



BY JARROD SHAPIRO, DPM

The Most Challenging Side of Podiatry: Managed Care

Here are some tips to help you cope with this exceedingly complex issue.



The Dreaded Prior Authorization

The primary issue with managed care is the need for authorizations. For those of you new to the profession or in a less managed area, certain insurance companies require physicians to request approval for services such as procedures, durable medical equipment, and office visits in order for them to pay for these services. Someone at the insurance company either approves or declines the request based on the company's protocols.

Practice Perfect is a continuing every-issue column in which Dr. Shapiro offers his unique personal perspective on the ins and outs of running a podiatric practice.

discussion, managed care organizations are insurance companies tasked with reducing costs while providing patients medical care by contracting with physicians and medical groups

Painful Examples

Here's a quick example. A patient with a bunion deformity presents with an authorization for an office visit. After examining the patient, the podi-

Taking care of patients with lower extremity complaints is quite challenging and already very complex. We need to have a thorough knowledge of many medical, scientific, and psychological topics. Podiatrists additionally perform many different types of technical procedures. All of this is done on our very complicated patients with their myriad issues.

However, the one issue that makes the practice of podiatry even more complex is managed care. In California, managed care is a major component of private practice. As a quick description to define this dis-

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to provide that care. As we know, the United States does not have a comprehensive national healthcare service, so patients have private insurance (such as a health maintenance organization, preferred provider organization, etc.), or government insurance like Medicaid, Medicare (for those 65 years and older and those disabled), or no insurance. Let's focus on the private insurances.

atrist has to request an authorization for radiographs, which will likely occur at a separate visit. If the podiatrist then decides to do surgery or treat the patient with foot orthosis therapy, they will have to request yet another authorization. This will create *three different office visits*, each with additional costs, where all of this could have been done in one office visit.

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PRESENT Podiatry

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Featured Lecture




Matthew Regulski, DPM
 Medical Director
 The Wound Care Institute of Ocean County, NJ
 Senior Partner
 Ocean County Foot and Ankle Surgical Associates
 Toms River, NJ

A Breakthrough in the Treatment of Chronic and Hard to Treat Wounds: Advanced Film-Forming Wound Dressing



0.5 CECH

In this Lecture...
 Matthew Regulski DPM, FFPM RCPS (Glasg), ABMSP discusses what makes the silicone film-forming wound dressings a new breakthrough treatment of all types of wounds. Dr Regulski also discusses the features and benefits of new silicone film-forming wound dressing as well as interpreting the results of the silicone film-forming wound dressing for treatment of chronic and hard to treat wounds.

Scan to go to the lecture



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It is easy to imagine where some complaints might arise. First, from a convenience and quality of care standpoint, the necessity to obtain approval delays care and is highly inconvenient for patients.

As another example, a new patient presents with an ingrown toenail with coverage by a certain HMO insurance company. They present with an “auth” for an evaluation and management code (essentially the office visit) but not a nail procedure code. The podiatrist then has the choice to either have the patient return for a second visit after the authorization has been approved or do the procedure on the same day, risking non-payment or billing the patient. Sending the patient away for a later return is obviously not a best practice in this situation, nor is it convenient.

This system also forces physicians to become billing and coding experts—clearly not something any of us wanted when we applied for medical school. For example, when requesting an authorization for custom functional foot orthoses, one must know the code (L3000). But wait, it’s not just L3000. That’s the number for a single orthosis. We must actually request L3000 x 2. Want to request authorization for radiographs? Ankle or foot? Bilateral or unilateral? How

many views? 73630, 73620, 73610 are just a few of the coding options. This goes on and on for hundreds if not thousands of codes.

But There’s More...

But that’s still not all! Many insurance companies will only authorize certain codes based on specific diagnoses. That means we have to

such as amyotrophic lateral sclerosis to hallux valgus. If you’re a patient with this particular insurance, and you suffer from pronatory foot disorders without one of these diagnoses, then you’re out of luck. These lists of approved codes vary with each company, requiring us to either memorize lists of codes or keep them on hand as a reference.

Physicians are not supposed to fit our diagnoses to the codes, but we are so often forced to find a “better” code.

become experts in ICD-10 diagnosis coding. As a simple example, Medicare will not pay for custom foot orthoses unless the patient has diabetes. Similarly, other insurance companies may cover night splints but not orthoses for plantar fasciitis. There is a list of approved diagnoses and services for which they will pay doctors, and we have to know each individual company’s preferences.

As a painful example of this, we recently received a communication from a practice’s authorization person educating us on which diagnostic codes to use to receive an approved authorization for foot orthoses from an insurance company. These codes ranged from diabetes to various neurological disorders

Many podiatrists find this aspect distasteful. First, many of us refuse to memorize lists of codes like this. We have other things to do. Second, and more importantly, physicians are not supposed to fit our diagnoses to the codes. The diagnosis is what it is regardless of what some insurance company wants. Some of us are likely to become angry and belligerent whenever our billers ask us to review our coding to find a “better” code.

Obviously, this is a very expensive process. Our practices must hire extra staff just to handle the administrative aspects of these insurances. Patients must return repeatedly for care that could have been done in one visit. And insurance companies

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themselves run at higher operating costs. Personally, a favorite insurance is Medicare plus a supplemental insurance because it does not require prior authorizations (for the most part) and it makes clear what services it does and does not cover.

The other part of this issue is that very specific wording in our charts is also necessary to “justify” treatment. For example, wound debridements require us to use words such as “excisional”, “non-excisional”, “selective”, and “nonselective.” Without proper wording, a doctor receiving an audit may end up having to pay back money previously paid to them. Clearly, this is a nightmare scenario and a risky aspect of practicing medicine.

So, how can the young podiatrist about to go into practice deal with this state of affairs?

1) *Suck it up*—Understand that this is the reality in many locales in

the United States. Acceptance will lead to less anxiety.

2) *Don’t want to suck it up? Get a job with a closed healthcare system such as Kaiser Permanente or the VA system*—These systems are much less concerned with coding and billing, keeping in mind that there are other prices to pay to maintain cost controls.

3) *Podiatric residencies should teach this to our residents*—Residency is a great time to build coding, billing, and practice management experience over a longer (thus less painful) time period. If your residency doesn’t teach this, then ask to shadow one of your attendings in their office with the goal to learn about coding.

4) *Attend a conference*—For example, the American College of Foot and Ankle Surgeons has a surgical coding conference, and the PRESENT Treasure Hunt Conference has excellent coding updates every year.

5) *Purchase any of the quality*

written resources on coding—The American College of Podiatric Medicine sponsors an excellent billing and coding manual.

6) *Build relationships with your insurance companies whenever possible*—Maybe you will be given the opportunity to affect their policies. For example, helping one of the local insurance companies, we created a pre-authorization program for certain commonly treated foot conditions to improve efficiencies.

Clearly, this has to be the least intellectually rewarding aspect of modern podiatric practice for most of us, and it’s not likely to disappear anytime soon. Become as educated as you can in the process and remember that you’re not alone. Welcome to private practice! **PM**

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Dr. Shapiro is editor of PRESENT Practice Perfect. He joined the faculty of Western University of Health Sciences, College of Podiatric Medicine, Pomona, CA in 2010.