# Diabetes Patient Education Programs

## Quality and Reimbursement

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To inform health-care providers and third-party carriers of the national quality assurance systems in place for diabetes education programs and the health professionals who provide education services and to indicate the need for consistent reimbursement of essential outpatient diabetes education services.
The components of an independent quality assurance mechanism were examined and a survey was conducted to determine reimbursement coverage of ADA recognized programs.
A national program to evaluate whether programs meet national standards is in place. Many ADA approved programs were reimbursed and official recognition helped in the process of attaining reimbursement. Insurance coverage decisions made by third-party carriers, however, were inconsistent and largely unpredictable.
Outpatient education and follow-up for diabetes is an integral component of care. These services need to be more clearly defined to enable appropriate coding and coverage decisions to be made by third-party payors.

Diabetes is a chronic disease in which patient education for lifelong self-management is integral to care. The acute care hospital is not the best setting for education and now, more often, patient education and follow-up services are being provided on an outpatient basis. The omission of outpatient education as a benefit in many insurance and health-care financing plans, however, constitutes a major barrier to the availability and accessibility of these services (1).

To justify reimbursement for any chronic disease management program, the process of quality assurance needs to be utilized. This process generically involves setting agreed-upon standards, developing criteria by which to measure standards, implementing a system for determining whether or not programs meet these criteria, and evaluating the process.

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### QUALITY ASSURANCE FOR DIABETES PATIENT EDUCATION PROGRAMS

—During the 1984 conference on Financing Quality Health Care for Persons with Diabetes, it became clear that having an independent quality assurance mechanism in place for both diabetes education programs and health professionals would benefit not only providers and consumers, but also the insurance industry as well (2). Responding in part to this need, a quality assurance process was developed specifically for facilities and professionals who provide diabetes education services.

The first generic component of a quality assurance process is to set agreed-upon standards. The National Standards for Diabetes Patient Education Programs were developed under the auspices of the National Diabetes Advisory Board. Following extensive field testing, the standards were finalized and distributed in 1983 (3). The 10 key components of these Standards are listed in Table 1. For each of these components, there are requirements for the facility and the program itself.

The second generic component of a quality assurance process is to develop criteria by which to measure the standards. Review criteria were developed by the National Diabetes Advisory Board and the American Diabetes Association (ADA) (4). For example, component one of the National Standards covers needs assessment. One of the needs assessment standards for the facility is that, "the facility shall assess its diabetes caseload to determine the allocation of personnel and resources to serve the instructional needs of the caseload." Correspondingly, the review criterion is that, "the applicant annually determines the case mix of diabetes patients to be educated."

One of the needs assessment standards for the program is that, "the needs assessment shall be the basis for the education program delivered to each patient." The corresponding review criterion is that, "a written individualized

**Table 1**—*Key components of the national standards*

| | |
|---|---|
| 1. NEEDS ASSESSMENT | 6. CONTENT AND CURRICULUM |
| 2. PLANNING | 7. INSTRUCTORS |
| 3. PROGRAM MANAGEMENT | 8. FOLLOW-UP |
| 4. COMMUNICATION AND COORDINATION | 9. EVALUATION |
| 5. PATIENT ACCESS TO TEACHING | 10. DOCUMENTATION |

education plan based on the needs assessment is developed. The person with diabetes is a participant in this process, and the written plan is shared with him/her before instruction" (4).

The third generic component of a quality assurance process is to develop a system that will determine whether or not applicant programs meet these criteria. The ADA Recognition Program is a national system designed to evaluate whether programs meet the National Standards and associated criteria, and thus provide quality education for individuals with diabetes.

## ADA Recognition

ADA Recognition is a voluntary process through which programs meeting the Standards are formally identified for their performance and quality. This process of achieving ADA Recognition provides, in essence, a nationwide independent quality assurance mechanism for diabetes patient education programs.

The ADA Recognition process includes the following steps:

1. Submission of an application. The questions in the application reflect the review criteria for both the facility and the education program as identified in the National Standards. Requested supplemental information documents the function or content of key program components, including an organization chart, policy and planning statements, advisory committee minutes, the curriculum outline, education materials, and two complete patient records. The applicant is required to select a 12-mo data period and document various program activities within that time period (5).

2. Review of an application. Each submitted application is sent to two volunteer peer reviewers, who present thorough and detailed critiques and make recommendations regarding approval of the applicant program. These trained ad hoc reviewers are experts in the field, represent a number of disciplines, and are geographically spread across the country.

3. Approval of an application. Most programs that complete the rigorous review process are approved. Approved programs receive ADA Recognition for a period of 3 yr. Completion of an extension application allows for an additional 3 yr of approval. Recognized programs are promoted both nationally and locally to consumers, health professionals, and health insurers. All third-party carriers identified by the applicant are informed by the ADA that the program has achieved Recognition, and the meaning of the achievement is briefly explained.

Diabetes education programs from various settings (hospital-based, office practice-based, outpatient clinic, health maintenance organization, Veterans Administration Hospital, physician private practice, and Indian Health Service), and of any size or location, are eligible for approval if they offer comprehensive services and conform to the National Standards. The ADA Recognition application was first made available late in 1986, and the first diabetes education programs were recognized in June 1987. As of 1 January 1992 there were 215 ADA-recognized diabetes education programs representing 45 states and the District of Columbia.

The fourth generic component in the quality assurance process is evaluation. Although there are different ways of evaluating the recognition program, one important and relevant concern is the impact of ADA recognition on reimbursement. A discussion of the findings of a 1990 survey of 120 recognized programs from 40 states follows.

Eighty-nine programs reported offering both inpatient and outpatient education services, and 25 programs offered only outpatient services. Six programs offered inpatient services exclusively. Table 2 represents the percentage of the 114 programs receiving reimbursement for outpatient services from various third-party payors at the survey

**Table 2**—*Recognized diabetes education programs receiving reimbursement for outpatient services (n = 114)*

| THIRD-PARTY CARRIER | % RECEIVING REIMBURSEMENT AS OF JUNE 1990 (N) | % RECEIVING REIMBURSEMENT ONLY AFTER ATTAINING RECOGNITION (N) |
|---|---|---|
| MEDICARE | 61 (70) | 25 (29) |
| MEDICAID | 28 (32) | 19 (22) |
| BLUE CROSS/BLUE SHIELD | 50 (57) | 30 (34) |
| PRIVATE | 57 (65) | 22 (25) |

**Table 3**—*Consistency of reimbursement coverage for recognized programs within 40 states*

| | Medicare | Medicaid | Blue Cross/ Blue Shield |
|---|---|---|---|
| States with no coverage | 9 | 23 | 15 |
| States with inconsistent coverage | 17 | 10 | 17 |
| States with consistent coverage | 14 | 7 | 8 |

date. The percentage of programs receiving reimbursement after attaining recognition is also indicated. Overall, one-third of recognized programs believed that their recognized status helped in the achievement or maintenance of reimbursement in some way. Although it is understandable that there might be variability from company to company in reimbursement by private carriers, a lack of uniform coverage from the other carriers, particularly Medicare, is clearly evident. Table 3 summarizes the following findings for 40 states:

1. Medicare. This is a federally administered program with clear guidelines for intermediaries to reimburse essential outpatient education services affiliated with a hospital or rural health clinic that are ordered by a physician. (A memorandum dated 25 August 1987, from the Director of the Office of Coverage Policy, Health Care Financing Administration, to a Medicare Regional Administrator delineating the above is available from the authors.) Recognized programs in nine states, however, indicated no Medicare activity at all. Programs in 17 of the states indicated disparity in Medicare reimbursement coverage, even when requested of the same regional office, and sometimes for the same services provided by a specific program. Programs in 14 states indicated consistent reimbursement. Those that were most successful at achieving Medicare coverage had the entire program preapproved by a Medicare representative and billed for diabetes education under a hospital revenue code, usually 942 or another as directed by the intermediary.

2. Medicaid. This state-administered program has very limited coverage for diabetes education. No recognized programs were reimbursed in 23 states; programs in 10 states were inconsistently covered, and programs in 7 states received consistent coverage.

3. Blue Cross/Blue Shield. No recognized programs were reimbursed in 15 states; 17 states had inconsistent coverage, and programs in 8 states received consistent coverage.

### Professional standards—certification of diabetes educators

The generic process of quality assurance can also be applied to health-care professionals for whom a certain base of knowledge, skills, and practice is required. Standards and criteria were developed by the National Certification Board for Diabetes Educators, and a written examination was implemented to test applicants for a base requisite knowledge of the components of diabetes education (6). On successful completion, individuals become Certified Diabetes Educators. As of October 1991, there were >6228 Certified Diabetes Educators throughout the United States, representing a number of health disciplines (nursing, dietetics, exercise physiology, social work, and medicine).

**DISCUSSION**—Inherent in the national standards and the process of quality assurance are three tenets. The first tenet is that education is essential to enable adherence to the complicated and time-consuming diabetes treatment regimen. This education is multifaceted, as evidenced by, among other things, the 15 content areas required by the National Standards (Table 4). The regimen frequently requires effective coordination by the patient of a consistent meal plan, regular exercise, and oral medication or injected insulin. Careful day-to-day self-management to help avoid acute complications and to influence the onset and severity of chronic complications will be required until a cure for diabetes is found.

To underscore the importance of education, ADA recently revised its position statement, "Third-Party Reimbursement for Outpatient Education and Counseling." Highlighted in this statement is the fact that diabetes patient education for self-management is an integral component of diabetes treatment (1). The ADA now has Standards of Medical Care for Patients with Diabetes Mellitus (7). Statements that indicate

**Table 4**—*Fifteen content areas required for the curriculum*

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|---|---|
| 1. General facts | 8. Monitoring |
| 2. Psychological adjustment | 9. Hyperglycemia and hypoglycemia |
| 3. Family involvement | 10. Illness |
| 4. Nutrition | 11. Complications (prevent, treat, rehabilitate) |
| 5. Exercise | 12. Hygiene |
| 6. Medications | 13. Benefits and responsibilities of care |
| 7. Relationship between nutrition, exercise, and medication | 14. Use of health-care systems |
| | 15. Community resources |

education is an integral component of medical care are found throughout this document and include such requirements as: *1*) individualized nutrition recommendations and instructions, preferably by a dietitian; 2) patient and family education: assessment of knowledge and understanding of diabetes and diabetes management skills; and 3) a plan for education consistent with the National Standards.

The second tenet is that patient education is not a single, isolated event, but rather a series of ongoing events: learning, life-style adaptation, application of knowledge and practice of skills at home, feedback, evaluation, and follow-up. The goal is for individuals with diabetes to be able to achieve and maintain desirable blood glucose levels consistently to help prevent costly acute and chronic complications. An example of effective education is that provided by the ambulatory diabetes education and follow-up program used by 30 education sites in the state of Maine. The total package, which is reimbursed by Medicaid, Medicare, and Maine Blue Cross/Blue Shield, includes two initial assessments (one performed by a registered nurse and one by a registered dietitian) to individualize the program for each patient, 10 h of education, a 1 mo postneeds assessment, education follow-up during the next year based on the postneeds assessment, and a 1-yr follow-up assessment (8).

The third tenet is that education is best conducted in the outpatient setting. The only education that should appropriately be provided in a hospital inpatient setting is basic or "survival" education for individuals recovering from an acute illness (9). Traditionally, inpatient education costs have been absorbed by different departmental budgets and daily room charges. In the outpatient hospital-affiliated setting, however, patient education services need to be identified as a separate treatment entity and reimbursed as such under appropriate revenue codes. Although Medicare has designated an appropriate hospital revenue code for diabetes patient education, consistent Medicare reimbursement is limited.

In private physician practices and other nonhospital-affiliated programs, diabetes patient education cannot be covered by Medicare unless it is coded as a physician office visit. Thus, a comprehensive self-management program delivered by a physician, nurse, and dietitian—that would, by necessity, extend over more than one or two visits—has no mechanism for reimbursement by Medicare in this setting. Some Blue Cross/Blue Shield and private insurers are more responsive to the cost savings associated with outpatient management of a newly diagnosed insulin-requiring patient compared with hospitalization and are more lenient in extending coverage.

**RECOMMENDATIONS**—Although the diabetes community has taken a big step in developing and implementing a system to identify quality diabetes education programs and qualified educators, further effort is needed to clarify, for both providers and payors, the specific components of acceptable, reimbursable education services. For example, the delivery methods, content, and duration of currently provided services vary so widely that it is difficult for third-party coverage determinations to be made in a consistent and predictable way.

The first recommendation, therefore, is that the diabetes community intensify efforts to work with the insurers, particularly Medicare, to modify coding guidelines so that covered components are appropriate, consistent, and clearly defined. Certainly, costs would need to be calculated to enable appropriate determination of charges and payment.

The second recommendation is that any program seeking to provide reimbursable diabetes education services should achieve a positive external quality assurance review. Because the ADA Recognition Program provides a successful, nationwide, peer review process based on sound interpretation of the National Standards for Diabetes Patient Education, it has become the major quality assurance system available to consumers, providers, and (most important in this context) third-party payors.

Diabetes education for patient self-management is an integral component of diabetes treatment that is most effectively and efficiently provided in an outpatient setting. However, without reimbursement, many quality outpatient hospital programs will be reduced or eliminated, few physician office programs will be viable, and many economically disadvantaged individuals with diabetes will not receive education. Patients will not learn the skills needed to maintain an expected quality of life or to avoid expensive hospitalization and treatment. The third recommendation, therefore, is that Medicare follows its existing plan to reimburse hospital-based outpatient diabetes education programs and expands its coverage to include alternative-based outpatient diabetes education programs such as those conducted in physician office practices.*

**CONCLUSIONS**—Excellent progress has been made in implementing standards for diabetes education programs and identifying qualified health professionals as educators. Clearly, however, consensus must be reached to ensure consistent, predictable third-party insurance coverage for essential diabetes patient education services. Productive interaction between the professional diabetes community, consumers, and

*In November 1991, U.S. Representative Rod Chandler (R-WA) introduced legislation, *Medicare Outpatient Diabetes Education Coverage Act of 1991* (H.R. 3806). The bill is designed to extend coverage for eligible diabetes outpatient education programs beyond hospital-based settings, and to link reimbursement with programs meeting quality standards for diabetes education. (A copy of the legislation is available from the American Diabetes Association.)

third-party payors is needed to clarify coding and coverage issues related to the delivery of outpatient education services in all appropriate settings.

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