Routine Foot Care Revisited

There are a number of controversial issues surrounding the profession’s long-standing “Bread and Butter”.

BY MARC HASPEL, DPM

In a recent posting to PM News, a podiatric physician lamented the fact that a trend was occurring in his community whereby allopathic medical doctors had begun employing nurses to perform routine foot care on patients in their practices rather than referring those patients out for specialty care. Obviously, that scenario was disheartening to that practitioner and should serve as notice to the remainder of the profession of the dire consequences in store for podiatric medicine if that trend were to continue unabashedly. Routine foot care, or what many now refer to as at-risk foot care when it is medically necessary, has always been the fundamental basis for the practice of podiatric medicine and surgery. Though this profession has made marked advances in podiatric orthopedics, medicine, and surgery, the bread and butter work of podiatry is routine foot care.

Of course, that does not mean that there are no issues about which to be concerned when discussing routine foot care. One major issue is determining how routine foot care should be viewed and reimbursed by both private insurance and Medicare, which draws upon proper documentation and now brings electronic health records into the mix. Another question is to what extent routine foot care which, needless to say, strikes directly at the core of their chosen profession.

Joining this month’s panel:

Michael Forman, DPM is in private practice in Cleveland, OH. Brian Kashan, DPM has been in private practice in Baltimore, Maryland for 31 years. He is a graduate of NYCPM, and did his residency at the Maryland Podiatric Residency Program. He has served on his State Board for two terms, was president of the State Board twice, served on the Maryland Podiatric Medical Association Executive Board, and is currently on the APMA Physicians Rehabilitation Committee. He is

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Nicholas Romansky, DPM is in private practice at Healthmark Foot and Ankle Associates in Media and Phoenixville, PA.

Elliot Udell, DPM is president of the American Society of Podiatric Medicine and is in private practice in Hicksville, NY.

PM: How much routine foot care do you perform in your practice?

Kashan: I’d like to define what I consider to be routine foot care. I like to separate this into two main categories, covered routine foot care and non-covered routine foot care. Covered routine foot care would be care associated with diabetics or PVD patients who meet the criteria for coverage by their insurance carrier. Non-covered routine foot care addresses patients without vascular or systemic disease who, for whatever reason, elect to come to the office for their podiatric needs.

In our practice, approximately 20% of our patients come in for covered routine foot care. Less than 2% come in for non-covered routine foot care.

Markinson: Under its traditional meaning, including mycotic nails and the treatment of corns and calluses, routine foot care is most of my practice. It is my firm belief that this is true for the majority of the profession.

Romansky: I do routine foot care every day. Every patient potentially has some form of routine foot care regardless of why the patient came in the first place.

Forman: In our three-doctor practice, we differentiate between routine foot care and at-risk foot care. We estimate that 20% of our patient visits are for non-covered routine foot care. Another 20% of our patient visits are spent with patients who are at risk for a variety of reasons such as circulatory deficiency, neurological disease, etc. Then, there is a subset of patients who are seen for other reasons such as plantar fasciitis, structural deformities, trauma, or surgery. These patients may need conservative foot care at times.

PM: From a practice management point of view, discuss how one can utilize routine foot care to expand other aspects of podiatric practice, including increased physician and patient referrals as well as marketing.

Markinson: I think if someone comes to a podiatric physician for routine foot care, then that is the opportunity to counsel the patient on the depth and variety of the practice and the different conditions that can be treated. Each podiatric physician can depend on the base of routine foot care patients within the practice to discuss foot problems with friends, relatives and co-workers, who will ultimately serve as a patient-based marketing resource.

Forman: Actually, I have an axiom. I like to say “Get your nose out of the nail groove.” It isn’t just a mycotic nail coming into your office—it’s a real live patient who is coming in for care. This patient may have other podiatric problems. Unless the patient is asked about those other problems, that patient may not discuss them. At every office visit for anything, I always ask the patient two questions which have served to build my practice: “Do you have any other problems?” “Do you have any questions?” I estimate that 20% of my routine or at-risk patients have other complaints they want addressed. Therefore, by getting my nose out of their nail grooves, I can help my patients.

Kashan: Over the course of years that patients are in our practice for routine foot care services, it is inevitable that these patients will have other problems or issues. These range, in a manner of pathology, from ingrown toenails, fungal infections, musculoskeletal issues, and just about anything else that we see in our practice. In addition, people who come to the office for routine foot care are frequently eligible for other services, e.g., diabetic shoes. Our practice tries to offer an assortment of services for all of our patients’ podiatric needs. Patients who come in for corns on their small toes every two months, for example, may benefit from diabetic shoes, which would take the pressure off the area and help them.

Lastly, we try to communicate to our referring physicians when there is a change in patients’ conditions. We believe that a small note referring to a new condition that is significant should be brought to the referring physician’s attention. Once these physicians see the assortment of services we offer, I have found that referrals increase. A fine example of this is vascular testing, where we send them copies of the testing results with notes indicating what we feel should or shouldn’t be done for follow-up.

Udell: For some, routine foot care means addressing any foot problem that has nothing to do with bone or deep soft tissue surgery. For others,
it means the cutting of non-pathologic nails and removal of hyperkeratotic tissue in the absence of any underlying pathology. What we need to be aware of is that the majority of patients we see do not come through the door requesting bone surgery. In most cases, advanced surgical cases evolve from the already established doctor-patient relationship that the podiatric physician has established as a result of rendering non-surgical routine foot care.

Udell: My feeling is that if we allow support staff to perform podiatric procedures, we are cheating our patients. People who present to podiatrists for foot care expect to be evaluated and treated by persons with a doctorate in podiatric medicine along with years of post-doctoral residency training. As an example, I was having a problem with one of my teeth. Commonly, most dentists have left the examination and cleaning of teeth to their hygienists with the dentists giving a superficial exam after the hygienists have finished. I went through three cycles of this scenario without resolving my particular problem.

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doctor. Today, dentists are using extended-function dental assistants, or EFDA's, who are super-qualified assistants. I think podiatry is in the same position as dentistry was. Today, podiatrists are able to do many more procedures and use newer methods. Podiatrists are busier and need help. Our practice employs two assistants who are trained to provide routine foot care and at-risk foot care. This frees up the podiatric physicians to do other tasks.

Markinson: I am totally in favor of allowing support staff to perform routine foot care, and if this does not become the norm, podiatrists will find themselves unable to provide more complicated services due to time constraints. In view of declining reimbursements, podiatrists won’t be able to make a living if they cannot devote more time to issues that bring in more money. Some don’t like to put it in these terms, but a bankrupt practice provides no care to anyone. Having technical people trim nails and debride keratoses frees up the podiatric physicians, and the income from the routine foot care services becomes passive, which is the best kind.

Romansky: I don’t have staff do routine foot care. I have a different perspective. Simply put, patients are there to see the doctor, not an assistant. While staff may have to do some part of routine foot care in the future in line with financial trends, in my practice, the staff will never do all of routine foot care.

Kashan: I have many friends and colleagues who allow their medical assistants to do what they consider “finishing”. This consists of the smoothing of nails with a grinder and the application of pads and similar type devices. They feel that it expedites their care and they are able to do other things to generate income. In my practice, I have found the opposite is true. I feel that I can do this quicker

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and with no delay, and that the patient spends less time in the office. It only takes a few seconds to smooth a few toenails and apply a padding. That’s just my opinion, and how I’ve been doing it for all of these years.

I am strongly against allowing staff to do more treatment, like trimming nails or calluses. This is for several reasons. Firstly, I believe the patient is paying for my service. If an assistant is providing the services, then the fee should be different, in my opinion.

Secondly, there are many times that, in the course of my providing routine foot care services, I find other pathology. During the course of my routine care visit, I am able to visualize all of the patient’s lower extremity issues. I may notice something that, quite frankly, an assistant may not. This may be something as simple as a tinea infection, or perhaps as serious as a pigmented lesion which may require biopsy. I also feel that prevention is vital in treating these patients. I am not comfortable with allowing ancillary staff to treat patients completely.

PM: How can the profession establish routine foot care as a medically necessary service in the eyes of payors like Medicare and private insurance companies?

Kashan: The best way to get medically necessary routine foot care covered by Medicare or other insurance companies is to provide financial evidence that it saves them money. Healthcare today is all about cost-saving. Unfortunately, while quality of care is important, bottom-line decisions rely on the bottom line. Documentation that performing routine foot care services helps prevent more costly procedures and pathology later on is essential in proving to the insurance industry that routine foot care services are beneficial.

I’m not aware of any study to date that analyzed amputation, or other pathology, in diabetics who did not have routine foot care services versus those who did. That would be the type of study that I feel would be helpful in getting our point across.

Forman: I believe the profession is well on the way. I agree that the profession needs evidenced-based studies on the benefits of various types of foot care. I believe the latest studies have shown that the number of amputations and hospitalizations has dropped dramatically since CMS initiated the diabetic shoe program.

Markinson: On the contrary, I think that the profession has been a dismal failure at getting routine foot care services paid. That’s because the prohibition on routine foot care is not from CMS, it’s written into the Social Security Act. Therefore, any attempt to make routine foot care payable—and, of course, it should be—requires an act of Congress. I have often thought that if we produced a quality video of enucleation of a deep plantar lesion, or the debridement of mycotic nails, it would soon be evident to members of Congress that this should not be done in the bathroom by a relative. We then introduce the disabilities brought on by Parkinson’s disease, joint replacement surgery, visual loss, systemic inflammatory arthritis, DJD, etc. A carefully planned presentation would get a lot of legislators thinking.

Romansky: It’s true that many systemic diseases are first noted in the foot and lower extremity including: AIDS, gout, rheumatoid arthritis, syphilis, Lyme’s disease, diabetes mellitus, vascular compromise, and psoriasis. Furthermore, many diseases are first noted in the nails, like cardiac and pulmonary diseases. Therefore, routine care can be proactive and preventative of further complications. An article in the Wall Street Journal, earlier this year, detailed as much.

Markinson: Same here. I can’t see any effect on the amount of routine foot care patients are not the same and that repetitive templates or canned notes should be avoided.

Udell: I have not observed any impact that electronic health records have had on the volume of non-surgical foot care.

Romansky: I believe the profession be mindful that all routine foot care patients are not the same and that repetitive templates or canned notes should be avoided.

PM: What are the potential consequences of failing to train future podiatrists to perform routine foot care?

Udell: The impact is simple. If we fail to render all aspects of foot care, we are creating a vacuum. It would not be too long before other healthcare professionals fill that void. Already pedicurists are doing more than clipping and polishing toe nails. Physical therapists and nurse practitioners are also rendering foot care, and chiropractors are even beginning to make orthotic devices with the
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blessings of some of some of our own podiatry orthotic labs. Of course, if a patient needs a surgical procedure in the course of being treated by a non-podiatric healthcare provider, I think it would be unlikely that the patient would definitely be referred to a podiatric physician.

Markinson: I was trained in routine foot care in podiatric school. It is expected that podiatric graduates can do this with competence. Their patients will not let them operate on them for that hammertoe, for example, if they are uneasy about their podiatric physicians’ skill and dexterity. Thankfully, most podiatrists are good at routine foot care, no matter if they call themselves podiatrists or reconstructive foot and ankle surgeons.

Kashan: Our profession has grown in leaps and bounds, and has done so geometrically. While complicated and intricate surgeries are becoming more commonplace in our profession, routine foot care, for many, seems less prestigious. Podiatry is a specialty; then the sub-specialties within it are what make us unique. We can choose to do or not to do anything in our practice. Today, however, podiatry has become synonymous with feet. It hasn’t always been that way. We have fought hard, through our professional organizations and individually, to have the public identify feet with podiatry, and not go to other specialists. It would be a shame to see that reversed. If that were to become the case, someone with a fungal toenail might wind up going to a dermatologist instead of a podiatrist in the future. Those patients will be lost to our profession. The training of our young in all aspects of podiatry is essential to our sustenance and existence.

Forman: From a historical perspective, in the 1970s, Gare Le-Compte, PhD., served as a dean at the Kent State University College of Podiatric Medicine, formerly Ohio College of Podiatric Medicine. All the way back then, he warned us that if we forgot our roots and gave up conservative foot care, someone else would step in and take this service away from us.

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PM: Given the development of three-year surgical podiatric residency training, what advice would you offer for new practitioners on how to incorporate routine foot care in the future?

Kashan: The reality of surgical residency training hasn’t changed much over time, although the length of the residency has. While the education, training, and skills have improved drastically, the ability to generate income and have a successful practice hasn’t changed much at all. The ability to perform a triple arthrodesis makes one no more successful than someone trimming nails and doing orthotic therapy. In fact, with today’s reimbursement, surgeons may actually get paid less for their services. Having a successful practice and providing an essential service to the public should be the goals of podiatric physicians. Being able to perform a surgical procedure is fine, but not being able to pay office bills is not.

Young practitioners may not understand these concepts, because these concepts are not always appealing. I stress to young practitioners to have open eyes and learn as much as they can from those who came before them. While they may enjoy doing surgery now, perhaps in five or 10 years they won’t, or perhaps due to a physical ailment, may not be capable of doing it any longer. Routine foot care services, on the other hand, should remain a part of practice. It may not be all of it, but I feel strongly that it should be maintained and offered in all podiatric practices.

Markinson: They have no choice. Even after all advances in scope and types of procedures podiatrists do, people still go to podiatrists for routine foot care. In my opinion, the overwhelming majority of three-year residency graduates, especially those wishing for a life in the operating room, will be disappointed to find out that, except for a select few, they will be making their livings in the office. Indeed, in the current healthcare climate, the thirty patient-per-day routine foot care cash practice will soon be the envy of nearly all in the profession.

Udell: I was lecturing to residents recently and one doctor in the audience completed a three-year surgical residency program along with special training in total ankle transplants. What he is finding is that podiatry is not specialized in the same way that medicine and dentistry is and, at this point in time, he was finding it hard to locate a practice where he could devote full time to practicing his surgical skills. Hence, I recommend that graduates of three-year surgical programs shadow some general podiatrists in their neighborhoods and learn how to perform all facets of foot care.

Romansky: Ultimately, private practice is comprised of not just surgery. While many residencies tend to focus on surgery and focus on inpatient hospital training, private practice typically has minimal hospital involvement. I feel that residencies should have more real world experience, including practice management.

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PM: Relate an instance where treating a routine care patient ultimately led to a more critical care

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treatment that resulted in a satisfying outcome for both you and the patient.

Forman: What I have been preaching to my colleagues and students is that patients often have additional complaints, and it is up to them to find out what the complaints are, how significant the complaint is, and then decide if more needs to be done. Personally, my experience is that at least one of five conservative care patients has another problem to discuss and, perhaps, have it addressed. That scenario satisfies both the doctor and the patient.

Kashan: This is an easy response. There are probably no podiatrists out there who have been practicing who haven’t saved a limb on a patient because of providing routine care services. Seeing the patient on a regular basis gives podiatrists an advantage of picking things up early and before they get severe. Podiatrists are able to determine vascular and other problems soon after they develop rather than waiting for their complications and subsequent disastrous results.

I have had at least three or four malignancies picked up in my office on patients who were coming in for something completely unrelated and routine. I have diagnosed numerous patients with vascular issues and referred them out for reconstruction that otherwise would have resulted in amputation or death. That is not to mention the advice and discussions I have with my patients regarding their diet, smoking, and other lifestyle changes.

Udell: Recently a diabetic patient presented for care of a painful hyperkeratotic lesion. Unbeknownst to the patient, he had an abscess beneath the callus. I performed an incision and drainage, placed him on appropriate antimicrobial therapy and the patient went on to heal.

Markinson: This happens regularly, especially with diabetics who I have been seeing for routine foot care and, suddenly, they come in with an infection, ulceration, or other problem that needs rapid and targeted intervention with medication, surgery, offloading, etc. Of course, sometimes it does not end in a satisfying outcome, but, rather, a tragedy. The whole concept of routine foot care as a not-medically-necessary procedure or treatment is fundamentally flawed and, often in the absence of it, there is unnecessary harm and pain to patients. A patient with a neck strain can get thousands of dollars’ worth of treatment with no mention of being routine. Why foot pain doesn’t garner the same respect is a travesty. PM

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