Offering EOTTS as a Patient-Pay In-Office Procedure

Here's a way to combine clinical good sense with solid practice management.

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Editor's Note: *Readers should be aware that Podiatry Management does not specifically endorse any of the technologies, concepts, or products discussed in our "Clinical Innovations" series.*

Health insurance was developed as a solution to assist people in paying for medical care of "very expensive" diseases. Over time, entropy crept in to create an absolute monster. Healthcare reform is necessary and is long overdue. Unfortunately, the general population has grown accustomed to having nearly all medical services covered with minimal contribution on their part. Now, deductible and co-pays have sky-rocketed and the payments to healthcare providers have dropped considerably. Healthcare providers are probably the only profession whose reimbursement for services provided has continued to shrink, year after year.

There are many orthopedic solutions that foot care specialists would like to offer their patients, but the health insurance industry has made every excuse not to cover these treatments. One such treatment is the minimally invasive hindfoot stabilization procedure involving the insertion of a sinus tarsi implant. The loss of stability and alignment of the talus on the calcaneus and navicular bones is orthopedic disease. This pathologic condition will never "auto-repair." It doesn't get better, it just gets worse.

The medical necessity for the use of sinus tarsi implants is well-established. It is very difficult for a foot specialist to argue against the hundreds of published, peer-reviewed articles documenting the need for a stable and aligned foot structure. Hundreds of millions of dollars are spent every year on arch supports whose primary role is to "treat" overpronation. There are millions of people suffering because of their misaligned feet with chronic pain to not only the the feet, but also the knees, hips, and back.

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So how are you going to treat those patients who have symptoms related to their misaligned talotarsal joint? Observation is medical neglect! Excessive abnormal forces continue to take their toll on the osseous and soft tissues with every step taken. An arch support is not proven to realign and stabilize the talotarsal joint; thus this sort of help could be considered a subpar treatment measure, when it pertains to addressing the underlying etiology of tissue deformation. Is the only other option a calcaneal osteotomy? Lateral column lengthening? Subtalar arthrodesis? Or triple arthrodesis?

The birth of non-arthrodesis procedures to realign and stabilize the TTJ began decades ago. Since that time an ever-growing array of materials and sinus tarsi implants has evolved to what is current available on the market. There have been more than 16 sinus tarsi implants cleared for use by the Food and Drug Administration (FDA) in the last 20 years. This is an indication that orthopedic companies have a demand to spend the hundreds of thousands of dollars it takes to bring these devices to market. Also, these devices should *not* be considered experimental or investigational because they are cleared by the FDA. The FDA has evaluated these devices and has deemed them safe to be marketed. Unfortunately, the insurance companies continue to label the insertion of a sinus tarsi implant as experimental and investigational due to "limited scientific validation."—even though there have been more than 70 published studies by both orthopedic and podiatric surgeons.

The battle to gain insurance coverage for this orthopedic solution continues being fought, but in the meantime what does that mean to you? How can you help more patients with this solution? The answer is not creative billing practices. You are the only one who will lose with that solution. The patient, of course, will have benefited from a realigned and stabilized talus, but the insurance

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company can come after you for fraudulent billing practices. They are on the lookout for ways to recoup money for services rendered. This solution is most definitely not a win-win.

But there is indeed a process you can and should implement if you feel your patient could benefit from a sinus tarsi implant. The first step is to submit for a pre-determination of services. The current procedure code (CPT) is 0335T—insertion of sinus tarsi implant. Make sure to attach a letter of medical necessity customized for that particular patient. If it comes back denied, have the patient request an internal medical review. Make sure that the patient submits the letter of medical necessity from your office along with the evidence basis and medical necessity of extra-osseous talotarsal stabilization (EOTTS) documents. It that comes back denied, have the patient request an external medical review with the same supplementary documents as with the internal review.

Even with the pre-existing knowledge that a certain insurance payor has denied or has a written policy against covering the insertion of a sinus tarsi implant, the continuation of physician and patient requests will show the payors that it would be in their benefit to cover the service rather than spend their money reviewing these requests. It is unfair that the insurance payor would cover a subtalar arthrodesis for the same patient who could have benefited from the insertion of a sinus tarsi implant.

If these attempts have failed to get the payor to cover the expense of the EOTTS procedure, what do you do? Is your only course of action to tell the patient "sorry, nothing else can be done for you?" EOTTS is a minimally invasive soft tissue procedure that can be performed in-office. This is not for all patients, but there are many patients who need only EOTTS as a stand-alone procedure. It may initially seem a strange or risky idea to perform it in-office, but think about it: Dentists drill into the bone of a patient's mouth and insert a titanium implant. EOTTS is a soft tissue, not osseous surgery.

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The EOTTS procedure involves a small incision with little risk of cutting important neurovascular structures. In fact, an ankle tourniquet is typically not needed. The procedure takes about 20 minutes from the initial incision to the last stitch. Of course, safeguards and strict following of sterile protocols must be practiced. It is also possible to request the services from an anesthesiologist to administer intra-venous sedation, or to simply pre-medicate your patient with an anti-anxiety medicine.

The EOTTS procedure may seem to be simple enough, but don't be fooled; there are very important steps that must be taken into consideration. However, as with any surgical procedure, there is a learning curve. Once mastered, EOTTS is a straightforward, relatively predictable procedure. The use of intra-operative imaging is highly recommended, but not entirely necessary to an experienced surgeon. Some sinus tarsi implant manufacturers mandate the use of intra-operative imaging, while others, such as HyProCure® (GraMedica, Macomb Michigan) do not, due to the design of the implant. Of course, it should be considered the standard of care to take, at minimum, immediate post-operative images to ensure the desired placement of the implant. This documents that it was placed correctly prior to the patient leaving the practice, protecting both the patient and the surgeon.

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Ideally, the practice should include the use of intra-operative fluoroscopic imaging. The patient should be shielded and other protective protocols for radiation safety will need to be implemented. Though many foot specialists see the acquisition of a mini c-arm as financially unachievable, the truth is that the purchase of a c-arm is not an expense; rather it should be viewed as a practice revenue generator. The lease payments of a pre-owned model can be as low as a few hundred dollars a month. Fluoroscopic imaging is a billable service. Furthermore, the practice should contact the services of a local builder to construct a small platform so that weightbearing fluoroscopic images can be taken of patients who have positive clinical findings consistent with a partially displaced TTJ.

If the patient is a candidate and you are able to offer them a patient pay in-office procedure, then you both will benefit. Many times, patients will pay less if you offer them a patient pay option rather than having it covered by their insurance. Most of us are unaware of the expenses the patient assumes for an outpatient procedure. There are facilities fees, medical clearance and testing, anesthesia fees, and finally your procedure fees. These fees add up very quickly and the pa-

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tient could end up with a bill for several thousands of dollars in deductibles and co-pays.

Offering them an in-office procedure could save them thousands of dollars in expenses. Most people ask, "How much should I charge a patient for an in-office insertion of a sinus tarsi implant?" My answer is that you should expect to be paid less than you would for a complex bunion surgery, such as a Scarf or Lapidus procedure. There is less surgery time, fewer risks and complications, and less post-operative follow up for EOTTS. The patient would be responsible for the cost of the sinus tarsi implant, surgical materials, and the procedure fee. You would need to make sure to also note special circumstances, such as: What is your policy is the patient has a partially displaced implant that needs to be repositioned? What if the implant needs to be resized? What if the patient has persistent pain and requires a permanent removal? All these situations must be discussed with the patient prior to their initial surgery. The policies must be in writing and agreed to between your practice and your patient.

The biggest challenge in this entire scenario is this: How do you present the patient pay option? This is a science and like surgery you and your office team must master this skill. To be a physician means being an educator and to be a surgeon means being the one who physically "fixes broken" parts of the body. You need to be skilled at both. The first rule is to make sure that the patient has clear understanding of "what needs fixing" and the importance of "fixing it." They need to know that the root of their symptom(s) stems from the excessive motion and instability occurring between their ankle and heel bones. The ideal method, in your expert opinion, is the insertion of a sinus tarsi implant and you feel that s/he is a candidate for this procedure. This method is preferred because it is an internal option that instantly stabilizes and aligns the unstable, misaligned bones. It is more effective than external options and is not associated with the extended recovery, risks or complications associated with other osseous procedures.

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Ideally, you (their physician/surgeon/healer) should not be the one to discuss the financial aspects of treatment. This should be handled by a treatment coordinator or office manager. A line is crossed, in my opinion, when a physician discusses money. The patient no longer sees you as their "healer" but as a "salesperson." You don't want to be a salesman. But there are many physicians who have no issues discussing finances with their patients, and ultimately it's your decision as to who will explain the financial component of the treatment process.

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Keep your fees reasonable. You are here to help as many people as you can in your career. The more you charge patients, the smaller the number of patients who can afford your services. The overall fee per foot is presented to the patient. If the patient requires both feet, then it is possible to offer a small discount. The patient will then have to decide how to pay for those services. There are four patient-pay options: 1) immediate payment by cash, check, or credit card; 2) the patient can pre-pay monthly until full payment is made and then the procedure can be performed; 3) the patient can use a health-savings account fund; and finally, the patient can apply to a third-party financing company. The practice should not perform the procedure without full payment up-front.

Do your patients a favor by offering them a real solution to their orthopedic deformity. You are not doing them a favor by selling them arch supports that are incapable of adequately realigning and stabilizing their hindfoot. You of course are not going to offer them a radical osseous procedure that can lead to further surgery and is known to lead to arthritic changes to adjacent joints within a few months of the procedure. Do not bill the insurance payor "creatively", as this only puts your career in jeopardy and it is not worth it. Do your patients a favor by offering them an affordable, in-office solution to their misaligned feet. **PM**

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