

An Epitaph for The Term “Routine Foot Care”

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The time has come to once and for all bury the term “routine foot care” as a legitimate designation for any procedure performed by a podiatrist in the everyday practice of podiatric medicine and surgery. Continued use of the term propagates the trivialization of painful foot lesions, and in some cases, has led to serious lower extremity morbidity. The involved podiatric conditions are hyperkeratotic lesions, and hypertrophic toenails.

Hyperkeratoses

Any podiatrist engaged in the active treatment of patients on a day to day basis can attest that it is indeed a rare situation when a patient has no complaint. When faced with the problem of hyperkeratotic lesions, the patient invariably has pain over a bony prominence. Whether this is a bunion, hammertoe, or metatarsal head is not important. What is important is that the patient requires treatment to restore pain free ambulation. That is why they came in the first place. It is not a matter of convenience, vanity or cosmesis. This pain is no different than a neck strain, tennis elbow, knee arthritis, or other such musculoskeletal afflictions that third party payers easily pay hundreds, even thousands of dollars for. There have been countless times in my office where healthy people come in with a complaint of a “corn that is killing me,” and on examination I find bleeding and ulceration. Sometimes these patients wait too long because of the busy circumstances of their lives, but many others delay care because “I know corns and calluses are not covered.” Even more common, “I tried to cut it myself and you see what I did.”

In the end, what could be accomplished for the cost of an office visit winds up costing more visits, x-rays, and laboratory examinations. Removing the constraints of routine foot care exclusions in these cases is the obvious ultimate in managing cost. Since there is nothing routine about the care for these problems, we should be able to call a painful corn a painful corn, and use any or all of the techniques available to us to relieve the pain. Although the terms “corn” or “callus” indeed do not conjure any images of serious medical problems in and of themselves, the pain that they cause should not be trivialized.

Often, podiatrists are told and *many accept* that this type of service can be performed by unlicensed professionals, like family members or pedicurists. This is not enough reason to exclude the care from coverage. A patient can apply a hot pack to their lower back, or have a family member do it, yet it is still a covered service if the sufferer elects to seek the care of any number of licensed professionals who will apply hot packs. There are many other covered medical procedures that can be done by the patient or a family member.

The next level of problem with reimbursement for painful hyperkeratotic lesions involves patients who are determined to be “at risk.” *The fact that keratotic lesions can be the initiating process leading to serious morbidity in patients with neuropathic, vascular, and other conditions is well accepted. The current guidelines for Medicare reimbursement provides a list of diseases and combinations of class findings that are required for reimbursement of the care of keratotic lesions.* A patient with low back pain may have an invasive spinal cord tumor, yet if medical evaluation yields a diagnosis of minor muscle spasm, care is not excluded. Untold thousands can be spent on a complaint of headache, yet the absence of a life threatening diagnosis does not exclude the condition from reimbursement. The gastro-intestinal system provides a veritable inventory of somatic complaints that are treated with nothing more than antacids and emotional hand holding, without question about reimbursement.

Painful foot lesions are no different, whether occurring in a high risk patient or not. In reality, hyperkeratotic lesions very often cause significant pain which can be markedly relieved with various non-invasive techniques including skilled debridement and dispersion padding, usually for the cost of an office visit. Occasionally, injections may be employed for additional relief of inflamed bursae. Orthoses can address the long term biomechanical problems that may relieve or eliminate painful hyperkeratotic lesions.

Who would dispute, however, that coverage for the care of these lesions would save significant amounts of money by giving the patient treatment choices? If someone could choose the option of four to six visits per year for these problems, at approximately \$40.00 - \$50.00 per visit, how much could be saved by reducing the frequency of more costly bursal injections, x-rays, orthoses, and surgical procedures. Most importantly, patients and podiatrists alike can be assured that there are no obstacles to obtaining and providing care for painful foot lesions, and at the same time insuring that those at varying degrees of risk get the attention required unencumbered by cookbook lists that determine medical necessity. Lastly, it is time to seriously consider the myriad of conditions not considered by CMS and other insurance carriers that when present pose serious risk to patients who self treat or who have untrained persons care for painful hyperkeratoses. Conditions like failing vision and/or blindness, dementia, parkinsonism, spinal stenosis, hip replacement, upper extremity amputation, degenerative joint disease, obesity, advanced age, diabetes without neuropathy or vascular complication, post-operative patients, congestive heart failure, lower extremity edema, mental disorders, anticoagulant therapy, etc.

Hypertrophic Toenails

The issues concerning the care of toenails mirror those regarding hyperkeratotic lesions, but only when it comes to the CMS recognized “*at risk*” patient. Otherwise, care of toenails, including mycotic toenails is considered “routine.” Many people seek cosmetic, vanity, or convenience care for toenails. This service is available at the beauty salon, and no one would object to these services being described as routine. Make no mistake however, that there are a great many of these people who are “at risk” and should be under the care of a podiatrist, but are not because they fear that the service is not covered or because they do not have the CMS required class findings. The assumption that people are not at risk if they do not have class findings is dangerous.

The costs of this in terms of complications far exceed the costs if this service were to be covered without restriction by cookbook lists. The money paid for one diabetic cellulitis admission (many diabetics do not have the necessary CMS class findings) to a hospital can pay for the yearly cost of nail care for many patients for several years. The overwhelming majority of senior citizens care for their own nails. Those who seek the care of a podiatrist have diseased toenails, or are unable to care for themselves because of the above aforementioned reasons listed under hyperkeratotic lesions.

The only exception for nail care covered without class findings is for care of mycotic nails, also subject to restriction by amount of pain, limitation of ambulation, clinical evidence of mycosis, etc. Some time ago, CMS announced plans to require the presence of a paronychia to bill for debridement codes. In effect, CMS is telling insured citizens that the only covered nail service is when you are in serious trouble, when the cost to Medicare will be greater than the cost of care for your problems before complications develop.

Historically there has been much talk about “clipping,” “trimming,” “cutting,” “debriding,” and other nonsense descriptions regarding the method of caring for one’s toenails. These terms are irrelevant to the central issue of medical necessity. It should be assumed that patients seeking the care of a podiatrist need medically necessary services. This is because they are almost always in pain (regardless of being “at risk” or not) and need professional attention. Senior citizens have better things to do than seek professional care when nothing is bothering them.

In essence, a good solution to the above problems would be to somehow bundle all care of hyperkeratotic lesions and toenails (including mycotic toenails) into a new or existing code. The care should be reimbursable 4 - 6 times per year, and those patients eligible for more frequent care should be identified by a much more liberal set of guidelines. The podiatrist should be the physician who determines if these guidelines are met, not the MD or other practitioner. Patients with nail infections or complications from keratotic lesions such as abscesses can receive additional care as needed under existing procedure codes. Billing for these procedures, however, would undoubtedly plummet because patients will be able to get regular care, reducing the need for urgent care. An additional benefit to CMS would be the ability to spot billing deviations readily. Since all practitioners would have the majority of their services covered, it only follows that fraudulent billing will decrease markedly. The cost savings would be enormous, as well as preserving the intent of the Medicare program, which is to provide medically necessary services to covered individuals.

So, in conclusion, an epitaph for “Routine Foot Care:”

Here lies “routine foot care”
A designation mistakenly born
Applied to painful afflictions of the footsore
To impede their ability to receive care
May it forever rest