



Introducing Mr. Smith: How to Maximize Outcomes and Revenue Opportunities Through the Integration of Protocols—Part 2

This case history shows how you can improve care while enhancing patient loyalty and compliance.

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This article, written exclusively for PM, appears courtesy of the American Academy of Podiatric Practice Management. The AAPPM has a forty-year history of providing its member DPM's with practice management education and resources.

In part 1 of this 2 part series entitled "Introducing Mr. Smith" (August 2008), we began to walk the reader through a sample wound treatment protocol with a fictitious patient named Mr. Smith. The goal of this article was to simply demonstrate how well thought out protocols, including the implementation

of ancillary services and technology, can heal patients faster while building your business and your reputation. In addition, the goals of this presentation include the following:

1) To demonstrate how effective protocols can improve out-

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comes;

2) To demonstrate how implementing ancillary services into your practice protocols can enhance outcomes and revenue;

3) To demonstrate how effective communication skills can improve compliance and patient satisfaction;

4) To demonstrate how to remain compliant by using documentation tools and templates.

As a summary of who Mr. Smith is and what treatments and services have been performed to this point:

1) Mr. Smith is a 65 year old male with a PMH of diabetes, Charcot osteoarthropathy, and a partial 5th ray amputation to his right foot.

2) He presents to you with a grade 2, non-infected ulcer to the plantar aspect of his right foot.

3) The wound has been debrided twice, he has been given an off-loading boot (Bledsoe Conformer) and he has been given Amerigel Hydrogel impregnated gauze (which he has been using faithfully every day for two weeks).

4) Based upon your physical exam, and from the information gleaned from the Pain Management Form (see Part 1, August 2008) that the patient filled out on visit one, Mr. Smith had a vascular test performed in your office (ABI's, TBI's PVR's), which came back within normal limits.

5) The patient at this point has had his wound open now for over three weeks and has noticed considerable improvement, but the wound is still approximately 1.2 cm. X 1.5 cm. in size. The wound is granular and clean with minimal fibrosis or necrosis.

Fourth Office Visit

Mr. Smith presents to you for his fourth office visit wearing his Bledsoe Conformer boot and it is apparent that Mr. Smith has remained compliant with your prescribed treatment.

As you inspect the wound and consider your options to expedite healing, you decide on the application of a biological alternative

tissue (BAT).

Certainly, there are many options for consideration when it comes to applying advanced tissues on chronic wounds, but for the purposes of this article and for expediency, Gammagraft biological alternative tissue from Promethian Life Sciences was chosen.

Considerations When Choosing a Biological Alternative Tissue (BAT)

1) **Choose what you know will work.** This may sound simple, but it's true. Is it Apligraf? Is it Dermagraft? Either is great. Whatever you use, understand

that these products are costly and require time and attention for wound bed preparation as well as the aftercare.

2) **Take into consideration the type of wound you are treating.** The depth of the wound will often determine the type of BAT, and the characteristics of the wound will most often determine the need for adjunctive therapy like wound VACs, hyperbaric oxygen, or compression devices.

3) **Consider the cost and reimbursement for the product you choose.** Make sure that you understand that some of

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FORM 1

Operative Note for Application of _____

Preoperative Diagnosis: Chronic Non Healing Wound (s) X _____

Diabetes: Yes / No

Wound Location: (s)

Wound #1 _____

Wound #2 _____

Wound #3 _____

Wound Measurements:

Wound #1: _____ cm (length) _____ cm (width) _____ cm (depth)

Wound #2: _____ cm (length) _____ cm (width) _____ cm (depth)

Wound #3: _____ cm (length) _____ cm (width) _____ cm (depth)

Wound has been open X _____ days / weeks / months

Postoperative Diagnosis: Same

Name of Operation: Wound debridement/ preparation for graft X _____ with application of _____ to wound site (s) X _____

Complications: None

Anesthesia: None / 1% Lidocaine Plain with .5% Marcaine Plain (____ccs)

Procedure in Detail:

_____ presents for an in-office sterile application of a _____ cm X _____ cm piece of _____. The Right / Left foot was scrubbed, prepped and draped in the usual aseptic manner and then attention was directed to the wound site (s). The wound site was aggressively surgical excised using a 15 Blade with Surgical nippers in order to prepare the wound site for the Graft Tissue. All necrotic and non viable tissue was passed from the operative field. No signs of infection or abscess were noted. The wound site was flushed with copious amounts of sterile saline. The Sterile Graft material was removed aseptically from its package and was then trimmed (as needed) to the appropriate size of the wound site with some margin left for suture placement. After measurements were made and the Graft material was trimmed, the Graft was placed in a basin of sterile saline in order to rehydrate. The graft was then carefully applied to the wound base using forceps. At this point, care was taken to make sure that the graft was in full contact with the wound base. No seroma or hematoma was noted with application. Sterile adhesive strips / 4.0 Nylon was then utilized to anchor the graft in a secure position. Addition sutures / adhesive strips were utilized to the wound base as needed to make sure complete contact was achieved.

After the graft was noted to be in perfect position, the area was carefully cleaned again with a gentle saline wash, then an antimicrobial hydrogel impregnated gauze pad was placed over the graft to maintain moisture and to prevent infection. 4X4's, Kling and Ace wrap were then applied.

This identical procedure was performed on wound sites as indicated above.

The patient was given thorough postoperative instructions in both written and oral form. Absolute non weight bearing, keep dressing dry and intact, follow-up in 5-7 days for dressing change.

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these products have J codes (product codes) while some do not. In addition, even those BATs with J codes often carry a price which makes it cost-prohibitive for you to dispense. Find out from the company that you order from how long they will carry the balance for the product you are ordering as it may take months to get reimbursement for the J code along with the procedure codes.

4) Local carrier determinations (LCDs) for most of these advanced biological alternative tissues are available either online or through the carrier. These guidelines usually have information regarding the number of applications of the BAT that are allowed as well as documentation requirements.

5) Be ready for the globals. Most (Apligraf being one of the few exceptions) have 90-

day global periods. The timing in which you use a BAT is critical. Using a BAT prematurely without preparing the wound properly can result in getting stuck in a very long global period.

So, Mr. Smith's wound is cleaned and prepped while your office staff prepares the room for the procedure. The BAT is prepared for application along with the dressing material you plan on

applying OVER the BAT. In our office, an Amerigel hydrogel impregnated gauze pad will be applied over the BAT to maximize incorporation and wound healing.

An aggressive excisional debridement of the wound, as needed, can be performed in preparation for the BAT which will better prepare the wound bed for the graft material (CPT 15004). CPT code 15004 is not intended to be reported for simple graft application alone or application stabilized with dressing. An operative note is needed for both the wound preparation using the 15004 and the appropriate application code.

Mr. Smith's wound was surgically prepped for the BAT and care was taken to make sure that the wound was not bleeding in order to achieve the best adherence of the BAT. Steri-strips were applied over the BAT followed by the hydrogel-impreg-

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Figure 1: Gammagraft is applied to the wound site with the Amerigel Gauze as the secondary dressing to provide a moist, antimicrobial environment to maximize incorporation and healing.

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nated gauze and a secondary dressing (Figure 1). Mr. Smith was given instructions for how to care for the BAT (do not remove, keep dry, continue use of the Bledsoe), and the patient was instructed to return to the clinic in one week.

Learning Points for Visit Number Four

1) Make sure the patient understands that the material placed on his foot is expensive and more than just a "traditional dressing." Failure to do this may result in non-compliance and BAT failure.

2) Make sure you review your LCDs to use the appropriate application code, J code, and preparation code (15004) as needed.

3) Make sure you have documented the characteristics of the wound and failure of conservative options.

4) Non-weight bearing after application of the BAT is vital.

5) Having a template op-note describing the procedure can make effective documentation a snap (Form 1).

Coding Summary for Visit Four

1) Wound bed preparation for a BAT: CPT 15004 (this may not be indicated for every wound in which a BAT is being applied. Review your LCD's for further information.

2) Application of allograft for wound closure: CPT 15320.

3) Appropriate J code: J734_.

Fifth Office Visit for Mr. Smith: The Beginning of the Global

Mr. Smith presents for his fifth office visit with his dressing intact, and with no significant appearance of exudate or odor. As this is a global visit, care is taken to make sure the patient understands the plan and the goals of treatment as well as to remind the patient of what he needs to continue to do in order to remain on schedule.

As you remove the secondary dressing, care is taken to make sure that the BAT is not disrupted. Mr. Smith's wound looks good

with no signs of infection or contamination. There is a clear film over the wound bed that WILL NOT be debrided as this is a sign of healthy incorporation of the BAT.

Mr. Smith is told to begin applying a piece of the hydrogel impregnated gauze (dispensed in office visit one) over the wound bed every day after a gentle cleanse. Mr. Smith is told to remain in his boot and follow up in one week.

Sixth Office Visit

Mr. Smith returns to your office two weeks status post-applica-

tion of the BAT. His wound has dramatically reduced in size and overall Mr. Smith is thrilled to see the dramatic improvement. As it is apparent that the wound will be totally healed within the next week or two, Mr. Smith is told that now is the time to start the process of putting in place tools to prevent future complications and skin breakdown.

Clearly, several viable options for off-loading Mr. Smith's Charcot foot deformity are available that include custom orthosis, custom/non-custom shoes, rocker

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FORM 2

DOCUMENT OF MEDICAL NECESSITY FOR ANKLE - FOOT ORTHOSIS

PATIENT NAME:	SSN:
DIAGNOSIS CODES:	
ADULT ACQUIRED FLATFOOT (PTTD) <input type="checkbox"/> Adult Acquired Flatfoot 734 <input type="checkbox"/> Rupture, Tendon; Ankle & Foot 727.88 <input type="checkbox"/> Pronation, Acquired 736.79	
DJD OF ANKLE & REARFOOT <input type="checkbox"/> Osteoarthritis, Localized, Primary; Ankle & Foot 715.17 <input type="checkbox"/> Pain, Joint; Ankle & Foot 719.47 <input type="checkbox"/> Tarsal Coalition 755.87	
DROPTFOOT <input type="checkbox"/> Dropfoot 736.79 <input type="checkbox"/> Hemiplegia 438.20	
LATERAL ANKLE INSTABILITY <input type="checkbox"/> Instability of Joint; Ankle & Foot 718.87 <input type="checkbox"/> Calc-fib Ligament Sprain 854.02	
OTHER <input type="checkbox"/>	

DESCRIPTION OF ORTHOSIS AND BILLING CODES:

The following Ankle-Foot-Orthosis & Component Parts have been dispensed to the above captioned patient on _____ (Date).

- L1970 AFO, plastic, molded to patient model with ankle joints
- L1940 AFO, plastic solid shell, molded to patient model
- L1971 AFO, plastic, with ankle joint, prefabricated
- L2820 Soft interface, below knee
- L2275 Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined
- L2210 Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint
- _____

PROGNOSIS:

DURATION OF TREATMENT WITH ANKLE FOOT ORTHOSIS:

NECESSITY OF ANKLE-FOOT-ORTHOSIS MOLDED TO PATIENT MODEL:

A custom (versus pre-fabricated) ankle-foot-orthosis has been prescribed based upon the following criteria which are specific to the condition of this patient. (check all that apply):

- The patient could not be fit with a prefabricated AFO
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than 6 months)
- There is need to control the ankle or foot in more than one plane
- The patient has documented neurological, circulatory, or orthopedic condition that requires custom fabrication over a model to prevent tissue injury
- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions

I hereby certify that the ankle-foot-orthosis described above is a rigid or semi-rigid device which is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. It is designed to provide support and counterforce on the limb or body part that it is being braced.

(Signature of Prescribing Practitioner)

(License Number)

(Date)

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bottom accommodations, among several other options. For Mr. Smith, however, another option was decided upon based on his specific deformity and overall condition.

Due to the need to stabilize Mr. Smith's neuropathic foot and ankle as well as offload his plantar deformity, an ankle foot orthosis (AFO) was chosen as the preferred vehicle to provide long-term support and offloading of Mr. Smith's foot. In addition, Mr. Smith will be measured for a diabetic shoe that will be worn with his AFO (on the contra-lateral foot).

Per the protocol, Mr. Smith is shown an example of the AFO that he will receive. This helps a patient understand what the brace looks like and often precludes the typical "surprise" that a patient experiences when seeing the brace for the first time. Next, the medical assistant applies an STS casting sock to the right foot with care taken to make sure the sock goes up to the lower leg (not too low on the ankle) and to make sure the sock captures accurately the plantar deformity. Lastly, as Mr. Smith has a partial 5th ray amputation on his right foot, a filler will be ordered to be placed on the Plastizote custom inlay within the AFO.

Here Are Some Further Considerations

1) Although there are several options for fabricating an impres-



Figure 2: With meticulous wound care and appropriate offloading, Mr. Smith's wound heals completely.

sion for an AFO, in cases like Mr. Smith's in which you have bony deformity, I prefer to cast the patient in neutral suspension. With the patient's foot suspended, you can accurately capture the plantar deformity in order to make sure you have an accurate "pocket" for the specific anatomical deformity.

2) Furthermore, it is vital to make sure that you never cast the patient in equinus. With this in mind, care must be taken to make sure the patient's foot is captured at 90 degrees.

3) In cases where spastic contracture is involved, having the patient in a semi-weight-bearing position is preferable. Keep in mind, however, that when you want to capture plantar deformi-

ty, you have to make sure the STS sock is "smoothed" out and appropriately marked (with a permanent marker) to make sure the lab knows where to pocket the AFO.

4) Mr. Smith's gauntlet-styled AFO will have several key components:

a) A full foot plate (attached to the AFO) that will extend to the toes and fully accommodate the patient's deformity (rocker bottom).

b) A custom plastizote insole (inlay) that will perfectly accommodate the patient's deformity from the heel to toe, including a filler for his partial foot amputation.

c) The gauntlet component of the AFO will stabilize the ankle as well as reduce pressure to foot.

d) All Velcro latches will be used without any laces or latches that can make it hard for the patient to apply the brace.

e) As you have marked the STS at all sites of bony prominence, the AFO

will accommodate the malleoli and all other deformities to prevent rubbing or friction.

Take into consideration the type of wound you are treating

Shoe Considerations for Mr. Smith

Choosing the right diabetic shoe is a lot more difficult than finding the right size and color. For a patient who is high risk, careful consideration is vital. Consider these pointers:

1) Take into account the patient's foot type. This includes not only the length and width of the foot, but also the thickness (girth) of the foot. In other words, patients who have swelling or conditions like



Figure 3a: An Arizona AFO with a full force plate along with accommodation for Mr. Smith's Charcot deformity has arrived.



Figure 3b: With the anatomical accommodation for Mr. Smith's Charcot deformity along with a filler for his partial 5th ray amputation, everything is in place to help prevent further ulceration.

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Charcot, need a shoe that has the ability to expand (flex) without causing friction or rubbing.

2) Don't ignore the presence of swelling. This can alter shoe fit in a major way. Get your patients in compression garments and educate them regarding the risk of swelling while confined in a non-expandable type shoe.

3) When it comes to choosing a shoe to fit with an AFO, consider shoes with a Lycra forefoot/tongue component with Velcro (e.g., Orthofeet Lycra Velcro, Apis Lycra, Pedor Lycra, or the Dr. Zen Lycra shoe) Shoes that come with extra-wide widths are also important for the best shoe fit.

4) With certain types of AFO's (Gauntlet style) finding the right shoe to fit over the AFO and the contra-lateral foot can be difficult, especially without the benefit of having specialty shoes in stock (Lycra, depth, extra-wide widths). And in some cases, two different size shoes may be necessary as long as function and stability are not compromised. Although in most cases the same size shoe can be found to fit the AFO and the contra-lateral foot, having to order two different size shoes (one shoe larger to accommodate the AFO) can sometimes be costly as many shoe companies don't allow this.

After Mr. Smith was cast for his AFO, a step box was procured for custom diabetic insoles for the left foot only. As Mr. Smith will have a custom orthosis and filler built into his AFO, no diabetic orthosis will be needed for the right foot.

Custom diabetic orthoses were chosen for the right foot (as opposed to heat-molded) due to the patient's cavus, intrinsic minus foot type and severe neuropathy.

Mr. Smith was told that his shoes (in this case, the Orthofeet Lycra Velcro Shoe), his custom diabetic insoles (Safestep) and his AFO (Arizona AFO) would be available in approximately four weeks and until this time, he was to continue the use of his off-loading boot.

FORM 3

Foot and Ankle Center

Diabetic Shoe and Insole Dispensing Note

_____ presents to the office today (____/____/____) for dispensing of therapeutic shoes (extra depth) and three sets of custom multi-density inserts. The shoes were chosen to best accommodate the patient's anatomy and needs as a high risk diabetic patient. There is certification from the physician managing the patient's diabetes on file. The insoles are custom fabricated to the patient's foot and thus are made to support the arch with full anatomic contact. Proper use and care was reviewed. The patient indicates that the shoes and insoles are comfortable with no pain, rubbing or irritation. ~~The shoes and insoles were fit by a qualified staff member of Foot and Ankle Center with over 1,000 hours of experience (Doctor of Podiatric Medicine, Pedorthist or Trained Medical Assistant).~~ The items dispensed were appropriate and not substandard. Written instructions and warrantee information was given and the list of the Durable Medical Equipment Supplier Guidelines. The below instructions were dispensed:

- ✓ For the first two weeks of wear: at least three or four times per day, remove your shoes to examine your feet and your device(s). Check for anything that looks different or out of the ordinary that may result in injury. Look for swelling, redness, calluses, cuts, scratches, blisters, or "hot spots". Please call our office immediately if you notice these issues and make an appointment to come in. Please do not try to adjust the device yourself.
- ✓ Inspect your feet daily. If you find anything out of the ordinary or have pain or bleeding, discontinue use immediately. Come in so that we may determine the cause and improve the function of your device(s). If you are unable to examine your own feet or device(s), get someone else to look at them for you, or use a mirror.
- ✓ For non-custom diabetic shoes, please perform the break-in period in your home, on carpet. Once you have verified that the shoes feel good and do not cause any rubbing of your skin, you may wear them outside. If you have any redness, issues, or concerns, please stop wearing the shoes immediately and call our office.
- ✓ Try to keep Velcro or other hook-and-loop straps free of hair and lint. Worn out straps can be replaced for a fee.
- ✓ Inspect the pads, straps, laces and accessories on the device weekly, and report any issues to our office.
- ✓ Your device will require periodic maintenance, which may include repairing normal wear-and-tear as well as updating your device to keep current with your requirements. It is important for you to continue to examine your feet and device(s) as long as you own the device(s). Please call us and make an appointment for regular follow-up visits.
- ✓ **Your diabetic shoes and insoles should never be worn without socks. If you are not able to get socks on yourself, contact our office. Diabetic socks are available at our office.**
- ✓ All devices eventually wear out through normal wear and tear. The products you received have a 12 month manufacturer's warranty against defects in materials and workmanship, assuming normal wear and tear. If the shoes are returned and the problems are related to ABNORMAL wear and tear the manufacturer's warranty will not apply. We will repair or replace, free of charge, devices that are under warranty. For issues of initial fit, please return within 7 days to our office so that we can address concerns of the initial fit of the device.
- ✓ **If you discover a problem with the shoe or with the fit of the shoe after they have been taken home, please return them as soon as possible so a replacement can be found.**
- ✓ **If your diabetic shoes are returned for cosmetic issues or any other issues aside from mal fitting or manufacture's defect and they have been worn outside, there will be no exchanges or returns.**

Provider/ Pedorthist

Documentation Pearls for Dispensing Ankle Foot Orthosis and Diabetic Shoes

1) As mentioned in part one of this series, a prescription for any DME device is a necessary component for compliance. Therefore, for Mr. Smith, a prescription for his AFO and his diabetic shoes and insoles were placed into the chart (Forms 2 and 3).

2) A signed certification of receipt must be in the chart for the AFO and for the supplier standards and warranty/wear information. This information can be on one form as long as your instruc-

tions and warranty information is clearly laid out for the patient to understand.

3) Furthermore, several key components are necessary for documentation when prescribing a custom AFO. They include the following:

- The patient could not be fit with a pre-fabricated AFO.
- The condition necessitating the orthosis is expected to be permanent or of longstanding duration. (more than six months)
- There is need to control the ankle or foot in more than one plane.

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- The patient has documented neurological, circulatory, or orthopedic condition that requires custom-fabrication over a model to prevent tissue injury.

- The patient has a healing fracture which lacks normal anatomical integrity or anthropometric proportions.

4) For Mr. Smith's diabetic shoes, the following documentation pearls are key:

- The patient's physical exam must be documented, clearly indicating that the patient meets the criteria for receiving diabetic shoes. Include the presence of neuropathy, deformity, the location of pre-ulcerative lesions, or the presence of previous ulceration or amputation.

- As noted above, a prescription for the diabetic shoes must be in the chart. This template-based prescription should have the name/type of shoe being prescribed along with the type of insoles. (custom or heat-molded)

- A signed certification of re-

ceipt must be in the chart for the diabetic supplies and for the supplier standards and warranty/wear information. This information can be on one form as long as your instructions and warranty information is clearly laid out for the patient to understand.

At the end of visit six, Mr. Smith has been STS-cast for an Arizona AFO that will include a custom, accommodative orthosis with a filler. In addition, diabetic shoes and insoles

have been ordered that are appropriate for the AFO and for prevention of ulceration on the contralateral foot. Mr. Smith has been told to stay in his Bledsoe boot until the items have arrived into the office. Mr. Smith will be applying the hydrogel impregnated gauze to his foot every day until seen again in two weeks.

Office Visit Seven: Dispensing Day

Mr. Smith presents to your office now completely

Using a BAT prematurely without preparing the wound properly can result in getting stuck in a very long global period.

healed. (Figure 2). The AFO and shoes have arrived and Mr. Smith is excited to get out of his boot (Figures 3a, b & 4).

The gauntlet-style AFO is fit to the patient's foot and the shoes and insoles are all put in place. The Lycra-styled Velcro shoe slides easily over the AFO; however, the same sized shoe is slightly large on the left foot. So, two shoe fillers (which come standard with many diabetic shoes) are placed under the diabetic insole in the left shoe, which seems to make the fit perfect.

The patient is now asked to walk to assess stability and comfort. Mr. Smith is thrilled. As Mr. Smith prepares to leave today, the following information is prepared for the chart:



Figure 4: Due to its flexible soft Lycra tongue and its easy-to-latch Velcro, the extra-depth Orthofeet Lycra Velcro shoe is chosen to fit over the AFO.

1) Aside from the above-mentioned certification of receipt and warranty/wear information which must be signed and put into the chart, a dispensing note needs to be placed in the chart which describes the fitting process, your gait evaluation, and the overall condition of the products being dispensed. For an example of this note, see Form 3.

2) Make sure the patient (and family) is educated thoroughly regarding the importance of skin inspection after the wearing of a custom device or a new shoe. As Mr. Smith is profoundly neuropathic, it is vital that he understands that pain will not be there as a warning sign of potential problems.

Coding Summary of Visit Seven

1) Arizona AFO with Filler:

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L1940, L2275, L2280, L2820, L5000 (filler).

2) Diabetic shoes X 1 pair: A5500.

3) Three single diabetic custom insoles for Left foot: A5513.

Although much more can be said about the impact of effective protocols, there is no greater reward than a healed patient. Protocols are about improving outcomes, one patient at a time and NOT about making more money. It just so happens that improved revenue comes naturally as a byproduct of well-executed ethical protocols as illustrated above. Protocols should be in place for all of the most common diagnoses that you see in your practice, including heel pain, onychomycosis, and others.

The beauty of having made such an impact on a patient's life (as we did with Mr. Smith) is that now we have a devoted patient for life. Not only will you be see-

ing his mother, wife, and kids, but you have a patient that you will be seeing for life.

In another two to three months, Mr. Smith will be coming to see you for his skin and nail check-up and next year Mr. Smith will need new diabetic shoes. In about another five years, Mr. Smith will need a new AFO and may likely need many more services that your office will offer as a diabetes center of excellence. Effective protocols are more than just ancillary services and products; they are a friendly staff and improved efficiency too. Make everything that you do in your office patient-centered, and you will be rewarded many times over.

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