Since 2007, Medicare’s PQRS program has offered bonus payments to eligible professionals, including psychologists, who successfully report data on designated outpatient service measures. Because of changes made by the Patient Protection and Affordable Care Act of 2010, PQRS will switch from a bonus program to one that imposes penalties beginning in 2015. Psychologists can best prepare themselves by starting to participate in PQRS in 2013.

To help eligible professionals avoid payment penalties, the Centers for Medicare and Medicaid Services (CMS) is allowing Medicare providers who are new to PQRS to report one service measure for at least one applicable patient in 2013 in order to avoid penalties in 2015.

However, in order to meet the requirements for bonus payment in 2013, psychologists must successfully report on at least 50 percent of applicable Medicare cases. Successful reporting involves selecting measures that are appropriate for the patient and service provided. For example, if the measure involves adult major depressive disorder, it may not be used for patients under 18 years of age.

In 2013 and 2014, psychologists who successfully participate in PQRS will earn an additional 0.5 percent payment on all of their Medicare charges. Beginning in 2015, CMS will no longer provide bonuses but instead will impose penalties on those who do not successfully report PQRS measures. The payment penalties will be 1.5 percent in 2015 and 2 percent in 2016.

As a bonus program, Medicare’s payments have been retroactive. Eligible professionals submitted their Medicare claims and were paid for their services, and the PQRS bonus payments were distributed months later. But now that PQRS will become a penalty-based program, Medicare must operate prospectively in order to have time to analyze reporting data before applying any payment adjustments. The 1.5 percent penalty adjustments for 2015 will be based on 2013 reporting data, while the 2 percent penalty for 2016 will be based on 2014 reporting data. Penalties will apply to all Medicare charges by a provider.
STEP-BY-STEP GUIDE

Following is a step-by-step basic guide for psychologists participating in PQRS for the first time in 2013.

**Step 1** Determine which PQRS reporting method is appropriate for your practice.

Although eligible professionals may choose from several methods for submitting PQRS data, most psychologists will use claims-based reporting. This option simply involves reporting measures based on the standard CMS-1500 claim form. Other options for PQRS reporting include registry-based, qualified Electronic Health Record (EHR), or a Group Practice Reporting Option (GPRO). Check the CMS website at go.cms.gov/Vkaa8V for information about the latter three options.

**Step 2** Select a measure.

Review the list of 2013 PQRS measures on the next page that psychologists are eligible to report and determine which ones match the services you provide. CMS recommends reporting on at least three measures, but you can report just one or two measures if fewer than three measures apply to your practice. (The reporting period for 2013 is 12 months, January 1 – December 31.)

**Step 3** Check the measures worksheets in order to determine the required procedure codes.

Measure worksheets are found in the 2013 PQRS Measures Specifications Manual, available in the related links section of the Measures Codes page at go.cms.gov/UmysQS. The procedure code is the CPT® code for the service provided. Be sure to use the new CPT codes for 2013 that are applicable quality code (For example: G8534).

**Step 4** Use the appropriate G-code to indicate whether the service was performed or why it was performed.

Quality codes, or G-codes, are used to indicate what action, if any, you took. G-codes can be found on the measures worksheets. Because PQRS is a reporting program rather than a pay-for-performance program, health care professionals may indicate they did not provide the action specified under the measure and still qualify for bonus payments in 2013.

For example, for Measure 181: Elder Maltreatment Screen, if the Elder Maltreatment Screen is documented as negative and no follow-up plan is required, G-code G8734 would be reported along with the procedure code. Both the procedure code and the G-code must be reported on the same CMS-1500 claim form.

**Step 5** Record the information on the CMS-1500 claim form.

The information noted below must be reported on the claim form (see page 4 for an example).

**Claims information**

*Line 1 Dates of service:* Record when the service was provided.

*Line 1 Procedures, services or supplies:* Use the procedure code from Step 3.

*Line 1 Charges:* List your charge for this service.

**Quality reporting information**

*Line 2 Dates of service:* Record the same information as above – when the service was provided.

*Line 2 Procedures, services, or supplies:* Use the applicable quality code (For example: G8534).

*Line 2 Charges:* List 0.00 (or 0.01 if your software will not accept 0.00) on this line.

The following are abridged descriptions of the thirteen individual PQRS measures psychologists may use in 2013 depending upon the population they treat and the services they provide. Complete descriptions can be found in the 2013 CMS Measures Specification Manual.

Psychologists who do not find any measures applicable to their services and/or patient population are advised to contact the CMS QualityNet Help Desk. If QualityNet cannot identify applicable measures for your patient population they will ensure you are not penalized for not reporting. See “Additional Resources” on the next page for more information.

**MEASURES AVAILABLE FOR PSYCHOLOGISTS FOR 2013**

- **Major depressive disorder (MDD): Antidepressant medication during acute phase (#9):** Patients aged 18 years and older diagnosed with a new episode of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase.

- **Major depressive disorder: Diagnostic evaluation (#106):** Patients aged 18 years and older with a new diagnosis or recent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified.

- **Major depressive disorder: Suicide risk assessment (#107):** Patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period.

- **Preventive care and screening: Body mass index (#128):** Patients aged 18 years and older with a calculated BMI in the past six months or during the current visit in the medical record and if the most recent BMI is outside parameters, a follow-up plan is documented.

- **Preventive care and screening: Tobacco use (#746):** 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.

- **Preventive care and screening: Screening for depression (#134):** Patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented. There is no diagnosis associated with this measure.

- **Preventive care and screening: Unhealthy alcohol use (#173):** Patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method within 24 months. There is no diagnosis associated with this measure.

- **Elder maltreatment and follow-up plan (#181):** Patients aged 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan.

- **Pain assessment prior to initiation of patient treatment (#131):** Patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each qualifying visit prior to initiation of therapy AND documentation of a follow-up plan. There is no diagnosis associated with this measure.

- **Preventive Care and Screening: Screening for clinical depression (#134):** Patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented. There is no diagnosis associated with this measure.

- **Documentation and verification of current medications in the medical record (#130):** Patients aged 18 years and older with a list of current medications with dosages and verification with the patient or authorized representative is documented by the provider. There is no diagnosis associated with this measure.

- **Pain assessment prior to initiation of patient treatment (#131):** Patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each qualifying visit prior to initiation of therapy AND documentation of a follow-up plan. There is no diagnosis associated with this measure.
Putting Your Practice Assessment to Work

2. CMS QualityNet Help Desk: The QualityNet Help Desk is available Monday through Friday, 7 a.m. to 7 p.m. Central Time, by telephone at 866-288-8912 (TTY 877-715-6222). Email inquiries may be sent to qnetsupport@sdps.org.