

A simple chart should consist of four basic sections:

1. Intake Information

All medical practices are governed by the Health Insurance Portability and Accountability Act (HIPAA). Each office must post its privacy policy in a public location and offer a printed version to each person presenting for treatment. Further, each patient must sign a privacy statement acknowledging that they understand the policy. The statement is countersigned by a witness, generally a member of the office staff performing the intake.

The patient's demographic information goes into this section and should include full name, address, birth date, contact telephone numbers and insurance claim numbers.

2. Insurance Information

If you bill any insurance companies, including Medicare, it is important to have all the most current data in your file and all the appropriate waiver and disclaimer forms in order to process a claim. Whether you do it yourself or use a billing service, you must have all the information. Make a copy of the front and back of the insurance card as it contains policy and group numbers as well as electronic payer number, contact phone numbers and mailing addresses for claims.

When dealing with Medicare, CMS has specific language for the assignment and release statement, and is available on your Jurisdiction's website. The disclaimer and assignment of benefits allows you to bill the patient's insurance and discuss their case with the proper parties. Your practice may utilize additional statements and disclaimers as necessary.

For your Medicare patients, you may need an Advance Beneficiary Notice (ABN). The ABN is a statement that Medicare may not cover the patient's services. You must state the service and

Billing and payments are the lifeblood of our practices.

why it may not be covered. Should the ABN be needed and is not signed, the patient cannot be billed for the service you provided. At no time should an ABN be considered a blanket document signed in all cases. It must be used in specific circumstances. The provider manual for your jurisdiction has complete ABN information.

3. Examination and Treatment Records

The examination is the key to determining a modality and its efficacy. Only after the empirical evidence is gathered can it be synthesized and transformed into a suitable solution. Having a quick reference checklist style examination report gathers the required information and puts it in a very easy to use format. The goal is to recreate in your mind the encounter and give you the opportunity to make notes of the visit along with pathologies, pathomechanics, and supporting information.

Exam documentation also includes a written lab order for the fabrication of the footwear, modalities and/or orthoses. Clear instructions are necessary for producing the kind of device that you envision. This is especially true if someone else is actually doing the fabricating. A separate form is used to delineate modifications on shoes. Once the orthoses, shoes and modifications are dispensed to the patient, report the trial fitting and final disposition of the case. Note any changes you needed to make during this process such as grinding down an area on the orthosis or fitting problems with the shoe.

Many offices use electronic documentation, and some use a combination of written and electronic. Just remember that all your records must be complete, accurate, and are subject to

HIPPA regulations.

4. Billing Records

Billing and payments are the lifeblood of our practices. Having accurate records is imperative to being paid in a reasonable period of time, and to avoid adverse actions from your billing sources.

Billing can be done manually (by paper) or electronically. Electronic claims are the preferred method as the claim information is already in a form suitable for processing. Medicare now requires electronic submissions and many private plans prefer it. Consult with the particular plan for their requirements.

Once a claim is processed and paid, the Explanation of Medical Benefits (EMB or EOMB) is sent along with your remittance. This form explains what was paid, how much was paid, and references any deductibles, co-payments, or other financial information.

Contracted practices agree to accept a certain amount for services, and any decrease from the billed amount is also on this form. The EMB will assess what the patient is responsible for and what amount you must write off, if any.

Documentation can be time consuming, but is time well spent. ■



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A Review of Foot Pain - A Step Forward for the Pedorthist

BY: ROBERT G. SMITH DPM, MSC. RPH., C.PED

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Read This Article, Take Survey to Earn Continuing Education Points

COMMERCIAL MEDIA REPORT SYMPTOMS OF FOOT PAIN AS BEING VERY COMMON AMONG ADULTS. THE EXACT PREVALENCE RATES IN THE GENERAL POPULATION ARE UNKNOWN. HISTORICALLY, THE NATIONAL HEALTH INTERVIEW SURVEY (NHIS) INCLUDED QUESTIONS ON BUNIONS, CORNS, CALLUSES AND TOENAIL PROBLEMS.¹ HAWKE AND BURNS COMPILED DATA AND CONCLUDED THAT FOOT PAIN IS EXPERIENCED BY 17 TO 42% OF THE ADULT POPULATION.² FOOT AND ANKLE CONDITIONS IN OLDER ADULTS ARE ASSOCIATED WITH MOBILITY AND BALANCE IMPAIRMENT, DISABILITY, FALLS, AND FRACTURES.³⁻⁵ IRRESPECTIVE OF THE UNDERLYING CAUSE, FOOT PAIN HAS A SIGNIFICANT IMPACT ON HEALTH-RELATED QUALITY OF LIFE. PEDORTHISTS CAN HAVE A TREMENDOUS IMPACT ON INVOLVING AND MOTIVATING THEIR PATIENTS WITH FOOT PAIN. ONE MAJOR ADVANTAGE FOR PEDORTHISTS IS THEIR AVAILABILITY. THE AIM OF THIS REVIEW IS TO OFFER A COMPREHENSIVE APPRAISAL OF THE LITERATURE ON FOOT PAIN, WITH SPECIFIC REFERENCE TO ITS DEFINITION, ETIOLOGY, AND COMMON FOOT PAIN SYNDROMES.

Foot Pain Defined

Clinically foot pain is defined as an unpleasant sensory and emotional experience following perceived damage to any tissue distal to the tibia or fibula; including bones, joints, ligaments, muscles, tendons, apophyses, retinacula, fascia, bursa, nerves, skin, nails and vascular structures.⁶ Hawke and Burns refer to "foot pain" as a general term, inferring neither pain class, injury mechanism nor histological pathology.² It is important for the pedorthist to recognize that foot pain is not the noxious-stimuli-induced activity in the nociceptive pathways,^{2,6,7} on the contrary it is the perception of this process and the consequential effects on suffering and pain-related behavior.⁸

Pathological foot pain is experienced following nociceptive pathology; involving dysfunction of either or both of peripheral or central nervous system.^{9,10} There are three essential criteria for classification as physiological foot pain.⁹⁻¹² The first criterion is noxious stimuli which are extrinsic to the nervous system. The second criterion is described as that

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To take advantage of the program, thoroughly read the adjacent article, "A Review of Foot Pain - A Step Forward for the Pedorthist (Part 1)," and then visit www.pedorthics.org and click on the Continuing Education Opportunities tab to purchase the 10-question quiz associated with this article. CEP quizzes cost \$15 for members and \$25 for non-members. The quizzes are worth 1.0 Scientific or Business CEP, depending on the content. Successful completion of the quiz will result in 1.0 CEP reported directly to ABC and BOC at the end of each quarter.

This article is the seventh CEP-eligible article in *Current Pedorthics*. Look for additional CEP-eligible articles in future issues of the magazine; previous articles are available in the magazine archive at www.pedorthics.org.

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A REVIEW OF FOOT PAIN - A STEP FORWARD FOR THE PEDORTHIST (PART 1)

the pain perception is proportionate to the magnitude of noxious stimulation. The last criterion is described as the pain diminishes when the stimuli are removed. The activity within the nervous system producing the experience pain is termed nociception.²

Within the feet these nociceptors are capable of both efferent and afferent transmission.¹² The transmission process occurs in three stages. The pain impulse is transmitted: from the site of transduction along the nociceptor fibres to the dorsal horn in the spinal cord; from the spinal cord to the brain stem; through connections between the thalamus, cortex and higher levels of the brain. The pain impulse is then transmitted from the spinal cord to the brain stem and thalamus via two main nociceptive ascending pathways. These are the spinothalamic pathway and the spinoparabrachial pathway.

While these pathways are complex, it is important for the pedorthist to maintain a clinical appreciation of the various levels at which dysfunction can occur and which therapy based on their mechanism of action assist in relieving foot pain.

Etiology of Foot Pain

Foot pain may be caused by many different conditions or injuries. Acute or repeated trauma, disease, or a combination of trauma or disease is the most common causes of foot pain. Trauma is a result of forces outside of the body either directly impacting the body or forcing the body into a position where a single or combination of forces result in damage to the structures of the body. Poor biomechanical alignment may lead to foot pain. Wearing shoes that are too tight or high heels can cause pain around the balls of the feet and the bones in that area. Shoes that are tied too tightly may cause pain and bruising on the top of the foot.

Vanderah recounts that tissue damage in the foot may occur by chemical, mechanical or thermal

stimulation associated with direct trauma, musculoskeletal overload, infection or systemic or proximal pathology.¹³ Mechanical stress either in part or fully has been the identified by Maganaris et al as the reason for many common types of foot pain such as tendonitis, stress fractures, calluses and corns.¹⁵ Mechanical stress is a normal component of foot function; however, tissue damage occurs when the maximum stress threshold is exceeded.^{16,17} Three descriptors of mechanical stress have been identified: short duration along with high magnitude stress; long duration with low magnitude stress; or repetitive moderate-magnitude stress.¹⁷

Footwear can be a contributor to foot pain. Poor fitting shoes in the short term can cause blisters, calluses, bruising and be a source of athlete's foot. The long-term effects may be bunions, corns, irritation of nerves and joints, misalignment of the toes, and the source of microtrauma injuries to the foot.

Common Foot Pain Syndromes

Calluses and Corns

The etiology of calluses is not clear. These foot lesions are hyperkerotic in nature: thick and hard superficial epidermis form from the body's reaction to increase pressure. Calluses present in areas of localized high pressure, and the callus itself generates elevated plantar pressures. There is a high risk of foot ulceration with the presence of calluses in a diabetes patient who has a loss of protective sensation. Removal of the callus is essential in at-risk diabetes; that is, those who have sensory deficit foot deformity, or who have had a previous foot ulcer.¹⁸

Pedorthists can have a great impact on patient care by providing education to patients with these lesions. Some patients enjoy the autonomy of paring, trimming, or applying corn "acid" to their corns and calluses. Because of peripheral neuropathy, lack of muscular

control, and poor eyesight common in diabetes patients, self-care could be disastrous and may result in loss of a limb.¹⁸ Pedorthists can counsel diabetes patients on the dangers of the use of over-the counter salicylic acid products and can emphasize this proper foot care through education to accentuate highlights previously made by the patient's primary care provider and podiatrist on points of foot hygiene and foot protection.¹⁸

Ingrown Toenail

An ingrown toenail, also known as a onychocryptosis occurs when the periungual skin is punctured by its corresponding nail plate, resulting in a cascade of foreign body, inflammatory, infectious and reparative process.¹⁹ Anyone can get an ingrown toe nail, teenagers and older people get them more often because teenagers feet sweat more and older individuals have trouble caring for their feet.²⁰ In adolescence, feet perspire more often, causing the skin and nails to become soft, resulting in easy splitting.²¹

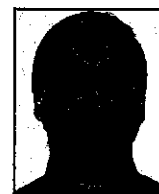
An ingrown toe nail may be caused by ill-fitting shoes or incorrect clipping of the nails. Factors like poor peripheral circulation, increase age, and can contribute to the nail plate to curve inward and hence increase the likelihood of ingrown nails. Signs and symptoms for ingrown toe nails include: swollen toenail area or toe inflammation, toe inflammation with reddened toenail area, toe pain, and pus under or besides the toe nail. Most mild to moderate ingrown toenails can be treated conservatively by soaking the foot in warm, soapy water and applying a topical antibiotic ointment.²⁰

Pedorthists should advise patients to always seek professional medical advice from a physician about any treatment or change in treatment plans if the ingrown toenail does not resolve in a timely fashion. The treatments for severe ingrown toe nails include surgical intervention (removal of the offending nail plate), antibiotics and antibiotic powders may be prescribed

by a clinician and soaking the toenail two or three times a day for 20 minutes. When the pedorthist suggest foot soaks to the patient prior to seeking medical evaluation, the pedorthists should educate the patient to proper water temperature of the water to avoid extremely high temperatures especially if the patient is elderly or diabetic because these patients may accidentally burn themselves because of their loss of sensation due to peripheral neuropathy. A decline in heat pain sensitivity is most noticeable after 70 years of age and may be pronounced in the distal extremities.² Pedorthist may suggest to the patient to keep nails clean and dry and that a twisted cotton wool under the nail edge has been used to prevent ingrown nail reoccurrence. ■

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