The mother-daughter team of Arlene and Amanda Quille are the first two people to receive licenses from the state through the new LCA program and have jumped right in to help Dr. Gregory Quille at Integrated Wellness, P.A., in Lawrenceville.

“Being the sole doctor here, it was really crazy. He was stretched so thin,” said Arlene, Dr. Quille’s wife and office manager, who registered for the LCA program the day it officially became available a year ago in July. “Now he is able to slow down and provide better care for the patients, and they appreciate it.”

“It definitely gives us a smoother dynamic in the office,” added Amanda, who started the program in early December after earning her Bachelor’s in culinary nutrition from Johnson & Wales University last year. “I saw there was definitely a need in my dad’s practice for extra help and hands.”

Both received their state licenses in June. Amanda returns to school in the fall to pursue a Master’s in nutrition and become a licensed dietitian. Her mother said that at some point, Dr. Quille hopes to train a few more LCAs.

Integrated Wellness includes a full gym, which many patients use as much as three times a week. Many of them need E-Stim therapy on those visits, and the new license allows Arlene and Amanda to oversee the rehab exercises and also administer E-Stim, freeing up Dr. Quille to treat other patients.

“Unless you’re a one-man band with one treatment room, you just can’t survive without help,” said Arlene. “It actually helps with the communication with the patients, too.”

The ANJC helped bring the LCA program to fruition last year after years in the making. Designed to be a 12- to 18-month course, the LCA curriculum provides the specialized training needed to pursue LCA licensure and become vital members of the chiropractic healthcare team. The course satisfies the 120-hour instructional component of the 500-hour LCA program. The remaining 380 hours are clinical training supervised by an approved LCA clinical trainer.

Some of the benefits of having LCAs on staff are:

- LCAs will be able to apply thermal, sound, light, mechanical, electrical modalities and hydrotherapy, allowing you to increase billable services
- LCAs will be able to instruct and monitor prescribed rehabilitative activities
- LCAs will be allowed to perform manual muscle tests, general orthopedic and neurologic tests, and functionality and outcome assessment tests

Having licensed chiropractic assistants helps chiropractic physicians save time, improve services to patients, and increase the bottom line of their practice. The ANJC is proud to announce that they will be launching their very own LCA Program this fall! Stay tuned for more information!
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Spring Summit has ended, and there was quite a lot to talk about. One of the best received presentations was Dr. Steve Clarke, who presented a history of “wins” the chiropractic profession in New Jersey has enjoyed. Highlights of importance include:

- **2009 - ANJC documents and prepares extensive claims information for NJ DOBI against Triad Healthcare, resulting in Triad being sanctioned and fined for improper business practices with improperly denied and underpaid chiropractic claims.**

- **Most recently, after a 6-year-long battle which was taken all the way to the 3rd Circuit Court, ASHN and CIGNA have agreed to an $11.75 million settlement for improperly denying chiropractic claims for nearly 10 years.**

These are just two prime examples of what Dr. Clarke said on stage a number of times, “Winning only occurs when you stand up and fight back. Do nothing … Get nothing.”

To help our members expand their knowledge on insurance appeals and complaints, we had an amazing group of volunteers at the summit who offered one-on-one advice on how to fill out appeals and DOBI complaint forms appropriately. That table was a beehive of activity throughout the summit. I couldn’t have been prouder seeing chiropractors helping fellow chiropractors. The main issues discussed with our members continue to revolve around various improper claim/payment denials, the cumbersome utilization management process and the curtailing of appropriate chiropractic care.

Let me reiterate something I said before, we at the ANJC hear you and understand the difficulties, and we are working on solutions every day. For those who stopped off at the table, please take action on what you learned and follow up with Matt at ANJC HQ (matt@anjc.info). If you do nothing, we’ll get nothing.

Dr. Anthony Lisi, the chiropractic program director for the US Veterans Health Administration, kicked off our summit by speaking about expanding the role of chiropractic in the Veterans Administration and emerging training opportunities for chiropractic students. The ANJC is looking to form a Veteran’s Committee, so if you are a member and also a veteran, we’d love to hear from you! Please email me at DrKovacs@anjc.info.

On a different note, summer is upon us and what a great time it is to make memories with family and friends. It’s too easy to focus on the negatives in your practice. You’ll be a better version of yourself – ready to take on the challenges that await you – if you enjoy some good times, recharge your spirit, and focus on the good in your life.
ANJC Scholarship

Applications Now Being Accepted!

For the eighth straight year, the ANJC will award six $1,000 scholarships to chiropractic students who reside and have a home base in New Jersey and plan to return to the state to practice.*

Application Deadline: July 30th

Winners are invited to attend the 2019 ANJC Fall Summit (Oct. 12-13) at the Hyatt Regency New Brunswick as ANJC’s guest. Awards will be presented at the summit on Saturday, October 12th.

Email info@anjc.info for an application or join the ANJC as a student member to download the application at www.anjc.info

*Previous ANJC Scholarship recipients are not eligible.

New Jersey Chiropractor is a quarterly publication of the Association of New Jersey Chiropractors.

ANJC Vision:
To position Doctors of Chiropractic as providers of first choice for New Jersey families to obtain optimal health and wellness, while improving the quality of their lives.

ANJC Mission:
To improve the health of patients, families and communities by promoting high standards of professionalism and patient care through chiropractic methods, education, advocacy and accountability.

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Each day, it is an honor and privilege for me to serve as the Executive Director of the Association of New Jersey Chiropractors. Having been a chiropractic patient for the majority of my life, I know the great impact of chiropractic. From twisted ankles to SI joint issues, pregnancy to surgical recovery – and a little bit of everything in between – it’s been a chiropractic physician who has treated me and gotten me up and running again.

Why do I – and my entire family – rely on our chiropractic physician to both “fix us up” but also keep us healthy? Because we know firsthand the importance of choosing effective, conservative care. We know to choose chiropractic first.

Today, more than ever, chiropractic care should be the first choice for those seeking care. Although we know the benefits of regular chiropractic visits, we also know that the majority of first-time chiropractic patients walk through your office doors looking for relief. As a chiropractic physician, you are able to ease their pain, expand their mobility and help them get their lives back.

The ANJC will be spearheading a statewide public relations campaign on the benefits of chiropractic care and urging the public to seek out ANJC member chiropractic physicians. In addition to creating a healthier New Jersey, the goal is to drive these patients to your offices. Through a multi-pronged approach, the campaign will cover the state and the impact will be far and wide.

Thank you for the great work you do each and every day! Best wishes for a wonderful, safe summer!

By Amy Boright Porchetta, CFRE
ANJC Executive Director

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Misconceptions Concerning the Supreme Court Decision Limiting Third Party Reimbursement for Limited No-Fault Policies

On March 26, 2019, the New Jersey Supreme Court held in a split decision that auto accident victims who chose the limited $15,000 coverage for No-Fault (PIP) benefits in their auto insurance policy cannot recover medical expenses exceeding that amount in their personal injury case from the third party that caused the accident.

The Court held that the New Jersey Legislature, when it amended the no-fault laws in 1998 to allow car owners to choose lower amounts of PIP coverage in return for lower premiums, never intended to depart from a no-fault payment system for medical bills and move to a fault-based system. The Court discussed the legislative history underlying the PIP statutory scheme and the Legislature’s efforts to reduce the cost of auto insurance while still providing benefits to those who need them. The Legislature created options for coverage as low as $15,000 in exchange for lower premiums in the 1998 amendments.

There are numerous misconceptions and rumors concerning the extent and scope of this decision. First and foremost, this decision does not reduce the amount of PIP coverage that a person can obtain in New Jersey to a maximum of $15,000. Insureds in New Jersey can still obtain up to $250,000 in PIP coverage provided they opt for such coverage in their policy and they pay the corresponding premium which is higher than $15,000 PIP coverage. The decision also does not prevent recovering in excess of the limited PIP coverage from other sources such as secondary health insurance coverage or a lien on a personal injury settlement. If a patient has secondary major medical coverage and PIP limits have been exhausted, the excess bills may still be submitted to major medical for payment subject to the terms of the major medical insurance policy. Also, if a doctor has a letter of protection signed by the patient’s personal injury attorney, the attorney is still obligated to protect the doctor’s lien and pay any unpaid bills in excess of the limited PIP coverage not to exceed the New Jersey PIP Fee Schedule amount of those bills. The decision reversed an Appellate Division decision that allowed victims in auto accident cases to recover medical expenses exceeding their $15,000 PIP coverage and present those expenses to the jury at a personal injury trial. The Appellate Division had previously ruled admissible at trial evidence of medical expenses above the $15,000 PIP policy limit but below the $250,000 PIP ceiling set forth in the PIP statute.

In sum, this decision only precludes attempting to recover for medical bills in excess of a limited PIP policy from the person who caused the accident. These excess bills are not “boardable” to be presented to a jury to award a line item of damages for these excess, unpaid bills. The Court held that based upon their extensive review of the PIP statutory legislative history, they could not conclude that the Legislature intended the PIP statutes to allow fault-based suits for economic damage claims for medical expenses in excess of an elected, lesser amount of PIP coverage.

At present, there have been indications that a bill or bills will be submitted in the New Jersey Legislature to override this decision by legislative act. However, as of the date of this article, none have been advanced in either house and, thus, the Supreme Court decision remains the law of the state.
Q Can a chiropractor in New Jersey own a practice with or employ a physical therapist?

A In New Jersey, chiropractic practice structure is governed by the “Permissible Practice Structure Regulations” contained in Title 44E of the New Jersey Administrative code as well as case law and attorney general advisories that have addressed practice structure. The physical therapy regulations are silent as to permissible practice structures at present. In general, a Doctor of Chiropractic (“DC”) and a Physical Therapist (“PT”) are considered “closely allied healthcare providers” and may practice together provided their association is structured compliantly.

If the DC and PT are co-shareholders in a professional corporation or limited liability company, the DC must have a majority of ownership interest as a chiropractic license is considered of higher scope than a PT license under controlling law. A DC is also permitted to hire a PT under a traditional employer/employee relationship and bill for their services as an employee under the same analysis. However, a PT could not employ a DC as a person of lower licensure cannot employ a person of higher licensure (i.e. a PT cannot employ a DC and a DC cannot employ an MD).

Q Is the practice of telemedicine permitted in New Jersey where I can consult with the patient via Skype or other electronic method?

A Yes, the New Jersey Legislature passed a law in August 2017 which permits licensed healthcare providers in New Jersey to perform telemedicine provided they meet certain criteria spelled out in the law.

“Telemedicine,” as defined by the law, means the delivery of a healthcare service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a healthcare provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening healthcare provider. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

A healthcare provider may remotely provide healthcare services to a patient through the use of telemedicine. Healthcare providers may also engage in “telehealth” activities to support and facilitate the provision of healthcare services to patients, which means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services as described in regulations that are to be adopted.

Healthcare providers using telemedicine or telehealth are subject to the same standard of care or practice standards as are applicable to in-person settings. If telemedicine or telehealth services would not be consistent with this standard of care, the provider must direct the patient to seek in-person care.

Q What types of telemedicine services are allowed in New Jersey and are they reimbursable under health plans?

A A healthcare provider engaging in telemedicine or telehealth may use asynchronous store-and-forward technology to allow for the electronic transmission of images, diagnostics, data, and medical information. However, a provider may use interactive, real-time, two-way audio in combination with asynchronous store-and-forward technology, without video capabilities if, after accessing and reviewing the patient’s medical records the provider determines that they are able to meet the same standard of care as if the health care services were being provided in person.

Medicaid, NJ Family Care, and certain health insurance providers, including the carriers of health benefits plans for the State Health Benefits Commission, and the School Employees’ Health Benefits Commission, are mandated to provide coverage and payment for services provided through telemedicine and telehealth on the same basis as, and at a provider reimbursement rate that does not exceed the provider reimbursement rate that is applicable, when the services are delivered in-person in New Jersey.

Jeffrey Randolph, Esq. (the author of Legal Ease and Legal Q&A) is an independent person of the ANJC and his views are not authorized, sponsored, or otherwise approved by the ANJC. The information provided is for general guidance on matters of interest only and may not take into account particular facts relevant to your individual situation. The application and impact of laws and health care can vary widely based on the specific facts involved. Given the changing nature of laws, rules and regulations, there may be omissions or inaccuracies in information contained in these materials. Accordingly, the information you receive is provided with the understanding that the author and the ANJC are not herein engaged in rendering legal, accounting, tax, health care or other professional advice and services nor are they providing specific advice with regard to your practice, the treatment of any specific illness, disease, deformity or condition, or any other matter that affects trade, commerce, or legal rights of others. As such, this article should not be used as a substitute for consultation with professional accounting, tax, legal, health care, or other competent advisers. Before making any decision or taking any action, you should consult an appropriately trained professional.
By Jon Bombardieri
ANJC Government Affairs Counsel

Senate President Steve Sweeney introduced a sweeping package of more than two dozen bills aimed at slashing the high cost of government in New Jersey.

Sweeney’s signature proposals, from his Path to Progress report, would reduce the costs associated with pensions and health care for government workers. These reforms, for which the South Jersey Democrat has long advocated, have already been met with fierce resistance from the Communications Workers of America, which represents tens of thousands of state workers, as well as from Governor Murphy, who is closely aligned with labor and has little political incentive to sign these proposals.

Sweeney introduced 27 bills in all and said he would put those involving pensions and health care before voters as constitutional amendments if the Legislature and governor don’t act on them. Other bills in the package target issues like school regionalization and increasing efficiency for municipal services. The proposals all originated from the Path to Progress report that was released in August. Sweeney commissioned a 25-member panel of economic and fiscal policy experts to write the report, and has been discussing it at a series of town halls across the state.

One of the cornerstones of the bill package is Senate bill 3754, which terminates the School Employees’ Health Benefits Program (SEHBP) as of January 1, 2020, and permits coverage for participants therein in the State Health Benefits Program (SHBP). Boards of education and other educational employers who have chosen to participate in SEHBP before that date will become participating employers in the SHBP. The State Health Benefits Commission and the Division of Pensions and Benefits in the Department of the Treasury will provide for the transition required by the bill and ensure that healthcare coverage for eligible employees, retirees, and dependents under the SEHBP, whose benefits will now be provided through SHBP, is continued without interruption. Prior to the creation of SEHBP in 2008, boards
of education and other educational employers could participate in SHBP.

The bill modifies the membership of the State Health Benefits Commission to include representation for certain local and educational employees and increases the number of members on the committee who represent public employers in a reciprocal manner. The bill adds a member to the commission with expertise in actuarial science and a member qualified by experience, education, or training in the review, administration, or design of health insurance plans for self-insured employers. The bill also eliminates the State Health Benefits Plan Design Committee and transfers the committee’s responsibility for plan design to the commission.

It also provides that healthcare benefits plans provided by the state, a county, a municipality, or a school district as an employer to its employees and retirees cannot exceed an actuarial value of 80 percent. This limit will apply to the contracts providing such plans entered into after the bill’s effective date. The bill requires that all public employers offer to employees and retirees a plan with an actuarial value of at least 60 but not greater than 62 percent, and, if an employee or retiree selects that plan, the bill bars the public employer from requiring the employee or retiree to make any contribution toward the annual cost of the plan. “Actuarial value” means a percentage of medical expenses paid

reinsurance, an insurance fund or joint insurance fund, or in any other manner, or any combination thereof.

The legislation prohibits a local government or school district that is not participating in the State Health Benefits Program from entering into a contract that provides health care benefits that exceed the highest level of benefits provided under the State Health Benefits Program.

Lastly, the legislation specifies that the bill may not be construed to prohibit a local public entity from renegotiating the terms and conditions of employment in a collective bargaining agreement in order to account for any modification thereof attributable to the bill. Finally, the bill requires the savings realized by a local government or school district as a result of this bill to be used solely and exclusively for the purpose of reducing the amount that is required to be raised by the local property tax levy for the local government or school district.

These proposals will certainly face resistance from Governor Murphy and the unions, and whether the Democrats in the Assembly will want to take them on prior to an election year or wait until after, during lame duck session, is yet to be known.

Jon Bombardieri and his firm, CLB Partners, serve as the Government Affairs Counsel to the ANJC.
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With the opioid epidemic at a daunting all-time high, especially here in New Jersey, we rely on doctors to be extra careful when prescribing pain medications to their patients. There are those patients that genuinely require and benefit from pain medications while there are those that either unknowingly become addicted or seek opioids for “recreational” purposes. Although the goal should always be to help those who are injured suffer less pain and return to a healthy state of mind and body, unfortunately things don’t always quite work out that way for the patient. Those who study pain and the opioid epidemic do not necessarily discount the patient’s suffering which has caused treating physicians to explore and accept holistic approaches to pain management. This creates a unique opportunity for those most qualified to treat neck and back pain.... Chiropractors.

Patients who pursue chiropractic care not only experience pain relief, they accomplish it naturally and without prescription drugs and opioids that other doctors may be too willing to prescribe. Holistic care allows the chiropractor and patient to communicate one on one, which plays an integral and necessary role in their treatment and documentation of the patient’s legal claims. Therapeutic prescriptions of pain medication such as opioids may provide pain relief but not necessarily aid in the healing process. Too often, conventional non-chiropractic medicine masks pain with medication because it is just plain easy. Any doctor can write a script and send a patient out the door, but it takes real time and energy to heal a person’s pain and suffering, and that is exactly what chiropractic care is all about.

While pain medications can provide some temporary relief, the long term effects can be harmful to both the body and mind. They can also have a damaging effect in the court room. For example, a person is injured in a car accident, and instead of seeking chiropractic care, they turn to opioids to mask the pain. If a lawsuit is filed, without a chiropractor giving testimony about the serious nature of the injuries and the impact upon the patient’s life, it can be detrimental to the outcome of their case.

Fortunately, there are few doctors that take advantage of their medical privileges and prescribe highly addictive drugs for their own benefit. A doctor in southern New Jersey is currently being sued for medical malpractice for over-prescribing Subsys, a powerful and highly addictive fentanyl spray, to a young woman who sought pain relief after being injured in two car accidents. According to court documents, the victim and her father were persuaded by both the doctor and a drug salesman into believing that the fentanyl would be the most effective way of curing the pain. Less than two years after being prescribed the drug, the young woman was found dead of an overdose.

The solution is to educate the public that chiropractic care provides true pain relief and healing without the risk of developing an opioid addiction. Then patients will understand that when they walk into a chiropractor’s office, there are no ulterior motives – the chiropractor is there for one reason – because they care and want to provide pain relief.

Garry R. Salomon, Esq., is a partner at Davis, Saperstein & Salomon P.C., a Premier Supporter of ANJC. He is certified by the Supreme Court of New Jersey as a Civil Trial Attorney. If you have any questions, feel free to reach out to Garry by calling 201-907-5000, or by emailing garry@dsslaw.com.
Sports Injury Rounds: 14-Year Old Gymnast with Low Back Pain

By Dr. Michael C. Stewart

Depending on the source, gymnastics is considered one of the most dangerous sports. It is not surprising that many of my sports injury patients come from this community of athletes. Back pain is by far the most common issue I see in gymnasts. I recently treated a young athlete with a particular injury that, had it not been properly diagnosed, could have led to catastrophic consequences.

A 14-year old female gymnast entered my office with low back pain that started a month ago after doing a practice session on the balance beam. The pain was sharp at first but eased up with OTC NSAIDs and rest. But every time she went back to practicing, her back pain would return. During our initial consultation, the patient revealed that she occasionally experienced shooting pain down her right leg, but that it doesn’t last very long. Both the back pain and occasional leg pain would occur only when sleeping on her stomach, standing for long periods, or practicing gymnastics. Sitting while at school or at home was not irritating. There was no recent history of other illness.

At this point my differential diagnosis included herniated disc with radiculopathy, subacute facet syndrome with sciatica, or spondylolysis with possible spondylolisthesis. Each of these diagnoses were plausible, however, a focused exam and proper imaging were essential to narrowing down the underlying injury and choosing the correct care path. An NMS exam also included a postural exam, squat test, and flexibility evaluation. Positive findings included a slight forward lean while standing, pain in the lumbar spine during a squat, tight hip flexors, pain during P to A palpation of the lumbar spine, positive Yoeman’s Test on the right, and a positive Stork Test bilaterally. All other tests including Leseguees, Sitting Root Test, and SLR were negative. All neurological tests were within normal limits.

It was unlikely that this athlete experienced a herniated disc because all of the space-occupying lesion tests were negative. Considering the nature of this injury, the length of time the patient had been experiencing symptoms, and the exam results, imaging was ordered. Imaging may include X-rays, CT, MRI, or bone scan. Each of these choices would be diagnostic in this case. However, due to cost and potential authorization delays related to MRI and CT, I opted to move forward with X-ray as the best initial imaging option. A good quality five-view X-ray would reveal if a fractured pars interarticularis and spondylolisthesis was present. Alternatively, a bone scan would reveal if active metabolic activity in a fracture site was present.

As a sports chiropractor, it is important to know the mechanisms of injury of all the most common sports. If you have treated enough gymnasts (or football linemen), certain injuries resulting from repetitive extension of the lumbar spine should come to mind first. In this case, the final diagnosis was spondylolysis with a Grade 1 spondylolisthesis. With proper wearing of an immobilizing brace (up to 6 months), non-force chiropractic care, and physiotherapeutic modalities, a patient can experience a full recovery from this injury. Self-care in the form of core strengthening and balance training will be required once it is determined through re-imaging that the area has healed. In some cases, if the spine doesn’t heal well, or the spondylolisthesis is severe, surgical consultation for fusion would be required.

Michael C. Stewart, DC, CCSP, is an ANJC member and received his Doctor of Chiropractic degree from Los Angeles College of Chiropractic in 1995. From 2006 through 2014, he honed his skills as a sports physician. In March 2014 Dr. Stewart volunteered at the U.S. Olympic Training Center for two weeks in Chula Vista, CA, where treatment was provided to past and future U.S. Olympic and Paralympic athletes for various sports injuries. As a result, he was offered to be the team chiropractor for the U.S. Paralympic Cycling Team at the 2014 Paracycling World Championships. Since then he has traveled through Europe with the team as the team chiropractor at World Championships and World Cups.
Summer Insurance Update

DOBI Complaints: With the myriad of serious issues in insurance authorizations and reimbursements that have arisen in 2019, it is imperative that providers and patients make the authorities aware of these problems. The best way to do this is to file a complaint with New Jersey’s Department of Banking and Insurance (DOBI). There are no costs or prerequisite requirements to do this. There is simply a one-page form that can be sent electronically, by fax or by mail.

To assist members in making their concerns heard by DOBI, we have provided links to the complaint forms, example completed complaint forms, step-by-step instructions and a brief webinar on how to complete and file these complaints. These materials can all be found at our website, www.anjc.info, under the Insurance tab > Appeals & Forms > Complaints.

ASHN-CIGNA Class Action Lawsuit: In early April we learned that a settlement had been reached in a class action lawsuit against CIGNA and ASHN regarding improper utilization review and claim processing procedures of out-of-network chiropractic claims.

There will be a monetary settlement of $11.75 million dollars that will be distributed on a pro rata basis to out-of-network chiropractors who had submitted claims between 2009-2015. There are also four actions that ASHN will take going forward as a result of the settlement.

1. ASHN will expand its Advisory Committee to include more stakeholders, specifically from the chiropractic profession.
2. ASHN will provide no-cost CEUs to chiropractors.
3. ASHN will make reasonable efforts to gather feedback from OON chiropractors on how to improve their claims process.
4. ASHN will provide educational webinars on how to use their utilization management review tools.

Postcards have been sent regarding the settlement to the members of the class. Below is a summary of the postcard’s information and instructions.

Who is included in the Class Action Settlement?
Class members include all out-of-network chiropractic providers who provided clinical services to a CIGNA plan member, whose claims for reimbursement of such services were subjected to the ASH policies or practices as part of the claims review or benefit process, and where some or all of the claim was denied.

What do I have to do?
You do not have to do anything. If you are part of the class as defined and wish to accept the settlement as reached, you will receive a pro-rated portion of the settlement based on the amount of your effected claims relative to the entire class.

IMPORTANT NOTES:
1. If you accept the settlement and do not OPT OUT, then you are surrendering any rights to pursue your own legal action against CIGNA or ASHN on these matters. If you wish to OPT OUT and preserve your right to your own legal action on these claims you must contact the settlement administrator to request exclusion no later than July 10, 2019. You can reach the settlement administrator at www.highstreetchirosettlement.com, by email at info@HighStreetChiroSettlement.com or by phone at 1-888-208-9083.

2. You can stay in the class but dispute your estimated payment by submitting a request in writing and providing evidence of the total claims for reimbursement of clinical services which were subjected to the ASHN policies or practices as part of the claims review or benefit determination process where some or all of the claim was denied. You would also contact the settlement administrator for this.

For more information on this settlement, contact information for the settlement administrator and the attorneys involved as well as the full court documents, please visit the settlement administrator website at www.highstreetchirosettlement.com
Diagnosis Coding Alert: We have seen a great number of denials based on diagnosis codes since the turn of the year. These have occurred mostly with Horizon and Amerihealth claims. There are three known reasons for diagnosis-code-based denials. The first, and most common, issue has been that the doctor reported two or more ICD-10 codes that are considered mutually exclusive to each other.

There are two categories that can be attached to ICD-10 codes called Excludes1 and Excludes2. If there are codes in these categories, they will be listed below the ICD-10 code in either your ICD-10 codebook or online resource. If a code is listed as Excludes1, it means these two codes cannot be reported on the same claim. Excludes2 codes are essentially codes that are related to your chosen code that you may want to report as well, if appropriate.

If you have received denials based on your diagnosis codes, check to see if any of the codes you reported are Excludes1 to any of your other reported diagnosis codes. The Excludes1 listings would appear this way:

**M54.5 Low back pain**
- Including: Loin pain, Lumbago NOS
- Excludes1:
  - low back strain (S39.012)
  - lumbago due to intervertebral disc displacement (M51.2)
  - lumbago with sciatica (54.4-)

In this example, if you had entered diagnosis code M54.5 on your claim, you would NOT be allowed to also enter these three diagnosis codes - S39.012, M51.2 or any code beginning with M54.4. If you did, they could be rejected by the carrier.

Another potential reason for diagnosis-code-based denial is using an unspecified code. Unspecified codes are often part of a series of ICD-10 codes broken down by laterality or vertebral segments. For example, M50.120 represents “cervical disc disorder with radiculopathy, mid-cervical region – unspecified.” This could be denied by a carrier as an unspecified code. You should always use the most specific ICD-10 code available. In this example there are codes for specific vertebral levels such as M50.121, “Cervical disc disorder with radiculopathy – C4-C5 level.” This rule of specificity applies to laterality as well. For instance, you should not use M54.30, “sciatica, unspecified side.” Instead you should report either M54.31, “sciatica, right side,” M54.32 “sciatica, left side” or both, if applicable.

The last, and least common, diagnosis code denial issue is not having enough diagnosis codes to justify the treatment rendered. For example, if you were to bill for a 98942 five region adjustment, but did not have a diagnosis code for each of the five regions that were presumably adjusted, carriers may deny this claim. This could also serve as a trigger for an audit or more investigation by some carriers.

For more information and detail on this topic please see the recording of Dave Klein’s webinar “ICD-10 Coding Review – Stop the Denials.” You can find this webinar at our website, www.anjc.info, under the Education tab > Webinars > “ICD-10 Coding Review – Stop the Denials.”

United-Optum: Beginning July 1, 2019, United Healthcare will require the GP modifier to be appended to any codes that are deemed “Always Therapy” codes according to CMS. These codes will include: 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97530, 97533, 97535, 97537, 97542, 97750, 97755, 97760, 97761, 97762, 97799, G0281, G0283.

This policy change was announced in the United Network Bulletin April 2019 (page 25) and United advises that a letter was sent to providers in April. You can view both the newsletter and the United letter to providers at our website www.anjc.info if you go to the Insurance tab > News and Updates > United to Require GP Modifier as of July 1, 2019 (posted May 29, 2019).

You may have received a denial for not having this modifier in the last few weeks of May. United has advised the ANJC that due to a coding error the claim edit went into effect early. The issue has been resolved and corrected payments should be in process. If you have an outstanding denial for this reason, please email me at matt@anjc.info.

Note: it is NOT advised that you add this GP modifier to other carriers who have not explicitly required it as part of their policy.

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**Chronic Low Back Pain: A Multimodal Approach**

*By Dr. Donald C. DeFabio*

*Chair, ANJC Physical Rehabilitation and Performance Council*

Current research supports a multimodal approach to the treatment of chronic low back pain. It is exciting to observe the research supporting spinal manipulation for both acute and chronic low back pain. Furthermore, the failure of opioids in addressing long-term management of chronic pain has underscored chiropractic’s position that treatment needs to address the underlying cause with the goal to restore homeostasis. Essentially the multimodal approach to care is chiropractic’s Five Pillars of Health: Diet, Exercise, Rest, Emotional/Spiritual Wellbeing and a Fully Functioning Nervous System, free from interference.

As with any condition, the starting point is an accurate diagnosis. A comprehensive history, examination and functional assessment is essential. Be sure to review any previous imaging and labs and consider if additional or new studies are needed. For long-standing patients, re-examine them thoroughly and thoughtfully, as you would your new or returning patients.

As part of your initial intake are Outcome Assessment Tools (OAT). This is essential for the chronic pain patient since it may be the only evidence of progress or based on ADL’s. For the low back patient, the most common choices are the Oswestry, Back Bournemouth and Roland-Morris. The Back Bournemouth and Roland-Morris incorporate questions which will help you find and monitor psychological overtones in the patient’s pain management. A functional rating scale can also be helpful. Regardless of the OAT you choose, use it every 30-60 days.

Psychological overtones in the chronic pain patient are real, can be significant, and at times serious obstacles to healing. If the patient has identified with their pain and is having difficulty accepting that they can take control of their pain with lifestyle changes, then perhaps cognitive behavioral therapy (CBT) is needed. Often performed in a group setting, CBT has been shown to be beneficial for chronic pain sufferers. Start building your referral team of CBT providers as part of your “pain recovery” network.

While pharmaceuticals work great for pain control, they are dangerous and lethal. From opioids to NSAIDs, pharmaceuticals for chronic pain control is falling out of favor with the general population. However, nutraceuticals are beneficial and have significantly lower risk. While the chronic low back pain patient may need a comprehensive nutritional workup, there are a few established protocols that you can use safely.

First, consider the anti-inflammatory protocols recommended by Dr. David Seaman. Stop the grains, beans, sugar, seed oils and hydrogenated fats while ramping up the consumption of vegetables, fruit, fish and poultry. Add an omega-3 fatty acid supplement, anti-inflammatory herbs (curcumin, boswellia, ginger, rosemary) to really shift the body into a less inflamed state. Hit this hard and strict for three weeks and have the patient complete the OAT again. When it works, it is a home run. However, the patient must be diligent and serious on the diet for three weeks to see if chronic low-grade inflammation is an issue in their low back pain.

The list of potential nutraceuticals for pain is extensive and beyond the scope of this article. For example, CBD is very vogue currently while joint formulas that contain glucosamine and chondroitin, MSN, white willow bark (salicylic acid), cat’s claw, bromelain, systemic enzymes and papain have been used favorably for pain control for perhaps generations.

As we discuss lifestyle changes in the chronic back pain patient, research has shown a lack of high quality sleep is related to fibromyalgia. In fact, sleep allows the body to heal, recover and rebalance. Inadequate quality or quantity of sleep will increase inflammation, weight gain, and prevent the body from restoring homeostasis. Again, proper sleep hygiene and nutraceutical intervention for sleep is the topic for another article.

(CONTINUED ON PAGE 17)
Mindsets for Being a Better Clinician

By Dr. David Graber
Chair, Council on Technique and Clinical Excellence

It goes without saying that among the most important factors in achieving excellence in any field is mindset. Mindsets are deeply held beliefs, attitudes, and assumptions we have about who we are and how the world works. To improve our abilities and be better at the practice of chiropractic, we can adopt the following four perspectives.

General vs. Specific Knowledge and Skill Sets:
Success in adjusting is like success in golf - a specific skill performed in a fairly consistent or “tame” environment. Expertise requires the application of Ericsson’s metaphorical 10,000-hour rule of deliberate repetitive practice: e.g. Tiger Woods. Too much emphasis on such a narrow band of abilities may lead a DC to become a technician or a “master of one” skill.

Success in practice is like success in tennis or quarterbacking. Performed in a highly changeable or “wicked” environment, it requires a degree of proficiency in a broad range of skills. It also demands a fluidity in their application to find a best match; e.g. Roger Federer, Russell Wilson, Cam Newton. Of course, too much emphasis on this generalist approach may lead a DC to become a dilettante, never achieving the needed mastery and forever being a Jack-of-all-trades.

One of the premises of the management theory of constraints states that every business, such as a chiropractic practice, can only grow to the limit of its least developed or weakest functioning area. There are many areas in practice, such as: clinical skills, communication skills, marketing, finance and accounting, human resources and personnel, operating systems, etc. Success in practice requires fluency in each of these areas. One of the reasons that some of the most talented clinicians and most proficient adjusters struggle to succeed in practice is that they don’t develop the global array of skill sets and strategies needed to run a practice. Conversely, a doctor who is mediocre in clinical skills but excels in the other areas can have a practice that can thrive.

Fixed vs. Growth Mindset
In a fixed mindset, people believe their basic qualities, like intelligence or talent, are simply fixed traits. They spend their time documenting their intelligence or rehashing their abilities instead of developing them. They also believe that talent alone creates success — either you have it or you don’t.

In a growth mindset, people believe that their most basic abilities can be developed through dedication and hard work — brains and talent are just the starting point. This view creates a love of learning and a resilience that is essential for great accomplishment.

Chiropractors with a fixed mindset too often assume that the theories and skills they learned in school or through a chosen technique system are timeless. They have low motivation to change or develop their skills. Continuing education is done to fulfill licensing requirements, not to learn better ways and methodologies of practice.

Those with a growth mindset come from the perspective that graduation from chiropractic college was just the beginning of their journey to excellence. They regularly develop their proficiencies, learn new skills and methods, and disrupt their modus operandi when new information challenges their assumptions. They recognize that the art and science of chiropractic and health care is never complete and continuously evolves.

Clinical Practices – Best, Good, Emergent
A best practice is a practice that has been proven to work better than other methods through research or over time. The practical goal of evidence-based practice is to uncover or produce methods, protocols and guidelines that are superior to its alternatives. Currently, there are few best practices in chiropractic practice.

[CONTINUED ON PAGE 20]
In April, 2019, CMS designed a Medicare Documentation Job Aid for DCs. Its purpose is to assist every DC with compliance in meeting the documentation requirements. Please use the following as a template and check list to help achieve this goal. Hope this helps...

**Patient Information**

- Name of beneficiary and date of service on all documentation

**Subluxation**

- Subluxation demonstrated by X-ray, date of X-ray: ________
  - A CT scan and/or MRI is acceptable evidence if subluxation of spine is demonstrated
  - Documentation of chiropractor's review of the X-ray/MRI/CT, noting level of subluxation
  - The X-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (for example, scoliosis), an older X-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

- Subluxation demonstrated by physical examination (P.A.R.T.)
  - Include dated documentation of initial evaluation
  - Primary diagnosis of subluxation (including level of subluxation)

- Documentation of presence or absence of subluxation must be included for every visit

**Initial Evaluation**

- History
  - Date of initial treatment
  - Description of present illness
  - Symptoms bearing a direct relationship to level of subluxation causing patient to seek treatment
  - Family history (if relevant) (recommended)
  - Past health history (recommended)
  - Mechanism of trauma (recommended)
  - Quality and character of symptoms/problem (recommended)
  - Onset, duration, intensity, frequency, location and radiation of symptoms (recommended)

- Aggravating or relieving factors (recommended)
- Prior interventions, treatments, medication, and secondary complaints (recommended)

- Contraindications (e.g., risk of injury to patient from dynamic thrust, discussion of risk with patient) (recommended)

- Physical examination (P.A.R.T.)
  - Evaluation of musculoskeletal/nervous system through physical examination

- Documentation of presence or absence of subluxation must be included for every visit

- Treatment given on day of visit
  - Include specific areas/levels of spine where manipulation was performed

**Treatment Plan**

- Frequency and duration of visits
- Specific treatment goals
- Objective measures to evaluate treatment effectiveness

**Subsequent Visit**

- History
  - Review of chief complaint
  - Changes since last visit
  - System review (if relevant)

- Physical examination (P.A.R.T.)
  - Assessment of change in patient condition since last visit
  - Evaluation of treatment effectiveness (address objective measures included in treatment plan)

- Documentation of presence or absence of subluxation must be included for every visit

- Treatment given on day of visit (include specific areas/levels of spine where manipulation was performed)

**General Guidelines**

- Ensure medical records submitted support the service is “corrective treatment,” rather than maintenance

- For Medicare purposes, an AT modifier must be placed on a claim when providing active/corrective treatment to treat acute or chronic subluxation
  - Do not use Modifier AT when maintenance therapy has been performed
  - Modifier AT must only be used when chiropractic manipulation is “reasonable and necessary” as defined by national and local policy
  - NOTE: Presence of the AT modifier may not in all instances indicate the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review. Be aware of these policies along with any local coverage determination in your area to better understand how active/corrective chiropractic services are covered.

- Submit records for all dates of service on claim
Documentation shall be legible and complete (including signatures)

- Legible signatures/credentials of professionals providing services
  - If signatures are missing or illegible, include a completed signature attestation statement for illegible signatures, include a signature log
  - For electronic health records, include a copy of electronic signature policy and procedures describing how notes and orders are signed and dated. Validating electronic signatures depends on obtaining this information.

- Abbreviation key (if applicable)

- Any other documentation provider deems necessary to support medical necessity of services billed, as well as documentation specifically requested in the additional documentation request (ADR) letter

- Copy of Advance Beneficiary Notice of Non-coverage (if applicable)

Richard C. Healy, DC, CCSP, is the treasurer and Medicare consultant for the ANJC. A New Jersey Medicare Carrier Advisory Committee delegate and a Certified Chiropractic Insurance Consultant, Dr. Healy is a graduate of New York Chiropractic College and has been in private practice in Dumont for more than 35 years.

In terms of exercise, the chronic pain patient needs to realize that pain does not equate harm. We need to get them moving to build strength, endurance and flexibility. When starting the chronic low back pain patient on exercises, start with core stabilization and cardio. For core stabilization deconstruct their movement patterns to the point where they can perform stabilization activities properly. When assessing core strength and endurance the goal is for the lumbar extensors to be slightly stronger than the flexors (1.3:1 ratio) yet, the lateral stabilizers need to be within 10% strength. Modified front, side and reverse planks can serve as a baseline for these ratios.

Cardio: the best is walking, if possible. Maintain strong posture with a balanced sagittal line, relaxed arm swing and feet straight ahead (less than a 10% foot flare). As soon as possible building up to a brisk cadence is the goal. Start with five minutes and build to 30+ minutes. To build endurance, exercises can be split into segments throughout the day.

Remember, pain does not mean harm. Just be sure you do not overload the patient too quickly.

Yes, adjust your chronic low back pain patients. The location, technique and frequency obviously is driven by the exam findings. In addition, here are a few insights from current literature that can be applied to get better outcomes:

- The highest concentration of peripheral mechano-receptors is found in the feet, SI joints and suboccipital regions: Adjusting all of these areas could be important.

- Mobility of the T4 region is essential in back pain management, so be sure to assess motion of the upper thoracic spine and keep it mobile.

- Using Boyle’s concept of mobility vs. stability, be sure the acetabular joints are mobile and not restricted at all, as well as the SI joints.

Chiropractic has been ahead of the research curve, and now we need to own it. The multimodal approach to chronic back pain management is supported in the current research and we have been providing it since 1895.

Donald DeFabio, DC, DACBSP, DABCO, is in private practice in Berkeley Heights, NJ, and is the team chiropractic doctor for a local university. His exercise protocols can be found on his YouTube Channel. He conducts Relevant Rehab, hands-on seminars to teach the keys of successful integration of active care into the everyday chiropractic office.
FASTING Considerations

By Dr. Julianne Monica
Chair, ANJC Nutrition Education Council

How many of your patients have asked you about the benefits of fasting? It is being touted as having anti-aging effects, facilitating fat loss, elevating mood and providing mental clarity and boosting cognition. Research supports the use of intermittent fasting for potential prevention and treatment of cardiometabolic disorders. The term intermittent fasting is defined as intermittent energy restriction, or intermittent calorie restriction, diet plans that cycle between a period of fasting and non-fasting over a defined period.

In 2013, Mosley & Spencer published a best-selling book titled “The FastDiet” which describes the benefits of severely restricting energy intake for two days a week but eating normally during the rest of the week. This was a big push for this popular concept.

In 2016, an internet search using the terms “intermittent/diet-fasting” had more than 210,000 hits. In contrast, there is a shortage of evidence-based support for intermittent fasting that can be used to generate recommendations for public health practices.

The bulk of scientific evidence for the health benefits of intermittent fasting primarily comes from studies of male rodent models. Human studies have largely been limited to observational studies of religious fasting (e.g. during Ramadan) and experimental studies with modest sample sizes.

In randomized, intervention trials studied thus far, the efficacy of intermittent fasting on human health supports weight loss. Data is lacking regarding the impacts of intermittent fasting on other health behaviors such as diet, sleep, and physical activity.

It’s typically assumed that pre-agricultural humans and our hominid ancestors experienced long periods of famine, or, at the very least, weren’t grazing and snacking all day. It’s more likely that they feasted and fasted, going some length of time between successful hunts. Today, this would be called alternate day fasting.

It has alternating fasting days, during which no calories are consumed, and feeding days, during which foods and beverages are consumed freely. This fasting regimen was as effective as simple daily caloric restriction in reducing obesity-associated body weight and fasting insulin and glucose concentrations. Alternate-day fasting in rodent models of obesity has also been shown to reduce total plasma cholesterol and triglyceride concentrations, reduce liver steatosis and inflammatory gene expression and have beneficial effects on cancer risk factors, such as cell proliferation.

Other considerations for these study purposes and the practice in general is hunger and mental status, as well as post-fast energy intake/calories which can offset the positive effects and are important outcomes to consider with extended fasting during waking hours.

In a recently reported study, 16 women did a two-day fast resulting in distraction, but not hunger, and was associated with a low mood and perceived work performance compared with two days prior to and following the fasting period.

The sparse data on alternate-day fasting suggest that this regimen can result in modest weight loss and lead to improvements in some metabolic parameters. However, reports of extreme hunger while fasting indicate that this may not be a feasible public health intervention.

Modified fasting regimens may be tolerated a bit better. They generally specify that energy consumption is limited to 20–25% of energy needs on regularly scheduled fasting days. The term fasting is used to describe periods of severely limited energy intake rather than no energy intake. This type of regimen, also called intermittent energy restriction, is the basis for the popular 5:2 diet which involves energy restriction for two non-consecutive days per week and unrestricted eating during the other five days of the week.

The outcome here was decreased visceral fat, leptin, and resistin, and increases in adiponectin. Similar studies conducted by this research group also found that in mice these fasting regimens appear to reduce adipocyte size, cell proliferation, and levels of insulin-like growth factor 1.

Time restricted feeding that had daily fasting intervals ranging from 12 to 21 hours in numerous rodent models were...
associated with reductions in body weight, total cholesterol, triglycerides, glucose, insulin, interleukin 6 (IL-6), and TNF-α, as well as with improvements in insulin sensitivity. Interestingly, positive health outcomes occurred despite the variable effects on weight loss. The long-term metabolic benefits associated with eating or not eating breakfast, or extending the nighttime fast until the lunch meal — are of great research and public interest.

Satiety and appetite-regulating hormones and peptides were affected by prolonged morning fasting, but these alterations did not significantly affect calorie intake. In a six-week controlled trial, researchers observed no benefit with respect to weight change, glycemic control, lipids, or inflammatory markers for the group omitting the breakfast meal compared with the control group.

Night time eating or not eating is another tool to consider. Data from the National Health and Nutrition Examination Surveys (known as NHANES) have shown that each three-hour increase in nighttime fasting duration was associated with significantly reduced odds of elevated HbA1c and significantly lower CRP concentrations in women who ate less than 30% of their daily calories after 5:00 pm.

A published analysis of the nightly fasting interval in 2,337 breast cancer survivors in the Women’s Healthy Eating and Living (known as WHEL) Study indicated that cancer survivors who fasted less than 13 hours per night during seven years of follow up had an increased risk of recurrence.

The same concept extends into prolonged, into the night, or night eating that we see in shift work. This is in part due to the circadian rhythm of insulin secretion and the insulin-impeding action of growth hormone, the pulsatile concentrations of which increase at night. Postprandial insulin and glucose responses to meals increase across the day and into the night. Thus, meals consumed at night are associated with greater postprandial glucose and insulin exposure than content-matched meals consumed during the day, leading to increased HbA1c levels and risk of Type 2 diabetes over time. Short-term intervention studies designed to mimic circadian rhythms in human participants have metabolic consequences. Inducing circadian misalignment in humans by extending the day from a 24-hour to a 28-hour cycle causes insulin resistance after only three cycles.

So, fasting regimens also have the potential to foster modifiable health behaviors. A study in eight overweight young adults found that increasing the nightly fasting duration to 14 or more hours resulted in statistically significant decreases in energy intake and weight, as well as improvements in self-reported sleep satisfaction, satiety at bedtime, and energy levels.

Modified fasting regimens appear to promote weight loss and may improve metabolic health. However, there are insufficient data to determine the optimal fasting regimen, including the length of the fasting interval, the number of fasting days per week, the degree of energy restriction needed on fasting days and recommendations for dietary behavior on non-fasting days. Which could potentially be successful with individual metabolic analysis for sustainable levels of deprivation.

Fasting appears to have numerous beneficial effects, but that doesn’t mean it’s appropriate for everyone. Individuals with Type 2 diabetes can fast safely, but under medical supervision is advised. Individuals taking certain medications may be advised to avoid fasting or to be sure to work with their doctor to make any necessary adjustments to medications that are typically taken with food, or whose potency or pharmacology may be affected by fasting. Fasting is not recommended for women who are pregnant or breastfeeding, nor for adolescents in an active growth stage. It’s also not advised that anyone with an eating disorder or a history of eating disorder adopt a fasting practice.

Another group of people for whom fasting is not recommended is the elderly, except under medical supervision. Many older people are already under-consumption of protein. It wouldn’t be wise for an individual already experiencing sarcopenia or dynapenia to become even more protein-deficient or malnourished overall.

As we know, some form of calorie restriction, especially in relation to sugar and starch-type foods, is a positive step for most for a metabolic upgrade. Because it is so impactful, it is prudent to tender with a clinical approach and some individual evaluation.

Julianne Monica, DC, CNS, DCBCN, practices in Sea Girt with an emphasis on clinical nutrition with a functional, non-drug approach to manage chronic conditions and achieve optimal, metabolic status for her patients.
Harlan Health Products Brings Winback Therapy to Tri-State Area

Harlan Health Products, Inc. is pleased to announce the addition of Winback Therapy to its family of products. Winback Therapy will help practitioners who perform manual soft tissue therapy, joint mobilization, and manipulation to stay on the leading edge of technology so they can enhance their clinical outcomes.

“Our clients are all in this competitive healthcare environment. It is imperative for us to provide our customer with the latest tools to help them get their patients get better, and faster than ever before. We are excited that the interest in Winback Therapy has been extraordinary thus far, and it has taken off much quicker than we anticipated. We know, from our years of experience, that the best practices are the practices that get the best results. Winback fits right into that model,” said Harlan Pyes, President of Harlan Health Products, Inc.

“SWIMS America Corp, the U.S. branch of the manufacturer of Winback, a French-based company, is delighted to announce the appointment of Harlan Health Products, Inc. as our exclusive dealer for the New York, New Jersey, and Connecticut regions,” said Paul J. Donnelly, Winback’s CEO. “We believe in a business philosophy which focuses on innovation, service and education, and we are delighted to find that Harlan Health Products, Inc. shares this same philosophy. It is clear that HHP’s strong values are a perfect match for what we look for in a distribution partner. We look forward to partnering together and to bringing the exciting Winback technology to market in these regions and beyond."

Winback Therapy is combined with manual therapy used to treat acute, sub-acute, and chronic pathologies faster than with manual therapy alone. It has been deployed clinically and internationally for over 15 years, and Winback alone works alongside 128 sports teams and associations and more than 7,000 practitioners.

Contact Harlan Health Products, Inc. at 1-800-345-1124, to discuss the benefits of Winback Therapy and schedule your office demonstration, or visit harlanhealth.com/product/winback-therapy for more information.

Good practice is the recognition that caring for real patients in the real world is more complicated, has more confounders, and is overall messier than many research designs can account for. It acknowledges that there are multiple options for achieving results with patients. Another name for good practice might be effective practice – it reliably generates desired outcomes, but may not have been rigorously studied. Both personal experience and professional consensus contribute to the development of good practices.

Often patients present themselves with complex problems and situations as such that no recognized good or best practice applies to them. Their problems are either unique and unconventional (i.e. unprecedented), or recurrent and ongoing (i.e. are continuously re-solved). These are cases where no guideline or clinical heuristic can be constructively applied. In these cases, the art of practice comes in. Through collaboration with other clinicians and “n of 1” trials, an emergent practice develops. Effective emergent practices that can be repeatedly applied to a similar cohort of patients adds to the growing catalogue of good practices we can utilize.

Everyone one of us can be better at the practice of chiropractic if we adopt these mindsets. In the end a curious mind, a compassionate heart, and a commitment to the continuing pursuit of the advancement of chiropractic practice benefits us all.

David Graber, DC, CCSP, is the chairperson of the ANJC Council on Technique and Clinical Excellence. He maintains a private practice in Parsippany, NJ.
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1 Kumar D, Jacob D, Subash PS et al. J Funct Foods 2016; 22, 578-587

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Your True Key to Success!

In every aspect of my business, every client I speak to, every book I write, every time I take to the lectern, there is one over-arching theme. This theme encompasses communication, accountability, processes, protocols, and the all-important power of systems. This theme is the true key to success.

This theme is... training... training... TRAINING! Never stop TRAINING!

The biggest mistake owners/managers can make is to hire a new employee and pop them into a single, week-long (I’ve seen even shorter!) training session and then throw the new hire to the proverbial wolves. Then there is the wide-eyed wonder: What went wrong? Why is my turnover so high? Why are my systems falling out? On and on the questions come, and the answer is right in front of you. I would scream it from the roof tops...

“Training should be an ongoing exercise for EVERY SINGLE position in your practice.”

There are four key aspects to every task and protocol, and when you are training, your goal is to instill each one:

• The What: The process
• The How: The standard/policy
• The Why: The objective
• The Outcome: The statistic/metric by which success is measured

In the practical application of these four key aspects, let’s take a brief look at the vital skill of multi-scheduling.

WHAT is multi-scheduling?

Restorative Care – scheduled according to the treatment plan frequency.

Maintenance – scheduled for a monthly visit

Management – scheduled for a follow-up visit

HOW do you schedule properly?

The patient should NEVER leave the practice without a future scheduled appointment.

WHY does multi-scheduling benefit the patient and the practice?

Increases patient visits – Improves practice efficiency and flow – Puts the practice in charge of the schedule

OUTCOME – Increased volume and retention!

It can seem a bit overwhelming to consistently train staff, and it can be tempting to take experience/time for granted. But, even the most seasoned employee benefits from regular training. The best way to ensure that training becomes integrated into the regular activities of your practice is during weekly staff meetings. I am a staunch advocate of well-planned and scheduled mandatory weekly staff meetings. When done correctly, they are an invaluable tool for communication, team building and education in your practice.

Following an agenda keeps staff meetings on task and I suggest the following outline on which to build this agenda:

1. Review Statistics
2. Patient Feedback & Survey Review
3. Marketing
4. Training – Most of the time in the meeting should be spent here. Training is the most important aspect of the meeting, and it is too often overlooked. The training session needs to be planned, and everyone needs to be cross-trained in all aspects of the practice. It doesn’t matter if your entire staff has been with you for years, training is constant and ongoing. Everyone benefits from refreshed knowledge.

The healthcare field is constantly growing and evolving, your training sessions should be as well.

5. Goals & Positive Motivation – As you can see in the agenda outline, training as incorporated in your weekly mandatory staff meeting, becomes an integral part of the culture of your practice. Training isn’t secondary. When training is your culture, it is primary and the thirst for growth and betterment is pervasive.

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We all know someone that suffers from migraines or severe headaches, and perhaps they are currently managing their migraines with prescribed medication including Botox injections or over-the-counter ingestible medication, but with that comes the risk of dependency and, also drug interactions. Everyone is looking for a safe alternative to manage their pain.

Patients turn to acupuncture, massage and to you, their chiropractor, to help manage their migraines and headaches. These aren’t solutions that patients can turn to immediately when feeling the first signs of a migraine.

Although many people say that aromatherapy with lavender, ginger or peppermint oils may help relieve tension headaches, there is still more research to be done to validate these claims.

There is, however, a unique, and proven topical solution to help relieve the pain from migraines as well as other types of headaches. Using a blend of specially selected ingredients and penetration enhancers, Stopain® Clinical Migraine & Headache topical gel offers safe and effective pain relief for migraines and headaches that can be applied up to four times daily.

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There is a Thomas Jefferson Study as well as a Frontiers in Neurology white paper written on the efficacy of Stopain® Clinical Migraine & Headache; you can view them and learn more about the product at http://migrainestudy.us

Stopain® Clinical topical analgesics, along with Stopain® Clinical Migraine & Headache are available for use and sale by healthcare professionals only. Since everything is done in its facility, Troy Healthcare is able to keep a low everyday cost for its products, helping to increase your cash flow in your practice.

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