Medicare's Physician Quality Reporting System (PQRS): Medicare's Unique Approach to Quality Assurance[1]

Samuel Knapp, Ed.D. ABPP

Director of Professional Affairs, Pennsylvania Psychological Association

Lynda Behrendt, Psy.D., R.N.

Director of Professional Affairs, Illinois Psychological Association

Rachael Baturin, MPH, J.D.

Professional Affairs Associate, Pennsylvania Psychological Association

While commercial managed care companies are experimenting with or debating pay for performance measures, Medicare has taken a unique approach through its Physician Quality Reporting System (PQRS; formerly called PQRI). Originally created to award a bonus for reporting, PQRS by law must become a penalty program in 2015. In 2014, psychologists (and other eligible professionals) who meet certain participation standards will receive an incentive payment equal of .5% of allowed charges while participants who meet lesser participation standards will avoid a 2% penalty starting for dates of service in 2016. Starting in 2015 PQRS shifts to a penalty-only program and professionals who do not participate will have payments for all services reduced by 1.5% in 2015 and 2% in 2016.

The participation requirements for 2014 vary according to whether a person wants to just avoid the penalty or also receive the bonus. Those who want to avoid the penalty need to report on 3 measures for 50% of their eligible patients. Those who want to both earn the bonus and

[1] We express appreciation to Drs. Jeff Gold, Jeanne Slattery, and Lance Lawrence for reviewing an earlier version of this manuscript and to Diane Pedulla of the APA Practice Organization for her detailed review of this article and for providing invaluable resources. This article is an update of previous articles written in 2013 on the PQRS written by Samuel Knapp and Rachael Baturin. However, in 2014, the standards for reporting the PQRS changed so substantially, that we urge readers to ignore the previous articles and focus on the standards presented in this article.

avoid the penalty must report on 9 measures from 3 domains for 50% of their eligible patients (See Table One Below). However, we describe below how the 9 measure/3 domain standard for earning the bonus is flexible, depending on the nature of the case load for the psychologist, so that many psychologists who fail to use 9 measures can still avoid the penalty and earn the bonus. We will explain what measures and domains mean in the text that follows.

Table One: Standards for Avoiding Penalties and Earning Bonus

	Number of Measures	Domains	Percent of Eligible Patients
Avoid penalty	3	n.a.	50%
Avoid penalty AND Earn Bonus	9	3	50%

Should I Participate in This Program?

Some psychologists who see only a few Medicare patients may debate whether it is worth their time to participate in the PQRS program. They ask whether the time they invest in learning and participating in the program will offset the relatively small changes in reimbursement. Of course this is an individual decision that each psychologist needs to make. However, we will note that once psychologists understand the basics of the system it does not appear that difficult. Also, it is possible (although not certain) that reporting systems, such as PQRS, may be more common in the future and it would be to the benefit of psychologists to start learning them now.

Getting Started with PQRS

The goal of the PQRS program is to learn the practice patterns of health care providers. At this time there is no penalty based on the nature of the reports. For example, it could be possible for a psychologist to report that he or she failed to conduct a suicide screening with a patient who had a Major Depressive Disorder without any penalty, inquiry, or additional oversight involved. The PQRS program is limited to Fee-For-Service Medicare and does not

apply to those services to patients in the Medicare Advantage programs, although we have heard reports that a few Medicare Advantage programs will voluntarily pay for PQRS reporting.

The PQRS process appears very complicated and cumbersome. However, we found that once readers have a basic grasp of it, they can participate without an excessive amount of difficulty.

The entire reporting procedure can be summarized in one sentence: identify the measures to be used, link the measures to the Quality Data Codes, and report them to Medicare. Psychologists do not need to do anything ahead of time to specifically enroll in the PQRS program. Participation occurs simply through putting information on the claims form (or other means referenced below). The steps are repeated in Table 2.

Step One: Select the Measures

The first step in the PQRS process is for psychologists to identify and select the measures they want to use. CMS has a list of more than 300 potential reporting measures (some of the measures change from year to year). The majority deal with different aspects of physical medicine and would be irrelevant for psychologists. For example, several measures deal with dermatological issues and would be reported only by dermatologists (or other physicians treating dermatological disorders). The measures that psychologists are currently most likely to use are found in Table 3. However, the measures that can be reported may change from year to year so psychologists should check on the eligible measures at the start of each year.

Table 4 includes more detailed information on the measures and the conditions under which they can be used. However, readers should use Table 4 only as a screening guide to determine which measures they should consider using. Before using any measure we recommend that psychologists look at the original and full description of the measures found on the CMS

website. The full description on the CMS website contains essential details that could not be fit into the brief summary chart. For example, the description on the CMS website concerning measure 107 (Adult Major Depression, Suicide Risk Assessment) contains four questions that must be asked as part of that suicide risk assessment. Again, in order to avoid the penalty or to qualify for the bonus, psychologists do not have to give the four questions as part of that suicide risk assessment. Instead, to avoid the penalty or qualify for the bonus, psychologists must report, using a g-code or a CPT-II Code, whether or not they used the four questions as part of that suicide risk assessment. However, if they did indicate through the g-code or CPT-II code that they did conduct a suicide risk assessment, then they should conduct it in the manner prescribed by CMS in the manner described in those measures. The administrating of those screening questions should also be documented in the patient's record.

To find the full descriptions of the measures psychologists can go to the CMS site: http://CMS.gov/Medicare/Quality-- Initiatives patient assessment instruments/PQRS/MeasuresCode.html, then scroll to the page and click on "2014 PQRS Individual Claims Registry Measure Specification Supporting Documents" and then, click on "2014 PQRS Individual Medicare Specification Manual." In this process psychologists may need to press "Accept" on the disclaimer page before the manual will open. Psychologists can then look at the specific descriptor for each measure. For example, Measure #181 (Elder Maltreatment Screen and Follow-Up Plan) is found on pages 358 to 361 of the manual and includes definitions, descriptions, special instructions, and the applicable Quality Data Codes (more on those below). We would recommend that the psychologist print out the pages for the measures they wish to use. These pages will include essential information such as the procedure

codes that can be used with the measure, whether certain screening instruments are approved, etc.

If psychologists only want to report 3 measures (to avoid the penalty in 2016), then they need to choose the quality measures based on the unique features of the population that they serve. For example, a psychologist who treats older adults with drug and alcohol disorders would likely pick 247 (Substance Abuse Disorders, counseling regarding options), or 248 (Substance Abuse Disorders, Screening for depression) as they deal with the overuse of alcohol or other drugs. Because Major Depression is common in the population in general, and in older adults, we suspect that many psychologists would choose to report on the measures dealing with depression: 106 (Adult Major Depressive Disorder: Comprehensive Diagnostic Evaluation); or 107 (Adult Major Depressive Disorder: Suicide Risk Assessment).

However, psychologists who want to both avoid the penalty and earn the bonus for 2016 must report nine measures and there are only 10 measures available to psychologists to use through the claims based reporting. Consequently, the psychologists would look through the 10 measures and simply de-select one of the measures that they would not report. Because of the nature of the distribution of the 10 measures across three domains, a psychologist would necessarily identify measures from three domains.

However, one problem arises is that many psychologists may not, because of the demographics of their patient population, may not be able to submit 9 measures or be unable to submit measures from three separate domains. For example, several of the measures are restricted to patients with a depression diagnosis or an alcoholism diagnosis. Psychologists who do not treat patients with depression or alcoholism will be unable to report on 9 measures from three domains.

In that case, psychologists should report as many measures as they can, and their reporting will be referred to a process called MAV (Measure Applicability Validation) which will determine whether the psychologist could have reported more measures. In that way, psychologists can still avoid the penalty and earn the bonus even if they cannot submit 9 measures from three domains.

Medicare has six domains for measures, but the measures for psychologists fall into only three domains. The six domains are listed below and the three open to psychologists are in bold print:

Patient Safety (2 measures; open to psychologists)

Person and Caregiver Centered Experience and Outcome

Communication and Care coordination

Effective Clinical Care (4 measures; open to psychologists)

Community/Population Health (4 measures; open to psychologists)

Cost Reduction

The second step is to identify the quality data codes that would be associated with each of the measures. CMS publications describe these in terms of a numerator and denominator which we do not find particularly helpful and will not review or discuss further. Nonetheless, the Quality Data Code (either or both a CPTII or a "G" Code) reports on what the psychologists did during the session that expands upon the primary CPT code. For example, when treating a patient with Major Depression, a psychologist might screen for suicidal risk (or not screen for suicidal risk) and then indicate whether the screening was done using a particular Quality Data Code. Remember that the PQRS system does not require the psychologist to conduct a suicide risk; only that they report on whether or not such a risk assessment was done.

The Quality Data Codes are linked to the CPT Code. For example, a psychologist reporting measure 181 (elder maltreatment screening) would do in conjunction with CPT Code 90791 (diagnostic intake), 96116 (psychological testing) or 96150 (intake for health and behavior codes). Nothing prohibits a psychologist from conducting additional screenings later in conjunction with another procedure code, however those screenings done in conjunction with other procedure codes would not count as fulfilling the PQRS reporting requirements. Table 4 contains information on which measures are linked to which CPT Codes.

Psychologists can report the data in one of four ways: claims-based reporting, registry-based reporting, electronic health record based reporting, and group practice reporting. Registries are large organizations that have to be approved by Medicare as reporting services. Although all registries provide PQRS reporting, some also provide billing services. There are some measures that can only be reported through a registry. A registry will take the PQRS measures and send them into Medicare in a batched format that is easier for Medicare to analyze. A list of some approved registries is provided in Appendix B. The next updated list should be posted on the CMS website by early summer. Nonetheless, we suspect that most psychologists in an independent practice or a small group practice would use claims-based reporting. More information on claims-based reporting will be presented below.

Reporting begins when psychologists submit the information (measures and Quality Data Codes; QDCs) on their claims form. One sample of filling out a claims form can be found at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_sampleCMS1500claim_12-19-2012.pdf. As can be seen in the form, the Quality Data Codes are reported under 24 D (Procedures, Services, or Supplies). The diagnosis pointer refers to the specific diagnosis which justifies the procedure

code. The diagnosis of a Major Depressive Disorder is required for the Quality Data Codes G8930 and G8126, therefore 24 E (Diagnosis Pointer) must reference the MDD diagnosis which is listed in 21. A. The third Quality Data Code G8427 does not require any specific diagnosis and for that measure the Diagnosis Pointer could be either 1, 2, or 12. On Line 24F of the form, the Quality Data Codes must be submitted with a line item charge of either $0.00 or $0.01 in order to be processed.

To retrace some of the steps, if psychologists select measure 181 (Elder Maltreatment Screen and Follow-up Plan), they can go to the CMS website (see link above) and then download the pdf file. Look for the page that reports on measure 181. The measure applies to patients who are 65 years old or older. The pages include a detailed description of elder maltreatment. CMS has a list of specific screening instruments mentioned for some measures. For this measure the screening for elder abuse does require a standardized tool which must be administered and documented in the patient's record. Then potential G Codes are listed as well. Measure 181 can be used in conjunction with the procedure codes 90791, 96116, and 96150.

Each eligible professional must satisfactorily report on at least 50% of eligible instances when reporting to qualify to the incentive. Nonetheless we recommend that psychologists routinely report on every patient, even if the report is simply that a screen was not done. Reporting on every patient helps ensure that the psychologist will reach the required 50% threshold for reporting, because it is possible that a psychologist may make an error in reporting some measures that subsequently do not get credited to the 50% figure.

How does this reporting influence the actual practice of psychology? It does require effort to learn the procedures and it does require a modicum of additional paperwork and perhaps the development of a brief reminder or checklist to ensure that the measures selected by the

psychologists are being used and documented. It is possible that these procedures will become automatic or second nature for psychologists and involve relatively little cognitive labor in the long run. It is also possible that the reporting process itself may help improve the quality of treatment by reminding psychologists to perform essential tasks, such as documenting medications or screening for depressed patients for suicidal ideation. We understand that those who participate in the PQRS may be subjected to a special PQRS audit, so it is important to ensure that the documentation reflects what was reported on the Quality Data Code. However, we have been told that this special audit was non intrusive and non-adversarial and differs substantially from the typical Medicare audit. Right now it appears that only time will tell whether the PQRS is worth the extra effort.

Further Resources

Here is an information source from CMS: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html. The APA Practice Organization has updated its video by staffer Diane Pedulla which was also helpful. CMS also has a help line available 7 to 7 (CST) at 1-866-288-8912.

Table 2: PQRS Step by Step

1. Read over the article to get an overview of the PQRS and how it works.
2. Select which measures would be most appropriate for your practice. You should try to select 9 measures from three domains. If you cannot, because of the nature of your patient population, find 9 measures from three domains, then we recommend that you select as many measures as are applicable. You can look at Table 2 to find a list of possible measures and then on Table 3 to find more detail on those measures. Use Table 3 only as a general guide to determine which measures you want to investigate further. The brief information in Table 3 leaves out some essential information that you will need to report the measures accurately. If you decide to use a measure go to the original CMS

site: http://CMS.gov/Medicare/Quality-- Initiatives patient assessment instruments/PQRS/MeasuresCode.html. Then scroll to the bottom of the page and click on "2013 PQRS measures Specification Manual." Press "Accept" on the disclaimer page and then the manual will open. Or, if you are a member of the Pennsylvania Psychological Association, you can find the measures open to psychology in a document on the PPA website ("members only" section, under Business and Practice, and the Medicare subdirectory).

3. Copy the pages of the measures you intend to use and read the descriptions carefully to ensure that you comply with the requirements as described. For example, measure 134 (Preventive Care and Screening for Depression) identifies examples of screening tools that may be used (clinicians can use other scales as well). In addition, it delineates the elements of a successful follow-up plan that must be conducted and documented in the patient's chart.

4. You may wish to develop a reminder sheet or checklist to assist you in remembering which measures to use.

5. Report the measures. There are several ways to do it, but the article describes only the one using the CMS claims form.

Table 3: 2014 Measures Open to Psychologists

106	Adult Major Depressive Disorder: Comprehensive Diagnostic Evaluation
107	Adult Major Depressive Disorder: Suicide Risk Assessment
128	Body Mass Index Screening and Follow-Up
130	Documentation of Current Medications in Medical Record
131	Pain Assessment and Follow-up

134 Screening for Clinical Depression and Follow-up Plan

181 Elder Maltreatment Screen and Follow-up Plan

226 Tobacco Use: Screening and Cessation Intervention

247 Substance Abuse Disorders (counseling regarding options)

248 Substance Abuse Disorders (Screening for depression)

Note: Two measures that were available to psychologists in 2013 (9 - Major Depressive Disorder: Antidepressant Medication during Acute Phase[2](registry only) and 173-- Unhealthy Alcohol Use Screening) can now only be reported on a registry.

Table 3: PQRS 2014

Number, Measure and Assessment Tools (if applicable)	Domain	Eligibility (age, diagnosis)	Reporting Period	Procedure Codes	G-Codes
106: Major Depressive Disorder: Diagnostic Evaluation	Effective Clinical Care	18 yrs & older New diagnosis OR recurrent episode of MDD.	Once per reporting period. Include episodes of MDD that began prior to reporting period.	90791, 90832, 90834, 90837, 90839, 90845,	**G8930**-Assessment of severity at initial evaluation. **G8931**- Assessment severity not documented, reason not given.

[2] This can be used by psychologists who monitor medication. It does not require that the psychologist has actually prescribed the medication.

Number, Measure and Assessment Tools (if applicable)	Domain	Eligibility (age, diagnosis)	Reporting Period	Procedure Codes	G-Codes
107: Major Depressive Disorder: Suicide Risk Assessment[3]	Effective Clinical Care	18 yrs & older Active diagnosis of MDD.	Minimum of once during reporting period. Include episodes of MDD that began prior to reporting period.	90791, 90832, 90834, 90837, 90839, 90845,	**G8932**- Suicide risk assessed at initial evaluation. **G8933**- Suicide risk not assessed at initial evaluation, reason not given.
108: Body Mass Index	Patient Safety	18 yrs & older Documented BMI outside of normal parameters. No diagnosis associated w/ this measure.	Once per reporting period.	90791, 90832, 90834, 90837, 90839,	**G8420**-BMI meets normal parameters, no follow-up plan required. **G8417**- BMI above normal parameters, follow-up plan is documented. **G8418**- BMI below normal parameters, follow-up plan is documented. **G8422**-BMI not documented, patient not eligible for BMI calculation. **G8938**-BMI outside normal parameters, no follow-up plan required, patient not eligible. **G8421**-BMI not documented, reason not given. **G8419**-BMI outside normal parameters, no follow-up plan documented, no reason given.
130: Documentation and verification of current medications in the medical record	Patient Safety	18 yrs & older No diagnosis associated. List must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. Include name, dosage, frequency, and route of entry.	Report each visit during the 12 month reporting period.	90791, 90832, 90834, 90837, 90839	**G8427-**Obtained, updated, or reviewed the patient's current medications. **G8430**-Patient not eligible for list of medications obtained, updated, or reviewed. **G8428**- List of medications not documented as obtained, updated, or reviewed, reason not given.

[3] Suicide Risk Assessment

Number, Measure and Assessment Tools (if applicable)	Domain	Eligibility (age, diagnosis)	Reporting Period	Procedure Codes	G-Codes
131:Pain assessment prior to initiation of patient treatment[4]	Community Population/ Health	18 yrs & older No diagnosis associated.	Report each visit during the 12 month reporting period.	90791, 96150	**G8730**- Positive assessment result from standardized tool, and follow-up plan is documented. **G8731**- Negative assessment result from standardized tool, no follow-up plan required. **G8442:** No documented pain assessment, patient not eligible for assessment. **G8939**: Positive assessment result from standardized tool, no follow-up plan documented, patient not eligible. **G8732**: No assessment documentation, reason not given. **G8509**: Positive assessment result from standardized tool, no follow-up plan documented, reason not given.
134: Screening for Clinical Depression[5]	Community Population/ Health	12 yrs & older; Screened for clinical depression. If positive, follow-up plan is documented.	Minimum of once per 12 month reporting period.	90791, 90832, 90834, 90837, 90839	**G8431**- Positive clinical depression screening, follow-up plan documented. **G8510**- Negative clinical depression screening, follow-up plan not required. **G8433**- No clinical depression screening documented, patient not eligible. **G8940**-Positive clinical depression screening, follow-up plan not documented, patient not eligible. **G8432**-No clinical depression screening documented, reason not given. **G8511**-Positive clinical depression screening, follow-up plan not documented, reason not given.

[4] Standardized tool is required: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

[5] Normalized and validated depression screening tool, not limited to: **Adolescent Screening Tools (12-17):** Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), PRIME MD-PHQ2; **Adult Screening Tools (18≤):** Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Number, Measure and Assessment Tools (if applicable)	Domain	Eligibility (age, diagnosis)	Reporting Period	Procedure Codes	G-Codes
181: Elder Maltreatment Screen and Follow-Up Plan[6]	Patient Safety	65 years & older; Documented elder maltreatment	Once during the 12 month reporting period.		**G8733**- Positive elder maltreatment screen documented, follow-up plan documented. **G8734**- Negative elder maltreatment screen documented, follow-up not required. **G8535**-No elder maltreatment screen documented, patient not eligible. **G8941**- Positive elder maltreatment screen documented, no follow-up plan documented, patient not eligible. **G8536**- No elder maltreatment screen documented, reason not given. **G8735**- Positive elder maltreatment screen documented, no follow-up plan documented, reason not given.
226: Preventive care and screening: tobacco use- screening and cessation intervention	Community Population/ Health	18 years & older Patient screened for tobacco use 1≤ times within 24 months, and received cessation counseling.	Once during the 12 month reporting period.	90791, 96116, 96150	**4004F with 8P**- Screened for tobacco use and no tobacco cessation counseling received. **4004F**-Patient screened and received tobacco cessation counseling. **1036F**-Current tobacco non-user **4004F with 1P**- Documented medical reasons for no tobacco-use screening. **400F with 8P**- No tobacco screening or cessation intervention performed, reason not otherwise specified.
247: Substance use disorders- counseling regarding psychosocial and pharmacologic treatment options for alcohol dependence	Effective Clinical Care	18 years & older Diagnosis of current alcohol dependence for patients counseled regarding psychosocial and pharmacologic treatment options.	Once during the 12 month reporting period.	90791, 90832, 90834, 90837, 90839, 90845, 96150, 96151, 96152	**4320F**- Patient counseled with psychosocial and pharmacologic treatment. **4320F with 8P**- Patient not counseled with psychosocial and pharmacologic treatment, reason not otherwise specified.

[6] Screening Tools include, but not limited to: Elder Abuse Suspicion Index (EASI), Vulnerability to Abuse Screening Scale (VASS), and Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST).

Appendix A: Glossary

CMS (Centers for Medicare and Medicaid Services): the federal government agency which is part of the Department of Health and Human Services which, among other responsibilities, oversees the Medicare and Medicaid programs

CPT (Current Procedure Terminology): Codes developed by the American Medical Association to designate which medical procedures were used.

Denominator: The eligible cases for a measure or the eligible patient population. Measures for the denominator include the ICD Code or patient demographics (age, gender, etc.) and place of service.

ICD (International Classification of Disease): The codes used to designate the medical condition of a patient.

Measure: One of categories that can be reported on. The categories open to psychologists in 2013 are found in Table 1.

Numerator: The specific clinical action taken as measured by the Quality-Data Codes (G Codes, see definition below).

PQRI (Physician Quality Reporting Initiative): the process by which Medicare rewards providers who voluntarily submit supplementary information on patients. In 2015, it will become a mandatory program.

Quality Data Code (CPT Category II Code or G Code): Codes used to identify whether or not a specific procedure was used or applied

Quality Measure: A metric that permits the calculation of the percentage of the patient population that receives a particular process of care or particular outcome, based on the numerator and denominator.

Appendix B: Partial List of Approved Registries

American Osteopathic Association Clinical Assessment Program	312-202-8198	www.osteopathic.org
CECity	877-509-7774	www.pqriwizard.com
Covisint PQRS	866-823-3958	www.covisint.com
Greenway Medical	877-304-8468	www.greenwaymedical.com
ICLOPS	888-442-5677	www.iclops.com
MedVentive	781-290-2500	www.medventive.com
NetHealth PQRSPRO	610-590-2229	www.PQRSPRO.com
Patient 360	617-715-6898	www.outcome.com/pqrs
PQRS Solutions	866-359-4458	www.pqrssolutions.com
Pulse PQRS Registry	800-444-0882	www.pulseinc.com