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The National Voice of Clinical Social Work

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PQRS Requirements for LCSWs

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The Physician Quality Reporting System (PQRS), a program managed by the Centers for Medicare and Medicaid Services (CMS), has been in effect since 2007. The goal of PQRS is to improve the quality of care provided to Medicare beneficiaries. The requirement that LCSWs report certain information to CMS on Medicare Patients with conditions covered by PQRS began in 2013; PQRS data submitted in 2015 (penalty occurs in 2017) is the first year that there is no bonus for complying with PQRS.

PQRS applies ONLY to LCSWs who are Medicare providers at this time. However, it is likely that accountable care organizations (ACOs) and health homes will be implementing similar "value" requirements in the near future. Keep in mind that while LCSWs do not *have* to submit PQRS information in 2015 (through "quality data codes" (QDCs)) there will be a penalty of 2% decrease in all Medicare reimbursement imposed in 2017 (based on 2015 data) if the LCSW does not submit these codes.

There are some other changes in the way that PQRS reporting needs to be conducted in 2015. LCSWs who are Medicare providers and want to avoid the 2% penalty in 2017 for

failing to comply with PQRS in 2015 must do the following: 1) 50% of all Medicare patients seen need as many measures covered in 2015 as possible out of the seven available to LCSWs using claims forms; 2) use as many domains as possible (see below to identity the four available); 3) measures must be submitted on a yearly basis, every reporting session, or every session; 4) check the PQRS "clusters" to see which measures are in a given cluster; and 5) some measures can only be reported through electronic health records (EHRs).

There are fewer QDCs available to LCSWs who are Medicare providers in 2015, part of the CMS push to eliminate fee-for-service reimbursement and medicalize mental health care . By 2020, the Medicare reimbursement goal is to have all LCSWs reimbursed through an ACO, a health home, or a registry.

Medicare Opt-In or Opt-Out for LCSWs

If you are an LCSW and have not enrolled with Medicare, *you must do so OR opt-out*. This is a Federal requirement for all LCSWs, *whether we see Medicare patients or not*. You may opt in or opt out; if you choose to do the latter, you must send a letter and copy of your private contract with Medicare beneficiaries to your Medicare Administrative Contractor. For more information on opting out, go to the CSWA website (Clinical Practice). You can also find copies of opt-out letters and a private contract in the Members Only section of the CSWA website. If you have opted-out of Medicare, you need read no further. PQRS applies only to LCSWs who participate in Medicare.

PQRS Measures

PQRS Measures are reported as Quality Data Codes (QDCs). Only 7 PQRS Measures apply to services provided by LCSWs for claims; 7 PQRS measures can be reported through registries. Claims-reported PQRS Measures are submitted on CMS-1500 forms as Quality Data Codes (QDCs), see below.

This information has been taken from CMS at the following link: and a webinar offered by CMS e-health at http://cms.gov/eHealth/downloads/Webinar_eHealth_September11_PQRSDeadlines.pdf . Many thanks to Bill Rogers, Medical Director of CMS and Lauren Fuentes and Ashley Spence of CMS. PQRS is complicated so be sure to follow all the steps listed below carefully.

PQRS REPORTING OPTIONS

There are two ways for LCSWs to report PQRS data in 2015: 1) to submit measures on CMS-1500 claims, or 2) join a registry which will process PQRS data for you. Here are the steps required.

For either option:

You must first have an NPI. As most of you know, the National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). As outlined in Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

You must then become a Medicare provider through the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) at (http://www.cms.hhs.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp) . This is a complex process. Be prepared to spend 2-4 hours completing the application. If you instead decide to opt out of being a Medicare provider, send a letter to CMS informing them that you are opting out of Medicare as a provider (see template at CMS website.) It is a Federal Regulation that you must opt in or opt out of Medicare.

Measures Submitted on CMS-1500 Claims

If you decide if you want to submit your PQRS information through your CMS-1500 claims (CSWA recommended) submit PQRS QDC Measures on your claim forms. To find the complete list of PQRS QDC measures, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqrs , the PQRS Specifications Manual, and look up the measures for mental health diagnoses. This paper describes the PQRS measures which are based on the CPT codes used by LCSWs, i.e., 90791, 90832, 90834, and 90837, found below.

The following information is called the patient "denominator" in PQRS, i.e., the basic information about the patient, including patient group; patient diagnosis; and patient CPT code, *all of which we already submit on Medicare claims.*

The PQRS Measures Codes, submitted as QDCs, are called the "numerator". QDCs all start with the letter "G" or end in the letter "F". To send in PQRS information for Medicare patients that you are billing for currently, use the G or F QDC codes, in addition to the ICD-9 diagnostic codes that you are already using (ICD-10 starting on October 1, 2015).

N.B.: You may not submit QDC Codes for Medicare claims that have already been processed.

To avoid a reimbursement penalty in 2017, LCSWs must submit at least 3 QDCs for 50% of Medicare patients on the CMS-1500 (see details below). *You must have 2014 PQRS data submitted by February 28, 2016 to avoid a penalty.*

For additional information, review the CMS fact sheet at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_SatisfRprtng-Claims_12192012.pdf

2015 PQRS Penalties

In December 2014, clinical social workers who are Medicare providers may have received letters from the Centers for Medicare and Medicaid Services (CMS) which informed them of a penalty in 2015 for not using the Physician Quality Reporting System (PQRS) in 2013. *LCSWs who used PQRS in 2013 and believe their 2015 PQRS 1.5% penalty was applied in error, may submit an online informal review request during the period of* ***January 1, 2015 through February 28, 2015***. Information about the request process is available at CMS.gov. For assistance, clinical social workers may contact the QualityNet Help Desk at 866-288-8912 (between 8-5 EST), TTY 877-715-6222, or by email at qnetsupport@hcqis.org.

There is no bonus in 2017 for QDCs submitted in 2015, as there was in the two previous years. The penalty for failing to comply with PQRS standards in in 2015 will be a 2% decrease for all Medicare reimbursements in 2017.

Where to Submit PQRS Information on CMS—1500

Here is a guide to how PQRS Information is to be included on the CMS-1500:

- Section 24D – under the CPT code, add up to five QDC measures in the white boxes provided
- Section 24E – use a ‘pointer’ if more than one diagnosis as to which one the QDC is connected to
- Section 24F – put “$.01” in each box following a QDC to indicate that there is no cost ($.00 does not register)

Measures Submitted through Qualified Clinical Data Registry (QCDRs)

There is more emphasis on LCSWs using registries in 2015 and it appears that we may be required to submit claims in registries starting in 2016 to avoid a 2% penalty in 2018.

To submit measures through a registry, go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Registry-Reporting.html and sign up with a registry to calculate your QDC measures. One good registry option is to use the American Psychological Association Registry at http://apapo.pqrspro.com/ . The cost is $199 per year.

To avoid a 2015 penalty in 2017, you must send in as many of the numerator measures that apply to 80% of Medicare beneficiaries seen across three domains, through a registry.

Review the CMS fact sheet at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_SatisfactoryReporting-Registry_041813.pdf

Cross-cutting Measures

This is a new set of measures which are designed to create more broadly based measures that can be recognized by the variety of systems using PQRS measures to assess outcomes. Only one cross-cut measure is needed per reporting period (yearly for most measures.) These may be assessed using screening tools developed by the American Psychiatric Association at http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level1 (for adults) and http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level2 (for children and adolescents). The tools are designed for specific conditions including personality disorders, depression, anxiety, mania, anger, sleep disturbance, OCD symptoms, and somatic disorders. The numerator for the QDC is the same.

MAV CLUSTERS

Measures-Applicability Validation:

Since there are fewer than nine measures reportable by LCSWs on a given patient, there is no way that LCSWs can meet the nine measure requirement to receive the 2015 to avoid the 2% penalty. A process has been established which will accept 1-8 measures if all applicable measures have been used, called the Measures-Applicability Validation Process (MAV), which will automatically review Medicare claims that have less than nine

PQRS measures. If all measures that *can* be reported have been included, the claim will be accepted as PQRS-compliant.

In 2014, there were clusters of measures that needed to be considered when one measure in the cluster was used. *In 2015 there are no clusters that apply to LCSWs; there are only 14 clusters and none of them have more than one measure used by LCSWs.* A list of the MAV clusters for those who want to review, can be found at http://www.acep.org/uploadedFiles/ACEP/Advocacy/federal_issues/Quality_Issues/2015_PQRS_MAV_ProcessforRegistryBasedReporting_01152015.pdf .

DOMAINS

National Quality Strategy Domains ("Domains") are the areas that the PQRS measures are loosely woven into. The QDCs that are the numerator for the PQRS measures fall into; the Domains are the general categories which are being measured as follows (italics added):

- *Patient Safety*
- *Communication and Care Coordination*
- Efficiency
- *Effective Clinical Care*
- *Community Population Health*
- Patient and Family Experience

Domains do not need to be identified on the CMS-1500 but *every effort* should be made to include QDCs from as many domains as possible. The only domains for the QDCs used by LCSWs are *Effective Clinical Care, Patient Safety, Communication and Care Coordination,* and *Community Population Health.*

INDIVIDUAL PQRS MEASURES USED BY LCSWs in 2015

Here is the heart of the ten PQRS Measures for LCSWs in 2015 (four for Registry only). PLEASE READ CAREFULLY. Most of the bullets represents a change from 2014.

- **These are the 2015 QDC Codes (connected to PQRS measures) and ICD-9/ICD-10 Codes that need to be submitted by LCSWs, with the Domains to which the Measures belong. *Some QDCs, as noted, do not have an ICD-9/ICD-10 Code specific to the QDC.***

- **All Measures listed below are for use with CPT codes 90791, 90832, 90834, or 90837 unless specifically noted otherwise.**
- **All Measures listed below are available to LCSWs to use in CMS-1500 Claims forms or through a National Qualified Clinical Registry (NQCR) unless specifically noted otherwise.**
- **Cross-cutting measures are noted as "CCM" – at least one CCM must be used per patient per year.**
- *** means that the measure is only available to submit through electronic health records (EHRs).**
- **If reporting through a registry, the MAV clusters do not apply, only the number of domains, which must be three.**
- **<u>2014 PQRS Measures for LCSWs no longer used in 2015 PQRS Measures Reporting in Claims or Registry: #9, #106, #107, #182, #247, #248.</u>**

PQRS 2015 Measures

- ## #46 Medication Reconciliation Following Hospital Discharge (Includes SNFs, Rehabilitation Facilities) "CCM" *

  Domain = Communication and Care Coordination

  Report Frequency = Within 30 Days of Every Discharge from Hospital, SNF, or Rehabilitation Facility

  Must be seen by LCSW within 30 days of discharge by LCSW – information must be received from hospital or facility or treating outpatient physician

  QDC Codes

- 1111F: Medications reconciled following discharge
- 1111F.8P: Medications not reconciled following discharge

- **#128 Documentation of Body Mass Index (BMI) "CCM"**

  Domain = Community/Population Health

  Report Frequency = Once a year based on report from physician or other mental health provider with BMI assessment in scope of practice

  ICD Codes (not required)

  Then add:

  QDC Measures~

  - G8420: Current BMI (Normal)
  - G8418: Current BMI (Below normal)
  - G8417: Current BMI (Above normal)
  - G8419: Current BMI not documented, reason not given

- **#130 Documentation of Current Medications in Medical Record "CCM"**

  Domain = Patient Safety

  Report Frequency = EVERY SESSION with report from physician/prescriber OR patient

  ICD Codes (not required)

  Then add:

  QDC Measures~

  - G8427: Current Medications Documented
  - G8430: Current Medications not Documented

- **#131 Documentation of Pain Assessment in Medical Record "CCM"**

  Domain – Community/Population Health

  Report Frequency = At first session ONLY through report from physician or other health care provider qualified to perform pain assessment in initial session ONLY

  ICD Codes (not required)

  Then add:

QDC Measures~

- G8731: Pain Assessment documented as negative
- G8730: Pain Assessment documented as positive with follow up plan

- ## #134 Preventive Care and Screening for Clinical Depression and Follow-Up Plan "CCM"

Domain = Community Population Health

Report Frequency = Once a year

ICD Codes (not required)

- Use of screening tool, e.g., 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); other assessment data; no DSM required

Then add:

QDC Measures~

- G8431: Positive screen for clinical depression with a documented follow-up plan;
- G8510: Negative screen for clinical depression, follow-up not required;
- G8433: Screening for clinical depression not documented, patient not eligible/appropriate; or
- G8940: Screening for clinical depression documented, follow-up plan not

- ## #173 Preventive Care and Screening for Unhealthy Alcohol Use (REGISTRY ONLY) "CCM"

Domain = Community Population Health

Report Frequency = Once a year

(Covers a spectrum that is associated with varying 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 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age.)

ICD-9-CM Codes /ICD-10-CM Codes (after 10/1/15)

- 291.0, 291.1, 291.2, 292.0, 303.0, 303.01, 303.02, 305.0, 305.00

QDC Measures~

- 3016F: Patient screened for unhealthy alcohol use using a systematic screening method
- 3016F-1P: unhealthy alcohol use screening not performed, for medical reasons, document reason for no screening
- 3016F-8P: unhealthy alcohol use screening no**t** performed, reason not otherwise specified

- ## #181 Elder Maltreatment Screen and Follow-Up Plan

Domain = Patient Safety

Report Frequency = Once a year

ICD Codes (not required)

- Document screening, reporting (if maltreatment found), and plan to end maltreatment

QDC Measures~

- G8733: Documentation of a positive elder maltreatment screen and documented follow-up plan at the time of the positive screen
- G8734: Elder maltreatment screen documented as negative

- ## #226 Screening for Preventive Care for Tobacco Use and Cessation Intervention “CCM”

Domain = Community Population Health

Report Frequency = Once a year

ICD-9-CM Codes for QDC Measures (not required)

QDC Measures~

- 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user
- 1036F: Current tobacco non-user; patient screened for tobacco use and Identified as a non-user of Tobacco

- **#325 Major Depressive Disorder – Coordination with Co-morbid Conditions (REGISTRY ONLY) "CCM" ***

Domain = Communication and Care Coordination

Report Frequency: Once a year

Co-morbid conditions requiring coordination with physician or other health care providers include diabetes; coronary artery disease; stroke; chronic kidney disease; congestive heart failure

QDC Codes~

- G8959: communication on co-morbid conditions with other health care providers completed
- G8960: communication on co-morbid conditions with other health care providers not completed

- **#402 Help Adolescents Discontinue Smoking (REGISTRY ONLY) "CCM" ***

(Domains=Community/Population Health)

Report Frequency: Once a year

QDC Codes~

- G9458: discussion of health risks of smoking or referral to smoking cessation program
- G9459: patient is non-smoker
- G9460: smoking cessation intervention not completed

GROUP MEASURE USED BY LCSWS

- **#280 Dementia Measures Group (<u>must have 20 patients with dementia to participate)</u>**

(Domains = Patient Safety, Community Population Health)

(N.B.: This is the only PQRS **group** measure that applies to mental health diagnosis and treatment. To use it you must have a sample group of 20 patients with dementia. For more information go to http://www.acr.org/~/media/ACR/Documents/P4P/Resources/2013/Specs/MeasuresGroupSpecifications.pdf)

Dementia: Staging of Dementia (#280)
Dementia: Cognitive Assessment (#281)
Dementia: Functional Status Assessment (#282)
Dementia: Neuropsychiatric Symptom Assessment (#283)
Dementia: Management of Neuropsychiatric Symptoms (#284)
Dementia: Screening for Depressive Symptoms (#285)
Dementia: Counseling Regarding Safety Concerns (#286)
Dementia: Counseling Regarding Risks of Driving (#287)
Dementia: Caregiver Education and Support (#288)

ICD-9-CM Codes#

- 293.0, 294.10, 294.11, 290.40, 294.9

QDC Measure

- G8902

= ICD-9-CM Codes (or DSM-IV-TR codes) listed are most commonly used for these conditions, but not exhaustive. ICD-9-CM Codes will be changing to ICD-10-CM Codes on October 1, 2015. See CSWA webinar "Compare and Contrast" in the Members Only Section of the CSWA website for more information.

~ = The QDC measures listed here are the most commonly used codes. For other options in QDC measures go to the PQRS information at www.cms.gov.

Future of PQRS Use for LCSWs

Although the value-based modifier (VM) program is a separate program, PQRS data is utilized in making the VM determination for therapists. Failure to participate in PQRS or unsuccessful participation in PQRS *in the 2016 calendar year* will result in a penalty of up to 4.0% penalty that will be applied in the 2018 calendar year. LCSWs who receive a penalty under the VM program in 2018 will also be subject to the 2.0% penalty under PQRS, for a cumulative penalty of up to 6.0% in 2018. Value-Based Modifiers for LCSWs have not yet been released by CMS. CSWA will let members know when they are available.

Here is a summary of the proposed changes in the reimbursement process that CMS will be making in the next five years:

- **By 2016**, connect 85% of all traditional Medicare payments to quality or value
- **By 2017**, connect 30% of fee-for-service Medicare payments to quality and value through emerging payments models, such as Accountable Care Organizations (ACOs) or bundled payments
- **By 2018**, connect 90% of all traditional Medicare payments to quality or value through Hospital Value Based Purchasing and Hospital Readmission Reduction Programs
- **By 2019**, connect 50% of payments to emerging payment models

ADDITIONAL CMS WEBSITES for PQRS Information

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_SatisfRprtng-Claims_12192012.pdf (This is the most useful information.)

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015MLNSE13__AvoidingPQRSPaymentAdjustment_083013.pdf

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_SatisfactoryReporting-Registry_041813.pdf

Appendix A: List of all Initiatives being Undertaken by Medicare (PQRS is #13 out of 26)

1. Hospice Quality Reporting
2. Inpatient Rehabilitation Facilities Quality Reporting
3. Long-Term Care Hospitals Quality Reporting
4. Hospital Inpatient Quality Reporting
5. Hospital Value-Based Purchasing
6. Prospective Payment System (PPS) Exempt Cancer hospitals
7. Inpatient Psychiatric Facility Quality Reporting
8. Hospital Readmission Reduction Program
9. End-Stage Renal Disease (ESRD) Quality Incentive Program
10. Home Health Quality Reporting
11. Hospital Outpatient Quality Reporting
12. Ambulatory surgical centers
13. Physician Quality Reporting System
14. Medicare Shared Savings Program
15. Physician Compare
16. Medicare and Medicaid EHR Incentive Programs
17. Children's Health Insurance Program Reauthorization Act Quality Reporting
18. CMS Nursing Home Quality Initiative and Nursing Home Compare Measures
19. Medicaid Health Home Programs
20. Health Insurance Exchange Quality Reporting
21. Initial Core Set of Health Care Quality Measures For Medicaid-Eligible Adults
22. Medicare Part C Plan Rating – Quality and Performance Measures
23. Medicare Part D Plan Rating – Quality and Performance Measures
24. Physician Feedback/Value-Based Modifier Program
25. Dual Eligibles Core Quality Measure Set
26. Hospital Acquired Conditions program