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Journal

OF THE
OHIO FOOT AND ANKLE MEDICAL ASSOCIATION

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INSIDE THIS ISSUE

A WORD FROM THE PRESIDENT

Sharing The Commitment of Involvement: Long Days, Short Months

Richard A. Schilling, DPM, FACFAS

As my time as your President comes to a close with the 2016 OHFAMA House of Delegates, we must look to the future and continue to move our Association forward. There are many accomplishments that we would be happy to extol, but it is not the time to sit back and watch the rest of the heath care community as it continues to be bombarded on all sides by regulations, reduced reimbursements, increased paperwork and decreased physician job satisfaction.

Getting involved with your medical association on any level is the best way to keep your profession moving in the right direction. Your leaders are committed to this, demonstrating positive results and having a plan for the future, but they are in need of your help both with time and money. I know it sounds like a broken record, but donations of time, money and energy are the things we cannot do without. It takes committed people, donating their time and energy and money to move the pendulum for organized podiatry.

On November 11 and 12, 2016, OHFAMA will host our annual House of Delegates in Columbus. This will be a great opportunity to observe, participate and learn about your association and profession. There will be ample opportunities at every level for all members and prospective members to gain experience and knowledge. At the HOD, reports will be given by affiliated groups, including the Medical Board representative, lobbyists, our national association, our local podiatry college and others. These reports will educate and enlighten even the most involved member. Please consider attending the HOD as a delegate, guest, or participant.

As I gear up to have the next President, Dr. Tom McCabe, take over in November, I can tell you that he will hit the ground running. Tom is capable and educated as well as motivated to continue the great work of our association over the last ten years under the very professional leadership of our Executive Director Dr. Rumberg. Our organization has advanced leaps and bounds, becoming more professional, organized and focused under the leadership of Dr. Rumberg.

All our members owe Dr. Rumberg and her staff a debt of gratitude. She has worked tirelessly and really has taken our issues as her issues. Only someone in my position can appreciate all that she has done, and continues to do, for our organization.

As the leadership continues to turn over in a predetermined pathway, we must continue to load the back-end of leadership. If you want to be involved, get involved. If you don't know how to get involved, please contact me (richardschilling@hotmail.com) and I will help you. We need new leaders and new ideas. We welcome and request your involvement.

Fraternally,

Richard A Schilling, DPM, FACFAS
President, OHFAMA

OHIO
FOOT AND ANKLE
MEDICAL ASSOCIATION

The Akron Marathon and Team Relays

As volunteers for the Akron Children's Hospital Akron Marathon Race Series, the OHFAMA members made a significant contribution to the community, sharing their skills and talents and helping to make the races successful world-class events for runners, families, and spectators!

During the September 24, 2016 Akron Marathon & Team Relays, OHFAMA Members Richard Hofacker, DPM, Tina Shahin, DPM PGY-1, and Binh Ta, DPM PGY-2 volunteered their medical skills.

In the National Spotlight

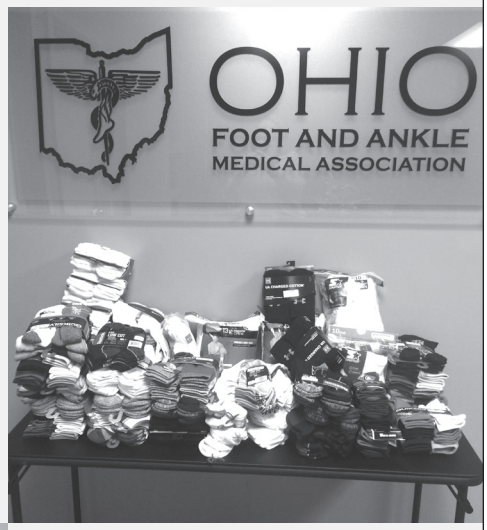
Ohio's Congressman Bill Johnson (R-6 Dist.) has agreed to be the lead GOP House sponsor of the HELLPP Act in the 115th Congress in 2017-2018. The House lead DEM sponsor has not yet been announced by the APMA. At this time, it is still uncertain if Senator Charles Schumer and Senator Charles Grassley will again serve as the lead DEM Senate sponsors for the HELLPP Act in 2017-18.

Congressman Johnson, a resident of Marietta, Ohio, serves on the House Budget Committee and was instrumental in telecommunication policies including telemedicine oversight. Johnson, a friend to podiatry, was a strong supporter and sponsor of the HELLPP Act during the 114th Congress.

"OHFAMA is most pleased that Congressman Johnson was asked to champion the HELLPP ACT by APMA. I know I speak for everyone in Ohio when I express that his selection was the perfect choice to advance this legislation during the 115th Congress," said Dr. Jimelle Rumberg, Executive Director of OHFAMA

OHFAMA Helps West Virginia Neighbors with Socks for Children Affected by June Floods

June caught many Southern West Virginia residents unaware of the devastation that was about to occur. The flooding killed twenty-four people, with the last child's body recovered in mid-August under a ticket of brush in Caldwell, West Virginia. The waters literally knocked houses off their foundations and even flooded the historic Old White Golf Course at The Greenbrier Hotel, canceling the Pro Golf Classic in White Sulphur Springs, West Virginia. While many families still await FEMA assistance, the Ohio Foot and Ankle Medical Association wanted to assist many school children who are displaced.



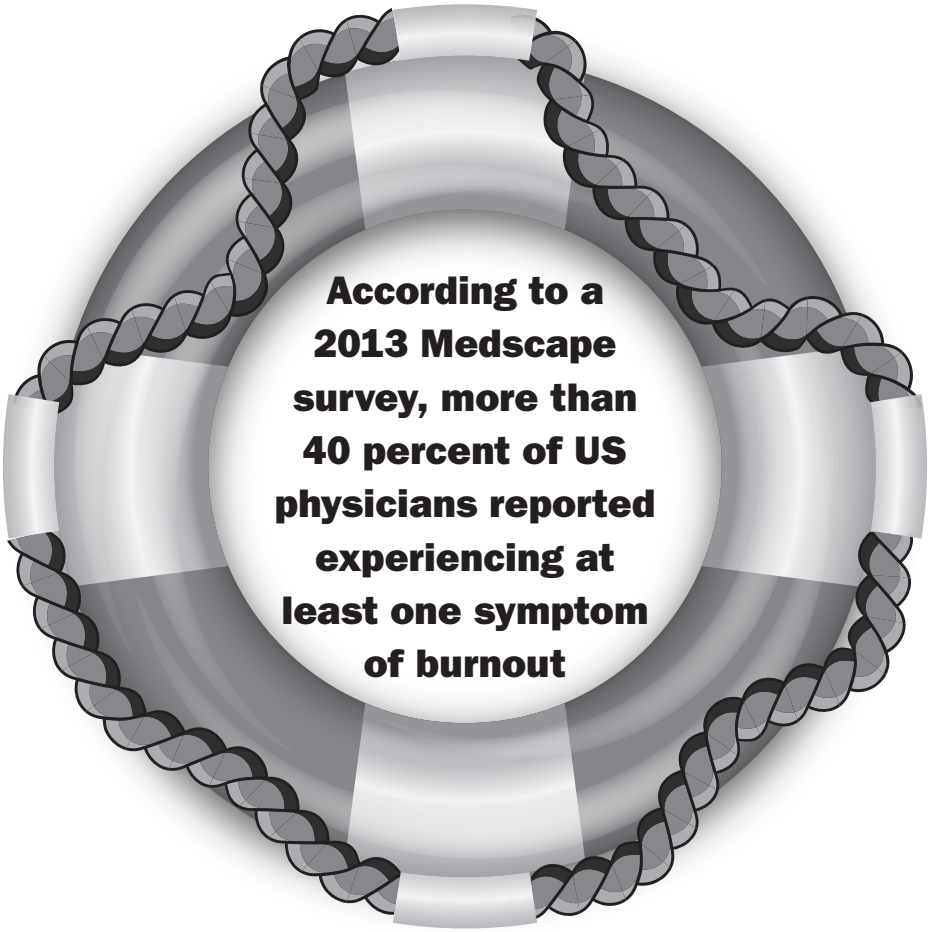
The June 23, 2016 flood in West Virginia and nearby parts of Virginia resulted from 8 to 10 inches of rain falling over a period of 12 hours.

OHFAMA's sock drive, aided by APMA, collected new samples of socks, shoes and boots that yielded $325 and 331 pairs of socks. The items shown in the photos were sent to Clendenin, West Virginia. The Clendenin community lost both schools and their entire town. OHFAMA pooled its resources and was fortunate to take advantage of the recent state tax-free holiday in Ohio to purchase the socks.

Many thanks to all those who so generously helped in these efforts. If you missed the OHFAMA deadline, you may send contributions to the community's distribution center: St. Thomas Episcopal Church, 205 West Main Street, White Sulphur Springs, WV 24986.

YOUR HEALTH IS VITAL TO ALL

Ohio Physician Health Program Helps Physicians Reclaim Their Lives



Medicine is a stressful profession. Mental ailments such as depression, substance use disorders, and other addictions are diseases, not behavioral choices. When health care professionals suffering from these diseases become patients it is in everyone's best interest to focus on treatment and return them to health and wellness as soon as possible.

Welcome, Medical Association Coalition

The OHFAMA is a part of the newly formed Medical Association Coalition (MAC). The MAC is working closely with the Ohio Physician Health Program (OPHP) to:

- Promote the health and well-being of physicians and other health care professionals;
- Facilitate timely treatment for those who struggle with potentially impairing illnesses; and
- Ensure that the Medical Board has an effective method that allows for a confidential pathway to seek treatment and rehabilitation.

According to a 2013 Medscape survey, more than 40 percent of US physicians reported experiencing at least one symptom of burnout (loss of enthusiasm for work, feelings of cynicism, and low sense of personal accomplishment). Administrative burdens, prior authorization requirements and "hamster wheel" medicine continue to negatively impact the wellbeing of healthcare professionals. With the reported growth of physician burnout, depression, and sometimes suicide, the role of OPHP is perhaps greater and more important than it has ever been.

One Bite Rule Impact

The past two years have been particularly important as the one-bite rule, which was legislatively established in the late 1980s, has been regularly challenged and faced with possible devastating change. The current one-bite rule allows a physician to seek treatment for a substance use disorder without reporting to the medical board so long as he/she has violated no other provision of the Medical Practice Act. The MAC and OPHP have advocated, educated, and communicated in a concerted effort to explain why a confidential pathway leads to early diagnosis and treatment which are critical to not only the physician, but to ensure the safety of Ohio's patients. As a result of those tenacious efforts, work is now underway to enhance and improve the one-bite rule rather than to implement changes that could result in a deterrence in physicians seeking the help they need.

The MAC and OHFAMA are proud of the collaborative work with OPHP and are fully committed to the OPHP mission "to facilitate the health and wellness of healthcare professionals in order to enhance patient care and safety." We are looking forward to improving the one-bite rule and to implementing a process that encourages physicians to seek treatment for their illnesses.

EXECUTIVE DIRECTOR'S MESSAGE

What Have We Done for You Lately? We're Glad You Asked!

What a great question! This year has been exciting and challenging on many fronts.

Jimelle Rumberg, PhD, CAE

A Huge Leap Forward

We feel one of our biggest accomplishments is the language agreement that finally addressed hyperbaric oxygen treatment (HBOT) for Ohio podiatric physicians – and to have our ORC Scope of Practice finished during this legislative biennium. Of course, we have to see its completion through the Lame Duck session. It's not official yet, but we will have a full-court press to YOU through our VoterVOICE network to contact legislators on its passage. Our alerts will let you know when to contact those key legislators via e-mail, letter, or phone calls. We will have template letters and messages so that we can achieve the final hurdle. We have been working on HBOT since 2007. In many ways, seeing the language finally agreed to on all fronts, including the State Medical Board, is extremely gratifying.

Prior Authorization Legislation Victory

The Prior Authorization legislation was quite a tandem accomplishment for the state medical providers. Ohio is only the third state to accomplish such legislation. We lobbied the legislative committee at 9:30 p.m. on a Saturday evening with podiatry's last push to get this passed. We worked this legislation with the Health Care Provider Coalition to the angst of many insurers. You will need to reference the details, starting on January 1, 2017, in the summer's issue of our OHFAMA newsletter. You may find that resource at the bottom of our website's homepage – follow the link to view past issues, Summer Issue – Page 15. Print it out so you may share those details with your staff.

Awaiting the TDDD Decision

The TDDD (Terminal Distributor of Dangerous Drugs) once again has reared its ugly head, now trying to target solo practitioners to purchase a license from the Ohio Board of Pharmacy. That item is currently on hold until April 1, 2017. Solo podiatric practices do not need to take action or purchase a solo license until we notify you of the pending outcome. Group practices are NOT exempt, so group practices need to continue purchasing a TDDD for their group. The main sticking-point regarding the TDDD is compounding. For podiatry, anesthetics with steroids, among other items injected, was our primary vocal objection. We have been working mostly with the Dermatologists on this issue with written push-back comments, so please keep the TDDD on your radar for the Board of Pharmacy's directive announcement in 2017. We will e-mail you when we know their decision.

Reaching Out to Communities to Assist and to Inform

Some summer projects began with a sock drive for West Virginia flood relief in July and with the taping of our latest state-wide commercial addressing shoe stores – they can't fix everything. Our assistant executive director, Luci Ridolfo, *aka* "One-Take Jake," was awesome at the microphone as she taped our latest radio commercial. We now have 30- and 60-second spot announcements on five important topics.

Advertising That Nets Results

The newest commercial was written purposefully to inform consumers regarding inserts and shoes and the claims made by specialty shoe stores. The Diabetes commercial will air in November; and the Heel Pain, Sports Injury and Foot Pain will resurface throughout the year. More importantly, we are getting calls at OHFAMA for member-only referrals to DPMs as a result of the commercials. It's a win-win! Please call Luci if you need to know a list of local radio stations airing these commercials.

We were also approached by the Buckeye Sports Bulletin to do advertising promoting our members. After reviewing the impressive demographics of their readership, your Board of Trustees agreed that this publication was a good price-point to try state-wide print advertising in this sports publication. We'll be sharing that ad at the upcoming HOD. Another great advertising initiative to drive patients to our members will be our new template print ads to run in your local hometown newspapers. Our graphic designer will customize our pre-set, camera-ready ads with your office information at a nominal fee. SCORE another member service to help you market your practice to consumers locally.

Establishing a Podiatry Only Registry of Use

You may have heard that APMA is expending some of their reserve funds to start a podiatry registry – a specific data bank to assist members with MACRA (which will be upcoming and delayed), and other current quality data measures that require a registry. The registry will be populated with podiatry-only quality data and will be a truly useful member-resource that is needed and timely.

We're Here to Listen and to Serve

Whew! Let us know how we can serve you. We welcome your input and ideas; and we realize that you appreciate how OHFAMA, first and foremost, delivers for our members – today, tomorrow and always.

2017 Service Awards

OHFAMA 2017 Service Award Applications Are Due Postmarked by December 15, 2016.

Four-Step Approach to Help Patients Avoid Falls

1 **Be proactive. Ask all patients age 65 or older if they have fallen in the past year.**

2 **Identify and address fall risk factors:**
- **Lower body weakness**
- **Gait and balance problems**
- **Psychoactive medications**
- **Postural dizziness**
- **Poor vision**
- **Problems with feet or shoes**
- **Home safety**

3 **Refer as needed to specialists or community programs.**

4 **Follow-up with patient within 30 days.**

Falls Prevention Minute

Falls are the leading cause of injury-related deaths and the most common cause of hospital admissions for trauma in older Ohioans. As a podiatric physician, you are uniquely positioned to actively assess their patients' risk and teach them prevention strategies. Older adults account for a disproportionate share of fall-related injuries. While Ohioans age 65 and older are 13.7 percent of our population, they account for more than 80 percent of fatal falls.

How Medical Professionals Can Prevent Falls

Create a policy for falls prevention and ensure staff are aware of and understand it.

View A Sample Policy

- Post signs designating your office or facility as a "Fall-Free Zone." Encourage patients to ask for help and report slipping and tripping hazards to staff.
- Empower staff to offer assistance to patients who appear to be having trouble getting around. Identify patients who use a walker or other assistive device and plan time that is sufficient to provide the services they need.
- When the weather is snowy or icy, contact older patients who have appointments that day and offer to reschedule so that they don't feel obligated to go out in hazardous conditions.
- If someone falls in your office or facility, document the incident and examine the cause so that you can prevent future accidents.
- Call to check on any older patient who misses an appointment. Have alternate phone contacts for all older patients.
- Train staff to recognize patients who regularly wear safety alert devices or use walkers, canes or wheelchairs. Empower staff to start a conversation with these patients if your staff see them not using their assistive devices.
- Be aware of extreme patient weight loss or gain. Improper nutrition may lead to muscle weakness and dizziness, which could result in a fall.
- Ensure that patients who wear glasses or hearing aides are wearing them and that they fit properly.
- If a patient has a history of falling, document his or her activities and look for patterns.

Adapted from "Preventing Falls in Older Patients: Provider Pocket Guide," published by the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

ICD-10 CODING UPDATES

Added, Revised and Deleted ICD-10 Codes

Andy Bhatia, DPM
on behalf of APMA Coding Committee

The comprehensive list for Podiatry, which is about 15 pages long, is available on APMA's Coding Resource Center. A Special thanks to David Freedman, DPM and Harry Goldsmith, DPM for helping put this list together.

Bunion – New Code

- M21.611 Bunion of right foot
- M21.612 Bunion of left foot
- M21.619 Bunion of unspecified foot

Bunionette – New Code

- M21.621 Bunionette of right foot
- M21.622 Bunionette of left foot
- M21.629 Bunionette of unspecified foot

Bilateral Neurological Coding

- G57.53 tarsal tunnel syndrome, bilateral lower limbs
- G57.63 Lesion of plantar nerve, bilateral lower limbs
- G57.73 Causalgia of bilateral lower limbs.
- G57.83 Other specified mononeuropathies of bilateral lower limbs.
- G57.93 Unspecified mononeuropathy of bilateral lower limbs.

Stasis Dermatitis – Discontinued

- (I83.1), varicose veins of lower extremities with inflammation [the terminology, stasis dermatitis, was removed under that code.]
- Varicose veins of right lower extremity with inflammation I83.11
- Varicose veins of left lower extremity with inflammation I83.12

Venous Insufficiency (Chronic) (Peripheral) I87.2 – New Code

Excludes[1]: stasis dermatitis with varicose veins of lower extremities (I83.1-, I83.2-)
Inclusion Term:
Stasis Dermatitis, Stasis Edema

- Chronic venous hypertension (idiopathic) without complications of right lower extremity I87.301
- Chronic venous hypertension (idiopathic) without complications of left lower extremity I87.302 -Chronic venous hypertension (idiopathic) without complications of bilateral lower extremity I87.303

Stasis Dermatitis – Skin Changes

Dermatitis and eczema (L20-L30)
Excludes: Certain conditions originating in the perinatal period (P04-P96), certain infectious and parasitic diseases (A00-B99), complications of pregnancy, childbirth and the puerperium (O00-O9A), congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99), endocrine, nutritional and metabolic diseases (E00-E88), lipomelanotic reticulosis (I89.8), neoplasms (C00-D49), symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R94), systemic connective tissue disorders (M30-M36), viral warts (B07.-),chronic (childhood) granulomatous disease (D71), dermatitis gangrenosa (L08.0), dermatitis herpetiformis (L13.0), dry skin dermatitis (L85.3), factitial dermatitis (L98.1), perioral dermatitis (L71.0), radiation-related disorders of the skin and subcutaneous tissue (L55-L59), stasis dermatitis (I87.2),

Gangrene Definition – Update

Gangrene, not elsewhere classified (I96)
Included a change from: Excludes[1]: gangrene in diabetes mellitus (E08-E13) to Excludes1: gangrene in diabetes mellitus (E08-E13 with .52)

For Your Diabetic Patients

Codes E08-E13: The instruction, Use Additional was revised from code to identify any insulin use (Z79.4)- to "code to identify control using: insulin (Z79.4); oral antidiabetic drugs (Z79.84) or oral hypoglycemic drugs (Z79.84)"

Gout Excludes[1] – Update

- No change to chronic gout (M1A)
- ICD-10 changed the Excludes1: acute gout (M10.-) to read Excludes2: acute gout (M10.-)

- No change to gout (M10), but did delete gout NOS and changed the Excludes1: chronic gout (M1A.-) to Excludes2: chronic gout (M1A.-).
- Excludes1 Revised with M21, (M21) remains the same as does varus deformity, not elsewhere classified (M21.1), but there was a coding correction from the Excludes1: Revise from metatarsus varus (Q66.2) to Excludes1: metatarsus varus (Q66.22)
- Excludes1 Change R50.82; Postprocedural fever (R50.82) is unchanged, but there is a change but…
- From: Excludes[1]: postprocedural infection (T81.4) To: Excludes1: postprocedural infection (T81.4-)

Physeal Fractures – New for 2017

- Please reference www.apmacodingrc.org for the new information
- The new subcategory of codes begins with S99.00 (unspecified physeal fracture of calcaneus) to S99.9 (unspecified injury of ankle and foot)
- Example: Salter-Harris Type I physeal fracture of right metatarsal, initial encounter for closed fracture S99.111A

Sesamoid Fracture – New Option

- Other fracture of foot, except ankle (S92.8) was added along with other fracture of foot (S92.81) which would include a sesamoid fracture of foot.

The specific sesamoid fracture coding options are:

- S92.811 Other fracture of right foot;
- S92.812 Other fracture of left foot; and
- S92.819 Other fracture of unspecified foot

Frequently Asked Questions

Pes Cavus?

- If Congenital: Q66.7 Congenital pes cavus
- If Acquired: Other acquired deformities of right foot M21.6X1 and Other acquired deformities of left foot M21.6X2

Achilles Bursitis, does it have its own code?

- Answer NO
- Achilles tendinitis, M76.6- has the Inclusion: Achilles bursitis

Synovial cyst what's its code vs ganglion cyst?

- Answer Other bursal cyst, right ankle and foot M71.371 and/or Other bursal cyst, left ankle and foot M71.372. Inclusion: Synovial cyst NOS

Versus

- Ganglion, right ankle and foot M67.471
- Ganglion, left ankle and foot M67.472

Is there a code for shin splints?

Answer:

- Other injury of other muscle(s) and tendon(s) at lower leg level, right leg S86.891
- Other injury of other muscle(s) and tendon(s) at lower leg level, left leg S86.892

What about Tarsi Syndrome?

There is no code just for sinus tarsi syndrome, best options for sinus tarsi syndrome:

- M25.571 Pain in right ankle and joints of right foot
- M25.572 Pain in left ankle and joints of left foot

Is there a good capsulitis code now?

Answer:

- Enthesopathy, unspecified.
- When you research the code it says: "Inclusion Term" Bone spur NOS; Capsulitis NOS; Periarthritis NOS; Tendinitis NOS.
- M77.51 Other enthesopathy of right foot
- M77.52 Other enthesopathy of left foot, [the cross walk from ICD9 to ICD10 put us at M77.9]

I need the diagnosis for exostosis, I have been using M77.51 or 2?

ICD-10: You are supposed to select the code(s) with the highest level of specificity, the best code for exostosis has been and remains the same as "osteophyte"

- M25.771 Osteophyte, right ankle
- M25.772 Osteophyte, left ankle
- M25.774 Osteophyte, right foot
- M25.775 Osteophyte, left foot

Upcoming Back to Basics Webinars at www.apma.org

- **October 20 at 8 p.m. EDT**
  CPT Updates and Bunionectomy Codes
- **November 17 at 8 p.m. EST**
  Durable Medical Equipment
- **December 15 at 8 p.m. EST**
  Wound Care
- **January 19 at 8 p.m. EST**
  Correct Coding Initiatives, Edits / Bundling
- **February 16 at 8 p.m. EST**
  Evaluation and Management (E/M) Codes

CGS JURISDICTION 15 | JUNE 21, 2016 REPORT

Kentucky and Ohio Carrier Advisory Committee Meeting

by Andy Bhatia, DPM

CMS is implementing a program called the LEAN initiative, a process-oriented technique used to reduce waste, energy and overall work. LEAN consultants will make on-site visits to willing participants and offer advice for value streamed management. CGS is starting a pilot program in late summer.

CGS has noticed many providers are utilizing third-party coders and billers for claim submissions. Often the address of these entities is listed in PECOS as the main address of the provider. Unfortunately, when their address is on file, it causes a disconnect in ability to communicate directly with the physician. Sometimes the practitioner is unaware that they are under review. It is important to remember the doctor or NPP is liable for bills submitted to Medicare. We recommend communicating with your staff or contracted billers that any information received from Medicare (other than routine request for records) is forwarded to the billing provider directly.

Home Health has updated their Face To Face documentation requirements. Now a hospitalists discharge report or other documentation may be used to meet the required elements of the F2F for home health referrals. We recommend educating referring providers in F2F requirements to assist with coverage for those services.

In 2016, CGS Medical Review will target:

- Evaluation and Management use of Modifier-25

Other reasons for denial were discussed and include:

- Evaluation and Management visits, billed under the physician NPI, but the record has no appearance the MD saw the patient or was involved in the encounter.
- Sometimes with EHRs all the visits look the same and are considered "cloned." The encounters must be personalized to the beneficiary and include specifics from each date of service.
- More providers are using scribe services for documentation. Please note the records must indicate the visit is a real time recording. Statements and signatures must also be timely to support the documentation was done in real time.
- With Split-Shared visits, documentation must show the billing MD had "significant and separate" involvement in the visit. A simple statement that the provider saw the patient and concurs with the NPPs assessment is not sufficient. The MD must comment specific findings in support of or in addition to the NPPs documentation. The statement need not be lengthy, but should clearly show the physician's involvement in the visit.
- Late signatures are becoming a focus. CMS expects records to be validated at the time of the visit or no more than 1-2 days following. If records are transcribed, a reasonable amount of time will be allowed, but certainly no more than 1-2 weeks at maximum. We recommend that, when documenting in the EHR, you close out the visit at the time of the visit. Additional information such as diagnostic findings may be added later as an addendum. This avoids late signature denials.

CMS implemented several changes to the Cycle 2 Revalidation process that started in March 2016. CGS will send providers notifications in the usual yellow notification envelope. If revalidations are not returned timely, providers risk being "deactivated" and may forgo reimbursement until reinstated.

The following LCDs were discussed:

New Policies: DL36690: Application of Skin Substitutes for Wounds, Lower Extremities

- Will replace current policy L34053 (Application of Cellular and/or
- Tissue Based Products (CTPs) for Wounds of Lower Extremities).
- New format and updated information concerning skin substitutes.

Retired Policies: L34053: Application of Cellular and/or Tissue Based Products (CTPs) for Wounds of Lower Extremities

- New products added as covered HCPCS codes Q4105, Q4127, Q4128, Q4137, C9349, Q4117, and Q4147

The Fall CAC meeting will be held in Ohio November 15, 2016.

A BUSINESS MODEL PERSPECTIVE

What Is LEAN?

The core idea is to maximize customer value while minimizing waste. Simply, LEAN means creating more value for customers with fewer resources.

A LEAN organization understands customer value and focuses its key processes to continuously increase it. The ultimate goal is to provide perfect value to the customer through a perfect value creation process that has zero waste.

To accomplish this, LEAN thinking changes the focus of management from optimizing separate technologies, assets, and vertical departments to optimizing the flow of products and services through entire value streams that flow horizontally across technologies, assets, and departments to customers.

Eliminating waste along entire value streams, instead of at isolated points, creates processes that need less human effort, less space, less capital, and less time to make products and services at far less costs and with much fewer defects, compared with traditional business systems. Companies are able to respond to changing customer desires with high variety, high quality, low cost, and with very fast throughput times. Also, information management becomes much simpler and more accurate.

A popular misconception is that LEAN is suited only for manufacturing. Not true. LEAN applies in every business and every process. It is not a tactic or a cost reduction program, but a way of thinking and acting for an entire organization.

Businesses in all industries and services, including healthcare and governments, are using LEAN principles as the way they think and do. Many organizations choose not to use the word LEAN, but to label what they do as their own system, such as the Toyota Production System or the Danaher Business System. Why? To drive home the point that LEAN is not a program or short-term cost reduction program, but the way the company operates. The word transformation or LEAN transformation is often used to characterize a company moving from an old way of thinking to LEAN thinking. It requires a complete transformation on how a company conducts business. This takes a long-term perspective and perseverance.

Thank you to our 2016 OPPAC Contributors as of 9-28-16

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Luci Ridolfo, CAE
Jimelle Rumberg, PhD, CAE

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

2016 Calendar

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

March 10-12
No Nonsense Seminar
Holiday Inn I Independence

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

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

CMS Relaxes Rules on Participation in MIPS/ MACRA.

by Michael Brody, DPM

Up until recently there was a lot of discussion on the possibility of delaying the implementation of Merit-Based Incentive Payment System/Medicare Access & CHIP Reauthorization Act of 2015 (MIPS/MACRA) for one year. CMS indicated that they heard the concerns of doctors and would be taking appropriate action. That action was to modify how we can participate in MIPS in 2017 and make it much easier for doctors to avoid penalties. Those who are able to fully participate can still earn incentives.

First Option: As long as you submit some data to the Quality Payment Program, including data from after January 1, 2017, you will avoid a negative payment adjustment. You do not have to send in everything and you do not have to submit data for the full year. This should be VERY easy for all providers and will allow you to become more familiar with the program for full participation in 2018 and beyond.

Second Option: Submit Quality Payment Program information for less than the full year. This means your first performance period could begin later than January 1. If you get up to speed during the year and are able to start full participation any time during the year you could possibly still earn an incentive payment.

Third Option: Participate for the full calendar year. For practices that are ready to go on January 1, 2017, you may choose to submit Quality Payment Program information for a full calendar year. This means your first performance period would begin on January 1, 2017.

Fourth Option: Alternative Payment Models. The way these are written and the way that the laws are written regarding ACO programs, podiatrists cannot take advantage of this fourth option.

If you do not send any quality data, you will have a negative payment adjustment. With this tiered approach that allows all practices that participate to avoid a payment penalty CMS is allowing us to get up to speed at our own pace. The goal is that all practices will be submitting full quality information for the entire year starting January 1, 2018. The sooner your practice fully participates in quality reporting, the better position your practice will be. Finally, we now know that as long as we get our practices involved in quality reporting any time during 2017, we can avoid penalties. We have a full year to become good at these quality programs to put us in the best possible position for future program years.

Navigating Merit-Based Incentive Payment System (MIPS) in 2017

Congress passed the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) which contains the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

Basics of MIPS:

- There are four different components to MIPS and those four components will determine your MIPS performance score and based on that score your payments can be adjusted up or down or remain neutral. These four components merge Meaningful Use (MU), Physician Quality Reporting System (PQRS), Value Modifier (VM) and add a new component—Clinical Practice Improvement Activities (CPIA).
- CMS allows four participation options for MIPS for 2017 (non-participation 4% reduction 2019):

1 **First Option**: Test the Quality Payment Program. (avoid penalty)

2 **Second Option:** Participate for part of the calendar year. (small positive payment)

3 **Third Option:** Participate for the full calendar year. (modest positive payment)

4 **Fourth Option:** Participate in an Advanced Alternative Payment Model in 2017. (5% payment)

Summary of MIPS Performance Categories

Performance Category	Points Need to Get a Full Score per Performance Category[1]	Maximum Possible Points per Performance Category
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high quality measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set. (replaces PQRS)	80 to 90 points depending on group size	50 Percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them. (replaces MU)	100 Points	25 Percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit. ***(new category)***	60 Points	15 Percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything. ***(replaces VM)***	Average score of all attributed resource measures.	10 percent

[1]Exemptions or adjustments may apply in some clinicians' circumstances that change the total category score.

YOU AND YOUR MONEY

What New Rules on Overtime Pay Mean to Physician Practices

In May, 2016 President Obama and the U.S. Department of Labor ("DOL") released the long-awaited Final Rule revising the minimum salary requirement for an employee to qualify for the overtime exemption under the Fair Labor Standards Act ("FLSA"). All changes under the rule will take effect on December 1, 2016.

The reason for the changes is explained in the text of the rule: "when left unchanged, the salary threshold is eroded by inflation every year. It has only been updated once since the 1970s – in 2004, when it was set too low…[Therefore,] too many [employees] have been left working long hours for no additional pay, taking them away from their families and civic life without any extra compensation."

In summary, the Final Rule does the following:

- raises the standard salary threshold for full-time salaried employees to qualify for the overtime exemption from $455 a week ($23,660 per year) to $913 a week ($47,476 per year).
- raises the highly-compensated employee salary threshold to qualify for the overtime exemption from $100,000 per year to $134,004 per year.
- allows up to 10% of the salary threshold for non-highly compensated employees to be met by non-discretionary bonuses, incentive pay, or commissions, as long as these payments are made on at least a quarterly basis.
- automatically updates the salary threshold every three years, beginning on January 1, 2020, to account for inflation. The DOL anticipates that beginning on that date the minimum salary threshold will be $51,168 for full-time salaried employees and $147,524 for highly-compensated employees.

The rule provides no differential for cost of living, average area compensation, or state income tax rates. Nor does it change the "duties test" that determines whether salaried employees earning more than the salary threshold are eligible for overtime pay. The DOL estimates that fewer employers will have to use the "duties test" because the increase in the salary threshold means more employees' exemption status will be clear from their salaries alone.

Source: Medical Economics July 04, 2016 (Zaenger /Waesch)

SMART MONEY MEMBER BENEFIT

Quantus Solutions EMV — One Year Later

by Michael DiPietro, Senior Vice President
Phone: 305-297-2137.
mdipietro@quantussolutions.com
www.quantussolutions.com

In March 2015, a lot of our member merchants asked about the EMV "smart chip" card impact since the "Liability Shift" of October 1st, 2015. We knew it was going to be a long and arduous migration. One year later, merchants may notice extra fees on their statements such as NON-PCI compliance fees; some as high as $85 to $125 a month. If this has happened to you, why haven't you considered OHFAMA's suggested vendor, Quantus Solutions? At Quantus Solutions, we continue to reach out to our merchants and to OHFAMA members, educating them on the importance in securing your EMV smart chip terminal solution without imposing any penalties to you.

We have established an "Open Enrollment Period" to all members in the health care industry and have a medical specific program dedicated to servicing your practice's needs. We encompass leading market fee structures extending to customer service and technical support. We remain a continued information channel between the physician's office and us. All of Quantus Solutions' medical clients have been converted to an EMV terminal. We convert each new doctor's office that is on-boarded. So what are you waiting for? Make sure that your office is EMV and PCI compliant.

Whether you have a desktop terminal, a gateway with a virtual terminal, a mobile solution or a practice management software, we will assist you during our Open Enrollment Period. Contact Quantus at 800-698-5150 to request your EMV terminal today! This is a group benefit offered to members of OHFAMA.

LEGISLATIVELY SPEAKING

Update on Prescription Drug Regulations, Education Initiatives in Ohio

Ohio is currently working to implement a recently passed law regarding terminal distributor of dangerous drugs (TDDD) licensing. The law requires prescribers that either personally compound drugs or possess compounded drugs to obtain a TDDD license from the Ohio Board of Pharmacy.

This law impacts all prescriber practices that were previously exempted from licensure. Based on the pharmacy board's recent interpretation of "compounding," this law even impact those who are engaged in a form of compounding commonly referred to as "reconstitution" (which can include vaccines).

As of June 2016, the pharmacy board had received a significant amount of feedback regarding this law and is continuing to evaluate how to best implement it. The board is expected to have further guidance following its July meeting, according to an update on its website.

OHFAMA submitted a letter to the pharmacy board expressing concerns with its interpretation of the new law. While we support the regulation of compounded drugs, we are concerned that the pharmacy board's interpretation of what constitutes 'compounding' in Ohio is overly broad based on the original intent of the regulation."

Compounding vs Reconstitution

More specifically, guidance recently issued by the pharmacy board indicates that Ohio law does not differentiate between compounding and reconstitution. National compounding rules and guidelines, however, explicitly state that compounding does not include reconstitution or other acts that are performed in accordance with the manufacturer's instructions. Accordingly, these new rules go beyond national compounding rules and guidelines are not based on any scientific evidence that the current practice is unsafe or otherwise dangerous for patients.

This letter acknowledged that DPMs already possess a license from the OSMB that allows the rendering of treatment and care within the scope of practice, which includes performing injections. DPMs are also required to routinely utilize the OARRS database and those who prescribe dangerous drugs are required to have a DEA license. With these regulations, and in light of the fact there is no evidence to suggest that in-office compounding as practiced today is dangerous, OHFAMA is confident that a revised less restrictive rule will allow DPM's in Ohio to continue the safe practice of podiatry without subjecting them to unnecessary regulatory requirements and expense.

Pending Legislation

Additionally, pending legislation would expand the TDDD licensure requirement mentioned above to include any health care professional (including dentists, physicians and veterinarians) who possess Schedule I, II, III, IV, or V drugs in their offices. This new initiative is designed to ensure that all locations that have controlled substances are regulated by the pharmacy board.

Opioid Prescribing Guidelines

Earlier this year, the Governor's Cabinet Opiate Action Team issued new opioid prescribing guidelines designed to help fight prescription drug abuse. The team recently sent an email to health care providers asking them to complete an online training module regarding the new Acute Pain Opioid Prescribing Guidelines.

The online training module includes a 10-minute training video that summarizes the new guidelines, plus a pre- and post-training quiz to gauge the effectiveness of the training videos.

More information on the new guidelines can be found at opioidprescribing.ohio.gov

OHIO'S OPIOID PRESCRIBING GUIDELINES

Acute Prescribers Guidelines

- **Emergency Department/Acute Care Facility Opioid Prescribing Guidelines:** In April 2012, the Governor's Cabinet Opiate Action Team released Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines to reduce "doctor shopping" for prescription pain medications that could be abused or sold illegally, to encourage emergency department clinicians to check Ohio's Automated Rx Reporting System to see a patient's other prescriptions for controlled medications, to urge prescribers to limit the quantity of opioids prescribed, and to refer patients to a primary care provider or specialist for evaluation, treatment and monitoring of continuing pain.
- **Opioid Prescribing Guidelines for Treatment of Chronic Pain:** In October 2013, the Governor's Cabinet Opiate Action Team released Opioid Prescribing Guidelines for Treatment of Chronic, Non-Terminal Pain to ensure the safety of patients on high daily doses of opioids for chronic pain lasting longer than 12 weeks, and to urge prescribers to check the Ohio Automated Rx Reporting System to see a patient's other prescriptions for controlled medications.
- **Opioid Prescribing Guidelines for Treatment of Acute Pain:** In January 2016, the Governor's Cabinet Opiate Action Team released Guidelines for the Management of Acute Pain Outside of Emergency Departments to encourage non-opioid therapies and pain medications—when appropriate—for the management of acute pain expected to resolve within 12 weeks, to urge prescribers to check the Ohio Automated Rx Reporting System to see a patient's other prescriptions for controlled medications, to encourage clinicians to prescribe the minimum quantity of opioid pills needed, to discourage automatic refills of opioid prescriptions, to help reduce the number of leftover opioids that could be diverted or abused, and to recommend the reevaluation of patients prescribed opioids at certain checkpoints.

OHIO STATE BOARD OF PHARMACY

Guidance & Updated Resolution: Terminal Distributor's License for Prescribers Compounding Dangerous Drugs

UPDATED 7/18/2016

The Board has recently been informed by a number of prescribers that they were unaware of the need to obtain a terminal distributor of dangerous drugs license if they were compounding on-site or ordering compounded drugs to their offices (ORC 4729.541). This requirement impacts all prescriber practices that were previously exempted from licensure, including those who are engaged in a form of compounding commonly referred to as reconstitution (which can include vaccines).

So as to not disrupt patient care, the Board is using its authority under section 4729.25 of the Ohio Revised Code to grant an extension to all prescribers that are performing drug compounding (including reconstitution) or ordering compounded drugs to their offices from the requirement to obtain a terminal distributor of dangerous drugs license. This extension is hereby valid until April 1, 2017.

Adopted: 7/11/2016 NOTE: This replaces a resolution adopted in May, 2016.

Updated Guidance

Due to recent feedback regarding the prescriber compounding rules, Board staff are advising previously exempt prescriber practices to refrain from application to the Board as a Terminal Distributor of Dangerous Drugs until the Board can finalize updates to Rule 4729-16-04 of the Ohio Administrative Code.

The Board will be posting these rule updates for public comment on its web site following the July, 2016 meeting. Prescribers and prescriber associations are encouraged to sign up for web updates by visiting: www.pharmacy.ohio.gov/update.

Please note: This does not impact the implementation and enforcement of OAC 4729-16-11 for hazardous prescriber drug compounding.

OHFAMA was vigilant in opposing the TDDD for solo practitioners and remitted written comments to the Pharmacy Board. We encourage members to sign up for web updates through their board's web site and be informed about new rules that may be adopted in Ohio.

TAKING THE NEXT STEP TOGETHER

Baby Steps

Rules on Pharmacist Consult Agreements with Physicians

On March 23, 2016, Ohio HB 188 (131st General Assembly) went into effect. This law makes the following modifications to pharmacist consult agreements with physicians (ORC 4729.39)

- Authorizes one or more pharmacists practicing under a consult agreement with one or more physicians to (1) manage a patient's drug therapy for specified diagnoses or diseases and (2) order and evaluate blood and urine tests.
- Creates a single process for establishing a consult agreement, in place of separate processes that were based on whether the patient's drug therapy was being managed within or outside a hospital or long-term care facility.
- Grants certain immunities from civil liability to pharmacists and physicians practicing under consult agreements.

New rules regarding consult agreements are effective August 18, 2016. A copy of the rules can be accessed by visiting: www.pharmacy.ohio.gov/consult. Although this language is more directed toward MD/DO with drug protocol items like INR/Coumadin therapy and other more closely monitored systemic conditions, OHFAMA wanted you to be knowledgeable about this regulatory change as your patients may be under this scenario from their PCP.

OHIO FOOT AND ANKLE MEDICAL ASSOCIATION

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IMPORTANT POLICY REVISIONS

ACA Rule Requires Some Podiatric Offices to Post Notices

Earlier this year, HHS' Office of Civil Rights (OCR), finalized its rule aimed at advancing health equity and reducing health-care disparities. Among other provisions, the final rule enhances language assistance for people with limited English proficiency and helps ensure effective communication for people with disabilities.

Covered entities, have new compliance requirements, including in-office and website postings, new accessibility standards for buildings not previously covered by the Americans with Disabilities Act (ADA), and new protections for individuals with disabilities and for individuals with limited English proficiency. Covered entities may include hospitals, health clinics, health insurance issuers, state Medicaid agencies, community health centers, physicians' practices and home health care agencies. For OHFAMA members, physicians' practices would be those receiving federal financial assistance through Medicaid payments, meaningful use payments, and other sources, but not Medicare Part B payments.

Required Posted Notices and Taglines

Under the rule, impacted providers must post notices of nondiscrimination and taglines that inform anyone with limited English proficiency to the availability of language assistance services. Providers must post a notice of nondiscrimination and taglines in at least the top 15 non-English languages spoken in the state in which the member is located or does business. These postings, covered below, must be prominently displayed on websites' homepages, in physical office locations, and in communications materials. Covered entities do not need to draft, translate, or create any of these notices, taglines, or nondiscrimination provisions on their own, although they are welcome to do so if they choose.

OCR has provided translations for 64 different non-English languages which will be compliant under the rule for covered entities' use. Covered entities also do not have to determine which languages are considered the top 15 in Ohio, The population standing is as follows: 1: Spanish – 88,196; 2: Chinese – 20,651; 3: German – 13,583; 4: Arabic – 12,864; 5: Pennsylvanian Dutch* – 10,900; 6: Russian – 8,141; 7: French – 6,525; 8: Vietnamese – 6,438; 9: Cushite* – 5,820; 10: Korean – 5,516; 11: Italian – 4,766; 12: Japanese – 4,709; 13: Dutch* – 4,255; 14: Ukrainian* – 3,735; 15: Romanian* – 3,055.

In the final rule, HHS acknowledges the lists are subject to change, as new census data is provided, so APMA suggests members have in place a policy for routine review and updates.

Websites, Practice Locations and Communciation Materials

Providers can post on their websites' home page by including a link in a conspicuous location that immediately directs the individual to the content of the notice elsewhere on the website. The final rule requires that the website provide both the notice of nondiscrimination and taglines in at least the top 15 non-English languages spoken in the state in which the member is located or does business. Additionally, providers must post the notice of nondiscrimination and taglines in a conspicuous location in a conspicuously-sized font in their physical offices. The taglines must be in the top 15 non-English languages spoken in their practice state, to inform individuals with limited English proficiency.

For small-sized significant communications, such as tri-fold brochures or postcards, in lieu of the full notice, the final rule requires posting of nondiscrimination statements and/or taglines in at least the top two non-English languages spoken by individuals with limited English proficiency in the state. The final rule allows you to exhaust your current stock of hard copy publications, and then update with notices when you replenish.

In its final rule, HHS addressed physicians' and medical students' concerns with the applicability of the rule. While HHS did not modify the rule, the following clarification was provided: Section 1557 applies to a recipient of Federal financial assistance, whether a hospital, clinic, medical practice, or individual physician. Where, for example, a doctor is an employee of a hospital and the hospital receives Federal financial assistance, the hospital's program is the relevant health program or activity and it is the hospital that will be held accountable for discrimination under Section 1557. Where, similarly, a doctor contracts as an individual to provide health services at a free neighborhood clinic that receives Federal financial assistance, the clinic is the recipient of Federal financial assistance and liable for discrimination; the doctor is simply a contractor who is assisting the clinic in performing clinic services.

When a doctor has a private medical practice that receives Federal financial assistance, and the doctor, through her practice, works as an attending physician at a hospital, it is the medical practice that is providing the services at the hospital, and thus the practice that is liable for the discrimination. Moreover, a solo medical practice (whether incorporated or not) that receives Federal financial assistance is a covered health program or activity.

For more information, or to get a copy of the regulation, contact the OCR at 800-368-1019. Contact the Health Policy and Practice Department at healthpolicy.hpp@apma.org with questions.

Classifieds

Associate Needed

Associate needed to join our busy practice in Toledo, Ohio and nearby suburb. This is a well-established practice with an excellent reputation. There is a strong internal and external referral base. We have an established partner with a large patient base who is moving out of state. The department doctor is willing to help with the introduction of the incoming doctor. This is a wonderful opportunity for an ambitious, well-trained and conscientious physician. Start time would be 2016. Please contact Kim Rodriquez at 419-893-5539 ext. 228 or email your CV to krpanwo@yahoo.com

Associate Needed – Toledo, Ohio

Single specialty group is searching to add another provider to perform all medical and surgical treatments of the foot and ankle. Hiring due to volume and expansion in Toledo, Ohio. Please email your CV to dr.mmehta@gmail.com or fax to (740) 596-1577.

MEMBER BENEFIT

OHFAMA Helped Members Control Workers' Compensation Costs with $29,960 of Savings in 2016

We are now in the time of year when employers are looking at their workers' compensation program for the next policy year. Ohio Foot and Ankle Medical Association members have begun to receive quotes in the mail for group rating plans for 2017. Our association's mission is to add value to our membership by providing members with the tools they need to do business. The CareWorksComp workers' compensation program is a key part of meeting that objective for OHFAMA.

A Partnership That Saves You Money

In partnership with CareWorksComp, OHFAMA has a strong workers' compensation group rating program. Collectively, our members who participate in the Group Experience Rating program save an annual average of $545 on their workers' compensation premiums. For the current 2016 policy year, Ohio Foot and Ankle members who participate in our group rating program are estimated to save $29,960 in workers' comp premiums. Additionally to the savings, the local presence of CareWorksComp provides our members with extensive consulting expertise in workers' compensation claims management, hearing representation, unemployment cost control services and much more.

Put OHFAMA to work for you!

For a no-cost, no-obligation program analysis, simply call Beverly Westover, Ohio Foot and Ankle Program Manager at CareWorksComp. Beverly can be reached at (800) 837-3200, ext. 57169 or via email at beverly.westover@careworkscomp.com. You may also request a quote electronically at http://www.careworkscomp.com/group-rating-application.php?name=OhioFootandAnkleMedicalAssociation Please remember that the Group Rating deadline is November 14, 2016.

CareWorksComp™
A York Risk Services Company

Since 1950, CareWorksComp has provided quality third party administrator (TPA) services to employers insured through the Ohio Workers' Compensation State Fund. CareWorksComp serves more than 48,000 state-fund insured clients and is proud to maintain one of the highest client-retention rates in the industry at 97 percent.

Have you looked at your group retrospective rating options?

This is Not Your Grandfather's Group Rating Program: Group Retrospective Rating

WHAT IS GROUP RETROSPECTIVE RATING?
A performance-based program where BWC-certified group sponsors pool businesses of like industry, that meet strict safety and claims management criteria and practices. As claim costs are controlled, the group members receive premium rebates. Plan savings are often greater than traditional group rating plans.

COMPREHENSIVE SAFETY SERVICES
We offer on-site safety and program evaluation at no additional cost to help ensure and optimize savings.

BEST-IN-CLASS CLAIMS SERVICES
- Rates & Payroll Underwriting
- Industrial Commission (IC) and Bureau of Workers' Compensation (BWC) Hearing Representation
- Claims Management
- Reporting

UNEMPLOYMENT CONSULTATION
Review and consult with our industry experts on unemployment claim issues.

For more information, contact CareWorksComp's Program Sales toll-free, at 1-800-837- 3200, ext. 57275.

FROM THE PRESIDENT

Preparing for the Future of WVPMA

This will be my last presidential message, as my term will conclude at the end of the October 8 WVPMA meeting. It has been a pleasure to have served these past two years. Working with Dr. Jimelle Rumberg has made my job easy. We have accomplished much, from increasing our enrollment in WVPMA, rewriting the bylaws, securing a new tax ID number, a new website and gaining a title change from *Podiatrist* to be more inclusive and to be titled in the state law as *Podiatric Physician and Surgeon*. These changes would not have happened without the help of the OHFAMA, APMA, and the West Virginia Board of Medicine. We are humbled to have accomplished so much.

Things you need to plan for upcoming months are DEA renewals; switching to digital radiography, which needs to be done by years' end to avoid a reduction in payments; and three credit hours of Pain Management for license renewal by May, 2017. We are re-evaluating our lobbying needs, and we will be instituting a contract for services for the upcoming two-year legislative term.

Our next WVPMA meeting is October 8, 2016 at UHC in Bridgeport, WV. Everyone should plan to attend. It should be a good meeting with the election of the new officers being installed. Three CME credits will be offered and lunch will be provided. I would like to thank Dr. Andy Dale and Dr. Carrie Lakin for organizing the meeting and for arranging the lectures. Most important, a special thank you to Dr. Jimelle Rumberg for everything she does for the WVPMA.

Jerry Hadrych, DPM
WVPMA President

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Robert C. Knittle | Executive Director

July 15, 2016

Jerry Hadrych, DPM
West Virginia Podiatric Medical Association
1960 Bethel Road, Suite 140
Columbus, Ohio 46220-1815

RE: West Virginia Board of Medicine Legislative Rule 11 CSR 11 Licensing and Disciplinary Procedures: Physicians; Podiatrists.

Dear Dr. Hadrych,

Thank you for submitting a comment with regard to the Board's proposed amendments to 11 CSR lA, Licensing and Disciplinary Procedures: Physicians; Podiatrists. Your comment requested that the Board modify 11 CSR lA to refer to the practice of "podiatric medicine and surgery" as opposed to the term "podiatry," and to refer to practitioners of podiatric medicine and surgery as "podiatric physicians and surgeons" rather than "podiatrists."

The Board considered your comment and determined that the proposed modernization of nomenclature is appropriate and is consistent with the practice of the profession as set forth in the West Virginia Medical Practice Act. W. Va. Code §30-3-2(4). Accordingly, throughout the rule, the term "podiatry," when referring to the practice of the profession, has been replaced with "podiatric medicine and surgery." Additionally, the term "podiatrist" has been replaced with "podiatric physician and surgeon" or "podiatric physician" throughout.

On July 12, 2016 the Board filed an Agency Approved version of 11 CSR lA with the Secretary of State's Office, which incorporates the above-mentioned modifications.

Sincerely,

Robert C. Knittle

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

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CHANGE SERVICE REQUESTED