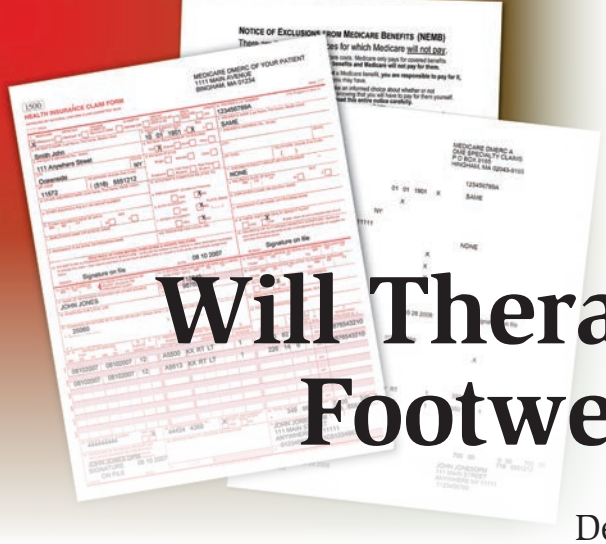

Will Therapeutic Diabetic Footwear Collapse?

Despite problems, there are many reasons not to abandon this program.

BY PAUL KESSELMAN, DPM

This month's column is written in response to the following letter to the editor which appeared in PM News:

"The complexities and document requirements of the Medicare diabetic footwear program have run amok to the point that many long-term, non-podiatrist shoe providers are getting out of the custom-molded business and just doing off-the-shelf footwear. I do not as a podiatrist dispense footwear. A few years ago I tried, but after the first few patients started complaining about "too heavy" or "too ugly," etc., I decided to just write the prescriptions and have shoe providers take the headache. Now, with ever-increasing frequency, I am getting requests for notes from the shoe providers as if patients who have had an amputation years ago can grow back the part that was amputated.

I predict the total collapse of the program due to over-regulation. In New York City now it is very difficult to get custom-molded footwear. The problem is starting to jam up my phone lines, with angry patients and shoe providers who know that if they stop participating with Medicare, they can work a third as much and make the same money."

Bryan C. Markinson, DPM

Here is my response:

The complexities and document requirements of the Medicare diabetic footwear program have indeed run amok, but to what degree depends on whom you speak with. From the perspective of large commercial suppliers, who are used to having to obtain complex and multiple documents from various prescribing entities, this is nothing new; nor is this type of level of documentation requirements new to the orthotics and prosthetics industry, which often have dire consequences if a claim for a $40K prosthetic is rejected due to a lack of "medical necessity."

The complexities and document requirements of the Medicare diabetic footwear program have run indeed amok, but to the degree depends on whom you speak with.

Speaking with those in the industry of both off-the-shelf and custom

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shoes, many manufacturers have told me that while they may have lost some business in the podiatric segment of the market, the orthotic and prosthetic segment of their marketplace has grown significantly in 2014. The BMAD will not reflect this until 2016, so rather than wait for that, one has to explore further.

The issues which Dr. Markinson speaks to, however, are real and justified, and he is certainly correct. Where we both practice, the costs of doing business are among the highest in the nation. This often makes the fee schedule rather unprofitable or at least frustrating to deal with when attempting to secure a quality product and yet still make economic sense for one's practice.

But there is far more to it than just a simple cost analysis and decision to reject your continued participation in the Therapeutic Shoe Program. Most responders to inquiries from APMA, AOPA, and other organizations to their shoe provider constituents, indicates that only a very small number (if any) are subjected to any sort of audit. This means that most claims are paid without an issue. This is also true for those who have been audited in the past and have passed, yet continue to be audited and who may fail those audited claims. It's hard to understand why this happens and why you might feel compelled to continue to subject yourself to this risk and harassment.

For those who are audited, and for whom Medicare speaks of a 90% rejection on pre-payment audit, one must keep in mind that approximately 25 to 33% of those audits are never answered, leaving one to wonder whether the shoes were ever dispensed at all—do I hear fraud? Or are suppliers, in particular larger suppliers, simply choosing to take a loss on those claims and move on?). What matters is that the remaining number of claims initially rejected are overwhelmingly paid upon any level of appeal (in excess of 65%). In my experiences with assisting suppliers with appeals, the same documentation which fails at the pre-payment carrier level passes on some level of appeal. The question one must pose is: why is that?

There is far more to it than just a simple cost analysis and decision to reject your continued participation in the Therapeutic Shoe Program.

As for the costs of custom-molded shoes and the crisis, to which Dr. Markinson speaks to, I tend to agree that Medicare pays far too little for custom fabricated shoes, and this has indeed become a problem. The costs to fabricate these are indeed significant (over $250) plus all the costs associated with obtaining the required data and the risks of audits, and hiring consultants.

However, there are cost-effective methods to assist your office with attempting to stay profitable:

1) Recent studies indicate that of all orthopedic shoes sold in the U.S., only approximately 10% of patients requiring and receiving orthopedic shoes require them to be custom fabricated. Thus, what Dr. Markinson speaks to at least with regard to shoes affects only a small segment of the population.

2) Farm these difficult cases out to those who are experts. The costs of sending shoes back and forth will quickly eat away at any profits. Patient and supplier frustration at the process may disenfranchise your relationship with the patient. Farming these out will also allow you to bill for an e/m each time the patient comes to you for an evaluation of the footwear prescription. This is no different than evaluating a patient's response to PT or medication you have prescribed.

3) If you are going to supply custom fabricated shoes, endeavor to have a cool head and be sure that you, your staff, and the patient have a proper level of expectation. Tell them, this will be the ugliest pair of shoes they've ever seen or worn, but at least they will be able to walk with the knowledge that the shoes are limiting their potential for further foot problems.

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4) Use a manufacturer who will re-manufacture or repair a poorly fitting shoe for free, no questions asked. Use one who will come to your office and teach you how to cast and/or to assist you with a difficult case, and one who can provide customer support for difficult cases, both before and after casting. There is a very high learning curve with these products. Be prepared to fail a few times. Everyone who eventually succeeds has numerous failures to discuss.

5) Use a manufacturer who has a set price (e.g., $250 for a pair of shoes), with one pair of inserts, in particular for those products which will be billed to Medicare.

6) Be sure you understand the coding for the other modifications. Simply because a third party payer has a limit on coverage does not mean you provide the patient with those other modifications for free (see #7).

7) Don't swallow the extra costs for those modifications Medicare or other third-party payers won't pay for because they are in excess of the two additional add-on codes they will pay for. Those "extras" are required modifications for a proper shoe fit and to reduce the patient's risk of developing further issues. Properly educate the patient on this before you cast. Be sure they understand their financial responsibilities for any required add-on costs not covered by their third-party payer, and of course properly document this (ABNs, etc.).

8) Ask someone in your office who understands the third-party policy to review the documentation you have received from the MD/DO and your own documentation which may have required some agreement from the MD/DO. A second pair of eyes is mandatory for this. My patients are educated that we will not cast, measure, or order any custom fabricated product or even order or dispense any off-the-shelf DMEPOS item until my office is satisfied that we have obtained the required documentation and that it will be sufficient on the date the item may be dispensed (which could be 4-6 weeks later).

9) Don't feel pressured to provide this level of service for all patients. Just as you "walk away" from patients who you feel may be poor candidates for surgical care, do the same with any DME service if your gut tells you to do so. It's just not worth ruining your day (week, month or year) over a disgruntled patient whom your office staff (or anyone else's for that matter) may not be able to satisfy.

10) Take the option of being a non-participating supplier. You can accept assignment, take partial payment from the carrier, and balance bill the patient. Bear in mind that you cannot do this if you are a participating Medicare provider and both your supplier and physician NPIs are linked to the same tax identifier.

11) Follow the Kenny Rogers mantra, know when to fold 'em, know when to run away and know when to hide.

As for the whole therapeutic shoe program, if we give up on this, we're just sending Medicare a clear message to continue to go ahead with undue audits and harassment at a time when many in the O&P industry are clearly not giving up. What's next? At-risk foot care? Will you give up that most basic of service when those audits start? What will be left?

The additional issue(s) here are that many patients requiring custom shoes also require toe fillers and/or AFOs and other prosthetic products which are outside the scope of the Therapeutic Shoe Program. These are additional revenue generating sources which may not be available to your practice if you were to outsource shoes to an orthotist, pedorthist, or other supplier type. Do not neglect this important income stream. **PM**

Dr. Kesselman is in private practice in NYC. He is certified by the ABPS and is a Fellow of the American Professional Wound Care Association and a founder of the Academy of Physicians in Wound Healing. He is also a member of the Medicare Provider Communications Advisory Committee for several Regional DME MACs (DMERCs). He is a noted expert on durable medical equipment (DME) for the podiatric profession, and an expert panelist for Codingline.com. He is a medical advisor and consultant to many medical manufacturers.