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Most Customers
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- Brian Blask, D.C.
  ChiroTouch Account Executive
  Catch Up with ChiroTouch Podcast & Webinar Host
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#2 Most customers
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#3 Designed for everyone
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#4 High ratings from happy customers
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#5 Long-time customers
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#6 Most developers, trainers, & staff
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Over half of customers chose ChiroTouch for ease-of-use

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Source: TechValidate survey of 2,030 users of ChiroTouch:
1 TVID: 9F7-9BA-2F1 2 TVID: 8A4-85E-E4C 3 TVID: EE5-BD6-9E4
DOCUMENTATION 2021

New E/M Coding, Core NCQA Guidelines

Top Reimbursement Strategies from Top DCs

Point-Counterpoint: Your Best Documentation?

Step-by-Step DC Medical Referrals Guide

YOUR PRACTICE PARTNER
Issue 4: March 7, 2021  chiroeco.com
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- Supports overall well-being
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DOCUMENTATION

EVEN THOUGH YOUR DOCUMENTATION IS “FINE,” it could be time for a self-audit or “white hat” audit from an outside agency. Why? The Health and Human Services’ Office of Inspector General (OIG) reports that as many as 94% of chiropractic records are missing, or inadequately reflect some key elements, according to Kathy “KMC” Weidner, who provides our feature this issue with tips on keeping your practice out of the auditor’s web.

Billing changes for 2021, top reimbursement strategies, best documentation procedures, new stimulus rules and the impacts for DCs, and the “right way” for MD referrals are just some of the articles in our Documentation Issue to provide you with the resources to shore-up your practice against audits while furthering your financials.

As noted above, if you think your documentation is squeaky clean, then you’re among only 6% of DCs in the U.S.

The coming of the ‘vaccine passport’

Vaccinations have always been a touchy subject in the chiropractic community (see our recent vax or anti-vax Point-Counterpoint at facebook.com/groups/344772412902399).

Now world experts are preparing for a “vaccine passport” that could not only apply to travel to other countries, but depending on acceptance of vaccines in the U.S., possibly between state travel.

The New York Times in February reported that countries such as Denmark and international airlines already have digital passports in the works, developed by the International Air Transport Association. IBM is also developing a digital passport to present proof of vaccination “to gain access to a public location, such as a sports stadium, airplane, university or workplace.”

Regardless of need, the vaccine passport has a number of hurdles, and may not debut before 2022 or beyond.

“The global passport system took 50 years to develop,” said Drummond Reed, chief trust officer for Evernym. “Now, ever-changing brave new world of health care.

The year 2021 is young but chiropractic has already experienced a number of “wins” in regard to the scope of patient care and assisting during the COVID-19 pandemic.

In Texas a 10-year court battle ended when the Texas Supreme Court ruled that nerve and related testing as it pertains to the musculoskeletal system is within the lawful scope of practice for Texas chiropractors.

“This decision, which recognizes the common sense and long-standing inclusion of associated nerves in chiropractic diagnosis and treatment, preserves and strengthens the essence of chiropractic,” wrote Mark R. Bronson, DC, FIANM, board president for the Texas Board of Chiropractic Examiners.

Also in January, Colorado Gov. Jared Polis signed an executive order allowing chiropractors and select other health care professionals to give COVID-19 vaccines to people “in hospital-like settings” to speed-up the distribution of COVID-19 vaccinations in the state.

“This executive order … [will] ensure that inpatient health care facilities have sufficient resources and personnel to treat patients suffering from COVID-19 and to ensure that inpatient facilities and outpatient settings have sufficient resources to administer COVID-19 vaccinations,” Polis wrote.

Last year saw chiropractic deemed an “essential service,” and 2021 thus far is shaping up along the same lines in the ever-changing brave new world of health care.

To your practice’s success,

Richard Vach
EDITOR-IN-CHIEF
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Shock Wave Technology provider debuts new name
In late January, Focus It and Advanced Muscle Skeletal Therapies announced their new name, Kinas Medical Technologies. A singular, unifying brand was needed to support the business’s recent growth, increased product lines and multiple solutions with two divisions: Human Health and Animal Health, each with its own product lines. “We are excited to see how the U.S. market has expanded in our last 20 years and delighted to evolve and grow with it as Kinas Medical Technologies,” said Gerhard Kinas, founder and CEO, who has been involved with shock wave therapy research and evolution since the 1990s. Today, Kinas serves 1,000+ practitioners across 48 states.
For info, visit kinasmedical.com.

Kinas
ChiroEco.com/kinas

Immune system mounts lasting defense after COVID-19 recovery
A Rockefeller University study suggests those who recover from COVID-19 are protected against it for at least six months, and likely much longer. The findings, published in Nature, provide strong evidence that the immune system “remembers” the virus after the infection has waned, and that immune cells keep improving the antibodies due to continued exposure to virus remnants hidden in gut tissue.
Based on these findings, the researchers suspect that when a recovered patient next encounters the virus, the response will be faster and more effective, preventing re-infection. For more information, visit rockefeller.edu.

The Joint named official chiropractor of South Florida Athletics
The Joint Corp., provider of chiropractic care through The Joint Chiropractic®, network, the University of South Florida and Vink Sports Group have signed an agreement naming The Joint the official chiropractor of South Florida Athletics, which sponsors 19 varsity teams, 18 of those at the NCAA Division I level.
“There is a long-standing record regarding the strong relationship between sports training and chiropractic care,” said Peter D. Holt, The Joint Corp. president and CEO. “The Joint is proud to support South Florida Athletics in continuing to compete at the highest levels of sports performance.” For more information, visit thejoint.com.

ChiroEco.com/the-joint-usf

Keep your emails out of patients’ spam filters
Have you ever opened your inbox to find it filled with your own marketing emails that have been bounced by spam filters? What went wrong — and how can you prevent it from happening again?

1. Know the law. Following the Federal Trade Commission’s CAN-SPAM guidelines (ftc.gov) will go a long way toward preventing your emails from getting stuck in spam filters.
2. Check the From line. Be absolutely transparent as to who you are in the “From” line; include your name or business, and originating email and domain name information. Recipients must be able to verify the email actually came from you or someone acting on your behalf.
3. Review the Subject line. You must accurately reflect the content of your email in the “Subject” line. For example, a newsletter with health tips can include “newsletter” in the subject, as long as you are not offering anything for sale in that same email. If your email promotes a discount on something you sell, the subject must clearly identify the email as an advertisement.
4. Honor opt-out requests within 10 days. Instructions should be clear and conspicuous for the average person to find and understand and should not require more than clicking to just one page. You cannot charge a fee or sell someone’s email after they have opted out.
5. Avoid trigger words. Words like “free” can easily trigger spam filters.  — Tina Beychok

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# Introducing ClinicDr 3.0

## Software Speed

<table>
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<tr>
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<td>3.7</td>
</tr>
<tr>
<td>Patient SMS completion</td>
<td>3.1</td>
</tr>
<tr>
<td>Report run</td>
<td>2.2</td>
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## ClinicDr Customer Service

<table>
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<td>Chat response</td>
<td>44</td>
</tr>
<tr>
<td>Email response</td>
<td>1 min 56 sec</td>
</tr>
</tbody>
</table>

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Drinking a glass of water before a meal can aid in weight loss!

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Although Brady will be wearing a different jersey this year, we are still wishing him the best of luck at SuperBowl LV!

This lovely young lady came into the office today for her second adjustment and I noticed she was wearing a really neat shirt that said “yay for today.”

Although Brady will be wearing a different jersey this year, we are still wishing him the best of luck at SuperBowl LV!

You can’t always be motivated, so you must learn to be disciplined.

Most injuries occur from doing too much, too fast after doing too little for too long
- Scot Morrison, DPT

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SCHOOL NEWS

Keiser University receives $100,000 donation for spinal research

Keiser University’s College of Chiropractic Medicine (KUCCM) received in January a donation from James M. Cox, DC, DACBR, FICC, Hon.D.Litt., FACO(H) — $100,000 toward spinal research. Cox is the developer of Cox Technic Flexion Distraction Manipulation and leads workshops in these techniques, along with several colleagues.

“We are thankful for the ongoing support from Dr. Cox, as his generosity and world-renowned expertise plays a valuable role in advancing research in the field of chiropractic medicine, and community partnerships such as this provide outstanding and unique opportunities for our students and our community as well,” said campus President Kimberly Lea.

Designated to foster chiropractic spinal research, specifically the effects of Cox Technic spinal manipulation, the proceeds will provide KUCCM’s Research Department the opportunity to pursue new and complete current research studies, which include the promising nonsurgical chiropractic treatment of spinal stenosis and postsurgical back and neck pain.

For more information, visit keiseruniversity.edu.
Colorado allows chiropractors to give COVID-19 vaccine shots

In January, Colorado Gov. Jared Polis signed an executive order allowing health care professionals such as dentists, chiropractors and veterinarians to give vaccines to people “in hospital-like settings” where the state has already approved COVID-19 distribution, according to the local NBC 9News.

The emergency rules were part of an executive order applying to inpatient, outpatient and hospital settings under certain delegations.

An amendment of the executive order reads, “I direct the Executive Director of DORA, through the Director of the Division of Professions and Occupations (DPO), to promulgate and issue temporary emergency rules to permit the licensed professionals listed below to cross train, supervise, and delegate responsibilities concerning the temporary care and treatment of patients to the professionals listed in Section II.B., below, in hospitals, inpatient medical facilities, including emergency departments, and outpatient settings, including but not limited to providing the COVID-19 vaccine, as long as such delegated responsibilities are appropriate based on each delegated professional’s education, training, and experience.”

The order was set to expire 30 days from Jan. 7 unless extended.

“My administration, along with other state, local, and federal authorities, has taken a wide array of actions to mitigate the effects of the pandemic, prevent further spread, and protect against overwhelming our health care resources,” Polis wrote. “This Executive Order ... [will] ensure that inpatient health care facilities have sufficient resources and personnel to treat patients suffering from COVID-19 and to ensure that inpatient facilities and outpatient settings have sufficient resources to administer COVID-19 vaccinations.”

For more information, visit colorado.gov/governor.

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CHIROPRACTIC ECONOMICS

MARCH 7, 2021 • CHIROPRACTIC ECONOMICS 13
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**CHIROPRACTIC NEWS**

**ACA lauds U.S. Congress for passing fair competition health legislation**

The U.S. Congress in January passed legislation that will promote fair competition in health insurance markets with the removal of a 75-year-old exemption that allowed these companies to avoid federal antitrust laws.

The Competitive Health Insurance Reform Act (H.R. 1418) passed the House of Representatives and the Senate last year and was signed into law on Jan. 13.

“The American Chiropractic Association advocated for this important change for many years. The passage of this bill is an essential step toward increasing competition in health insurance markets and lowering prices for consumers,” said ACA President Robert C. Jones, DC.

H.R. 1418, bipartisan legislation introduced by Reps. Peter DeFazio (D-Ore.), Paul Gosar (R-Ariz.) and House Judiciary Committee Chairman Jerrold Nadler (D-N.Y.), repeals the McCarran-Ferguson Act, passed in 1945, which allowed health insurance companies that conducted business in more than one state to operate outside of federal antitrust laws established by the Sherman Act. Health insurers will now be subject to the same laws that other businesses are required to comply with and that prohibit unfair practices such as price fixing, price gouging, collusion and market allocations that hurt consumers.

“We’ve been close to getting this legislation passed by both chambers before,” said John Falardeau, ACA senior vice president of public policy and advocacy. “Persistence has paid off, and health insurers will now have to abide by this country’s antitrust laws, an exemption they’ve held onto for far too long.”

More information about the new law is available at acatoday.org.

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**14 CHIROPRACTIC ECONOMICS • MARCH 7, 2021**
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DOCUMENTATION: TIPS THAT WILL KEEP YOU OUT OF THE AUDITOR’S WEB

Keep up with 2021 code changes and put these procedures in place

BY KATHY (KMC) WEIDNER, MCP-S, CCPC
TIME TO READ: 13-15 MIN.

THE TAKEAWAY
A new look at procedures to put in place that can give you a new outlook on tackling appeals to reimbursements.

THE OFFICE OF INSPECTOR GENERAL (OIG) AND “ME TOO” PRIVATE INSURERS love to go after fraudulent practitioners because the government, unsurprisingly, prosecutes fraud. But equally significant is that going after fraud is highly profitable: Fines and recoveries from big offenders can earn the U.S. federal government and other third-party payers up to a cool $1 million per audit.
Errors and ignorance
Most DCs aren’t deliberately and knowingly breaking the law. They make documentation errors not with the cold intent to defraud, but from sheer ignorance or overwhelm. But just because you may not be one of the “big offenders” that auditors are looking for doesn’t mean you can breathe a big sigh of relief and ignore required elements of documentation.

The Office of Inspector General (OIG) has estimated over the years that anywhere from 80-94% of chiropractic documentation is incomplete and/or incorrect, and you can get caught in the same net they’re using to sweep for the big fish. They will not throw you in prison if your documentation is simply sloppy and spotty as opposed to criminally misleading, but they can still make your life extremely difficult and demand enough in recouped reimbursements to put you out of business.

So job one is to get your documentation in impeccable shape. It takes time to put procedures in place, but once you’ve got the steps down, it’s actually far easier to just do it right the first time around than to deal with time-sucking records requests, or worse, the extensive time and stress spent preparing for and recovering from an audit. Here are some ideas to get you started.

New 2021 coding and staying updated
Make sure you’re using the most current version of the CPT, HCPCS and ICD codes. And make sure you stay up to date by reviewing ICD-10 changes that are effective on a fiscal year of Oct. 1, and CPT changes that go into effect on the calendar year of Jan. 1 on an annual basis.

For example, the new Evaluation and Management (E/M) coding rules that went into effect in January 2021 had big changes for practitioners. Missteps related to the changes or simply ignoring the new guidelines are the recipe for a fiasco.

Likewise, learn to speak fluent modifier. If you’re not using the correct modifier, you’re not going to get reimbursed. It’s as simple as that.

Modifiers have a job to do. With Medicare, for example, use of the AT (active treatment) modifier indicates that your documentation represents active treatment that meets their definition of medical necessity. Billing with the AT modifier and expecting reimbursement, but without the necessary elements of medical necessity in the documentation, is an example of waste and abuse.

Understand medical review policy, and what it means to you
Don’t make unnecessary errors by failing to know the rules of the game you’re sitting down to play with your $200,000 chiropractic license as an ante.

Familiarize yourself with your carriers’ medical review policies, most of which can be found online. If the insurers with which you participate have specific rules and you’re not following them, you’re in violation of the agreements you signed. Worse, they are stingy with the information, and often make it difficult to find it. But as a participating provider or one who bills out of network, on behalf of a patient, you are obligated to ensure that coded and billed services match the documentation in the health record.
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Nothing is more important to us than quality. We believe that true healing starts with the type of products you use. Sombra® is proudly manufactured in our GMP own facility, ensuring we have utmost control over quality. Our pain relieving gels have always contained natural, vegan ingredients without harsh chemicals.

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For example, if kinesiology taping is considered experimental, investigational and unproven, as it is with most insurance payers, and you bill it with a code that might be covered, such as a strapping code, the coding doesn’t match the documentation. And you can see how that might be considered sneaky — a workaround — even when you may have simply not known any better. But a cursory review of medical review policy would have indicated that it is not a billable service.

The definition of medically necessary care varies based on the payer type. Some may follow Medicare’s guidelines and require a documented spinal subluxation that is causing a neuromusculoskeletal condition while others may allow doctors to diagnose and treat patients based on their scope of practice. The patient must have a significant health condition necessitating treatment with a reasonable expectation of recovery. The ability to improve the patient’s function through treatment is also a requirement.

The best way to prove medical necessity is through the provider’s documentation which includes the initial intake, history, exams, daily treatment notes, a treatment plan with measurable, functional goals, and imaging when appropriate. When medical necessity is established, this is called active care. When this criterion is not met, the patient will be under maintenance care. Many third-party payers only reimburse for active care.

**Necessity vs. maintenance care**

Get clear on medically necessary care versus clinically appropriate care. Yes, yes and yes, everyone with a spine deserves ongoing wellness care. But that doesn’t mean third parties will (or should) pay for it.

Medically necessary care is episodic care, with a clear beginning, middle and end of treatment. It’s also care undertaken with the reasonable expectation of progressive functional improvement. Weekly adjustments may well make a senior’s arthritic hip feel better, but they won’t be considered medically necessary without documented functional improvement, and Medicare isn’t going to pay for them. Likewise, third-party payers expect there to be documentation of progress day to day.

We suggest using the functional goals from the treatment plan to guide the questions in your subjective portion of the SOAP note on an encounter-to-encounter basis. This allows for a clear “story” of the patient’s progression through active treatment, through to therapeutic withdrawal, and then to discharge.

All along the way, the return to function (or the lack thereof) is well-documented and aligns beautifully with the projected duration. If there are hiccups in the treatment plan, or the patient fails to progress, the encounter notes explain that and continue the story.
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Since no two patients are alike, each patient’s documentation should be individualized for the treatment they need. Some examples of how medical necessity can be established in a patient’s chart include the following:

### Use NCQA guidelines

The National Committee for Quality Assurance (NCQA) is an organization dedicated to improving health care quality. It has helped build consensus for important health care quality issues through its work with large employers, policymakers, doctors, patients and health plans. They determine what’s important, how to measure it and how to promote improvement. The use of NCQA guidelines sends a powerful message: Quality matters.

Defining and implementing these standards for medical records documentation in your practice is also a critical part of building a strong compliance program. NCQA guidelines for medical record documentation contain 21 different commonly accepted components. These guidelines transcend provider type, so a practice should use these components to develop and define its own standards for medical record documentation.

I think the most important guidelines to implement for quality documentation are these 12. Those in bold are the six that NCQA states are the most core guidelines, as applicable to a practice.

1. The patient’s name or ID number must appear on each page
2. Author’s identification in the form of a handwritten signature, unique electronic identifier or initials
3. Date
4. Must be legible to someone other than the author
5. Significant illnesses and medical conditions must appear on the problem list
6. Medication allergies and adverse reactions OR if none, the absence of allergies or a history of adverse reactions are prominently noted in the record
7. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses
8. The history and physical examination identify appropriate subjective and objective information pertinent to the patient’s presenting complaints
9. Working diagnoses are consistent with findings
10. Treatment plans are consistent with diagnoses
11. If a consultation is requested, a note from the consultant is included in the record
12. There is no evidence that the patient is subject to inappropriate risk by a diagnostic or therapeutic procedure

<table>
<thead>
<tr>
<th>Patient consultation and history data</th>
<th>• What is the mechanism of injury?</th>
<th>• Has the patient ever had this problem before?</th>
<th>• Does the patient have other health problems that will impact treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical examination findings, tests and measurements</td>
<td>• Orthopedic/neurologic tests</td>
<td>• Palpation of involved structures to evaluate for pain, swelling, hypertonic/hypotonic muscles</td>
<td>• Range of motion</td>
</tr>
<tr>
<td>Subjective complaints mentioned by the patient</td>
<td>• Quality and severity of pain</td>
<td>• Activities of daily living (ADLs) that are affected by the complaint</td>
<td>• What relieves the pain, provokes the pain</td>
</tr>
<tr>
<td>Diagnosis/diagnoses</td>
<td>• Be as specific as possible with the diagnosis</td>
<td>• Only report diagnoses that can be confirmed</td>
<td>• Use signs and symptoms codes sparingly when possible</td>
</tr>
<tr>
<td>Treatment plan(s)</td>
<td>• Frequency and duration of the recommended treatment</td>
<td>• Short-term and long-term functional goals that are specific and measurable</td>
<td>• Treatment services with a rationale consistent with the patient’s condition</td>
</tr>
<tr>
<td>Achievable, functional goals as the result of your care</td>
<td>• Reassess the patient every 30 days or at a reasonable interval for any changes in their condition</td>
<td>• Complete outcome assessment tools (OATs) to help determine progress</td>
<td>• Provide an explanation if improvement is not seen as expected and make necessary changes to the treatment plan</td>
</tr>
</tbody>
</table>
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This is not an all-inclusive list, but to be on par with accepted documentation standards, this is a great place to start.

**Red flags to watch for**
Auditors look for under- and over-coding, because billing too much or too little puts your practice outside the norms. They also watch for what appear to be cloned records, i.e., when all your documentation looks the same. Make sure each visit and documentation is encounter-specific. Overuse of a code, or too many notes that say something like “same as last visit” make your documentation stand out. You don’t want your documentation to stand out.

Don’t submit records requests with incomplete documentation. That would be documentation that lacks all the correct dates, codes, modifiers, treatment plans, notes, progress reports, time for timed codes, and the practitioner’s signature. An unbelievable amount of chiropractic documentation is missing some or all of these details.

**When it’s real you must appeal**
Feeling confident about your documentation but still getting rejected claims? Time for your next step: Appeal them. Every last one of them.

**Why?**
Here’s an insider secret that comes courtesy of a former insurance claims adjuster: Up to 30% of all claims submitted to insurance carriers are denied on the initial submission whether they are correct or not. Why? Because only about 25% of chiropractic practices spend the time and energy to appeal rejected claims. In other words, it’s profitable for insurers to randomly reject claims, because they know most DCs won’t push back.

Just as it’s “worth it” to third-party payers to randomly reject claims because statistics tell them you won’t bother to put up a fight, it’s more than worth your time to write standard operating procedure for appealing rejections and follow it faithfully. Some DCs and their staff worry that appealing claims will result in more rejected ones, but this simply isn’t true. You won’t be punished for submitting appeals. And you stand to win with increased reimbursements and a far more robust bottom line.

The OIG estimates recent annual recoveries from audits recouped health care reimbursements at $4.9 billion. So a small fish may make for a small meal, but a net full of many small fish can feed a village — or the coffers of a third-party payer — quite nicely. Claim your rightful reimbursements.

KATHY (KMC) WEIDNER, better known professionally as Kathy Mills Chang, is a Certified Medical Compliance Specialist (MCS-P) and a Certified Chiropractic Professional Coder. Since 1983, she has been providing chiropractors with reimbursement and compliance training, advice and tools to improve the financial performance of their practices. Kathy leads the largest team of certified specialists under one roof in the profession at KMC University and is known as one of our profession’s foremost experts on Medicare and documentation. She or any of her team members can be reached at 855-TEAM-KMC or info@KMCUniversity.com.
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THE PATIENT RECORDS ‘BLOCKING RULE’
Coming in April, could it lead to a Universal Health Record?

BY JENNIFER KIRSCHEMBAUM, ESQ., AND ZACHARY SHER, JD
TIME TO READ: 13-15 MIN.

THE TAKEAWAY
The Blocking Rule will become enforceable in April, and doctors of chiropractic need to be aware of the rules — and penalties — for failing to provide electronic patient records within the relegated time frame.

THE BALANCE BETWEEN ACCESS AND PRIVACY is a constant strain on chiropractic and health care practitioners and patients alike, daily. From a regulatory perspective, the Health and Human Services Office for Civil Rights (OCR), the enforcement and oversight arm of the federal government overseeing federal HIPAA Privacy and Security Rules (45 C.F.R. Parts 160 and 164, Subparts A, C and E) has historically stressed the privacy component and addressed patient access to records on seemingly a one-off basis — by patient complaint.

Tides are shifting and a new rule, the Information Blocking Rule (45 CFR 171), is taking effect as of April 5, 2021, aiming to effect immediate patient access to their health records, bringing us closer toward the coveted unicorn, the Universal Health Record.

The Blocking Rule
The Blocking Rule approaches the goal of a Universal Health Record from several different directions.

The Blocking Rule requires software developers and health information exchanges to develop a competitive marketplace to obtain an electronic solution to provide patients immediate access to their health record, and also requires action by providers to utilize the marketplace and provide their patients access to their health record without causing interference or disruption — or face the consequences. Competitive marketplaces, immediate access, conforming with legal requirements to protect privacy, consequences; these are all powerful words creating meaningful consequences to those impacted, and those intended to be impacted appear to be a significant sector of society — IT providers, utilities, providers and patients.

Most relevant to our concern, where do practitioners fit in? Will there be more requirements to follow? How should our approach toward patient information, protected health information and patient access change? The purpose of this article is to explore issues for practitioners and further explain the intention of the Blocking Rule, as well as other influences in the regulatory scheme of HIPAA currently at work impacting practitioners.

As of April 2021, each practitioner is required to share basic elements of a patient chart (such as patient name, address, allergies, care team members and laboratory test results) upon patient request, electronically, and provided immediately. Providers will be expected to share this information through consultation notes, discharge summary notes, history and physical, imaging narratives, laboratory report narratives, pathology report narratives, procedure notes and progress notes.
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“There are so many successful doctors here, it is so great to be able to rub shoulders with the best of the best in our profession. Dr. Kaplan is the Godfather of this Decompression and Dr. Bard is amazing at marketing. So, the two of them are like the M&M, the marketing and management. What I love about them is their philosophy in Chiropractic. I love how passionate they are. When I heard Dr. Bard’s story, it just gave me more of a drive in what we do. It makes me want to be able to give more into the profession. So, that’s priceless”……..DR. HOANG - Louisiana

“I’ve been in practice 23 years and I’ve been very successful. The one thing that I was lacking was a key component on how to really treat Disc Patients, Bulging, Herniated & Slipped Discs. Thru Dr. Kaplan & Dr. Bard, I’ve even gone up exponentially and I’ve helped so many more people avoid surgery. Everything you need is laid out for you in a beautiful presentation, down to internet marketing, down to what you’re going to hand a patient, all the information is there, all the research, and at the end of the day, you don’t want to reinvent the wheel. It’s beautiful. Patients love it”…….. DR. HESSER - New Mexico

“Before I attended, I struggled from month to month to pay my bills, to keep the staff paid, to pay my rent and everything on time. Insurance had just dwindled down to nothing. We were really suffering. They showed me how to package and present cases of Spinal Decompression, of Neuropathy and of Laser. It’s just been tremendous in the amount of services that I’m able to perform that are not insurance dependent. The communication is unmatched. If I text Dr. Kaplan or Dr. Bard, I get a text back, if I email them, I get an email back. They’re always there, and they’re always available for me. The Chiro Event made this happen”……..DR. ROE - Texas

“Prior to attending we didn’t feel like we got compensated for the effort and the dedication and time that we put into caring for our patients. Just by accident, I came across a webinar Drs. Kaplan/Bard were doing. We watched the webinar, got in contact with Dr. Bard and had an excellent conversation and went to meet these guys at The Chiro Event. It just felt like it was right. That has made a huge difference in the way that we feel about practicing & in our practice itself. If anybody is struggling or just not happy with what they’re doing, I would encourage you to reach out to Dr. Bard. Have a conversation with him. He’ll answer all of your questions. You have to see what this is all about”……..DR. RADOSTA - Louisiana

“Prior to attending The Chiro Event, my Patients that would come in, all they wanted was two or three adjustments, get me out of pain and get me out of the office. Without addressing the problem, you’re not fixing the cause you’re just giving them some temporary relief. The Chiro Event changed that. We’ve gone from just being a Chiropractor to being a specialist. These guys are phenomenal. It is a family. They give you everything that you need. I can’t say enough about Perry and Eric”……..DR. SIMONS - Wisconsin

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In addition, practitioners are required to comply with the HIPAA Privacy and Security Rule in the transmission of the electronic health record to the patient. On or before around October of 2023, providers will be expected to completely comply with the Blocking Rule, and without violating patient privacy.

Exceptions to the Blocking Rule
The Blocking Rule acknowledges scenarios where providing a patient record would be a breach of the HIPAA Privacy and Security Rules or against public policy, and has provided for several noteworthy exceptions, as follows:

1. Preventing Harm Exception. A practitioner may deny access of a patient record where the practitioner reasonably believes not providing the record is reasonable and necessary to prevent harm to a patient, provided certain conditions are met.

2. Privacy Exception. A practitioner may deny access of a patient record where the practitioner reasonably believes the disclosure would violate any relevant state or federal privacy laws.

3. Security Exception. A practitioner may deny access of a patient record where the practitioner reasonably believes not providing the record is reasonable in order to protect the security of the electronic health record.

4. Infeasibility Exception. A practitioner may deny access/not fulfill a request of a patient due to the infeasibility of the request. This is if there are legitimate practical challenges which render the fulfillment of a request for the electronic health record impossible or impracticable because of lack of technological capabilities, legal rights, or other means necessary to enable access. To qualify for this exception the practitioner must not be able to grant access because of an uncontrollable event, like a public emergency, natural disaster.
or internet service disruption, or the inability to segment the information in an unambiguous manner.

5. **Health IT Performance Exception.** A practitioner is permitted to temporarily make electronic health information unavailable to benefit the overall performance of the health IT. This exception recognizes that for health IT to properly function, it must be maintained and updated, requiring electronic health information to be taken offline temporarily. Practitioners are given leeway in order to ensure that the system remains stable and current in order to continue to work at maximum efficiency.

6. **Content and Manner Exception.** A practitioner may limit the content of its response to a request for an electronic health record or the manner in which the provider fulfills the request.

Notably, with the use of each aforementioned exception, the practitioner denying access should, with specificity, document the rationale for denying access, and further document with specificity the rationale for any delay in production as well.

Fees may be assessed to the patient, as under the HIPAA Privacy and Security Rules. Specifically, the Blocking Rule provides that providers may charge reasonable fees for accessing, exchanging or using electronic health records if the fee is applied in a non-discriminatory manner and related to the provider’s cost.

**Electronic marketplace creation**

One of the greater impacts of the Blocking Rule is the guided consolidation of innovation and marketplace for electronic health records. Third-party application developers are being called on to generate apps, capable of being accessed on smartphones and other devices, which will allow patients to easily and efficiently access and share their medical records.

**$591,500 HIPAA RIGHT-OF-ACCESS PENALTIES TO 10 HEALTH CARE PROVIDERS SINCE SEPT. 2019**

Developers may enter into a certification program which sets standards and guidelines for storing and sharing medical information. While entering into the certification program is currently voluntary, it is difficult to forecast how developers who do not become certified will compete in the field. There

"Dr. William H. Koch, Chiropractor personifies everything that I believe to be true about human healing. By addressing the "root cause" of complaint, he gently persuades the muscles, joints and fascia using his unique instruments to specifically bring about balance. Being someone who hears the painful screaming and forcing of clinical management, I cherish and truly appreciate how Dr. Koch's gentle and effective approach has helped me and my family. I readily refer my patients to him without reservation as his teaching and his practice emphasizes the importance of providing personalized, holistic healthcare that treats the cause, not just the symptoms."

- Joanne M. Keller, APRN - Family Nurse Practitioner

"It is not unusual for my new patients, at the end of their first visit, to say, 'Wow, I need to send my mom in here' (or sister, brother, child). And a day or two later I get calls from family members and friends asking for an appointment. If you can produce great results, quickly and comfortably, exceeding patient's expectations, your gain is far more than what you are getting paid on any given visit."

- Dr. Bill Koch

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The provisions of the Blocking Rule will become enforceable April 5, 2021.

is a possibility that users will not trust their apps or that additional rules are passed which make certification a requisite for competing in the field.

At this point it is not clear exactly how this marketplace will function and how providers will interact with it, but it is expected to offer both providers and patients an extremely user-friendly interface which easily stores and transmits electronic health information. Providers will be expected to have all of their patients’ medical records converted into an electronic format which will then become transmissible to third-party applications. Many providers already have experience with this type of technology and often utilize health care portals to share electronic medical records with patients. Other providers utilize Gmail or other similar email services to send patients their health records directly. These providers will likely not have to make drastic changes to their current systems of operations to ensure they are compliant with the information Blocking Rule.

**30 DAYS**

**TIME IN WHICH HIPAA RULES GENERALLY REQUIRE COVERED HEALTH CARE PROVIDERS TO PROVIDE MEDICAL RECORDS TO PATIENTS UPON REQUEST**

Instead, they are expected to continue maintaining records in an electronic format which will be securely transmitted to patients. Other providers who do not primarily keep their records in electronic format will have to spend time from now until April 5, 2021, ensuring that their practices develop internal systems to convert records into an electronic format. Those providers will have to spend money to train staff and develop internal procedures to guarantee that their practices will be compliant and able to quickly provide patients with their records in a secure manner.

**Penalties for Blocking Rule non-compliance**

The provisions of the Blocking Rule will become enforceable April 5, 2021. Based on similar initiatives in the realm of HIPAA Privacy and Security, we anticipate the promulgation of a penalty construct that will involve monetary penalties for non-compliance.

Currently, it is known that the Office of Inspector General has authorized penalties up to a $1 million fine on providers who violate the Blocking Rule. When assessing the amount of a potential fine, it is likely the Office of Inspector General will consider the severity of the consequences caused by the information blocking, the number of patients impacted, and the amount of time during which the violation persisted.

Even though there are broad guidelines for how providers can be penalized, there still remains a fair amount of obscurity for how strictly these provisions will be enforced going forward. The Office of the National Coordinator has stated that the “HHS must engage in future rulemaking to establish appropriate disincentives.” At this point we can only speculate as to how strict the regulators will be and how high potential monetary penalties will range. In the past, we have seen other regulatory bodies strictly enforce patients’ right to quickly and affordably access their health records.

**HIPAA general enforcement**

The Office for Civil Rights set an extremely severe precedent when enforcing the HIPAA right of access initiative discussed below.

Since Sept. 9, 2019, the OCR has settled 10 investigations against providers concerning the HIPAA right of access initiative which guarantees patients the ability to affordably and quickly access copies of their medical records. These investigations determined that the practices of numerous providers were likely in violation of the right-of-access provisions and resolved in settlements to pay the OCR monetary penalties ranging up to $160,000. In total, the combined reported amount of monetary penalties thus far collected in settlements is approximately $591,500.

In the written report on its first reported settlement, the OCR announced “this initiative as an enforcement priority” and promised to “vigorously enforce” patient rights to receive copies of health information.

The report details how Bayfront Health St. Petersburg (“Bayfront”) failed to respond to a mother’s request for records regarding her unborn child. HIPAA rules generally require covered health care providers to provide medical records within 30 days of a request — Bayfront responded after nine months. For this infraction Bayfront paid $85,000 to OCR and implemented a corrective action plan to address issues like that one going forward.

The second report, dated Dec. 12, 2019, announced a settlement for $85,000 against Korunda Medical LLC, for failing to timely provide medical records in electronic format to a third party on behalf of a patient. Director of OCR Roger Severino said, “for too long, health care providers have slow-walked their duty to provide patients their medical records out of a sleepy bureaucratic inertia. We hope our shift to the imposition of corrective actions and settlements under our Right of Access Initiative will finally wake up health care providers to their obligations under the law.”
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“For too long, health care providers have slow-walked their duty to provide patients their medical records out of a sleepy bureaucratic inertia.”

On Sept. 15, 2020, a little more than a year after the first settlement was announced, the OCR produced a report regarding five more settlements with potential infractions of the HIPAA right-of-access initiative. Severino made clear that these settlements are meant to “send a message” to the health care industry about the importance and necessity of complying with the HIPAA rules. He added that the intention of the regulations and the desire to ardently enforce them is to continue to empower patients to take charge of their health care decisions.

Since then, three more investigations have been settled, making the final number until this point 10 total.

These investigations and the strong, unambiguous rhetoric from Severino clearly demonstrate how determined the OCR is to making sure all medical providers are in strict compliance with information blocking laws. While the particular disincentives have not yet been announced, it is safe to project that the OCR will be just as keen to enforce the information blocking provisions of the Cures Act in order to continue safeguarding and supporting patient values.

Prepare for the rule’s effective date
The Blocking Rule effective date is approaching, and while most practitioners have systems in place for storing and transmitting their patients’ electronic medical records, those who do not have such systems are expected to fall in line.

Ensuring that your practice is capable of complying with the rule is important because there will be a risk of audit and fines for non-compliance (likely to initiate from a patient complaint if at some point you cannot electronically share a patient record).

On a positive note, the implementation of the Blocking Rule will also give rise to (hopefully) a transparent competitive marketplace for electronic health records and electronic health record migration and sharing technology that will be compliant and cost-effective.

JENNIFER KIRSCHENBAUM, ESQ., manages Kirschenbaum & Kirschenbaum, P.C.’s health care department and devotes her practice to representing chiropractors and other providers in the establishment and operation of multi-disciplinary practice structures, licensure matters, audit defense, contract issues, buy/sell, partnership development and disputes, and general practice matters. She can be reached at Jennifer@Kirschenbaumesq.com or 516-747-6700 x302.

ZACHARY SHER, JD, is an associate in K&K’s health care department.
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TOP REIMBURSEMENT STRATEGIES
Tips to take your practice over the $1 million mark

BY JAMES R. FEDICH, DC
TIME TO READ: 5-7 MIN.

THE TAKEAWAY
These tips and techniques for insurance analysis, durable medical equipment, cash services, collections and retention can increase the “Big 3 Metrics” to take your practice over the top.

THE DOCTOR I EXTERNS WITH was a great influence over my life and practice. This doctor taught me more about chiropractic practice than I learned from just about anywhere else in life. This is why I give back, having interns and coaching other doctors.

This doctor was phenomenally successful by any stretch of the imagination in practice and life. But he always fell just short of a million dollars in collections. He was obsessed and just could not quite get over this hurdle. So, when I started a practice this became a de facto focus of mine, to break $1 million. It took over 10 years to get there, and I never went back below that collections mark. It felt good to get over a million and it is a sign of business success, but it does not mean everything.

Here are some tips to maximize reimbursement to increase collections, no matter how large of a practice you have:

Insurance analysis
The first step we do on all new patients is a thorough insurance verification. Before we develop a treatment plan with a patient, we want to know exactly what is covered.

Do they have DME coverage, is there a visit limit, do they need pre-authorization? We need to know exactly what is covered up front. I also would rather charge the patient for deductibles and copay up front, rather than try to collect it months later after treatment has ended.

Get the information up front. Some things to check include DME coverage, deductible, copay/co-insurance, visit limit, pre-authorization, out-of-pocket max, etc.

Durable medical equipment
Not all areas of the country have a DME benefit, but many do. A lot of insurance policies cover DME that patients want, will use, and will help them get better and stay better.

DME benefit is usually different from chiropractic benefit. Sometimes we will find that a patient has mediocre chiropractic coverage but has excellent DME coverage. Get some training in this — my biller is a certified DME specialist and I have attended many seminars.

Some DME to look at for a chiropractic clinic include orthotics, back braces, TENS units, knee braces, and wrist and cervical braces.

Cash services
I do not believe in turning a chiropractic office into the local pharmacy. Has everyone else noticed they seem to sell everything but medications?

I think a chiropractic practice should be about chiropractic. But look for other related areas of revenue. We offer spinal decompression as a cash service, DOT physicals, CBD
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**Collections — front desk and billing**

Again, the key to good collections is a proper verification up front — that solves 90% of collection problems. Other tips include billing daily or weekly, and keeping collections coming.

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For my clients and my own clinic, we separate out front-desk collection from insurance collections. Front-desk is literally everything that comes across the front desk such as copay, deductible and cash services. Besides adding cash services, we can increase front-desk collections by making sure copay and deductible are handled up front. The majority of our patients will pre-pay for care and deductibles. If they choose to pay as they go, they pay on the way in; no sneaking out after a visit without paying.

**Add retention and you’re golden**

These are some tips to increase collections. Besides the strategies above, working on retention is a key to getting total collections higher.

**90%**

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CHIROPRACTIC MAINTENANCE CARE
The latest studies give insight into the followed yet ill-defined approach

BY CHIROPRACTIC ECONOMICS STAFF
TIME TO READ: 7-9 MIN.

THE TAKEAWAY
Older American doctors of chiropractic favor maintenance care over younger DCs and other new data from international studies of maintenance care, including how patients see the practice.

MANY PATIENTS, AND DOCTORS OF CHIROPRACTIC, rely on chiropractic maintenance care to maintain holistic health — “a traditional chiropractic approach, whereby patients continue treatment after optimum benefit is reached,” according to the research paper “Chiropractic maintenance care — what’s new? A systematic review of the literature,” published in November 2019 by authors Iben Axén, Lise Hestbaek and Charlotte Leboeuf-Yde.

The paper followed two prior reviews in 1996 and 2008, both of which “concluded that evidence behind this therapeutic strategy was lacking.” But since then, a systematic research program in Nordic countries, involving some U.S. doctors of chiropractic, was undertaken to “uncover the definition, indications, prevalence of use and beliefs regarding maintenance care to make it possible to investigate its clinical usefulness and cost-effectiveness.”

Method and results
The team included 14 original research articles in their review, where maintenance care was defined as “a secondary/tertiary preventive approach, recommended to patients with previous pain episodes, who respond well to chiropractic care. Maintenance care is applied to approximately 30% of Scandinavian chiropractic patients.

“Only one of these studies utilized all the existing evidence when selecting study subjects and found that maintenance care patients experienced fewer days with low-back pain compared to patients invited to contact their chiropractor ‘when needed.’ No studies were found on the cost-effectiveness of maintenance care.”

Defining maintenance care
The authors note that new evidence regarding the natural course of spinal pain should lead to a shift in treatment approaches from cure of the condition to management of pain trajectories with maintenance care.

“The acute episode of spinal pain, similarly to an episode of asthma, may be short-lived, but the condition is often, as for asthma, life-long,” the authors wrote, noting that chiropractors appear to have been in the forefront in this domain.

Some chiropractors recommend maintenance care as a form of precaution, the authors said, while other DCs “seem to have used it to ‘keep patients going,’ when they had chronic or recurring problems.” The authors note that the term “maintenance care” has been used for decades but remains without an official definition.

Based on recommendations for further study, a research project called “The Nordic Maintenance Care Program” was launched with the aim to increase knowledge regarding maintenance care, utilizing chiropractors in Denmark, Sweden, Finland and Norway.

Review objectives and data
The objectives of the systematic review of studies were:
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RESEARCH

1. To define the concept of maintenance care and the indications for its use.
2. To describe chiropractors’ belief in maintenance care and patients’ acceptance of it.
3. To establish the prevalence with which chiropractors use maintenance care and possible characteristics of the chiropractors associated with its use.
4. To determine its efficacy and cost-effectiveness for various types of conditions.

The 14 articles/studies included were published between 2008-2018 and included ones from Canada, the U.S. and Egypt.

“There was a mixture of qualitative (focus groups and interviews) and quantitative studies (surveys, observational studies and randomized controlled trials),” the authors wrote. “One study was described as a structured workshop, but it was designed like a focus group discussion with a resulting qualitative summary. Eight studies collected their data from chiropractors who either estimated their responses or consulted their patient files, four studies collected their data from patients, in one study data were collected from both chiropractors and their patients, and one study used workers’ compensation claims data.”

Patients and DCs on maintenance care
One study specifically investigated the patient perspective of maintenance care; patients were interviewed and asked to explain why they would visit their chiropractor on a regular basis. Patients stated that:

• The purpose was to prevent recurrences (78%);
• The purpose was to remain pain-free (68%);
• The purpose was maintenance care as a wellness approach (17%).

By contrast, the prevalence with which chiropractors use maintenance care in studies saw that “some studies investigated the frequency of use of maintenance care from simply asking chiropractors to estimate their use of maintenance care the previous week (mean estimate 22%), to have them check the proportion on a typical clinic day (reported in two studies to be 28 and 35%, respectively), or actually observing in clinic and counting (reported in two studies to be 26 and 41%, respectively). Thus, the mean proportion of patients seen on a maintenance care regimen by Scandinavian chiropractors was around 22–41%, with large individual variations ranging from 0 to 100%.”

Regarding the spacing of maintenance care treatments, most visits were scheduled by patients within a range of 1-3 months.

American DCs and maintenance care
In one survey the majority of chiropractors from the given countries (98%) stated they believed that “maintenance care
could be used as a preventive tool, at least sometimes.”

In an interview study it was found that some chiropractors “favored a universal approach, claiming that maintenance care was always beneficial and would prevent disease.”

In regard to American chiropractors, “One study conducted in Denmark investigated chiropractic factors associated with maintenance care use and found that it was more common among experienced chiropractors, clinic owners, and those who received their chiropractic degree in the U.S.”

At the time of the particular study, “the older chiropractors were almost all trained in the U.S., whereas the younger chiropractors were primarily educated in Denmark. Therefore, it is not known, if it is age (experience) or educational background that guided the use of maintenance care among these chiropractors.”

Further defining the term and use
Across the Nordic countries in the study, approximately 30% of chiropractic patients are maintenance care patients. Visits were usually between 1-3 months for these patients, with DCs emphasizing a full-spine approach.

As the authors note, “Clinical indications vary, but patients suitable for maintenance care are commonly thought to be those with persistent or episodic pain, who react well to the initial treatment.”

Three trials dealt with the clinical usefulness of maintenance care. “In one, patients who received maintenance care had better outcome than those who received short-term treatment or short-term sham treatment. The other two studies compared two types of maintenance care (with or without exercises, or different length of the follow-up treatments) and found no difference of outcomes between groups.”

The study concluded in part, “Presently, maintenance care can be considered an evidence-based method to perform secondary or tertiary prevention in patients with previous episodes of low back pain, who report a good outcome from the initial treatments. However, these results should not be interpreted as an indication for maintenance care on all patients, who receive chiropractic treatment.”

The full study is available at chiromt.biomedcentral.com/articles/10.1186/s12998-019-0283-6#citeas.

“The acute episode of spinal pain, similarly to an episode of asthma, may be short-lived, but the condition is often, as for asthma, life-long,” the authors wrote...

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1. They are ALL paid in cash from companies. No insurance is used at all, due to the fact that the company is mandated by the government to provide the services.

2. Everything but a physical can be done by a trained assistant. So while you are treating patients, or fishing, or sleeping in one morning, your assistant can go to a company and make you $5000 or $10,000, or $20,000 in a single day.

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4. The work is in every single city in America. School districts, banks, cities, counties, state and federal agencies, as well as companies of just about every kind need some kind of OccMed service.

5. It is a low barrier to entry in terms of money and time invested. You can do physicals, drug testing, DNA testing, respirator fit testing with no equipment to buy. Other services you can start doing for less than $100 in equipment all while producing hundreds or thousands of dollars in income.

6. All the mandated services must be done ANNUALLY which means repeat business year after year.

7. If you are good at OccMed services, every single company I work with asks me to be their company doctor, and ALL work injuries are sent to me. I'm in the driver's seat. I don't have to deal with MD referrals, or work comp adjusters because the company makes everyone see me FIRST!

8. When doing physicals, most people say “You have told me more in 5 minutes than my MD told me in 5 years. Can I be your patient?” Yes! New patient generating machine!

9. The number of providers doing DOT exams went from everyone (500,000 providers) to only 60,000 due to the government requiring a “12 hour webinar certification course” and the MD's all quit because they didn't have time. That means all the work now filters down to the 60,000 providers who did. AND trucking all by itself is growing at 6% a year due to demand.

10. DCs can be the most economical providers of these services which means you can literally strip the business away from anyone else in your town. I HAVE DONE IT and can show YOU how to do it successfully.

Here is an example of how this process works:

A company called me in 2010 and said they were hiring 20 new employees which all need several services like physical, drug test, alcohol test, hearing test, PFT, respirator fit test, heavy metals evaluation and hand dexterity testing. It adds up to about $1162 each. During my normal 8 hour work day of treating patients, my staff did the work on these 20 OCCMed clients. I had to stop in between patient adjustments to do a physical (4 minutes average) every thirty minutes. By the end of the day, I added 20 x $1162 = $23,245 (four times my chiro income) yet I did much less work.
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I have done 500 drug tests in a single day for a nice $10,000 check. I have a company with 700 employees that wants to drug and alcohol test 10% a month, so 70 people x $65 = $4550 in one day, every month—and my assistant does it. I don’t go. I don’t do anything at all except cash the check. This is called leveraging your time. It’s why MD’s have 5 nurses doing all the work and they just sign off on charts, but get paid the big bucks. You need to have employees that can actually make you money without you needing to be there.

Here’s my latest contract from last month for $20,000 in about 8 hours where my assistants did almost 200 covid tests at a company. I DID NOTHING BUT PUT THE MONEY IN THE BANK! You can do this too! I have over 200 DCs all over the USA doing this.

I was paid $20,000 cash by a company to COVID test 180 employees over 2 days.

(2 assistants did 4 hours on 2 days in the early morning while I slept in.)

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RELEVANT REHAB AND HOW TO GO BIG

Education is key — this isn’t your father’s rehab or physical therapy

BY DONALD C. DEFABIO, DC, DACRB, DACBSP, DABCO

TIME TO READ: 12-14 MIN.

THE TAKEAWAY

Patients are familiar with physical therapy and rehab, but chiropractic rehab cares for joints, soft tissue imbalances, movement patterns, and lifestyle and nutrition to bring patients not only back to health but to homeostasis.

CHIROPRACTIC PHYSICAL REHABILITATION IS BIG. Regardless of your practice style, incorporating chiropractic physical rehabilitation (rehab) into your practice has big returns for your patients and your bottom line, regardless of your practice style.

Whether it is low- or high-tech, properly applied rehab improves outcomes, patient satisfaction, referrals and is an additional service your office can provide. However, the main reason chiropractic rehab is big is because of the exceptional outcomes it achieves.

How chiropractic rehab is different

Chiropractic rehab is not physical therapy, personal training, group training, myofascial release or athletic/performance training. These disciplines are beneficial and address faulty movement patterns and muscular imbalances between tight and weak muscles (length-tension relationships) and expect joint mechanics to normalize along the way.

Chiropractic rehab is different: We treat and assess the entire body, adjust the hypomobile joints (local as well as within the entire kinetic chain), and then address the soft tissue imbalances, faulty movement patterns and altered...
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muscular length-tension relationships to enhance the effects of chiropractic manipulative therapy (CMT).

Finally, we discuss lifestyle and nutrition to fully restore homeostasis. This approach is the reason chiropractic rehab is big in creating superior outcomes.

**Begin with the basics**

NFL Hall of Fame coach Vince Lombardi started every season by holding up a football and announcing to the team, “Gentlemen, this is a football.” Therefore, regardless of if you have no experience with rehab or are in an interdisciplinary facility with the newest rehab equipment, let’s start with the basics and build your practice to where you feel comfortable.

1. **Sharpen your spinal and extremity adjusting skills.** This is essential in correcting kinetic chain imbalances. Also, as patients recognize your office is big in rehab, they will expect you to treat more than just the spine.

2. **Have a go-to soft tissue technique.** Be ready to address soft tissue issues with manual, instrument-assisted or even high-tech modalities — be proficient in at least one.

3. **Start in your current treatment rooms.** Elastic resistance bands, physioball, balance discs and a foam roller can all be used effectively in your current treatment rooms with excellent results for the acute, sub-acute and corrective phases of care. There is no need for a dedicated rehab suite to go big in rehab.

4. **Learn low-back and neck exercises** for mobility, stability and strength. These will be the most common conditions that will arrive in your office.

**Building on the foundation**

Thoughtful rehab is a process that incorporates CMT, soft tissue work, active and passive exercises, taping/bracing, nutrition and lifestyle advice. Exercise principles need to address both the local stabilizer muscles as well as the global prime movers.

Exercises must also address mobility and symmetry between left and right as well as front and back. Anyone can look up exercises on the internet; however, as a chiropractic rehab provider you need to know which exercises are appropriate and correct technique. Improper technique is simply not acceptable for optimal results.

1. **Take courses and get hands-on experience** in exercise prescriptions for spinal and extremity conditions. Start with the most common extremities: shoulder, knee and hip. Consider starting a study group with other local colleagues to sharpen your skills.

2. **Be prepared to address the Top 3** common postural distortions of tech neck (forward head posture), lower crossed distortion (hyperlordosis with anterior pelvic tilt), and pronation distortion.

3. **Apply all exercises in proper alignment and strong posture.** Use postural correction as the transition from treating the patient’s “pain” to a corrective “non-pain” model of care.

4. **Learn to assess and correct faulty movement patterns.**

5. **Video your patient’s exercises** on their own phone for home care. Video exercise software programs are also available.

6. **Create a professional referral base** for patients when they get to return to sport and higher levels of activity. This phase of rehab is time-consuming and requires more extensive equipment and space. Patients still remain under care for adjustments, soft tissue work and oversight. This is a triple win: The patient, the local gym and your office all benefit at this stage of rehab.

**Growing to the next level**

Active care takes time and it may affect your appointment scheduling. Be prepared to add “rehab slots” to your appointment book for patients to learn and review exercise prescriptions.

As your rehab practice grows and your patients tell others you “do more than just give adjustments and heat,” the decision needs to be made on expansion. You may need additional space at this time and/or additional providers.

1. **Moving to an open-concept adjusting room** can make the space for your rehab suite right in front of you. This will
enable you to adjust patients while observing other patients performing active care. Caveat: If you are billing insurance carriers for exercise therapy, you need to have one-on-one patient contact. However, it does not have to be continuous, so you can intersperse exercise instruction between adjustments.

2. **Hire another professional to oversee your rehab.** Depending on your state’s laws and scope of practice, it could be an ATC, licensed chiropractic assistant, PT, PTA, RN, DC, OT, personal trainer, exercise physiologist or massage therapist. Again, be sure to check with your local licensing board on the requirements.

3. **Consider higher-tech machines** to add to your menu of services. These offer services you can prescribe but do not have to oversee directly. Many of these novel therapies do not have CPT codes and are a cash service, which helps cash flow.

The hallmark of success in chiropractic rehab is the whole-body approach...

**Growing into the interdisciplinary model**
The interdisciplinary model for rehab is effective and profitable; however, it can change the focus of treatment.

Often the intake physician is a DC and they schedule the patient for the appropriate care with the other providers in the office. This offloads the DC greatly; however, it is important the team has weekly clinical rounds to assure the patient is progressing as well as maintaining their treatment schedule.

Remember, the hallmark of success in chiropractic rehab is the whole-body approach we use with a foundation of the chiropractic adjustment. Multi-disciplinary clinics can fall into a reductionistic model.

1. **Conduct weekly clinical rounds** with the entire team to ensure patient response and compliance.

2. **As the DC on the team, be aware of the active care** being provided. Understand the exercise prescriptions the other providers are incorporating.

3. **Be mindful that there is a difference** between “churning” the patient and comprehensive care — patients know the difference.

4. **Monthly re-exams and progress reports** are integral to compliance.

5. **The patient can always begin a postural correction program** once they are pain-free.

**Chiropractic rehab is big**
Expanding rehab in your practice is supported by research and patient demand. Numerous studies indicate a multi-modal approach to musculoskeletal pain that incorporates active care is the current paradigm.

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In addition, patients are looking for active care solutions and desire to be independent. They appreciate the knowledge of a provider who can counsel them to attain their health goals and embrace technology that demonstrates postural and muscle imbalances, faulty movement patterns and physical limitations.

Finally, as mentioned above, active care is a reimbursable code for insurance carriers.

1. **Make sure patients are scheduled for a mini report of findings** to review the results of any movement, postural or kinetic assessment. Simply emailing the results is not enough.

2. **When billing for active care**, be sure to bill and code correctly. Active care can be billed under several allowable codes, both individual and group. Take a course or speak with a coding/billing specialist to ensure compliance.

3. **Perhaps the easiest code** to document for one-on-one active care is 97110, Therapeutic Procedures. The code 97110 is billed based on the outcome of the intended procedure, not the procedure itself. Therefore, if the goal is to increase range of motion (ROM), any technique (other than CMT) designed to increase ROM to that region can be applied.

4. **Depending on your state’s scope of practice and laws**, patients may be able to pay directly for a personal trainer in your office to oversee their rehab. Since this is not billed to the insurance, it is direct pay.

Chiropractic rehab adds an exciting dimension to your practice. For doctors interested in adding rehab to their practice, start with the steps outlined above. You can use low tech in your current treatment rooms and address the conditions that currently present to your office.

Develop your rehab assessment and exercise skills and then decide if you want to take it to the next level. For doctors looking to expand, you can keep it “chiro-centric” or grow into an interdisciplinary model. Both models allow for appropriately coded reimbursement from insurance carriers. However, active care and non-billable high-tech machines can be direct-pay cash services, too.

**Aligning chiropractic rehab**
Chiropractic rehab is effective because it is different than generic rehab. It is a corrective procedure that centers around the adjustment and the patient’s individual goals.

Our approach is to first restore joint motion to hypomobile areas (CMT), then proceed to restore soft tissue compliance before strengthening weak muscles and correcting faulty movement patterns. Performing strengthening exercises before joint mechanics and soft tissue compliance are restored simply reinforces the underlying pathomechanics.

Finally, reinforce strong posture and proper joint alignment with every exercise to improve outcomes and to transition the patient to postural correction, beyond pain control. Incorporating chiropractic rehab into your practice from low-tech to multi-disciplinary and high-tech will have big rewards for your patients and your practice.

NOTE: Check your state laws and regulations on billing for active care and follow appropriate documentation guidelines before incorporating the steps outlined in this article.

DONALD C. DEFABIO, DC, DACRB, DACBSP, DABCO, teaches Relevant Rehab with virtual and hands-on seminars throughout the US. His e-book, “The Six Keys to In Office Rehab,” is available free on his website, DeFabioDifference.com; exercise protocols can be found on his YouTube channel, which has over 32,000 subscribers. He can be reached at DeFabioChiropractic@gmail.com to schedule him as a speaker or register for his workshops.
DEAR DOCTOR OF CHIROPRACTIC,

You are essential to the health care of America. Your patients count on you to help them through this difficult time, as do your family and friends. If you’re a business owner your employees are counting on you also.

In “normal” times you could escape the pressure by seeing friends socially, going to a restaurant, or maybe going to a movie theater. Now we're trying to find that new normal as a society, trying to make it look as close to the old normal we can.

WE’RE IN IT TOGETHER

Last year we told the story of the two young chiropractors who 30 years ago attained their DC degrees, both near the top of the same graduating class and full of enthusiasm to enter chiropractic care. When they returned for their 30-year reunion, both were married with family and had stayed in touch over the years. But while one worked in a multi-doctor practice, the other had founded his own multi-location practice and as CEO was contemplating an early retirement.

THE DIFFERENCE?

How and why did the two DC’s paths diverge? Both sought success. Both were near the top of their class in school. Both entered the field with enthusiasm. The difference-maker was the business of chiropractic – learning the economics of the industry. The eventual CEO subscribed to Chiropractic Economics and gained the knowledge to take his practice to the next level.

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Sincerely,

Richard Vach
Editor-in-Chief

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HOW DOES THE NEW STIMULUS IMPACT DCS AND PRACTICES?
What to know and various application deadlines and extensions

BY TY TALCOTT, DC
TIME TO READ: 12-14 MIN.

THE TAKEAWAY
What to expect from the announcement of another round of small business loans that the majority of chiropractors will be eligible for.

IN JANUARY A NEW YEAR ARRIVED ALONG WITH A NEW STIMULUS AND RELIEF BILL. The new stimulus bill, the second stimulus bill, the last stimulus bill — whatever you want to call it, it has far-reaching effects that may benefit a chiropractic practice ... with one big exception.

The negative
The new stimulus bill does not offer liability protection or protection from HIPAA fines or audits. While the stimulus bill may offer assistance in many ways, it does not provide liability protection.

This means many risks remain if you are seeing patients during the crisis, and documented action will be needed to protect your practice. It is critical you have a documented crisis compliance and HIPAA program in place.

The crisis compliance program
In the event someone contracts COVID-19 in your office you could be open to a lawsuit. You have to defend yourself and, in a lawsuit, he who has the best documentation typically wins.

There may ultimately be legislation to mitigate such risk, but even then, it may only be for those who were “not negligent.”

Since there are no hard-and-fast rules as to what constitutes compliance, you have to focus your program upon showing that you are “not negligent” and are paying attention to crisis guidelines and documenting good faith efforts to comply with lockdowns, mask requirements, sanitation and screening requirements, etc.

To show you have complied with these guidelines takes a program that is well-documented. This is best served by having an audit tool that is continuously updated, showing what you have done (to sanitize, protect staff and patients, etc.), when you started performing each measure, when you stopped and your rationale for doing so. “I didn’t feel like doing it,” or “my staff didn’t like it,” or “my patients did not want to comply,” or “I am politically against it,” etc., does not make for a reasonable rationale.

Good news on the HIPAA front
As of Jan. 5, 2021, there is a new law that may help protect chiropractors. The topic of HIPAA is vast, but for now one update is critical.

A new bill, modifying the HITECH act, was signed into law on Jan. 5, 2021. This law outlines what is close to a “safe harbor” for doctors who are regulated under HIPAA. President Trump signed into law HR7898 to specifically provide incentives for
covered HIPAA entities (nearly every chiropractor) and business associates to put cybersecurity safeguard programs in place, as required under the HIPAA law.

This modification of the HITECH law will provide much-needed protections for covered entities as it gives HHS and OCR the opportunity to reduce or eliminate fines and/or reduce or eliminate audits against a covered entity that has been breached or is being audited — if they can document 12 months of adherence to known cybersecurity policies and procedures.

This is a huge incentive for doctors to get the right HIPAA program in place — get with your compliance expert to make a plan.

More good news and PPP
NOTE: There are financial and legal risks, and rules change continuously, so it is highly recommended you consult the proper legal, financial and compliance experts.

The Consolidated Appropriations Act of 2021 ("CAA" or the "ACT") was signed into law on Dec. 27, 2020, containing more than 5,500 pages. For chiropractors it concerns:

• New PPP loans
• Changes in tax impact of government monies
• Changes in Economic Injury Disaster Loan (EIDL) forgiveness
• Changes in once-prohibited grant forgiveness
• Medicare benefits

Approximately $284 billion was appropriated for a new PPP loan program, giving eligible borrowers an opportunity to receive a second round of funding.

To qualify for a second PPP loan you must be a schedule C taxpayer, LLC, S corporation or partnership with no more than 300 employees. You must have suffered a 25% gross receipts reduction in any quarter in 2020 as compared to the same quarter in 2019 (receipt of a PPP loan does NOT add your loan amount to your gross receipts), and you must have used all proceeds from the first PPP loan toward approved expenses by the time you receive the second loan.

You cannot apply for the second loan if you have declared bankruptcy, and you have until March 31, 2021, to apply.

This funding is also for those who, due to confusion, received less than the proper amount and/or who returned or did not accept their original PPP1 loan.

Amount and tax consequences
As with the first round of PPP, the second PPP amount will be determined based on your payroll average at the time of applying, and the forgiveness amount will be determined by your employee retention. Other rules apply and your banker or CPA should be
Rules change continuously, so it is highly recommended you consult the proper legal, financial and compliance experts.

able to help you calculate the appropriate amount.

The Internal Revenue Service took the stand that any “free” (forgiven) PPP government money that is used to pay for “allowed expenses” cannot be used for normal business expenses at tax time. They viewed this through the eyes of traditional “grant money language,” asserting it is “double dipping” to get free money and then use those items again to reduce your taxes.

That might be true during normal times, however, it would be pretty silly for the government to go to the expense and trouble to assure you get money only to take it away at tax time — what would be the point?

Example: You obtain a “forgiven” PPP loan. You spend $5,000 on rent. Then at tax time you are not allowed to reflect that rent as a deduction, therefore $5,000 of your gross income has no offsetting deduction and, depending on your tax rate, that may cause you to have to pay an extra $1500, plus or minus, in taxes.

But great news: This new law states that you can obtain the free money and use the expenses at tax time.

Are SBA EIDL emergency funds ‘free money?’

Many people were confused during the rollout of the first stimulus bill when they were told to check the SBA site for PPP details. Upon arriving at the website they saw there was a disaster loan (EIDL) available for emergency relief and thought it was the PPP loan.

Many doctors applied and received $1,000 per employee, up to $10,000, for emergency relief and then were instructed to take out an additional loan that had to be repaid with interest. They were informed that the up-front emergency money would be forgiven, but the larger loan was to be repaid. They later realized this was not the PPP loan.

They then applied for and received the PPP loan, only to be told that the EIDL loan would no longer be forgiven since they also had a PPP loan.

The new stimulus changed all of this.

The front-end EIDL is now forgiven, even if you have a forgiven PPP loan and the items paid with the loans are also tax-deductible. They also repealed the requirement that borrowers of PPP loans reduce their loan forgiveness by the amount of the EIDL advance and stated that Congress has instructed that all borrowers of PPP loans previously affected by this will be “made whole.” Procedures to do so are not clear, but money will be refunded. The U.S. government appropriated $20 billion for targeted EIDL advances for small businesses in low-income communities that have suffered greater than 30% economic loss. This gives an opportunity to receive a full $10,000 grant, no matter your number of employees. These EIDLs are available through Dec. 31, 2021.

Medicare and other updates

Medicare put into effect a temporary pay raise of 3.7% for those who treat Medicare patients. There is also an additional $3 billion earmarked for health care providers, but no details as to distribution yet.

There are new benefits for chiropractors that will definitely require the assistance of a CPA or banker. There are benefits in regard to extra deductions you might be able to take if your business was severely impacted by the pandemic and/or if you were paying employees sick leave due to COVID-19 or had to care for family members who were infected. Originally these benefits were not available to you if you also had a PPP loan, but that was eliminated under the new stimulus, so you might be eligible.

In addition, Deferral of Employee Payroll Taxes was extended to Dec. 31, 2021, and the Section 7(a) Debt Relief Program, designed to pay six months of SBA loan payments, was extended by three additional months.

This is a massive stimulus bill with many more details. At the time of this writing it looks as though there will be even more stimulus on the way — stay plugged in.

TY TALCOTT, DC, is a certified HIPAA Privacy and Security Expert (CHPSE) and president of HIPAA Compliance Services. He has consulted for thousands of health care practices relative to business development and protection. He can be contacted at 469-371-8804 or at DrTyTheComplianceGuy.com.
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DO YOU EVER GET FRUSTRATED when scientific facts seem to change from day to day? Instead of getting frustrated, here is a way to reframe how we look at research and science.

Early in my career, I thought that research could answer all of my questions once and for all. However, I was wrong. That is not really how “research and science” works. Research is not a search for a final answer, but a means to find greater truths. And research is a process we must engage in so that our profession may continue to grow.

A cyclical process
So how should we look at research and science? One way is to think of it as a continuous quality improvement cycle, which is a concept that comes naturally to most chiropractors. This cyclical process allows us to ask questions, gain new information, then incorporate that new information to improve our theories and models.

Research is about asking questions and testing our hypotheses, not closing our minds once we have found out just one answer, since there may be several correct answers to one question. Thus, the facts are supposed to change and improve as we gain new knowledge. And as we explore chiropractic, we know that chiropractic care can be very powerful, so keeping our minds open to the possibilities is important.

Through the wonderful and fluid processes of research and science, we can drill down to the minute details or we can go really big with analyses and models. Research is a tool that provides us with a way to better understand what we are doing and how we can do it better. This process means that we may continue to grow as individuals and as a professional community.

Strengthening chiropractic

Through research and science, we also have the opportunity to strengthen the foundations of our clinical practices and our profession.

When asked about the Journal of Manipulative and Physiological Therapeutics (JMPT), Journal of Chiropractic Medicine, and the Journal of Chiropractic Humanities, President Emeritus James Winterstein, DC, DACBR, replied, “The bottom line is that without peer-reviewed and indexed scientific journals, the academic and clinical reputation of our industry as a whole would suffer. These journals give relevance and significance to our practice because they represent the
science that undergirds what chiropractic physicians do. Their presence has both promoted and published research, which in turn has given stature to our researchers who can, because of them, publish in other scientific journals.”

Thus, our chiropractic journals help to provide opportunities for our researchers and contribute to strengthening the chiropractic body of scientific knowledge, which helps to secure our future.

Supporting chiropractic journals and research

Whether a chiropractor reads one or many different journals, scientific journals are important for the health and security of our profession. Building our science reservoir means that we are building a library of information so that it is ready when it is needed. We cannot rely solely on other professions to build our library for us; we have the responsibility to do this for ourselves. Thus, our chiropractic journals are essential. The information we incorporate into chiropractic research and science fortifies the foundation of the chiropractic profession, therefore it is our duty as chiropractors to support our research and science, and to support our chiropractic journals.

For example, the JMPT was established at a time when no other scientific peer-reviewed journal of its kind existed. In the 1960s and 1970s, which was a tumultuous time in chiropractic history, Joseph Janse, DC, ND, witnessed the oppression imposed by the established medical scientific community and how they influenced legislation and the practice of chiropractic. In 1978, he took a leap of faith knowing that there had been prior failed attempts at establishing a respected indexed journal; however, he knew that a scientific chiropractic journal was desperately needed by the profession. After a few years, the JMPT became the first chiropractic journal to be listed in MEDLINE and continues to lead the way in chiropractic scientific publications.

Since that time, the JMPT has published thousands of papers and has helped our chiropractic researchers establish a scientific track record so that they can continue their research and publish in a wide variety of journals. And the articles from the JMPT have helped practitioners in many ways to establish the legitimate science of chiropractic and to show that there is evidence for what we do.

Supporting research

I sometimes hear, “I am a practicing chiropractor, not a researcher. How can I participate in research and science?” My
One does not need to be a professional artist to appreciate and support art. Thus, one does not need to do research to appreciate and support chiropractic research.

If you find value and see the importance of research and science for the chiropractic profession, then you are in good company.

The Practice Analysis of Chiropractic 2020 reported that the majority of chiropractors in the United States value research and science. In their analysis, 96.2% of chiropractors report reading peer-reviewed research and 90.3% report using research-based treatments. This is fabulous news when we consider that knowledge is a critical component in order to be invited to sit at the decision-making table, which ultimately determines what happens with the chiropractic profession.

Chiropractors read journals to attain, maintain, and improve their competence and to stay current with health care trends. Reading scientific journals is an efficient method of increasing awareness about evidence-based approaches to health care. So, the bottom line is that:

1) information is expected to change and improve over time, and; 2) research and science are participatory.

It is our responsibility as chiropractic practitioners to know what is being done and published within and about our profession. And it is also our duty to support the journals that support chiropractic to make sure that they continue to serve chiropractic far into the future.

Many great thinkers in our profession have demonstrated their love for knowledge and that one is never too old to learn new facts or propose new hypotheses. By continuing to ask questions, measuring the facts, appraising them if they are worthy of considering, then applying what was found to practice, we continue to improve. And being able to speak and understand the language of science gives us a voice so we may be included at the table when important decisions are being made, both locally and nationally, about chiropractic.

Additional research needed

There is still much to be explored in the world of chiropractic research. In 2021, although we have a good start on our body of scientific knowledge, we only know a small fraction about what chiropractic can do and its full potential to impact the health of our patients. There is much to be explored about the mechanisms of chiropractic care, not only on the cellular and systems level, but on the level of the whole patient and its impact on the community.

As chiropractic research moves forward, we will need additional research related to pragmatic clinical applications and ways that practicing chiropractors can engage and give input into this process. Our research and science will help guide chiropractic into the future and each of us has the responsibility to be a participant.

CLAIRE JOHNSON is a professor at the National University of Health Sciences, editor of JMPT, JCM and JCH, and has served as the peer review chair of many scientific chiropractic conferences. She is the administrator of the Research and Science Society (RASS), which is a membership-based, online forum for chiropractic practitioners who are interested in better understanding and applying research and science. This society engages stakeholder participation by encouraging members to learn, apply, and impact research and science. Learn more by visiting ResearchScienceSociety.org.
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YOUR NEW NEW-PATIENT STRATEGY
Developing relationships with MDs — the right way

BY CHEN YEN
TIME TO READ: 6-8 MIN.

THE TAKEAWAY
Follow these strategies to develop an MD referral network by learning how to approach MDs (and how not to) while overcoming barriers such as MD knowledge of chiropractic and the need to develop trust for the best interest of patients.

DEVELOPING RELATIONSHIPS WITH MEDICAL DOCTORS is a great avenue for attracting patients into your practice, as they are willing to refer if they know about you and how you can help their patients produce better outcomes. Many MDs have thousands of patients in their practices, including patients whose health issues are not fully addressed by drugs and surgery.

According to the AAMC (Association of American Medical Colleges) it’s expected that there will be a significant shortage of primary care and specialty care physicians by 2033. The United States could see an estimated shortage of 54,100-139,000 physicians, including shortfalls in both primary and specialty care, by 2033. With a current and increasing need for health care, chiropractors are well-positioned to contribute more expansively to patient care in the U.S. health care system.

MD referrals are stickier
Referrals from MDs are also more likely to move forward with chiropractic care and stick with it. Imagine having three

2033
THE YEAR BY WHICH IT’S EXPECTED THAT THERE WILL BE A SIGNIFICANT SHORTAGE OF PRIMARY CARE AND SPECIALTY CARE PHYSICIANS
MDs sending you just two referrals per week. That’s 24 new patients a month.

Having helped many visionary acupuncturists, chiropractors, naturopathic doctors, and functional medicine practitioners with growing and fulfilling six- to seven-figure practices “the introverted way,” let me share the best strategy to develop relationships with MDs and have them refer patients to you consistently.

How to begin
Getting referrals from MDs and other practitioners sounds like a great idea. But a lot of chiropractors aren’t sure of the best way to get started. How do you approach MDs to develop relationships?

When we understand a typical MD’s experiences we can engage more effectively with MDs. This is where the right strategy can make or break a relationship with MDs.

Sometimes MDs simply don’t have an understanding of how chiropractic can help. Others do but are limited in their understanding of the scope of how you can help their patients. Or it may be as simple as them not resonating with you on a personal level. MDs are less likely to refer to you under that circumstance, even if they feel like your modality can help their patient.

Many chiropractors make the mistake of expecting too much without putting at least some sort of concerted effort into it. For example, a mistake often made by some chiropractors is sending out a letter to many MDs in the area without a strategy. MD offices frequently receive all kinds of mail from people and organizations, which is why sending such a letter can be challenging. Sending a letter without a strategy can lower the odds of receiving referrals. You need to build trust and develop long-lasting relationships to get MD referrals.

Getting your foot in the door
A hot tip that is working right now is sending a short video. What’s so great about this strategy is a video can be created once and sent to many MDs, and it feels more personal, without the need for creating something new every time.

You could alternatively go the extra mile and record a personal intro for each doctor. If you don’t like the idea of creating a video that can do the work for you over and over again, there are other approaches you can use. Reach out to MDs in your area via LinkedIn messaging, call their...
office, or stop by to inform them about your practice and how it can be complementary to the care they provide their patients.

One of our chiropractor clients is successfully connecting with MDs through LinkedIn, then setting up a Zoom call.

Once you have their attention
Many medical doctors are just like you, trying to give patients the best care. If they’re concerned about safety or efficacy, they most likely won’t refer their patients to you.

This is why communicating the right way is essential. One of the biggest mistakes often made is having a good conversation with an MD and expecting referrals without bringing up why they should give you referrals. If it is about developing relationships first, how can you build a long-lasting relationship early on that benefits both parties? Part of it comes down to how you frame things.

For example, does the following script sound familiar:

“If you have any patients who could benefit from chiropractic care, send them to me.”

That is how some chiropractors encourage MDs to send referrals. But if we reframe that to make it more effective, we could approach with something like this:

“I’d love to hear more about your practice. I’m looking for a good _______ (insert physician’s type of practice) to send my patients to when the need arises. What’s your philosophy or approach?”

When you use this script, the conversation is more about them. And early in the relationship, this is a setup for a win-win. MDs like the idea of getting referrals even if they are busy with patients.

Set the stage for a relationship
Developing relationships with MDs and other health care providers will help your patients mutually. It doesn’t have to be intimidating.

Some chiropractors manage to have full practices primarily from MD referrals. How incredible would it be to have the kind of practice where patients are coming in the door while you look to fit them into your tight, busy schedule? What’s important is being strategic about approaching MDs. Setting the stage for a great relationship frames the benefits to all parties, including the increasing number of patients you will help.

CHEN YEN is a national speaker and founder of Fill My Holistic Practice, providing introverted visionary chiropractors a step-by-step process and specific guidance to grow a six- to seven-figure practice that runs without them. Clients include a past president of the American Chiropractic Association Sports Council, a recent president of the American Association of Naturopathic Physicians, and a board member of the American Society of Acupuncturists. She can be reached at mentor@fillmyholisticpractice.com or through introvertedvisionary.com.
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— D. Rottinghaus, DC

Medical necessity is key
It is interesting when we ask doctors how their documentation of patient notes are — we hear “It’s fine,” “I’m on top of it,” or “I am 100% compliant.” Perhaps, a more appropriate question should be, how healthy are your notes and do they demonstrate medical necessity? Many times as human beings we do the same things over and over, day after day; we can develop a tendency to start taking shortcuts and not even realize it. When taking shortcuts, the attention to detail in documentation is lost, critical and necessary elements of treatment notes are left out ... the documentation must show a direct correlation between presenting complaints and treatment delivered. Documentation must include any testing or exams utilized to demonstrate medical necessity, the area of the spine adjusted, the technique used for each area of adjustment, and finally how the patient tolerated the treatment ... For the health of your practice, it is important to have your documentation and claims screened to ensure your documentation is healthy as well, and is able to stand the scrutiny of an audit or investigation.
— D. Barton, DC, MCS-P, CIC

Don’t inadvertently wave red flags
Doctors know the treatment they give an individual patient and therefore feel justified in how they code the service — but if documentation doesn’t support the code, there is a problem. Remember, as far as a third-party payer (or auditor) is concerned, if it isn’t in writing, it didn’t happen. If, for example, you bill a chiropractic manipulative treatment (CMT) code for a certain level of service, but the documentation only justifies a lower number of regions treated, you’ve just waved another red flag. Most documentation software programs start with the notes from the last visit, so you can modify from there. The mistake here is when you get rushed or lax and are tempted to minimally modify and move on. Resist the impulse, and make sure each visit and its documentation is “encounter-specific.”
— K. Weidner, MCS-P, CCPC, CCCA

Be thorough in description of present illness
The mechanism of trauma must be documented appropriately. Many DCs are using insidious onset too frequently without properly demonstrating due diligence in their efforts to rule out other mechanisms. This has caused reviewers to question as to how a patient can have a “significant neuromusculoskeletal condition” if the patient cannot remember how it occurred.
Unfortunately, many people do not correlate activities of daily living to the mechanism of pain. That’s why it is important to be a good historian as clinicians. Ask your patients to think about things that they may have lifted, places they have ridden to, a time when they may have slipped, or any other activities of daily living that may have caused their pain. If they absolutely cannot recall anything then instead of writing “insidious onset,” write down your questioning.
For example, you may document this by explaining the mechanism of trauma: “The patient cannot correlate his pain to any specific incident. The patient stated his pain was not due to lifting, riding, slipping or any other activity, therefore it is considered insidious in nature.”
— T. Wakefield, DC, DACBSP, CSCS, CCST

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