ON THE COVER—
DON'T MISS THIS ONE!

The 100th Annual Scientific Seminar

25 Contact CME Hours

June 9–11, 2016

Columbus Hilton at the Easton Town Center

See Page 9

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Journal

OF THE
OHIO FOOT AND ANKLE MEDICAL ASSOCIATION

VOLUME 58 | NUMBER 2 | SPRING 2016

A WORD FROM THE PRESIDENT

Strategic Planning: Completing Goals and Envisioning The Future

Spring is finally here!

Like most of the country, OHFAMA is really gearing up for a busy Spring and Summer. There is so much happening at OHFAMA thanks to the hard work of members like you, your local academies, officers, members of the Board of Trustees, Executive Committee, the Executive Director and of course the staff of OHFAMA.

Richard A. Schilling, DPM, FACFAS

At our last BOT meeting, Dr. Henry Green and Dr. Mark Gould were chosen to receive the Distinguished Service Award for 2016. This is the highest honor OHFAMA bestows on its membership. These two candidates are very deserving recipients. Please join me in a congratulations to these two respected members of our association. Their investiture will be held on June 9 just before the PICA lecture at our Scientific Seminar.

We continue to work towards the goals set forth by the Board of Trustees at the last strategic planning session. During the last Board meeting, Dr. Alan Block agreed to be the Chair of the External Relations pillar. Dr. Thomas McCabe agreed to be the Chair of the Legislative Advocacy pillar. Dr. Mark Gould agreed to be the Chair of the APMA Relationships pillar. Dr. Corey Russell agreed to be the Chair of the Parity pillar.

OHFAMA has been working with the Ohio State Medical Board on the issue of Podiatric supervision of hyperbaric oxygen treatments. With the help of our lobbyists, language has been remitted to the State Medical Board for consideration by their attorneys and committees. This will satisfy multiple pillars moving our profession forward in parity, working through advocacy and external relations.

There is much preparation ongoing by the OHFAMA delegation to the APMA House of Delegates meeting in Washington, DC. During the March 19-21 visit, the delegation will be spending time with APMA members, representatives and candidates for office. Our delegation is busy studying House Resolutions and motions and will be ready to bring a powerful Ohio voice to the 2016 APMA House of Delegates.

Through all these activities OHFAMA continues to be innovative and responsive to its membership with incredible educational opportunities.

- On Saturday, April 9th, the 2016 Sports Injury Clinic will be held in Columbus and will offer 8 CME Category I hours. This meeting will feature local and national speakers with a variety of expertise and perspectives on multi-disciplinary science, injury, nutrition, and athletics.
- On Friday, April 15th the 2016 Coding and Financial Institute will be held in Columbus and will offer 7 CME Category II hours. This meeting will feature local and national speakers representing a broad base of expertise and perspectives on insurance and coding. There will be content for all members of the podiatric profession including physicians, residents, office staff and billing professionals.

This year's Annual Ohio Foot and Ankle Medical Association Scientific Seminar marks yet another milestone. OHFAMA will celebrate its 100th Scientific Seminar and while there will not be a petting zoo or clowns, the meeting will be our best ever. There are many exciting things to look forward to including top notch speakers, interesting new topics, improved variety of sponsors and some exciting new wrinkles in store for you. Look for the brochure soon and sign up early for the early bird discount!

Fraternally,

Richard A. Schilling, DPM, FACFAS

MEMBERS IN THE NEWS

2016 OHFAMA Service Award Winners Announced

The Ohio Foot and Ankle Medical Association's Board of Trustees is pleased to announce the winners of the 2016 OHFAMA Service Award. They are and Mark Gould, DPM from the Northeast Academy and Henry Green, DPM from the Northwest Academy.

MARK GOULD, DPM served as OPMA president in 2008. He is a past president and member of the Northeast Academy of OHFAMA, where he currently serves as their Scientific Chair of the Super Saver – The Fall Classic CME Seminar. He is currently serving as the Chief Delegate of the APMA Delegation to the APMA House of Delegates and has been a Delegate since 2009. He is in private practice in Avon Lake, OH. Gould is Board Certified by ABPS and served as Chief, Division of Podiatry as well as Credentials Committee and on the Tissue and Surgical Practice Committee, St. John West Shore Hospital. He served as a Trustee of the OCPM Alumni Association Board from 2005-2008. Gould has served as the Reference Committee Chair of the OPMA House of Delegates several times since 2006. Congratulations Dr. Gould for your continuous service and commitment to organized podiatry in the state and national arenas.

HENRY GREEN, DPM served as OPA president in 1983. He is a past president and member of the Northwest Academy of OHFAMA and in private practice in Rossford and Perrysburg, OH. He is a 1968 graduate of the Ohio College of Podiatric Medicine and was inducted into the Ohio College of Podiatric Medicine Hall of Fame Society in 2007. He served as Chief of Podiatry at Riverside Mercy Hospital in Toledo, OH from 1983-1998. He was a past president of the Fund for Podiatric Medical Education, raising $1,000,000 providing 45 scholarships to students. He served as past chairman of the Northwest Ohio Regional Emergency Medical Services Council. He is a recipient of various awards and honors. He served on the OCPM Board of Trustees until May of 2012. He currently serves on the KSUCPM Advisory Board and has served on the OCPM Foundation Board since July of 2012. Congratulations Dr. Green for your dedication and loyalty to advance podiatry in Ohio.

OPPAC

Thank you to our 2016 OPPAC Contributors as of 3-31-16

Central Academy
Animesh Bhatia, DPM
Scot Bertolo, DPM
Timothy Brown, DPM
Roderick Fuller, DPM
William Munsey, DPM
Richard Schilling, DPM

Eastern Academy
Bruce Blank, DPM
Mitch Dalvin, DPM
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Corey Russell, DPM
Kathryn Schramm, DPM
Pamela Sheridan, DPM
Thomas Vail, DPM

Southern Academy
Ruth Ann Cooper, DPM
Brad Wenstrup, DPM

Additional Contributors
Daniel Leite, Lobbyist
James McLean, MBA
Luci Ridolfo, CAE
Jimelle Rumberg, PhD, CAE

ADD YOUR NAME TODAY

Meet the 2016 Ohio Delegation to the APMA House of Delegates

Delegates (L-R) Drs. Alan Block; Marc Greenberg; Bruce Blank; Delegation Chair Mark Gould; Speaker of the House Jerry Ferritto; Karen Kellogg; Corey Russell; Richard Schilling; Executive Director Jimelle Rumberg; Alternate Delegates Atta Asef and Thomas McCabe.

Color Guard at the APMA 2016 Meeting

Finance Committee Hearing at the APMA House of Delegates 2016

APMA Election Results

During the 96th APMA House of Delegates meeting, delegates elected new officers, board members, and other representatives. President-elect: Ira H. Kraus, DPM; Vice President: Dennis R. Frisch, DPM; Treasurer: David G. Edwards, DPM; Elected to the Board of Trustees: David Yeager, DPM. Re-elected to the Board of Trustees were Sylvia Virbulis, DPM and Laura Pickard, DPM; Elected Speaker of the House: JD Ferritto Jr., DPM; Elected HOD liaison to the JCRSB: William Chagares, DPM

Meet The Young Physicians 2016 OHFAMA Board of Trustee Members

Anastasia Samouilov, DPM, YP Trustee

DR. STACEY SAMOUILOV was elected as the OHFAMA Young Physician Board member to the OHFAMA Board of Trustees. She is presently a second-year Resident at the VA Hospital in Dayton.

"I am involved, I am aware, and I am passionate. Residency is challenging at times, but I have proven that I am able to handle the extra responsibility and am positive I will continue to do so. I think I bring a unique perspective to the table as a resident. I want to be there to help, expand and improve our profession. I think that best way that desire can become a reality would be for me to continue serving my colleagues and peers as the Young Physician member of the Board of Trustees. I can offer insight from my perspective as a young member, involved from the very start, but also draw upon the experience and knowledge that I have gained in the past few years. I would like to continue serving Podiatrists in Ohio."

DR. DAMIR JOZIC will serve as Alternate Trustee as the YP to the OHFAMA Board of Trustees.

"I am currently a resident physician at the Cleveland VAMC. I started this position in July 2014 and will be there until June 2017. I am very familiar with the OHFAMA board of trustees. I have previously held the student member position on the board of trustees (2011-2012). I have thoroughly enjoyed this position and have gained much knowledge into the field of podiatry that was not taught at the college. I was

Damir Jozic, DPM, YP Alternate Trustee

a recipient of the OHFAMA Silver Gavel Scholarship which included an online course developed by the National Association of Parliamentarians about procedures. This class helped me become a better Board of Trustee member by understanding the process of meetings and voting. During my time on the BOT, I have met people who have shaped me into the podiatrist I am today."

EXECUTIVE DIRECTOR'S MESSAGE

Raising The Bar on Service, Membership, and Professionalism

Raising the Bar...AGAIN and AGAIN
How do we possibly keep raising the bar?

Jimelle Rumberg, PhD, CAE

Honestly, you'd think that OHFAMA was a participant in "The Arnold."

We keep pumping more iron and flexing our collective podiatric muscles. At the recent APMA HOD, our Delegation was impressive and represented YOU well. We are now the fifth largest podiatric member association in the United States (rising from the #8 position in 2015); and, hands (and feet) down, OHFAMA offers some of the best selective CME programming in Ohio.

Celebrating The 100th Annual Foot and Ankle Scientific Seminar

In June, we will have an outstanding venue for podiatry as we celebrate our 100th Annual Foot and Ankle Scientific Seminar. ARE YOU ATTENDING? We celebrated one heck of an association centennial last year. Now it's our seminar's turn.

PROGRAMMING

We have two receptions offered nightly this year at the Annual Seminar and will also recognize KSUCPM's Centennial before the PICA presentation. At that time, we will be investing our 2016 Service Award winners. Drs. Gould and Green. Our programming will consist of panel discussions on Diabetes Management, surgical, infectious disease, and a full venue of workshops for hands-on learning.

LUNCH & LEARNS

Our lunch and learns are ever-popular, and will be exciting this year. You are cordially invited to attend and participate. Check out our outstanding programming on www.ohfama.org.

REGISTRATION

Register yourself and your staff. The assistant programming is equally impressive. We will once again have a conference mobile app.

NEW FEATURES THIS YEAR

This year we will utilize a new app as well called 2Shoes. You will be able to ask the panels questions and do other interactive items during the seminar's presentations right from your smart phone. What great technology!

COME FOR THE SEMINAR, STAY FOR THE EXPERIENCE!

We invite you to come and experience a fun-filled adventure celebrating our 100th annual scientific seminar. As a reminder, bring your office shopping list for some discounted convention sales so that we can continue to ensure a fantastic line-up of exhibitors. We keep them happy when you place your orders for your office. Without business orders, exhibitors aren't happy. Let's keep them happy.

EXHIBITORS APPRECIATE YOU

Please let every exhibitor know how much we value their participation at our meeting and just say THANK YOU for supporting podiatry in Ohio. We appreciate them, their products, their door prizes and their time, but more importantly we appreciate their support of podiatry in Ohio.

2016 Calendar

April 14
Budget/Finance BOT
OHFAMA Headquarters I Columbus

April 15
Coding and Financial Institute
Crowne Plaza Columbus I Dublin

June 9-11
The Annual Foot and Ankle Scientific Seminar
Hilton at Easton I Columbus

August 4
Budget/Finance BOT
KSUCPM I Independence

August 25-27
GXMO Training
OHFAMA Headquarters I Columbus

September 24
2016 Quickie Seminar
Hilton Garden Inn I Dayton

October 13
Budget/Finance BOT
OHFAMA Headquarters I Columbus

October 27-30
Super Saver Seminar
Marriott Cleveland Airport I Cleveland

November 3-5
GXMO Training
OHFAMA Headquarters I Columbus

November 11-12
OHFAMA House of Delegates
Embassy Suites Airport I Columbus

For more calendar information please visit the Events webpage at www.ohfama.org

FEBRUARY 16, 2016

CGS Jurisdiction 15: Kentucky and Ohio Carrier Advisory Committee Meeting

Report by CAC-Rep Andy Bhatia DPM

Dr. Berman, Medical Director, discussed Comprehensive Error Rate Testing (CERT) which is a data driven measurement to identify trending errors among the provider community and ultimately protect the Medicare Trust Fund. The reviews provide valuable information and assist greatly in identifying educational opportunities for improvement.

CERT Errors Findings

One of the largest drivers in CERT errors is laboratory testing which measured more than 1.1 billion dollars in improper payments last year. The most common reason for lab test errors is lack of orders. The requisition must be signed and provide a notation supporting medical necessity for the procedure in addition to the ICD-10 codes. The diagnosis must also be payable under a particular test and ordered by an appropriate provider type. For example, we would expect to see a higher number of biopsies coming from a general surgeon or drug testing from pain management. CGS recommends laboratories not accept specimens that do not have the required information.

Problematic Home Visits Billing

A new high error is noted in billing of Home Visits. These encounters require specific documentation as to why seeing the patient in the home is necessary. The documentation differs from home health requirements that the beneficiary be "homebound". However, the information must clearly show the doctor's level of concern preventing their patient from being seen in the office.

Other easily remedied errors occur due to improper coding and / or no response to requests for medical records.

Clinical Versus Technical Errors

Additionally, Dr. Berman continues to petition the CERT contractors and CMS for a distinction between technical errors and those of clinical significance. They appear open to having a clear Medical CERT rate and an Overall CERT rate, but have not yet agreed to this change.

The focus of Medical Review generally coincides with the largest drivers in errors such as Evaluation and Management encounters for office visits, ER visits, critical care and home visits. Additional data analysis is pending for laboratory testing.

When a billing outlier is identified, CGS will conduct a focused review of 20-40 claims in order to obtain an error rate. CGS then provides education to the practitioner before conducting a follow up review. Depending on follow up results, the doctor may be moved to targeted pre-payment reviews.

Provider Education Factors

One very problematic element in provider education is that often feedback is conducted with the billers and coders without being shared with the physician. Dr. Berman requests billers to expedite correspondences from CGS regarding Corrective Action Plan (CAP) or Probe Review to the physician. Remember, if inappropriate billing practices are identified, the doctor is held accountable, not the billing entity.

Essentially if a company comes under review, the physician is responsible for communicating information to the billers. CMS/CGS does not review their work. Dr. Berman suggests a self-audit.

Required Components, Records and Documentation

Another significant driver is related to improper level of service for Evaluation and Management visits. Many times all of the required components are not met. Additionally, CGS recommends avoiding templated visits offered in most EHR programs. Problems occur when templated information is pulled from previous visits thus allowing the system to set at a higher level of service at each visit. Not all information carried over is pertinent to follow up visits. In general if the data is not needed to support decision making, it doesn't need to be in the record. Notes should support medical necessity and the intensity of the visit.

EHRs also present problems with cloning of records where documentation reads identically throughout an individual's record, or the same information is seen from patient to patient within a practice setting. It is important that each note is patient and visit specific.

We are also seeing more records where documentation is conducted by use of a scribe. When this occurs, at the beginning of the note there should be a statement such as:

"This is ____ scribing for Dr. ____ in real time for the visit."

The scribe and practitioner must work side by side throughout the encounter after which the record should be validated by the physician indicating:

"This record was scribed by ____ for Dr. ____ and conducted at the same time."

Both practitioners should sign at the bottom of the record to further support it was a real time recording.

A Helpful *Internet Only Manual* (IOM)

For teaching services the Internet Only Manual (IOM) contains a templated sentence to document it was a teaching visit. If documented accordingly and filed with the appropriate modifier CGS will pay the claim, assuming all other coverage criteria are met.

Practitioner signatures or validation of the record must occur in a timely manner. Issues often occur when notes are suspended in the EHR while awaiting additional information such as lab work. CGS recommends closing out the record at the time of the visit and adding the additional information as an addendum to the initial report. This will assure the encounter is validated in a timely manner. A reasonable amount of time is allowed for transcription services.

Plan To Attend The 100th Annual Ohio Foot and Ankle Medical Association Scientific Seminar

The OHFAMA's educational mission is to purposefully advance the art and science of podiatric medicine by providing the highest quality of didactic and clinical learning experiences to OHFAMA members, non-members, and their medical assistants, and shall include a variety of instructional sessions aimed at significantly enhancing patient care, treatment protocols and practice efficiency. The program may include interactive educational adult learning methods and principles utilizing lectures, panel discussions, point-counterpoint, excuse the interruption forums, case studies, question and answer, handouts, audio visual materials (including media or narrations), hands-on workshops and roundtable discussions with moderators to achieve a well-rounded venue of postgraduate instruction.
(ADOPTED APRIL 2011)

KEY GOAL

To achieve 25 Hours of CME Category I in evidenced based podiatric medicine for professional development.

Schedule at a Glance

Thursday, June	Course Title | Presenter(s)
7:00 – 9:30 AM	**100th Annual Foot and Ankle Scientific Seminar Welcome and Course Introduction | President OHFAMA** Richard Schilling, DPM **Diabetic Fundamentals | Presenters:** Robert Brightwell, DO; Windy Cole, DPM; Lawrence DiDomenico, DPM; Lawrence Harkless, DPM; Mitch Silver, DO
9:30 - 10:00 AM	**BREAK—Exhibit Hall / Easton Grand Ballroom**
10:00 - 11:30 AM	**Surgical and Non-Surgical Treatment for Diabetic Foot Infections | Presenters:** Randall Contento, DPM; Lawrence Harkless, DPM; Warren Joseph, DPM; Roger Marzano, CPO, CPed; Brad Mehl, DPM
11:30 AM - 1:00 PM	**Lunch and Learn (Pick up tickets in Exhibit Hall.)** **A. Acelity: KCI and Systagenix—Healing Complex Wounds with a Spectrum of Products and Incorporating Procedures such as Epidermal Grafting | Presenter:** Andy Bhatia, DPM **B. ProScan Imaging—Basic Concepts of Musculoskeletal Imaging with Emphasis on the Lower Extremity: Ligaments, Tendons & Bones! | Presenter:** Richard Rolfes, MD **C. CSI—A Modern Approach in Collaborating to Treat Critical Limb Ischemia | Presenter:** Krishna Mannava, MD and Richard Schilling, DPM
1:00 - 3:00 PM	**Scientific Paper Competition: Presentations from Podiatric Physician Residents in Ohio | Chair:** Robert Brarens, DPM
1:00 - 3:00 PM	**Amerx Workshop: Essential Wound Care Products and Protocols for Your Practice: In-Office Pearls to Streamline ICD-10 Coding & Compliance | Presenter:** Jonathan Moore, DPM
2:00 – 3:00 PM	**WVPMA Membership Meeting**
3:00 - 3:30 PM	**BREAK—Exhibit Hall / Easton Grand Ballroom**
3:30 - 5:30 PM	**PICA Risk Management Lecture—Doctor-Patient Communication: Improving Patient and Physician Satisfaction | Presenter:** Ron Hofeldt, MD
5:30 - 6:30 PM	**PICA Welcome Reception**

Friday, June 10	Course Title
7:30 - 9:30 AM	**Diabetic Reconstruction and Bone Biopsies | Presenters:** Lawrence DiDomenico, DPM; John Grady, DPM; Brad Mehl, DPM; Laurence Rubin, DPM; Jeff Shook, DPM; Randall Thomas, DPM; Bud Visser, DPM
9:30 - 10:00 AM	**BREAK—Exhibit Hall / Easton Grand Ballroom**
10:00 - 12:00 PM	**The Surgical Reconstruction of the Charcot Foot and Ankle | Presenters:** Randall Contento, DPM; Lawrence DiDomenico, DPM; Robert Mendicino, DPM; Laurence Rubin, DPM; Jeff Shook, DPM
12:00 PM - 1:30 PM	**LUNCH—Exhibitors' Marketplace—Easton Grand Ballroom |** Sponsored by Kent State University College of Podiatric Medicine
1:30 - 3:00 PM	**Forefoot Surgery | Presenters:** John Grady, DPM; Elizabeth Hewitt, DPM; Robert Mendicino, DPM; Randal Thomas, DPM; Bud Visser, DPM
1:30 - 3:30 PM	**Bako Workshop—Podiatric Dermatology for Today's Lower Extremity Clinician: A "Hands-On" Workshop | Presenter:** Brad Bakotic, DPM, DO
3:00 - 3:30 PM	**BREAK—Exhibit Hall / Easton Grand Ballroom**
3:30 - 5:30 PM	**Cavus Foot Reconstruction | Presenters:** Lawrence DiDomenico, DPM; John Grady, DPM; Jeff Shook, DPM; Bud Visser, DPM
5:30 - 7:00 PM	**OCPM Foundation Reception**
7:30 AM - 5:30 PM	**Assistants Program**

Saturday, June 11	Course Title | Presenter(s)
7:30 - 9:30 AM	**Fractures | Presenters:** George Gumann, DPM; Elizabeth Hewitt, DPM; Robert Mendicino, DPM; Jeff Shook, DPM
9:30 - 9:45 AM	**BREAK—Exhibit Hall / Easton Grand Ballroom**
9:45 - 11:30 AM	**Ankle Arthritis | Presenters:** Lawrence DiDomenico, DPM; George Gumann, DPM; Elizabeth Hewitt, DPM; Robert Mendicino, DPM; Jeff Shook, DPM; Bud Visser, DPM
11:30 AM - 1:00 PM	**Lunch and Learn (Pick up tickets in Exhibit Hall.)** **D. Orthofix—Biophysical Stimulation of Bone Repair: Cellular Mechanisms and Clinical Approaches | Presenter:** James Ryaby, PhD **E. Organogenesis—Shifting The Antimicrobial Paradigm: A Novel Purified Collagen Matrix And Antimicrobial Technology For Wound Management | Presenter:** Adam Teichman, DPM **F. Osiris—Real World Practice: Managing Complex Cases with Cryopreserved Viable Human Placental Products | Presenter:** R. Dan Davis, DPM
1:00 - 3:45 PM	**Cases, Cases, Cases—Forefoot, Midfoot, Hindfoot and Ankle | Presenters:** Lawrence DiDimonico, DPM; John Grady, DPM; Robert Mendicino, DPM; Laurence Rubin, DPM; Jeff Shook, DPM; Bud Visser, DPM

CASE STUDY

A Rare Metatarsal Stress Fracture

David J.C. Arens, DPM
Third Year Foot and Ankle Surgery Resident
at Hennepin County Medical Center

Case Study

This quarter's clinical case focuses on metatarsal stress fracture treatment. The patient was a 57-year-old, non-athletic female who presented to clinic with pain and swelling in her right foot. The pain had been present for two months and began after a long day of standing in high heeled shoes. X-rays revealed a stress fracture with cortical thickening at the base of the second metatarsal (Fig. 1). She was treated with immobilization in a CAM boot for eight weeks until clinical healing was obtained and sufficient bone callus was seen on x-ray (Fig. 2). She returned to clinic two months later with the same complaint of pain and swelling after a long day wearing heels. X-rays showed that she had developed a non-union at her previous stress fracture site, which was now mildly displaced (Fig 3). Patient did not want to undergo surgical correction so a bone stimulator was ordered along with CAM boot immobilization. On her next follow-up x-ray another stress fracture on the third metatarsal shaft was identified. An increase in bone healing around the second metatarsal was also identified (Fig 4). Due to the multiple stress fractures she was sent to her primary care physician for a vitamin D deficiency work-up as well as a DEXA scan. She was found to be deficient in vitamin D—18 ng/mL—and was started on a supplemental regimen. Her DEXA scan was normal. She continued the bone stimulator and CAM boot for eight weeks until she obtained clinical healing again. At that time she was allowed to ambulate in regular shoes as tolerated and was pain-free at her last check.

Figure 1. Initial x-ray. Callus formation around base of second metatarsal.

Figure 2. Eight weeks after initial x-ray. Strong callus formation and evidence of radiographic union.

Figure 3. Two months post clinical union of second metatarsal stress fracture. Now with non-union and refracture.

Figure 4. Four weeks post initialization of bone stimulator. New third metatarsal shaft stress fracture with bone callus and new bone formation around second metatarsal base.

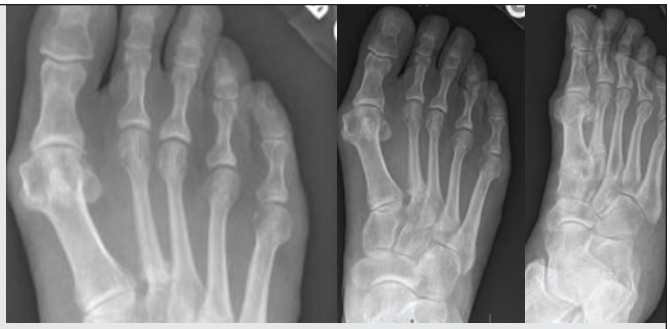

Figure 1 Figure 2

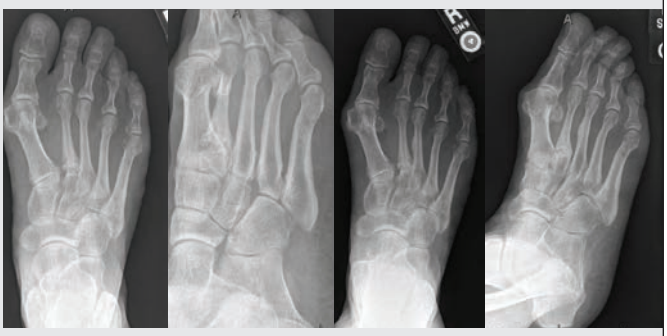

Figure 3 Figure 4

Discussion

Stress fractures are defined as normal bone that breaks under repetitive stress. They occur in many bones of the lower extremity including the metatarsals. In the general population the fracture commonly occurs in the shaft of the metatarsal, and proximal base fractures are usually only seen in ballet dancers. Patients with proximal metatarsal stress fractures are more likely to have multiple stress fractures and abnormalities in bone density.[1] Treatment starts with conservative immobilization, but proximal stress fractures do have a higher propensity for non-union, requiring surgical stabilization.[2]

The use of bone stimulators at the onset of symptoms for stress fractures has been shown to increase their healing rate.[3] This treatment is normally reserved for athletes returning to sports quicker, as it is not commonly covered by insurance for initial treatment. However, it will be covered if the fracture proceeds to a non-union.

Forty-seven percent of patients with any foot and ankle fracture have a vitamin D deficiency, and this has been identified as a common cause of stress fractures.[4] Serum 25-hydroxyvitamin D levels below 20 ng/mL may also be implicated in fracture non-unions.[5] Randomized studies have shown an increase in callus formation in patients with fractures taking vitamin D supplements.[6] The goal of supplementation, which can be managed by the primary care physician, is to maintain a serum value above 30 ng/mL.

A proximal second metatarsal base stress fracture in the general population is rare. Treatment is the same conservative management as metatarsal shaft fractures, but the location does warrant longer immobilization to achieve pain-free activity. Additionally, the location of these fractures increases the chance of non-union. Although this patient did progress to a non-union, she did not require surgical intervention. Conservative use of a bone stimulator and vitamin D supplementation was enough to get her back to her activities pain-free.

1. Chuckpaiwong B, Cook C, Pietrobon K, Nunley, JA. Second metatarsal stress fracture in sport: comparative risk factors between proximal and non-proximal locations. Br J Sports Med. 2007;41:510-14
2. Boden, BP, Osbahr DC, Jimenez C. Low-risk stress fractures. Indian Am J Sports Med. 2001;29:100-11.
3. Saxena A. Treatment of lower extremity stress fractures with pulsed electromagnetic fields (PEMF): A case-control study and comparison to the literature. Foot Ankle Quarterly. 2000; 13(2):43-50.
4. Smith JT, Halim K, Palms DA, Okike K, Bluman EM, Chiodo CP. Prevalence of Vitamin D Deficiency in Patients with Foot and Ankle Injuries. Foot & Ankle International. 2014; 35(1):8-13.
5. Brinker MR, O'Connor DP, Monla YT, et al. Metabolic and endocrine abnormalities in patients with nonunions. J Orthop Trauma. 2007;21(8):557–570.
6. Doetsch AM, Faber J, Lynnerup N, et al. The effect of calcium and vitamin D3 supplementation on the healing of the proximal humerus fracture: a randomized placebo-controlled study. Calcif Tissue Int. 2004;75(3):183–188.

Interested in submitting a clinical case? Email case information with clinical photos and x-rays to jrumberg@ohfama.org

IN YOUR LEGAL CORNER

Rules Regarding Termination of Podiatrist-Patient Relationships and Proper Notice to Patients upon Podiatrist Termination

by Daniel S. Zinsmaster

Ohio law has undergone a number of developments in recent years concerning the appropriate means of notifying patients when a podiatrist leaves a practice, as well as the proper steps for terminating a patient from a medical practice.

The Law and You

Since March 22, 2013, health care entities are required to advise patients when an employed podiatrist leaves the entity or medical practice, regardless of whether the podiatrist's departure was a result of the employer's or the podiatrist's decision. See Ohio Revised Code Section 4731.228. Administrative rules subsequently adopted by the State Medical Board of Ohio ("Board") added to this requirement, as well as outlined the necessary steps for discharging or terminating an individual patient from a medical practice.

Practice Notification Requirements

Any podiatrist leaving, selling or retiring from a practice must comply with Ohio Administrative Code Rule 4731-27-03. Specifically, within thirty days of learning of a podiatrist's termination or resignation, a medical practice must send notice by mail or by HIPAA-compliant electronic means to all patients treated by the departing podiatrist within the past two years. A medical practice may transfer this notification mandate to the departing podiatrist by providing a list of patients treated along with patient contact information to the podiatrist.

The notice to patients must contain all of the following:

- A statement that the podiatrist will no longer be practicing at the health care entity.
- The date the podiatrist ceased or will cease providing services at the health care entity.
- If the podiatrist will be practicing at another location, the contact information for the podiatrist's new location.
- Contact information for alternative providers at the health care entity who can provide care to the patient.
- Contact information so the patient may acquire their medical records.

Practice Notification Caveats

The notification requirements do not apply to podiatrists who have provided treatment on an episodic basis or in an emergency department setting. Notice is not required to patients treated by podiatry residents and fellows. Furthermore, a health care entity is not required to provide contact information for the podiatrist's subsequent location when a good faith concern exists regarding patient safety.

Discharge or Termination Requirements

In terms of the discharge or termination of a patient from a medical practice, the podiatrist must send notice by certified mail, return receipt requested, or by HIPAA-complaint electronic means to the patient. If the electronic communication is not viewed within ten days by the patient, notice by certified mail must be provided. The notice must state that the podiatrist-patient relationship has been terminated, that the podiatrist will provide emergency care and access to services for up to thirty days, and that the patient's medical records will be available to transfer to another provider. The podiatrist is not obligated to aid or assist the patient in acquisition of a new provider.

Discharge or Termniation Notification Caveats

Similar to an individual podiatrist's departure from a health care entity, a podiatrist is not required nor expected to provide notice of formal termination if the podiatrist treated the patient in an emergency setting or on an episodic basis. Moreover, notice of termination is not necessary if the patient's care has been formally transferred to another podiatrist who is not within the same medical practice, or when the patient is the person responsible for terminating the podiatrist-patient relationship. Nonetheless, such events should be documented in the patient's chart.

Know Your Ethical Mandates

Ohio podiatrists must also be cognizant that ethical mandates published by the American Podiatric Medical Association similarly prohibit the patient abandonment, and set forth appropriate steps for ending podiatrist-patient relationships. Breach of statute, administrative rule or ethical code may expose a podiatrist to professional licensure sanction by the Board and other entities. In light of this evolving area of health care regulation, medical practices and individual podiatrists must be mindful of the specific notification mandates when an established podiatrist-patient relationship is concluded.

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Ohio Guidelines for Acute Pain Management Outside of ERs Announced

In 2014, more than 262 million opioid doses were dispensed in Ohio for the management of acute pain 35 percent of the state's 750 million total dispensed opioid doses. Prescription opioids remain a significant contributor to unintentional drug overdose deaths in Ohio, contributing to nearly one half of all deaths in 2014.

The new guidelines urge prescribers to first consider non-opioid therapies and pain medications when appropriate, for the outpatient management of acute pain. This approach can help to prevent the potential misuse and abuse of leftover opioids. When opioid medications are necessary to manage a patient's acute pain, the guidelines recommend that the clinician prescribe the minimum quantity necessary without automatic refills.

"No prescriber can predict which patients will become addicted to their opioid pain medication, so why take the chance if the patient's acute pain can be managed by less dangerous treatment options?" said Dr. Amol Soin, a pain management specialist, and Vice President of the State Medical Board of Ohio.

"Just because clinicians can prescribe a 30 day supply of opioid medication doesn't mean that they should," he said. "Prescribing only the amount necessary based on each individual patient's needs will help reduce the number of leftover, unused opioids and the potential for diversion and abuse." Soin also noted that, like the emergency department and chronic pain prescribing guidelines, the new acute pain guidelines call for prescribers to check the State Board of Pharmacy's Ohio Automated Rx Reporting System (OARRS) before prescribing an opioid. A review of OARRS is required for most opioid and benzodiazepine prescriptions of seven days or longer.

Ohio is making it even easier for prescribers to check OARRS. Last October, Gov. Kasich announced an investment of up to $1.5 million a year to integrate OARRS directly into electronic medical records and pharmacy dispensing systems across Ohio, allowing instant access for prescribers and pharmacists.

More than 110 hospitals, pharmacies and physician offices already have requested integration. Ohio's opioid prescribing guidelines are having a positive impact in the fight against prescription drug abuse:

- The number of prescriber and pharmacist queries using OARRS increased from 778,000 in 2010 to 9.3 million in 2014.
- The number of individuals "doctor shopping" for controlled medications decreased from more than 3,100 in 2009 to approximately 960 in 2014.
- The number of opioid doses dispensed to Ohio patients decreased by almost 42 million from 2012 to 2014.
- The number of patients prescribed opioid doses higher than chronic pain guidelines recommend to ensure patient safety decreased by 11 percent from the last quarter of 2013 to the second quarter of 2015.
- Ohio patients receiving prescriptions for opioids and benzodiazepine sedatives at the same time dropped 8 percent from the last quarter of 2013 to the second quarter of 2015.

STEPPING INTO SPRING

Baby Steps

State Medical Board Reminder: Wallet Cards Discontinued

Due to a change in Ohio law that went into effect on September 29, 2015, the Medical Board no longer issues wallet cards at the time of initial licensure or renewal.

Online license status verification is available 24/7. Use the license status feature on the Medical Board's website - www.med.ohio.gov – to verify information regarding physicians (MD, DO, DPM), acupuncturists, anesthesiologist assistants, cosmetic therapists, genetic counselors, oriental medicine practitioners, and radiologist assistants. To verify information regarding massage therapists or physician assistants use the license lookup feature on the new E-License center at https://elicense.ohio.gov/.

PQRS News

The PQRS program will be stopping December 31st, 2018; however, starting in 2019 Medicare will start a new program, called MIPS, which will track the PQRS and will also track other factors. The VM (Value Modifier) program expands on the quality of care initiatives of the PQRS program and goes beyond to combine with cost measures. CMS will calculate this based on specific medical conditions, outcomes, and hospital admissions/readmissions. These and other measures are detailed more on the CMS website. You can visit this directly by entering https://goo.gl/zz3SYD

If you did not report PQRS in 2015 or you did not successfully report your PQRS quota in 2015, you automatically fail the VM program. If you successfully met the PQRS quota in 2015, you could still fail the VM program. This VM program has a separate penalty. Therefore if you did not successfully report PQRS or did not report PQRS in 2015, you will get a 2% penalty for the PQRS and you will get another 2% penalty for the VM program, totaling a 4% penalty on each of your Medicare claims for 2017. If you successfully meet PQRS for 2015 but fail the VM program, you will only be penalized 2% for the VM program. The VM program will be ending December 31, 2018 as well when the new program starts up.

Ohio Board of Pharmacy Adopts New Rules on Drug Compounding by Prescribers

On May 1, 2016, the following Board of Pharmacy rules on prescriber drug compounding will go into effect.

- 4729-16-04 (NEW) - Drugs Compounded by a Prescriber:

Specifies requirements for prescribers who compound non-hazardous drugs.

- 4729 -16-11 (NEW) - Hazardous Drugs Compounded by a Prescriber:
- Specifies requirements for prescribers who compound hazardous drugs.

For a complete copy of these and other rules relating to drug compounding, please visit: www.pharmacy.ohio.gov/compounding2016. REMINDER: All locations (no exception) are required to hold a license as a terminal distributor of dangerous drugs in order to possess, have custody or control of, or distribute dangerous drugs that are compounded or used for the purpose of compounding. Pharmacies and wholesalers will not be able to ship compounded drug products or drugs used for the purpose of compounding to an entity that is not licensed by the Board. This applies to compounded drugs sent to prescribers acting as pick-up stations. More information on this requirement can be accessed here: www.pharmacy.ohio.gov/compounding

Academy News
Midwest Academy

by John Stevenson, DPM, President

The Midwest Academy will host the 2016 Quickie Seminar on Saturday, September 24th, 7 am to 4 pm, at The Hilton Garden Inn South/Austin Landing just off of I-75 at 12000 Innovation Drive, Dayton,Ohio, 45432. Six CME hours total will be available. See our website http://www.midwestacademyohio.com/

Advertisements

Quantus Solution: The Smart Chip Aftermath

Medical providers have been asking about the "smart chip" (EMV) card impact since the "Liability Shift" of October 1st, 2015. Did you realize that Quantus Solutions is America's proven low-cost choice for Medical and Dental Processing? Quantus has been deploying EMV certified terminals since the end of July 2014—a full 15 months before the deadline. Quantus is providing every podiatric office with a FREE EMV Terminal as long as the podiatry merchant is processing with Quantus.

Just a few factoids to monitor these trends: When Canada rolled out the EMV conversion in their country, it took several years. Even then, it was still at a 90% adoption range. EMV has been used in Europe for the past 15 years. Meanwhile in the United States, October 1, 2015 came and went. Despite having almost three years to prepare for EMV, banks and merchants were caught empty-handed as the deadline approached. No one in the industry expected every credit and debit card to have a chip, nor did we expect all merchants to have the capability to accept those cards. Remarkably, the industry seems to be fine with it for now. Currently, the biggest issue seems to be the argument over chip-and-signature vs. chip-and-PIN; the latter of which is the more-secure option when it comes to chip cards. The FBI caused a stir last week when it issued a warning that urged consumers to use a PIN with their cards. The problem with that proclamation is that the majority of EMV cards in circulation are not capable of working with a PIN. From the card holder still not having their smart chip card to use, to the issuing banks which provide us our cards to use, to the processors and gateway solutions not being ready, to the terminal manufacturers, this will definitely be a long conversion process before the America's credit card accepting merchants will be fully engaged.

We are standing-by ready to help your practice be compliant as OHFAMA's preferred low-cost EVM terminal processor. Contact Quantus at 800-698-5150 to request your FREE EMV terminal today!! This is another group benefit offered to every Foot & Ankle practice for being a member of OHFAMA or WVPMA. This benefit is brought to you by Quantus Solutions, a proudly endorsed partner of the OHFAMA. Visit us to learn more at www.quantussolutions.com

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WVPMA MEMBER UPDATES

Dr. Windy Cole of Kent, Ohio presented Wound Care Updates for 2016

West Virginia Winter Meeting in Charleston

WVPMA held its Winter Meeting on January 16 at the Holiday Inn Express Civic Center in Charleston, WV. The membership met prior to the lectures that were given by Dr. Wayne Bakotic of Alpharetta, GA and Dr. Windy Cole of Kent, Ohio.

Exhibitors represented were Bako Integrated Physician Solutions (Todd Slack, Representative); Integra (Greg Oakley, Representative) and Soluble Systems (Greg Eads, Representative).

The next quarterly meeting will be held by video-conference on Thursday, April 21 at 7:00 p.m. Agendas and conferencing links will be sent to all members prior to the meeting.

WVHA Announced Opioid Rx Guidelines

The ***WVHA Guidelines for Use and Prescribing of Opioids in Hospital Emergency Departments*** result from work by front-line experts from state hospitals and other leading health care professionals, including physicians and nurses. The guidelines were written and endorsed in partnership with the West Virginia Chapter of the American College of Emergency Physicians. The WVHA represents 66 acute and specialty hospitals and health systems.

The new guidelines consist of 10 principles that establish baseline recommendations for opioid screening, prescribing practices, and appropriate use of resources to work with patients prior to prescribing an opioid pain medication in a hospital ED. The overall goal is to ensure that health care providers have current, standardized resources and tools to work with, and to educate patients on the risk of taking opioid medications. The guidelines also recognize that each patient's medical condition is unique, so it is not intended to interfere with or supersede the professional judgement of a treating clinician.

West Virginia also has the highest drug overdose mortality rate in the nation. ED visits associated with pharmaceutical misuse or abuse increasing 114% between 2004 and 2011 in West Virginia.

The Hospital Association's Ten Guidelines

1. In compliance with the West Virginia Medical Practice Act, one medical provider should provide all opioids (narcotics) to treat a patient's chronic pain. For exacerbations of chronic pain, the emergency medical provider should attempt to contact the patient's primary opioid provider or pharmacy. It is recommended that a summary of the ED care be sent to the primary opioid provider.
2. A prescription for a controlled substance should not be given to a patient without a government issued photo ID.
3. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbation of chronic pain is not in the patient's best interest and is discouraged.
4. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, stolen, destroyed or finished prematurely.
5. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone program without consultation with the methadone program.
6. The ED will not prescribe or dispense suboxone. The ED will not prescribe opioid pain pills to those identified as enrolled in a suboxone clinic without consultation with the suboxone clinic, except in the case of an acute injury or illness such as a broken bone.
7. Long-acting or controlled-release opioids should not be prescribed in the ED, with the rare exceptions of some hospice patients, and only after consultation with hospice.
8. Prescriptions for opioids from the ED for acute injuries, such as broken bones, will cover the shortest appropriate time. If the emergency provider does elect to provide pain medication for chronic pain, it will only be enough to cover until the next business day.
9. The ED may coordinate the care of patients who frequently visit the ED to establish a patient specific policy/treatment plan, which should include treatment referrals for patients with suspected prescription opioid abuse problems.
10. ED providers, or their delegates, should consult the West Virginia Controlled Substance Automated Prescription Program (CSAPP) before writing a controlled substance prescription.

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