ATHEROSCLEROSIS
SUBLUXATION
MEDICARE

All DCs are required to document the same way

Modic Classifications
Childhood Concussion
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ACA Annual Meeting Notice

There will be an annual meeting of the ACA House of Delegates on Friday, Feb. 27 and Saturday, Feb. 28, 2015 at the Hyatt Regency Washington in D.C.

Proposed amendments to the ACA bylaws must be submitted to the ACA Corporate Secretary at least sixty (60) days prior to the meeting. ACA bylaws in odd numbered calendar years may be amended by a two-thirds (2/3) vote of the House of Delegates, only after the proposed amendment is designated as “emergency” by a majority of the House of Delegates (Article XII, Section A). Deadline for receipt of proposed amendments to bylaws is Dec. 29, 2014.

Proposed resolutions must be sent to the ACA Corporate Secretary at least forty-five (45) days prior to the meeting (ACA Standing Rules, Article 9, Section C(7)(a)(iv)). Deadline for receipt of proposed resolutions is Jan. 13, 2015.

All officers of the ACA, the board of governors, the executive officers, department heads, ACA specialty councils and ACA committee chairmen must file written reports of the year’s activities. The reports must be submitted to the ACA corporate secretary at least forty-five (45) days prior to the opening of the annual meeting. (Article VIII, Section C(2)). Deadline for receipt of reports is Jan. 13, 2015.

Please email all proposed resolutions in Word format to the corporate secretary at CorporateSecretary@acatoday.org. For a bylaw or resolution template, please email Janet Ridgely at jridgely@acatoday.org.

ACA ANNUAL AWARDS

Submit Nominations for ACA Chiropractor, Humanitarian, Delegate, Alternate Delegate, Flynn-Lynch, Academic and Research of the Year Awards.

The following awards will be presented at the ACA 2015 annual House of Delegates meeting:

- Chiropractor of the Year
- Humanitarian of the Year
- Delegate of the Year
- Alternate Delegate of the Year
- Flynn-Lynch Memorial Award
- George B. McClelland - Researcher of the Year
- Academic of the Year

Nominations—which must include the name of the nominee, a brief essay on why he or she should be considered for the specific award and the nominee’s CV—must be sent to the ACA secretary at least forty-five (45) days prior to the annual business meeting or by Jan. 13, 2015. All nominations should be sent to the ACA Corporate Secretary at CorporateSecretary@acatoday.org.

James G. Potter
ACA Corporate Secretary

Dr. Scott Haldeman to Give Keynote Address at NCLC

SCOTT HALDEMAN, DC, MD, PHD, a respected author and expert in evidence-based medicine whose work has helped to advance the understanding and treatment of spinal disorders, will give the keynote address during the inaugural McAndrews Leadership Lecture at ACA’s National Chiropractic Leadership Conference (NCLC), Feb. 25-28, 2015, in Washington, D.C.

NCLC is the premier national conference for doctors of chiropractic, chiropractic assistants and chiropractic doctoral students. The event prepares chiropractic’s leaders — current and future — for success by exposing them to professional briefings, cutting-edge educational programs and opportunities to meet with elected officials.

Dr. Haldeman’s presentation will focus on the historical challenges of chiropractic clinical practice and how current movements such as evidence-based practice and value-based payment models will influence how and where doctors of chiropractic practice and their role in the continuum of care.

“We are honored to welcome Dr. Scott Haldeman to NCLC 2015. His work provides invaluable insight into the future of health care practice and how the chiropractic profession can continue to adapt and thrive for the benefit of our patients.”

— ACA President Anthony W. Hamm, DC

“We are honored to welcome Dr. Scott Haldeman to NCLC 2015,” said ACA President Anthony W. Hamm, DC. “His work provides invaluable insight into the future of health care practice and how the chiropractic profession can continue to adapt and thrive for the benefit of our patients.”

Dr. Haldeman is well-known for his published works on the management and economics of spinal disorders. He is an authority on evidence-based medicine and guidelines development. He served on the federal government’s AHCPR Clinical Guidelines Committee on Acute Low Back Problems in Adults and on the Bone and Joint Decade 2000 to 2010 Task Force on Neck Pain and Its Associated Disorders. A graduate of Palmer College of Chiropractic and the University of British Columbia medical school, Dr. Haldeman also holds a PhD in neurophysiology. He currently serves as an associate professor of neurology at the University of California at Irvine.
Chiropractic Added to Joint Commission Standard on Pain Management

By Lori A. Burkhart

DEPARTMENT OF INTEGRATIVE MEDICINE

THE CHIROPRACTIC PROFESSION GOT OFF TO A GREAT START in 2015 as the Joint Commission revised its pain management standard to include chiropractic services. Clinical experts in pain management who provide input into the commission’s standards affirmed that treatment strategies may consider both pharmacologic and nonpharmacologic approaches. Previously nonpharmacologic approaches were not included. Services provided by doctors of chiropractic (who were recognized in 2009 as physicians by the commission) and acupuncture are now included in the standard of care for pain management, effective January 2015.

The new standard also advises organizations, when considering the use of medications to treat pain, to weigh the benefits to the patient, as well as the potential risks of dependency, addiction and abuse of opioids. The change allows the chiropractic profession to help more patients who might not previously have been informed by their health care system or doctor of non-drug approaches to pain management.

Cultural Shift

The news of this guideline change reached ACA via Karen Erickson, DC, FACC, who sits on the board of trustees at New York College of Chiropractic. She is an ACA media spokesperson and owns a practice in New York City. Dr. Erickson previously worked with the two non-chiropractors responsible for the guideline change.

Having chiropractic mentioned in guidelines that apply to every hospital and most major outpatient centers in the United States is of great consequence, even though guidelines are not a mandate. “What’s important is that it changes the culture of health care,” Dr. Erickson notes. “It’s like redrawing a map; the new map’s contours now have two categories for pain management – there is the pharmacologic category and the nonpharmacologic category,” she says. In essence, a new paradigm has been created, where providers will become educated about nonpharmacologic approaches to consider, including chiropractic and acupuncture.

“It’s also significant from a cultural point of view that the commission uses the words ‘chiropractic’ and ‘osteopathy’ and didn’t use ‘manipulation,’” Dr. Erickson points out. “It’s of cultural significance, because there has been a tendency even in excellent chiropractic research literature to use the word ‘manipulation.’” She says using chiropractic “puts us on the map and correctly identifies our profession.”

Hospital Credentialing

Dr. Erickson makes clear that this win for chiropractic at the Joint Commission was accomplished by Arya Nielsen, PhD, director of the Acupuncture Fellowship for Inpatient Care, Mount Sinai Beth Israel Department of Integrative Medicine, with support from Ben Kligler, vice chair of the department of integrative medicine at Mount Sinai Beth Israel.

Dr. Erickson’s role at the Beth Israel Medical Center from 2001 to 2004, tells a lot about the early history of chiropractic and integrative health care. She was the first clinician hired at the Continuum Center for Health and Healing, part of the Beth Israel Medical Center, in New York City (since bought by Mount Sinai so its name has changed), which is the largest integrative health center in the United States. Her practice at the center was the largest.

When the executive director, Woodson Merrell, MD, author of The Detox Prescription and chairman of the Department of Integrative Medicine at Beth Israel Medical Center, invited her to join the Continuum Center, Dr. Erickson became the first chiropractic physician credentialed at a major teaching hospital in the United States. At the time, there were no credentialing guidelines for a DC.

The Continuum Center is an outpatient center located off the Beth Israel campus, and it has department status at the hospital. Beth Israel needed to create credentialing guidelines for DCs. Initially an outside consultant worked with the credentialing committee and Dr. Merrell to negotiate guidelines; Dr. Erickson found them unacceptable.

These proposed guidelines said a DC could practice at the Continuum Center, but patients would be required to obtain a letter from their MDs saying there were no contraindications to chiropractic care. “I thought that was outrageous, regressive, insulting and patronizing on every level,” says Dr. Erickson. “In one fell swoop, they had wiped out 30 years of work done to gain parity by the chiropractic profession.”

Dr. Erickson believes the chiropractic profession owes a debt of gratitude to Dr. Merrell for what he did next. He reconvened the committee and had her negotiate the credentialing guidelines. The credentialing committee is made up of every department head at the hospital. The re-negotiated guidelines allow DCs to practice within their scope in New York State. “Dr. Merrell truly understands the importance of having chiropractic physicians practicing at a major teaching hospital like Beth Israel,” Dr. Erickson says.

Great value came from her opportunity to teach during grand rounds held every week within the center. “All physicians collaborated. I learned a lot about medicine and how MDs clinically think about and treat conditions; I also had the opportunity to educate medical
On the surface, it might appear that there is not much in common among atherosclerosis, subluxation and Medicare; however, the opposite is true.
Atherosclerosis originated in the early 1900s, which is the same period when doctors of chiropractic (DCs) began to embrace the word “subluxation.” It is important to note that the word did not originate in the chiropractic profession. Subluxation had been around since the late 1600s; the chiropractic profession embraced the word because it seemed to fit the condition/dysfunction being treated with the adjustment.

An examination of the history of atherosclerosis shows how our understanding of the disease has changed since the early 1900s. The current understanding of atherosclerosis is now completely different. The name is the same, but its meaning has changed since 1900. This would be a useful approach for us to apply to subluxation.

Consider that atherosclerosis is far less emotional than subluxation as a topic. Also, there is no internal professional war within medicine regarding the nature of atherosclerosis. For example, medical doctors in one faction do not accuse those in another faction of being anti-medical because they do not believe in atherosclerosis. Unfortunately, our chiropractic profession has such factions. In some circles, if one does not believe in the traditional subluxation model, one is castigated for being anti-chiropractic.

The problem is that one faction embraces traditional subluxation, another faction denies all things subluxation and a third tries to ignore the fighting factions. In my opinion, all three factions are missing an obvious fact. Medicare has operationally defined subluxation for us, which means that all three factions need to change their mindsets and focus on Medicare. It does not matter whether you are a believer, denier or ignorer of subluxation: As matter of federal law, specific subluxation criteria and other important details must be documented in the record based on specific history and examination findings.

**Atherosclerosis**

Atherosclerosis was originally thought to be a buildup of plaque on the arterial wall resulting from endothelial cell injury. This view is still embraced today to varying degrees, but began to change in the late 1900s. The evolution of the understanding of atherosclerosis may be useful for chiropractic physicians to apply to their understanding of subluxation. Until about 1970, atherosclerosis was incorrectly perceived as a type of lipid storage disease. Lipid and other plaque components were thought to form on the surface of the arterial wall. Libby states that “this traditional concept viewed atherosclerosis as analogous to the buildup of rust in a water pipe.” Then Russell Ross published several papers in the 1970s that changed the perception that atherosclerosis was a “vessel wall reaction to injury.” Originally, it was thought that endothelial cells were denuded during the injury process, leading to plaque formation.

It was later discovered that atheromas developed beneath uninjured endothelial cells. So in 1986, Ross wrote an update in the *New England Journal of Medicine (NEJM)* that served to revive his hypothesis. He stated that endothelial cells may be injured but remain intact and that the atheroma grows beneath them. Ideally, Ross should have stated, “While I have embraced, promoted and made my living on the reaction to injury hypothesis, perhaps it is wrong.” However, that is tough for humans to do. But Ross did so 13 years later.

In 1999, Ross wrote another article in *NEJM*, entitled, “Atherosclerosis – an inflammatory disease.” It

Dr. Seaman is a professor of clinical sciences at the National University of Health Sciences in Pinellas Park, Fla. He has authored a book on clinical nutrition for pain and inflammation and has written several chapters and articles on this topic. His website, deflame.com, is devoted to this topic. Dr. Seaman’s book *The DeFlame Diet* is soon to be released.
is important to note that despite this clear title, he still clung a bit to the “reaction to injury” view:7

“Numerous pathophysiologic observations in humans and animals led to the formulation of the response-to-injury hypothesis of atherosclerosis, which initially proposed that endothelial denudation was the first step in atherosclerosis. The most recent version of this hypothesis emphasizes endothelial dysfunction rather than denudation. Whichever process is at work, each characteristic lesion of atherosclerosis represents a different stage in a chronic inflammatory process in the artery; if unabated and excessive, this process will result in an advanced, complicated lesion.”

When he states, “whichever process is at work,” in the context of endothelial dysfunction or a denudation, we see that he is still clinging to hope that a denuding injury might be important. While Ross did not completely give up his reaction-to-injury model, he substantially changed his position over a 25-to-30-year period. Chiropractic physicians should consider making similar concessions regarding subluxation.

Since 1999, it has been established that no denuding injury is needed for atherosclerosis to develop. It develops in areas of turbulence and is known to be a chronic inflammatory process that does not heal.

Metabolic Syndrome
What was just described is how scientific thinking and the scientific process have led to a more accurate understanding about the nature of atherosclerosis. The related practice of medicine has not been so scientific. The current challenge for medicine is to overcome the dogma surrounding saturated fats and cholesterol, which have been deemed to be the absolute causes of inflammatory atherosclerosis. For a recent critique written by an interventional cardiologist that properly criticized his profession, please read, “Saturated fat is not the major issue,” which was published in the British Medical Journal.8 In short, Malhotra explained that saturated fat and cholesterol are not the cause of heart disease; saturated fat is protective. The real issue is metabolic syndrome. And regarding treatment, adopting the Mediterranean diet after a heart attack is almost three times as powerful as statin therapy in reducing mortality.8

Understanding how metabolic syndrome creates heart disease does involve cholesterol, but not in the way we are taught. We are told that LDL cholesterol rises and HDL cholesterol lowers, and this somehow damages arteries and leads to plaque.

The dietary issue is the consumption of excess foods made of sugar, flour and trans fats. When these chemicals hit the blood-stream, they create low-grade inflammation in many ways. It is very well known that HDL is anti-inflammatory; however, what is not well known is that HDL transforms into a radicalized and inflamed HDL. The consumption of refined carbohydrates and trans fats over time is associated with the expression of metabolic syndrome and the transformation of HDL into a molecule that is no longer capable of participating in proper cholesterol transport and actually promotes atherosclerosis.

The story for LDL cholesterol is similar. Normal LDL is soft and buoyant; however, the consumption of refined carbohydrates and trans fats increases the total amount of LDL and converts it into a molecule that is small and dense (sd-LDL). The continued consumption of pro-inflammatory foods and the development of metabolic syndrome further transform sd-LDL into oxidized sd-LDL (ox-sd-LDL), which is highly inflammatory. The immune system behaves as if ox-sd-LDL is a foreign antigen and wages an all-out attack that is initially silent but will eventually lead to excess plaque formation in the vessel that may result in a vascular event. Oxidized LDL is not yet a commonly available clinical laboratory test. The only indication we have that suggests that LDL is in the transformation process is the identification of elevated LDL.

When we see low HDL and elevated LDL, we need to consider that the patient may have metabolic syndrome. This is an important concern for DCs because patients with metabolic syndrome are at greater risk for developing the most common musculoskeletal pains that have traditionally been perceived as being solely mechanical in nature (e.g. BMI, weight gain, ppm, met syn). Statins and red yeast rice are incorrectly believed to correct the dietary imbalance-induced inflaming of LDL and HDL.

Lessons Learned
So, what does the history of atherosclerosis teach us? In my view, we can learn two important lessons. First, we should endeavor to absolutely change our perceptions about the nature of a health condition if the science supports such a change – that is the nature of evidence-based healthcare. Second, we should abandon treatments if they are deemed to be ineffective. Medicine has succeeded in the first lesson, but has in many cases failed miserably in the second. DCs, in my opinion, have failed in the first lesson; we have not adequately advanced the science of subluxation.
in a professionally beneficial fashion. However, regarding the second lesson, we have succeeded in delivering a primary treatment (the adjustment) that has proven to be very beneficial for many forms of musculoskeletal pain and related symptomatology.9,10

Step back for a moment and consider the subluxation battle that continues to rage within chiropractic, and it seems that the profession has lost focus. The believers continue to call deniers anti-chiropractic, and the deniers scoff at subluxation because it is unscientific and yet to be a proven clinical entity. Each side is firmly entrenched in its positions, and it does appear to be a situation that will not improve or be resolved. I believe subluxation should be viewed similarly to atherosclerosis, and thus, subluxation should be reframed. The believers, deniers and ignorers of subluxation far outnumber people like me who could be called reframers. But my perception of subluxation does exist in a very specific and ignorant manner within federal law; this is true whether you are a believer, denier, ignorer or reframer.

**Subluxation**

To understand the operational definition of subluxation in Medicare, a mind-set change is required. Whether one is a believer, denier, ignorer or reframer, all DCs have to unlearn our preconceptions and do what Medicare directs us to do. In other words, Medicare subluxation is a new reality.

From a mental health perspective, focusing on Medicare would also be beneficial because it would avoid the negative outcomes associated with blaming others for having a contrasting view of subluxation. This would benefit current and future DCs in making them effective at addressing subluxation in the context of Medicare. Space does not permit a detailed analysis of the perceptual shortcomings held by believers and deniers, the groups that, in my opinion, create most of our trouble. I also say with assurance that most believers in subluxation view me as a denier, so I will briefly criticize some of the perceptions of the deniers. In particular, deniers commonly say that Medicare and its Local Coverage Determination (LCD) are a chart (See Documentation Requirements and Procedures for Medicare Patients, Page 20) to assist DCs. We first published this in *Dynamic Chiropractic.*12 My recommendation is to compare the flow-chart we created with your LCD.

**Medicare Requirements**

After reading the chart of documentation requirements, it should be obvious that most chiropractic physicians harbor misconceptions about Medicare documentation, especially if they have yet to read the MBPM and LCD. Medicare has essentially done to subluxation what science has done to atherosclerosis; Medicare has updated and created an operational definition of subluxation.

In short, it makes no difference what a believer believes, a denier denies, an ignorer ignores or a reframer thinks he or she is reframing, when it comes to Medicare, the requirements are exactly the same for all of us. And if we do not comply, the potential penalties can be swift and painful no matter the subluxation camp in which one may reside. Medicare documentation may be an area on which we can focus and set our differences aside.
### Documentation Requirements and Procedures for Medicare Patients

<table>
<thead>
<tr>
<th>Management flow per Medicare but applicable to all patients</th>
<th>Management/documentation components required to be Medicare compliant</th>
<th>Procedure and action steps to ensure Medicare compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Medicare patient enters office complaining of low-back pain that extends into his buttocks. He cites various functional limitations (disabilities) due to his pain.</strong></td>
<td>Must establish medical necessity for spinal manipulation.</td>
<td>Is the beneficiary experiencing a significant neuromusculoskeletal health problem necessitating manual manipulation by the chiropractic physician? Based on this presentation, the answer is yes, which permits us to proceed to the history.</td>
</tr>
</tbody>
</table>
| **2. History (#s 2-8 relate to the initial visit)** | • Symptoms cause the patient to seek treatment  
• Family history, if relevant  
• Past health history  
- prior injuries/traumas  
- prior surgeries  
- prior hospitalizations  
- current medications  
• Check for contraindications  
• Description of present illness/symptoms causing patient to seek treatment—these symptoms must bear a direct causal relationship to the spine  
- mechanism of trauma  
- quality and character  
- onset, duration, intensity, frequency, location and referral/radiation  
- aggravating and relieving factors  
- prior interventions, treatments and medications  
• Secondary complaints | The history demonstrates medical necessity only if the patient is functionally limited, which is almost always due to pain. The chance of a functional limitation without pain is exceedingly rare. Chiropractors should acquire or develop a new patient/history form that addresses the history components required by Medicare. Important to note is that Medicare's history requirements are a basic guideline. A comprehensive history is required due to all the probable red flag and non-red flag disorders that need to be considered. Proceed with examination only if history substantiates medical necessity. |
| **3. Red flags** | In Medicare terminology, RF conditions refer to relative and absolute contraindications (RC & AC):  
**Relative Contraindications**  
1. Arthritic hypermobility and circumstances where the stability of the joint is uncertain  
2. Severe demineralization of bone  
3. Benign bone tumors of the spine  
4. Bleeding disorders and anticoagulant therapy  
5. Radiculopathy with progressive neurological signs  
**Absolute Contraindications**  
1. Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation including acute rheumatoid arthritis and ankylosing spondylitis  
2. Acute fractures and dislocations or healed fractures and dislocations with signs of instability  
3. An unstable odontoid process  
4. Malignancies that involve the vertebral column  
5. Infections of bones or joints of the vertebral column  
6. Signs and symptoms of myelopathy or cauda equina syndrome  
7. For cervical spinal manipulations, vertebrobasilar insufficiency syndrome  
8. A significant major artery aneurysm near the proposed manipulation | Red flags (RC & AC) can be identified in a new patient/history form and from an individual red flag form. If absolute contraindication(s) are identified, then consider immediate referral. For relative contraindications, consider a referral and precautions to HVLA thrusts. The patient record must indicate the presence or absence of contraindications. Chiropractors should acquire or create history forms that include screening questions for these contraindications. |
| **4. Physical examination** | Medicare clearly mandates that the physical exam must demonstrate a causal relationship between the spine and the patient’s presenting complaint, which demonstrates medical necessity for spinal manipulation. In addition, the manipulation must have a direct beneficial therapeutic relationship to the patient’s condition. The manipulative service must provide reasonable expectation of recovery or improvement of function. | The physical examination leads to the generation of three important documentation requirements: (1) the selection of the vertebral level that is capable of generating the painful symptoms, (2) PART and (3) an appropriate ICD-9 code, all of which establish medical necessity for spinal manipulation. |
| **5. PART** | The acronym PART has been used to describe the examination components indicating that a patient is suffering from a spinal condition amenable to manipulation. At least 2 of the 4 PART criteria must be met, with at least one of them being the “A” or “R” component. What about radiographs? They are not required to satisfy Medicare documentation requirements. When should radiographs be used? For pathological diagnosis purposes. | The designation of PART in the record demonstrates to Medicare that the stated spinal level of dysfunction, as per the listed regional 739 code, has been examined/identified and correlated to the secondary ICD-9 code. The following quote from the 2009 OIG report demonstrates that we have not met the above documentation expectations. From page 11 of the 2009 OIG Report (3): “The records would indicate a problem in one area of the spine which was examined, but indicated treatment to three to four areas of the spine and changed according to procedure without correlation to diagnosis.” We suggest using/developing examination forms that lead to appropriate documentation of the correlation between PART and the 739 and secondary ICD-9 codes. |
Management flow per Medicare but applicable to all patients

<table>
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<th>Management/documentation components required to be Medicare compliant</th>
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<tr>
<td>6. Generation of a diagnosis and related ICD-9 code</td>
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<tr>
<td>With the exception of regular Medicare in Florida, Puerto Rico and the U.S. Virgin Islands, the primary diagnosis for Box 21 of the 1500 billing form will be the 739 code series; one 739 code for each spinal region billed. Each primary 739 code should be followed by a secondary diagnosis, which should reflect the correlated significant neuromusculoskeletal condition that is painful and limiting a patient's function.</td>
</tr>
<tr>
<td>In Florida, regular Medicare* billed to First CoastServices Options, the 739 code series is not billed as a diagnosis code, but all other examination, treatment, and documentation requirements are identical.</td>
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<tr>
<td>*Railroad Medicare and Medicare Advantage require 739 series on the bill.</td>
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<tr>
<th>Procedure and action steps to ensure Medicare compliance</th>
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<tbody>
<tr>
<td>A thorough history to include pain diagrams that is followed by an appropriate exam can help to identify the most likely pain generator, which leads to (1) the selection of the offending vertebral level and (2) the generation of an appropriate secondary diagnosis code. Chiropractors can accomplish this by developing forms that utilize appropriate spinal examination criteria:</td>
</tr>
<tr>
<td>1. Pain drawings</td>
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<td>2. Souza’s spinal examination chapters (14)</td>
</tr>
<tr>
<td>3. Diagnosis-Based Clinical Decision Rule (15-19)</td>
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<tr>
<td>4. Laslett’s criteria for SI joint pain (20)</td>
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<td>5. Laslett’s criteria for lumbar Z joint pain (20)</td>
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<td>6. Weiner’s criteria for cervical radiculopathy (20)</td>
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<td>7. History predictors for lumbar stenosis (20)</td>
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<td>8. Clinical Prediction Rules for spinal manipulation (20)</td>
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<td>9. Prediction rule for spinal stability (20)</td>
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