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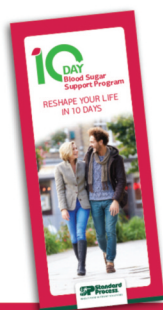
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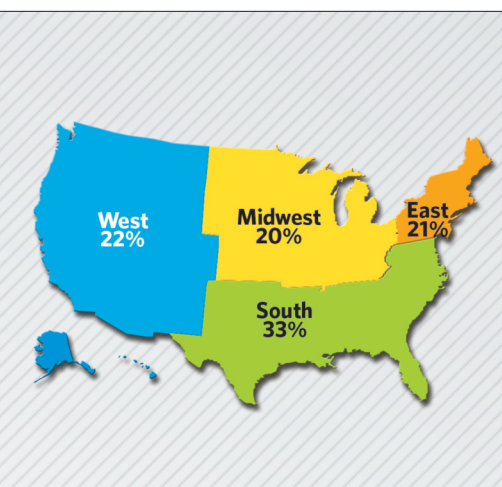


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Chiropractic Economics (ISSN 1087-1985) (USPS 019-178) is published monthly except semi-monthly (twice a month) in January, February, April, May, June, August, September, and October; 20 issues annually. Address: Chiropractic Economics Inc., 820 AIA N, Suite W18, Ponte Vedra Beach, FL 32082. Phone: 904-285-6020; Fax: 904-285-9944. Website: www.chiroeco.com. (A Florida Corporation) Postmaster: Please send form #3579 to Chiropractic Economics, PO Box 3521, Northbrook, IL 60065-9955. Periodicals class postage paid at Ponte Vedra, Florida and at additional mailing offices. GST #R1268416. Subscription Rates: U.S. and possessions, \$39.95 one year, Canadian subscribers add \$35 per year shipping and handling; overseas subscribers add \$60 per year shipping and handling. Students, \$19.95. Single copy, \$4. Statement: While encouraging the free expression of opinion by contributors to this publication, Chiropractic Economics and members of its staff do not necessarily agree with or endorse the statements made in the advertisements or contributed articles. Chiropractic Economics is owned by Chiropractic Economics, Inc., a Florida Corporation, Joseph D. Doyle, President and CEO and Daniel Sosnoski, Editor. Authorization for the use of photographs and/or illustrations is the responsibility of the author(s). All materials submitted for publication shall remain the property of this magazine until published. Change of Address: Six to eight weeks prior to moving, please clip the mailing label from the most recent issue and send it along with your new address (including zip code) to the Chiropractic Economics circulation Department, PO Box 3521, Northbrook, IL 60065-9955. For a faster change, go to www.ChiroEco.com and click on "Magazine."

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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. Here's what's new:



Fearless Chiro

What really matters. Experiencing loss.
Perry Chinn, DC



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What challenges are killing chiropractic practices?
Drew Stevens, DC



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And then there's data about the state of the chiropractic profession itself. There are a few statistics most chiropractors hear and repeat and, over time, they become gospel. How many licensed DCs are there? About 60,000. How many Americans access chiropractic care? About 10 percent.

But we should ask where those numbers came from, and if they are true. The colleges and insurance companies have some parts of the puzzle; the state associations and boards have others, but for the most part they keep that data to themselves.

This is one reason we're pleased to present our biannual surveys—the salary survey each spring, and the fees and reimbursements survey in the fall. We've been conducting these for nearly 20 years now, and we faithfully share the results with you so you can gauge where you stand among your peers. We salute everyone who took the time this year to complete the surveys; we're grateful for the consistent support.

Another survey has just been completed that deserves your attention. A joint effort by Palmer College and the Gallup organization, it is titled "Public Perceptions of Doctors of Chiropractic," and it was published in September in the *Journal of Manipulative and Physiological Therapeutics*. We report on this survey in this issue, and we recommend you read the results.¹

When you compare those findings with our survey results, a clear picture takes shape, one that should bring a smile to your face. It's a pleasure to bring you good news.

To your success,

Daniel Sosnoski, editor-in-chief

Reference

¹ Weeks WB, Goertz CM, Meeker WC, Marchiori DM. Public Perceptions of Doctors of Chiropractic: Results of a National Survey and Examination of Variation According to Respondents' Likelihood to Use Chiropractic, Experience With Chiropractic, and Chiropractic Supply in Local Health Care Markets. *JMPT*. <http://www.jmptonline.org/article/S0161-4754%2815%2900124-4/fulltext>. Published Sept. 2015. Accessed Sept. 2015.

chiropractic economics

VOLUME 61, NUMBER 16

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TOP NEWS

Gallup and Palmer College release results of national survey on Americans' perceptions of chiropractic

According to a new Gallup report released in September, an estimated 33.6 million U.S. adults (14 percent) used chiropractic care within the last 12 months. Studies from other sources, including the 2012 National Health Interview Survey (NHIS), have measured yearly chiropractic use at only about 20.6 million U.S. adults (8 percent).

The report, officially named, the "Gallup-Palmer College of Chiropractic Inaugural Report: Americans' Perceptions of Chiropractic," also indicates that more than half of U.S. adults view doctors of chiropractic positively and agree they're effective at treating neck and back pain. However, nearly half of U.S. adults don't know whether their insurance covers chiropractic care.



To learn more about the survey results, visit ChiroEco.com/gpsurvey2015.

Source: Palmer College of Chiropractic, palmer.edu

Foundation for Chiropractic Progress aligns with National Fibromyalgia & Chronic Pain Association

The Foundation for Chiropractic Progress (F4CP) announced that it is representing the chiropractic profession at the first National Fibromyalgia & Chronic Pain Association and International Myopain Society's Treating and Preventing Chronic Pain Conference, in Arlington, Virginia, October 8 through 10, 2015.

Kristine Dowell, executive vice president, F4CP, will serve as one of 40 roundtable participants—spanning government, regulatory, and private sectors addressing fibromyalgia and chronic pain—to express the valuable role of chiropractic and integrative care for patients.



To read more about the partnership, visit ChiroEco.com/nfcpa.

Source: Foundation for Chiropractic Progress, f4cp.com

Lance Armstrong, DC, receives 2015 Humanitarian Award

Lance Armstrong, DC, was presented the 2015 Performance Health and Florida Chiropractic Association Humanitarian Award at the 2015 FCA National Convention. Performance Health annually partners with the FCA to honor individuals who go above and beyond for their community in the spirit of giving back and making a difference in a humanitarian effort.

"I am grateful to the FCA for their work in protecting their members, educating the public and advocating to legislators. I'm also grateful to the FCA for partnering with Performance Health to honor humanitarians that give so much to others. This is a wonderful profession because of the service-minded people it attracts and the good that you collectively achieve," said Marshall Dahneke, chief executive officer, Performance Health. Dahneke had the pleasure of presenting the award in person to Armstrong.



To learn more about Armstrong, visit ChiroEco.com/lahumanitarian.

Source: Performance Health, performancehealth.com

COLLEGE NEWS

Life University students switch to virtual anatomy tables

Anatomy classes at Life University (LIFE) have officially switched from traditional cadaver labs to virtual anatomy labs. With eight Anatomage tables in its Virtual Anatomy Lab, LIFE currently has more anatomy tables than any other institution. "Anatomage has taken cadaveric dissection to the next level by creating virtual dissection," says Leslie King, DC, dean of LIFE's College of Chiropractic. "The Anatomage tables eliminate the chemical-filled environment and provide an opportunity for every student to learn at their own pace."

The tables, which are roughly the same size and shape of pool tables, depict actual multilayered scans of the anatomy of a male and female. Within the classroom, they allow the vast majority of students to partake in lessons, something that was more challenging in cadaver labs due to student sensitivity to chemicals.



For more details about the tables' features, visit ChiroEco.com/lifeanatomage.

Source: Life University, life.edu

ChiroHealthUSA announces \$10,000 chiropractic scholarship

At the Florida Chiropractic Association National Convention and Expo, ChiroHealthUSA announced the Foxworth Family Scholarship in honor of President Ray Foxworth's parents, Betty Pace Matthews and Charles Vernon Matthews, DCs. ChiroHealthUSA will award \$10,000 to one chiropractic student each year and an additional \$10,000 donation to the winning student's chiropractic college.

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Students may begin submitting applications immediately. The deadline for submissions is February 29, 2016. Winner notifications will go out on or before June 1, 2016, and the winner will be announced during The National Convention in Orlando in August 2016.

 To read about the inspiration behind the scholarship, visit ChiroEco.com/chusascholar.

Source: ChiroHealthUSA, chirohealthusa.com

Logan University graduates 39 doctors of chiropractic and 33 master's degree students at its 177th commencement

Logan University held its 177th commencement for the degrees of doctor of chiropractic, master of science in nutrition and human performance, and master of science in sports science and rehabilitation on Saturday, August 22, 2015, in the William D. Purser, DC Center on the campus of Logan University in Chesterfield, Missouri.

The ceremony, which included the academic hooding of each graduate, honored 39 students with the conferral of Logan's flagship doctor of chiropractic degree by Logan President Clay McDonald, DC, MBA, JD. In addition, 10 students were conferred with the masters of science degree in nutrition and human performance and 23 students with the masters of science degree in sports science and rehabilitation.

 To read the full article, visit ChiroEco.com/logancommence.

Source: Logan University, logan.edu

INDUSTRY NEWS

The National by FCA breaks attendance records

The National by the Florida Chiropractic Association (FCA) took place from August 27 through 30 at the Hyatt Regency Orlando, and shattered all previous records in attendance and expo participation.

During the convention, 3,100 registered attendees and some 400 additional shoppers visited the 407-booth expo. Doctors of

chiropractic from as far away as Australia made the trip to take advantage of all that the FCA-sponsored convention had to offer. Featuring more than 120 class offerings for chiropractors, chiropractic assistants, X-ray technicians, and massage therapists, The National is the world's largest continuing education (CE) event and expo for the chiropractic profession.


 For further details about the convention, visit ChiroEco.com/fcanational2015.

Source: Florida Chiropractic Association, fcachiro.org

Cash Practice Inc. ranks on the 2015 Inc. 5000 with three-year sales growth of 65 percent

Inc. magazine ranked Cash Practice Inc. No. 4254 on its 34th annual Inc. 5000, an exclusive ranking of the nation's fastest-growing private companies. The list represents a comprehensive look at the most important segment of the economy—America's independent entrepreneurs. Companies such as Yelp, Pandora, Timberland, Dell, Domino's Pizza, LinkedIn, Zillow, and many other well-known names gained early exposure as members of the Inc. 5000.

"Our growth as a company is simply a reflection of the growth of our members," said Cash Practice Systems' CEO, Miles Bodzin, DC, upon hearing the good news. "More and more chiropractors want to free themselves from insurance dependence, and we've been the go-to company helping them. I am very proud of this accomplishment and look forward to continuing to help doctors of chiropractic flourish in spite of a worsening health insurance reimbursement environment."

 To read more about the company and the annual Inc. 5000 list, visit ChiroEco.com/cp-ranks.

Source: Cash Practice, cashpractice.com

Foot Levelers sets company sales records at FCA National

Foot Levelers set company sales records at the Florida Chiropractic Association National Convention in Orlando. Foot Levelers offered its full line of custom functional orthotics and its

new line of custom orthotic flip-flops, as well as its innovative 3D BodyView imaging system.

"There was an unbelievable response to our booths, speakers, and products," said Foot Levelers Senior Vice President Dawn Galbraith. "From our brand new Bling custom orthotic flip-flop, to the XP3 functional orthotic, to our Billing and Coding manual, attendees were very enthusiastic about the products and services they know will make a positive difference in their practices."

Long one of the knowledge leaders in the chiropractic profession, Foot Levelers also sponsored three speakers at the convention, including Kathy Mills Chang who lectured on the impending change to ICD-10 insurance coding.


 To learn more about the record-setting weekend, visit ChiroEco.com/fl-fca2015.

Source: Foot Levelers, footlevelers.com

HEALTH NEWS

The overlooked culprit that sabotages sleep

Sleeping late now and then may feel like a luxury. But an inconsistent sleep schedule can throw off the body's sleep and waking pattern, or circadian rhythm, reports the September 2015 *Harvard Health Letter*. "It can lead to insomnia, but people don't realize that their schedule is causing the problem," says sleep specialist Cynthia Dorsey, PhD, assistant professor of psychology in Harvard Medical School's psychiatry department.

To get sleep and waking patterns back on track, Dorsey recommends talking to a sleep expert. The first step is a physical exam to rule out underlying health conditions that may cause insomnia. If no underlying cause is found, try a sleep journal. Each morning, write down the wake time, the bedtime from the night before, how long it took to fall asleep, and whether there was any waking in the night—and if so, how many times. After two weeks, a pattern will emerge. It can help pinpoint any changes that need to be made. 

 For additional information, visit ChiroEco.com/sleepsabotage.

Source: Harvard Health Letter, health.harvard.edu



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WARRENGOLDSWAIN/THINKSTOCK

From the ground up

Understand when your patients need biomechanical support during the gait cycle.

BY MARK CHARRETTE, DC

DURING THE ACT OF WALKING, THE LOWER EXTREMITIES interplay with the spine. A normal gait creates repetitive motions from the feet to the lower extremities, to the pelvis and spine, up to the head. As a smooth symmetrical gait is associated with proper vertebral function, likewise abnormalities in one or both feet can cause spinal subluxations to develop and recur.^{1,2}

Problems with gait

Problems with walking can be caused by a number of neuromuscular conditions and biomechanical abnormalities. Neuromuscular conditions include ataxic gait (due to cerebellar or sensory problems), Parkinsonian gait (shuffling

and festination), Trendelenburg gait (due to weakness of the gluteus medius muscle), steppage gait (caused by foot drop), or hemiparetic gait (with circumduction due to partial paralysis).³ These conditions require extensive evaluation and testing but are rarely seen in clinical practice.

Biomechanical abnormalities are more common, and are frequently the source of persistent symptoms seen in chiropractic patients. Whenever there is a chronic or persistent subluxation complex, a search for underlying factors must include the feet and lower extremities.

Gait cycle components

Bipedal walking consists of two phases

for each lower extremity—the *swing phase*, when the foot is off the ground, and the *stance phase*, when the foot is on the ground and bearing weight. During normal walking, at one point both lower extremities bear weight (one is finishing toe-off and the other is starting heel strike). This is called *double support*. When running, there is an instant during which there is no contact with the ground—the runner is briefly flying through the air between phases, and then lands on one foot.

Swing phase

After push-off, the free leg swings through the air for about 40 percent of the gait cycle.⁴ The pelvis rotates forward and the hip flexes, accelerating

Posture, balance, coordination, and efficient musculoskeletal function all depend on a smooth gait during normal activity.

the leg forward. Muscles contract concentrically to pull the body forward. The knee and ankle flex to clear the ground, and then extend to prepare for the impact of touchdown.

While the swing phase is not usually symptomatic, it may be associated with gait abnormalities due to loss of neurological coordination or muscular weakness.

Stance phase

Once the foot touches down, the leg begins to bear the weight of the body. The stance phase is the most important portion of the gait cycle, as this is when the foot becomes fixed to the ground. It is also the longest phase, at 60 percent. The leg now bears the full weight of the body and supports the pelvis and spine.

It is during the stance part of gait, when the spine is supported on a single leg, that the biomechanics of the foot can interfere with chiropractic care. The three components of the stance phase are: heel strike (touchdown), foot flat (midstance), and toe-off (propulsion).

Heel strike

As the heel contacts the ground, the calcaneus is inverted and the foot is supinated. The ground reaction force is transmitted into the foot at the heel pad, and then the ankle joint absorbs some of the impact. The muscles in the lower leg, primarily the anterior and posterior tibialis muscles, contract eccentrically to slow down the plantar flexion of the foot. When overloaded, these muscles can become painful, causing "shin splints."⁵

Legs, pelvis, and spine

The force of heel strike transmits a shock wave up the leg to the pelvis, the spine, and into the skull. An experiment with human volunteers found that normal walking produces around 5 Gs of force on the foot and ankle, and a shock wave travels rapidly up the spine.

Within 10 milliseconds of heel strike (faster than conscious response), the scientists recorded a 0.5 G impact at the skull.² Running multiplies the impact of heel strike on the body by about three times (the rule of three).⁶ This is a significant concern for

patients who cannot tolerate this level of force, in particular those with degenerative changes in the joints of the lower extremities and the spine.

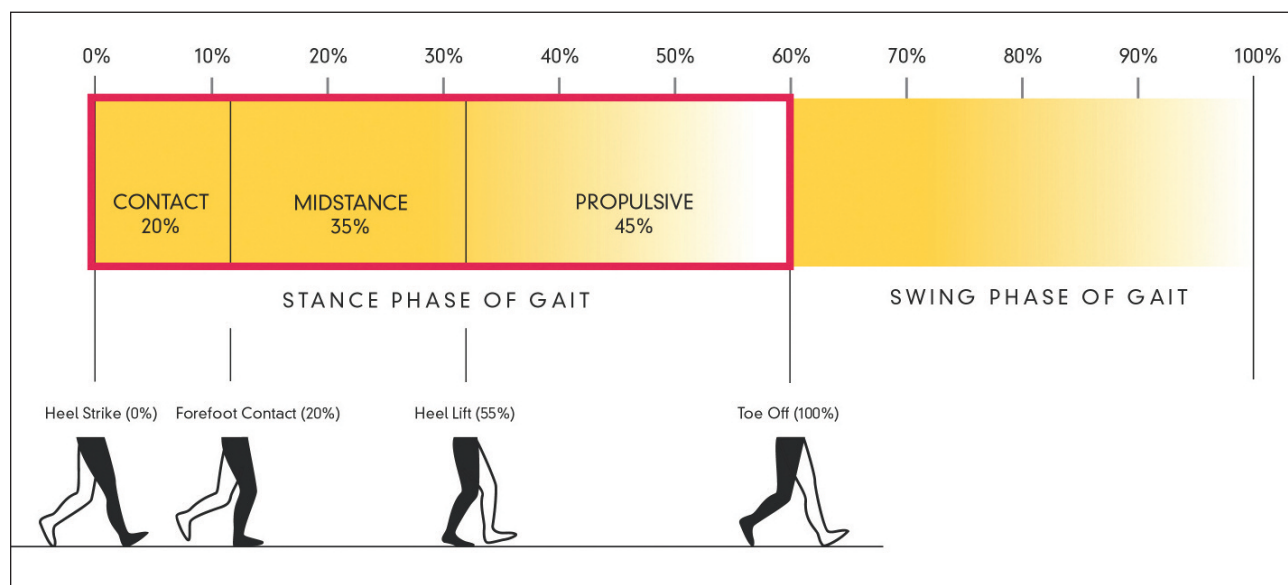
Biomechanical support

If a patient has shin splints, heel pain, or significant knee or spinal joint degeneration, additional shock absorption can be supplied by orthotic prescription. Several studies have found that the use of a viscoelastic polymer heel cup to reduce heel strike shock will significantly decrease both foot and back symptoms.^{7,8}

Foot flat

As the foot contacts the ground, it must adapt to a variety of surfaces. From heel strike to foot flat, the foot undergoes a complex rolling inwards, primarily at the subtalar joint. *Pronation* accommodates to variable ground surfaces and helps absorb the shock of the entire bodyweight.

Pronation causes a depression of the medial longitudinal arch of the foot, which is sustained by the elastic plantar fascia. If this connective tissue has





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undergone plastic deformation, it will no longer spring back and the foot stays pronated. When the foot goes too far into pronation, or stays in this position for too long, it won't progress smoothly into the next phase. Excessive pronation is commonly associated with many foot symptoms.⁶

Excessive pronation

As the foot pronates during the stance

phase of gait, there is a normal inward (medial) rotation of the entire leg into the pelvis. In persons with excessive or prolonged pronation, this twisting movement is accentuated.

The increased rotational forces are transmitted up the leg into the pelvis, and especially the sacroiliac joint.⁵ In response, various compensatory pelvic subluxation complexes can develop. These include pelvic tilt (usually

anterior or to one side), innominate rotation (usually postero-inferior), and other complicated adaptations.

The loss of arch height that occurs with excessive pronation allows the pelvis to drop to the more pronated side during stance and gait.⁵ The resulting pelvic tilt lowers the sacral base and drops the lowest freely moveable vertebra. A lateral curvature can then develop in response to the lack of solid support for the base of the spine.

Biomechanical imbalances associated with leg asymmetry and pelvic tilt transmit abnormal forces and sustained stresses to the spinal joints, resulting in classical patterns of microtrauma, cartilage wear, and osteophytes.⁵

Pronation support

Pronation problems require support for the arches of the foot—primarily the medial longitudinal arch (navicular), but also the lateral (cuboid) and the anterior (metatarsal) arches. This relieves stress on the supportive connective tissues and the plantar fascia in particular.

Especially in heavier or more strenuously active patients, additional torsional rigidity must be supplied to prevent medial collapse. In some cases, a special support for the heel prevents excessive eversion—the pronation correction or “varus/valgus wedge” is added under the medial aspect of the calcaneus.

Toe-off

The final aspect of the stance phase starts with heel lift, which progresses to toe-off and provides the propulsion needed to move into the next phase. Biomechanically, the foot goes into *supination*, becoming a rigid lever. This is aided by extension (dorsiflexion) of the metatarsophalangeal joints and tightening of the plantar fascia (the “windlass effect”). When the plantar fascia is weakened or the first metatarsophalangeal joint is stiff, the foot can't push off well and tends to roll medially.

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This causes the foot to flare outward and leads to symptoms at the first toe, such as hallux valgus or osteoarthritis.

At toe-off, the leg rotates externally and the pelvis moves posterior. Walking with an abnormal gait and poor toe-off causes back pain that can be treated with functional orthotics.³ Poor propulsion adds to the effort required for doing simple activities, and increases oxygen consumption during

normal walking.⁶ Sports performance can be hampered significantly.

Metatarsal support

At toe-off, the foot needs to be guided into supination and encouraged to flex at the metatarsal break. This requires a functional orthotic that is flexible at the first metatarsophalangeal junction, yet provides support to the medial foot and first two toes.

A connected system

While the feet seem far from the spine, they are intimately connected to it. Both structural and neurological factors demonstrate this interrelated and integrated system. Posture, balance, coordination, and efficient musculoskeletal function all depend on a smooth gait during normal activity. It is important to investigate the functioning of this interconnection between the feet and the spine.

By providing proper support for each phase of the gait cycle, you can ensure balanced function throughout the musculoskeletal system. **CE**

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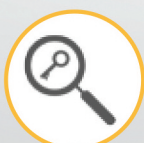
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Calculated decision

Rethinking what we know about optimal vitamin D dosing.

BY JOLIE ROOT

THERE IS NO DEBATE ABOUT THE MANY BENEFITS OF VITAMIN D.

The “sunshine vitamin” supports the musculoskeletal system by governing calcium for optimal bone strength and density, in addition to enhancing muscle tone. Vitamin D also supports a robust immune response, reduced levels of certain inflammatory cytokines, and reduced risk of heart attack. Vitamin D has even been shown to support the production of serotonin in the brain by activating the enzyme tryptophan hydroxylase-2.

The Institute of Medicine (IOM), part of the National Academies of Sciences, Engineering, and Medicine, citing evidence on bone density and the reduction of falls in the elderly, recently set recommendations of 600 international units (IU) of vitamin D for daily intake, increasing the dose to 800 IU for those over age 70.

Calculations by researchers at the University of California, San Diego, and Creighton University have shown that these doses are only about one-

tenth those needed to support vitamin D levels linked to reducing incidence or risk of diseases related to vitamin D deficiency.

How did the IOM get vitamin D dosing so wrong and how does the clinician make a more appropriate suggestion?

To begin with, the current vitamin D recommendations are inadequate due to mathematical error.¹ There are two issues with respect to the IOM stance on vitamin D requirements: The IOM chose 20 nanograms per milliliter (ng/ml) of serum concentration of 25-hydroxy vitamin D to be an adequate level, but vitamin D researchers now believe that's too low.

Most laboratories that perform vitamin measurements use a value of 30–100 ng/ml as the normal range. The IOM appears to indicate that 20 ng/ml is the beginning of adequacy, a level that the vitamin D community feels is insufficient.

In addition, to maintain a level of 20 ng/ml, the IOM says you need to take

600 IU a day up to age 70, and 800 IU if you're over 70. But research indicates this is wrong, and likely due to the result of a mathematical error.

Taking another look

In 2014, two investigators from the University of Edmonton published a paper in the journal *Nutrients*, in which they showed that the IOM had made a calculation error in defining the intake needed to reach and maintain a vitamin D level of 20 ng/ml.² Had the IOM calculated it correctly, the recommended dietary allowance (RDA) would have been 10 times greater.

The RDA is the intake considered necessary to meet the nutritional needs of 97.5 percent of the population.

Nearly half the people who get 600 IU of vitamin D a day do not reach the 20 ng/ml level, and thus are deficient. The Edmonton investigators, using the same studies on which the IOM had based its calculation, determined an intake of 8,895 IU per day would be

As a doctor you are free to disregard bureaucratic confusion with regard to vitamin D dosing.

necessary to achieve 20 ng/ml in 97.5 percent of the population. Robert Heaney, MD, is a prominent vitamin D researcher, and his group Grassroots Health has been compiling a vitamin D research database to determine more

appropriate dosing levels for vitamin D. Using the same set of IOM studies, Heaney's group found that 7,000 IU would bring 97.5 percent of people above 20 ng/ml. As a clinical endocrinologist, Heaney has spent

much of the last 50 years doing clinical research, most of it in the field of vitamin D, working on quantifying the level of vitamin D intake needed for optimal health.

Until the IOM's error resulted in an inadequate vitamin D dosing recommendation, 20–30 ng/ml levels were considered insufficient. For some reason, now the IOM feels that 20 ng/ml should be the new minimum range.

Fortunately, as a doctor you are free to disregard bureaucratic confusion with regard to vitamin D dosing. Given the absence of evidence that vitamin D levels greater than 30 ng/ml are harmful, and given the many studies showing 40–60 ng/ml as being more physiologically ideal, you are free to recommend more clinically relevant doses.

In general, the vitamin D community of clinicians suggests that 4,000–5,000 IU daily is appropriate dosing, with an upper limit of 10,000 IU. Many physicians recommend a 50,000 IU weekly dose for a few months to bring up levels in patients who are beneath 20 ng/ml. And routine measurement of serum 25-hydroxy vitamin D is an efficient way to assess an individual's response to the dose you recommend. ^{CE}

JOLIE ROOT is the senior nutritionist and educator for Carlson Laboratories in Arlington Heights, Illinois. She travels throughout North America attending medical conferences, lecturing, and educating the public about the role of nutrition in integrative medicine. Root can be followed on Twitter @jolieroot, and contacted through jolieblogs.com.

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There's got to be a morning after—doesn't there?

Surveying the new landscape in an ICD-10 world.

BY KATHY MILLS CHANG, MCS-P, CCPC

BY THE TIME YOU READ THIS, WE'LL HAVE JUST PASSED THE ICD-10 implementation date. So that happened.

And now we can all relax, right? No, that wouldn't be the best thing to do.

Having labored long and hard, we've arrived at this triumphant moment when the nation's healthcare providers are all using an entirely new coding language. It's nothing less than the biggest change in healthcare in over three decades. But instead of being able to rest on your laurels, you're under more pressure than ever before. It's frustrating. It's unfair. And it's also the new reality.

You might remember, back before ICD-10 preparations kicked into gear, that the Office of Inspector General

(OIG) released its most recent Work Plan. Let's review how that plan was relevant to chiropractic:

A whopping 75 percent of the OIG's funding is devoted to Medicare and Medicaid oversight. And since chiropractors can't "opt out" of Medicare, that means the OIG is spending a chunk of its budget taking a look at you and your colleagues.

- Do you know what Medicare wants to see in your documentation to support medically necessary care? Equally importantly, are you actually doing it?
- What would happen if the OIG decided to take a close look at your practice? Would your documentation hold up, or would you be at coughing up recoupments?

"But I don't treat that many Medicare patients," many of you are saying.

"This isn't going to affect me." Here's the thing: Independent insurers look to the OIG and Medicare to set the pace and tone of billing rules, and tend to fall in line and enforce the same guidelines. Even if you were "safe" from Medicare (and there's truly no such thing), you're likely not safe from all of your contracted carriers.

- How would your documentation stand up to closer scrutiny by any of the carriers with whom you have a contract? Do you know what they want and expect to see?
- Could you handle it if one of them came after you and began demanding that you send money back—money you've probably already spent?

Get crystal clear on what documenting for medical necessity looks like—especially now that you're coding with ICD-10.

Why can't these people just leave you alone? There are a few good reasons. In fact, there's about five billion of them. The OIG estimated its 2014 intake from last year's audits and investigations at \$4.9 billion. Do you think the government is going to turn

its back on that kind of money? Do you think that private insurers haven't sat up and taken notice?

The OIG genuinely believes that improving chiropractic documentation is good for the profession. But it also believes the best means to that end is

to put your documentation under a microscope, shake it around a bit, and see how much money falls out.

You've already put emergency money aside in case there are delays in reimbursements post-ICD-10. Can you handle it if, on top of potentially delayed reimbursements, you find out you have to give back a bunch of money you received last year?

Do you think you are safe from government or private-insurer scrutiny? Sadly, practices that have already been through an audit aren't immune. There are DCs who've been through this stressful process again and again.

These are only the potential financial ramifications. But there are far worse possible outcomes of an audit, and the news is filled with stories of doctors who've lost the luxury of assuming they'll get paid (because they are now required to submit documentation in advance of treatment, almost like being "pre-audited," until they re-earn trust).

There are also the doctors who lost their freedom by being sentenced to jail time. And doctors who lost their livelihood. It doesn't happen often, but egregious offenders can lose their license to practice.

Still skeptical? During 2014, the OIG:

- ▶ excluded 4,107 "individuals and entities" from participating in federal health insurance programs (how quickly do you think private insurers followed suit?);
- ▶ brought 971 cases of criminal charge; and
- ▶ filed 533 civil actions against offenders.

If that doesn't get your attention, it's hard to imagine what will.

It would have been better had the OIG headed into 2015 confident that DCs were all going to straighten up and fly right, but it didn't. The government



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entity has had enough experience to know that many chiropractors are poor documentarians, and it has said—in writing—that it will be stepping up its efforts to identify and bring to light cases of abuse, noncompliance, and

fraud. And it has kept its word.

The news is rife with cases of doctors who are getting punished, and punished severely, sometimes for outright fraud and sometimes for sheer ignorance. One DC had to come up with almost

\$800,000 in recoupments because he was coding all of his treatments as five-spine adjustments, whether medically necessary or not.

You don't have to read the OIG's 90-page Work Plan, but do take the risk of being audited seriously. Get crystal clear on what documenting for medical necessity looks like—especially now that you're coding with ICD-10.

Your chances of making innocent documentation errors that put you at risk are greater than ever before. CMS has said that Medicare won't reject claims for incorrect codes alone, as long as those codes are in the right coding family. But this will do absolutely nothing to protect you from other kinds of documentation mistakes and their ramifications.

So on this particular “morning after ICD-10,” things are not quite as safe as we'd like them to be. But that doesn't mean you face a reign of terror, either. Doctors who've put their nose to the grindstone, located their coding errors, and made a true effort to fix them have seen great turnarounds. Many practices put on probation have worked their way back to full privileges again.

The OIG doesn't think DCs know how to document correctly. Let's prove them wrong. **CE**



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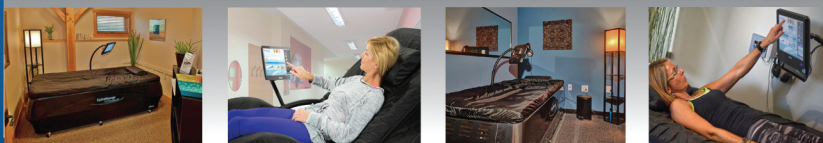
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Making the first move

To encourage primary-care physician referrals, start by extending a professional invitation.

BY MARK SANNA, DC

PHYSICIAN-REFERRED PATIENTS ARE A SOURCE OF PRIDE FOR THE fortunate practices that receive them. A physician's referral is a strong endorsement. A base of referring physicians can generate large numbers of new patients and, if arranged properly, become a self-sustaining business model.

Yet reaching out to local physicians is something that many chiropractors hesitate to do. They enjoy practicing in their comfort zone—but this can be a colossal mistake.

The rise of the specialist

When adults have a fever, nasal congestion, or a common condition such as asthma, more than 40 percent will seek medical care from a specialist rather than a primary care physician (PCP).

Many patients believe that specialists are better able to treat specific conditions than general physicians. The nation's shortage of PCPs is also leading patients to obtain medical services from specialists. By 2020 there will be

an estimated shortage of 45,000 PCPs, according to the Association of American Medical Colleges.

If you can't beat them

Why are specialists so busy? They learned long ago to *behave* as specialists. Specialists send reports without being asked and acknowledge the professionals who refer patients to them.

Some chiropractors don't receive many direct referrals from allopathic physicians. You can change this by acting like a specialist and sending reports and acknowledgments to PCPs as if they were direct referrals.

The first step in building these relationships is to ask the name of the patient's PCP (even for non-referred patients). Also ask patients if you can send their physician a report of your findings. At first, you may not hear anything from the PCP, but once a few of your reports and thank-yous come across the PCP's desk, the referrals will start to flow.

To accomplish the first step, simply

meet the expectations of being a specialty practitioner. You may choose to call PCPs initially if you have no prior experience with them, and then follow up by sending a report.

Sending reports to PCPs introduces you as a healthcare professional. It lets them know that their patient was in for a neuromusculoskeletal evaluation and that you will provide an initial report of findings as well as periodic updates of the patient's progress.

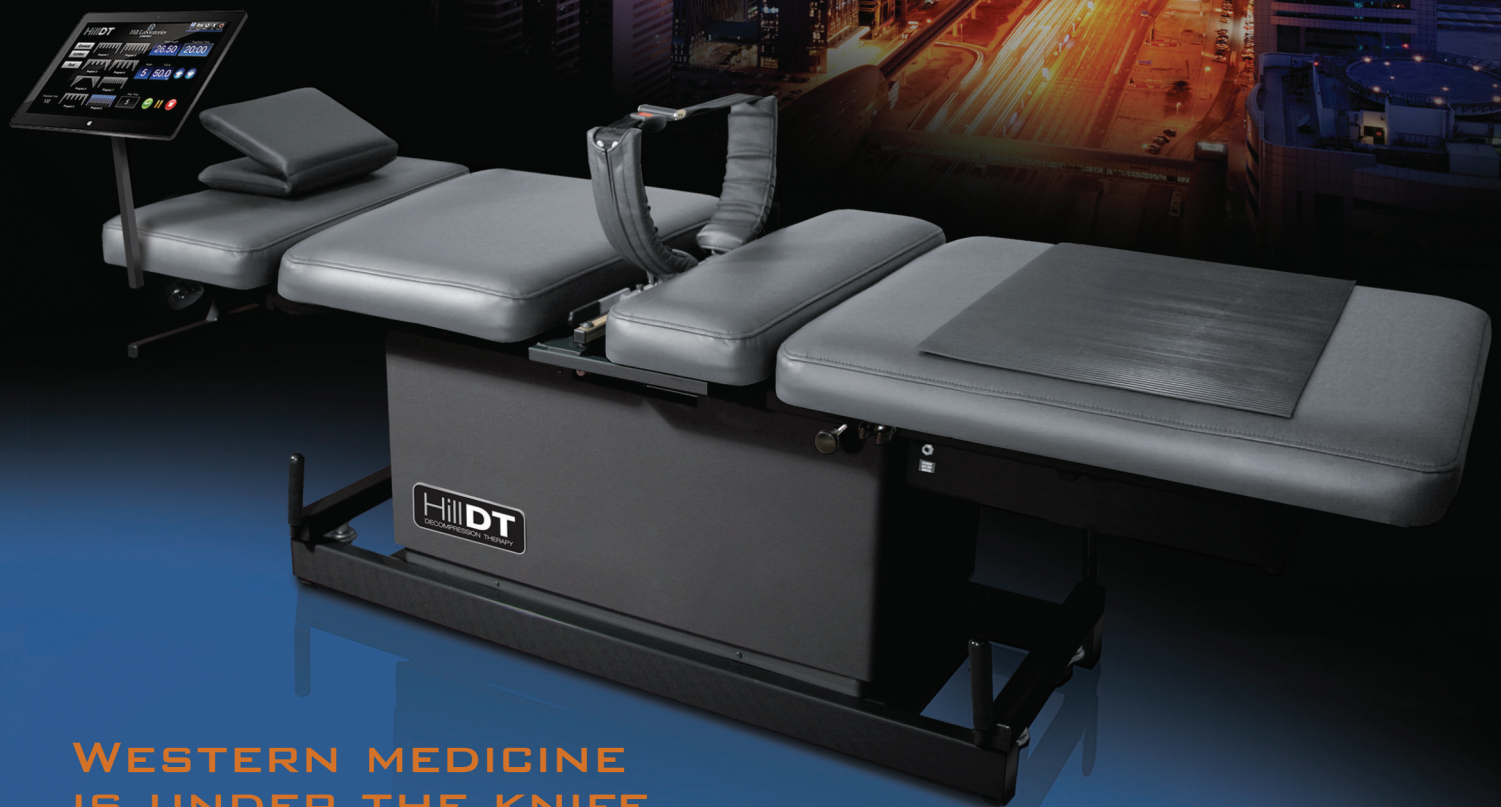
This reassures PCPs that you will provide noninvasive, conservative treatment and that you will refer back to them.

Keep reports short

Long narrative reports are critical for potential litigation cases such as personal injuries, but they are not necessary for PCPs. Reports to PCPs and other healthcare professionals should be brief and to the point. The reports you receive from radiologists serve as an example—they are likely brief, factual, and without filler language.

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The personal follow-up

Choose one evening to be a “work night” and invite a medical doctor or osteopathic PCP to dinner. If the PCP hasn’t referred a patient to you lately, referrals will increase overnight after you visit over a meal. Make it a social evening by including your spouses or significant others. In addition, sporting events such as golf or tennis work effectively in this regard.

In the allopathic community, specialists treat referring doctors like gold. Pay attention to your own referring doctors. Patients who are referred from MDs and DOs are like diamonds. They look up to you as a specialist. They follow through, they pay, and they refer other patients like themselves.

Professional breakfast meetings

Morning coffee gatherings can work

well for professionals with busy schedules. Everyone has time for a breakfast meeting or at least a short get-together for coffee and a muffin at the local shop. Develop and nurture the relationships that you form in your professional community. If you don’t, someone else will.

To get started, develop a list of the medical doctors you are targeting for referrals. This list can be extensive, but try *not* to limit your thoughts to who you believe would or would not refer you. You may be surprised.

Once you identify a doctor you would like to take to breakfast, the next step is getting the professional to meet with you. It’s easier to obtain a meeting when you know someone in common.


For example, you may have a patient in common with another healthcare

provider. You can call the provider and explain that you’ve begun treating one of his or her patients, and that you always like meeting with the other members of a patient’s healthcare team.

You may also have a patient who knows the physician from the golf course or another social context. Ask your patient to intervene and give the “seal of approval” before you call the doctor to set up a meeting. During these interactions, closely follow HIPAA policy.

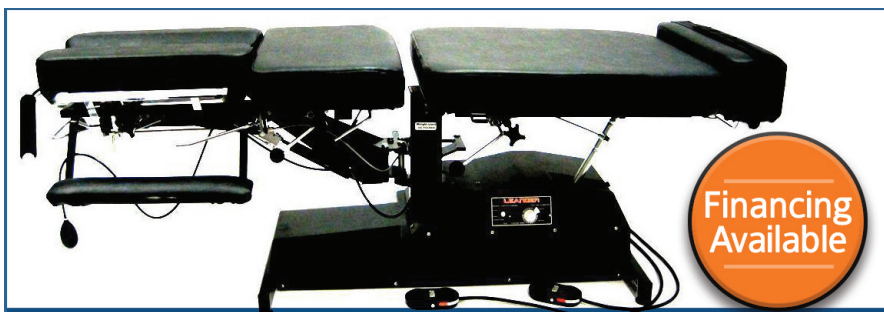
Track your results

Create a file on the professionals you connect with and record the results of each meeting. Details worth noting include doctors’ likes and dislikes, family information, and items about their practice. In addition, track the referrals that come from each professional.

Implement these strategies successfully, and you’ll tap into a virtually unlimited stream of medically referred patients. 



MARK SANNA, DC, ACRB Level II, FICC, is a member of the Chiropractic Summit, the ACA Governor’s Advisory Board, and a board member of the Foundation for Chiropractic Progress. He is the president and CEO of Breakthrough Coaching and can be reached at 800-723-8423 or through mybreakthrough.com.



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Myth busters: Why MDs don’t refer to DCs

1. MDs hate DCs. **True/False**
2. MDs think that DCs are not real doctors. **True/False**
3. MDs think DCs are uneducated. **True/False**
4. MDs think that DCs will steal their patients. **True/False**
5. Most MDs simply do not know what DCs do. **True/False**

Answers: 1.F, 2.F, 3.F, 4.F, 5.T

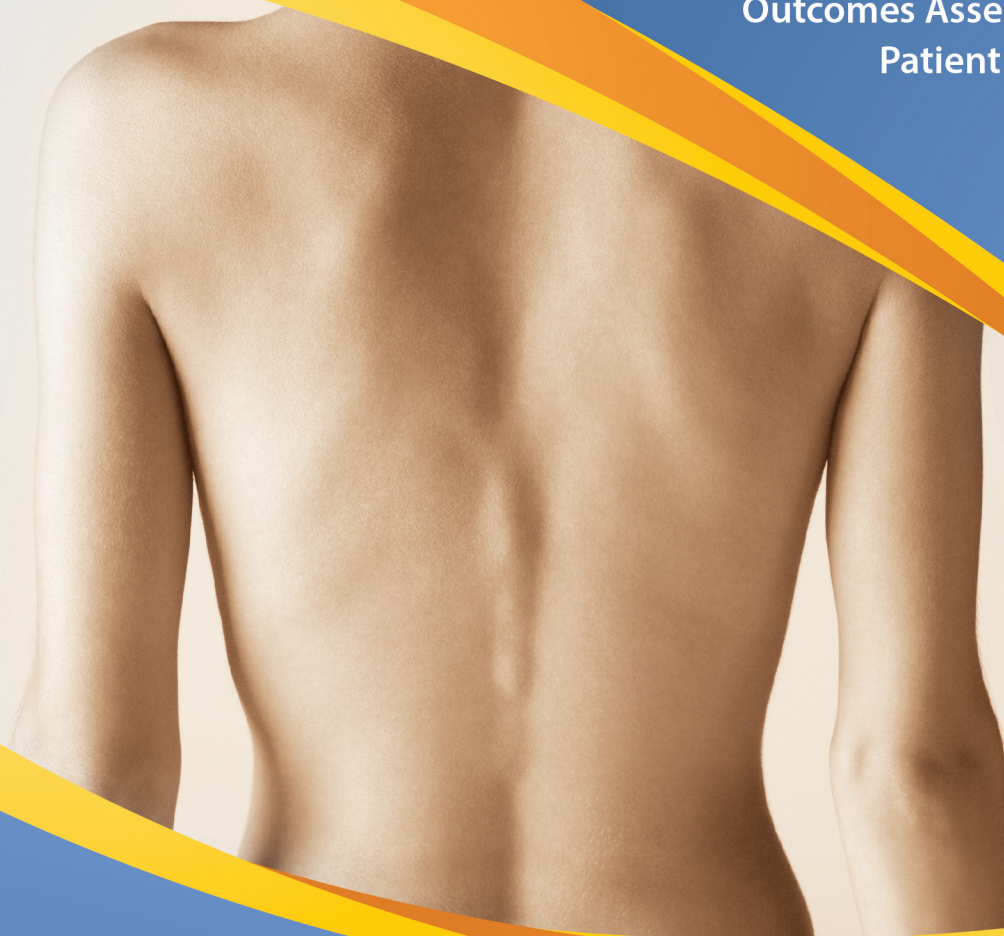


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Stake your claim

As the data show signs of modest financial growth in the chiropractic industry, multiple waves of change stand to impact future reimbursements. But healthcare reform that increasingly favors low-cost effective care plays right into the profession's innate strengths.

BY CAROLINE FEENEY

If expectations for healthcare providers by the government and patients alike could be summarized today with a quintessential word, it would be “quality.”

Defined as something's degree of excellence, quality already describes the status of your job as a healthcare provider. It represents the extensive education required to become a doctor and the relatively high income you earn. This elevated status actually worked against you when the 2008 recession caused the economy to shrink, and lower-wage (and arguably lower-quality) positions were the first to re-enter the workforce.¹ We saw this reflected in the industry's declining reimbursements from 2009 to 2013.

The economic conditions *now* are such that you might be starting to feel the effects of higher-wage job recovery, even if it has materialized in your practice as “two steps forward, one step back” over time. The results from our 2015 survey support a trend toward financial growth, as we saw average reimbursement rates rise by four percentage points to 66 percent. In addition, fee and reimbursement values (\$66 and \$43, respectively) mostly held steady or registered slight

improvements, though not to the same extent as reported by MDs. These numbers, of course, reflect data recorded before the ICD-10 switch.

Then, there's the public's perception of chiropractic, a subject on which Palmer College of Chiropractic in conjunction with Gallup shed further light with a first-of-its-kind national survey (P-G Survey).² Released in September 2015, the survey results showed that more than half of U.S. adults have a positive view of DCs and agree that they're effective in treating neck and back pain. And although previous data had estimated chiropractic use at around 8 percent, 14 percent of the P-G survey respondents reported using chiropractic care within the past 12 months.

Several keys to reaching more of the population were also revealed in the P-G Survey, one of which was educational outreach. The more likely respondents were to opt to access chiropractic care, the more likely they were to perceive DCs as trustworthy and effective. This simply shows that people get real—and quality—results from the treatment you provide. But first, they have to walk through your door (and understand what you do).

Finally, the shift toward value-based reimbursements may soon be the new

normal when working with Medicare patients and those payers that follow suit. That means the fee-for-service model you see displayed across the following pages may look different next year and the years to come as we reflect those changes, as well as the transition to ICD-10.

Fundamentally, the goal of a value-based payment model is to refocus on *quality* rather than patient volume and service duplication, and to lower costs. DCs are capable of delivering on this expectation in the form of conservative nonsurgical care, and have been since the dawn of chiropractic.

Time will tell if the profession can take full advantage of the demand for quality. Disguised in documentation and the uncomfortable nature of change, it may be actually be a blessing for those who can stake their claim in evidence-based results and proven patient outcomes with EHR software.

To be adept in this evolving realm, though, you must also be adaptable. Here are several key takeaways from this year's Fees and Reimbursements Survey:

The more, the wealthier? Our *Chiropractic Economics* survey may further support findings from the P-G results: Areas more densely saturated

About this survey

Throughout August 2015, *Chiropractic Economics* extended an invitation to readers to complete a Web-based survey on fees and reimbursements. Additionally, we encouraged a number of state, national, and alumni associations to distribute the survey to their members.

We limited survey participants to practicing chiropractors or their designated office managers/CAs to ensure accuracy.

Number of participants. This year's analysis is based on responses from 353 respondents.

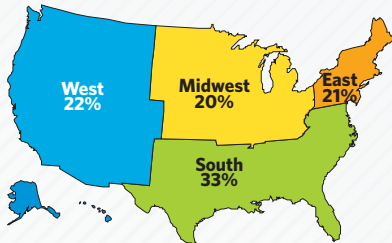
Regional distribution.

Participants hailed from the South (33 percent), the West (22 percent), the East (21 percent), and the Midwest (20 percent). The remaining 4 percent of respondents did not specify a region or are located outside the U.S. There were five states not represented in this year's survey including Alaska, Delaware, Hawaii, West Virginia, and Wyoming.

Averages. Unless indicated otherwise, all numbers are given as averages.

Cash-only practices. Cash-only practices reported fees equal to reimbursement.

The survey results are provided for informational purposes only. They are not intended to be used as a recommendation for setting fee levels.



Profile of Respondents

	2015	2014	2013
Personal characteristics			
Male	73.7%	73.3%	74.4%
Female	26.3%	26.7%	25.6%
Average age	49.3	48.2	48.2
Age range	26-81	26-82	26-79
Average yrs in practice	20.1	19.5	19.0
Types of practice			
Solo	74.1%	76.4%	67.6%
Group	23.6%	22.4%	26.1%
Associate	2.3%	1.2%	6.3%
In a franchise operation	3.8%	6.6%	4.8%
Integrated healthcare practice (DC+MD/DO)	5.3%	6.2%	5.5%
Cash-only practice	15.9%	19.1%	11.9%
Fees and reimbursements			
Average fees	\$66.2	\$67.2	\$67.0
Average reimbursements	\$43.4	\$41.5	\$41.0
Average reimbursements rate	65.6%	61.8%	61.2%
Geographic location			
Eastern region	20.7%	15.0%	14.4%
Southern region	33.1%	41.6%	25.9%
Midwest region	19.5%	22.3%	36.3%
Western region	21.8%	21.0%	19.4%
Outside U.S./Unspecified	4.9%	0.01%	4.0%
Licensure			
One state	80.2%	80.9%	71.3%
Two states	13.6%	13.9%	19.9%
Three or more states	6.2%	5.2%	8.8%

with chiropractors are associated with a higher use of chiropractic, and a more favorable perception of DCs.

In our survey, 31 respondents (9 percent) hailed from California, the state with the highest employment level for chiropractors.³ Respondents from California made up a large portion of the Western region, which reported the highest reimbursements and reimbursement rates in the nation. It's possible that your competition isn't undermining you but rather raising the credibility of your practice, and therefore your earnings.

All together now. This year, 24 percent of survey respondents reported working in a group practice, and these doctors indicated higher fees and reimbursements (\$69 and \$47, respectively) than

the overall average. In addition, the 54 percent of doctors who reported having specialists on staff also fared better financially than those without.

A decline in cash overall, but not for women. In 2014, 19 percent of total respondents collected cash only for their services. That number decreased to 16 percent in this year's survey. One reason for this could be that the absence of insurance coverage is a major barrier for those patients seeking chiropractic care.² Still, 23 percent of the women polled reported operating a cash-based practice, compared to 14 percent of men. Last year, that percentage was equal for both genders at 19 percent.

Doing away with payment plans. The number of DCs offering payment plans

declined again, this year by 7 percent, perhaps reflecting a lower patient demand for such financial assistance. •



CAROLINE FEENEY is the associate editor of *Chiropractic Economics*. She can be reached at cfeeney@chiroeco.com, 904-567-1559, or through ChiroEco.com.

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In your neck of the woods

Average fees and reimbursements among chiropractic practices continue to vary by region. For the second year now, those doctors reporting from the West have indicated the highest reimbursements and reimbursement rates.

Interestingly, the most recent Fee Schedule Survey from *Physicians Practice* also reported higher reimbursement levels from doctors in the West, specifically for their existing

patient visits.

Taking into account the codes shown below, this year's overall fees (\$69) rose slightly, as did reimbursements (\$45) for an average reimbursement rate of 66 percent.

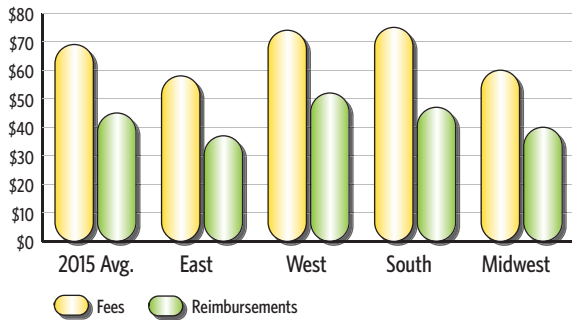
The Midwest had the second-highest reimbursement rate (66 percent) but reported lower average fees and reimbursements (\$60 and \$40, respectively), compared to last year.

The South, falling behind the West in reimbursements, reported the highest average fees at \$75 (up from \$69 last year) with reimbursements also rising since 2014.

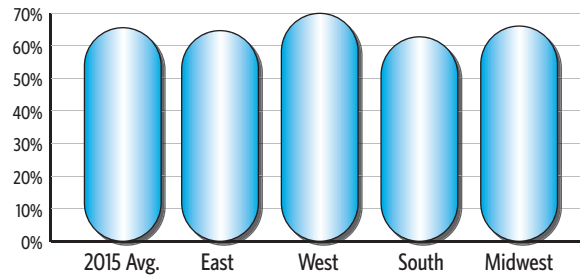
Although the East reported the lowest fees and reimbursements (\$58 and \$37, respectively), the region's average reimbursement rate rose from 59 percent last year to 65 percent in 2015. •

PROFESSIONAL CARE	2015			Eastern Region		
	FEE	REIMB.	% REIMB.	FEE	REIMB.	% REIMB.
98940 Chiropractic manipulative trmt., 1-2 regions	\$47	\$32	68.1%	\$46	\$32	69.6%
98941 Chiropractic manipulative trmt., 3-4 regions	\$55	\$38	69.1%	\$53	\$39	73.6%
98942 Chiropractic manipulative trmt., 5 regions	\$61	\$44	72.1%	\$60	\$42	70.0%
98943 Extra spinal manipulation, 1 or more regions	\$40	\$26	65.0%	\$42	\$29	69.0%
99212 Established patient E/M services	\$54	\$37	68.5%	\$51	\$35	68.6%
99213 Established patient E/M services	\$80	\$55	68.8%	\$65	\$48	73.8%
99214 Established patient E/M services	\$108	\$81	75.0%	\$92	\$52	56.5%
NEW PATIENT EXAM						
99201 New patient E/M services	\$73	\$52	71.2%	\$78	\$51	65.4%
99202 New patient E/M services	\$91	\$60	65.9%	\$89	\$54	60.7%
99203 New patient E/M services	\$122	\$80	65.6%	\$108	\$65	60.2%
99204 New patient E/M services	\$159	\$110	69.2%	\$129	\$79	61.2%
RADIOLOGY						
72020 Single view X-ray	\$51	\$29	56.9%	\$41	\$25	61.0%
72040 Cervical, 2 or 3 views	\$80	\$49	61.3%	\$68	\$49	72.1%
72050 Cervical, 4 views	\$121	\$78	64.5%	\$103	\$74	71.8%
72052 Cervical, complete, including oblique and flexion and/or extension studies	\$154	\$92	59.7%	\$50	\$33	66.0%
72070 Thoracic, 2 views	\$82	\$51	62.2%	\$67	\$49	73.1%
72100 Lumbrosacral, 2 or 3 views	\$85	\$52	61.2%	\$79	\$52	65.8%
72170 Pelvis, 1 or 2 views	\$72	\$48	66.7%	\$52	\$31	59.6%
PROCEDURES AND MODALITIES						
97012 Traction, mechanical	\$27	\$17	63.0%	\$28	\$15	53.6%
97014 Electrical muscle stimulation (or G0283)	\$27	\$17	63.0%	\$26	\$15	57.7%
97035 Ultrasound	\$27	\$16	59.3%	\$27	\$14	51.9%
97110 Therapeutic exercises	\$42	\$27	64.3%	\$40	\$25	62.5%
97112 Neuromuscular re-education	\$41	\$26	63.4%	\$42	\$30	71.4%
97124 Massage	\$47	\$34	72.3%	\$43	\$30	69.8%
97140 Manual therapy	\$42	\$29	69.0%	\$37	\$20	54.1%
97530 Therapeutic activities	\$44	\$27	61.4%	\$34	\$25	73.5%
S8948 Low level laser, ea. 15 min.	\$38	\$18	47.4%	\$44	\$13	29.5%
S909 Spinal decompression therapy	\$57	\$37	64.9%	\$25	\$20	80.0%
OVERALL AVERAGES	\$69	\$45	65.5%	\$58	\$37	64.6%

Comparisons by Region



Percent Reimbursed by Region



Western Region			Southern Region			Midwestern Region		
FEE	REIMB.	% REIMB.	FEE	REIMB.	% REIMB.	FEE	REIMB.	% REIMB.
\$48	\$34	70.8%	\$47	\$30	63.8%	\$45	\$31	68.9%
\$57	\$36	63.2%	\$57	\$38	66.7%	\$53	\$36	67.9%
\$65	\$42	64.6%	\$66	\$46	69.7%	\$55	\$42	76.4%
\$42	\$26	61.9%	\$40	\$24	60.0%	\$35	\$23	65.7%
\$56	\$43	76.8%	\$62	\$38	61.3%	\$44	\$32	72.7%
\$84	\$62	73.8%	\$95	\$60	63.2%	\$66	\$47	71.2%
\$106	\$75	70.8%	\$131	\$106	80.9%	\$79	\$63	79.7%
\$69	\$49	71.0%	\$81	\$50	61.7%	\$55	\$42	76.4%
\$99	\$63	63.6%	\$95	\$60	63.2%	\$76	\$50	65.8%
\$125	\$86	68.8%	\$136	\$87	64.0%	\$109	\$74	67.9%
\$173	\$111	64.2%	\$188	\$127	67.6%	\$119	\$100	84.0%
\$53	\$40	75.5%	\$54	\$27	50.0%	\$51	\$26	51.0%
\$85	\$63	74.1%	\$84	\$46	54.8%	\$81	\$44	54.3%
\$142	\$125	88.0%	\$133	\$71	53.4%	\$109	\$68	62.4%
\$170	\$103	60.6%	\$174	\$107	61.5%	\$140	\$82	58.6%
\$95	\$61	64.2%	\$87	\$48	55.2%	\$70	\$53	75.7%
\$80	\$58	72.5%	\$92	\$51	55.4%	\$80	\$52	65.0%
\$92	\$75	81.5%	\$76	\$45	59.2%	\$60	\$46	76.7%
\$26	\$19	73.1%	\$29	\$18	62.1%	\$24	\$15	62.5%
\$31	\$18	58.1%	\$30	\$18	60.0%	\$21	\$15	71.4%
\$29	\$16	55.2%	\$30	\$18	60.0%	\$24	\$14	58.3%
\$41	\$28	68.3%	\$45	\$30	66.7%	\$38	\$20	52.6%
\$39	\$20	51.3%	\$47	\$34	72.3%	\$31	\$16	51.6%
\$60	\$51	85.0%	\$44	\$28	63.6%	\$40	\$27	67.5%
\$44	\$32	72.7%	\$45	\$31	68.9%	\$37	\$27	73.0%
\$51	\$31	60.8%	\$47	\$28	59.6%	\$38	\$23	60.5%
\$30	\$8	26.7%	\$38	\$17	44.7%	\$44	\$28	63.6%
\$85	\$77	90.6%	\$49	\$34	69.4%	\$68	\$21	30.9%
\$74	\$52	69.9%	\$75	\$47	62.7%	\$60	\$40	66.0%

Small steps

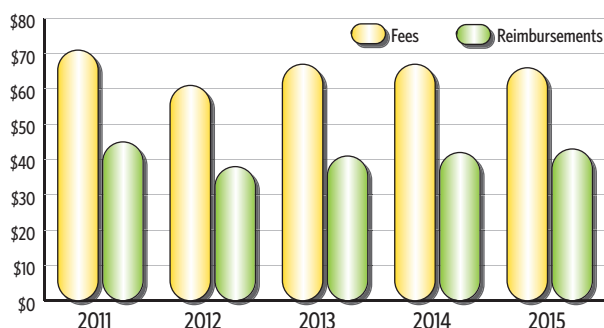
Last year we described an era of increased confidence in the chiropractic industry with an overall leveling of fees and reimbursements post-recession. That consistency remained true among our 2015 survey participants, with some additional signs of growth.

Our annual survey showed the slightest dip in fees from \$67 in 2014 to \$66 this year, and the slightest rise in reimbursements (\$42 to \$43). This raised overall reimbursement rates somewhat significantly, from 61.8 percent last year to

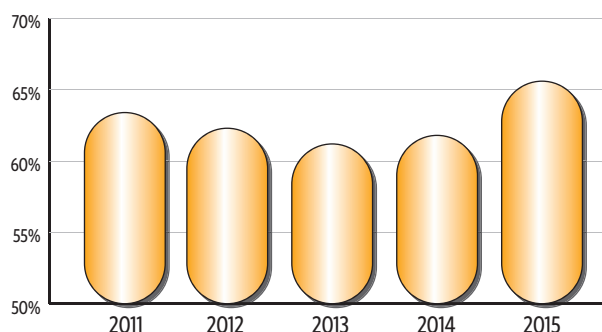
65.6 percent in 2015.

While in the last three years reimbursement rates have held steady between around 61 and 62 percent, this year we saw a notable increase of around 4 percentage points. These improvements may not mean the coast is fully clear, and only time will tell how recent major changes in healthcare will affect the industry. But the results show small steps toward growth for the time being, and that the opportunity for a bright future is within grasp. •

Year-to-Year Comparison of Fees and Reimbursements 2011-2015



Year-to-Year Comparison of Reimbursement Rates 2011-2015





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The benefits of group think

Among our survey participants this year, 24 percent reported operating in a group setting. This is up from the 22 percent who reported in 2014, but down a bit from 2013's 26 percent, which was the highest percentage of group practice participants recorded in 16 years.

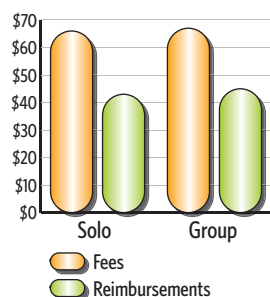
Respondents reporting as associates rose slightly from 1 to 2 percent this year. Coming in at 74 percent, DCs with solo practices made up the vast majority of our survey respondents.

On average, group practices reported higher fees, reimbursements, and reimbursement rates than solo operations in 2015. Group practices had average fees of \$69 and average reimbursements of \$47, while solo practices had average fees and reimbursements of \$67 and \$44, respectively.

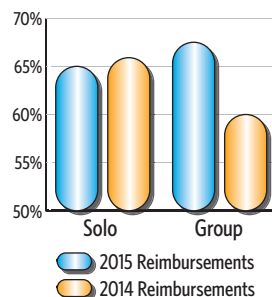
Reimbursement rates in solo practices remained level with last year's 66 percent, while reimbursement rates in group settings rose a significant 8 percentage points from 2014's survey (60 to 68 percent).

As expected, group practices reported a significantly higher percentage of specialists working in their clinics. When asked what specialists they employed, 53 percent of solo DCs answered "none" while just 26 percent of group practitioners answered the same. •

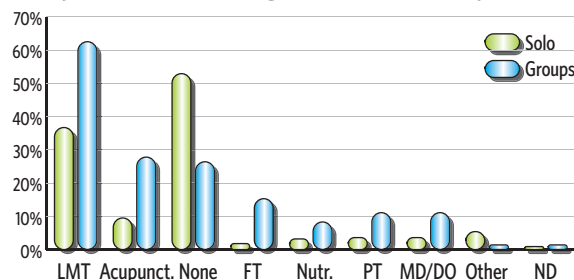
Solo vs. Group Fees and Reimbursements



Solo vs. Group Reimbursement Rates



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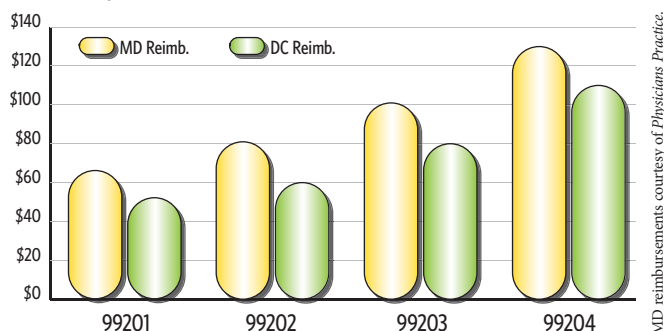
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DCs and MDs: comparing common ground

The ebb and flow of reimbursements in the chiropractic field often mirror what's happening in the healthcare industry as a whole, but to a different or lesser extent. These parallels can be observed by evaluating the common codes shared by both MDs and DCs, specifically 99201 (evaluation and management for new patients) and its variations including 99202, 99203, and 99204.

Comparison of MD and DC Reimbursements



For example, last year, the overall decline in MD reimbursements recorded by *Physicians Practice*, a business journal for medical doctors, was in contrast with the slight growth or leveling of these same codes for DCs. While the dollar values of MD reimbursements for these codes remained a bit higher on average than those values reported by their DC counterparts (even with declining reimbursements), the results showed a shrinking financial gap between the professions with regard to these core codes.

Optimistically, in 2015, DCs (per this survey) and MDs (according to the *Physicians Practice* survey published in February 2015) reported higher reimbursements on average for all four codes. DC reimbursements for 99203 were the only exception, a number that declined slightly from an average of \$82 to \$80.

The increase in reimbursements reported by MDs was markedly steeper than the growth indicated by chiropractors. So while both industries saw improvement, the 2015 results illustrate a return to a broader cleft dividing the industries, with MDs experiencing a recession recovery at a faster rate.

Because *Physicians Practice* now reports solely on reimbursements, our comparisons will be limited to DC reimbursements as well. The breakdown of specific codes in 2015 is as follows:

For code 99201, DCs averaged reimbursements of \$52, while MD reimbursements were \$66. This is up from \$46 (DCs) and from \$53 (MDs) last year.

For code 99202, MD reimbursements were \$81, up from \$67 the previous year, and DCs reported an average of \$60, up slightly from \$58 in 2014.

For code 99203, MD reimbursements increased from \$86 last year to \$101 this year. DC reimbursements declined slightly from \$82 last year to \$80 this year.

For code 99204, MDs reported a reimbursement average of \$130, a significant increase from last year's \$102. Chiropractors reported average reimbursements of \$110, up from \$103 last year. •

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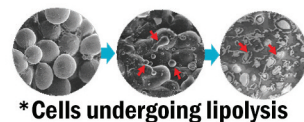
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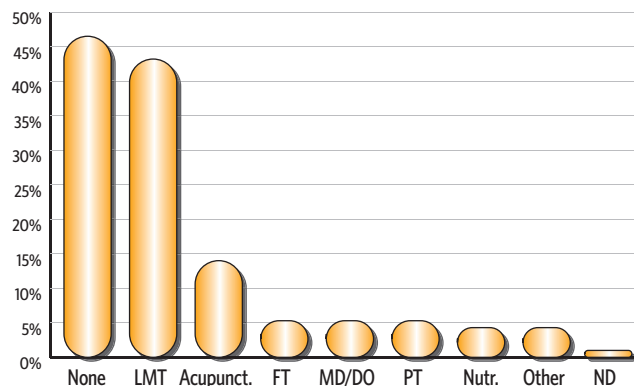
In May 2015, our annual Salary and Expense Survey showed that teaming up with complementary specialists clearly boosts a DC's total compensation and salary. Those salary survey participants with specialists working within their practice reported average earnings of nearly \$100,000 compared to the \$77,000 reported by strictly solo operations.

In addition, multidisciplinary practices participating in *this* survey reported higher fees and reimbursements than those without specialists. The results demonstrate the multifaceted benefits of running a practice with diverse specialties.

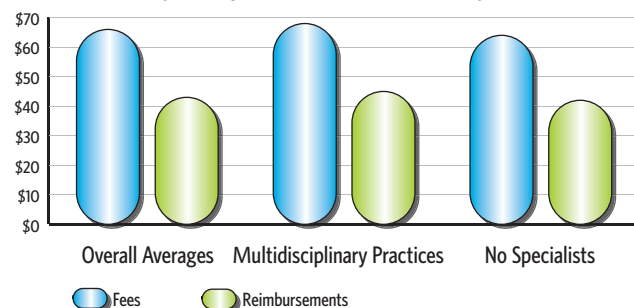
Specifically, practices with specialists reported average fees and reimbursements of \$68 and \$45, while nonspecialist practices reported average fees and reimbursements of \$64 and \$42, respectively.

For multidisciplinary practices, licensed massage therapists (LMTs) remained the most popular practice add-on, with 43 percent having one on board. LMT was followed by acupuncture (14 percent), fitness trainer (5 percent), physical therapist (5 percent), MD/DO (5 percent), nutritionist (4 percent), and naturopathic doctor (1 percent). The 4 percent that answered "other" specified working with such specialists as a psychologist, hypnotherapist, foot reflexologist, and a Pilates instructor. •

Specialists on Staff in Chiropractic Practices



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Would you like a franchise with that?

Although we saw an increase in survey participants reporting as franchises over the past three years, in 2015 that percentage dropped to 4 percent of respondents (compared to 7 percent last year).

The financial picture for franchisees appeared to be bright this year, however. Fees for franchise owners rose slightly to \$65, while reimbursements for these same doctors increased significantly from \$38 in 2014 to \$50 this year. As a result, reimbursement rates for franchise doctors grew to 77 percent, a number that is more than 10 percentage points greater than overall 2015 reimbursement rate averages.

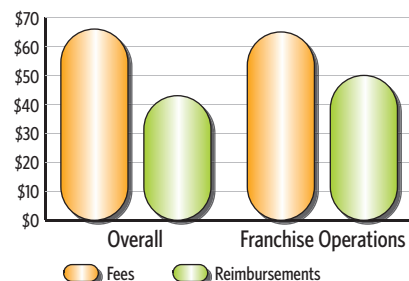
More to the story

This year's survey indicates that franchise owners are younger than the overall average age (47 years old compared to 49 years old). In addition, 77 percent of respondents reporting as franchises in 2015 were male.

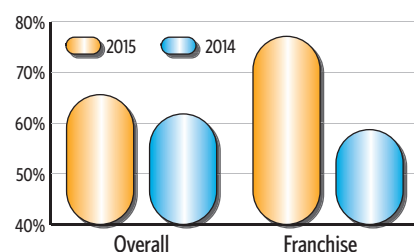
The average franchise owner has been practicing for 16 years (compared to the 20-year average among all respondents), owns one practice, and is licensed in one state.

Although last year the vast majority of franchise owners reported running a solo practice (85 percent), in 2014 this sect split more evenly between solo and group practices, with 46 percent reportedly operating in a group setting. •

Comparison of Franchise Fees and Reimbursements with Overall Averages



Franchise Reimbursement Rates



Cash savvy

Although the percentage of cash-only practice survey participants decreased from nearly 20 percent in 2014 to 16 percent this year, those DCs who did report operating a cash-based practice fared well in their collections.

For cash-based practices, average fees were reported at \$76, a value that is \$10 more than overall average fees. In 2013, cash fees came in at \$61, then grew to \$70 in 2014, so this year's indicate that cash collections continue to be on the rise.

By strict definition, a cash-based practice has no reimbursements. So, fees in a cash-only practice are equivalent to reimbursements (collections). Cash-only practice fees of \$76 are 77 percent greater than the overall average reimbursement of \$43.

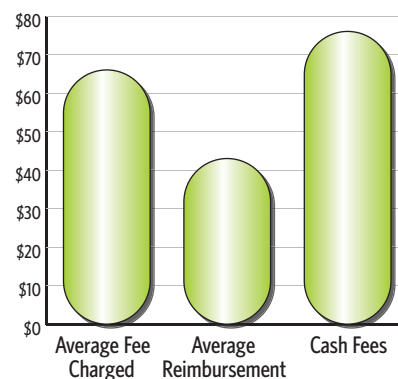
The typical cash-only practice respondent is male (62 percent), but the breakdown was split more evenly between genders this year with women making up 38 percent of this group,

compared to 26 percent last year. Cash-based practice survey participants had an average age of 49, and typically work in a solo clinic (83 percent). These respondents have been working as practitioners for 18 years on average.

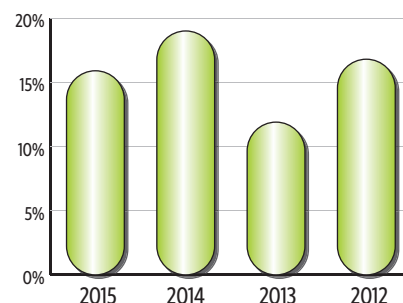
Here's a breakdown cash-based practice offerings:

- ▶ Nutrition (60 percent)
- ▶ Instrument adjusting (58 percent)
- ▶ Exercise programs (35 percent)
- ▶ Massage (29 percent)
- ▶ Instrument-assisted soft tissue mobilization (27 percent)
- ▶ Physical therapy (25 percent)
- ▶ Acupuncture (24 percent)
- ▶ Homeopathy (24 percent)
- ▶ Laser (24 percent)
- ▶ Weight-loss programs (22 percent)
- ▶ Ultrasound (20 percent)
- ▶ Electrotherapy (18 percent)
- ▶ Decompression (15 percent)
- ▶ Fitness devices (15 percent)
- ▶ Medical services (0 percent) •

Cash Fees vs. Reimbursements



State of Cash-Only Practices



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Ladies and gentlemen

Over the past few years, the number of female survey respondents has hovered around one-quarter of all participants. In 2012, we saw an all-time high of 28 percent, and this year 26 percent of our respondents were female.

Female chiropractors reported slightly lower average fees than male DCs (\$65 compared to \$67), with

slightly lower reimbursement averages (\$42 to \$45). Female practitioners also reported somewhat lower reimbursement rates than male DCs (64 percent to 67 percent).

The 67 percent reimbursement rate for men is up from 61 percent last year, whereas reimbursement rates for women remained in line with averages

from 2014. Interestingly, however, 22 percent of women reported operating a cash-only practice, a number markedly higher than the overall cash-only average of 16 percent.

Women respondents reported younger ages (46), compared to men (51). In addition, female DCs reported being in practice for fewer years (15), while male respondents have been in practice for an average of 22 years.

With regard to modalities, instrument adjusting (60 percent) and ultrasound (60 percent) were the most popular among men. A greater percentage of female practitioners reported offering nutrition (58 percent) than male (52 percent), making it the second most popular modality among women, behind only instrument adjusting (73 percent). •

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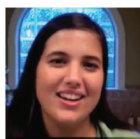
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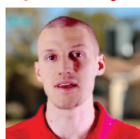
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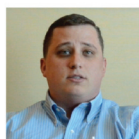
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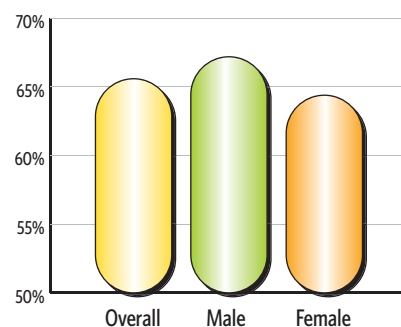
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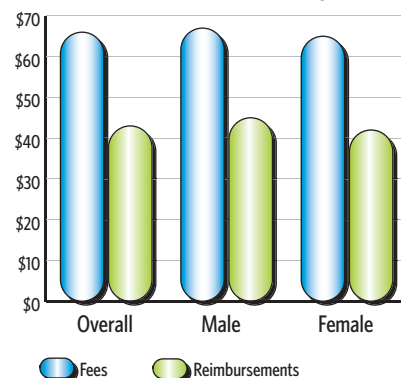
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Reimbursement Rates:
Male vs. Female



Comparison of Fees
and Reimbursements by Sex



Comparisons by Sex

	Overview	Male (74%)	Female (26%)		Overview	Male	Female
PERSONAL				MODALITIES			
Age	49.3	50.7	45.6	IASTM	30.0%	29.4%	32.2%
Years in practice	20.1	21.7	15.4	Decompression	28.3%	30.6%	22.2%
TYPES OF PRACTICES				Laser	26.9%	27.0%	24.4%
Solo	74.1%	73.3%	76.7%	Acupuncture	23.4%	19.1%	35.6%
Group	23.6%	24.3%	21.1%	Weight loss	19.1%	19.1%	18.9%
Associate	2.3%	2.4%	2.2%	Fitness	17.7%	17.5%	16.7%
Owens franchise	3.8%	4.0%	3.4%	Other	12.9%	11.5%	15.6%
Cash only	15.9%	13.9%	22.5%	Homeopathy	12.3%	9.9%	18.9%
MODALITIES				MD/DO	4.0%	4.8%	2.2%
Chiropractic	97.7%	97.6%	100.0%	SPECIALISTS			
Instrument adj.	63.4%	60.0%	73.3%	None	46.5%	50.9%	35.5%
Ultrasound	57.7%	59.5%	52.2%	LMT	43.2%	38.6%	55.3%
Exercise	53.4%	55.6%	47.8%	Acupuncture	14.0%	11.4%	22.4%
Nutrition	53.4%	52.0%	57.8%	PT	5.3%	5.5%	4.0%
Electrotherapy	53.1%	56.4%	42.2%	MD/DO	5.3%	5.9%	2.6%
Massage	45.4%	41.3%	55.6%	FT	5.3%	4.6%	7.9%
PT/Rehab	40.3%	41.3%	37.8%	Other	4.3%	3.2%	6.6%
				Nutrition	4.3%	4.1%	4.0%
				ND	1.0%	1.4%	0.0%



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*Chiropractic Economics 2015 Salary & Expense Survey

Pondering payment plans

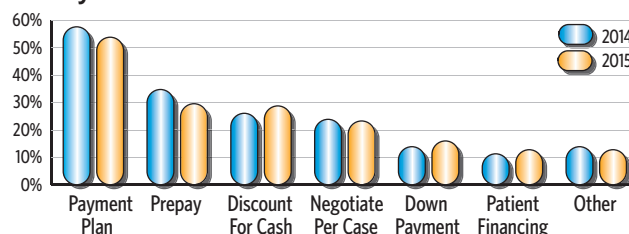
The number of doctors offering payment plans to patients this year decreased overall (54 percent compared to 58 percent in 2014). The 2015 results appear to be in line with the steady decline in payment plan offerings since 2010 and 2011, when nearly 70 percent of DCs had such plans.

The most significant change this year was reported by those DCs offering prepayment plans, an area that has shown fluctuation in years past. In 2013, 20 percent of DCs said they offered prepayment plans compared to 35 percent in 2014. Falling somewhere in the middle, around 30 percent of this year's respondents reported offering prepay options.

And while discounts for cash saw a decline from nearly 40 percent of DCs offering it in 2013 to only 26 percent in 2014, that number appears to be leveling off at around 29 percent in 2015.

The remaining responses were "negotiate per case" (23 percent), "down payment" (16 percent), "patient financing" (13 percent), and "other" (13 percent). •

Payment Plans



While we're in code mode

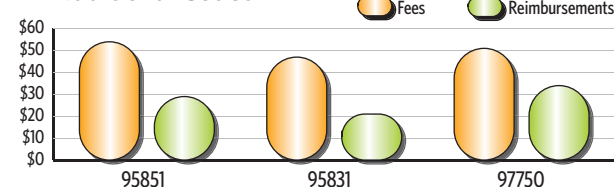
Year to year, we ask doctors of chiropractic to report on three additional codes: 95851, range-of-motion testing; 95831, muscle testing; and 97750, physical-performance evaluation. It should be noted that we *did* include these codes when calculating the fees and reimbursement averages for the other sections, not including the regional comparison chart.

Average fees for range-of-motion testing were \$54, while average reimbursements were \$29—a reimbursement rate of 54 percent.

Average fees for muscle testing were \$47, with an average reimbursement of \$21—a reimbursement rate of 45 percent.

Average fees for physical-performance evaluation were \$51, with an average reimbursement of \$34, and a reimbursement rate of 67 percent. **CE**

Additional Codes



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?

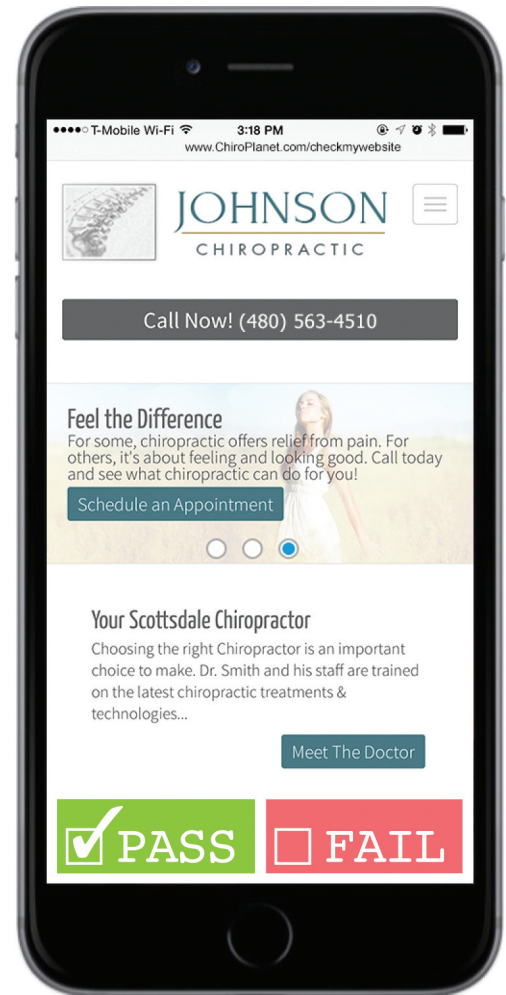
Since 2014, mobile internet usage has exceeded desktop usage with that trend increasing through 2015. Additionally, 48% of users start their research on search engines when looking for a business. Research also shows that local search on mobile phones has the highest conversion rate compared to both 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.



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The rest of the story

For your patients, sleep is a vital healthcare concern.

BY JACK DELL'ACCIO

SLEEP HAS BEEN A SOURCE OF WONDER AND CURIOSITY SINCE the existence of humankind. Undoubtedly, sleep is an essential part of human life and health. You've felt the aftermath of staying up late, and you know the uplifting feeling of having gotten a good night's rest.

One way or another, everyone eventually learns that sleep is *not* to be compromised. It functions as a recovery period for the human body and brain and allows for optimal function throughout the waking day.

Sleep science

The body, brain, and sleep are closely connected. Giving the body sleep allows it to learn, remember, and perform. As you may have noticed, you often feel delusional and irritable when you resist sleep, which greatly

inhibits your ability to focus and learn. Throughout the night, the brain goes through different stages of consciousness and sleep, each uniquely affecting memory and learning.

As noted in a recent Harvard sleep study, fact-based memory is associated with rapid eye movement (REM) sleep and serves as a way for the brain to process newly learned materials.¹ REM sleep is also critical for procedural memory, the remembering of how to do something. Interestingly, this is also the stage of sleep where most dreaming takes place.

Furthermore, a study conducted on the Stanford basketball team made the connection between sleep and performance; players drastically improved in all areas of the game by over 10 percent after improving their sleep patterns.² As the research demonstrates, there is

no question that sleep is paramount for a truly healthy life. Understanding the science of sleep and its factors will help you guide your patients toward a full night of restful sleep.

Sleep cycles

To cope with a 24-hour day, the human body is hardwired to be awake for 16 hours.¹ The brain has a “flip-flop” switch from wakefulness to sleepiness; accordingly, researchers have found that certain parts of the brain are associated with arousal and sleepiness. Namely, the hypothalamus is responsible for both.

The area of the hypothalamus called the ventrolateral preoptic nucleus (VLPO) holds neurons that shut down arousal signals stemming from the tuberomammillary nucleus (TMN).¹ Therefore, the VLPO is responsible for

Throughout the night, the brain goes through different stages of consciousness and sleep, each uniquely affecting memory and learning.

the brain's transition to sleep. These areas of the brain work conversely, which is why humans are able to stay awake for a long period of time and then fall asleep quickly.

In general, people require about 15 minutes to unwind and relax enough to fall asleep. Typically, the deepest stage of sleep happens 20 or more minutes after sleep onset; however, sleep onset can occur in an instant.¹ The same goes for waking up, as most people can awaken from an alarm clock in less than a second; however, it may take a few minutes for a person to be fully alert after awakening.

Sleep factors

There are many factors that contribute to the switch between falling asleep and waking up. Internal factors include the homeostatic sleep drive that accumulates the longer a person stays awake, and circadian rhythms that set up a day-to-night pattern over a 24-hour period.¹ Other environmental factors that contribute to falling asleep include noise and light exposure.

Additional considerations when trying to achieve a night of sleep are both comfort and pain. Discomfort limits the depth of sleep and will only allow short periods of slumber between awakenings throughout the night. Medical conditions and bedroom environment contribute greatly to these factors.

Sleep environment

By understanding the factors that go into creating the best sleep possible, the following are recognized as the constituents of a *replenishing* night of sleep:

- 1. Muscular comfort and pressure relief.** Unobstructed blood circulation allows for full cell repair, eliminating numbness and soreness.
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5. Clean air environment. An environment with low volatile organic compounds prevents obstruction of the central nervous system and allows for proper rest.

Sleep preparation

Extra steps can be taken to improve your sleep such as using a high-quality sleeping platform, and avoiding heavy foods, caffeine, and exercise in the later hours of the day. These activities stimulate the brain and make it more difficult to fall asleep. Instead, create a pre-sleep routine to calm down and prepare for bed. Reading a book, taking a bath, and breathing deeply are great alternatives to get in the right mindset for rest. 



JACK DELL'ACCIO is CEO and founder of Essentia, makers of the only natural memory foam mattress. After experiencing a family member's battle with cancer, Dell'Accio realized that chemicals in everyday items are detrimental to health. This was his motivation to create a cleaner, healthier approach to sleep. He can be contacted through myessentia.com.

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¹ Division of Sleep Medicine at Harvard Medical School. "The Science of Sleep." <http://healthysleep.med.harvard.edu/healthy/science>. Published March 2008. Accessed August 2015.

² Mah CD, Mah KE, Kezirian EJ, MD, Dement WC. The Effects of Sleep Extension on the Athletic Performance of Collegiate Basketball Players. *Sleep*. 2011;34(7):943-950.

Quick Tip

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— *The Baseline of Health Foundation, JonBarron.org*

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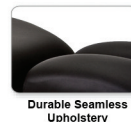


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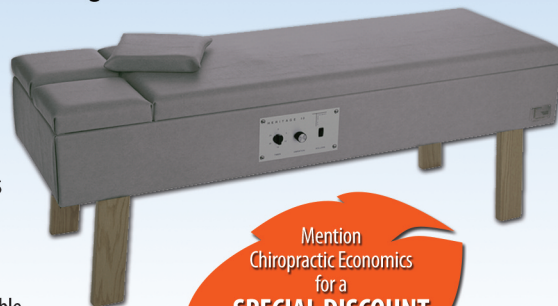
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BY PETER G. FERNANDEZ, DC.

IT'S ALMOST A GIVEN THAT THE STUDENTS WHO HAVE BIG PRACTICES in their college clinic will also become successful doctors with thriving practices after they graduate. The students who struggle through college clinic without referrals from their patients, upperclassmen, or from people in the community, will ultimately struggle after graduation.

Touch and tell

While you're still in the college clinic, the touch-and-tell procedure is a simple method to educate your patients and stimulate their referrals. (This procedure has been effectively used in chiropractic for over 100 years.)

When palpating patients' subluxations, explain which nerves are being pinched, where they go, and the health problems that can result. Mention the health problems you are relieving and preventing.

Here's a basic script for a six-step touch-and-tell visit:

1. While palpating the subluxation to be adjusted, say, "This bone is out of place."
2. "It pinches the nerve going to [the part]."
3. "If the nerve stays under pressure, [health problem] can occur."
4. "I have lots of patients with [health problem]."
5. "I can fix [health problem] by setting this bone back into place. Once the nerve heals, the [health problem] can heal."

6. "Let's set this bone back into place so you don't get [health problem]."

Here's how this script would play out in a clinical encounter:

Upper cervical subluxation: "This bone is out of place. It pinches the nerves that go over the top of your head, and that's what's causing your headaches. I have lots of patients coming to me for headaches, and I help them by setting this bone back in place. Let's get your bone back in place so you won't get headaches."


Lower cervical and upper thoracic subluxations: "This bone is out of place. It pinches the nerves that go into your shoulders, arms, and hands. If the nerves stay under pressure, pain, numbness, and tingling will occur in your shoulders, arms, or hands. I have lots of patients who come to me for these problems, and I fix them by setting this bone back into place. Let's set your bone back into place so you won't get these problems."

Mid-thoracic subluxation: Explain to the patient that an out-of-place vertebra here can pinch the nerves that go out between the ribs, causing pain radiating from the mid-back around the rib cage. Then say, "I have lots of patients coming to me with pain radiating between their ribs. I fix their rib pain by setting this bone in place. Let's set your bone back in place so you don't get pain between your ribs."

Rules to remember

- Keep your language simple and clear. When you use complicated medical terms, patients tend to tune you out.
- Notice in the examples above that the words "subluxation," "intervertebral misalignment," and such aren't used. Simpler terms like "bone out of place" work better.
- Only talk about one health problem that the patient is suffering from during each visit.
- Write on the patient's file or travel card the subluxation you talked to the patient about.
- Your explanation of the effects of a subluxation and how you can help this health problem should take no longer than five to 10 seconds.

Students: Your patients don't know that you can take care of headaches as well as shoulder, arm, leg, and rib pain. Once you've educated them, they can refer their friends who have these problems to you.

The old-timers built their practices by using the "touch-and-tell" method. It was effective then, and it still is today. 



PETER G. FERNANDEZ, DC, the "start-up coach," has been a practice consultant for almost 30 years. He has consulted in the opening of more than 3,000 new practices and can be contacted through The Practice Starters Program at 800-882-4476, drpete@drfernandez.com, or through practicestarters.com.


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Oct. 17-18	Spinal Pelvic Stabilization	Boston	Foot Levelers	800-553-4860
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Oct. 17-18	Graston Technique M2 Advanced Training	Orlando, FL	Graston Technique	888-926-2727
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Oct. 22-23	CEAS I: Ergonomics Assessment Certification Workshop	Atlanta	The Back School of Atlanta	404-355-7756
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Oct. 24-25	MOTUS Soft Tissue and Kinesiology Taping	Chesterfield, MO	Logan University	800-842-3234
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Dec. 5-6	A Biomechanic and Radiologic Perspective	Cincinnati	Foot Levelers	800-553-4860

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Dec. 5-6	Stress, Structure, and Neurology	Cincinnati	Foot Levelers	800-553-4860
Dec. 12-13	Graston Technique M1 Basic Training	Atlanta	Graston Technique	888-926-2727
Dec. 12-13	Graston Technique M2 Advanced Training	Atlanta	Graston Technique	888-926-2727
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Dec. 12-13	Graston Technique M2 Advanced Training	Anaheim, CA	Graston Technique	888-926-2727
Dec. 12-13	Lower Extremity Extravaganza	Charleston, SC	Foot Levelers	800-553-4860
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Feb. 4-5, 2016	CEAS I: Ergonomics Assessment Certification Workshop	Los Angeles	Back School of Atlanta	800-783-7536
Feb. 19-20	CEAS I: Ergonomics Assessment Certification Workshop	San Jose, CA	Back School of Atlanta	800-783-7536
March 4-5	CEAS I: Ergonomics Assessment Certification Workshop	Houston	Back School of Atlanta	800-783-7536
April 28-29	CEAS II: Aging Workforce Ergonomics Solutions Certification	Phoenix	Back School of Atlanta	800-783-7536

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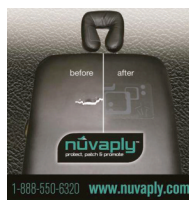
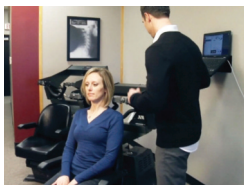


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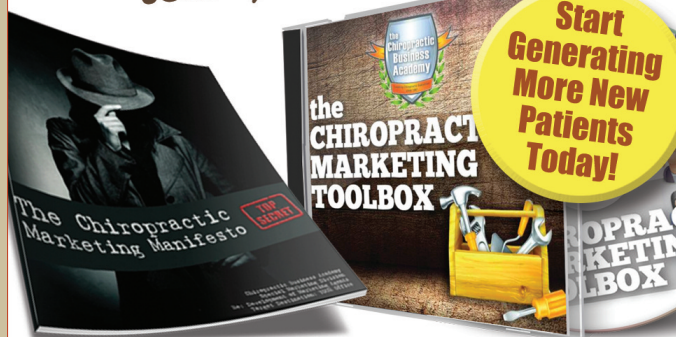
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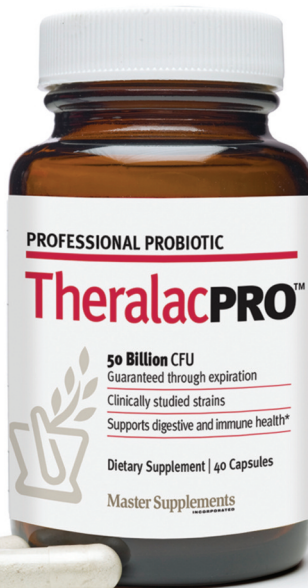


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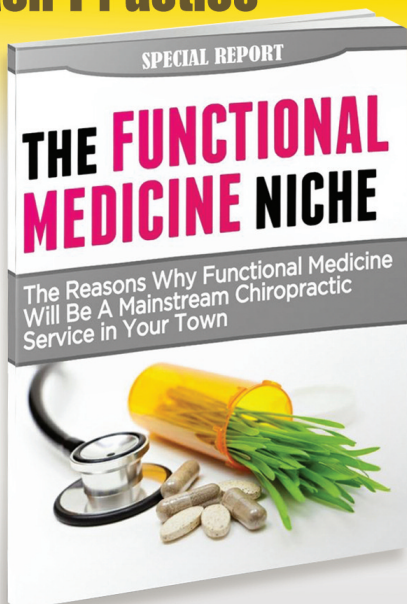
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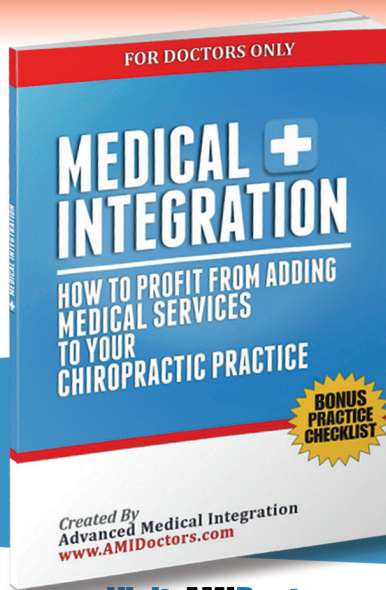
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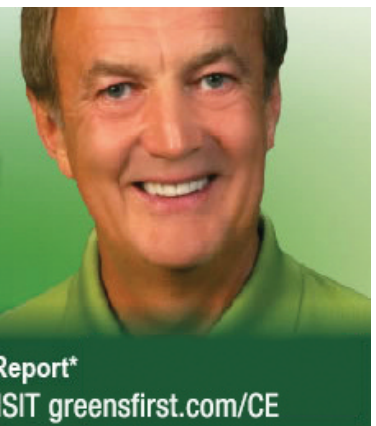
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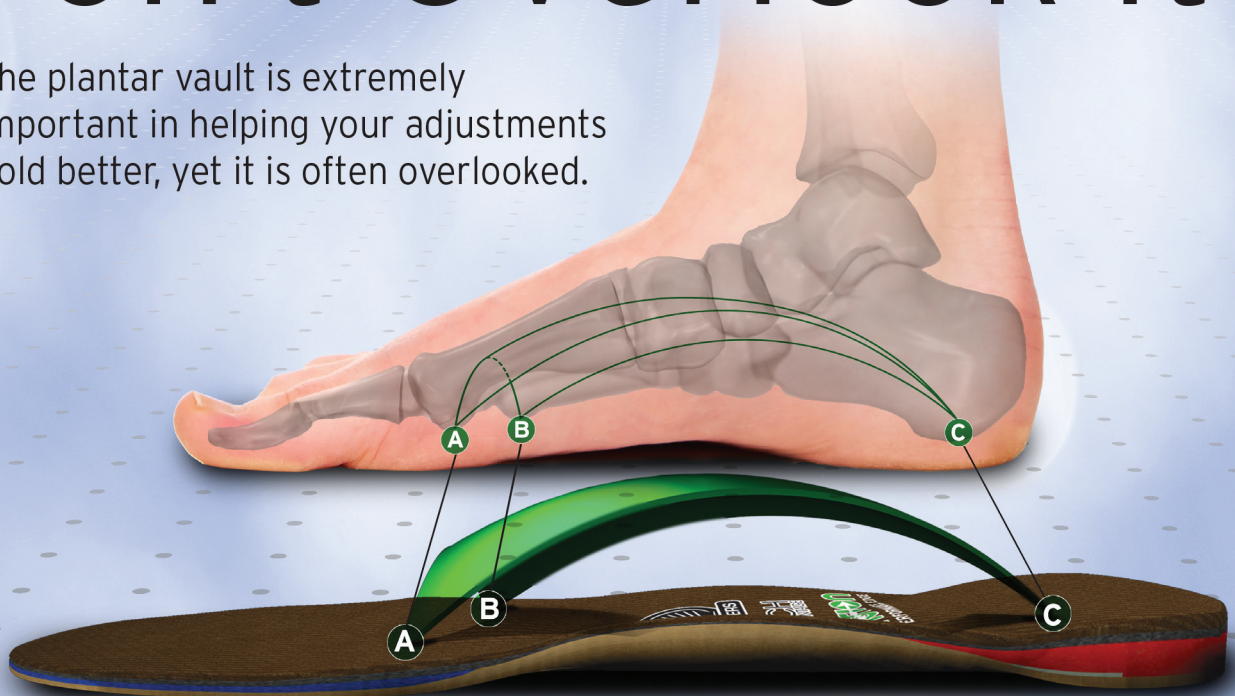
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