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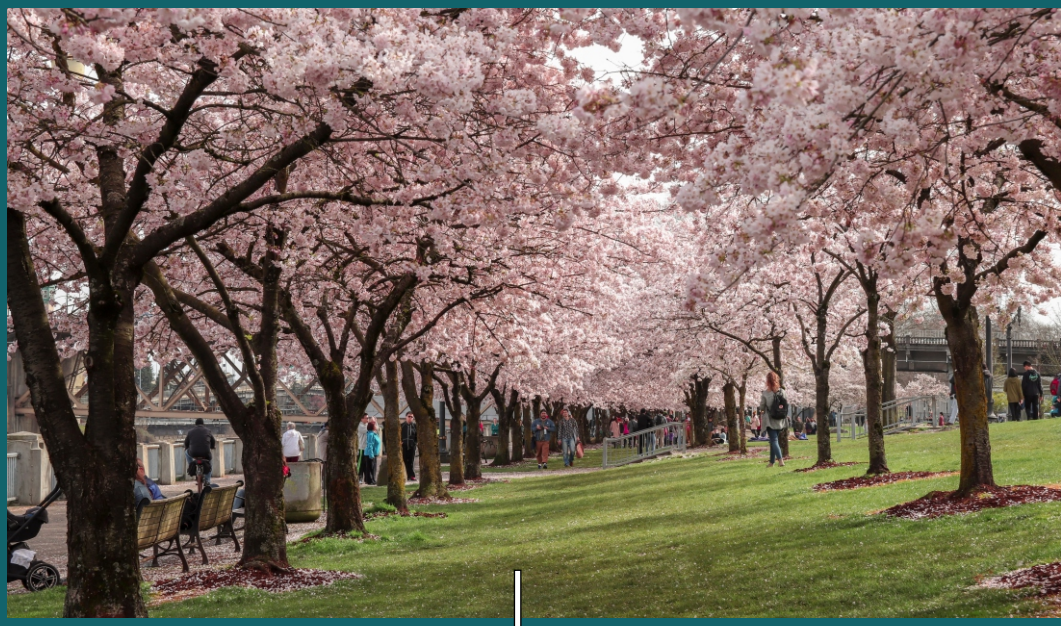
INSIDE THIS ISSUE:

2022 SPRING CONVENTION A SUCCESS!



The OCA Convention was once again a success. It was a great in person event to get us back to face to face after two years of the pandemic. We had great speakers, sponsors and fun & games.

See photos on page 14-15.

THE ALIGNED ATHLETE –FILM RELEASE

Sports performance was forever changed in the 1970's, when chiropractor Dr. LeRoy Perry met legendary track coach Tracy Sundlun. Their relationship would put the sports world on notice, showing the media and athletes that chiropractic works. But, while Dr. Perry had the media, athletes, and basketball great Wilt Chamberlain behind him, the medical establishment was still against him. Despite Dr. Perry being taken by police and barred from track events for being a chiropractor, his work carried on and his athletes became his messengers. Due to the success of Dr. Perry's athletes on the track and their activism off of it, chiropractic finally gained the respect it deserved. From this point on, sports chiropractic only grew in influence and in practice.

In 1985, chiropractic reached new heights with the Prefontaine Classic, an annual track and field event held in Eugene, Oregon. It was here that Dr. Richard Gorman was named the meet chiropractor, a decision that helped chiropractic become the standard of care at meets across the globe.

In The Aligned Athlete, 8 respected chiropractors and 10 accomplished track and field athletes speak on how chiropractic can not only maximize athletic performance, but can improve the overall quality of one's life. Among these 10 athletes, 8 Olympic gold medals and 29 World Championship gold medals have been won.

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A Note from the President

For Doctors by Doctors

OCA Presidential Address - Spring 2022

Thank you OCA Members...

Life took a welcome turn toward normalcy with the 2022 OCA Convention as we offered the event live this year and with online options for doctors and their staff to collaborate and interact. I shared with both OCA members and soon-to-be-members the joy and enthusiasm of professional fraternity that permeated this year's event.

Every time Oregon chiropractors come together in events like this to participate and share their interests and concerns, when they freely give and take as part of the OCA professional community, our association evolves and it's voice and it's face more accurately reflect each of you who now are the chiropractic profession of Oregon. Your professional commitment to OCA membership amplifies our message and drives our successes across the state.

The 2022 Oregon Primary elections this May set the field for the November 8th general election that will choose legislators whose decisions will bring consequences to our chiropractic practices. In 2013 Oregon chiropractors united the two former state associations to form the OCA, empowering the chiropractic profession with a single public face and message that we put forward to legislators to make our case. Your membership and participation in the OCA, your financial contributions to the ChiroPAC fund, allows us to find, educate, and endorse candidates chosen for their potential to advance our chiropractic agenda.

Supporting ChiroPAC has never been simpler. Now, with just a tap of the OCA website's 'Online Donation' button you can support the OCA's tireless efforts to support you and your practices. I am very excited to introduce to our ChiroPAC fundraising effort the 2022 Presidential Challenge. Use the online donation button between now and the end of June to be entered into a drawing for prizes – more on that soon.

I'm pleased to announce that the OCA established a Covid Advisory Committee at our May 19th Board of Directors meeting with the purpose of creating a position paper to be presented to the BOD for approval. We sent a letter of invitation to the Oregon Board of Chiropractic Examiners, and invite all interested parties, to collaborate with us to assure that the rules and policies under which we practice reflect a complete spectrum of peer-reveiwed scientific research to best support public health and safety.

The OCA is collaborating with the University of Western States to provide developmental opportunities for student interactions with practicing chiropractors and OCA board members. The UWS administration has warmly welcomed our invitation and OCA BOD member, Dr. Arah McLaughlin, is coordinating with UWS for regular on-campus meetings.

The Oregon Chiropractic Association exists solely to benefit you, the members. It is through your association with the OCA and the professional values we support that you are acknowledged as a professional that conducts yourself to the highest standards of education, collaboration and accountability. Your membership in the OCA insures that you will be seen in the positive light that this association's work casts on every affiliated Oregon Doctor of Chiropractic.

We are embarking on a membership drive this summer and are coming to your community. We will be partnering with the Gatti Law Firm to provide a Lunch and Learn / BBQ style event free to all chiropractors. This is a membership drive so invite your “unattached” colleagues to attend.
As president of the Oregon Chiropractic Association I invite you to connect with your peers and make our community blossom, Join the OCA Today!

Todd Turnbull, DC, CCSP, CBIS/T

CONVENTION 2022 HONORS A SPECIAL MEMBER AND DIRECTOR

Dr. John Checkal Honored for 50 years in Chiropractic

Dr. John Checkal attended the University of Wisconsin Eau Claire, at Eau Claire, Wisconsin and National College of Chiropractic in Lombard, Illinois. He holds degrees in Human Biology and Doctor of Chiropractic.

Dr. John Checkal was licensed in Oregon in February 1971. He started his professional chiropractic practice in Canby, Oregon where he practiced from 1971-1998. He then moved his practice to Tigard from 1998 to 2003. In 2004, he served for a time as the main chiropractor for a health club in Hillsboro, before leaving to again enter private practice. He currently practices in his clinic located in North Plains using several techniques that include Gonstead and Diversified.

His outside interests include current membership in the Oregon Chiropractic Association (OCA) and past memberships in the Mazamas, Toastmasters International, American Chiropractic Association (ACA) and Lions International. He is a charter founding member of the International Raw & Living Food Association where he served as Board President. Dr. Checkal was also the creator of Dr. John's VitaCrisp Crackers.

Jan Ferrante Honored for 20 years of Service as Executive Director

Jan Ferrante, Executive Director was honored at the 2022 convention on Saturday April 30, 2022 for her 20 years of service. Jan has served as the Executive Director of the Oregon Chiropractic Association (OCA) since 2009 and former association, Chiropractic Association of Oregon (CAO) from 2002-2009.

Leanne Burke, the OCA Administrative Assistant (pictured lower right with Jan) spoke about Jan and how the two of them have formed the OCA staff/team since 2014 when Leanne was hired. Dr. Todd Turnbull, OCA President presented the award on behalf of the OCA Board of Directors.

OCA BOARD MEMBERS ACKNOWLEDGED FOR THEIR SERVICE

During the convention weekend the 2021 OCA Board of Directors was thanked for their service. Those present from that 2021 board pictured below were Dr. Judith Allan, Dr. Dennis Cozzocrea, Dr. Amanda Tipton and Dr. Dan Beebe. In addition, Dr. Eric Hubbs past President was given a special award for his service to the OCA as President in 2020 and 2021.

The 2022 ~ Current Board of Directors was also Introduced on Saturday April 30.

Pictured above L to R =
Dr. Amanda Tipton, Dr. Michael Arnot, Dr. Michael Lell, Dr. Dennis Cozzocrea, Vice President, Dr. Dan Beebe, Dr. Les Feinberg and Dr. Todd Turnbull, President. (Missing were Dr. Arah McLaughlin & Dr. Robert Richards)

CONTINUING EDUCATON VIDEOS:
AVAILABLE ON DEMAND — ONLINE FROM OCA

CONVENTION ATTENDEES THAT WISH TO VIEW ADDITIONAL PRESENTATIONS

Convention attendees that wanted to hear speakers that were presenting at the same time as another speaker at the event, have been emailed information on how they can login to their profile and view those speakers online at NO additional charge through June 20, 2022, as a courtesy from the OCA.

MOBILIZE — COMMUNITY FORUM — OPENING DOORS:

The OCA Forums have proved to be a success and an asset to our members and other Oregon Chiropractor as well as other affiliates. It has helped to open the doors of communication withing the profession. Our OCA community forum has been up for about two years now and is called MOBILIZE. It is an easy way to communicate with colleagues as well as get up to date information as it comes available from the OCA. In addition to the online version there is also an APP that is available for your mobile devices.

If you are not already utilizing this way to communicate with colleagues around Oregon you can find out more through the OCA office and speak to Leanne the Forum Administrator.

&mobilize

THE VIDEOS FROM THE 2022 CONVENTION ARE NOW AVAILABLE ONLINE.

The 2022 convention had a variety of speakers that gave their educational presentations and those are now available for viewing from CE21 through the OCA video library. Cultural Competency presentations that meet the OBCE requirements for 2022 are also available. We also have PAIN Management hours available for Year 2 DCs that have a CE requirement for licensure renewal.

Item #	Title	Speaker	CE hours	CE Type DC / CA
2022-01	Sagittal Plane: Spine Subluxaton, Pain, Disability and more	Dr. Deed Harrison	3.5 CE	Pain Mgmt DC
2022-02	Management of Common Infant Con-Conditions	Dr. Jennifer Brocker	3.5 CE	Pediatrics DC
2022-03	Pain, Posture and Performance	Dr. Sherry McAllister	1.5 CE	Pain Mgmt DC / CA
2022-04	Upper Extremity Adjusting	Dr. Mark Charrette	4 CE	Adjustive Tech DC
2022-05	Lower Extremity Adjusting	Dr. Mark Charrette	3 CE	Adjustive Tech DC
2022-06	Case Studies of Spine & Extremities	Dr. Bev Harger	2 CE	Radiology DC
2022-07	Shockwave: New & Innovative Therapy	Dr. Dennis Cozzocrea	1 CE	Pain Mgmt DC / CA
2022-08	Rehab: Isometric Strength Training	Dr. Todd Turnbull	2 CE	Rehab DC / CA
2022-09	Injury Identification and Predictive Factors for Recovery of Motor Vehicle Collisions	Dr. Joe Betz	4 CE	Personal Injury & Case Mgmt DC
2022-10	Diagnosing, Documentation & Determining MVA Case Mgmt	The Gatti Law Firm	1.5 CE	Personal Injury & Case Mgmt DC / CA
2022-11	Immune Fittest	Lynn Toohey, PhD	3.5 CE	Nutrition DC
2022-12	The Vestibular System and its Implications for the Chiropractor	Dr. Laura Swingen	2 CE	Functional Neurol-ogy DC
2022-13	Functional Neuro Treatment of Traumatic Brain Injury (TBI)	Dr. Glen Zielinski	2 CE	Functional Neurol ogy DC
2022-14	Leaky Gut & the MBG Connection	Lynn Toohey, PhD	3.5 CE	Nutrition DC
2022-15	Billing, Coding & Medicare	Dr. Evan Gwilliam	3.5 CE	Billing/Coding DC / CA
2022-16	Your Role as a CA in Creating a Successful Practice	Lori Morgan, Parker Team Teacher	3 CE	Office Procedures CA
2022-17	Proper Scripting and Bringing the WOW to Every Patient Visit	Lori Morgan, Parker Team Teacher	2.5 CE	Office Procedures CA
2022-18	Cultural Competency	Lori Holt, RN-BC	1.5 CE	Cultural Comp DC / CA
2022-19	No Surprises Act 2022	Dr. Mario Fucinari	1 CE	Office Procedures DC/ CA

For the COMPLETE LIST OF ALL available continuing education videos visit our website at

WWW.OCANOW.COM

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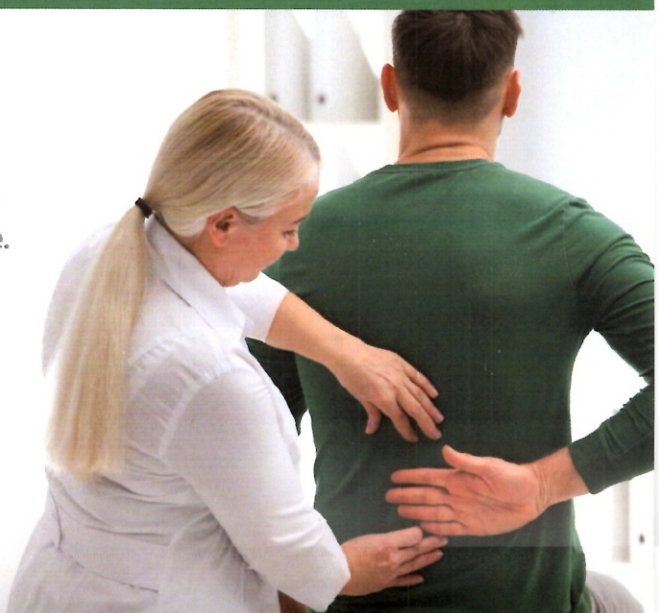

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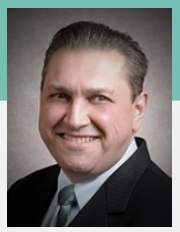


A Date with Box 14
By Mario Fucinari DC, CPCO, CPPM

Medicare audits have resumed as part of the contractor's responsibilities. While it is true that typically they are just "fishing," certain information you send in with your claims may trigger an audit. One of these items is the date in Box 14. Even in conventional insurance, box 14 is still a pertinent piece of information to signal the start of a treatment plan, known as the episode of care.

The claim form is used not only to obtain payment, but carriers and other third parties will use the information on the claim form to gain information about the case through data mining. If used properly, Box 14 of the claim form will give information that will answer questions before they arise. If the information is misused, it will probably lead to denial and a possible audit.

Box 14 of the claim form asks for the date of onset, injury, or date of the last menstrual period (LMP). The LMP is used only for obstetrics. The claim form box 14 also contains a space for a qualifier (Qual). Depending on the carrier, box 14 will usually require the qualifier "431", which indicates the date of onset or injury. **In Medicare, Box 14 indicates the date the patient first began treatment in your office for the diagnosis listed in line A of Box 21.** Since in Medicare the date is neither the date of the onset nor the LMP, you do not use a qualifier.

In all Medicare and commercial insurances (Blue Cross, Aetna, UHC, and so forth), the date in Box 14 should be updated if an exacerbation of the condition occurs. According to Medicare, the definition of an exacerbation is, "an acute exacerbation is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition."

The Comprehensive Error Rate Testing Program (CERT) consistently ranks maintenance care, a non-covered service, as one of the top three errors in Medicare. Blue Cross is looking for maintenance care as an offender as well.

Whether the date is the onset of injury or the date that you first began treating the patient for a certain condition, you can see that if the date has not been updated as indicated, it could trigger an audit. **Especially in Medicare, if the date is over 90 days old, it means that you have been treating the patient for over 90 days for the condition.**

Blue Cross updated its policies to indicate that the "episode of care" should not exceed 90 days unless complicating factors are present to delay the healing process. If complicating factors affect the patient's care, these diagnosis codes should be listed on the claim form. Complicating factors must always be placed as the last diagnostic code listed on the claim form.

The only case where you never want to update or change the date in Box 14 is in a personal injury or worker's compensation case. In these types of cases, the date in Box 14 indicates when the accident occurred. Changing the date while the patient progresses would suggest that another injury has occurred. This will usually trigger a questionnaire to see if there is another source of injury.

Your first line of communication to a carrier is the claim form. Clear communication is one step toward unencumbered reimbursement. The doctor and staff must be aware of information that reviewers are looking for in an audit. Internal monitoring and self-audit of records before they are sent to the carrier will decrease denials, ensure proper reimbursements and decrease recoupment.

Dr. Fucinari is a frequent lecturer for NCMIC, Foot Levelers, and ChiroHealthUSA. Dr. Fucinari is a Medicare and Compliance national speaker. He is a Certified Professional Medical Compliance Specialist and serves on the Carrier Advisory Committee for Medicare. To get in touch with Dr. Fucinari at Doc@Askmario.com

OBCE Candidates/Nominees Needed
Returning to the Statutes (ORS) for Appointments

The OCA wants to get back to the written statutes when it comes to how the appointments to the OBCE are being made. OCA Members step up to this challenge!!!

Per ORS 684.130 State Board of Chiropractic Examiners:

- (2) (a) Board members required to be chiropractors may be selected by the Governor from a list of three to five nominees for each vacancy, submitted by any professional organization representing chiropractors.

- (b) The chiropractor members must have practiced chiropractic in this state for five years prior to appointment.

The OCA leadership feels that WE, as the ONLY professional organization in this state representing chiropractors, feel it is very important that we return to the statutes as stated for these OBCE appointments.

As such, the OCA is forming a list of 3-5 nominees and would like any OCA member interested in serving on the OBCE to reach out to the OCA Office ASAP and let us know. Interested DCs must have been in practice in Oregon for at least five years and will need to submit the formal application online as well. We can help direct you to the online application process. Applicants from all geographic areas and ethnicities are also encouraged. Time is of the essence.

The OBCE board voted on May 23, 2022, to include Basic Life Support (BLS) /Cardiopulmonary Resuscitation (CPR)/Automated External Defibrillator (AED) certification as a part of each licensee/certificate holder's annual renewal requirement, effective immediately. This means that licensees must hold an active certificate of completion when renewing each year. If licensees/ certificate holders do not currently hold this certification, they must obtain one as soon as possible. A breakdown of hours for each license type is available below and changes are highlighted. Like other annual CE, unless audited, licensees/certificate holders will not currently be required to submit proof of certification.

DC first year – 8 hours total (Does not include BLS/CPR/AED as most will already hold certification for education purposes)
Over the counter, non-prescriptive substances – 4 hours
Evidence-based medicine – 2 hours
Cultural Competency – 1 hour
Suicide Intervention Training – 1 hour

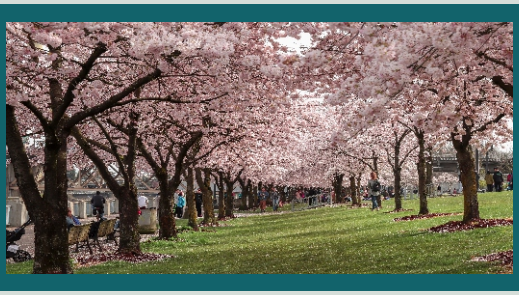
DC second year – 20 hours total
Pain Management Education – 7 hours *please see specifics within CE rule
Cultural Competency – 2 hours
Suicide Intervention Training – 1 hour
General Continuing Education, which must include maintenance of BLS/CPR/AED certification – 10 hours

DC active status – 20 hours total
Cultural Competency – 2 hours
Suicide Intervention Training – 1 hour
General Continuing Education, which must include maintenance of BLS/CPR/AED certification – 17 hours

DC senior active – 6 hours total
Cultural Competency – 1 hour
Suicide Intervention Training – 1 hour
General Continuing Education, which must include maintenance of BLS/CPR/AED certification – 4 hours

CA first year – 6 hours total
Vitals Training – 2 hours
Cultural Competency – 1 hour
General Continuing Education, which must include maintenance of BLS/CPR/AED certification – 3 hours

CA active status – 6 hours total
Cultural Competency – 1 hour
General Continuing Education, which must include maintenance of BLS/CPR/AED certification – 5 hours



Oregon Chiropractic Association 2022 Spring Convention

PHOTO GALLERY

Dr. Arah McLaughlin, Dr. Michael Arnot, And Dr. Amanda Tipton

Frank Woodley, Leanne Burke, Dr. Charlie McGrath Jan Ferrante, and Theresa Rawls

Dr. Steve DeShaw, Dr. Richard Gorman, Dr. Dan Beeson and Dr. Dan Miller

Dr. Michael Underhill-visitsthe Vendors in Exhibit Hall

Dr. Herb Freeman and Jan Ferrante, ED pose for their annual photo

Dr. Teri Pitcairn and her brother Dr. Clark Pitcairn get refreshed

Attendees listening to the speaker

Dr. Les Feinberg & Dr. Michael Arnot are Seated at the head of this class

Dr. Todd Turnbull, OCA President accepts
$1500 check from Von Thompson of Foot Levelers

L to R: Dr. Evan Gwilliam (Pay DC) , Lori Holt, Rn-BC, (NCMIC)
Von Thompson (Foot Levelers), Sheena Ryals (CHUSA) and
Dr. Sherry McAllister (Foundation 4 Chiro Progress)

Dr. Gretchen Blyss of Portland was the grand prize winner of the Vendor Hall Raffle. She won a 2 night stay at the Sheraton Portland Airport.

Scoliosis Treatment: Why Health Professionals Must Treat the Whole Person, Not Just the Spine

By:Rosemary Marchese, Bachelor of Applied Science (Physiotherapy)
Head of Education & Research at ScoliCare

Scoliosis is a condition that affects the whole person, not just the spine. The Cobb angle is an important sign for health professionals to measure in scoliosis, but it is not the only reason to treat scoliosis. Patient care must extend beyond the spine. It must encompass the entire human being.

The focus of health care professionals

Yes, there are structural changes that occur to the spine with relative anterior spinal overgrowth (RASO) regularly cited in the literature. The obvious lateral deviation that comes with scoliosis makes it very easy for health professionals to fixate on the Cobb angle, which is a 2D measurement taken from an X-ray however scoliosis is a 3D condition. There is also a focus on the posterior-anterior view of the X-ray, however health professionals must remember that scoliosis encompasses changes in all three planes, but particularly in the transverse plane because rotation of the spine will exist with scoliosis.

Questioning the traditional approach

Health professionals have a wide variety of training, expertise, and experience when it comes to scoliosis. The more traditional approach in the medical profession has been the 'wait and see' approach, which is waiting to see if the Cobb angle progresses to 50 degrees or more so that surgery can be recommended. This has stemmed from a lack of strong evidence to show that bracing and scoliosis specific exercises are effective in treating scoliosis and also a fixation on the reduction of the Cobb angle being the goal of treatment, but this is rapidly changing. We now have a situation where there is more evidence emerging to support bracing and scoliosis specific exercises.

This support for conservative treatment is not just about changing the Cobb angle. Patients are also seeking conservative treatment options and are frustrated by the 'wait and see' approach (1). We need to recognize that there are many more reasons beyond the Cobb angle to 'treat' the patient with scoliosis.

Why do we treat scoliosis?

A consensus paper by international scoliosis experts gives us some strong insight into why health professionals treat scoliosis and why patients seek treatment (2). These experts in scoliosis assessment and treatment agreed that patients will often need to address many factors beyond the Cobb angle, including but not limited to:

- aesthetics
- pain
- function
- minimizing the need for treatment later in life (2).

Unfortunately, it's easy to become trapped in focussing on the Cobb angle alone. This may have evolved from a medical tendency to 'wait and see' if

the Cobb angle progresses to the point of surgical recommendation. It's not always easy to navigate appropriate recommendations for scoliosis when there is still a large push from some untrained medical professionals to seek inappropriate treatments for patients. It can be easy for these health professionals to also overlook the emotional and mental impacts that scoliosis has.

How is lifestyle affected?

When we look at the impacts of scoliosis on the individual, it's quite clear that these can extend beyond the spine. As health professionals, it's vital that we don't catastrophize scoliosis and also that we are aware of whether or not the patient is catastrophizing the situation. This can easily happen as a result of other influences such as knowing a friend who had a negative treatment outcome. A holistic approach is always necessary. Let's look at a few examples of lifestyle considerations for patients:

- The impact of the postural asymmetry can be significant for teens that are wanting to head to the beach on the weekend or wear a particular outfit.
- Children may be fearful of wearing a brace to school.
- They may be wondering how their sport will be affected.
- The pain that is associated with some cases of scoliosis also needs to be addressed.
- The change in biomechanics of the trunk may be significant for an elite tennis player who is finding that their serve style is changing as the deformity in the trunk changes.

The structural changes caused by scoliosis may affect the way the trunk moves. Think about this in terms of impact on sports, posture and daily activities.

How do the structural changes affect patients' lives?

The asymmetry that results from RASO needs to be addressed in the treatment of scoliosis. For example, the rotating rib cage can affect range of motion of the shoulders. This might not be significant for some people but for others, it can create huge problems. Let's look at a teen tennis player example (you can extrapolate this to many other scenarios). If a tennis player is starting to lose tennis matches because their serve is losing impact but the doctor or other health professional they are seeing is not assessing the impact of the scoliosis posture on the child, this might lead to one very unhappy teenager!

Think about it. This teen turns up to practice for many hours per week. They are used to having a powerful serve and then slowly this starts to change. The coach is trying to help to manage the changing serve stroke but can't work out 'why' the teen just can't produce the right swing anymore. A missed underlying scoliosis or a failure to address biomechanical changes occurring may be the missing piece of the puzzle. This can be incredibly frustrating! Teens are already navigating an often turbulent and challenging period of their lives. Teens with scoliosis may have these challenges compounded.

Mental health and scoliosis

Let's now think about the psychological state of the person with scoliosis. In rare instances, patients realize that they can live totally unaffected by their scoliosis. However, we must always be aware that this isn't always the case. Sometimes the patient doesn't realize that they are affected mentally and emotionally by their scoliosis. Perhaps you can check in with the parents of a teen patient with scoliosis. Has a parent reported to you that their teen daughter stopped wearing jeans because they don't 'fit' properly? Is the patient reluctant to head to the beach because they don't want people to see the uneven rib cage while wearing a pair of swimmers? As isolated instances, these may not be significant, but over time or combined with other challenges such as strained friendships at school or difficulties at work, these issues may compound.

It's important for the person with scoliosis to feel 'heard' by their family members and their scoliosis health professional. Not all health professionals are trained or have the expertise to treat the scoliosis spine and the impacts of the scoliosis on the on the individual. If you are not specifically trained in scoliosis assessment and management then it is important to refer the patient for appropriate assessment.

Can conservative scoliosis treatment help the 'whole person' not just the spine?

A scoliosis brace, such as ScoliBrace®, combined with scoliosis specific exercise that stops a 30-degree curve from progressing during the fast growth period of the adolescent years may also contribute to:

- improved muscle strength
- improved muscle balance
- a more neutral coronal balance
- reduction in pain.

Spread awareness of scoliosis!

Scoliosis Awareness Month in June is an ideal time to spread awareness of scoliosis in the community and amongst your colleagues. If you or someone you know is affected by scoliosis it may be timely to reach out to them to see how they are going. It's also important to recognize that school screening for scoliosis is not occurring in many places around the world. It's important these cases are not missed and that all patients are given the opportunity to have the right treatment at the right time. Early diagnosis, before the structural changes are significant, can increase

the chances of 'success' of conservative treatment options. Remember that spinal fusion surgery has a time and a place, many patients can benefit from early conservative treatment. Scoliosis trained health professionals can work with the patient, and where applicable, the parents, to treat the whole person, not just the spine. Instead of focusing just on the Cobb angle, addressing patient goals and desired outcomes of treatment are imperative to success.

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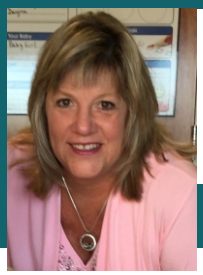


A Message from your Executive Director

We have had a lot happening withing the state association since our last full publication. We have had our 2022 Convention at the Sheraton Portland Airport, we have gotten the On demand videos uploaded to our OCA On Demand library and we have been working hard on getting some important issues and tasks in order.

The OCA Board has assigned BIG ROCKS (tasks) to each Board member and they have been diligently working on these tasks to move our association forward. Here are the board members and their assigned Big Rocks:

Dr. Todd Turnbull:	President & OBCE Liaison	Dr. Les Feinberg:	Board member & Mission-Vision-Values
Dr. Dennis Cozzocrea:	Vice President & Bylaws	Dr. Michael Lell:	Board member & Membership / Social media
Dr. Robert Richards:	Secretary & Membership outreach	Dr. Arah McLaughlin:	Board member & UWS Liaison
Dr. Michael Arnot:	Board member & Insurance Relations	Dr. Amanda Tipton:	Board member & Convention/CE/Events
Dr. Dan Beebe:	Board member & Legislative Chair		

The OCA Board officially adopted our OCA Districts at the May 19, 2022 Board meeting. What this means for us as a state association, is that when issues arise around the state we will be able to call on members to help in those geographic areas. In addition, Dr. Todd Turnbull and I will be coming up with a summer tour around Oregon over several different weekends to bring OCA updates to your areas by hosting lunch & learns. We will be asking our members to bring a non-member with them to these lunches so that they can hear what the OCA is currently doing and also give us valuable information about what they want to see from the state association. We want to also learn what issues each of these 10 Districts are experiencing and how we can help them either legislatively or through insurance reform.

The OCA Convention was once again a success. It was a great in person event to get us back to face to face after two years of the pandemic. We had great speakers, sponsors and fun & games. The vendors that were present at the event are listed in this publication. Please review that list and keep it some where to use as a reference for products and services. By supporting the companies that come to our event you help to support the OCA and make our future events possible. We count on the vendors, affiliates, and other sponsors for our success at the event and through out the year.

I have been inundated at the OCA office with phone calls from DCs and CAs around the state regarding CE requirements for 2022. Lot's of questions are revolving around the OBCE website needing clarification. I reached out to the OBCE to suggest an update to their website that would clear up some of these questions but that was met with ambivalence by a staff person. So I will explain it here for you so that it will hopefully be clear. The OBCE apparently adopted some CE requirements in 2021 that are going forward in 2022 and future years. These specific CE hours include Cultural Competency and Suicide Intervention Training that will NOW be an ANNUAL REQUIREMENT. Thus, it is NOT considered "DC Board-mandated education for the current license year", according to the OBCE staffer. It is now simply part of the annual requirements. So I hope this will clear up the issue for everyone but members can certainly feel free to call me if you are still unsure of what you need for 2022 renewal. I have inserted the current 2022 requirements into another page of this newsletter for your reference.

The OCA is excited to announce that the documentary film "The Aligned Athlete" is being released. We first learned about this movie being created by our own Dr. Rich Gorman of Eugene at our 2020 OCA Convention. At that event both the OCA and the Foundation for Chiropractic Progress (F4CP) stepped up to give some initial support to this movie. The movie debuted at our 2022 OCA Convention and the final step — DVD production is currently in the works. Those of us that saw this film at our OCA convention were touched. The testimonials from world class athletes about how their performance was affected by their chiropractors is very moving. The OCA and the F4CP are named in the credits of this wonderful film and we are excited to have been part of this project. I will forward more information as I receive it on how you can purchase your own copy of this ground breaking movie.

Lastly, I was very touched by the recognition I received at the 2022 Convention for my 20 years of service to this profession as your Executive Director. It has been and continues to be my honor to serve you in this capacity. Thank you to Dr. Bob Richards for spear-heading this award, to my assistant Leanne for sharing her thoughts during the presentation and to Dr. Turnbull, OCA President for presenting this on behalf of the OCA Board.

Stay safe and healthy..... JAN

2022 Convention Vendors Support our Event!

Vendor Name	*Booth*	*Representatives in Booth*	*Phone*	*Product/Service*
The Gatti Law Firm	1	Attorneys at Law	800-289-3443	Legal Services
The Gatti Law Firm	2	Attorneys at Law	800-289-3443	Legal Services
Rayus Radiology	3	Kellie Fine	503-253-1105	Center for Diagnostic Imaging
Biotics Research NW	4	Melanie Figeley, Kristin Tennison & Lisa Hauer	800-636-6913	Nutritional Supplements
Chattanooga/ LightForce Therapy Lasers	5	Rob Hannon & David Hebert	877-627-3858	Laser Equipment
ChiroHealthUSA (CHUSA)	6	Sheena Ryals	888-719-9990	Discount Medical Plan Organization
Foot Levelers	7	Ivon Thompson	800-553-4860	Customized Orthotics
Bridge City Law	8	Jim Dwyer, Attorney	503-274-0404	Legal Services
Pacific Xray Technologies	9	Bob Rants & Andy Manville	253-831-4118	X-Ray Equipment
Standard Process/ Vital Health	10	Julie Shively & Kieren Shivley	503-651-6000	Whole Food Supplements & Herbs
ELvation Medical	11	Joe Lemon & Dennis Cozzocrea	770-295-0049	Therapeutic Equipment / Modality
Ayush Herbs	12	Marze Kasalar	425-637-1400	Ayurvedic Herbs & Vitamins
NutriWest Pacific	13	Dr. Mark Earnhart	800-458-7606	Nutritional Supplements
Magic Hands / Birdhill	14	Steve & Pam O'Dwyer	503-987-1286	Hand Held Percussion Massagers
Advanced Wellness Center	15	Mark Gabriel. Kaitlin Leonard, Dan Kemper & Jody Henrikson	503-389-5545	Regenerative Medicine
Topical Pain Solutions	16	Marilyn Brett	503-381-8920	Pain Relief Patches
Chiro One Wellness Centers	17	Dr. Narmda Kumar	630-415-6030	Job opportunities, job shadow and preceptorships.
NCMIC	18	Lori Holt, RN-BC	800-321-7015	Malpractice Ins & Financial Services
Univ of Western States (UWS)	19	Pat Browne & Dr. Virginia Jones	800-641-5641	Alumni Services & Internships
NW Functional Neurology AND Framework Functional Psychiatry & TMS	20A 20B	Dr. Glen Zielinski Shauna Hahn, MS, PMHNP	503-850-4526 503-228-7134	Functional Neuro Services AND Mental Health Services
DeShaw Trial Lawyers	21	Dr. Aaron DeShaw, Esq.	503-227-1233	Legal Services & Books
Multi Radiance	22	Janelle Beery	440-542-0761	Pulsed Laser Devices
Wellsong Energetics	23	Jeff and Sue Whittaker	503-851-7927	Broad Spectrum DeTOX
Myovision	24	Paul Adams	800-969-6961	Diagnostic Equipment
Foundation 4 Chiropractic Progress	28	Dr. Sherry McAllister	866-901-3427	Positive Chiropractic Research & PR
Doctor's Data, Inc.	29	Geneva Olson	630-377-8139	Functional Medicine Laboratory Services
CBP Seminars	30/A	Dr. Deed Harrison	208-939-0301	Chiropractic Bio-Physics Seminars
PayDC	30/B	Dr. Evan Gwilliam	888-306-1257	Cloud Based EHR

Oregon Legislative Update

By Vern Saboe Jr., DC, DACAN, FICC, DABFP, DACO
OCA Lobbyist, ACA Delegate for Oregon

Non-Discrimination in Commercial Health Insurance. As you may recall the OCA passed **House Bill 2468** during the **2015** Oregon legislative session, the first of only two states to achieve this. Ourbill inserted the federal non-discrimination provisions in the federal law Obamacare (PPACA) known as Section 2706a. Trouble is, the insurers and health plans have been disregarding the law and the OCA has been battling to gain proper enforcement since 2014. In **2021** the OCA introduced **House Bill 2328** in hopes of gaining relief from discrimination against the chiropractic profession as it pertains to reimbursement. During hearings on our bill, the insurer and health plan representatives testified that our bill was inappropriate because formal regulations were going to be written by the federal departments of **Health and Human Services** (HHS), **Treasury**, and **Labor**, regarding the details of Section 2706a. However on January 19, 2022, these federal departments held a **"listening session"** regarding provider nondiscrimination under section 2706a..." During this listening session insurer representatives predictably suggested in part, 1. there was no problem back at the state level and 2. they should be able to play fast and loose with reimbursement amounts using their discretion regarding different provider types providing the same covered service. These federal regulations will likely be drafted and presented for public comment in roughly six months. As a consequence, the OCA will again be introducing a reimbursement bill during the long 2023 long legislative session, we simply will not rely on the coming federal regulations being written properly reflecting the original congressional intent.

Oregon Workers' Compensation. The OCA will be working on expanding chiropractic management of Oregon injured workers with the goal of returning Doctor of Chiropractic back to full attending physician status for the life of a workers' compensation claim. We will also address the continued unlawful coercing and forcing by some employers for injured workers to treat with a particular clinic e.g., local occupational medical clinic or urgent care clinic. This with the employer never providing **Form 801** nor informing the injured worker they choose their healthcare provider, and their employer cannot force the worker to treat with a certain healthcare provider or clinic (choose for them).

Auto PIP Insurers. With the goal of revealing to the auto insurers that closed panel managed care is both unnecessary and counterproductive, the OCA has been meeting with auto PIP insurers describing all that the chiropractic profession has accomplished to improve the quality of chiropractic care in Oregon. We are attempting to schedule Zoom online meetings with auto PIP insurers, their claim managers and claims representatives, reviewing the quality improvement steps the profession has taken over the years. For example, The OBCE **Oregon Chiropractic Practice and Utilization Guidelines** (OCPUG) with the most recent update occurring in 2016, containing an especially important treatment algorithm. This algorithm formerly adopted by the OBCE and the OCA requires treating chiropractic physicians to re-assess their patients under curative care every 12th visit or six weeks, whichever comes first. **Clinical Justification Administrative Rule**, first presented to the OBCE by the OCA in 2005, permanently adopted in 2008, instructs DCs they must provide evidence-based outcomes management of their curative care patients to validate a progression of care (improvement). The rule requires we provide both provider driven outcomes, our examination findings, as well as patient driven outcomes to

validate our treatment is, has been, and continues to be necessary. Patient driven outcomes being self-reported measures of their current pain and activity intolerances (disability). We will also discuss with the auto insurers the **OCA Code of Ethics and Policy Statements** wherein we discuss several issues; advertising, massage therapy, cash vs. insurance pricing, passive vs. active treatment interventions, and concussions. The OCA will present these documents and their rational to the auto insurers with a roundtable discussion with Q &A. The goal, to convince the auto insurers that moving to a closed panel managed care organizations system would be both unnecessary and inappropriate.

Medicare Chiropractic Modernization Bill. This congressional session the American Chiropractic Association has garnered huge bipartisan support for our federal Medicare bills with 138 congressmen and congresswomen co-sponsoring our House version **H.R. 2654**. These 138 co-sponsors are almost split down the middle half being Democratic members and half Republican. This is the most co-sponsors the ACA has ever obtained for any bill in the association's history and very encouraging. Recently we introduced a Senate version of our bill **S. 4042** and we are actively gathering co-sponsors for that bill as well. This federal legislation is not simply about Medicare, but since it redefines us in federal law as physicians and as such, when passed will allow chiropractic physicians to participate in many other federal programs such as, **Federal Workers Compensation, Federal Motor Carrier Safety Regulations, Civilian Health & Medical Program of the Uniformed Services** (CHAMPUS)**, Indian Health Care, Federal Railroad Administration, Department of Transportation, Family & Medical Leave Act, quality improvement organizations, and private insurance adopting Medicare policies.**

ChiroPAC. The OCA has made it easier to give to our "Political Action Committee" (PAC) with a button on the OCA webpage under "Legislative," so you can give electronically either a one time donation or monthly, quarterly donations, whatever you choose, here is the link https://ocanow.com/chiropac/ We have just over 200 doctors giving to ChiroPAC but we really need as many "hands on deck" as possible since campaign fundraisers for returning legislators and new candidates good on our chiropractic issues will be in full swing this summer leading up to the November general election. These donations are critical for us to be a force in Salem, allowing us to support key members of the Oregon Legislature that are ardent supporters of chiropractic. The money that comes in every month allows us to be present at key fundraiser events showing our support and allowing me to speak to our issues. Additionally, I continue to schedule many one-on-one meetings around the state with a check in my hand for that key legislator. These one-on-one meetings allow me time to really get into the details this or that legislative bill we are pushing makes evidence-based sense. This "interim" time between legislative sessions is so extremely critical, it is the time when legislators have the time to truly listen to our issues and facts. I have already had several such meetings around the state and many more scheduled through the summer, so, please consider donating to our ChiroPAC today.

Gross inspection demonstrated multiple, white firm to hard rounded fragments with smooth edges aggregating to 3.7 cm x 2.8 cm x 1.0 cm. The largest fragment represented 3 ossific nuclei wrapped in 1 large chondral shell. These pathologic findings are consistent with chondroosseous loose bodies. The final diagnosis was primary synovial chondromatosis also known as Reichel syndrome.

Discussion:
Primary synovial chondromatosis is a benign condition that arises from the articular synovial membrane, synovial sheaths, or periarticular bursae. Cartilaginous bodies are formed within the synovium and subsynovial connective tissues. There are three phases of this disease process: metaplasia of synovium with active synovitis and absence of loose bodies (Phase 1), active synovitis with formation of cartilaginous loose bodies (Phase 2), and loose bodies that then calcify and synovitis subsides (Phase 3).

Though there are reports of occurrence in childhood, primary synovial chondromatosis most commonly occurs between the third to fifth decade of life. Large joints are the most involved with the knee being the most common joint affected.

The initial diagnosis is made through a thorough history and physical examination and radiological evaluation of the affected joint. The typical chief complaint is pain and swelling of the joint. Occasionally, the patient will experience locking or catching in the joint as seen with this case. Radiologic findings are frequently pathognomonic revealing multiple intraarticular calcifications within a synovial joint without underlying joint pathology. MRI, if needed, can help differentiate and diagnose bursal extension of the disease process.

The management consideration for primary synovial chondromatosis is centered on joint preservation by removal of the osseous lesions.surgical intervention typically involves surgery to remove the loose bodies of cartilage. In some cases, the synovium is also partially or fully removed (synovectomy). Surgery can be done either through an open procedure or an arthroscopic procedure depending upon the size and locations of the lesions. Indications for surgical intervention include: 1) The number of loose bodies 2) The size of the loose bodies and 3) The condition of the synovium. Removal of loose bodies with partial synovectomy results in decreased pain, improved mechanical function, and decreased swelling in most cases. Open procedures have similar results, but surgical morbidity is greater. Post-operative management includes a progressive range of motion and strengthening of peri-articular muscle groups.

Primary synovial chondromatosis if left untreated it can severely damage the articular surfaces of the affected joint and eventually, lead to early osteoarthritis. Early recognition and treatment are important for pain relief and to maintain the articular surfaces of the joint.

About the Authors and References: See next page.

A Rare Cause of Chronic Knee Pain in a Child: Primary Synovial Chondromatosis

A Rare Cause of Chronic Knee Pain in a Child: Primary Synovial Chondromatosis

Key Clinical Points

Knee pain is a common musculoskeletal complaint in children.
The evaluation requires a thorough history and examination. The characteristics of the pain, onset, location, duration, severity, and radiation need to be identified.

Radiography is the initial imaging modality for assessing knee pain.

Introduction

Knee pain accounts for more than a third of the musculoskeletal complaints amongst the pediatric population. In addition to a thorough history and examination, plain radiography offers a fast, inexpensive, and readily accessible imaging modality. Knee x-ray studies are indicated when a child presents with persistent knee symptoms without explanation. A rare cause of pediatric knee pain is presented in this case study.

Case Report

A normal appearing, healthy 10-year-old female presented with chronic left knee pain. Her gait was normal, with occasional locking in the left knee with minimal knee effusion. The knee range of motion was full bilaterally., Lachman, pivot shift and anterior drawer orthopedic tests were negative. The patellar examination demonstrated negative apprehension and patella grind tests. The hips had full passive pain free ranges-of-motion in all planes.

Chronicity of pain is an indication for imaging. Radiographic examination of the left knee revealed multiple osteochondral loose bodies of similar size distributed throughout the knee joint and one large body located posterolaterally **(See Images 1 and 2)**. Radiographic comparative examinations of the right knee and bilateral ankles were unremarkable.

The patient underwent arthroscopic surgical intervention to remove the fragments. The largest loose body in the posterolateral compartment was removed through a posteromedial incision.

Image 1. *AP Knee. Multiple intraarticular calcifications clustered around the knee joint. The loose bodies are of similar size except for one larger body superimposed over the lateral condyle of the distal femur.*

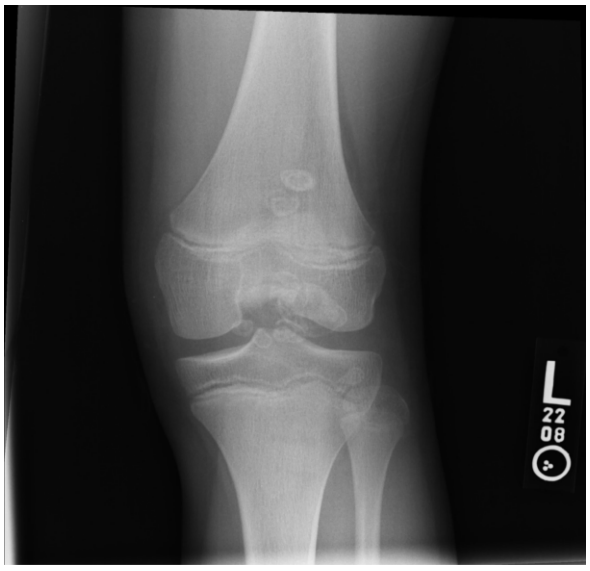
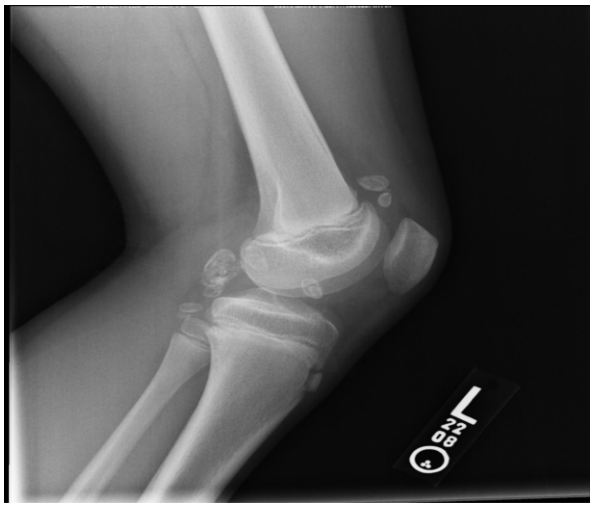


Image 2. *Lateral knee. Multiple intraarticular calcifications clustered around the knee joint. The loose bodies are of similar size except for one larger*



About the Authors

Dr. Beverly Harger is the Director of Diagnostic Imaging at the University of Western States and a diplomate of the American Chiropractic Board of Radiology with over 33 years of clinical experience.

Heather Portus is a Quarter 11 student at the University of Western States Doctor of Chiropractic program. She is currently working with Drs. Moreau and Harger as a clinical intern and plans to pursue a specialty in diagnostic imaging

Dr. Bill Moreau is the Chief Medical Officer of University of Western States with 40 years of clinical experience with an emphasis in sports chiropractic. He oversees clinical operations and patient care at UWS. During his tenure at USOC, Dr. Moreau served as the Team USA chief medical officer during the Rio 2016 Summer Olympic Games, and the PyeongChang 2018 Winter Olympic Games as well as serving as the medical director for the London 2012 Summer Olympic Games and the Sochi 2014 Winter Olympic Games. .

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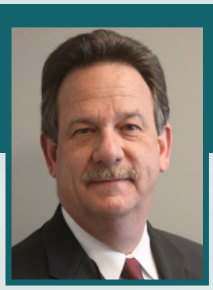
Is Helping Your Patients Putting You at Risk?

Article by: Dr. Ray Foxworth



Over the past decade, we have seen health care costs rising faster than the average annual income in the U.S. Many of our patients are feeling the pain from higher premiums, deductibles, and copays. As a patient, I understand the pain. As a provider, I feel the increased burden of rising costs in my practice and diminishing reimbursements. When facing similar challenges, some doctors try to justify not charging for some services in their practices. I hear it all the time, "Well, I do XYZ for free. But, it's okay because I don't charge my patients or the insurance company." That sounds good in theory, but the reality is that giving away any service for free can be risky.

Although, as business owners, we all feel that we should be able to operate our businesses as we see fit, the truth is that we can't always do what we want, especially in health care. The business of health care is the second most regulated industry in the U.S. If we choose to participate with third-party payors, then we are held to the obligations outlined in our contracts, many of which include a clause stating we will not charge the insurance company more than we charge a private-pay patient. Additionally, when it comes to Medicare and other federally funded programs, the rules must be followed explicitly. For example, if your actual exam fee is $100, and you run a promotion that gives the exam away for $29, you could be faced with penalties from Medicare for offering an "inducement." Per Medicare regulations, you are not allowed to give away anything of value over $15 or you could be accused of inducing a patient to use your office or your services over another provider, and the charge could be considered less than fair market value, which is also part of the inducement prohibition.

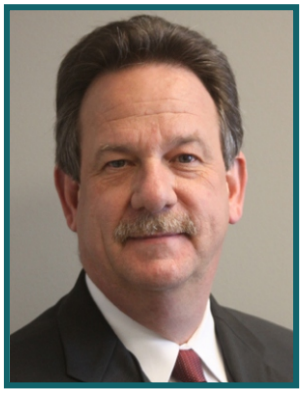
In March of 2018, one of our colleagues in Iowa, agreed to pay nearly $80,000 for violating the False Claims Act. He is alleged to have violated the False Claims Act by improperly billing Medicare and Medicaid for chiropractic adjustments after providing free electrical stimulation to influence those people to receive chiropractic adjustments. The investigation lasted over 18 months, and in the end, the doctor agreed to the settlement due to rising costs of legal fees and the reasonable settlement offer.

In July 2016, two primary auto insurance payers filed suit in Federal Court against a chiropractor alleging fraud. What sets this apart from other cases is that the payers appear to be claiming that the doctor was charging lower fees to cash-paying patients, advertising-free consultations, and free massages, just to name a few. The National Association of Chiropractic Attorneys' member, Larry Laurent, has said, "You cannot charge one fee for insurance cases (e.g., PI) and a lower fee to cash patients – despite the obvious fact that your cash patients require lower overhead."

We know there is a wealth of inaccurate information disseminated within our profession. I'm sad to say that I must agree with my frustrated colleagues when they vent about all the conflicting advice they receive. That's why ChiroHealthUSA has relationships with many compliance specialists, to help get accurate, reliable information out to the profession.

Being a part of ChiroHealthUSA is not the one-stop solution to being compliant in practice, but simply a piece in a larger puzzle. It is important that every person working in your practice understands the rules and regulations, and understands why you chose to participate in ChiroHealthUSA. We have providers who believe that their practices are utilizing ChiroHealthUSA only to find out months, and even years, later that their staff is not utilizing it correctly or even offering it at all. One ChiroHealthUSA-participating practice discovered that hundreds of federally insured patients were being offered discounts outside of ChiroHealthUSA on non-covered services, after conducting an internal audit. What kind of disaster might that have been in the event of a Medicare audit?

You simply need to read the headlines, posts, and tweets, about providers across the healthcare profession being audited, fined, and some even convicted, to see that the costs of non-compliance are real. We tell ourselves, “It won’t happen to me.” The reality is that it easily could. Your license is your livelihood. Your families, employees, and patients, are depending on you do the right thing, in the right way, by following the rules and regulations. Helping patients shouldn’t put your practice at risk. We encourage you and your team to take the **Discount Challenge**. Test your knowledge and have some fun. **Every correct answer gets you one entry (up to 10 entries) for a chance to win $15,024!**



Dr. Ray Foxworth, DC, FICC, isand CEOChiroHealthUSA. For over 35 years, he worked "in the trenches" facing challenges with billing, coding, documentation, and compliance, inpractice. Hea former Medical Compliance Specialist andcurrently serves as chairman of The, an at-large board member of the Chiropractic Future Strategic Plan Committee, a boardof the Cleveland College Foundation, andexecutiveboard member of the Foundation for Chiropractic Progress. He is a former Staff Chiropractor at the G.V. Sonny Montgomery VA Medical Center and past chairman Mississippi Department of Health.

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Billing and Documenting for Therapeutic Exercises vs. Therapeutic Activities

Chiropractors treat, among other things, issues with the musculoskeletal system. Active therapeutic procedures are accepted as effective ways to treat many common conditions and therefore can be billed and generate revenue for a clinic. Two common CPT codes that might be used in a chiropractic setting include:

- 97110 - Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
- 97530 - Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

Though Medicare does not reimburse chiropractors for either of these codes, their policies are the gold standard for private payers. They tell us that, "Therapeutic procedures are procedures that attempt to reduce impairments and restore function through the application of clinical skills and/or services." So, first and foremost, in order for either of these services to be justified, there must be some sort of functional loss and the service must provide functional gains, requiring the skills of someone who knows what they are doing.

There are several other things that these codes have **in common:**

- Codes in the Physical Medicine and Rehabilitation section of the CPT code book are not limited to any particular specialty group. That is, they are not just for physical therapists.
- These codes require one-on-one contact, usually with a licensed provider, but some state scope of practice and some payers allow for delegation to unlicensed individuals. Check with your insurance plans and state board to be sure.
- These codes are time-based, in 15-minute increments.
  Per the Medicare 8-minute rule, which is the accepted standard for most carriers, a minimum of 8 minutes must be completed to bill for the first unit. Less than 8 minutes is not billable.
  To bill for two units of either of these codes (or both of them at the same encounter), the total time must be at least 23 minutes (8 + 15).
- Some payers require modifier GP to be added to this code on the claim form. This tells the payer that there is a therapy plan in place for the code. If your records are reviewed, and you used the GP modifier, make sure you clearly have a plan around the service and it was not just arbitrarily added to an encounter with no clear purpose.
- Therapeutic procedures are often billed as part of an ongoing series of encounters. It is essential to periodically document progress. It might be wise to tie a goal to each procedure and comment on the progress of that goal as it relates to the service billed, every 2-3 visits, and in greater depth at a re-exam or discharge exam.
- The specific exercise or activity needs to be documented. Think of the record as a script for a play. If it contains enough information to re-enact the encounter, then it is sufficient. Otherwise, it may be lacking.
- Each service must include documented functional progress at reassessment and discharge. If no progress, the reason for lack of progress documented and/or alternative treatment strategy.

Though Medicare does not pay chiropractors for 97110, we can learn from their policies. LCD L35036 tells us that:

"Therapeutic exercise is designed to develop strength and endurance, range of motion, and flexibility and may include: active, active-assisted or passive (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening) exercises. The exercise may be medically reasonable and necessary for a loss

or restriction of joint motion, strength, functional capacity or mobility that has resulted from a specific disease or injury. It is considered medically reasonable and necessary if an exercise is taught to a patient and performed by a skilled therapist for the purpose of restoring functional strength, range of motion, endurance training, and flexibility. Documentation must show objective loss of joint motion, strength or mobility (e.g., degrees of motion, strength grades, levels of assistance). This therapeutic procedure is measured in 15-minute units with therapy sessions frequently consisting of several units.

Many therapeutic exercises may require the unique skills of a therapist to evaluate the patient's abilities, design the program, and instruct the patient or caregiver in safe completion of the special technique. However, after the teaching has been successfully completed, repetition of the exercise, and monitoring for the completion of the task, in the absence of additional skilled care, is non-covered."

The takeaway is that if the documentation shows that the patient has a loss of strength, range of motion, endurance, or flexibility, then 97110 can be justified. However, the goals for exercise should clearly document improvement in those same parameters.

If we look at CMS policies (see LCD L35036) around **97530** we learn that:

> "This procedure involves using functional activities (e.g., bending, lifting, carrying, reaching, catching and overhead activities) to improve functional performance.
> The activities are usually directed at a loss or restriction of mobility, strength, balance or coordination. They require the professional skills of a qualified professional and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active treatment plan and directed at a specific outcome."

For **97530**, the record needs to document some sort of loss of the ability to perform activities and explain how the procedure restores that loss. The activity description would often include a verb ending in "ing". The patient's condition should be such that he/she is unable to perform therapeutic activities except under the direct supervision of a physician or physical therapist. Related diagnoses might include:

- Loss of strength (M62.81)
- Loss of balance (R27.0)
- Loss of coordination (R27.8)

97110 focuses on one parameter, such as strength. 97530 takes things to the next level and focuses on some activity that may be dependent on multiple parameters in addition to strength. For example, shoulder strengthening exercises might be billed as 97110, for the but tossing a ball against a trampoline and catching it would be 97530.

In a clinical setting, a patient may begin care with stretches to improve ROM (billed as 97110). After four weeks of stretches, and the goals are reached, perhaps care starts to focus on strengthening exercises due to findings of weakness in the initial exam. This would also be billed as 97110. Once the strength goals are reached (maybe after another four weeks), the new procedure could focus more on the dynamic activity of lifting boxes, which would then be billed as 97530.

When deciding which code is more appropriate, make sure the documentation includes objective findings that line up with the code description, and goals that focus on the parameters that are outlined by the code and the guidelines above.

Dr. Evan Gwilliam is a certified coder, auditor, and compliance officer. He trains clinicians on how to create rock solid records with PayDC, which is a dynamic cloud based EHR software. If you would like to learn more, email him at evang@paydc.com.

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Tech Neck and the Upper Extremity

By Brian Jensen, DC

As the use of personal electronic devices continues to entrench itself into our society, we are beginning to see connections between the posture created by staring downward at a screen and associated physical problems in the upper extremities and spine. Neck, shoulder, and upper thoracic spine issues seem to present themselves together on a more consistent basis with the ever-increasing use of handheld devices.

According to data from DataReportal, the average American spends 7 hours and 4 minutes looking at a screen every day1. Another study by the University of California-San Francisco found that US adolescents' screen time doubled during the pandemic. Researchers found that 12 to 13-year-old children in the United States doubled their non-school-related screen time to 7.7 hours in May 2020, compared to just 3.8 hours the day before the pandemic2.

Does tech neck affect the neck, upper back, shoulders, and arms? A study looking at the association between forward head, rounded shoulders and thoracic kyphosis concludes that these can exist alone or in any combination3. Quantifying posture with an App like PostureScreen® and scanning the feet with a 3D laser technology Kiosk gives an accurate assessment of where the patient's posture is weak and if the feet are a contributing factor to that posture.

According to Kendall et al,5 there should be vertical alignment between the midline of the shoulder and the mastoid process. If the acromion processes are more anteriorly positioned compared with the mastoid processes, a condition known as forward shoulder posture (FSP) or rounded shoulders or protracted shoulders6,7; this condition is characterized by protracted, internally rotated, anteriorly tilted, elevated, and abducted scapula along with winging of scapula.7,8,9 This poor alignment of the shoulders leads to greater torque production by gravitational forces, which is being offset by greater internal forces generated by muscles and other soft tissues around the shoulder.
These imbalances create stress at the cellular level resulting in the pain-producing inflammation which we see every day. The persistence of the inflammatory reaction creates the potential for injury and degeneration.

The origins of tech neck

As chiropractors, we know that posture is developed by repetition. Neural networks that affect posture and movement patterns are developed by what we practice the most. If you sit slumped over a computer screen eight hours a day, that is the posture pattern that will be created. Those patterns are significantly affected by bilateral, asymmetrical pronation patterns of the feet which feet sensory input into the cortex with every step and with every moment of standing.

In addition to the physical stress created by the tech neck posture, spending more time on screens has mental health effects, including more depression and anxiety, said Jason Nagata, MD, lead author on the JAMA Pediatrics study and UCSF assistant professor of pediatrics. "As screen time increased, so did adolescents' worry and stress, while their coping abilities declined," Nagata said.

The presence of anxiety and worry are components of an over-aroused sympathetic nervous system that also contributes to inhibited postural tone. This forward head posture has been shown to create significant stress on our ability to process sensory information.

According to the study by Ibrahim M. Moustafa, Ahmed Youssef, Amal Ahbouch, May Tamim and Deed E. Harrison, "Is forward head posture relevant to autonomic nervous system function and cervical sensorimotor control?" cross sectional study[4], it was concluded that forward head posture negatively affects cervical sensorimotor control, it negatively affects the autonomic nervous system, and that there is a strong correlation between the Cervical Vertebral Angle and cervical sensorimotor outcomes. Forward head posture, which is commonly the result of our chronic, persistent use of electronic devices, negatively affects our ability to efficiently process sensory input which produces optimal movement patterns and posture.

This is such an important point; the body is not capable of good posture and efficient functional movement if the sensory input telling the muscles when and how to contract is compromised neurologically. This process is also deeply rooted in the feet with the asymmetrical pronation pattern that is typically seen. This foundational pattern elicits a nociceptive reflex that inhibits postural tone. The presence of a neurologically compromised pedal foundation along with the habitual cervico-thoracic flexion posture creates the perfect storm for developing neck pain, upper back pain, rotator cuff syndrome and radiating symptoms into the arm and hands.

Chiropractors are uniquely skilled to treat tech neck

As chiropractors, we have a significant number of tools available to us to address the various components of this potential pain syndrome, but it is important to be sure to address all the major contributors. Only addressing pain with chiropractic adjustments and modalities misses many of long-standing causes of dysfunction and pain.

Successful resolution of the upper extremity/rotator cuff syndrome often includes a multifaceted approach. This approach often includes a strategy that addresses the effect that feet have on posture with custom, 3-arch flexible orthotics. Spinal and extremity adjusting paired with therapeutic exercise to re-engage muscles of posture is effective in creating new patterns of movement. The use of a cervical pillow to support the lordotic curve during sleep is also beneficial. Cervical decompression and cervical extension-traction exercise is also helpful in creating new postural patterns. While there are many things we can do in our practice, behavior modifications must also be implemented. Creating a more ergonomic workspace with a standing desk may be helpful. Being mindful to hold the phone or tablet at eye level while reading or texting will break the cycle of looking down in flexion.

As we continue down the path of increasing technology use, we must create new habits and patterns to counteract the negative effects of tech neck.

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