MOVING INDIANA FORWARD

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INDIANA PODIATRIC MEDICAL ASSOCIATION

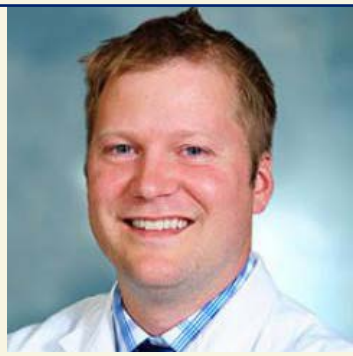
Forward

ISSUE FOUR | WINTER 2021

IN THIS ISSUE

PRESIDENT'S MESSAGE

BRIAN DAMITZ, DPM | IPMA PRESIDENT



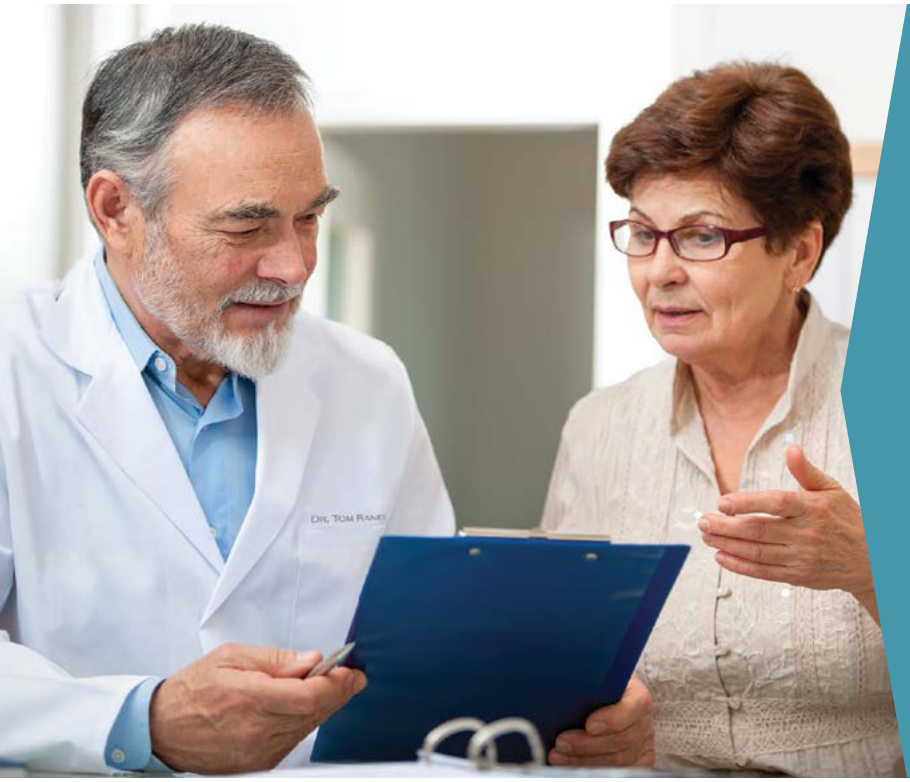
As my term of office nears its end, there are many I would like to thank for their service to the association. I have the utmost respect for our current and past board members and trustees. Volunteers all, they are the eyes, ears, and voice of the membership. I also want to thank everyone who supported the association through their membership and participation and I ask for your continued support as we slowly return to normal.

We continue to face numerous challenges on multiple fronts but together as a profession, we can tackle any challenges that arise. Podiatry is an amazing profession that has blessed us all with a lot of benefits. The IPMA needs you to be involved and engaged to make change happen for podiatrists, our patients, and our practices. One is just one but as all we are mighty. None of us can achieve this alone but we can as a group by getting involved with the IPMA. Podiatry has a bright future if it is cultivated with optimism and enthusiasm derived from wisdom and imagination. Everyone has something to contribute that can make our association better.

As always, I welcome members to continue to reflect on the association and provide me with feedback with thoughts and ideas on how we can strengthen the IPMA. While it was not the two years I expected, it has been a privilege to serve with and on behalf of so many great people.

If you have any questions or concerns, please do not hesitate to contact me.

Predict treatment efficacy like never before



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**Available only as part of the Onychodystrophy PCR Test; Terbinafine resistance currently unavailable in NY.*

Gupta, A.K., Renaud, H.J., Quinlan, E.M. et al. The Growing Problem of Antifungal Resistance in Onychomycosis and Other Superficial Mycoses. Am J Clin Dermatol 22, 149–157 (2021).

BKMDTAP003200621

APMAPAC UPDATE

SANDRA RAYNOR, DPM
APMAPAC COORDINATOR

I am proud to say that we have nearly met our goal for 2021. Our goal is $17,617. So far we have raised $17,284. That's 98% of our goal!

DIAMOND LEVEL ($2,500-$4,999)
Dr. Patrick DeHeer
Dr. Zahid Ladha
Dr. Sandra Raynor

PLATINUM LEVEL ($1,000-$2,499)
Executive Director Matt Solak

GOLD LEVEL ($500-$999)
Dr. Gary Adsit
Dr. Christopher Grandfield
Dr. Nathan Graves
Dr. Kenneth Krueger
Dr. Walt Warren

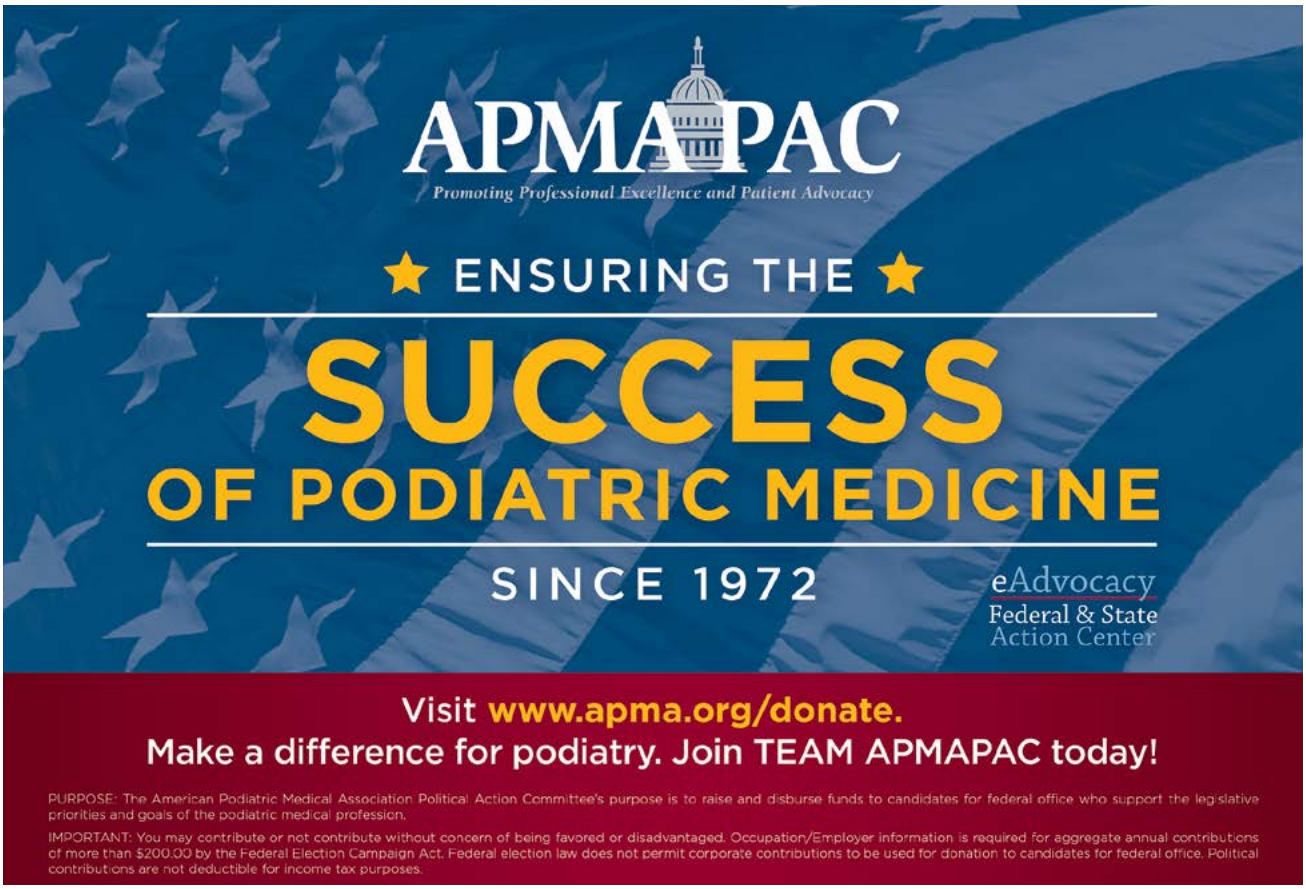
SILVER LEVEL ($300-$499)
Dr. Brian Damitz
Dr. Patricia Moore
Dr. Kathleen Neuhoff
Dr. Scott Schulman
Dr. Wendy Winckelbach

BRONZE LEVEL ($150-$299)
Dr. Michael Carroll
Dr. Cathy Coker
Dr. Robert Freestone
Dr. Pratap Gohil
Dr. Jeffrie Leibovitz
Dr. Scott Neville
Dr. Tod Reed
Dr. Chase Stuart
Dr. Aaron Warnock

PATRIOT LEVEL (LESS THAN $150)
Dr. Kent Burress
Dr. Jay Frazer
Dr. Miranda Goodale
Dr. Sarah Standish

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.



FOOT SUPPORT PAC UPDATE

The goal for 2021 is $8,000. So far we have raised $6,500 for 81% of our goal. Thank you to the below contributors so far this year:

PLATINUM LEVEL SUPPORTERS ($1,000-$2,499)
Dr. Patrick DeHeer
Dr. Sandra Raynor

GOLD LEVEL SUPPORTERS ($500-$999)
Executive Director Matt Solak
Dr. Nathan Graves
Dr. Kenneth Krueger

SILVER LEVEL SUPPORTERS ($300-$499)
Dr. Brian Damitz
Dr. Christopher Grandfield
Dr. Kathleen Neuhoff
Dr. Wendy Winckelbach

BRONZE LEVEL SUPPORTERS ($150-$299)
Dr. Michael Carroll
Dr. Cathy Coker
Dr. Pratap Gohil
Dr. Scott Schulman
Dr. Aaron Warnock
Dr. Walt Warren

PATRIOT LEVEL SUPPORTERS (LESS THAN $150)
Dr. Jeffrie Leibovitz

To make a contribution, please contact IPMA at 888.330.5589.

MIDWEST PODIATRY CONFERENCE

THE PREMIER MEETING FOR PODIATRISTS & ASSISTANTS

SAVE THE DATE

APRIL 6-9, 2022

HYATT REGENCY CHICAGO

Stay tuned for more details!

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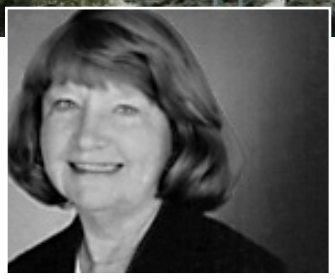

LEGISLATIVE REPORT

BY GLENNA, SHELBY, JD, PARTNER
LEGISGROUP PUBLIC AFFAIRS, LLC

As of October 1st the Indiana General Assembly adjourned the 2021 session, having completed the second of the only two tasks required of it this session—passing a biennial budget and redistricting the Indiana General Assembly and Congressional districts. The Session adjourned/recessed April 22nd after passing **HEA 1001**, a $37.4-billion two-year budget. It reconvened Sept. 20th to re-draw the district maps, the delay in redistricting is attributable to the late delivery of the 2020 US census data on which the district-drawing is based. The statute requiring final adjournment of a budget session by April 29th had been amended during the session to permit this nearly 5-month delay.

The new district maps aren't expected to result in significant changes in political party balance in either the General Assembly or Indiana's Congressional delegation. But a number of legislators from both parties are reportedly not pleased with their new districts.

As the session was nearing its April 22nd adjournment, budget writers got an unplanned increase when the April revenue forecast came in $2-billion higher than the December forecast, the amount on which HB 1001 had been based. Legislators allocated half of the unexpected inflow to K-12 education. Restoration of full funding for mental health programs, $900-million into an infrastructure fund, $250-million for broadband expansion, and $500-million for regional development initiatives were part of the compromise reached that left only 5 legislators voting "no" on HB 1001. The "no" votes were two Republicans in the House and three Democrats in the Senate.

The 2021 session managed to avoid a full recess caused by COVID, but the public's direct access to legislators was significantly reduced—public testimony in legislative committee hearings was done virtually with legislators in one room and the public testifying on-line from another room.

223 bills ultimately passed and were signed by the Governor, out of roughly 1025 introduced bills. The Governor vetoed 3 bills, one of which (**SB1123**) was immediately overridden before the session ended. That bill permits the General Assembly to call itself into Special Session if the Governor has declared an Emergency. The Governor sued to have the bill declared unconstitutional, claiming Indiana's constitution limits to the Governor the right to call a Special Session. **SB 5** would have limited County Board of Health authority during a declared emergency by requiring local county commissioners to approve any local order that is more stringent than a statewide emergency

order. The Governor also vetoed (**SB303**), a bill to require increased labeling on ethanol fuel.

Having just finally adjourned the 2021 legislative session, legislators will return in early November for Organization Day, the largely ceremonial beginning of the 2022 legislative session. Here are some bills of interest that became law:

COVID

- **SEA 1** provides immunity from civil liability for damages resulting from exposing others to COVID unless the plaintiff establishes by clear and convincing evidence gross negligence or willful misconduct.
- **HEA 1002** Protects health care providers from licensure discipline regarding conduct during a declared state public health emergency unless the conduct (1) constituted gross negligence or willful misconduct, or (2) constitutes actions that are outside the skills, education, and training of the health care provider, unless the health care provider's actions are undertaken in good faith and in response to a lack of resources caused by a declared state public health emergency. It sets specific standards that make it more difficult to sue individuals/entities related to COVID exposure.

OPERATIONAL

- **HEA 1447** includes some follow-up clarification to the good faith estimate law passed in 2020. Among the changes are more flexible requirements relating the notices that must be made available to the patients. The act lists 8 potential methods of notification and requires any 3 of them. It requires that requested estimates for nonemergency services be provided within 5 business days. The law extended the effective date of the mandatory good faith estimate requirements to Jan. 1, 2022, and aligns the requirements with the new federal "No Surprises Act".
- **HEA 1421** provides that patients are not barred from receiving any requested good faith estimates due to language included in provider contracts with health care plans. This applies to any contract entered into, amended, or renewed after June 30, 2021.
- **SEA 325** Increases the number of services for which a hospital must post price information. Provides that if an ambulatory outpatient surgery center offers fewer than 30 services, the center must post all of the services provided.
- **SEA 3** changes the term "telemedicine" in Indiana Code to "telehealth'. It prohibits the Medicaid program from requiring originating site or distant site requirements. It provides that Medicaid patients waive confidentiality for any information provided during a telehealth visit that is heard by another individual in the vicinity of the patient. It expands the providers able to participate in telehealth from "prescribers" to a long list of providers.
- **HEA 1405** Requires a health care provider to provide health records to a patient within 30 days of the request. Violations are subject to a fine of up to $5,000.
- **HEA 1402** establishes a statewide database of healthcare cost and quality data. It creates a 9-member advisory board with specified membership that does not include a dedicated spot for DPM's. The majority of the advisory board members represent employers or insurance interests.
- **HEA 1468** contained a retroactive provision extending the mandatory date for electronic prescribing of controlled substances to January 1, 2022, to align with a similar federal requirement for Medicare Part D prescriptions.

LICENSING/SCOPE OF PRACTICE

- **SEA 59** allows occupational therapists to treat patients without a referral for 42 days. After 42 days, they must have a referral from a listed healthcare provider, including DPM's.
- **HEA 1392** provides that when a military spouse applies for a provisional license, they do not have to submit a criminal history background check. Instead, the board to which they are applying has to verify whether the applicant has a disqualifying criminal history.

The full text of all bills introduced in the 2021 Indiana General Assembly may be viewed at iga.in.gov/legislative/2021/bills.

As always, LegisGroup Public Affairs, LLC appreciates the opportunity to represent the Indiana Podiatric Medical Association's interests in the Indiana General Assembly.


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KRIEG DEVAULT

COURT ISSUES NATIONWIDE TEMPORARY STAY OF CMS MANDATORY VACCINATION RULE

BY SHELLEY M. JACKSON AND AMY J. ADOLAY

The Biden Administration's push for mandatory vaccinations in the workplace has been dealt another blow, this time to the **Interim Final Rule** (the "CMS Rule") issued on November 5, 2021 by the U.S. Centers for Medicare and Medicaid Services ("CMS") and scheduled to go into effect on December 6, 2021.

The CMS Rule applies to health care facilities which are subject to CMS conditions of participation, including ambulatory surgical services, hospice care, programs of all-inclusive care for the elderly, hospitals, long term care facilities, home health services, comprehensive rehabilitation programs, infection prevention and control and antibiotic stewardship programs, end-stage renal disease facilities, community mental health centers, psychiatric residential treatment facilities, and federally qualified health centers. It requires such facilities to adopt mandatory vaccination policies for its employees and other covered staff members unless such individuals work 100% remotely, are granted a medical or religious exemption, or whose vaccinations are temporarily delayed due to medical contraindications.

On Tuesday, November 30, 2021 a U.S. District Court in Louisiana issued an **order** (the "CMS Nationwide Injunction") which temporarily stays implementation of the CMS Rule nationwide, including in Indiana, except for 10 states which are already subject to a prior **stay** issued on November 29, 2021 by a U.S. District Court in Missouri. The CMS Nationwide Injunction will remain in place until conclusion of the case, upon further order of the issuing court, or upon the order of a higher court reviewing the order on appeal.

For health care facilities subject to the CMS Rule, there are a few key takeaways:

- The stay temporarily halts implementation of the CMS Rule, which was scheduled to begin with Phase 1 on December 6, 2021.
- The stay does not prohibit covered facilities from voluntarily implementing or continuing mandatory vaccination programs, subject to applicable law.
- Covered facilities should carefully monitor the situation and remain prepared to comply, as compliance obligations may happen rather quickly if the stay is lifted. For example, preparatory activities such as ascertaining current vaccination status of covered staff or processing medical and religious exemption requests may be already be in process.
- Covered facilities should determine their anticipated course of action and communicate the action plan with covered staff. Individuals may still have many questions and concerns regarding the CMS Rule or other COVID-19 related safety measures.

The CMS Nationwide Injunction joins a series of other legal developments with respect to the federal mandatory COVID-19 vaccination provisions announced as part of President Biden's Path out of the Pandemic, including with respect to both the U.S. Occupational Safety and Health Administration's ("OSHA") Interim Final Rule applying an Emergency Temporary Standard ("OSHA ETS") and the federal contractor mandate.

The OSHA ETS, which requires most employers with 100 or more employees to mandate COVID-19 vaccination or require weekly COVID-19 testing, suffered its first blow on November 6, 2021, when the Fifth Circuit Court of Appeals temporarily stayed the mandate and then on November 12, 2021 issued a preliminary injunction reaffirming its initial stay. On November 16, 2021, that case was reassigned to the Sixth Circuit Court of Appeals, which will handle the ongoing challenge to the OSHA ETS. In response to the Fifth Circuit's issuance of the preliminary injunction, OSHA announced that it has suspended its activities relating to implementing and enforcing the OSHA ETS.

The federal contractor mandate, which requires covered contractors to implement mandatory COVID-19 vaccination without a testing option, but which does allow for religious and medical exemptions, is also being challenged in various cases around the country. Some of these challenges include a lawsuit filed in a U.S. District Court in Florida as well as a lawsuit filed in a U.S. District Court in Missouri on behalf of ten states, all seeking an injunction of the federal contractor COVID-19 vaccination mandate. Further, on November 30, 2021, a U.S. District Court in Kentucky issued a preliminary injunction temporarily blocking enforcement of the federal contractor mandate in Kentucky, Ohio, and Tennessee. In addition to other state challenges, a federal prison employees union has filed a lawsuit seeking to stop the federal contractor mandate. Despite these challenges, as of the writing of this article, the federal contractor COVID-19 vaccination mandate remains in effect in all states except Kentucky, Ohio, and Tennessee.

*For more information on the CMS Nationwide Injunction, mandatory vaccination programs, or other COVID-19 related compliance questions, please contact any member of Krieg DeVault LLP's **Labor and Employment** practice.*

COMMUNICATION IS KEY WHEN IT COMES TO PATIENT'S FINANCIAL OBLIGATIONS

A very high percentage of patients who leave a medical practice is due to some sort of misunderstanding regarding financial responsibilities. Financial misunderstandings are also a trigger for possible malpractice suites.

Our patients are our number one priority. If we want our relationship with our patients to be solid and trusting, we need to make sure our communication regarding possible charges that they will be responsible for, is done prior to the charges being incurred. The office financial policy needs to clearly state financial expectations from the patient. They need to understand how the billing process will be handled. If they have copayments, balances, and deductibles they need to know when they are to be paid. The practice financial policy needs to be in clear, simple language that patients can understand without guessing. A staff member needs to review the policy prior to the patient being seen and ask the patient if they have any questions regarding its content or the expectation of payments that may be due.

Taking a few extra minutes prior to the patient seeing the doctor to make sure that they clearly understand the financial policy, especially if they have a copayment or deductible that they will be responsible for on the day of service, is time well spent. Patients should also be informed what methods of payment are accepted at the practice and if the practice offers any type of financial assistance through "CareCredit" or another line of credit lender.

Insurance benefits must be verified on patients with commercial insurance. This is much easier now as many companies have the information regarding limitations, deductibles, and durable medical equipment information online that can be accessed and printed in a few minutes. Giving the patient a copy of their benefits shows them that you do know what their insurance coverage is, and what they will owe. By giving them their insurance information, it also shows that you care about your relationship with them and want to prevent any misunderstanding as far as their financial obligation.

Having contracts with your patients for durable medical equipment will help them to understand that you have contacted their insurance, have checked their benefits, and have a reference number for the call. Having the patient sign the contract and given a copy so if there are any issues that come up after items are dispensed and billed, they will have the information to help you fight for their claim.

Patients must also know if any item is not a covered benefit and what the cost will be to them. Let them make the decision if they can afford it or not. If they can, have a contract that spells out the costs, non-coverage, and any expectations.

When you give the patient the information and have explained to them why it is not covered, and they sign acknowledging such, you are protecting your relationship with your patient. Remember, no one likes unexpected surprises, especially when it comes to paying out money. Our patients are our number one priority, and we need to protect our relationships with them by providing all the financial facts they need to know.

Tina Del Buono is the Director/Coach of Top Practices Virtual Management Institute and Founder and CEO ofPractical Practice Management. If you have any questions regarding this topic, please do not hesitate to contact ***Tina Del Buono, PMAC.***

21ST ANNUAL JOINT NATIONAL PODIATRIC CAC-PIAC REPRESENTATIVES' MEETING

WENDY WINCKELBACH, DPM
INDIANA CAC REPRESENTATIVE
& IPMA PAST PRESIDENT

I recently attended the 21st Annual Joint National Podiatric Carrier Advisory Committee (CAC)-Private Insurance Advisory Committee (PIAC) Representatives' Meeting, held in-person and virtually on November 12, 2021, on behalf of our association. The meeting featured experts and leaders on both private and public insurance issues, as well as opportunity to hear from our colleagues around the country and discuss new and ongoing trends and challenges that might impact our members.

Attendees were first updated on the CY 2022 Medicare Physician Fee Schedule Final Rule from Cindy Moon, MPP, MPH, vice president at Hart Health Strategies and APMA Health Policy and Practice Consultant Jeff Lehrman, DPM. Of significant concern to members is the possible up to 9.75 percent reductions to Medicare provider reimbursement for 2022, due to expiration of the temporary increase for 2021, the Medicare sequester reductions that were suspended for COVID-19, and the PAYGO sequester reductions. Significant advocacy is underway to avert these reductions, including an APMA eAdvocacy campaign for members and APMA working with other stakeholders to lobby Congress and CMS to avert these reductions. Write to Congress to at **www.apma.org/eAdvocacy**.

Additionally, the final conversion factor is 33.5983. The estimated impact on podiatrists for 2022 not including scheduled payment reductions is +1 percent. CMS also finalized the following changes:

- Retain all Category 3 services on the Medicare telehealth services list through December 31, 2023;
- Allow physician assistants bill directly for services they perform, as required under law; and
- Delay onset of AUC penalties until January 1, 2023 or the January 1 that follows the end of the Public Health Emergency, whichever is later.
- Members can learn more at **www.apma.org/Medicare**.

Finally, a few other important items to be aware of:

- Effective 2022 there is no global period for CPT 28001, 28002, and 28003 Incision and Drainage codes.
- If you choose to report MIPS, 2021 will also be waived this year if you choose to not submit without a hardship request.
- There is no more fall risk assessment in MIPS coding.

APMA private insurance consultant Kelli Back, Esq., also updated attendees on ongoing issues for Medicare Advantage and commercial plans. She noted the following key highlights:

- No Surprises Act: Ensures patients are not obligated to pay more than the in-network cost sharing under their commercial health plan in certain situations when out-of-network providers furnish services and sets forth a process for non-contract providers and insurers to come to agreement on payment amounts. This will be effective January 1, 2022. Learn more about the No Surprises Act on January 11, 2022 in a Webinar hosted by APMA. Register at **www.apma.org/Webinars**.
- Medicare Advantage continues to be problematic for providers with onerous record requests and frequent denials. APMA and other medical specialty societies recently met with CMS to address member concerns.

- Ms. Back also reminded attendees that Advanced Beneficiary Notices (ABN) are not appropriate for use with Medicare Advantage plans and should only be used with Medicare Fee-For-Service.

Given that record requests are one of the biggest sources of headaches for our members, Ms. Back spent a good amount of time reviewing the reasons for data mining and what providers can do when they receive onerous record requests. She also reviewed the significant advocacy work that APMA has done and will continue to do on behalf of APMA members to resolve this burden Members can learn more about responding to Medicare Advantage Record Requests in the July/August issue of APMA News or log on to **www.apma.org/MedicareAdvantage**.

Attendees also heard directly from and were able to pose questions to two Noridian carrier medical directors (CMDs), Gary Oakes, MD, and Larry Clark, MD. Drs. Oakes and Clark addressed member questions about the LCD process and development changes, concerns about amniotic injection denials, and other critical CAC concerns.

Health Policy and Practice Chair Ed Prikaszczikow, DPM spent time addressing best practices for CAC and PIAC representatives. Some of Dr. Prikaszczikow' s advice is also relevant to every member, such as:

- Know the Medicare Program Integrity Manual and understanding the Local Coverage Determination and Local Coverage Article Process
- Use APMA resources and communicate with both APMA and your state association regularly
- Stay in the know by subscribing to private and public payer newsletters.

Ross Taubman, DPM, President and Chief of Medical Officer of PICA, addressed how members can benefit from administrative defense coverage (ADC), via PICA or another medical malpractice carrier. ADC can be used to help with coding and billing audits from both public and private payers, state board investigations whether related or unrelated to a malpractice claim, decertification from an insurance plan, and more.

He covered how important it is to know how your billing compares to your peers in a region or nationally, having competent and well-trained billing staff is, and that all providers should implement and follow good, written corporate compliance and documentation practices.

Finally, as in years past, attendees spent time discussing regional concerns in both the public and private insurance spheres. This key feature allows representatives to share experiences and collaborate on solutions to common issues. In the public insurance arena, the biggest areas of concern are the continued DME same and similar denials, coverage for wound care, and amniotic injections/skin substitutes. For private payers, bundling and reimbursement issues for Medicare Advantage versus Original Medicare, denials or reimbursement reduction for claims billed with the -59 or -25 modifiers, DME audits, prior authorizations, and record requests.

During the meeting, Iowa CAC Rep Theresa Hughes, DPM, was recognized as the "CAC-PIAC Rising Star of the Year." She was also elected to serve as APMA's new CAC Chair. Tennessee CAC Rep Ira Kraus, DPM was recognized as "CAC-PIAC Representative of the Year."

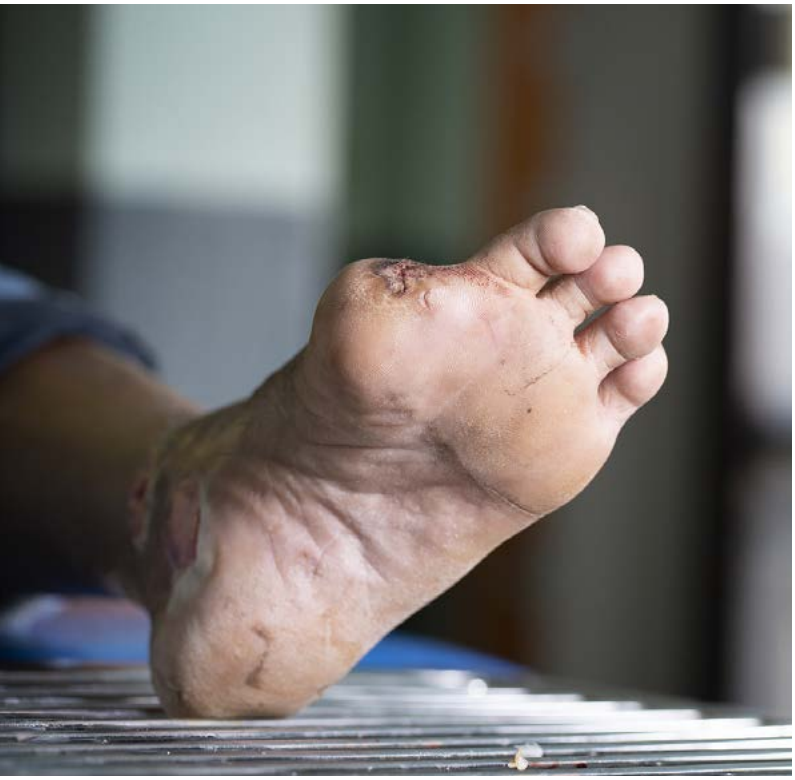
*More information on is available at **www.apma.org/CACPIAC2021**.*

NEW MASS GENERAL PROGRAM AIMS TO PREVENT AMPUTATION DUE TO DIABETES

CONTRIBUTOR: ANAHITA DUA, MBCHB, MBA, MSC
DIRECTOR, VASCULAR LAB, MASSACHUSETTS GENERAL HOSPITAL, ASSISTANT PROFESSOR, VASCULAR SURGERY, HARVARD MEDICAL SCHOOL

KEY FINDINGS

- The complicated combination of diabetes and peripheral artery disease (PAD) often leads to limb amputation because of loss of the micro vessels of the foot
- Patients who are socioeconomically disadvantaged or from minority groups are disproportionately affected by both diabetes and amputation
- A new Massachusetts General Hospital program named the Limb Evaluation and Preservation Program (LEAPP) combines expertise from many specialties to proactively improve blood flow; control diabetes; and prevent pain, wounds, infections and amputations
- The program is reaching out to community hospitals, primary care providers and other health care professionals to help recognize which patients need early intervention to prevent amputation and how to refer patients
- Vascular specialists at Massachusetts General Hospital have joined forces in a new program that helps patients with diabetes and peripheral artery disease (PAD) manage this complicated pair of conditions. The ultimate goal is to protect their limbs from amputation, a common and traumatic outcome in this population.



BOTTOM OF FORM

"Patients with diabetes and PAD have multiple medical challenges, including limb pain, wound care difficulties and reduced blood flow. Every 30 seconds in the United States, a leg is amputated because of diabetes, but this outcome may be avoided with early intervention to optimize patient care," says **Anahita Dua, MD, MBA, MSc**, assistant professor of **Vascular and Endovascular Surgery**, associate director of the **Wound Care Center**, director of the Vascular Lab and co-director of the Peripheral Artery Disease Center at Mass General.

The new **Limb Evaluation and Preservation Program (LEAPP)** at Mass General brings together a multidisciplinary group of specialists to advocate for patients with PAD and achieve better outcomes by providing early, targeted, multidisciplinary intervention to avoid amputation.

TEAM APPROACH TO DIABETES AND PERIPHERAL ARTERY DISEASE FOR LIMB PRESERVATION

Dr. Dua and her vascular surgery and medicine colleagues offer the best possible cutting edge options for limb salvage—including open and endovascular deep venous arterialization (DVA) to improve limb blood flow, resolve pain and heal chronic wounds—all with the goal of saving limbs that may otherwise be amputated.

However, Dr. Dua emphasizes that this complicated patient population needs more than invasive interventions at a time of crisis. The care must be holistic from the start.

"As a vascular surgeon, I can give a patient beautiful blood flow with a bypass or a complex endovascular procedure, but if the wound care is not up to scratch, diabetes is out of control or the foot is not appropriately off-loaded, it's not going to matter in the long run because the leg may still be amputated," she says. "Patients often come to us 10 years too late. The time to deal with these issues is not when the person gets a wound—it is all about preventing a wound from every developing by ensuring excellent medical management, education about the disease progression and prompt, multidisciplinary intervention at the earliest sign of an issue. Essentially, to optimize outcomes and prevent amputation, patients need to be seen earlier by a variety of specialists to proactively prevent the issues that can lead to

amputation. This is challenging sometimes because there are so many providers that it is difficult for patients to navigate the maze of patient care. That is where our LEAPP program to salvage limbs comes in and takes care of the navigation for our patients."

When a patient is referred to the Limb Evaluation and Preservation Program, a vascular nurse coordinator acts as a care coordinator, gathering all pertinent information, reviewing the case, then making appointments with any and all specialists the patient may need, including:

- Cardiology and interventional cardiology
- Endocrinology
- Infectious diseases
- Interventional radiology
- Podiatry
- Supervised exercise experts
- Wound care
- Vascular lab
- Vascular medicine
- Vascular surgery

"The onus is usually on the patients, who may not even be able to advocate for themselves," Dr. Dua says. "We take the burden off the patient and off the primary care provider. We apply very deliberate patient management strategies to optimize care and outcomes and protect these threatened limbs."

USING EVIDENCE AND TOOLS TO PREVENT AMPUTATION

One of the program's tools is the toe pressure, a quick, non-invasive test that determines the blood pressure of the toe. The Ankle-brachial index is another readily used tool that can establish a diagnosis of PAD before the condition becomes limb-threatening in a non-invasive, quick way.

If a patient is confirmed to have PAD, he or she then is routed to the specialists they need to manage the disease and prevent long-term complications that can lead to invasive procedures and amputation. For example, if a patient has a wound, poor blood flow and diabetes, the LEAPP program will coordinate visits with podiatry, vascular surgery, vascular medicine, endocrinology, wound care and infectious disease seamlessly and in a timely fashion.

Another example is the management of patients who have no wound but present with calf pain when they walk short distances. For this group, the pain may make walking so difficult it impacts their ability to enjoy life. This is called intermittent claudication where pain in the calves induced by exercise and relieved by rest.

"These patients often wind up having interventional procedures, but data show that they may simply need noninvasive supervised exercise," Dr. Dua says. "We have developed and proven a protocol that can avoid or delay invasive intervention."

The program specialists have a case conference every month to discuss patient progress and needs, ensuring comprehensive, whole-patient care. They follow patients over time, monitoring blood supply, ensuring that wounds are prevented or treated, encouraging diabetics to control blood sugar and making sure patients are not lost to follow-up. Dr. Dua wants community providers to reach out to the LEAPP before it's too late for their patients.

"We welcome calls from community hospitals and other providers," she says. "We would love to help in any way we can whether that be by consulting about your patients or bringing them into our LEAPP program through the Mass General PAD center to optimize their care."

REACHING POOR AND MINORITY PATIENTS

Published literature shows that both diabetes and limb amputation are much more common among people who are poor or of minority status. Patients who do not have access to health care also may use the emergency department for primary care because of this lack of access or lack of insurance or both.

Dr. Dua is working to educate emergency department personnel about the LEAPP program to ensure these patients are rapidly routed to the team of specialists so their limbs can be salvaged. "It's endemic, and we need to take conscious action to help," Dr. Dua says. "We want to educate these care providers to recognize the emergent nature of this condition and ideally route patients to the Mass General program so we can get them holistic, multidisciplinary care fast."

She is currently seeking a grant to launch an outreach program that would educate primary care providers about the availability of Mass General's multidisciplinary expertise so that they immediately refer diabetic patients with PAD.

SETTING THE STANDARD FOR LIMB SALVAGE

Dr. Dua says Mass General is perfectly positioned to lead the multidisciplinary care of these complicated conditions, as well as establish the standard of care in the field.

"There is variance in skill, training and outcomes throughout the country and the region, but we have world experts in every specialty needed to care for these patients to reduce amputation rates. Mass General is known for its excellence in care coordination, and this program applies that to a population who really need it. Our specialists talk to each other, eliminate inefficiencies and follow established protocols that work. We have a huge research arm that allows us to see what works, get an evidence base, set the bar for care of this patient population, then be nimble to implement those changes."

ANOTHER BREACH AT A VENDOR

BY MICHAEL BRODY, DPM
CEO, TLD SYSTEMS

The most recent breach was reported by QRS Healthcare Solutions who has the EHR product Paradigm. What does this mean and what can you learn to protect your practice? There are already attorneys advertising a **class action lawsuit** against QRS for the following reasons:

- Did QRS fail to adopt security safeguards that would have prevented a data breach?
- Did QRS notify customers as soon as it learned of the data breach?
- Did QRS provide a complete list of all individuals affected by the data breach?
- Did QRS provide security in line with industry standards?

According to reports, this breach was due to security issues at a patient portal. When a breach happens, the HIPAA Breach Notification Rule requires that the MEDICAL PROVIDER notify patients about the breach. QRS is the vendor and vendors are not required to notify patients as per the rule, but a good Business Associate Agreement can require the notification to be provided by the vendor. The cost of notification in case of a breach can be huge. Now is a good time to look at the Business Associate Agreements you have in place and make sure that if one of your vendors experiences a breach, the costs associated with the breach are the responsibility of the vendor. In this case QRS sent notification letters to all affected individuals on behalf of it's clients. QRS is also offering complimentary access to identity theft protection services. Once again this goes beyond the regulations but is something that can be written into the Business Associate Agreement.

The incidents of breaches at both Health Information Vendors and Health Care facilities is increasing exponentially. Even with the steps that QRS has taken, the health care providers who utilize QRS for EHR services are likely to experience significant financial costs. It is important to remember that when a breach occurs, the HIPAA regulations place all of the responsibility upon the health care provider. That places you and your practice directly in the cross hairs even though the breach did not occur at your location. It is still your data and your responsibility.

What can you do to protect yourself from events such as this which are completely beyond your control?

- Look at all vendors that you do business with and make sure you have a Business Associate Agreement (BAA) with any vendor that you share patient data with. Even is they say they are not required to give you a BAA, tell them you require one in order to do business with them. The BAA protects you and places responsibility upon the vendor so many times vendors will do everything possible to avoid signing these agreements. At TLD Systems we have seen some companies go as far as to sent letters to health care providers from their attorneys explaining why they do not need to give out the BAA. The vendor is trying to protect itself and make sure all the financial and administrative burden of a breach they may create is on you. Do not let this happen.
- Review your BAA's with your health care attorney and make sure that the BAA places as much responsibility for a breach upon the vendor shielding you from many of the costs related to breach remediation, including patient notification, providing credit monitoring services and other costs.
- Get Cybersecurity Insurance. The costs associated with a breach can be huge and without Cybersecurity Insurance a breach could financially ruin your practice.
- Make sure your HIPAA Security Risk Analysis and risk mitigation plan are up to date. If they are not, please **contact TLD Systems** now to take care of this vital step in protecting your practice.

The number of HIPAA Breaches continues to increase and your risk of having YOUR data involved in a breach becomes greater each and every day. Don't wait until it is too late to protect your practice.

*Dr Brody is the CEO of TLD Systems. TLD Systems assists practices in compliance with HIPAA, OSHA and the Federal Fraud, Waste and Abuse statutes. For more information visit **www.tldsystems.com**, email **Info@tldsystems.com**, or call (631) 403 6687.*

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 offers a 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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