CHIROPRACTIC NEWS & VIEWS

Presented by:

Hawaii State Chiropractic Association, Inc.

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HAU'OLI MAKHIKI HOU!

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THE HAWAII STATE CHIROPRACTIC ASSOCIATION BOARD OF DIRECTORS WISH ALL MEMBERS AND THE CHIROPRACTIC COMMUNITY THE HAPPIEST, HEALTHIEST AND MOST PROSPEROUS NEW YEAR!

PRESIDENT'S MESSAGE

Joseph G Morelli Jr DC FICC, HSCA President & ACA District 7 Governor

Aloha All:

I hope you all had a wonderful Christmas and New Holiday! Mine was very nice, spending some quality time with family and friends. I am recharged, very optimistic for 2015!

Now, we get to see what this New Year promises, as the days and weeks progress.

We are somewhat hopeful with a new Governor and refreshed State Legislature that things may be a little more positive for our profession here in Hawaii.

On the national scene, my legislative/political contacts in ACA are encouraged with a new Congress. With over 70 new congressional and senatorial members, we are already knocking on doors and introducing our issues. So far, we seem to have been having a very positive response. I am hopeful we can finally get some positive legislative through.

Locally, we have some significant challenges ahead of us here with the final phases of "ObamaCare", kicking in.

We have recently met with HMSA, and will be following up with them regarding how they are interpreting our practice and clinical abilities.

We caution or doctors to pay very close attention to your billing procedures and documentation practices. HMSA may start to ask to see your documentation and clinical files to support the services you are billing.

Since the new laws have been generally integrated into payment and provider policies, the carriers are watching very carefully our utilization of services, and billing of claims.

We have already been told of some possible abuse by our providers regarding their improperly billing of services. They suspect improper "upcoding" and misuse of certain E&M and Procedure codes.

They are already trying to come up with some punitive measures to neutralize what they see as possible fraud and abuse.

We have made it our mission to do what is possible to "educate" the insurers since we believe that some of their suspicions are fed by not understanding our practice and proper coding procedures. Therefore, what may look to them as potential fraud, may really only be errors in billing and coding on our part, and/or misinterpreting our practice procedure codes on their part!

Of course, there are always "outliers", who have little or no regard for the proper method of coding and billing for their services. It appears that there are some who are just looking to maximize every patient encounter regarding what they can get a third party to pay them.

Well, let me tell you that some of these ill-conceived practices are being noticed, and tracked by HMSA, and other carriers.

I have heard that some DC's are comparing this to the early 1990's when we squandered a great and lucrative position, and got smacked down hard by very restrictive legislation/regulation.

I hope this is not the case regarding the opportunities that ObamaCare has opened up for us with the anti-discrimination section of the law, that now forces health insurers to pay us for what we are licensed to provide!

The HSCA will be there doing what we can to help clear up this difficult and potentially negative situation with HMSA, and other carriers.

When we have gotten to a point that it is feasible, we plan to hold educational programs for our Hawaii practitioners and staff. We are hopeful that HMSA will also participate in this effort.

Additionally, we will be bringing in experts to help us better get our arms around the PQRS and Meaningful Use regulations that are being fully realized in this year and next.

You may have already gotten a notice from the Centers for Medicare Services in Washington regarding your status in 2015 and beyond. As you know, there are penalties and fee reductions for non-compliance, and bonuses for compliance with the regs.

And then there have been some updates to the HIPAA privacy regs, and of course the implementation of the ICD-10 diagnostic coding scheme wholly replacing the ICD-9 system on October 1st this year!

We are contemplating on doing one large event covering all the relevant topics, or possibly breaking it up into several seminar events. We will be developing such plans to try to minimize the expense and practice disruption. Please pay attention in the upcoming weeks on announcements regarding these educational programs.

Happy and healthy 2015,

Aloha, Dr. JOE Morelli

REMINDER NOTICE:

HSCA 2015 General Membership Meeting, this Friday (January 9, 2015) 7:30pm, St. Louis Alumni Clubhouse (Oahu). Neighbor Islands by teleconference.

IT *SOUNDS* LIKE GOOD NEWS . . .

Gary K. Saito, D.C., HSCA Immediate Past President

Those of us who still read the paper, the Start Advertiser carried an article about a movement that started on the mainland and is gradually coming to Hawaii. After decades of practice as usual, the medical profession is finally reanalyzing its practices and protocols.

Are all those diagnostic tests really necessary? Do patient really need as many prescription drugs as they have been getting?

A national campaign started by the American Board of Internal Medicine Foundation called "Choosing Wisely" is carefully reviewing the latest evidence and collaborating with 60 medical specialty societies to come up with a list of "Things Providers and Patients Should Question".

This initiative is aimed at breaking old, outdated habits that don't improve health and may even indicate inappropriate or even harmful care. Kudos to the medical profession.

But, before anyone gets too excited, it seems that there is no enforcement or implementation authority, and we all know what can be the outcome: good advice, but no real change in policy, at least not one mandated by any federal, state, or professional entity. They are so far being regarded as "guidelines" with no real consequences for NOT following them.

These recommendations will be passed on to physicians, but according to the article, "They will include the reasons for the recommendation, (but the) physicians decide based on what they know about their patients.

There is a recognition, at least, that some tests and prescriptions don't improve outcomes and may even cause harm. Hawaii's hospitals are looking into this "Choosing Wisely" Program.

THE JOINT COMMISSION NOW RECOGNIZES CHIROPRACTORS AS PHYSICIANS

by William Morgan, DC (Chair, ACA DOD & VA Committee)

The Joint Commission, the largest credentialing body for hospitals and health care organizations in North America, has recently changed its stance on the recognition of chiropractors. This organization now recognizes chiropractors as physicians. This is a major policy change from decades ago, when the commission published an article entitled "The Right and Duty of Hospitals to Exclude Doctors of Chiropractic."

The Joint Commission (JC) was one of the organizations named in the *Wilk* antitrust lawsuit for allegedly restricting the profession of chiropractic. It has grown in maturity since those days and is now a major force for good in the provision of health care in the United States and in Department of Defense (DOD) medical facilities worldwide. JC is no longer simply a private policeman for the health care industry; it now considers itself a partner in health care. This is evident in its new motto: *Helping Health Care Organizations Help Patients*.

The current list of JC-recognized physicians includes medical doctors, dentists, podiatrists, optometrists and chiropractors. Chiropractors and optometrists are recent additions.

What Is the Joint Commission?

The Joint Commission, formerly the Joint Commission on Accreditation of Health Care Organizations (JCAHO, pronounced *jay-co*), is a non-profit private organization that accredits health care organizations. JC credentials 17,000 different health care entities. It provides a fee-based credentialing process, in which hospitals participate. Even though submitting an application to this private organization for credentialing is technically voluntary, from a practical perspective, failure to have JC accreditation would very likely lead to the closure of a hospital. Joint Commission credentialing is the standard that all successful hospitals, including government facilities, attain.

JC has changed in recent years from being an inspection and credentialing institution to being a proactive partner in improving health care. The new JC identifies particular patient safety needs and educates participating organizations about how to optimize treatment and to prevent sentinel events, prescription errors, wrong-side surgeries, nosocomial infections and a variety of patient safety concerns. It now provides leadership, guidance and education to the hospitals it credentials.

Every hospital-based chiropractor can tell you about the impact that JC has on clinic standards, record keeping and policy. Hospital-based chiropractic clinics write their policy with JC in mind. Fortunately, JC values interdisciplinary collaboration greatly and likes to see evidence of patient-focused teamwork.

Not Everyone Is Happy With This Change

Even though JC clearly stated this change will in no way diminish the authority of medical doctors, there has still been an outcry from certain medical organizations[5] that do not want chiropractors (and optometrists) added to the list of physicians. These organizations are lobbying JC in an attempt to have DCs and optometrists removed from physician status.

Why Is Physician Status Important?

The reason that we should be concerned about JC's physician designation is the wide-sweeping impact JC has on health care in North America. JC influences Medicare, Medicaid, the DOD, the Veterans Administration, the Public Health Service and virtually every hospital in the United States. This private organization will have a monumental impact on how all of the other players in health care perceive and treat chiropractors in the future. Being designated as a physician by a prestigious organization lends far more credibility to chiropractic than being categorized as technicians.

OTHER NATIONAL NEWS

Josephine P. Briggs, M.D., Director, National Center for Complementary and Integrative Health (NCCIH), National Institutes of Health announced that after a recent policy review regarding Chiropractic and other so-called "CAM" health care professions, a formal name change in an important federal agency.

NCCAM (National Center for Complementary and Alternative Medicine) has a new, congressionally mandated name—the **National Center for Complementary and Integrative Health, or NCCIH**. President Obama signed an omnibus budget measure, which included a provision to change the name of the Center.

Our new name reflects the Center's continuing research commitment to studying promising health approaches that are already being used by the American public. For more information about the name change, read the press release at http://nccam.nih.gov/news/press/12172014.

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COMBINING BENZODIAZEPINES WITH OTHER SUBSTANCES RAISES RISKS

EDITORS NOTE: The following article was posted for medical practitioners to help educate providers on complications that their patients may present considering the medications they are using. We bring this forward to our readers, since here in Hawaii we are encountering patients presenting for our Chiropractic services with significant "co-morbidities". Additionally, many DCs in Hawaii are now treating VA patients referred to them by the Veterans Administration who happen to present to us while also taking many of this class of medications.

These drugs are often prescribed for clinical depressions, panic attacks, anxiety, traumatic brain injuries, PTST, etc. It is very important for us as practitioners to keep abreast of this type of information that comes out of the CDC, etc. Knowledge is power, and the more we are aware of complicating factors in a patient's presentation, the better we may be able to advise them as questions and clinical complications arise. Dr. J. Morelli (Editor)

Benzodiazepines, such as Alprazolam, Diazepam, Clonazepam and Lorazepam, are a class of drugs used to relieve symptoms of anxiety, panic attacks and seizures. They are generally considered safe when taken as prescribed and directed under a health professional's supervision. However, benzodiazepines can sometimes cause adverse effects – especially if used improperly or in combination with substances like opioid pain relievers or alcohol.

A new report by the Substance Abuse and Mental Health Services Administration (SAMHSA) shows that 32 percent of hospital emergency department visits involving benzodiazepines resulted in serious medical outcomes such as hospitalization (or in rare cases death).

In emergency department visits involving the use of benzodiazepines in combination with opioid pain relievers the risk of a serious outcome rose to 44 percent. Similarly, 44 percent of emergency department visits associated with the combined use of benzodiazepines and alcohol resulted in serious medical outcomes. Serious health results occurred in 50 percent of hospital emergency visits involving the combined use of benzodiazepines, opioid pain relievers and alcohol. This report only analyzed emergency department visits involving benzodiazepines alcohol and opioids.

SAMHSA's report also indicates that older patients may be at significantly higher risk for serious health outcomes. Seventy percent of emergency department visits involving people aged 65 or older who had combined benzodiazepines with alcohol and opioid pain relievers resulted in serious outcomes, compared to 39 percent of visits involving people aged 12 to 34 using the same combination of substances.

"Benzodiazepines are commonly prescribed medications that can benefit some patients but, like all medications they must be properly used and monitored," said SAMHSA's Chief Medical Officer, Dr. Elinore McCance-Katz. "The adverse events being seen in emergency departments are often the result of drug-drug interactions that can occur between benzodiazepines, opioids and alcohol. Physicians and other prescribers must inform patients taking these medicines of the potential risk of drug interactions that can result in serious adverse events and even death. Healthcare providers and patients must work together to ensure that prescribed medications are taken in a way that maximizes benefits and diminishes risks."

SAMHSA's Center for Substance Abuse Prevention has several initiatives to prevent the misuse of prescription drugs. These include school-based programs educating parents and students about the potential dangers of misusing prescription drugs. Other prevention programs provide informational materials to health professionals, including prescribers, on the risk of overprescribing.

SAMHSA grant programs like the Substance Abuse Prevention and Treatment Block Grant, and Partnerships for Success, fund a wide variety of programs designed to help prevent prescription drug misuse and abuse, such as ensuring proper training of first responders for drug overdose situations and implementing prescription drug take-back programs for unused medications.

The report entitled, *Benzodiazepines in Combination with Opioid Pain Relievers or Alcohol: Greater Risk of More Serious Emergency Department Visit Outcomes* is based on findings from the 2005 to 2011 Drug Abuse Warning Network (DAWN) reports. DAWN is a public health surveillance system that monitored drug-related morbidity and mortality through reports from a network of hospitals across the nation. In 2011, DAWN reported that there were approximately 5 million substance-related visits to hospital emergency department.

DUAL CODING - FRIEND OR FOE?

Jill Foote, ACA Dept. of Insurance, Insurance Quality Analyst III

(Editor's Note: ACA recently sent the following recommendations to its members as a practice prep to help in the conversion process from the ICD-9 to the ICD-10 diagnostic code sets. I believe this makes great sense in practices of all sizes to gear up to the federally mandated change on October 1, 2015. The HSCA will be presenting a formal program on the ICD-10 process to be announced soon-Dr. J. Morelli)

Many providers are under the impression that two or three months is sufficient time to prepare for the transition to ICD-10. Thankfully, we have many other countries' experiences to draw from and know that a few months is not near the average time for implementation. In this article, we cover the concept of dual coding, which refers to coding the same record in both ICD-9 and 10 for training and testing purposes. Dual coding can be especially helpful when vendors begin testing their systems for ICD-10 transactions. This will require you and your ICD-10 CA to work closely with vendors and payers early in the implementation process. What can you do to get ready? Listed below are a few simple steps:

- Create a list ICD-9 codes commonly used in your clinic as outlined in Step #2 of ACA's Implementation Checklist.
- Look up the ICD-10 GEMS for each of your ICD-9 codes and make a list. Looking up the GEM (General Equivalence Mapping) is the first step to finding and choosing from the full list of equivalent codes. ACA's ICD-10 Toolkit contains a helpful ICD-9 Conversion Worksheet along with a list of fully

mapped ICD-10 codes, called the Mapping Tool, to assist your clinic with this step.

- Schedule ICD-10 Training for you and your staff. ACA's online webinars and State Trainings provide education tailored to the needs of the chiropractic profession.
- Choose 1 to 2 cases per day and code the case in ICD-9 first. Then look up and assign the ICD-10 code that most closely matches each patient's condition(s).
- Compare the differences in the code sets and analyze areas that need improvement in your documentation to support the specificity within the ICD-10 code definition.
- Create a "MID" (Missing in Documentation) list. The Team Leader can use this list to track missing documentation and then work with the clinician areas where improvement is needed to support the specificity of ICD-10.
- Record the amount of time it takes to carry out the dual coding process and make note of this for when you begin budgeting your implementation costs related to productivity. ACA's ICD-10 Toolkit contains a helpful printable Budget Worksheet to assist you with this important step.
- Follow up with vendors to obtain information regarding their "acknowledgement testing" and "end-to-end" testing schedule. ACA's ICD-10 Toolkit also contains a helpful printable Vendor Worksheet.

There are significant advantages to developing a dual coding process in your clinic--namely, safeguarding revenue. Countries that have already implemented ICD-10 reported a 50 percent drop in medical coding productivity and one year later, productivity remained at 40 percent lower than normal. By initiating this method of coding early in the implementation process, your billing staff will gain speed, accuracy and confidence, which can lead to increased productivity and revenue.

The article *Why You Can't Afford to Delay Dual Coding* states "*The key in being able to code and bill properly is whether the data is documented in the charts. If it's not there, then this whole thing goes off the rails really quickly. Going through the dual coding process shows where physicians have gotten on board with documentation specificity and where to focus more attention because your revenue is at risk.*" The dual coding process allows providers to schedule time to discuss challenging cases with staff and make needed adjustments in documentation.

Most importantly, your clinic will have the necessary test data in order to properly evaluate vendor readiness through end-to-end testing. This information will be valuable for your financial impact analyses to compare average reimbursement under ICD-9 to reimbursement under ICD-10.

Clinics should begin now to make time for dual coding or later face potential longer reimbursement cycles, denied claims, frustrated staff, and lost revenue. If you begin to prepare now, you will more likely be able to identify and address coding errors, workflow and budgetary concerns, and documentation inaccuracies before they begin to impact your reimbursement. ACA encourages all clinics to take advantage of the helpful ICD-10 resources listed in this article which can also be found at www.ACAtoday.org/ICD10.

SOME STILL PLAYING THE SAME OLD GAMES!

by Joseph G Morelli Jr DC FICC, HSCA President & ACA Dist. 7 Governor

As most of us "old timers" in practice can remember when the whole profession, spearheaded by 10 brave Doctors of Chiropractic, took on the AMA and the major medical establishment with a federal class action, antitrust lawsuit.

The action became known as the Wilk vs. AMA lawsuit. Most of the profession rallied around this cause, and raised funds, and gave moral support for our "trial of the century" or "David vs. Goliath" as some in the legal profession called it.

The initial filings began in 1976 and all the major actions and additional trials culminated with favorable for chiropractic rulings in 1987 in the US District Court of Northern Illinois.

Later, both sides cross-appealed, and the district court's decision was affirmed by the U.S. Court of Appeals on February 7, 1990 (*Wilk v. American Medical Ass'n*, 895 F.2d 352, 7th Cir. 1990). The AMA petitioned the U.S. Supreme Court three times, but each time the Court denied *certiorari* (on June 11, August 13, and November 26, 1990).

Under considerable pressure of the trial that was still on-going at the time, the AMA eliminated Principle 3 of its Bylaws in 1980 during a major revision of ethical rules. Its replacement stated that a physician "shall be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services." Thus, the AMA has permitted medical doctors to refer patients to Doctors of Chiropractic for such manipulative therapy if the medical doctor believes it is in the best interests of the patients. Prior to this change, it was a violation of the AMA ethical code, and was grounds for loss of membership and in some cases specialty certifications.

I bring this all up because of a copy of a letter that I received as a member of the ACA Board of Governors, by the lead attorney in the "Wilk case", Mr. George McAndrews.

Apparently, some medical authorities still are trying to promote a boycott against our profession.

The following is a letter sent by Mr. McAndrews to Louisiana State Senator, Mr. J. P. Morrell complaining of the blatant discrimination against Doctors of Chiropractic by the interference of the Louisiana State Medical Board concerning MD/DC professional relationships.

I was taken aback when I first saw this document, since I naively thought that the blatant discrimination against our profession was formally put to rest over a quarter of a century ago, and had generally abated with time and enlightenment! Boy was I mistaken!

I present the following as a reminder that our fight for our rightful place in the health care world continues on.

(Editor's note: The following letter from Mr. McAndrews was reformatted from legal double space formatting to be reproduced on one printed page. The content has not be altered from the original document, and is an accurate copy)

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December 24, 2014

Senator J. P. Morrell
6305 Elysian Fields Avenue
Suite 404-B
New Orleans, LA 70122,

RE: Louisiana State Medical Board Interference with Medical Doctor/Chiropractor Relationships

Dear Senator Morrell:

I note in your bio that you once complained about the Louisiana State Medical Board interfering with medical physicians'/nurse practioners' relationships.

Doctors of chiropractic are the third largest portal of entry health care providers in the United States after medical physicians and dentists.

The American Medical Association is under a nationwide injunction prohibiting it and its affiliates from interfering with voluntary professional associations between medical physicians and doctors of chiropractic, following a fourteen year antitrust suit where the AMA was found guilty of a brazen effort to "contain and eliminate" the profession of chiropractic. A Louisiana medical physician, Dr. Sabatier, M.D., now deceased, served on the AMA Committee whose task it was to destroy the competitive practice of chiropractic.

May I ask that you review the enclosed communication to the Federal Trade Commission, with four attached exhibits, to see the current efforts of the Louisiana State Medical Board to pressure medical physicians to cease any voluntary professional association between medical physicians and doctors of chiropractic.

On behalf of the doctors of chiropractic in Louisiana and the patients of both medical doctors and doctors of chiropractic, I ask that you give your attention to this deplorable effort to restrict voluntary cooperation between these learned professions and the obvious damage imposed on the patients that would otherwise benefit from such association.

WITH RESPECT,

George P. McAndrews

GPM:rd
Enclosures

INTERESTING INFORMATION FROM THE ACA DEPARTMENT OF INSURANCE RELATIONS:

ELECTRONIC HEALTH RECORDS SYSTEMS AND WHERE THINGS STAND TODAY

As we have all realized, an EHR is now so critical to Chiropractic practice. However, there are major problems if an information system does not communicate with other systems. There have been problems with efforts of stakeholder organizations toward a solution. Here, we will explore the challenges and efforts related to creating uniformity in these complicated electronic systems. This information can be very helpful to those considering purchasing an EHR for the first time, or for those wanting to migrate to a new system or upgrading. Asking the right questions about interoperability and assuring that your contract covers future needs are essential to avoid unnecessary costs and clinic downtime during transition phases.

Most know that the HITECH Program gives incentive payments to providers who migrate to EHR systems. One of the many purposes for the program is to facilitate interoperability, or the communication of patient data through an EHR to other compatible systems. For example, if you are part of an interdisciplinary team such as an accountable care organization (ACO), you must be able to share clinical data with other providers treating the same patients. Shared data has huge benefits: lowered costs, increased quality of care, and the ability to improve population health through analysis of these data. However, none of these benefits are possible unless systems can communicate. Since providers have received taxpayer dollars through the HITECH Act's provisions, experts now ask whether lack of interoperability is a fatal flaw in the HITECH Program.

While there have been some standards set for EHR systems under HITECH, there has been little regulation that encourages vendors to make data formats compatible. There is also a competitive advantage for vendors to make their systems proprietary. Some vendors charge thousands of dollars to create interfaces for clients who need their EHR to communicate with another system, and then charge even more in order to maintain them.

In a recent survey of 62 ACOs, the data showed that 100 percent of respondents had trouble with data interoperability with different business partners. Those who took the survey also had difficulty merging data they received from other companies into their EHRs, and 83 percent reported problems integrating data analytics into work processes.

In August, staff from the Senate Finance Committee and the Health, Education, Labor and Pensions Committee discussed how the third stage of meaningful-use rules should address interoperability requirements. Recently, the Health Information Technology Policy and Standards committees discussed national interoperability and their hope to release a 10-year national interoperability plan by the end of the first quarter of 2015.

There is a standard for what is referred to as the consolidated clinical document architecture, or CCDA, which is a summary format for a patient's clinical information. In 2013, the EHR Association in its code of conduct stated that vendors should build in the provision for providers to move data from one EHR to another; however, this only referred to moving data in summary formats such as CCDA rather than entire records. Migrations of data can sometimes leave out key information and data can also be corrupted in transit.

It is clear that standards are needed to support development of systems that are interoperable, particularly as we move toward increased use of accountable care models and transition to value-based payment. A new report prepared for the Office of the National Coordinator for Health IT stated that amid the focus on creating accountable care models through improved care coordination across organizations, interoperability challenges continue to hinder progress.

For individual practitioners, changing to a new EHR can be costly, especially when vendors charge large fees to migrate data. Further challenges can occur if not all the data carries over to the new system. Asking questions up front about interoperability is important when negotiating with a new EHR vendor. How much support will you receive to move your data to a new system? What will it cost? Will all the data transfer completely? What types of systems does your vendor's software work with? As with any major practice decision, it is always wise to take your time and ask the necessary questions for you to consider all your options carefully.

NARROWING NETWORKS: BACK AGAIN

The Patient Protection and Affordable Care Act (PPACA) brought many changes to the health insurance landscape, including exchange plans, essential health benefits, and Section 2706. But one of the more overlooked changes in how health plans are accommodating the financial impact of PPACA is the narrowing of networks.

The term "narrow networks" is essentially what it sounds like: Plans (especially those offered on exchanges - around 48%) have reduced the number of providers and hospitals that are within their networks. Payers insist that narrow networks are necessary for cost control. It's hard to argue that point when a recent report found that plans with narrow networks have premiums that are approximately 13-17% less than plans with traditional, broad networks. However, many states have found that when plans reduce the number of network participants, it has a significant impact on patient choice and access. So much so that at least one provider group has filed legal action in Connecticut against United Healthcare for dropping thousands of providers from their Medicare Advantage network. Additionally, there are several states where regulators are seeking to implement legislation that would force payers to widen the networks again.

However, for the time being, narrow networks are here to stay. There is evidence to indicate that payers may be moving their regular plans to narrow networks, as well. It is important to note that payers are focusing not only on low-cost but also high quality when selecting doctors for these narrow networks, so many providers are looking to form or join patient-centered medical homes (PCMH) and accountable care organizations (ACO) in order to stay competitive and attractive to networks.

Providers should closely monitor communications from payers for network terminations. If such a notice is received,

it is important for providers to promptly notify patients affected by such a change. It will also be necessary to notify new patients whose plan uses a narrow network in which the doctor does not participate. If a process isn't already in place, providers are strongly encouraged to begin using a verification of benefits form that prompts staff to ask appropriate questions regarding plans that have changed due to PPACA. Pertinent information may not be evident just by looking at the patient's insurance card. To that end, ACA has made available to members a comprehensive verification of benefits form (available on the ACA website in the Practice Resource Center). Providers are strongly urged to monitor their network status with all plans and keep patients informed as necessary.

>>PRACTICE FOR SALE<<

Fully Furnished Practice For Sale in Pearl City, Oahu, HI
Great Location, Street Frontage on Busy Street, Freeway Close, Cheap Rent
Digital X-Ray, modern equipment, well established patient base,
New Website, Great Online presence,
Cloud Based CRM and management.....Turn-Key Operation
Need to sell quickly: Sale Price: negotiable
Reasonable offers will be Accepted!
CONTACT: email: mpt145@gmail.com

>>HSCA GENERAL MEMBERSHIP MEETING<<

Date: Friday, January 9, 2015
Place: Oahu: St. Louis Alumni Clubhouse
916 Coolidge Street, Honolulu, HI 96826
Neighbor Isle's: Contact your Island Director
Time: **7:30pm**
Info: Call HSCA office: (808) 926-8883

>> OFFICE SPACE TO SHARE<<

Location: Kailua, Oahu on Uluniu Street
20+ years established Chiropractic Practice
Currently 2 DC's, one is retiring soon
Space: Shared waiting room, front desk, x-ray suite
Developing room/laundry.
Available Now:
Your own Chiropractic adjusting room 8'x8.5'
Available May 1, 2015:
2 rooms (Therapy/exercise/storage) 17'x13.5'
Size: Office space is 1,048 sq. ft. total
Call: **Dr. Deborah Glenn: (808) 262-2099**
eMail: koolaufamilychiro@earthlink.net