PQRS For Neuropsychologists

By Randi Most
ABN Practice Committee Chair

If you provide services to Medicare patients, and you are not familiar with the Physician Quality Reporting System (PQRS) – then it's time to get your head out of the sand and pay attention. This program is Medicare's entrance into the new world of "pay for performance", and psychologists are not only eligible to participate – but will soon be penalized for not participating. Participation will become mandatory in 2015. However, you must start reporting this year, to avoid a financial penalty in 2015. Medicare has delineated a variety of clinical measures that need to be performed, documented and coded. APA, NAN and CMS have published comprehensive descriptions of the PQRS requirements and the purpose of this article is to attempt to consolidate that information into a user-friendly starter kit, specifically aimed at neuropsychologists. *Please note that this information is for educational and guidance purposes only and is not to be construed as legal advice, or a guarantee of reimbursement or passing a Medicare audit. Clinicians assume sole responsibility for their actions in utilizing these measures within their practice.*

APA has addressed the 13 individual measures that are available for use by psychologists for therapy and general clinical issues (i.e. depression, substance abuse, etc.) and this information is available on the APA website. Additionally, Medicare has identified 3 sets of measures that can be utilized by neuropsychologists: Dementia (Group Measure), Epilepsy (Individual Measures #266-268) and Parkinson's (Group Measures #289-294, see pages 176-183 of this CMS Group Measures document for details. You should select the one that is most applicable to your patient population. Since the Dementia measures are the ones that will probably be used by most neuropsychologists, those are the ones that will be reviewed in detail in this article.

Reporting: Number of Patients and Timeframe

There are two issues involved in when deciding what and how much to report:

1. In order to avoid the 1.5% penalty (i.e. you will be paid 98.5% of the posted reimbursement rate) in 2015, you need to report only one full set of measures on one patient during 2013.
2. In order to earn the 0.5% incentive payment, you must report the full set of dementia measures on a minimum of 20 eligible patients during 2013. If you think you will see less than 20 eligible patients during 2013, you can either forfeit the incentive payment (which is unlikely to be a significant sum of money for most folks), or you can choose to report at least three individual measures (i.e. either epilepsy or the ones used by general psychologists, not the dementia codes) on 50% of eligible patients.

Eligible Patients

Any patient with one of the following 24 diagnostic codes is considered eligible for reporting the dementia measures: 094.1, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.0, 294.10, 294.11, 294.20, 294.21, 294.8, 331.0, 331.11, 331.19, 331.82

Procedure codes that can be used with these diagnoses are: 90791, 90792, 90832, 90834, 90837, 96116, 96118, 96119, 96120, 96150, 96151, 96152, 96154

Dementia Measures

There are 9 measures within the dementia group. You must report on all 9 measures on each patient that you wish to "count" towards your total. The measures are as follows:

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

Coding and Documentation

Each measure has a set of codes to choose from when reporting. It is imperative that you document in your clinical record how each of these measures has been addressed. How you choose to address these measures with each of your patients is up to you. NAN has a table listing the specific codes that go with each of these measures on their website.
Additionally, CMS has a detailed description of both the codes and clinical criteria associated with each of these measures, including scales/tests that would meet these criteria. It is recommended that you review pages 162-175 of CMS Measures Groups Specifications Manual, referenced and linked in the second paragraph, for this information.

Much of the information that Medicare is looking for would typically be included in any neuropsychological evaluation and will not require much, if any special attention. This would certainly be the case for #280 Staging of Dementia and #281 Cognitive Assessment. #282 Functional Status Assessment can be done via clinical interview with the patient/family and/or by use of a scale. In addition to those mentioned by CMS, there are numerous other clinical measures that many neuropsychologists probably use for this purpose – including (but not limited to) the Texas Functional Living Scale. The Everday Cognition Scale (ECog) or the Blessed Dementia Rating Scale should also meet the CMS criteria for this measure.

For #283 Neuropsychiatric Symptom Assessment, CMS lists a sample of specific activity, mood and thought/perceptual disturbances they are interested in. This information can be obtained via clinical interview and/or using measures of your choice. This sample list is likely the type of information for which an auditor would search. Therefore, it would be wise to comment on these symptoms somewhere in your records. With regard to #284 Management of Neuropsychiatric Symptoms - a note in your records indicating that the patient is either already receiving psychiatric treatment or psychotropic medication should suffice. If you feel that the patient needs treatment, but is not currently receiving any, then making such a recommendation in your report to the referring physician, or actually referring the patient to an appropriate specialist, should meet the criteria for "ordering" neuropsychiatric treatment as outlined by CMS. #285 Screening for Depressive Symptoms can probably be accomplished via clinical interview with the patient and family, and/or with a scale – such as the Geriatric Depression Scale.

The last three measures are best suited to feedback sessions, which raises the issue of how to handle these measures with patients who do not return for feedback. This question was posed to CMS and they indicated via written communication that recommendations regarding Safety, Driving, and Caregiver Education can be provided in the report back to the referring physician. They will consider the measure completed even if the direct counseling is provided by the referring physician – since it is based on recommendations originating in the neuropsychological report. The criteria can also be met by providing information to the patient/family at the time of the evaluation and/or by mailing any pertinent materials in lieu of a feedback session.

#286 Counseling Regarding Safety Concerns – CMS again lists specific safety concerns that they are interested in. Much of this can be included in interview and/or discussion section of the neuropsychological report. Checklists and surveys on this issue can be found on the Alzheimer's Association Website and adapted for your use.

#287 Counseling Regarding Risks of Driving – both assessing driving capabilities and counseling the patient/family should be addressed. In addition to using neuropsychological measures and clinical interview to address this issue, there are several excellent websites that provide surveys and informational material that can be adopted for use by the clinician, as well as questionnaires and videos for the patient/family. Some suggested websites are AMA, AAA, and AARP.

#288 Dementia: Caregiver Education and Support – this is obviously a pretty generalized category that can be met in many ways. Here is a fairly comprehensive list of caregiver resources that can be adopted by the clinician to assist in meeting the criteria for this measure.

Coding on CMS 1500 Claim Forms

The codes are entered onto the claim form as a line item – just as any other procedure. The first thing you must do is notify Medicare that you intend to report on the Dementia Group Measure. This only needs to be once for the entire year. Do this by using code G8902 on the claim form for your first eligible patient. Use the date of the first visit and make sure the diagnosis pointer is attached to one of the eligible diagnoses previously listed. Use 1 cent (0.01) as the charge for this line item (apparently some systems will not accept 0.00).

In order to receive credit towards your 20 cases, you must report on all 9 measures for that patient. All measures do not have to be completed in one visit and multiple visits are acceptable. If you do not complete the action needed for all 9 measures, then you will need to use the "no action taken" codes, that can found in either the NAN or the CMS documents referenced above. If you complete the action needed for all 9 measures, you use can use one composite code - G8761. Enter this code for the visit date that you completed the last one. If you did not complete all 9 actions, but you plan to report on all 9 measures, you will need to code each measure individually. Enter these the same way as the intent code described above. A sample of a completed CMS 1500 claim form can be found here (Sample Claim).

Please note that there is a difference between reporting on a measure and taking action on it. Let's take for example, measure #287 - Counseling Regarding Risks of Driving. If you provide such counseling, then you have completed the action required by this measure, and it will count towards the composite code G8761. But what if your patient is legally blind and has no driver's license? Obviously, such counseling is not appropriate. So you would need to use code 6110F with 1P as the modifier – "counseling not provided regarding risks of driving for medical reasons". This will count towards the 20 case minimum, but you cannot use the composite code with this patient.

The EOB will show a denial remark code (N365) for the line items containing the reporting codes (i.e. G8761). This indicates the code is not payable, is used for reporting purposes only.

Each measure only has to be addressed one time per patient.

The above represents a simplified version of the most up-to-date information on the PQRS system that we currently have available. If anyone has any additional information, corrections to the above, or anecdotal experiences to share please contact me at dr@rmost.com.