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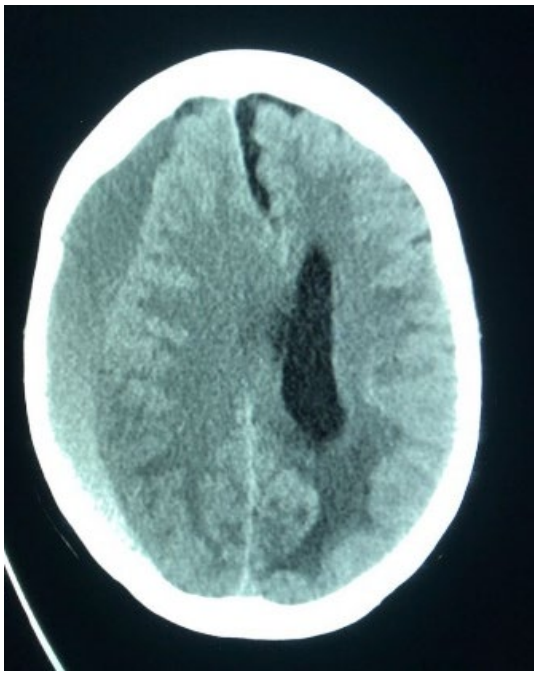

Large acute on subacute subdural hematoma with a 1.5 cm midline shift to the left.

. Chiropractor at the Veterans Administration

. Trigeminal Autonomic Cephalgias

. Concussion/TBI & Dynamic Functional Cranial Nerve Assessment

. Convention Information

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Upcoming Events	
March 25	Digital Motion X-ray, Part I Mike Winberry Aaron's office
April 30	Digital Motion X-ray, Part II Mike Winberry Aaron's office
May	
June 11, 12	AAC Convention Wild Horse Pass
July 30	AAMVI PI Seminar Great Wolf Lodge
August 13	ABCs of PI Bill Gallagher Flagstaff
Sept	Jeff Cronk 2 hr. webinar on CRMA
Oct 22, 23	Tucson Convention Sheraton Hotel & Suites
Oct	MRI Webinar Sean Mahan MD, 2 CEs
Nov	
Dec 11, 12	Convention with Toys for Tots Phoenix
Multiple dates	Documentation and Record Keeping Free for AAC members

About the Journal

This journal is a publication of the AAC and is put together by members of the AAC for the benefit of all chiropractors licensed in Arizona.

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THE REWARDS OF COMMITMENT

I want to thank the leadership of the Arizona Association of Chiropractic for awarding me the AAC Lifetime Achievement Award. Its presentation at our convention in Prescott caught me completely by surprise and as a result I found myself without sufficient words to express my heartfelt gratitude for being honored with this very special recognition.

I have been blessed to belong to a profession that is worthy of fighting for. I have felt the pain of defeat in these struggles and have reveled in our victories for three decades. In the process I have found myself in the foxhole with many dedicated colleagues, committed to service to our profession and to our patients. The rewards of having shared these experiences are deep and profound. They exceed by far any measure of monetary "success".

It humbles me greatly when I think about joining the small cadre of Arizona chiropractic leaders upon whom this award has been bestowed, people such as my old and dear friend and mentor, Dr. James Badge.

I see a future that is bright for our profession, if we can only recognize the opportunities before us and have the wisdom and initiative to reach out and seize them. As I look around me today, I am encouraged by the many bright minds and caring healers who, God willing, will step forward to lead our profession to a new level of prosperity and effectiveness. When these leaders follow through with their commitment of service, I know that their own lives will be, as mine has been, immensely more fulfilling because of the work that they will have done for the common good.

I find myself wondering who the next recipient of the Lifetime Achievement Award might be.

Will it be you?

~Wayne Bennett

Life Is Not Measured by the Number of Breaths We Take, but by the Moments That Take Our Breath Away

Have your patients had insurance company issues?

By: James Bogash, DC

For several years now, the AAC has been aware of grave concerns regarding the behavior and relationship between regional third-party administrators and several of the companies that manage claims and benefits for. We have brought this issue to the attention of the Attorney General of AZ.

In the YEARS that the AZ AG had this issue before it, they have done nothing. It's time for a different approach, but we need your help.

We need the help of those of you who are IN network with a TPA in AZ (the two biggest examples are ASH and Optum) and have patients with a high deductible plan with a HRA.

This means that the patients have a tax-advantaged savings plan that pays for the deductible after the claim is processed.

There is a chance that you have had claims processed that show a disturbing pattern.

This pattern centers around the payment and processing of claims and notable differences between what is billed by the provider and what the insurance companies ultimately take out of a patient's account for payment of these services.

An example would best illustrate this.

A chiropractic claim is submitted by a provider and this provider is reimbursed $45. However, on the patient's explanation of benefits provided by the insurance company, this same exact claim is processed for $65 and this money is subtracted from the patient's Health Savings Account or Flex Spending Account.

In this example, there is an extra $20 being paid by the patient for MEDICAL CARE. However, this $20 is not actually being paid to the provider, but is being kept by either the TPA or the insurance company.

The magnitude of this problem is likely far greater than the 50 or so claims that we have documentation for because it is a rare instance for the patient to bring in the paperwork he

or she receives from the insurance company and compare it to what the provider is paid.

In other words, your patients are paying more than you think for your services, but you're not getting all the money.

This is where we need your help. We need you to identify these potential claims—look for a patient who had a high deductible plan with a HRA account that paid the deductible. Ask these patients to bring in a copy of THEIR EOB. If that amount they paid is different than what you get paid, you've got what we need.

Reach out to us if you have any questions, need more clarification or, better yet, have examples of this happening.

Jamie Bogash is VP of the AAC and is active with insurance company issues and nutrition for health. He can be reached at lfecare@aol.com or 480 -839-2273

Trigeminal Autonomic Cephalgias: Characteristics and Descriptions

Gregory Katsaros, DC, DAAPM
Tempe, AZ

Abstract
Trigeminal Autonomic Cephalgias (TACs) are a group of primary headache disorders characterized by ipsilateral cranial autonomic features and their frequency and duration of occurrence. Headaches within this category include cluster headaches, paroxysmal hemicrania, SUNCT, SUNA, and hemicrania continua. It is essential that physicians caring for patients with TACs and other headaches have a comprehensive understanding of headaches. Patients presenting with TACs can be challenging, and a thorough history and evaluation of the patient is essential for proper diagnosis and care.

Basic Descriptions and Pathophysiology of TACs
The International Classification of Headache Disorders (ICHD-3) describes 3 major groups of headache types including Primary Headaches, Secondary Headaches, and Neuropathies & Facial Pains and other Headaches. Examples of primary headache include migraine, tension type headache, and Trigeminal Autonomic Cephalgias (TACs). Secondary headaches include those headaches secondary to other causes such as whiplash or substance abuse. An illustration of a headache within the category of Neuropathies & Facial Pains and other headaches would be a headache resultant of a lesion or disease of the trigeminal nerve (1).

Trigeminal Autonomic Cephalgias are classified as a primary headache disorder. The general categorization of the TACs is based upon the commonality of autonomic features and pain in the trigeminal distribution (2). While the exact pathophysiology of trigeminal autonomic cephalgia is not known, there are aspects which are well understood. There are two major clinical characteristics of TACs. These include pain along the trigeminal distribution and ipsilateral cranial autonomic symptoms (3). The pain producing innervation projects through branches of the trigeminal and upper cervical nerves to the trigeminocervical complex where nociceptive pathways project to higher centers, while a reflex activation of the cranial parasympathetic outflow provides the efferent loop (4-7). Similar to migraine, this pain producing pathway contributes to elevated calcitonin gene related peptide (CGRP) seen in TAC headaches. There are also commonalities in terms of the distribution of both TAC and migraine with both being generally unilateral and demonstrated about the trigeminal distribution. However, while the general pathway is similar for the two headache types, there are characteristic differences in symptoms and pathophysiology. An important pathophysiologic difference is the activation of the hypothalamus in TACs. There are direct hypothalamic-trigeminal connections, and the hypothalamus is known to have a modulatory role on trigeminovascular nociceptive and autonomic pathways (8). Functional imaging studies have demonstrated ipsilateral posterior hypothalamic activation in TAC headaches however, this has not been demonstrated in migraine headaches (8-13). It is therefore plausible that hypothalamic involvement and activation may be considered a significant factor in the pathophysiologic difference between TACs and migraine.

Commonalities among TAC Headaches
Trigeminal autonomic cephalgias are a group of primary headache disorders characterized by unilateral trigeminal distribution of pain that occurs in association with prominent ipsilateral cranial autonomic features. In TAC headaches there is excessive cranial parasympathetic autonomic reflex activation to nociceptive input in the

ophthalmic division of the trigeminal nerve. Typical cranial autonomic symptoms include conjunctival injection, lacrimation, nasal congestion, eyelid edema, forehead/facial sweating, miosis and ptosis. TAC headaches are typically seen in adults, although adolescents may also report these (14). TAC headaches include cluster headaches, paroxysmal hemicrania, SUNCT, SUNA, and hemicrania continua (3).

Cluster Headaches

Cluster headaches are the most common of the trigeminal autonomic cephalalgias. The term cluster headache is so described as the headache attacks occur in groups, or clusters. A cluster headache is a debilitating headache disorder that has been described as the most painful condition in humans (15). They are three times more common in males than females. The typical pain quality is of sharp stabbing pain of severe intensity. The distribution is unilateral and demonstrates about the ipsilateral orbital region. Cranial autonomic symptoms are present and may include conjunctival injection, lacrimation, nasal congestion, eyelid edema, forehead/facial sweating, miosis and ptosis. Attack frequencies occur from 1-8 per day with a duration of approximately 30 to 180 minutes each. Approximately half the time symptoms of nausea and photophobia/photophobia are demonstrated with cluster headaches, and as such it is necessary to differentially diagnose these from migraine. The pathophysiology involves activation of the trigeminovascular complex and the trigeminal-autonomic reflex, and accounts for the unilateral severe headache and the prominent ipsilateral cranial autonomic features. In addition, the circadian and circannual rhythmicity unique to this condition is thought to involve the hypothalamus and suprachiasmatic nucleus (16). The circadian rhythmicity often involves patients reporting the attacks occurring at the same time each day. Most patients with cluster headache also have one or two cluster periods annually with each lasting between 1–3 months. Often, a circannual periodicity is seen with these bouts occurring in the same month of the year. Although the duration of the cluster and remission periods varies among individuals, these periods remain relatively consistent within the same individual (17). Cluster headaches can be described as both episodic and chronic. Episodic cluster headaches are described as at least two cluster periods lasting from 7 days to 1 year with the cluster periods separated by pain free remission periods of at least 3 months. Chronic cluster headaches are those which occur without a remission period or with remissions lasting less than 3 months for at least 1 year (1).

Paroxysmal Hemicrania

Paroxysmal Hemicrania is a rare headache type characterized by unilateral, severe, short-lasting pain occurring with cranial autonomic symptoms. The typical characteristics include relatively short lasting attacks of about 2-30 minutes with at least 5 attacks per day, although the average attacks per day is eleven (18). The distribution is most commonly noted about the ipsilateral orbital and temporal regions, but may also include the retro-orbital, frontal, and occipital regions (19). Paroxysmal hemicrania resembles cluster headache in the location and quality of pain as well as the pattern of associated autonomic features, however it can be distinguished by its shorter duration and absolute response to indomethacin (20). Paroxysmal hemicrania can be described as both episodic and chronic. Episodic paroxysmal hemicrania is described as having at least two bouts of paroxysmal hemicrania lasting from 7 days to 1 year and separated by pain free remission periods of greater than 3 months. Chronic paroxysmal hemicrania is described as having paroxysmal hemicrania for at least 1 year without remission or a remission period of less than 3 months (1).

SUNHA – Short-lasting Unilateral Neuralgiform Headache Attacks

SUNHA are a category of Trigeminal Autonomic Cephalgias which includes two separate types, SUNCT and SUNA. While these two types of headaches are distinct, studies have shown that differentiating between SUNCT and SUNA does not appear to be clinically relevant (21). SUNHA are described by attacks of moderate to severe intensity lasting 1 to 600 seconds. These can occur as a single stab, a series of stabs or in a saw-tooth pattern. The attack frequency is highly variable, usually from 1 to 100 attacks per day with a median attack frequency of 20 for SUNA, and 30 for SUNCT, although this may be as high as 600 attacks per day (22,23). The distribution of SUNHA is unilateral head pain with orbital, supraorbital, temporal and/or other trigeminal distribution. These are also associated with prominent lacrimation and redness of the ipsilateral eye. Other cranial autonomic symptoms may also be present. SUNHA can be expressed as episodic and chronic. Episodic SUNHA are described as attacks occurring in periods lasting from 7 days to one year, separated by pain-free periods lasting at least 3 months. Chronic SUNHA are described as attacks occurring for more than 1 year without remission, or with remission periods lasting less than 3 months (1).

SUNCT – Short-lasting Unilateral Neuralgiform headache attacks with Conjunctival injection and Tearing. These are

SUNHA headaches which specifically include ipsilateral conjunctival injection and tearing, although they may also involve other cranial autonomic features. During active periods, the frequency of attacks may up to 30 per hour.

SUNA – Short-lasting Unilateral Neuralgiform headache Attacks with cranial autonomic symptoms. SUNA is the other headache type within the category of SUNHA. In comparing SUNA to SUNCT, SUNCT requires features including both conjunctival injection and tearing, whereas SUNA requires only one of these.

Hemicrania Continua

Hemicrania continua is a rare headache disorder characterized by a continuous low-level baseline hemicranial headache with superimposed exacerbations of more severe pain and demonstrating with cranial autonomic features (24,25). The attack exacerbations occur on the ipsilateral side of the low level baseline headache, and typically occur about three to five times per 24-hour cycle. Hemicrania continua often presents with migrainous symptoms such as photophobia and phonophobia. Hemicrania continua can mimic paroxysmal hemicrania, the difference being that hemicrania continua has a constant low level ipsilateral hemicranial pain between exacerbations, while paroxysmal hemicrania is pain free between attacks. Both however demonstrate an absolute response to indomethacin.

Conclusion

Trigeminal Autonomic Cephalgias are a group of primary headache disorders demonstrating with a trigeminal distribution and with ipsilateral cranial autonomic symptoms. There is often symptomatic overlap among the TACs and also with other types of headaches such as migraine. Diagnosis and treatment of TACs can be challenging, and a comprehensive understanding of these and other headache types is essential for proper diagnosis and care of patients suffering from headaches.

Acknowledgments

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Stages of Healing & Phases of Care

By: Aaron L. Wiegand, DC, CCST, FIAMA, SFDN

Lifetime Chiropractic Care for optimal health has been a constant theme since this profession's inception. While the theory of spinal misalignments causing nerve interference and end-organ disease runs contrary to our current understanding of physiology, there is still a way to maintain the traditional ideals of lifelong care for general health that is supported by the evidence. We may just need to change what we do based on the unique health needs of the patient instead of recommending the same care for different reasons. The most basic example of this would be the thing that motivates most patients to walk into our offices every day...pain resulting from a soft tissue injury.

We all know that tissue naturally undergoes three phases of healing. The initial, or "Inflammatory Phase" can last for 3-5 days. During this stage of healing, the process is cleaning up the debris with changes in circulation and alerting the brain via chemical pain. The "Proliferative Phase" where the fibroblasts get hard at work patching the area quickly, albeit, sloppily. The collagen is laid down in a disorganized pattern like a bowl of spaghetti. Over time, a year or more, those fibers reorganize into more of an elastic quilt that is strong where it needs to be strong and flexible where it needs to be flexible. That's the "Remodeling Phase". We call this phenomenon "Davis' Law" which is like "Wolff's Law" for soft tissue.

I've been in hundreds of chiropractic offices and what I've seen is a lot of space and equipment dedicated to the first phase of healing, with very little, if any, for the 2nd or 3rd phases. Ice, E-Stim, Massagers, Ultrasound, and a myriad of other passive modalities, which are great for gaiting symptoms during the initial stage of healing. However, after the first week or two when it's time for the patient to take responsibility, or begin "Active Care", very little time, equipment, or space can be found allocated to treatment for the final stages of care in these clinics.

The irony is that we as a profession have historically preached the necessity for more treatment, yet the *type* of treatment doesn't seem to change as our patients are healing. Perhaps, instead of simply changing the reason the patient still needs care, we change the care plan to include new adjuncts to address the changes in tissue during each stage of healing. Imagine being able to tell a patient that their next visit will begin a new phase of care and in addition to their spinal adjustments their will now be experiencing the effects of different procedures incorporated to bring about even further change and how it is necessary to complete the circle of healing. Don't just change the "why" they need to come back...change the "what" they will receive when they come back. Explain how the final phase of care is tailored to their individual needs and aimed at maintaining the stability the care has brought about thus far.

Give them a customized experience that is more patient oriented, and your chances of getting enough time to make the changes necessary to allow them to achieve their long-term goals and change their lives forever, increases ten-fold. Changing lives- isn't that what we are supposed to be doing?

The following illustrates:

Phase One (Fireman): Reduce pain and inflammation with passive modalities. Adjustments, Stim, Soft Tissue, Needling Techniques, Ultrasound, Heat, Etc.

"Mr. Bewell, your house is on fire. I am in control and my job is to immediately, as quickly as possible, put out the flames with these tools (modalities, procedures) and your job, for now, is to keep your appointments. I expect 50-80% improvement if you can make the 3 visits this week, (or whatever number you determine appropriate). Next week, you will take control and begin to actively participate in your recovery. Can you remind me next week that I promised to give you a couple of stretches to do at home?"

This explains your roles, sets expectations, provides hope that this pain isn't forever, and gives the patient ownership in their progress.

Phase Two (Contractor): Increase mobility by using passive modalities to promote less painful motion, and reinforcing that motion with stretches/mobilizations that regain a loss of function. You're subbing out the care to the patient like someone doing their own remodel on one of those HGTV shows. Those people always take more pride in that new kitchen when they themselves did the work, even if the host had held their hand.

"Ms. Jones. You're feeling better so we're going to change what we're doing. The flames are almost out, but before you move back in, we need to clean out the debris so it doesn't catch fire again. Today, we're going to adjust the joints and work the muscles so they can move again. Then, we're going to make that motion last with those stretches we talked about last week. Knowing you're going to do these stretches at home, as your body becomes more capable of healing itself, I will be seeing you less and less over the next few weeks. If you don't do what I tell you, then your body won't heal properly and you are likely to catch fire again and you will be in the same pain you were in last week. However, if you take my recommendations, then next month I can give you the exercises that will make you strong so you can do the things you love with far less fear that this will happen again. Now, let me see you do your stretches so that I know you're doing them correctly at home."

You told them they would be better, and now they are. That is credibility and trust. You are also rewarding them by reducing the number of times they need to take time out of their day to see you. Perhaps best of all, you have given them ownership responsibility, which means not only are they starting to trust you, but you've shown trust in them, and that's how lifelong relationships begin.

Phase Three (Coach): Reinforce the new mobility with strength and coordination. The only passive care should be small tune-ups to functional losses. This visit is likely to be little more than an adjustment and just making sure they are performing their exercises appropriately. They may need more challenging ones if the old ones become too easy or regarding the health needs of our community.

boring. "Ms. Jones, I remember when you first came in and you were in so much pain. But you were also afraid that you may not be able to do the things you loved anymore. Now, you're back to those things you love because of all the hard work you've put in over the past month. You've made your visits. You've done your exercises. And now I just get to do your occasional tune-ups which I'm sure is a better visit for you and me. I think once a week to once every other week would be a good fit. We can also begin to discuss any other aspect of your health you like from nutrition to exercise to reduce stress. What would you like to do next?"

This is my favorite phase because I go from "boss to servant". We have established trust and I trusting them to make their own decisions from here. They may want to quit care. If this is the case, my role is to simply be their mechanic as they go through the process repeatedly. It's not what I would want for them, but they must take responsibility for their choices. They may want to continue care, but just for what they perceive to be the bone and joint health benefits. I know I can offer them more, and maybe I will get another chance as we go on, but I respect their decision. Patients may want to learn more about how their habits and the choices they make can impact their health for the better. This is where I think we can do the most for the least amount of effort. Habits take a long time to change and you can give them small goals with simple instructions that make big improvements in their health. In any case, my role has changed to meet their needs, and they will remain my patient regardless of the path they choose.

In order to deliver our patients from "Pain Relief" to "Wellness", we may need to advance our thinking to consider not only what services we offer, but the role we play throughout the course of our patient care plans. This change in basic assumptions will empower our patients to be more self-reliant, and will experience chiropractic results delivered with integrity, and substantiated by the current evidence.

Dr. Wiegand is a second-generation chiropractor. He teaches hands-on Dry Needling classes which can be found at www.ChiroNeedle.com. You may contact him at Dr.Wiegand@ChiroNeedle.com with questions.

Telehealth and Chiropractic:

By: Wayne Bennett, DC, DABCO

More Questions Than Answers

When the topic of telehealth is brought up amongst doctors of chiropractic the '*first question*' chiropractors often asked is, "***since we cannot adjust our patients over the internet, is telehealth really relevant to me?"*** If the answer is *'no'* then the conversation is probably over- but what if the answer is '*yes*'?

Agree, or disagree, the correct answer to the question above **is** *'yes'*. Let me explain. COVID-19 has caused telehealth to explode and it is still growing at an exponential rate. The video and audio connectivity that allows *virtual* meetings to occur in real time, from almost any location, has changed the landscape of modern healthcare. This method of delivering healthcare services has been embraced by physical therapists, nurses, doctors of medicine and osteopathy, and many other mainstream healthcare provider groups, all of whom have been gearing up to provide virtual care via telehealth platforms everywhere.

During the COVID pandemic both state and federal governments issued executive orders that relaxed telehealth restrictions so that care could be provided remotely to patients. These executive orders are now expiring, making it necessary for governments to issue new legislation for the regulation of telehealth on an ongoing "*new normal*" basis. This legislation will include a determination as to who decides what healthcare services can appropriately be delivered virtually. It is imperative for the chiropractic profession and the patients that they treat to be engaged, represented, and involved in this process.

A good example of this is Arizona's HB 2454, which was recently signed into law by Governor Ducey. This legislation creates the **'Telehealth Advisory Committee on Telehealth Best Practices**', which is tasked with determining what healthcare services may be delivered virtually. There are 25 designated members on this committee representing healthcare provider groups, and a few other stakeholders. The chiropractic profession is not represented on this committee. This places our profession in a position where all decisions regarding chiropractic telehealth in Arizona will be made by a committee with no representation from our profession.

So, '***if we cannot adjust a patient over the phone or via the internet, why should we care about a seat at the table?"*** The reason we should care is simple. Whether or not a patient can be adjusted via a telehealth platform is a question like so many others regarding the scope of chiropractic, that should be discussed and debated by Chiropractors, not those outside the profession. Clearly, we need to arrive at a consensus and decide on this matter before a '*committee*' decides for us.

There is another question that needs to be answered. ***'Should we be allowed to evaluate, (examine) and manage our patients via telehealth'?*** Most of us would agree that the answer to this is "absolutely", and that the best and safety of our patients would be met with our ability to remotely perform periodic, and follow-up examinations. We need to establish a position on this subject and be at the table when this decision is made.

What about modalities and procedures? ***'Should we be allowed to provide non-manipulative physical medicine modalities to our patients via telehealth?'*** In another year or so the healthcare system in the United States will be joining most of the world in implementing ICD-11, which includes a new chapter on Chronic Pain. This chapter mandates a shift from the medical management of chronic pain model to the biopsychosocial model of patient care. This change in basic assumptions emphasizes doctor/patient engagement in managing their own chronic pain issues, and encourages doctors to provide counseling on activities of daily living, home exercise and rehab, etc. Much of this will be done virtually. If it is determined that a chiropractor's services cannot be delivered using a telehealth platform, then this profession will be losing the opportunity to treat literally millions of chiropractic patients who would benefit from these services. We must not let this happen!

Finally, ***'do we want out-of-state chiropractors to be permitted to treat Arizona patients***?' The Covid-related, telehealth rule relaxation facilitated patient's access to care

from out of state doctors. Prior to Covid there was a growing population of states who created "interstate provider compacts" for doctors to be licensed in multiple states. The newly implemented HB 2454 language creates a similar mechanism that permits out of state doctors to engage patients who reside in Arizona through telemedicine. Presently, at least one telehealth franchise company in another state is licensing doctors of chiropractic to treat patients in Arizona. They do not provide chiropractic adjustments and confine their interaction to other physical medicine modalities. They never actually meet and examine the patient in a face-to-face encounter. Is this a good thing for our patients and our profession? What position should we take on this matter? Do we want this mechanism to be determined by an advisory committee that has no chiropractic representation?

Currently the Arizona Board of Chiropractic Examiners is addressing the regulatory aspects of these issues through the channels available to them. The Arizona Association of Chiropractic is actively addressing the rest of these concerns through their public policy resources, though there is still much work that needs to be done.

The ability to use telehealth to access health care services remotely and manage, improve, and support public health is here to stay. To remain competitive, efficient and generate revenue, chiropractors will need the broad spectrum of services they provide their patients to be accessible through telemedicine.

You can do something about this by raising these questions amongst yourselves, and with your patients and community relations who are involved with public policy. You have an AAC leadership team that is representing you in getting your voice heard and obtaining answers to all these questions. Your trust and support of that team can, and does, make a difference to the success of our profession and the health and safety of our patients.

Let's make sure that the decisions about the future of our profession are made by our profession! Step up and make your voice heard!

Dr. Wayne Bennett is a Diplomate with the American Board of Chiropractic Orthopedics and the American Board of Chiropractic Consultants.
Email: drbennett@cableone.net phone 928 772 7200

ARIZONA ASSOCIATION OF CHIROPRACTIC 2022 ANNUAL CONVENTION

JUNE 11, 12

GILA RIVER RESORTS & CASINOS WILD HORSE PASS

5040 Wild Horse Pass Blvd, Chandler, AZ 85226

Topics include: Closed Head Injuries, Radiology, Headaches, Ligament Injuries, Nutrition, Documentation and Record Keeping and more.

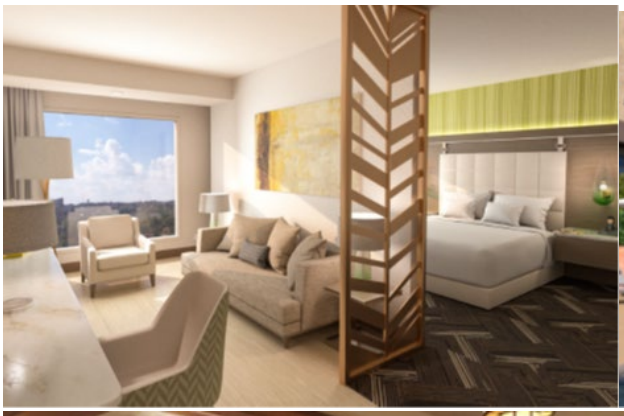
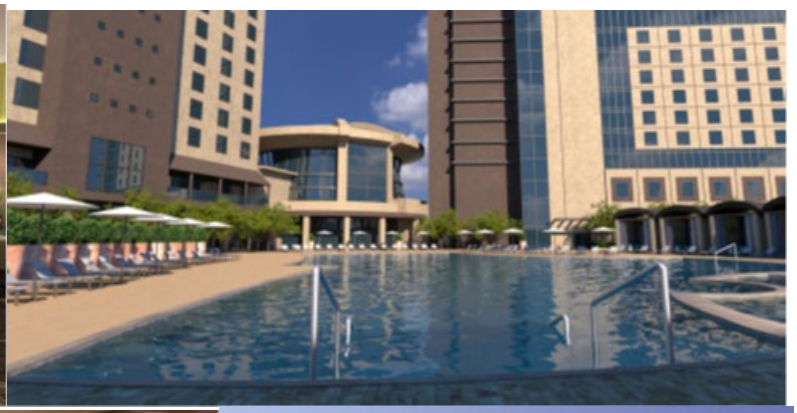
Saturday June 11				
8:00-9:40	***Van Merkle, DC Science Based Nutrition***	***Greg Katsaros DC Headaches***	***Mike Winberry DC Digital Motion Xray***	***Amy Cannatta DC CA training***
10-11:40		***Bill Gallagher DC Concussions***	***Jeff Cronk DC, JD CRMA***	
11:40-1:00	***Lunch***	***Lunch***	***Lunch***	***Lunch***
1:00-2:40	***Van Merkle, DC Science Based Nutrition***	***Ty Talcott Documentation***	***Sean Mahan MD Radiology***	***Amy Cannatta DC CA training***
3:00-4:40		***Jim Naccarato DC Psychology of Pt mgmt AZCE20566***		
Sunday June 12				
8:00-9:40	***Van Merkle, DC Science Based Nutrition***	***Ty Talcott HIPAA Compliance and documentation***	***Mike Winberry DC Digital Motion Xray***	***Bill Gallagher DC Concussions***
10:00-11:40			***Ian Hoffman DCstudent loan***	***Mark Slater PI Marketing***

Registration includes:
Conference and Continuing Education credits
Breakfast and Lunch
Hors d' Oeuvers Reception
Over 25 vendors and Exhibits

Early Registration by May 20	Late Registration
Members $59.00	$99
NonMembers $99.00	$149

Staff Free with Doctor

Special Hotel rates of $109 per Room or $209 per Suite. Room Reservations need to be made by May 15, 2022 to receive the special room rate. Mention the Arizona Association of Chiropractic when making the reservation to receive the discounted rate"

More information at https://azchiropractic.org/

Attention All Readers!

We are excited to announce that Dave Morrison has graciously offered to donate valuable time and will share his insight, offer opinions, and answer questions that any AAC members have pertaining current matters effecting the chiropractic profession. His column "Legally Speaking", gives a platform from which members can share concerns and ask questions that will be answered by a man with comprehensive knowledge and experience in all legal matters involving the chiropractic (and other) healthcare professionals.

And remember to fill out the application for membership on the backside of this cover to join the AAC, to have an opportunity to have your questions answered. This is just one of the many benefits of becoming a member of the Arizona Association of Chiropractic!

Dave Morrison is a solo practitioner with offices in Phoenix and Prescott Arizona. He has been our legal counsel for over 30 years, and has always provided legal services to AAC members for free. He has assisted at the Legislature, when necessary, and attends several nationally sponsored meetings a year to keep the AAC up-to-date on current issues within the legal and healthcare communities.

Mr. Morrison is a past President of the Arizona Health Care Lawyers, the current Secretary for the National Association of Chiropractic Attorneys, and has been practicing Personal Injury Law for over 40 years. In more recent years, he has represented several members and non-members who have had licensing issues with the AZ State Board. Mr. Morrison, a Board approved instructor also teaches courses for continuing education in Arizona, which he offers free to AAC members! His generosity and integrity are matched only by his dedication to the profession.

Doctors, please help demonstrate our gratitude and appreciation for all Mr. Morrison does for the chiropractic community, by continuing to refer your patients who need quality representation to one of the professions finest personal injury attorneys!

COMPLIANCE CORNER

By Angela Giordano Powell

Discounting Fees for Services

I was purging documents the other day and came across a letter from a doctor who was given advice by his management consultant that was so far off the mark I felt it was important to share the response. I sent it not only to the doctor, but the head of the consulting group as well. The question was about "discounting" fees for services.

The doctor was told that "*cash discount programs should not even be initiated until the patient reaches a structural correction phase for non-covered non-medically necessary care".* **Huh?!** The communication received further states that *"there is no version of saving that you are allowed by law to provide the patient"* you are "*treating for* ***a diagnosis***". My immediate thought was, **WHAT?!** Unless you are under the constraints of a managed care contract or the patient is a Medicare beneficiary, (and even then you can discount as long as the discounted fee is clearly expressed in the appropriate box on the claim form), you can reduce your fee for a service or services to any amount that is no less than Medicare's allowed amount. For example, if your standard fee for 1-2 region spinal manipulation is $60. and Medicare's allowed amount is $40., the discount cannot exceed 33% or approximately $20. Using this same example, if you discount the $60. to $35. you cannot charge Medicare or the Medicare beneficiary more than $35. The amounts would vary slightly depending on your provider status.

Medicare patients will always be beneficiaries of the lowest fee you charge for spinal manipulations. That being said, Workers Compensation Laws differ from state to state and doctors must always adhere to the financial mandates of their state which are unaffected by Medicare fees for service.

Discounting fees is not dependent on whether the patient is "*being treated for a diagnosis".* Regardless of the care type, as long as the HCFA claim form does not misrepresent the amount the patient is responsible to pay for the service, you can discount therapeutic or palliative care.

Doctors who maintain fee schedules that are excessively higher than their discounted fees should proceed with caution. Auto carriers are starting to look at the average

charges for services doctors provide to arrive at numbers that are considerably less than standard fees. This is because they calculate the '*usual and customary'* fee using an average of both the discounted and standard fees. They are exploiting this information to reduce settlement amounts in personal injury cases. The information is available to them in a number of ways. What you may not realize is that discounts are producing a new schedule of '*usual and customary'* fees for services, which is a principal and guiding factor in deciding reasonable fees physicians should be paid.

So, should you offer discounts? What is the rationale for discounting fees? I am aware of a company that insists doctors join an organization to avoid any legal ramifications they believe are associated with discounting. These organized minds operate from the premise that a '*discounted fee'* equates to a '*dual fee'*. This would be a false premise. If you understand the reason or rationale for offering a discount, it becomes clear that a third- party intervention is not required. The reason for discounting your fees is to eliminate the burdensome tasks associated with managing patient accounts receivables. If a patient will pay for services at the time they are rendered, the practice can save up to a reported 33% to 68% in administrative costs associated with the collection of those fees. So now you know what you CAN do, let's talk about what you CANNOT do.

If a patient with insurance decides for whatever reason to pay for their care and you offer them a discount, you should not bill their insurance. If you do you are negating the purpose of the discount. If you believe the contrary because you are not waiting for payment, then that discount should be less than what you would ordinarily discount. Remember you cannot charge their insurance carrier a higher fee for the service you are providing than the lesser amount you collect from the patient as payment in full. The fee the patient is responsible for paying is exactly what you must report on the claim form as the cost of that service.

If you generate a claim form that reflects your standard fee for a service but the fee was discounted to allow the patient to pay an amount less than your standard fee you are committing insurance fraud. Additionally, you cannot bill an insurance carrier your standard fees for services to help a patient meet their deductible if you are collecting less than the full fee from the patient. So, no matter how you do the math, a $5000. deductible cannot be met until the patient has actually paid out of pocket $5000.

Is it appropriate to offer the patient a superbill or receipt so they can submit a claim for personal reimbursement?

Practices should always provide a patient with a receipt of some sort. It will assist the patient in obtaining reimbursement for service provided and they will have an accurate record of what their medical expenses are for tax purposes. Make sure the superbill or receipt documents your actual or standard fee for each service and the amount of the discount which should produce exactly what they paid. Their insurer will know to reimburse the amount they paid, and not the standard fees. Once again, to present a bill for your standard fee misrepresents the amount the patient tendered as payment in full and is considered a violation of the False Claims Act, which can result in a minimum penalty of $5,000 for each false claim.

For more information on chiropractic compliance, billing and coding, follow me in ***The Arizona Chiropractic Journal, under*** *the* ***Compliance Corner****. If you have any questions contact me at Compliance Consultants International Inc. 480-570-4204.*

Philosophy Meets History

By Trever Penny, DC

Modern day health care was developed and refined over the millennia of human history. Early physicians were called by different names like elder, healer, or shaman; and they were the only physicians in their communities. Therefore, the village healer practiced all the forms of health care known and shared that knowledge with other village healers when possible.

Brain surgery is not new! Skulls have been found with square and circular holes chiseled into them for brain surgeries performed centuries ago. We know the patient survived the procedures by seeing that the bone had grown back. There are even Egyptian hieroglyphs of how to perform this procedure.

There are ancient healing textbooks from India, china, and Japan on using plants and animals for different forms of medicines.
Ancient acupuncture textbooks have been found in China; and we have found human remains in Europe from thousands of years ago with tattoos demarking acupuncture sites. This point also gives credibility to the theory that the

ancient cultures of the world were not as isolated as modern historians believe.

And yes, we have ancient drawings and descriptions of manipulation of the spine and joints with patients hanging from trees or rolling over large rocks.

Throughout time these healing techniques were refined and put into categories: surgery, medicine, chiropractic, acupuncture, physical therapy/rehab, exercise, counseling, and nutrition. New successful techniques were developed and absorbed while others that were unsuccessful died off. Each category is exclusive and can not be absorbed by another category.

These techniques / categories became more specialized in recent times due to the vast increase in knowledge. Which has caused the healers to become more specialized and form professions. Unfortunately, this created ignorance between the professions followed shortly by competition and politics.

I go through this history lesson to make this point. All the forms of health care that we have today were refined over thousands of years. They are separated by the types of conditions they treat, and the treating techniques implemented. If you imagine the history of health care in the form of a river flowing like a rainbow of different forms of health care. You will see the finger of modern-day politics stuck in the river diverting chiropractic patients away from chiropractic and towards providers that will never be able to treat them properly. This has, in part, created the opioid crisis we have today.

The Arizona Association of Chiropractic is dedicated to fighting this political short sightedness. Please help us by attending our functions, CE seminars, or becoming a member.

Trever Penny, DC is founder and owner of West Valley Pain Solutions and past president of the AAC

Interview with Gina Larragoite, DC

Chiropractor at the Veterans Administration

By Jerome Longoria, DC

Thank you so much for taking the time to provide an interview for our state journal. I feel like this would be a great way to grow the presence of DCs in a hospital setting. Banner Health here in Arizona has a couple on staff, which is amazing to see.

Q. Firstly, thank you for taking the time today I know you have a busy schedule. How did you first learn about Chiropractor positions within the VA Healthcare System?

A. I remember in chiropractic school listening to Dr. Clum, the President at LCCW discussing lobbying efforts to include chiropractic care in the DOD and VA. At that time, I couldn't believe that it was not an option for active military or veterans. In 2004, the VA started hiring chiropractors. After several years in private practice, I remember seeing posting for VA positions on USAJOBS. These postings were few and far between. In 2014, I was hired by the Iowa City VA Medical Center, I was the 67th chiropractor to be hired in the VA. Today, there are over 250 chiropractors working for the VA. There has been a significant amount of growth in the past 7 years.

Q. For anyone interested in applying for VA position, what should they prepare for regarding the application process, interviews, skillsets etc.?

A. The VA chiropractic positions are highly competitive. If someone is interested in working in the VA. I would suggest going to USAJOBS.com, creating a profile, search CHIROPRACTOR and save the search. USAJOBS will notify you when new jobs are posted. When you see a position that interests you, complete the application packet in its entirety. Some sites may require your school transcripts to be uploaded, so you may want to request those in advance.

This is an exciting time as there are so many chiropractic positions available right now in the VA. Today I saw 10 job postings for chiropractors in the VA, all over the country.

Q. Throughout school, we are largely presented with the idea that we should open a private practice or work within an established practice. Given your experience with private

practice and now working in the VA Healthcare system, what are some of the challenges you initially faced when you transitioned into a hospital-based setting?

A. When I graduated from school, working in a private practice setting was really the only option. I worked in a private practice in Anthem, AZ for 12 years and loved working in that environment. I worked in a medical complex which allowed me the opportunity to meet and work with medical providers in my area. We developed a great referral network because of this.

As I transitioned into the VA, I used my experience with working with other healthcare providers here. By working in the VA I am helping to guide Veterans to the correct service. I think the biggest challenge in the beginning was not knowing everything that the VA had to offer. Working as a team in patient management, discussing with providers the best treatment options for a patient. Every employee I have had the pleasure of working with is Veteran centered. I am so happy to address any concerns or offer any treatment that I can to help my patients live more fulfilling lives. However, I do not have to be an expert in everything, but I may know someone who is. Then you refer the patient to that provider, therapies, nurse or health coach. In private practice I would refer out and wait for the patient to report back to me how other providers were treating and the response to care.

Q. The VA offers a residency program for students to work alongside doctors like yourself, as well as many other physicians and health care providers. How valuable do you feel the standardized residency program the VA offers has been to students? And do you see a future of expanding residencies for chiropractic students?

A. One of the four statutory missions for the VA is to conduct an education and training program for health professions, students and residents to enhance the quality of care provided to veteran patients within the VHA (Veterans Healthcare Administration) healthcare system. The VA offers two different educational opportunities for chiropractors.

First is the student clerkship program. I have been part of this program for many years. This allows students in their final months of school to practice in a VA chiropractic clinic. The program is offered through chiropractic schools who have academic affiliations with different VA Healthcare Systems. I love this program. It introduces students to a hospital-based practice and allows them the opportunity to work alongside a chiropractor and co-manage with different specialties. The clerkship program offers experiences to chiropractic students they would never have in the school health center and it provides them with access to complex patients, some of which they may never see in private practice. I would encourage any student who has the opportunity to participate in this program to do so. The skills that you learn during this time will shape the way you practice.

The second is the Chiropractic Residency Program. This program was developed in 2014 and recently expanded in 2020. Miami is one of the locations that was part of the expansion and I transitioned to the Miami VA to assume the role as Chiropractic Residency Director in 2021. The residency program is for graduates. It is a one-year paid program that gives chiropractors the opportunity to learn more and integrate further into the VA. The residency program is a combination of patient care, scholarly activity and inter-professional rotation. I have been working with my current resident for 7 months now and watching him grow and gain confidence in his clinical skills has been very rewarding. The resident program is very competitive and almost all of the graduates have been hired into the VA. This is a great program for newer graduates interested in working in the VA.

Q. Do you have any memorable experiences with your student interns?

A. I have many memorable experiences with my student clerks, remembering all their success makes me smile. I love to see their confidence grow as they treat more difficult patients. I remember listening at the door while one clerk was completing the health history on a bi-polar patient. One moment the patient is so upset and frustrated that they are hurting so much, the next moment is so quiet. I later asked what happened and the clerk said she put her hand on the patient's shoulder and told the patient that she was here to help. That was all it took to change the visit and build rapport with the patient. A different clerk returned from a rotation with the anesthesiologist in the injection clinic full of pride and confidence. The anesthesiologist asked her to read the MRI of the patient they were treating and asked what she saw. They were so impressed with her ability; she was the first chiropractor they had worked with. The clerk then explained the benefits of chiropractic care and how we could co-manage patients together. We had three consults at our clinic from them by the end of the day. The best part is staying in touch with my students and watching their continued success following graduation.

Q. How have your patients benefited from having a Doctor of Chiropractic within a multidisciplinary care team?

A. We all know the benefits of chiropractic care. My patients love that chiropractic is being offered at the VA. Being in a multidisciplinary team allows me to work with other health care providers to give recommendations that would be beneficial to my patients. For instance, I have a patient who is working PT on increasing his movement, back and knee pain. He sees us on two different days during the week. We decided to both have him work on the SciFit bike to ensure that he was getting more activity. We had a patient experience a new episode of vertigo and we were able to walk her over to audiology department and get her care evaluated immediately. When patients are having health concerns that may not be musculoskeletal in nature, I am able to work with their primary care team to contact the patient to set up an appointment.

Q. How do you feel the inclusion of Doctor of Chiropractic in hospital-based settings will benefit the profession as a whole?

A. I believe that including Doctor of Chiropractic any hospital-based environment is extremely beneficial for the chiropractic profession. Having chiropractors working alongside medical providers allows them to experience first hand how we manage musculoskeletal conditions. They see the value in our treatment, and they recognize us as the experts that we are. It is my experience that most medical providers do not know what to do with patients suffering from lower back pain. They are happy to have the referral to the chiropractor as a treatment option. Another benefit working in a teaching facility, like the VA, the next generation medical doctor is also learning the benefit of chiropractic care.

That's all I have for now. Hope these are interesting enough for our readers. Thanks again.

Jerome Longoria DC, CCSP, ICSC practices in Prescott. He was the AACs Chiropractor of the year in 2021. You can email him at Drjerome@lifestylechiroaz.com

Radiology Case Brief Report

Gregory Katsaros, DC, DAAPM
Tempe, AZ

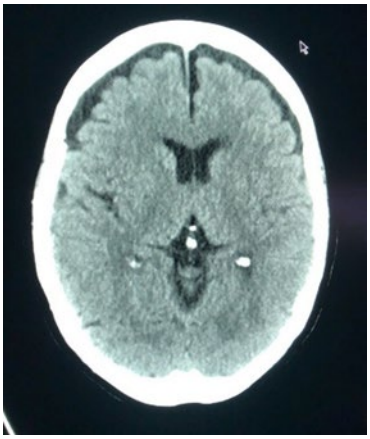


Figure 1. Initial CT scan with no evidence hematoma subdural with a 1.5 cm midline shift to the left.

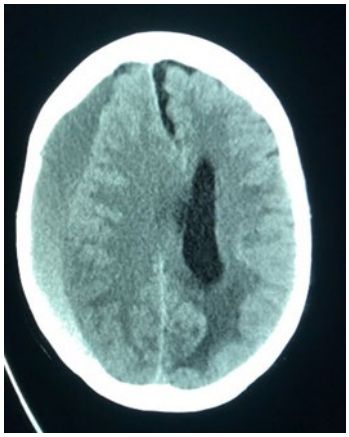


Figure 2. Large acute on subacute of hemorrhage.

A 74 year old male presented with complaints of headaches, dizziness, lightheadedness, and nausea. Three and a half weeks prior he fell and sustained a closed head injury but denied any loss of consciousness. He was seen later that day at an emergency room where a CT scan of his head was read as negative for acute findings (Figure 1). His medications at that time included antihypertensives and an anticoagulant. He had no interim follow-up. His headaches worsened and he developed dizziness and lightheadedness. Following evaluation 3½ weeks after his closed head injury, he was referred for an emergency CT scan of his brain which demonstrated a large subdural hematoma (Figure 2).

Subdural Hematoma

A subdural hematoma (SDH) is a collection of blood resultant of a hemorrhage in the potential space between the dura mater and the arachnoid mater. Subdural hematomas are the most common type of traumatic intracranial mass lesion and are often resultant of falls, motor vehicle accidents, or other blunt force trauma to the head. A severe head trauma is not necessary for development of an SDH, as even mild closed head injuries can cause an SHD, particularly in elderly patients or those who are on anticoagulative therapy. Subdural hematomas may also be spontaneous or caused by procedures such as epidural injections.

Subdural hematomas are described based upon their size, location, and the amount of time since the triggering event. While size and location are specific, the time components are more general and are classified as acute, subacute, or chronic. An acute subdural hematoma is generally defined as being demonstrated within the first 72 hours of a triggering event. Subacute hematomas are generally defined as those presenting between 4 and 21 days after onset, and chronic subdural hematomas are those presenting 21 days or more after the triggering event. While these time frames provide for a general guideline, imaging characteristics provide a more accurate classification and are important when the occurrence of the triggering event is unknown. While small SDHs may not require surgery, SDHs greater than 1 cm at the thickest point generally require immediate surgical interventional.

The Presidents Message


Dr. Andrew Altman, DC

I would like to take this opportunity to thank all our members for their ongoing efforts to support of the Arizona Association of Chiropractic. As a result of your participation the AAC was able to collaborate with other professionals to achieve important goals in the areas of education, legislation, and even the expansion our scope of practice. Your work and dedication do not go unnoticed. For those of you who were not members I would like to summarize a few of this year's events.

First, we were able to expand our scope of practice in diagnostic testing. We took on the Attorney General's decision and were able to pass legislation to expand our scope to include additional diagnostics on patients when the Attorney General advised the Board that we could not do it. This was about matching our scope of practice with our education. We did not stand for it and we prevailed. This expansion in our scope is the first in over a decade.

Another great accomplishment came about as a result of our collaboration with other organizations, and legislation. Whether you are an in network or out of network provider Blue Cross Blue Shield will now honor your patient's assignment of benefits. You will receive direct payment from the payer-no more hoping the patient brings you the check from their insurer or administrator.

SB1021 - Health care liens; limitation that was sponsored by Senator Michelle Ugenti-Rita to eliminate the use of medical liens. This would prohibit a health care provider and other entities from recovering an injured person's medical payment coverage when asserting a lien on the injured person's claims settlement. This will turn chiropractors into collection agents. If your cost for treatment of the patient is less than $20,000 it will go to the attorney and the patient first. **This is a good example of why we need to band together and increase our membership to fight things like this.**

SB1077 - Senator Nancy Barto introduced this bill that would provide AHCCCS (Medicaid) patients the option of seeking chiropractic treatment. It has already passed the Senate Appropriations Committee unanimously. Representative Joanne Osborne who chairs the House Health committee will hear the bill on February 28th, 2022. Representative Osborne has assured the Association that she will support it. **Another good example of why to band together and increase our membership to move things forward.**

Lastly, we have commissioned a committee to put together seminars year-round. These seminars will be offered for continuing education hours. There will be a nominal fee to member and the regular rate will be charged to non-members. There will be at least a one 12 hour's fee continuing education per year. Another good reason to join the Association! If there is anyone local or someone out of state you would like us to bring to Arizona or if there is a subject matter that would be of interest to us all, please let us know. The Association would love to hear from you!

In our last executive meeting membership prices have been adjusted. We reduced a prepaid yearly rate by 30 %. We are also working on other packages as well.

I hope I have answered that most frequently asked question, "what does the Association actually do for me?", and that you will consider joining us this year for the many benefits that will be available to you not only by way of accomplishments but discounts on legal advice, seminars, filing medical liens, consulting services etc. Many changes and events will prove worth the cost of your membership. Please call us so we can give you further details concerning the issues I have touched on in this letter. Your questions and comments are always welcome!

On a final note, I wish to extend my condolences to the family of Dr. William Risley who passed after serving the community for more than 40 years. I did not know him but by all accounts, he was an exceptional man whose litany of contributions to this profession remain legendary.

Arizona Legislative Report
February 21, 2022

By Maelle Quartetti & Melissa Bahati
Legislative Interns, Arizona State University

The week ending February 18, 2022 marked the last week that bills could be heard in their chamber of origin. This deadline is the last chance for proposed legislation to pass out of the chambers in which they were introduced and move forward to be considered in the opposite chamber. Bills not heard after this deadline have a slim chance of being enacted in this session. As the legislature reaches the crossover deadline in the 55th Legislative session it has become abundantly clear that there are two topics at the forefront of our legislators' agendas: Covid-19 and Elections.

Since January, dozens of Covid-19 related bills have been introduced in both the Arizona House and Senate. Most of these bills are aimed at regulating vaccine and mask mandates. Specifically, legislators were interested in assessing employer liability for cases in which an employee is terminated for refusing to get vaccinated due to religious or personal reasons or gets sick from a vaccine where the employer mandates it as condition of employment. The various proposals are aimed at giving employees a pathway to seek restitution for losses suffered due to vaccine mandates.

Moreover, 127 election related bills have been introduced in the Arizona House and Senate. Of these bills, 28 pertain to voter registration, 18 aim to regulate early voting procedures, and 11 affect voting centers and polling places. Common themes among these bills are the regulation of election equipment, various ballot counting procedures, and election integrity. There have been other bills hoping to appropriate money for anti-fraud ballot paper and future audits. Many of these bills aim to prohibit many election procedures such as, emergency voting, electronic ballot adjudication, same-day voter registration, mail in ballot elections, and drive-up voting.

Another hot topic this session has been the aggregate spending limitation for education. The expenditure limit for education fluctuates based on school attendance from the previous school year as well as inflation. As a result of the Covid-19 pandemic, school attendance decreased last year. This has reduced the limit this year. Proposition 301 was extended by the legislature but its exemption from the aggregate expenditure limit was not continued. In order for schools to utilize the money they already have, the limit would need to be extended. If the limit is not passed to extend by March 1st, schools could face a situation where they have 1.6 billion dollars they are not allowed to spend. This could result in shutdowns for many educational facilities. Both houses have now passed the required legislation with an emergency clause so that the schools will remain open.

A notable success for the Chiropractic and Health related communities this session has been to so far block legislation that aims to eliminate the use of medical liens (SB1021). This bill stalled in the Senate Rule Committee January 25 and its future is in question. The proponents of this bill know that unless they address the concerns of the chiropractic community, this bill's fate in the house is dim.

Unfortunately, the bill that would prohibit the fee that is charged for removing a filed lien (SB 2154) did not move forward this session as the county recorders were unwilling to negotiate for any change in lien fees.

But the highlight of the session for chiropractors so far is SB 1077, which seeks to expand AHCCCS to include chiropractic care. This bill passed through 3 committees in the Senate and by a vote to 26-2 on the Senate floor. This bill is ready to move on to the House. During stakeholder meetings held by the Chair of the House Health Committee, Rep. Joanne Osborne, the AHCCCS chief, Jamie Snyder, said that any group wanting to pass this type of legislation should look at the chiropractic community and how we worked with her agency. "They do it the right way," she said.

With bills beginning to be heard in their opposite chambers the week of February 28th, it will be interesting to see what legislators do with the introduced legislation of their counterparts. Session may extend far past the standard 100 days as many legislators seek to pass their go-home bills before the upcoming elections. And, of course, the budget negotiations still looms large.

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Concussion/TBI & Dynamic Functional Cranial Nerve Assessment

By Bill Gallagher, DC & Lois Laynee

Of all the injuries that are not diagnosed in motor vehicle collisions the one most missed is concussions or traumatic brain injury, TBI. Studies have shown that up to 56% of adults and over 60% of children seem in emergency departments had clear signs of concussions but the diagnosis was not made.

Part of the problem is a failure to agree on a definition for a concussion and with that comes a lack of understanding of what to look for in an examination. While many, including ICD-10 codes, look for a loss of consciousness any alteration in mental state or neurologic deficit coupled with a trauma is sufficient to establish the diagnosis.

The key to diagnosing this condition is to understand the mechanism of injury and with that what structures that may be injured. At the ER that usually comes down to a CT of the brain to rule out a brain bleed. Without a positive test, if the patient can walk out on their own, they will be released.

However, when you understand the risk of brainstem trauma with a whiplash, the origin of ten of the twelve pairs of cranial nerves takes on new significance with an examination. For that matter if you understand the amount of force needed to damage ligaments, discs, and bones in the cervical spine you will never again diagnose that whiplash without a concussion.

In school we all learned how to perform a cranial nerve exam. Unfortunately, with a lack of positive findings most of us have abandoned that testing or at best have reduced it to a cursory exam.

The problem here is twofold. First, most doctors forget what to look for and as such are less likely to see positives even when they do exist. Second, is the time it can take to assess each function of all twenty-four cranial nerves.

The Dynamic Functional Cranial Nerve Assessment taught as part of the core curriculum of the American Academy of Motor Vehicle Injuries is as comprehensive as a cranial nerve examination can be. This exam assesses all motor and sensory functions of each of these nerves. When done bilaterally there are well over one hundred functions evaluated. It is not enough to simply measure deficiencies found on these nerves. With this assessment how these deficiencies affect the patient injured in a motor vehicle collision is equally important.

With the shift to functional medicine, an asymptomatic compression fracture or herniated disc rarely has a value greater than 0%. When the findings are established in the beginning of care, even if your treatments help them to resolve, the value increases. This holds true for TBIs too.

The more findings you can document at the beginning and the end of care, the greater the value to the lawyer negotiating a settlement. More than that, the more you can document the better chance the patient will have of getting the care they need and deserve.

Scottsdale chiropractor, Bill Gallagher teaches personal injury seminars through the American Academy of Motor Vehicle Injuries. He can be reached at drbillgallagher@yahoo.com or 480-664-6644.

Lois Laynee is the founder of Restoring Breathing and developed the Dynamic Functional Cranial Nerve Assessment Tool™, She can be reached at 480-664-6655