Podiatry Faces New Challenges in 2024

It's up to you and your staff to find solutions.

BY PAUL KESSELMAN, DPM

It is hard to believe we are starting a new calendar year. It seems apparent that our elders were right when they told us that when you are young, the days seem to crawl by and as you age, the years fly by. But within each day, the challenges that medicine has faced this year seem to have been insurmountable. More audits of all types of medical practices (podiatry is far from alone), enrollment challenges, a new Medicare contractor to appeal enrollment denials and PTAN deactivations, and mandatory fingerprinting of DMEPOS providers are all now part of the daily landscape of the practice of medicine.

Recent polls in *Becker's Health Care* have commented that 25% of U.S. medical students and 23% of nursing students are planning on dropping out of their degree programs. Only 40% of physicians recommend a career in medicine and 26% of physicians are considering transitioning to non-clinical careers within medicine.

So where does that leave the practicing podiatric physician? Will we continue to face reduced fee schedules into the foreseeable future as we have for the fourth year in a row with escalating costs and inflation? Is it true that as more physicians age over 60, they will be retiring in droves? Will the reduction in providers leave more patients for each clinical practitioner to see and with less time to see each patient? Will the inaccessibility of specialists to patients, who may be forced to wait months for appointments, result in patients developing more complex issues due to lag-time between symptom onset and their initial appointment?

These are all very complex questions facing our society but do not address what clinical practitioners must start doing today. One must think smarter and more efficiently, especially if one wants to maintain standard of living, pay back student loans, and remain in private practice. If one wants their practice to be attractive to one of the larger supergroups, these factors also may apply.

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Automating the patient intake process so that new patients almost self-enter all their information with as little interaction from staff as possible may be a good place to start. Using EHR/EMR—which can in an automated fashion check on insurance eligibility, deductible and co-pay status, and prior authorization—can cut down on the number of staff members and/or time dedicated to this task. Many physicians have self-check-in kiosks where the patient can check in and speak to the front office staff only if needed. Some offices can even make your appointments online using their portals. This has cut down on the number of employees needed and leaves existing ones with more time dedicated to claims processing and other direct revenue-generating tasks. The use of call centers to answer phones, while done as a cost-saving measure, is awful, and often results in patients seeking care elsewhere.

More efficient use of office space—like cutting down on wasted space and turning it into a revenue stream—is a great investment. Do you still have paper charts? If so, why not have those charts scanned and shredded? In addition to eliminating the headache of having to store them for up to 7 years (or more if the patient is a minor), why not use that space for adding an in-office retail shoe store, DME dispensing suite, or aesthetic salon? Or convert it into an orthotic laboratory where you can fabricate or do in-house repairs, cutting down on your orthotic costs?

Continued on page 38

2024 Challenges *(from page 37)*

Other revenue streams include remote physiologic or remote therapeutic monitoring services, which use their staff and not yours to conduct the monitoring and refer any issues to you for immediate treatment. This can generate additional revenue provided by RPM/RTM CPT codes for both entities while still providing significant savings to society by seeing patients prior to the onset of significant pathology.

The pandemic has introduced virtual visits with many patients demanding that those continue for minor issues or follow-up. Virtual visits, no matter their coding structure (telehealth E/M, phone-in, Medicare check-in) are all covered to some degree by most third-party payers.

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It will be interesting to see where artificial intelligence (AI) goes with assisting physicians with diagnostic image and report review. AI may also have a role in documentation assistance in complying with Local Carrier Decision and Policy Articles (LCD and PA). Will robots be able to be programmed to debride ulcers and trim toenails and hyperkeratosis?—yet another challenge medicine may face.

Relative Value and Conversion Factor changes also will affect each practice differently based on your particular CPT code utilization. A potential 50% reduction in reimbursement for HBO therapy may result in many wound care centers closing. This could increase demands placed on office-based wound care practitioners, such as podiatrists, who will need to employ alternative treatment strategies to save limbs.

Each January presents similar challenges. Fee schedule, policy changes, patient insurance changes, copayment changes, and deductibles are but a few of the changes your front office staff must deal with at the beginning of the year. But societal changes and payment policy changes not within our control are also factors one must consider in running your practice. **PM**

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