MOVING INDIANA FORWARD

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INDIANA PODIATRIC MEDICAL ASSOCIATION

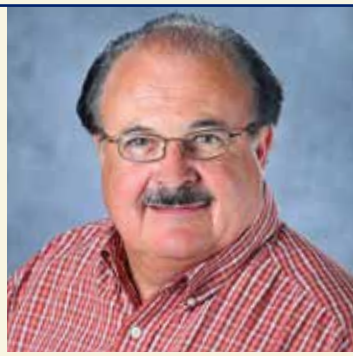
Forward

ISSUE TWO | SUMMER 2019

IN THIS ISSUE

PRESIDENT'S MESSAGE

RICHARD LOESCH, DPM | IPMA PRESIDENT



I hope everyone has been having a good summer. In April, many IPMA members headed to Chicago for the Midwest Podiatry Conference. The Midwest provided a fantastic opportunity to catch up with friends and colleagues from throughout the region. I enjoyed seeing many of you while I was there.

Although we are all enjoying the warm weather, BBQs and family vacations the fall is already on the horizon. We have a couple of very exciting opportunities for the IPMA this fall. Of course, we all know about our yearly annual convention. I believe that a strong convention is key to the success of the IPMA. The IPMA Annual Convention is approaching and I hope to see you in Indianapolis this fall. The convention will be held at the Hyatt Regency Downtown, Indianapolis, IN, October 10 – 13, 2019. The IPMA offers a strong education program while providing an opportunity to meet with other IPMA members. I also hope that you take the time to invite a colleague who you have not seen at the convention in a while.

In addition to the annual convention this year the IPMA will be hosting the Annual KCF Tournament in French Lick, Indiana. The KCF event honors three legends of podiatry (Earl Kaplan, DPM, Theodore Clarke, DPM and Oliver Foster, DPM) by supporting the profession's legislative advocacy. IPMA should be proud to have a namesake of the event with our own Teddy Clarke. I would encourage all members who enjoy golf to attend and support this important event. The event will be from September 11-15.

As always, in addition to your financial support through dues, we continue to need the time and talents of all members in order to remain a strong organization. If you are interested in getting involved, please do not hesitate to contact me or the IPMA office.

If you have any thoughts, concerns or suggestions regarding the activities of the IPMA please do not hesitate to contact me.

SELF-CARE LEADS TO BETTER PATIENT CARE

IPMA/APMA cares about you and your health. We have identified and reviewed many resources on the subject of clinician well-being and burnout. Take some time to learn more about burnout, the importance of work-life balance, and how to talk about substance abuse, suicide, and other difficult topics. APMA has committed to collaborate with other concerned organizations to end clinician burnout.

Juggling professional and personal responsibilities can sometimes prove to be a bit overwhelming. APMA recognizes physician well-being is a topic of interest to our membership. Below are a range of resources for physician well-being and resilience. If you are interested in learning more about what you can do to help your profession tackle physician burnout, contact Dyane Tower, DPM.

YOUR WELL-BEING

- APMA's Physicians' Recovery Network (PRN)
  The Physicians' Recovery Network identifies available resources for impaired (whether by substance abuse, physical or mental conditions) for podiatric physicians and/or members of the podiatric medical family to assist them to return to full life and effective professional practice. Biff Kramer, DPM, provides a 10-minute video introduction on how substance use disorders/addiction issues can happen to anyone—explaining how even the best and brightest can have up to a 20-percent chance at developing personally harmful substance habits. But with a little support, about 80 percent of affected physicians make a full recovery. Dr. Kramer introduces how the APMA's PRN serves members with great dedication, discretion, and empathy for doctors impacted by this issue.
- 50 Ways to Take a Break
  This colorful graphic identifying multiple ways of de-stressing can be printed and posted for office use.
- American Academy of Family Physicians: Physician Health First
  The American Academy of Family Physicians (AAFP) understands that the health-care system is broken. For those who are AAFP members and have log-in access, this resource allows you to determine how affected you are by this troubled system, using the Maslow Burnout Inventory. The website provides the steps you can take to make an effective plan for coping with the stresses of working within a troubled health-care system and then helps you track your progress. Nonmembers are welcome to attend the Family Physician Health and Well-being Conference June 5–8 in Phoenix.
- American Psychological Association: The Road to Resilience
  Read the American Psychological Association's guide to resilience and coping mechanisms.
- Institute for Healthcare Improvement's Joy in Work
  Highlighting the importance of a joyful workforce in health care, this resource offers a published paper and numerous videos of leading experts who share principles, techniques, and a framework to find joy in work and help avoid burnout.
- International Doctors in Alcoholics Anonymous
  International Doctors in Alcoholics Anonymous (IDAA) is a fellowship of doctors and their families whose primary purpose is to support one another in recovery from alcoholism and other drug addictions. The website provides information and resources for members, their families, and friends. The IDAA HelpLine is a network of volunteer doctors who talk to other doctors about addiction or related problems. The IDAA helps members find local meetings in their area.
- Mayo Clinic Program on Physician Well-Being
  The high prevalence of physician burnout costs this country 3.4 billion dollars per year in medical errors that can lead to increased patient mortality and medical malpractice. It also poses a serious threat to the quality, affordability, and compassion of care the medical industry strives to provide. The Mayo Clinic's multi-program approach to address burnout includes providing resources to promote well-being, implementing control studies, increasing physician efficiency, increasing resilience, and building social support networks.

RESOURCES TO LEARN MORE

- AAMC News: Building a Framework for Clinician Well-Being and ResilienceAPMA's Statement of Support
  The American Podiatric Medical Association and National Academy of Medicine members commit to collaboration while combating clinician burnout not only through identification of evidence-based effective ways to alleviate factors of physician burnout, but by effecting delivery of these means with immediacy. Physician burnout is contributing to an American health-care crisis from an increasing shortage of physicians.
- The Association of American Medical Colleges (AAMC) reported on the July 2017 meeting of the National Academy of Medicine, which highlighted the greater risk of burn-out experienced by minorities, women, and young physicians.
- AAMC News: When Physicians Become Patients
  This article reflects a call to action from Darrell G. Kirch, MD, president and CEO of AAMC. As a psychiatrist, he has treated physicians for burnout, depression, and suicidal ideation. He discusses the upward trend of this ideation and its toll, which is not only personal, but also professional, affecting patient care.

- AMA Model Bill: Physician Health Programs Act
  This act was created to allow for early identification of physicians with potentially impairing conditions (e.g., substance abuse, mental health, medical disease), in order to provide them with access to professional resources and support.
- AOA Critical Issues Article
  Burnout in Orthopaedic Surgeons: A Challenge for Leaders, Learners, and Colleagues
- Ending Physician Burnout: It's Time for Physicians to Take Back Control of Their Environment and How They Deliver Care
  This article by Bridget Duffy, MD, chief medical officer at Vocera, discusses the importance of physician well-being and how streamlined technologies can help mitigate physician burnout.
- Federation of State Medical Boards: Physician Wellness and Burnout
  The report and recommendations of the Workgroup on Physician Wellness and Burnout of the Federation of State Medical Boards approach physician wellness and burnout from a non-punitive perspective to advance a positive cultural change that reduces the stigma among and about physicians seeking treatment for mental, behavioral, physical, or other medical needs of their own.
- Federation of State Physician Health Programs
  The data indicates a 15–20-percent lifetime prevalence of substance use disorders and mental health problems among physicians. Physicians should have the opportunity for rehabilitation, confidential support, and access to community specific resources. The Federation of State Physician Health Programs (FSPHP) provides a forum for education and exchange of information among state physician health programs. The FSPHP aims to support physician health programs in improving the health of medical professionals and enhance awareness of issues related to physician health and impairment.
- The Impaired Physician & Suicide Prevention: 33 Orthopaedic Surgeon Suicides. How to Prevent #34.
  A keynote address delivered by Pamela Wible, MD, at the 19th Annual Chicago Orthopaedic Symposium in 2018, exploring the hidden factors behind physician suicide.
- Medscape 2018 Report: Patients Sexually Harassing Physicians
  An article by Leslie Kane, MA, addressing sexual harassment in the medical workplace.
- Medscape Article: Physicians Experience Highest Suicide Rate of Any Profession
  The alarming one-per-day completed-suicide rate among physicians, residents, and medical students (28–40/100,00, double the rate of the general population), is driven mainly by the stigma within this group related to seeking professional help for depression, alcoholism, and treatable mental disorders. Growing awareness of this problem has allowed for implementation of initiatives to prevent physician suicide. Open discussions allow physicians, residents, and medical students to view suicide as an illness that needs treatment in an effort to shed the stigma that is acting as a major obstacle to seeking professional care.
- Medscape Article: Resident Suicide: A Tragedy, and What Can Help?
  A brief discussion of burnout among residents and medical students.
- Medscape Interview with Talt Shanafelt, MD: Isolation and Burnout in Physician Culture: Innovative Solutions
  An interview with two Stanford physicians about causes and treatment of burnout.
- Medscape National Physician Burnout & Depression Report 2018
  Medscape's National Physician Burnout & Depression Report describes the variety of factors that contribute to physician burnout.
- National Academy of Medicine: Action Collaborative on Clinician Well-Being and Resilience
  The National Academy of Medicine has created several committees to raise the visibility of physician burnout, improve understanding of well-being of physicians, and determine ways to improve patient care by improving the overall well-being of physicians. This site provides links to a wealth of information about the five working groups that are researching physician burnout, as well as the latest research in physician self-care.
- National Academy of Medicine: Clinician Well-Being Knowledge Hub
  This site is an offshoot of the National Academy of Medicine, linking physicians directly to peer-reviewed literature, opinion pieces, and in-person meetings, as well as research on physician burnout causes, treatment, and effects.
- New England Journal of Medicine Perspective: To Care Is Human "To Care is Human—Collectively Confronting the Clinician-Burnout Crisis" tackles four central goals: increasing the visibility of clinician stress and burnout; improving health-care organizations' baseline understanding of the challenges to clinician well-being; identifying evidence-based solutions; and monitoring the effectiveness of implementation of these solutions.
- ScienceDaily Medical Errors and Physician Burnout Article
  This article, "Medical errors may stem more from physician burnout than unsafe health care settings," links physician burnout to medical error, and reports on the national epidemic of high burnout linked to suicide.
- STAT Moral Injury Article
  This article, "Physicians aren't 'burning out.' They're suffering from moral injury," identifies physician burnout as a symptom of the broken health-care system, resulting in moral injury as physicians are forced to go against their will to provide high-quality care.

ONLINE LIMITED PODIATRIC RADIOGRAPHY EDUCATIONAL PROGRAM

The Indiana State Department of Health (ISDH) requires all podiatric medical assistants who take x-rays to be licensed as a limited podiatric radiographer.

The IPMA wants to remind the membership of its new limited podiatric radiography program that meets the ISDH requirements and is designed to instruct the podiatry assistant in the safe and effective use of x-rays in the podiatric practice.

Content includes:

- History of the x-ray
- Risks and safety measures associated with radiography
- Image production and film development
- Principles of CT Scan, MRI, and Bone Scan
- Anatomy of the foot and ankle
- Positioning and x-ray machine placement

PROGRAM STRUCTURE

The program consists of four online content modules, each with a final exam, one attestation module, a student manual, and an x-ray log. A Certifying Physician must guide the applicant in the clinical portion of the program and the completion of the x-ray log. The podiatry assistant must document competency by demonstrating the proper performance of 60 x-ray views in the podiatrist's office.

At the successful conclusion of the program, the applicant will have the proficiency and skill necessary to obtain the limited podiatric radiography license and will receive a Certificate of Completion. The Certificate, the completed Application for Proficiency Certification for Limited Radiographer and signed x-ray log should be sent to the IPMA.

To learn more about this program or to register, click here.

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SOCIAL MEDIA IN HEALTHCARE: BENEFITS AND RISKS

As social media continues to proliferate, both in terms of usage and number of platforms, it is redefining both personal and professional communication and knowledge-sharing. Research shows that nearly 70 percent of U.S. adults use social media sites — such as Facebook, Twitter, Instagram, YouTube, Snapchat, Linkedin, and Pinterest — and the typical American uses three of these networking sites. [1] Because social media use is more prevalent with younger age groups, it is realistic to assume that its popularity and role in many types of communication will continue to grow.

Unlike some industries, healthcare was relatively slow to implement social media as marketing and communication tools, primarily because of concerns about violating patient privacy. However, as consumer demand has risen, and organizations attempt to find new ways to connect with patients, social media is becoming more of a mainstay for healthcare organizations of all types and sizes.

The beneficial aspects of social media are numerous. Many healthcare providers use social media to connect with professional groups and peers and to stay current with new information and research that might affect patient care and daily practice. Further, providers use social media to post educational content and other information for patients, to market and advertise services, and to enhance visibility and reputation.

For consumers, social media can assist with searching for new healthcare providers, keeping up with healthcare issues and concerns, finding support groups, researching alternative medications and side effects, tracking information from health apps, and more. Data from the Pew Research Center show that more than one-third of U.S. adults have used the internet to try to figure out a medical issue, and other research shows that social media tools influence the choice of a specific hospital, medical facility, or doctor for 4 in 10 people.[2]

Undoubtedly, social media offers various functions that can enhance the dissemination of healthcare information and communication among healthcare providers and between providers and patients. But what about the risks? Like any type of technology, social media can create safety and liability issues if it is not used responsibly. Additionally, because social media changes rapidly, standards and best practices are not always well-defined.

To help address these challenges, MedPro Group's Patient Safety & Risk Solutions Team has developed a short, educational webinar that focuses on current trends in social media, the role of social applications and interactions in healthcare, potential benefits and risks, and proactive strategies for reinforcing appropriate social media practices.

To access the program, titled "Managing Social Media Challenges in Healthcare," visit www.medpro.com/social-media-challenges. Participants can watch the webinar, download the slides, and print a certificate. Additionally, a checklist for managing social media risks is available at www.medpro.com/documents/10502/2899801/Checklist_Management+of+Social+Media+Risks.pdf.

1 Pew Research Center. (2018, February 5). Social media fact sheet. Retrieved from www.pewinternet.org/fact-sheet/social-media/; Smith, A., & Anderson, M. (2018, March 1). Social media use in 2018. Pew Research Center. Retrieved from www.pewinternet.org/2018/03/01/social-media-use-in-2018/

2 Fox, S., & Duggan, M. (2013, January 15). Health online 2013. Pew Research Center. Retrieved from www.pewinternet.org/2013/01/15/health-online-2013/; Brimmer, K. (2012, June 13). PwC report shows importance of social media to healthcare. Healthcare Finance. Retrieved from www.healthcarefinancenews.com/news/pwc-report-shows-importance-social-media-healthcare

NOMINATIONS FOR 2019 IPMA AWARDS ARE NOW BEING ACCEPTED

Is there are podiatrist or staff member deserving of recognition to the profession and the association? If so nominate them for consideration of the following awards to be recognized at the annual convention this fall.

DR. T. H. CLARKE ACHIEVEMENT AWARD

The Dr. T. H. Clarke Achievement Award is IPMA's highest award, and is bestowed upon the member who has demonstrated not only contributions to his/her profession but also service in behalf of the podiatric welfare of the public and service to the community at large. Judging criteria:

- Public Service – Service to the country, state, or other political sub-division in any capacity; service to education; service to the community; service to religious or service institutions; service to charitable causes; philanthropy.
- Service to the Podiatric Welfare of the Public – Service with groups; activity with governmental committees; participation in governmental health care programs; participation in public service programs; other similar activities.
- Service to Podiatric Medicine – Contributions of personal effort and time in behalf of the profession's advancement; educational and research activities; contributions to the profession's literature; similar acts of service.
- Service to the American Podiatric Medical Association, Indiana Podiatric Medical Association, or its affiliates – Service as an officer, department or committee chairman, committee member, etc.; promotion of the association's goals and programs; activity in support of association's organizational projects; cooperation with public relations activities; similar acts of service.

MERITORIOUS SERVICE AWARD

The Meritorious Service Award(s) shall be presented only to IPMA members for long-time service rendered to the profession of podiatric medicine performed within the state Association OR for an outstanding current record in a specific category or categories which merits recognition, but does not meet the IPMA Podiatrist of the Year standards.

OUTSTANDING PUBLIC SERVICE AWARD

The Outstanding Public Service award is bestowed upon an individual outside the profession, usually in governmental or political areas, or other professions, or the news media.

GINNY JEWELL STAFF MEMBER OF THE YEAR AWARD

The Ginny Jewell Medical Assistant of the Year Award is presented to the staff member who has demonstrated contributions to the Association or has demonstrated outstanding leadership and commitment to his or her podiatric office. This award nomination is to be submitted by a DPM who wishes to honor his or her staff member for their outstanding work.

Nominations are due to the IPMA office by **Tuesday, October 1 at 5:00 p.m**. Award winners will be presented at the IPMA Annual Fall Convention.

If you have any questions, please contact Matt Solak at the IPMA Offices at 888.330.5589 or matt@kdafirm.com.

2019 IPMA AWARDS NOMINATION FORM

Please complete a separate form for each nomination.

I would like to nominate _____

- ☐ Dr. T. H. Clarke Achievement Award
- ☐ Outstanding Public Service Award
- ☐ Meritorious Service Award
- ☐ Ginny Jewell Staff Member of the Year Award

Qualifications *(Please attach additional information as needed)*

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Signature

Printed Name _____ Phone _____

Email _____ Date _____

NOMINATION FORMS ARE DUE TO THE IPMA OFFICE BY

MONDAY, OCTOBER 1, 2019 AT 5:00 P.M.

Return forms to matt@kdafirm.com or via fax at 517.485.9408.

HONORING A TRUE HERO IN PODIATRY

I am a proud Hoosier through and through. It's my home. I grew up in Indy and came back after podiatric medical school to do my residency and go into practice. Although Indiana's number of podiatric physicians put us in a mid-range state, the Indiana Podiatric Medical Association (IPMA) has a long and storied history. At the top of that list is Theodore "Teddy" H. Clarke, DPM from Kokomo, IN.

Dr. Clarke served all the offices within IPMA, including President in 1971. In 1975, he was selected Indiana Podiatrist of the Year. Dr. Clarke went on to serve as a Delegate to the APMA House of Delegates. He was elected to the APMA's Board of Trustees (American Podiatry Association at the time, APA). In 1978 he was inducted as the first African-American President of APMA. Teddy was awarded the APMA Distinguished Service Citation (DSC) in 1993.

His DSC states, "Dr. Clarke has served as an advocate to students of podiatric medicine and was active in obtaining seating for students in the APMA House of Delegates, the Council on Podiatric Medical Education, and other podiatric organizations. Dr. Clarke's general enthusiasm, intelligence, moral integrity, and a lifetime to dedication to podiatric medicine has had a profound effect on the profession." Jay Levrio, Ph.D. (APMA Deputy Executive Director and Chief Operating Officer) put it so beautifully in our personal communication regarding Dr. Clarke, "He served as a strong professional role model for African-American DPMs and students of color interested in a career in podiatric medicine."

The APMA Kaplan-Clarke-Foster Golf Tournament & Practice Management Seminar September 11-15 (https://www.apma.org/KCF) celebrates its 30th anniversary this year in French Lick, Indiana. The event has raised more than $800,000 for the APMA Protecting Our Profession (APMA POP) formerly known as the APMA Government Education Fund (APMA GEF). This fund provides support to the association by sponsoring programs such as the Annual Podiatric Medical Legislative Conference, which is held in conjunction with the annual APMA House of Delegates meeting in Washington, DC. The fund also supports educational outreach to members of Congress about the importance of podiatric medicine in today's health-care system.1

The event honors three legends of podiatry (Earl Kaplan, DPM, Theodore Clarke, DPM and Oliver Foster, DPM) by supporting the profession's legislative advocacy. It is a GREAT event. The camaraderie is like any other event in podiatry. This year's event is in beautiful southern Indiana at the French Lick Resort (FrenchLick.com) featuring two renowned golf courses designed by Pete Dye and Donald Ross (https://www.frenchlick.com/golf/petedye) (https://www.frenchlick.com/golf/donaldross).

If you enjoy golf, want to support the profession, play two incredible golf courses, and visit my beautiful home state; please consider participating in this year's KCF event. Better yet, if you want to honor a true hero within the podiatric profession, Dr. Teddy Clarke, join us this September 11-15 by registering now (https://www.apma.org/KCF).

30th Kaplan-Clarke-Foster

Practice Management Seminar

FRENCH LICK RESORT

FRENCH LICK & WEST BADEN · INDIANA

September 11–15, 2019

Resort packages start at $2,027 per person
(based upon double occupancy).

Benefiting apma | Protecting Our Profession

Contact Ben Wallner at 301-581-9231 or email ***bjwallner@apma.org.***

Hotel reservations deadline is August 10, 2019.
Hotel rooms are assigned on an "as available" basis.

www.apma.org/kcf

Fax completed form to Ben Wallner at 301-571-4905. Deadline to register is August 31, 2019.

Amount to Charge: **$300:** Registration Fee **$150:** Non-DPM Registration Fee **$125:** Facility Fee

Payable to APMA Protecting Our Profession

❑ Check this box if you prefer to pay your registration and facility fee in monthly installments.

Name

Address

City State Zip Credit Card Number Expiration Date

Shirt Size: S M L XL XXL

E-mail Address Signature Date

TIME MANAGEMENT TIPS

BY LYNN HOMISAK
SOS HEALTHCARE MANAGEMENT SOLUTIONS

"Practice management" encompasses a variety of organizational skills that help to, well…***manage*** your ***practice***. That includes managing your finances, employees, standards of operations, and time. Regarding time, if I had a nickel for every instance someone said to me, ***"There are just not enough hours in my day"***, I'd be uber rich on nickels. That said, I believe introducing my five proven time management methods (below) will help open some eyes in the office on how to be more time-conscious. Then, if one or two (or all) of them could become routine, who knows? They just might, ***in time***, even eliminate some unwanted headaches and, crazy talk here… make your practice work for you. In fact, I KNOW they will!

PLAN AND PRIORITIZE

It helps to have effective tools to help keep you (and your day) on task. In other words, plan your work and work your plan. Start by keeping a neat work area. You can work a lot faster when everything is in its proper place. Second, create a list of "things to do" and put it on paper so you can visualize it. Any of these simple approaches will work: a) jot down random tasks as you think of them and in no particular order; b) organize your task list according to categories, i.e., outgoing phone calls, errands, correspondence, projects, misc., etc. Then, tackle by group; c) differentiate urgent tasks from non-urgent and important from not important, focusing on the urgent and important ones first; and finally, d) partition your work day into hourly slots and fill each timeframe with tasks you want to accomplish. Of course, checking off tasks on ANY "to do" list means you have, in fact, "done" them. Revel in your productivity! *(see end note)

STRUCTURE YOUR DAY FOR BEST ACHIEVEMENTS

Don't ignore your internal clock. That means working in coordination with your own energy levels by scheduling more activities and work during your energized time and less during those lazy times. It is proven that during your prime, energized time, your batteries are charged, your brain is ON and your focus is good. But when you are in slow mode and dragging, so too does your brain. By the way, doctors should also consider taking this approach when creating their patient schedule. Late riser? Start late; work late. Early riser? Start early; end early. The start of your day, whenever that is, is your most productive. And be sure to **start on time!** Not doing so is the #1 reason we fall behind schedule. Don't forget to use automation when available; it's there to make your life easier. Take advantage of it.

DO NOT PROCRASTINATE

Nike had the right idea. "Just do it!" However for 20% of our population who are chronic procrastinators, that is easier said than done. Something or someone holds them back from starting and/or completing what they set out to do. If you don't know what or who is holding you back, maybe it's because you never really made an effort to find out. Try a little introspection. Ask yourself why, by finishing this statement…"I'm avoiding this task because…" Your response might provide all the insight you need to forge on. If certain projects feel overwhelming, start small. Small action is still action. You're on your way.

DON'T MULTI-TASK; DO DELEGATE

There is a part of us that thinks we can effectively multi-task – and for some things we actually can because we've developed a "we can do this in our sleep" mentality that enables us to accomplish menial, routine, mindless tasks, like walking and talking at the same time. But the term "multitasking" was actually created for computers, not humans. Our brains are not wired to multi-task. In fact, our IQ is lowered by as much as 10 points and we are said to be 50% LESS effective and accurate when we try to juggle two (or more) things at the same time. When we do, we spend more time correcting errors, redoing work and overlooking important steps. It leads to less focus, less productivity, wasted time and far more stress. Experts agree. In order to do a job well, we must concentrate on one thing at a time. Start it. Finish it. Begin the next task. Now, if you find you have too much on your plate, rather than trying to take it all on yourself, ask for help. Remember, though, you do not delegate a task because it is too difficult or boring; you do so because someone else (a staffer or co-worker) possesses the proper skills and is perfectly capable to pitch in. Another reason is to help them learn and expand their responsibilities. That's the essence of teamwork.

ELIMINATE DISTRACTIONS AND TIME WASTERS

Determine where you are wasting your minutes that lead to wasted hours. Is it the phones, emails, unlimited social time

with patients or co-workers, unnecessary paperwork, or not being able to make prompt decisions? Identify them; then slowly weed them out and voila! Suddenly, there will be more room for productive ones.

Maybe it's because I'm entering the "Autumn" of my life (Medicare enrollment will do that to you!) but I don't have to tell you that each minute we are given is a valuable commodity. Until we value our time, we fail to care how we spend it. Isn't it about time we started caring?

**End note...anyone wishing to receive a copy of any of these "to do" lists, email lynn@soshms.com. They are complimentary for the asking.*

Ms. Homisak, President of SOS Healthcare & Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of Podiatry Management's Lifetime Achievement Award and recently inducted into the PM Hall of Fame. Lynn is also an Editorial Advisor for Podiatry Management Magazine and recognized nationwide as a speaker, writer and expert in staff and human resource management.

PROPOSED SOLUTIONS TO SURPRISE MEDICAL BILLS A GROWING SOCIAL RISK FOR THE HEALTHCARE INDUSTRY, SAYS MOODY'S

BY JEFF LAGASSE, ASSOCIATE EDITOR
PUBLISHED JUNE 25, 2019 IN *HEALTHCARE FINANCE*

The impact of legislation to curb surprise medical bills would be pronounced for those with lots of interaction with out-of-network patients. Solutions that have been proposed to resolve the problem of surprise medical bills are a growing social risk for the healthcare industry, Moody's Investors Service said in a new report. Unexpected bills are generally received by insured patients who inadvertently receive care from out-of-network providers, mainly in emergency situations. As a result, the impact of any legislation to curb surprise medical bills would be most pronounced for companies that have a high level of interaction with out-of-network patients, including hospitals, air ambulances and physician staffing companies that specialize in emergency care.

WHAT'S THE IMPACT

Solutions under consideration include capping out-of-network charges for emergency medical services at in-network levels, setting up an arbitration process to resolve out-of-network charges and requiring patients' consent for out-of-network charges. Other approaches would be to require a single, "bundled bill" for all care received in an emergency room, or have hospitals guarantee that all their affiliated doctors and service providers are in-network.

Among those options, bundled billing/in-network guarantee would be the most negative for hospitals and staffing companies, given that many hospitals outsource all their emergency department operations and billing to staffing companies. Meanwhile, an in-network guarantee would present steep challenges, since many physicians and ancillary service providers aren't employed or controlled by the hospital. The largest providers would be least affected by any changes, Moody's said. Their scale gives them significant negotiating leverage with insurers, making them more likely to be in-network.

Subsequently, out-of-network exposure across Moody's-rated healthcare companies is relatively limited, though legislation could indirectly affect how they negotiate in-network rates with insurers and could pressure prices over time. Plus, some of the proposed changes are likely to lead to industry consolidation as independent or smaller-scale providers look to become part of a larger in-network provider.

On Wednesday, the Senate Committee on Health, Education, Labor and Pensions is scheduled to consider the "Lower Health Care Costs Act," which includes a provision regarding surprise medical bills — a provision that's opposed by the American Medical Association. According to the AMA, the outline "fails to address some of the fundamental reasons why surprise billing occurs — inadequate provider networks, higher patient-cost sharing requirements for out-of-network services, and non-competitive local markets that empower plans to offer take-it-or-leave-it contracts."

THE LARGER TREND

In March, Physicians for Fair Coverage, a nonprofit, non-partisan physician alliance, partnered with both state and national consumer organizations on a legislation model to protect patients from surprise out-of-network medical bills that they hope will inspire federal lawmakers.

The proposal seeks to ban providers and insurers from balance billing patients for unanticipated out-of-network care, also known as surprise medical bills. It creates a national protocol for alternative dispute resolution, or ADR, which is a model to prohibit surprise medical bills and establish reimbursement standards.

ON THE RECORD

"Curbing surprise medical bills, which is part of the conversation around the affordability and accessibility of U.S. healthcare, has rare bipartisan support, raising the likelihood of legislative or regulatory action at the federal level," said Jessica Gladstone, a Moody's associate managing director. "Even absent any action, surprise medical bills and the scrutiny around them represent a growing social risk for the healthcare industry and can ultimately harm some healthcare providers' relationships with their customers."

INSURANCE REPORT

BY DR. ED PRIKASZCZIKOW, DPM
IOWA PODIATRIC MEDICAL SOCIETY PIAC REP.

WPS

WOUND CARE LCD L37228

The WPS Wound Care LCD, L37228, has many deficiencies that can compromise patient care or at the very least, denials for billing of legitimate services. I will not review all the deficiencies since I have addressed this in previous publications.

In January 2019, APMA Health Policy and Practice Committee submitted a formal reconsideration to WPS to have changes made in the LCD that we had deemed necessary and appropriate. We recently received a response from WPS. They were convinced that the LCD should be reviewed regarding the items addressed by APMA. Unfortunately, this has to wait until the next scheduled CAC meeting in October 2019. We feel we have made strong arguments to have the LCD changed for everyone's advantage. We will keep you updated on how this progresses.

CMS

PROCEDURES WITH 10 DAY GLOBAL PERIOD

As I reported in 2017, CMS took a hard look at the 10 day and 90 day global periods and what services were furnished during these global period. For every procedural CPT code, the value of the CPT code also includes a certain number of postoperative visits. CMS had suspicions that the number of postoperative visits included with the reimbursement of these codes, were not utilized. Therefore, they assumed that a lot of these codes were overvalued. As such, CMS proposed that 10 day and 90 day procedure codes should have the postoperative visits unbundled from the value of the codes, and that the code should be revalued. They proposed that each postoperative visit should be billed separately. In the 2016 Final Rule, CMS decided to study the problem further before making any rash decisions on reducing reimbursement for these codes. They started with a list of codes having 10 day global periods. In 2017, nine states were chosen to study this problem. What CMS found was that postoperative global visits following these procedures were very rarely performed. A low submission volume has led CMS to believe that these services are not being provided, which can have a negative impact on the value of many procedures podiatrists perform.

APMA has sent CMS extensive comments regarding their analysis and the fact that the conclusions they derived were based on flawed data. We have not seen the last of this issue. Medicare is always seeking ways to reduce the value of codes and this analysis may give them the ammunition to seek reductions in codes having 10 day global period. If this occurs with the 10 day global codes, we can expect this to also have an impact on 90 day global procedural codes. Stay tuned, as APMA and many other organizations will be fighting this issue.

QMB PROGRAM

CMS is constantly updating information related to the Qualified Medicare Beneficiary program.

MLN Matters Article MM11230 is the latest information published. This has an effective date of October 1, 2019. This article alerts providers of further modifications to Medicare's claims processing systems to ensure that the Medicare Summary Notice (MSN) appropriately differentiates between QMB claims that are paid and denied and to show accurate patient payment liability amounts for beneficiaries enrolled in QMB. Please make sure your billing staffs are aware of these modifications. The MLN article can be found at: https://tinyurl.com/y3bfv8bq

DME

SAME OR SIMILAR

Many of us are seeing denials from Noridian DME due to patient having received a same or similar device within the last five years. It is becoming imperative that we check on the Noridian portal to determine if the patient has had a same or similar device within the last five years. I have had the opportunity to submit multiple appeals for denials based on this policy. It is becoming frustrating in the dealing of this policy, in order to get the patient the appropriate AFO that they medically require.

APMA along with multiple other organizations/stakeholders have joined forces in trying to rectify this absurd regulation. As is typical of CMS or its MACs, they have a way of taking a regulation that was designed to help reduce waste in the Medicare program and applying their twist on it, morphing it into something nonsensical that in the long run compromises patient care.

On May 29, 2019 APMA and four other involved organizations sent a joint letter to CMS outlining the concerns that this regulation poses.

NATURE OF CONCERNS

1. Many of the items on the Same or Similar list are not appropriate for this list due to typical 5-year Reasonable Useful Lifetime (RUL) implications
2. Many of the items on the list are intended for use with acute conditions over very short durations and should be removed from the list

3. Same or Similar Policies do not account for sound clinical practice, such as for patients that develop different diagnoses on the same limb within the time restriction or those that need a change in therapy for the same site and condition(s).

This regulation is a priority item for APMA and the other involved organizations. We will continue to fight for the rights of patients and our members in getting this issue resolved. In the meantime, continue to check the Noridian and CGS portals for previously dispensed AFOs, and continue to appeal when applicable.

I think I have broken this down to 4 basic questions when determining whether an appeal is applicable. I derived this information by searching the Noridian website, and extrapolated from the information I found. If submitting an appeal, there are documents that ***should*** be included with the appeal (any level appeal - see below). If these documents are not submitted, DME will have other reasons to uphold their denial, and make this even more complicated.

The 1st 3 questions together or the 4th question by itself (see below) will determine if an appeal is applicable. If you answer «yes» to question #1, then answering questions #2 & 3 (in a letter with office notes) should serve as the basis of the appeal.

APPEAL ALGORITHM

1. Is there a new medical necessity? ¨ Yes ¨ No (if "yes" - go to next 2 questions) (if "no" - you are out of luck)
2. Describe condition for previous need of previous device:
3. Describe new/changed condition for the new device:
4. Was the AFO lost, stolen, or irreparably damaged?

Item #4 is a separate category that allows for "replacement". Under this category, we probably should have a signed statement by the patient stating the item was lost/stolen/irreparably damaged and any supporting document the patient might have, such as police report, homeowners insurance claim (stolen, fire, storm, tornado, truck ran over AFO, etc if available). Remember, theft and resale of AFOs have a higher "street value" than jewelry, electronics, drugs, etc (yeah, RIGHT!!!)

APPEAL DOCUMENTS

If a claim is denied due to same or similar, suppliers can submit a redetermination. Supporting documentation would need to be included. Examples of applicable supporting documentation that is required includes:

1. Detailed Written Order / physician order
2. Signed pick up and delivery forms,
3. A detailed outline of events and any changes in medical need (the 3 questions above)
4. A copy of the ABN
5. Redetermination or Reconsideration Appeal Form with the supporting documentation

DIABETIC SHOES/INSERTS

As a result of the complexities associated with prescribing and dispensing of therapeutic shoes for persons with diabetes, many suppliers have quit supplying this valuable asset to diabetic patients at risk for developing ulcers. At least the prepayment complex medical reviews have gone by the wayside. However, the volume of paperwork associated with dispensing of diabetic shoes has not changed. APMA continues to fight for its members in attempting to reduce the complexities and volume of the required documentation associated with this benefit. APMA Health Policy and Practice Committee recently had discussions with a CMS official in charge of Reduction of Physician Burden initiative. This person has an interest in making changes to this program to make it easier for all involved by reducing some of the nonsensical requirements.

APMA continues to look for solutions to the problems members have had with prescribing and dispensing TSDs. APMA believes that the current requirement to have the certifying physician sign multiple forms should be done away with under CMS' Patients over Paperwork initiative and other burden reduction programs—the prescribing physician's statement of medical necessity and the Statement of the Certifying Physician should be sufficient to demonstrate the necessity of TSDs. APMA also stressed that other stakeholders have expressed their frustrations with this requirement both formally and informally. CMS expressed interest in addressing this duplicative requirement and will investigate it further.

ABN FORM: GAIN A BETTER UNDERSTANDING TO AVOID DENIALS

Have you received a denial for an invalid Advance Beneficiary Notice of Noncoverage (ABN) form? Visit the Noridian ABN webpage at: https://med.noridianmedicare.com/web/jddme/topics/abn to expand your knowledge on the Limitation of Liability, Refund Requirements, see examples, and access educational resources about the process.
Last Updated Jun 11, 2019

CODING

TOTAL CONTACT CASTING (TCC)

Total Contact Casting (CPT 29445) is still considered a gold standard for treatment of diabetic foot ulcers. Billing can be little tricky and confusing, depending on whether you are billing for a Medicare patient or private insurance patient. The rules may be different. Medicare considers TCC to be a "dressing" when applied to the same limb following wound debridement. Dressings are considered bundled into the CPT code for wound debridement. Therefore, you cannot bill Medicare for a TCC if you are billing for wound debridement on the same limb. CPT has defined TCC somewhat differently and does not consider TCC to be a "dressing". Therefore, for some private insurers, you may bill both the wound debridement and a TCC on the same limb if the private insurer does not follow Medicare's rules on

this. You will need to check with the involved private insurer to determine if they allow separate billing for both services. Another question that came up recently involves the cast supply codes (Q4001 – Q4051), and whether the cast materials can be billed separately with TCC, CPT 29445. As most of you know, cast supplies are separately billable, using the appropriate Q codes listed above. However, since a TCC is not used as an immobilization device but used as an offloading device, the materials used for TCC are *NOT* separately reimbursable. This was defined by CPT in 2011. The reference is:

CPT ASSISTANT

September 2011, Volume 21, Issue 9, page 11
Application of Contact Cast in Wound Care Center

MODIFIER 59 AND "X" MODIFIERS

As I reported in the April-May Issue of this newsletter;

MM11168 with effective date of July 1, 2019, informs MACs about changes to National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits.

Modifiers 59, XE, XS, XP, and XU are among the NCCI-associated modifiers. The Multi-Carrier System (MCS) currently requires that modifiers 59, XE, XS, XP, or XU be appended to the column two code of a PTP edit to bypass the edit. With the implementation of CR 11168, Medicare will allow modifiers 59, XE, XS, XP, or XU on column one OR column two codes to bypass the edit.

What I am not sure about (yet) is whether private insurance will follow this change made by CMS. Even though most private insurance companies use NCCI as one of their edit programs, they are not obligated to use NCCI. As such, they still may require that the 59 and X modifiers be used on column two codes. To prevent erroneous denials, I will recommend that we follow the old rules and append the modifier to the column two codes.

WELLMARK

PROVIDERS FEE SCHEDULE

Participating providers can access the provider fee schedules effective for dates of service on and after July 1, 2019, as well as the practitioner update letter, on the secure provider portal at Wellmark.com. If you do not have secure access to Wellmark.com, take one of the following steps:

- If your Taxpayer Identification Number (TIN) is not registered, select "Register now" on the provider page at Wellmark.com.
- If your TIN is registered and you want to expand or change your user access, contact your office's designated security coordinator (DSC).

WELLMARK SKIN SUBSTITUTES

Wellmark updated their skin substitute policy in March 2019. Below is a list of covered products that may be considered medically necessary

DIABETIC FOOT ULCERS

- AlloPatch®
- Apligraf
- Dermagraft
- Biovance®
- Epifix®
- Grafix™

VENOUS ULCERS

- Apligraf®
- Oasis™ Wound Matrix'

PREFERRED DME SUPPLIERS

Wellmark announced a new collaboration with a preferred, in-network durable medical equipment (DME) and disposable medical supply vendor. Better Living Now is a mail-order DME supplier that is a preferred participating provider for all Wellmark members. This is in addition to Edgepark® Medical Supplies, another preferred DME vendor that works with Wellmark.

Using one of the preferred DME suppliers will help Wellmark members decrease their out-of-pocket expenses. Whenever possible, members should be referred to in-network providers to keep their costs low.

FIND A PROVIDER TOOL

If you need to order DME supplies for a member, visit the Find a Provider tool at Wellmark.com/Finder. Whenever a search is conducted for a DME-related term, a window will appear at the top of the search results displaying helpful information that directs users to one of the preferred DME vendors.

Orders can also be placed directly through the DME supplier webpages:

- BetterLivingNow.com
- Edgepark.com

CONFIDENTIAL VOICEMAIL

If a provider's voicemail message does not indicate that information left on it will be confidential, Wellmark can only leave a message requesting the provider return their call. This creates more back-and-forth and can extend the utilization management (UM) process.

If a provider's voicemail meets HIPAA standards for confidentiality, one way providers can help shorten the UM process is to indicate that any information left on their voicemail is confidential. This allows Wellmark to leave information relevant to specific UM cases in the provider's voicemail.

MISCELLANEOUS

TRICARE PT/OT

APMA submitted comments to the Department of Defense (DoD) on May 22 supporting its proposed rule to allow DPMs and allied health providers to refer TRICARE beneficiaries to physical therapy and occupational therapy (PT/OT) services.

APMA has been on the front lines of advocating that TRICARE fix its regulations that prohibit podiatrists from acting within their scope of practice and prescribing PT/OT services. APMA worked closely with military podiatrists and the office of Rep. Brad Wenstrup, DPM, and repeatedly communicated directly with TRICARE officials on the need to update this and other outdated regulations.

In its comment letter to DoD, APMA again shared its concerns that this outdated rule has significant patient impact by delaying patients' ability to obtain PT/OT services. APMA also took the opportunity to again educate DoD officials on the education, training, and experience of doctors of podiatric medicine.

In its comment letter, APMA urged DoD to finalize its proposed rule and to implement this policy swiftly. APMA had encouraged members and other stakeholders to submit comments by the June 7 deadline and support this proposed rule.

PRIVATE INSURERS PAY HOSPITALS MORE THAN DOUBLE MEDICARE RATES

- A report from RAND details what most in the industry already know: Private plans typically pay hospitals far more for services than Medicare does. Researchers examined payment and claims data from 2015 to 2017 representing $13 billion in healthcare spending across 25 states at about 1,600 hospitals.
- The study authors looked at relative prices, defined as what private insurers pay as a percentage of Medicare prices, and found they increased from 235% of Medicare in 2015 to 241% of Medicare in 2017.
- Relative prices had wide swings among different states and even within health systems, ranging from 150% of Medicare to more than 400% of Medicare. The study also comes with a detailed data spreadsheet showing the prices paid to individual hospitals.

APMAPAC REPORT

BY CHRISTOPHER GRANDFIELD, DPM
APMAPAC COORDINATOR

We are about halfway through the 2019 APMAPAC Campaign. The IPMA has met its APMPAC PAC goal the last four years and we must continue the momentum. We are off to a strong start but have a long way to go yet this year. I am proud to say that IPMA members have stepped up again and we are well on our way to meeting our 2018 APMAPAC Goal. As of June 14th, IPMA members **have contributed 75% of its 2019 fundraising goal**. These contributions have come from only **20 of the 217 IPMA members**. We are asking each member to make some contribution no matter the amount.

We ask all members to strongly consider a recurring monthly contribution of $20.00. This allows members to make a meaningful contribution while avoiding the necessity of writing one large check.

DIAMOND LEVEL SUPPORTERS ($2,500-$4,999)

Dr. Patrick DeHeer
Dr. Sandra Raynor

PLATINUM LEVEL SUPPORTERS ($1,000-$2,499)

Dr. Zahid Ladha
Executive Director Matt Solak

GOLD LEVEL SUPPORTERS ($500-$999)

Dr. Chris Grandfield
Dr. Walter Warren

SILVER LEVEL SUPPORTERS ($300-$499)

Dr. Brian Damitz
Dr. Patricia Moore
Dr. Kathleen Toepp Neuhoff
Dr. Wendy Winckelbach

BRONZE LEVEL SUPPORTERS ($150-$299)

Dr. Miranda Goodale
Dr. Anthony Jagger
Dr. William Oliver
Dr. Chase Stuart
Dr. David Sullivan
Dr. Amanda Vujovich
Dr. Aaron Warnock

PATRIOT LEVEL SUPPORTERS (LESS THAN $150)

Dr. Kent Burress
Dr. Robert Freestone
Dr. Robert Loesch

The future of podiatry and your future depends upon your support of APMAPAC. Click here to make a donation.

PURPOSE: The American Podiatric Medical Association Political Action Committee's purpose is to raise and disburse funds to candidates for Federal office that support the legislative priorities and goals of the podiatric medical profession.

IMPORTANT: All amounts are simply suggested amounts. You may contribute or not contribute without concern of being favored or disadvantaged. Occupation/Employer information is required for aggregate annual contributions of more than $200.00 by the Federal Election Campaign Act. Federal election law does not permit corporate contributions to be used for donation to candidates for federal office. Political contributions are not deductible for income tax purposes.

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