

# Third-Party Reimbursement: Now Comes the Really Difficult Part

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The establishment of federally mandated benefits for diabetes supplies<sup>1</sup> and educational services<sup>2</sup> has opened a new era of opportunity for diabetic people. These guidelines permit diabetic Americans access to at least some supplies for home glucose monitoring, and, under specific but widely applicable clinical circumstances, access to diabetes patient education. Because the provision of patient education services has been tied by Medicare regulations to Education Recognition by the American Diabetes Association (ADA), the system includes assurance of reasonable quality for these services. In addition, these precedents set by Medicare increase the likelihood that voluntary advocacy may encourage similar coverage for diabetic people from other health insurers. These advances are all significant and are discussed further in the ADA position statement, "Third-Party Reimbursement for Diabetes Care, Self-Management Education, and Supplies," which is reprinted in this issue (p. 183).

However, they come at a time of new and growing challenges to the adequate provision of care for diabetic Americans, especially older Americans. These challenges may affect the availability not only of the very benefits that have been specifically mandated by Medicare, but also of essential health care itself. Given the potential significance of these issues, it seems important that we all become versed in them and watchful of trends that may raise concern.

As discussions have noted in this journal and others,<sup>3-6</sup> diabetes care, as described by accepted national guide-

lines,<sup>7</sup> is often complex and costly to provide. In part, the cost and complexity reflect the variety of services that diabetic patients need and should have in the provision of routine care, including physician care, ongoing instruction in self-care, and nutrition counseling. Such services are frequently necessary even during the most routine office visits. However, they increase the cost of rendering care because they lengthen visits and, in many office settings, require a more intense use of personnel per visit.

This cost structure for diabetes care has not been met by ongoing changes in insurance reimbursement for that care. Despite the higher cost of service for diabetic patients, there is no premium paid by insurers for their care versus the care of other, less costly patient groups. Insurers, working with the ADA, have defined positive guidelines for the care of diabetic people.<sup>7,8</sup> Although attention to these guidelines increases the cost and complexity of care, providers receive no incentives or rewards for meeting those guidelines. Thus, financial analyses of the office care of diabetic people have noted that the current system of reimbursement encourages physicians to do less—not more—for their diabetic patients or to avoid the care of diabetic people altogether.

Until recently, these fiscal issues in the outpatient care of diabetic people seemed theoretical and ameliorated by the much stronger concern of most physicians and other providers for the welfare of their patients first. However, trends arising during the past 2 years suggest that these concerns may merit closer attention now. In that time frame,

physician reimbursements for office medical care by Medicare have been reduced by 12%. An increasing number of doctors have either limited the number of Medicare recipients in their practices or excluded Medicare clients from their practices.

A similar, if not worse, situation exists with regard to Medicaid patients. Medicaid reimbursement for nonsurgical outpatient care is quite low in many states. In some states, physician participation in the Medicaid program has declined significantly. Because diabetic patients as a group have a lower socioeconomic status than do nondiabetic patients,<sup>9</sup> physician participation in Medicaid programs is relevant to the availability and degree of excellence of diabetes care for eligible participants.

Physicians are also becoming more concerned about demands for services for which there is no compensation or for which there is a substantial "hassle factor." Lack of compensation for completion of multiple administrative forms with or without added administrative and legal worries obstructs patient access to supplies and services related to those documents. This is the case with access to diabetes supplies and, to a lesser degree, diabetes patient education services.

There is a peculiarity in the Medicare regulations for diabetes supplies that constitutes a severe hassle factor for physicians. It states that, if a provider approves diabetes supplies for the same patient in duplicate (i.e., during a defined time period), the provider, and not the supplier, is guilty of fraud and abuse and may be subject to a fine. The

national suppliers of diabetes testing materials and other items offer providers no guarantee that they will not be asked to authorize supplies in duplicate (personal communication, Liberty Medical Company). They are concerned only that they have provider authorization to ship the customer supplies rather than that they protect the potential legal liability of the provider. Thus, providers have to maintain some sort of record-keeping system to prevent duplicate authorization without compensation.

The broad implication of these trends suggests a need to become watchful about whether the realities of the reimbursement scheme attract providers to engage in diabetes care and encourage them to offer the best care. If these trends progress in a negative fashion, the outcome may be to reduce the interest of providers to deliver diabetes care. The risks are especially pronounced for Medicare patients.

Similarly, we should keep in mind the realities facing the providers who

approve diabetes supplies and education. If the act of authorizing diabetes supplies puts the provider at risk for a substantial fine, clearly that is a problem that merits our attention. These concerns may be at least as important as our advocacy to expand the access of diabetic people to the many other services and supports they deserve to help them contend with this life-long condition.

## REFERENCES

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<sup>2</sup>Health Care Financing Administration: Medicare Intermediary Manual. Part 3: Claims Process. U.S. Department of Health and Human Services, Washington, D.C. 2001, p. 3618

<sup>3</sup>Leichter SB: Costs and reimbursements as determinants of the quality of diabetes care: I. Direct cost determinants. *Clin Diabetes* 19:42–44, 2001

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<sup>6</sup>Brandle M, Zhou H, Smith BRK, Marriott D, Burke R, Tabaei BP, Brown MR, Herman WH: The direct medical cost of type 2 diabetes. *Diabetes Care* 26:2300–2304, 2003

<sup>7</sup>American Diabetes Association. Clinical Practice Recommendations 2003. *Diabetes Care* 26 (Suppl. 1)S1–S143, 2003

<sup>8</sup>American Medical Association, Joint Commission on Accreditation Healthcare Organizations, and the National Committee for Quality Assurance: Coordinated performance measurement for the management of adult diabetes. [www.ama-assn.org/ama/pub/category/3798.html](http://www.ama-assn.org/ama/pub/category/3798.html).

<sup>9</sup>Cowie CC, Eberhardt MS: Sociodemographic characteristics of persons with diabetes. In *Diabetes in America*. 2nd ed. Harris MI, Cowie CC, Stern MP, Boyko EJ, Reiber GE, Bennett PH, Eds. Washington, D.C., U.S. Govt. Printing Office, 1995 (NIH publ. no. 95-1468), p. 85–116

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