



Developing Your “Whole Body” Diabetic Treatment Program



Proper evaluation and patient education are key.

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Practice Management Pearls is a regular feature that focuses on practice management issues presented by successful DPMs who are members of the American Academy of Podiatric Practice Management.

The American Academy of Podiatric Practice Management (AAPP) has a forty-year history of providing its member podiatrists with practice management education and resources they need to practice efficiently and profitably, through personal mentoring and sharing of knowledge. To contact AAPP call 517-484-1930 or visit www.aappm.org.

As we all know, the diabetic patient can provide a continual source of revenue to your practice, but are you truly maximizing your profits by fully incorporating a whole body medical management approach? After all, a diabetic patient is not only foot care and shoes. Diabetics are comprised of systems that interconnect, and can directly impact each other. Podiatrists are doctors, not glorified nail technicians, so it is time to approach the patient from the mindset of a physician, and instill that mentality in the patient as well. This is where the education begins.

In order for the patient to truly understand diabetes and its effect on the body, spending time educating the patient and establishing trust in your medical care, as their physician,

is critical. This is where the numbers come in to play. According to the American Diabetes Association (ADA), a Hemoglobin A1C of 6.5% is officially the value associated with diabetes which clinically correlates to a fasting plasma glucose (FPG) of 126mg/dl or a random plasma glucose test of 200mg/dl.

As you can imagine, A1C is the last number that most patients understand most clearly. Therefore, it

their individual physical and mental capabilities, in the presence of other co-morbidities.

Initial Encounter

On your initial encounter with the diabetic patient, perform a comprehensive diabetic examination (CPT 99203 or 99213), and based upon that, devise a treatment program with the patient to address his/her individual needs. It is with this program that

It is your job to help diabetic patients understand what their Hemoglobin A1C means in terms of their glucose levels.

is your job to help them understand what their Hemoglobin A1C means in terms of their glucose levels. Now here is where it becomes confusing for the patient and many practitioners because the American Association of Clinical Endocrinologists (AACE) recommends a target Hemoglobin A1C below 6.5%, the ADA recommends values be below 7%, and the American College of Physicians (ACP) contradicts the ADA and AACE, and recommends a Hemoglobin A1C between 7% and 8%.

With the discrepancies in recommendations, it is your job, in conjunction with the patient diabetic doctor, to help the patient establish a healthy and realistic goal based upon

the timeline and importance of routine diabetic foot care can be discussed and established. Be mindful of what they are wearing into your office and evaluate the patient's footgear. Work with them on selecting appropriate diabetic shoes and insoles based on lifestyle, activity, and swelling. Discuss the importance of vascular testing, and evaluation and treatment of structural and “neuropathic” symptoms to their feet.

Treatment Program

Your diabetic treatment program should almost always include in-office vascular testing. Performing an ABI (CPT 93923) is not only

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a more thorough way to assess a patient's vascular status, but it is a great source of revenue in the office. We are all well aware that many of the vascular changes associated with diabetes are initially silent, and the majority of diabetics, including

Charcot Restraint Orthotic Walkers (CROW) may need to be utilized. Now, evaluation for shoes should not be the only aspect assessed. Muscular strength and gait are critical determinants for the long-term physical and mental health of a patient.

For the most part, it is true that the independent patient lives longer.

subjective complaint of burning, tingling, and numbness by the diabetic patient is not always what it seems. There are numerous conditions that can masquerade as diabetic neuropathy, or can magnify the severity of the symptoms; therefore, it is important to fully evaluate the patient for these possible etiologies, and devise a treatment regimen for specific needs.

The podiatric physician must rule out the possible presence of nerve entrapments, neuromas, sciatica, radiculopathies, and autoimmune conditions. Many diabetic patients have undiagnosed autoimmune disorders and deficiencies that can be the primary source of their symptoms or are contributing to them. It is important to take the time to obtain a proper personal and family history on the patient. A neuropathic profile can be performed to evaluate for some of these possible conditions. The profile should include, at minimum, a CBC with differential, thyroid function, CMP, Hemoglobin A1C, B-Vitamins: B1, B3, B6, B12, Vitamin E, and Vitamin D 25-hydroxy.

More in-depth testing for assessment of an autoimmune disorder

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well-controlled patients, manifest these changes internally. Therefore, it is recommended that diabetic patients should have a baseline ABI performed. All patients with abnormal results should have the test repeated at least once a year, and high-risk patients can have the ABI performed every six months. This is where establishing trust in your medical evaluation skills comes in to play. Every patient is told that this pain-free vascular test is used to identify any underlying problems that may even be unknown to the patient. Being able to discover abnormal values in the patient's vascular status will aid in increasing the chances of obtaining successful treatment by a vascular surgeon in a reasonable timeframe, thus lowering their risk of an amputation.

Lowering Amputation Risk

Amputation risk is also lowered when the podiatric physician appropriately assesses the foot for any structural abnormalities, and provides accommodative and supportive devices to address these deformities. Pending the examination, the patient may simply need heat-moldable or custom diabetic insoles with diabetic shoes. As a general guideline, if the patient has any structural deformities, a custom diabetic insole should always be utilized. This is not because it is more profitable, but because it will provide a greater level of protection for the patient. Of course, in more severe situations such as rocker-bottom foot types associated with Charcot, custom-molded diabetic shoes, Bledsoe Conformers, or

Patients who shuffle, are off-balance, have profound foot or ankle deformities, those who are weaker and rely heavily on an assistive walking device are at greater risk for falls that lead to permanent impairment and rapid decline in physical and mental health. Therefore, assess the patient for possible AFO brace utilization.

There are numerous braces that can be fabricated to account for chronic ankle joint instability, ankle and foot deformities, severe PTTD, or balance issues. Selecting the appropriate AFO brace based upon the individual need of the patient, in con-

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junction with prescribing physical therapy for gait training, strengthening, and brace utilization can yield a more independent patient—a patient with the capacity for increased physical activity, and with a decreased probability for the depression that is often associated with dependency and loss of mobility. Aiding in improvement of physical and mental well-being is what makes us better physicians.

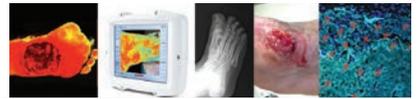
Diabetic Neuropathy

The evaluation of “neuropathic” symptoms is far more complex than many practitioners truly realize. The

should include P ANC A, C ANCA, ANA, HLA B27, Anti-CCP, Rheumatoid Factor, C3, C4, CH50, ESR, and C Reactive Protein. All test results should be discussed in person and you, as the physician, may need to prescribe a medication to treat a deficiency or potentially refer the patient to a family physician or rheumatologist for further treatment.

Do not be afraid to perform more invasive neurological tests when the answers are not very clear, or the patient requests further confirmation. A simple in-office procedure that can be performed is epidermal nerve fiber

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density testing (CPT 11100) to assess for small fiber peripheral neuropathy. Depending where you practice, in-office EMG (CPT 95860-95864) or NCV

new drug, start the patient on a low dose, and have the patient return to the office in one month to evaluate the current drug regimen. To ensure compliance and deterrence of abuse, perform intermittent urine

patient go unaddressed.

Lastly, do not fear stepping on another physician's toes. Your patient came to you with a problem, and they are trusting you to use your medical expertise to provide them the care they deserve and need. The way you approach the diabetic patient is what can distinguish you from "a toenail doctor" to a respected practitioner. It is important for you, as podiatrists, to realize that you do not only treat the lower extremity, that the systems of the body are connected, and you must therefore treat the body as a whole. **PM**

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(CPT 95907) can be performed. Often times, patients will have underlying spinal issues that may warrant a referral to a spinal specialist.

When dealing with neuropathy pain, do not fear prescribing patients medications that may decrease the severity of their symptoms. Pharmacological agents such as Gabapentin, Lyrica, Cymbalta, and Amitriptyline have been proven to be very effective medications to combat these subjective symptoms. When initiating a

drug screens, and monitor the scheduled prescription electronic reporting system, if available in your state.

Evaluating and treating the diabetic patient can be profoundly complex. It can be both financially and professionally rewarding. When providing care, do not be afraid to order or perform tests. Also, don't assume that someone else, such as the patient's family care physician, has already performed these. Much of the time, complaints by the diabetic



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