



# Orthotech Professional

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*A monthly publication of the National Association of Orthopaedic Technologists*

## TIP OF THE MONTH

### FIBERGLASS TOE PLATFORM CAST

*by Bill Satterfield, OTC*

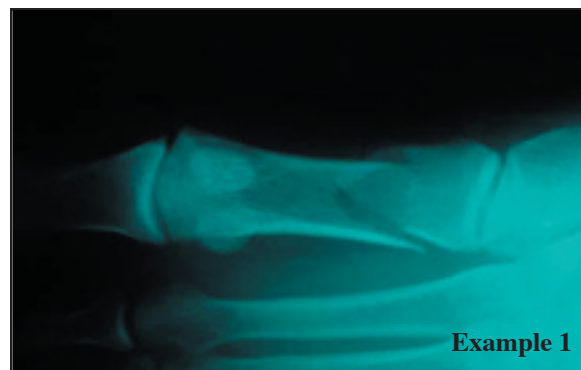
One of the surgeons in our clinic has been practicing for nearly fifty years. When we see a patient with a metatarsal fracture, he always laments that he just can't make a proper toe platform cast with fiberglass (Ex. 1). His goal is to extend the bottom surface of the cast past the end of the patient's toes while stopping the top of the cast well short of the MCP joints. The cast is built then, after it has cured sufficiently, is cut to shape and then padded.

Using the following technique, we can come close to satisfying our surgeon in only about ten minutes. We use stockinet, cotton cast padding and 3M cast material. Since most of these casts are usually meant to be weight bearing, we use a cast stand to ensure a neutral ankle position.

The stockinet is sized and placed on the patient's leg with one end well over the knee and the other end coming about an inch past the ends of the toes (Ex. 2). With the patient sitting on the edge of the exam table, the end of the stockinet is rolled back over the foot and the foot placed on the stand. It is important that the end of the stand come only to about the level of the MCP joints. Next, roll the stockinet back over the toe and stand.

Roll on cast padding per the usually accepted method. Make sure to extend the padding past the end of the big toe. Start rolling the cast tape from behind the toes where you want the top of the cast to end. I use two rolls of four-inch to roll the cast from toe to tibial tubercle. Pull down the stockinet and cast padding at the top of the cast. Fan fold a third roll of four-inch cast tape to six layers (Ex. 3). The length of the fan fold should be long enough to extend from just past the big toe to the tip of the heel. Using the techniques illustrated, apply the fan fold to the bottom of the cast. It is OK if the part of the fan fold that is beyond the first two rolls hangs down (just work quickly). Extend this third roll up to the top of the cast, catching the rolled down stockinet and cast padding to establish a finished look.

Now comes the tricky part. Fold the stockinet and padding on the top of the foot to achieve that finished look



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## TOE PLATFORM CAST

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we all are so proud of. Working quickly, hold the toe end of the fan fold with one hand and fold the stockinet and padding under with the other to help hold it in place (Ex. 4, 5).



With some practice, you can even shape the end of the toe plate to match the cascade of the toes. Using one roll of two-inch cast tape, follow the contour of the top and bottom of the cast. This technique requires you to roll the two-inch cast tape on a bias. Be careful to catch the stockinet on the bottom of the cast. This extra roll of two inch, in addition to reinforcing the toe plate, also reinforces the bottom of the cast for walking. After the cast hardens, fit the cast with a cast shoe.

### ABOUT THE AUTHOR



*Bill Satterfield, OTC has worked at Southwest Georgia Orthopedics & Sports Medicine for the last six years. He spent most of the last 20 years teaching Science to high school students. Bill received his BS degree from the University of Georgia, a MS degree from Albany State University and is currently enrolled in the Nursing program at Darton College.*

## CODING CORNER

### PRE FAB VS. CUSTOM FAB

by Cindy Henderson, OTC, LO

With the ever-increasing cost of running a medical practice, more and more offices are deciding to charge for ancillary services and providing durable medical supplies and equipment is one way to increase the bottom line. However, remember, if you chose to provide this service, it is essential that you keep abreast of the billing and coding changes -- especially if you are a Medicare provider of DME.

Recently, billing codes and descriptions for knee braces were changed as well as corresponding reimbursement procedures. DMERC has clarified that the L1845 for a prefabricated double upright knee orthosis with condylar pads and adjustable joints is a complete code and add-on codes will not be recognized nor reimbursed. DMERC also is stating that the person receiving this type of Knee Orthosis should be ambulatory.

**PROVIDERS BEWARE!** Medicare is tagging certain codes as "hot" codes, and L1846 (custom fab) is one such code. Medicare will send an audit letter requesting further information and documentation before reimbursing charges linked to this code. It is important that when fitting patients with custom fabricated braces that documentation specifically details the need for custom fabricated verse custom fit. The majority of the population will fit well into a prefabricated knee orthosis so if you are using a custom fabricated for some individuals, you should document to justify the medical necessity.

Reasons for custom fab over pre-fab include:

- Severe angular knee deformity
- Disparities in muscle mass between thigh and calf
- Minimal muscle mass
- Thin skin at risk for breakdown
- Excessive thigh tissue
- Leg size will not fit non-custom fabricated

If you receive the audit letter from Medicare, you have 30 days to respond, so make sure your records are complete each time you provide a knee orthosis to prevent delay of payment or denial of Medicare reimbursements.

### ABOUT THE AUTHOR



*Cindy Henderson, OTC, LO has 28 years of experience as an Orthopaedic Technologist. She has been a member of the NAOT Executive Board of 20 years and recently co-chaired the 2004 AAOS OT1 course held in San Francisco. She is employed at The Brace Place in Oklahoma City, OK.*

**WEDNESDAY, AUGUST 4, 2004**

PRE-CONFERENCE WORKSHOPS (2)

1:00 pm - 5:00 pm	Basic Casting	<i>Tony Campagna, 3M</i>
1:00 pm - 5:00 pm	Spinal Bracing	<i>Dulcey Lima CO, OTR/L</i>
7:30 pm - 9:30 pm	Welcome Reception	<i>sponsored by BSN Medical</i>

**THURSDAY, AUGUST 5, 2004**

7:45 am - 8:00 am	President's Welcome	<i>Michael Gill, OTC, OT-SC</i>
8:00 am - 8:45 am	How to Put the Squeeze on Healing	<i>Nancy Hilt, MS, RN, ONC, Aircast</i>
8:45 am - 9:30 am	Fracture Description	<i>Michael Tidwell, MD</i>
9:45 am - 11:15 am	Fundamentals of Fracture Bracing	<i>Augusto Sarmiento, MD</i> <i>Loren Latta, Ph.D.</i>
11:15 am - 3:00 pm	Exhibit Hall Open/Lunch	
1:00 pm - 1:45 pm	Foot Deformities	<i>Wesley King, MD</i>
2:00 pm - 3:30 pm	Tibial Fracture Requiring External Fixation	<i>Christopher Iobst, MD</i>
2:00 pm - 3:30 pm*	Advanced Casting	<i>Tony Campagna, 3M</i>
2:00 pm - 3:30 pm*	FCT: Upper Extremity Munster	<i>Pett Allen, Jr. OTC, BSN Medical</i>
2:00 pm - 3:30 pm*	Clubfoot Cast Application	<i>Johnny Johnson, OTC</i>
3:30 pm - 5:00 pm	Sawbones Workshop: Tibial Fixation	<i>Christopher Iobst, MD</i>
5:30 pm - 7:30 pm	Evening Reception	<i>sponsored by Texas Medical Industries</i>

**FRIDAY, AUGUST 6, 2004**

8:00 am - 8:45 am	Safety in the Cast Room for the Patient and the Tech	<i>Tom Byrne, OTC, OPA-C</i>
8:45 am - 10:15 am	General Business Meeting	
10:15 am - 11:00 am	NBCOT Question and Answer Session	
10:45 am - 2:00 pm	Exhibit Hall Open/Lunch	
2:00 pm - 2:30 pm	Corporate Advisory Board Meeting	
2:00 pm - 2:45 pm	ACL Surgery for Female Athletes	<i>Carl Olliverre, MD</i>
2:00 pm - 3:30 pm*	FCT: Spine	<i>Chris Fletcher, BSN Medical</i>
2:00 pm - 3:30 pm*	Understanding How and Why We Brace OA Patients	<i>Bob Downey, Generation II</i>
2:00 pm - 3:30 pm	Physical Examination of the Knee	<i>Stephen Swirsky, MD</i>
2:00 pm - 3:30 pm*	Reimbursement	<i>Cindy Henderson, OTC, LO</i>
3:30 pm - 5:00 pm	Physical Exam Upper Extremity	<i>Stephen Swirsky, MD</i>

**SATURDAY, AUGUST 7, 2004**

8:00 am - 8:45 am	From the Patient's Point of View	<i>Lynn Casto, OTC, RT(R)</i>
8:45 am - 9:30 am	Wrist Fractures in Children	<i>Kenneth Niblack, OTC, OPA</i>
9:45 am - 10:15 am	Overview of Spinal Surgery	<i>Nathan Leibold, MD</i>
10:15 am - 11:00 am	Breaking the Language Barrier	<i>Lazaro Garcia, OTC</i>
11:00 am - 1:00 pm	Exhibit Hall Open/Lunch	
1:00 pm - 1:45 pm	Cervical Fractures Requiring Halo Fixation	<i>John Ragib, MD</i>
2:00 pm - 3:30 pm*	Halo Traction Set Up	<i>Tom Byrne, OTC, OPA-C</i>
2:00 pm - 3:30 pm*	FCT: Lower Extremity	<i>Pett Allen Jr., OTC</i>
2:00 pm - 3:30 pm*	Fracture Classification (basic level)	<i>Jeff Virgo, OTC, OT-SC, OPA-C</i>
6:00 pm - 9:30 pm	Reception & Closing Banquet	<i>Speaker sponsored by 3M</i>

\*repeated 3:30 pm - 5:00 pm

**REGISTRATION FEES:** NAOT members - \$275

**CEUs:** Approved for 25 hours (maximum)

**HOTEL ACCOMMODATIONS**

The official hotel for the 22nd Annual Clinical Symposium is the Hyatt Regency Miami at the Miami Convention Center. For reservations, please call (800) 233-1234 or (305) 358-1234. Don't forget to mention that you are attending the NAOT Annual Clinical Symposium to receive the reduced room rate of \$135 per night single/double occupancy. These rates will be offered until July 8, 2004, so we urge you to make your reservations as soon as possible. For more information on the hotel, please visit: [miamiregency.hyatt.com](http://miamiregency.hyatt.com).

**NATIONAL ASSOCIATION OF ORTHOPAEDIC TECHNOLOGISTS**  
 22nd Annual Clinical Symposium  
 August 4-7, 2004 • Hyatt Regency Miami • Miami, Florida USA

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## ORTHOTECH PROFESSIONAL • March 2004

### ORTHOPAEDIC DICTIONARY

#### Linea Aspera

A thickened, longitudinal crest on the posterior surface of the shaft of the femur. It is most prominent in the middle third of the femur, where lateral and medial lips are developed. The nutrient foramen of the femur is located along the linea aspera. This crest is an insertion site for the hip adduction muscles and the origin of much of the vastus musculature.

#### Myositis Ossificans

A condition in which heterotopic ossification occurs in muscles and other soft tissues. This general term applies to all three types of ossification – myositis ossificans progressiva, myositis ossificans circumscripta, and localized traumatic myositis ossificans – but is commonly applied to the latter condition. This posttraumatic form usually follows blunt trauma and hemorrhage and is most often seen in the quadriceps muscle and around the elbow. It may be confused with an osteogenic sarcoma if the history of trauma is obscure. It can be differentiated by a number of factors: its presence over the diaphysis; a decrease in pain and mass over time; radiographically, by an intact underlying cortex; and histologically, by a zonal pattern, with the more differentiated tissues at the periphery of the lesion.

#### Talar Tilt

Any abnormal tilting of the superior aspect of the talus from its usually horizontal level with the distal tibia. It is evaluated on a mortise view or stress view of the ankle. The presence of a talar tilt of more than 5 degrees indicates ligamentous injury to the ankle, or can be normal in an extremely loose-jointed patient.

### New Members

NAOT is pleased to welcome the following new members into the association, including our newest CAB Member, **Flex Orthopedic Services**. If you have a colleague that would be interested in joining NAOT, please contact our offices at (925) 472-5822 or via email at [naot@hp-assoc.com](mailto:naot@hp-assoc.com).

Matthew Almeida	Lacombe, LA
Michelle Brady	Brunswick, GA
Sandy Briggs	Richmond, TX
Tracy Brown	Fresno, OH
Arthur Cantu	Ingleside, TX
Daniel Cochran	Oklahoma City, OK
Paige Crowder	Hughson, CA
Rebecca Doucette	Burlington, VT
Jennifer Edwards	Manchester, NH
Jorge Escobar	Chico, CA
Michael Evans, Sr.	Philadelphia, PA
David Fanning	Sparks, NV
Anthony Hampton	APO, AE
Loretta Johnson	San Diego, CA
Jason S Jones	Salem, OR
Glenda King	Florence, AL
Michelle Labosky	Fairlawn, OH
Cathleen Lane	The Woodlands, TX
Mel Laushaul	Bel Aire, TX
Guillermo Leon	Miami, FL
Jennifer Locke	St. Paul, MN
Joanie Mason	E. Bernstadt, KY
Gregory McCabe	Novato, CA
Shawna McCarthy	San Diego, CA
Charles Mears	San Diego, CA
Joann Miles	Janesville, WI
James Miller	Green Bay, WI
Ann Murphy	Conroe, TX
David Ortiz	Anaheim, CA
Ruben Pacheco	Rockwell, TX
Clayton Plenar	Lansing, MI
Patricia Reader	Long Beach, CA
Kevin Sanford	Chicago, IL
Karen Scott	Marion, MA
Christina Yousif	El Cajon, CA