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PracticePerspectives

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Reporting PQRS Measures for Medicare in 2013

NASW encourages clinical social workers who are Medicare providers to participate in the 2013 Physician Quality Reporting System (PQRS). Doing so not only increases practice revenue by .5 percent, but helps clinical social workers avoid a 1.5 percent penalty in 2015 for not using measures in 2013.

Background

PQRS was established by the Tax Relief and Health Care Act of 2006 (TRHCA). It is a voluntary quality reporting system for Medicare providers and was first implemented during the period of July 1, 2007 through December 31, 2007. PQRS is formerly known as PQRI (Physician Quality Reporting Initiative).

Current Program

The final rule of the 2013 Medicare Physician Fee Schedule continues PQRS for 2013 and includes a .5 percent bonus incentive payment of the total allowed charges for Medicare covered services performed by each provider. Although participation in PQRS for 2013 is optional for clinical social workers and other Medicare providers, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made PQRS a permanent program. Medicare is converting to a value-based purchasing system. Beginning in 2013, clinical social workers and other providers will be subject to a penalty when they do not report performance measures. 2014 will be the last year clinical social workers and other Medicare providers will receive a bonus incentive for participating in PQRS. Because PQRS varies each calendar year, clinical social workers must become familiar with the rules and regulations of this program annually.

Measures

PQRS identifies specific measures that may be used by clinical social workers in independent private practice to improve the quality of care provided to Medicare beneficiaries. These measures are standards of care based on evidence-based practices. For 2013, there are a total of 259 available performance measures. Clinical social workers have access to 11 individual measures and no measure groups. Although Medicare providers have the options of reporting measures by claims, electronic health records, registry, or measures groups, claims reporting appears to be the best method of reporting measures for clinical social workers who are independent practitioners in solo or group practice. Clinical social workers should select individual measures that best describe the services provided in their private practice. 2013 PQRS measures available for use by clinical social workers include:

PQRS Number	Measure Descriptions
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
106	Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity
107	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
130	Documentation of Current Medications in the Medical Record.
131	Pain Assessment and Follow-Up
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
173	Preventive Care and Screening: Unhealthy Alcohol Use-Screening
181	Elder Maltreatment Screen and Follow-Up Plan
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
248	Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence

Instructions

For 2013, PQRS claims reporting is the best method to report measures for clinical social workers in solo or independent private practice. Clinical social workers do not need to sign-up nor pre-register to participate in PQRS. Participation in PQRS is indicated by reporting quality data codes (QDCs) on the CMS-1500 Form during the 2013 reporting period. QDCs vary for each measure. A summary of instructions is as follows:

- **Reporting period:** PQRS measures should be reported during the 12 month period of 2013. A brief delay in getting started should not interfere with successful reporting in 2013.
- **Selecting a measure:** For 2013, select an individual measure(s) from the list above that best describes the services provided in your private practice. Report at least three measures. If less than three measures apply to your Medicare patient population, you may select one to two measures to report for 2013. Make sure that the measure applies to the patient.
- **Reporting criteria:** Report your chosen measure(s) for 50 percent or more of your Medicare beneficiaries seen during the reporting period of 2013.
- **Claims reporting:** Participation in the 2013 PQRS is indicated by reporting QDCs on the CMS-1500 form. The QDC is reported directly below line 24D under the primary psychotherapy service code.
- **Where to find quality data codes:** It is important to follow the measure specifications for reporting the appropriate quality data codes. You may download the 2013 PQRS Measures Specification Manual at the following link: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html. To assist you in your search, below you will find a summary of quality data codes for each of the measures listed above.

2013 PQRS Measures for Clinical Social Workers

Measure 9. Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD. Percentage of patients aged 18 years and older diagnosed with new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase.

- This measure should be reported for each occurrence of MDD during the reporting period
- In order to use this measure, patient must have one of the following diagnosis for MDD: 296.20, 296.21, 296.22, 296.23, 296.24, 296.25, 296.30, 296.31, 296,32, 2969,33, 296,34, 296.35, 298.0, 300.4, 309.0, 309.2. 311.
- Choose a QDC to report for all patients with a diagnosis of Major Depression, New Episode who were prescribed a full 12 week course of antidepressant medication or at the completion of a 12-week course of antidepressant medication. QDCs for this measure are:
  - **G8126:** Acute Treatment with Antidepressant Medication. Patient with new episode of MDD documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

Or

- **G8128:** Acute Treatment with Antidepressant Medication not Completed for Documented Reasons. Clinical social worker documented that patient with a new episode of MDD was not an eligible candidate for antidepressant medication treatment or patient did not have a new episode of MDD.

Or

- **G8127:** Treatment with Antidepressant Medication not Completed, Reason not Given. Patient with new episode of MDD not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase.

Measure 106. Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity. Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with evidence that they met the DSM-IV-TR criteria for MDD and for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified.

This measure should be reported a minimum of once per reporting period for all patients with an active diagnosis of MDD seen during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinical social workers who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

In order to perform this code, the patient should have one of the following diagnosis: 296.20, 296.21, 296.22, 296.23, 2969.24, 296.30, 296.31, 296.32, 296.33, 296.34.

Select a QDC and one G code for measure 106. The measures are:

- **1040F:** DSM-IV™ for MDD documented at the initial evaluation and **G8930:** Assessment of depression severity at the initial evaluation

Or

- **1040-8P:** DSM-IV-TR for MDD not Documented, Reason not Otherwise Specified

Or

- **G8931:** Assessment of depression severity not documented, reason not given

Measure 107. Adult Major Depressive Disorder (MDD): Suicide Risk Assessment: Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

Measure 107 should be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder who was seen individually during the reporting period, including episodes of MDD that began prior to the reporting period.

Patient must have one of the following diagnosis when reporting this code: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34.

One of the following QDCs may be reported using this measure:

- **G8932:** Suicide risk assessed at the initial evaluation

Or

- **3092F:** MDD in remission

Or

- **G8933:** Suicide risk not assessed at the initial evaluation, reason not given.

Measure 128. Preventive Care and Screening: Body Mass Index (BMI) Screening: Body Mass Index (BMI) Screening and Follow-Up. Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record and if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit. Normal paramenters are age 65 years and older BMI>23 and <30, Age 18-64 years BMI >18.5 and <25.

Choose one of the following QDCs to report this measure:

- **G8420:** Calculated BMI within normal parameters and documented or **G8417:** Calculated BMI above normal parameters and a follow-up plan was documented or **G8418:** Calculated BMI below normal parameters and a follow-up plan documented.

Or

- **G8422:** Patient not eligible for BMI calculation or **G8938:** BMIis calculated, but patient not eligible for follow-up plan

Or

- **G8421:** BMI not calculated or **G8419:** Calculated BMI outside normal parameters, no follow-up plan documented.

Measure 130. Documentation of Current Medications in the Medical Record. Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include all prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements and must contain the medication's name, dosage, frequency, and route of administration.

This measure is to be reported at each visit during the 12 month reporting period. There is no diagnosis associated with this measure.

Choose one of the following QDCs to report this measure:

- **G8427:** Current Medications Documented. Clinical social worker attests to documenting the patient's current medications to the best of his/her knowledge and ability.

Or

- **G8430:** Current Medications not Documented, Patient not Eligible. Clinical social worker attests the patient is not eligible for medication documentation. To be not eligible, a patient must be in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Or

- **G8428:** Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Given. Current medications not documented by clinical social worker, reason not given.

Measure 131. Pain Assessment and Follow-Up: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit and documentation of a follow-up plan when pain is present.

This measure should be reported each visit during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. The documented follow-up plan in the record must be related to the presence of pain, example: "Patient referred to pain management specialist for back pain." The follow-up plan must include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or referrals to other health care providers if appropriate.

Patient's pain assessment is documented through discussion with the patient including the use of a standardized tool and a follow-up plan is documented when pain is present. Characteristics of pain include location, intensity, quality, and onset/duration.

Examples of standardized tools for pain assessment include:

- Brief Pain Inventory (BPI)
- Faces Pain Scale (FPS)
- McGill Pain Questionnaire (MPQ)
- Multidimensional Pain Inventory (MPI)
- Numeric Rating Scale (NRS)
- Verbal Descriptor Scale (VDS)

The QDCs to report this measure are as follows:

- **G8730:** Pain assessment documented as positive utilizing a standardized tool and a follow-up plan is documented or G8731: Pain assessment documented as a negative, no follow-up plan required.

Or

- **G8442:** Documentation that patient is not eligible for a pain assessment or **G8939:** Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate. A patient is not eligible if one or more of the following exists: (1) Severe mental and/or physical incapacity where the person is unable to express himself/herself/in a manner understood by others and (2) Patient is in an urgent situation where time is of essence and to delay treatment would jeopardize the patient's health status.

Or

- **G8732:** 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 or **G8509:** Documentation of position pain assessment; no documentation of follow-up plan, reason not given.

Measure 134. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan. Percentage of patients aged 12 years and older screened for clinical depression on the date of encounter using an age appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the positive screen.

This measure is reported a minimum of once per reporting period for patients seen during the reporting period. A documented follow-up plan must be related to positive depression screening, for example, "A psychiatric evaluation re-assessment is rescheduled due to positive depression screening."

When screening, a clinical or diagnostic tool is completed to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms. Examples of standardized depression screening tool include the

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire (MFQ), Beck Depression Inventory (BDI or BDI-II)
- Geriatric Depression Scale (GDS)
- Cornell Scale Screening
- Center for Epidemiologic Studies Depression Scale (CES-D)

A follow-up plan must include one or more of the following:

- Additional evaluation
- Suicide Risk Assessment
- Pharmacological interventions
- Other intervention for the diagnosis or treatment of depression

QDCs for this measure are as follows:

- **G8431:** Positive screen for clinical depression with a documented follow-up plan 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. A patient is not eligible/appropriate if one of the following exists:
  - Patient refuses to participate
  - Patient is in an urgent or emergent situation where time is of essence and to delay treatment would jeopardize patient's health status
  - Patient has an active diagnosis of depression or bipolar disorder.
  - Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools such as in cases of delirium or court appointed situations.

Or

- **G8432:** Clinical depression screen not documented, reason not given or **G8511:** Positive Screen for clinical depression documented, follow-up plan not documented, reason not given.

Measure 173. Preventive Care and Screening: Unhealthy Alcohol Use – Screening: Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months.

This measure is reported a minimum of once per reporting period. There is no diagnosis reported with this measure.

Unhealthy Alcohol Use is defined as different degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standards drinks per week or >3 drinks per occasion for women and persons 65 years of age; >14 standards drinks per week or >4 drinks per occasion for men <65 years of age.

QDCs for this measure are:

- **3016F:** Patient screened for unhealthy alcohol use using a systematic screening method.

Or

- **3016F with 1P (Modifier):** Documentation of medical reason(s) for not screening for unhealthy alcohol uses (eg, limited life expectancy, other medical reasons.)

Or

- **3016F with 8P (Modifier):** Unhealthy alcohol use screening not performed, reason not otherwise specified.

Measure 181. Elder Maltreatment Screen and Follow-Up Plan. Percentage of patients aged 65 years and older with a documented elder maltreatment screen on the date of encounter and a documented follow-up plan on the date of positive screen.

This measure is reported once during the reporting period. The documented follow-up plan must be related to positive elder maltreatment screening. For example, "Patient was referred to Adult Protective Services for positive elder maltreatment screening." A follow-up plan may include documentation of a referral or discussion with other providers, ongoing monitoring or assessment, and/or a direct intervention.

There is no diagnosis code associated with this measure. An elder maltreatment screen includes assessment and documentation of the following components:

- Physical abuse
- Emotional or psychological abuse
- Neglect (active or passive)
- Sexual abuse
- Abandonment
- Financial or material exploitation,
- Self-neglect
- Unwarranted control

QDCs for this measure are:

- **G8733:** Documentation of a positive elder maltreatment screen and documented follow-up plan at the time of the positive screen or **G8734:** Elder maltreatment screen documented as negative, no follow-up required.

Or

- **G8535:** No documentation of an elder maltreatment screen, patient not eligible or **G8941:** Elder Maltreatment Screen Documented, Patient not Eligible for Follow-Up. A patient is not eligible if one or more of the following exist: (1) patient refuses to participate or (2) patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Or

- **G8536:** No documentation of an elder maltreatment screen, reason not given or **G8735:** Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given.

Measure 226. Preventive Care and Screening: Tobacco: Screening and Cessation Intervention. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received cessation counseling intervention if identified as a tobacco user.

This measure is reported once per reporting period. There are no diagnosis codes associated with this measure. Tobacco use includes use of any kind of tobacco. Cessation Counseling intervention includes brief counseling of three minutes or less.

QDCs for this measure includes the following:

- **4004F:** Patient screened for tobacco use and received tobacco cessation intervention counseling, if identified as a tobacco user or **1036F:** Current tobacco non-user.

Or

- **4004F with 1P (Modifier).** Documentation of medical reasons for not screening for tobacco use (eg., limited life expectancy, other medical reasons).

Or

- **4004 with 8P (Modifier).** Tobacco screening or tobacco cessation intervention not performed, reason not otherwise specified.

Measure 248. Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence. Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting.

This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of current substance abuse or dependence seen during the reporting period.

The following diagnosis for Alcohol Dependence (ICD-9-CM) may be reported with the measure 248: 303.90, 303.91, 303.92, 304, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 301.70, 304.71. 304.72, 304.80, 304.81, 304,82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 33305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.82, 305.82, 305.90, 395.91, 395.92.

QDCs for this measure are:

- **1220F:** Patient screened for depression

Or

- **1220F with 1P (Modifier):** Documentation of medical reason(s) for not screening for depression

Or

- **1220F with 8 (Modifier):** Patient was not screened for depression, reason not otherwise specified.

The Centers for Medicare and Medicaid Services provides online resources to assist clinical social workers in reporting measures successfully for PQRS. They include:

- **QualityNet Help Desk** – Available Monday-Friday, 7:00 am – 7:00 pm CST. The phone number is 1-866-288-8912 and the e-mail address is Qnetsupport@sdps.org
- **Step-by-Step Instructions in Getting Started With PQRS**
  www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html
- **2013 Physician Quality Reporting System (PQRS): Claims Reporting Made Simple**
  www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_SatisfRprtng-Claims_12192012.pdf

The Physician Consortium for Performance Improvement (PCPI) has been selected by the Centers for Medicare and Medicaid Services (CMS) to enhance the quality and value of patient care by developing evidence-based performance measures for health care providers. Information about the PCPI is available online at www.physicianconsortium.org. Through PCPI, NASW is advocating for additional performance measures for clinical social workers to use when participating in PQRS.

Additional Resources

Federal Register. November 16, 2012. Volume 77, Number 22. Government Printing Office. Washington, DC. [Online]. Available at www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf (last visited February 26, 2013.)

Center for Workforce Studies & Social Work Practice Recent Publications

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- *2012 Medicare Updates for Clinical Social Workers*
- *Clinical Social Workers and 5010: Frequently Asked Questions*
- *Clinical Social Workers Be Aware: Version 5010 is Coming*
- *Documenting For Medicare: Tips For Clinical Social Workers*
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- *Organizing For Office Safety*

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- *The Affordable Care Act: Implications for Low and Moderate-Income Women's Health and Well-Being*
- *Overcoming Economic Hardships*

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- *Accountable Care Organizations (ACOs): Opportunities for the Social Work Profession*
- *Career Coaching: A Valuable Resource For Social Workers*
- *Furthering Your Social Work Education: Obtaining A Doctorate*
- *Negotiating A Higher Salary*
- *Networking: Finding Opportunities for Career Development*
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