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# chiropractic economics

## A Vicious Cycle

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### RESEARCH RESULTS

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### CODING KEYS

ICD-10 lessons learned

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21 DAYS**

**DAY  
21**

DAY  
18

DAY  
15

DAY  
10

DAY  
5

**↑  
HEALTHY  
LIVING**

**DAY  
1**

**BRAIN  
FOG**

**FATIGUE**

**WEIGHT  
GAIN**



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Our latest webinar, Laser therapy: "Take aim at pain," presented by Jerome Rerucha, DC, and Erchonia, explains how low level laser therapy can address a variety of common health conditions.

Download any of our webinars at [ChiroEco.com/webinars](http://ChiroEco.com/webinars).

### Expert Insights

#### ChiroEco.com/blogs

**Blogs** by Anthony Lombardi, Mark Sanna, Drew Stevens, Josh Wagner, Kelly Robbins, Perry Chinn, Shawne Duperon, and the *Chiropractic Economics* editorial staff.



#### Legal Secrets to Improve Your Bottom Line

*Post-payment audits may be unlawful under ERISA*  
Richard Quadrino, Esq.



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*DCs need to be where people need us*  
Anthony J. Lombardi, DC



#### EHR Guru

*Why ICD-10 is so complicated*  
Alex Niswander

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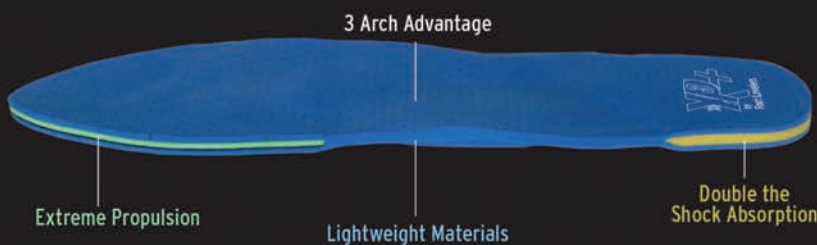
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# Pieces of the puzzle

What you do is largely detective work.

**T**ALK TO ANY MEDICAL PRACTITIONER AND YOU'RE LIKELY TO HEAR THEM SAY, AT SOME POINT, "OTHER doctors treat symptoms, but I deal with the root cause of illness." This conceit is nearly universal because it underpins a critical issue in healthcare: The presenting problem may be a manifestation of an issue in some other part of the body, or stem from a behavioral or environmental cause.

A patient who complains of knee pain or tendinitis may very well benefit from direct manipulation, physical therapy, and home exercise. Yet an investigation might reveal that



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the problem is stemming from excessive pronation during gait, which if uncorrected will consistently cause the symptoms to recur.

In a similar way, your business is largely concerned with the removal of subluxations, but it's always worth looking into what is causing them to manifest in your patients. Poor diet, stress, endocrine or hormonal disorders, poor workplace ergonomics—the list of potential culprits is a long one, yet the search can lead you to a lasting solution.

Before you can determine the etiology of your patient's condition, however, you have to know what to look for. In this issue of *Chiropractic Economics*, we examine systemic inflammation and metabolic disorders. Our experts will show you how to spot and address these issues and, more importantly, investigate their possible origins.

Several recent studies, most notably one published December 16, 2015, in *Nature*, suggest that up to 90 percent of cancers in humans are caused by external factors and lifestyle behaviors.<sup>1</sup> The solution may ultimately be less about curing this disease and more about preventing it from arising.

To your success,

Daniel Sosnoski, editor-in-chief

**Reference**

<sup>1</sup> Wu S, et al. Substantial contribution of extrinsic risk factors to cancer development. *Nature*. 2015;doi:10.1038/nature16166.

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## THE CHIROPRACTIC PULSE

### In memory of Martin I. Lawrence, DC

Martin I. Lawrence, DC, passed away peacefully and gracefully at his home in Boca Raton, Florida, on November 25, 2015, after a brief illness. His wife Francine and their adoring children Peter, Scott, and Cathy were with him at his bedside.

Raised in the Bronx, New York, and educated at Stuyvesant High School, Lawrence attended New York University and then graduated the Chiropractic Institute of New York (CINY) in 1949, becoming the 22nd licensed chiropractor in New York state. He was also an anatomy professor at CINY for 10 years. He had offices both in the Bronx and in Jericho, New York.

Lawrence was a committed family man, an avid golfer, a lover of life, and a gentle and kind soul. He is survived by his wife, three children, two daughters-in-law, six grandchildren, and two great-grandchildren. The profession has lost one of its modern founders and we are thankful and appreciative of all his sacrifices and victories on behalf of our great profession.

The family has requested that any donations be made to Friends of the IDF: [fidf.org](http://fidf.org)



To learn more about Lawrence, visit [ChiroEco.com/mlawrencedc](http://ChiroEco.com/mlawrencedc).

Source: Jerusalem Family Wellness Center, [drheidfleiss.com](http://drheidfleiss.com)



### New legislation would include doctors of chiropractic in U.S. Public Health Service

A new bill in the U.S. House of Representatives would improve the quality of America's healthcare infrastructure by further integrating doctors of chiropractic throughout the nation's official delivery and research networks. H.R. 3851, introduced by Rep. Gene Green (D-Texas), calls for the appointment of chiropractors as officers in the U.S. Public Health Service (USPHS) Commissioned Corps.

"A top priority of the American Chiropractic Association (ACA) has always been to increase access to and utilization of chiropractic services available through the federal government," said ACA president Anthony Hamm, DC. "The services of chiropractic physicians will be a tremendous value to the Public Health Service's Commissioned Corps, and enacting this legislation will be another important milestone in the mission to fully integrate chiropractic care into the nation's healthcare delivery system."



To read more about the new legislation, visit [ChiroEco.com/chiro-phs](http://ChiroEco.com/chiro-phs).

Source: American Chiropractic Association, [acatoday.org](http://acatoday.org)

### ACA seeks full physician status for DCs

The American Chiropractic Association (ACA) has launched a national grassroots effort to eliminate a blatantly anti-competitive provision of Medicare law that arbitrarily limits reimbursement for medically necessary services delivered by doctors of chiropractic.

The statutory change ACA seeks would define DCs as "physicians" under Section 1861 of the Social Security Act for the provisioning of any existing Medicare covered service that falls within the scope of practice of an individual DC as defined by their applicable state law. The centerpiece of ACA's campaign will focus on generating a robust level of patient grassroots support aimed at Congress that seeks to ensure that Medicare beneficiaries have full access to a broader range of covered services provided by chiropractic physicians than current law permits.



For additional details, visit [ChiroEco.com/acaphysician](http://ChiroEco.com/acaphysician).

Source: American Chiropractic Association, [acatoday.org](http://acatoday.org)

## BY THE NUMBERS



# 2014

the year that the Texas Association of Acupuncture and Oriental Medicine filed suit against the Texas Board of Chiropractic Examiners (TBCE), claiming that **acupuncture** and other procedures involving needles are outside the scope of practice of chiropractic

Source: American Chiropractic Association

# 3

number of consecutive years that Sherman College of Chiropractic has been designated as a **Military Friendly School**

Source: Sherman College of Chiropractic



# 259,000,000

number of **painkiller prescriptions** written in 2012 (according to the CDC)—enough for every U.S. adult to have an individual bottle of pills

Source: Foundation for Chiropractic Progress

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Ames BN. Low micronutrient intake may accelerate the degenerative diseases of aging through allocation of scarce micronutrients by triage. Proc Natl Acad Sci. 2006; 103(47):17589-94.

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## ■ TRENDS IN VETERAN SERVICES

### Veterans center opens at Northwestern Health Sciences University

The Home Depot Foundation, the charitable arm of the national home improvement retailer, provided a \$6,400 grant to Northwestern's Students Serving Veterans Club to help furnish and equip the center in the main Northwestern building overlooking a park and a lake on the Bloomington campus.



"Our student veterans have given to our country, and this is one way we can give back to them," Northwestern president Christopher Cassirer said. "We're fortunate to have a large group of students who are veterans. This is an example of how we help them succeed as they take the next steps with their educations and the health professions they have chosen."

Northwestern offers tuition discounts to veterans and covers additional costs as a veteran-friendly Yellow Ribbon School. It has organized "Feed 'Em and Treat 'Em" events for veterans to try chiropractic, massage, acupuncture, and other treatments to address pain, often caused by injuries they suffered in military service.

 To read more about the new center, visit [ChiroEco.com/nhsuserves](http://ChiroEco.com/nhsuserves).  
Source: Northwestern Health Sciences University, [nwhealth.edu](http://nwhealth.edu)

### Senate passes bill to expand chiropractic services at major VA medical centers

The U.S. Senate has approved legislation that will improve the delivery of benefits to America's veterans, bringing them one step closer to gaining further access to the essential services provided by doctors of chiropractic

at major Department of Veterans Affairs (VA) medical centers. S.1203, the 21st Century Veterans Benefits Delivery Act, passed under unanimous consent and has been referred to the U.S. House of Representatives, where it awaits action.


Section 102 of the Act, titled "Expansion of Provision of Chiropractic Care and Services to Veterans," calls for the chiropractic benefit to be carried out at a minimum of two additional medical centers or clinics per Veterans Integrated Service Network (VISN) no later than two years after enactment of the bill, with the program being implemented at no less than 50 percent of all medical centers in each VISN within three years of enactment. There are nearly 160 VA treatment facilities nationwide. Currently, DCs serve at 66 treatment facilities across the country.

 For further details, visit [ChiroEco.com/va-bill](http://ChiroEco.com/va-bill).  
Source: American Chiropractic Association, [acatoday.org](http://acatoday.org)



### National University of Health Sciences expands services at Veterans Clinic

National University of Health Sciences (NUHS) in Lombard, Illinois, has been providing free acupuncture for combat veterans with post-traumatic stress syndrome (PTSD) since 2010. Since then, the Veterans Clinic at the NUHS Whole Health Center has provided close to 4,000 free treatments to veterans and their families.

The university is now expanding the program, offering more services for veteran healthcare needs. The expanded services are made possible by donations from corporate sponsor China-Gel manufacturer of herbal topical pain relievers. The NUHS Veterans Clinic will now offer full acupuncture services for all health conditions, as well as moxibustion and tui na therapies. Moxibustion is the therapeutic application of heat to specific acupuncture points on the body to accelerate healing. Tui na is a vigorous and therapeutic form of massage along acupuncture meridians. 

 Learn more about the new services at [ChiroEco.com/nuhs-va](http://ChiroEco.com/nuhs-va).  
Source: National University of Health Sciences, [nuhs.edu](http://nuhs.edu)

## ■ WHAT'S HAPPENING IN HEALTH?

### Brisk, regular walking helps lessen heart disease risk

**FROM EXPERTS AT HARVARD:** Walking is a low-impact, do-anywhere exercise that helps lower blood pressure and stave off diabetes. And two large, long-term Harvard studies suggest that walking for about 20 minutes a day may cut the risk of heart disease by as much as 30 percent, according to the December 2015 *Harvard Heart Letter*.

But many people need some added inspiration to start—and stick with—a walking program. One of the best ways is to find walking buddies, says Lauren Elson, MD, physical medicine and rehabilitation instructor at Harvard Medical School. "I find that if I can get someone to walk with—a partner, a spouse, or a friend—that helps a lot." Even better is getting several friends to walk together, because they all hold each other accountable. "They call each other up and say, 'Where are you?'" Elson says.

 Want to learn more? Visit [ChiroEco.com/walkinghealth](http://ChiroEco.com/walkinghealth).  
Source: Harvard Heart Letter, [health.harvard.edu](http://health.harvard.edu)



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# A separate diagnosis

The Tupler Technique can serve your low-back pain patients afflicted with diastasis recti.

BY JULIE TUPLER, RN



DANIEL HEYWOOD/THINKSTOCK

**A**MONG THE MANY CAUSES OF BACK PAIN, POOR POSTURE AND obesity are two of the most commonly cited culprits.<sup>1</sup> Rarely, however, will diastasis recti, also known as abdominal separation, make the short list—even though it may well be the reason for a person's poor posture and often coincides with an enlarged stomach area. Given that approximately 30 million Americans experience lower back pain, and considering that back pain is one of the most prevalent reasons people seek help from a doctor, properly diagnosing the source of the pain from this widespread problem is crucial to ensure proper recovery.

Back pain and diastasis recti go hand in hand. The outermost muscles (rectus abdominis) serve as a support

system for the back and organs. When these thick muscles separate, a thin connective tissue has to do all the work, and the side effects from this ineffective support system can cause back pain, umbilical hernia, poor posture, and gastrointestinal and pelvic floor problems.

This condition also puts a pregnant woman at risk for a caesarean section. Unfortunately, the medical community has failed to connect the dots between diastasis recti and these issues. Thus, most people with these side effects are not checked for a diastasis, and treatment for this condition has been largely ignored.

## Understanding the condition

Everyone is born with their abdominal

muscles separated. At around 3 years of age, after the nervous system has developed, the muscles usually come together. Occasionally, they don't or, in other cases, continual pressure on the connective tissue from the activities of daily living, exercising, sports, abdominal surgery, or weight gain in the stomach will cause the muscles to separate again. The weak spot in the linea alba at the umbilicus makes the connective tissue more vulnerable to separating.

All patients with back pain should be checked for diastasis recti, a process that includes evaluating both the distance of the separated muscles and the condition of the connective tissue. If a patient has weak connective tissue, it will take longer for the separation to

**The goal of the four-step Tupler Technique program is to heal the weakened connective tissue between the two recti muscles called the linea alba.**

close. To check the distance of the diastasis correctly, it needs to be assessed when the diastasis is at its largest.

The recti muscles come together as patients bring their shoulders off the floor, making the diastasis appear smaller. Check patients when the recti muscles first start to move. If, upon shoulder lift, the patient has a bulge in the shape of a half-football or a protruding belly button, the diastasis may be severe and you will want to use two hands when checking the distance of the separated muscles.

Feeling with your fingertips across the stomach midline, determine the strength of the connective tissue based on the depth of the crevice. (The deeper you're able to feel, the weaker

the tissue). Another sign of weakness is the presence of a pulsing sensation. If you confirm the presence of diastasis recti after performing this evaluation, it's time to implement an effective treatment plan.

**The Tupler Technique**

For more than 20 years, the Tupler Technique program has been treating clients with diastasis recti.<sup>2</sup> It is the only research- and evidence-based program for this condition.<sup>3</sup> Tupler Technique statistics featuring data from 1,200 clients show that within six weeks after starting the program, patients can make a diastasis 55-percent smaller.

The goal of the four-step Tupler

Technique program is to heal the weakened connective tissue between the two recti muscles called the linea alba. The technique aims to strengthen both the abdominal muscles and connective tissue for improved health. The program promotes healing by:

**1. Continually approximating the connective tissue and recti muscles.** This takes the stretch off the weakened tissue, allowing it to heal. It also puts the recti muscles in the correct position so they move backward, rather than sideways, when a patient performs exercises. A backward movement of the muscles strengthens the area, while a sideways movement not only fails to strengthen it but also



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## TECHNIQUESPEAK

stretches the weakened connective tissue.

### 2. Protecting the connective tissue from movements, exercises, and activities that stretch it, including:

- ▶ Exercises in the hands-and-knees position. In this position, the weight of the organs stretches the connective tissue (swimming, planks, push-ups).
- ▶ Exercises while the back is arched

and the ribs are flared (backbends, yoga upward facing dog).

- ▶ Exercises doing a forward crossover movement (tennis, golf, oblique crunches, swimming, Pilates).
- ▶ Exercises while lying back-down with the shoulders off the floor (crunches, Pilates, rollbacks).

### 3. Strengthening the transverse muscle.

Transverse strength and awareness is

important in activities of daily living and when incorporating it in into a diastasis-safe exercise routine. The isometric strengthening exercises bring blood flow to the connective tissue.

During the first six weeks of the program, emphasize developing transverse strength while performing activities of daily living to allow the connective tissue to heal. Doing other exercise programs simultaneously is discouraged.

Patients can still do aerobic exercise such as walking on a treadmill or riding on an upright stationary bike during this time. Then, in week six of the program, patients are taught how to use their now-strengthened transverse muscle during the exercise routine and how to modify it so it remains diastasis-safe.

The exercises progress over 18 weeks. Photos of the patient's belly area should be taken from the front and side before starting the program. They are taken again in weeks three, six, and 18, as they motivate patients to stay committed to the program.

The time it takes to close a diastasis depends on the severity of the condition and the patient's commitment to the program. A severe diastasis usually takes no less than one year and as long as three years to close. Patients will see the healing process begin within the program's first couple of weeks. If the connective tissue fails to heal properly, the patient can reopen the diastasis.

The four overarching steps of the program are:

1. Three exercises (seated elevator, contracting, and back-lying head lifts)
2. Approximating the muscles and connective tissue with a splint and holding a splint in week four of the program.
3. Developing transverse awareness with activities of daily living and while exercising to prevent force on the connective tissue, which stretches it.
4. Getting up and down correctly from:



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## TECHNIQUESPEAK

- ▶ Seated to standing
- ▶ Standing to seated
- ▶ Back lying to seated
- ▶ Seated to back lying

The above movements use the patient's whole body weight. This is a tremendous amount of force on the connective tissue.

Patients having abdominal surgery should strengthen their transverse muscle before surgery so they will have the strength and awareness to use it in the recovery process and maintain the integrity of the sutures. Strengthening the connective tissue before surgery also makes the opening easier to sew.

Your pregnant patients should keep their diastasis as small as possible to not only prevent back pain during pregnancy but to keep the uterus in the proper position, ensuring the cervix is aligned with the vaginal canal. With a large diastasis, the top heavy uterus tilts forward, making the cervix point sideways instead of downward. A sideways facing uterus puts a pregnant woman at risk for a c-section.

To address the full range of back-pain instigators, chiropractors need to start checking their patients for diastasis and incorporating the treatment of this condition as part of their protocol. 



**JULIE TUPLER, RN**, is a certified childbirth educator and personal trainer. She developed the Maternal Fitness Program in 1990 and for more than 20 years has been

teaching and developing the Tupler Technique Program for treatment of diastasis recti for women, men, and children. She is a frequent speaker at medical and fitness conferences including the 1st World Conference on Abdominal Wall Hernia Surgery.

### References

- <sup>1</sup> American Chiropractic Association. "Back Pain Facts & Statistics." [http://www.acatoday.org/level2\\_css.cfm?T1ID=13&T2ID=68](http://www.acatoday.org/level2_css.cfm?T1ID=13&T2ID=68). Accessed November 2015.
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*In my 34-year career, I've seen a lot, including what factors really make a difference in a malpractice lawsuit. Among my recommendations ...*



Michele Quattlebaum, J.D.

## #1 **Knowledge is Power**

For D.C.s, there is nothing worse than getting a claims representative on the phone who has no idea what you are talking about or an attorney that you have to educate. You can tell immediately if they don't know anything about chiropractic.

This is a common problem that insurance carriers have with defense lawyers. Many experienced attorneys have previously defended *medical* doctors and could have developed the prejudice that the medical profession has against chiropractic.

**NCMIC strives to "weed out" those defense attorneys who do not understand chiropractic and do not believe in the value of the chiropractic profession in healthcare.**

Learn about Michele's other recommendations by going to **[www.ncmic.com/Recommends](http://www.ncmic.com/Recommends)**  
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## A novel solution

Ahiflower oil offers you a vegetarian option for omega-3 fatty acids.

BY GREG CUMBERFORD



**A** NEW PLANT-BASED ESSENTIAL FATTY ACID DERIVED FROM Ahiflower (*Buglossoides arvensis*) oil is now available to healthcare practitioners and patients. Developed over 12 years from selected wild oilseed cultivars, the resulting dietary oil offers rich and biologically advanced essential fatty acids from a non-genetically modified crop.

A recent randomized, double-blind, controlled human clinical trial published in the British *Journal of Nutritional Science* showed that Ahiflower oil converts to omega-3 eicosapentaenoic acid (EPA) in circulating cells up to four times more efficiently than flaxseed oil.<sup>1</sup> This is due to its highly available omega-3 stearidonic acid (SDA) content (18–20 percent). SDA is a long-chain omega-3 fatty acid with many cardiovascular and anti-inflammatory health benefits.

Ahiflower oil is also a source of anti-inflammatory gamma linolenic acid (GLA), and it offers a clean-label, vegan pathway to meeting omega-3 recommended daily intakes. Ahiflower oil combines the anti-inflammatory benefits of fish oil and evening

primrose or borage oil in a clean-tasting product with no fishy burps, leading to greater patient compliance.

In addition, Ahiflower oil is now available to U.S. practitioners in vegan softgels through a range of brands and distributors.

### A closer look at SDA

Dietary SDA is commercially available only from vascular plant origins, although it occurs naturally at low levels (0.5 to 2 percent) in edible oily fish. Metabolically, SDA is synthesized from dietary alpha-linolenic acid (ALA), a more widely abundant omega-3 found in some seed and nut oils such as flax and chia.

ALA is converted to SDA by delta-six desaturase ( $\Delta 6D$ ), an enzyme originating in the liver. While critical to the synthesis of long-chain omega-3s, this enzymatic conversion is particularly inefficient in humans. SDA is then converted to the well known omega-3 EPA. Cellular membranes require unsaturated fatty acids to be incorporated as phospholipids to maintain proper fluidity, porosity, and integrity and to serve as reservoirs of

anti-inflammatory response mediators. While SDA is itself a product of ALA metabolism, direct dietary SDA intake offers an efficient way to synthesize EPA from non-marine sources.

As such, SDA has been dubbed a “pro-EPA” omega-3 fatty acid as it bypasses the  $\Delta 6D$  rate-limiting step in humans that causes plant-derived ALA sources to convert poorly to the more elongated omega-3s of EPA, docosapentaenoic acid (DPA), and docosahexaenoic acid (DHA). Clinical studies have shown that while SDA does not convert to DHA to any significant degree, SDA converts to EPA in tissues and circulating cells up to five times more efficiently than ALA. Further, as SDA is less unsaturated than EPA and DHA, it is more stable, less prone to oxidation, and more amenable in applications where fishy off-flavors pose challenges to consumer acceptance.

### Supply and sustainability

Recently, the FDA granted Ahiflower oil with “generally recognized as safe” (GRAS) status with no objections in the U.S. Ahiflower oil may be consumed in foods and dietary supplements at

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daily intake rates up to 2.25 grams SDA, or about 11 to 12 grams of Ahiflower oil per day.

An effective daily dose of Ahiflower oil is about 2.3 to 3 grams, providing the internationally recommended daily equivalent of 200 to 250 mg of EPA, as compared to the 5.6 to 11.2 grams of flaxseed oil needed to achieve the same EPA conversion benefit.

Moreover, Ahiflower oil has none of the ecological impact on marine fisheries that fish oil consumption causes. In fact, one acre of Ahiflower crop yields the same amount of oil as about 80,000 sardines.

In 2014 and 2015, one of the Peruvian anchoveta fisheries and the U.S. west coast sardine fishery were closed due to plummeting fish stocks. And the Peruvian fishery is responsible for supplying about 70 percent of the world's omega-3 fish oil, as reported by the Global Organization for EPA and DHA (GOED).

This event underscored the growing need for an "all-in" approach to supplying omega-3 fatty acids from marine, algal, and plant sources. Diverse new omega-3 nutritional sources are needed to address long-term demand and respond to consumers who cannot or will not eat marine animal products.

In 2013, the GOED reported that in 12 industrialized countries, 220 million consumers had stopped taking marine-derived omega-3 supplements due to sustainability concerns. This is a large and expanding patient base that healthcare practitioners can now address with Ahiflower oil.


### SDA clinical evidence

SDA has an emerging body of scientific and clinical research, supporting health benefits that are aligned with and in some cases independent of omega-3 ALA, EPA, and DHA findings. This is true in both topical and ingestible SDA applications. Recent peer-reviewed references

include the following benefits or activities associated with SDA:

- ▶ Anti-obesity. SDA can suppress adipocyte (fat cell) differentiation.<sup>2</sup>
- ▶ Anti-diabetes (Type 2). SDA can suppress Type 2 diabetes biomarkers.<sup>3</sup>
- ▶ Anti-inflammation. Plant SDA oil decreases intestinal prostaglandin E2 (PGE2) sequestration and reduces endogenous production of COX-derived arachidonic acid metabolites.<sup>4</sup>
- ▶ Coronary artery disease prevention. Plant SDA oil sources decrease cholesterol blood fractions and triglycerides, benefiting people at risk for CHD/CVD.<sup>5,6</sup>
- ▶ Anti-carcinogenesis. SDA reduces the growth of human breast cancer cells *in vitro* and *in vivo*. SDA also enhances the chemosensitivity of canine lymphoid tumor cells. And SDA enhances the anti-tumor activity of doxorubicin in human prostate cancer cell lines.<sup>7,8,9</sup>

Long-term prospective studies investigating the health effects of SDA consumption have yet to be conducted. However, preliminary studies indicate that SDA has beneficial effects on various biomarkers of disease, particularly relating to cardiovascular and inflammatory pathways. This only enhances the recognized anti-inflammatory benefits of Ahiflower oil's gamma linolenic acid.

As healthcare practitioners respond to concerns about the sustainability, traceability, purity, and sensory appeal of omega-3 nutrition sources, Ahiflower is a novel and highly responsive omega-rich alternative. 



**GREG CUMBERFORD** is a 25-year botanical natural products industry executive and vice president of strategic initiatives with Nature's Crops International.

He can be contacted through [ahiflower.com](http://ahiflower.com).

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MANUEL-F-O/THINKSTOCK

## Foundational support

Should you be using orthotics in your practice?

BY JOHN K. HYLAND, DC

**A**T A RECENT SEMINAR, IN A DISCUSSION ABOUT THE USE OF orthotics that covered some of the technical aspects of providing and fitting them for patients, one of the doctors present asked, “What I don’t understand is, why do chiropractors need to use orthotics? I don’t use them in my practice and I don’t see what the big deal is.”

As orthotics have been an integral part of chiropractic and rehabilitation for many years, his question suggests that there are still DCs who don’t appreciate the value and benefits of orthotics for their patients. You could list all of the spinal and lower extremity conditions that can be improved with an effective combination of chiropractic care and orthotics; however, the

primary reason you should use orthotics is to benefit your patients.

### Key orthotic benefits

Orthotics are helpful in addressing a variety of conditions, but the benefits fall roughly into three areas:

First, they can alleviate many symptomatic musculoskeletal conditions, including the No. 1 reason patients visit a chiropractor: low-back pain.<sup>1</sup>

Next is their ability to improve musculoskeletal efficiency and sports performance.<sup>2,3</sup>

And finally, custom-made orthotics can aid in the prevention of future problems (see sidebar).

These benefits are due to the combination of improved lower

extremity biomechanics and better absorption of repetitive skeletal impact.

### Better biomechanics

One of the major goals of custom-made orthotics is to improve foot and ankle function by supporting the foot’s arches and reducing pronation forces. In addition to interfering with gait and decreasing athletic performance, excessive pronation is dangerous for two major reasons: The likelihood of developing painful foot and ankle disability over time and (especially important for doctors of chiropractic) the probability of transferring abnormal stresses up the lower extremities and into the pelvis and spine.

Athletes often suffer from a number of overuse injuries that can be linked

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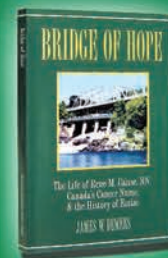
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to excessive pronation.<sup>4</sup> Often, these developing problems go unnoticed for months or years, and it is only when a new walking or recreational program is begun that symptoms arise.

Other times, it is the painful end stage of abnormal biomechanics that brings a patient in for care. The following is a list of symptomatic conditions and musculoskeletal pathologies that are associated with excessive pronation.<sup>5</sup>

### Foot conditions

- ▶ Calcaneal periostitis (heel spur)
- ▶ Hammer toes
- ▶ Hallux valgus
- ▶ Interdigital neuroma
- ▶ Longitudinal arch collapse
- ▶ Medial calcaneal compartment syndrome
- ▶ Metatarsal calluses
- ▶ Metatarsalgia
- ▶ Navicular stress fracture
- ▶ Plantar fasciitis

- ▶ Sesamoiditis
- ▶ Spring ligament sprain
- ▶ Tailor's bunions
- ▶ Tarsal tunnel syndrome
- ▶ Toe extensor muscle spasms

### Lower Leg Problems:

- ▶ Achilles tendinitis
- ▶ Fibula stress fracture
- ▶ Flexor digitorum longus strain/tendinitis
- ▶ Flexor hallucis longus strain/tendinitis
- ▶ Peroneal tendinitis
- ▶ Tibialis posterior strain/tendinitis
- ▶ Tibial periostitis
- ▶ Tibial stress fracture<sup>6</sup>

### Knee Pathology:

- ▶ Anterior cruciate injuries<sup>7</sup>
- ▶ Chondromalacia patellae
- ▶ Knee joint capsulitis
- ▶ Patellofemoral pain syndrome<sup>8</sup>
- ▶ Pes anserine bursitis

### Hips, pelvis, and spine

- ▶ Anterior pelvic tilt
- ▶ Excessive lumbar lordosis
- ▶ Functional scoliosis
- ▶ Hip adductor muscle strain
- ▶ Hip flexor muscle strain
- ▶ Hip joint capsulitis
- ▶ Iliotibial band syndrome
- ▶ Piriformis muscle strain
- ▶ Sacroiliac problems
- ▶ Tensor fascia lata strain
- ▶ Trochanteric bursitis

### Reduced skeletal impact

Orthotics can significantly reduce the deleterious skeletal effects of the repeated stresses of walking. At the moment of impact during heel strike, a shockwave is propagated through the entire musculoskeletal system.<sup>9</sup>

This shockwave passes through the skeleton at over 200 miles per hour, and jolts the base of the brain up to half a millimeter in normal walking.<sup>10</sup>

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## RESEARCH RESULTS

### Benefits of orthotics

- ▶ Alleviate musculoskeletal symptoms
- ▶ Improve musculoskeletal efficiency and sports performance
- ▶ Prevent future musculoskeletal problems

This amount of force can be the cause of persistently painful and stiff joints, especially in patients with degenerative changes in their spinal discs and joints. When made with modern viscoelastic materials, orthotics can decrease current symptoms and can help to prevent further degeneration.

### Desirable outcomes

The combination of better biomechanical function during gait and decreased skeletal impact when walking and running provides significant benefits to patients. Symptomatic conditions are more easily treated, sports and daily activities are less taxing thanks to improved mechanical efficiency, and numerous musculoskeletal problems can be either avoided or minimized.

Orthotics should be considered a vital component of chiropractic care for many if not most patients. Doctors of chiropractic who employ these effective tools are bound to experience better outcomes and greater treatment satisfaction. <sup>CE</sup>



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## Modifier misuse

As it turns out, the AT modifier does not stand for “all the time.”

BY KATHY MILLS CHANG, MCS-P, CCPC

**W**HEN THE CENTERS FOR MEDICARE AND MEDICAID Services (CMS) told chiropractors that it would only approve claims submitted with the AT (active treatment) modifier, those chiropractors listened. In fact, they listened so well that according to a recent Office of Inspector General (OIG) report, slightly more than 95 percent of Medicare claims submitted in 2013 (the last year studied) were coded with the AT modifier.

The only problem is that almost half of those claims were for what the OIG later determined to be maintenance therapy.

No matter what new issue comes down the pike, from EHR changes to ICD-10 coding, Medicare remains the subject DCs find the most confusing. What's the difference between active treatment and maintenance care? How does that differ, if at all, from medically

necessary care as opposed to clinically appropriate treatment?

### Details matter

First, active treatment is for acute conditions or for the stabilization of chronic conditions. CMS considers a patient's condition acute when “the patient is being treated for a new injury, identified by X-ray or physical exam,” and it can be reasonably expected that chiropractic manipulation will improve or at least arrest deterioration of the patient's condition.

A chronic condition is a different matter altogether. CMS considers a condition to be chronic when it “is not expected to significantly improve or be resolved with further treatment,” but chiropractic treatment can be reasonably expected to result in some degree of *functional* improvement. Once that chronic condition is stable and not expected to improve further, any

additional treatment is considered maintenance therapy.

And maintenance therapy, according to CMS, is “a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life” (wellness care) or “therapy that is performed to maintain or prevent deterioration of a chronic condition” (supportive care).

Ironically, maintenance therapy is what most chiropractors advocate for and believe in. DCs sigh, with good reason, over patients who “only show up when it hurts,” and understand that this kind of emergency-room approach to chiropractic is doing both patients and practitioners a disservice. But while maintenance care may be professionally satisfying, arguably advisable, and clinically appropriate, it isn't considered medically necessary. Therefore, Medicare won't cover it. Most third-party payers won't, either.

## Appropriate documentation and coding practices aren't complicated to learn, but they do require time and attention.

Maintenance therapy is vital to wellness, and you should continue to render it. You also must prepare your patients to pay for it out of pocket—and educate them about why it's important to make maintenance therapy a part of their budget.

It would be one thing if getting your codes wrong just meant a denied claim. And that, in and of itself, is no small problem. Denied claims can grind revenue to a halt. But an even bigger problem is that intentionally or even unknowingly miscoding your claims, no matter how strong your conviction that the patient deserved covered treatment or the degree of your misunderstanding of the AT modifier, puts you at high risk of

records reviews and audits.

Based on its findings over the past few years, the OIG is recommending that CMS scrutinize chiropractors more closely and even launch oversight programs for chiropractors with high error rates. If you're billing the highest CMT codes possible (98942, for example) and appending the AT modifier aimlessly, you're waving a huge red flag from the roof of your practice. And the consequences for red-flag behavior grow higher every year.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which became law in April 2015, contains provisions for the oversight of Medicare chiropractic services, including requiring preauthorization

for services provided by chiropractors with aberrant billing or high rates of denial. It remains to be seen what that will look like in reality, but the OIG is hoping to put such oversight into place by 2017 at the latest, making the next year a critical one for getting your documentation in order and your coding in compliance.

So what constitutes "aberrant billing," according to the OIG? The government entity uses four primary measures:

**Treatment "suggestive of maintenance therapy."** To the OIG, that means a high number of claims per beneficiary per episode of care. The OIG says the average is, believe it or not, eight. Some flagged claims average as high as 25.

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## PRACTICECENTRAL

**Potentially up-coded claims.** The OIG says that in its opinion, only about 10 percent of all paid chiropractic services should be for the highest code, 98942. But its previous investigations find a much higher percentage of 98942s billed—and it believes almost half of them were up-coded.

**Sharing of beneficiaries.** A high average of beneficiary sharing with other DCs and practitioners, according to the OIG, increases incidences of fraud, including medical identity theft and kickbacks.

**A high or unlikely number of services per day.** What strikes the OIG as an unreasonable number of services billed in one day suggests, it says, diminished quality of care at best, and outright misrepresentation of services rendered (i.e., fraud) at worst.

### Time and attention

Most chiropractors are not intentionally fraudulent. The OIG considers only 2 percent of the coding “outliers” it investigated to be willfully breaking the law. Most chiropractors are trying to do the best they can with what little time they have. It’s easy to throw a five spinal region adjustment code onto a claim form, tack on the AT modifier, and call it good. It’s even easy to justify treating all five regions, and many DCs, especially those who use specialty adjustment techniques, advocate that this is good practice.

The bottom line is that it doesn’t matter what you or any other chiropractor thinks. The rules and regulations are federally mandated and enforced.

Appropriate documentation and coding practices aren’t complicated to learn, but they do require time and attention. Your documentation should accurately and compellingly make its case for active treatment of an acute or improvable chronic condition, and tell the story of a beginning, a middle, and an end of an episode of care—preferably in eight visits or less. Then, make sure the code(s) you’ve selected match up.

AT means active treatment. Use it all the time, and you’re sending the wrong signal—one that says you either don’t know or don’t care what you’re doing. The consequences, quite simply, aren’t worth it. **CE**



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# Change your frame

8 ways to make difficult patients disappear.

BY MONICA WOFFORD, CSP

**Y**OU LOVE YOUR PATIENTS. BUT YOU ALSO KNOW THAT DEALING with patients isn't always easy.

In fact, some of them lie, some don't show up, and some blame you for their symptoms even though they haven't followed your directions. All of this and more can cause enough stress to make you want to show them the door.

What if, instead, you could make difficult patients disappear—without going to jail or experiencing the backlash most fear when terminating a problem patient? When working in a fast-paced environment with clients who are in pain, conflict and stress can occur. But it doesn't have to be the norm if you are willing to make one decision, one that keeps these kinds of problems to a minimum.

When you run a practice, it doesn't take much for one difficult patient to find all your buttons and push them hard. The same is true for your team who, in fact, take the brunt of a mean patient's ire. But when you choose to minimize the impact of difficult people, you'll be pleasantly surprised that at some point the behavior—and occasionally the people sharing it—disappears. The following 12 strategies will help make that happen.

## Clarify perceptions

Perceptions are your point of view and, when you form them, you tend to agree with your own data. The key question is whether your perceptions are accurate and a true gauge of what other people are thinking and doing.

Are you interpreting others' behaviors correctly? Did they mean to rattle your nerves on purpose or were they just acting naturally, as you do? Perceptions are powerful and, once made, they encourage you to label.



ELENA ELISSEVA/THINKSTOCK

The challenge is that most labels, like difficult patients, are assigned on the basis of how you perceive actions and outcomes. If you change your perceptions you'll likely change the way you view behaviors.

## Set boundaries

Some of your stress can come from a

failure to set boundaries. How many times a day do you hear "Gotta sec?" How often do you say yes?

In an environment where doctors float around the office floor and are seen as more effective if they have an open door, time for you can be slim and create reactions you might regret. Moreover, these reactions, and the

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## PRACTICECENTRAL

tension you feel in keeping them at bay, rubs off on those team members and patients who enter the practice on that particular day. Much as admitting it is tough, behavior from the leader can often provoke the kind of behavior one would call difficult. To prevent infecting all in your path, effectively block out time and politely let others know when you are available. Let people know your preferred form of communication. Do you respond to emails or texts faster than a voicemail? Do people know you're always accessible, even if it's adding to your stress? Difficult people and patients may balk if you're not at their beck and call, but they'll adjust and disappear if you consistently set appropriate boundaries.

### Assess before you arrest

Driven leaders with an entrepreneurial bent, like those who become doctors and open their own practices, can also have a tendency to judge quickly. But that's like making an arrest before determining guilt. As a result, labeling people with terms like "difficult," "challenging," or "a pain in the neck" can occur quickly.

### Leaders learn to recognize what lies below the emotional surface and address the real issue at hand.

Act like the jury instead of the judge, and assess before you arrest. Ask questions before you make a mistake in how you view a person. For example, if patients don't communicate the way you do, your conversations may be strained and tempt you to "convict" them of not listening.

Instead, assess what they need from you first, as you should do as a doctor, and don't just look for the answer you expect. The danger is that once you give a person a negative assessment, it has a tendency to stick and soon you'll begin looking for affirmation of the label you gave.

### Eliminate conflict

When people struggle for what they need to hear, feel, or experience, and aren't getting what they need, it can create conflict. Your role in this goes beyond chart reading, adjustments, and diagnosis—it requires emotional intelligence. It doesn't mean you become conflict averse, it means you need to understand their wants.

Learn to read between the lines and become adept at calming patients down. Most people will enter a conversation with good intentions, but sometimes may struggle with articulating what they really need. Leaders learn to recognize what lies below the emotional surface and address the real issue at hand.

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**Understand what they really need**

The patient who screams at your front desk staff may appear demanding and rude when what they really want is someone to be responsive and show them they're important. Those who keep quiet and seem aloof are likely disagreeing with what they think you're doing.

With a modicum of awareness of the personalities of your patients and teams, you can truly accomplish amazing things in the area of communication and understanding. This is a key element in the art of making difficult people disappear.

**See the big picture**

Behavioral analysis is a big-picture idea, and in your practice it is worth doing. Does a particular patient's behavior need to impact your whole day? Is it something that should get in the way of enjoying your family time

or developing your team?


Sometimes, your focus can become so small that you drop the larger ball in your interactions. Avoid giving one person's actions more significance than necessary, while not taking them too lightly. Big-picture thinking means looking at your business strategically and deciding what will get the results you seek.

Your patients have individual needs and lives of their own (that may not be going so well). If, in frustration, they take their stress out on you and your team, your job is to be the leader your people need. Teach them how to let some things go. Show them how to keep their eye on the goal and act in a professional demeanor that, no matter what is said, is always what is shown.

**Keep the culture you create**

This kind of leadership, teamwork, and unity creates a culture. How you lead

determines how your team treats you and your patients. How you communicate determines how they will, too. You can make difficult people and patients disappear by observing these straightforward steps.

The challenge is to commit to putting these suggestions into practice on a daily basis. And your overall goal is to create the kind of culture and leadership described above. Cultivating this mindset will contribute to everyone's overall good health. 



**MONICA WOFFORD, CSP**, is the CEO of Contagious Companies, an Orlando, Florida-based training and consulting firm and a consultant in the chiropractic industry. She works with chiropractic practices, healthcare, retail, hospitality, and government industry leaders to develop their leadership skills. She can be contacted about training, coaching, or consulting at 866-382-0121 or through [contagiouscompanies.com](http://contagiouscompanies.com).

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# A vicious cycle

Some of your patients are trapped in the Metabolic Syndrome, but you can rescue them.

BY DANIEL SOSNOSKI

**Y**ou are likely familiar with a certain type of patient: He or she is overweight or obese, with an apple-shaped figure caused by excess adipose tissue about the midsection.

Blood testing will generally reveal a poor lipid profile and high fasting blood sugar. And these symptoms will present in combination with hypertension marked by high blood pressure and psychological stress.

While researchers had been noticing these problems often occurring in concert, it wasn't until a paper was presented to a European diabetes conference in 1965 that a name was given to the condition defined as a grouping of these risk factors: "Syndrome X."

In 1989 it was renamed "The Deadly Quartet," in 1992 called "The Insulin Resistance Syndrome," and near the end of the 20th century Gerald Reaven described it as "Metabolic Syndrome (often abbreviated as "MetSyn" or "MetS") in his landmark paper "Role of insulin resistance in human disease."<sup>1</sup>

To date, researchers aren't entirely sure about the etiology of this disorder, but it is alarmingly common. Some one-third of all US adults are affected, with some variation showing increased risk for older adults and certain ethnic groups.<sup>2</sup> Because excess weight is a frequent culprit for back and joint pain, chances are you are already seeing a considerable number of these patients.

The bad news is that obesity and

hyperglycemia are on the increase. The good news is that the ability to treat and potentially reverse MetS lies well within your power, and in many ways you are ideally suited to make a positive intervention in these patients' lives.

## A constellation of concerns

One doctor who sees this condition frequently is **Julie Beck**, DC, CSCS. "In conventional medicine, via observation, using the term *syndrome* is a diagnosis of a group of symptoms. MetS is the collection of high blood pressure, insulin resistance, and dyslipidemia." She notes that once you become familiar with MetS, you can spot it visually or by symptoms, and you can run labs to confirm it (if allowed by your state's scope of practice).

Another expert in this area is **John Troup**, PhD. He notes that MetS is defined by five criteria developed through clinical research, consisting of the following:

- ▶Waist circumference more than 40 inches in men, 35 inches in women.
- ▶Triglycerides above 150 mg/dL.
- ▶High blood pressure more than 130/85 mmHg.
- ▶Fasting plasma glucose equal to or greater than 110 mg/dL.
- ▶High density lipoprotein (HDL) less than 40 mg/dL in men and less than 50 mg/dL in women, together with elevated low-density lipoprotein (LDL).<sup>3</sup>

According to **Adam Killpartrick**, DC, who also works with this type of patient, "These areas get out of

balance. You have elevated cholesterol and blood sugar, and then belly fat and obesity, which raise the risk for heart disease and diabetes." As a functional medicine practitioner, Killpartrick is less interested in diagnosis and more involved in addressing the root imbalances of MetS.

"Note that if you have only one of those symptoms, like elevated blood sugar, you don't have MetS. If you do have one of the symptoms, though, your tendency to have the others increases." If you have elevated cholesterol, he says, it can result in high blood pressure: "They're intimately connected, and the web they weave raises risk."

**James Wilson**, DC, ND, PhD, is an expert in treating MetS and related disorders. He views the syndrome as the product of a combination of excesses: "It's not a disease as much as a condition that leads to disease. Excess stress, excess cortisol, excess insulin. Excess sedentary lifestyle. It's really stress-driven, and of course stress elevates cortisol."

If he suspect MetS is in the picture, he'll proceed to testing: "We check blood pressure, and albumen in urine. With a dipstick you can perform the test right in your office," Wilson says. He notes that fasting and post-prandial insulin testing can be done easily with a finger stick. "Measuring fasting insulin just before eating breakfast and then again at 30, 60, 90, 120, and 150 minutes post-prandial is a much more accurate way to determine insulin resistance than only measuring fasting insulin. If any of the post-prandial

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**John Troup, PhD**, chief science  
officer and president of the  
metaproteomics research  
division of Metagenics.  
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**Adam Killpartrick, DC**, chief  
science officer for DaVinci  
Laboratories of Vermont.  
[davincilabs.com](http://davincilabs.com)



**James L. Wilson, DC, ND, PhD**,  
founder of ICA Health, creator  
and director of research and  
formulation for Health Science  
Research Foundation.  
[icahealth.com](http://icahealth.com)



**Todd G. Singleton, DC**, owner  
of Doctor's Goldmine.com, a  
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readings are more than five times  
fasting insulin level, it shows insulin  
resistance.”

Wilson finds that cortisol levels are  
best checked with a saliva test. “When  
you look at it, cortisol is the driver  
behind a lot of the symptoms of the  
Metabolic Syndrome. Increased stress  
causes increased cortisol. Cortisol  
causes a rise in glucose by stimulating  
conversion of glycogen, fatty acids,  
peptides, and proteins to glucose to  
meet the increased need for cellular  
ATP during times of stress.”

**Presenting problems**

All of the experts consulted agreed that  
once you have some experience in  
treating this patient base, you become  
adept at identifying those patients at  
risk. Spotting the problem is fairly  
straightforward, but are some patients  
more likely than others to manifest  
MetS?

According to Beck, the standard  
American lifestyle and diet are key  
culprits. “Drinking coffee to wake up,  
drinking wine or taking Ambien to  
sleep—it’s a lifestyle-associated illness,  
but it’s not a genetic time bomb,” she  
says.

On the other hand, MetS may be a  
result of epigenetic expression, the  
interface between genetics, physiology,  
and lifestyle. That’s why one person  
might succumb to the syndrome and  
not another, even if both follow a  
similar diet. “It’s not the genetics doing  
something wrong,” Beck says. “It’s the  
expression of genes via lifestyle  
behaviors.”

Wilson starts by observing the  
patient: “Does his stomach precede  
him? A pot belly, a personal spare tire?  
Does he have fatigue, brain fog, or an  
inability to focus? It’s not unlike  
adrenal fatigue, as many of the  
symptoms are the same.”

Other symptoms Wilson looks for  
are: sleepiness after a large meal,  
unspecified depression, erectile  
dysfunction, and intestinal bloating.  
Each of these factor into the etiology  
of MetS. And if the patient just looks  
rundown, out of shape, and overweight,  
you have good reasons to check for  
further evidence of the syndrome.

In Killpartrick’s experience, there are  
few patients he sees who are not  
potentially at risk, because poor quality  
food, a sedentary lifestyle, and a lack of  
daily attention to wellness are fairly  
ubiquitous to the American lifestyle.  
“Lately, I’m seeing more and more  
kids—children—having symptoms that  
used to be seen in adults exclusively. I  
think you’re going to be increasingly  
seeing MetS in younger people,” he says.

Another doctor who sees this  
syndrome frequently is **Todd Singleton**,  
DC: “Over half of the patients I see are  
MetS—they’re pre-diabetic. So, one of  
the first ways to diagnose it is to  
perform a visual inspection. Then  
check for blood pressure that’s greater  
than 140 over 90. These are just physical

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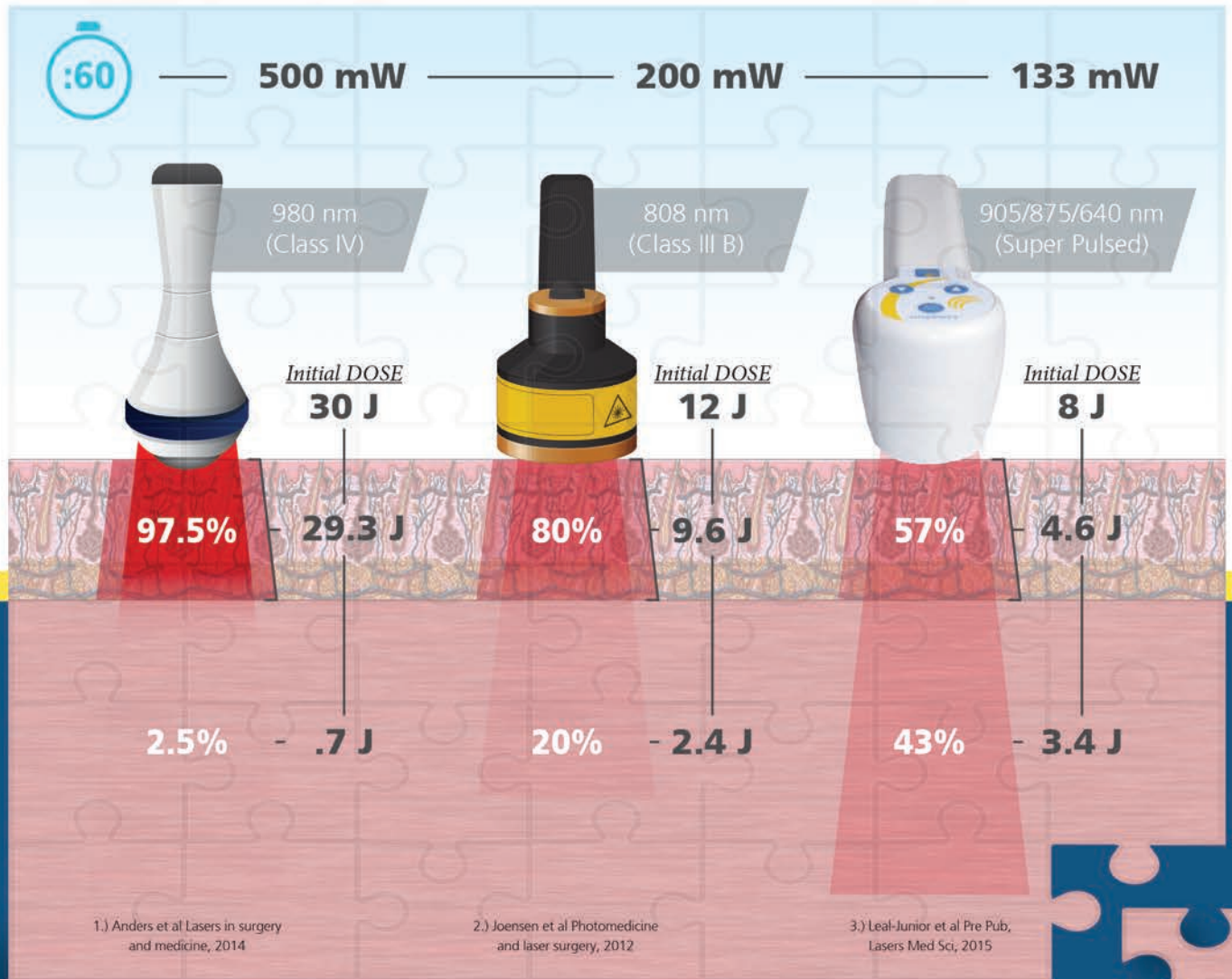
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## Metabolic Syndrome symptoms

The five risk factors below are each major risk factors for MetS. Any single one is a health concern, but a patient who has three or more is considered to be suffering from MetS.

- ▶ Large waistline. Abdominal adiposity is the most-visible sign of MetS. Usually, an “apple-shaped” body is considered worse than a “pear-shaped” body with excess weight distributed lower on the hips.
- ▶ Low HDL cholesterol (known as the “good” cholesterol). Because HDL helps transport LDL (“bad” cholesterol) from the arteries, low HDL is correlated with high LDL and cardiovascular disease.
- ▶ High triglycerides. Levels above 150 mg/dL are indicative of MetS.
- ▶ High blood pressure marked by systolic BP greater than 130 or diastolic BP greater than 85 mm Hg indicate hypertension common to MetS patients.
- ▶ Insulin resistance. MetS is comorbid with diabetes, so look for fasting plasma glucose above 100 mg/dL.

things you can get in the office.”

If Singleton can order or obtain a blood test, he'll look for elevated triglycerides of 150 mg/dL or more, reduced HDL, and fasting glucose

greater than 100 mg/dL. Because inflammation is so strongly associated with MetS, patients will generally have higher-than-normal C-reactive protein.<sup>4</sup>

Not all patients are equally at risk,

however. Troup notes that African Americans and Latinos tend to be at highest risk, and women are at a higher risk than men. “Anybody with one of the five criteria is at higher risk of the syndrome,” he says. If a patient presents with a BMI of 30 or higher, then they're definitely candidates who should be screened for the other four criteria. Taking a family history is strongly advised.

“They should be checked for blood pressure, blood glucose, and a cholesterol panel,” Troup says, adding the caveat that it differs by state whether DCs are in their scope of practice when looking to order certain tests.

## Business as usual?

Given that addressing MetS in your practice involves a lot more than giving an adjustment, you may be tempted to overlook the symptoms. Again, it will vary by state, but some third-party

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payers allow DCs to bill for nutritional counseling, and some may allow you to obtain non-RD licensure. Otherwise, you might offer this on a cash basis, or bring an RD on board to assist you.

Consider the possible outcomes for your patients if their MetS is left untreated, given that each of the factors is a strong health risk individually. Combined, these risks become potentially devastating.

Troup observes that MetS can lead to cardiovascular disease, atherosclerosis, hypertension, and diabetes, which are comorbidities. MetS is thus a precursor to these chronic disease states. "It can lead to very serious events," he says, "and increased mortality has already been established."

When Singleton's patients are showing signs of MetS and are coming in specifically because they're sick and want to lose weight, he puts them on a diet and exercise program. "I warn

them that [otherwise] they'll wind up in an assisted living facility—which is expensive."

The direct risks patients face are considerable, but the indirect risks can be equally if not more alarming. For example, "MetS is connected in the literature to Alzheimer's and dementia, and it causes your blood sugar to be dysregulated. When blood sugar is spiking all the time, it causes dAGEs—an acronym for dietary advanced glycation end products—which are like bruising as they are highly radical."

This clarifies the picture. Oxidative stress and free radicals are damaging to all kinds of tissues, which is why diabetes and neurological problems are associated with dAGEs, and with an aging population this is a daunting proposition.

MetS often progresses to non-insulin-dependent diabetes. "Now the patient needs external hormonal

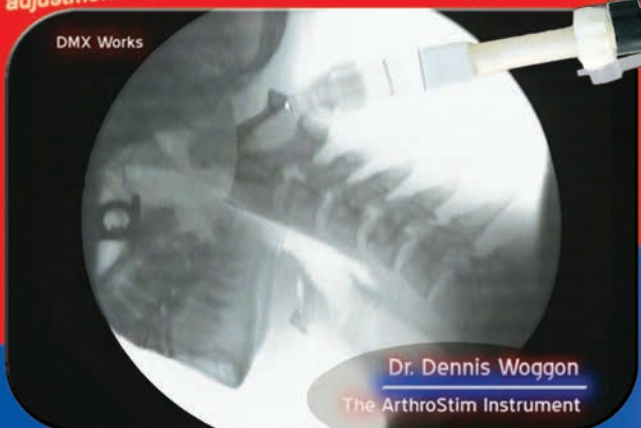
supplementation, while suffering from circulation problems, peripheral neuropathies, and vascular destruction," Beck says. These are results of excess dAGEs, which finally lead to tissue necrosis.

And it gets worse: When you see raised insulin you tend to see excess cortisol. "This can be damaging to neural tissue and a lot of tissue in the body, Killpartrick says. He warns that if you don't address these issues, if you let insulin get out of control, you get diabetes and then you get morbidity. "Increased estrogen and the lack of ability to deplete it from the system is a risk for cancer."

There is a general progression these patients will experience, which Wilson describes as follows: "They go from insulin resistance to mild dyslipidemia, to hypertension, to diabetes, and finally to heart disease or cancer." The MetS patient may find it difficult to

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lose weight because he or she will have increased estrogen and lowered testosterone, and dysglycemia, all of which depress thyroid function, slowing metabolism further.

**Turning things around**

MetS doesn't occur overnight. The components of the syndrome reinforce one another so that patients may well succumb to a downward spiral in

health, but the onset can be insidious and take years to manifest. In a similar manner, bringing the patient's metabolic systems back into balance will take time and commitment. The good news is that plenty of DCs have established that you can indeed lead a patient back to recovery.

"MetS is a metabolism problem," Beck says. "If the hormonal system is like an orchestra working in harmony,

then if one player is off, others will be off, too." She notes that if there's an imbalance, there will be an inflammation problem. And when a person is nutrient deficient, the mitochondrial membrane can get "leaky" and struggle to contain glucose.

There may be more than one approach to resolving MetS, but the general solution will be something like this:

1. Reduce inflammation
2. Reduce weight
3. Restore lipid balance
4. Address hormonal imbalance
5. Increase physical activity

Only addressing one component is akin to treating a symptom. What you're looking for is a multipronged approach that gets the above targets working toward supporting one another and creating a virtuous cycle.

"A lot of approaches are natural ones," Killpartrick says. "Like, if you have elevated cholesterol, instead of taking cholesterol medication try red yeast rice. You can supplement with magnesium." But, he says, that's not dealing with the underlying issue. First, you want to identify the primary cause that led to the original imbalance.

For example: Take cholesterol—ask why it's being elevated. Is it hormonal? Is it due to cellular damage? Stress can even cause cholesterol to elevate. Blood pressure is another factor. Why is it so high? Is it due to a vertebral misalignment? Is it caused by obesity and stress on the blood vessels?

"The underlying cause is the key," Killpartrick says. "And if you don't address that, and are just using natural medicine in the place of regular medicine, any positive gains will be short-lived."

In Wilson's approach, he first looks to minimize stress. There are relaxation techniques he uses to help patients get into parasympathetic balance. "We teach them to breathe slowly, alternating breaths through one nostril at a



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time.” He recommends yoga as well.

“I have them take a sheet of paper, and write *good for me* on one side, and *bad for me* on the other,” Wilson says. He has patients list items on each side, then prioritize them into the top three, and finally isolate the most important. Then they make a written plan for maximizing the positive element and minimizing the negative one.

“After three weeks, they move to the next item. After implementing changes needed for the top three on each side, they usually start feeling better,” he says.

For his part, Troup finds DCs to be uniquely positioned and qualified to take care of MetS patients with nutrition support, therapy, and counseling. “A 12-week program with diet and activity can help transport the patient back to a health point.”

Inflammation has two phases: The initiation phase (after a long history of following a bad diet the patient is hyper-inflamed), which increases risk. The second phase is called the resolution phase, which allows tissues to heal.<sup>5</sup> When these phases are in balance, a person is able to experience cellular health. But if the resolution pathway is overwhelmed, inflammation becomes chronic.

“There are pathway modulators in medical foods that help reduce inflammation. Those, in combination with diet, constitute a nutrition therapy that’s beneficial to patient outcomes,” Troup says.

Troup recommends moving patients to a 40-30-30 diet plan, which is 40-percent carbohydrates, 30-percent protein, and 30-percent fat (commonly known as the Zone diet).

In a similar vein, Wilson suggests patients should follow a Mediterranean diet, which is low in sodium, high in vegetables, and favors low-glycemic-index foods. This is typical of the kind of low-calorie, high-nutrient diet MetS patients need.

“The biggest thing,” Wilson says, “is to cut out white foods—white flour, white sugar, and they need to look at labels. They may not realize how much sugar their food contains. Barley malt, fructose, dextrose, pasteurized honey—any sweet foods that immediately go to fat. And they want to avoid caffeine as it stimulates cortisol.”

As most people with MetS are magnesium deficient, Wilson finds they need about 500 mg of magnesium citrate. He also recommends supplemental trivalent chromium, manganese, vanadium, and zinc gluconate. In addition, Wilson finds these work well with several herbs such as bilberry (*Vaccinium myrtillus*), bitter melon (*Momordica charantia*), cinnamon, fenugreek, Indian kino tree bark (*Pterocarpus marsupium*), gymnema sylvestre, and jambolan (*Syzygium cumini*).

“It’s the combination of the nutrients and herbs that makes a difference. Almost all of these reduce and prevent hyperglycemia, and mainly work to normalize blood sugar,” Wilson says.

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Singleton's clinic has health and dietary coaches who assist with lifestyle counseling. "Within three to six months of educating patients and creating new dietary habits, we can reverse the majority of the symptoms of MetS. Their blood pressure comes down, their weight comes down, and their glucose improves. That's our window of opportunity."

In Singleton's experience, when

patients start to see positive changes, they're more inclined to stay on the path to recovery. "After six months of the program, then they're autonomous. But if they regress to their old habits, there's not much we can do."

### Expectations and outcomes


Killpartrick stresses that a MetS program will normally be tailored to each patient. And in the spirit of

functional medicine, he points out that if you and your patient aren't obtaining expected results, you should investigate further and make adjustments.

"One of the first things that will be observed in the initial 12-week period," Troup says, "is a major reduction in weight." Concomitantly, expect a decrease in BMI and waist circumference. "Triglycerides and lipids will be reduced and blood pressure will be controlled again." He also cites outcome studies that demonstrate reduction of three of the five MetS components in three- to four-month timeframes.

Beck adds that, "Physiology-wise, looking at recycling cells, we're talking maybe six to eight weeks. But patients should start feeling better in about two weeks."

It would be best if your MetS patients never developed the condition in the first place. Those who would like to avoid it entirely (which should be everyone who doesn't have it) should do the same things MetS patients in a recovery program do: reduce weight and maintain it at a healthy baseline, adopt a healthy diet, avoid stress and causes of inflammation, and engage in regular physical activity.

Trends in the U.S. population suggest that Metabolic Syndrome will be with us for a long time to come. You are exceedingly well-positioned to assist those afflicted onto the road to recovery. As our experts in this article will tell you, the patients you help will become your staunchest supporters and a reliable source of referrals. 



**DANIEL SOSNOSKI** is the editor-in-chief of *Chiropractic Economics*. He can be reached at 904-567-1539, [dsosnoski@chiroeco.com](mailto:dsosnoski@chiroeco.com), or through [ChiroEco.com](http://ChiroEco.com).

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## Beating the burn

Recommend these 3 anti-inflammatory nutritional remedies for post-exercise relief.

BY STEPHANIE KRAMER

**D**ESPITE ITS BENEFITS, EXERCISE OFTEN CAUSES MUSCLE ACHES and soreness. The pain can be frustrating, especially if it limits physical activity. Yet exercise alone may not be to blame—the real culprit could be a person's diet.

“Muscle pain is very common, especially if people are starting a new activity or if they increase the number of repetitions,” says Christopher Black, PhD, assistant professor of exercise physiology at the University of Oklahoma. Strenuous exercise can cause microtears in the muscles, triggering inflammation and pain. Mild inflammation is natural after a heavy workout, but excessive inflammation can block recovery,

reduce performance, and lead to injury.

Many people use nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen or aspirin to relieve the pain that accompanies inflammation and then continue training. Painkillers may cause side effects, however, including stomach cramps and nausea. Using NSAIDs can also mask a serious injury.

“Multiple studies have been done on anti-inflammatory foods,” says Leslie Bonci, RD, MPH, owner of Active Eating Advice and sports nutrition consultant to Carnegie Mellon University and the Pittsburgh Ballet. “There is also interest among athletes who want to avoid taking medications.”

Here are three nutritional diet additions that your patients can start with before turning to medicinal relief.

### Fishing for solutions

Fish and fish oil are the best sources of inflammation-fighting omega-3 fatty acids. The American Heart Association recommends two 3.5-ounce servings of fish per week. According to a 2014 study published in *Nutrition Journal*, however, most people do not consume enough omega 3s.<sup>1</sup> A lack of anti-inflammatory omega 3s and an excess of pro-inflammatory omega 6s (found in processed foods) has been linked to inflammation and various diseases.

“A lot of people are choosing to eat chia seeds to get omega 3s into their

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## WELLNESS APPROACH

### You can help patients propel their exercise routine without the limitations that persist with soreness.

diet," Bonci says. The quicker athletes can reduce inflammation, the sooner they can continue to train.

Salmon, sardines, mackerel, and tuna are all rich in omega 3s. Cod liver oil contains omega 3s as well as vitamin D, which helps build strong bones. Good plant sources for omega 3s include walnuts, soybeans, seaweed, and flaxseed oil.

#### Ginger to spice things up

Ginger has been used for centuries as a traditional remedy and now is gaining recognition in modern medicine. A study co-authored by Black showed that eating two grams of ginger daily can reduce muscle pain by 25 percent.<sup>2</sup>

"The compounds that give ginger its unique flavor and spiciness can also relieve pain after exercise," Black says. The results, published in the *Journal of Pain*, compared supplements containing raw or heat-treated ginger versus placebo. Participants were assessed for muscle pain and inflammation before performing 18 extensions of the elbow flexors with a heavy weight and then for three days afterward.

"Both forms of ginger were equally effective," Black says. Muscle pain went away within 24 hours in each study group.

In addition to its texture and zest, ginger is also highly versatile. It can be eaten fresh, cooked, crystallized, or as a spice.

#### Tart cherry juice for sweet relief

Tart cherry juice is another powerful anti-ache remedy. In a study involving 20 London Marathon runners, drinking cherry juice sped the recovery process and reduced inflammation.<sup>3</sup> One cup of juice is enough to confer the benefits.

Led by Glyn Howatson, PhD, an exercise physiologist at Northumbria University in the U.K., the study found that competitors who drank tart cherry juice twice daily for five days before running and for two days afterward regained their strength faster than those who received a placebo drink.

"Cherry juice does dual duty because it has anti-inflammatory and anti-oxidative properties," Bonci says. The anthocyanins in cherries contain enzymes that block the formation of oxidants, which can lead to further damage.

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**Restoring balance**

Many people ask whether they should avoid certain foods. Bonci suggests posing the question another way: “Are there more anti-inflammatory or pro-inflammatory foods on my plate?”

Eating more nutritious foods such as whole grains, fruits, vegetables, oils, and nuts can help reverse the imbalance between inflammatory and anti-inflammatory compounds. “Whole wheat, brown rice, and amaranth decrease C-reactive protein, which is one of the markers of inflammation,” Bonci says. “Greens such as spinach, kale, lettuce, and broccoli contain vitamin K, which also reduces inflammatory markers.”

**Proactive instead of reactive**


You can help patients propel their exercise routine without the limitations that persist with soreness. “Intense pain may prevent people from exercising,”

Black says. “It’s important to limit any discomfort people experience with exercise, so they get the benefits.”

First, encourage patients to remain active. “It sounds counterintuitive, but exercise can actually relieve pain,” Black says. “Physical activity such as walking or jogging leads to a decrease in the pain sensation.” Stretching is also a powerful pain reliever, though it may hurt in the short-term. Black notes that it can provide 30 to 45 minutes of pain relief afterward.

In addition, encourage patients to take charge of their diet. Bonci emphasizes that an honest assessment of regular eating habits can go a long way toward prevention. “Medications are reactive, and food is proactive,” she says.

As you know and witness firsthand at your practice, change takes time. With some patients, Bonci says, it may take up to eight weeks to begin

noticing a difference in their health. “It’s the gift that keeps on giving,” she says. “If people feel better, they will train harder, get more out of exercise, and be healthier overall.” 



**STEPHANIE KRAMER** is a freelance writer and translator. Her writing on health, wellness, and the performing arts has appeared in *Dermatology News* and other publications.

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ROBERT DAVID/THINKSTOCK

## Be alert with ICD-10

The sky didn't fall, but make adjustments now to stay ahead of the curve.

BY JOHN DAVILA, DC

**N**OW THAT THE DUST HAS SETTLED AFTER THE OCTOBER 1, 2015, implementation date for ICD-10, we are beginning to see what some of the problems and misconceptions regarding ICD-10 are really about. *For example:* The concerns about DCs not being paid due to ICD-10 were largely overstated and those in the billing business have yet to see such cases reported to date.

In fact, there was never even a *slowdown* in the processing of clean claims by insurance companies. This shouldn't come as a surprise, as the Centers for Medicare and Medicaid Services (CMS) stated they would not strictly enforce the specificity of ICD-10 coding for the first 12 months. This is also evident in the private third-party payer side, too where NOS (not otherwise specified) codes are being

accepted even though there are more specific codes available.

But two main problems have arisen since October 1 that must be addressed by practitioners in order to stay ahead of the curve.

### Differing interpretations

The biggest issue so far with ICD-10 has been with people over-generalizing the codes. Yes, the codes do come from a single entity, but they are being accepted by groups with different opinions about what they mean and how they are used.

*For example:* One national office for a large insurance carrier told groups they thought A-D-S (seventh character encounter extensions) should be used as follows:

A: Active care  
D: Wellness care

S: Late effect

This created a lot of confusion—and rightly so. But the Blue Cross Blue Shield Association (BCBSA) is a national federation of 36 independently owned companies that do not run in lockstep with one another and have differing policies on many things, including which ICD-10 codes will be accepted for reimbursement. This is no different from the policies they offer where some BCBS policies pay for adjustments only and some policies pay for much more.

Furthermore, some BCBS carriers have posted (and accepted) the seventh character encounter extension of D for active care, while others have not. In this respect, ICD-10 is not unlike ICD-9 in that some of the codes are regionalized (just as some ICD-9 headache codes were accepted in some states but

not in others), meaning the best way to know what codes should be used is to find out from your insurance carrier.

**Something to prove**

Another issue that is arising with ICD-10 is the documentation requirement to support the codes billed. Following ICD-10 implementation, we've seen documentation requests for services billed that ultimately had the reim-

bursement denied because the diagnosis code reported was not adequately proven in the notes. In one particular case, during a regular medical necessity review, a Medicare carrier denied services because "PART" was not adequately documented and the claim was denied. Following an on-the-record review, we were able to show where each component of PART was located in the notes and tied to the proper

diagnosis using the exact wording from ICD-10, and the claim was paid.

This process is in line with the comments from CMS that stated they won't deny claims because a less-specific code was used. But they *did* try to deny this claim due to lack of support for the diagnosis code reported. Note the importance of this process by Medicare carriers, especially since the last release of figures from Palmetto GBA Rail Road Medicare reveal a post-payment denial rate of 60 percent for chiropractic claims.

With the soft launch of ICD-10 in effect until October 2016, the fact a claim was paid with the current code set you're using may not mean much once documentation is requested.

In the near future, DCs will look back at October 2015 the same way people look back at the claims of how the Y2K rollover would be the end of the world. But hindsight is 20/20, and now it's easy to look back and laugh at the people who were building bunkers because they thought computers would melt down.

The same is true with ICD-10 and the October 1, 2015, implementation date with one exception: January 1, 2000, was just business as usual because there were no real issues with the date change. With ICD-10, however, even though payments have continued and the sky isn't falling, it is anything *but* business as usual. Going forward, you still need to pay close attention to how ICD-10 is used by your local carriers for reimbursement and what it takes to document the specific codes. ☺



**JOHN DAVILA, DC**, established and operated three practices in South Carolina for 13 years. Since 2000, he has been training doctors and their staff about

federal and state insurance compliance. He also has consulted for major insurance carriers. He is also the founder of Custom ChiroSolutions, and can be contacted through [customchirosolutions.com](http://customchirosolutions.com).

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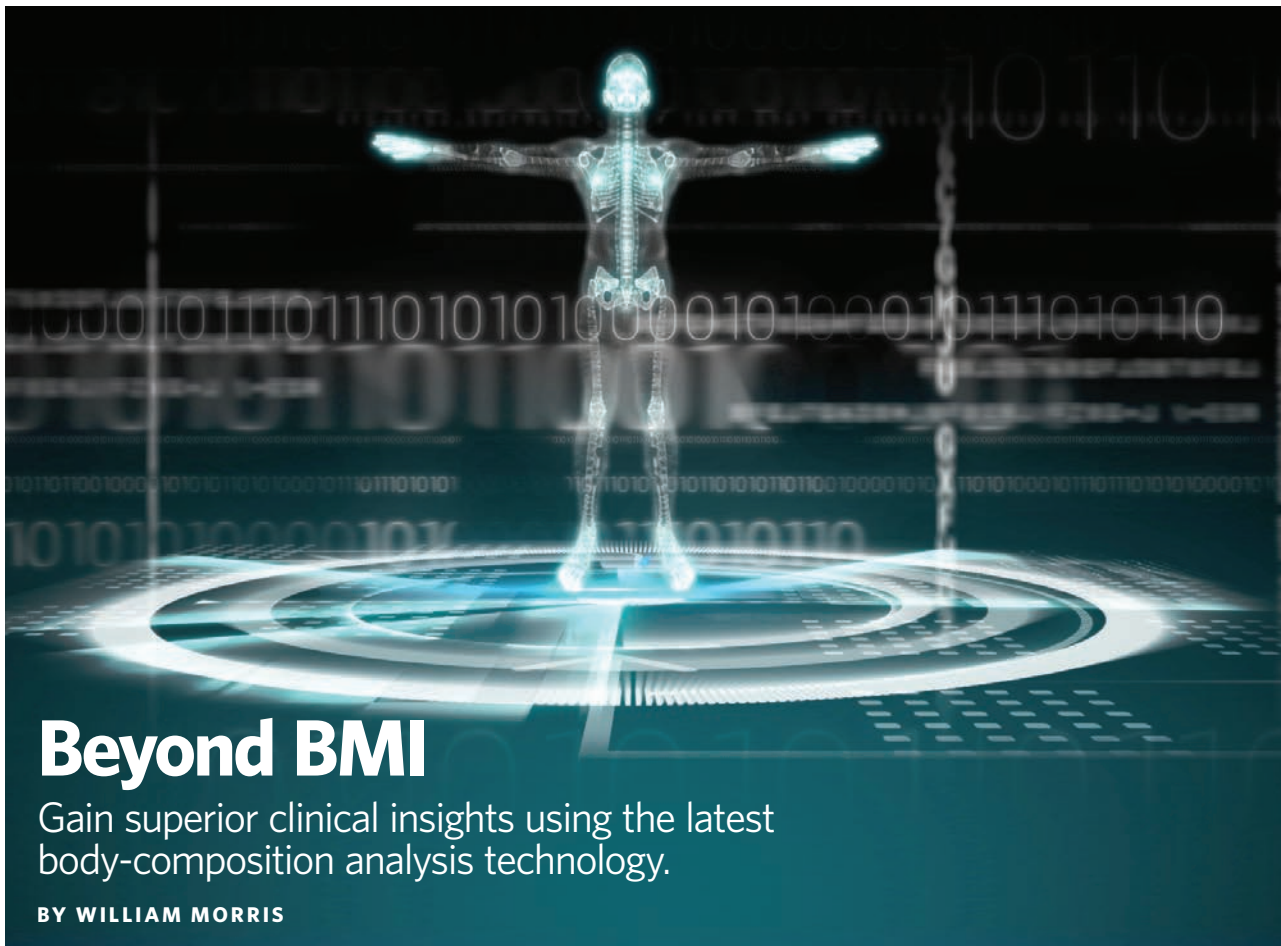
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## Beyond BMI

Gain superior clinical insights using the latest body-composition analysis technology.

BY WILLIAM MORRIS

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**I**F YOU ARE PLANNING ON INCORPORATING TREATMENT PROTOCOLS AND services related to metabolic management, or contemplating a move into the specialization of wellness aging, body composition analysis (BCA) should be high on your list of items to address. Consider the current technology available to address two of the most prevalent conditions you're likely to encounter on a daily basis in your practice.

In both metabolic syndrome (MetS) and wellness-aging specialties, you can expect to encounter a large percentage of patients presenting the symptoms of MetS—a cluster of conditions consisting of increased blood pressure, high blood-sugar levels, excess body fat around the waist, and abnormal cholesterol levels. The presence of one symptom by itself does not constitute MetS; however, two or more occurring together indicates an increased risk of heart disease,

stroke, and diabetes.

This condition is similar to the concept of cardiometabolic risk (CR). How do the two differ? CR is similar to MetS, but more inclusive, as it also takes into account smoking status and glucose levels in the diabetic range. As a result of this classification, the CR population is larger than that presenting MetS.

In this regard, assessment of patients by body mass index (BMI) is not enough. BMI alone is simply a correlation between height and weight which, used by itself, provides little insight into the absolute amounts of fat mass and skeletal muscle mass in the body.

An obese person and a professional body builder, for example, could have the same BMI. The application of BMI is meaningful data when used for one of its better purposes; namely, as a statistical tool for the analysis of large populations, such as the average BMI of persons in the U.S. (the age-adjusted

mean BMI nationally was 28.7 as of 2010, according to the CDC's NHANES study)<sup>1</sup> or predicted BMI-related healthcare costs on a population basis, as another example.

Patients are looking for new approaches to help them lose weight. Body composition analysis (BCA) provides a clinically relevant tool that provides the needed insight into fat mass, lean mass, basal metabolic rate, and other elements important for an effective treatment plan.

Patients will have a different experience if you perform body composition testing and present them with another way to stay motivated: knowing their measured baseline starting point and then tracking their progress in a weight-loss program. Patient awareness and motivation should never be underestimated, as they can be the vital difference in a successful treatment program.

## Body composition analysis can give you a competitive edge in the marketplace.

Accurate BCA is now far easier and practical thanks to recent advancements in bioelectrical impedance analysis (BIA) technology available on the market. Using tiny, imperceptible signals passing through the body from electrodes positioned on the hands and feet, a BIA device can produce measured values of fat mass, skeletal muscle mass, fat-free mass, visceral fat amount, extracellular and intracellular water, resting energy expenditure, and phase angle.

Depending on the device, measured values can be highly accurate, in contrast to the assumptive algorithms found both in lesser-quality devices such as consumer floor-scales that advertise BIA functions, and in devices

used by health providers that lack the engineering of the more-accurate models available. The design and quality of the product can make a significant difference in the accuracy of your measurements.

Wellness-aging providers who offer some form of hormone replacement therapy (HRT) will find BCA relevant to tracking changes over time in the quantity of fat mass and lean muscle mass of patients participating in HRT.

BIA is a practical way to replace a quaternary of methods that, when used together, are considered the “gold standard” in assessment. The term describes the scientifically accepted method for determining body compo-

sition with maximum accuracy.

The actual gold standard process can take hours to conduct and be cost prohibitive, involving whole-body air displacement plethysmography (ADP), magnetic resonance imaging (MRI), deuterium dilution (D2O), and sodium bromide dilution (NaBr). The correlation between BIA measurement results and the gold standard is seen as the best validation of the accuracy of a particular BIA device.

Your practice can benefit by differentiating from competitors such as fitness and diet centers. Body composition analysis can give you a competitive edge in the marketplace, as patients experience your higher level of care and science-based treatment protocols.

You can also stand out from other categories of providers, who may focus on fitness regimens, dieting and meal replacement products without reference to the patient’s actual lean mass and fat mass as a baseline. Just as importantly, you’ll be able to show patients whether their values are improving as their treatment plan progresses.

Body composition analysis using BIA tools is non-invasive, easy to administer, and provides key clinical insights relevant to treatment protocols. It can offer a compelling proposition for your business model now, or when transitioning to a new specialization in MetS or wellness aging medicine. ☕



**WILLIAM MORRIS** is product manager for seca North America in Chino, Calif. He is the principal liaison between clinical users, medical researchers, and the seca product development team and sales division throughout the U.S. and Canada. He fosters the implementation of seca technology, and helps shape the development of future products. He can be contacted at [william.morris@seca.com](mailto:william.morris@seca.com), 800-542-7322 ext. 53, or through [seca.com](http://seca.com).

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<sup>1</sup>Centers for Disease Control and Prevention. “NHANES 2009-2010.” [http://www.cdc.gov/nchs/nhanes/search/nhanes09\\_10.aspx](http://www.cdc.gov/nchs/nhanes/search/nhanes09_10.aspx). Updated Dec. 2015. Accessed Dec. 2015.

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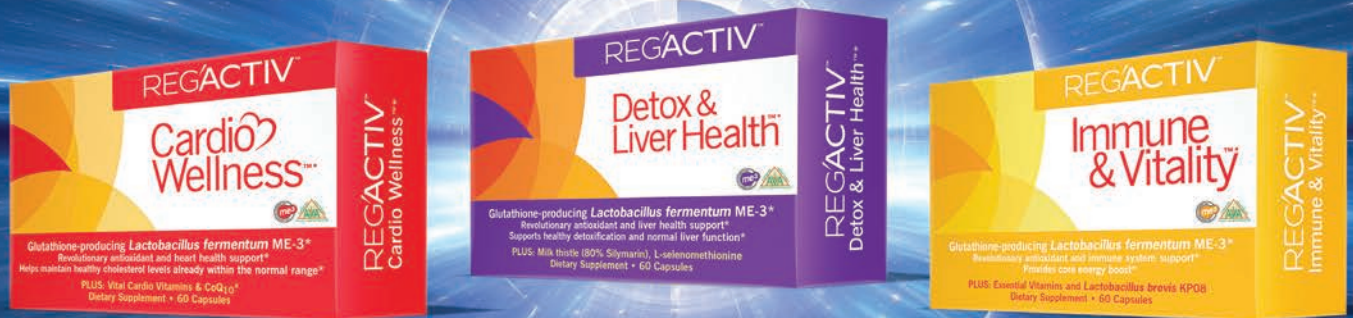
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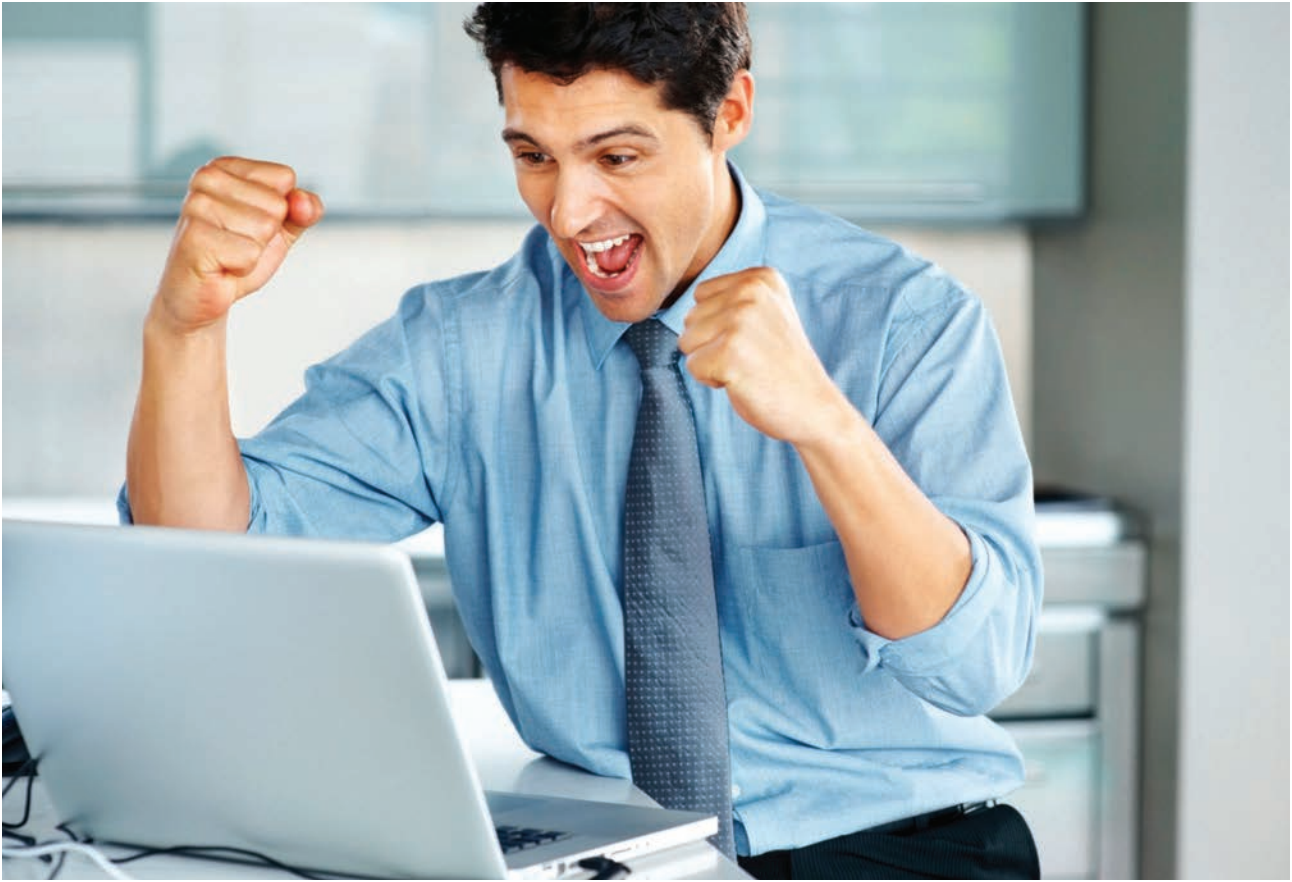
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JACOB WACKERHAUSEN/THINKSTOCK

## Play to win

Follow these savvy tips to improve your credit score.

BY GARRETT B. GUNDERSON

### THE RULES OF THE CREDIT SCORE GAME ARE CLOAKED IN MYSTERY.

Instead of laying out an obvious, intuitive set of guidelines, the system often manifests as finicky and opaque. For example, paying your bills on time is not enough to guarantee a good credit score. And those who have seemingly done everything right can still get hit with a 30-point reduction in their Fair Isaac Corporation (FICO) score because they aren't aware of all the elements that go into this complex calculation.

Let's say you have the optimal number of credit cards (three to five), always pay your balances on time, and keep the balances low. You also have a mortgage with no late payments, no recorded interactions with collections,

and no errors on your report to bring your score down.

You'd think these factors alone would result in a perfect credit score, but they don't. In fact, you could get docked up to 30 points because you're missing a critical piece on your report: an installment loan.

### What is an installment loan?

An installment loan is granted for a set period of time with a fixed minimum payment. If you make the minimum payment (and not a dollar more) every cycle, the loan will be paid off at the end of the established term. It's usually possible to pay off the loan early by tendering more than the minimum payment, but doing so will not lower your minimum payment.

Consider a car loan for example. At today's rates, if you get a \$20,000 five-year loan for a car, you'll be paying about \$360 per month for the next 60 months—or sooner if you pay more than the minimum.

For whatever reason, the credit bureaus want to know that you can handle this type of loan, so it's in a separate category from credit-card or mortgage loans. And if you don't have a recent installment loan, then your credit report shows a big question mark for this section.

### Get creative

If you'd rather lease than buy a car, a lease still counts as an installment loan as far as your credit is concerned. But if you're not in the market for a car,

## Paying your bills on time is not enough to guarantee a good credit score.

there are other ways to get an installment loan on your credit report.

A jewelry loan will do the trick, as will a signature loan, which is a personal loan backed only by your signature and your promise to pay it back.

A signature loan can be for almost anything. I have a friend who helped a client get a signature loan from a bank, just so he could get an installment loan on his credit report. The client told the bank he wouldn't even spend the money. The bank agreed to put the money in his account and make monthly withdrawals until the debt was repaid.

That's one option. Another is to take out a loan on a car you already own. If you don't need a new car, simply refinance the one you have.

Dale Clarke, a cash-flow specialist at my company, did exactly that. After checking his credit score, he discovered it to be well below 800 because he didn't have a recent installment loan.

After refinancing his car, an installment loan appeared on Dale's

credit report. He was able to pay off the loan quickly, and his score jumped 30 points. This was possible for Dale because a person's "credit mix" makes up 10 percent of the score. By improving his credit mix and showing he was responsible in the three main credit categories (installment loans, credit cards, and mortgages), Dale's score got a boost.

It was also significant that Dale's installment loan was recent. To get the best results, you want to have an installment loan within the last two years of your credit history—either one that you're paying down now or one you've already paid off.

### Accounting for all factors

It's been reported that nearly 85 percent of consumers have errors on their credit report, so check yours regularly for misreported limits, duplicate accounts, and anything else that may be incorrect.

You can get a free report once a year from [annualcreditreport.com](http://annualcreditreport.com). To get your credit reports and an accurate

score like the one lenders will see, go to [myfico.com](http://myfico.com). If you do find problems, don't dispute more than three errors at a time with the same bureau.

Next, it's best to have three to five credit cards with the maximum limit that you can qualify for. Try to keep your balances low at all times—no higher than 30 percent of your limit, but the lower the better. And don't cancel old cards. The length of the card's credit history helps your score.

Finally, make sure to have an installment loan within the last two years of your credit history. That can be a car loan, a jewelry loan, a signature loan, or even a car lease. If you follow these steps, your efforts will go a long way toward maximizing your credit score. **CE**



**GARRETT B. GUNDERSON**, a lifelong entrepreneur, is a financial advocate to chiropractors and engages in a vitalistic financial philosophy to assist DCs in creating sustainable wealth. His company, Wealth Factory, helps entrepreneurs navigate personal finances and investing. He wrote the New York Times' bestselling book *Killing Sacred Cows*. Get a signed hardcover copy at [ebookforchiro.com](http://ebookforchiro.com).

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## Leveraged opportunities

Used wisely, debt can be an effective business tool.

BY MARK E. BATTERSBY

**O**NE OF THE MOST DAUNTING FOUR-LETTER WORDS FOR ANY chiropractor—especially those with smaller practices—is the word “debt.” Not surprisingly, the tightening of credit, reduced sources of capital, and general skittishness on the part of lenders, has made avoiding debt easier for the principals in small practices. But is operating and growing a debt-free practice really practical?

### Debt 101

Debt can best be compared to “leverage,” because borrowed funds help many chiropractors grow their practices using someone else’s money. Despite its negative connotation, even the healthiest of corporate balance sheets will include some level of debt.

In reality, a DC’s practice typically has two financial resources for growth:

debt and equity. Raising equity requires the practice to sell ownership interests—if permitted under local licensing regulations. Debt, on the other hand, allows the practice to obtain the funds needed to grow and operate by borrowing it.

Bottom line: Debt can be extremely advantageous and a useful tool for any practice. The benefits of debt include:

**Maintaining ownership:** When funds are borrowed from a bank or another lender, the sole obligation is to make the agreed-upon payments on time. But that is the extent of your obligation to the lender; the practice can be run as you see fit without outside interference.

**Building credit:** Practices with good credit histories usually have an easier time establishing credit with suppliers,

eliminating up-front payments and the personal liability of the practice’s principal or partners.

**Deducting taxes:** Because borrowing funds or incurring debt in most cases results in a tax deduction, it is hugely attractive. Usually, the interest portion of the loan repayments can be deducted on your practice’s tax returns as an expense.

**Lowering interest rates:** Tax deductions also have an impact on interest rates. *For example:* If a lender is charging 10 percent for a loan, and the government taxes the practice at a 30 percent rate, there is an advantage to tax deductible loans. Take the interest rate and multiply it by the tax rate, which in this case is the 10 percent interest rate multiplied by the 30 percent tax rate,

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# Autumn8

## MONEY MANAGEMENT

which equals 7 percent. In other words, after tax deductions, the practice is paying the equivalent of a 7 percent interest rate.

**Increasing cash flow:** Practices generally incur debt such as loans to create cash flow. And creating cash flow can be critical during seasonal slow periods. At times, there may be a gap between income flowing into the practice and

bills coming due. Debt can be a useful tool in filling this gap.

Obviously, there are also drawbacks to debt financing, including:

**Repayment:** As mentioned, the practice's sole obligation to the lender is to make payments. Unfortunately, even if the practice fails, payments must still be made. And if the practice

is forced into bankruptcy, the lenders will have a repayment claim before any equity investors.

**High interest rates:** Even after calculating the discounted interest rate from tax deductions, the practice may still be faced with a high interest rate—if it can find a lender. Interest rates will vary due to economic conditions, the practice's history, the practice's credit rating, and the principal's personal credit history.

**Credit rating impact:** While the assumption of debt when your practice needs money can be seemingly attractive, each loan will have an impact on your practice's credit rating. The more that is borrowed, the greater the lender's risk and the higher the interest rate charged.

**Cash and collateral:** Even where a loan is needed to acquire an important asset, the practice must ensure that it will generate sufficient cash flows to repay the borrowed funds. And don't forget the collateral often required to protect the lender should the practice default on its payments.

### Using debt financing

Lenders usually want installment payments to begin shortly after funds are borrowed. Thus, to begin making those payments, the practice will need cash. Unfortunately, since even a thriving practice may find itself short of cash at times, every borrower should ask: *Are the borrowed funds to be used for fixed or variable assets?*

If the money is to be invested in a fixed asset such as equipment, near-term cash is unlikely to be generated. If the funds are for a variable asset, such as inventory, supplies, or costs associated with new patients, then the debt should generate needed cash flow.

*What are my patients like?* Patients who consistently pay on time are critical to cash flow. Learning the payment habits of patients and consid-

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# Which one are *you*?

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Joe  
Non-Seminar

Non-Attendee



## Philosophy

- Body's ability to heal itself
- Practice & personal growth come from within
- Acute, corrective, and wellness care
- To positively influence community health

## Practice Methodology

- Steady flow of new patients and retention
- Convincing and confident ROF
- Invests in advanced certifications and new equipment

## Favorite Tools

- Daily affirmations and visualizations
- The Parker Experience mobile app
- Modern patient education
- Office celebrations for achieving goals

## Persona

- Lives in prosperity
- Has loving relationships
- Has tremendous pride in chiropractic

## Overheard

- "Loving service is my first technique."

## Philosophy

- Symptomatic relief
- Practice built on and limited by insurance
- Primarily condition-based care
- Leaves practice growth to luck

## Practice Methodology

- Always thirsting for more new patients
- Haphazard ROF
- Fears spending on self and the practice

## Favorite Tools

- Dreams without deadlines
- Friends' Facebook™ posts
- Outdated patient pamphlets
- Close early due to lack of patients

## Persona

- Always worried about money
- Conflicted with work-life balance
- Lacks chiropractic confidence

## Overheard

- "Why aren't people calling to schedule appointments?"

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This is a great question that needs careful consideration. Choosing the right coach is imperative for your success. The following guidelines should help you.

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5. Look for a 100% money-back guarantee
6. Find one who teaches strategic marketing
7. Seek one who teaches how to achieve financial independence
8. Find someone you respect



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## MONEY MANAGEMENT

ering incentives such as discounts to get them to pay early are important. Also, check with associations and competitors to ensure your practice's payment terms are in line with industry standards.

*Where is my practice in its lifecycle?*

In the early stages of a practice, debt financing can be risky. In all likelihood, a new practice will lose money at first, making loan payments difficult. Also, as net income will be low, the tax advantages of debt will likewise be minimal. As the practice grows and matures, debt becomes a stronger option. The tax advantages will be greater, cash flow more predictable, and the risk posed by bankruptcy lessened.

### Measuring it all

While it is true that borrowing enables a practice to take actions or grow at a pace that might otherwise not be sustainable, it can also result in a less flexible operation. After all, the more the practice borrows, the more it must spend on debt payment and interest. But how much debt is too much?

Lenders love to analyze ratios that let them to see how a practice is doing and compare it to other practices they've loaned money to. Ratio analysis is also a useful tool.

How healthy is your practice? Basic ratio analysis may tell the story. Your financial ratios allow you to check your practice's current temperature, diagnose potential problems, and see if you are doing better or worse over time.

Consider the "total debt ratio."

The name says it all; the total debt ratio shows how much the practice is in debt, making it an excellent way to check the operation's long-term solvency. The formula is:

$$\text{Total debt ratio} = \frac{\text{total debt}}{\text{total assets}}$$

These numbers can be taken from your balance sheet and plugged in. To illustrate, a practice with \$22,375 in total assets and \$25,000 in total debt would have a total debt ratio of

$\frac{\$25,000}{\$22,375} = 1.11\text{-to-}1$ .

Thus, this practice has \$1.11 in debt for every dollar of assets. Obviously, the total debt ratio reveals this practice is not in good health and may become gravely ill. For good health, the total debt ratio should be 1-to-1 or less.


### Debt-free

While you may find becoming debt-free to be intimidating, the evidence shows that during economic downturns the less debt a practice has, the greater the odds of survival. And when the economy is looking brighter, the debt-free practice is often in the strongest position to take advantage of opportunities.

Becoming a debt-free practice can be a lengthy process. While there are no guarantees in life, it is certain that the owner of a small practice will sleep better at night knowing that the debt-free business is stronger and more secure in these uncertain times. Unfortunately, for the majority of practices that choose to be debt-free, growth tends to be slow.

### Bottom line

For more than for any other reason, practices fail from a lack of cash. And most practices need capital. While today credit is an increasingly available resource, it must be used wisely.

Debt can be paid off when the practice is ready to stop growing. Until then, the practice should leverage all possible funding resources for investment in the operation. If you ignore debt as a practice tool, it could hurt your prospects for growth. 



**MARK E. BATTERSBY** is a tax and financial adviser, freelance writer, lecturer, and author located in suburban Philadelphia. He can be reached at 610-789-2480.

**DISCLAIMER:** The author is not engaged in rendering tax, legal, or accounting advice. Please consult your professional adviser about issues related to your practice.

# On April 21st Your Website Took a Major Hit From Google

... if your website was not compatible with Google's NEW mobile-friendly algorithm.

## According to Google and their new ranking algorithm,

“Starting April 21, we will be expanding our use of mobile-friendliness as a ranking signal. This change will affect mobile searches in all languages worldwide and will have a significant impact in our search results. Consequently, users will find it easier to get relevant, high quality search results that are optimized for their devices.”

## Google modifies their ranking algorithms constantly. Why is this April 21, 2015 update so important?

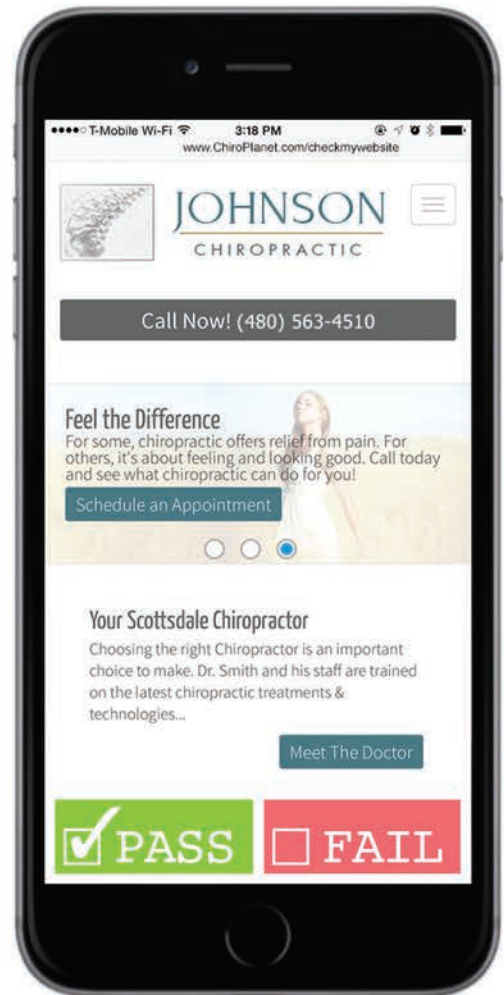
Since 2014, mobile internet usage has exceeded desktop usage with that trend increasing through 2015. Additionally, 48% of users start their research on search engines when looking for a business. Research also shows that local search on mobile phones has the highest conversion rate compared to both desktop and tablet searches. In short, mobile search is important to your business. The importance of having a mobile-friendly website, as newly defined by Google, has never been higher.

## Did your current website provider fail to educate you on Google's new mobile search requirements?

On April 21, 2015, Google updated their mobile search ranking algorithm. This change has impacted millions of websites and mobile search results. Did your current website provider fail to provide you with proper knowledge of this update and other critical changes impacting your business? Perhaps it's time to reconsider which companies are truly valuable and proactive partners in your business success vs. just another company repeatedly processing your credit card.

## How do I determine if my website meets Google's new standards?

Many businesses believe their websites to be mobile-friendly when in fact, after the recent April 21, 2015 implementation of Google's new standards, they are not. To assist, ChiroPlanet has designed and is now offering free of charge, a simple yet accurate solution for small businesses wanting to evaluate their website's mobile friendliness using Google's new standards.



## FREE Mobile Friendliness Report

To learn whether or not your business website meets these new standards and obtain your FREE Mobile Friendliness Report visit, [www.ChiroPlanet.com/checkmywebsite](http://www.ChiroPlanet.com/checkmywebsite)

Each Mobile Friendliness Report indicates whether the website passes the new Google mobile-friendly requirements and includes the specific reasons when it does not.



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The Association of New Jersey Chiropractors - [www.anjc.info](http://www.anjc.info)

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## On the level

How to avoid the crosshairs of CMS auditors.

BY JONATHAN D. SCHUMAN, ESQ.

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**T**HE FEDERAL GOVERNMENT HAS ANNOUNCED IT WILL SOON BE using “targeted tactics” to audit a select group of chiropractors who exceed rendering 12 visits per year to Medicare patients.

In a report by the Department of Health and Human Services Office of Inspector General (OIG), the Center for Medicare and Medicaid Services (CMS) announced that provisions for oversight include requiring preauthorization of services provided by chiropractors with aberrant billing or high rates of denials. These audits would be performed by the Medicare Fraud Strike Force. This federal investigative arm is situated in Miami and other cities.

Most alarming is the finding that between 40 to 47 percent of all paid chiropractic claims went for “mainte-

nance therapy,” which Medicare does not cover. Even the use of the AT modifier for active treatment (which means that the patient is not receiving maintenance therapy) is being audited. Apparently, the CMS intent of having the AT modifier did not separate “maintenance” therapy from “active” treatment.

### Warning flags

The latest statistic shows the average chiropractor renders only eight services per year to each Medicare patient treated. Arguably, exceeding this number may provoke suspicion if other factors exist.

Medicare is finding that the patient may be obtaining chiropractic care from more than one chiropractor at the same time. Chiropractors are urged to ask their patients if they are doing this.

This was a key finding in the OIG report.

Medicare pays for three CPT codes for chiropractic care; namely, 98940 (treatment of one to two spinal regions), 98941 (treatment of three to four spinal regions), and 98942 (treatment of five spinal regions). While Medicare only pays for manual manipulation of the spine for subluxation, there is no CPT code for “subluxation.”

The CMS investigation was launched following the finding that nearly \$75 million in Medicare payments to chiropractors were for questionable payments suggestive of maintenance therapy. For example, Medicare alleges that 2 percent of all chiropractors are responsible for half of the questionable payments. This means that about 7,200 chiropractors received questionable payments in 2013. Most of those DCs

## Chiropractors should be aware that upcoding can now be used as the basis of a False Claims Act case.

provided 25 services per beneficiary. In contrast, *all* other chiropractors provided an average of eight services per beneficiary during fiscal year 2013.

### Insufficient documentation

Of the four major error categories (no documentation, insufficient documentation, lack of medical necessity, and incorrect coding), the OIG found that improper payment rates attributed to insufficient documentation by year are as follows:

Year	Percentage
2010	39.5
2011	72.9
2012	76.2
2013	92.5
2014	92.2

A challenge for chiropractors who want to avoid a Medicare audit—or prevail in one—is that CMS provides no guidance on how to properly document a chiropractic Medicare claim. To boot, there is no precise definition in the *Medicare Carriers Manual* as to what constitutes a “medically necessary” service.

About 10 percent of all chiropractic claims were for the highest CPT code, 98942-AT. CMS concludes from this that almost 50 percent of such claims are upcoded.

Chiropractors should be aware that upcoding can now be used as the basis of a False Claims Act case, brought by federal or state investigative authorities.

Medicare set high limits for how

many hours per day a chiropractor can work and still receive reasonable and necessary payments. After consulting with industry experts, the OIG established a surprisingly high 16-hour-per-day threshold. As that number would allow an unlikely number of services to be provided in a day, chiropractors working anything approaching that number of hours should look carefully at their billings.

You may be wondering how much Medicare pays all eligible chiropractors in a given year. In 2013, CMS paid out \$502 million for chiropractic services.

Medicare believes that about 15 percent of your patients are being treated by more than one chiropractor at a time. In your subjective history

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That means we will have 2.5 months of pure growth. I was able to bring on an associate this year and that has blessed me with the time & freedom that I had wanted.

I have the house of my dreams, a fantastic family to share it with, and a practice that makes money... even when I am not there. I can honestly say, we would not be here without Dr. Erich and the Practice Wealth Team.” *Dr. Gunney, TX*



**“I Stopped Working for Minimal Wages, Now I am making over \$100K /mth.”**

Before I met Dr. Erich, I was working long hours and making minimal pay, in fact...

my wife had to come and help out in my office.

Well now a couple years later, we have averaged over \$100,000.00 per month in 2015. It's been a good year. I have kept the stress of running a busy practice to an absolute minimum, spending plenty of time with my family, taking longer vacations (and still making money) and overall... enjoying my life.

That's what practice is all about to me. It's not the Hokey Pokey after all. Thanks for your amazing simple system and all your help. *Dr. Eliot, TX* **Are You Ready**

## TWO KINDS OF DOCTORS ... Which one are you?



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form, it is recommended you obtain this information from each patient. You can be audited even though you don't know that your patients are seeing one or more other chiropractors. One defense to this type of audit is your chart indicating that you asked the patient about this issue.

Chiropractors often advertise that they treat complex conditions. This type of promotion can raise red flags. Medicare concludes that almost half of the claims for chiropractic services with CPT code 98942 were upcoded.

### Audit defense and prevention

First of all, write good old-fashioned SOAP notes—not diagrams and drawings that only you can understand. Rather, with computer documentation, specify what the patient is subjectively complaining about and link that to your objective findings, including X-rays.


Second, although not well known, deep inside Medicare policy is the requirement that treatment parameters “can be extended” based on medical necessity. This is good preventive advice and it has been used successfully in defending audit cases.

Third, if you have a high percentage of denied claims, you may be targeted for an audit or for post-payment or even prepayment reviews. Don't be afraid to call the Medicare medical director for your state and ask for a sit-down meeting. Often, chiropractors are too hesitant to ask for help from the federal government.

Fourth, ask for an educational contact from your Medicare representative. The *Medicare Carriers Manual* permits this.

Fifth, just because your colleagues overbill or upcode and are not caught, there's no guarantee you will be so lucky. Be aware of the anti-kickback statute and Stark law, at both federal and state levels.

Last, many private insurance companies use Medicare guidelines for determining what is a necessary chiropractic item or service. Oftentimes, private insurers take your provider number and share this information with CMS. Know your number of private insurance denials.

Because neither the federal government nor most private insurance companies clearly define what a medically necessary item or service is, this can be used as a defense against audits. 



**JONATHAN D. SCHUMAN, Esq.**, is a former Florida assistant state attorney, a former prosecuting attorney for the Office of General Counsel Medicare Part B, and a 20-year private practitioner defending providers in Medicare and private insurance audits. He has defended

chiropractors in 37 states and published more than 22 articles on how to avoid or prevail in a federal or private insurance audit. He can be contacted at [jdschuman34@gmail.com](mailto:jdschuman34@gmail.com) or through [jdschumanlaw.com](http://jdschumanlaw.com).



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## A tale of two practices

BY GARY A. BORING, DC, BCOA, LCP (HON.)

**A**S A CHIROPRACTIC GRADUATE, YOU DOUBTLESS HAVE MANY dreams. Will you share the chiropractic miracle of spinal adjustment through a high-volume practice or one offering more personalized care? The time a DC spends interacting with patients is a significant difference between these two clinical approaches.

### The high volume doctor

Every DC dreams of a healthier world through chiropractic. Since there are only so many minutes available per patient interaction, the high-volume-practice doctor believes the most beneficial contribution is adjusting and releasing the spine from subluxation.

This chiropractor is motivated by the instant gratification felt after delivering a successful spinal adjustment.

Chiropractic delivers what it promises: healthier living. That instant feeling can become addictive to high-volume-practice chiropractors.

The treadmill this doctor creates allows him or her to quickly master the adjusting technique and be rewarded with patients who, having experienced amazing results, share their delight with others. As the office becomes busier, staff and patients alike feel the rising level of positive energy.

But beware: Overconfidence and a false sense of importance can cause a doctor to drift from excellence. And straying from the clinical art can cause patient satisfaction (and income) to

drop. For the focus is now on what chiropractic can do *for the doctor* and not for the patient.

Focusing on the number of treatments given and money collected each day can become another trap. It is tempting to consider patient volume and fee totals as the hallmarks of a good practitioner. This doctor has forgotten that every chiropractor is only as good as his or her last adjustment.

The high volume doctor is now focused on how much can be done *to* a patient instead of how much can be done *for* a patient. Longer hours mean more time away from family—another drawback.

The question is, do you want to sprint through life and can you control the treadmill a high volume practice creates?

### The personalized practitioner

This chiropractor is equally addicted to the chiropractic clinical interaction. Chiropractic, after all, universally benefits those receiving adjustments. This doctor's calling is fueled by patients who don't want to feel like a number. This doctor's detailed clinical approach addresses:

- ▶ patient expectations,
- ▶ patient questions,
- ▶ a treatment plan, and
- ▶ patient acceptance of their responsibilities.

This doctor is addressing the patient's mind, body, and spirit. Patients

understand their daily choices about healthcare can have positive or negative consequences.

Doctors can only offer so much advice on diet, exercise, work, and sleep mechanics. All chiropractors and their are limited by the level of decay each patient brings into their office. Stopping or even reversing a patient's health issues through chiropractic adjusting is a chiropractor's dream.

But the doctor focused on personalized care is susceptible to the danger of becoming *too* involved with patients and crossing from being their doctor to their friend.

*For example:* Because these patients are now friends rather than patients, they might ask, "Do the office hours available and pricing really apply to me?" Once you cross the patient-friend line, you can't go back.

Whether you lean toward a high-volume practice or a more personalized mode of care, consistent results are what builds both the high-volume and personalized-care practice. **CE**



**GARY A. BORING, DC, BCOA, LCP (Hon.)**, is a board member of the Sweat Foundation, practiced for 42 years at Boring Chiropractic, and is the author of *Driven Towards*

*Excellence 2014*. He is also an extension faculty member at Cleveland Chiropractic College. He can be contacted at [gboring@everestkc.net](mailto:gboring@everestkc.net).

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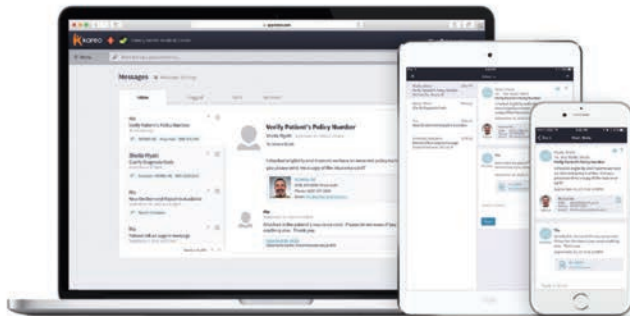
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Jan. 16-17	Graston Technique M1 Basic Training	Chicago	Graston Technique	888-926-2727
Jan. 21-22	CEAS II: Aging Workforce Ergonomics Solutions Certification	Austin, TX	Back School of Atlanta	800-783-7536
Jan. 22-24	Seminar One: Food Enzyme Deficiencies	Los Angeles	Loomis Institute	608-273-8115
Jan. 22-24	Koren Specific Technique Seminar	Boston	Koren Specific Technique	800-537-3001
Jan. 23-24	Graston Technique M1 Basic Training	Charlotte, NC	Graston Technique	888-926-2727
Jan. 23-24	Graston Technique M1 Basic Training	Phoenix	Graston Technique	888-926-2727
Jan. 30-31	Graston Technique M1 Basic Training	Newark, NJ	Graston Technique	888-926-2727
Jan. 30-31	Graston Technique M1 Basic Training	Orlando, FL	Graston Technique	888-926-2727
Jan. 30-31	Graston Technique M1 Basic Training	Denver	Graston Technique	888-926-2727
Feb. 4-5	CEAS I: Ergonomics Assessment Certification Workshop	Los Angeles	Back School of Atlanta	800-783-7536
Feb. 5	Strengthening Postural Balance for Fall Prevention	Bloomington, MN	BodyZone	770-922-0700
Feb. 13-14	Graston Technique M1 Basic Training	Houston	Graston Technique	888-926-2727
Feb. 19-20	CEAS I: Ergonomics Assessment Certification Workshop	San Jose, CA	Back School of Atlanta	800-783-7536
Feb. 20	KT3: Kinesio Taping Clinical Concepts	St. Louis	Kinesio Taping Association	410-777-2939
Feb. 20-21	Graston Technique M1 Basic Training	Boston	Graston Technique	888-926-2727
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March 5-6	<b>Graston Technique M2 Advanced Training</b>	Omaha, NE	Graston Technique	888-926-2727
March 10-11	<b>Graston Technique M1 Basic Training</b>	White Plains, NY	Graston Technique	888-926-2727
March 12-13	<b>Graston Technique M1-Basic Training</b>	Baltimore	Graston Technique	888-926-2727
March 12-13	<b>Graston Technique M1 Basic Training</b>	Chicago	Graston Technique	888-926-2727
March 12-13	<b>Posture, Balance, and Motion</b>	Knoxville, TN	BodyZone	770-922-0700
March 14-15	<b>Graston Technique M1 Basic Training</b>	Des Moines, IA	Graston Technique	888-926-2727
March 17-18	<b>CEAS I: Ergonomics Assessment Certification Workshop</b>	Charlotte, NC	Back School of Atlanta	800-783-7536
March 18-20	<b>Posture Assessment, Rehab, and Certification</b>	Orlando, FL	BodyZone	770-922-0700
March 19-20	<b>Physical Demands Analysis and Employment Testing Cert. Workshop</b>	Atlanta	Back School of Atlanta	800-783-7536
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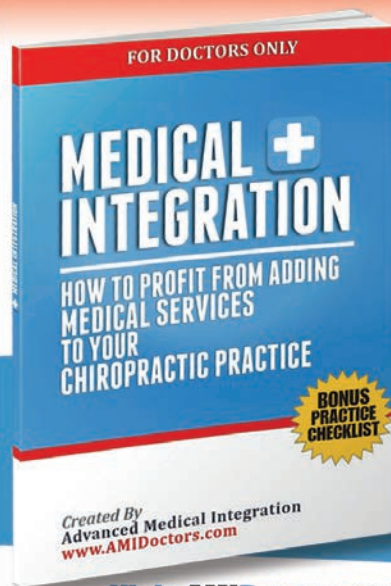
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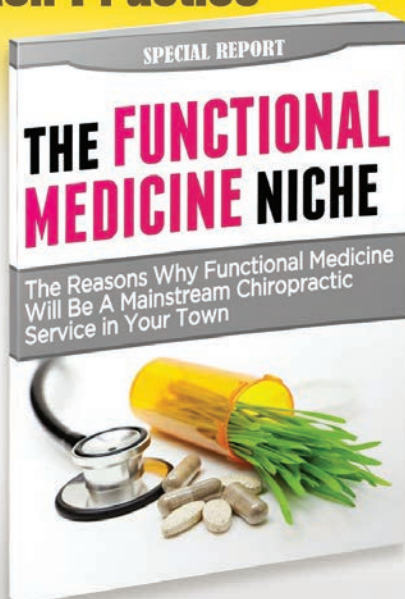
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- Aquatrek™ insole and rugged outsole for slip-resistance
- Silky smooth nylon straps to prevent chaffing
- Extremely soft and cushiony EVA mid-layer for irresistible comfort



**Fiji**






**Mavi**

See Pages 18-19

Escape with **Fiji for Her** and **Mavi for Him** and lose yourself in a paradise of comfort and support. Both are offered in a variety of colored straps: Black Pearl, Black Chevron, Manta Gray and Palm Green.



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