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FROM THE PRESIDENT

What Does Love Got To Do With It?

Since we were children, parents, teachers and the heroes we’ve looked up to have always told us, to do something well you have to like it. We’ve even been taught a four word mantra repeat to ourselves in silent reflection and consideration – “do what you love.” But is it really that simple and enough to tell people this – to love what you are doing and you will be a success?

Let’s face it, doing what you love can be … well … complicated.

Steve Jobs once said, “You’re got to find what you love. Your work is going to fill a large part of your life, and the only way to be truly satisfied is to do what you believe is great work. And the only way to do great work is to love what you do.”

Considering the source of this profound quote, I can’t help but ask myself this very question about life and happiness. If we love and enjoy what we are doing for a living, can it make a difference?

The difference between a job, career or a life long passion can be as simple as a decision to follow what you enjoy. A great example is a violinist. Is there a difference between one who is considered a professional musician and one that has been labeled a virtuoso? Both can draw the listener in with their great technique, passion and ability to read music – something both performers have equally developed over hours, days and years of practice and performance. The only difference between the two could be as simple as one was a child prodigy, but both share similar goals when it comes to a job, career and their lifelong passion doing something they truly love.

Success will breed success, in your life and career if you ultimately love what you do because let's face it, what you decide to do as a job or career, you are going to be doing it a lot during your life time.

Every endeavor in life or business always has the burden of an ideology we are taught compared to the actual reality. It’s very hard to get up every day and take care of yourself and your family; go to work; pay your bills and focus on the future. In theory, these activities are the small things and are an important part of those decisions that can WEIGH you down, yet in reality it’s these everyday and mundane tasks that can defeat you.

Whatever direction you are currently pursuing in the health industry, you know it can be very rewarding – and also very difficult. It’s tough to get a career going in the first place. It requires commitment, determination, and persistence.
Whatever direction you are currently pursuing in the health industry, you know it can be very rewarding – and also very difficult. It’s tough to get a career going in the first place. It requires commitment, determination, and persistence. Again, though, the ideal is to do what you love, most experts will agree that this ideal is something we need to do every day as a requirement to live happily. This means you must pursue your passion if you are to be successful and happy in life. What is necessary for you to remember though is for you to love what you do. And that’s possible for anyone and everyone.

So, let’s turn the tables and advise loving what you do instead. This is not an easy task, but your attitude toward your job is totally up to you. Deadlines have moved up against your wishes, people didn’t do the work they were supposed to do, you name it. You can get angry and have it affect your entire outlook. However, you could have chosen to view it differently. You could have focused on the flexibility the job offers and the fact that you get to attend most of your children’s events. You could have accepted that you can’t control Medicare, referral sources and patients and just done the job at hand instead of taking things personally. Therefore, by doing that, you will hopefully reduce the frustration level and just appreciate the industry that you have an opportunity to utilize to make a living. You will always have bad days, but realize, how you can dislike something you are vested in.

Hopefully you can decipher the difference between doing what you love and loving what you do. And if you haven’t yet chosen or if you’re in the process of deciding what to do with your future employment or business options in pedorthics, explore the possibilities of something that relates to your passions. Use a full scope of practice to help you decide your passions, have a vision of what could be. Explore all the opportunities. Once you have made a decision, make a commitment to do whatever it takes to achieve success in the area you love.
The Importance of Belonging

The financial crisis that hit the U.S. and many other countries several years ago has certainly forced people to prioritize their spending – take a vacation or a stay-cation, purchase a new car or get a few thousand more miles out of the existing one, pay their pedorthic certification or licensure fee or renew their membership with the Pedorthic Footcare Association (PFA). All legitimate and thoughtful considerations.

For the purpose of this note to the membership, I want to focus on why you should not only remain a member of PFA or come back if your membership has lapsed, but also encourage your fellow pedorthists to become members. First and foremost, PFA is the only national association solely representing the interests of the individual pedorthic practitioner – PFA is a professional society, not a trade association such as the American Orthotic and Prosthetic Association (AOPA), whose membership is composed of companies and not people.

Another reason are the networking opportunities provided by PFA. Sure, it’s taken a hit the past couple of years due to numerous factors, but the annual Symposium and Exhibition is still, by far, the largest single educational and networking event solely dedicated to the pedorthic profession. Where else can you spend three days talking with colleagues, meeting the foremost experts in the pedorthic field and other allied healthcare specialties, and viewing the latest in products and services to help you better serve your patient/client population? Want to experience all this and more? Then we’ll see you in Boston, October 31 – November 2!

As a member, you receive the only professional publication solely devoted to the practice of pedorthics – Current Pedorthics magazine. Six times a year, articles on practice management, pedorthic pathologies and treatment methodologies, patient care, government affairs and more, are delivered right to your door. Supplemetning Current Pedorthics is the monthly PFA Online, presenting time-sensitive news and information critical to the pedorthic community.

PFA is one of the foremost providers of continuing educational opportunities to help you maintain your edge – and your credential! Webinars, seminars and the annual Symposium and Exhibition, in addition to specially featured articles in Current Pedorthics, are all produced to help you become an even better pedorthic practitioner year after year.

PFA is the only organization representing the credentialed pedorthist in Washington, DC and the state capitols through its lobbying efforts and government affairs committee. PFA maintains a presence on Capitol Hill, visiting with Members of Congress and regulatory officials to keep the issues most important to pedorthists at the forefront. PFA also works with other allied healthcare associations in coalitions, building relationships and advancing causes with larger numbers of constituents. At the state level, PFA works with members to advance state licensure for pedorthists, placing them on a level playing field with O & P.

PFA offers a host of services designed to help the business side of your practice: a shipping program with PartnerShip saves PFA members literally thousands of dollars a year (based on your shipping volume) – many times more than membership dues in PFA; a pedorthic-centric professional liability/malpractice insurance program; merchant credit card processing, and more. In fact, in the next month, PFA will be rolling out a host of new services, available exclusively for members that will include health insurance for you, your family and your employees; travel insurance; equipment financing; website design services; low cost printing; and much more.

Finally, PFA maintains a bookstore stocked with resources for the pedorthist and their practice: practice management texts, marketing brochures, continuing education products, foot and ankle charts and models, clinical texts, and more. Members receive substantial discounts on products designed to help you be the best pedorthist that you can be.

Compared to other organizations, membership in PFA is relatively inexpensive, and you can make up for your membership dues by utilizing some of PFA’s business services. PFA brings a lot to the table, and you can too. By being a member of PFA, you provide a stronger organization and a stronger voice for your profession. You enhance the quality of our communications content in Current Pedorthics and PFA Online, as well as the educational content of the Symposium and other continuing education offerings.

We like to think that the survival of PFA is directly tied to the survival and future prosperity of the pedorthic profession – and vice versa. PFA’s volunteer leadership and staff are doing everything possible to enhance the membership value proposition – of both tangible and intangible benefits – to keep you as a member and add many more. Not to mention being the only voice out there solely dedicated to your profession.

You can do your part for yourself and your profession by understanding the value of belonging, remaining a member and encouraging others to do the same.
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Dean Mason, C. Ped., OST, BOCO, CO
Dean owns North Shore Pedorthics, LLC in Lorain Ohio, and is a member of PFA’s Board of Directors as Treasurer, co-chair of PFA’s Government Affairs Committee and a member of the Publications Committee.

Robert Sobel, C. Ped.
Rob started his pedorthic career as a technician at an orthotics and prosthetics facility. With more than 25 years of patient care experience, Sobel is now the owner of his own pedorthic practice in New Platz, NY, and is a member of PFA’s Board of Directors as Vice President, chair of the Publications Committee and member of the Marketing & Membership Committee.

Dr. Thomas Michaud, DC
Dr. Thomas Michaud is the author of Human Locomotion: The Conservative Management of Gait-Related Disorders, the content of which forms the basis for this and subsequent articles. All illustrations in this article appear in the book and are reproduced with permission. Dr. Michaud is a 1982 graduate of Western States Chiropractic College and practices in Newton, Mass., where he has treated thousands of recreational and elite runners. His first textbook, Foot Orthoses and Other Forms of Conservative Foot Care (published in 1993), was eventually translated into four languages and is used in physical therapy, chiropractic, pedorthic and podiatry schools worldwide.

Margaret Hren, Editor & Staff Contributor, Current Pedorthics
Margaret Hren has worked extensively in the nonprofit and for-profit industry marketing and developing branding, membership and fundraising programs for numerous organizations and associations in the U.S. and abroad. With her expertise in marketing, editing and writing, she had published on various topics both in traditional publishing sources and online, as well as conducted onsite workshops on how to market your business and other business and personal topics of interest.

Dr. Adam Teichman, DPM
Dr. Adam Teichman is the Senior Managing Partner of East Penn Foot and Ankle Associates, and a board certified podiatric physician and surgeon. He is also the Chief of Podiatric Surgery at Sacred Heart Hospital in Allentown, PA where he is also a member of the Limb Salvage Team. In addition, he is also a surgical instructor at the Podiatric Residency Program at St. Luke’s Hospital and Health System and a Panel Physician at Sacred Heart Wound Center and the Official Team Podiatrist of the Lehigh Valley Iron Pigs, the AAA team of the Philadelphia Phillies. He is also recognized for his outstanding results in the correction of deformities and improvement of function in the foot and ankle, and achieved unparalleled success rates in diabetic wound management and limb preservation, where he aims to achieve the fastest possible healing times.
Near the beginning of every New Year, the shipping experts at PartnerShip dig into the small package carriers’ annual rate increase announcements. We like to read between the lines for our customers, digest the tables and charts, see what information is out there that FedEx and UPS didn’t say, or maybe just hinted at. As always, how much more expensive your particular small package shipments will be in the New Year largely depends on many factors, including shipment volumes, sizes, weights, and modes.

Seemingly every year through this exercise, we reveal a familiar story: the actual rate increases most shippers will experience in the New Year are larger than the average rate increases announced by FedEx and UPS—in some cases much larger. This year is no different, except for a new wrinkle. Like years past, many services and lanes will feature rate increases larger than the average increases the carriers announced. But this year, our analysis shows the increases are somewhat lower on the more expensive premium services, and higher on the deferred services the carriers offer, to capitalize on the impact of shippers trading down to economy services.

As the global economy struggles to grow, both major carriers have noted a significant shift by customers away from premium package-delivery services toward less expensive “economy” modes. Part of the reason for these changing market dynamics is that the difference between express and ground delivery times continues to shrink for both FedEx and UPS. Many businesses and consumers no longer believe the 1-2 day difference in shipping time is worth the extra cost of a premium service, unless it “absolutely, positively has to be there overnight,” as the old FedEx commercial used to say. Also, as technology products get smaller and lighter, the carriers charge less to ship them (the Apple iPhone 5 is about 17 percent lighter than the original iPhone). Such diminishing revenue must be made up somewhere.

Both FedEx and UPS have witnessed explosive growth in business to consumer (B2C)/home delivery shipping, fueled by large catalog and online retailers. In 2012, UPS reported that about 40 percent of the parcel shipments moving through the UPS U.S. network in Q3 were B2C shipments as the result of ecommerce transactions. Given that Amazon.com is currently the 8th most visited website in the world and certain analysts predict the online retailer will overtake retail giant Wal-Mart in overall sales by the year 2020, it is safe to predict that B2C shipping will continue to grow.

Trends show that customers are willing to defer shipping to slower, more economical services. As such, our analysis of this year’s rate increases shows much higher percentage increases on economy services to try to offset customers trading more expensive, faster options for more economical, slower options. Where the carriers will make up that revenue is by simply charging more for the products and services shippers use the most. We think it’s safe to predict that rate increases on lightweight, B2C services will continue to outpace other premium service rate hikes well into the future.

Quick Facts
- UPS rate increase in effect December 31, 2012
  - 4.9% average rate increase for UPS Ground (5.9% average increase -1% reduction in the fuel surcharge)
  - 4.5% average rate increase for UPS Air (6.5% average increase -2% reduction in the fuel surcharge);
- FedEx rate increases in effect January 7, 2013
  - 4.9% average rate increase for FedEx Ground and FedEx Home Delivery services (5.9% rate increase -1% reduction in the fuel surcharge)
  - 3.9% average rate increase for FedEx Express services (5.9% average increase -2% reduction in the fuel surcharge)
- UPS will enjoy an extra week of the rate increases by beginning 12/31/12 to FedEx’s 1/7/13.

Your Rates May Will Vary
It’s important to remember that the FedEx and UPS rate increase announcements are presented in terms of averages. You might think then that your 2013 small package shipping rates with FedEx and UPS should go up about 4.9% for ground shipping and 3.9% to 4.5% for air shipments. If you guessed this way to forecast and budget your 2013 shipping costs, you might want to make some adjustments!

Like we detail in this article every year, the FedEx and UPS average rate increases are just that—averages. The “average rate increase” is arrived at by larger rate increases on certain shipment types and lower increases on others. Like always, several factors will determine your real rate increase impact in 2013, among them your package characteristics (size and weight); the service you most often utilize (ground or air); and the zone to which you ship your packages.
2013 Ground Package Rate Increases
As stated earlier, both the FedEx Ground and UPS Ground rate increases are based on a 5.9% increase in the base rate, less a 1 percentage point reduction to the index-based ground fuel surcharge. But let’s examine the true impact to your bottom line based on the weight of packages you ship and the zone to which they are shipped.

FedEx Ground and UPS Ground have identical published base rates for ground packages up to 70 pounds, making apples to apples comparisons possible. Overall, the largest percentage increase for both carriers occurred on packages weighing 20 pounds and less, regardless of zone. This is a result of many shippers migrating lower zone air shipments to the carriers’ more economical ground services. The increase for all packages under 20 pounds ranges between 5.8% and 8.9% over 2012 rates.

Air Rates Increase Dramatically for Smaller Packages
The increases in base rates for FedEx Priority Overnight ranged from 4.0% to 6.5% for packages 150 pounds and lighter. On the UPS side, base rates for UPS Next Day Air increased an average of 5.1% to 7.7%. Of note this year is that FedEx Envelopes are not leading the rate increase tables in terms of largest percentage rate increase, for the first time in recent memory. UPS Letters, true to recent form, were above the stated average in all but one Zone. This year’s highest rate increases appear to have less to do with weight than distance, according to our analysis. Everything from Envelopes/Letters to 150 pound packages is seeing above average rate increases beyond Zone 4/104. This is bad news for higher zone shippers.

As we said at the outset of our article, this year’s largest rate increase percentages are featured on many of the slowest and least expensive shipping options the carriers offer. As we begin to dissect slower and more economical services, we correspondingly begin to see larger average rate increase percentages. FedEx Standard Overnight and UPS Next Day Air Saver saw rates on shipments of nearly all weights and to almost every zone rate increase beyond the stated averages the carriers announced. FedEx Standard Overnight increases range from 4.6% to 7.5% on packages less than 150 pounds, while UPS Next Day Air Saver increases range from 5.2% to 8.5% over the 2012 rates.

Correspondingly, our analysis shows that the rates for shipments in every weight break and every zone we examined for FedEx 2Day and UPS 2nd Day Air went up by more than the stated averages the carriers announced. The rate increases for FedEx 2Day ranged from 6.5% to 7.5% for packages less than 150 pounds we analyzed; and all rates for packages in the same range increased anywhere from 7.5% to 8.8% over 2012 rates for UPS 2nd Day Air.

Some of the largest increases occur with FedEx Express Saver and UPS 3 Day Select services—some weights and zones actually hitting double-digit rate increases, which we haven’t seen for a long time. Every FedEx Express Saver weight and zone we analyzed featured rate increases above the stated carrier average, ranging from 6.0% to 10.3%, with the largest increases in the shorter zones. UPS also took substantial increases on its 3 Day Select service as you can see in the below table, with increases ranging from 5.4% to 9.7%.

UPS Air Rates vs. FedEx Air Rates
Our analysis examines UPS Daily Rates and FedEx Standard List Rates. It is important to acknowledge that in early 2011, UPS introduced a new set of base rates, Standard List Rates. UPS Standard List rates are higher than UPS Daily Rates and virtually identical to FedEx Standard List Rates. UPS has been placing all new customers who establish a UPS scheduled pickup account on Standard List Rates, rather than Daily Rates as they did in the past.

And keep in mind that both carriers have Retail Rates, with higher base rates than either Standard or Daily Rates, which affect customers who ship from a retail store location. These rates, while not included in this analysis, are also increasing for 2013.

Don’t Forget About The Surcharges!
Both FedEx and UPS also announced increases to other fees and surcharges for 2013. It may surprise you to learn that fees for extra services can account for up to 20% or more of your total transportation costs.

Conclusion
As it has been in the past, the real impact of the 2013 rate increases depends on what you ship, where you ship it, and the size and weight of your packages. The important takeaway when thinking about your shipping expenses in 2013 is that the announced average increases paint an inaccurate picture of the true impact these new rate increases could have on your business. If you find yourself confused by rate bases, average increases, and surcharges — rest assured that you are not alone...
The Pedorthic Footcare Association (PFA) is pleased to announce their partnership with the American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) and The Board of Certification/Accreditation (BOC) to develop and distribute our first comprehensive professional survey focusing on the pedorthics, pedorthics practice and the pedorthics profession since 2007. This survey scheduled to begin in late April, 2013 and will be distributed to all members of the PFA, ABC and BOC. The results of this survey and study are scheduled to be presented at PFA’s 54th Annual Symposium and Exhibition in Boston, October 31 – November 2, 2013.

The scope of this professional survey is to focus on detailed questions and comments, allowing for a more concise and detailed insight into pedorthic professionals and the pedorthics profession on all levels of certification and practice. Such areas of inquiry will be on demographics information both personal and regional, education, types of certification, practice management, patient care, salaries and benefits, patient costs, income, and professional liability to name just a few of the topics questions will covered. All responses will be kept anonymous for statistical purposes.

With the changes and growth in the pedorthics profession, the purpose of this survey is to help pedorthic professionals gain a comprehensive insight into their profession around the country, along with assisting other allied health care professionals gain a clear understanding of our industry and its purpose.

If you have any questions or areas of interest you would like to see considered for this survey, please email your suggestions to info@pedorthics.org.

Now That the Holidays are Over, It’s Time to Respond to PFA’s 2013 Call for Presentations - DEADLINE: FEB 28, 2013

The Pedorthists Are Coming! The Pedorthists Are Coming!

Or, more specifically, PFA’s 54th Annual Symposium & Exhibition is coming...to the John B. Hynes Veterans Memorial Convention Center and the Sheraton Boston Hotel in Boston, MA October 31 - November 2, 2013.

PFA is expecting hundreds of pedorthists, allied healthcare providers and exhibitors from across the U.S. and around the world to attend the world’s largest single educational and networking event solely dedicated to the pedorthic profession.

PFA’s Council on Pedorthic Education (COPE) is inviting you to help PFA celebrate its 54th year of providing high-quality pedorthic healthcare education by sharing your knowledge and expertise as a Symposium presenter.

COPE is seeking presentations in topical areas such as (but not limited to):

- Diabetes
- Sports medicine
- General pedorthics
- Pediatric pedorthics
- Geriatric pedorthics
- Biomechanical research
- Multi-disciplinary approaches to assessment and treatment of lower extremity conditions
- Technical sessions by PFA Vendor/Manufacturer members/exhibitors

Visit our website at www.pedorthics.org to learn more about PFA’s Symposium and how you can become an integral part of the educational program.

The deadline for submissions is on or before February 28, 2013. You will be notified by April 1, 2013 if your submission has been accepted.

Questions about the Call for Presentations? Contact PFA at speakers@pedorthics.org or call (703) 610-9035.
PFA Welcomes New Members in 2012

Thank you and Welcome! The Pedorthic Footcare Association is proud to recognize the following individuals who joined our association during the 2012 calendar year. We appreciate your commitment to educating, practicing and improving the pedorthic profession as we begin a new and exciting year in 2013!

- Linda Ainsworth
- Laura Allen
- Rose Amichand-Mohan
- Robin Anderson
- Joshua Bailey
- Ioan Banheghi
- Mark Bellanger
- Matthew J. Bertrand
- Timothy Brown
- R. Mario Calderone
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A Tale of Two Pathologies:
A New Case Study on Congenital Talipes Equinovarus (CTEV)

BY DEAN MASON, C. PED., OST, BOSCO, CO
At one time, a diagnosis of Congenital Talipes Equinovarus (CTEV) was a nearly impossible situation to manage based on the manifestation. The condition is commonly known as club foot as the deformity makes the leg and foot look like a club. CTEV manifests from mild varus position to a significant pathology that can result in an inability to walk or even stand. Since the 1960’s, CTEV for the most part, is a manageable condition, with the introduction of the Ponseti Method. Serial casting, tendon releases and other associated surgical procedures, Denis-Browne splints and foot orthoses have made poor results of this condition almost non-existent.

CTEV is one of the most common congenital structural foot deformities in children. Its presentation is of a plantarflexed, inverted, and adducted position of the foot. At the nadir of the deformity is the talar neck, which is positioned in varus and plantargrade. In general there are two recognized types: those who respond to strapping or casting, and the resistant types that require surgical correction. To a new parent, this presents a serious emotional issue. Every parent dreams of a healthy, normal delivery of their child; to a parent whose child has CTEV, it is a nightmare, even if of the simple variety.

There is a long history of treating this condition going back to the ancient Greeks. The condition was first described by Hippocrates and was treated with manipulation. Plaster was first used by Guerin in 1836. A wrench invented by Thomas was introduced for forced manipulation and is only mentioned in the literature for its historical value as it was regarded as too brutal for use. In 1930, Kite described a modified wedge plaster modality that is occasionally used to this day. Surgical procedures were introduced in 1792. We have come a long way.

This topic will be a series of articles that will appear here and in other media over the course of the next year, tracking two different patients with two manifestations of CTEV nearly fifty years apart. Both are of the resistant variety and there are two very different outcomes.

Our first and original patient Albert was born in 1950 with a rather severe form of CTEV. We have already met him in a previous article. Without successful correction, adulthood presents a serious pressure problem on the plantar surface. Pressures are maldistributed across the lateral border of the foot and presents as serious callosities, often painful. Such is the case of Albert.

Our second and newest patient, Tommy, was born...
in 2002, also with a significant manifestation of CTEV. I met Tommy through his mom, who is a nurse at a nursing home I was working in. What started as an evaluation of mom turned into a request that Tommy be seen and possibly helped with pedorthic modalities.

Once Tommy arrived, the CTEV was pretty obvious. His mom said that before Tommy was born, he did not kick as often as her first son did. She also felt discomfort in her lower ribcage during the pregnancy. In some cases of CTEV, the foot can get trapped about the mother’s ribcage. Many CTEV births have a much lower rate of movement with reference to activity in the uterus than normal births.

Within a short time after birth, Tommy was beginning the serial casting that is standard protocol for management. He went through many months of cast changes and positioning changes as the casts were reapplied. Since the human foot at birth is mainly composed of cartilage, the feet maintained their relatively normal positioning through the process. As he grew out of the protocol for serial casts, he was put into standard straight last shoes attached to a Denis-Browne splint. Again, this is standard treatment protocol.

As a refresher, the Ponseti Method, is a treatment developed by Dr. Ignacio Ponseti in the 1950s, and repopularized in 2000 by Dr. John Herzenberg and NHS surgeon Dr. Steve Mannion. This manipulative treatment of the CTEV deformity is based on the inherent properties of the connective tissue, cartilage, and bone, which respond to the proper mechanical stimuli created by the gradual reduction of the deformity.

The ligaments, joint capsules, and tendons are stretched under gentle manipulations. A plaster cast is applied after each manipulation to retain the degree of correction and soften the ligaments. The displaced bones are thus gradually brought into the correct alignment with their joint surfaces progressively remodeled yet maintaining congruency. After two months of manipulation and casting the foot appears slightly over-corrected.

After a few weeks in splints however, the foot looks normal.

It is important to remember that proper foot manipulations require a thorough understanding of the anatomy and kinematics of the normal foot and of the deviations of the tarsal bones in the clubfoot. Poorly conducted manipulations will further complicate the CTEV deformity. The non-operative treatment will succeed better if it is started a few days or weeks after birth and if the podiatrist and/or pedorthist understand the nature of the deformity and possesses manipulative skill and expertise in plaster-cast applications.

This method was employed in Tommy’s course of treatment. Things were looking like Tommy was going to have a normal foot. However, looks can be deceiving, and this proved true here.

The ossification of the bones in the foot as Tommy was in the 3-4 year range spelled the beginning of the problems he would encounter. His feet, never completely in the correct anatomic position, began to lapse back into equinovarus. He was taken to pediatric orthopedic surgeons who charted a course of surgical corrections that were part of the standard protocol. (The sequella of these procedures will be discussed in future articles). As the surgeries began piling up, their successes were called into question. Tommy’s parents were very concerned that their son would not run, play and grow up with normal gait. Tommy was taken to see Dr. Ponseti prior to his death, where he recommended that Tommy be seen at a Shriner’s Hospital. His parents did just that where more surgery were performed that transformed the equinovarus into a calcaneovalgus with a very mobile ankle mortise.

Walking became difficult as Tommy tired easily and there was a significant amount of pain and discomfort in the foot and ankle region. His mom was getting worried as Tommy became more and more sedentary. A child ten-years old is far too young to attain couch potato status.

This manipulative treatment of the CTEV deformity is based on the inherent properties of the connective tissue, cartilage, and bone, which respond to the proper mechanical stimuli created by the gradual reduction of the deformity.
While I was evaluating mom’s condition, she began talking about her son and his travails with doctors and orthotics. He has had plenty of devices over his young life, most of which were unable to restore stability, function and comfort to his feet. We have all had the experience of the “bog of orthotics” being dumped out on the floor when we see a patient who has been through it all. I had to visualize Tommy’s devices as his mom described them. Needless to say, my pedorthic juices began flowing and I was very anxious to meet this remarkable boy who wanted to walk. My chance would come about a week later.

My anticipation was of a very strange looking foot and an equally strange gait. Tommy’s look was nearly normal and the gait was really strange compared to others with CTEV. I was bound and determined to help this child out, especially to reach his goal to play soccer and do what every ten year old wants to do. No ten-year old should want to sit more than get out and play.

Some additional background information on Tommy needs to be mentioned. Tommy’s doctors have predicted that when he reaches adulthood, he will be six foot seven to six foot nine inches tall. Both mom and dad are very tall, and height runs in the dad’s family. His uncle is six foot seven with a size sixteen shoe. At present, he is in fourth grade and is the tallest boy in his class, and in most of the school. Because of his current height, people assume that Tommy is older. While he is very mature for his age, he still acts like a ten year old. It will be challenging for him to be in junior high and to be a child trapped into an adult sized body.

This is Tommy’s future. It is imperative that a suitable solution is found.

In the next installment, we will cover the similarities and differences in management from 1950 and 2002, as well as the technical details about surgery and management modalities. Stay tuned as we go through the year with Albert and Tommy and what pedorthics has done to improve their lives.


How The Ponseti Method is Applied to CTEV

Step 1:
The calcaneal internal rotation (adduction) and plantar flexion is the key deformity in CTEV. The foot is adducted and plantar-flexed at the subtalar joint, and the goal is to abduct the foot and dorsiflex it. In order to achieve correction of the CTEV, the calcaneum should be allowed to rotate freely under the talus, which also is free to rotate in the ankle mortise. The correction takes place through the normal arc of the subtalar joint. This is achieved by placing the index finger of the operator on the medial malleolus to stabilize the leg and levering on the thumb placed on the lateral aspect head of the talus while abducting the forefoot in supination. Forcible attempts at correcting the heel varus by abducting the forefoot while applying counter pressure at the calcaneocuboid joint prevents the calcaneum from abducting and therefore everting.

Step 2:
Foot cavus increases when the forefoot is pronated. If cavus is present, the first step in the manipulation process is to supinate the forefoot by gently lifting the dropped first metatarsal to correct the cavus. Once the cavus is corrected, the forefoot can be abducted as outlined in step 1.

Step 3:
Pronation of the foot also causes the calcaneum to jam under the talus. The calcaneum cannot rotate and stays in varus. The cavus increases as outlined in step 2. This results in a bean-shaped foot. At the end of step 1, the foot is maximally abducted but never pronated.

Step 4:
The manipulation is carried out in the cast room, with the baby having been fed just prior to the treatment or even during the treatment. After the foot is manipulated, a long leg cast is applied to hold the correction. Initially, the short leg component is applied. The cast should be snug with minimal but adequate padding. The person doing this procedure should paint or spray the limb with tincture of benzoin to allow adherence of the padding to the limb, or if preferred, apply additional padding strips along the medial and lateral borders to facilitate safe removal of the cast with a cast saw. The cast must incorporate the toes right up to the tips but not squeeze the toes or obliterate the transverse arch. The cast is molded to contour around the heel while abducting the forefoot against counter pressure on the lateral aspect of the head of the talus. The knee is flexed to 90° for the long leg component of the cast. The parents can soak these casts for 30-45 minutes prior to...
to removal with a plaster knife. The preferred method is to use the oscillating plaster saw for cast removal. The cast is bivalved and removed and then reconstituted by coating the 2 halves. This allows for monitoring of the progress of the forefoot abduction and, in the later stages, the amount of dorsiflexion or equinus correction.

**Step 5:**
Forcible correction of the equinus (and cavus) by dorsiflexion against a tight Achilles tendon results in a spurious correction through a break in the midfoot, resulting in a rockerbottom foot. The cavus should be separately treated as outlined in step 2, and the equinus should be corrected without causing a midfoot break. It generally takes up to 4–7 casts to achieve maximum foot abduction. The casts are changed weekly. The foot abduction (correction) can be considered adequate when the thigh-foot axis is 60°. After maximal foot abduction is obtained, most cases require a percutaneous Achilles tenotomy. This is performed in the cast room under aseptic conditions. The local area is anesthetized with a combination of a topical lignocaine preparation (e.g. EMLA cream) and minimal local infiltration of lidocaine. The tenotomy is performed through a stab incision with a round tip (#6400) Beaver blade. The wound is closed with a single absorbable suture or with adhesive strips. The final cast is applied with the foot in maximum dorsiflexion, and the foot is held in the cast for 2–3 weeks.

**Step 6:**
Following the manipulation and casting phase, the feet are fitted with open-toed straight-laced shoes attached to a Dennis-Brown bar. The affected foot is abducted (externally rotated) to 70° with the unaffected foot set at 45° of abduction. The shoes also have a heel counter bumper to prevent the heel from slipping out of the shoe. The shoes are worn for 23 hours a day for 3 months and are worn at night and during naps for up to 3 years.

**Step 7:**
In 10–30% of cases, a tibialis anterior tendon transfer to the lateral cuneiform is performed when the child is approximately 3 years of age. This gives lasting correction of the forefoot, preventing metatarsus adductus and foot inversion. This procedure is indicated in a child aged 2–2.5 years with dynamic supination of the foot. Prior to surgery, cast the foot in a long leg cast for a few weeks to regain the correction.
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It’s All About Trust.
Working With Pediatric Patients
BY ROB SOBEL, C. PED.

Pediatrics is a small percentage of the majority of pedorthic practices. This population, although small, has the potential to be the patients that we will see for the longest period of time. Your adult patients’ feet will change as well but not with the frequency of the pediatric patient. These patients can be challenging, especially if one tries to rush the process, and they do need to be treated somewhat differently. I will use a couple of my recent pediatric cases to illustrate certain points, both clinically and interpersonally. Patient names have been changed for purposes of confidentiality.

Sarah

The first order of business is to gain trust. This may start before the actual office visit. My patient “Sarah” is a shy 10-year-old with Arthrogryposis and a leg length discrepancy. After Sarah had the prescription but before the appointment was set, her mother grilled me as to who would be assessing her, who would be doing the work on the footwear and whether the individual(s) have the expertise to do the job. Sarah’s mom was very protective, as are many parents of children with disabilities or malformations of limbs. Do not be offended. Be honest and through your honesty, you will gain the parent’s trust. Sarah’s mom also asked if she could bring along Sarah’s physical therapist so we would all be on the same page. I had never had such an entourage for a shoe build up before, but anytime people can be introduced to pedorthics, “the more, the merrier.” The appointment was set, and I got to meet the lovely miss Sarah.
Gaining patient trust can include the following:

1. Start with a warm professional greeting and introduction to all in the treatment room. (It does not hurt if, like me, you genuinely like children.)

2. Do not jump right into taking the history or physical exam. Take a few moments to find out other very important things like their favorite color, their favorite class, their interests and whether they have a pet. Share yours with them; you are building trust.

3. Do the practitioners in your office wear lab coats? I do not; this can be scary for children and adults, too. (The dreaded “White Coat Syndrome”).

4. Schedule a longer-than-usual appointment when you see a new pediatric patient. It may take longer to gain their trust and allow an assessment, and getting a mold if orthotics are required.

5. Ask direct questions and give clear explanations to the patient and the parent. Make them a part of the process. It is, after all, all about them.

6. Acceptance is the next part of the process. Dealing with any patient, pediatric or adult, being fit for something they may deem “ugly and not wearable” can be a challenge.

For Sarah, acceptance was to be a 1 ¼” lift to her right shoe and a sandal. I assured Sarah and her mother that the lifts would be
It’s our job to stress the importance of compliance and to get everyone on board with the pedorthic treatment prescribed by the physician.

Contoured to limit the “orthopedic” appearance of the footwear. I also explained the sandal lift would be red and white to match the sandal. The physical therapist was also consulted as far as the rocker sole and adjusting it for Sarah’s line of progression. Everyone left the initial office visit satisfied. Upon delivery, both Sarah and her mother were very excited to see the results. This leads to the final part of the process — compliance.

Compliance is a huge part of the process. If the child refuses to wear the footwear or device(s), everyone loses. It is our job to stress the importance of compliance and to get everyone on board with the pedorthic treatment prescribed by the physician. If the pedorthic footwear or device(s) are “cool,” includes the patient’s favorite color or does not look “Frankenstein-esque,” then the chances of getting the patient to be compliant is greatly enhanced. I am glad to say Sarah was compliant, and I look forward to treating her for many years to come.

Pablo

My other recent patient, “Pablo,” was different. Pablo is an outgoing seven-year-old boy whose dad noticed he would often fall when running and described in his limited English a “foot slap.” Pablo’s Doctor of Podiatric Medicine (DPM) sent not only a prescription but a full-page exam and diagnosis sheet. His DPM diagnosed him with Ligamentous Laxity, Leg Length Discrepancy (LLD) and Internal Tibial Torsion. The prescription called for a pair of University of California-Berkeley Laboratory (UCBL) foot orthotics and extra depth shoes.

Gaining Pablo’s trust was uncomplicated, and the assessment went smoothly after giving him a retractable tape measure to play with. His father was interested in everything that was done, and Pablo liked the idea of taking home an imprint of his foot (one of the inked pressure mat sheets that I felt did not properly capture his foot). Because I was going to have to take a mold of Pablo’s foot, I was going to have to employ another process left out in Sarah’s visit — demonstration.

Demonstration is important because even with a child who seems to be okay with everything you are doing, you never know when something will spook the child. If it does, you have to start all over again to regain their trust. For Pablo this meant being able to press his finger into the corner of the foam impression box before his feet were to go in. Through this demonstration of how it feels, I let him become comfortable with the process and included him in his treatment. I also allowed him to play with the pediatric Brannock device while taking the impression. This did two things: It allowed him to get comfortable with the device before I applied it to his feet, and it also distracted him while I was taking the impression of his feet so I did not get “help.”

When Pablo came in for his orthotics, they were, as promised — his favorite color and a pair of white sneakers. Again, acceptance leads to compliance. Pablo and his father both had it explained to them in detail how the shoes and orthotics would help but that they only help if they are worn. I explained they may feel a little weird or feel like they push up in the arch but after getting used to them, it would go away.

The first follow-up visit revealed Pablo is semi-compliant. He is high energy and his mom told me at first he did not want to wear the shoes. Pablo’s parents had the good sense to keep on him to wear the shoes and orthotics. This is why it is so important to have the parents on board with the device(s) dispensed. Parents do not want their children to be uncomfortable and if the child is persistent, some parents will fold. The information they receive, though, will help them persevere in the healing process.

Summary

Keeping in mind there are a few tips that should help make the pediatric patient’s office visit faster, smoother and less stressful for all involved, including:

- Gain their trust;
- Explain everything;
- Demonstrate procedures before performing them;
- Acceptance of the device(s) is crucial; and
- Compliance by the patient and parent(s) is essential.

As a credentialed pedorthist who has had success with pediatric patients, I highly encourage you to educate yourself in this arena. When you are adequately armed with the knowledge and experience necessary, market to this population through referral sources. You’ll be doing your practice and your community a favor.
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Enthesopathy in Pedorthics

ARTICLE UPDATE BY MARGARET HREN, CURRENT PEDORTHICS STAFF CONTRIBUTOR

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This disease displays itself as a form of chronic inflammation where the tissue swells and becomes tender causing the tendons, ligaments or the articular capsule to the bone not to function as well as it should, causing an abnormal attachment.

The first time people hear of enthesopathy it is usually following an MRI. The term refers to a disorder of enthuses - bone attachments. Most often this condition is known to be inflammatory, or more precisely called an enthesitis. Enthesopathies are disorders of peripheral ligamentous or the muscular attachments. Examples include spondoarthropathy such as ankylosing spondylitis, plantar fasciitis, and Achilles tendinitis.

This disease displays itself as a form of chronic inflammation where the tissue swells and becomes tender causing the tendons, ligaments or the articular capsule to the bone not to function as well as it should, causing an abnormal attachment. The tissues may also start to break down as the body attacks the inflammation and the tissue becomes stretched and strained. Many people often develop inflammation because of injury, chronic stress, or autoimmune disease. Usually, the affected area becomes stiff and sore. Sufferers also can experience pain, heat, and tenderness.

When treating a patient with enthesopathy, it is important that you work alongside the patient’s primary doctor who has diagnosed the problem. They will have conducted a physical examination and medical imaging study of the involved area of the body, along with finding out how tender and swollen the patient is, along with other signs of inflammation, bone injury, and structural defects. This will help with determining what the problem is and how to create your plan of treatment.

In most cases with enthesopathy, sufferers are required to rest, allowing the inflamed tissue a chance to recover. The patient is often prescribed some gentle physical therapy during the resting period and after the recovery to build up strength and flexibility. Good physical therapy can help patients avoid future injuries, and may involve tips and tricks to teach patients how to use their bones and joints more safely. Braces and orthotics can play a big part in a treatment plan to provide support and assistance.

If you are working with a patient suffering from enthesopathy, keep in mind that there are medication that can be prescribed; drugs to manage inflammation and pain along with medications available to treat specific conditions. Sometimes injections like steroids are necessary if a patient experiences extreme pain and swelling. The goal is to prevent further injury to the soft tissue by minimizing the amount of inflammation at the site as well as the awareness that drug side-effects could hinder the use of certain orthotic devices.

The Physiological Roadmap of the Attachment of Tendon, Ligament and the Articular Capsule to Bone

When working with a patient who have an enthesopathy condition, it is important to remember the physical textbook-aspects of how the inflamed area should look and work. Think of this as a visual roadmap. The more you understand how that part of the body works, the greater success you will have in treatment.

The area where the attachment occurs to the bone is identified by four zones. Each of these zones gradually merges into adjacent zones. The furthest area from the bone is the first zone known as tendon proper. This consists of collagen fibers interspersed with fibroblasts or “tendon cells.” As you move closer to the bone, the tendon cells are more rounded and arranged in pairs with a continuation of collagen fibers into the second zone, known as fibrocartilage. Progressing towards the third zone, the tendon cells will increase in size and become vaculated, with its surrounding substance the size of crystallization with mineral deposits. Though the fibrocartilage fibers remain unchanged, as you move into the fourth and final zone, a dark, regular band lies at the junction of fibrocartilage and calcified cartilage. This is known as the cement line.
The important changeover from attachment of a tendon, ligament, or articular capsule to bone acts has a go-between by two tissues – fibrocartilage and its calcified counterpart. The diffusion of pressure is greatly minimized when tension absorptions are reduced when the connection is permitted to transmit stress equally to the area, rather than become injured by the pressure it is exposed to.

An example of this is with the Achilles tendon’s attachment to its corresponding bone, the os calcis. The Achilles tendon fans out at its insertion to the bone, and still expands at its proximal extension as a muscle. This type of broadening will effectively reduce the occurrence of stress and distribute the pressure more widely.

Physically, the enthesis or insertion is comprised of the attachment portion of the tendon; the attachment portion of the bone which is covered by the periosteum and any other structure, such as bursae, fibrous tissue, adipose tissue and sesamoid bones. The periosteum contributes to a firmer hold to the tendons and ligaments where they affix to the bone. These fibrous structures become built-in at their attachment, and are a direct continuation of the tendinous fibers.

It is good to remember that in the fourth zone, the cartilage layer adjacent to the bone is calcified and known as Yoshida’s Zone, which passes into the boney structure. These fibers are not calcified.

The Relationship Between Enthesopathies and Degenerative Disease of Bones and Joints

There is a simultaneous relationship between enthesopathies and degenerative diseases of bones and joints. It becomes an integral part in rheumatic diseases such as rheumatoid spondylitis. The capacity to elude new bone formation is lacking; therefore in rheumatoid spondylitis slackening of ligamentous tension occurs, giving a joint laxity. Also, joints do not develop stiffness and ankylosis.

In another condition such as Reizer’s Syndrome, a disorder in which insertion of tendons and facia become inflamed verified by bone scans, heel pain occurs in more than 50% of patients and calcaneal periostitis or erosions may be seen in x-rays. In addition, ‘sausaging’ or diffuse swelling of the toes is common and reflects combined articular and soft tissue involvement. Also in this Syndrome, the enthesitis of the calcaneous is at first destructive and erosive. The enthesitis is most often localized to the distal, superior surface of the oscalcis. The anthesis is often symmetrical.

In psoriatic arthritis, the calcaneal enthesitis is also seen,

A treatment plan should center on a few common goals to improve disorders of posture and gait, and to prevent contractures and eliminate the underlying cause of disease.

but the changes are often asymmetrical with less bone spur formation.

The relationship between enthesis and other associated metabolic enthesopathies are most evident when the enthesis is known as ochronosis. These are deposits of pigment in tendons and their intersections which may include the apatite crystals.

In articular chondrocalcinosis (pseudogout), calcium pyrophosphate dehydrate crystals are found in the cartilaginous structures or articular capsule. In podagra, or urate gout, tophaceous involvement of the Achilles tendon may produce erosive changes in bone.

Enthesopathies are often encountered in hyperparparathyroidism, both primary and secondary to hemodialysis; in hypoparathyroidism; osteomalacia, acromegalic arthoropathy and in paraplegic victims.

A treatment plan should center on a few common goals to improve disorders of posture and gait, and to prevent contractures and eliminate the underlying cause of disease. In acute entheopathies, such as gout inflammation or sports related injuries to the Achilles tendon insertion, intermittent and short-term immobility many be necessary in order to avoid development of contractures.

The local application of ice compresses are also beneficial. This should be supported with elevation of the part, rest and oral analgesics for pain and discomfort. For subacute or chronic enthesopathies, warm or hot compresses are effective. This is further supported with physical therapy involving whirlpool and ultrasound in an attempt to improve the local circulation and enhance healing.

Enthesopathies can become chronic, requiring a lifetime of management including rest, medications, gentle exercises, and other tactics to prevent flare-ups and further injuries. Beyond arthritic conditions, it has been verified over the last decade that even diabetics are sufferers of chronic enthesopathies, especially those that affect gait, knee, hip and ankle, which depending on age may benefit from an orthotic device to improve the mobility.
Pain on the top of your foot can be excruciating, making it difficult or impossible to walk even a few steps. Assuming there is no visible injury, and you can attribute the pain to falling, twisting your ankle, barefoot running, or dropping furniture on your foot, the cause could be anything from an ingrown toenail to gout. A podiatrist would have to do a thorough examination to determine the specific cause, but here are the most common reasons you might have pain in the top of your foot:

Nerve Entrapment – Your shoes have quite an effect on the health of your foot. Shoes that are too tight, including athletic footwear, can cause Nerve Entrapment – also known as a “pinched nerve”. Repeated pressure on one area irritates the nerve and can cause a surprising amount of pain. Ice, rest, and a change to less constricting footwear should resolve the pain.

Midtarsal Fault – The arches in your feet are meant to absorb the shock of running, walking, and standing. When the arches fall and you suffer with flat feet, the tarsal bones can become compressed, which leads to damaged joints, bone spurs, and irritation. The top of your foot may be slightly swollen, have red spots, and pain will increase with activity. Improper footwear is one of the main causes of this condition.

Metatarsal Stress Fracture – Stress on the metatarsal bones (the five long bones in the front of the foot) can cause tiny cracks in the bones. This is a very common injury for athletes, dancers, and those who return to exercising after a long layoff.

Extensor Tendonitis – The Extensor Tendons lie just under the skin on the top of the foot. Their job is to pull the toes up away from the ground, and when they become irritated, the pain can be excruciating and often confused with a fracture. The most frequent cause of this complaint is once again, footwear that’s too tight.

Other reasons for pain in the top of the foot may include bone spurs, sprain, a Ganglion Cyst, aging (arthritis), hammertoes, or gout.

Pain on the top of the foot could indicate a mild irritation to your nerves or tendons from tight shoes, or a more serious condition. If rest, ice, and over the counter anti-inflammatory medications do not relieve the symptoms, call your podiatrist for an immediate examination. They can help determine the cause of your pain and create a customized treatment plan for you.

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The Smaller The Patient,
The Smaller The Device for Treatment

BY DEAN MASON, C. PED., OST, BOCO, CO
Let’s admit it. In most of our pedorthic practices, we are most often treating adult patients facing pathologies and treatments usually developing from the onset of aging, disease or injury. These individuals are the most easiest and plentiful to treat, keep our practices busy and profitable. But too often we tend to overlook or avoid an entire population that has similar, yet different treatment needs.

Children … pediatrics … if you want to be more specific. It’s a population that fall in between the ages of newborn to eighteen, and we often forget they have pedorthic needs as much as the adults we treat. For many years, pediatric podiatry has been a hit or miss specialty. In the literature available to individuals practicing pedorthics, many of these cases were not actively pursued, since by the time a child reached adulthood, an estimated half of these cases would correct on their own without treatment. It also doesn’t help that insurance companies are also reluctant to cover pediatric cases based on this practice.

There are the obvious cases such as CTEV(club foot), hip dysplasia, avascular necrosis of the hip, Legg-Perthes disease and so forth which have always been treated. Rarely would you find doctors prescribing modalities to manage pes planus and pes cavus deformities, mostly because the ossification of the foot is not complete until the early teen years. Historically it was thought that time and resources would be wasted on a foot that may correct itself.

Since then, allied health providers, podiatrists and pedorthists have come to understand that many of the maladies that affect children are hereditary. There may have been hidden problems that never had a chance to manifest themselves as our ancestor’s life expectancy was half of what it is now. Flat feet, cavus feet, bunions, hammertoes, all have a genetic predisposition and tend to run in families. We have all seen an abnormally worn lateral heel on a child’s shoe and know that overpronation is the likely cause. Similarly, a wickedly twisted shoe or one with an upturned forefoot is indicative of an ankle problem and a shoe width problem respectively.

Speaking from experience, the sainted man who fit my shoes as a child had his work cut out for him. Being blessed with a foot one full size larger, a habit of overpronating, and the choice of a leather sole/rubber heel dress shoe made the task difficult. Thomas heels were a staple of shoes for me, and even those wore out fast. This was in the days before neoprene soling and accommodative uppers. There were shoes with widths, however, nothing like we have today.

Many retailers who carry children’s shoes are painfully aware of the needs of children. New mom’s and grandma’s know that they need “good shoes” for their child’s feet. That works pretty much until they need to graduate to young adult footwear.

A good example is a situation where a mom brought her second grade son into a store to return the school shoes she had bought him just a few weeks earlier. It was a boat shoe with no counter to speak of. The child had a foot like rubber, very flexible. Though he did not complain of foot pain and difficulty when he was running, it was noted that he fell during recess because the shoe “slid out from under him.” The problem wasn’t the shoe; it was the foot that was inside it. Foot problems are perhaps the biggest reason for returns in a retail store. Rarely is it the shoe that has the defect.

There are many customers who bring in the “fatty, fleshy, wide” toddler for fitting. You do your best because you are still working with a foot laden with cartilage. Children’s feet are generally very flexible and they don’t complain about minor foot issues the way an adult will.

A serious issue begins when the cartilage ossifies and the many articulations of the feet ossify. There are also issues with tendons and ligaments that are attaining their adult form. There are more than a few who have midtarsal coalitions that are unable to be seen on radiograph until much later, in which case there is surgery in their future.

All of health professionals who have dedicated their careers and practices to helping people with podactic problems, they should not be scared to take on a pediatric patient for any type of pedorthic correction. If anything, it is important to know that in our field of practice, there are many suppliers and manufacturers who specialize in treatments and treatment devices to assist the pedorthists, and shoe fitters with the task of helping “the little people” get the most out of corrective devices that focus on their changing physiology and even injury. If not treated correctly this will lead to problems later on as an adult.

Many may not be aware, but the pioneer in pediatric devices for foot, ankle and gait issues is The M.J. Markell Shoe Company. Founded in 1914 as a family shoe store in Brooklyn, NY by Maurice J. Markell, a podiatrist by training, he became the first store to begin specializing in comfort shoes, shoe corrections, and orthopedic prescriptions by 1918.

Focusing on a population that was in need of its own growing orthopedic market, Maurice Markell was an innovator in development and design. In 1932 and 1933, he first presented his new and original Tarso Supinator (inflare shoe), and Tarso Pronator (outflare shoe) at the national conventions of the American Academy of Orthopaedic Surgeons and the American Academy of Pediatrics. Shortly thereafter, he began advertising and wholesaling Tarso Shoes to shoe stores in other cities. These readymade therapeutic shoes for children in that era
was a fresh new concept, and their wide acceptance signaled an important advance in the care of children with valgus and varus foot disorders.

In 1953 The Markell Shoe Company relocated to Yonkers and became exclusively a wholesale business. By the 1950’s and in the 1960’s their most important products were still the Tarso Pronators for treatment of children with metatarsus adductus and corrected clubfoot, and Tarso Supinators for children with hypermobile and symptomatic flatfoot. By the late 1960’s and 1970’s, the use of straight lasted shoes and shoes with arch support features were also developed and offered as a pediatric pedorthic treatment device. It was also at this time that Markell began producing open-toe boots in both straight and reverse lasts for use on night bars, also known as Denis Browne splints.

It is the development of open toe boots and the Denis Browne bars that have emerged as their dominant product line coming into the 21st century. Today the standard of care for the treatment of clubfoot (talipes equinovarus) is the Ponseti Method. This method involves a series of long leg casts, followed by a percutaneous tenotomy of the Achilles tendon(s), and then bracing for up to 5 years. Open toe boots and some form of abduction bar or Denis Browne bar are integral to the Ponseti Method as a treatment device and in the maintaining of therapeutic correction.

There are many more companies and appliances on the market for children’s feet than ever before, especially with new technologies, materials and treatments available for pedorthists to utilize in their treatment programs for pediatric patients. Prefabricated foot orthoses are available in ever increasing numbers while Whitman plates are still on the market and rarely used as a treatment option. The advent of truly customized shells has opened up a new world of possibilities.

Tiny AFO’s are manufactured by several vendors, and many labs fabricate custom devices for children. Children have leg length discrepancies and need modifications to shoes. Many doctors still prescribe forefoot wedging, and you need to know how to apply these modalities. Sadly, some pediatricians tell parents of a child with pigeon toes to buy shoes and put them on the wrong feet. A lot of good a canvas shoe on the opposite foot will do to correct the problem, yet it happens.

It you are working a team approach with a pediatrician, the first thing they will tell you they have learned is that a child is not a miniature adult. Children have different needs than adults; they are not very patient, and squirm a lot. Children with developmental disabilities (DD) can make the process even more difficult. Many a shoe fitter has been kicked by a DD child while working with them, and it is even more difficult to make casts for this population.

However, providing good pedorthic care to a child with a foot deformity is a very heartwarming experience. When you take a child who is fairly sedentary, put them into the proper pedorthic modalities, and watch them walk or even run, you will find great instant gratification; the parents are ecstatic, and you even may see a few tears of joy shed.

Parents will do more for their child than they will do for themselves. For most parents, paying for your services is something they will do even if not covered by insurance. One of our largest problems is convincing doctors that pedorthic treatment can improve function and the child’s lifestyle. Most kids won’t complain about their feet, they just don’t use them as intended. Part of the pedorthic brand is marketing to all the populations that can use our services, children included.

There is hope for a change in the medical community. More and more physicians are taking children’s foot issues more seriously than they have in the past. This is a great step forward for the doctor, and especially their pediatric patient. It has long been our position that managing a foot condition from an early stage produces the best outcome for the patient. And isn’t a good outcome what we always seek?

Remember, going forward it will be increasingly important for manufacturers, pedorthists, orthotists, and doctors to work together as a team to treat, fit, educate, and advise parents and their children. Pedorthists have and will always continue to be an invaluable source of knowledge and expertise with respect to the proper footwear, fitting, and modification necessary to help both children and adults.

When you take a child who is fairly sedentary, put them into the proper pedorthic modalities, and watch them walk or even run, you will find great instant gratification; the parents are ecstatic, and you even may see a few tears of joy shed.
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There are medical problems that come with age that may start in the upper regions of the body, but their extensive collateral damage makes its way to the pedorthist’s area of expertise.
Working With an Aging Patient Population in Your Practice

BY ROB SOBEL, C. PED.

If one was to run a statistical analysis of their patient demographics, my guess is the majority of the readership here would find a greater percentage of geriatrics among their patients. There are certain aspects of dealing with this group of patients that make them unique. As pedorthists we are familiar with the normal foot issues these patients present with:

- Adult acquired flatfoot
- Arthritis, both osteoarthritis and rheumatoid arthritis
- Charcot foot
- Diabetes related issues
- PAD (peripheral arterial disease) and PVD (peripheral vascular disease)

These are just a few of the foot related issues that we deal with on a day to day basis, but there is so much more. We need to expand our view of just treating a patient with a single pathology, but seeing the patient as a whole person. There are medical problems that come with age that may start in the upper regions of the body, but their extensive collateral damage makes its way to the pedorthist’s area of expertise.

When a patient suffers a CVA (cerebrovascular accident) or stroke, the insult to the body originates in the head. However they may develop a drop foot requiring an AFO, a shoe that can accommodate said device, and a rocker sole. The patient who suffers an MI (myocardial infarction) or heart attack originating in the chest, may not recover well and have a decreased ejection fraction meaning the heart does not pump as efficiently as it once did causing the patient to retain fluid (edema) at their feet and ankles. This may require shoes that accommodate the edema and possibly compression hose.

There are certain things we notice about the geriatric patient that make caring for them a challenge. They move more slowly, are susceptible to falls, they may have some degree of hearing loss, their vision may not be as good as it once was, and they may become forgetful. Hearing loss and forgetfulness can be an issue when trying to obtain a history from the patient. So it may be helpful to have a family member in the room during the history taking process if the patient finds that acceptable.

Obtaining a history is one of the most important things we do, and taking the time to get an accurate history may save significant time later on. In my practice we see a large percentage of patients who have failed interventions by previous practitioners. In my opinion the majority of those failed interventions could have been avoided by the practitioner doing a more thorough exam, but more often by them taking a more accurate history.
Remember, ask those patients about their medical history, not just about diabetes for example. Take your time here, and get a thorough history; do not get mired in the “well in 1972 they removed my gall bladder.” Keep it pertinent, concise and to the point. The dialog may have to be redirected intermittently but keep it flowing. What medications do they take? What medicines are they supposed to take? These questions are similar, but not the same.

The geriatric patient may stop or change how they take their medications for a variety of reasons. Financial concerns (the donut hole) may cause them to stop taking one of their medications or cutting down the frequency they take them. Maybe the medications have a side effect that they find disagreeable.

An example of this is the patient who stops taking their diuretic because it makes them have to urinate frequently and that makes a day out even just to the doctor’s office a potentially embarrassing event. Sometimes when these patients stop a medication or change how frequently they take it, they do so without consulting their physician. Ask them if the doctor adjusted the amount of their medications recently, as an adjustment up or down with a diuretic will affect the edema at the foot and ankle. Ask them if they had a recent increase in edema, or “is the swelling they have today normal?” It may be the difference of a shoe that fits this week, but next week will be too big or too small.

Some of the common diuretics these patients may be on: Lasix, Furosemide, Bumex, Demadex, HCTZ, Dyazide, and Aldactazide.

Many of the medications these patients may be on are not without their side effects. These patients may be prone to episodes of lightheadedness especially when changing position from lying down or sitting to standing (postural hypotension), so give them a minute to get their balance and let their blood pressure catch up to their “altitude change.” Falls are bad, especially on your watch.

In 2010 there were 2.3 million non-fatal falls treated in emergency rooms, 662,000 required hospitalization, at a cost of $30 billion in the U.S. according to the CDC. Common injuries include fractures of the spine, hip, forearm, leg, ankle, pelvis, humerus, and hand. The 75 year old and up age group are four to five times more likely to be placed in a long term care facility after a fall.

The number one cause of traumatic death in the geriatric population (over 65 years old) is falls. There were 20,400 deaths due to falls in 2009 in the geriatric population. Falls are the leading cause of TBI (traumatic brain injury), and in the year 2000, 46% of fall fatalities were secondary to TBI. Why do geriatrics sustain such a high percentage of TBI, and why is it so often fatal? There are several reasons.

First, most elderly people do not move quickly. When they start to fall, their protective instinct to get their arms and hands out in front of them to prevent hitting their head on the ground either partially or totally fails. The brain also shrinks with age.

In comparing a CAT scan of an eighty-year old compared to one of a twenty-year old, there will be a slight gap between the skull and the brain of the eighty-year old’s; while the twenty-year old’s will show the brain taking up the whole cranial cavity. Subsequent impact of the head striking the pavement and then the brain striking the inside of the skull, creates a double threat. In addition to this, the blood vessels and connective tissues do not have the same resilience that younger tissues do, and they may be on anti-coagulants or “blood thinners”. Those medicines are intended to prevent a patient from a stroke or heart attack by preventing aggregation of blood cells.

Some common anti-coagulants are: Coumadin, Pradaxa, Warfarin, and Plavix. Over the counter medicines and vitamin supplements will have the same but lesser effect, like aspirin and fish oil capsules.

These patients do not all have to suffer from falls. Some other contributing factors include poor eye sight, poor range of motion, poor balance, and decreased leg strength. Keep in mind that as their fear of a fall grows, they are likely to limit their physical activity which will only add to the contributing factors.

Be a patient advocate. If there are signs that a geriatric patient is at risk, speak to their doctor about getting them in to see an exercise physiologist, or physical therapist for some leg strengthening, balance, and stretching exercises. If asked they will tell you that they have cataracts, glaucoma, or macular degeneration. Geriatric patients are not all frail, and many have some great tales to tell, take care of them, the whole patient, not just the feet. We can do so much more and still operate within our scope of practice.
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Managing Sesamoid Injuries

BY DR. THOMAS MICHAUD, DC

The word sesamoid is Latin for "sesame seed." These small bones are located inside specific tendons, where they improve mechanical efficiency by pulling the tendon farther away from the joint's axis of motion. (Figure 1).

The classic example of a sesamoid is the patella, which improves mechanical efficiency of the quadriceps by more than 50 percent.1

The foot also possesses important sesamoids. Located beneath the first metatarsophalangeal joint, the tibial and fibular sesamoids (also known as the medial and lateral sesamoids) are situated in the tendon of the flexor hallucis brevis muscle, where they are separated by a small groove on the plantar surface of the metatarsal head. These small sesamoids are invaluable during the gait cycle, as they increase force production beneath the great toe during the propulsive period, which greatly improves stability.

Unfortunately, because they are located in a weight-bearing area, the sesamoid bones of the feet, unlike the patella, are subjected to tremendous compressive forces. The most common cause of a sesamoid injury is the rigid plantarflexed first ray. This alignment pattern is present in approximately 14 percent of the population and is extremely common in people with high arches. (Figure 2) Treatment in this situation is to reduce pressure by incorporating a sub-one balance. (Figure 3) This balance can be made in-office simply by taking a 1/8-inch-thick piece of felt and cutting out a J-shaped balance, which is then attached beneath the shoe or sneaker insole. Pre-made sub-one balances can also be purchased and added to the shoe gear. (These balances are often referred to as dancer’s pads.)

Excessive compression of the sesamoids, particularly the tibial sesamoid, also occurs in people with extremely low arches. This being the case, the excessive rearfoot eversion drives the medial forefoot into the ground with a greater force, eventually confusing the medial sesamoid. Effective treatment in this situation often requires prescribing an orthotic to distribute pressure away from the sesamoid onto the medial arch.

Regardless of the cause, the flexor hallucis brevis muscle often responds to chronic sesamoid injury by reflexively tightening. Increased tension in the flexor hallucis brevis often worsens the...
sesamoid injury, as it pulls the sesamoid into the plantar first metatarsal head when the hallux dorsiflexes during propulsion. A similar situation occurs in the knee when chronic retropatellar pain increases quadriceps tightness: The increased tightness of the quadriceps muscle displaces the patella into the femoral condyles when the knee flexes.

In their two-year study of biomechanical factors responsible for the development of retropatellar pain, Witvrouw, et al., determined that quadriceps tightness was one of the best predictors of patellofemoral pain syndrome. In fact, quadriceps tightness played a more significant role in the development of retropatellar chronicity than a high Q angle and/or altered lower extremity alignment.

While most chiropractors are aware that deep-tissue massage and quadriceps stretches are invaluable for the treatment of chronic retropatellar pain, few practitioners evaluate tension in the flexor hallucis brevis muscle when treating chronic sesamoid injury. The presence of flexor hallucis brevis contracture is easily confirmed by evaluating non-weight-bearing dorsiflexion of the first metatarsophalangeal joint. (Figure 4)

When an asymmetrical range is present, tension in the flexor hallucis brevis muscle may be reduced by performing deep-tissue massage over the entire length of the muscle, followed with a gentle muscle energy mobilization. Because first metatarsophalangeal joint dorsiflexion is associated with superior glide of the proximal phalanx on the metatarsal head, this mobilization is performed by coupling long-axis distraction, hallux dorsiflexion, and superior glide of the proximal phalanx on a metatarsal head. (Figure 5).

When a tight flexor hallucis brevis muscle is responsible for limiting first metatarsophalangeal joint dorsiflexion, it is often possible to restore an additional 10 degrees of dorsiflexion within a few minutes of performing this mobilization. (This is significant, since surgical release of the plantar fascia has been proven to restore only 10 degrees of first metatarsophalangeal joint dorsiflexion.)

The patient almost always reports that the mobilization is comfortable; if it produces anything more than mild discomfort, the possibility of a sesamoid fracture and/or tendon injury should be considered and the appropriate diagnostic tests ordered. Home care is recommended and the patient is instructed to massage the flexor hallucis brevis muscle prior to performing the stretch illustrated in Figure 6. By incorporating in-office treatments and home mobilizations, full range of first metatarsophalangeal joint dorsiflexion can usually be restored within 4-6 weeks.

Just as the restoration of quadriceps flexibility is essential for comprehensive rehabilitation of retropatellar pain, improving flexibility of the flexor hallucis brevis muscle is essential when treating chronic sesamoid injury. By coupling manual therapy to restore motion with orthotic intervention to distribute pressure, even the most recalcitrant cases of sesamoid pain often have excellent outcomes.

References


Symposium 101

What Does It Take To Put-On The Greatest Show Around?

BY: MARGARET HREN, CURRENT PEDORTHICS STAFF CONTRIBUTOR
Consider this common scenario. You receive in the mail your yearly invitation to attend a yearly professional conference located somewhere close to home or off in a distant city. The conference as always, offers you the opportunity to immerse yourself in educational information and new opportunities featuring the latest in treatments and technologies sure to help improve your practice and professional skills. Better yet, there is the opportunity to meet up with old friends and colleagues you haven’t seen face to face in a while. It’s a great excuse to get away from the daily routine you have fallen into and recharge your professional batteries.

As you’re reading further into the details, you realize that the location is a well known US city, but small compared to other cities you would assume as a first choice, especially if you could pick the location, to hold the conference. And, hotel accommodations? Wow, it seems ridiculously high when you add it together with a conference fee that might have gone up slightly since the previous year.

As a potential conference attendee, you’ll either become excited and positive about the upcoming conference and sign-up right away, or possibly feel a bit frustrated because you can’t understand the logic of why your professional association isn’t considering a bigger city, a cheaper hotel or a more reasonable expense to attend.

If you haven’t planned a professional conference, even the size of PFA’s Annual Symposium and Exhibition, it may come as a surprise that there is a true logic and science in planning and executing professional conferences. From the selection of the location, hotel accommodations, travel and transportation needs, speaker recruitment, catering and menu planning, signage, registration, shipping and freight, volunteers and even promotional materials, each detail is looked at, budgeted and re-budgeted before the first attendee goes online to register.

As the saying goes, “it takes a village,” so too can this sum up what it takes to put on the ‘greatest show around.’

Deciding on Potential Locations

When selecting and booking a conference, associations are planning, selecting, contracting and finalizing locations at least two to three years out from the actual date of the event. It can take up to a full year before the actual execution of a conference takes place to find a location that will meet the conference’s needs and work within the estimated preliminary budget approved by the board of directors. These numbers are based on averages taken from previous conferences. Many associations hire an events management company to help take care of all the details in researching out potential locations, sending out requests for bids and then collecting and compiling all the pertinent information to assist your board of directors in making a decision of where you will hold your conference.

When deciding potential locations for a conference there are at least two things that are big factors in consideration the cities you will request to submit bids to hold your conference:

1. Potential Number of Attendees. When deciding on which cities to consider for a conference, the first questions your organization will always be asked is “How many people will be attending?” Many cities that are equipped to handle conferences of various sizes, have either one or more conference center locations available either as a convention center setting or conference accommodations in one or more hotels and non-hotel locations. Available hotel accommodations in/or surrounding the conference venue are also a big consideration as well. It is important to note, large, medium and small cities across the US are actually tiered in regards to their popularity and even the number of attendees they can handle. Cities that are the most popular say for example Las Vegas or Chicago, will cost more because of their popularity. In all cases, conference cities will require a guaranteed number of attendees or minimum number...
SYMPOSIUM 101: PART 1 - WHAT DOES IT TAKE TO PUT ON THE GREATEST SHOW AROUND

If you haven’t planned a professional conference, even the size of PFA’s Annual Symposium and Exhibition, it may come as a surprise that there is a true logic and science in planning and executing professional conferences.

attendees to offer a certain rate for space and hotel discounts. However, with minimums and guarantees, if you do not book the number of attendees stipulated in your agreement, or have a date to decrease your guaranteed number, your organization will be penalized and required to pay the difference or a percentage for default.

2. Time of Year. The time of year and the city you are deciding on where to have a conference will be a big factor in determining where and when to hold your conference. Rates can fluctuate from city to city, and depending on the time of year can be a peak season depending on the city, allowing for hotels and conference centers to charge higher rates. An example would be Miami. Miami will charge a lot in the Winter, but not a lot in the Summer. Place like Boston and Chicago still charge high rates in the Fall because it is a peak time for them, versus winter. Washington DC is not too high in the Spring but is in the Summer and Fall during their peak tourist season. Selecting a location is very seasonal and each city has its high peak and low peak times.

But even a smaller conference can sometimes afford popular big city costs. There are instances larger groups and even smaller groups like PFA are able to take advantage of receiving a remarkable rate in what is considered a top tier city. Sometimes a conference that has booked in advance on the dates you originally wanted may cancel. In these cases, timing can be lucky and you can book your smaller conferences for a more affordable rate if offered.

Putting Together a Working Budget and Timeline.

Once the decision has been made where your association’s conference will be held, the next step in planning will be in the other costs associated with finalizing the budget costs estimates and a timeline reflecting the steps and individual tasks needed to be proficient in making sure your conference is up and running when the first attendee walks through the door that very first day.

1. Food and Beverage Costs. This is a huge part of your conference costs and budget, and fluctuates from location to location. Based on the number of days the conference will run, you have to work with the catering office at the conference location to create an appetizing menu with enough food to feed all your attendees, and keep your costs reasonable.

Along menu varieties, you have to calculate in the number of attendees, how many and what type of meals – breakfast, lunch, coffee breaks, etc. are needed each day. Also dietary need to be taken into consideration. Tricks to passing on saving to attendees is to offer a variety of dining options throughout the conference; maybe have a box lunch one afternoon, and the next a theme buffet which can help keep costs in line.

Sometime attendees wonder why a coffee service is not always available in-between workshops and only during breakfast in the morning. This item alone is a great example in food cost management.

Depending on the city, a gallon of coffee at a potential conference venue is available for $75-$100/gallon. If you have 400 attendees each drink two-8 ounce cups of coffee during one break, you are looking at 50 gallons of coffee needed to be served. At $75/gallon, the total cost for the coffee is $3,750; but this doesn’t include the costs of cups, condiments and staff to set-up and serve. Without adding in those incidental costs, the coffee itself is $4.69 per 8-oz. cup which ends up being $9.38 per 400 attendees! This is one reason alone that many conferences have switched to ice water and bottled drink stations.

2. Audio/Visual Equipment. It takes numerous people beyond the conference location to supply enough audio visual equipment and other technologies to help a conference run smoothly. From logistic set-up, feeds into meeting rooms, the exhibition hall, individuals running the behind the scene sound and lighting, and hand held contacting devices beyond a cell phone, it takes a small army to make sure everything is not only set up on time, but is working properly and if something goes down, someone is there to fix it right away. This is also an area that is contracted out to keep costs down and reasonable.

3. Timeline. From the time a venue is selected, the team planning the conference will put together a working timeline and staging guide with dates to help keep the execution of the conference on track and working in a timely and level manner. Logistics, marketing, speakers, registration and other areas, are tasked and planned out in detail with both start and target completion date to make sure nothing is forgotten or overlooked. This will also include a site visit by the conference staff and some of the board of directors to help plan the layout of the conference workshops, exhibit hall and other rooms available for special use.

For now, this is just the tip of the iceberg when it comes to planning a conference. In part two, we will take on what goes into marketing a conference, travel and hotel accommodations and developing a registration process. As we said before, it takes a small village to put on a professional conference, and we want to make sure you get the most out of your conference experience in the future.
ABC Names Timothy E. Miller, CPO New President

The ABC Board of Directors announced on December 1, 2013 that Timothy E. Miller, CPO, will assume the role of President. As part of ABC’s annual leadership transition, Miller takes over the presidency from Donald D. Virostek, CPO of Dallas, Tex. Virostek will continue to serve ABC as Immediate Past President.

“Tim has shown a commitment to ABC over the past 20 years while serving on various ABC committees and has been instrumental in many aspects of leadership associated with the ABC exams,” said Virostek. “With all of his professional experience, Tim will be an exceptional leader for all of ABC’s programs.”

Miller has served as an orthotic, prosthetic and technician examiner, exam team member, chair for several ABC exam and certification committees, and has written key components of the written and written simulation exams. He joined the ABC Board of Directors in December, 2008. Since then, Miller has played a role in creating many of ABC’s current policies and brings with him over 30 years of experience working in the orthotic and prosthetic profession. “Tim has been an eager and invaluable volunteer for ABC for many years. I look forward to working with him as he serves as President of the board and initiates programs that keep our mission relevant and contemporary,” said Catherine Carter, ABC’s Executive Director.

Miller received his bachelors from Iowa State University and attended Northwestern University for his orthotic and prosthetic education. He earned his Certified Prosthetist/Orthotist credential from ABC in 1992.

ABC Board of Directors Transitions into the New Year

ABC announces the transition of its Board of Directors for 2013. At its September 4th meeting in Boston, Mass., the board elected two new members and bid farewell to three retiring members. James H. Wynne, CPO, FAAOP was elected Secretary Treasurer of the board and joins fellow Executive Committee members Curt A. Bertram, CO, FAAOP, President Elect, Donald D. Virostek, CPO, Immediate Past President and Timothy E. Miller, CPO, President. Those members joining the ABC board December 1 are Dennis W. Dillard, C.Ped., CTO and Eric Ramcharran, CPO.

Dennis W. Dillard, C.Ped., CTO of Hanna City, Ill. has been volunteering with ABC for many years and currently serves on the Facility Accreditation Committee and is Chairperson of the ABC Pedorthic Exam Team. Dillard is also Vice Chairperson for the State of Illinois Orthotics, Prosthetics and Pedorthics Board, which advises the Illinois Department of Professional Regulation on matters pertaining to discipline, licensing and standards of practice. Dillard completed his pedorthic education at the University of Oklahoma, Okmulgee and currently works for Comprehensive Prosthetics and Orthotics in Peoria, Ill. “I am proud to be a part of ABC, both as a pedorthist and a technician,” commented Dillard. “Over the last few years, serving on various committees of this cutting edge organization has been an enjoyable and rewarding experience. I look forward to serving on the ABC board and being able to contribute to ABC’s mission.”

Eric Ramcharran, CPO of Tallahassee, Fla., is a second generation practitioner and comes to ABC with a great deal of experience working in the orthotics and prosthetics profession. Ramcharran has volunteered for several years as an exam site coordinator and Clinical Patient Management prosthetics examiner and committee member. He completed his orthotic and prosthetic education at the University of Texas Southwestern Medical Center and currently works for Hanger P&O as an Area Clinical Manager. Ramcharran has also participated in several humanitarian projects providing services to both Mexico and Haiti. “If it wasn’t for the orthotic and prosthetic profession,” said Ramcharran, “I would have never had the opportunity to live and grow up in the United States. Simply put, this profession has given me my entire life. I am so honored and humbled to be on the ABC Board of Directors.”

Those members retiring from the ABC Board of Directors include, John (Mo) Kenney, CPO, FAAOP, Donald L. Pierson, Jr., CO, C.Ped. and Charles H. Dankmeyer, Jr., CPO. These individuals have spent many years serving ABC and are leaving having made numerous contributions to the organization.

“ABC is very fortunate to have dedicated and hardworking volunteers such as the three members leaving the board this year. I am grateful for the leadership and guidance they have provided throughout their board tenure,” says Catherine Carter, Executive Director of ABC.

John (Mo) Kenney, CPO, FAAOP of Nicholasville, Ky. initially became involved with ABC as a volunteer and joined the ABC Board in 2003. In 2010, Kenney served as ABC Board President and played a major role in creating many of ABC’s current policies throughout his time on the board. Kenney received his bachelors from Emory University and attended Northwestern University for his orthotic and prosthetic training. He earned his Certified Prosthetist/Orthotist credential from ABC in 1995 and has gained over 17 years of experience working in the orthotic and prosthetic profession. Today, Kenney owns and operates four O&P facilities and his company, Kenney Orthopedics, has been involved in several humanitarian ventures over the years. Kenney reflected on his
time with ABC, stating, “It has been my highest honor to have served on ABC’s board. In the last nine years, I have seen many changes in our profession. Through it all, ABC has maintained the highest standards and a strong focus on patient care.”

Donald L. Pierson, Jr., CO, C. Ped. of Mesa, Ariz. joined the ABC Board of Directors in December 2008, has served as board liaison for the ABC Facility Accreditation Committee and has been a key voice representing the pedorthic and central fabrication aspects of the profession. Pierson also played an integral role during the integration of the Board of Certified Pedorthists (BCP) with ABC, serving as liaison to ABC for the BCP Board of Directors. Pierson began his career as an orthotic technician, quickly working his way to becoming a certified pedorthist and orthotist. Currently Pierson is Vice President of Operations for Arizona AFO, a central fabrication company in Mesa, Ariz. “I began in this profession as an ABC orthotic technician over 28 years ago,” said Pierson. “I never, ever imagined that I would have the opportunity to serve on the ABC board. I was able to get to know and learn from my fellow board members who are not only leaders in the profession, but such top quality folks for whom I have much respect.”

Charles H. Dankmeyer, Jr., CPO of Arnold, Md. began volunteering with ABC shortly after completing his orthotic certification in 1969. Over the years, Dankmeyer has served as an ABC examiner, Orthotic Exam Development Committee member and Chair of the Orthotic Exam Team. He was elected to the ABC Board of Directors in 1974 and served as President of the board from 1976-77, during which he also played integral roles in helping ABC lobby congress for the funding of O&P schools and the development of ABC’s Facility Accreditation Program into the practice evaluation tool it is today. “ABC’s role has expanded significantly to identify and include areas of O&P that were orphans only a few years ago,” remarked Dankmeyer. “Today, ABC’s growth and expansion have made it a large organization with a staff and directors to manage each department. Without their work, we would not have a profession to identify. As someone once said, ‘when you are through changing, you are through!’”

PW Minor Announces New Sales Support Structure

In their continuing efforts to provide superior customer service and sales support, pw minor is establishing a new, company employed, in-house sales group. This new, dedicated sales group will work more closely with their key accounts and provide increased coverage and responsiveness. Mr. Jim Domrowski and Ms. Beth Crane have already taken over three western territories, and Mr. Drew Gallagher will start on January 2, 2013, with current independent sales territories to be reassigned to this three person team. Ms. Crane will continue to work as the supervisor of their Sales & Service Team. Everyone on these sales teams will report to EVP, Andy Simonds.

PW Minor has also committed to attending and displaying at several additional trade shows over the next year. Please look for them, and their reps, at Platform, the Atlanta Shoe Marketplace and MedTrade, as well as the regional rep shows. They will also explore other show opportunities as they develop.

To round off a truly new start to 2013, pw minor is also developing a new business-to-business website that will provide dealers with product availability, online ordering and tracking, new product intro videos and literature, and enhanced marketing support. This will be a welcome and robust addition to their dealer support efforts. This website is scheduled go live in the first half of 2013.

Foot Solutions Founder Raymond Margiano Inducted to the Entrepreneurship Hall of Fame

Raymond Margiano, the founder of Foot Solutions and Balance Walking, was recently inducted into the Entrepreneurship Hall of Fame. Margiano was awarded the Veteran Entrepreneur Award as a result of his more than 25 years experience founding and leading four successful businesses. According to Margiano, “Entrepreneurs don’t talk about it, they do it. All entrepreneurs are driven by a burning passion, they see a vision so clearly even though everyone else does not, it’s in their DNA.”

Margiano first branched out from the corporate world to start his own business in 1984; since that time he has founded four different companies including two international franchise companies, now in more than 40 countries. These companies, including Foot Solutions and Heel Quik, have generated approximately $200 million in total sales and have helped over a thousand individuals to open their own businesses, creating more than 5,000 jobs.

The new Balance Walking, Margiano’s recent concept, is a simple 15-minute a day program that improves the way a person looks and feels. He began the Balance Walking movement to help everyone lead a fuller more active lifestyle, and is targeting to have one million Balance Walkers over the next two years.

Margiano is also involved in a number of non-profit organizations, including Susan G. Komen, American Diabetes Association, Arthritis Foundation, International Council on Active Aging (ICAA), and Soles4Souls. In 2010, he
was named the Vetrepreneur of the Year and since that time focused on helping veterans transition into training programs, jobs, and business opportunities. He is also involved with a number of Wounded Warrior programs and initiatives.

The Atlanta-based Entrepreneurship Hall of Fame & Museum (EHOF) is the premier destination to recognize and celebrate the major contributions to the world by the greatest entrepreneurs in history. It will also be the epicenter for studying and teaching entrepreneurship, especially to our youth. Foot Solutions is a leading international retailer of properly-fitting, comfortable, high-performance shoes, custom inserts and technology-driven health and wellness products to consumers across the globe. With more than 175 stores in 13 countries, Foot Solutions is the world’s largest health and wellness franchise dedicated to foot care.

**ABC Releases Assistant and Therapeutic Shoe Fitter Practice Analyses**

ABC recently released the first practice analyses of both the ABC Certified Assistant and Therapeutic Shoe Fitter credentials. ABC’s Practice Analysis Task Force and ABC Executive Director, Catherine Carter, worked with Professional Examination Services to create and implement practice analyses of these important professions.

The strategy for both surveys included a validation study to determine current trends in patient care, technology and practice management in both the orthotic and/or prosthetic assistant profession and the provision of therapeutic shoes by ABC certified individuals. “We wanted to get an idea of what these practices look like in order to meet the ever changing needs of the profession,” said Steven R. Whiteside, CO, FAAOP, and ABC’s Practice Analysis Task Force Chair. “We were very pleased with the positive responses we received from the professionals surveyed.”

The overall response rate for both surveys was very high, with 32% for the assistant survey and a response rate of 31.5% for the therapeutic shoe fitter survey, both very high response rates for this type of survey. “The professionals who participated in these surveys provided a great service to their profession,” said Whiteside. “Only those working within the profession can give us a comprehensive and contemporary look into their specific knowledge and skill sets.”

ABC will use the results of the practice analysis surveys to assure that its assistant and therapeutic shoe fitter credentialing exams are continually relevant for individuals entering these professions. The results will also be used to identify specific topics for in-service and/or continuing education programs, as well as provide guidance for education providers in regard to curriculum review and/or program self-assessment.

A complete copy of both the Practice Analysis of ABC Certified Assistants in the Disciplines of Orthotics and Prosthetics and the Practice Analysis of ABC Certified Therapeutic Shoe Fitters are available at www.abcop.org.

<table>
<thead>
<tr>
<th>Words</th>
<th>Member</th>
<th>Non-Member</th>
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</thead>
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<tr>
<td>50 or fewer words</td>
<td>$25</td>
<td>$45</td>
</tr>
<tr>
<td>51-75 words</td>
<td>$45</td>
<td>$65</td>
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<tr>
<td>76-150 words</td>
<td>$65</td>
<td>$125</td>
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The following rates are calculated by counting complete words. (A telephone number is counted as a complete word.)

To place a classified ad, email margaret@pedorthics.org, send a fax to (202) 367-2145, or mail to Pedorthic Footcare Association, ATTN: Current Pedorthics, 2025 M St., NW, Suite 800, Washington, DC 20036.
Fifth Quarter Results of Widespread Prepayment Review of Claims for Therapeutic Shoes (HCPCS A5500)

Current Review Results

The Jurisdiction D DME MAC Medical Review Department is conducting a widespread complex review of HCPCS code A5500. The fifth quarter edit effectiveness results from September 2012 through November 2012 are as follows:

The A5500 review involved 2178 claims of which 1950 were denied. This resulted in an overall error rate of 90%.

Primary documentation errors that resulted in denial of claims

- 26% of A5500 claims received a denial as Criterion 2 was not met per Policy Article (PA) A37076:

  In order to meet criterion 2, the certifying physician must either:
  
g. Personally document one or more of criteria a – f in the medical record of an in-person visit within 6 months prior to delivery of the shoes/inserts and prior to or on the same day as signing the certification statement; or
  
h. Obtain, initial/sign, date (prior to or on the same day as signing the certification statement), and indicate agreement with information from the medical records of an in-person visit with a podiatrist, other M.D or D.O., physician assistant, nurse practitioner, or clinical nurse specialist that is within 6 months prior to delivery of the shoes/inserts, and that documents one of more of criteria a – f.

  Note: The certification statement is not sufficient to meet the requirement for documentation in the medical record.

- 20% of A5500 claims received a denial as Criterion 3 was not met per PA A37076:

  There must be documentation to support that the certifying physician has documented in the patient's medical record one or more of the following conditions:

  a. Previous amputation of the other foot, or part of either foot,
  b. History of previous foot ulceration of either foot, or
  c. History of pre-ulcerative calluses of either foot, or
  d. Peripheral neuropathy with evidence of callus formation of either foot, or
  e. Foot deformity of either foot, or
  f. Poor circulation in either foot;

  a. Have an in-person visit with the patient during which diabetes management is addressed within 6 months prior to delivery of the shoes/inserts; and
  
b. Sign the certification statement (refer to the Documentation Requirements section of the related Local Coverage Determination) on or after the date of the in-person visit and within 3 months prior to delivery of the shoes/inserts.

  Note: Per Policy Article A37076 the Certifying Physician is defined as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is responsible for diagnosing and treating the patient's diabetic systemic condition through a comprehensive plan of care. The certifying physician may not be a podiatrist, physician assistant, nurse practitioner, or clinical nurse specialist.

- 8% of A5500 claims received a denial as there was no documentation from the supplier to support an in-person visit at the time of delivery per Local Coverage Determination (LCD) L157 and PA A37076:

  There must be documentation from the supplier to support an in-person visit at the time of delivery. The supplier must conduct and document an in-person visit with the patient. The in-person evaluation of the patient by the supplier at the time of delivery (refer to related Policy Article, Non-Medical Necessity Coverage and Payment Rules, criterion 5) must be conducted with the patient wearing the shoes and inserts and must document that the shoes/inserts/modifications fit properly.

- 7% of A5500 claims received a denial as there was no documentation from the

Historical Data of the Error Rate for A5500 Review
supplier to support an in-person visit prior to selection of the item billed per Local Coverage Determination (LCD) L157 and PA A37076:

There must be documentation from the supplier to support an in-person visit prior to selection of the item billed. Prior to selecting the specific items that will be provided, the supplier must conduct and document an in-person evaluation of the patient. The in-person evaluation of the patient by the supplier at the time of selecting the items that will be provided must include at least the following:

1. An examination of the patient’s feet with a description of the abnormalities that will need to be accommodated by the shoes/inserts/modifications.
2. For all shoes, taking measurements of the patient’s feet.

For custom molded shoes (A5501) and inserts (A5513), taking impressions, making casts, or obtaining CAD-CAM images of the patient’s fee that will be used in creating positive models of the feet.

**Education resources**

It is important for suppliers to be familiar with the documentation requirements and utilization parameters as outlined in the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination (LCD) L157 and Policy Article A37076.

Suppliers can also review specific policy resources for Therapeutic Shoes for Persons with Diabetes on the NAS website at https://www.noridianmedicare.com/dme/coverage/resources/therapeutic_shoes_for_persons_with_diabetes.html. There, you will find, information related to proper documentation requirements including a physician letter, documentation checklists, FAQs, and a presentation used during Web-based workshops.

Noridian Administrative Services’ provides educational offerings by scheduling for supplier workshops, training opportunities, and presentations. Educational training and events are located at https://www.noridianmedicare.com/dme/train/index.html#tools.

Information about probe/error validation reviews may be found in CMS Publication 100-8, Program Integrity Manual (PIM), Chapter 3 located at: http://www.cms.gov/manuals/downloads/pim83c03.pdf

**HHS OIG Find That Improvements are Needed at the Administrative Law Judge Level of Medicare Appeals**

The U.S. Dept. of Health & Human Services’ Office of the Inspector General (HHS OIG) conducted this study because Administrative law judges (ALJ) within the Office of Medicare Hearings and Appeals (OMHA) decide appeals at the third level of the Medicare appeals system. In 2005, among other changes, ALJs were required to follow new regulations addressing how to apply Medicare policy, when to accept new evidence, and how the Centers for Medicare & Medicaid Services (CMS) participates in appeals. Medicare providers and beneficiaries may appeal certain decisions related to claims for health care services and items.

The HHS OIG found that providers filed the vast majority of ALJ appeals in FY 2010, with a small number accounting for nearly one-third of all appeals. For 56 percent of appeals, ALJs reversed QIC decisions and decided in favor of appellants; this rate varied substantially across Medicare program areas. Differences between ALJ and QIC decisions were due to different interpretations of Medicare policies and other factors. In addition, the favorable rate varied widely by ALJ. When CMS participated in appeals, ALJ decisions were less likely to be favorable to appellants. Staff raised concerns about the acceptance of new evidence and the organization of case files. Finally, ALJ staff handled suspicions of fraud inconsistently.

The HHS OIG recommended that OMHA and CMS: (1) develop and provide coordinated training on Medicare policies to ALJs and QICs, (2) identify and clarify Medicare policies that are unclear and interpreted differently, (3) standardize case files and make them electronic, (4) revise regulations to provide more guidance to ALJs regarding the acceptance of new evidence, and (5) improve the handling of appeals from appellants who are also under fraud investigation and seek statutory authority to postpone these appeals when necessary. Further, the HHS OIG recommend that OMHA: (6) seek statutory authority to establish a filing fee, (7) implement a quality assurance process to review ALJ decisions, (8) determine whether specialization among ALJs would improve consistency and efficiency, and (9) develop policies to handle suspicions of fraud appropriately and consistently and train staff accordingly. Finally, they recommend that CMS: (10) continue to increase CMS participation in ALJ appeals. OMHA and CMS concurred fully or in part with all 10 of our recommendations.

To view the full HHS OIG report, visit PFA’s website at www.pedorthics.org and click to the Information for DMEPOS Suppliers section.
Toe Fillers and Diabetic Shoe Inserts - Coding Clarification

The Jurisdictional DME MACs have provided the following guidance in response to questions that have recently arisen about the correct coding for shoe inserts used to accommodate missing digits (toes) on feet for beneficiaries with and without diabetes. These items fall under two separate benefit categories and use two distinct Healthcare Common Procedure Coding System (HCPCS) codes, L5000 and A5513.

**Beneficiaries without Diabetes**

Shoe inserts for beneficiaries with missing toes or partial foot amputations who are not diabetic are considered for coverage under the prosthetic benefit. Code L5000 is described by:

L5000 - PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER

These items fall under two separate benefit categories and use two distinct Healthcare Common Procedure Coding System (HCPCS) codes, L5000 and A5513.

As noted in the descriptor, code L5000 describes a shoe insert with a rigid longitudinal arch support that also incorporates material accommodating the void left by the missing digit(s) or forefoot. Additional soft material is added where contact is made with the residual limb/toes. For beneficiaries missing digits, particularly the hallux (great toe), or the forefoot, L5000 inserts are designed to provide standing balance and toe off support for improved gait. The biomechanical control required of L5000 differs from the foot-protective function provided by inserts used as part of diabetes management.

For beneficiaries who are non-diabetic and require accommodation of missing foot digit(s) or forefoot, suppliers must only bill code L5000. Codes A5512 and A5513 describe inserts used with therapeutic shoes provided to persons with diabetes (see below) and must not be billed for non-diabetic beneficiaries.

**Beneficiaries with Diabetes**

A separate benefit category allows Medicare coverage of therapeutic shoes and inserts for persons with diabetes. Shoe inserts for persons with diabetes are described by the codes below:

A5512 - FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, DIRECT FORMED, MOLDED TO FOOT AFTER EXTERNAL HEAT SOURCE OF 230 DEGREES FAHRENHEIT OR HIGHER, TOTAL CONTACT WITH PATIENT’S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 1/4 INCH MATERIAL OF SHORE A 35 DUROMETER OR 3/16 INCH MATERIAL OF SHORE A 40 DUROMETER (OR HIGHER), PREFABRICATED, EACH

A5513 - FOR DIABETICS ONLY, MULTIPLE DENSITY INSERT, CUSTOM MOLDED FROM MODEL OF PATIENT’S FOOT, TOTAL CONTACT WITH PATIENT’S FOOT, INCLUDING ARCH, BASE LAYER MINIMUM OF 3/16 INCH MATERIAL OF SHORE A 35 DUROMETER OR HIGHER), INCLUDES ARCH FILLER AND OTHER SHAPING MATERIAL, CUSTOM FABRICATED, EACH

For a beneficiary with diabetes missing digit(s) or a forefoot, suppliers have two options for billing inserts:

Option 1: For diabetic beneficiaries who do not require the rigidity and support afforded by code L5000 (e.g., beneficiaries missing digits excluding the hallux), suppliers must bill code A5513 for an insert appropriately custom-fabricated to accommodate the missing digit(s). Codes L5000 or A5512 may not be billed in addition to code A5513.

Option 2: For beneficiaries missing the hallux or a forefoot that require rigidity and support for effective gait, suppliers must bill L5000 for an insert appropriately custom-fabricated to accommodate the missing digit(s) or forefoot as well as providing the foot-protective functions required for a person with diabetes. Codes A5512 or A5513 may not be billed in addition to code L5000.

Suppliers are encouraged to review both the Therapeutic Shoes for Persons with Diabetes Local Coverage Determination and related Policy Article and the Lower Limb Prostheses Local Coverage Determination and related Policy Article for additional information on the coverage, coding and documentation of these items. These documents can be found on the PFA website for each DME MAC Jurisdiction, or on the individual Jurisdictional DME MAC website.
FEBRUARY 2013

February 23 – 24
Advanced Evaluation & Treatment for the Functional Rehab of the Foot and Ankle
North American Seminars: Legacy Emanuel Medical Center, Portland, OR
Speaker: Joshua Bailey, PT, DPT, OCS, CSCS, C. Ped.
Contact www.healthclick.com or 800-300-5512
Approved CEUs: 16 (S) ABC

February 25
Therapeutic Shoe Fitter’s Course
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or visit www.npsfoot.com
E-mail: nholborow@npsfoot.com

February 26
Understanding AFOs
Pedorthic Footcare Association Webinar
Presenter: Erick Janisse, Co, C. Ped.
Time: 7 PM – 8:30 PM Eastern Time
Registration at www.pedorthics.org
PFA Members: $50/person | Non-members: $75/person
Approved CEUs: This webinar is currently under review to determine exact CEUs to be award by ABC and BOC; historically this type of program will earn up to 1.5 CEUs and will be posted on the PFA website and noted in confirmation email.

MARCH 2013

March 23 – 24
Advanced Evaluation & Treatment for the Functional Rehab of the Foot and Ankle
North American Seminars: Saint Peter’s University Hospital, New Brunswick, NJ
Speaker: Joshua Bailey, PT, DPT, OCS, CSCS, C. Ped.
Contact www.healthclick.com or 800-300-5512
Approved CEUs: 16 (S) ABC

March 26
Weird Diagnoses – You Have What???
Pedorthic Footcare Association Webinar
Presenter: Erick Janisse, Co, C. Ped.
Time: 7 PM – 8 PM Eastern Time
Registration at www.pedorthics.org
PFA Members: $50/person | Non-members: $75/person
Approved CEUs: This webinar is currently under review to determine exact CEUs to be award by ABC and BOC; historically this type of program will earn up to 1 CEUs and will be posted on the PFA website and noted in confirmation email.

APRIL 2013

April 13-15
Hands-on Custom Foot Orthosis Fabrication Course
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or visit www.npsfoot.com
E-mail: nholborow@npsfoot.com
Approved CEUs: 18.25 ABC

April 24
Offloading the Diabetic Foot Ulcer: Using Removable Cast Walkers Instead of Total Contact Casts
Pedorthic Footcare Association Webinar
Presenter: Dr. James McGuire, DPM, PT, C. Ped., PFA Medical Advisor
Time: 7 PM – 8 PM Eastern Time (date subject to final confirmation)
Registration at www.pedorthics.org
PFA Members: $50/person | Non-members: $75/person
Approved CEUs: This webinar is currently under review to determine exact CEUs to be award by ABC and BOC; historically this type of program will earn up to 1 CEUs and will be posted on the PFA website and noted in confirmation email.
MAY 2013

May 3-5, 2012 & September 13-15, 2013
A Hands-On Approach to Footwear Modifications
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or visit www.npsfoot.com
E-mail: nholborow@npsfoot.com
Approved CEUs: 19.25 ABC

May 4 – 5
Advanced Evaluation & Treatment for the Functional Rehab of the Foot and Ankle
North American Seminars: NRH Regional Rehab OCOR, Washington, DC
Speaker: Joshua Bailey, PT, DPT, OCS, CSCS, C. Ped.
Contact www.healthclick.com or 800-300-5512
Approved CEUs: 16 (S) ABC

May 5 –6
Manual Therapy for The Foot & Ankle: To Stabilize or to Mobilize?
Conducted By: FootCentric, at Foot RX Running, Asheville, NC
Contact FootCentric at www.footcentriconline.com or 919-433-7515
Approved CEUs: 8 ABC/16 PT

May 18 – 19
Advanced Evaluation & Treatment for the Functional Rehab of the Foot and Ankle
North American Seminars: St. Elizabeth Hospital, Florence, KY
Speaker: Joshua Bailey, PT, DPT, OCS, CSCS, C. Ped.
Contact www.healthclick.com or 800-300-5512
Approved CEUs: 16 (S) ABC

JUNE 2013

June 7
Therapeutic Shoe Fitter’s Course
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or visit www.npsfoot.com
E-mail: nholborow@npsfoot.com

AUGUST 2013

August 16-18
Hands-on Custom Foot Orthosis Fabrication Course
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or visit www.npsfoot.com
E-mail: nholborow@npsfoot.com
Approved CEUs: 18.25 ABC

SEPTEMBER 2013

September 13-15
A Hands-On Approach to Footwear Modifications
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or visit www.npsfoot.com
E-mail: nholborow@npsfoot.com
Approved CEUs: 19.25 ABC

OCTOBER 2013

October 18-20, 2013
Pedorthic Extremes: Managing Difficult and Challenging Feet
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or E-mail: nholborow@npsfoot.com
Visit: www.npsfoot.com

October 31 – November 2
Pedorthic Footcare Association 54th Annual Symposium and Exhibition
John B. Hynes Veterans Memorial Convention Center
Boston MA
Contact: (703) 610-9035; info@pedorthics.org or www.pedorthics.org

NOVEMBER 2013

November 15
Therapeutic Shoe Fitter’s Course
National Pedorthic Services, Milwaukee WI.
Contact: Nora Holborow at (414)438-6662 or visit www.npsfoot.com
E-mail: nholborow@npsfoot.com
(703) 610-9035; info@pedorthics.org or www.pedorthics.org
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HELPWANTED

C. Peds Wanted

Pride Pharmacy Group is expanding services in Texas, Oklahoma, Colorado, New Mexico, Missouri, Florida, Kansas, Indiana, Iowa and New York and we are hiring C Peds for these open positions. We offer Full Time employment with a full benefit package. Please email your resume to: rcapasso@pridepharmacygroup.com

C. Ped and Pedorthic Technician Wanted in Nashville.

Have immediate opening for a C. Ped. in Nashville to service referral base that consists of Podiatrists, Orthopedists, and Wound Care Physicians. Need a self-motivated practitioner with strong clinic skills. Technician position is located in Murfreesboro, TN at our Central Fabrication facility. Experience with shoe modifications, AFO fabrication, custom diabetic inserts and foot orthoses a plus. We offer a competitive salary and benefits package. Send resume to: Restorative Health Services, Inc., 1272 Garrison Drive, Suite 307, Murfreesboro, TN 37129. Phone: (615) 890-2160; fax: (615) 890-2361; e-mail: lvaughnrhs@aol.com

Fitter Wanted

Service oriented fitter with orthotic fabrication skills wanted. Park City Ski Boot is a retail wintersport footwear and orthotic store looking for a fulltime Pedorthist for athletic and therapeutic appointments. You must be very personable, enthusiastic with strong sales skills. Responsibilities include handling our daily schedule, working on orders and client related issues. We offer a comfortable and professional working environment; commission and bonus plan with highly competitive starting salary. Email your resume to coputh@gmail.com

Certified Pedorthist Needed

Growing orthotic and primarily running shoe store needs C. Ped. Near Newport, RI, and located within Physical Therapy office. Very clinically oriented, great selection of running and walking shoes for active population. No Medicare Shoe Bill or repairs. Work alongside PT’s, C. Ped., and retail to learn, grow and thrive. Salary strong, will train on products. E-mail to breid555@aol.com, or call 401-845-0840. Serious professionals only. Also will need a shoe repair specialist
This reference guide is intended solely to make it easier for individuals, facilities and companies to locate pediatric foot products. Companies listed in the guide are PFA vendor/manufacturer members. Companies may produce additional products beyond those listed, and most companies are pleased to provide additional information on request. As a courtesy to our readers, Current Pedorthics has noted the year the company joined PFA in parentheses after the company’s name. Inclusion in this list does not suggest or imply PFA endorsement of companies or products. Vendor/Manufacturer members are encouraged to keep their listing up-to-date. To arrange changes in your company’s listing, email info@pedorthics.org.
Dr. Comfort (2004)
Dr. Comfort manufactures, warehouses and distributes the finest quality extra-depth shoes for diabetics or patients who need quality comfort shoes.
Mequon, WI
Phone: (262) 242-5300
Fax: (262) 242-9300
Email: eric@drcomfortdpm.com
Website: www.drcomfortdpm.com

Dr. Kong Footcare Limited (2005)
Manufacturer of children’s, men’s and women’s healthy shoes insoles, footcare accessories and computerized assessment software. 33 chain shoe shops in Hong Kong. Provides check and fit services and healthy products for everybody.
Kwai Chung, N.T., Hong Kong
Phone: (852) 2744-2638
Fax: (852) 2744-8845
Email: raymond@footcare.com.hk
Website: www.dr-kong.footcare.com.hk

Foot Solutions (2012)
Feet are your foundation for life. At Foot Solutions, we use the most advanced technology combined with a full understanding of biomechanics of feet and gait, along with the highest quality footwear on the planet to fit your unique feet. Through our customized solutions, we will improve your comfort and body alignment and help you achieve better health through your feet.
Marietta, GA
Phone: (888) FIT-FOOT
Fax: (770) 953-6270
Website: www.footsolutions.com

Finn Comfort (1993)
Luxury comfort footwear. Men’s and women’s walking shoes, sandals and boots featuring removable/modifiable orthopedic footbeds. Hand-crafted in Germany.
Thousand Oaks, CA
Phone: (805) 375-0038
Fax: (805) 375-0848
Email: info@finncomfort.net
Website: www.finncomfort.de

Goodhew, LLC (2012)
Goodhew, a leader in the ModernCraft movement, spins fresh designs, natural performance yarns, and the heritage of American craftsmanship to create high performance socks for the everyday world. Goodhew: a sock for every walk in the walk of life.
Chattanooga, TN
Phone: 423-643-0821
Fax: 423-643-0825
E-mail: eckardt@goodhew.us.com
Website: http://www.goodhew.us.com

Guard Industries, Inc. (1996)
Components for shoe care, foot comfort, orthotics and prosthetics. Complete listing of available products will be sent upon request.
St. Louis, MO
Phone: (800) 535-3508
Fax: (314) 534-0035
Email: guard@dill.com
Website: www.guarddill.com

Haflinger/Highlander (Gerda Hoehm) (1999)
Boiled wool slippers, latex arch support, felt and leather clogs, cork molded footbed. Highlander is Gerda Hoehm’s new high-quality comfort line with a removable footbed. Both Haflinger and Highlander are made in Germany.
New York, NY
Phone: (212) 949-6767
Fax: (212) 949-8833
Email: haflingerny@worldnet.att.net

Hapad, Inc. (1988)
Hapad is a leading manufacturer of 100% natural wool felt foot products and sports replacement insoles used for conservative management of common, painful foot complaints. Correctly skived and adhesive backed for a quick and easy fit, Hapad products are an affordable alternative to custom made devices or they can be used to make custom modifications.
Bethel Park, PA
Phone: (800) 544-2723
Fax: (800) 232-9427
Email: info@hapad.com
Website: www.hapad.com

Shoe modification components, foot comfort products and shoe repair supplies. Products from Aetrex, Spenco, Vibram and Solestech.
Granite Quarry, NC
Phone: (704) 279-5568
Fax: (704) 279-5261
Email: jhc@cookwindstream.net

KLM Laboratories (2006)
An industry leader in the manufacture of foot orthotics and insoles, specializing in custom orthotics, pre-fabricated orthotics, orthotic insoles and orthotic materials.
Valencia, CA
Phone: (800) 556-3668
Fax: (800) 556-3338
Email: cservice@klmlabs.com
Website: www.klmlabs.com

Jerry Miller L.D. Shoes, Inc. (1977)
Jerry Miller Shoes extensive custom-molded shoemaking experience has also been applied to a new family of custom AFODs - Buffalo Brace. Both shoes and braces feature state-of-the-art CAD technology, high quality glove leather, various color options and a choice of closure methods. Jerry Miller Shoes and Buffalo Brace. For all walks of life!
Buffalo, NY
Phone: (716) 881-0349
Fax: (716) 881-0349
Website: www.jerrymillershoes.com and www.buffalobrace.net

JMS Plastics Supply (1992)
JMS Plastics Supply, Inc. is your one source for materials and equipment for fabricating Orthotics. We have in stock TL-2100/ XTIV/ mortons toe extension plates, J-turf in pre cuts and full sheets. Our new products include the KLEZen multi-purpose Sanitizer machine, kills up to 99.7 percent of bacteria. Great for a diabetic patients footwear. The Orthofoot line of shoes, insoles and socks with Bamboo. Posting strips with adhesive on one side, Gel Knee sleeves and Masterflex. A polyethylene plastic sheet that is great for knee bracing. Call (800) 342-2602 for your free catalog and sample ring or view our website at www.jmsplastics.com.
Neptune, NJ
Phone: (800) 342-2602
Fax: (732) 918-1131
Email: steve@jmsplastics.com
Website: www.jmsplastics.com

KLM (1977) (1968)
KLM (1977) (1968)
PRODUCTS & SERVICES

Klogs-USA (2007)
Sullivan, MO
Phone: (573) 468-5564
Fax: (573) 468-5560
Email: jennifer@altitudesinc.com

Landesman Bros., Inc. (2003)
Distributors of foot comfort products, pedorthic, orthopedic and wound care supplies. Same day shipping.
Island Park, NY
Phone: (800) 852-8855
Fax: (516) 899-1253
Email: shoe@juo.com
Website: www.landesmanbros.com

Lord Custom Molded Shoes, Inc. (1994)
Fashionable custom-molded shoes for men, women, and children. Guaranteed fit and service.
Bohemia, NY
Phone: (800) SHOES11
Fax: (516) 471-3090

MacPherson Leather Co. (2005)
MacPherson Leather Company has provided a tradition of caring service since the early 1900s. As a generational family business, we are committed to providing excellent service and expertise for all of our customers’ needs.
As a wholesale and retail company, we offer quality products for saddle and tack, shoe findings, and leather craft trades. We hope you find what you are looking for on our site and please contact us with any questions you may have.
Seattle, WA
Phone: (206) 328-0855
Fax: (206) 328-0859
Email: info@macphersonleather.com
Website: www.macphersonleather.com

Mephisto (1998)
With worldwide headquarters in Sarrebourg, France, MEPHISTO - the WORLD’S FINEST FOOTWEAR, was founded more than 40 years ago by Martin Michaeli. Mephisto has a loyal following and a strong international reputation for comfort and quality. Its high-quality handcrafted footwear styles include sandals, boots, clogs, dress and classic walkers, as well as the ergonomic brand, Mobil. In recent years, the company also introduced the more athletic inspired brand, Allrounder by Mephisto and their latest collection with superior toning technology, Sano by Mephisto.
Franklin, TN
Phone: 800-775-7852
Fax: 615-771-9355
E-mail: info@mephistousa.com
Web site: http://www.mephisto.com/

Miami Leather Company (2001)
Wholesaler to the orthopedic, prosthetic, retail shoe and shoe repair trade. Wide variety of products.
Miami, FL
Phone: (305) 266-8328
Fax: (305) 266-8728
Email: sales@miamileather.com
Website: www.miamileather.com

M. J. Markell Shoe Company, Inc. (1973)
Men’s, women’s and children’s comfort and orthopedic footwear.
Yonkers, NY
Phone: (914) 963-2258
Fax: (914) 963-9293
Email: info@markellschoe.com
Website: www.markellschoe.com

MMAR Medical Group, Inc. (2003)
Distributor of multiple diabetic shoe brands at manufacturer-direct wholesale pricing. Other products include AFO’s, ankle braces and cam walkers.
Houston, TX
Phone: (800) 662-7033
Fax: (713) 465-2818
Email: service@mmarmedical.com
Website: www.mmarmedical.com

New Balance/Aravon (1990)
New Balance is a leading manufacturer of technologically innovative athletic products.
Boston, MA
Phone: (817) 783-4000
Fax: (817) 783-7050
Website: www.newbalance.com

Orthofoot, Inc. (1999)
Manufacturer and distributor of high quality depth-shoes and orthotics.
Northvale, NJ
Phone: (800) 524-2845
Fax: (201) 787-6748
Email: orthofeet@tai.com
Website: www.orthofoot.com

PartnerShip (2000)
PartnerShip, in cooperation with PFA, offers members-only discounts and savings on small package shipping with FedEx Ground, and on large freight shipments with Yellow Freight.
Cleveland, OH
Phone: (800) 599-2902
Fax: (800) 439-8913

PediFix, Inc. (2001)
Foot specialists since 1885, PediFix is the only fourth generation, family-owned business in the pedorthic industry. Choose from more than 150 quality foot treatment products, including a unique OTC line guaranteed to generate cash sales, keystone profits and doctor referrals, an assortment of both traditional and exclusive Visco-GEL foot pads and cushions, new dermatology products, GelStep silicone insoles and orthotics, Diabetic Solutions Socks, Pediplast and more. 15 new products are being introduced this year.
Contact PediFix today for a free color catalog.
Brewster, NY
Phone: (800) 424-5581
Fax: (845) 277-2851
Email: sales@pedifix.com
Website: www.pedifix.com

PEL Supply Company

Remington Products (2000)
Insoles and sheet packages, rigid arch supports, viscoelastic heel cups, 3/4 and full insoles.
Wadsworth, OH
Phone: (330) 335-1571
Fax: (330) 336-9462
Email: jwert@remprod.com
Website: www.remprod.com

Milwaukee, WI
Phone: (414) 778-2288
Fax: (414) 778-2247

SAS Shoemakers (1992)
San Antonio, TX
Phone: (210) 924-6561
Fax: (210) 921-7460
Email: barmwood@sas-shoes.net
Website: www.SASShoes.com

STS Company (1997)
Resin-impregnated tubular and fitted socks made to take foot and ankle impressions for custom shoes and foot/ankle orthotic devices.
Mill Valley, CA
Phone: (800) 787-9097
Fax: (415) 381-4610
Email: sttssox@att.net
Website: www.sttssox.com

SafeStep (1994)
SafeStep makes it easy to utilize the Medicare Therapeutic Shoe Program by streamlining shoe ordering, document procurement and Medicare billing.
Milford, CT
Phone: (866) 712-7837
Fax: (203) 728-0091
Email: jwert@remprod.com
Website: www.safestep.net

SAS Shoemakers (1992)
San Antonio, TX
Phone: (210) 924-6561
Fax: (210) 921-7460
Email: barmwood@sas-shoes.net
Website: www.SASShoes.com

P.W. Minor, Inc. (1968)
P.W. Minor is the premium brand that provides pedorthically superior, precision-fit footwear for discriminating consumers unwilling to compromise style when preventing or caring for their foot-health needs. Delivering foot-health through precision fit shoes is a brand mission that remains as true and relevant today as it was back in 1867.
Batavia, NY
Phone: 800-796-4667
Fax: 585-343-1514
Email: info@pwminor.com
Website: http://www.pwminor.com/
Complete line of orthotic and prosthesis equipment including finishers/grinders, vacuum pans, pumps, presses, industrial sewing machines, fume busters and more.
Goshen, NY
Phone: (800) 354-6278
Fax: (845) 291-7097
Email: shoesystemsplus@hvc.rr.com
Website: www.shoesystemsplus.com

SoleTech, Inc. (1994)
Orthopedic footwear, cushioning and rubber materials, and adhesives.
Salem, MA
Phone: (800) 225-2192
Fax: (978) 741-2091
Email: tjcnahant@aol.com
Website: www.soletech.com

Sole Supports, Inc. (2012)
Sole Supports is an innovative, medical-grade foot orthotics manufacturer. We make custom foot supports that follow your doctor’s prescription in order to provide both immediate pain relief and prevention of any new pains or deformities. Medical practitioners must first be certified to order from us because we offer a completely different type of support than the ones for which they were trained in school and because we must have the best possible cast of your foot to make the best support.
Lyles, TN
Phone: 931-670-6111
Fax: 931-670-6008
E-mail: info@solesupports.com
Website: www.solesupports.com

Spira (2004)
El Paso, TX
Phone: (866) 838-8640
Fax: (915) 838-8641

Sroufe Healthcare Products, LLC (2006)
Custom diabetic inlays, casting foam boxes, pre-fabricated orthotics and orthopedic softgoods.
Ligonier, IN
Phone: (260) 894-4171
Fax: (260) 894-4092
Email: sales@sroufe.com
Website: www.sroufe.com

Ferndale, WA
Phone: (360) 384-1820
Fax: (360) 384-2724
Email: here@superfeet.com

Tekscan, Inc. (1994)
Broad range of pressure assessment and clinical/research evaluation tools for use in orthotics, brace evaluations, joint biomechanics, and gait analysis.
Boston, MA
Phone: (617) 464-4500
Fax: (617) 464-4269
Email: marketing@tekscan.com
Website: www.tekscan.com

Therafirm (A Division of Knit-Rite, Inc.) (1999)
Quality medical-grade compression hosiery and diabetic socks.
Ellerbe, NC
Phone: (800) 582-2701
Fax: (910) 652-2438
Website: www.therafirm.com

Thor-Lo, Inc. (2001)
Statesville, NC
Phone: (704) 872-6522
Fax: (704) 838-6323

Tru-Mold Shoes, Inc. (1980)
Tru-Mold Shoes offers a complete line of contemporary, fully accommodating custom-molded shoes, including the Thera-Medic Shoe package – the most flexible, highest value shoe package for Medicare-eligible patients with diabetes.
Buffalo, NY
Phone: (800) 843-6653
Fax: (716) 881-0406
Email: info@trumold.com
Website: www.trumold.com

Vibram USA (1998)
Quabag Corporation is the U.S. manufacturer of Vibram soling products and Barge adhesives.
Concord, MA
E-mail: jonathan.shaffer@vibramusa.com
Web site: www.vibram.us

Ziera Shoes N.Z., Ltd. (Formerly Kumfs Shoes N.Z., Ltd.) (1999)
Ziera Shoes, formerly Kumfs Shoes, are women’s shoes, sandals and boots that are truly orthotic friendly. Ziera Shoes come in a wide range of heeled fashion and walking footwear. We have widths in stock from M through XXW in sizes 34 through 45.
Los Gatos, CA
Phone: 877-717-0588
Fax: 877-717-0589
Web site: http://www.zierashoes.com/
To view the entire collection, visit www.aetrex.com/footwearcatalog