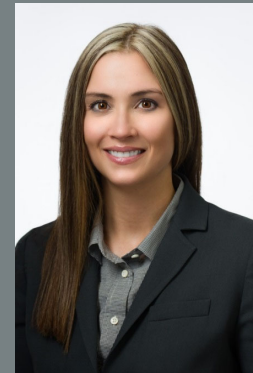


Trending Now: Complex Claims Podiatric Physicians & Surgeons Face Today



*Christopher L. Reeves, DPM, FACFAS
Orlando Foot and Ankle Clinic*



*Laura D. Eschleman
Nall & Miller, LLP*

Disclosure

Legal Notice

Disclaimer

The information contained in this presentation does not establish a standard of care, nor does it constitute legal advice.

The information is for general informational purposes only and is prepared from a risk management perspective to aid in reducing professional liability exposure.

Please review this presentation for applicability to your specific organization. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.

Objectives

- Understanding and managing the risks of DVT
- Understanding the role of procedure selection and documentation of the rationale for the procedure selected
- Understand why patient selection is so important
- Review the role of communication in assisting mitigating risk
- Review common characteristics of complex and recurrent malpractice cases

Emerging Trends in the Professional Liability Industry

- Steady uptick in claims severity
- Complexity of cases (tar, major reconstruction, etc.)
- Recurrent catastrophic cases (cancer, dvt, bka, etc.)

Current Litigation Environment

- Frequency of plaintiff verdicts increasing
- Jury awards based on emotion rather than fact
- Plaintiff's attorneys emboldened
- Increase in judicial hellholes
- Political and racial considerations

Litigious Patients...

- ...are **desperate**
- ...are **angry**
- ...are **irresponsible**
- ...are **litigious**
- ...**blame problems** on others
- ...are **addicted to drugs or alcohol**
- ...are **high maintenance**
- ...**complain about bills**

How To Deal With Problem Patients?

- Use Best Practices
 - Over-communicate
 - Offer assistance
 - Take extra time
 - Perfect documentation
 - Establish expectations
 - Practice defensive medicine

Last resort consider terminating the physician-patient relationship

Commonly, the overwhelming number of people who suffer an injury due to the negligence of a doctor **never file** a malpractice suit at all. Patients don't file lawsuits because they've been harmed by shoddy medical care. Patients file lawsuits because they've been harmed by **standard of care--and something else happens to them.**

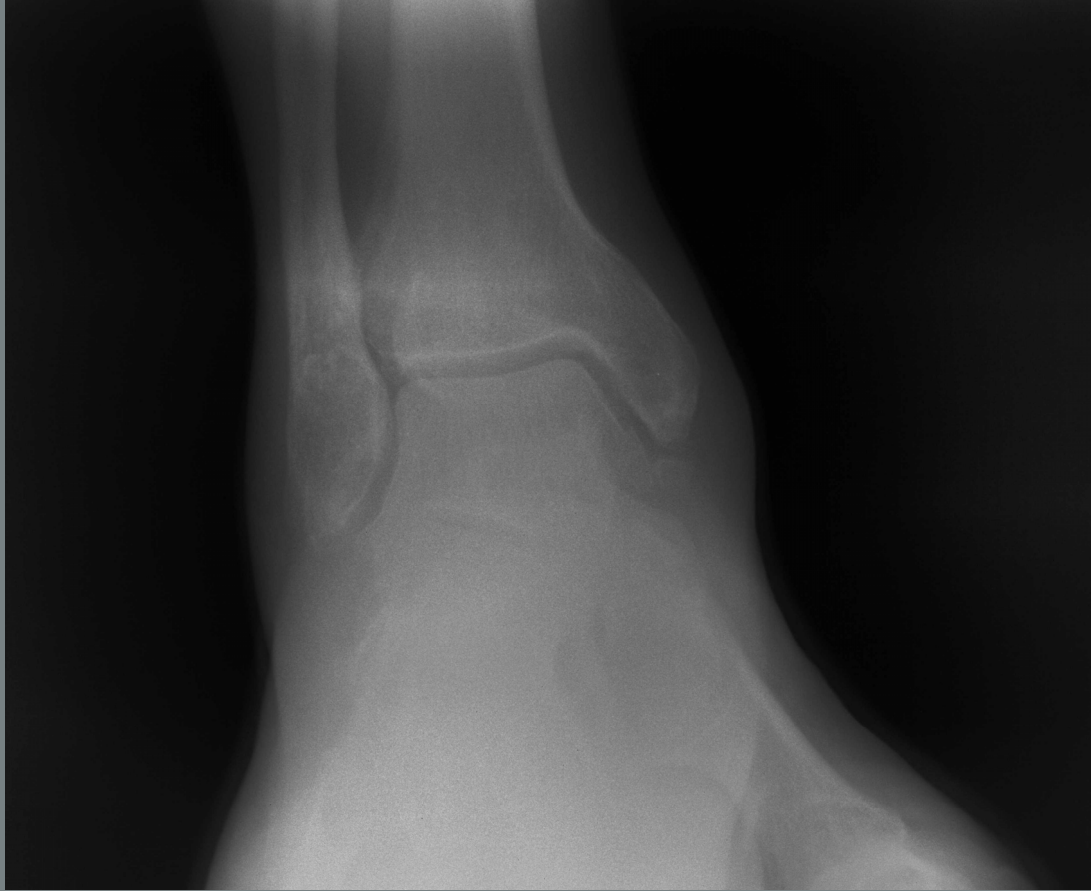
Patient Selection



Case 1

- 58 yo male, active 5' 9" 200 lbs, bmi 32.5
- Chronic right ankle pain
- H/o fx 30 yrs ago w orif
- Hwr
- 10-17-16 initial office visit
- X-rays- djd
- Steroid injection / ankle brace

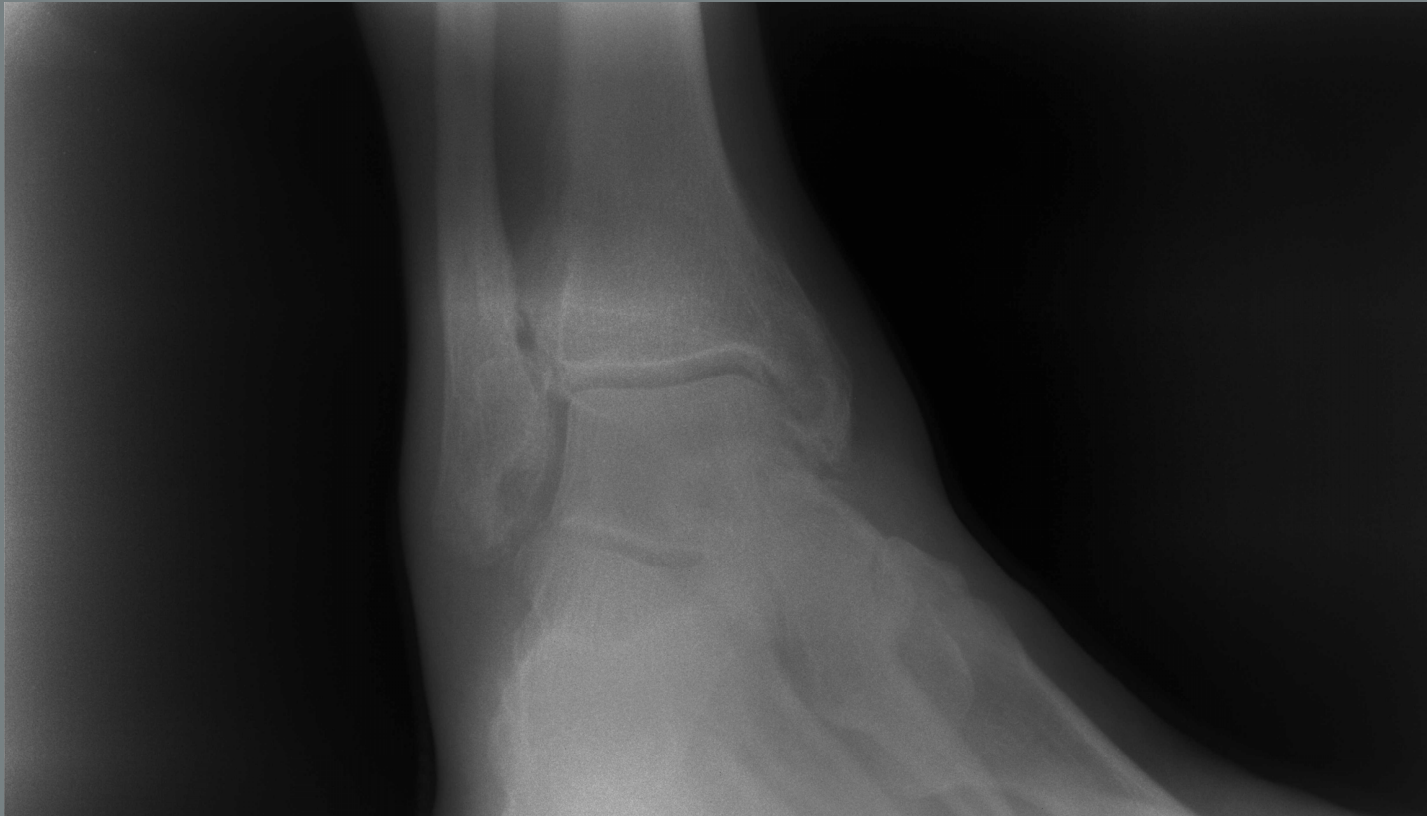
Case 1



Case 1



Case 1



Case 1



Case 1

- Second Visit- 10-25-16
- Injection- 3 days relief
- Rom near normal w/o crepitus
- “Pt. would benefit from MRI for both diagnostic and pre-surgical work up”

Case 1

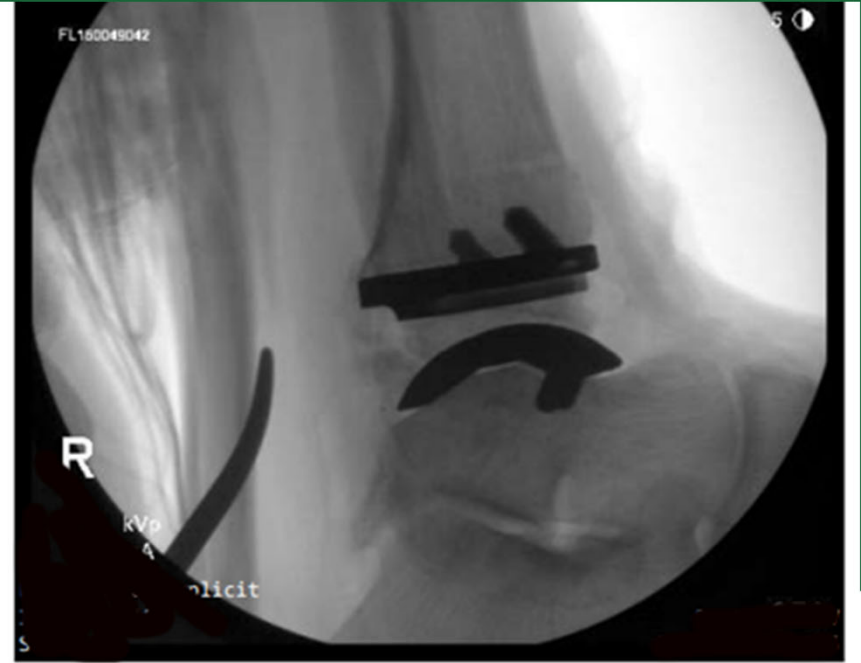
- 11-8-16
- MRI djd ankle with lateral atfl edema
- discussed conservative vs surgical options
- “pt elects surgical tx”

Informed Consent

Case 1

- 12-16-16
- Total ankle replacement

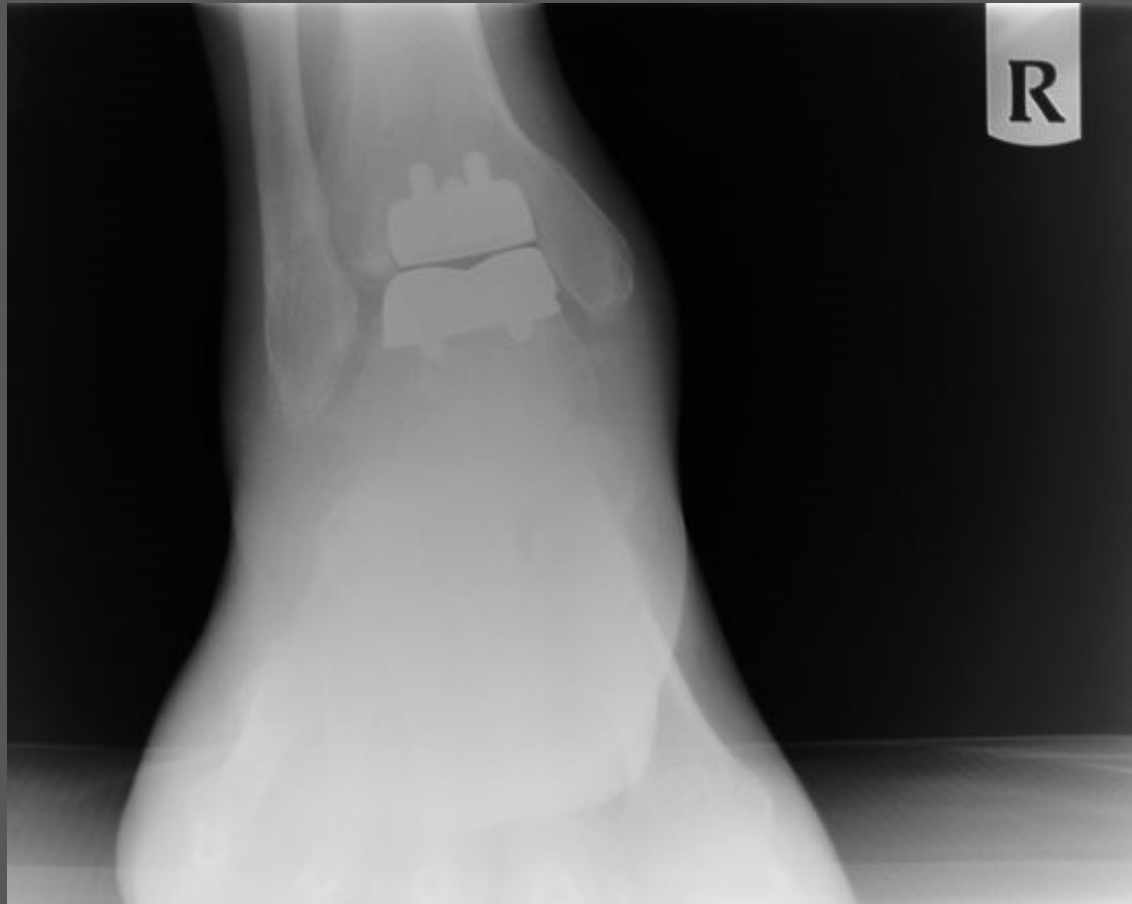




Case 1

- Unremarkable Post Op Course for 2 Weeks

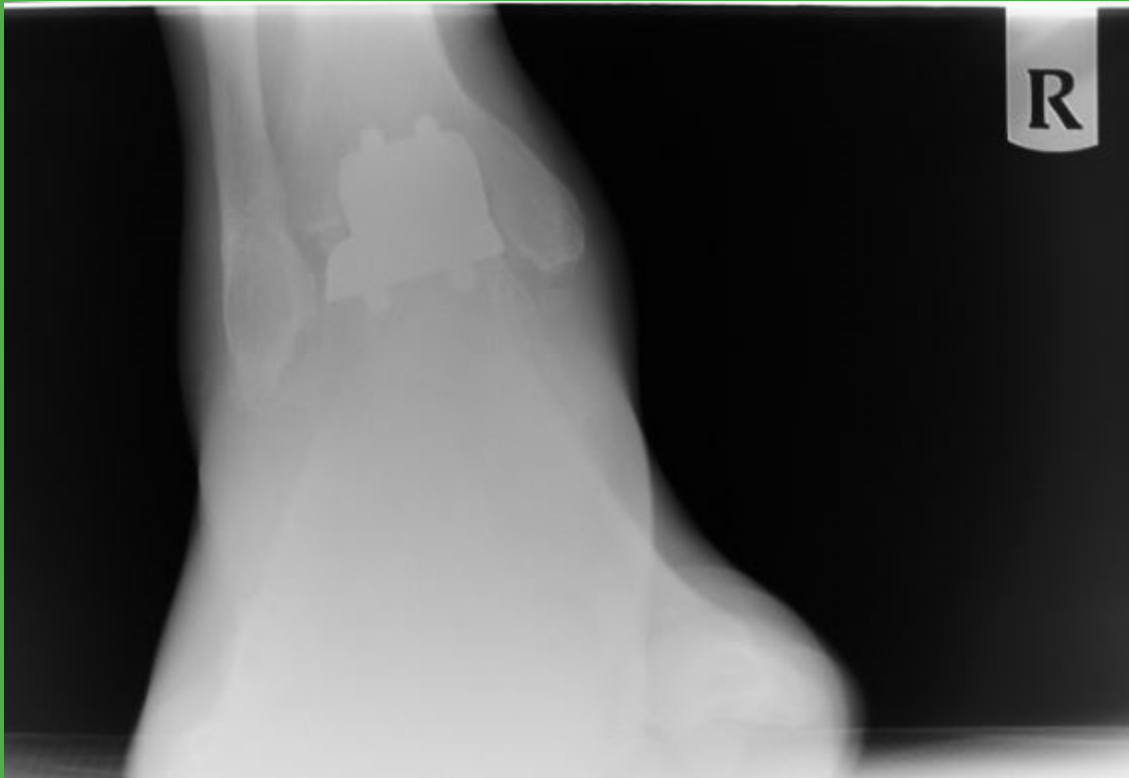














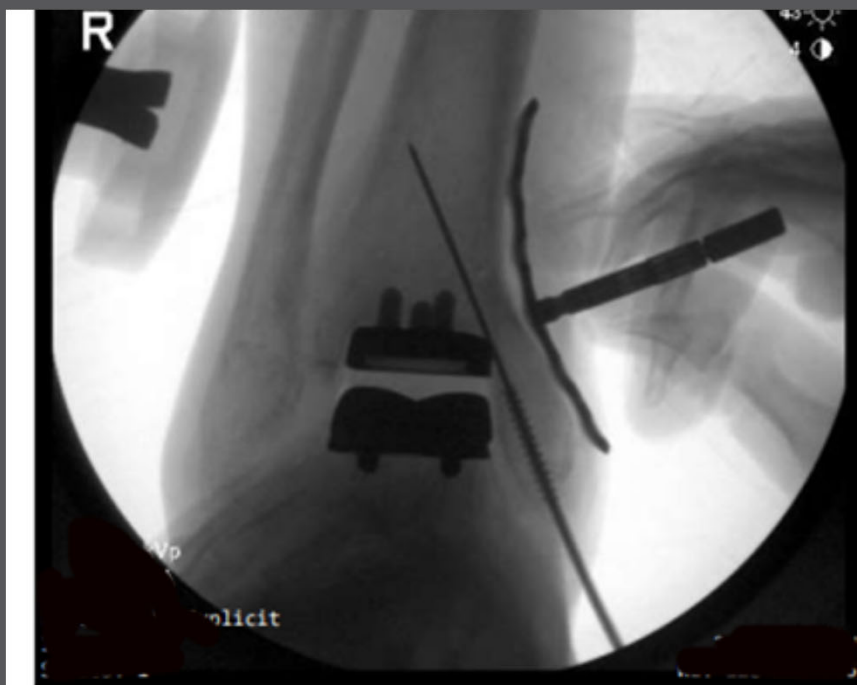
Case 1

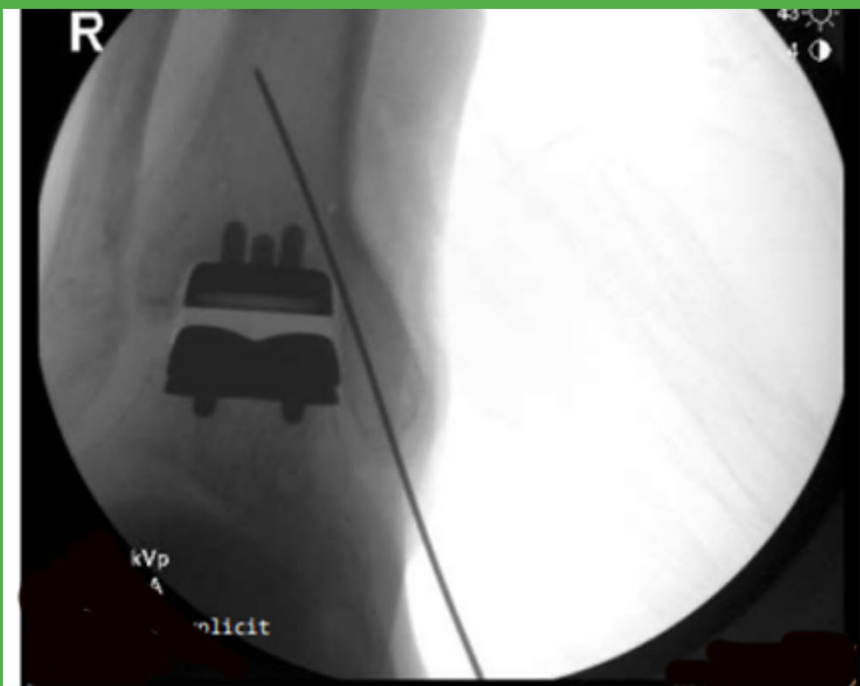
1-5-17 – P.T. Reports PT reports to P.T. C/O Fall w
Edema/Pain
X-Rays – WNL

2-1-17 X-Rays WNL

Case 1

- 2-23-17 worsening pain / can barely bear weight
- X-rays- “ maintained alignment w slight varus positioning”
- “ Interval change to medial malleolus with widening of lateral gutter suggestive of stress riser from medial superior gutter”
- ORIF recommended









Case 1

- Ongoing pain post op
- Orthopedic second opinion 10-23-17
- “ Failed tar with tibial component subsidence with redidual varus deformity with rigid ankle varus contracture”
- Revision tar recommended

Case 1

- Allegations
- Unnecessary tar “ not clinically indicated” based on pt’s age, weight, level of activity, minimal arthritis
- Lack of conservative tx
- Improper sizing and placement of implant (varus)
- Medial malleolar fx was evident on post op x-rays and likely occurred during surgery and was not recognized until 10 weeks post op

Case 1

- Medical review panel
- 2 ortho/ 1 dpm
- Unanimous- breach of standard of care
- Lack of conservative care
- Improper placement of the implant (varus)
- Failure to address implant position/ stability during the orif surgery

Result

- Settled in Mediation

Risk Mitigation Strategies

- Patient selection
- Exhaustion of conservative care
- Procedure selection
- Complication recognition and management

Proper Documentation

- **Why is This Important?**
- Patient Complaints in Own Handwriting
- Conservative Care You & Patient Tried
- Physician Judgment

Documentation Risk Issue:

- **Surgery Without Supporting Data and Conservative Care**
 - No description of patient complaints or loss of function.
 - No description of clinical findings that correlate with the diagnosis.
 - Lack of generally accepted testing or evaluation modalities.
 - No indication as to why surgery was needed for the patient at the time that it was performed.

Documentation Risk Issue:

- **Lack of Physician Judgment**
 - If you do something out of the norm – document your judgment:
 - If a test is not done for some reason
 - Change in surgical procedure during surgery
 - Choosing a surgery that is not commonly done for the issue

Reduce Your Risk

- Note clinical findings that match the diagnosis.
- Consider appropriate studies that your colleagues would use.
- Enter functional limitations preop, if present
 - Can not go to the grocery store without pain
 - Pain is present every day
 - Pain develops after 10 minutes of walking
 - Has not been able to exercise for ...

Case 2

- 60 yo female unremarkable pmh
- 2-14-14 painful great toenail
- Hallux nail was injured one year prior “smashed and bruised”
- Growing back irregularly / painful
- “Hallux nail is hypertrophic, discolored”
- Partial avulsion performed

Case 2

- 3-26-14
- Same issue –pain /dystrophic changes
- “ Pre paronychia” condition is noted/ no ulcers or lesions
- Debridement/partial avulsion/ keflex

Case 2

- June 3, 2014
 - Area remains painful
 - Pt reports it “ bleeds sometimes”
 - Pre paronychia w serosanguineous discharge
 - Total avulsion performed
- June 17, 2014
 - Minimal pain / no infection/ ret in 3 months

Case 2

- Sept 29, 2014
 - Pain and drainage continue left hallux nail bed
 - Area bled when probed
 - Spongy material in nail bed
 - Edema of hallux
 - “Pt instructed to contact dermatologist for possible biopsy to determine cause”

Case 2



Case 2

- Oct 4, 2014
 - Clark's level 4 Melanoma
- Deceased May 2020

Case 2 - Allegations

- Insured and his medical practice were negligent for failing to timely diagnose her melanoma, and for failing to timely refer her to a dermatologist for diagnostic work up of her left great toe.
- Plaintiff claims she suffered bodily injury, pain and suffering, disfigurement, mental anguish, disability, inconvenience, loss of capacity for the enjoyment of life, the cost of hospital, nursing, medical, and rehabilitative care, loss of earnings, and diminished wage earning capacity.

Result

- Settled for significant \$\$\$\$

Case 2

Risk Management Strategies

- Index of suspicion for non-healing or recurrent skin/ nail conditions

Skin Cancer Cases Never Go Away

- Skin cancer of the lower extremity is far more common than you may think
 - Failure/Delay to “diagnose”
 - Negligent “treatment”
 - Failure to properly disclose the diagnosis

Reduce Your Risk (Cont.)

- **NLDOCAT** Evaluation Still Matters in H & P
 - Nature of the problem
 - Location
 - Duration
 - Onset
 - Characteristics
 - Aggravating or Alleviating Factors
 - Treatments

Case 3

- 48 yo male, obese, uncontrolled hypertension
- 2013 left ankle fusion / post op pulmonary embolism
- Right ankle sprain 1-4-16
- Evaluated by insured 1-21-16
- Non-displaced right lateral malleolar fx

Case 3

- Placed in cam walker
- Strict NWB
- Advised weight bearing would likely lead to displacement which would require ORIF
- Pt collapses 2-26-16 and dies

Case Example 3

- Discovery
- Wife (a registered nurse) testifies she asks insured if anticoagulation is necessary
- ASA daily is adequate according to insured
- No documentation of prior PE
- Coagulopathy work up after previous PE was reportedly negative

Routine DVT, PE prophylaxis questionable in foot, ankle surgery

By Terry Stanton

Routine administration may be unnecessary or even harmful

The risk of deep vein thrombosis (DVT) and pulmonary embolism (PE) and the appropriate measures to prevent these conditions continue to be subjects of research and discussion among orthopaedic surgeons. At the American Orthopaedic Foot & Ankle Society (AOFAS) 2011 Specialty Day, several surgeons provided information and perspectives on the issue.

<p><u>Each risk factor = 1 point</u></p> <ul style="list-style-type: none">• Age 40-59 years• Minor surgery planned• BMI ≥ 30kg/m2• History of prior major surgery (<1 month)• Swollen legs (current)• Varicose veins• Sepsis (<1 month)• Abnormal pulmonary function (COPD)• Acute myocardial infarction (<1 month)• Congestive heart failure (<1 month)• History of IBD• Medical patient currently at bed rest	<p><u>Each risk factor = 2 points</u></p> <ul style="list-style-type: none">• Age 60 – 74 years• Arthroscopic surgery• Major open surgery (> 45 minutes)• Laparoscopic surgery (> 45 minutes)• Prior cancer (except non-melanoma skin cancer)• Present cancer (except breast and thyroid)• Confined to bed (>72 hours)• Immobilizing plaster cast• Central venous access	<p><u>Each risk factor = 3 points</u></p> <ul style="list-style-type: none">• Age ≥ 75 years• History of VTE• Family history of VTE• Present chemotherapy• Positive Factor V Leiden• Positive Prothrombin 20210A• Positive Lupus anticoagulant• Elevated anticardiolipin antibodies• Elevated serum homocysteine• Heparin-induced thrombocytopenia (HIT)• Other congenital or acquired thrombophilias								
<p><u>For women only (1 point each)</u></p> <ul style="list-style-type: none">• Pregnant or post-partum• History of unexplained or recurrent spontaneous abortion• Oral contraceptives or hormone replacement therapy	<p>Caprini risk category based on total risk score</p> <table><tr><th>Total score</th><th>Category</th></tr><tr><td>0 - 4</td><td>Low</td></tr><tr><td>5 - 8</td><td>Moderate</td></tr><tr><td>≥ 9</td><td>High</td></tr></table>		Total score	Category	0 - 4	Low	5 - 8	Moderate	≥ 9	High
Total score	Category									
0 - 4	Low									
5 - 8	Moderate									
≥ 9	High									
		<p><u>Each risk factor = 5 points</u></p> <ul style="list-style-type: none">• Major surgery lasting > 6 hours• Stroke (<1 month)• Elective major lower extremity arthroplasty• Hip, pelvis, leg fracture (< 1 month)• Acute spinal cord fracture or paralysis (< 1 month)• Multiple traumas (< 1 month)								

Caprini risk assessment tool

Caprini Score	Risk	VTE Incidence	Recommended prophylaxis
0-2	Very low	<1.5%	Early ambulation, IPC
3-4	Low	3%	LMWH, UFH or IPC
5-8	Moderate	6%	LMWH + IPC Or UFH +IPC
>= 9	High	6.5-18.3%	LMWH + IPC Or UFH +IPC Consider extended duration

Case 3

- Make sure patient has tried conservative care prior to an elective surgery
- Little things (i.e., vitals) matter
- If you place patients on medications ask and DOCUMENT if they are taking it (i.e., ASA,ABX)
- Check the calves at each visit and DOCUMENT presence and absence of signs/symptoms
- Postoperatively, DOCUMENT the clinical assessment for DVT at each visit

Case 3

- Educate patients on what to do if there is sign/symptoms of PE/DVT and then DOCUMENT it at each visit
- When in doubt, get a medical clearance
- Do not forget to refer
- If you order labs: Review, Follow up and DOCUMENT (abnormal EKG/abnormal H&H)
- Use a DVT /PE assessment scoring system preoperatively

Risk Assessment

- The American College of Surgeons National Surgical Quality Improvement Program (NSQIP)
- A risk calculator <http://riskcalculator.facs.org>
- Based on
 - Type of procedure (CPT code)
 - Age, functional status, ASA class, BMI, steroid use, systemic sepsis within 48 hrs of surgery, diabetes, HTN requiring medication, previous cardiac event, the presence of CHF, dyspnea, smoking history, a history of COPD, need for dialysis, acute renal failure, and body mass index (BMI)

Risk Assessment

- NSQIP
 - An objective estimated risk value serious complication, any complication, pneumonia development, cardiac complication, surgical site infection (SSI), urinary tract infection, venous thromboembolism, renal failure, a return to the operating room, death, discharge to a rehabilitation facility, and the predicted length of stay.

Enter Patient and Surgical Information

i Procedure

Click

Begin by entering the procedure name or CPT code. One or more procedures will appear below the procedure box. You will need to click on the desired procedure to properly select it. You may also search using two words (or two partial words) by placing a '+' in between, for example: "cholecystectomy + cholangiography"

Reset All Selections

i Are there other potential appropriate treatment options?

☐ Other Surgical Options

☐ Other Non-operative options

☐ None

Age Group

75-84 years ▼

Sex

Female ▼

Functional Status **i**

Partially Dependent ▼

Emergency Case **i**

No ▼

ASA Class **i**

Severe systemic disease ▼

Diabetes **i**

Insulin ▼

Hypertension requiring medication **i**

Yes ▼

Congestive Heart Failure in 30 days prior to surgery **i**


Yes ▼

Dyspnea **i**


With Moderate exertion ▼

Current Smoker within 1 Year **i**


Yes ▼

Steroid use for chronic condition 


No ▼

Ascites within 30 days prior to surgery 


No ▼

Systemic Sepsis within 48 hours prior to surgery 


None ▼

Ventilator Dependent 


No ▼

Disseminated Cancer 


No ▼

History of Severe COPD 


Yes ▼

Dialysis 

No ▼

Acute Renal Failure 

No ▼

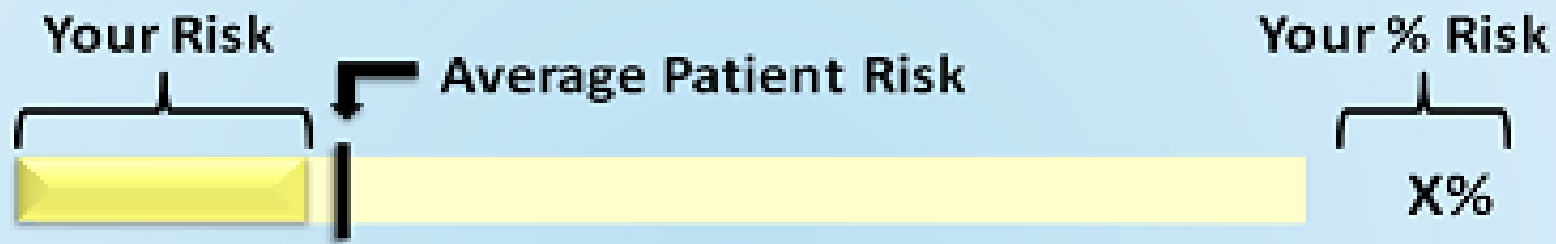
BMI Calculation: 

Height: in / cm

Weight: lb / kg

<http://riskcalculator.facs.org/RiskCalculator/PatientInfo.jsp>

How to Interpret the Graph Above:



Urinary Tract Infection 10 20 30 40 50 60 70 80 90 100% 6.5% 2.4% Above Average

Surgeon Adjustment of Risks

This will need to be used infrequently, but surgeons may adjust the estimated risks if they feel the calculated risks are underestimated. This should only be done if the reason for the increased risks was NOT already entered into the risk calculator.

1 - No adjustment necessary



1 - No adjustment necessary

Back

Continue

Step 3 of 4

Note: Your Risk has been rounded to one decimal point.

Outcomes

Serious Complication



6.2%

2.3%

Above Average

Any Complication



10.2%

3.6%

Above Average

Pneumonia



0.7%

0.2%

Above Average

Cardiac Complication

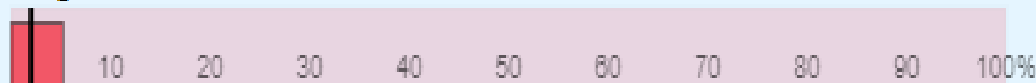


0.5%

0.1%

Above Average

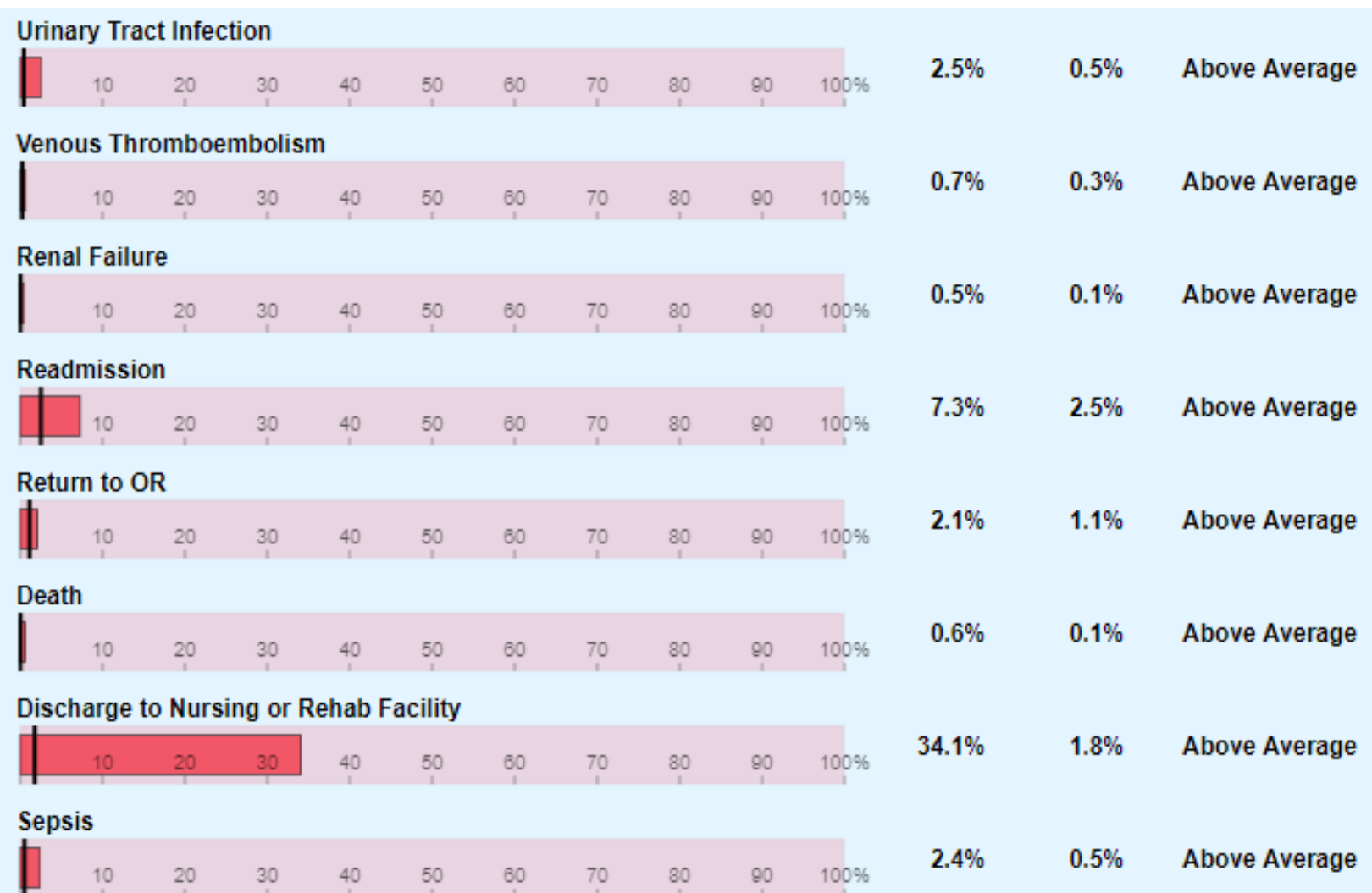
Surgical Site Infection



5.2%

2.0%

Above Average



Predicted Length of Hospital Stay: 0.5 days

Approved by the AOFAS Board of
Directors, July 9, 2013

POSITION STATEMENT The Use of VTED Prophylaxis in Foot and Ankle Surgery

There is currently insufficient data for the American Orthopaedic Foot & Ankle Society (AOFAS) to recommend for or against routine VTED prophylaxis for patients undergoing foot and ankle surgery. Further research in this field is necessary and is encouraged.

VTED can occur in patients undergoing foot and ankle procedures, although with less frequency than in knee and hip arthroplasty. The incidence is difficult to determine, given the diversity of foot and ankle procedures as well as the wide range of their magnitude and complexity. It is also confounded by the fact that the thrombotic endpoint varies in the literature (e.g. clinical versus phlebographic detection and proximal versus distal location). In one study examining Achilles tendon repair, the overall incidence of phlebographically confirmed DVT was 36% in patients not receiving prophylactic anticoagulation. The incidence of proximal DVT was only 6%. **These rates were not significantly different compared to patients who received prophylactic anticoagulation.** Meanwhile, in a much larger study that examined clinically symptomatic disease, the rate of VTED was under 1% in over 45,000 patients undergoing ankle fracture surgery.

<https://docplayer.net/21284381-Position-statement-the-use-of-vted-prophylaxis-in-foot-and-ankle-surgery.html>

POSITION STATEMENT The Use of VTED Prophylaxis in Foot and Ankle Surgery

In one study examining Achilles tendon repair, the overall incidence of phlebographically confirmed DVT was 36% in patients not receiving prophylactic anticoagulation.

These rates were not significantly different compared to patients who received prophylactic anticoagulation

Conclusion

There is currently insufficient data to recommend for or against routine VTED prophylaxis for patients undergoing foot and ankle surgery. We do recommend, however, that patients be assessed pre- operatively for VTED risk. If sufficient risk factors are present, VTED prophylaxis may be considered and weighed against the potential risks of prophylaxis. Acceptable options for prophylaxis include mechanical and chemical agents. Exactly what constitutes sufficient risk, however, especially in the absence of substantial risk factors, remains undetermined. Further, the optimal means and **duration** of prophylaxis is also undefined.

The AOFAS recognizes that further research in this field is necessary and strongly encourages future investigations into VTED and foot and ankle surgery.

Risk Management Strategies for Improvement

- Exploring, if not exhausting, conservative treatment options
- Ensuring that the patient is fully informed of the risks involved with both conservative care and surgery
- Procuring the patients full informed consent
- Conducting proper pre-operative testing
- Conducting the surgical procedure within the standard of care

Risk Management Strategies for Improvement

- Providing appropriate post-operative instructions
- Scheduling post-operative appointments to monitor progress
- Duty includes an assessment of the patient's risk of developing a DVT or blood clot, followed by a decision on whether or not to utilize prophylactic anti-coagulation medication

Case 4

- 75-year-old married male
- Medical history of diabetes, benign prostatic hypertrophy and hypertension
- Admitted – septic knee
- Developed cellulitis, blister left foot
- Unna boot applied, left 11-11-15
- Discharged to LTC facility 11-13-15

Case 4

- Unna boot removed one week later (11-18-15)
- Hemorrhagic blister larger-deroofed
- No culture taken
- Another Unna boot applied

Case Example 4

- One week later 11-25-15 Unna boot removed
- Gangrenous changes noted left foot
- Vascular consult ordered
- “No pedal pulses” “Femoropopliteal occlusion”
- CT angio – “complete occlusion of anterior tibial artery”

Case 4

- Five debridements performed between 12-4-15 and 1-8-16
- No documentation of contact with vascular surgeon
- Admitted to hospital 1-20-16 “sepsis secondary to infection/osteo left foot”
- Partner of insured recommends BKA

Case Example 4 – Subseq treat



Case Example 4 – Subseq treat



Case Example 4 – Subseq treat



Case Example 4 – Subseq treat



Case Example 4 – Subseq treat



Case Example 4 – Subseq treat



Case Example 4

- Assessment on admission indicated wounds:
 - Right knee, multiple
 - Left heel
 - Left lower leg
 - Buttocks
- No progress notes by insured, but the record contains a note on practice letterhead dated 1/18

Case 4

- Pt admitted to hospital 1/20 for sepsis caused by an infection in the left foot with osteomyelitis
- 1/29 BKA performed

Case Example 4 - Allegations

- Insured failed to properly treat the cellulitis which led to the open ulcer
- Insured failed to properly fit the Unna Boot which led to the open ulcer and gangrene

Case 4 Risk Management Strategies

If You are Dealing With a Wound

This from your EMR helps, but a detailed description in addition to this helps more



Drainage: None Minimal Moderate Severe **Type:** _____

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

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

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

Wound 4: _____ cm (length) X _____ cm (width) X _____ cm (depth)

Wound Care



Wound Evaluation Template

Patient Name _____

Date _____ Wound visit # _____

Chief Complaint: Open Wound x _____ days / _____ months

Other Subjective Symptoms: _____ pain _____ numbness _____ fever _____ chills _____ nausea

Medical and Mental Condition:

_____ immobility _____; _____ infection; _____ diabetes type I or II; _____ chronic pressure;
_____ arterial insufficiency/small vessel ischemia; _____ venous stasis; _____ edema; _____ CPOD;
_____ malnutrition; _____ CHF; _____ anemia; _____ Other: _____

Wound/ Dermatitis/ Pre-Ulcerative Lesion Status: _____ improved (_____ %)
_____ declined (_____ %)

Medicines/Allergies: _____ Reviewed and in chart.

Compliance: Good Questionable Poor **Dressing Status:** Clean Exudates Dirty
Odor

Associated Deformity(s):

WOUND CHARACTERISTICS:

☐ PAINFUL ☐ NOT PAINFUL
☐ SLOUGH
☐ ESCHAR TISSUE ____% OF WOUND
☐ NECROTIC TISSUE ____% OF WOUND
☐ GRANULATION TISSUE ____% OF WOUND
☐ FIBROTIC TISSUE ____% OF WOUND
☐ KERATOTIC TISSUE ____% OF WOUND
☐ UNDERMINING ☐ DRY
☐ TUNNELING
☐ EXUDATE ☐ PUS
☐ ERYTHEMOTOUS BASE
☐ PSORIATIC
☐ SUB EPIDERMAL BLEEDING
☐ VENOUS WEEPING
☐ CHRONIC/NON HEALING
☐ LEG ULCERATION
☐ NEED FOR MOISTURE

ULCERATION TYPE

___Pre-Ulceration/Keratoderma; ___Venous; ___Arterial; ___Diabetic/Neuropathic; ___Pressure;
___Rheumatoid/Deformity; ___Post Surgical; ___Post Chemical Burn

Skin Condition: ___Normal ___Thin ___Atrophic ___Stasis Wound/Venous ___Ischemic

Wound Staging:

___Pre-Ulcerative/Keratoderma; Wagner Grade 0
___Superficial ulcer without subcutaneous tissue involvement; Wagner Grade 1
___Full Thickness skin to subcutaneous tissue/fascia: NPAUP Stage III; Wagner Grade 2
___Full Thickness skin through fascia/muscle: NPUAP Stage IV; Wagner Grade 3
___Full Thickness skin to Bone: NPUAP Stage IV; Wagner Grade 4

Treatment:

___The wound cleaned, flushed, irrigated and prepared for debridement/dressing. Manual sharp debridement was performed with ___#15 blade ___curette ___tissue nipper down the level of the tissue at the base of the wound that may include muscle, tendon, bone, or any necrotic tissue. The debridement was performed to reduce risk of infection and improve wound healing.

Anesthesia Used: YES NO (Patient Neuropathic)

Type of tissue removed from the wound: ___Necrotic ___Fibrinous
___Granular ___Tissue Biopsy Performed

Evaluation of possible infection: ___ Culture and Sensitivity ___X-Ray ___Blood
Work ___ Biofilm Analysis

___**Oral antibiotics prescribed:**

Impression: ___Healed ___ Improved ___ Initial Assessment ___Unchanged
___Worsening

___Treatment plan was given to the patient verbally.

___The patient and their family were educated thoroughly regarding the wound
care regimen. All materials and supplies were dispensed per the patient needs.
Home instructions were reviewed and all questions answered in detail.

Topical Wound Care Plan: Unna Boot Hydrogel Foam Dressings Helix 3 –
CP Helix 3 – CM

Products Dispensed:

_____ (Please see
attached prescription and Patient Acknowledgement of Receipt.)

Goal of Current Therapy: ____ Complete Resolution ____ Infection
Control ____ Palliative Care

Prognosis: ____ Good ____ Fair ____ Poor

Footgear Recommendations: ____ AFO ____ Non-Pneumatic AFO
with Molded Inlay ____ Diabetic Therapeutic Shoes and Insoles

Follow-Up for Wound Care: _____ day(s); _____ week(s)
____ Picture Taken

Physician Signature:

TOP 10 “PEARLS” for the New Provider

1. Be honest with your patients on treatment options and expectations regarding outcomes
2. Do not be a hero....if you are not sure that you can helplet the patient know
3. Encourage patients to get a second opinion
4. Be careful when implementing new surgical techniques and hardware: Avoid the “first on the block” scenario
5. Be careful when you select a procedure...how can you rescue the outcome should it fail?

TOP 10 “PEARLS” for the New Provider

- 6) Never blame the patient
- 7) Never give a guarantee—The only guarantee you can give is that you will do your best!
- 8) Get involved in your hospital/community/associations- build a positive “Character”
- 9) Document thoroughly and document timely
- 10) **Must have great malpractice coverage**

New Provider Guidance

- Know your skill sets; your limitations
- Ask for help / Refer for second opinion
- Select good office staff
- Practice Balance: Conservative vs surgical
- Non-adherent patients & Complications
- Good documentation

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