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

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While commercial managed care companies are experimenting with or debating pay for performance measures, Medicare has taken a unique approach through its Physician Quality Services System (PQRS; formerly called PQRI). This is currently a bonus program. In 2013 and 2014, psychologists (and other professionals) who participate will receive an incentive payment equal of .5% of allowed charges. Starting in 2015 it shifts to a penalty program and professionals who do not participate will have payments for all services reduced by 1.5% in 2015 and 2% in 2016. It is especially important that psychologists who currently do not participate begin to do so in 2013 to avoid the 1.5% reduction in 2015, which will apply even if they participate in 2014 or later. It is estimated that only about 3% of psychologists currently participate in this program.

The goal of the 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 they failed to conduct a suicide screening with a patient who had a Major Depressive Disorder without any penalty, inquiry, or additional oversight involved. The program is limited to Fee-For-Service Medicare and does not apply to those services to patients in the Medicare Advantage programs.

Getting Started

[1] We express appreciation to Diane Pedulla of the APA Practice Organization for her detailed review of this article and for providing invaluable resources.

We found it difficult to understand the process, but now that we have a basic grasp of it, we think it can be doable without too much difficulty. We are going to present what we understand about PQRS as clearly as we can. In addition, Dr. Sheri Groat-White, a geropsychologist in Exton, PA, has agreed to participate in the PQRS program and will report on her progress in navigating this system and we will report on her progress. However, we caution that there may be glitches that we have not anticipated. .

The entire reporting procedure can be summarized in one sentence: pick 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 1.

The first step in the PQRS process is for psychologists to 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 can currently use are found in Table 2. 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 3 includes more detailed information on the measures and the conditions under which they can be used. However, readers should use Table 3 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.

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 bottom of the page and click on "2013 PQRS measures Specification Manual." They need to press "Accept" on the disclaimer page and then 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 386 to 388 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.

Then psychologists 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 173 (unhealthy alcohol use screening), 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: 9 (Major Depressive Disorder: Antidepressant Medication during Acute Phase); 106 (Adult Major

Depressive Disorder: Comprehensive Diagnostic Evaluation); or 107 (Adult Major Depressive Disorder: Suicide Risk Assessment).

Psychologists can report individual measures by submitting at least three applicable measures that will impact the clinical quality within the practice. Psychologists do not have to report three measures, but must report at least one. However, if they report less than three measures, they may be subject to an additional inquiry to determine if they are eligible for the bonus payment. It is recommended that psychologists make every effort to select three measures.

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. The numerator refers to the service that is being provided to the patient. The denominator refers to the class of the patient. For example, if a psychologist is treating an older adult with depression, then the status of being a depressed older adult would be the denominator. If the psychologist were to screen that older adult for elder maltreatment, then that screen would be the numerator. It can be viewed visually in the Figure 1 below.

Figure 1

<u>NUMERATOR: Intervention (e.g., screening for maltreatment)/ CPT/Quality Data Code</u>

DENOMINATOR: Class of individual (e.g., older adult)/ICD Code (if applicable)

The numerator above refers to a Quality Data Code (either or both a CPTII or a "G" Code). The Quality Data 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.

The Quality Data Codes are linked to the CPT Code. For example, it would be expected that a psychologist would use measure 181 (elder maltreatment screening) at intake. Nothing prohibits a psychologist from conducting additional screenings later. However, psychologists are not expected to do this screening in every session. In contrast, it is more likely that a psychologist would use measure 130 (reviewing medications) at every visit.

As a practical matter, a psychologist who selected three measures related to Major Depression Disorder would likely print out the Quality Data Codes related to the measures of Depression Disorder and have the pages conveniently available for reference. In addition, it may be convenient for psychologists to develop a special office form or checklist for their personal use for every eligible patient and document as to whether the Quality Data Code was used. We are experimenting with some forms now, but nothing stands out as especially useful or creative other than a simple listing of patients name, CPT Code, whether a particular G Code needed to be used, and which one.

There are four ways to report the data: claims-based reporting, registry-based reporting, electronic health record based reporting, and group practice reporting. 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) on their claims form. We found one most useful document for understanding billing to be *Claims made submission made easy*: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PQRSSatisfRprtngClaims-ICN907868.pdf;. An example of the relevant portions of the claims form is shown in Figure 2. 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 either1, 2, or 12. On Line 24F of the form, the QDC 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 http://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2013_PQRS_IndClaimsRegistry_MeasureSpec_SupportingDocs_12192012.zip, click on accept (for the disclaimer) and then enter or download the pdf file. Page 386 of that file reports on measure 181. The denominator refers to all patients who are 65 years old or older. The numerator refers to "patients with a documented elder maltreatment screen on the date of the encounter and follow-up plan documented on the date of the positive screen" (p. 386). The following page includes a detailed description of elder maltreatment. CMS has a list of specific screening instruments mentioned for some measures, but not for this screening. The screening for elder abuse does not necessarily have to be a formal questionnaire. It could be a series of questions unique to the individual. However, it should cover all of the components of elder maltreatment as found in the description in the manual in the website. 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. It is recommended 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 Medicare's Physician Quality Reporting System website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/30_educational%2520resources.asp which has resources to help understand the incentive program.

In trying to learn about the reporting system we participated in a webinar with Dr. Paula Hartman-Stein (www.centerforhealthyaging.com) and found it very helpful. 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 One: PQRI Step by Step

1. Read over the article to get an overview of the PQRI and how it works.

2. Select which measures would be most appropriate for your practice. We recommend that you select at least three measures. 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.

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 Two: 2013 Measures Open to Psychologists

9	Major Depressive Disorder: Antidepressant Medication during Acute Phase[2]
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
173	Unhealthy Alcohol Use Screening
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)

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

Table Three: Quick Summary of Measures[3]

Measure	Eligible	Procedure Codes	Diagnosis	When Reported
9- MDD antidepressant medication	18 + and new episode of diagnosis of MDD[4]	90791, 90832, 90834, 90837, 90839, 90845, 90849, 90853	YES- MDD	"each occurrence of MDD during the reporting period"
Q106 MDD comprehensive depression evaluation	18 + and diagnosis of MDD	90791, 90832, 90834, 90837, 90839, 90845,	YES-MDD	"Once per reporting period"
107MDD suicide Risk assessment	18 + and diagnosis of MDD	90791, 90832, 90834, 90837, 90839, 90845,	YES-MDD	"Once per reporting period"
128 BMI Screening[5]	18 +most recent BMI "outside of normal parameters"	90791, 90832, 90834, 90837, 90839,	NO	"once per reporting period"
130 Documentation of Current Medications[6]	18+	90791, 90832, 90834, 90837, 90839	NO	"each visit"
131 Pain Assessment and Follow-Up[7]	18+ with documentation of pain assessment and follow-up	90791, 96150	NO	"each visit"
134- Preventive Screening Clinical Depression[8]	12+	90791, 90832, 90834, 90837, 90839	NO	"once per reporting period"
173- Unhealthy alcohol use[9]	18 + screened within last 24 months	90791, 90832, 90834, 90837, 90839, 90845, 96150, 96152	NO	"once per reporting period"
181 Elder Maltreatment[10]	65+	90791, 96116, 96150	NO	"once during the reporting period"
226 Screening Tobacco Use	18 +	90791, 90832, 90834, 90837, 90839, 90845, 96150, 96151, 96152	NO	"once per reporting period"
247 Counseling re: Treatment for Alcoholism	18 + diagnosis of current alcohol dependence	90791, 90832, 90834, 90837, 90839, 90845, 96150, 96152	YES 303.90, 303.91, 303.92	"once per reporting period"
248 Screening for depression among patients with SA	18 + diagnosis of SA screening for depression in last 12 months	90791, 90832, 90834, 90837, 90839, 90845, 96150, 96152	YES 303.90 to 305.92	"once per reporting period"

[3] This is a quick summary to help psychologists decide which measures to consider. It is NOT a substitute for looking at the full description of measures as reported in CMS documents.
[4] And documented treatment with antidepressant medication during 12 week acute treatment phase
[5] LT 23 or GT 30; age 18-64, LT 18.5 or GT 25
[6] Include herbal, over the counter, nutritional supplements, and prescription,
[7] Specific screening instruments named, although others may be used
[8] Specific screening instruments named, although others may be used
[9] Referred to NIAAA publication
[10] Specific features described in document

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.