Don't Let Coding Issues Be Part of Your Potential Burnout

Understanding billing helps reduce stress.

BY MICHAEL J. KING, DPM

Recent studies in several medical journals have been about the level of physician burnout increasing in the United States. Podiatric physicians are not immune. We are just as prone to burnout as is any other provider of healthcare. Specialty, demographics and years in practice are just a few parameters that have been recently studied as part of physician burnout.

This article is not about burnout, but it is about not letting worries about coding be a contributing factor. Yes, we are constantly hounded for records from the Medicare Advantage Plans (MAPs). We are audited for single procedures that we know more about than anyone who performs them (especially those at carriers reviewing them). We are expected to keep meticulous records while providing the best foot and ankle care possible and… make a living.

Podiatrists are among the best and the brightest at proper coding. As a former Medicare auditor, I have seen claims from some of the worst providers in America; rarely were those from a DPM. It is amazing how creative many can be at getting services paid for, when the code and procedure just don't match up. Those of us who teach and review coding truly want all of us to be paid fairly for our services and to never need to be audited for a legitimate reason.

So, let's continue to be the best and most accurate coders we can. Many blogs and posts comment about coding experts trying to simply get you paid more, even if by not using the correct coding. This is pure bull. Coding does not have to be creative or difficult, nor a great stress on you and your practice. Yes, it takes some work but with so many resources available today, we can all be coding experts. Heck, you already are! Let's chat about a couple of FAQ areas:

Modifiers and At-Risk Foot Care (AKA Routine Foot Care)

Modifiers

It's astounding that payers are barking so much about "excessive use" of modifiers. They invented the darn system requiring their use, to force us to only use one code per day. Modifiers are there to alert the payer to the separately identifiable service we may provide simultaneously with another service. We are a specialty dealing with multiple moving parts, multiple issues, and rarely do we see a patient who has but one simple issue, say…just tinea pedis. Proper use of modifiers is key though. The CCI, or correct coding initiative, is not

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as difficult as it may seem. It quickly lets us know 1) do we even need a modifier? 2) should it be paid with a modifier? and 3) the bizarre codes they link in some cases.

Modifiers do not need to be a point of consternation when used properly. Yes, sometimes it is confusing which one fits best, or is required, especially for a unique problem during a global period. I find the APMA CRC (Coding Resource Center) to be an invaluable resource when looking up modifiers, the CCI, and global periods.

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At Risk Foot Care: (ARFC)

"Routine foot care" it is called by many, especially Medicare. I don't think there is any such thing as routine foot care. There is "non-covered foot care" but that is not routine, perhaps cleansing or trimming nails or calluses, or whatever awful term Medicare uses for those services, as they value them so little.

We know, and soon will prove, through EBM (Evidence Based Medicine), that our at-risk foot care services save limbs and lives, and therefore the beloved dollar of the third-party payer. At-risk foot care, CPT codes 11719, 11720/21, 11055-57 are some the most important services we render despite their lack of sexiness to many providers. Our surgical care is critical to our patients as well, and I am not belittling that—I'm simply focusing for now on the challenges of ARFC.

ARFC is one of the most scrutinized services we provide. Medicare has made it downright onerous for coverage, but we can't let that deter our providing those services when needed or allow the work involved in coding them burn us out. We know the at-risk patient and why they need our services. The payers know it too; many just don't want to admit it. As we provide the evidence-based medicine, it will become increasingly clear, and perhaps we can lessen some of the burdens of documentation, phone calls for "last date of visit with PCP", and the like.

You know the coding of foot and ankle services better than anyone in medicine. Don't let the stress of figuring out the next code lead to early burnout. Attend seminars, ask colleagues, read Codingline. Do whatever it takes. DPMs are good coders. **PM**

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