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Journal

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OHIO
FOOT AND ANKLE
MEDICAL ASSOCIATION

A WORD FROM THE PRESIDENT

Thank You For A Successful 100th Annual Scientific Seminar

Thank you all! I wanted to take the time to thank those who contributed to the success of our 100th Annual Scientific Seminar. The Ohio Foot and Ankle Medical Association would not be successful without all of you. Members attend, speakers teach, exhibitors sponsor and the staff and your Board of Trustees bring it all together. The list of names to thank is way too long and I do not want to leave anyone out, but I must stop and give thanks to Luci Ridolfo, Sarah Wenger, Cyndi Colburn and most of all Executive Director Dr. Jimelle Rumberg for all their hard work behind the scenes. Dr. DiDomenico and Dr. Mendicino should also be commended for their fine job of arranging the lecturers and topics. To all the students, residents, board members and at-large members who volunteered their time, we could not have done it without you!

Richard A. Schilling, DPM, FACFAS

With that said, the Annual has evolved into a world-class meeting where education, networking and camaraderie intersect. I thoroughly enjoyed all the interactions with those who attended. We are practicing in a time of much change in medicine and truly bringing our profession forward to be on par with other medical specialties and even taking a leadership role in many areas. I am so proud to be a podiatrist in 2016 and even more proud of being the President of the Ohio Foot and Ankle Medical Association.

It was very special to oversee the ceremony for the OHFAMA Distinguished Service Award. I want to give one more heart-felt congratulations to Dr. Green and Dr. Gould.

Seeing the diversity of attendees in age, culture, gender and specialty was remarkable as well. We have come a long way in the last 100 years, but we cannot rest on our laurels. Now, is the time to push forward, to gain more education, more expertise and to lead the way as the innovators of the field of foot and ankle medicine.

We are building bridges both internally and externally by following the pillars set forth in our most recent strategic planning initiative.

- *We have built a strong relationship with APMA, both the current and immediate past presidents were in attendance at our meeting.*
- *We are working closely with other medical specialties, as represented by the different non-podiatric physicians in attendance.*
- *We are working closer with KSUCPM and their educational initiatives to bring us closer to educational parity.*
- *Last, we have continued to move our legislative agenda forward with the state medical board.*

Success is all around, but it did not happen by accident. Success is made from hard work and good people.

And, success also costs money. If you have not had a chance to donate to OPPAC, please do. If you do not know why you should donate or what we are doing with your donations, please ask.

All this hard work has lead us to this point, but we want to achieve our next big goal of parity. Ohio Foot and Ankle Medical Association wants you to practice medicine to your ability, within your training and without arbitrary restrictions. The goal is to practice according to your training and your education. With our strong membership and directed leadership, we will accomplish this goal!

Fraternally,

Richard A. Schilling, DPM, FACFAS

IN THE SPOTLIGHT

Deadline Extended for Sole Proprietors to Register with Board of Pharmacy as Terminal Distributors of Dangerous Drugs

As we previously reported, the Ohio State Board of Pharmacy (Board) in January adopted new compounding standards, including a rule which would require previously exempt sole proprietors to register as Terminal Distributors of Dangerous Drugs (TDDD) by May 1, 2016 if they possess, have custody or control of, or distribute dangerous drugs that are compounded or used for the purpose of compounding.

This rule will have significant impact on many providers, including dentists, physicians, podiatrists, and the like, many of whom may have been "compounding" without being aware of it. However, at its most recent meeting, the Board heard from providers who would be impacted by the rule and has extended the May 1, 2016 registration deadline ***to September 1, 2016.*** Further discussions are on-going. This topic will be on the July agenda of the Board.

In the interim, the Board will consider the scope of its new compounding rules and how they impact previously exempt sole proprietors. The OHFAMA did make comment on behalf of the membership. ***The Board is advising previously exempt providers (Sole Proprietors) to refrain from application to the Board as a TDDD until further notice.***

It is important to note that this extension does not impact group practices or the implementation and enforcement of Ohio Administrative Code 4729-16-11, which regulates prescriber compounding of hazardous drugs.

We will monitor the progress of these rules and related developments and will advise our members as soon as details are available.

OHFAMA HBOT FOCUS ON LEGISLATIVE RADAR

Hyperbaric Oxygen Treatment for Podiatric Supervision

It's not a done deal; however, at the June 8 meeting of the State Medical Board's Scope of Practice Committee and during the regular general Board meeting, language for hyperbaric oxygen treatment (HBOT) for podiatric supervision was discussed and approved to insert into the podiatric Scope of Practice legislative bill revisions. While the final language is not yet in writing, we can relay that the language will be included in the legislative bill to update the Scope of Practice for podiatry in Ohio. The language was sent to the appropriate legislative channels (CSI and JCARR). The final copy was not available at press time.

Of note will be the need for Advanced Lifesaving Training Certification, a minimum of a 40 hours course of hyperbaric training, and podiatric board certified or podiatric board qualified recognition of the ABFAS or the ABPM. There was also an agreement to include a required hyperbaric consultation (with a HBO certified physician) and a requirement that the consultant physician be *readily* available while the treatment is underway. Language will also be added to allow the DPM to have direct supervision of the HB Technician.

Special commendation should be given to OHFAMA President Dr. Richard Schilling, Lobbyist Dan Leite and Supervising Board Member Dr. Bruce Saferin of the SMB for their assistance. Please be on notice that until this language passes legislatively or is legislatively inserted into a bill and signed by the Governor, DPMs will not be allowed to supervise HBOT in Ohio. More details will follow on our listserv and website.

CRITICAL DEADLINE UPDATE

Bureau of Workers' Compensation New True-Up Process Deadline

The first-ever payroll True-up period for private employers begins July 1, 2016. Payroll true-up reports are due to BWC no later than August 15, 2016.

At the end of each private employer policy period (July), it is necessary to reconcile estimated payroll with actual payroll. This is called the True-up. This report can be completed online at: http://ow.ly/4mWUlm or over the phone by calling 1-800-644-6292.

This new payroll True-up process is part of prospective billing, and as a result, Ohio businesses are now required to reconcile their actual payroll annually for the prior policy year and also reconcile any differences in premium paid. According to BWC, the True-up allows more accurate premium calculation. Even if actual payroll for the year matches the original BWC estimate or a business had zero payroll, the True-up report must be completed.

The quickest and easiest way to True-up is online with a BWC e-account. If you do not have a BWC e-account you can create one by signing on to: https://www.bwc.ohio.gov/SelfSvcAccountAdmin/newacc.asp.

You can also complete the True-up through the BWC call center however wait times may be extremely high, as a result BWC encourages the use of their online reporting system.

Again, August 15, 2016 is the due date for your True-up report to be completed with BWC. This is a critical deadline, as the BWC has indicated that if a business does not complete the True-up timely, they may not be eligible for current, and future alternative rating and premium discount programs such as Group Rating and Group Retrospective Rating. Once more, reports must be submitted either online at (http://ow.ly/4mWUlm) or by phone at 800.644.6292.

OHFAMA LEGAL TEAM AT YOUR SIDE

Substantial Increase in FCA Penalties Puts Many Health Care Providers on Edge

by Daniel S. Zinsmaster and Jenna G. Moran

In an interim final rule just released in May 2016, the amount of civil monetary penalties under the False Claims Act (FCA) would double; inciting panic among many, including health care providers, who fear similar increases which could lead to frightening effects.

The False Claims Act Provisions

The False Claims Act (FCA)[1] provides that any person who knowingly submits or causes the submission of a false or fraudulent claim for payment to the government must pay a civil penalty. There is no requirement for proof of specific intent under the FCA. While the FCA applies to any person who submits a false claim to the government for reimbursement, of the $3.5 billion recovered by the Department of Justice in fiscal year 2015 from FCA settlements and judgments, $1.9 billion came from companies and individuals in the health care industry.

In November 2015, Section 701 of the Bipartisan Budget Act of 2015, entitled the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the 2015 Act), went into effect amending the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 1990[2] to require agencies to publish regulations adjusting the amount of civil monetary penalties (CMPs) provided by law within the jurisdiction of the agency by July 1, 2016. The 2015 Act requires a one-time catch-up adjustment, followed by subsequent annual adjustments.

The Railroad Retirement Board and FCA Penalties for Inflation

On May 2, 2016, The Railroad Retirement Board (RRB) became the first federal agency to publish its interim final rule adjusting FCA penalties for inflation, as required under the 2015 Act. As explained in the interim final rule, the formula for adjusting the amount of CMPs was given by statute, with no discretion by the agency. The adjustment amount was calculated based on the percent change between the consumer price index (CPI) for October of the last year in which penalties were previously adjustment and the CPI for October 2015. According to the RRB, the new, post-adjustment minimum penalty under the FCA would increase from $5,500 to $10,781. The new, post-adjustment maximum penalty would increase from $11,000 to $21,563. The adjustment is a whopping 216 percent penalty increase.

The RRB is just the first agency to make the adjustments. Other agencies will be making their adjustments, which should be similar if not identical, before the July 1 deadline. While the 2015 Act gives agencies discretion to adjust the amount of CMP by less than the required amount if the increase would have "a negative economic impact," it is unlikely that agencies will pass up an opportunity to receive the maximum amount allowed by law.

Impact on Health Care Providers

For health care providers, the increase is especially daunting considering the penalty amount would apply to each false claim submitted to the government for payment. The increase will also boost the Department of Justice's and Relators' leverage in settlement discussions. On the flip side, this massive increase may also fuel arguments about the Eighth Amendment Excessive Fines Clause. In particular, an Eighth Amendment argument could be successful in a case involving a vast number of false billing claims but only a small amount of actual damages.

In light of this considerable increase in FCA penalties and the impending release of other agencies' similar adjustments, it is vital that health care agencies and practitioners develop and implement a strong compliance plan by working closing with their health care counsel to evaluate their programs and make changes where necessary.

Endnotes

1 31 U.S.C. § 3729
2 28 U.S.C. § 2461

APMA OFFERS INSIGHT FOR MEMBERS

CMS Imaging Service Payment Reduction

We have received several calls regarding the CMS's announcement about cuts to imaging services. Here is the APMA's understanding of the Medicare film/cassette imaging service payment reduction provision in section 502 of Division O of the Consolidated Appropriations Act, 2016. Please note that CMS will have to implement these provisions through rule making. We expect to see its interpretation of the law in the Medicare Physician Fee Schedule (MPFS) proposed rule (due this summer).

Section 502(a)(1) adds a new paragraph (9) to section 1848(b) of the Social Security Act (which contain various rules that Congress wants CMS to follow in establishing the Medicare Physician Fee Schedule (MPFS)). Thus, this new section 1848(b)(9) tells CMS to reduce payment under the MPFS for imaging services that are X-rays (1) that use film or (2) that use cassette-based imaging (which uses an imaging plate to create the image involved). While there are timing rules (2017 for film and 2018 for cassette-based) and different payment reduction percentages, 1848(b)(9) is fairly broad in scope.

The law reduces the physician fee schedule technical component (including the technical component portion of a global service) by 20% beginning FY 2017 for imaging services using film. Similarly, the provision reduces the physician fee schedule technical component (including the technical component portion of a global service) by 7% for FYs 2018-2022 for x-rays taken using computed radiography technology and by 10% beginning in FY 2023. These physician fee schedule changes apply to the individual services as well as to the imaging portion of a service.

The APMA will keep members posted through the Weekly Focus and their website APMA.org.

EXECUTIVE DIRECTOR'S MESSAGE

Optimist or Pessimist: Why Don't You Refill Your Glass?

Happy summer! Too hot or too rainy? Busy or slow? It's the eternal question of optimism *vs.* pessimism, isn't it? If you ask someone if their glass is half-empty or half-full, you'll usually get an answer, but honestly, they are missing the point. Don't they ever realize you can always refill the glass?

Jimelle Rumberg, PhD, CAE

Steadfast Optimism Wins the Race

Eternal optimism sports many fine examples here in Ohio. The Cavs won the National Championship – the first Cleveland has seen since 1964. The Indians will always have next year and, as far as Brown's fans, they are always die-hard and steadfast. With the same religious fervor and passion of sports optimism, podiatrists must stay the course. You can always see eyes roll at the mention of "Title XIX." Similarly, the "parity" word has many meanings – financial, scope of practice, insurance reimbursement.

Perseverance Pays Big Dividends

For members who really want to achieve that next step for the profession, won't you plan on assisting us by visiting your Congressman or Congresswoman this summer in their home district offices? We need to pay it forward for this and the future generations of podiatric physicians and surgeons.

A Strategy to Employ

Here's the game plan: OHFAMA is making a concerted effort this summer to help you visit Congress on YOUR home turf. Face it OHFAMA, it would be hard for your elected Representative to look at you, in their office, hear your patient stories of limb salvage and patient care and fail to consider helping us achieve the HELLPP Act.

We Need You!

We need academy involvement state-wide to really make this a successful venture. It's not up to those APMA Delegates to always make Hill visits in DC to represent YOU. You have totally missed the point of refilling the glass – Congress wants to hear from YOU, their constituent and neighbor. You can certainly carry your own water if you firmly want to be equal, achieve parity and assist the profession of podiatry.

OHFAMA will be doing all the work in making the appointment and we will have an experienced past Hill visitor with you to assist in every academy appointment.

Get Set, Get Ready — Go For It!

Most members have never met a member of Congress, so if you will give us a half day out of your schedule, OHFAMA will make it happen. We will have all the talking points and printed materials. All we ask is that you help US, help YOU on the HELLPP Act (Title XIX – *Doctors of Podiatric Medicine: Saving Lives, Saving Limbs, Saving Health-Care Dollars*).

Can We Count On You, Now?

Will you carry the water when your academy president sends out the call in mid-July? Congress is on vacation in home districts in late July and August – so now is the time. We will make appointments and visit all 20 offices based on the availability of the Representative. We will also visit our two Senators regarding the advocacy message of VA Physician Recognition.

Look for details soon from academy presidents. Instead of bringing a glass, bring a bucket – we have a lot of glasses to fill and it's time that members carry the water in Ohio.

2016 Calendar

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

2017

January 19-21
NWOAPM Scientific Seminar
Kalahari I Sandusky

February 4
Foot and Ankle Surgery Symposium
Embassy Suites Airport I Columbus

February 25
Sports Injury Clinic
Quest Conference Center I Columbus

June 8-10
Annual Scientific Seminar
Hilton at Easton I Columbus

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

Thank you to our 2016 OPPAC Contributors as of 7-11-16

Central Academy
Sarah Abshier, DPM
Animesh Bhatia, DPM
Scot Bertolo, DPM
Timothy Brown, DPM
Jerauld Ferritto, DPM
Roderick Fuller, DPM
William Munsey, DPM
Lee Pearlman, DPM
John Phillips, DPM
James Ritchlin, DPM
Richard Schilling, DPM
Adam Thomas, DPM

Eastern Academy
Bruce Blank, DPM
Edward Cosentino, DPM
Mitch Dalvin, DPM
Heather Petrolla, DPM

Mideast Academy
Edward Benedict, DPM
Windy Cole, DPM
Jeanna Fascione, DPM
Gary Greger, DPM
Richard Hofacker, DPM
Karen Kellogg, DPM
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Darrell Ballinger, DPM
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Philip Cain, DPM
Deanna Chapman, DPM
Marc Greenberg, DPM
Brian Kuvshinikov, DPM
Donald LeMelle, DPM
Lisa Nicely, DPM
Gerald Perelman, DPM
John Stevenson, DPM
Kevin Sunshein, DPM
David Trimble, DPM
Susan Yu, DPM

North Central Academy
Christopher Bohach, DPM
Daniel Duffy, DPM
Eugene Kubitz, DPM
Brian Zimmerman, DPM

Northeast Academy
Atta Asef, DPM
Michael Bodman, DPM
Mark Gould, DPM
Jerry Lamendola, DPM
Neal Marks, DPM
Debra Thornton, DPM
Kelly Whaley, DPM

Northwest Academy
John Clarke, DPM
Thomas McCabe, DPM
Corey Russell, DPM
Kathryn Schramm, DPM
Pamela Sheridan, DPM
Thomas Vail, DPM

Southern Academy
Brian Ash, DPM
Renee Ash, DPM
Ruth Ann Cooper, DPM
Kelly Heppert DPM
John Rootring, DPM
Brad Wenstrup, DPM

Additional Contributors
Daniel Leite, Lobbyist
Donnalyn Moeller, DPM
Luci Ridolfo, CAE
Jimelle Rumberg, PhD, CAE

****ADD YOUR NAME TODAY*****

A Successful Centennial Seminar in Photos

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OHFAMA Service Award for 2016

Dr. Mark Gould of Avon Lake and Dr. Henry Green of Bowling Green were invested into the second class of the OHFAMA Service Award for 2016. This distinguished award is in recognition of service to the association and the profession of podiatry. Congratulations, Dr. Gould and Dr. Green.

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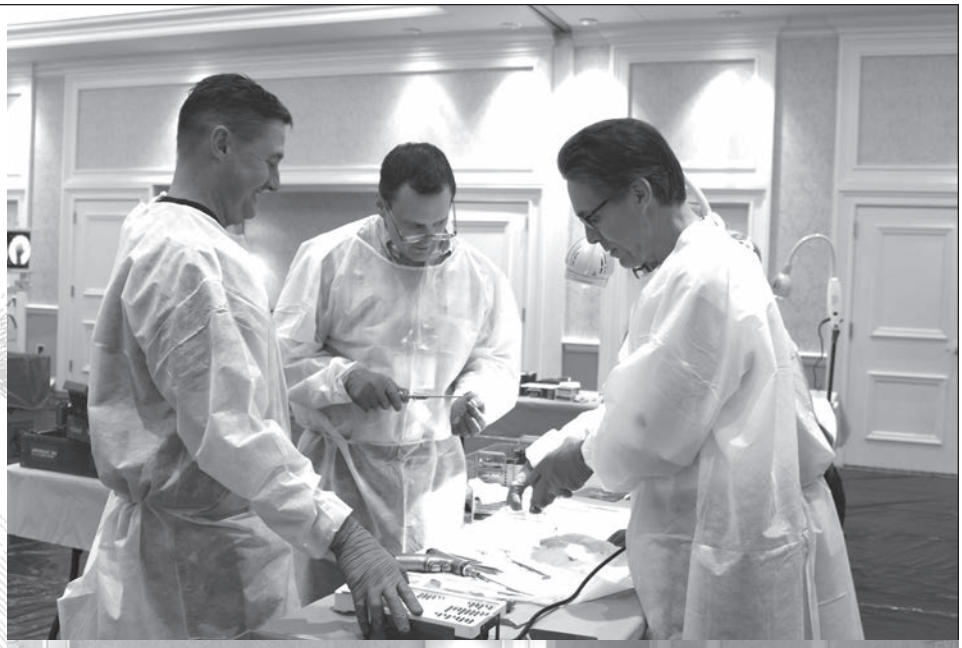

Cutting Edge Laser Technologies

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BAKO Workshop

BAKO Biopsy workshop was a full house.

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Dr. Sheridan, Dr. Greenberg and Dr. Perelman rally for OPPAC donations.

OHFAMA Members enjoying the OCPM Foundation Reception: Dr. Atway (Central Academy), Dr. Springer (Mideast Academy) and Dr. Ballinger (Midwest Academy).

Dr. Richard Schilling, OHFAMA President, addresses members of the Silver Gavel Club during their annual luncheon. Silver Gavel Club members are all past presidents of the association.

Leadership Meeting

Leadership teams join forces and meet during the Annual Scientific Seminar on Ohio matters: Dr. Mark Gould, APMA Delegate; Dr. Marc Greenberg, APMA Delegate; Dr. Phill Ward, APMA Immediate Past President; Dr. Dan Davis, APMA President; Dr. Jimelle Rumberg, Executive Director; Dr. Richard Schilling, President; Dr. Corey Russell, Immediate Past President; and Dr. Thomas McCabe, First Vice President.

The Kent State University College of Podiatric Medicine

The Kent State University College of Podiatric Medicine Centennial Video highlighted some of the Century of Podiatric education in Ohio. Following the video, Dr. Boike extended an invitation for all to join in the upcoming celebration in September at KSUCPM.

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The 100th Annual Ohio Foot and Ankle Scientific Paper and Poster Competitions

Thank You to Competitions Chairman Robert Brarens, DPM, FACFAS; Residency Paper Submission Judges: Mark Gould, DPM; Richard Hofacker, DPM; Todd Loftus, DPM; Pam Sheridan; and Rick Weiner, DPM. Residency Paper Presentation Judges Sarah Abshier, DPM; Windy Cole, DPM; Duane Ehredt, DPM; Lee Hlad, DPM; and Karen Kellogg, DPM. Residency Poster Submission Judges Renee Ash, DPM; Marc Greenberg, DPM; Eric Miller, DPM; and Amanda Quisno, DPM.

The 100th Annual Ohio Foot and Ankle Scientific Seminar's Gerard V. Yu, DPM Scientific Paper Competition

Resident Paper Competition Finalists: Amanda Lutter, DPM; Breanna Ferguson, DPM; Brianna David, DPM; Craig Udall, DPM; Caleb McFerren, DPM; and Chair Robert Brarens, DPM.

The 100th Annual Ohio Foot and Ankle Scientific Seminar's Scientific Poster Competition

Resident Poster Competition Finalists: Grace Chuang, DPM; Erin Younce, DPM; Chair Robert Brarens, DPM; Eric So, DPM; and Rebecca Sundling, DPM.

Congratulations, Winners!

Third-year resident at The Ohio State University, Winner of the 2016 Resident Paper Competition Dr. Craig Udall (near right) is congratulated by Dr. Richard Schilling, OHFAMA President.

Dr. Eric So (far right), second-year resident at Grant Medical Center, was the Winner of the 2016 Resident Poster Competition.

A CASE REPORT

Syme's Amputation

by Michael B. Canales, DPM, FACFAS, Chief of the Division of Podiatry, St. Vincent Charity Medical Center – Cleveland, Podiatric Surgical Residency; Grace Chuang, DPM, Resident, Post-Graduate Year 2; Kartick Patel, DPM, Resident, Post-Graduate Year 2

Case Presentation

A 57 year-old female presented with a painful, swollen right ankle. Approximately 20 years ago, she developed osteomyelitis from long-term steroid use and wound complications associated with an ankle arthrodesis on her left side. She endured ten operative debridements in an effort to preserve the extremity. Nonetheless, the patient underwent a left transtibial amputation.

Fifteen years later, the patient had a right ankle arthrodesis to address painful symptoms secondary to the increased load on her ankle due to her left side amputation. At initial presentation to our service, the patient developed painful symptoms in her right ankle.

History

Past Medical History: Chronic osteomyelitis, hypertension, hyperlipidemia, depression secondary to her left transtibial amputation and chronic pain to her right ankle. Past Surgical History: Left transtibial amputation 20 years ago and right ankle arthrodesis 15 years ago. Social History: Non-contributory. Medication: Lisinopril, hydrocholorothiazide, Lexapro, protonix, levothyroxine, pravastatine, bupropion, tramadol, & multivitamin. Allergies: Macrolide antibiotics, IV pyelogram dye, codeine and Azithromycin.

Physical Exam

Neurovascular status intact. Full thickness wound right anterior ankle measuring 0.2cm x 1.3cm with granular base and mild periwound erythema. Diffuse right ankle pain despite clinical evidence of arthrodesis. Decreased subtalar joint and midtarsal joint range of motion with pain. Radiographic Images: Ankle arthrodesis with adjacent joint. Lucency within the medial ankle.

Stage One

Bone biopsy and culture performed of the tibia, fibula, calcaneus, and talus. Tibia and talus with positive bone cultures with salmonella as the infecting organism. Pathologic examination of the bones of the ankle demonstrated fragments of bone with degenerative changes.

The patient was started on multivitamins and Ensure® due to suboptimal total lymphocyte count and pre-albumin levels. Patient was also started on hyperbaric oxygen treatments due to her history of chronic osteomyelitis.

Preoperative Requirements and Predictors of Success

DESCRIPTION	HEALING PARAMETERS	PATIENT
Ankle – Brachial Index	>0.5	1.29
Transcutaneous Oxygen Pressure	30mm Hg	30mm Hg
Total Lymphocyte Count	1500	1434
Serum Albumin Level	3.0 g/dL	3.1 g/dL
Serum Glucose Level	<250 mg/dL	90 mg/dL
Highly Motivated Patient		yes
Access to a Highly Skilled Prosthetic		yes

Table 1: Syme wound healing parameters by Yu et al. and Pinzur et al.

Stage Two: Syme's Amputation

Incision was carried out. The plantar incision was carried to the level of the calcaneocuboid joint to ensure adequate flap length. Disarticulation of the Chopart's joint was performed. Both malleoli and the distal tibia were resected and incision was closed.

Microbiology of both fibula and tibia showed no growth. Pathology of right foot and ankle disarticulation was consistent with chronic osteomyelitis.

Postoperative Course

After two days, drain removed and short leg cast applied and changed at two-week intervals until resolution of edema and stump shrinkage achieved. NWB for 6 weeks.

At three weeks, sutures removed. At one month and two weeks,prosthetic referral for fabrication of permanent brace once stump stabilized. Physical therapy Referral
At two months, the patient was ambulating with aid of walker; and at six months, walking without assistive device.

Conclusion

Case reports continue to affirm the long-term durability of the Syme level of amputation and demonstrated to have a significant decrease in energy and metabolic expenditure with ambulation in comparison to proximal amputations[1].

The prosthetic should compensate for the loss of foot and ankle motion while providing propulsive energy required for ambulation[2]. Per prosthetist, "The Symes amputation afforded a longer lever arm for additional weight bearing surface and higher level of control of the prosthesis than a transtibial amputation. An additional advantage of the Symes amputation is to be able to transfer safely."

Thorough discussion between the patient, prosthetist, and surgeon are critical for success. The aim of this case report was to stimulate surgeons to consider this level of amputation when faced with complicated cases of lower extremity pain and deformity.

References

1 Dickhaut SC, DeLee JC, Page CP. Nutritional status: importance in predicting wound healing after amputation. J Bone Joint Surg Am 1984; 66: 71-75.

2 Yu G, Meszaros A, Schinke T: Chapter 14 Syme's amputation: A retrospective review of 10 cases. Podiatry Institute. 78-88, 2005.

3 Pinzur, M. Syme's Ankle Disarticulation. Foot Ankle Clin N Am 15. 487-494. 2010.

Acknowledgement

Special thanks to Teresa Masters, CPO of Masters Prosthetics & Orthotics.

SB 129 ANALYSIS

Governor Kasich Signs Prior Authorization Reform Bill

On June 15, Ohio Governor John Kasich signed Senate Bill 129, legislation that reforms Ohio's current prior authorization system. Ohio becomes the third state to establish prior authorization standards either in statute or the administrative code. OHFAMA would like to thank **Senators Randy Gardner** and **Capri Cafaro** and former House Insurance Committee chairwoman **Barbara Sears** for their hard work on this bill.

The podiatric physician and surgeon community is grateful to Senator Gardner, who is a strong supporter of our organization and profession, for reaching out to representatives of our association throughout difficult negotiations to ensure that the interests of members were reflected in SB 129, especially regarding "clinical peer review" of PA requests and appeals.

Some provisions will be implemented by January 1, 2017 and others by January 1, 2018. The bill impacts Health Insuring Corporations (HICs—ORC 1751), tradition Indemnity Plans (ORC 3923) and Medicaid Managed Care Plans (ORC 5160). Certain time lines will not apply to Medicaid plans' requirements of state Medicaid plans through federal laws or federal Medicaid administrative requirements. A summary of SB 129 follows.

January 1, 2017

- Providers will have access to electronic PA forms and PA requests shall be accepted through secure electronic transmissions;
- Health plans must respond using NCPDP SCRIPT standard ePA transactions;
- A FAX is not considered to be an electronic transmission nor is a proprietary portal for prescription drug requests that does not use NCPDP SCRIPT standard;
- A provider and a plan may enter into an agreement to process a PA request that does not use electronic means due to certain factors;
- There will be a 48 hour response required for urgent care services (originally 24 hours);
- There will be a response required within 10 calendar days for non-urgent services (originally 5 days was requested);
- The "PA clock" starts when receipt of all information necessary is received by the health plan from the practitioner;
- These time frames DO NOT apply to emergency services as defined in the bill;
- In these time frames, the plans must clearly state if the PA request has been approved, denied or is incomplete;
- A specific reason must be given for a denial and if the submission is incomplete, the plan must request and cite specific information needed;
- The provider must respond within 72 hours to this request for additional information upon receipt from the plan;
- Plans must provide an electronic receipt for this transaction.

PA Process For Prescribed Drugs — January 1, 2017

- The PA will be either 12 months or until the last day of the person's coverage eligibility, whichever is less;
- Plans can check with the provider no more than quarterly to check if the patient's chronic condition has changed. These consultations shall be done within medical or scientific evidence as defined in ORC 3922.01;
- The practitioner must respond within 5 days to the request for information by the plan or the PA can be terminated;
- A 12-month PA will no longer be valid or will be terminated if changes are made to state or federal laws or guidance regulations that say the prescribed drug is no longer approved or safe for its intended purpose;
- A 12-month PA is not required or apply to medications prescribed for non-maintenance conditions (not defined), medications for conditions that have a typical treatment plan of less than one year, medications that require an initial trial period to determine effectiveness or tolerability, medications where there is medical or scientific evidence under ORC 3922.01 that does not support a 12-month prior approval, medications that are Schedule I or II controlled substances or any opioid analgesic or benzodiazepine as defined under ORC 3719.01, or medications that are not prescribed by an in-network provider as part of a case management program;
- A 12-month PA MAY be granted but is not required for medications that are prescribed for a rare disease (as defined as a disease impacting 200,000 or less per year in the US), medications that are controlled substances that are not opioids or benzodiazepines as defined in earlier section;
- The substitution of a drug by a pharmacist that is already allowed under current Ohio law will not be prevented nor will be impacted by the granting of a prior authorization. A similar provision on interchangeable biologics was attempted by the health plans to be added at the last minute but was not accepted by the bill sponsor and others;
- The bill also states specific conditions under which a retrospective review of a PA can be made by the plan;

Notice Requirements

- By January 1, 2017, plans must make available to all participating providers on its website or provider portal listing its PA requirements and needs for PA information (to make a submission complete) as well as listing of all services, devices or drugs to which a PA authorization requirement exists.

Appeals Process — by January 1, 2018

- Plans must establish PA process;
- Urgent care appeals shall be concluded within 48 hours of receipt;
- All others must be completed within 10 days of receipt;
- Appeals that are done are required to be done between submitting practitioner and a clinical peer;
- If the appealing party is not satisfied with the plan's appeal process or result, they may request an external appeal as allowed under ORC 3922.

Retroactive Denial of PA — January 1, 2017

- Absent fraud or materially incorrect information, plans shall not retroactively deny a granted PA when all the following apply: the practitioner has submitted a PA request to a plan, the plan has approved the PA after determinations made of allowed factors and the plan's standards have been met for PA and medical necessity.

Ohio Department Of Insurance

- The bill will allow ODI to adopt rules needed to implement requirements of this section.

OHIO FOOT AND ANKLE MEDICAL ASSOCIATION

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PRESIDENT: Richard A. Schilling, DPM, FACFAS

PUBLISHED BY:
Jimelle Rumberg, Ph.D., CAE, Executive Director

ADVERTISING:
Luci Ridolfo, CAE, Assistant Executive Director

CONTACT INFORMATION:
1960 Bethel Rd., Ste. 140 | Columbus, Ohio 43220
Phone: 614.457.6269 | Fax: 614.457.3375
Web page: http://www.ohfama.org
Email jrumberg@ohfama.org;
lridolfo@ohfama.org; swenger@ohfama.org;
ccolburn@ohfama.org

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TAKING THE NEXT STEP

Baby Steps

Signature Log Can Be the Key to Surviving an Audit

All medical records need to be signed, whether they are paper or electronic. A common reason for failing an audit is unsigned medical records. When using your EHR system, please be sure to sign your notes in a timely manner. Each time you sign your record electronically, a time/date stamp is placed into your record that memorializes the time and date you signed the record. A large gap between the date of service and date of the signature can result in questions regarding the authenticity and accuracy of the signed record.

Paper records also require signatures. With a paper record, there are times when a signature may not be legible. For paper records, a signature log is very important and should be kept. This can be especially useful should a provider leave the practice, since that provider will no longer be available to authenticate his/her signature. A signature log is a typed listing of the provider(s), identifying their name(s) with a corresponding handwritten signature. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation.

Source: Michael Brody, DPM, TLD Systems Reimbursement Update

Lack of Documentation Affects Provider Reimbursement

Wonder why your reimbursement may be declining. Here are some easy guidelines for documenting medical records that you need to review with your staff. All information about services performed must be documented. If it isn't documented, then no one knows what was performed. Candidly how do you expect to be reimbursed appropriately?

Remember these Documentation Rules:

- All information about services performed must be documented.
- If it isn't documented, then it wasn't performed. Clerks and Reviewers do not know the services provided if there is no documentation.
- You are paid for what you document, not what you did.
- Document, Document, Document.

More lengthy explanation is always better when it comes to documentation.

Signature: CERT Denials

Comprehensive Error Rate Testing (CERT) contractors have noted significant error findings for missing or illegible physician and non-physician signature on medical record documentation. In these cases, the performing physician did not sign their medical record documentation in accordance with Medicare regulations. This has been an ongoing problem as reported to us by CGS in their quarterly meetings.

Signature reminders: 1) Upon request for an attestation statement, the medical record documentation should not be resubmitted to CERT with a signature added; 2) If the signature is missing from a progress note supporting intent, a signature attestation statement will be accepted; 3) If the signature is illegible, a signature attestation statement or a signature log can be submitted; 4) An attestation cannot be used for unsigned physician orders and unsigned laboratory requisition form. Each specific laboratory or diagnostic test should be listed in the progress note and signed.

For more information, refer to the CMS Internet-Only Manual, Publication 100-08, Chapter 3, Section 3.3.2.4 - Signature Requirements, and the article Signature Guidelines for Medical Review Purposes.

CMS Reminder: Mandatory Payment Adjustment Percentage of 2% Extended

For the Medicare Fee-for-Service (FFS) program, claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will continue to incur a 2 percent reduction in Medicare payment until further notice, due to sequestration.

The claims payment adjustment will continue to be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction.

CMS encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to continue discussions with beneficiaries the impact of sequestration on Medicare's reimbursement.

For more information, please refer to the Sequestration Frequently Asked Questions (FAQs) located at http://www.cgsmedicare.com/ partb/faqs/sequestration_faqs.html.

Medical Marijuana Legislation Signed by Governor

Legislative topics covered in the House and Senate ranged far and wide, but no doubt the one that generated the most attention on Cap Square was legislation that would legalize and regulate from seed-to-sale medical marijuana in Ohio.

The passage of House Bill 523 also set in motion the final days of the Marijuana Policy Project's (MPP) campaign to place a medical marijuana issue on November's ballot. That proposal would have cemented in Ohio's constitution pages and pages of marijuana policy that would be rigid and difficult to reform should any concerns arise in future years. The bill was signed into law by Governor Kasich. MPP wisely decided to withdraw its constitutional amendment proposal.

Full implementation of the medical marijuana legislation will be carried out within the next two years between the Ohio State Medical Board, The Board of Pharmacy and the Department of Commerce. Podiatric physicians and surgeons will not be able to prescribe Medical Marijuana.

Baby Steps continued on page 18.

Baby Steps continued from page 17.

ABFAS Candidates Short of 3-Year Residency Given 2018 Deadline

For those candidates without Board-Qualified ABFAS status and shy of completing a three-year CPME-approved residency, they MUST complete the ABFAS board certification process by December 31, 2018. After the December 31, 2018 date, these candidates will be ineligible for ABFAS certification, as stated in ABFAS Document 110. Visit ABFAS.org for more information.

Source: PPMA Update – May, 2016

Suspected Zika Virus Infection Protocol in Ohio

Mosquito season in Ohio is underway and the Ohio Department of Health (ODH) would like to ensure that all suspected cases of Zika virus infection are promptly reported and given information to prevent transmission within Ohio. This is a reminder that this is a class B reportable disease.

If you see a patient who meets the criteria for Zika virus testing, please advise that patient to go immediately to their PCP, Urgent Care or Minute-type Clinic for the following actions:

1 The Clinic or PCP should test the patient per the OH Health Department's protocol.
2 The Clinic or PCP should counsel the patient on how to prevent transmission.
3 The Clinic or PCP should provide the patient with fact sheets on Zika virus infection and mosquito bite prevention.
4 The Clinic or PCP should report the suspected case to the local health jurisdiction where the patient resides as soon as possible, but no later than the next business day.

FDA Issues Warning On Use of Ketoconazole for Skin and Nail Infections

FDA is warning healthcare professionals to avoid prescribing the antifungal medicine ketoconazole oral tablets to treat skin and nail fungal infections. Use of this medication carries the risk of serious liver damage, adrenal gland problems, and harmful interactions with other medicines that outweigh its benefit in treating these conditions, which are not approved uses of the drug.

FDA approved label changes for oral ketoconazole tablets in 2013 reflecting these serious risks and to remove the indications for treatment of skin and nail fungal infections. However, an FDA safety review found that oral ketoconazole continues to be prescribed for these types of conditions. Since the 2013 labeling change, one patient death has been reported to the FDA due to liver failure associated with oral ketoconazole prescribed to treat a fungal infection of the nails. Healthcare professionals should use ketoconazole tablets only to treat serious fungal infections when no other antifungal therapies are available.

Source: FDA [5/19/16] via PM News May 20, 2016 #5,668

UPDATE ON VETERANS

VA Proposed Rule on Advanced Practice Nurses

On May 25th, the Department of Veterans Affairs (VA) issued proposed regulations to amend its medical regulations to permit full independent practice authority by all VA advanced practice registered nurses (APRNs) when they are acting within the scope of their VA employment, regardless of individual state law. This proposal would allow advanced practice nurses (APRN) within the VA to practice independently of a physician's clinical oversight. The VA states that this rulemaking would increase veterans' access to VA health care by expanding the pool of qualified health care professionals who are authorized to provide primary health care and other related health care services to the full extent of their education, training, and certification, without the clinical supervision of physicians.

The American Medical Association said it was disappointed by the proposed plan because it runs counter to physician-led, team-based care, which it called the best approach to improving quality. Comments must be submitted to the VA on or before July 25, 2016. To date, there have been nearly 38,000 comments submitted. The proposed regulation is available at: http://tinyurl.com/zqvso4w

FROM THE PRESIDENT

A Successful Year In Review

Since West Virginia switched regions and joined with Ohio and the Ohio Foot and Ankle Medical Association, WVPMA has increased its membership from 23 to 35 members. Under executive director, Dr. Jimelle Rumberg, the WVPMA has adopted new bylaws, started a web page, became incorporated in WV and has a nonprofit tax ID. This was facilitated with the help of the APMA. The 100th Annual Scientific Seminar in Columbus was successful, providing a wealth of knowledge from the exceptional speakers, and a PICA lecture that offered a 15% discount off malpractice premium renewal.

During the WVPMA meeting, a proposed slate of new officers was nominated for a vote during our October 8 meeting. The proposed slate for 2017-2018 are President, Robert Dale, DPM; Vice President, Carrie Gosselink, DPM; Secretary/Treasurer, Jeff Findling, DPM; and Immediate Past President, Jerry Hadrych, DPM. Dr. Phill Ward, APMA Immediate Past President, attended the meeting along with the OHFAMA Executive Committee.

The next meeting, October 8, will be at UHC Hospital in Clarksburg. The meeting will offer CME credit. Details will follow for lunch and registration. Please plan to attend.

CMS will require you to start taking digital radiographs in the future or you will have a reduction in payment from Medicare. To convert from analogue to digital x-rays will be costly, so start planning and do your research prior to 2018's deadline. See you on October 8 at UHC Hospital.

Jerry Hadrych, DPM
WVPMA President

WVPMA Meeting Attendees: Drs. Rusty Cain, Dave Franke, Andy Dale, Jeff Findling, Jerry Hadrych, Jimelle Rumberg, Curtis Arnold and Carrie Gosselink.

WV 2016 Legislative Wrap-up

During the 2016 Legislative Session, legislators introduced 1,896 bills and passed 277. Healthcare-related bills that completed legislative action are summarized.

SB 7 The Wrongful Conduct Rule: The WVSMA strongly supported this bill. The need for this bill became apparent after the Tug Valley case last summer, in which the WV Supreme Court ruled that substance abusers could sue their physicians for damages related to their own wrongful conduct. (See the story in the July/August 2015 issue: "Court Watch: Criminal Drug Abusers are Allowed to Sue their Doctors.") SB 7 passed the Senate unanimously and by overwhelming majority in the House. It went into effect on May 24, 2016.

SB 15 The Learned Intermediary Doctrine: The bill provides pharmaceutical companies and sellers with a defense from suit when they provide information about their product to a learned intermediary (e.g., a physician, podiatrist, or others) who then is responsible for warning the consumer regarding risks from potentially dangerous medications and medical devices.

According to the American Bar Association, 22 states adopted the doctrine. Courts have carved out exceptions for companies engaged in direct-to-consumer advertising.

West Virginia was the only state to reject the Learned Intermediary Doctrine; this bill reinstates it. In a wrongful death case in which a patient died after taking Propulsid®, the WV Supreme Court of Appeals held, "manufacturers of prescription drugs are subject to the same duty to warn consumers about the risks of their products as other manufacturers." (Johnson & Johnson v. Karl, 220 W. Va. 463 (2007). The bill creates a burden for physicians and podiatrists who will have to document conversations regarding medications and medical devices. The bill went into effect on May 17, 2016.

SB 627 Allowing Physicians to Decline Prescribing Controlled Substances: This bill allows physicians and podiatrists to decline prescribing controlled substances to patients. It limits the liability of providers who prescribe in accordance with FDA recommendations, including those who decline to prescribe a controlled substance based on reasonable judgment that a patient is misusing or diverting the substance. The bill went into effect on June 8.

HB 4334 The APRN Bill: The final bill permits APRNs to have a three-year path to autonomy, no Schedule II authority, 30-day prescriptions of Schedule III drugs, and global signatory authority except for certificates of merit in medical malpractice cases. It allows for an advisory committee, but not joint rule making. It went into effect on June 10.

THE APPALACHIAN ADDICTION & PRESCRIPTION DRUG ABUSE CONFERENCE:PAIN & ADDICTION, BEST PRACTICES & PROPER PRESCRIBING will take place October 20-22 at the Embassy Suites in Charleston. There are many topics of interest relative to addiction, proper prescribing, addressing the stigma of addiction, safe prescribing with comorbid conditions, physician burnout and wellness, alternative non-addictive treatment of pain, physiology of addiction, current overdose statistics, infectious disease and marijuana. CME credit will be available for multiple disciplines including licensure boards. Please reference www.wvmphp.org for further details.

Ohio Foot and Ankle Medical Association
1960 Bethel Road, Suite 140
Columbus, OH 43220-1815

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