25 110	26 39
29 113	30 103			

It appears that this practitioner only works a half day on Fridays.

To put the number of patients seen in a day into perspective, when one hundred patients are seen in a seven hour day, the average treatment time per patient is 4.2 minutes. If a six hour day is worked, the treatment time per patient is 3.6 minutes. This does not include time walking between rooms or any breaks, telephone calls, etc. simply time spent with patients. If 120 patients are seen in a day and a six-hour day is worked, every patient is seen 3 minutes or less.

The review process time frame
Any orders made by the Review Committees are restricted to a period of not more than 19 consecutive months beginning not earlier than 25 months prior to the day that written notice is served. Once an individual is served notice that the committee is considering their file, the clock stops. Prior to some legislative changes, by using some delaying methods such as requesting court interpretations, practitioners were able to let the clock tick by and, effectively, remove consideration of activities from the past.

The interview process
The interview is a formal process governed by the rules outlined in regulations for *The Saskatchewan Medical Care Insurance Act*. The practitioner may come alone or may be assisted by a friend or counsel. A court reporter is in attendance. A stratified random sample of patient files is requested prior to the interview. Practitioners are asked to bring the actual patient files to the interview. The patient files are examined one by one. These files provide a good cross-section of how the practitioner manages his practice.

Some definitions are in order again:
Stratified Random Sample: a method of sampling which mirrors the variations in the population to be reviewed.

For instance, suppose that in the practice under review, sixty percent (60%) of the patients were seen less than 10 times. The selection process will provide a random selection resulting in sixty percent of the sample coming from those patients in the practice seen less than 10 times. So if 50 files were to be analysed, 30 would come from this group and the other 20 would come from those patients seen ten or more times. The practitioner is asked to explain what is so different about his or her practice that the practice requires such a high services per discrete patient figure when compared with his peers.
Case Mix: any practice contains a range of diagnoses of varying severity. The committee would expect to see some variation in how patients are managed depending on the particular diagnosis and the severity of the particular problem.
Initial Visit: includes a record of the presenting complaint, history of the complaint, any other health history, record of examination done with positive and negative findings, treatment if any and a plan of management.
Subsequent Visit: includes a record of any subjective changes, relevant health history, treatment and management. Payment for a visit service assumes that not only have the appropriate examinations been performed, and the appropriate treatment performed but also that an adequate record has been kept.

Keeping adequate records is crucial to your practice
It is difficult to defend an individual being reviewed if their records are inadequate. It is disheartening to be faced with unintelligible or missing records. A list of dates of treatment with a diagnostic code does not constitute an adequate record. Does the file contain demographic information about the patient? Is a plan of management and a diagnosis recorded? What was the patient's status at the time of each visit? Was the area of treatment recorded? Is there correspondence indicating interaction with other health care practitioners? The Canadian Chiropractic Association's *Clinical Guidelines for Chiropractic in Canada* very clearly outlines chiropractors' responsibilities for record keeping.[6]

Manage your patients not your practice
Every patient deserves an individual plan of management. The committee becomes concerned when it becomes apparent that

all patients entering a particular office are subjected to the same regimen of treatment regardless of the patient's individual problem.

What should you do if you are contacted by the review committee?

First, do not panic. Do not take the letter as a personal affront. The committee is simply asking straightforward questions. They are asking you to explain why your practice pattern differs significantly from your peers.

Take the time to critically analyse your practice. Actually do a random selection of your patient files to see what you can find. A simple random selection method is to pull every tenth file from your active files and then look at these files. Is there something difficult about many of the files? Do many of the patients have chronic health problems? Have other health care professionals seen many of the patients? Are many of your patients unresponsive to other forms of care? Have you tried to vary the time between visits? Do all of the patients have the same prescription of treatment regardless of diagnosis?

MCIB produces a quarterly and annual profile of practice document providing comparison to the mean of all your peers. If your practice profile is quite different, you need to consider why.

If your analysis of your files reveals that your case mix is indeed a difficult one, then simply summarize your findings in your reply to the committee. If your analysis does not reveal any unusual cases, it is time to rethink how you manage your patients. It is unlikely that your peers are marching out of step with you. Your treatment is supposed to improve the health status of your patients. Improving the health status of your bank account is an unacceptable rationale for treatment.

Conclusion

This paper has provided an overview of the analysis used by the Joint Chiropractic Professional Review Committee. Although individual state or provincial circumstances may vary slightly, the Saskatchewan model provides an excellent model for reviewing the patterns of practice of health care providers.

Patients are entitled to receive the care that they need, care that is clinically necessary. Patient care involves time spent to teach, counsel or examine in addition to the actual treatment. Practitioners are encouraged to consider their practice statistics carefully. Every practice has some more difficult cases and some less complicated patients. It must be emphasized that the committee simply compares the doctors under review to their peers. Practitioners whose statistics differ significantly from the practice patterns of their peers should carefully consider the management of their patients. The question must be asked. What is so different about my practice that my statistics are so different from my peers?

If a physician's case mix contains a preponderance of patients with complicated problems, the practitioner should have a higher than average cost per discrete patient value. The files should indicate the multivariate management of the patients. If the circumstances require, appropriate referral should be indicated by the correspondence in the file.

A request for information from the committee does not automatically result in a reassessment (recovery of money). Several practitioners have been able to clearly identify why their practice pattern is different from their peers and the committee has thanked them for their time and sent them on their way. Many practitioners are simply contacted by letter and the matter is ended with correspondence. Only a few interviews result after correspondence by letter and only some interviews result in a recovery of money paid out by MCIB.

This Joint Professional Review Model has several strengths. First, the model is a joint committee with representation from the insurer but with a majority from the profession. Second, evaluation is done by peers with input from the public and the insurer. The guidelines for analysis are set by peers in conjunction with expert opinion. Third, adherence to the use of random selection of files to be reviewed, provides a fair and unbiased analysis of patterns of practice. Finally and most importantly, comparisons of patterns of practice are to that which is provided by the peers of the health care provider under review.

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