2016 is the 9th reporting year for the Physician Quality Reporting System (PQRS) which identifies measures used by clinical social workers in private practice to improve the quality of care provided to Medicare beneficiaries. Because PQRS varies each calendar year, clinical social workers must become familiar with the reporting criteria of this program annually. NASW encourages its members who are Medicare providers to use PQRS 2016 as one of the indicators for the provision of quality services and to avoid a negative payment adjustment in 2018 of two percent.

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. For 2016, a negative payment adjustment of two percent will occur for lack of participation in PQRS or failing to report PQRS successfully. In addition, the value-based modifier differential payment based on the quality of care furnished, will
not apply in 2016 to non-physician practitioners such as clinical social workers and psychologists.

PQRS measures are developed through a variety of resources including the Centers for Medicare and Medicaid Services (CMS), the National Quality Forum (NQF), and the National Committee on Quality Assurance (NCQA). NASW has participated in the development of PQRS measures and is advocating for additional performance measures for clinical social workers.

2016 PQRS Measures

PQRS measures are standards of care based on evidence-based practices. For 2016, there are a total of 281 measures, and 11 of these are available for use by clinical social workers. 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. For clinical social workers, registry reporting is a second option which may require an annual fee to use.

In 2016, it is important for clinical social workers to familiarize themselves with the reporting criteria of each measure they choose to report because the reporting criteria may vary including the frequency and timeframe.

PQRS 2016 Retired Measures Used by Clinical Social Workers

In 2015, there were a total of 8 claims and registry measures used by clinical social workers. In 2016, one of those measures has been retired. It is:

<table>
<thead>
<tr>
<th>PQRS Number</th>
<th>Reporting Option</th>
<th>Retired Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>173</td>
<td>Registry</td>
<td>Preventive Care and Screening: Unhealthy Alcohol Use-Screening</td>
</tr>
</tbody>
</table>
PQRS 2016 Claims and Registry Measures Available for Use by Clinical Social Workers

Clinical social workers who select the option of claims reporting have a total of five PQRS measures to report. Those who choose the option of registry reporting have a total of 11 measures to report. Claims reporting is generally used by those in solo or group practices with a small Medicare population. Solo or group practices with a large Medicare population may benefit from registry reporting. For 2016, the claims and registry measures available for use by clinical social workers include the following:

<table>
<thead>
<tr>
<th>PQRS Number</th>
<th>Reporting Option</th>
<th>Active Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>128</td>
<td>Claims, Registry</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
</tr>
<tr>
<td>130</td>
<td>Claims, Registry</td>
<td>Documentation of Current Medications in the Medical Record</td>
</tr>
<tr>
<td>134</td>
<td>Claims, Registry</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
<tr>
<td>181</td>
<td>Claims, Registry</td>
<td>Elder Maltreatment Screen and Follow-Up Plan</td>
</tr>
<tr>
<td>226</td>
<td>Claims, Registry</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td>325</td>
<td>Registry</td>
<td>Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions</td>
</tr>
<tr>
<td>370</td>
<td>Registry</td>
<td>Depression Remission at Twelve Months</td>
</tr>
<tr>
<td>383</td>
<td>Registry</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
</tr>
<tr>
<td>402</td>
<td>Registry</td>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
</tr>
</tbody>
</table>
INSTRUCTIONS FOR CLAIMS REPORTING

For 2016, 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 or the electronic 837P form. QDCs identify the measures used by Medicare providers and also vary for each measure. For claims reporting, PQRS is reported at the same time a claim is submitted for services performed.

Reporting Period
PQRS measures are reported during the 12 month period of 2016, January 1 – December 31, 2016. A brief delay in getting started may not interfere with successful reporting in 2016.

Selecting a Measure

For 2016, select an individual measure from the PQRS measure list provided in this document that best describes the services most frequently provided in your private practice. Avoid an individual measure that does not apply to the services you provide to Medicare patients. PQRS measure reporting is also required in the patient’s clinical record and may include the following:

- Measures name(s) and number(s)
- Quality Data Code(s)
- Domain
- Cross-cutting measure selected (at least one cross-cutting measure should be reported)
- Screening tool used, if appropriate
**Reporting Criteria**

Clinical social workers should give special attention to the reporting criteria of PQRS 2016 which includes the following:

- Report PQRS measure for at least 50 percent of Medicare Part B patient population who are fee-for service, Railroad Retirement Board, and Medicare Secondary Payer. For example, clinical social workers with a total of five Medicare patients should report PQRS measures for a least three Medicare patients. NASW recommends its members to report PQRS for all of their patients.

- Report at least 9 measures covering at least three National Quality Strategy (NGS) domains. Clinical social workers who do not have 9 measures to report, may report 1 to 8 measures covering three domains.

- Domains associated with the measures are:
  - Patient Safety
  - Person and Caregiver-Centered
  - Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction

- When at least one Medicare patient is seen in a face-to-face encounter, clinical social workers should report at least one measure that is cross-cutting. A cross-cutting measure draws attention to symptoms that are important across diagnoses. Cross-cutting measures listed in this document are measure numbers 128, 130, 134, 226, 402, and 431.

- Measures with a 0 percent performance rate are not counted in PQRS.
- Clinical social workers and other Medicare providers who report 1 to 8 PQRS measures covering three NQS domains for at least 50 percent of their Medicare fee for service patients, may be subject to the Measure-Applicability Validation (MAV). This process determines whether Medicare providers should have reported quality data codes for additional measures and NQS domains. It also verifies whether clinical social workers are reporting cross-cutting measures.

**Claims Reporting**

The deadline for submitting PQRS 2016 by claims is February 24, 2017. Claims for services furnished near the end of the reporting period should be submitted promptly. In addition:

- Participation in PQRS 2016 claims option 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- if applicable, charges, and the National Provider Identifier (NPI) number of the rendering provider or the provider. A sample of a completed CMS-1500 form is available online at the following link on page 46: [https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads/2015_pqrs_implementaionguide.pdf](https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/downloads/2015_pqrs_implementaionguide.pdf)

- For charges, you may list $0.00 or $0.01 (some computers do not allow $0.00) which is a non-chargeable fee provided to help ensure QDCs are processed into the CMS claims database. It is required for PQRS reporting purposes only. On the explanation of benefits, clinical social workers who charged $0.00 will receive the denial code, N620, which indicates the PQRS codes are valid for the PQRS 2016 reporting year. Clinical social workers who charged $0.01 will receive the denial code CO 246 N620. The N620 denial code is only an indicator that the QDC codes are valid for PQRS 2016. It does not guarantee that the QDC is used correctly.
• Clinical social workers should follow their normal billing practice of placing their individual NPI on the CMS-1500 Form, line item number 33a. When a group bills, the rendering provider’s NPI is submitted on line item number 24j for allowed charges and quality-data line items.

• QDCs reported on claims denied for payment are not included in the PQRS analysis.

• 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.

**Modifiers**

QDC 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 measure specifications. There are two types: exclusion modifiers and 8P reporting modifier. Exclusion modifiers fall into three categories:

1. **1P Performance measures exclusion modifier due to medical reasons** includes
   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., supplies)
b. Insurance coverage or payer-related limitations  
c. Other reasons attributable to health care delivery system

The 8P reporting modifier is available for use only with QDCs to facilitate reporting an eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending the reporting modifier to the QDC are included in the applicable measure.

PQRS 2016 INDIVIDUAL MEASURES FOR CLINICAL SOCIAL WORKERS

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Measure Number 128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.

Domain: Community/Population Health  
Reporting Options: Claims or Registry  
Cross-Cutting Measure: Yes

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

Instructions for Measure Number 128

- 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.
• One of the following CPT codes must be used when using this measure: 90791, 90832, 90834, 90837, 90839, 96150, 96151, and 96152.

• This measure may be reported by clinical social workers who perform the quality actions described in the measure based on the services provided at the time of the visit. The BMI documented in the medical record may be reported if done in the provider’s office or if a BMI is documented with the previous six months in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented during the current encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, for example: “Patient referred to nutrition counseling for BMI above normal parameters.” If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met.

• If a BMI is not obtained from an outside medical record, the provider is required to measure both height and weight in the same six months. Self-reported values cannot be used.

• BMI normal parameters are: Age 65 years and older BMI >23 and <30 kg/m², Age 18-64 years, BMI > 18.5 and < 25 kg/m².

• BMI can be calculated using:

   English Units: BMI = Weight (lbs) /Height (in) X Height (in) X 703

• The follow-up plan outlines the treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include, but is not limited, to the following:

   1. Documentation of education
   2. Referral to registered dietitian, nutritionist, mental health professional, primary care provider, etc.
3. Pharmacological interventions
4. Dietary supplements
5. Exercise counseling
6. Nutrition counseling

- A patient is not eligible for a BMI calculation or a follow-up plan if one or more of the following is documented.

1. Patient is receiving palliative care.
2. Patient is pregnant.
3. Patient refuses BMI measurement.
4. Other reasons should be documented in the clinical record as to why the BMI calculation or follow-up plan was not appropriate.
5. Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient’s health status.

Choose one of the following QDCs to report this measure.

- **G8420**: BMI is documented within normal parameters and no follow-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
- **G8938**: BMI is documented as being outside of normal limits, follow-up is not documented, documentation the patient 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.**

**Domain:** Patient Safety  
**Reporting Options:** Claims or Registry  
**Cross-Cutting Measure:** Yes  

**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 must include all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements and must contain the medications’ name, dosage, frequency and route of administration.

**Instructions for Measure Number 130**

- 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, complete, and accurate medication list during each encounter.

- 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, 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 interview.

• Route of administration is documented by the way the medication enters the body. Examples include oral, topical, sublingual and subcutaneous injections.

• 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 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 reviewed by the clinical social worker. Patient is not eligible if they are in an urgent or emergency medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.

  OR

• G8428: Current list of medications not documented as obtained, updated, or reviewed by the clinical social worker, reason not given.

Measure Number 134. Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan.

Domain: Community/Population Health
Reporting Options: Claims or Registry
Cross-Cutting Measure: Yes

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.

Instructions for Measure Number 134

- This measure is to be reported a minimum of once per reporting period.

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

- A screening is a completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

- The name of the age appropriate, validated, 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 (DEPS), 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

• **G8432**: Clinical depression screening not documented, reason not given.

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

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

**Measure 181: Elder Maltreatment Screen and Follow-Up Plan**

**Domain:** Patient Safety  
**Reporting Options:** Claims or Registry  
**Cross-Cutting Measure:** No

**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 a minimum of once during the reporting period**. The documented follow-up plan must be related to positive elder maltreatment screening.

- 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 one or more of the following:
- **Physical Abuse** – infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.

- **Psychological Abuse** – Willful infliction of mental or emotional anguish by threat, humiliation, or other verbal or nonverbal conduct.

- **Neglect (active or passive)** – Involves attitudes of others or actions caused by others such as family members, friends, or institutional caregivers that have an extremely detrimental effect upon well-being.
  - Active – behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.
  - Passive – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

- **Sexual Abuse** – Forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.

- **Elder Abandonment** – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder or by a person with physical custody of an elder.

- **Financial or Material Exploitation** – Taking advantage of a person for monetary gain or profit.

- **Unwarranted Control** – Controlling a person’s ability to make choices about living situations, household finances, and medical care.

- Follow-Up Plan must include a documented report to state or local Adult Protective Services (APS) or a similar agency in patient’s jurisdiction where the Elder maltreatment is taking place.
• Patient is not eligible for this measure if one or more of the following reasons is documented:
  ➢ Patient refuses to participate and has reasonable decisional capacity for self-protection.
  ➢ Patient is in an urgent or emergency situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.

• Document the elder maltreatment screening tool used. Examples include but are not limited to the following:
  ➢ Elder Abuse Suspicion Index (EASI)
  ➢ Vulnerability to Abuse Screening Scale (VASS)
  ➢ Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)

Choose one of the following QDCs to report this measure:

• **G8733**: Elder maltreatment screen documented as positive and a follow-up plan is documented.

OR

• **G8734**: Elder maltreatment screen documented as negative, follow-up is not required.

OR

• **G8535**: Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen.

Or

• **G8941**: Elder maltreatment screen documented as positive, follow-up plan not documented. Documentation the patient is not eligible for follow-up plan. Patient is not eligible if one or more of the following reasons is documented:
  ➢ Patient refuses to participate and has reasonable decisional capacity for self-protection.
  ➢ Patient is in an urgent or emergency situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.
Or

- **G8536**: No documentation of an elder maltreatment screen, reason not given.

Or

- **G8735**: Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given.

**Measure Number 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention.**

**Domain**: Community/Population Health  
**Reporting Options**: Claims or Registry  
**Cross-Cutting Measure**: Yes

**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.

**Instructions for Measure Number 226**

- This measure is reported once per reporting period per patient.
- There is no diagnosis associated with this measure.
- Tobacco use includes use of any type of tobacco.
- Tobacco cessation intervention includes brief counseling (3 minutes or less) and or pharmacotherapy.
- One of the following CPT codes must be reported when using this measure: 90791, 90832, 90834, 90837, 90845, 96150, 96151, and 96152.

Select one of the following quality data codes to report this measure
- **4004F**: Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both) if identified as a tobacco user.

**OR**

- **1036F**: Patient screened for tobacco use and identified as a non-user of tobacco.

**OR**

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

**OR**

- **4004F with 8P modifier**: Tobacco screening or tobacco cessation intervention not performed, reason not otherwise specified. Also report when patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention.

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**Measure 325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions**

**Domain**: Communication and Care Coordination  
**Reporting Option**: Registry Only  
**Cross-Cutting Measure**: No

**Description**: Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition.

**Instructions for Measure Number 325**

- This measure is **reported a minimum of once per reporting period**.
- One of the following CPT codes must be reported when using this code: 90791, 90832, 90834, 90837, 90845.

- One of the following diagnosis for Major Depressive Disorder must be used when reporting this measure:

**Diagnosis for MDD (ICD-10-CM):** F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9

AND


OR


OR

**Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-10-CM):** I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.222, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

OR

**Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-10-CM):** N18.4, N18.5, N18.6
Diagnosis for heart failure: 111.0, 113.0, 113.2, I50.1, I50.20, I50.21, I50.22, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9

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

- **G8959**: Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition

- **G9232**: Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition for specified patient reason

- **G8960**: Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition, reason not given

**Measure Number 370: Depression Remission at Twelve Months**

**Domain**: Effective Clinical Care  
**Reporting Option**: Registry Only  
**Cross-Cutting**: No

**Description**: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score >9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 indicates a need for treatment.

**Instructions for Measure Number 370**

- This measure is to be **reported once per reporting period** for patients seen during the denominator identification measurement period with a diagnosis of depression and an initial PHQ-9 greater than 9.
• One of the following CPT codes must be used: 90791, 90832, 90834, and 90837.

• **Patient must have a diagnosis of MDD (ICD-10-CM):** F32.0, F32.1, F32.2, F323.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1

• Adults who achieved remission at twelve months must have a PHQ-9 score of less than five.

• Patients are ineligible for this code if they died, received hospice or palliative care service, were permanent nursing home residents, had a diagnosis of bipolar disorder or personality disorder.

Select one of the following QDC codes to report this measure:

**G9509:** Remission at twelve months as demonstrated by twelve month PhQ-9 score of less than five.

Or

**G9510:** Remission of twelve months not demonstrated by a twelve month PHQ-9 score of less than five. Either PHQ-9 score was not assessed or is greater than or equal to 5.

**Measure Number 383: Adherence to Antipsychotic Medications for Individuals with Schizophrenia**
Domain: Patient Safety
Reporting Options: Registry Only
Cross-Cutting Measure: No

**Description:** Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescriptions filled for any antipsychotic medication and had a Proportion of Days Covered (PDC) of at least .8 for antipsychotic medications during the measurement period.

**Instructions for Measure Number 383**

- This measure is to be reported a minimum of once per reporting period.

- Diagnosis associated with this measure are: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.888889, F20.9, F21, F25.0, F25.1, F25.8, F25.9

- One of the following CPT codes must be used: 90791, 90832, 90834, 90837, 90839, 90845, 90847, and 90853.

- Select one of the following place of service codes to use: 11, 12, 13, 14, 15, and 33

- Typical antipsychotic medications include: chlorpromazine, fluphenazine, haloperidol, loxapine, molindone, perphenazine, perphenazine-amitriptyline, pimozide, prochlorperazine, thioridazine, thiothixene, trifluoperazine, aripiprazole, asenapine, clozapine, olanzapine, olanzapine-fluoxetine iIoperidone, lurasidone, paliperidone, quetiapine, risperidone, ziprasidone.
Select one of the following G codes:

- **G9512**: Individual had a PDC of 0.8 or greater
- OR
- **G9513**: Individual did not have a PDC of 0.8 or greater

**Measure Number 402: Tobacco Use and Help with Quitting Among Adolescents**

**Domain:** Community/Population Health  
**Reporting Options:** Registry  
**Cross-Cutting Measure:** Yes

**Description:** The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.

**Instructions for Measure Number 402**

- This measure is **reported once per reporting period**.

- Patients must be screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) and received tobacco cessation counseling intervention if identified as a tobacco user.

- Clinician must document active or current use of tobacco products including smoking.

- Clinician must document tobacco use status such as “never” or “non-user.”

Select one of the following QDC codes to report this measure.

- **G9458**: Patient documented as tobacco user and received tobacco cessation intervention (must include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or
tobacco cessation support programs, or current enrollment in smoking or tobacco use cessation program) if identified as a tobacco user.

OR

- **G9459**: Currently a tobacco non-user

OR

- **G9460**: Tobacco assessment or tobacco cessation intervention not performed, reason not otherwise specified.

**Measure Number 411: Depression Remission at Six Months:**

**Domain:** Communication and Care Coordination  
**Reporting Option:** Registry Only  
**Cross-Cutting Measure:** No

**Description:** Adults 18 years and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

**Instructions for Measure Number 411**

- The measure is **reported once per reporting period**.

- One of the following diagnosis for MDD must be used: F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.2, F33.3, F33.40, F33.41, F33.42, F33.9, F34.1

- Select one of the following CPT codes to use: 90791, 90832, 90834, 90837.

- Ineligible patients for this code are: patients who died, received hospice or palliative care service, were permanent residents in a nursing home, had a diagnosis of bipolar or personality disorder.
• Patient must achieved remission at six months as demonstrated by a six month PHQ-9 score of less than five.

Choose one of the following QDC codes:

**G9573**: Remission at six months as demonstrated by a six month PHQ-9 score of less than five.

**Or**

**G9574**: Remission at six months not demonstrated by a six month PHQ-9 score of less than five. Either PHQ-9 score was not assessed or is greater than or equal to five.

**Measure Number 431: Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling**

**Domain:** Community/Population Health  
**Reporting Option:** Registry Only  
**Cross-Cutting Measure:** Yes

**Description:** Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for unhealthy alcohol use using a systematic screening method and who received brief counseling if identified as an unhealthy alcohol user.

**Instructions for Measure Number 431**

- This measure is **reported once per reporting period**

- There is no diagnosis associated with this measure.

- One of the following CPT codes must be reported when using this code: 90791, 90832, 90834, 90837, 90845, 96150, 96152.

- Patients must be seen twice for any visits or have a least one preventive care visit during the 12 month measurement period.
• Recommended screening method include the following:
  ➢ Audit Screening Instrument (score .8)
  ➢ Audit-C Screening Instrument (score >4 for men; score>3 for women
  ➢ Single Questions Screening – How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >2)

• Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation, and development of a personal plan to reduce drinking.

Select one of the following codes:

**G9621**: Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling.

OR

**G9622**: Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method.

OR

**G9623**: Documentation of medical reasons for not screening for unhealthy alcohol use.

OR

**G9624**: Patient not screened for unhealthy alcohol screening using a systematic screening method or patient did not receive brief counseling, reason not given

**INSTRUCTIONS FOR REGISTRY REPORTING**

Registry reporting is one of the mechanisms used to report PQRS. It is a maintenance certification program which has self-nominated and successfully
completed a vetting process as specified by CMS to demonstrate its compliance with PQRS qualification criteria. A “qualified registry” collects and submits PQRS quality measures data on behalf of clinical social workers and other Medicare providers. A fee may be charged.

Clinical social workers who satisfactorily participate in a qualified registry may avoid the 2018 PQRS payment adjustment of a minus 2.0 per cent.

CMS maintains a list of qualified registries for Medicare providers to select from and has announced it will post on March 31, 2016, an online final list of 2016 qualified registries on the Registry Reporting Page of the CMS PQRS Website. The qualified registry posting will include the vendor’s name, contact information, the programs and measures being supported, and fee information for the registry services. NASW will assess the CMS registry list at that time and make recommendations to its members for reporting PQRS via registry for psychotherapy services.

Clinical social workers may submit their 2016 PQRS information to a chosen registry who may submit PQRS information on their behalf for a fee. The deadline for qualified registries to submit quality measure data is March 31, 2017 for the PQRS reporting period ending on December 31, 2016.

NASW encourages its members to use PQRS 2016 measures to avoid reimbursement deductions in 2018. The Association will host several PQRS trainings to help its members incorporate PQRS into their private practice. To assist clinical social workers in reporting PQRS, several online resources are provided by CMS which include:

- **2016 Physician Quality Reporting System (PQRS): Claims-Based Coding and Reporting Principles January 2016.** Available online at:  

- **2016 Physician Quality Reporting System Individual Measures Specifications and Measures Flow Guide for Claims and Registry**

- **QualityNet Help Desk:** Available Monday thru Friday, 7:00 am – 7:00 pm CST. The email address is qnetsupport@hcqis.org. The phone number is 1-866-288-8912; TTY is 1-877-715-6222.

**Additional Resources**


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