Physician Quality Reporting System (PQRS) 2014 for Psychology, Neuropsychology and Social Work

IMPORTANT FOR PSYCHOLOGISTS - OFFICE STAFF – BILLING PERSONNEL!

This is the last year providers can qualify for an incentive payment of 0.5 percent under PQRS, and a minimum of 9 measures are required for reporting using either individual claims-based or the dementia group measure. In 2015 there will only be penalties for failure to achieve satisfactory reporting for less than 3 measures covering one NQS domain for at least 50% of eligible patients seen to which the measure applies.

Endorsements:

“Dr. Hartman Stein... presents a clear introduction to the use of PQRS. Like many of my colleagues what seemed like a daunting task was made accessible by someone who has long been a leading writer and teacher on all Medicare developments.”
- Peter S. Kanaris, PhD, Smithtown, NY

"I have visited the CMS website multiple times. I have tried to understand how I can use the information in my practice (SNFs and assisted living facilities), and it appeared to be complicated! I had negative attitude toward using PQRS. The information in your presentation was precise, and I have already started to use the data collection sheet. My work has become smoother, and now I have better ideas about what this is about. Thank you, Dr. Hartman-Stein!" - Emi Iijima, PsyD, Los Angeles

Dr. Paula Hartman-Stein offers these products to help you navigate PQRS for 2014:

1. Physician Quality Reporting System (PQRS) 2014 Update for Psychology & Social Work: A Clinician's Perspective includes a 68 minute video (with Dr. Hartman-Stein & a billing professional); 65 slides; a data collection/tracking sheet for claims-based reporting; a Q and A follow up document in PDF format. $100

2. PQRS 2014 Made Simple for Psychologists Working in Long Term Care Settings includes a 105 minute training video (with Dr. Hartman-Stein & a billing professional); 114 slides including Reasons to participate in PQRS, how to get started in PQRS, differences between claims based vs registry reporting, 16 FAQ from psychologists from around the country and answers; one data collection/tracking sheet for LTC settings; examples of screening tools for pain, depression, & elder abuse; and three sample HCFA 1500 claim forms with coding of appropriate PQRS measures for both psychology and neuropsychology services. $120

3. Comprehensive PQRS 2014 training package without video and slides includes Frequently Asked Questions from Psychologists & Neuropsychologists (23 questions); three data collection/tracking sheets: one for LTC use, one for outpatient use, and one for Dementia Measures groups for Neuropsychologists; and three sample HCFA 1500 claim forms with coding of appropriate PQRS measures for both psychology and neuropsychology services. $40

4. Private individualized consultations are also available. To set one up, call (330) 678-9210.

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Medicare’s current emphasis on pay-for-reporting will likely shift to pay-for-performance in which providers could earn bonuses or penalties of 4 percent in 2018 and up to 12 percent in 2021 and beyond. The Physician Quality Reporting System (PQRS) “best practice” measures will continue to be used as a means of improving quality of care.

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PAULA E. HARTMAN-STEIN, PH.D.
Center for Healthy Aging

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Larger bonuses and penalties coming for Medicare

By Paula E. Hartman-Stein, Ph.D.

Medicare’s current emphasis on pay-for-reporting will likely shift to pay-for-performance in which providers could earn bonuses or penalties of 4 percent in 2018 and up to 12 percent in 2021 and beyond.

In order to abolish the sustainable growth rate (SGR) formula and avert a 23.7 percent rate reduction in Medicare reimbursement, bipartisan companion bills were introduced recently by the leadership of the House Ways and Means Committee, the House Energy and Commerce Committee and the Senate Finance Committee.

James Georgoulakis, Ph.D., J.D., APA’s advisor to the American Medical Association’s Relative Update Committee, said the new program is called the Merit-Based Incentive Payment System (MIPS) with the versions submitted by the three committees differing somewhat on the rules, including the amounts of penalties and bonuses.

According to a comparison chart on the AMA website that explains the bills, the Physician Quality Reporting System (PQRS) “best practice” measures will continue to be used in the MIPS as a means of improving quality of care.

The proposals are drafted as “revenue neutral,” so where will the money come from to pay for performance bonuses? From the penalties for noncompliance, Georgoulakis said. “The money for the increase is going to come from those individuals who are not participating in the program. For example, psychologists who refuse to participate will pay for bonuses of psychiatrists who do.”

He said regardless of disgruntlement among providers regarding PQRS, Congress is intent on reducing health care costs while improving patient care.

And PQRS may not affect only Medicare providers for long. Most quality measures can be used for patients age 18+, not only for geriatric patients. A few measures can be used for children age 12 and above. Georgoulakis predicts that other third party payers will adopt the penalties for clinicians who refuse to report quality measures once a decision is made on which congressional plan will be put into effect.

When Medicare announced that practitioners failing to meet reporting requirements on quality of care in 2013 would incur automatic 1.5 percent reductions in payments in 2015, many psychologists bristled. The requirements were minimal then. To avoid penalties a practitioner needed report only one “best practices” measure on one patient.

Many had ignored the “carrots” that began in 2008 for psychologists and social workers with a possible bonus of 1.5 percent that climbed to 2 percent payment in 2009 and 2010 for reporting three best practice measures, such as screens for pain, depression or elder maltreatment. CMS data revealed that only 3 percent of psychologists who are Medicare providers participated in PQRS in 2010.

Bonuses have declined while requirements have increased. From 2012 to 2014 bonuses decreased to 0.5 percent. In 2014 the number of measures required to report jumped from three to nine.
There is an exception to the nine measure requirement. A system of reviewing medical claims called Measure Applicability Validation (MAV) will occur for Medicare providers who report less than nine measures to determine if they reported adequately to receive the bonus. The complex and extensive rules are found in hundreds of pages on the CMS.Gov website.

In 2014 there are 287 measures physicians can choose to report while psychologists currently have about 12 available, depending upon the setting where they practice. For example, in primary care psychologists may be able to report body mass index screening and follow up, screen for high blood pressure or reconcile medications for patients recently discharged from an in-patient facility. Neuropsychologists may choose to report nine measures specific for patients with dementia if they sign up for a Registry.

One reporting option open to physicians is the Group Practice Reporting Option (GPRO) via Web Interface that includes 22 individual measures that target high cost chronic conditions, preventive care and patient safety.

Why does the American Medical Association support the PQRS program that many of its members find time consuming and cumbersome?

“The AMA is concerned if they are not players in the system, the system will play without them,” Georgoulakis said. He said the AMA wants to get involved more in how the payments are structured.

“Are psychologists thinking about these things?” he asked rhetorically. “The APA is supportive of PQRS, but the membership isn’t supporting it. While many are still waiting to roll back the clock, the train has left the station.”

Georgoulakis contends that the driving force behind PQRS is not to stamp out fraud. However, he speculates that providers who are not reporting the measures may be opening themselves up to audits. As a health care attorney and psychologist, Georgoulakis gets calls from psychologists with audit problems. He said, “In the last 18 months, not one of the over 50 psychologists I have worked with has been participating in PQRS. I am not assuming cause and effect. I realize it is a small sample size, but at the very least it is odd that I don’t have at least one.

Are there alternatives to playing by the PQRS rules? Georgoulakis said if patients pay cash, the clinician does not have to be concerned.

Antonio Puente, Ph.D., neuropsychologist and voting member of the AMA’s panel of the Current Procedural Terminology (CRT) Committee, said “The PQRS is here to stay. As health care moves from fee for service to pay for performances, the initial step toward that decade long migration will be to focus on documentation. PQRS appears to be the most viable standardized and professionally vetted system for documentation.”

However inevitable the changes appear to those close to federal decision makers, an informal email poll of about 70 rank-and-file practicing psychologists indicates opinions ranging from vehemently opposed to supportive.

P. Scott Parker, Ph.D., of Indianapolis said, “Several other psychologists and I are writing our congressional reps and imploring them to stop PQRS, as we view it as yet another expansion of an ever-expanding bureaucracy and, in our opinion, a major impediment to the
provision of our services to Medicare patients.” Parker added, “I have been practicing for the past 18 years and will absolutely not comply with PQRS.”

Bruce H. Vermeer, Psy.D., of Wyoming, Mich., said, “I believe PQRS is an extremely poor approach to assuring quality care. The quest for excellent quality care begins in the graduate school classroom, when such concepts are being developed by students. Our government has absolutely no business legislating such matters. That is not a productive use of time and resources!”

Dori Bischmann, Ph.D., of Waukesha, Wisc., representative for APA at the Physician Consortium of Performance Improvement (PCPI), said, “PQRS has not improved the quality of my practice.” She is concerned about an apparent push toward reporting measures through large data base companies called registries. “Registries cost money to join. This makes it difficult for psychologists to participate,” she said. According to Bischmann, psychologists may be unduly penalized because the infrastructure in place favors physician practices, especially in large health care delivery systems.

Peter Kanaris, Ph.D., APA’s public education coordinator, expressed mixed feelings. “Using the measures allows for the gathering of useful data and for some flexibility for the clinician to select relevant measures to his/her patient population, and it encourages the use of metrics to support clinical judgment. It encourages thoroughness in patient evaluation and helps to prevent clinician complacency.”

But, said Kanaris, a negative aspect is the disruption in the flow of the session that can break the rapport with the patient. “It is a distraction from attending and focusing on patients in session. More subtle conversational approaches are replaced by screens that can confuse and intimidate an elderly population. It can be a pain in the neck.”

Mary Schaffer, Ph.D., of Grand River, Ohio, said, “I am and remain excited about the PQRS program as I am a strong advocate of utilizing clinical outcomes as a means of collecting pertinent data, formulating treatment plans, as well as, a monitoring tool for treatment outcomes. The most useful and rewarding measure for me has been screening and cessation intervention for tobacco use. However, the PQRS program has been mentally exhausting and time consuming at times. This is the first year I will not attempt to obtain an incentive payment as the request for nine measures is over the top and unreasonable in my opinion.”

Stephen Daniel, Ph.D., of Johnson City, N.Y., said he found screening techniques for depression to be a beneficial area in nursing homes because it brings up conversations with nurses and physicians on the importance of anti-depressant medication and psychotherapy. “I am excited about these developments.” Donna Rasin-Waters, Ph.D., of New York, N.Y., said. “As psychologists and neuropsychologists we need to be participating in PQRS. This is the beginning of standardization of best practices and we should be honored to be included in these efforts.”

According to Rasin-Waters, “Those not wanting to make these changes will find themselves far behind their colleagues once the reporting becomes fully transparent and consumers adapt to the system. It will be no different for psychologists. Would I choose to send a depressed loved one to the clinician who refuses to quantify the level of depression or screen for suicidal risk? I think not.”
Paula Hartman-Stein, Ph.D., offers webinars and workshops to make PQRS simple for psychologists. She was former chair of the first psychology work group to develop measures for PQRS in 2007 and recently has been appointed to three technical expert panels to review measures for 2015. She can be reached through www.centerforhealthyaging.com.