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Medicare and Podiatric Medicine: A 2016 Update

Our experts explore this ever-challenging love-hate relationship.

BY MARC HASPEL, DPM

It's fair to characterize the relationship between physicians and Medicare as one of both love and hate. Of course, most physicians naturally love and appreciate the opportunity to see a multitude of patients each day, supported by this vast federal program. On the other hand, most physicians will most likely admit to hating the increasing rigmarole involved in getting paid for these very same patients. Podiatric physicians are, by no means, exceptions to this rule, especially today. In recent years, for example, podiatric physicians were clobbered annually by the threat of the sustainable growth rate, or SGR, which has since ended, and has been replaced with a new payment system. The light at the end of that long tunnel, however, has been dimmed by the onslaught of new initiatives such as ICD-10 and mandatory PQRS reporting.

Additionally, podiatric physicians must be ready to respond with short notice to newly proposed, and potentially damaging, Medicare LCDs that always seem only to limit patient access and reimbursements for services. Certainly, national organizations and assigned committees stand ready to protect their members in all of these situations. On an individual level, the never-relenting threat of Medicare audits just might lead exasperated podiatric doctors to consider opting out of the Medicare program altogether. Realistically, however, podiatric physicians should arm themselves for the end of fee-for-service payments in favor of a system of controlled fixed payments as the mode of healthcare delivery continues to evolve.


Elderly woman: © Andres www.fotosearch.com

Podiatry Management has assembled a leading panel of experts on these and other pressing issues involving CMS. Joining this month's panel:

Joseph Borreggine, DPM is past president of the Illinois Podiatric Medical Association. He is a Scholl graduate and has been in practice in East Central Illinois for the last 25 years.

Harry Goldsmith, DPM is the CEO of Codingline, a foot and ankle coding, reimbursement and practice management Internet-based information company. In addition, Dr. Goldsmith is a consultant to the American Podiatric Medical Association's Health Policy & Practice Department on matters of coding, reimbursement, and practice management, as well as a consultant to PICA.

Paul Kesselman, DPM has been in private practice for 34 years with significant expertise in the use of DME in the lower extremity. He is

Continued on page 88

Medicare *(from page 87)*

chair of APMA's DME Workgroup, under APMA Health Policy committee and is a former member of APMA Coding Committee. Dr Kesselman performs peer reviews for several insurance companies and is an expert panelist for Codingline.

Janet Simon, DPM has been in private practice in Albuquerque, New Mexico since 1991 and is partner in a single specialty group, Foot and Ankle Associates of New Mexico. She has served as New Mexico's CAC and PIAC representative since 1995; she is past president of the New Mexico Podiatric Medical Association and is currently Executive Director. Dr. Simon is chair of APMA's Public Health and Preventative Podiatric Medicine Committee and is Governing Councilor for the Podiatric Health Section of the American Public Health Association. Salt

Phillip Ward, DPM is president, American Podiatric Medical Association. He has been a member of the APMA Board of Trustees since 2004. He graduated from the University of North Carolina in Chapel Hill and received his Doctor of Podiatric Medicine from Des Moines University and followed that with a residency and a fellowship in foot surgery. He practices in Durham, NC within a large statewide podiatric super group. He is board certified by the American Board of Foot and Ankle Surgery and by The American Board of Podiatric Medicine. He is the podiatric advisor to the AMA CPT Panel and serves on the AMA CPT Assistant Editorial Board. He is the first podiatrist ever to be elected to that panel. He is a past president of the North Carolina Foot and Ankle Society and is a former city councilman.

PM: *How has the end of the sustainable growth rate, or SGR, affected podiatry?*

Ward: The general consensus on the end of the sustainable growth rate, or SGR formula, as the basis for determining Medicare physician reimbursement, has been a good thing for the medical community, including podiatric physicians and surgeons. APMA has long advocated for repealing and replacing Medicare's fundamentally flawed SGR. The SGR formula often led to unsustainable deep rate deductions from year to year, which were fortunately never realized, but which always had to be addressed with last minute fixes from Congress. The SGR was replaced on April 16, 2015, with the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Much uncertainty, however, remains around the new payment environment created by MACRA, which puts in place a new system that looks to reward quality, efficiency, and innovation. APMA, along with other specialty medical societies, will lead the effort to identify quality measures and develop alternative payment models that will be used under a revised reimbursement system. These measures will address clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. APMA will be on the forefront in working to ensure these measures and models make sense for podiatric physicians and their practices.

APMA, along with other specialty medical societies, will lead the effort to identify quality measures and develop alternative payment models that will be used under a revised reimbursement system.—Ward

Borreggine: Many doctors did breathe a sigh of relief when legislation passed to end the SGR. What they did not take notice of are the numerous pages attached to the bill that completely change reimbursement in the future for physicians. MACRA creates a time-table till 2019 that guarantees physicians a 0.5% increase in their fee-for-service payments. By 2019, however, physicians must choose a path for reimbursement for their practices: either the Merit-Based Incentive Payment System (MIPS) or another alternative payment model. Alternative payment models have already entered the scene, i.e. bundled payments, patient-centered medical homes, value-based reimbursement, accountable care organizations, to name a few. The common denominator in these programs is that they are all tied to metrics. The care provided must be at the highest quality, yet at the cheapest price. With EMR on the scene, the data provided will guide patients, and more so, guide insurance companies to seek out cost-effective providers.

Simon: The annual uncertainty along with the extra work that accompanied the flawed SGR is gone. For the past several years, our offices were challenged with starting the year with one physician fee schedule that was then updated a month or so later, requiring time-consuming adjustments to patient accounts.

Having a known fee schedule is helpful for our offices' budget forecasting, and the SGR replacement MACRA maps out specific annual updates to payments for the next ten years and beyond.

Also, associated with the legislation that fixed SGR was the reinstatement of global surgical bundles that had been the method of payment since the early 1980s. Although still on CMS' radar for the future, the disruption in our offices that would have occurred if these global bundles went away would have been great, in combination with the transitional anxieties that ICD-10 held for us. The doing away of these global bundles seems to me to be in the opposite direction from what is occurring in other medical services payments with global bundling being proposed and beta tested in several different settings.

Continued on page 90

Medicare *(from page 88)*

Goldsmith: The end of SGR signals the end of the annual fight over future Medicare payment levels that were determined based on what everyone knew to be a flawed sustainable growth-rate formula. Now there is hoped to be some semblance of predictability in the fee reductions doctors have learned to expect from Medicare, without the wild swings in the fee schedule allowances that were seen previously and, later on, readjustments in payments.

Kesselman: Unfortunately, the new formula is over seventy-five pages long and extremely complex with many unknowns. There are bound to be many changes to come prior to its implementation in 2016. The average practitioner of any medical specialty has neither the time nor the abilit, to properly understand all the challenges this new complex formula presents. APMA and other organized medical associations must be sure that their constituents are adequately represented throughout the process.

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PM: *What problems have arisen with PQRS and how should they be dealt with?*

Kesselman: PQRS has been a huge problem for certain providers who did not adequately receive the proper training for its implementation, or whose IT systems did not properly integrate and report the appropriate codes. It was even more difficult for those who did not use EMR to track their PQRS performance, and who relied on paper documentation, and then reported the appropriate HCPCS codes on their own. The CMS website and personnel also do not appear to have been adequately staffed to handle the amount of complaints they received. As a result, many providers continue to have the ideology that the penalties of not reporting PQRS are worth taking.

Ward: APMA is in general support of PQRS, Value Modifier (VM), Meaningful Use, and similar programs that rely on measure development and reporting, and encourages our members to participate in the interests of patient safety and favorable reimbursement. In fact, podiatric physicians and surgeons have been among the most active adopters of these measures. Nevertheless, a number of issues have arisen with the advent of PQRS and Meaningful use. Our primary concern is that these measures are meaningful to our members, and that they reflect the current practices of podiatric physicians and surgeons; and APMA has advocated strongly on behalf of the profession to establish these measures. Of course, APMA recognizes the additional burden that the recording of these measures places on the daily practices of our member physicians and, therefore, expect that CMS would implement this program in a fashion so that it is best positioned to succeed. More recently, our members have been experiencing issues with the notification process for alerting affected physicians facing possible penalties. In many cases, notification letters were late or failed to explain why penalties were applied. APMA has sent a letter to CMS to request that stronger steps be taken to protect physicians from 2016 Medicare payment penalties stemming from data issues and systemic problems within PQRS and Value Modifier (VM) programs. One suggestion offered was to apply a hold harmless policy for all physicians assessed a penalty, so long as they attempted to comply in good faith.

Borreggine: CMS has built an over-regulated, and under-innovative, digital world that does not let the physician practice medicine. PQRS, or as it should be called, "Quality Data Collection", was set for the government to see how well physicians are practicing medicine. There are 22 unique webpages at CMS.gov to teach physicians how to participate in PQRS. Most of the pages have up to a dozen more links to more pages only leading to increased confusion. All this is time-consuming work for physicians in order to avoid a 2% payment reduction from Medicare. Physicians have even brought in tech teams to extrapolate the data from their offices to send to CMS. Taking into account the cost of computer hardware and software for EMR, along with the time needed to gather the data and attest to it, I feel that it is clear that doing all of this is not worth saving the two percent. More importantly, this exercise takes time and energy away from physicians spending time with their patients, which, of course, is what the primary job should be.

CMS has built an over-regulated, and under-innovative, digital world that does not let the physician practice medicine.—Borreggine

The worst part is following all the instructions, and uploading the data, only to have it rejected by CMS for some fault in the data recording, which, most of the time, physicians have correct but CMS computers cannot recognize. It even still remains unclear what CMS will do with the data. I feel that PQRS reporting is nothing more than another forced step placed upon physicians to take to ultimately leave Medicare.

Continued on page 92

Medicare *(from page 90)*

Q ***PM:*** *What have been/might be the advantages and disadvantages of ICD-10?*

Goldsmith: Regarding ICD-10, I find several advantages and disadvantages. The biggest advantage is that the United States is using the same basic diagnostic system as 130-some other countries, which allows for much more detailed descriptions with more accuracy and more specificity. On the other hand, all the other countries will be moving to ICD-11 in a few years, and the United States will once again be behind for a long time. A certain disadvantage, I find, is with the CMS/CDC inclusion of laterality, and the 7th character in ICD-10. This is something which is unique to the world, by the way, and only adds to the burden of the transition, increases the cost of practice, and lowers productivity. In reality, there was no real urgency to add these coding requirements since payers, the primary benefactors, in my opinion, have not established what they are going to do with that extra information, which, in the end, may or may not be accurate.

Simon: I actually see no advantages to ICD-10. The disadvantages I see include needing multiple resources to verify correct ICD-10 coding that has only added to the cost of doing business, and increased amount of time spent by physicians and billing staff. It has not resulted in direct improvement in patient care whatsoever.

Ward: ICD-10 was designed to address gaps in diagnosis code reporting, and to allow for greater specificity in documentation and reporting. APMA's Coding committee has done an excellent job preparing APMA's members for the transition to ICD-10, including the crosswalks and notes on the APMA Coding Resource Center, over 20 free webinars and seminars, as well as the resource page at www.apma.org/icd10. It is fair to say that APMA's members were better prepared than any other medical specialty in the country. There have been, however, some issues related to the transition, most notably with the transition to ICD-10, and generally involve the omission of diagnosis codes frequently used by podiatric physicians.

Borreggine: ICD-10-CM offers greater detail and increased ability to accommodate new technologies and procedures. The codes have the potential to provide better data for evaluating and improving the quality of patient care. For example, data captured by the code sets could be used in more meaningful ways to better understand complications, design clinically robust algorithms, and track care outcomes. ICD-10's increased specificity offers payers and providers the potential for considerable cost savings through more accurate trends and cost analyses. Greater detail can improve payers' abilities to forecast healthcare needs, trends and analyze costs. It will improve payers' and providers' ability to monitor service and resource utilization, analyze healthcare costs, monitor outcomes, and measure performance. In other words, it is for the insurance companies to find ways to deny or reduce payment. There is no direct benefit for physicians.

Kesselman: What I find troubling about ICD-10 is that while Medicare carriers tested their computers to see if the ICD-10 codes would be recognized, they failed to properly ensure that they would agree with the many specific CPT codes contained in their governing LCDs. As a result, we have seen a proliferation of denials rejecting for the given reason of not having "a valid diagnosis". Also, many LCDs did not properly cross-walk many of the ICD-9 codes to ICD-10. Of course, a direct code one-to-one or one-to-three translation may have been successful, but the more extensive code translation ratio of one to ten, or greater, as in the case of routine foot care or therapeutic shoe claims, has been a nightmare in many Medicare jurisdictions. Fortunately, the policy writers and computer IT teams at the Medicare MACs have appeared to be taking full responsibility for these flaws, but the time table for their repairs is, at best, unacceptably too long.

Q ***PM:*** *How can podiatric physicians best prepare for the end of fee-for-service payments?*

Ward: Though it may appear that the end of fee-for-service may not be as immediate as some healthcare analysts have predicted, it is reasonable for podiatric physicians and surgeons to determine how they fit into the evolving model of healthcare reimbursement. We already know that MACRA puts in place a new system that looks to reward quality, efficiency, and innovation. APMA, along with other specialty medical societies, will lead the effort to identify quality measures and develop alternative payment models that will be used under a revised reimbursement system. These models and measures will address clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention.

APMA will work with other societies in developing innovative models that include the services that podiatrists provide to their patients, and which also correctly reflect the value that podiatric physicians play in that treatment of these patients. Podiatric physicians, themselves, will need to use available tools to demonstrate their individual values and to market themselves to large medical groups, IPAs, or hospital systems, to name a few. APMA is working with a number of parties to enhance the metrics by which doctors of podiatric medicine can measure themselves against other specialties, including such measures as work relative value units, which

Continued on page 94

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Medicare *(from page 92)*

allow potential payers and employers to evaluate podiatric practitioners on an equal footing with their MD and DO colleagues. While there likely will remain a role for smaller practices, many podiatric physicians and surgeons may find that they are better able to compete by aligning themselves with larger groups, multispecialty groups, or hospital-based systems.

Simon: New payment systems are on the horizon, but it is unlikely that those systems will totally replace fee-for-service entirely. To prepare for this shift that has been occurring in the last several years, for which the office of Health and Human Services has been gathering quality data, podiatric physicians must not bury their heads in the sand, but rather gather, and discuss, through their professional organizations, the impact these changes will have on providing quality medical care to their patients. Since the healthcare system does have significant variances throughout the country, alternative payment methods may not make practical sense in communities where the requisite infrastructures are not developed.

Nevertheless, even if with the advent of some type of alternative payment methods, fee-for-service will continue to play some role in reimbursements especially during the transition period. The government can do much to facilitate physician-led improvements in care, not just by setting goals and providing funding, but also by simplifying reporting requirements, eliminating poor or redundant measures, and easing counter-productive regulations like meaningful use. It also can help physicians do what they are intrinsically motivated to do, which is to provide the best possible care to their patients.

Goldsmith: This is a very serious question. Payers, primarily led by CMS, are moving very rapidly to replace fee-for-service for alternative payment models, the details of which are still under development. The problem for podiatric physicians, as well as other physicians, many of whom are in solo or small group practices, will be competing for patients and dollars, if they are not part of a larger entity like an accountable care organization, hospital provider network, some large medical group, medical home, or independent practice association. I strongly recommend that podiatric physicians not wait for the hammer to fall. Short of retirement, there may be no other realistic alternatives, other than to conform. I recommend looking for quality seminars or talks on the subject of alternative payment models, joining or forming groups, and weighing the benefits and negative aspects of each choice.

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Borreggine: I see the following inevitable trends developing. With higher insurance deductibles, private practices in medicine will be far and few in-between. Those remaining will be on a cash-for-service basis. The culture is slowly transitioning to a cash payment for services. Also practices should be prepared for all-inclusive care, which would include running small operating rooms, pharmacies, and physical therapy departments. Hospitalization will be for the very sick and trauma surgery only. Making a transition now out of the hospital for surgery will reap rewards down the road. With the advent of very safe anesthesia meds, office-based surgery will be the norm down the road. Procedures should be kept simple, effective and, most of all, keep patients ambulatory.

PM: *What is your opinion of the controversial new Novitas Medicare LCD regarding painful fungal toenails?*

Ward: APMA is aware of and handling a number of issues related to local coverage determinations including the Novitas Debridement of Mycotic Nails LCD (L35013). APMA, and the Novitas Carrier Advisory Committee (CAC) representatives have known about this issue for some time and have been working to address it. One must understand that Medicare only covers symptomatic foot care. The fact is, and has always been, that the toenails must be painful. Medical records must always have included documenting which of the nails are causing the pain, and stating as to how that pain affects the patient. Those CAC reps, with the guidance and assistance of APMA, have formulated a response and have taken these concerns to the Novitas medical directors. Per these discussions, it appears that the impact of that LCD may not be as problematic to podiatric physicians as first believed. APMA's CAC representatives discussed this policy along with other troublesome policies at our most recent annual joint meeting of the CAC and Private Insurance Advisory Committee in November in Washington, DC.

Goldsmith: I'm not sure that Novitas even knows what it is doing. Certainly, its LCD is confusing regarding whether lab evaluation of nail specimens is needed to confirm the presence of mycosis, and whether definitive treatment, for example, in a 92 year old semi-comatose patient with severely infected thick ugly nails which are painful qualifies for debridement of the nails at all. Certainly, that patient doesn't need a pharmacological miracle, but instead needs periodic humane palliative care of the nails over the long term. All the other MACs seem to accept that a mycotic toenail is diagnosed upon appearance. In reality, the Novitas policy could

Continued on page 96

Medicare *(from page 94)*

well end up being the financial boon that pathology laboratories have been waiting for to cash in on all those forthcoming fungal cultures.

Kesselman: Patients who are candidates for pharmaceutical treatments, whether topical or systemic, should absolutely be cultured; particularly those patients being treated for reasons of pain. There are a myriad of medical/legal and economic issues as to why one should culture these types of patients. Conversely, I don't believe, however, that patients, particularly the elderly, and those receiving palliative care, need to be cultured. This would truly be an added unnecessary expense for Medicare. Realistically, whether patients have dystrophic toenails, because of mycosis or psoriasis, or a myriad of other disease states for that matter, they still require palliative care. Culture results will not impact the care they receive in the least. Denying them this care will only serve to have a huge negative impact on their health and well-being.

Simon: For many years, I have personally been involved in monitoring my carrier's LCD on painful fungal nails. At times, it has been clear that the carrier has been attempting to drive down utilization. LCDs are fraught with interpretation problems for they are often poorly written, and this particular LCD in question is no exception. I do not feel this new LCD version of this policy will have great effect in my state, for the message has previously been disseminated that coverage for these services is already very limited. If nail debridement procedures are performed without well-documented pain per toenail, then these services must be self-paid by patients.

Q ***PM:*** *In general, how should podiatric physicians deal with prospective changes in Medicare LCDs that may negatively impact their practices?*

Borreggine: The only thing that I can suggest is to continually stay as updated as possible with respect to the ever-changing LCDs. As previously noted, an egregious problem right now is that with ICD-10 transition, the cross-reference ICD-9 to ICD-10 code set did not include all the codes that were usually available to qualify for use with specific CPT codes that are normally used in podiatric medicine. In turn, this has caused delay in payments and reduced cash flow to medical practices.

Simon: First, I recommend podiatric physicians getting on the email lists from their carriers or have assigned staff be reviewing the LCDs on a regular basis. The Medicare CAC representatives are doing their utmost to stay on top of the proposed changes and alerting the podiatry community of possible effects, but they cannot do it on their own. When requests are released to review specific LCDs, the podiatric community must do so promptly, and submit their comments back to their CAC representatives and to their Medicare carriers. Today, this is an easy process done via the Internet, and is extremely important for the podiatric perspective to be heard. Podiatric medicine is a small specialty, and changes deemed insignificant by the carrier can have huge financial impacts. This year, podiatric CAC representatives dealt with an LCD change that would have denied podiatric physicians the ability to supervise hyperbaric oxygen therapy. This ultimately was defeated by the coordinated efforts of our CAC representatives supported by APMA.

Kesselman: I, too, urge podiatric doctors to be proactive. They must stay in touch with their CAC representatives. Also, they should educate their patients so that their patients understand the value of the services provided. In terms of taking appropriate action, I suggest starting a letter-writing campaign with patients to local congressional delegations. Patients can be the best advocates and often possess important contacts their physicians don't have. At the very least, I recommend that podiatrists attend their local division meetings to stay informed.

Q ***PM:*** *How can APMA make certain active groups like the RUC and the CAC more effective in protecting the interests of podiatric physicians?*

Ward: RUC and CAC reflect excellent opportunities for APMA and our members to have a powerful voice in the evolution of healthcare, due to the access they provide our members to key decision-makers. In the RUC environments, our members are part of critical committees that determine how fees are set for how our physicians get paid. APMA's representatives have established valuable relationships with other specialty society representatives that podiatric physicians rely upon in many other situations. As an example, APMA has already been involved with other specialty societies in discussions that will drive the creation and implementation of alternative payment models in the emerging healthcare environment. APMA will remain vigilant to ensure that newly developed models include services that the members provide to their patients and that adequately value podiatric physicians' contributions to this care. Similarly, through the CAC process, APMA's CAC representatives have direct access to the carrier medical directors and drafters of the LCDs, and policies that directly impact the services that the members

Continued on page 98

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Medicare *(from page 96)*

provide. Many of the CAC representatives have established professional relationships with their carrier medical directors that give them direct insight and input into the drafting and implementation of these policies. In fact, these carrier medical directors often reach out to these same CAC representatives proactively with questions or concerns.

When adverse policies or provisions are occasionally drafted and put forth, the CAC representatives are able to notify APMA and work directly with the MACs to address these problematic terms. APMA also benefits from strength in numbers, and has frequently coordinated the efforts of all CAC representatives in individual MAC jurisdictions through conference calls or joint letters to the MAC. APMA is currently exploring options to allow for more efficient and expedient communication among the various CAC representatives that allow for additional flexibility. APMA has also helped solidify the relationships among CAC representatives, the carrier medical directors, other MAC officials, and APMA by consistently inviting these officials to speak again at the annual CAC-PIAC meeting each November in Washington, DC.

Borreggine: The Relative Value-Based Update Committee and the Carrier Advisory Committee are both vital the podiatric profession. RUC provides surveys to the profession to obtain the relative value units of a CPT code based on the time involved in the care and treatment of a patient. Hence, these RVUs create the payment base for a CPT code. Global time frames for most surgical procedure codes are either 10 or 90 days, and there is concern that global periods will be eliminated in the near future. This will certainly reduce reimbursement potential for any care provided by podiatric physicians if particular diagnoses are used even after the primary problems have been resolved. RUC is also responsible for participating with the AMA in the CPT coding committee to make sure that the codes that are used by the majority of the podiatric community are protected, and not withdrawn or eliminated from use. The CPT coding committee is also responsible for establishing new codes that either have to be refined or established to better reflect the practice of particular specialties. Thus, it is very important that the APMA have well informed members in RUC, who best protect the interests of podiatric medicine.

I feel that the purpose of the CAC is self-explanatory. As the APMA states on its web site, "Carrier Advisory Committee (CAC) representatives serve to improve the relations and communication between Medicare and the physician community, disseminate proposed LCDs to colleagues in their respective states and specialty societies to solicit comments, disseminate information about the Medicare program obtained at CAC meetings to their respective state and specialty societies, and discuss inconsistent/conflicting LCDs."

Simon: Put simply, the effectiveness of APMA and its dependent sub-committees is directly related to the input it receives from the membership. When podiatric doctors are asked to participate in the RUC surveys or review LCDs, they should do so in a timely manner.

Kesselman: APMA must strive to become a full participating member of the RUC as is the case with other medical specialties. It makes absolutely no sense that APMA is relegated to a second-class status. Despite this scenario, members who do receive RUC questionnaires need to properly and promptly respond. CAC representatives are, for the most part, very knowledgeable with respect to coding and policy. I've often heard that CAC reps do not respond to complaints as effectively as they can. Perhaps it's more likely that those complaining are not getting the answer they want, or that the CAC representatives are being frustrated per usual by Medicare. In many cases, CAC reps receive complaints verbally, but don't receive the requested written documentation required to follow through with the carriers. Incidentally, PIAC representatives also face the same level of difficulty.

PM: *If faced with Medicare audits, what steps do you recommend podiatric physicians take in response?*

Goldsmith: First and foremost, when faced with a true Medicare audit, not a simple request for records on a single patient, I recommend that podiatric physicians contact their malpractice insurance carriers

Continued on page 99

Medicare (from page 98)

to get advice, and also to see if they have Administrative Defense Coverage. This type of coverage may be labeled differently among liability companies. Years ago, the recommendation was that, if asked for thirty or more charts or dates of services, physicians should contact their attorneys. Now, with all the agencies out there auditing, not only government plans but also commercial plans, they mustn't hesitate at seemingly benign audit requests; those indeed may be probes for bigger things to come. It takes representatives with a depth of knowledge on various topics to defend physicians faced with audits.

Ward: When faced with audits, while APMA encourages its members to comply fully with the requests of the audit, APMA also recommends that members understand that they have rights as well as responsibilities. APMA recommends that members carefully read all materials they receive and use the contact information provided, if they have questions, and to be sure to document all correspondence with the payers, including timeframes. Many members may not realize that their medical malpractice carriers frequently offer advice or support for no additional cost under the terms of their policies to those facing audits or audit defense. For any issues related to physician payment which impact the financial well-being of their practices, APMA recommends that members consider obtaining attorneys licensed in their jurisdiction who are familiar with healthcare law.

Audits are now a common reality in practice today.—Simon

Kesselman: Physicians should never ignore audit requests, no matter how small. There are many types of audits with some random, and others targeted. Some are pre-payment, while others are of the post-payment variety. Many professional insurance carriers do now offer audit protection as an included benefit. This provides both legal and expert witness assistance to mitigate or avoid losses altogether. In today's climate, having this protection should no longer be considered a luxury.

Simon: Audits are now a common reality in practice today. I feel that identifying what type of audit and the audit's scope is first on the list. If it's a pre-payment audit, or post-payment audit of one or two charts, the exposure is minimal. If it's a comprehensive audit of five charts or more, this suggests that the carrier is seeking a pattern of miscoding. If the carrier finds a pattern, overpayments can translate into big money, and in rare cases, the audits may result in criminal or civil penalties. That's why podiatric physicians need to be prepared. By contacting their attorneys and malpractice insurance carriers, physicians can hire coding experts to review the charts, preferably prior to submitting them to the carriers.

Of course, all charts need to be reviewed by the physicians before submitting them to the carriers. In every instance, physicians must be certain to include everything that could support each of their claims. For example, if a history refers to an earlier note, that note must be provided. If there is any missing documentation supporting the claims, a clearly labeled and dated addendum should be added, or that information should be included in an explanation on a cover letter. Needless to say, these audits are inconvenient, but they needn't hurt podiatric physicians or damage their practices unnecessarily.

Q ***PM:*** *Discuss the possible advantages/disadvantages of deciding to opt out of Medicare.*

Goldsmith: Obviously, there is a big difference between opting out of Medicare and simply choosing nonparticipating provider status. In opting out, for a two year period, doctors are completely out. Payment of fees is handled between doctors and the patients only. The advantages are elimination of audits, Medicare penalties, PQRS, and so on. The disadvantage is that if practices rely on surgery, trauma, even nursing home volume, doctors may feel resistance when patients

Continued on page 100

Medicare (from page 99)

balk at paying out-of-pocket. On the other hand, cash practices or practices that limit themselves to palliative care, other than in nursing homes, or just evaluation and management services, for example, might be prime candidates for opting out.

Simon: The biggest advantage I find to opting out is that physicians will have no worries about whether the care provided will be reimbursed. The looming disadvantage is that many patients who rely on their Medicare insurance to cover the cost of care, will ultimately transition to a new podiatric physician who has remained in Medicare. Patients are generally financially conscious and, with the ever-rising cost of healthcare, they may be fearful of new uninsured expenses. The loyalty of patients to stay with opted out physicians, in my opinion, is probably limited.

Ward: Currently, there are a number of converging issues, including the advent of the Merit-Based Incentive Payment System (MIPS), alternative payment models, quality measures, and ICD-10 that raise questions about the future of reimbursement, and which may lead members to reconsider their relationship with Medicare and consider all available practice options. In considering whether or not to opt out of Medicare, podiatric physicians, like other physicians, may want to consider a number of issues including, but not limited to, the demographics of their patient populations. In addition, they may want to consider whether or not most of their patients can afford their fees for visits, tests, and/or surgery, and of course, what other podiatric competition exists in their practice areas. Podiatric physicians would also need to consider their practice types, including their percentage of Medicare patients. Moreover, physicians may also need to be prepared to offer selected patients pro-bono treatment.

Kesselman: I believe that if podiatric physicians can develop unique practices in economic environments where they can opt out of all plans, not just specifically Medicare, then deciding to opt out would be an option to strongly consider seriously. Having niche practices in areas where patients can both afford and are willing to pay for services sounds ideal. They are, however, the types of practices that most physicians, podiatric or otherwise, cannot likely easily achieve. **PM**

Dr. Haspel is senior editor of this magazine and past-president of the New Jersey Podiatric Medical Society. He is a member of the American Academy of Podiatric Practice Management.