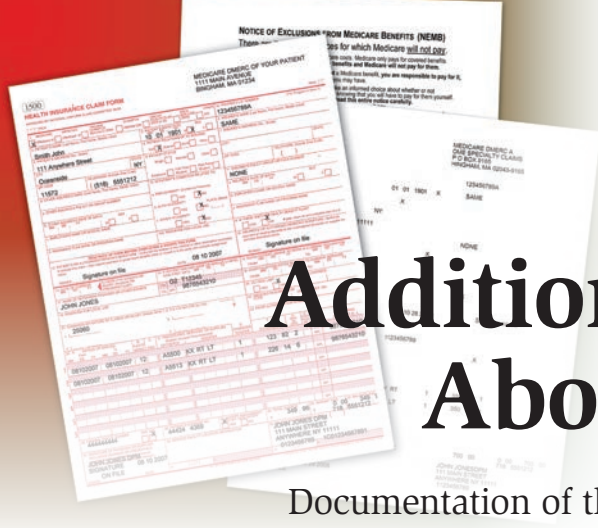

Additional Thoughts About CDFEs

Documentation of the medical necessity is paramount.

BY PAUL KESSELMAN, DPM

In the November/December 2024 issue of *Podiatry Management*, Dr. Guiliana wrote a very interesting article entitled "A New and More Responsible Look at the CDFE Comprehensive Diabetic Foot Examination". If one were to carefully read into the intent of the title, it would seem to infer that podiatrists should be doing something "new and innovative". I think Dr. Guiliana's intent, while introducing some new tools to many, was also to issue a "warning shot across the bow", and to awaken those providers who still don't get the idea of the CDFE or any evaluation and management (E/M) service.

This serves as a stern reminder of what must be done to qualify the patient for any E/M service. The frequency of that service done once a year or more is not the point. The emphasis must rather be on documentation of the medical necessity of the service being provided. This can only be done by performing a thorough examination and documenting your findings and noting recommendations for treatment. The absence of a chief complaint does not rule out medical necessity for performing such an examination. The patient may not be aware of an ever-present danger to their lower extremity health, and thus this does not rule out the medical necessity for the performance of such an exam.

Take for example the poorly controlled Type I diabetic patient with long-standing neuropathy who presents simply for nail debridement. Many providers would be in and out of the room in 10 minutes or less having performed a thorough nail debridement. Did you notice that the patient had interdigital erythema and excoriation? And if you did, was it documented? If documented, what treatment did you discuss with the patient and did you document that treatment regimen?

Never mind "CDFE" and using that term simply to qualify the patient for shoes. If both those evaluations and treatment were not documented and provided, then your practice may have just let a mid-level reimbursement walk out the door. More importantly, the patient you just let out the door may end up in the hospital with cellulitis secondary to a tinea infection, simply because you may have noticed this before and failed to either document or treat it. Why? Because this and other similar patients never previously had an issue. Your excuse… well, they simply have had tinea for a long time and never had an issue. But for this one patient (and for others) perhaps, you didn't bother to ask them about their A1C. Perhaps this one patient had their A1C increase from 6 to 9 or 10 since their last visit to your office. Perhaps their endocrinologist sent them to a nephrologist because their creatinine and BUN were also increasing. Did you or your staff bother to ask when they last saw their PCP or endocrinologist? More importantly, did you or your staff ask if they saw any other medical specialist since their last visit to your office?

These are all very critical questions that you and/or your staff should be asking at every single visit.

The Physical Examination Course taken at ICPM in the mid-1970s taught how to perform a head-to-toe physical examination, with the physician instructor telling the class, "What we can teach you is what to look for as far as abnormalities. But that is not enough. We must also teach you to be a good listener. For with the right knowledge, if you listen correctly, most of the time your patients will likely tell you what is wrong with them." Many years later, after learning to be a good listener and taking a surgical board review course, the lesson learned is that the most effective way is to ask the right questions, enabling anyone to document those essential elements.

The absence of a chief complaint does not rule out medical necessity for performing such an examination.

Listen to your patients and know what to look for. Certainly, using the right tools as noted by Dr. Guiliana is a right start, but knowing how to interpret those findings and the implications for your patient are as important. Today that

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is not enough. You must also document what was learned from your patient's examination and what you are doing about it.

The CDFE is not meant to be an examination to be done once a year simply to screen patients for pathologies or qualify patients for therapeutic shoes under Medicare or other third-party payer requirements.

From the liability perspective, your patients should be examined each time they come to your office. They deserve nothing less. If you were the last physician who saw and examined that patient with cellulitis secondary to tinea, you can bet that your name and your charts may draw the attention of the patient's attorney.

For an astute physician, determining Capillary Filling Time (CFT), palpating pules, and examining skin color texture, hyperkeratosis, and any changes, etc., and observing for any dermatological abnormalities should not take an excessive amount of time. Biomechanical and neurological changes must also be documented.

Then comes the hard part. Documenting the medical necessity for treatment, education of the patient, and any suggested treatment elements must be documented along with possible untoward events should the patient not follow treatment guidelines.

Recent statistics show an almost 60% increase in foot amputations by all surgical specialties within a recent four-year period.

The forefather of the Diabetic Shoe Bill, Dr. Doran Edwards (now retired as a Medicare Medical Director), has been discussing the essential elements of the CDFE going back more than two decades. He shares a passion for the need to document those elements noted in both the exam and recommendations for treatment.

This sage advice is not limited to diabetic foot examinations, but with other conditions of patients who seek our professional advice. They may not be aware of the emergence of skin cancer, thinking it is a simple contusion, or because they can't see or feel it. According to Dr. Edwards, the absence of a chief complaint does not in and of itself demonstrate a lack of medical necessity.

Dr. Guiliana's wake-up call is especially urgent, given the worldwide prevalence of diabetes. Recent statistics show an almost 60% increase in foot amputations by all surgical specialties within a recent four-year period. That, along with inaccessibility for many patients in obtaining therapeutic footwear due to Medicare's audits, predicts a huge increase in expenditures on diabetic foot-related issues.

I agree with Dr. Guiliana's position in his article and his closing statement, "…. It (performing the CDFE) can ultimately change our role in the healthcare system, as well as have a very positive impact on our practice's economy." **PM**

Dr. Kesselman is board certified by ABFAS and ABMSP. He is a member of the Medicare Jurisdictional Councils for the DME MACs and a member of the enrollment subcommittee. He is a noted expert on durable medical equipment (DME) and consultant for DME manufacturers worldwide. He is the owner of Park DPM and co-owner of PARE Compliance. He is also co-owner of www.thedoctorline.com, a new online forum for coding and reimbursement.