Cost and Reimbursement as Determinants of the Quality of Diabetes Care: II. Indirect Influences on Cost

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Author's note: *This is the second of a three-part series on the cost and reimbursement issues that influence the delivery of diabetes care.*

As discussed in the first article of this series,[1] the complexity of adequate diabetes care delivery that meets guidelines for care[2] renders the direct costs of care higher than those for other forms of contemplative primary or specialty care. For any level of reimbursement, this means that the margin of profit is relatively slim.

However, any economic activity, whether rendering a product or a service, also carries with it a set of indirect costs. These costs are inherent in conducting the economic activity; however, they are neither essential nor obviously related to the process of delivering the product or service itself. They are ancillary costs, which are unavoidable. The actions associated with them do not enhance either the cash flow or the profitability of the economic endeavor. Nevertheless, they are costs that must be met as conditions for the constructive economic activity to occur.

In diabetes care delivery, these indirect costs are quite significant and, relative to other care delivery activities, fairly numerous. Without careful attention and control, they represent a substantial part of the risk of loss caused by excessive expenditures versus revenue in this area of medicine.

The Indirect Costs of Diabetes Care

In general, there are four categories of indirect costs related to diabetes care. They are:

1. costs related to guidelines for care and office operation;
2. costs of documentation for issues associated with the rendering of care but not directly involved in it;
3. costs related to arrangements for services and supplies to patients;
4. costs of communication for issues not pertinent to the direct care of the patient.

For any given patient, many of these costs are reasonable and constitute expected costs of providing care. However, the demand for these services may escalate in the absence of careful controls, making these costs quite unreasonable. Therefore, the imposition of fair, but active, controls over such costs is important.

1. Costs of Guidelines

Various guidelines and rules now affect the operation of the diabetes care organization. Guidelines include diabetes care guidelines,[2] guidelines for a safe environment for personnel in the office (Occupational Safety and Health Administration guidelines), and others. We previously published an analysis of how guidelines for diabetes care may have an effect on indirect costs.[3] Other guidelines may exert a negative effect that can exceed that of diabetes care guidelines.

This may be especially true for guidelines imposed by individual managed care plans on diabetes provider offices. These guidelines may require costly modifications to office structures and equipment. Providers face the choice of adhering to these guidelines or being excluded from participation in various plans or contracts.

2. Costs of Documentation

Documentation costs entail costs related to the provision of information about patient health status for purposes unrelated to the direct provision of care. These purposes include:

- disability documentation;
- documentation for work status;
- documentation for nonmedical legal issues, such as adoption or divorce proceedings;
- documentation for licensure, including driver's license or professional licensure;
- documentation for travel.

Usually, providers must furnish their own written communication about these matters or complete forms provided by the group or agency requesting the information.

These costs are less defined than the costs of guidelines, and they threaten a higher risk of being excessive. Because the population of diabetic patients entails higher actuarial risks for illness and disability, providers of diabetes care are more likely to receive requests for this sort of documentation than providers to other patient groups. For example, all states require specific documentation about glycemic control and risks of hypoglycemic events in all diabetic drivers who are on insulin therapy. The complexity of these forms varies from state to state. A similar situation exists for work-related documentation of health status. Forms from some companies or

agencies may be quite complex and extensive.

Disability determinations represent a specific area of concern in documentation and indirect cost to providers. In many states, such as Georgia, attorneys and other agencies may request copies of medical records for disability determination at no cost to the requesting agencies. This means that health care providers must bear all the costs of duplication. In addition, advocates for disability applicants or agencies adjudicating these claims often request that the applicant's health care provider submit an original, written narrative that describes specific aspects of patient function. Usually, no fee is offered for these lengthy narratives.

3. Costs Related to the Provision of Services and Supplies to Patients

Almost every diabetes care provider knows that an active industry has arisen to provide supplies and home equipment to diabetic patients. This activity is associated with a flurry of forms to document the prescription for these supplies by diabetes providers. The vendors for diabetic supplies cannot get paid for their sales by Medicare or other insurance companies without these completed forms.

These vendors do not pay providers for the completion of the forms. There is some justification for this policy: many believe that such payments could be viewed by Medicare as fee-splitting or as illegal inducements to entice providers to use specific products or vendors.

From the provider perspective, these forms are one category of unreimbursed extensions to daily work time. They vary widely in complexity, and obviously, the simpler and more convenient the form, the more attractive the vendor in terms of provider cost and overhead.

Excluding physician time, the average approval form requires at least 5 min of staff time to complete. Staff must pull the patient chart for the provider to fill out the form and fax or mail the completed document. Our office averages 10 such forms per day. Therefore, per year, these sorts of forms require ~1,300 h of work, or more than half of a clerical staff position.

Medicare rules regarding the provision of these supplies govern the degree to which this utilization may be controlled. Providers cannot approve more than a given amount of supplies per unit time. Because the amount of supplies depends on whether an individual patient uses insulin or other diabetes treatments, the physician must review the patient chart to confirm the treatment. The provider must also attest that the patient has been seen within the 6-month period prior to certification of the form.

4. Costs of Communication for Unrelated Issues

In addition to the volume of interactions related to documentation, providers receive a wide variety of communications every day regarding other, miscellaneous issues about and from patients that are not directly related to patient care. These communications include issues regarding patients' family members or friends who are not patients of the same practice. There are inquiries regarding patient participation in various social activities, ranging from clubs and travel groups to health spas. And, with the growth of the Internet and mass media, there are many calls about information that patients or their family members see or hear elsewhere.

These contacts can represent a substantial minority of all communications to a provider's office on a given day and can significantly expand the work load. Another problem with this type of contact is that the individuals making them usually request rapid feedback.

Controlling Indirect Costs

The same strategy for managing indirect costs of care applies to all categories of work attributable to indirect cost except for the costs of meeting required standards and guidelines. That strategy is to develop screens and filters in the office work process to manage this large volume of contacts effectively and economically. The best strategy for dealing with guidelines and standards, however, is for providers to program methods of complying as soon as they determine that the guidelines in question are meaningful.

Early programming of steps to comply with required guidelines may occupy some office time and resources in a clear and measurable manner; however, in the end, this planning leads to lower costs, either by direct expenditure or by disruption of staff time and effort.

In our office, we developed a protocol for adhering to guidelines that involves a staff meeting as the first step. All employees participate. This helps us make positive decisions about the best methods of dealing with the particular guidelines in question. In addition, we appoint an office captain to oversee our efforts to meet the requirements. A nurse became our captain to adhere to OSHA guidelines, whereas a receptionist became our captain to meet guidelines for the Health Plan Employer Data and Information Set. We have learned that we should not enter our process for meeting guidelines with any preconceived notion about how to achieve our goals: our office group often devises interesting solutions that were not expected before the process started.

To deal with the mass of communication and documentation that comprises the other types of indirect costs of diabetes care, screens and filters are essential. These screens and filters work to set expectations for our responses to others and to set priorities on the communications provided. For example, our reception staff automatically returns uncompleted forms to diabetes supply vendors if those forms request more information than Medicare requires to certify diabetes supplies for patients. For each documentation request we receive, we consider: *1*) whether we believe it is our responsibility to provide the information requested; *2*) when we will complete the request form; and *3*) whether we will require payment for the service of completing the form. Certainly, the specific

decisions made about the common groups of requests for documentation will vary from office to office; it is important to consider developing a policy for handling them.

The same is true for telephone communications. We have policy about whether and how we will answer telephone inquiries. Some inquiries, such as those for which we do not have a legal release from our patients, we refuse to answer. Others are handled with an eye to their relevance to the overall work load of the office. These considerations are based on policy, and many are stated in the office brochure we provide to our patients. By giving some systematic consideration to policies regarding telephone contacts, providers can make the daily work flow in their offices more logical, efficient, and economical.

Obviously, decisions about how to handle indirect costs and the service demands that generate them rest with the best judgment of individual providers and provider organizations. In many instances, the provision of services associated with indirect costs represents the good will of providers toward the patients they serve. In the business world, this type of financial obligation is also known as "good will" and is a recognized liability. The many issues and potential risks faced by diabetic patients mean that this patient population, like others with chronic and progressive medical conditions, requires more "good will" for service than other patient groups.

On the other hand, the sincere good will of providers may be abused. Therefore, it is always prudent business planning for diabetes providers to implement policies and procedures to limit and prioritize these demands for services. Providers always have the discretion of limiting the majority of these service demands. Building flags and screens into office systems can help to identify situations that may require such limits.

REFERENCES

[1]Leichter SB: Cost and reimbursement as determinants of the quality of diabetes care: I. Direct cost of determinants. *Clinical Diabetes* 19:142–144, 2001

[2]American Diabetes Association: Standards of medical care for patients with diabetes mellitus (Position statement). *Diabetes Care* 24 (Suppl. 1):S33–S43, 2001

[3]Leichter SB: Economic considerations in the application of clinical standards and requirements in diabetes care. *Clinical Diabetes* 18:91–93, 2000

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