

Medicare Diabetic Measures That Pay

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There are few situations in health care in which everyone can be a winner. Unfortunately, in most cases, for someone to win, someone else has to lose. Thankfully, in aggressive diabetic management for assisted living (AL) residents, everyone can be a winner—from residents to healthcare providers to facility administrators.

Residents win because aggressive diabetic management delays the progression of diabetes complications, allowing those with diabetes to remain in their homes for longer periods. While this obviously and directly benefits diabetic residents, it also benefits those without diabetes because the AL community remains more stable. The facility benefits from increased occupancy through lower turnover. Physicians benefit through their participation in Medicare's Physician Quality Reporting Initiative (PQRI), which includes pay-for-performance initiatives aimed at diabetes management.

Under Medicare's PQRI, physicians can continue earning extra revenue from Medicare in 2008, based on their voluntary reporting of quality measures for treatment of patients with many diseases and conditions, including diabetes.

PQRI is Medicare's first entry into the pay-for-performance system, one that promises more requirements with more dollars attached. The 2008 PQRI provides bonuses based on reporting in 2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Extension Act), signed by President Bush in December 2007, authorized continua-

RENAL FUNCTION TEST (腎臟功能試驗)	
Sodium (鈉) (137 - 150)	141 mmol/l
Potassium (鉀) (3.5 - 5.2)	4.4 mmol/l
Chloride (氯) (94 - 111)	104 mmol/l
Urea (尿素) (10 - 50)	34 mg/dl
Creatinine (肌酸酐) (♂ 0.7 - 1.4 ♀ 0.6 - 1.1)	0.8 mg/dl
	4.6 mg/dl

URINE ANALYSIS (尿液分析)	
Urine FEME	
Colour (顏色)	Str
Transparency (透明度)	Cl
pH (酸鹼反應)	6
Proteins (蛋白)	
Glucose (糖)	
Ketone (酮體)	

tion of the PQRI for 2008. Eligible professionals can earn a bonus payment of up to 1.5% of total allowed charges for covered Medicare physician fee schedule services provided during the reporting period of January 1, 2008, to December 31, 2008. Bonuses will be paid in a lump sum in mid-2009 from the Federal Supplementary Medical Insurance (Part B) Trust Fund, the same fund as in 2007.

Registration is not required to participate in the PQRI. However, CMS offers updated tools to assist professionals in 2008 PQRI reporting. These tools can be accessed by clicking the "PQRI Tool Kit" at www.cms.hhs.gov/pqri/. Also available are measures and codes, educational training, and a series of frequently asked questions.

The 2008 PQRI quality measures relate to important processes of care that are linked to improved healthcare quality outcomes. They are evidence- and consensus-based measures that reflect the work of national organizations involved in

quality measure development, consensus endorsement, and adoption. There are currently 119 quality measures for 2008.

Reporting Requirements

There is no need to enroll to be eligible to participate in the 2008 PQRI. Just report the appropriate quality measure data on claims submitted to your Medicare claims processing contractor. Eligible professionals include physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals, physical therapists, occupational therapists, and qualified speech-language therapists.

PQRI Reporting Details

The 2008 PQRI quality-data codes are HCPCS codes, and reporting requirements follow current rules for reporting other HCPCS codes (eg, CPT Category I codes). On the ASC X12N 837 professional healthcare claim transaction, HCPCS procedure codes are submitted in the SV1 "Pro-

Table 1.
Sample Reporting for Diabetes

The example below shows how to report Category II codes for 3 measures: A1c, LDL, and blood pressure. The codes are specific to the patient's results for each measure, which are listed beneath the codes.

ICD-9 code	CPT code	CPT II code for A1c	CPT II code for LDL	CPT II code for systolic BP	CPT II code for diastolic BP
250.xx	99214	3044F	3048F	3074F	3078F
Diabetes	Level-IV Service	A1c <9.0%	LDL <100 mg/dL	Systolic BP <130 mm Hg	Diastolic BP <80 mm Hg

fessional Service" Segment of the 2400 "Service Line" Loop. The data element for the procedure code is SV101-2 "Product/Service ID." You must also identify that you are supplying a HCPCS code by submitting the "HC" code for data element SV101-1. For claims submitted on the CMS 1500 Form, procedure codes are reported in field 24D.

Once a quality code with a diagnosis code has been reported, that diagnosis code must be accompanied by the appropriate quality code(s) 80% of the time for you to qualify for the bonus payment. Even if the test or service in question was not performed at the patient's visit, the code should be reported with the appropriate exclusion modifier, as indicated on the data collection sheet. For more details on the reporting process, visit the CMS site at www.cms.hhs.gov/PQRI/.

Because the data reporting function is integrated with billing data, reporting can be completed efficiently at the time of service. Having the data collection sheet stapled to the superbill can serve as an excellent reminder. EHR users can create an alternative reminder system with staff to make sure the quality codes are submitted to Medicare.

2008 Measures for Treating Diabetes

The 2008 PQRI encompasses 119 quality measures, including 2 structural measures. The structural measures

include use of EHR and e-prescribing.

- **Measure 1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus**

Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent hemoglobin A1c >9.0%

- **Measure 2: Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus**

Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent LDL-C level <100 mg/dL

- **Measure 3: High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus**

Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (<140/80 mm Hg)

Note: Two CPT II codes must be used to report: one for systolic and one for diastolic.

Diabetes Management Process

1. Choose a practice diabetes management leader. Valuable resources are available to assist in the development of clinical practice guidelines (<http://mdm.ca/cpgsnew/cpgs/handbook/index.htm>), but a critical starting component is having a practice leader.
2. Identify diabetic patients within your practice. This can be done on most practice management systems by creating a report of all patients who had charges

posted with particular ICD-9 codes. The reports can also provide the CPT codes that were reported on the claims.

3. Send a pre-appointment letter with prescriptions for blood work. Include in the letter prescriptions for getting needed diabetic measures such as hemoglobin A1c and cholesterol panel prior to the appointment.
4. Use a diabetes management chart for each patient. See the AAFP Physician's PQRI Data Collection Sheet available at: www.aafp.org/online/en/home/practicemgt/quality/qitools/perfmeasure/demoproject/cmstpqi/pqridata/sheetguide.html.
5. Provide group visits and patient education specific to diabetes. Most research now shows that a diabetes education component increases adherence to treatment regimens and improves glycemic control.¹
6. Begin working with a pharmacist to improve adherence. Future PQRI measures will be evaluated based on achieving improved health outcomes; therefore, ensuring adherence to medication regimens will be vital.

Quality Improvement

CMS will send you personal reports comparing your PQRI data to that of your peers nationwide; the first one will be available in the middle of 2009.

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Figure 2.
TUG sample test form

SAMPLE TEST FORM
TIMED UP AND GO/TUG TEST TO PREDICT RISK OF FALLS

NAME: _____ GENDER: _____ DATE OF BIRTH: _____ DATE: _____
AGE: _____

NORMATIVE DATA¹

AGE	GENDER	MEAN (seconds)	NORMAL RANGE (seconds)
60-69	MALE	8	4-12
60-69	FEMALE	8	4-12
70-79	MALE	9	3-15
70-79	FEMALE	9	5-13
80-89	MALE	10	8-12
80-89	FEMALE	11	5-17

Instructions to patient: "On the word 'go' you are to get up and walk at a comfortable and safe pace to the line/cones 3 meters away, turn, return to the chair, and sit down again."

Observations may include (but are not limited to): quality of sitting and standing balance, safety during transfers, quality of gait, use of assistive device, ability to turn and change direction, activity tolerance, functional visual deficits, cognition: memory and safety awareness, footwear, any loss of balance episodes

TRIAL 1: _____ seconds OBSERVATIONS: _____

TRIAL 2: _____ seconds OBSERVATIONS: _____

AVERAGE: _____ seconds

Sensitivity and Specificity²:
If score < 14 seconds: 87% not a high risk of falls
If score ≥ 14 seconds: 87% high risk of falls

Multiple studies have confirmed the content validity, concurrent validity, and predictive validity of the test.²

Research supports the use of the TUG Test for people with Parkinson's

disease; elderly people with or without cognitive impairment (but who are able to follow directions); people with lower limb amputations, total joint arthroplasty, hip fracture,

rheumatoid arthritis and osteoarthritis; and deconditioned elderly people.

Multiple studies have confirmed a high intrarater and interrater reliability. The TUG Test can be performed by physicians, nurses, and physical and occupational therapists.

The TUG Test can be easily incorporated into an existing fall prevention program.

The information in this article was presented at the 2006 annual symposium of the American Medical Directors Association (AMDA). **ALC**

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1. Steffan T, Hacker T, Mollinger L. Age- and gender-related test performance in community dwelling elderly people: six-minute walk test, Berg balance scale, Timed Up & Go Test, and gait speeds. *Phys Ther.* 2002;82:128-137.
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AAFP Physician's PQRI Data Collection Sheet: Diabetes

The AAFP has developed data collection sheets to help you report measures and select quality codes at the time of service. These are available online at: www.aafp.org/online/etc/medialib/aafp_org/documents/prac_mgt/quality/cmspvrp/diabetes-measures.Par.0001.File.tmp/diabetespqrimasures.xls

Things to Know About the PQRI²

- Use your NPI to bill. Data are analyzed using an individual's NPI; bonuses are paid using an individual's taxpayer identification numbers (TINs).
- Choose at least 3 applicable measures to report.
- Measures reported use CPT Category II codes with ICD-9 codes that link to patient diagnoses. Once a CPT II code has been

PQRI and Pay-for-Performance Resources

PQRI and Pay-for-Performance Resources

AAFP PQRI Web site: www.aafp.org/practicemgt/pqri

CMS PQRI Web site: www.cms.hhs.gov/PQRI

List of 2008 PQRI measures: www.cms.hhs.gov/apps/ama/license.asp?file=/PQRI/Downloads/2008PQRI MeasuresList.pdf

Reading

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2. Endsley S, Baker G, Kershner BA, Curtin K. What family physicians need to know about pay for performance. *Fam Pract Manag.* 2006;13(7):69-74.
3. Endsley S, Kirkegaard M, Baker G, Murcko AC. Getting rewards for your results: pay-for-performance programs. *Fam Pract Manag.* 2004;11(3):45-50.

reported, it must be included with the diagnosis 80% of the time to be eligible for the bonus payment.

- The reporting period for 2008 initiatives begins January 1, 2008, and ends December 31, 2008. CMS must receive claims by February 28, 2009, for them

to be included in the 2008 reporting period. **ALC**

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