

Commentary

Costs of Future Medical Care in the United States: The Unique Contribution of the Physiatrist

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Commentary

In 2018 the United States (US) healthcare costs exceeded \$3.65 trillion. This figure is expected to increase by more than 5% annually due, in large part, to increases in health care services and pharmaceutical. Both of these inverse costs are associated with incidence and prevalence of chronic diseases. The Centre for Medicare and Medicaid Services estimates that the US spent more than \$10,739 per person on healthcare in 2017 [1]. This alarming figure is two to three times higher than what is spent in most developed countries including Sweden, France and the United Kingdom. Despite these astronomic costs, in comparison to other developed countries, the US has experienced steadily increasing morbidity, declining health outcomes and comparatively lower life expectancies [2-4]. In addition, disease processes often seen in rehabilitation practices, notably Musculoskeletal, neurologic and transport-related injuries, are associated with increased spending in keeping with the 5% annual average increase, with the second largest increase in annual spending due to low back and neck pain, conditions commonly involved in personal injury litigation [5].

When a patient sustains an injury resulting in a personal injury claim, it is critical to ensure that accurate and effective evidence and testimony is provided in court, in order to secure that claim and provide for the patient's optimal future needs and potential recovery. The standards for assessment and diagnostic formulation in medicolegal work must meet current consensus practice or Daubert standards [6,7]. In our recent peer journal, it was asserted that physiatrists are the most qualified physicians to render competent opinions as part of a Comprehensive Rehabilitation Evaluation (CRE) [8]. By definition, a CRE is a forensic medical report that uses knowledge, training, clinical practice experience, and peer reviewed literature to define impairment, disability, costs of future medical care and life expectancy [8].

In this article, we expand the conclusions, outline the methodology and elements of an effective CRE. We also address the unique contributions of physiatrists in estimating, and possibly curtailing, the escalating costs of healthcare in the US.

The heart of personal injury litigation rests with assessment of catastrophic and non-catastrophic disabling impairments, which physiatrists are most qualified to complete [9,10]. Physiatrists have specific education and training that uniquely qualifies them to provide thorough and accurate CREs [11]. Physiatrists must, out of necessity,

have an extensive working knowledge of the CRE; which includes a Continuation of Care Plan (CCP). The accumulation of data needs to support the retail costs of the patient's future medical care and continuation of treatment.

According to Gonzales and Zotovas (185-186), the accepted methodology to define the cost for future medical care includes three stages:

(1) Collecting and reviewing medical records as well as interviewing and/or physically examining subjects. In this stage, the physiatrist considers evidence (including medical record data and diagnostic studies, plus the physician's own clinical examination findings) and the subsequent impact on the subject's current and future health function;

(2) Formulating life expectancy and diagnostic conclusions; developing opinions regarding and impairment, disability, comorbidities; and providing evidence-based recommendations for future medical needs. Examples of future care categories include physicians' services, diagnostic tests, medications, rehabilitation services, durable medical equipment and supplies, nursing and attendant care, environmental modifications, household services and acute care services; and

(3) Conducting extensive treating physician and vendor surveys to obtain retail cost data for future care recommendations, and using that data to perform cost calculations in order to draw quantitative conclusions. Utilizing sample data from sources that are geographically near to the subject's primary residence or location of care and the lowest procured estimates are most beneficial [11].

The costs associated with the patient's medical treatment procedures, support care and durable medical products should be unreduced retail costs. This is in keeping with a long-standing evidentiary rule known as the collateral source rule, which prevents an injured person's damages from being reduced by payments from their own medical insurance, workman's compensation, or other third-party sources. The collateral source rule further prohibits the admission of evidence that the plaintiff/patient has received compensation from some source other than the damages sought from the defendant in a personal injury case. While several states have altered or partially abrogated the rule by statute, it is still a widely-followed federal doctrine [12].

Additionally, collateral sources such as Medicare, Medicaid, marketplace insurance offered under the Affordable Care Act, and managed care insurance company plans often do not cover services or reimburse at the rate whereby a physician's services, support care, and durable medical products can be obtained. The healthcare insurance system and government entitlement programs are subject to political influences and change related to the current political landscape. Thus, the only way to guarantee that a patient will have sufficient funding to obtain quality healthcare for optimized recovery is to assume that each patient will be required to obtain care at retail rates. Insurance coverage for certain treatment may or may not become available, but cannot be relied upon when forecasting the funds needed to obtain care.

Contacting individual physicians, support care, and durable medical providers directly and utilizing retail prices in the patient's home territory will greater guarantee the availability of funds to obtain support services and durable medical products. This is of paramount importance for a patient who has suffered a catastrophic or noncatastrophic injury, as medical care in the United States is more expensive than in any other developed country in the world, yet continues to rank extremely low in terms of access and service delivery [13]. In many instances, it is only through appropriate legal channels that healthcare, support services and durable medical products can be obtained. Creation of a reliable and valid CCP includes contacting as many treating physicians and vendors as possible to confirm procedures, protocols and pricing in the geographic location in which the patient resides or is going to reside for continued treatment.

As noted previously, the spirit and intent of the CCP is to decrease the patient's morbidity by decreasing his/her pain to the fullest extent practicable and to mitigate against increased pain as the patient progresses through the aging process. Chronic pain (to which patients usually become less tolerant over time), often leads too much greater disability [8]. The CCP addresses the three components of chronic pain, including the specific physical component, increased suffering over time, and the subsequent depression that frequently arises. A physiatrist's clinical experience provides the skills to craft a CCP which addresses all three components.

It should be noted that non-physiatrist treating physicians may be unfamiliar with the appropriate methodology to construct a CCP or to credibly defend it in court [6,10,11]. This can be devastating to the patient because the relevant information which affects the formulation of appropriate diagnostic and rehabilitation conclusions constitutes the proper foundation for future medical care and rehabilitation needs [11]. In contrast, physiatrists are taught during residency training a comprehensive approach to the assessment of medical and rehabilitation needs. Thus, physiatrists receive the best training to determine what medical conditions remain relevant to the patient's future care considerations [8,11].

According to Gunn (in Weed and Debra, 2010, 793-797), "It is the role of the physician to establish the existence of physical and mental impairment and it is inappropriate for a rehabilitation consultant to present opinion testimony as the existence of a medical condition or its likely progression." [14] The medical management of catastrophically and non-catastrophically injured patients must be the responsibility of the treating physician or disability evaluating physician. A non-physician life care planner is actually providing a disservice if he or she attempts to medically manage a patient's injury or disability, due to their lack of formal, structured medical education and real-world practice experience [10,11,14].

Physiatrists who treat patients and serve as expert witnesses possess extensive working knowledge of peer-reviewed published literature; they are able to apply accepted methodology to accurately complete the CRE. Further, they have extensive clinical experience in the chronic care of persons with a variety of disabilities, and are consequently able to accurately identify all of the patient's future needs [10]. Physiatrists already provide the services on a routine or frequent basis when taking care of their own patient population with equivalent diagnoses. As previously affirmed, a physiatrist's capacity to independently and credibly defend medical opinions, used as evidence in personal injury trials, is unsurpassed [11].

Physiatrists consider individual needs and the cost of providing services which have reasonable probability of restoring patient function, but must defer to a medical economist to provide sufficient scientific data to support a specific dollar loss [9]. After the physiatrist produces the CRE utilizing the appropriate methodology, it should then be presented to a qualified medical economist who is familiar with medical inflation and discount rates [8,9,15]. An economist has the education, experience and skills to translate those future medical care needs into present money value dollars, in order to determine the ultimate present value dollars needed to fund the costs requires by the patient. Failure to follow this prescribed methodology can lead to misleading testimony, resulting in underfunding requirements desperately needed by catastrophically and non-catastrophically injured patients, or worse, disqualification of the physiatrist as an expert by the court, for failing to satisfy the minimum qualifications identified in Daubert challenge for scientific expertise [7].

Conclusion

In summary, physiatrists are eminently qualified to identify and quantify a patient's rehabilitation needs following catastrophic and non-catastrophic injuries. It is also the natural domain of physiatry to complete a Comprehensive Rehabilitation Evaluation with a Continuation of Care Plan in support of the patient's rehabilitation needs, using appropriate methodologies under current consensus practice standards, and to credibly defend this evidence in a court of law. The most accepted methodology requires gathering and analysing objective medical data; formulating life expectancy and diagnostic conclusions and opinions - regarding impairment and disabilities; and presenting recommendations for future medical needs, with due consideration of the components of chronic pain. This is followed by directly contacting treating physicians, support care, and durable medical providers to research follow-up care and pharmaceutical costs and obtain geographically based, unreduced retail cost data for future' care recommendations, with quantitative conclusions supported by a qualified medical economist. These services are vital to patients in order to decrease their pain and maximize their function. With exploding healthcare costs and shifting political climates that may affect patient access to insurance and limit litigation remedies, it is incumbent upon physiatrists to create accurate and reliable CREs and testify on behalf of injured patients, thus fulfilling this role for which they are uniquely suited.

Disclosures

Dr. Lichtblau, Dr. Pettingill, Ms. Cardillo, Ms. Meli, and Mr. Warburton reported no disclosures.

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