SPECIAL REPORT TO THE MEMBERSHIP

A Primer on How to Participate in Medicare's REQUIRED 2013 Physician Quality Reporting System (PQRS)

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Introduction & Disclaimer:

Medicare reimbursement for many outpatient services has changed in a manner affecting us all. Since 2007 the Medicare program has offered bonus incentives for providers willing to participate in their Physicians Quality Reporting System. Such participation involved the systematic recording of quality measures on certain parameters selected by CMS. To date it is estimated only 3% of Psychologists have participated in the program. 2013 brings a critical change for instead of the PQRS program being optional, it is now **REQUIRED** for all Medicare providers. **If you don't participate in this program, you will be fined monies beginning in 2015 for work done in 2013 (1.5% per session) and the payment penalties in 2016 for work done in 2014 will be 2.% per session.**

If you are a Medicare provider, you must learn how to participate in the program, how to measure their designated quality indicators, and how to properly file your claim forms in 2013 in order to avoid future automatic penalties. Providers can locate this information on the CMS website and wade through 637 pages of Medicare program regulations contained in the document entitled "2013 Physician Quality Reporting System: Claims/Registry Measure Specifications Manual". Those who render neuropsychological services will find additional information that pertains to them in the companion "2013 Physician Quality Reporting System: Getting Started with Measures Groups". If you are a member of APAPO, the most recent publication of **Good Practice (Winter 2013)** contains a very informative article on these new requirements. Diane Pedulla, Medicare Compliance Specialist of the APAPO and other APAPO staff members have prepared some excellent materials to assist us, proving once again the value of being a member of APAPO!

As a service to our membership, some of whom are not APAPO members, the following primer is prepared in the hope of clearly informing you of what you need to do (or not do) in order to participate in the program and how to do it, from selecting measures and methods to

the nuts and bolts of filing a claims form. We hope this primer is of assistance to our members. Operating details on these types of programs change rapidly. As such, this advisement is provided as a primer and not the final authority on these matters for we anticipate future changes as the required program unfolds. The information contained in this primer is intended to be informative and does not supersede CMS regulations on these matters. The ultimate responsibility of the validity, utility and application of information contained in this primer lies with the individual, not with TPA or the author of this primer. Make sure you watch for future advisements from TPA on these matters as we will try to keep you abreast of developments.

To Be or Not To Be a Medicare Provider

Some of our members are tiring of the continuous problems with Medicare and its threatened wage cuts year and year. They believe, probably correctly, that Medicare rates to providers will be increasingly cut as health care reform evolves. They believe, probably correctly, that participation in the PQRS program will increase the probability of being subjected to a Medicare audit. The threat of payment penalties feels like the "last straw" for them and as such, they are considering dropping out of the Medicare program.

Keep in mind that if you are a Medicare provider and the patient has Medicare, you have to take their Medicare, even if you've been treating them as a fee-for-patient for the last two decades or more. You can contract with Medicare patients privately if you have never been a Medicare provider. You can also formally drop out of the Medicare program. You **must** officially drop out of the Medicare program if you've been in it **before** you can see a Medicare patient on a private contract. To remove yourself from the program, you must contact the Medicare Administrative Contractor of your area (West Tennessee has a different administrator than East Tennessee) and get the proper forms for you to prepare your affidavit withdrawing from the program. Moreover, you must remind Medicare every two years you are no longer interested in being a Medicare provider. Lastly, once removed, you need a properly drawn contract with your patient that indicates they know they could use their Medicare to see another Medicare- eligible provider but of their own free will, they want to see you, the non-Medicare participating provider, and lastly, the patient knows they will incur costs from you that Medicare will not reimburse.

What Kind of Medicare and How Many Patients Do I Need to "Measure"?

The PQRS program applies to fee-for-service Medicare plans and does **NOT** apply to Medicare Advantage Plans. You may ask "what is a Medicare Advantage Plan" in Tennessee? It is easier to answer the question by reminding you that "fee-for-service Medicare plans" are the old fashion Medicare products with the red-white-and blue identification cards. The new Medicare products offered by BCBS, UBH, Humana and others are **NOT** included (at this time) in the PQRS program. So keep in mind the program applies to **ONLY a certain kind** of Medicare patient, be it the primary or secondary insurance you patient is using.

You are expected to "measure" at least fifty (50%) of your "applicable Medicare cases", which is an unspecified term at this point in time. Those performing neuropsychological services must report from the Measures Groups for Dementia on at least unique 20 patients (more on that later). There are only 13 individual PQRS Measures (kinds of problems or categories being assessed) that apply to most Psychologists at this time from a list of over 300 different types of health related problems. Anxiety is not one of the problem areas. Does that mean your patients with anxiety disorders do not count in your total N being seen? While 50% is the cut-off figure, the most prudent course of action is to do PQRS measures on all of your Medicare patients. In a few years it will be for all 100% of your Medicare cases so you might as well get started now.

For now, understand that you MUST report on at least one (1) PQRS Measure one time during calendar year 1/1/13-12/31/13 in order to avoid penalties in 2015 and beyond. In order to be eligible for bonus payments, you must report on fifty percent (50%) of program-eligible patients from a fee-for-service Medicare plan. You can begin reporting anytime in 2013 but the sooner the better. If you wait too long, you may run out of calendar time for meeting that 50% requirement.

The Dreaded Medicare Audit

Will you be audited to see if you really did participate in the PQRS program? Absolutely. If you choose to be in the program, you **MUST** make sure your documentation in the patient's chart and billing records matches what you submit on your claims forms. If you said you measured some of the PQRS parameters, then your chart should contain the methods and data you used to execute these measures, dates you performed the service, and other supportive documentation in the chart. **Make sure you use the new CPT codes, use them accurately, and literally record the exact time you started and ended the session. Some measures, like Assessment of Suicide, REQUIRE certain documentation in the chart.**

THE PQRS PROGRAM FOR PSYCHOLOGISTS: GETTING STARTED

Okay, you've decided to stay with Medicare and join the PQRS program. How do you do "sign up"? There are four ways to sign up and report PQRS data: claims forms, electronic health records, registry participation or a Group Practice Reporting Option. Since most of us will report our PQRS data via the claims process, this primer is restricted to the claims reporting option.

You do not have to formally enroll in the program. When you list the Quality Data Codes on your claims forms you submit for payment (to be discussed later), listing those codes trips the PQRS reporting wire and you are now "in" the program. You can list QDC numbers on twelve of the 13 PQRS Individual Measures currently applicable to Psychologists (not counting the Group Measures for Dementia for those rendering neuropsychological services).

PQRS Measure #325 CAN ONLY be reported by those using a registry to report their PQRS data (registry reporting is typically done for high volume physical disorders; as such, it is unlikely a mental health provider, especially in solo or group practices, are going to report PQRS measures via registry reporting vs. the other available options).

The program currently contains over 300+ health related categories but only a handful of these apply to Psychologists. Generally speaking, there are 13 health related categories that are potential candidates for Psychologists to select in deciding what health problems to "measure". There are also PQRS Group Measures for Dementia #280-288 involving neuropsychology services which are addressed later in this primer. For the vast majority of us, it is these 13 problem areas that are of interest to you. Those 13 areas are listed below. The PQRS program calls all of these areas "Measures" and gives them an assigned number:

1) Major Depressive Disorder: antidepressant medication during acute phase (PQRS #9)
2) Major Depressive Disorder: diagnostic evaluation (PQRS# 106)
3) Major Depressive Disorder: suicide risk assessment (PQRS # 107)
4) Body Mass Index (PQRS #: 128)
5) Documentation and verification of current medications in the medical record (PQRS#130)
6) Pain assessment prior to the initiation of pain treatment (PQRS #131)
7) Screening for clinical depression (PQRS # 134)
8) Unhealthy alcohol use (PQRS #173)
9) Elder maltreatment screen and follow-up plan (PQRS # 181)
10) Preventive care and screening: tobacco use—screening & cessation intervention (PQRS#226)
11) Substance use disorders- counseling regarding psychosocial & pharmacologic treatment options for alcohol dependence (PQRS # 247)
12) Substance use disorders –screening for depression among patients with substance abuse or dependence (PQRS #248)
13) Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions (PQRS #325)

These 13 problem areas are the only ones you are expect to "measure". How often you "measure" varies, depending on the problem area. PQRS #9, #130, and #131 must be reported for each visit; for the other ten areas the "reporting period" varies from either once every six months or once a year. To make things simple, it is recommended you utilize a method of measurement for #9, #130 and #131 for each visit and for the other 10 areas, one measurement method every six months.

How Many PQRS Measures of the 13 do I choose?

CMS says you have to pick at least one measure but recommends you choose three of them, in accordance with the nature of your practice. **Pick any three that fits your practice but we strongly recommend you pick three.** It does not have to be three measures per patient; just 3 of the 13 areas across all of your patients. For some you'll track medications every time.

You may have only one patient with alcohol concerns and only one with suicidal concerns. Those three areas, suicide concerns and medication tracking and alcohol use total three areas you've measured over the year.

Can I charge CMS for participation in the PQRS Program?

No. The manual says you can list a charge of 0.00 or 0.01 on your claim form but Diane Pedulla tells us that the computer payment programs of some vendors will not honor the 0.00 charge, resulting in a rejected claim. It is recommended you list a charge of 0.01 for the reporting of your QDC information, knowing you may not get paid that fee (but at least you won't have to resubmit the claim).

Okay, I have picked the three PQRS Measures I will use. Now what?

Each of these 13 areas of concern have their own "reporting period" requirements. Some PQRS Measures have prescribed methods of measuring the variable you have selected. For some of these 13 variables, the manual says the "methods of screening tools include but are not limited to", giving the impression of flexibility in measurement methods, while recommending certain instruments for a particular area of concern. For other problem areas, no specific measurement method is recommended.

For each of these areas, after you have made your assessment of the PQRS Measure # in question, you are to select the appropriate quality code (which is a G Code or a CPT II code or both that you are going to list on your claims form) that cues CMS into the fact that you have conducted your assessment of this specific PQRS Measure. You MUST list either a G Code or CPT II Code # or both a G Code AND a CPT II #, depending on the PQRS measure and what you did, ON YOUR CLAIM FORM IN ORDER TO GET PAID AND TO INDICATE YOU ARE PARTICIPATING IN THE PROGRAM. Do not confuse the Quality Data CPT II Codes with your regular CPT procedure codes. It is unfortunate CMS used a similar term for it might confuse you. As you go through the thirteen PQRS measures you will see that most of the time you will be listing a G Code.

By now you may be starting to get overwhelmed. Pause a moment, breathe, you are almost there in understanding the program. You are now ready to review the 13 areas of focus, known as PQRS measures, while correspond to some but not all DSM-IV diagnoses**. Notice as you go through this summary of these PQRS measures the diagnostic and Quality Data Codes. The diagnosis identify which DSM-IV diagnosis is applicable to the measure, applies (i.e., note that in #9 it takes about MDD but 300.4 and 311.00 are additional diagnoses you can assess with this particular PQRS measure). The Quality Data Codes are key for that is how you are going to tell CMS you are participating in the program, what you did or did not do, and the code you need to list for payment. Note that there are a few "special scoring rules" at the end of this summary, known as "diagnostic pointers".**

Here now are your 13 PQRS measures of interest, and the G Codes or CPT-II Codes you need to get paid. You may want to copy this primer and put this document somewhere because you'll be referring to it often in order to get the proper PQRS Measures & Quality Data Codes for payment.

A SUMMARY OF YOUR 13 PQRS CODES: SELECT THREE OF THEM

PQRS Measure #9: MDD: Antidepressant Medication During Acute Phase for Patients with MDD (For adults, 18 and older, with a diagnosis of a new episode of MDD. Patient must have a diagnosis of 296.20, 21, 22, 23, 24 30, 31, 32, 33, 34, 35; 298.0; 300.4; 309.0; 309.1; 311)

Reported for each occurrence of MDD during the reporting period. We recommend making a formal measurement once every six months (your "reporting period"). No specific method of identifying the diagnosis is specified although in later sections CMS recommends use of these methods:

(a) 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), and Prime MD-PHQ2

(b) Adult Screening Tools (18 years or older): 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-PQH2.

A New Episode is defined as a "patient with major depression who has not been seen or treated by any practitioner in the prior four months. A new episode can either be a recurrence for a patient with prior major depression or a patient with a new onset of major depression".

<u>Quality Data Codes</u>: Pick one of these 3 G Codes for your claims form:

G2186 Patient with <u>new episode of MDD</u> (new episode means Patient was not treated by ANY practitioner during the past 4 months or MDD recurred after a 4 month remission period) AND <u>documented as being treated with antidepressant medication.</u>

OR

G8128 Patient with new episode of MDD AND not was not an eligible candidate for antidepressant medications OR Patient did not have a new episode of MDD (whether or not they were treated with antidepressants).

OR

G8127 Patient with a new episode of MDD AND NOT documented as being treated with antidepressant medication

Measure 106

Measure 106: Adult MDD: Comprehensive Depression Evaluation: Diagnosis & Severity (For all adults, 18 and older, with active diagnosis of MDD, including episodes that began prior to reporting period. Patient must have a diagnosis of 296.20, 21, 22, 23, 24 30, 31, 32, 33, 34)

Reported a minimum of once during a reporting period. We recommend your reporting period to be once every six months.

Methods of assessment include "PHQ-9 and other validated tools based on DSM-IV-TR criteria" for MDD. Remember that CMS previously referenced methods for assessing depression:

(a) 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), and Prime MD-PHQ2

(b) Adult Screening Tools (18 years or older): 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-PQH2.

Quality Data Codes: Must have one CPT II Code AND one G-Code on the claim. Pick one of the three below:

CPT II 1040F: criteria for major depression documented at initial evaluation **AND**
G8930 Assessment of depression severity conducted at the initial evaluation

OR

CPT II 1040F with 8P: criteria for major depression NOT documented at initial evaluation and reason not otherwise specified

OR

G8931 Assessment of depression severity not documented, reason not given

Measure 107

Measure 107: Adult MDD: Suicide Risk Assessment (For adults, 18 and older, with MDD, new or recurrent episode. Patient must have a diagnosis of 296.20, 21, 22, 23, 24 30, 31, 32, 33, 3.)

Reported a minimum of once per reporting period for patients with MDD. Required diagnosis of MDD and CPT procedure codes: 90791, 90792, 90832, 90834, 90839, 90845.

Methods for suicide assessment in this section refer to the American Psychiatric Association's 2010 Practice Guidelines for Assessment and Treatment of Patients with Suicidal Behaviors. Create your own form that covers the parameters mentioned in these guidelines or use a standardized measure that assesses suicidal risk domains. **YOUR SUICIDAL ASSESSMENT OF YOUR PATIENT MUST INCLUDE: (1) suicidal ideation, (2) patient's intent of initiating a suicide attempt AND if either is present, (3) patient's plans for a suicide attempt, and (4) whether the patient has the means for completing suicide.**

Quality Data Codes: Pick one of these codes for your claims form

G8932 Suicide risk was assessed at the initial evaluation

OR

CPT II 3092F Major Depressive disorder in remission

OR

G8933 Suicide risk was not assessed at the initial evaluation, reason not given

Measure 128

Measure 128: Body Mass Index Screening. For patients 18 years and older with a BMI in the last six months "outside of normal parameters."

Normal parameters are defined for persons 65 or older as BMI greater than or equal to 23 and less than 30 and for those 18-64, BMI is greater than or equal to 18.5 and less than 25. It is to be reported once per reporting period.

The Procedure Codes that can be used with this are 90791, 90792, 90832, 90834, and 90839. No specific methods are mentioned for this measure.

Quality Data Codes: Pick One of These G Codes:

G 8420 Calculated BMI within normal parameters and documented **OR**
G8417 Calculated BMI above normal parameters and follow-up plan was documented **OR**
G8418 Calculated BMI below normal parameters and follow-up plan was documented **OR**

OR

G 8422 Patient not eligible for BMI calculations **OR**
G 8938 BMI calculated but patient not eligible for follow-up plans **OR**

OR

G 8421 BMI not calculated **OR**
G8419 BMI outside normal parameters, no follow-up plans documented

Measure 130

Measure 130: Documentation of Current Medication in the Medical Record (For all adults, 18 and older, no matter what their diagnosis. Clinicians attest to the best of their ability that their record contains a list of all medications and supplements that the Patient is taking and includes the medication name, dosage, frequency, and route of administration. **Measure is to be reported at each visit.)**

Medications refers to over-the-counter, herbal, and prescription medications with the name, dosage, frequency, and administrated route noted. The information should be "current,

accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter."

It is recommended that your method of assessment is to create your own medication log that you review for each appointment and have the patient countersign your log.

Quality Data Codes: Pick One of these G Codes:

G8427 Attestation that list of Patients' current meds is documented

OR

G8430 Current meds are not documented because Patient is not eligible for medication

OR

G8428 Current meds with name, dosage, frequency, route are not documented, reason not given

Measure 131

Measure 131: Pain Assessment and Follow-up (for patients 18 and older with documentation of pain assessment including the use of a standardized tool **on each visit** and documentation of a follow-up plan when pain is present).

Standardized Tools listed by CMS could be, but are not limited to: Brief Pain Inventory, Faces Pain Scale, McGill Pain Questionnaire, Multidimensional Pain Inventory, Neuropathic Pain Scale, Numeric Rating Scale, Oswestry Disability Index, Roland Morris Disability Questionnaire, Verbal Descriptor Scale, Verbal Numeric Rating Scale, and Visual Analog Scale

Quality Data Codes: Pick the appropriate one for your claims form

G 8730: Pain assessment is documented as positive utilizing a standardized tool AND a follow-up plan is documented

OR

G 8731 Pain assessment documented as negative, no follow-up plan required

OR

G 8442 Documentation that patient is not eligible for a pain assessment

OR

G 8939 Pain assessment documented, follow0uppolan not documented, patient not eligible/appropriate

OR

G 8732 No documentation of pain assessment, reason not given

OR

G8509 Documentation of positive pain assessment no documentation of a follow-up plan, reason not given

Measure 134

Measure 134: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan (For persons 12 and older. The measure is to be reported on once per reporting period; six months is recommended reporting period. Patient can have any diagnosis.)

This PQRS Measure lists those depression screening instruments cited earlier for possible use by you:

(a) 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), and Prime MD-PHQ2

(b) Adult Screening Tools (18 years or older): 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-PQH2.

<u>Quality Data Codes:</u> Pick one for your claims form:

G8431 Positive screen for clinical depression AND a follow up plan is documented

OR

G8510 Negative screen for clinical depression, follow up not required

OR

G8433 Screening for clinical depression not documented, patient not eligible/appropriate

OR

G8940 Screening for clinical depression documented follow up plan not documented, patient not eligible/appropriate

OR

G8432 Clinical depression screening not documented, reason not given

Measure 173

Measure 173: Preventive Care and Screening: Unhealthy Alcohol Use. Patients aged 18 or older who were screened for unhealthy alcohol se using a systematic screening method within 24 months. It is to be used once per reporting period; six month reporting period recommended. No specific diagnosis is associated with this PQRS measure.

While no specific methods are mentioned, CMS does reference The National Institute on Alcohol Abuse and Alcoholism publication, *Helping Patients Who Drink Too Much: A Clinician's Guide* includes additional information on systematic screening. Some sort of "systematic method of assessing for unhealthy alcohol use should be utilized". Choose the instrument you prefer for conducting this Unhealthy Alcohol Use assessment.

Quality Data Codes: Pick One for Your Claims Form

CPT II 3016F: Patients screened for unhealthy alcohol use using a systematic screening method

OR

3016F with IP: Documentation of medical reasons for not screening (such as limited life expectation or other reason)

OR

3016F with 8P Unhealthy alcohol use screening not performed, reason not otherwise specified

Measure 226

Measure 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention. Patients aged 18 or older were screened for tobacco use one or more times within 24 months AND receives tobacco cessation counseling if they used tobacco.

It is to be used once per reporting period which is recommended to be once every six months. The intervention must be at least 3 minutes long.

Quality Data Codes: Pick One for Your Claims Form:

CPT II 400 4F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy or both) if identified as a tobacco user.

OR

CPT II 1036 F: Does not use tobacco

OR

CPT 4004F with IP: Documentation of medical reasons for not screening for tobacco use (limited life expectancy, other medical reason)

OR

4004F with 8P: Tobacco screening or tobacco cessation intervention not performed, reason not specified.

Measure 247

Measure 247: Substance Abuse Disorder: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence.

Patients aged 18 or older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatments within the 12 month reporting period. Should have an ICD-9 diagnostic code of alcohol dependence (303.90, 303.91, 303.92)

Methods here included documentation of pharmacotherapies for alcohol-dependent patients and psychosocial treatments such as motivational enhancement therapy, cognitive-behavioral

therapy, behavioral therapies, 12-step facilitation, marital and family therapies, group therapies, and psychodynamic therapy/interpersonal therapy.

Quality Data Codes: Pick One for Your Claim Form

CPT II 4320F: Patient counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence.

OR

CPIT 4320F with 8P: Patient not counseled regarding psychosocial and pharmacologic options for alcohol dependence, reason not specified.

Measure 248

Measure 248: Substance Abuse Disorder: Screening for Depression Among Patients with Substance Abuse or Dependence.

Patients aged 18 or older with a diagnosis of current substance abuse dependence seen within the 12 month reporting period. Should have an ICD-9 diagnostic code of alcohol dependence (303.90, 303.91, 303.92) or other substance abuse (304 through 305.92). Reporting period in once every twelve months.

The screening would follow a full diagnostic interview that uses standard diagnostic criteria to determine depressive disorders. See past listing of depressive methods listed for other PQRS measures diagnosing depression. Severity of depression should be addressed.

Quality Data Codes: Pick One for Your Claims Form

CPT II 1220F: Patient screened for depression

OR

1220F with IP: Documentation of medical reason for not screening for depression

OR

1220F with 8P: Patient was not screened for depression, reason not specified

Measure 325

Measure #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions

Measure is to be reported once per reporting period (recommend six months) for patients 18 and older with MDD and a specific diagnosed comorbid condition (i.e., diabetes, coronary heart disease, etc).

Quality Data Codes: Pick One for Your REPORTING ON YOUR REGISTRY: YOU CANNOT REPORT ON MEASURE #325 VIA A CLAIMS FORM; REGISTRY REPORTING ONLY FOR THIS ONE

G8959 Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition

OR

G8960 Clinician treating Major Depressive Disorder did **not** communicate to clinician treating comorbid condition
Points:

KEY FEATURES FOR ALL THIRTEEN PQRS MEASURES:

Age: All of the measures are for patients who are 18 or older except for 173 (elder abuse) which is restricted to persons who are 65 and older and 134 (screening for clinical depression) which is for patients who are 12 or older.

Diagnosis: Measures 9 (anti depressant medication), 106 (depression evaluation), and 107 (suicide risk assessment) are restricted to persons with MDD. 247 (Counseling about treatment options for alcohol dependence) and 248 (Screening for depression among patients with substance abuse or dependence) are restricted to persons with alcoholism or substance abuse disorders respectively. Other measures are not restricted to diagnostic class.

Procedure Code: Psychologists can use any of these measures with 90791. There is considerable variation as to when the measures can be used with other procedure codes.

Frequency of Documentation: All procedures can be reported once per reporting period except for 130 (current medications) and 131 (pain assessment) which must be assessed each visit and 9 (anti-depressant medication) which is assessed once during each episode of Major

Depression. To be on the "safe side", unless the PQRS measure specifically says assess with each visit, then make your reporting period once every six months.

Penalties If I Don't Measure the Category? At this time there is no penalty if you fail to conduct an assessment on the PQRS measure in question hence, there is no penalty if you report a G Code that says "I failed to measure the category".

Specific Methods: CMS does not require specific methods for assessing pain, depression and some of the other categories of the PQRS Measures however, they do give examples. The best course of action is to use one of their suggested methods of measurement.

DOCUMENTATION & RETENTION OF DATA: Make sure you document like you are instructed to do, make in comprehensive, and keep the data you collect in the patient's chart for future audits. You will file claims to CMS but that's it; you don't send them the data you collect, but you keep it in the chart so that you will pass your audit

FILING MY CLAIMS TO GET PAID:

Filing the claims form requires a few extra steps beyond what you do now when filing your claims. Go to the Sample Claims Form provided so you can review it as you learn about how to get paid for participating in the PQRS Program.

Your billing person can also go to the following CMS website to learn how to file claims: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PQESSatisfRprtngClaims-ICN907868.pdf. Here's how you do it:

Imagine your patient is a 68 year old recently widowed, white male evidencing signs of a depressive disorder per reports of his children following the death of his wife of 45 years. He lives alone, has multiple medical problems, and a history of both excessive alcohol use and past depressive disorder. You see him for your initial evaluation and in the first month of care give him two diagnoses: (1) Major Depression, Recurrent, Moderate (#296.32) and (2) Alcohol Abuse #305.00. You've saw him for two individual sessions in January 2013 besides the initial intake appointment and now that January is over, you are filing your claims to get paid.

You submit your claims form—look at the example.

The DSM-IV diagnoses, dates of service, charges, place care rendered and NPI # is listed like you always do. **IMPORANT: Note the use of the new CPT procedure codes –make sure you use the new ones that started in January 2013.**

To participate in the PQRS program, you merely need to add the appropriate Quality Data Codes and Diagnosis Pointers for the PQRS Measures you are using on the dates you made your PQRS assessment, and charge 0.01 for that QDC assessment. In this case the Psychologist used Measures #106, (Adult MDD: Comprehensive Depression Evaluation, Diagnosis and Severity; #107 (Suicide Assessment) and #173 Unhealthy Alcohol Use Screening. The PQRS Measure #106 required BOTH a Quality Data Code of CPT II 1040F Code and a G Code; the #107 Measure required the appropriate G Code and the #173 Measure required a Quality Data Code of CPT II 3016F Code. The exact G and CPT II code per each PQRS Measure is found in aforementioned summary of measures.

By listing these Quality Codes, CMS now knows the provider is participating in the PQRS program. The diagnostic pointer corresponds to your DSM-IV diagnostic codes and the provider has listed two diagnoses. The Quality Data Codes that relate to the MDD diagnosis are given the Diagnostic Pointer of 1, telling CMS that the QDC assessment made is related to the first diagnosis the provider listed. The Diagnostic Pointer of 2 listed on 1/29/13 tells CMS that the CPT II 3016F Quality Data Code is related to the second diagnosis and that the provider assessed for Unhealthy Alcohol Use. CMS recommends using three different PQRS measures and in this example, the provider has done what is necessary to do for the first six months of care.

For most of us, the aforementioned gets you up to speed on the PQRS program. But there is more for those who render neuropsychological services.

NEUROPSYCHOLOGY: SPECIAL REPORTING REQUIREMENTS

The thirteen (13) PQRS Measures described in this primer are individual reporting categories. Some of us also perform neuropsychology services. It is possible you render neuropsychology services for those with Parkinson's, epilepsy, and dementia. Most of our colleagues performing neuropsychology services will find the Dementia Measures most applicable to them. If so, you are going to report on the Group Measures for Dementia when you render neuropsychological services. The reporting requirements for these neuropsychological services differ considerably than the reporting requirements covered for the aforementioned thirteen PQRS measures.

Those Psychologists reporting on this class of PQRS Measures report ONCE a year on the Measures Group for Dementia, generally as a composite measure rather than individual measures, although patient limitations may make it impossible to measure each component of the composite measure. The following PQRS Measures are contained in the Group Measures for Dementia:

280- Staging of Dementia
281-Cognitive Assessment
282-Functional Status Assessment
283-Neuropsychiatric Symptom Assessment

284-Management of Neuropsychiatric Symptoms
285-Screening for Depressive Symptoms
286-Counseling Regarding Safety Concerns
287-Counseling Regarding Risks of Driving
288-Caregiver Education and Support

The reader is referred to the 12/19/12 NAN Professional Affairs & Information Committee Report on the PQRS program. That report is excellent, difficult to improve upon, and NAN is to be commended for that document! **If you perform neuropsychology services and intended to participate in the PQRS program, you need to read that NAN report!**

Some issues worth mentioning to our members:

1) Those reporting Group Measures for Dementia are expected to report on twenty (20) fee-for service Medicare patients across **ALL nine (9)** sub-categories (#280-288). Will you see that many fee-for-service Medicare patients? If not, remember you need to report on at least 50% of **ALL** your fee-for-service Medicare patients, be it on Group Measures for Dementia or the other aforementioned PQRS measures. So, do keep an eye on your fee-for-service Medicare patient count;

2) The Group Measures for Dementia **ASSUMES** a Dementia diagnosis; if a Dementia diagnosis is not present, check to see if you should report on an individual PQRS Measure instead;

3) Many of the Measures listed in #280-288 cite a specific example of the kind of method acceptable to CMS for completing your assessment (i.e., Blessed Orientation-Memory-Concentration Test or Montreal Cognitive Assessment and others for #281; or Lawton IADL Scale or Barthel ADL Index or Katz Index of Independence in ADL for #282; or Cornell Scale for Depression in Dementia or Geriatric Depression Scale or PHQ-9 for #285). **Those performing neuropsychological services should read the exact CMS requirements from pages 162-176 of the 2013 PQRS Measures Groups Specifications Manual to make sure they are using methods acceptable to CMS so that when CMS comes to audit you everything is in order.**

If you don't know how to find that CMS website for the PQRS Measures Groups Specification manual, go to www.go.cms.gov/UmysQS. After accepting their conditions the various documents you want will appear, click on the Group Measures manual, and go to pp. 162-176 to read the kinds of methods for assessment CMS finds acceptable, and ones you should use.

4) If you are performing on Group Measures for Dementia, **you are expected to report on ALL nine sub-categories of this Group Measure.** It can be confusing here because you are expected to report on ALL nine subcategories, yet nine individual sub-categories and their respective G codes are listed for potential reporting purposes. Why list these individual G Codes per sub-category if you are expected to report on ALL nine measures?

You are expected to do the following:

1) When you see the appropriate Medicare fee-for-service patient with a Dementia problem, you send in your Claim Form and report on that claims form, preferably on the first visit the G code that says you are going to report on the Group Dementia Measures like so:

1/15/13	90781	150.00
1/15/13	G8902	Diagnostic Pointer #1 which refers to your Dementia Dx
		Charge 0.01 for G Code 8902 reporting

G Code 8902 = I intend to report on the Dementia Measures Group

The **G Code 8902** tells CMS that you are going to report on the Dementia Measures Group **but you do not have to conduct all nine assessments on that first appointment**. You can take your time per the patient's condition.

Then you conduct your typical Dementia evaluation. Fortunately, a competent neuropsychological evaluation usually covers these nine categories so you will go about your usual clinical work and at the end of it, on your claim form, ASSUMING you have covered ALL nine categories, you will list the following composite G Code on your claim form:

G Code: 8761: All quality actions for the applicable measures in the Dementia Measures Group have been performed for this patient.

IN SHORT, MOST OF THE TIME WHEN YOU REPORT ON THE MEASURES GROUP FOR DEMENTIA YOU ARE GOING TO REPORT TWO CODES ON YOUR CLAIMS FORM:

G Code: 8902 (I intend to report on the Dementia Measures Group) and
G Code: 8761 (after all nine categories assessed, you report you have collected data on all nine measures via the composite G Code listing). Charge 0.01.

Your 20 patients required for the Group Measures for Dementia assessment MUST result in twenty patients you have successfully assessed on ALL nine sub-categories. IF YOU SKIP OR CANNOT COMPLETE ONE OF THE NINE SUB-CATEGORIES, YOU CANNOT GIVE A COMPOSITE SCORE AND INSTEAD, YOU'LL HAVE TO REPORT ON EACH SUBCATEGORY INDIVIDUALLY WITH THE APPROPRIATE G-CODE PER SUB-CATEGORY.

What if you can't give a composite score because the patient was not able to complete ALL nine (9) subcategories? For those patients you report the G8902 "intend to report code" AND the individual G Codes listed for each sub-category. When you review the CMS manual, you will see that there are G Codes for those situations when one or more of the nine sub-

categories could not be formally assessed due to the patient's condition. THE COMPOSITE SCORE ASSUMES YOU COULD ASSESS ALL NINE SUB-CATEGORIES; IF YOU CAN'T, LIST THE INDIVIDUAL G-CODE PER CATEGORY #280-288 AS LISTED IN THE CMS INSTRUCTIONS. Your 20 required cases requires assessments on all nine subcategories and if you could not assess the patient on a particular subcategory, then that particular patient does not "count" towards your twenty patient reporting requirement, but you could still be eligible for bonus incentives since you did do the work (you are not penalized because the patient or you could not complete a particular sub-category).

Lastly, make sure you have the data and documentation in the patient's chart for all of the Measures and sub-categories you have or have not assessed.

We hope this primer is of assistance to you. If we can be of any further help on this subject, please do not hesitate to contact TPA (901-372-1015, tpamember@juno.com) or myself directly (865-584-8547 or LANCETL@aol.com).

LTL
January 2013

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY

ZIP CODE TELEPHONE (Inclu ( )

9. OTHER INSURED'S NAME (Last Name, First Name

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M

c. EMPLOYER'S NAME OR SCHOOL NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

READ BACK OF FORM BEFOR

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE to process this claim. I also request payment of governm below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) INJURY (Accident) OR PREGNANCY(LMP)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

DE LAB? ES NO $ CHARGES

21. DIAGNOSIS OR NATU OR INJURY (Relate Items 1, 2, 3 o

ID RESUBMISSION ORIGINAL REF. NO.

1. 296.32

3.

UTHORIZATION NUMBER

2. 305.00

4.

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B PLAC SER ES, OR SUPPLIES stances) JODIFIER E. DIAGNO POINTE S. G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #

1	01 15 13	01 15 13	11	90781			150.00	1		NPI	Provider NPI #
2	01 15 13	01 15 13	11	CPT 11 1040F C8932		1	0.01	1		NPI	Provider NPI#
3	01 22 13	01 22 13	11	90834			110.00	1		NPI	Provider NPI#
4	01 29 13	01 22 13	11	90834			110.00	1		NPI	Provider NPI#
5	01 29 13	01 29 13	11	CPT 11 3016F		2	0.01	1		NPI	Provider NPI#
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $ 370.02

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI

33. BILLING PROVIDER INFO & PH # ( )

a. NPI

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

IN FILING YOUR CLAIMS WITH CMS:

Listing dates of services, outpatient office, CPT Procedure Codes, charges, NPI # and other usual and customary billing items remain the same. Two things change:

1) You must add a modifier in the diagnosis pointer section on the form which refers to the specific diagnosis which justifies the procedure code. Your billing person will select the proper modifier.

2) Depending on the PQRS Measures, you must add either (1) your G Code OR (2) your CPI II Code # OR (3) BOTH your G Code AND CPT II Code with the date you made the assessment and charge 0.01 for your work. CMS permits a charge of either 0.00 or 0.01 for the Quality Codes but some carriers won't take the 0.00 charge so make your charge 0.01

Your DSM-IV Dxs

List Quality Codes on the date you rendered the assessment for the PQRS Measure you've chosen and charge 0.01 for this work

Outpatient Office

NEW CPT Procedure Codes

Correct Modifier