

V. Mercantile considerations for postural optimization.

There are ample numbers of patients who stand to benefit from this procedure. Back pain is second only to the common cold as a reason Americans visit their doctors.¹⁰⁸ The lifetime prevalence of low back pain is approximately 80 %. Thirty-one million Americans have low back pain at any given time. The financial consequences of back pain are estimated to cost American society \$40 billion dollars per annum for costs of treatment and loss in productivity.

With respect to business, our present difficulty is not a shortage of patient need for service. To date, no profession for health care has presented to the public a reliable, safe, and effective method for the enduring relief of common, chronic pain of the low back alone, much less for chronic pain for the greater portion of the N.M.S. P.O.P. is a uniquely effective, affordable, and safe treatment for the same.

Now that we have such a model and method, how are we to deliver this service to the public at a price that is satisfactory for both the patient and the operator? There exist several substantial difficulties that are necessary to overcome in order to succeed.

Adoption of this practice will be regulated by the advantage and constraint inherent in the

1. increased conceptual breadth of a 3-D model over the 2-D models already in place;
2. increased therapeutic efficacy; and
3. decreased costs and risks from care, medication, surgery, and diminished productivity.

These imports bear on the future of society politically, professionally, and economically.

The politics of health care has had a turbulent decade of rising health costs, rising litigation, and intrusion of third-party risk-sharers into the management of medical care. The momentum of these unwelcomed changes is based largely on the increased and indefinitely increasing cost of health care.

¹⁰⁸ Robertson JT The rape of the spine. *Surg Neurol* 1993;39:5-12.

A substantial portion of this cost can be attributed to treatment of the effects of sub-optimal posture. These services can include physician attention, antiinflammatory medication, analgesics, physical therapy, proliferative therapy of lax ligaments, manual manipulation of somatic dysfunction, surgery for degenerating joints, and acupuncture. **Accepted treatments and therapies, where used in concert with postural optimization, can be expected to have a far greater and more enduring clinical outcome.**

Effective implementation. of this 3-D model for postural optimization has cost advantage from which adaptive change at many levels of health care can follow. The existing and rising cost of health care can be substantially reduced, with a proportionate reduction of the participation of third-party risk sharers in medical management, thus further subtracting from the net cost of care. The health care system stands to gain increased stability and economy. With less therapeutic intervention, always with the factors of risk and cost, fewer complications and therapeutic misadventures occur, with a significant reduction in related litigation.

Implementation of this procedure can have two strong and countering effects on office finance. One effect is with respect to established patients, and the other is with respect to new patients. For the established patient, there follows a marked reduction in episodic and maintenance care with respect to the N.M.S. **This reduction in services can translate early on to a reduction in clinic income. This reduction is countered by the attraction of new patients from the large and presently underserved population with sub-acute or chronic pain of the N.M.S.**

To maintain financial stability through the adoptive and adaptive period, one can limit the number of patients undergoing this procedure to perhaps 10% of those presently eligible. As these patients are released from this care, one can encourage them to refer others with such pain. Common pain is commonly encountered by the layman, who can be a valuable source of referral of new patients to replace those satisfied with their own reduced need for service.

This procedure is rather time and operator intensive, extending for 2 and 1/2 months of biweekly visits for an average cost of US\$1,800. The initial evaluation and treatment is one hour, for which a representative charge is \$250. This charge includes the taking of the history, physical examination, interpretation of radiographs, manual manipulation of 5-6 regions, and a prescription of the heel lift and/or foot orthotics, and occasionally a dental referral for the evaluation of craniomandibular occlusion.

An early effect of the first visit is a noticeably improved stability and comfort. This improved stability is evidenced by the paucity of unscheduled presentations in extreme pain. Such presentations can disrupt the office flow and the timely meeting of appointments. Patients value the routine progression and promptness of meeting the appointed time that this procedure permits. Time is money, and time spent in the waiting room is a substantive cost of care.

The average time for each treatment is 30 minutes, for a charge of \$140. This charge breaks into charges for an extended office visit, manual manipulation of 5-6 regions of the body, and incidental supplies (heel lifts).

After the conclusion of this course, the typical patient is released from ongoing care and is seen only occasionally, if at all, for episodic care. Perhaps 5-10 % require maintenance care.

The operator can enjoy a marked increase in patient and professional satisfaction, while maintaining or improving the office productivity. Patient reliance on medication is progressively reduced, with less time spent writing prescriptions and monitoring medication usage.

This brings us to the topic of the share of the medical dollar by third-party groups. Remember that the role of such parties is that of a risk sharer to reimburse their client for a portion of their medical cost and thus limit the risk of expensive and prolonged treatment. Where the risk is minimal, the value is good and affordable, there is little need for participation of a third party as a risk sharer. Those dollars can remain with the patient and the physician, with a net reduction of the added cost of health care from insurance premiums.

Commonly, third-party payers provide low or no reimbursement for the customary fee charged for a set of orthotics that ranges from US\$200 to \$350. This disregard extends from the argument by these parties that

1. treatment of pain and deformity that is not a threat to mortality is less a medical necessity, and
2. the uncertain efficacy of foot orthotics relative to the cost is not supportable.

There is a fundamental flaw with the use of the phrase 'medical necessity' as a criteria for reimbursement by third-party payers. One cannot reasonably assess

what is medically necessary without also knowing what is the standard for the contemplated treatment. In other words, one can say that treatment X is medically necessary in order to

1. save life or limb (minimal standard);
2. reduce disease, dysfunction and/or pain to an extent that is sufficient to permit return to the activities of daily living (standard of sufficiency); or
3. restore function and comfort (standard of optimal).

By this incompleteness of the phrase, "medically necessary", one party can arbitrarily presuppose any one of these three standards without there necessarily being agreement on this standard among the concerned parties. A system of medical care that is regulated by the arbitrary standard of 'medical necessity' is often penalized for practice in accord with the traditional standard of optimal care; where the insurers can prefer--and enforce by denying payment--a lesser standard than that of optimal. Examples abound in the contemporary constraint of health care by insurers who's mercantile interests are best served by the lower standards of medical care, and where the patient and the physician presuppose the standard of optimal care.

It is successfully argued that insurers have the hapless job of weaning the practice of medicine from the standard of best care for reason that such care is unaffordable. An example of medical care that is both economic, safe, and highly effective is the use of postural optimization to alleviate common, chronic pain where this pain is without objective cause, and in cases where postural stress can mediate or aggravate the objective malcondition, such as osteoarthritis or rheumatoid arthritis. This strategy can strongly reduce reliance on analgesic and anti-inflammatory medications,¹⁰⁹ with a substantial reduction of risk and cost.

¹⁰⁹ Hoffman K, Hoffman, L 1994 Effects of adding sacral base leveling to osteopathic manipulative treatment of back pain: a pilot study. *Journal of the American Osteopathic Association* 3:217-226.