The Tax Relief and Health Care Act of 2006 identifies clinical social workers as eligible professionals to participate in the Physician Quality Reporting System (PQRS). Participating in PQRS 2014 increases clinical social workers’ practice revenue by .5 percent. In addition, successful reporting of PQRS allows clinical social workers to avoid a two percent penalty in 2016 for not using measures in 2014.

2014 is the last year clinical social workers and other Medicare providers will be able to receive a bonus incentive payment for using quality measures satisfactory when providing services to Medicare beneficiaries. Because PQRS varies each calendar year, clinical social workers must become familiar with the rules and regulations of this program annually.

For clinical social workers, PQRS is used when providing psychotherapy services to Medicare beneficiaries who are covered by traditional Medicare fee for services (FFS), Railroad Retirement Board, and Medicare Secondary Payer. Not included in PQRS are Medicare Advantage Plans and Federally Qualified Health Centers.

2014 Measures

This document does not discuss PQRS group measures for situations in which a group practice is defined as a single Tax Identification Number (TIN) with two or more individual Medicare providers who have National Provider Identification (NPI) numbers and have reassigned their billing rights to the TIN. Group measures are discussed in a separate NASW Perspectives, Reporting Medicare PQRS 2014 Group Measures.

PQRS identifies individual measures that may be used by clinical social workers in private practice to improve the quality of care provided to Medicare beneficiaries. These measures are standards of care based on evidence-based practices. For 2014, there are a total of 110 claims performance measures and 8 of these are available for use by clinical social workers in private practice. Although Medicare providers have the options of reporting PQRS by claims, electronic health records, registry, or measure groups, claims appear to be the best method of reporting measures for clinical social workers in private practice. Clinical social workers should select individual measures that best describe the services provided in their private practice. PQRS 2014 measures available for use by clinical social workers include the following:

- The Affordable Care Act: Implications for Low and Moderate-Income Women’s Health and Well-Being
- Overcoming Economic Hardships
- 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
- Securing The Social Work Job You Seek: Advice For The Interview Process
- Setting and Maintaining Professional Boundaries
- State Health Insurance Exchanges: What Social Workers Need to Know
- The Value Of Social Work Mentoring
- Transitioning Across State Lines: Licensing Tips Beyond 9 To 5: ‘Working As A Consultant’
### PQRS Measures

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### Reporting Criteria
- Report each measure for at least 50 percent of the Medicare Part B Fee-For-Service patients seen during the reporting period for 2014.
- Report at least 9 measures covering at least three National Quality Strategy (NQS) domains. Domains associated with the measures are:
  1. Patient Safety
  2. Person and Caregiver-Centered Experience and Outcomes
  3. Communication and Care Coordination
  4. Effective Clinical Care
  5. Community/Population Health
  6. Efficiency and Cost Reduction
- If less than nine measures covering at least three NQS domains apply to you, report 1 to 8 measures covering 1-3 domains.
- Measures with a 0 percent performance rate will not be counted.

### INSTRUCTIONS

For 2014, clinical social workers do not need to sign-up nor pre-register to report PQRS individual measures. Participation in PQRS is indicated by reporting quality data codes (QDCs) on the CMS-1500 Form. Quality data codes identify the measures used by the Medicare provider and vary for each measure. A summary of instructions is as follows:

### Reporting Period

- PQRS measures are reported during the 12-month period of 2014, January 1 – December 31, 2014. A brief delay in getting started should not interfere with successful reporting in 2014.

### Selecting a Measure

- For 2014, select an individual measure from the list provided above which best describes the services most frequently provided in your private practice. Make sure the measure applies to the patient being seen. Avoid individual measures that do not or infrequently apply to the services you provide to Medicare patients.

### Claims Reporting

- Participation in PQRS 2014 is indicated by reporting QDCs on the CMS-1500 Form or electronically on the 837P Form. After reporting the psychotherapy services on item number 24, line 1, report the related QDCs on the following list by listing the date of service, place of service code, QDC, diagnosis pointer, modifier, charges, and the National Provider Identifier (NPI) number of the rendering provider.
- For charges, let $0.01 which is a non-chargeable fee provided to help ensure QDCs are processed into the CMS claims database. If applicable and by April 1, 2014, clinical social workers should update their billing software to accept the $0.01 charge prior to implementing PQRS 2014.
- Claims may not be resubmitted for the sole purpose of adding or correcting QDCs.
- If a denied claim is resubmitted through the appeals process to the Medicare Administrative Contractor (MAC) with accurate codes, then appropriate QDCs should also be included on the resubmitted claim.

### Claims Submission

- Claims submitted in 2014 with QDCs must be filed by February 27, 2015.
- On the Explanation of Benefits, denial code N365 is indication that the QDCs were received into the CMS claims database. N365 reads, “This procedure code not payable. It is for reporting/information purposes only.”

###Modifiers

- PQRS modifiers are unique and can only be used with QDCs to indicate actions in QDCs. If a modifier is required, it will be noted in the coding instructions. There are two types:
- Exclusion Modifiers and BP reporting modifier.
- Exclusion modifiers fall into three categories:
  1. 1P Performance measures exclusion modifier due to medical reasons
     - Not indicated (already received/performed, other)
     - Contraindicated (patient allergy history, potential adverse drug interaction, other)
     - Other medical reasons
  2. 2P Performance measure exclusion modifier due to patient reasons includes
     - Patient declined
     - Economic social or religious reasons
     - Other patient reasons
  3. 3P Performance measure exclusion modifier due to system reasons includes
     - Resources to perform the services not available (e.g., supplied)
     - Insurance coverage or payer-related limitations
     - Other reasons attributable to health care delivery system

### WHERE TO FIND QUALITY DATA CODES

It is important to follow the measures specifications for reporting the appropriate quality data codes.

**For 2014, clinical social workers do not need to sign-up nor pre-register to report PQRS individual measures. Participation in PQRS is indicated by reporting quality data codes (QDCs) on the CMS-1500 Form.**

**MEASURE NUMBER 106: ADULT MAJOR DEPRESSIVE DISORDER (MDD) COMPREHENSIVE DEPRESSION EVALUATION: DIAGNOSIS & SEVERITY**

Description: Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 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.
- The domain for this code is effective clinical care.
- One of the following Current Procedural Terminology (CPT) Codes must be used with this measure: 90791, 90832, 90834, 90837, and 90845.
- In order to use this measure, patient must have one of the following diagnosis for MDD:
  2. Diagnosis for MDD (ICD-10-CM) for use October 1 – December 31, 2014: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9.
- The clinical social worker should document evidence that the patient met the DSM-5 criteria for MDD and provide an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified.
For 2014, clinical social workers do not need to sign-up nor pre-register to report PQRS individual measures. Participation in PQRS is indicated by reporting quality data codes (QDCs) on the CMS-1500 Form.

REPORTING CRITERIA
- Participation in PQRS 2014 is indicated by reporting QDCs on the CMS-1500 Form or electronically on the 837P Form. After reporting the psychotherapy services on item number 24, line 1, report the related QDCs on the following line by listing the date of service, place of service code, QDC, diagnosis pointer, modifier, charges, and the National Provider Identifier (NPI) number of the rendering provider.
- For charges, list $0.02 which is a nonchargeable fee provided to help ensure QDCs are processed into the CMS claims database. If applicable and by April 1, 2014, clinical social workers should update their billing software to accept the $0.02 charge prior to implementing PQRS 2014.
- Claims may not be resubmitted for the sole purpose of adding or correcting QDCs. If a denied claim is corrected through the appeals process to the Medicare Administrative Contractor (MAC) with accurate codes, then appropriate QDCs should also be included on the resubmitted claim.
- Claims submitted in 2014 with QDCs must be filed by February 27, 2015.
- On the Explanation of Benefits, denial code N365 is indication that the QDCs were received into the CMS claims database. N365 reads, "This procedure code not payable. It is for reporting/information purposes only."

MODIFIERS
PQRS modifiers are unique and can only be used with QDCs to indicate actions in QDCs. If a modifier is required, it will be noted in the coding instructions. There are two types: Exclusion Modifiers and BP reporting modifier. Exclusion modifiers fall into three categories:
1. 1P Performance measures exclusion modifier due to medical reasons
   a. Not indicated (already received/performed, other)
   b. Contraindicated (patient allergy history, potential adverse drug interaction, other)
   c. Other medical reasons
2. 2P Performance measure exclusion modifier due to patient reasons includes
   a. Patient declined
   b. Economic/social or religious reasons
   c. Other patient reasons
3. 3P Performance measure exclusion modifier due to system reasons includes
   a. Resources to perform the services not available (e.g., supplied)
   b. Insurance coverage or payer-related limitations
   c. Other reasons attributable to health care delivery system

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 2014 PQRS Measures Specification Manual at the following link: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html. To assist in your search, below you will find a summary of quality data codes for each of the measures listed in this document.

INSTRUCTIONS
For 2014, clinical social workers do not need to sign-up nor pre-register to report PQRS individual measures. Participation in PQRS is indicated by reporting quality data codes (QDCs) on the CMS-1500 Form. Quality data codes identify the measures used by the Medicare provider and vary for each measure. A summary of instructions is as follows:

SELECTING A MEASURE
- For 2014, select an individual measure from the list provided above that best describes the services most frequently provided in your private practice. Make sure the measure applies to the patient being seen. Avoid individual measures that do not or infrequently apply to the services you provide to Medicare patients.

CLAIMS REPORTING
- Claims reporting for PQRS 2014 is indicated by reporting QDCs on the CMS-1500 Form or electronically on the 837P Form. After reporting the psychotherapy services on item number 24, line 1, report the related QDCs on the following line by listing the date of service, place of service code, QDC, diagnosis pointer, modifier, charges, and the National Provider Identifier (NPI) number of the rendering provider.
- For charges, list $0.01 which is a nonchargeable fee provided to help ensure QDCs are processed into the CMS claims database. If applicable and by April 1, 2014, clinical social workers should update their billing software to accept the $0.01 charge prior to implementing PQRS 2014.
- Claims may not be resubmitted for the sole purpose of adding or correcting QDCs. If a denied claim is corrected through the appeals process to the Medicare Administrative Contractor (MAC) with accurate codes, then appropriate QDCs should also be included on the resubmitted claim.
- Claims submitted in 2014 with QDCs must be filed by February 27, 2015.
- On the Explanation of Benefits, denial code N365 is indication that the QDCs were received into the CMS claims database. N365 reads, "This procedure code not payable. It is for reporting/information purposes only."

MODIFIERS
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   a. Not indicated (already received/performed, other)
   b. Contraindicated (patient allergy history, potential adverse drug interaction, other)
   c. Other medical reasons
2. 2P Performance measure exclusion modifier due to patient reasons includes
   a. Patient declined
   b. Economic/social or religious reasons
   c. Other patient reasons
3. 3P Performance measure exclusion modifier due to system reasons includes
   a. Resources to perform the services not available (e.g., supplied)
   b. Insurance coverage or payer-related limitations
   c. Other reasons attributable to health care delivery system

WHERE TO FIND QUALITY DATA CODES
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PQRS 2014 INDIVIDUAL MEASURES FOR CLINICAL SOCIAL WORKERS

CPT copyright 2013. American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.
Choose both of the following QDC to report on the claim form:
• 1040F: DSM-5 criteria for major depressive disorder documented at the initial evaluation
AND
• G9930: Assessment of depression severity at the initial evaluation
OR
Choose one QDC to submit on the claim form.
• 1040F with IP modifier: DSM-5 criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified
OR
• G9931: Assessment of depression severity not documented, reason not given

MEASURE NUMBER 107: ADULT MAJOR DEPRESSIVE DISORDER (MDD): SUICIDE RISK ASSESSMENT

Description: 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 of recurrent episode was identified.

• This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder (MDD) seen individually during the reporting period, including episodes of MDD that began prior to the reporting period.
• The domain for this code is effective clinical care.
• One of the following CPT codes must be used when using this measure: 90791, 90832, 90834, 90837, and 90845.
• In order to use this measure, patient must have one of the following diagnosis:
  2. Diagnosis for MDD (ICD-10-CM for use October 1 – December 31, 2014: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9)
• It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.
• Clinical social workers must document a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. The suicide risk assessment should include questions about the following:
  1. Suicidal ideation
  2. Patient’s intent of initiating a suicide attempt
  3. Patient’s plans for a suicide attempt
  4. Whether patient has means for completing suicide
One of the following QDCs may be reported using this measure:
• G9932: Suicide risk assessed at the initial evaluation
OR
• G9933: Suicide risk not assessed at the initial evaluation, reason not given

MEASURE NUMBER 128: PREVENTIVE CARE & SCREENING: BODY MASS INDEX (BMI) SCREENING & FOLLOW

Description: Percentage of patients aged 18 years and older with a documented BMI during the reporting period for all episodes of MDD that began prior to the reporting period, including episodes of MDD that began prior to the reporting period.

• This measure is to be reported a minimum of once per reporting period for patients seen individually during the reporting period.
• The reason for not documenting a BMI at the initial evaluation should be documented in the medical record.
• One of the following CPT codes must be used when using this measure: 90791, 90832, 90834, 90837, 90839, 96150, 96151, and 96152.
• Clinical social workers must document, update, or review a patient’s current medications using all immediate resources available on the date of the encounter.
• The domain for this measure is patient safety.
• There is no diagnosis associated with this measure.
• One of the following CPT codes must be used when reporting this measure: 90791, 90832, 90834, 90837, 90839, 96150, and 96152.

• Clinical social workers reporting this measure should document whether medication information is received from the patient, authorized representative(s), caregiver(s) or other available health care resources.

Select one of the following quality data codes to report this measure:
• G8420: BMI is documented within normal parameters and no follow-up plan is required
• OR
• G8417: BMI is documented above normal parameters and a follow-up plan is documented
• OR
• G8418: BMI is documented below normal parameters and a follow-up plan is documented
• OR
• G8422: BMI not documented, documentation the patient is not eligible for BMI calculation
• OR
• G8938: BMI is documented as being outside of normal limits, follow-up is not documented, documentation the patient is not is not eligible.
• OR
• G8421: BMI not documented and no reason is given
• OR
• G8419: BMI documented outside normal parameters, no follow-up plan documented, no reason given

MEASURE NUMBER 130: DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD

Description: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list should include all known prescriptions, over-the-counter, herbal, and vitamin/mineral/dietary supplements and should contain the medications’ name, dosage frequency and route of administration.

• This measure is to be reported each visit during the 12 month reporting period
• Clinical social workers should make their best effort to document a current and accurate medication list during each encounter.
• The domain for this measure is patient safety.
• There is no diagnosis associated with this measure.
• One of the following CPT codes must be used when reporting this measure: 90791, 90832, 90834, 90837, 96150, and 96152.

• Clinical social workers must document, update, or review a patient’s current medications using all immediate resources available on the date of the encounter.
• Route of administration is documented by the way the medication enters the body. Examples include oral, topical, and subcutaneous.
• Clinical social workers reporting this measure should document whether medication information is received from the patient, authorized representative(s), caregiver(s) or other available health care resources.

Select one of the following quality data codes to report this measure:
• G8427: Clinical social worker attests to documenting in the medical record the they obtained, updated, or reviewed the patient’s current medications. This measure should also be reported if the clinical social worker documented that the patient is not currently taking any medications
• OR
• G8430: Clinical social worker attests to documenting in the medical record the patient is not eligible for current list of medications being obtained, updated, or
Choose both of the following QDCs to report on the claim form:

- 1040F: DSM-5 criteria for major depressive disorder documented at the initial evaluation
- G9930: Assessment of depression severity at the initial evaluation

And:

- 1040F with SP modifier: DSM-5 criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified
- G9931: Assessment of depression severity not documented, reason not given

MEASURE NUMBER 107: ADULT MAJOR DEPRESSIVE DISORDER (MDD): SUICIDE RISK ASSESSMENT

Description: 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.

- This measure is to be reported a minimum of once during the reporting period for all patients with an active diagnosis of major depressive disorder (MDD) seen individually during the reporting period, including episodes of MDD that began prior to the reporting period.
- The domain for this code is effective clinical care.
- One of the following CPT codes must be used when using this measure: 90791, 90832, 90834, 90837, and 90845.
- In order to use this measure, patient must have one of the following diagnosis:
  2. Diagnosis of MDD (ICD-10-CM for use October 1 – December 31, 2014: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
- It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.
- Clinical social workers must document a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. The suicide risk assessment should include questions about the following:
  1. Suicide ideation
  2. Patient’s intent of initiating a suicide attempt
  3. Patient’s plans for a suicide attempt
  4. Whether patient has means for completing suicide

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

- G9932: Suicide risk assessed at the initial evaluation
- G9933: Suicide risk not assessed at the initial evaluation, reason not given

MEASURE NUMBER 128: PREVENTIVE CARE & SCREENING: BODY MASS INDEX (BMI) SCREENING & FOLLOW

Description: Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months. When the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

- This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period.
- There is no diagnosis associated with this measure.
- The domain for this code is community/population health.
- One of the following CPT codes must be used when using this measure: 90791, 90832, 90834, 90837, 90839, 96150, 96151, and 96152.
- The domain for this measure is patient safety.
- The measure is to be reported every six months. When the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months.

One of the following QDCs to report this measure:

- G8420: BMI is documented within normal parameters and no follow-up plan is required
- G8417: BMI is documented above normal parameters and a follow-up plan is documented
- G8418: BMI is documented below normal parameters and a follow-up plan is documented
- G8422: BMI not documented, documentation the patient is not eligible for BMI calculation
- G8938: BMI is documented as being outside of normal limits, follow-up is not documented, documentation the patient is not eligible
- G8421: BMI not documented and no reason is given
- G8419: BMI documented outside normal parameters, no follow-up plan documented, no reason given

MEASURE NUMBER 130: DOCUMENTATION OF CURRENT MEDICATIONS IN THE MEDICAL RECORD

Description: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list should include all known prescriptions, over-the-counter, herbal, and vitamin/mineral/dietary supplements and should contain the medications’ name, dosage frequency and route of administration.

- This measure is to be reported each visit during the 12 month reporting period.
- Clinical social workers should make their best effort to document a current and accurate medication list during each encounter.
- The domain for this measure is patient safety.
- There is no diagnosis associated with this measure.
- One of the following CPT codes must be used when reporting this measure: 90791, 90832, 90834, 90837, 90839, 96150, and 96152.
- Clinical social workers must document, update, or review a patient’s current medications using all immediate resources available on the date of the interview.
- Route of administration is documented by the way the medication enters the body. Examples include oral, topical, and subcutaneous.
- Clinical social workers reporting this measure should document whether medication information is received from the patient, authorized representative(s), caregiver(s) or other available health care resources.

Select one of the following quality data codes to report this measure:

- G8427: Clinical social worker attests to documenting in the medical record the patient’s current medications
- G8428: Clinical social worker attests to documenting in the medical record the patient’s current medications that are not currently taking any medications
- G8430: Clinical social worker attests to documenting in the medical record the patient’s current medications that are not currently taking any medications
- G8431: Clinical social worker attests to documenting in the medical record the patient’s current medications that are not currently taking any medications
- G8432: Clinical social worker attests to documenting in the medical record the patient’s current medications that are not currently taking any medications
on the date of the encounter using an age years and older screened for clinical depression Description: [DEPRESSION & FOLLOW-UP PLAN. MEASURE NUMBER 134. PREVENTIVE CARE tool and if positive, a follow-up plan is appropriate standardized depression screening OR documented on the date of the positive screen. The name of the standardized depression screening tool utilized must be documented as being positive and a follow-up plan is documented as obtained, updated, or reviewed by the eligible professional, reason not given.

SELECT ONE OF THE FOLLOWING QDCS TO REPORT THIS MEASURE:

G8431: Screening for clinical depression is documented as being positive and a follow-up plan is documented OR

G8510: Screening for clinical depression is documented as negative, a follow-up plan is not required OR

G8433: Screening for clinical depression not documented; documentation stating the patient is not eligible OR

G8940: Screening for clinical depression documented as positive, a follow-up plan not documented; documentation stating the patient is not eligible OR

G8432: Clinical depression screening not documented, reason not given OR

G8511: Screening for clinical depression documented as positive, follow-up plan not documented, reason not given.

MEASURE NUMBER 135. PREVENTIVE CARE & SCREENING: SCREENING FOR CLINICAL DEPRESSION & FOLLOW-UP PLAN.

Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the 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 to be reported a minimum of once per reporting period.

The domain for this code is community/ population health.

One of the following CPT codes must be reported when using this measure: 90791, 90832, 90834, 90837, 90829, 96150, and 96151.

The name of the standardized depression screening tool utilized must be documented in the medical record. Examples of depression screening tools include but are not limited to the following:

a. Adolescent Screening Tools (12-17 years). Patient Health Questionnaire for Adolescents (PHQ-10), Beck Depression Inventory-Primary Care Version (BDI-PCV), Mood Feeling Questionnaire (WFQ), Center for Epidemiologic Studies Depression Scale (CES-D) and PRIME MD PHQ2.

b. Adult Screening Tools (18 years and older). Patient Health Questionnaire (PHQ-9, Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (BESS), Duke Anxiety Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD PHQ2.

c. The follow-up plan must be related to a positive depression screening and must include one or more of the following:
   a. Additional evaluation for depression
   b. Suicide Risk Assessment
   c. Referral to a practitioner who is qualified to diagnose and treat depression
   d. Pharmacological interventions
   e. Other interventions or follow-ups for the diagnosis or treatment of depression

A patient is not eligible if one or more of the following conditions are documented:

a. Patient refuses to participate
b. 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

c. Situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example, cases of delirium or certain court appointed cases.
d. Patient has an active diagnosis of depression

Patient has a diagnosis of bipolar disorder

Select one of the following QDCs to report this measure:

G8431: Screening for clinical depression is documented as being positive and a follow-up plan is documented OR

G8510: Screening for clinical depression is documented as negative, a follow-up plan is not required OR

G8433: Screening for clinical depression not documented; documentation stating the patient is not eligible OR

G8940: Screening for clinical depression documented as positive, a follow-up plan not documented; documentation stating the patient is not eligible OR

G8432: Clinical depression screening not documented, reason not given OR

G8511: Screening for clinical depression documented as positive, follow-up plan not documented, reason not given.

MEASURE 181: ELDER MALTREATMENT SCREEN & FOLLOW-UP PLAN.

Description: Percentage of patientsages 65 years and older with a documented elder maltreatment screen using an [ELDER MALTREATMENT SCREENING TOOL] on the date of encounter and a documented follow-up plan on the date of the positive screen.

This measure is to be reported once during the reporting period. The documented follow-up plan must be related to positive elder maltreatment screening.

The domain for this code is patient safety.

One of the following CPT codes must be reported when using this measure: 90791, 90832, 90834, 90837, 96150, and 96151.

Patients must have a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of the encounter and follow-up plan documented on the date of the positive screen. Screen for elder maltreatment includes the following:

a. Physical abuse
b. Emotional or psychological abuse
c. Neglect (excludes self-neglect)
d. Sexual abuse
e. Abandonment
f. Financial or material exploitation and other medical reasons.
g. Unwarranted control

Patient is not eligible for this measure if one or more of the following reasons is documented:

a. Patient refuses to participate
b. 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

c. Situations where time is of the essence and to delay treatment would jeopardize the patient’s health status

Documented as negative, follow-up is not required.

Documented as positive, follow-up plan not documented, documentation stating the patient is not eligible for elder maltreatment screening.

DOCUMENTED AS POSITIVE, FOLLOW-UP NOT DOCUMENTED

Documented follow-up plan on the date of the positive screen. Screen for elder maltreatment includes the following:

a. Additional evaluation for depression
b. Suicide Risk Assessment
c. Referral to a practitioner who is qualified to diagnose and treat depression
d. Pharmacological interventions

e. Other interventions or follow-ups for the diagnosis or treatment of depression

A patient is not eligible if one or more of the following conditions are documented:

a. Patient refuses to participate
b. 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

c. Situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example, cases of delirium or certain court appointed cases.
d. Patient has an active diagnosis of depression

Patient has a diagnosis of bipolar disorder

SELECT ONE OF THE FOLLOWING QDCS TO REPORT THIS MEASURE:

G8431: Elder maltreatment screen documented as positive, follow-up plan documented OR

G8535: Elder maltreatment screen documented as positive, follow-up plan documented, reason not given.

MEASURE NUMBER 226: PREVENTIVE CARE & SCREENING: TOBACCO USE SCREENING & CESSATION INTERVENTION.

Description: 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 per patient.

The domain for this measure is community/ population health.

Tobacco use includes use of any type of tobacco.

Cessation Counseling intervention includes brief counseling (3 minutes or less).

One of the following CPT codes must be reported when using this measure: 90791, 90832, 90834, 90837, 90839, 90845, 96150, 96151, and 96132.

Select one of the following quality data codes to report this measure:

• 4004F: Patient screened for tobacco use and received tobacco cessation intervention counseling if identified as a tobacco user.

• 1036F: Patient screened for Tobacco Use and identified as a Non-User of Tobacco.

• 4004F: With 1p modifier: Documentation of medical reason(s) for not screening for tobacco use (eg., limited life expectancy, other medical reasons).

• 4004F with 8p modifier: Tobacco screening or tobacco cessation intervention not performed, reason not otherwise specified.
on the date of the encounter using an age
years and older screened for clinical depression
Description:
DEPRESSION & FOLLOW-UP PLAN.
 tool and if positive, a follow-up plan is
appropriate standardized depression screening
• G8428: Current list of medications not
documented as obtained, updated, or
reviewed by the eligible professional,
reason not given.
MEASURE NUMBER 134. PREVENTIVE CARE & SCREENING: SCREENING FOR CLINICAL DEPRESSION & FOLLOW-UP PLAN.
Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the 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 to be reported a minimum of once per reporting period.
• The domain for this code is community/population health
• One of the following CPT codes must be reported when using this measure: 90791, 90832, 90834, 90837, 90829, 96150, and 96151.
• The name of the standardized depression screening tool utilized must be documented in the medical record. Examples of depression screening tools include but are not limited to the following:
  a. Adolescent Screening Tools (12-17 years). Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D) and
  PRIME MD PHQ2.
  b. Adult Screening Tools (18 years and older). Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (BDIPS), Duke Anxiety Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and
  PRIME MD PHQ2.
• The follow-up plan must be related to a positive depression screening and must include one or more of the following:
  a. Additional evaluation for depression
  b. Suicide Risk Assessment
  c. Referral to a practitioner who is qualified to diagnose and treat depression
  d. Pharmacological interventions
  e. Other interventions or follow-up for the diagnosis or treatment of depression
• A patient is not eligible if one or more of the following conditions are documented:
  a. Patient refuses to participate
  b. 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
  c. Situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example, cases of delirium or certain court appointed cases.
  d. Patient has an active diagnosis of depression
  e. Patient has a diagnosis of bipolar disorder
Select one of the following QDCs to report this measure:
• G8431: Screening for clinical depression is documented as being positive and a follow-up plan is documented
OR
• G8510: Screening for clinical depression is documented as negative, a follow-up plan is not required
OR
• G8433: Screening for clinical depression not documented, documentation stating the patient is not eligible
OR
• G8940: Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible
OR
• G8432: Clinical depression screening not documented, reason not given
OR
• G8511: Screening for clinical depression documented as positive, follow-up plan not documented, reason not given

MEASURE NUMBER 135. PREVENTIVE CARE & SCREENING: SCREENING FOR ELDERR MALTREATMENT SCREEN & FOLLOW-UP PLAN.
Description: Percentage of patients ages 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter and a documented follow-up plan on the date of the positive screen.
• This measure is to be reported once during the reporting period. The documented follow-up plan must be related to positive elder maltreatment screening.
• The domain for this code is patient safety.
• One of the following CPT codes must be documented when using this measure: 90791, 90832, 90834, 90837, 96150, and 96151.
• Patients must have a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of the encounter and follow-up plan documented on the date of the positive screen. Screen for elder maltreatment includes the following:
  a. Physical abuse
  b. Emotional or psychological abuse
  c. Neglect (excludes self-neglect)
  d. Sexual abuse
  e. Abandonment
  f. Financial or material exploitation and uninsured control
• Patient is not eligible for this measure if one or more of the following reasons is documented:
  a. Patient refuses to participate
  b. 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
• The following conditions are documented:
  a. Elder Maltreatment Screen not performed, reason not otherwise specified
  b. Elder Maltreatment screen not performed, reason not given
Select one of the following quality data codes to report this measure:
• 4004F: Patient screened for tobacco use and received tobacco cessation intervention counseling if identified as a tobacco user
• 4004F with 8P modifier: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reasons)
• 1036F: Patient screened for Tobacco Use and identified as a Non-User of Tobacco
• 4004F: Patient screened for tobacco use and received tobacco cessation intervention counseling if identified as a tobacco user

MEASURE NUMBER 226. PREVENTIVE CARE & SCREENING: TOBACCO USE SCREENING & CESSATION INTERVENTION.
Description: 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 per patient
• The domain for this measure is community/population health.
• Tobacco use includes use of any type of tobacco.
• Cessation Counseling intervention includes brief counseling (3 minutes or less)
• One of the following CPT codes must be documented when using this measure: 90791, 90832, 90834, 90837, 90839, 90845, 96150, 96151, and 96132.
Select one of the following quality data codes to report this measure:
• 4004F: Patient screened for tobacco use and received tobacco cessation intervention counseling if identified as a tobacco user
• 1036F: Patient screened for Tobacco Use and identified as a Non-User of Tobacco
• 4004F: Patient screened for tobacco use and received tobacco cessation intervention counseling if identified as a tobacco user
• 4004F with 8P modifier: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reasons)
• 4004F with 8P modifier: Tobacco screening or tobacco cessation intervention not performed, reason not otherwise specified
Description: 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 period.

- 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 domain for this measure is effective clinical care.
- One of the following CPT codes must be reported when using this measure: 90791, 90832, 90834, 90837, 90839, 90845, 90847, 96150, 96151, and 96152.
- The patient must have one of the following diagnoses when using this measure.

1. **ICD-9-CM Diagnosis for substance abuse or dependence for use January 1, 2014 – September 30, 2014:**
   - 303.90, 303.91, 303.92, 304.00, 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, 304.70, 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, 305.32, 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, 305.81, 305.82, 305.90, 305.91, 305.92

2. **ICD-10-CM Diagnosis for substance abuse or dependence for use October 1, 2014 – December 31, 2014:**

Select one of the following quality data codes to report this measure.
- **1220F: Patient screened for depression**
- **1220F with a 1P modifier:** Documentation of medical reason(s) for not screening for depression
- **1220F with 8P modifier:** Patient was not screened for depression, reason not otherwise specified.

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

- **Physician Quality Reporting System:** Available online at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/PQRS/MeasuresCodes.html
- **Additional Resources:**
  - Physician Quality Reporting System: Available online at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
  - Quality Net Help Desk: Available M – F, 7:00 am – 7:00 pm CST. The phone numbers are 866-288-8912 and TTY: 877.715.6222. The email address is Qnetsupport@adps.org
  - NASW has participated in the development of PQRS measures and is advocating for additional performance measures for clinical social workers.
years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period.

- 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 domain for this measure is effective clinical care.
- One of the following CPT codes must be reported when using this measure: 90791, 90792, 90832, 90834, 90837, 90845, 90846, 90847, 96150, 96151, and 96152.
- The patient must have one of the following diagnoses when using this measure.

1. ICD-9-CM Diagnosis for substance abuse or dependence for use January 1, 2014 – December 30, 2014:
   - 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.24, 304.28, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 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, 305.32, 305.33, 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, 305.81, 305.82, 305.90, 305.91, 305.92

2. ICD-10-CM Diagnosis for substance abuse or dependence for use October 1, 2014 – December 31, 2014:

Select one of the following quality data codes to report this measure.

- **1220F**: Patient screened for depression
  - **OR**
  - **1220F with a 1P modifier**: Documentation of medical reason(s) for not screening for depression
  - **OR**
  - **1220F with 8P modifier**: Patient was not screened for depression, reason not otherwise specified.

**Additional Resources**


*Hyperlinks may change without notice.*
Using Medicare PQRS 2014 Individual Measures in Clinical Practice*

The Tax Relief and Health Care Act of 2006 identifies clinical social workers as eligible professionals to participate in the Physician Quality Reporting System (PQRS). Participating in PQRS 2014 increases clinical social workers’ practice revenue by 5 percent. In addition, successful reporting of PQRS allows clinical social workers to avoid a two percent penalty in 2016 for not using measures in 2014.

2014 is the last year clinical social workers and other Medicare providers will be able to receive a bonus incentive payment for using quality measures satisfactory when providing services to Medicare beneficiaries. Because PQRS varies each calendar year, clinical social workers must become familiar with the rules and regulations of this program annually.

For clinical social workers, PQRS is used when providing psychotherapy services to Medicare beneficiaries who are covered by traditional Medicare fee for services (FFS), Railroad Retirement Board, and Medicare Secondary Payer. Not included in PQRS are Medicare Advantage Plans and Federally Qualified Health Centers.

2014 Measures
This document does not discuss PQRS group measures for situations in which a group practice is defined as a single Tax Identification Number (TIN) with two or more individual Medicare providers who have National Provider Identification (NPI) numbers and have reassigned their billing rights to the TIN. Group measures are discussed in a separate NASW Practice Perspectives, Reporting Medicare PQRS 2014 Group Measures.

PQRS identifies individual measures that may be used by clinical social workers in private practice to improve the quality of care provided to Medicare beneficiaries. These measures are standards of care based on evidence-based practices. For 2014, there are a total of 110 claims performance measures and 8 of these are available for use by clinical social workers in private practice. Although Medicare providers have the options of reporting PQRS by claims, electronic health records, registry, or measure groups, claims appear to be the best method of reporting measures for clinical social workers in private practice. Clinical social workers should select individual measures that best describe the services provided in their private practice.

PQRS 2014 measures available for use by clinical social workers include the following:...