The Comprehensive Diabetic Foot Exam (CDFE) - A Win-Win For Doctor and Patient

Don't miss these opportunities for diabetic foot care.

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The vast majority of podiatrists are honest, ethical and very hard-working physicians. The reimbursement climate has made all doctors work longer hours, see more patients, and add new services to their offices to simply maintain their incomes. There is a new service you can provide with a minimal increase in practice expense that is so apparent; it is actually invisible to most podiatric physicians. It has to do with diabetics - the lifeblood of all podiatric practices. It does not matter whether you provide all facets of diabetic foot care or just limit yourself to at-risk foot care, your patients and your practice can benefit from what I have to tell you.

A patient, who is initially diagnosed as a diabetic by a primary care physician is referred to a myriad of medical specialists, including the ophthalmologist. The ophthalmologist's visit consists of an evaluation and management of the patient's overall eye health. This may include an eyeglass prescription, if needed.

Following the first visit, the ophthalmologist recommends the diabetic patient specifically return to the office every six months for a detailed retinal exam and annually for a comprehensive eye exam that includes the retinal exam and refraction for eyeglasses. For other patients he may recommend an eye exam every two years. Why is this sequence of events the accepted practice pattern for diabetic eye care? Most importantly it is because the ophthalmologists declare there is scientific evidence behind this recommendation: The claim that a patient, solely by virtue of their diabetes, is "at-risk" for retinopathy, so a retinal exam should be performed every six months. Early recognition of diabetic retinopathy can be followed by appropriate intervention which decreases morbidity. So a semi-annual retinal exam is unquestionably a "medically necessary" service.

The Podiatric Paradigm

What is the current podiatric paradigm for a diabetic patient? The newly diagnosed diabetic patient is referred to the podiatric physician to rule out diabetic foot complications. The new patient receives a comprehensive history, exam, and diabetic foot care counseling in addition to at risk foot care. The patient is then asked to return for at risk foot care every few months, but is never specifically

reappointed again for a comprehensive diabetic foot exam (CDFE). Why not? I wish I knew for sure.

One reason for not scheduling annual diabetic exams has been a misinterpretation of Medicare regulations which has resulted in podiatric physicians believing that "at risk foot care ", a group of specific procedures usually non covered for most beneficiaries, but covered for many diabetics, is the same as medical evaluation and management of the diabetic patient. In fact, the CDFE and "at-risk foot care procedures "are two independent and distinct medically necessary services. These two services, one procedural and one cognitive (evaluation and management) have the same goal - to prevent patients with diabetes from suffering foot related morbidity. They are in fact two distinctly significant and separately identifiable services each deserving independent payment. I suspect another reason for the lack of a scheduled CDFE is deeply rooted in podiatric psyches. Podiatrists generally underestimate the value of E/M visits. As has stated by many in our profession, a podiatric encounter is just not considered "complete" by the podiatrist if the podiatrist does not touch the patient with a surgical instrument. We are skilled physicians. We are not technicians. I value the role of podiatry in providing at-risk foot care, but it is time we keep our instruments at bay, and use the power of good history taking and solid physical exam skills to the benefit of our diabetic patients and our practice.

At-Risk Foot Care Procedures

"At-risk" foot care" procedures, while important in and of themselves, are only a portion of the larger framework of comprehensive diabetic foot care services. Podiatrists are in a unique position to provide both of these services and are entitled to be reimbursed for each one independent of the other. There is no health care professional with more education and experience preventing and treating diabetic foot complications than the podiatrist. Doesn't properly managing a diabetic's feet involve both a cognitive service (E/M) and a procedural service (minor surgery)? Think about it….

Can E/M services and "at-risk" foot care surgical procedures be performed at the same patient encounter? What does the coding bible say? The AMA CPT Manual states that there is an inherent amount of E/M service in each surgical CPT code. It is for that reason that only when an E/M service is "significant and separately identifiable" from the procedure, that both an E/M code and a procedure code may be billed at the same time. In that case, the E/M code is appended with the -25 modifier.

What does Empire Medicare – New Jersey say? In the June 2002 Empire – New Jersey News Brief the following was printed: "…Medical care provided on the same day as routine foot care by the same doctor for the same condition is not eligible for payment except if it is for an initial E and M service performed to diagnose the patient's condition or if the E/M service is a separately identifiable service. In this case the modifier 25 must be reported with the E and M service and the medical records must clearly document the E and M service reported. Routine foot care should not be reported using the E/M codes. We will deny an E and M service when the sole diagnosis represents only one of the routine foot care

conditions unless it is the initial visit to diagnose the patient's condition. Any payment for routine foot care includes the allowance for the visit unless it is the initial visit to diagnose the patient's condition or a modifier 25 is reported."

In my professional opinion, the work value associated with a CDFE, which includes a measure of plantar pressure, is so much greater than the inherent E/M service which is included in an "at-risk" foot care procedure code, that it must be considered a totally separate and distinct service.

It is important to note that I am not stating that an E/M service should be billed for merely documenting updated class findings. Updating class findings is not a "true" E/M encounter as it does not involve either an interim history or have decision-making elements – it is simply a Medicare regulation that it be documented and allows for presumptive coverage for "at-risk" foot care.

The diabetic patient presents to the office for a CDFE comprehensive foot exam on a different day than that of "at-risk" foot care! The nature of the CDFE diabetic foot exam itself is a separate patient encounter. Do not be confused, this has nothing to do with reimbursement. Third-party payers and Medicare are paying the same amount for the two services whether they were performed on one day or two days, since the procedure and E/M would be paid at 100% in any scenario.

Appropriate Care Standards

Which body is the official arbitrator for what constitutes appropriate care for the podiatric diabetic patient ? What about our peers who make up the educational arms of the podiatric profession? There is an excellent combined position of the American College of Foot and Ankle Surgeons (ACFAS) and the American College of Foot and Ankle Orthopedics and Medicine (ACFOAM) on diabetic foot care in the Supplement 2000 to The Journal of Foot and Ankle Surgery entitled Diabetic Foot Disorders: A Clinical Practice Guideline.

This project was funded by an education grant from Ortho-McNeil and ACFOAM. The document is available to anyone on the www.acfas.org web site. Among the ten authors of this document were the most prolific diabetic researchers and educators in our profession. This clinical practice guideline includes all the elements expected of an encounter with a diabetic and is an eye opener. It is practical and can be performed by DPMs in the trenches. The encounter is divided into a history, exam, diagnostic procedures, and counseling.

The ACFAS/ACFOAM guidelines cited above describe a method of communicating and classifying cumulative risk using four risk categories as follows:

Table One

Category	Risk Profile	Evaluation Frequency
0	No neuropathy	Annual
1	Neuropathy	Semi-annual
2	Neuropathy, PVD, and/or deformity	Quarterly
3	Previous ulcer or amputation	Monthly

This risk stratification has been accepted by the International Working Group on the Diabetic Foot, International Consensus on the Diabetic Foot, Amsterdam, The Netherlands, 1999. Dr. David Armstrong, one of the authors of the Diabetic Foot Care Guidelines, is one of only two Americans on the panel. <u>This classification assumes that a podiatric physician does not provide any at-risk foot care</u>, so I am not suggesting that patients require a CDFE four times a year. I am suggesting that once a year a CDFE is appropriate and possibly more often for patients with severe pedal pathology.

Communicating Risk Status

Communicating risk status to diabetics is a critical element of diabetic foot care, and the CMS E/M guidelines state that if more than one half of the typical time of an E/M encounter is spent face-to-face on counseling or coordinating care, an E/M code may be billed. For example, if a total encounter for a follow-up patient was 15 minutes and more than half of that time (7 minutes, 31 seconds) was spent face-to-face on counseling and coordinating care, a 99213 may be billed. One must document the subject matter of the counseling and it would be necessary to document the start and stop time of the visit, or total time of the visit.

Diagnostic Procedures

One area of management of the diabetic patient discussed within these guidelines is diagnostic procedures. These procedures include laboratory studies, imaging studies, vascular procedures, neurological testing, and plantar foot pressure assessment. High plantar foot pressures have been identified as a significant risk factor for foot ulceration. Therefore, plantar pressure measurement should be obtained for every diabetic patient at regular intervals.

Previously, plantar pressure measurement was difficult to perform and required expensive equipment. A new, cost-effective, and easy-to-use-and-interpret technology is called PressureStat. It is so simple that podiatric assistants can be easily trained to perform the two-minute test, which is followed by physician interpretation. PressureStat is a patented single-use pressure-sensitive mat, which records a visual and permanent semi-quantitative assessment of plantar pressures that serves as a marvelous tool for assessing a patient's risk for ulceration.

PressureStat is a visual aid to reinforce patient education about the diabetic foot. A picture is worth a thousand words, and in this case it is absolutely true. Patients can now "see" abnormal pressure in a way they have not been able to do before. PressureStat has been proven to be comparable to the optical pedobarograph in a published study in Diabetic Medicine, the publication of the British Diabetic Association. The calibration card that is included detects areas of pressure that are statistically susceptible to ulceration. PressureStat has been shown to be so reproducible based on inter and intra observer measurements as to be useful in research according to a recent publication by Andrew Boulton. Two

PressureStat mats are needed per patient exam at a total cost of $4.00 - proving to be very cost-effective.

CDFE

I have assisted Footlogic in creating a turn key system for making the CDFE an integral part of podiatric practice. We have created two different letters to patients, one for diabetic patients new to the practice, and one for diabetic patients who are established to the practice, explaining the concept and value of a CDFE. We have created a patient history form which can be completed by the patient in the reception room and then reviewed and signed by the physician.

In addition, a new CDFE form is a fill-in-the-blank-type form which covers the medically necessary aspects of a comprehensive diabetic foot exam. The two-sided 8 ½ x 11 exam form meets the CMS requirements for a CPT 99213 when fully completed. The 99213 may be linked to a diagnosis of diabetes at the highest specificity, is covered by Medicare in most states, or another clinical finding established and documented by the examination. Footlogic makes these copyrighted exam forms available to podiatrists who purchase a starter kit of PressureStat mats. More information may be found at www.footlogic.info, or by calling (866) 385-6442, or by circling #198 on the reader service card.

A Vision For Diabetics

Step into my vision of podiatric medicine for diabetics… All diabetic patients will be educated about the value of a stand-alone annual CDFE and its associated counseling session scheduled annually independent of their "at-risk foot care" procedural visits and existing "at-risk diabetic foot care patients" will be educated about the "new" ACFAS/ACFAOM recommendations for an annual CDFE using the supplied form letters. The supplied exam form makes documentation of the CDFE consistent and painless.

The patient encounter might begin with the patient bringing in a list of all medications and completing an updated medical form, while in the waiting room, that includes past medical history, medications, and allergies and the review of systems. The form uses words in the patient's language.

Next your staff member performs the PressureStat exam which takes all of two minutes and you are ready to see the patient and review his/her history, perform an exam, and explain the PressureStat results as part of counseling about home diabetic foot care. PressureStat's visual format helps evaluate a patient's need for therapeutic shoes and dramatically reinforces the patient's need to continue to wear therapeutic shoes and innersoles.

You simply review the patient's history form and sign off on it. If the history reveals the patient is suffering from increasing intermittent claudication and night cramps, you document the diagnosis by either a non-invasive vascular exam or by referral to a vascular surgeon, and you consider a medication to improve his/her circulation along with a strict exercise program and the proper shoe gear. If the history establishes that his/her painful neuropathy is worsening over time, you may discover your patient has only been taking diabetes medication every other day

because it is too expensive or that the patient has not seen a primary doctor or is not following any suggested diet.

You will then insist that the patient find a new primary care doctor. If your exam discovers a suspicious lesion on the foot, you schedule a biopsy for a later date. If you discover xerosis, tinea pedis and onychomycosis, you prescribe medication to treat these chronic conditions.

Lastly, you always counsel patients on the importance of good glycemic control, seeing a primary care doctor regularly, and inspecting feet daily with a mirror. Discuss guidelines for shopping for shoes, breaking them in, and the value of even moderate exercise in controlling blood sugar and weight. You might show them a videotape or a DVD on diabetic foot care and reinforce the education with take-home reading materials.

And then you repeat this as often as medically necessary till the patient dies or moves away.

Then podiatrists will pay less money for malpractice insurance because when a lawsuit is filed, the medical records are found to be so good and the care so thorough, the suit is found to be baseless. In fact, patients realize the doctor has done all that is humanly possible to prevent amputation and will not even consider a lawsuit - even though their hungry lawyer is looking for a quick buck. By the way, these patients refer their friends and neighbors to your office and you are more and more successful.

If I am correct, diabetic patients will still expect us to trim their nails, but they will recognize that is just a small portion of what we can offer them. I am really looking forward to comments on this article. Send them to me at drmedicare@aol.com.

Disclaimer:

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Coding and documentation rules are not simply black and white, and are subject to many interpretations. The various Medicare carriers differ in their medical policies for coding and documentation of the identical patient encounter. Unfortunately, there are many private insurers that maintain unique coding and documentation requirements that are in conflict with the AMA CPT Manual.

The reader is urged to contact his or her local insurance carrier to discuss any statements made in this article considered controversial. In cases where variability exists, the physician must conform to the rules promulgated by the local carrier.