Medicare’s 2015 Physician Quality Reporting System (PQRS): Medicare’s Unique Approach to Quality Assurance
Medicare’s 2015 Physician Quality Reporting System (PQRS): Medicare’s
Unique Approach to Quality Assurance

Samuel Knapp, Ed.D., ABPP
Director of Professional Affairs, Pennsylvania Psychological Association

Lynda Behrendt, Psy.D., R.N.
Director of Professional Affairs, Illinois Psychological Association

Rachael Baturin, MPH, J.D.
Director of Legal and Regulatory Affairs, Pennsylvania Psychological Association

Program Description: The purpose of this article is to help psychologists to understand basic information about Medicare’s 2015 Physician Quality Reporting System (PQRS) for psychologists. The workshop reviews basic information about the PQRS system, how to identify relevant measures, and how to report them through claims-based or registry reporting. Group practice reporting options will not be covered in this article.

If you wish to receive credit for reading this program, you can click on the document entitled “Purchase the CE Quiz.” You will also be asked to complete an evaluation form.

Program Learning Objectives: At the end of the article the participants will be able to

1. Identify relevant measures that they can use for Medicare reporting in 2015; and
2. Understand how to report these measures through claims-based or registry reporting.

While commercial managed care companies are experimenting with or debating pay for performance measures, Medicare has taken a unique approach through its Physician Quality Reporting System (PQRS; formerly called PQRI). Originally a bonus program, PQRS has transitioned into a penalty program. In 2014, psychologists (and other professionals) who met certain participation requirements received an incentive payment equal to .5% of allowed charges, while participants who met lower participation standards avoided a 2% penalty that will be applied to payments for services in 2016. Starting in 2015 PQRS shifted to a penalty-only program and professionals who do not participate will have payments for all services reduced by 2% in 2017.

The participation requirements for 2015 focus only on avoiding a penalty. Those who want to avoid the penalty need to report on 9 measures across 3 domains for 50% of their Medicare fee-for-service patients. In addition, health care providers who engage in a face to face practice...

We express appreciation to Drs. Jeff Gold, Jeanne Slattery, and Lance Lawrence for reviewing an earlier version of this manuscript and to Diane Pedulla of the APA Practice Organization for her detailed review of this article and for providing invaluable resources. This article is an update of previous articles written in 2013 on the PQRS written by Samuel Knapp and Rachael Baturin and in 2014 by Samuel Knapp, Lynda Behrendt, and Rachael Baturin. However, in 2015, the standards for reporting the PQRS changed so substantially, that we urge readers to ignore the previous articles and focus on the standards presented in this article.

There is a group practice reporting option that will not be covered in this home study. The group practice reporting option (GPRO) requires those group psychologists to bill under a single tax ID. Group practice must self-nominate...
face encounter with a patient must use at least one cross-cutting measure (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html). However, the cross cutting measure requirement imposes no additional decision making on most psychologists, because most psychologists would have had to use one or all of the cross cutting measures anyway in order to meet the requirement to use 9 measures with their patients.

Below, we describe how the 9 measure/3 domain standard for avoiding the penalty is flexible, depending on the nature of the case load for the psychologist, so that many psychologists who fail to use 9 measures can still avoid the penalty. We will explain what measures and domains mean in the text that follows.

**Should I Participate in This Program?**

Some psychologists who see only a few Medicare patients may debate whether it is worth their time to participate in the PQRS program. They ask whether the time they invest in learning and participating in the program will offset the relatively small changes in reimbursement. Of course this is an individual decision that each psychologist needs to make. However, once psychologists understand the basics of the system it does not appear that difficult. Also, it is possible (although not certain) that reporting systems, such as PQRS, may be more common in the future and it would be to the benefit of psychologists to start learning them now.

**Getting Started with PQRS**

The goal of the PQRS program is to learn the practice patterns of health care providers. At this time there is no penalty based on the content of the reports. For example, it could be possible for psychologists to report that they failed to use a standardized instrument in conducting a screening for elder abuse without any penalty, inquiry, or additional oversight involved. The PQRS program is limited to fee-for-service Medicare and does not apply to those services to patients in the Medicare Advantage programs, although we have heard reports that a few Medicare Advantage programs will voluntarily pay for PQRS reporting.

The PQRS process appears very complicated and cumbersome. However, we found that once readers have a basic grasp of it, they can participate without an excessive amount of difficulty. The entire reporting procedure can be summarized in one sentence: (a) identify the measures to be used; (b) link the measures to the Quality Data Codes (G –codes or CPT Category II codes), and (c) report them to Medicare. Psychologists do not need to do anything ahead of time to enroll in the PQRS program. Participation occurs simply through putting information on the claims form (or other means referenced below). The steps are repeated in Table 1.

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3 The cross-cutting measures available to psychologists are: #128 (Body Mass Index screening and follow-up) #130 (Documentation and verification of current medications in the medical record); #131 (Pain assessment prior to initiation of patient therapy and follow-up); #134 (Screening for clinical depression and follow-up plan); and #226 (Tobacco use assessment and cessation intervention). Psychologists should report on at least one cross-cutting measure.

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Step One: Select the Measures

The first step in the PQRS process is for psychologists to identify and select the measures they want to use. CMS has a list of more than 300 potential reporting measures. Most deal with different aspects of physical medicine and would be irrelevant for psychologists. For example, several measures deal with dermatological issues and would be reported only by dermatologists (or other physicians treating dermatological disorders). The measures that psychologists can currently report through claims based or registry submissions are found in Table 2. Because the measures that can be reported may change from year to year, psychologists should check on the eligible measures at the start of each year.

Table 3 includes more detailed information on the measures and the conditions under which they can be used in claims based submissions and Table 4 includes more detailed information on the measures and the conditions under which they can be used for registry submissions. However, readers should use Tables 3 and 4 only as a screening guide to determine which measures they should consider using. Before using any measure we recommend that psychologists look at the original and full description of the measures found on the CMS website. For the convenience of the readers, the CMS descriptions of these measures can be found in the document entitled “PQRS 2015 Measures” which accompanies this article and home study. The full description from the CMS website contains essential details that could not be fit into the brief summary chart. For example, the description on the CMS website concerning Measure #131 (Pain assessment and follow-up) requires psychologists who report that they use a screening inventory to use one that is normed and valid and they give a list of potentially acceptable screening instruments. Psychologists do not have to use a screening instrument as part of the pain assessment. Instead, to avoid the penalty, psychologist must report a G code that indicates whether or not they assessed pain in the manner described in the CMS document.

Readers can find the full description of these measures in the accompanying “PQRS 2015 Measures” document. Those psychologists who want to find the full descriptions of the measures can get them from the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html then scroll to the bottom of the page to 2015 PQRS Individual Claims Registry Measure Specification Supporting Documents and click on the link. They need to press “Accept” on the disclaimer page and then click on downloaded file for the individual measures and the manual will open.

Psychologists can then look at the specific descriptor for each measure. For example, Measure #131 (Pain assessment) is found on page 207 of the manual and includes definitions, descriptions, special instructions, and the applicable Quality Data Codes (more on those below). We would recommend that the psychologist print out the pages for the measures they wish to use. These pages will include essential information such as the procedure codes that can be used with the measure, whether certain screening instruments are approved, etc.

Psychologists who use the PQRS need to select the quality measures based on the unique features of the population that they serve. For example, a psychologist who treats adults with drug and alcohol disorders would likely pick Measure #173 (Unhealthy alcohol use screening), as they deal with the overuse of alcohol or other drugs. Because depression is common in the
population in general, and in older adults, we suspect that many psychologists would choose to report on the measures dealing with depression: Measure #134 (Screening for clinical depression).

However, psychologists who want to avoid the penalty in 2017 must report 9 measures and there are only 10 measures available to psychologists to use through the claims-based or registry reporting. Consequently, psychologists could look through the 10 measures and simply de-select one of the measures that they would not report. However, because of the nature of the distribution of the 10 measures across the domains, a psychologist might not be able to identify measures from three domains.

Many psychologists, because of the demographics of their patient population or the types of services they provide, will not be able to submit 9 measures or be unable to submit measures from three separate domains. For example, several of the measures are restricted to patients with a depression or an alcoholism diagnosis. Psychologists who do not treat patients with depression or alcoholism may have more difficulty finding 9 measures from three domains.

In that case, psychologists should report as many measures as they can, and their reporting will be referred to a process called MAV (Measure Applicability Validation), which will determine whether the psychologist could have reported more measures. In that way, psychologists can still avoid the penalty even if they cannot submit 9 measures from three domains.

Medicare has six domains for measures, but the measures for psychologists fall into only three domains. The six domains are listed below. Those most applicable to psychologists are in bold print with the associated measures that can be reported listed below. All measures can be reported through claims, unless indicated otherwise.

**Claims or Registry Eligible Measures and Their Domains**

1. **Patient Safety**
   - 130 Documentation of medication (cross cutting measure; claims or registry)
   - 181 Elder maltreatment (claims or registry)
   - 383 Antipsychotic medications for patients with schizophrenia (registry or EHR)

2. **Person and Caregiver Centered Experience and Outcome**

3. **Communication and Care coordination**

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4 For all practical purposes, there are only 10 measures open to psychologists. However, two other measures (#9 [Major Depressive Disorder medication] and #107 [Major Depressive Disorder suicide risk assessment]) are open to psychologists but can only be reported through Electronic Health Records (EHRs). Another measure (#391) is open to non-physicians, but it is not linked to any of the CPT codes commonly used by psychologists.

5 Measures #9 (Major Depressive Disorder medication) and #107 (Major Depressive Disorder suicide risk assessment) are open to psychologists, but may only be reported through electronic health records.

6 CMS stated that measure #391 (Follow-up after hospitalization for mental illness) would be open to non-physicians. However, this measure is not linked to any of the procedure codes traditionally open to psychologists. Consequently, we are not listing it as a measure available to psychologists.
4. Clinical Care

5. Community/Population Health

128 Body Mass Index (BMI) screening and follow-up plan (cross cutting measure; claims or registry)
131 Pain assessment and follow-up\(^7\) (cross cutting measure; claims or registry)
134 Depression screening (cross-cutting measure; claims or registry)
173 Unhealthy alcohol use (registry only)
226 Tobacco use screening (cross cutting measure; claims or registry)
317 Blood pressure screening (claims or registry)

6. Cost Reduction

The second step is to identify the quality data codes that would be associated with each of the measures. The Quality Data Code (a CPT-II and/or a G-code) reports on what the psychologists did during the session that expands upon the primary CPT code. For example, when treating a patient for the first time, a psychologist might screen for pain (or not screen for pain) and then indicate whether the screening was done (or not done) using a particular Quality Data Code (G-code). Remember that the PQRS system does not require the psychologist to screen for pain; only that they report on whether or not such a screening was done.

The Quality Data Codes (CPT Category II codes or G-codes) are linked to CPT codes. For example, a psychologist reporting measure #181 (elder maltreatment screening) would do in conjunction with CPT code 90791 (diagnostic intake), 96116 (psychological testing), 96150 (intake for health and behavior codes), or 96151 (reassessment for health and behavior codes). Nothing prohibits a psychologist from conducting additional screenings later in conjunction with another procedure code. However those screenings done in conjunction with other procedure codes would not count as fulfilling the PQRS reporting requirements. Table 3 contains information on which claims reported measures are linked to which CPT codes. Table 4 contains information on which registry reported measures are linked to which CPT codes.

Psychologists can report the data in one of four ways: claims-based reporting, registry-based reporting, electronic health record (EHR) based reporting, and group practice reporting. Registries are large organizations that have to be approved by Medicare as reporting services. Although all registries provide PQRS reporting, some also provide billing services. Some measures can only be reported through a registry while others can only be reported through EHRs. A registry will take the PQRS measures and send them into Medicare in a batched format that is easier for Medicare to analyze.

\(^7\) A previous CMS document incorrectly listed this as under Communication and Care.


**Should I Use a Registry?**

Our impression is that most psychologists in an independent practice or a small group practice would use claims-based reporting. More information on claims-based reporting will be presented below.

However, even psychologists in independent solo practice may want to consider using a registry for several reasons. First, CMS is creating incentives for using registries by requiring registry or EHR reporting for more measures. CMS announced in the final rule on the 2015 Medicare fee schedule that it will eliminate claims-based reporting at an unspecified time in the future.

Second, registries have higher success rates in meeting PQRS standards and have other advantages such as the ability to amend submitted data - which cannot be done with PQRS submissions made through paper claims. Registries have a success rate for fulfilling PQRS requirements around 96%, compared to approximately 55% for claims based submissions. Furthermore, some measures that can be reported through a registry cannot be reported through claims-based submissions (i.e., #173 Unhealthy alcohol use; #325 Adult Major Depressive Disorder; and #383 Antipsychotic monitoring).

The American Psychological Association Practice Organization has developed an agreement with one registry, Healthmonix, for affordable and convenient enrollment for psychologists. Information can be accessed through [http://apapo.pqrspro.com](http://apapo.pqrspro.com). There is an annual fee for using a registry ([Government Relations and Communication Staff, 2014](#)). Healthmonix offers educational and support services to its customers.

**Claims Made Submissions**

Reporting begins when psychologists submit the information (measures and Quality Data Codes; QDCs) on their claims form. An example of the relevant portions of the claims form is shown in Figure 1. As can be seen in the form, the Quality Data Codes are reported under 24 D (Procedures, Services, or Supplies). The diagnosis pointer refers to the specific diagnosis that justifies the procedure code. The diagnosis of a Major Depressive Disorder is required for the Quality Data Codes G8930 and G8126, therefore 24 E (Diagnosis Pointer) must reference the MDD diagnosis which is listed in 21. A. The third Quality Data Code G8427 does not require any specific diagnosis and for that measure the Diagnosis Pointer could be either 1, 2, or 12. On Line 24F of the form, the Quality Data Codes must be submitted with a line item charge of either $0.00 or $0.01 in order to be processed.

To retrace some of the steps, if psychologists select measure #131 (Pain assessment and follow-up), they can go to the “PQRS 2015 Measures” document or to the original CMS website [http://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2013_PQRS_IndClaimsRegistry_MeasureSpec_SupportingDocs_12192012.zip](http://www.cms.gov/apps/ama/license.asp?file=/PQRS/downloads/2013_PQRS_IndClaimsRegistry_MeasureSpec_SupportingDocs_12192012.zip), click on accept (for the disclaimer) and then enter or download the pdf file. Page 287 of that file reports on measure #131. It applies to all patients who are 18 years old or older. The following page includes a detailed description of pain assessment. CMS has a list of specific screening instruments mentioned for some measures. For

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8 "It is our intention to eliminate the claims-based reporting mechanism in the future" ([Final Rule, Federal Register, November 13, 2014, Vol. 79, p. 67784](#)). Later in the same document CMS acknowledged that its goal was to gradually ramp up the standards for satisfactory reporting.
this measure the screening for pain assessment does require a standardized tool that must be administered and documented in the patient’s record. Then potential G codes are listed as well. Measure #131 can be used in conjunction with the procedure codes 90791, 96116, 96118, 96150 and 96151.

Each eligible professional must satisfactorily report on at least 50% of eligible instances when reporting to avoid the penalty. Nonetheless we recommend that psychologists routinely report on every patient, even if the report is simply that a screen was not done. Reporting on every patient helps ensure that the psychologist will reach the required 50% threshold for reporting, because it is possible that a psychologist may make an error in reporting some measures that subsequently do not get credited to the 50% figure.

Psychologists should note that measures have various reporting frequencies. Some are done only at the initial assessment, but others can be used during other visits as well. For example, measure #181 (Elder maltreatment) is linked to procedure codes dealing with initial visits (such as 90791, 91116, 96150 or 96151), whereas other measures such as #134 (Screening for clinical depression) is linked to numerous other procedure codes including initial contact codes and psychotherapy codes (such as 90832 etc.). In addition, some measures need to be reported once per reporting period while others need to be reported in every visit. For example, #134 (Screening for clinical depression) needs to be reported once during the reporting period (which is twelve months), whereas #130 (Documentation of the medical record) needs to be done once for every patient encounter.

How does this reporting influence the actual practice of psychology? It does require effort to learn the procedures and it does require a modicum of additional paperwork and perhaps the development of a brief reminder or checklist to ensure that the measures selected by the psychologists are being used and documented. It is possible that these procedures will become automatic or second nature for psychologists and involve relatively little cognitive labor in the long run. It is also possible that the reporting process itself may help improve the quality of treatment by reminding psychologists to perform essential tasks, such as documenting medications or screening for depressed patients for suicidal ideation. We understand that those who participate in the PQRS may be subjected to a special PQRS audit, so it is important to ensure that the documentation reflects what was reported on the Quality Data Code. However, we have been told that this special audit was non-intrusive and non-adversarial and differs substantially from the typical Medicare audit. Right now it appears that only time will tell whether the PQRS is worth the extra effort.
Further Resources

Here is Medicare’s Physician Quality Reporting System website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/30_educational%2520resources.asp, which has resources to help understand the incentive program.

More information about registries can be found at:


In trying to learn about the reporting system we participated in a webinar with Dr. Paula Hartman-Stein (www.centerforhealthyaging.com) and found it very helpful. The APA Practice Organization has updated its video by staffer Diane Pedulla, which was also helpful. CMS also has a help line available 7 to 7 (CST) at 1-866-288-8912.
Table 1: PQRS Step by Step

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

2. Select which measures would be most appropriate for your practice. You should try to select 9 measures from three domains (including at least one cross-cutting measure). If you cannot, because of the nature of your patient population, find 9 measures from three domains, then select as many measures as are applicable. You can look at Table 2 to find a list of possible measures and then on Tables 3 and 4 to find more detail on those measures. (Table 3 includes information on measures that can be reported with claims-based submissions; Table 4 includes information on measures that can be used with registry submissions). Use Tables 3 and 4 only as a general guide to determine which measures you want to investigate further. The brief information in Tables 3 and 4 leaves out some essential information that you will need to report the measures accurately. If you decide to use a measure go to the “PQRS 2015 Measures” document or to the original CMS website. Then scroll down the page and click on “2015 PQRS Individual Claims Registry Measure Specification Supporting Documents.” Press “Accept” on the disclaimer page and then then click on “2015_PQRS_IndividualMeasureSpec_ClaimsRegistry_122314.pdf” and the manual will open. Or, if you are a member of the Pennsylvania Psychological Association, you can find the measures open to psychology in a document on the PPA website (“members only” section, under Business and Practice, and the Medicare subdirectory).

3. Copy the pages of the measures you intend to use and read the descriptions carefully to ensure that you comply with the requirements as described. For example, measure #134 (Screening for depression) identifies examples of screening tools that may be used (clinicians can use other scales as well). In addition, it delineates the elements of a successful follow-up plan that must be conducted and documented in the patient’s chart.

4. You may wish to develop a reminder sheet or checklist to assist you in remembering which measures to use.

5. Report the measures.
<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>128</td>
<td>Body Mass Index Screening and Follow-Up (cross cutting measure)</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of Current Medications in Medical Record (cross cutting measure)</td>
</tr>
<tr>
<td>131</td>
<td>Pain Assessment and Follow-up (cross cutting measure)</td>
</tr>
<tr>
<td>134</td>
<td>Screening for Clinical Depression and Follow-up Plan (cross cutting measure)</td>
</tr>
<tr>
<td>173</td>
<td>Unhealthy Alcohol Use—Screening (registry only)</td>
</tr>
<tr>
<td>181</td>
<td>Elder Maltreatment Screen and Follow-up Plan (claims or registry)</td>
</tr>
<tr>
<td>226</td>
<td>Tobacco Use: Screening and Cessation Intervention (cross cutting measure; claims or registry)</td>
</tr>
<tr>
<td>317</td>
<td>Screening for Blood Pressure and follow-up Documentation (claims or registry)</td>
</tr>
<tr>
<td>325</td>
<td>Adult MDD: Coordination of Care of Patients with Specific Comorbid Conditions (registry only)</td>
</tr>
<tr>
<td>383</td>
<td>Antipsychotic medications for individuals with schizophrenia (registry or EHR only)</td>
</tr>
</tbody>
</table>

*Measures #9 (Major Depressive Disorder medication) and #107 (Major Depressive Disorder suicide risk assessment) can only be reported through Electronic Health Records (EHRs).*
Table 3: Quick Summary of Measures for Claims-Based Submissions\textsuperscript{10}

<table>
<thead>
<tr>
<th>Number, Measure, and Assessment Tools (if applies)</th>
<th>Domain</th>
<th>Eligibility (age, diagnosis)</th>
<th>Reporting Period</th>
<th>Procedure Codes</th>
<th>G-codes or CPT Category II codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>130: Documentation and verification of current medications in the medical record (cross cutting measure)</td>
<td>Patient Safety</td>
<td>18 yrs &amp; older, No diagnosis associated.\textsuperscript{11}</td>
<td>Report each visit during the 12 month reporting period.</td>
<td>90791, 90832, 90834, 90837, 90839, 96116, 96150, 96151, 96152</td>
<td>G8427-Obtained, updated, or reviewed the patient’s current medications. G8430-Patient not eligible for list of medications obtained, updated, or reviewed. G8428-List of medications not documented as obtained, updated, or reviewed, reason not given.</td>
</tr>
</tbody>
</table>

\textsuperscript{10} This is a quick summary to help psychologists decide which measures to consider. It is NOT a substitute for looking at the full description of measures as reported in CMS documents.

\textsuperscript{11} List must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. Include name, dosage, frequency, and route of entry

\textsuperscript{12} Standardized tool is required including but not limited to Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).
<table>
<thead>
<tr>
<th>Number, Measure, and Assessment Tools (if applies)</th>
<th>Domain</th>
<th>Eligibility (age, diagnosis)</th>
<th>Reporting Period</th>
<th>Procedure Codes</th>
<th>G-codes or CPT Category II codes</th>
</tr>
</thead>
</table>
| 134: Screening for Clinical Depression\(^{13}\) (cross cutting measure) | Community Population/ Health | 12 yrs & older; Screened for clinical depression. If positive, follow-up plan is documented. | Minimum of once reporting period. | 90791, 90832, 90834, 90837, 90839, 96116, 96118, 96150, 96151, 96152 | **G8431**- Positive clinical depression screening, follow-up plan documented.  
**G8510**- Negative clinical depression screening, follow-up plan not required.  
**G8433**- No clinical depression screening documented, patient not eligible.  
**G8940**-Positive clinical depression screening, follow-up plan not documented, patient not eligible.  
**G8432**-No clinical depression screening documented, reason not given.  
**G8511**-Positive clinical depression screening, follow-up plan not documented, reason not given. |
| 181: Elder Maltreatment Screen and Follow-Up Plan\(^{14}\) | Patient Safety | 65 years & older | Minimum once per reporting period. | 90791, 90832, 90834, 90837, 96116, 96150, 96151 | **G8733**- Positive elder maltreatment screen documented, follow-up plan documented.  
**G8734**- Negative elder maltreatment screen documented, follow-up not required.  
**G8535**-No elder maltreatment screen documented, patient not eligible.  
**G8941**- Positive elder maltreatment screen documented, no follow-up plan documented, patient not eligible.  
**G8536**- No elder maltreatment screen documented, reason not given.  
**G8735**- Positive elder maltreatment screen documented, no follow-up plan documented, reason not given. |
| 226: Preventive care and screening: tobacco use-screening and cessation intervention (cross cutting measure) | Community/ Population Health | 18 or older | Once during the 12 month reporting period | 90791, 90832, 90834, 90837, 90845, 96150, 96151, 90845 | **4004F with 1P**: documentation of medical reasons for not screening  
**4004F**: Screened and received cessation counseling  
**1036 F**: screened and non-user  
**4004 with 8P**: medical reason for not screening or not receiving cessation counseling |
| 317 Blood pressure | Community population health | 18 or older | Once per reporting period | 90791, 90832, 90834, 90837, 90839, 96118, 90845, 90880 | **G 8783** normal BP no follow-up  
**G8950** prehypertensive and follow-up  
**G 8784** BP not documented, patient not eligible  
**G 8951** prehypertensive or hypertensive documented, follow-up not documented patient not eligible  
**G8785** BP not document no reason given  
**G 8952** prehypertensive indicated, followed up not documented, no reason given |

\(^{13}\) Normalized and validated depression screening tool, not limited to: **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), PRIME MD-PHQ2;  
**Adult Screening Tools (18<):** 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-PHQ2

\(^{14}\) Screening must meet certain specifications found in the measure description.
Table 4: Quick Summary of Measures for Registry Based Submissions

<table>
<thead>
<tr>
<th>Number, Measure, and Assessment Tool</th>
<th>Domain</th>
<th>Eligibility (age, diagnosis)</th>
<th>Reporting Period</th>
<th>Procedures Codes</th>
<th>G-codes or CPT Category II codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>173: Unhealthy Alcohol Use</td>
<td>Community/Population Health</td>
<td>18 yrs &amp; older, No diagnosis associated w/ this measure.</td>
<td>Minimum once per reporting period</td>
<td>90791, 90832, 90834, 90837, 90845, 96150, 96151, 96152</td>
<td>3016F-Patient screened for unhealthy alcohol use using a systematic screening method 3016F with 1P-Document of medical reason(s) for not screening for unhealthy alcohol use 3016F with 8P-Unhealthy alcohol use screening not performed, reason not otherwise specified</td>
</tr>
<tr>
<td>325: Adult Major Depressive Disorder: Coordination of Care of Patients with Specific Comorbid Conditions</td>
<td>Effective Clinical Care</td>
<td>18 yrs &amp; older, Diagnosis of MDD and specific comorbid condition</td>
<td>Minimum once per reporting period</td>
<td>90791, 90832, 90834, 90837</td>
<td>G8959-Clinical treating MDD communicates to treating clinician of comorbid condition G9232-Clinician treating MDD did not communicate to clinician treating comorbid condition for specified patient reason G8960-Clinician treating MDD did not communicate clinician treating comorbid condition, reason not given</td>
</tr>
<tr>
<td>383: Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
<td>Patient Safety</td>
<td>18 yrs &amp; older, Diagnosis of Schizophrenia or Schizoaffective Disorder, Prescribed antipsychotic medication(s)</td>
<td>Minimum once per reporting period</td>
<td>90849, 90875, 90791, 90832, 90834, 90837, 90853, 91849</td>
<td>G9369-Performance Met: Individual filled at least two prescriptions for any antipsychotic medication and had a PDC of 0.8 or greater G9370-Performance Not Met: Individual who did not fill at least two prescriptions for any antipsychotic medication OR did not have a PDC of 0.8 or greater.</td>
</tr>
</tbody>
</table>

15 All of the measures that can be reported through claims-based submissions can also be reported through the registry. This chart only covers those measures that can be reported through the registry, but not through claims.

16 Unhealthy Alcohol Use, Systematic Screening Method: Alcohol Use Disorders Identification Test (AUDIT), CAGE Screening Instrument, AUDIT-C Screening Instrument, Single Screening Instrument

17 Medical records sent to treating comorbid condition physician

18 #383 may also be reported using electronic health records.

19 Readers are encouraged to look at the original CMS description of the measure because some procedure codes are linked to particular places of services.
Appendix A: Glossary

CMS (Centers for Medicare and Medicaid Services): the federal government agency that is part of the Department of Health and Human Services which, among other responsibilities, oversees the Medicare and Medicaid programs.

CPT (Current Procedure Terminology): Codes developed by the American Medical Association to designate which medical procedures were used.

Denominator: The eligible cases for a measure or the eligible patient population. Measures for the denominator include the ICD Code or patient demographics (age, gender, etc.) and place of service.

ICD (International Classification of Disease): The codes used to designate the medical condition of a patient. As of October 1, 2015, health care professionals must use the ICD-10 for billing insurance companies.

Measure: One of categories that can be reported on. The categories open to psychologists in 2015 are found in Table 2.

Numerator: The specific clinical action taken as measured by the Quality Data Codes (G codes, see definition below).

PQRS (Physician Quality Reporting System): the process by which Medicare rewards providers who voluntarily submit supplementary information on patients. In 2015, it became a penalty-based program.

Quality Data Code (CPT Category II code or G code): Codes used to identify whether or not a specific procedure was used or applied.

Quality Measure: A metric that permits the calculation of the percentage of the patient population that receives a particular process of care or particular outcome, based on the numerator and denominator.
**HEALTH INSURANCE CLAIM FORM**

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INSURED'S ID NUMBER</td>
<td>(For Program in Item 1)</td>
</tr>
<tr>
<td>2. PATIENT'S NAME</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3. PATIENT'S BIRTH DATE</td>
<td>(Month, Day, Year)</td>
</tr>
<tr>
<td>4. INSURED'S ID NUMBER</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5. PATIENT'S ADDRESS</td>
<td>(Street, City, State, Zip Code)</td>
</tr>
<tr>
<td>6. PATIENT-RELATIONSHIP TO INSURED</td>
<td>(Self, Spouse, Child, Other)</td>
</tr>
<tr>
<td>7. INSURED'S ADDRESS</td>
<td>(Street, City, State, Zip Code)</td>
</tr>
<tr>
<td>8. PATIENT STATUS</td>
<td>(Single, Married, Other)</td>
</tr>
<tr>
<td>9. OTHER INSURED'S NAME</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>10. IS PATIENT'S CONDITION RELATED TO:</td>
<td>(Employment, Auto Accident, Other Accident)</td>
</tr>
<tr>
<td>11. INSURED'S POLICY GROUP OR FECA NUMBER</td>
<td></td>
</tr>
<tr>
<td>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>(Typed or Handwritten)</td>
</tr>
<tr>
<td>13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE</td>
<td>(Typed or Handwritten)</td>
</tr>
<tr>
<td>14. DATE OF CURRENT ILLNESS</td>
<td>(Month, Day, Year)</td>
</tr>
<tr>
<td>15. ASSOCIATED ILLNESS OR INJURY</td>
<td>(Month, Day, Year)</td>
</tr>
<tr>
<td>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</td>
<td>(Month, Day, Year)</td>
</tr>
<tr>
<td>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</td>
<td>(NPI)</td>
</tr>
<tr>
<td>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</td>
<td>(Month, Day, Year)</td>
</tr>
<tr>
<td>19. RESERVED FOR LOCAL USE</td>
<td></td>
</tr>
<tr>
<td>20. OUTSIDE LAB?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>21. DIAGNOSIS OR NATURE OF ILLNESS</td>
<td>(Other than item 1, 2, 3 or 4 to item 24E by line)</td>
</tr>
<tr>
<td>22. MEDICAID RESUBMISSION CODE</td>
<td>(Original Ref. No.)</td>
</tr>
<tr>
<td>23. PRIOR AUTHORIZATION NUMBER</td>
<td></td>
</tr>
<tr>
<td>24. DATE(S) OF SERVICE</td>
<td>(Month, Day, Year)</td>
</tr>
<tr>
<td>25. FEDERAL TAX I.D. NUMBER</td>
<td></td>
</tr>
<tr>
<td>26. PATIENT'S ACCOUNT NO.</td>
<td></td>
</tr>
<tr>
<td>27. ACCEPT ASSIGNMENT?</td>
<td>YES/NO</td>
</tr>
<tr>
<td>28. TOTAL CHARGE</td>
<td></td>
</tr>
<tr>
<td>29. AMOUNT PAID</td>
<td></td>
</tr>
<tr>
<td>30. SERVICE LOCATION INFORMATION</td>
<td></td>
</tr>
<tr>
<td>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</td>
<td></td>
</tr>
</tbody>
</table>

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