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I hope all ICS members realize how much information the ICS produces for us. I also hope all ICS members appreciate all that the ICS staff and board members do to protect our Illinois chiropractic licenses. Please take the opportunity to go to ilchiro.org, sign in, and look at the vast amount of the information available to help us run our practices efficiently and ethically.

The ICS board and staff have several new programs that will benefit our practices more than ever before:

First, the IPA has started. In the coming months, you will receive more information on the benefits and will be given the opportunity to join. This IPA will give each practice the chance to obtain more patients and do less paperwork. It will provide members more flexibility as to which network contracts they choose to accept as well. Also, there will be no additional (double) “middle man” administrative fees deducted from your reimbursement.

We also will introduce a group health insurance plan that ICS members who are employers can use to obtain health insurance at lower rates. We have an agreement with Infinedi, a clearinghouse available to ICS members at lower cost to our practices. Also, remember the Scrip discount and Chirocode discounts on some of their products, such as the Chirocode Deskbook. These programs will be available only to members of the ICS.

I would like to personally thank you for your commitment to the ICS. Remember, the more members we have, the stronger we are. We are continuing to work toward our goal of 18% by 2018.
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Lost in the **Shuffle**

The sheer volume of information with which we are inundated every single day is unbelievable. Back in 2009, I mentioned a study that indicated we consume over 100,000 words in a day. However, that was prior to social media's modern-day dominance. I recently read an article that indicated we now consume an average of over 50,000 words a day on social media alone. I can't imagine what the total consumption of information amounts to today.

The result? Too many things can be lost in the shuffle, and sometimes it isn't the big things in life that are important — sometimes it is the accumulation of many little things. For example, here at the Illinois Chiropractic Society, too often we do not tell our doctors all the little things that we do for the profession in Illinois. Here are just a few things that may have been lost in the shuffle, or of which you may be unaware:

- We worked closely with key legislators to secure the **appointment and Senate confirmation of Dr. Douglas Matzner** to the Illinois Medical Licensing Board.
- We have met and continue to meet with **major hospital groups** to find ways to work with other health care providers and within the current health care system, with accountable care organizations, and within the population health management paradigm.
- We lobbied on your behalf regarding cleanup changes to the Medical Practice Act, new opioid restrictions and rumors at the Statehouse about workers' compensation changes.
- We launched a significant **marketing campaign** for chiropractic in Illinois — [www.healthierillinois.com](http://www.healthierillinois.com).

- We are working closely with national organizations (including the American Chiropractic Association) to **expand the role of chiropractic physicians in Medicare**. If you have not begun to urge patients to sign our Medicare petition, start today: [www.acatoday.org/equality/doctors](http://www.acatoday.org/equality/doctors).
- We met with a large number of Congresspersons regarding national pro-chiropractic initiatives. One such meeting included Rep. Rodney Davis, to thank him for his sponsorship of a bill that would allow chiropractic physicians to **opt out of Medicare** and co-sponsorship of a bill to include chiropractic care in TRICARE.
- We continue to work with other state and national chiropractic associations, with several attorneys regarding potential legal action and with the Illinois Department of Insurance to find a resolution for the recent changes to UnitedHealthcare/Optum's reimbursement policy, which we believe violate federal nondiscrimination laws.

This is just a small sampling of the action that the Illinois Chiropractic Society has taken and continues to take on your behalf every day. What are some actions you should be taking but may be allowing to be lost in the shuffle?

- Is your street address and email address up to date with the Illinois Department of Financial and Professional Regulation (IDFPR) and on your IDFPR profile? (You will need this in order to renew your license.)
- Is your business name registered appropriately? (See May's *The Advantage* for more information.)
- Have you kept up with your continuing education (re-licensure in 14 months)?
- Have you trained your new staff on HIPAA and your policies?
- Are you filing liens to patients, insurance companies and attorneys on ALL of your personal injury cases?

Of course neither of these lists is exhaustive, but they are a reminder of the amount of information thrown at us daily. Fortunately, the ICS helps members to prioritize the deluge of information and helps prevent the important things from getting lost in the shuffle.
In much the same way, we can look at some of the bills that have been proposed and try and get an idea where people stand to get an indication of the efforts that might gain momentum for next year. With tensions high and the state in shambles, there is not a lot of legislation making it into the statute books this year. Every step toward a budget, countless innocuous laws and even a handful of legislative primary battles have all been seen as a proxy war for Speaker Madigan and Gov. Rauner. However, many health care discussions are still happening and some ideas are coming to the surface.

Note: At the time of this writing, we are entering the 11th month without a budget, there is still over a month left of session, and many things can change in the final few weeks.

**Scope of Practice Bills**
The Medical Practice Act is up again for renewal, as it has been every year in recent memory. Our act is one of the only with a one-year expiration (called a “sunset”), and many believe the reason is to force the doctors to come back to the negotiation table on an annual basis. The current version of the bill, SB 2537, contains a 10-year sunset and officially removes the Illinois Department of Financial and Professional Regulation’s (IDFPR) obligation to mail paper notices of licensure renewal, opting instead for electronic notification. Update your IDFPR profiles! I expect this measure to pass although I would not be surprised to have the 10 years reduced back down to one.

Other groups are pushing for broader scope of practice and recognition. Physical therapists are pushing the IDFPR to declare “dry needling” as within their scope of practice (the ICS has issued an opinion to the department objecting the inclusion of dry needling to physical therapy scope). Optometrists want limited surgical rights with HB 6166. Unlicensed midwives are seeking state certification in HB 4364. And finally, pharmacists are seeking rights to dispense prescription birth control on their own. I do not expect much movement on any of these issues.

**Workers’ Compensation Reform**
Gov. Rauner has called out workers’ compensation reform as a main point in his turnaround agenda. The governor is pushing for tighter causation standards, usage of AMA guidelines for permanent partial disability (PPD) awards, tightening definitions of traveling employees, and finally another 30 percent reduction in the workers’ compensation fee schedule. I would expect some of the governor’s points to be addressed, specifically the PPD and causation. There has been a lot of “push back” from the medical community regarding another fee schedule cut: However, even if there is a second reduction, leadership has indicated that E&M (evaluation and management) and physical medicine codes (specifically including chiropractic) would be exempt.

**Insurance Reform Efforts**
A number of different efforts are being pushed currently. A large bipartisan movement for insurance network adequacy and transparency is being discussed currently under a few different bills. HB 6562 would not only require a network to include a number of chiropractic physicians within its network, but also require transparency with regard to network provider directories and details into how the network assigns tiers to its providers (something the ICS has long sought out). SB 2379 is similar to provisions of a previous ICS initiative requiring greater accountability from the insurance company when making a recoupment demand from a doctor. Currently, insurers frequently use extrapolation to “estimate” how much a doctor owes the insurance company. SB 2379 would require any such requests to be individually cited and specific to each claim, rather than extrapolated. Finally, SB 2807 would prohibit insurance companies from declaring a service as “not medically necessary” when what they mean is “not covered by their policy.” The phrase “not medically necessary” carries with it an implication that a provider was acting inappropriately by using a particular procedure, rather than simply indicating a lack of coverage for the procedure.

**Statement of Legislative Intent**
A piece of legislation sometimes can be construed to mean something different from its sponsor’s intended purpose. In these instances, legislators will often read a prepared statement into the record of the debate to clarify what they were thinking and how they meant the legislation to be applied. This doesn't change the language of the law, but these little dialogues for the purposes of legislative intent can give a sneak peek at some of the behind-the-scenes discussions that took place before that moment.
Elevate Your Practice Using These Marketing Ideas

You may find that your schedule doesn’t always afford you time to learn about ways to market your practice. For that reason, at the ICS we continuously strive to empower our members with marketing advice. Here are just a few simple ideas to assist in growing your practice:

• **Join the ICS** – If you’re not already a member – this is a great way to market yourself as a policy leader and expert in your field, to connect with your peers who may be able to help grow your practice and to be included in our Healthier Illinois public awareness campaign.

• **Brand yourself** – Get your team custom apparel with your company name and logo. Get your patients interested in wearing your brand with great concepts and design ideas that they would enjoy wearing, creating walking advertising through your team and patients.

• **Always have business cards** – You never know when you’ll meet someone who could use your help.

• **Attend free events** – Check out any local opportunities to meet new people. Search for groups that discuss topics of interest to you, weekly networking events, etc. Any chance to meet potential patients and peers in your field works. ICS mixers are a great place to start!

• **Volunteer** – No matter how little time you think you have, there’s always time to give. Offering to share your knowledge and services with others who need it is an opportunity for growth.

• **Utilize your print collateral** – Develop simple marketing pieces on fliers, coasters, stickers, pens, etc. that include your website and social media URLs, QR codes and practice information.

• **Connect your waiting room** – With your dedicated area for patients, make their wait more productive. Set up a laptop – opened up to your Facebook page, blog, YouTube channel or Twitter account – to encourage their social engagement in your practice.

• **Claim your online listings** – This is a quick and easy way to solidify your online presence. Just by claiming your business on medical review sites, you’re letting potential patients know where you’re located and that you’re an existing practice.

• **Optimize your website** – SEO (search engine optimization) is a very powerful element of your online marketing strategy. This is a beneficial avenue to attract more quality leads through your website and develop a strong and fruitful presence.

• **Start a blog** – This is a long-term activity that deserves attention and dedication. Invite readers to comment on your posts, and reach out to fellow bloggers to contribute to your blog in the form of guest posts. This will benefit them and also provide your blog with more substance and diversity.

• **Develop a presence on social media networks** – Get your brand on Facebook, Twitter, YouTube, etc., and stay up to date on new trends and changes. This is a free marketing opportunity that is a fantastic way to tap into the largest source of new patients. You can also choose to create through these channels paid advertising that allows you to reach out to additional new untapped resources.

• **Publish videos** – This is another great way to present yourself and your practice as a valuable resource to the community. If you have a smartphone, you can shoot short, simple videos that cover a specific topic of interest – whether it’s about what’s happening at your practice or in chiropractic or answers to commonly asked questions.
Medicare recently released three clarifications on documentation requirements. Documentation is not only critical for proper reimbursement but also necessary for risk management and continuity of care. Providers must maintain proper documentation even for the cash patient to decrease the risk of allegations of negligence or malpractice. Electronic health records (EHR) are effective to provide accurate records in an efficient manner. While EHR is an effective tool, if misused, it could significantly increase our risk of recoupment, fines or jail time in an audit. Below I have noted the most common issues and errors pertaining to electronic record keeping.

1. **No Chief Complaint or History of Present Illness (HPI)**
   
   Evaluation and management documentation guidelines require that a chief complaint be clearly documented in order to establish medical necessity. Guidelines require that only the physician document the HPI.

2. **No Review of Systems**
   
   The review of systems provides a method to detect red flags. This is especially important to make sure that there are no contraindications to treatment. Without a review of systems, the examination automatically becomes a level one exam (99201/99211), which is known as “the nurse’s code.” A level one examination does not require the presence of the physician and is not really meant for physician use.

3. **Information Is Automatically Carried Forward From Visit to Visit**
   
   Software may be enabled to carry information forward from day to day. Examination findings and other information, such as blood pressure, if carried forward, would indicate that it was done that day. This leads to inaccuracies in the record and may be considered fraud. Errors may also occur if a physician does not change a result that may have been positive at a previous visit but is negative for the current visit.
4. Recording Only the Positive Findings
Positive findings and negative findings have significant bearing on whether a diagnosis has been ruled in or ruled out. Remember the old adage: If it is not written down, it never happened.

5. Listing Only the Diagnosis Each Visit for the Assessment
The assessment is the portion of the daily encounter that indicates the provider’s opinion and professional judgment as to what is occurring in the case. Only listing the diagnosis each visit will not establish medical necessity (see number seven below).

6. Utilizing the Same List of Diagnoses for Every Patient
We physicians are guilty of having our favorite diagnoses list. Choosing from a select list of diagnoses or codes will limit our thinking. The history and examination must support each diagnosis. In addition, a diagnosis of lumbalgia or cervicalgia is not specific and should be avoided.

7. Documentation That Contains an Incomplete Assessment or Lacks an Assessment
The assessment portion of the note indicates medical necessity. This is an area where the physician indicates how the patient is improving and the rationale for procedures. Two questions must be answered in each encounter: “How has the patient improved?” and, “Why does the patient still need care?” The inclusion of this information will provide the thought processes that the physician used in the evaluation of the patient’s progress.

8. Documentation Does Not Support the Level of Manipulation
Often the physician will examine areas outside of the patient’s complaints. Preventive or wellness care is not a covered benefit under any insurance program. Wellness care to a specific region should never be billed to the carrier as an active treatment. If you are performing manipulation to three to four regions, then you should have findings and a diagnosis for all of the three to four regions.

9. Lack of Audit and Internal Monitoring Policies
Independent audits are tremendously important to any organization’s compliance process. It is quite useful and a wise investment to employ a certified, independent auditor who is knowledgeable in documentation requirements for each carrier, as well as the standard of care in our profession. An audit is your evidence of a good faith effort to be compliant. Through the audit process, you can uncover and address documentation concerns with your EHR software, which will aid in developing policies or changes in your computer software to address deficiencies.

10. Lack of Training in EHR Requirements
All doctors and staff should be thoroughly trained in the requirements for EHR. Medicare, commercial carriers, malpractice carriers, the American Chiropractic Association and state associations provide guidance on the meaningful use guidelines, clinical parameter guidelines and the standard of care for documentation. A team approach in clinical and billing guidelines will result in enhanced compliance for the office and peace of mind for all. Knowing the risks of EHR is the first step in improving your documentation and reducing your risk of audit.

Dr. Fucinari and the ICS will be presenting several classes in the coming months to aid the doctor and staff in the implementation of documentation and billing guidelines. For an updated schedule of classes and locations, go to www.ilchiro.org or www.AskMario.com. Dr. Fucinari is a certified medical compliance specialist and a certified medical compliance officer. Dr. Fucinari is the author of several books and other resources, including Compliance Program Manual for the Chiropractic Office, available at www.AskMario.com. For further information on compliance audits, books or record reviews, please contact Dr. Fucinari at Doc@AskMario.com.
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About the Speakers

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Stephen Perle, DC: Professor of Clinical Sciences at University of Bridgeport, International Lecturer

Terry Yochum, DC, DACBR: Author of Essentials of Skeletal Radiology, a benchmark publication for the profession

Scott Munsterman, DC: South Dakota House of Representatives Health Service Committee and Legislative Planning Committee Chair

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*Through Logan College of Chiropractic, CME approval will be applied for Colorado; Connecticut; Washington, D.C.; Delaware; Florida; Georgia; Idaho; Illinois; Indiana; Iowa; Montana; North Carolina; Nebraska; Ohio; Oregon; Rhode Island; South Carolina; Utah; Virginia; Vermont; and Washington.
Summer ushers in a new season of outdoor activities, ranging from running to water skiing. Unfortunately, the relatively high physical demands of these activities can lead to painful injuries of unconditioned muscles and tendons. The powerful hamstring muscle is a common victim, with strains carrying the potential for prolonged recovery.

**The Top 37 Clinical Pearls for Managing Hamstring Strains**

The hamstring muscle group — consisting of the semimembranosus, semitendinosus, and biceps femoris — performs hip extension and knee flexion. These muscles may be strained from excessive load during eccentric contraction or from extreme stretch. Strains most commonly involve the biceps femoris near its musculotendinous junction.1,2 Hamstring strains are classified from grade 1 to grade 3, based upon the amount of tissue damage, with grade 1 representing strain without significant fiber tearing, grade 2 indicating partial muscle tearing, and grade 3 signifying complete muscle or tendon rupture.

The hamstring muscle is the most commonly strained muscle in the lower extremity of elite athletes.3 Sports that involve sprinting and jumping, like track, football and soccer, predispose athletes to eccentric strain injuries while participants in water skiing, martial arts and dancing are more prone to stretch-type injuries.1,3,4 Strains related to sprinting or running often occur during terminal swing phase, just before foot contact, as the hamstring muscles are stretched and working hardest.6,7 The muscle is most vulnerable to injury at the moment when its function rapidly changes from eccentric deceleration of the forward swinging tibia to concentric extension of the hip joint.8

The majority of sports-related hamstring injuries tend to occur during competition, particularly as the athlete tires.3,8 In addition to muscular fatigue, a combination of several other factors increases the risk of hamstring strain, including insufficient warmup, a history of prior injury, and hamstring inflexibility or weakness.1,8,10,11,16,57,58

An imbalance of muscular strength, i.e. low hamstring to quadriceps ratio (less than 0.6), leads to injury when excessive quadriceps strength overpowers the capacity of the hamstring to eccentrically decelerate forward progression of the tibia during the terminal swing phase of gait.9,38

Additional known biomechanical risk factors include hypertonicity in the quadriceps or illopos, inadequate control of lumbo-pelvic muscles and poor running mechanics.1,3,4,5,8 Injuries are thought to occur when the number of risk factors reaches a critical threshold. Hamstring injuries are more common with age and affect African-Americans more frequently.13,56 A study of college soccer players suggests that hamstring injuries are more common in males.12

The majority of hamstring injuries occur abruptly during activity, with a tearing feeling accompanied by significant pain. In approximately 9 percent of cases, symptoms start more gradually.2 Symptoms of hamstring strain vary from a mild annoyance to debilitating pain, based upon the site and amount of tissue damage. The most common presenting symptoms include pain in the lower buttock and posterior thigh when straightening the leg, particularly while ambulating or flexing forward.

Clinical evaluation may demonstrate bruising, which begins at the site of injury and slowly gravitates inferiorly. Palpation will reveal local tenderness, swelling and hypertonicity. The point of maximum tenderness often represents the site of injury. Range of motion testing may produce pain upon passive hip flexion and knee extension, i.e., straight leg raise. Manual muscle testing should reproduce pain upon resisted hip extension or knee flexion. Due to the bi-articular nature of the hamstring, multiple test positions may be needed to assess function. Resisted knee flexion should be tested from a prone position with the hip stabilized at zero degrees and resistance applied at both 15 degrees and 90 degrees of knee flexion. Hip extension should be assessed with resistance applied to the posterior thigh with the knee positioned at 90 degrees and zero degrees of flexion. Muscular assessment commonly demonstrates hypertonicity in the hamstring, quadriceps and psoas muscles.

Orthopedic evaluation may demonstrate a positive doormat sign (https://goo.gl/pTjcT7) wherein the patient reports pain when simulating the movement of wiping a foot on a mat while standing. The hamstring drag test (https://goo.gl/KaoJEF), or “take off the shoe test” (TOST), is performed by asking a standing patient to take off the shoe of the injured leg while holding that shoe on the ground with the forefoot of the unaffected leg. The slump test (https://goo.gl/gvQnK) may help differentiate between hamstring injury and lumbar radiculopathy. It
is important to note that individuals who have sustained recurrent hamstring injury may have scar tissue that interferes with normal sciatic neurodynamics. Motion palpation may reveal deficits in sacroiliac or lumbar mobility. Neurologic evaluation of hamstring strain injuries should be normal with any positive findings raising suspicion of radiculopathy.

The diagnosis of hamstring strain should be based upon an accurate history and physical evaluation. Radiographs are generally unnecessary unless there is suspicion of avulsion fracture of the ischial tuberosity (riders bone) or other bony pathology. Advanced imaging of the hamstring, including MRI or ultrasound (with MRI being more sensitive), is reserved for more severe injuries in order to help determine whether surgical intervention will be necessary. The differential diagnosis for hamstring strain includes contusion, fracture, neoplasm, hip pathology, posterior compartment syndrome, adductor strain, ischial bursitis, herpes zoster, piriformis syndrome and, most notably, lumbar referral. Clinicians should be particularly alert to the possibility of radiculopathy in patients who present without a specific mechanism of injury or when pain extends beyond the knee.

The management of hamstring injuries is challenging for both clinicians and patients, as healing is often delayed with persistent symptoms and re-injury rates between 12 and 31 percent. The average convalescent period ranges from one to three weeks and is based upon the severity and location of the injury. The proximity of the injury to the ischial tuberosity generally correlates with the recovery period, with more proximal injuries requiring longer convalescent periods. Injuries that result from slow speed stretching generally take longer to heal. Recurrent injuries often take twice as long to heal as the initial injury. Athletes who do not adequately rehabilitate their injury and return to sport prematurely are at greater risk of re-injury and diminished performance.

The rehabilitation of hamstring injuries can be divided into three phases. The focus of phase I is reduction of pain and swelling immediately following an injury. A campaign of rest, ice, compression and elevation (RICE) should be initiated. Ice or ice massage may be applied over the injured area for 15 minutes at a time. Use of a compression bandage may help to limit intramuscular swelling. There is some controversy regarding the use of nonsteroidal anti-inflammatory drugs (NSAIDs) for hamstring strains, as some studies suggest that these drugs may have a negative effect on recovery. Electrical stimulation and ultrasound are often used in the initial phase although support for these modalities is lacking. A short period of immobilization, including the use of crutches, may be necessary for more severe strains. Patients should avoid sustained knee flexion while using crutches, as this will place excessive tensile load on the healing tissue. Pain tolerance should dictate return to normal gait as well as initiation of light range of motion exercises, including active knee flexion and extension. Excessive stretching of the injured tissue should be avoided initially, and range of motion may be defined by the onset of pain. Manipulation may be utilized to resolve joint restrictions in the lumbar spine, sacroiliac joints or lower extremity.

Progression to phase II begins when the patient can walk without pain and can tolerate a moderate degree of resisted knee flexion. The goal of phase II is to improve flexibility, strength and biomechanical function of the hamstring and related lumbopelvic tissues. Athletes should gradually increase running to 50 percent of their maximum and avoid sprinting. Cross-training with stationary cycling or swimming may be incorporated. Stretching exercises may be utilized to gradually restore flexibility to the hamstring as well as the psoas, adductors, quadriceps and lumbar spine. There is significant evidence suggesting that the incorporation of (Nordic) eccentric strength training exercises assists in rehabilitation of hamstring injuries and minimizes recurrence (https://goo.gl/f2IQV3). Rehabilitation programs that incorporate trunk stabilization and progressive agility drills have been shown to decrease re-injury rates when compared to more traditional isolated stretching and strengthening programs. See the “15 Minute CORE” webinar at https://goo.gl/83RkTg.

Soft tissue manipulation and myofascial release techniques, including instrument-assisted soft tissue manipulation (IASTM), may be implemented judiciously for the hamstring and associated hip musculature (https://goo.gl/mHVaMW). Nerve mobilization techniques may help restore neurodynamic flexibility, particularly for severe or recurrent injuries (https://goo.gl/WUYJ1g).

Progression to phase III begins when the patient is able to perform pain-free resisted knee flexion and can run at 50 percent speed without pain. The goal of phase III is to return the patient to activity through sport-specific drills and trunk stabilization. During this final phase, patients will gradually increase from jogging at 50 percent intensity to full sprinting. Clinicians should address any gait abnormalities and consider footwear/orthotic needs. Athletes should not be returned to unrestricted sporting activities until they have achieved full range of motion, adequate hamstring-to-quadriceps strength ratios (greater than 0.6) and restoration of pain-free sport function. Return to competition before restoration of pain-free, sport-specific function will likely result in recurrent or more severe injury. Athletes should be counseled on proper warmup and cool down as they return to activity. A study of NFL cheerleaders suggested that performing closed-chain eccentric strengthening exercises twice per week lowered the rate of hamstring injury. 

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that does not contain “Jane/John Doe, D.C.”), Illinois law considers the name under any name that does NOT contain their actual, personal name (anything May Have Missed

References

Will Your Practice Name Cause You Legal Problems?
by Adrienne J. Hersh, JD, ICS General Counsel

Did you know if the name of your practice does not contain your given name, under the law you are using an assumed name, regardless of the business structure of the entity? Conducting business under this type of name is often referred to as a “dba/a” or “doing business as” the entity using an assumed name.

When owners or shareholders of any health care office, whether operating as an individual owner, partnership, corporation or limited liability company (LLC), transact business under any name that does NOT contain their actual, personal name (anything that does not contain “Jane/John Doe, D.C.”), Illinois law considers the name to be “assumed” and requires the owners to register with the county where the business is located. In addition to registering with the county, corporations and limited liability companies using assumed names must also register the name with the secretary of state, as detailed below.

Providing additional “teeth” to this requirement, the Medical Practice Act says that a physician practice may only use an assumed name “as provided by law.” This language is included in the disciplinary section of the Act and permits the State of Illinois to sanction a license when a physician fails to properly register a name. Fortunately, the “provided by law” language means that you may use an assumed name if it is correctly registered, according to the type of business structure of your practice.

Editor’s Note: This full article including step-by-step instructions for each type of entity registration can be found in the May edition of the ICS member’s only publication The Advantage.
Chondromalacia patella (CP) is a relatively common condition involving the knee that pathologically features softening of the hyaline cartilage of the patella. Unlike degenerative conditions, however, it tends to involve a younger age group. The condition is slightly more common in females. Typically, there is anterior knee pain on ascending or descending stairs or after kneeling or squatting for long periods of time.

The imaging findings on plain film X-ray may be few or nonexistent. CT arthography may be useful for imaging purposes once the disease has progressed to actual focal cartilage defect but is not good at detecting early change and has the additional disadvantage of being an invasive procedure. MRI, however, is a good modality to show the cartilage degradation that may occur with this condition, even in the initial stages. MRI is uniquely suited to demonstrate the early softening of the hyaline cartilage. In addition, MRI provides excellent visualization of all of the soft tissues of the knee, as well as the osseous structures, and can demonstrate other conditions that may mimic CP symptomatically, such as Sinding-Larsen-Johansson disease.

Patellar hyaline cartilage is usually best demonstrated on the axial T-2 or fat-suppressed sequences. Abnormality of the cartilage manifests as increased signal intensity on these sequences, compared to normal cartilage.

The grading for CP generally utilizes a I to IV scale1 with the following MRI criteria:

- Grade I consists of focal areas of increased signal on the fat-suppressed images without cartilage attenuation.
- Grade II manifests as a frayed appearance of the surface of the cartilage with a degree of cartilage swelling.
- Grade III will show partial thickness loss of the cartilage with focal areas of ulcerative change.
- Grade IV shows full thickness cartilage loss with reactive underlying osseous change.

Fat-suppressed axial images were utilized in the following descriptions of figures 1 to 6. Figure 1 shows normal uniform thickness hyaline cartilage. In Figure 2, there are focal areas of increased signal within the cartilage, representative of grade I change. Figure 3 demonstrates an appearance of increased cartilage thickness at the medial patellar facet with irregularity of the cartilage surface representing a grade II lesion. In Figure 4, there are areas of focal partial thickness cartilage loss corresponding to a grade III lesion. Figure 5 represents large areas of full thickness cartilage loss with adjacent high signal intensity osseous marrow change. Plain film X-rays of this same patient in Figure 6 and Figure 7 fail to demonstrate the advanced nature of this involvement.

Underlying factors that may be associated with CP include patellar tracking abnormalities. Figure 8 demonstrates a lateral subluxation of the patella, which may result in asymmetrical stress across the patellofemoral articulation and increased pressure on segments of the cartilage. Other predispositions to CP may include pes planus, overpronation gait syndromes and obesity.

Conservative care remains the treatment of choice for the majority of cases of CP. Surgical options are available when conservative measures fail. In severe cartilage loss with loose body formation, arthroscopic debridement, as well as articular resurfacing, may be indicated. In extreme cases, patellectomy may be considered.

MRI is the modality of choice in effectively demonstrating the severity of involvement in CP, as well as being able to detect early change. This can be done noninvasively and without discomfort to the patient.

References
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Health care services liens can be a valuable asset when it comes to protecting your accounts receivable from your patients’ other judgment creditors. Health care services liens have always been a feature of the law in this state, but under the Illinois Health Care Services Lien Act, the process by which liens attach (become enforceable) and perfect (establish priority over other creditors) was streamlined. It also incorporated in the definition of “health care professional” a number of license categories, including osteopathic, chiropractic and medical physicians, as well as other licensed providers, and discarded the patchwork of laws surrounding the process of setting up liens, which varied depending on the nature of the provider.

Under the law passed in 2003, health care liens attach “to any verdict, judgment, award, settlement, or compromise secured by or on behalf of the injured person.” A typical example of this may occur when a patient seeks chiropractic care as the result of a spinal injury stemming from an auto accident. The patient is treated over the course of several months but cannot afford to pay because of protracted litigation surrounding the accident. As treating doctors, chiropractors want to help their patients get better as quickly as possible. However, bills cannot go unpaid at a practice. How do you, as a provider, ensure you are paid out of the eventual settlement or jury verdict?

The answer is by attaching and perfecting a health care services lien. Liens attach when the health care provider renders services to a patient’s injuries relating to an accident. Health care services liens are then perfected by serving both parties to the lawsuit, including the patient, with notice of the health care services lien. The Health Care Services Lien Act specifies the information that must be contained within the notice, including the name of the party allegedly responsible for the accident, the name and address of the patient, the date the accident occurred, and your name and address as the provider. An attorney may be helpful to navigating this process but is not required to serve a notice of lien.

The formal attachment and perfection of the health care services lien does not end with notice, however. Providers are also required under the act to respond, on written request, to any party in a lawsuit, with written medical authorization signed by the patient, regarding the provider’s “treatment, care, and maintenance of the injured patient.”

This request must be satisfied within 20 days under the act, the answer to which must contain the following or the lien is void:

1. A written statement of the nature and extent of the injuries sustained by the injured person
2. A written statement of the nature and extent of the treatment, care, or maintenance given to or furnished for the injured person by the health care professional or health care provider
3. A written statement of the history, if any, as given by the injured person, insofar as shown by the health care records, as to the manner in which the injuries were received

The statutory requirement may be difficult to satisfy if the provider does not keep thorough records relating to the cause of the patient’s injuries. As a rule of thumb, it is prudent practice to keep detailed records of this nature on any patient believed to have suffered injuries as the result of an accident, in the future, to the event that a dispute springs up in the future. Also, ask the right questions. Although statutes of limitations vary in different jurisdictions, in Illinois, they can be up to two years after an auto accident. This is another area where an attorney can provide practical guidance.

There are also some limitations under the act that allow all health care providers, in aggregate, to collect no more than 40 percent of the judgment or settlement amount in the case. This aggregate limit was designed in conjunction with an attorney fee limit of 30 percent to ensure that the injured party in an accident case can recover at least the remaining 30 percent as compensation for injuries. The law makes good policy sense, but it may mean that providers cannot recover their full cost of services rendered from the lawsuit.

At the end of the day, a properly filed and perfected health care services lien can provide peace of mind to the provider and increase the likelihood of recovering a significant portion of fees for services rendered to patients. Without a health care services lien, however, that likelihood of recovery under the act is often nonexistent.

Editor’s Note: The Illinois Chiropractic Society can work with member doctors who are trying to determine the exact amount allowable under the Health Care Services Lien Act. Please call the ICS at 217.525.1200 with the settlement amount, your lien and other medical lien information, or for assistance with other personal injury issues.

Michael D. Robinson, MPH, MBA, JD, LLM, is an attorney licensed in Illinois and currently runs a small health law practice, The Law Firm of Michael D. Robinson & Associates, L.L.C., located in Chicago, where the firm focuses on food and drug law, regulatory compliance, and professional licensure. He may be reached at MDRobinson@MDRobinsonLaw.com.

References

1. 770 ILCS 23/, et seq.
2. Id. at 23/20.
3. Id. at 23/10(b).
4. Id. at 23/15.
5. Id. at 23/25(a).
6. Id. at 23/10(a).
A growing area of concern in our practices today is financial and collection policies. Why? I am convinced that how we explain our fees can be one of the greatest tools for the financial success of our practices. Our financial policies and how we present payment options for our patients can be one of our greatest areas of RISK in practice. These policies can be used as a weapon against us if they are not compliant with all the layers of regulations we face today. They can cause problems from audits, fines and penalties than you are from malpractice claims. That’s not my opinion. It’s a fact. One of the top reasons for complaints filed with boards of examiners is not over our clinical care, but financial policies.

Your office financial policy should always be compliant with the rules and regulations of your provider agreements and other regulations, consistently applied to every patient and considerate of the financial challenges that people may have. Many provider agreements make it clear that you should NOT collect in advance for services that are covered by the plan. This means prepaids can get you in trouble if you are unsure if they are allowed in your state or by the health plans. Check with your State Board or legal counsel, and don’t assume that prepaids are legal just because everyone offers them.

A sound financial policy in your clinic can help you avoid:

- **Dual fee schedules** – This occurs when providers charge more to insurance patients than cash patients, which invites problems in most cases.
- **Improper time-of-service discounts** – Discounts must be “reasonable and defensible.”

Most experts say between 5 and 20 percent is reasonable, but make sure you are not discounting deductibles or copayments. That may violate your provider agreements.

- **Inducement violations** – Be cautious when you consider offering discounts to your patients if you don’t know all the rules. Far too often, we forget that a health care “system” regulates us, and we must comply with all layers of the system. Respect the rules and regulations from your board of examiners, provider agreements, state department of insurance and attorney general’s office, as well as Centers for Medicare & Medicaid Services and the Office of Inspector General (OIG). It sounds like a daunting task, but it is possible with the proper financial policy.

More importantly, despite having the best, most legal, most enforceable financial policy known to man, always stop and ask yourself, “Is it simple enough that anyone on staff can explain it clearly and concisely?” If your financial policy is so complicated that only one person on staff can explain it, then it doesn’t matter that it is compliant. Keep it simple. If you would like a copy of a one-page, simple financial policy that can be used to set the stage for a simple, compliant financial system in your office, visit www.chirohealthusa.com/FROF.

Dr. Ray Foxworth is a certified medical compliance specialist and president of ChiroHealthUSA. A practicing chiropractor, he remains “in the trenches” facing challenges with billing, coding, documentation and compliance. He has served as president of the Mississippi Chiropractic Association, staff chiropractor at the G.V. Sonny Montgomery VA Medical Center and is a fellow of the International College of Chiropractic. You can contact Dr. Foxworth at 888.719.9990 or info@chirohealthusa.com, or visit the ChiroHealthUSA website at www.chirohealthusa.com.
Why would Congress, in a bipartisan and nearly unanimous vote, replace an existing formula for payment to Medicare providers? Clearly costs of care have been skyrocketing without consideration for quality of care, and now pay for performance has finally arrived. For years, we have heard of pay for performance, reimbursement based on outcomes, value-based reimbursement, etc. For years, we have not seen any substantial progress toward making this work, but in April 2015, President Obama signed into law the Medicare Access and CHIP Reauthorization Act 2015 (MACRA). This is an act to amend Title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate, to strengthen Medicare access by improving physician payments, to reauthorize the Children’s Health Insurance Program and more. Within this law are two different payment options: One is the advanced payment model (APM), and the other is the initiation of the merit-based incentive payment system (MIPS). This is the blueprint for pay for performance by Medicare.

There are five key principles of the MACRA law you should understand:

1. Every Medicare enrollee needs a dedicated and well-organized primary care team.
   MACRA actively promotes patient-centered medical homes (PCMH) and patient-centered specialty practices (PCSP). These are types of practices recognized by accrediting organizations, such as the National Committee for Quality Assurance (NCQA), to validate that these practices meet specific qualifications for value-based reimbursement.

2. Measurement must be specified appropriately for each different unit of accountability.
   If you are familiar with clinical quality measures and meaningful use, then you will have a basis to help you understand this aspect of the MACRA. The MACRA states that measures must be specified for each payment model, or unit of accountability, yet still facilitate comparison between and among all payment models. Measures also must be tailored for the different types of care furnished by clinicians in different payment models.

3. Measurement should support rapid improvement and clinical decision making.
   Beyond assessing and paying for value, measurement also needs to help clinicians rapidly identify gaps in quality in order to improve their performance. The EHR meaningful use program that MACRA incorporates into MIPS already encourages use of data for population health, decision support and measuring quality. Meaningful use requirements must include accurate, prompt reports for clinician quality improvement efforts.

4. A core set of measures will let all stakeholders make comparisons across programs.
   Core measures will be specified appropriately for the differing situations for individual clinicians, practice teams, accountable care organizations (ACOs) and Medicare Advantage plans, yet aligned in concept and intent to allow meaningful comparisons. The measures will draw from data in claims, EHRs and patient surveys to determine levels that matter most to consumers, clinicians, plans, the community or the state. Measures also must continually transform for advances in clinical evidence.

5. Quality measure results should be easy for consumers and payers to get and use.
   MACRA provides for transparency through the Physician Compare website. All stakeholders need user-friendly information to make meaningful comparisons across all payment models. Clinicians need more specific data about how they compare to local and national peers to identify improvement opportunities and achieve value-based payment rewards. Clinicians also need timely, actionable feedback as close as possible to delivery of care. Embedding results in clinical care workflow is essential.

Doctors of chiropractic must begin now to understand this new payment environment that is quickly approaching, as 2016 is setting the stage for the MIPS program going into effect January 2017. The draft rules for MIPS will come out by June or July and the final rule by November 2016.

Dr. Scott Munsterman is founder and CEO of Best Practices Academy (BPA) and is an acknowledged expert on the transforming model of health care delivery with a commitment to the promotion and advancement of the chiropractic profession. BPA assists chiropractic physicians to focus on growth, risk management, technology and quality improvement through a value-based practice management system. Dr. Munsterman is presenting Merit Based Incentive Payment Systems at the 2016 ICS Chicago National Convention & Expo. Register today at www.chicagonationalconvention.com.
Swansea, Illinois – Independent Contractor
Independent contractor opportunity available in a successful evidence-based chiropractic office. We provide space, equipment and staff. You provide clinical proficiency and a strong desire to grow. Excellent long-term opportunities. Contact Brandon, steelebc@gmail.com.

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Motivated Associate Wanted
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Immediate opening for an associate doctor to replace a doctor retiring after being in practice since 1980. The clinic is one of the oldest (est. 1949) and most successful in northern Illinois. Doctor will be joining another chiropractor and have excellent coaching offered. Anticipate $60,000 to $90,000 income in the first year, depending on how motivated the doctor is. Location is in town close to Rockford, Illinois. Small town with excellent school system. Please send résumé to jphulsebus@yahoo.com.

Faculty Instructor
Palmer College of Chiropractic is seeking a full-time faculty instructor to teach coursework within the chiropractic business and practice management department within the doctor of chiropractic program on the Davenport, Iowa, campus. Candidates must have a first professional degree in a health care discipline or a graduate degree in an appropriate field of business from an institution accredited by a nationally recognized agency or its foreign equivalent. Applications will be accepted until filled. Visit www.palmer.edu/job openings for full posting and application instructions. EEO AA M/F/Vet/Disability employer. Applicants selected for interviews who may require access accommodations are encouraged to contact the Human Resources Office.

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Belleville, Illinois, Chiropractor
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Mission-Minded Chiropractors Needed: Aurora, Illinois — If you would like to utilize your God-given gifts, talents and abilities in an urban mission setting, please prayerfully consider volunteering one time per month at Mission Possible. See www.onjesusmission.org for more information. Contact Linda Baer at 630.415.8080 or linda@onjesusmission.org.

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Universal MPX 525 X-ray Machine with Mini Medical 90 processor and 10 cassettes. X-ray machine, developer and 10 cassettes. Everything you need to start taking X-rays. Local pickup only in North Aurora, Illinois. Very little use on it. $8,100 for all, or best offer! Email for pictures. chiroeric@hotmail.com.

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I’m seeking full- or part-time employment in an established clinic downtown or on the north side of Chicago. 20-plus years’ experience. I’m certified in acupuncture and Cox technic. Ideal practice would have Cox table available, but not necessary. Contact keochiro@gmail.com.

St. Charles, Illinois, Associateship
This associateship is one I would want for my own sons and daughters. I will help you develop into an experienced, confident chiropractor who has acquired all the necessary knowledge and skills to build the practice and life of YOUR dreams starting on day one. You can build your practice within mine and end up as a partner or satellite clinic owner, or earn while you learn here then go start your own. Requirements: chiropractic license, excited, clear goals that are worth the work it will take to attain. References from our current and past associates are available! Email CV and cover letter. drkleinfelter@yahoo.com.

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Dr. Patrick Kennedy, December 6

Seminars

2016 Medicare Guidelines
Dr. Mario Fucinari
June 23, 2016
1-5 p.m. (4 CME)
Tinley Park Convention Center
Room: Pavilion 1
18451 Convention Center Dr.
Tinley Park, IL 60477

2016 Medicare Guidelines
Dr. Mario Fucinari
August 4, 2016
1-5 p.m. (4 CME)
Wyndham Springfield City Centre
Room: Plaza 3
700 E. Adams
Springfield, IL 62701