GUIDE TO PREPARATION OF CASES FOR CERTIFICATION

I) **Introduction**

- **It is important that you read and follow these instructions thoroughly.**
- Give particular attention to the areas in **bold**, ***italic,*** or underlined type.
- Non-compliance with the instructions contained therein may result in the rejection of cases.
- Notification of pass/fail results for case documentation will be sent in writing within 2 weeks of the case review process.

II) **Preparing Your Cases**

- **3 fully documented cases are required**
- **Digitized copies** of all **original** chart notes, consultation reports, laboratory reports, pathology reports, etc., must be provided.
- Please be sure to **remove or completely cover any patient's social security number** on any documents before creating the Disc. Patient names and date of birth is optional and leaving it as part of the documentation is in compliance with HIPAA.
- Handwritten chart notes are not accepted. A typed version must be provided.
- **Hospital or other institutional notes must be scanned but do not need to be typed.**
- Radiographs, pathology, lab reports, etc. must be organized into **separate** folders from the chart notes.
    - The contents of each folder must be submitted in **chronological** order.
- Cases in which a patient has been followed for an extended period of time require only the portion of the case relating to the diagnosis provided on Form 111.
    - You must however, submit the initial H & P along with the most current H & P performed for the submitted diagnosis.

III) **Formatting Your Cases**

- Cases must be submitted on thumb drive OR emailed in a zipped folder.
- The preferred file format is PDF and all files must have the ability to open in a Windows environment. Cases must be organized in the following manner:

Folder – Case Number and Patient Initials (e.g. B5 C.J.)

Folder Contents

(Files A & B are mandatory. Additional files are expected, but are created based on the content of each case):

Note: As folders and files are computer generated, headquarters is aware that the order of files may not appear as listed below.

File A – Form 121
File B – Chart notes
File C – Imaging studies
File D – Biomechanical exams
File E – Laboratory reports
File F – Consultation reports
File G – Pathology reports

3) Board Headquarters recommends that the cases be sent via certified or registered mail and applicants **retain** a copy of their receipts. Applicants should retain a copy of all submissions as originals will not be returned.

4) **Send the original disc or thumb drive bearing your name to:**

ABPM Headquarters
1060 Aviation Blvd.
Suite 100
Hermosa Beach, CA 90254

IV) Errors

A) Common Errors in Preparation of Cases

The following are common errors that we find in the **preparation of cases.** Since it is the Board's desire that you pass your case documentation process, you will find that the following lists of errors are repetitions of the instructions found elsewhere in this guide. They are listed for emphasis. **Refer to this list before you seal and mail your disc(s) to us**.

1. Failure to write your name on the disc(s)
2. Failure to include Case Documentation Form 121 with each case
3. Failure to provide the proper formatting of the documentation by designating separate folders for each case and separate files within each case folder
5. **Failure to remove social security number** where listed on all documentation
6. **Submitting original discs from Radiology departments or imaging centers. You must submit photos of the images in JPEG or PDF format**

B) Common Errors in Charting

The following are common **podiatric/medical** errors that we find occurring repeatedly in the applicant's chart records in the handling of their patients:

1. Lack of appropriate patient identification on radiographs and appropriate indication of left or right foot
2. Incomplete or missing history of present illness
3. Incomplete or missing biomechanical examination, if appropriate to the case
4. Missing vital statistics, such as height, weight, etc.
5. Incomplete or missing review of systems (common error)
6. Incomplete or missing history of prior treatment
7. Inadequate documentation of physical examination relative to presenting complaint and patient history
8. Inadequate documentation of medication history
9. Inadequate documentation of primary and/or differential diagnosis
10. Inadequate documentation of lesion size, shape, depth and description, where indicated
11. Failure to document treatment plan
12. Failure to include appropriate radiographic views to depict pathology
13. Failure to include weight bearing radiographs where appropriate
14. Inadequate documentation of post-surgical management, where indicated
15. Inadequate documentation of physical therapy prescription and directions where appropriate
16. Failure to include the relevant classification system when one is utilized e.g. for muscle testing, epiphyseal fractures, etc.