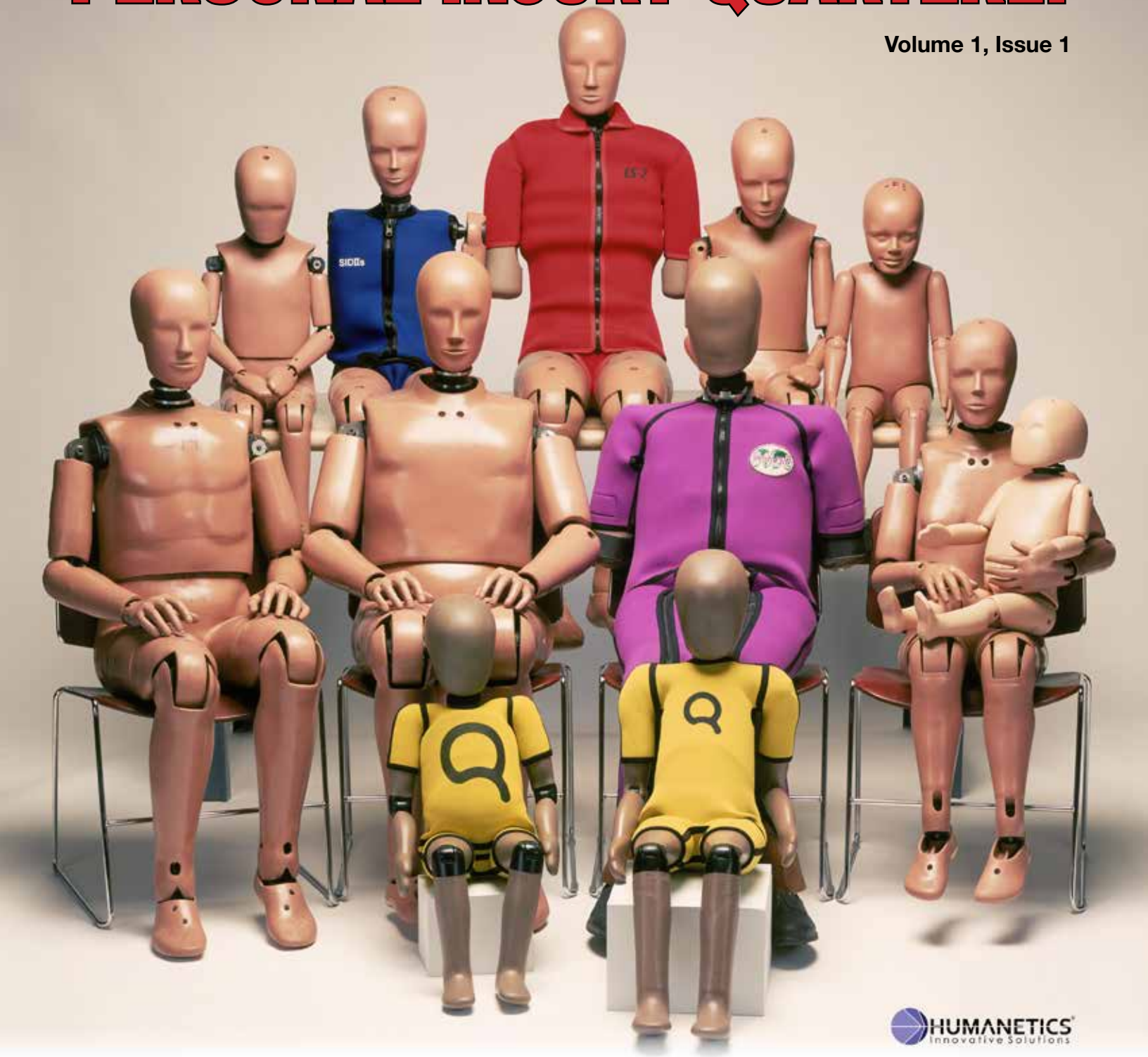
ARIZONA ASSOCIATION OF CHIROPRACTIC

PERSONAL INJURY QUARTERLY

Volume 1, Issue 1



INSIDE THIS ISSUE:

Articles by AAC members to help you to better manage your PI cases.

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Contents

The AAC Personal Injury Quarterly

2017—4th Quarter— Issue 1

A special thanks to Dr. Bill Gallagher for his tireless efforts and dedication to seeing this publication through!

Publisher	**AAC**
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A Letter from the Editor

Angela Giordano-Powell CPC, CCO

The Arizona Association of Chiropractic is a non-profit organization whose committees are comprised of volunteers that generously donate their time and resources to organizing and hosting special events, providing easy access to affordable educational opportunities, and maintaining a strong political presence to protect the profession from a misuse of power. Over the years, the AAC has published a quarterly journal to keep readers up-to-date on these matters, but it was only available through membership.

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Thanks to our forward thinking committees, to keep all chiropractors in the loop of knowledge, and to further unify and strengthen what is often perceived as a fragmented profession, '*The Personal Injury Quarterly'* will now be distributed to **all** chiropractors licensed by State of Arizona, with its focus on matters related to the procurement, and care management of personal injury cases. Why focus on *''Personal Injury"*? There are a number of reasons.

The treatment of personal Injuries is a complex subject of paramount importance that until now, has been given very little attention. With the number of motor vehicle accidents nationwide on the rise today, more than ever a publication like this is needed. We know that chiropractic has great success treating conditions that result from these accidents, but the profession as a whole has not taken the steps necessary to prove it, mainly because they don't know how. The information delivered through in these quarterly publications can help in that quest.

In terms of the diagnoses and management of personal injury patients, there are none more complicated. That being said, it's Important for providers to be familiar with the multitude of diagnostic and assessment instruments as well as treatment options and their efficacy. Minimal use of diagnostics and outcome assessments instruments, as well as inadequate diagnosing, provide the *'good cause'* or the reason an attorney may hesitate to refer clients to a chiropractor. If chiropractors are to be perceived as experts and respected specialty providers, they must maintain a place in good standing with the legal community, and step-it-up in the area of education. The Chiropractic Profession will need to call to arms all the resources available to make this happen. This magazine will provide information about those resources.

So beyond reporting news on the political front and hosting calendared events, the Personal Injury Quarterly brings all chiropractors licensed by the state of Arizona, important insight and views from both the legal and healthcare communities. It will keep readers informed on educational opportunities and certification programs like those like those offered by the American Academy of Motor Vehicle Injuries .

This publication was developed with higher education in mind and it is our hope that all Arizona Chiropractors will find it confidence inspiring and take advantage of the education opportunities as they present. Who knows, completing a certification program that permits you to follow your *signature* with *PIC,* may just make you, every P. I. Attorneys, new best friend!

Compliance Corner

Why Are Attorneys Asking Providers to Bill Medicare?

By Angela Powell CPC

"My patient's attorney wants me to submit my patient's bills for their car accident to Medicare for payment, do I have to do that? Do I have a choice?"

Clients often ask this question of me and my response is '*you always have choices but in this case the right choice is to* ***not*** *bill Medicare, and here is why.*

In general, when the injured party is a Medicare beneficiary liability insurance (including self-insurance) and no-fault insurance are, by law, primary payers to Medicare.

If a Medicare beneficiary has no-fault coverage, providers, physicians, and other suppliers must bill the no-fault insurer first. It is not a choice. If a Medicare beneficiary has made a claim against the liability insurance (including self-insurance), the provider, physician, or other supplier must bill the liability insurer first unless it has evidence that the liability insurance (including self-insurance) will not pay "promptly" which is 120 days according to CMS's regulations. In these cases, Medicare *may* make conditional payments on claims for spinal manipulation. These payments are "conditional" because if the beneficiary receives an insurance or workers' compensation settlement, judgment, award, or other payment, Medicare is entitled to recover the total sum paid for spinal manipulation.

By statute, Medicare is secondary to liability insurance (including self-insurance), no-fault insurance, and workers' compensation. Insurers or a self-insured entity that allege that they are "supplemental" to Medicare are not, because they cannot by contract or otherwise, supersede federal law.

(Continued on Page 8)

Pain Management

By Trever Penny, DC MUAC CICE

Over the past decade of my practice, I have been attempting to bring chiropractors together in a productive working relationship; in place of the tried and true "Only the Strong Survive" belief, where the profession eats its young. Instead, chiropractors need to co-manage some patients with other professionals and chiropractors! Yes, I said it.

One way to do this would be to refer some patients to chiropractors that own a pain management office. That type of office would understand that they would be managing the patient's pain with a chiropractor's conservative care. And not STEALING the patient and referring them for physical therapy.

When I talk to chiropractors about pain management, I often see brows clench with glazed over eyes that stare off into the distance. The subject is not as intimidating as you might think. It also is more chiropractic friendly than you would initially think. Chiropractic is the standard of care when treating an otherwise healthy body. But what do we do with a patient with debilitating pain that is not responding to our conservative care?

Both acute and chronic tissue damage may not respond to the normal drugless care that we are so very proud of. We have numerous tools to use for pain and the inflammatory process: cold packs, lasers, OTC NSAIDS, and other therapeutic modalities. However, every chiropractor has had those STUBBERN patients that don't seem to WANT to get better.

We know that chiropractic care works; we have helped many patients. But why not these few?

Could it be that the physiology of these few patients are different, or at least different at the location of the pain? We know that diabetes and smoking can constrict and harden the capillaries restricting blood flow that mitigates the normal healing; along with deep tissue scab and scar formations, as in old injuries or arthritis.

If we continue to treat for a long period of time with only a conservative approach, the chances are good that the patient's body will eventually adapt to the pain. Or worse, the patient will just give up and be convinced that he/she will have to live with pain.

Fortunately, I have learned there is a more effectual approach. And yes, it requires co-management with a pain management specialist.

There are two primary avenues of care for a board-certified pain management specialist. Oral medication for a systemic approach usually in the form of a narcotic; or an injection procedure applied to a very specific pain generator.

The oral or systemic approach has fallen out of favor due to the addictive qualities of the narcotic drugs. With that said, there are still some terminally sick patients with symptoms that need our care along with the oral or systemic approach of pain management. However, in general there are still some drugs as well as specific injections that are not as addictive and can still be used to help us achieve our goals.

Pain management with injection procedures has been criticized for a lack of long term progress. But this is due to the medical model ***not incorporating the conservative care that we provide***. Personally, I am still astonished when certified interventional pain management doctors tell me that their "care means nothing without our conservative treatment." And that the patients need both types of care in tandem to see affective progress.

End

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Concussion / TBI and Dynamic Functional Cranial Nerve Assessment

by Bill Gallagher, DC &
Lois Laynee, PhD

Of all the injuries that are not diagnosed in motor vehicle collisions the one most commonly 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 goes to understanding the mechanism of injury and with that what structures that may be injured. At the ED 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 a brainstem trauma with a whiplash, the origin of ten of the twelve pairs of cranial nerves takes on new significance in 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.

(Continued on Page 7)

(Continued from Page 6)

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 nerves 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 are able to 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 are able to document the better chance the patient will have of getting the care they need and deserve.

(Continued from Page 3)

The section of the Social Security Act known as the Medicare Secondary Payer (MSP) Provision, makes Medicare secondary to **workers compensation, liability, no-fault and self-insurance** benefits. Liability insurance (including self-insurance) is coverage that indemnifies or pays on behalf of the policyholder or self-insured entity against claims for negligence, inappropriate action, or inaction, which results in injury or illness to an individual or damage to property. It includes, but is not limited to, the following:

- Homeowners' liability and general casualty insurance.
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

Liability insurance payment means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan."

Entities and individuals engaged in a business, trade, or profession are **self-insured** to the extent they have not purchased liability insurance coverage. This includes responsibility for deductibles. Please note that government entities are considered entities engaged in a business.

> Medicare regulations prohibit "balance billing" once the provider has received payment from Medicare. This is a settled issue in the courts of several states, in three Federal Circuits and in the Federal Districts of Arizona and Florida. In Arizona, the Federal District Court case known as '*Lizer*' has asserted that the rights of medical providers to balance-bill using liens are cut off once they receive payment. Therefore, if an attorney asks a provider to bill Medicare and they submit claims, whatever amount Medicare pays for spinal manipulation will constitute payment in full. Here is where black and white turn grey.

Does a chiropractor have a right to charge standard fees for spinal manipulation and collect the balance of any portion of that fee which was not paid by the negligent party or their insurer using a '*lien*' filed in the name of the injured party/patient?

> Settlement agreements/releases with insurers usually contain a requirement that the injured party agree to pay the "balance-billing" lien. In fact, there will be a requirement that the injured party agree to indemnify the negligent party and its insurer from such claims. So at the settlement, the obligation to satisfy a balance-billing lien has been effectively transferred to the injured party through the settlement agreement's terms. This is because payment for their medical bills is included in the total amount paid in settlement. In turn, the injured party's lawyer negotiates those liens down as much as possible to get the client the maximum settlement. Using this case law to reduce the medical bills is one way to improve the look of a poor settlement particularly when you consider that any sums paid by Medicare must be paid back.

Chiropractors cannot *'opt out'* of the Medicare program and contract independently with eligible Medicare beneficiaries, which means they are bound by the laws the social security act imposes which prohibit chiropractors from collecting the difference between what Medicare allows and their standard fee for spinal manipulation.

"So can I charge my standard fees for all other services and file a lien to ensure payment?"

Yes. Chiropractors can collect 100% of their standard fees for all other services they provide, and to the extent they extend the Medicare patient credit, a lien may insure payment of those services NOT covered by Medicare.

In Arizona, statutes give medical providers the right to file liens in an effort to recover monies due them or any unpaid portions of their patient's bill. In order to have an enforceable claim, the provider must file a lien within the statutory timeframe. If a lien has not been filed timely, there is no enforceable "balance billing" claim against the settlement. It should be noted however, that if the patient actually owes the provider a copay, deductible, or coinsurance amount, the patient is still personally liable for the amount he/she actually owes, regardless of the lien issue.

Is there ever an instance when we should bill Medicare?

When a Medicare beneficiary is involved in a no-fault, liability, or workers' compensation case, his/her provider may bill Medicare if the insurance company responsible for paying primary does not pay the claim promptly (usually within 120 days). In these cases, Medicare **may** make conditional payments for the spinal manipulation. These payments are ***'conditional'*** because if the beneficiary receives an insurance or workers' compensation settlement, judgment, award, or other payment, Medicare is entitled to recoup the total amount they paid for the spinal manipulations. Furthermore, a Medicare beneficiary who receive a liability settlement, judgment, award, or other payment has an obligation to refund any conditional payments made by Medicare within 60 days of receipt of such settlement, judgment, award, or other payment.

So remember every attorneys first responsibility is to their client. That being said shame on any attorney who would ask a provider to bill Medicare knowing what they know. With few exceptions a provider should not to submit claims for treatment related to conditions or injuries that are the result of an accident, unless there is no hope of a settlement or until it is determined that no other collateral sources exist.

Lien questions are complex and fact-specific. As you can see, the state of the law is not settled and it is ever changing – the result being that lawyers rarely agree as to what the correct answers are and, to the degree, an answer is correct today, it is usually incorrect tomorrow. Do not act in reliance on any of what you just read; it is for informational purposes only and is not legal advice. Let your attorney advise you.

End

Angela Giordano-Powell has over 35 years experience working one-on-one with Medicare carriers, and intermediaries, as well as federal regulatory agents to ensure the chiropractic profession receives the most accurate and up-to-date information regarding claims submission, appeals, audits and patient record reviews. For more information regarding when you can submit claims to Medicare for reimbursement of treatment related to a personal injury, call the Claims and Reimbursement Specialists at Compliance Consultants International Inc.480-570-4204

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ERIC W. SCHMIDT

Attorney Eric W. Schmidt is a seasoned litigator who has dedicated over 14 years to practicing exclusively in the area of personal injury law and insurance claims. Over the course of his career, he has gained experience practicing in both California and Arizona, and was the founding Partner of two law firms.

A graduate of San Diego State University and Western State College of Law, Attorney Schmidt has served as the lead trial lawyer in over 20 Maricopa County jury trials, and has participated in more than 200 mediations and arbitrations, the majority of which resulted in significant results for his clients. Eric Schmidt will provide competent legal representation to Phoenix and Arizona residents, and to those who are injured in California.

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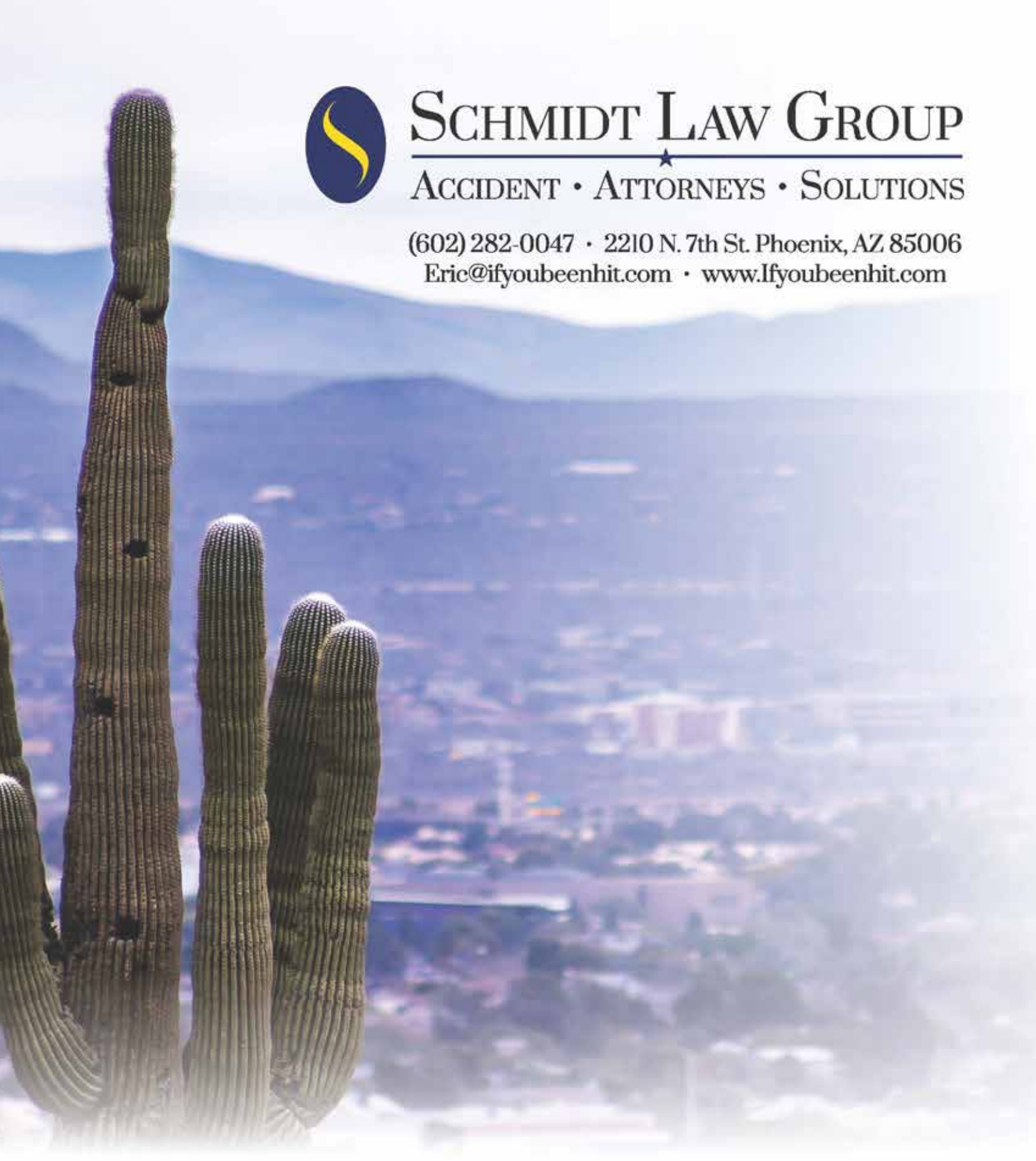
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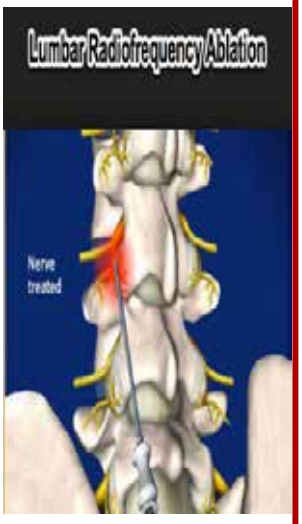
RADIO-FREQUENCY ABLATION

By Trever Penny, DC MUAC CICE



When the facet joint becomes a pain generator for a patient, the interventional pain management specialist will often refer to it as Axial Pain. This refers to the mesodermal simits during embryonic development that become the axial skeleton. An axial pain pattern is different than the radicular pain pattern, and recognizing this is very important in choosing a differential diagnostic procedure and ultimately formulating the appropriate treatment plan.

The pain specialist will perform a facet joint injection or a medial branch block (MBB) to ascertain if the facet joint is an actual pain generator. If the patient receives significant pain relief with one or both procedures, even if only for a short time, this diagnostic procedure points to the facet joint being the pain generator. With this knowledge, the interventionists can now consider performing ***radio-frequency ablation*** (RFA)

The medial branch nerve splinters from the dorsal ramus of the spinal nerve; and innervates the facet joint. Since the facet joint is made from two distinct vertebrae, one upper and one lower, the procedure must be performed at two levels to affect one facet joint. This is usually performed with multiple probes at the same time.
A radio-frequency probe is inserted down a special needle to approximate the medial branch nerve. Special care is used to make sure that only sensory nerves and not motor nerves are being treated. A high-pitched frequency is delivered to coagulate the proteins that make up the medial branch nerve, essentially burning a short part of the peripheral nerve.

R***adio-frequency ablation*** (RFA) is used to provided pain relief that can last from 6 or 9 months. Occasionally, RFA is performed on other peripheral nerves to provide long term pain relief. Look for a more in-depth discussion on this topic in the next issue of the **AAC Personal Injury Journal**-

Mechanism of Injury in a Motor Vehicle Crash

By Bill Gallagher, DC

The American Academy of Motor Vehicle Injuries was created to educate doctors about how to properly diagnose, document, and manage a personal injury case. The coming issues of this quarterly will cover each of the major subjects in the hopes of getting you at least the basics of how to do a better job with these cases.

The Academy offers a series of ten, fifteen hour seminars leading to a certificate in motor vehicle injury. Half of these classes focus on diagnosing the injuries that are often overlooked in motor vehicle collisions. We will save the diagnosis discussion for the next issue of this magazine and in this issue we will begin at beginning.

In order to be able to make a diagnosis, the process is greatly simplified with the understanding of what could be injured. Before we get into that it is important to understand that the injuries sustained in a crash are not what a chiropractor would usually see in their average patient.

The patient who calls you on Monday to fix what they did over the weekend has not endured the forces that would be seen by the patient in a crash. The muscle strains seen after a weekend of gardening or sleeping with their head in the wrong position on the sofa are not the same as the muscle strains and tendon tears seen in a crash.

Likewise the twisted ankles your weekend athlete is able to walk out does not compare with the ligament laxity so commonly seen in a whiplash type injuries. Despite the similarity, sprains and strains in a crash tend to be far more severe because of the amount of force that is introduced.

I remember being told that mechanically there are two ways to cause a subluxation. One was a little bit of force over a long period of time. This is commonly the patient who has fallen asleep with their head against the arm rest. The second way is with a lot of force over a short period of time, a crash.

Most can understand the physics formula of f = ma; force equals mass times acceleration. You do not need to be a mathematician to see that there is a huge difference between a football player taking a hit from a 250 pound linebacker and your patient in a collision with a 2,500 pound Honda Civic.

To keep it simple the head and neck involved in a motor vehicle collision will endure considerably more force with the acceleration caused by the mass of the striking vehicle. I will not go any further into the physics involved in part because this magazine is not large enough to fully explain the concepts and also because I want you to continue reading.

The bottom line is that greater force leads to greater risk of injury.

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The bottom line is that greater force leads to greater risk of injury. Once you understand that, the next step is to appreciate the dynamics of injury. The mechanism of injury is a matter of the simple mechanics and physics of what happens when two vehicles collide. What happens to the human body requires us to look at the dynamics of a collision.

How the human body responds depends on a multitude of variables. Size, age, gender, and physical condition are only the beginning of the list. Each of these is important toward understanding the possible extent of injury.

Equally important is understanding how the direction of the impact factors in. It is simple enough to understand that someone struck from behind will suffer different problems than someone struck from the front or side. The key is that when you understand what can be injured you greatly increase your chances of finding those injuries. Unless you can make the proper diagnoses you patients will not get the proper care that they need and deserve.

The Pituitary Gland

By Robert Menner

The pea size gland or pituitary gland lies within a bony enclosure called the sella turcica supplied mainly by long hypophyseal vessels. The pituitary gland is at risk of damage at time of injury because of its position within the sella turcica. Basal skull fractures and subsequent fracture of sella can directly damage pituitary gland, infundibulum and hypothalamus especially by rotational and shearing impact during injury.

The hypophyseal portal vessels and nerve fiber tracks in the infundibular stalk are vulnerable to acceleration and deceleration forces that can result in shearing. The sella turcica is a restricted space that permits pituitary constriction via edema, and encourages an ischemic environment.

The Pituitary gland consists of 2 lobes, anterior and posterior. The Anterior lobe hormones secrete their hormone in response to hormones reaching them from the hypothalamus of the brain, which are TSH, FSH, LH, Prolactin, GH, ACTH and alpha-MSH. ACTH acts on the cells of the adrenal cortex stimulating production of cortisol, aldosterone, and male sex hormone Testosterone. Thyrotropin releasing hormone (TRH) from the hypothalamus would stimulate the secretion of TSH.

The diagnosis of central hypothyroidism in TBI patients is easily made when low serum free T4 is associated with normal or low serum TSH values. The presence of severe . head injury was associated with lower levels of TSH and free T3. Mortality was 37%. Survival was associated with higher TSH and T3 levels, but not with higher T4 levels. TSH levels exceeding 1 mU/l on the first day were only observed in survivors

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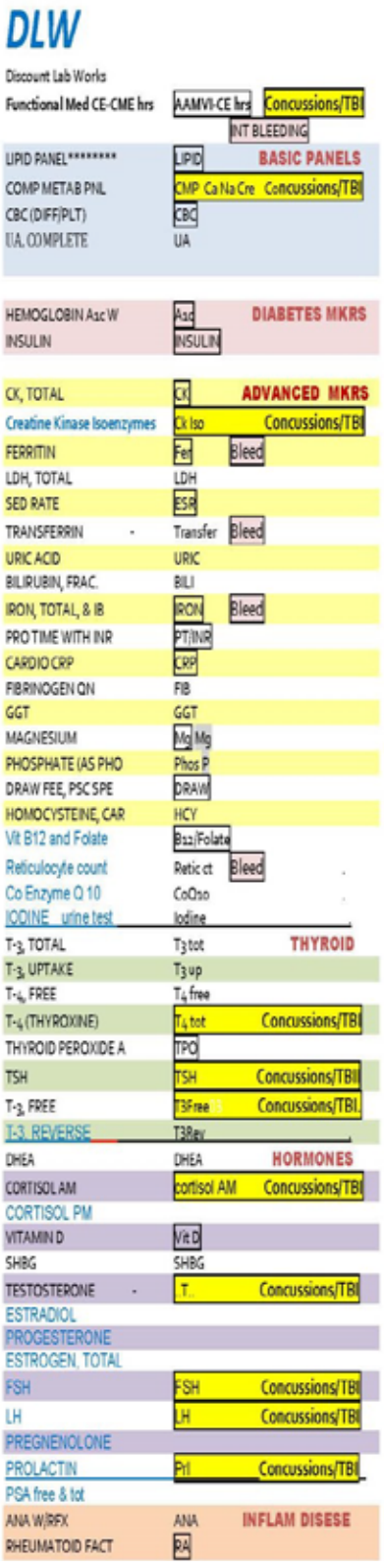

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Studies showed that serum cortisol increase in acute-phase and then back to normal after several days.

Posterior lobe releases 2 hormones vasopressin aka the antidiuretic hormone (ADH) and oxytocin. ADH helps with the reabsorption of water into the blood. If there is a deficiency of ADH can lead to an excessive loss of urine known as diabetes insipidus.

The acute head trauma can lead (directly or indirectly) to dysfunction of the hypothalamic neurons secreting antidiuretic hormone (ADH) or of the posterior pituitary gland causing post-traumatic DI (PTDI).

Follow-up and testing: Current evidence suggests high prevalence of pituitary dysfunction after moderate to severe TBI, though the values are varied. The exact timing of occurrence cannot be predicted and a follow-up of at least 1 year with regular pituitary assessment has been suggested regardless of clinical evidence for pituitary dysfunction

The presence of traumatic hypopituitarism should be considered during the acute phase as well as during the rehabilitation phase of patients with TBI. All patients with moderate to severe TBI require evaluation of pituitary function. In addition, symptomatic patients with mild TBI and impaired quality of life are at risk for hypopituitarism and should be offered neuroendocrine testing.

Zeeshan Javed, Unaiza Qamar, and Thozhukat Sathvapalan **Pituitary and/or hypothalamic dysfunction following moderate to severe traumatic brain injury:** Current perspectives Indian J Endocrinol Metab 2015 Nov-Dec; 19(6): 753–763
Tiffany Greco, David Hovda, and Mayumi Prins.The Effects of Repeat **Traumatic Brain Injury on the Pituitary in Adolescent Rats** J Neurotrauma. 2013 Dec 1; 30(23): 1983–1990. Chiolero RL, Lemarchand-Beraud T, Schutz Y, de Tribolet N, Bayer-Berger M, Freeman J **Thyroid function in severely traumatized patients with or without head injury.** Acta Endocrinol (Copenh). 1988 Jan;117(1):80-6

Cristina Capatina, Alessandro Paluzzi,Rosalid Mitchell,and Niki Karavitaki **Diabetes Insipidus after Traumatic Brain Injury** J Clin Med. 2015 Jul; 4(7): 1448–1462. Tritos NA, Yuen KC, Kelly DF; **AACE Neuroendocrine and Pituitary Scientific Committee.** AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS AND AMERICAN COLLEGE OF ENDOCRINOLOGY DISEASE STATE CLINICAL REVIEW: A NEUROENDOCRINE APPROACH TO PATIENTS WITH TRAUMATIC BRAIN INJURY. Endocr. Pract. 2015 Jul ;21(7):823-31. SAME AS 5

ENDOSCOPICALLY SPEAKING

By Craig Peterson

All chiropractors know that there are extremely rare cases that warrant full-blown surgery. Although chiropractors are masterful at improving function, decreasing pain and improving health, sometimes there are situations when a patient is not a chiropractic candidate or fails conservative care.

What would you do?

Let's say your patient presents with low back pain and radicular symptoms. You diagnose and treat. Your patient does not make progress and may even have worsening symptoms. You order an MRI. The report comes back with a large disc herniation clearly compressing the exiting spinal nerve; the spinal cord has an extrusion migrating down the spinal canal. You continue to treat with disc-specific protocols that yield no improvement. The patient decides to get epidural injections at their pain management center with no relief. What's the next step for the patient? Most likely a surgical consult.

What if this patient was your family member? What would you do and who would you send them to?

We believe that you would send them to a surgeon that you trust. You would send to a surgeon that is pro-chiropractic.– one you know is going to perform the least invasive procedure possible. You would look to refer them to a surgeon that does not routinely promote fusion surgeries or any surgeries, as a primary course of treatment for his patients. Well look no further—here we are. We are the surgery center, who even chiropractors themselves, have turned to when they find themselves with a practice-stopping disc herniation. They have become our patients because they have come to trust us with their patients.

What **is** endoscopic laser spine surgery?

This patient example with the large disc herniation would likely be a candidate for our endoscopic laser disc surgery. Just like a knee surgery can be done endoscopically, which decreases scar tissue, improves function and reduces recovery time, endoscopic spine surgery can produce the same results. Endoscopic laser spine surgery can be done through a single incision less than a centimeter long. The surgeon uses an endoscopic camera to clearly see the disc, remove the disc extrusion and repair it using a laser. No screws. No hardware. No loss of mobility. Although the surgery will take the surgeon more than twice as long to perform when compared to a traditional open or "mini-open" surgery, the patient's recovery is significantly shorter and more pleasant. Many patients don't need any prescribed pain medications through recovery because they experience immediate relief. Our facility is happy to work with the referring chiropractor to refer the patient back for post-surgery rehab if desired.

We invite you to come tour our facility and meet our physicians. We strive to be a resource for you that you can truly depend on. We are happy to provide a second opinion or MRI review at any time.

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CHECK APPROPRIATE CATEGORY FOR MEMBERSHIP
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__ AZ Affiliate DC Membership:	$200 per year

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__ Corporate Membership: $500/$1000/$1500 per year (for product/service providers)
(Please email AAC at admin@azchiropractic.org for category details)

I hereby apply for membership in the Arizona Association of Chiropractic (AAC), for the purpose of serving the Chiropractic profession and for the benefits I may receive from such membership. As an Association member, I agree to comply with the Constitution and By-Laws of this Association.

Today's Date: Signature:

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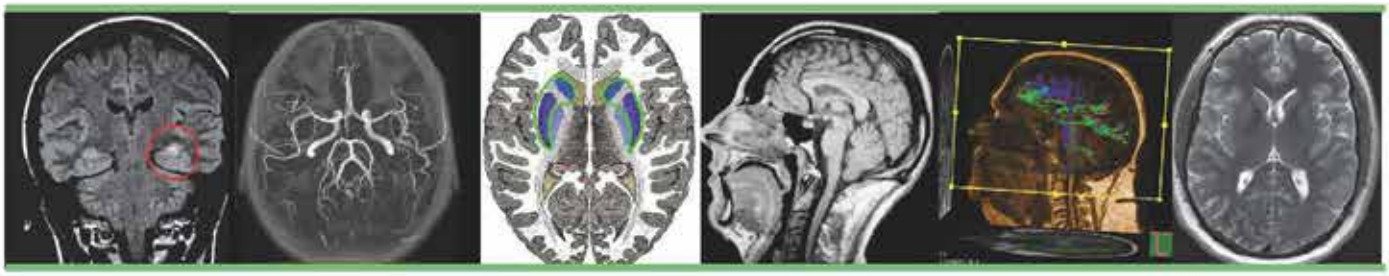

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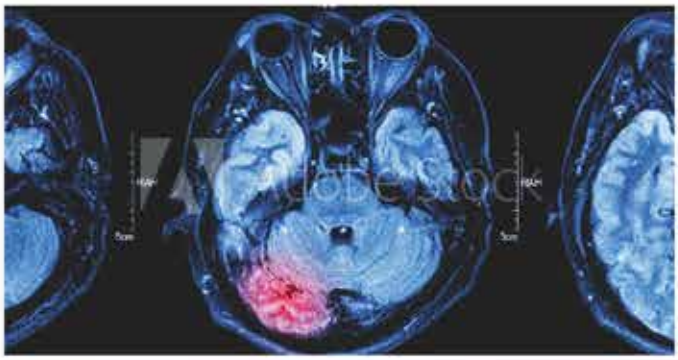

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