

While these FAQs were developed for our audio conference which took place in April 2007, many of the answers such as where to place the quality codes on the claim form are still relevant. Please use these in conjunction with the FAQs developed based on our January 2008 audio conference on the PQRI program.

GENERAL INFORMATION

Q: What is the long-term purpose of reporting quality measures to Medicare?

A: "The PQRI is a first step toward linking Medicare health professionals' payments to quality, which is consistent with Medicare's ongoing transformation from passive payer to active purchaser of high-value health care."

"Physicians and other eligible professionals who choose to participate in the PQRI will gain experience in capturing and submitting data on the quality of care they furnish. Participants will receive confidential feedback reports regarding their practices and may earn incentive bonuses."

Q: Is participation in the PQRI program mandatory? Will this, or similar process, be mandatory in the future?

A: "No. Participation in the PQRI is voluntary." There is no indication at this time that this program will necessarily become mandatory in the future. CMS acknowledges that it is interested in "linking Medicare health professionals' payments to quality, which is consistent with Medicare's ongoing transformation from passive payer to active purchaser of high-value health care."

OUTPATIENT THERAPY SETTINGS ELIGIBLE/ NOT ELIGIBLE TO PARTICIPATE IN THE PQRI IN 2007

Q: Which outpatient therapy settings are able to participate in the PQRI initiative and obtain the 1.5% bonus in 2007?

A: In 2007, physical therapists in private practice and occupational therapists in private practice that submit claims to Medicare carriers using the 1500 claim form or 837-P are the **only** settings that are able to participate in the quality reporting initiative and obtain the bonus. Each physical therapist in private practice obtains his/her NPI number which is placed on the claim form. This NPI number is then used to track whether there was successful reporting on the quality measure.

Q: Which outpatient therapy settings are **NOT** able to participate in the PQRI initiative and obtain the bonus in 2007? Why are these settings unable to participate?

A: In 2007, the following settings in which outpatient therapy services are furnished will **NOT** be able to participate in the quality reporting initiative and obtain the 1.5% bonus:

- Skilled nursing facilities (Part B)
- Home health agencies (Part B)

- Outpatient hospital departments
- Rehabilitation agencies (ORFs)
- Comprehensive outpatient rehabilitation facilities (CORFs)

These settings submit their claims for outpatient therapy services to intermediaries using the UB-92 (UB-04) form or 837-I.

CMS's desire is to have as many providers as possible report on these quality measures. However, the reason that physical therapists working in these settings cannot participate is that there is no place (field) on the claim form used by these settings to put the individual NPI of the physical therapist. Quality reporting is analyzed at the individual practitioner's level and therefore it is necessary for CMS to have the individual NPI on the claim form in order to determine whether the measures were reported 80% of the time. There is a field on these claim forms to place the facilities (organization's) NPI, but successful reporting cannot be based on the NPI of the organization or facility. CMS and APTA are working to address this issue so that these providers may participate in 2008.

Q. I submit my claims to an intermediary (not a carrier). Am I eligible to participate in the quality reporting initiative?

A: No. You are not able to participate due to limitations of the claim form used when submitting claims to intermediaries. There is no place on the form for the therapist's individual NPI, which is necessary for reporting. Please reference the question above for the rationale.

Q. I submit my claims using the UB-92 (UB-04) claim form. Am I eligible to participate in the quality reporting initiative?

A: No. You are not able to participate due to limitations of the claim form. There is no place on this form for the individual therapist's NPI, which is necessary for reporting.

Q. I submit my claims using the 837-I. Am I eligible to participate in the quality reporting initiative?

A: No. You are not able to participate due to limitations of the claim form. There is no place on this form for the individual therapist's NPI, which is necessary for reporting.

Q. I submit my claims to a Medicare carrier (not an intermediary). Am I eligible to participate in the quality reporting initiative?

A. Yes. You are able to participate. There is a place on the claim form that you use to include the individual NPIs of the physical therapists in the practice.

Q. I submit my claims using the 1500 claim form. Am I eligible to participate in the quality reporting initiative?

A. Yes. You are able to participate. There is a place on the claim form that you use to include the individual NPIs of the physical therapists in the practice.

Q: I submit my claims using the 837-P. Am I eligible to participate in the quality reporting initiative?

A: Yes. You are able to participate. There is a place on the claim form that you use to include the individual NPIs of the physical therapists in the practice

Q: I provide PT services to the Medicare beneficiaries in a group practice. I bill on a HCFA 1500 form, however it is electronically submitted using PCproace through First Coast. Am I eligible for the bonus?

A: If you submit using the 1500 claim form, you should be eligible for the bonus as long as the 80% threshold for reporting was met. .

Q: I work in a rehab agency. We bill on a UB92 through the fiscal intermediary UGS. Is it possible for us to bill on the 837P claims form or is the form we bill on determined by CMS?

A: The claim form a facility uses is determined by their designation (hospital, private practice, etc) as established by CMS. As a rehab agency, you would bill using the UB-92 (UB-04). It is not possible for a rehab agency to bill on the 837P claim form.

Q: How many facilities would you expect to participate? If falls risk screening is the only measure, we can use, how would we have the quantity of patients to make participation financially viable?

A: At this time, it is not possible to determine how many health care providers will participate in 2007. Because CMS is working to include providers in more practice settings, there is potential for growth in 2008. The screening for future falls risk measure can apply to all Medicare patients over the age of 65. Therefore, we believe that it is appropriate to report that measure for many patients who would be receiving physical therapy services.

Q: What type of facilities would be encouraged to participate? My concern is that the types of facilities that may participate because of both types and quantity of patients may skew data collected from the outcomes study. For example, nursing homes (a type of facility that may provide a quantity of patients) see a high percentage of patients with co-morbidities. Therefore, the success rate of intervention would likely be lower than the success rate of treatment in an outpatient facility. As CMS uses this information in the future pertaining to reimbursement, the lower success rate associated with the study could adversely affect payments for services in outpatient facilities.

A: For 2007, physical therapists in private practice are encouraged to participate in the PQRI. Nursing homes will be unable to participate in 2007. At this point payment is linked to reporting, rather than outcomes. In the future if payment under a pay for performance system was based on outcomes, it would become necessary to risk adjust for different patient characteristics.

Q: Is there hope that CMS will allow additional provider settings to participate in the PQRI program by July 2007?

A: Unfortunately at this time it does not appear that providers using the UB-92 forms will be able to participate in 2007. Although CMS would like these provider settings to participate in the PQRI program, it

is not feasible because there is no place on the UB-92 claim form for the individual practitioners (e.g., physical therapists) to place their NPI. The PQRI program requires that the quality measures be analyzed at the level of the individual

Q: What steps are the APTA taking to address the inability of certain outpatient therapy provider settings to participate in this program?

A: APTA has had a number of discussions with CMS officials regarding the inability of provider settings that bill intermediaries to participate in the quality reporting program. APTA is working with CMS on ways to enable these providers to participate in 2008. One possibility may be to report to registries on quality measures. By reporting to registries it would be possible to avoid limitations on the claims forms. When more information becomes available APTA will update our membership by articles in PT Bulletin, distributing information to components and state chapters, and by placing information on APTA's website.

NPI

Q: Is a physical therapist practicing in a SNF, hospital, CORF, or rehabilitation agency required to obtain an NPI?

A: Only providers considered "covered entities" under HIPAA are required to obtain an NPI. "Covered entities" are those individuals who submit electronic claims or conduct other business via electronic means (email, etc). Physical therapists whose therapy services are billed by hospitals and skilled nursing facilities in which they furnish services are not considered covered entities under HIPAA. The facility is the covered entity and therefore the facility (e.g. hospital, SNF) would be required to obtain an NPI. Individual providers in these practice settings do not need to get an NPI for Medicare billing, but it is recommended that they obtain an NPI. It is possible that commercial health plans may require the physical therapists in these settings to obtain an NPI.

All physical therapists are eligible to obtain an NPI and APTA encourages them to do so. The application process is free and takes 15-20 minutes to complete. If a provider were to leave their facility to go into private practice, having the NPI application process completed would be one less step to climb in establishing a practice. The application is available online at:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Q. Is a physical therapist in private practice required to obtain an NPI?

A: A physical therapist in private practice is required to obtain an NPI in order for that therapist's services to be billed to Medicare.

CLAIMS SUBMISSION

Q: When can we start submitting our claims with this quality information? Can we start now or do we need to wait until July 1st?

A: ["The reporting period for 2007 PQRI begins on July 1, 2007, for covered services provided to Medicare beneficiaries between July 1 and December 31, 2007, and paid under the Medicare Physician Fee Schedule."](#)

Because the program does not begin until July 1, physical therapists can not re-submit claims for services provided before July 1. You can only submit claims indicating that you did a falls screening for patient evaluations conducted on and after July 1, 2007. However, CMS is encouraging providers to "test" their practices readiness to report the claims by submitting claims with the quality reporting data between now and July 1. Any "test" claims submitted before the July 1 program start date would not apply towards the bonus payment.

Q: Do we have to report a quality code on patients if tracking is not going to occur?

A: The PQRI is a voluntary program. No category of provider is required to participate. Providers need to determine if participating in the program is right for them. If a physical therapist determines he/she is not interested in participating, he/she does not need to alter the way he/she documents or submits claims for a patient.

Q: Where should the CPT Category II code goes be placed on the claim form ?

A: The CPT Category II code would be placed in box 24 D where you put other CPT codes.. **For example,** a completed box 24D would be:

97001

97035

97110

1100F

1100F would have a \$0.00 charge associated with it on the claim form.

Q: Once we use that 1100F on our patient on their initial evaluation, when they return at a later date and each visit there after, do we use that category II code (1100F) again per each visit?

A: Because the falls screening assessment is only associated with 97001 and 97002 (evaluation and re-evaluation respectively), you should only submit the quality code on the same claim form as the initial evaluation or re-evaluation(s). You should not submit it with every claim associated with a particular patient.

Q: If a patient qualifies under more than one measure, do you report all? Or do our nurse practitioners and physicians bill for their own bonus (In SNF setting)?

A: ["Eligible professionals should select measures directly relevant and applicable to their patient panels and the services they provide to those patients."](#)

In other words, for 2007 a physical therapist should ONLY report for the falls screening assessment as that is the only quality measure physical therapists are approved to report on. Other provider specialties have their own quality measures and should only report on the measures that apply to their practice and the patient they are treating. Successful reporting is analyzed based on the individual practitioner's NPI.

Q: If we report the measures, how will we know that our report information has been accepted by CMS?

A: A physical therapist will be able to tell if the quality reporting data he/she has submitted has been accepted when he/she sees the remittance advice from Medicare. Remittance advice remark code "N365" indicates that the quality measurement was received by Medicare for PQRI purposes. "N365" indicates a denial meaning there is a \$0 payment for the quality measure (eg 1100F or 1101F). The 1.5% bonus payment will be made in as a lump sum in mid-2008 if the 80% reporting threshold has been met.

80% REPORTING REQUIREMENT

Q: How is the 80% reporting threshold determined?

A: The 80% is determined by the individual therapist's NPI number. Medicare can determine from the billing forms the patients who were over age 65 and when a 97001 or 97002 CPT code (which would be associated with the falls risk screening measure) is billed. From that information, Medicare can determine whether the 80% threshold was met.

Q: To calculate the 80%: Say 65 year old Mr. Smith is evaluated 97001 on day 1 and we screen for falls and include the 1100F. Mr. Smith comes to therapy 10 visits within 30 days and is then discharged. No other claim sent for his therapy had the 1100F on it and a re-evaluation was not performed because he was discharged before 30 days. Mr. Taylor, 65 years old, is evaluated (97001) on day 1 and we screen for falls and include the 1100F; then 30 days later 97002 performed and no screen performed. Here we have 2 claims with the screen sent in on the claim. Is that 100%? Or do you consider the 97001 that was performed on Mr. Smith, the 97001 performed on Mr. Taylor with the screen, and the 97002 performed on Mr. Taylor a claim without report, and so the % is 66%-2/3 claims sent with report?

A: The falls risk screening measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Assuming that you only had two patients over the age of 65 to which the falls risk screening measure applied (Mr. Smith and Mr. Taylor). For Mr. Smith, you provided a falls risk screening assessment on the date of the initial evaluation and for Mr. Taylor you also provide the falls risk screening on the date of the initial evaluation. You later reevaluated Mr. Taylor and did not provide a falls screening at that time. If you had only these two patients, you would have reported 100% of the time, because the measure needs to be reported once per reporting period.

Q: Are all my Medicare patients over 65 included in the determination of whether the 80% threshold has been met?

A: To determine whether you have met the 80% threshold for reporting, CMS will look at whether the physical therapist reported the screening for future fall risk measure in at least 80% of the patients to which it is applicable. This measure applies to patients over the age of 65. If a physical therapist is treating a Medicare patient under the age of 65, that claim would be excluded from the analysis of whether the 80% threshold has been met.

Q: As a PT there is only 1 measure that applies to us, screening for falls. In regards to the 80% threshold, does this mean that if I have 10 new Medicare patient evaluations, I have to screen at least 8 of them for falls?

A: For 2007, as a physical therapist there is only one measure, screening for future fall risk, that applies. As you stated in your question, if you have 10 new Medicare patient evaluations (for patients over 65 years), you should screen for future risk of falls and report on that measure for at least 8 of them to meet the 80% threshold for successful reporting.

Q: Does a patient enrolled in a Medicare HMO (e.g. Humana) count toward the 80% threshold? I have a question regarding HMO Medicare.

A: The PQRI initiative only applies to fee for service Medicare beneficiaries, not those enrolled in HMOs. Therefore, the beneficiaries enrolled in Medicare Advantage would not be applied toward the 80% threshold.

SCREENING FOR FUTURE FALLS RISK

Q: What code should we use to report that a screening for future fall risk was performed?

A: Numerator Coding:

Screening for Future Fall Risk Performed

CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

Screening for Future Fall Risk not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **1100F** or **1101F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory)

OR

Screening for Future Fall Risk not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1100F** to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.

- **8P:** Patient was not screened for future fall risk, reason not otherwise specified

Q: Will the denominator coding be only CPT code 97001 (physical therapy evaluation or 97002 (physical therapy reevaluation)?

A. The denominator codes for the falls risk screening measure are the following: 97001, 97002, 99201-99205, 99212-99215, 99241-99245, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99354, 99355, 99387, 99397, 99401-99404

Physical therapists would only be able to submit claims using CPT code 97001 or CPT code 97002.

Q: Do the CPT II codes 1100F and 1101F need to have a GP modifier?

A: No.

Q: When submitting the claim for fall risk in order to qualify for bonus, what other measures need to be included in the evaluation or re-evaluation (i.e. Berg Balance Scale, Timed Up and Go or other measures)? Or is simply asking whether the patient has fallen sufficient?

A: Simply asking whether the patient has fallen and identifying whether that patient fell more than twice in the past year or fell and injured himself/herself at least once in the past year, is sufficient.

Q: Is this to be done for any/all Medicare beneficiaries age 65 or older regardless of ICD.9 diagnostic code or only those patients at risk for falls? If only for beneficiaries at risk for falls, how is CMS going to know when the measurement is not applicable?

A: This falls risk screening may be done for all Medicare beneficiaries age 65 or older regardless of ICD-9 diagnostic code. The purpose is to identify whether the patient is at risk for falls.

Q: Does this measure only apply to Medicare patients over the age of 65 and not those Medicare patients under the age of 65? Will those Medicare patients under the age of 65 be filtered out of the 80% reporting threshold?

A: The screening for future fall risk measure applied only to those patients over the age of 65. Therefore, Medicare patients under the age of 65 would not be considered in the analysis for successful reporting.

Q: Is the intent to screen all Medicare patients over 65?

A: The falls risk screening measure does apply to all Medicare patients over 65. There could be scenarios where the physical therapist is unable to conduct a falls risk screening. For example, perhaps the patient had a stroke and is unable to respond to the questions from the physical therapist.

Q: When you say the frequency, context and characteristics can you give an example of context? Do we just ask the screen questions on the initial evaluation and then not again during their treatment time?

A: By context, we are referring to the circumstances under which the fall occurred. For example, patient A was standing in his/her kitchen, became dizzy, lost her balance and fell. A physical therapist should ask a patient questions regarding falls risk whenever he/she feels it is important to gather that information. However, a physical therapist can only submit the quality code on the claim form on the same date of service for the evaluation or re-evaluation(s).

Q: How would I handle the reporting if the same patient comes in on several different admissions for different reasons within a year? Would I screen them every time?

A: If a physical therapist sees a patient multiple times a year for different episodes and is conducting an evaluation or re-evaluation as appropriate, he/she can report the quality code multiple times for the same patient.

Q: What are the specific questions I need to ask the patient during the fall screening?

A: CMS has not established any specific questions. However, you do need to determine in your questioning whether the patient fell 2 or more times in the past year or fell and injured himself/herself. We recommend the following questions be posed

- 1) Have you fallen in the past year?
- 2) How many times have you fallen?
- 3) Did you sustain an injury when you fell and if so, please describe.
- 4) Under what circumstances did you fall (e.g. location, using assistive devices, transferring, etc.)

Q: When defining a fall, it is written "...land at a lower level, on an object, the floor..." what if the object is a wall, the back of a couch, or a table? If the wall or table wasn't there they would have fallen. Is this considered a fall?

A: For purposes of this measure, a fall is defined as "a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti)." You need to evaluate the circumstances on an individual basis for your patient and determine whether this definition of a fall has been met. If not, then you would report CPT II code 1101F.

Q: If we are currently treating a patient who is at risk for falls how can we include them in our 80% if we've already done the 97001? Do we need to conduct a reevaluation (97002)?

A: The PQRI program applies to services furnished after July 1, 2007. Patients for whom a physical therapist has conducted a falls risk screening for before July 1 are not eligible using the evaluation code (97001) but one could report the measure with the re-evaluation code (97002) if the re-evaluation is medically necessary and performed after July 1, 2007.

Q: If a patient reports multiple falls in the past 12 months but all the falls are due to external force, seizure and/or paralysis, whether or not an injury is sustained, would the appropriate Category II code be "1101F"?

A: If the falls are due to external force, seizure and/or paralysis, then it does not meet the definition of a "fall" under this quality measure. For purposes of this measure, a fall is defined as "a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti)."

Therefore, the correct coding would be as below:

CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

Q: If a patient has been seen by another PT previously and later comes to our practice for the first time, how will we know if the patient has previously been asked the questions about their fall history?

A: If you are seeing a patient for the first time and you conduct a falls screening assessment as part of the patient's initial evaluation, you can report the quality code on the claim. If you are unsure as to whether the patient was assessed for falls risk by another PT, it is appropriate to conduct a falls risk screening.

Q: Can we ask any Medicare patient 65 years and older about falls even if they are only coming in for neck pain? Is that wrong?

A: The PQRI applies to patients 65 years of age and over. Neck pain or other conditions which may warrant physical therapy services but do not necessarily indicate an increased risk for falls does not prevent a physical therapist from conducting a falls screening assessment. Because there are a variety of reasons a patient may be at risk for falls (balance issues, medications, problems with dizziness, etc) which may not be the primary purpose for a patient to see a physical therapist, conducting a falls screening for many of your patients may be appropriate.

Q: Is there a preferred fall assessment protocol to be used?

A: Before answering this question it is important to realize that the Quality Indicator approved for physical therapists entitled "Screening for Future Falls Risk" requires the PT to report on whether they asked if the individual had fallen within the past year and to document the frequency, context, and characteristics of the fall. This measurement does not require anything further than asking questions. We agree that any physical therapist who has determined that a patient is at risk for falls would want to evaluate the patient further and develop a plan to decrease the risk for future falls

Briefly, there have been a number of studies that have identified specific risk factors associated with falls risk, some include: muscle weakness, arthritis, history of falls, impaired ADL's, gait deficit, depression, balance deficit, cognitive impairment, visual deficits, medications, and other neurological and cardiovascular deficits. In addition, environmental factors have also played a significant part in the prevalence of falls.

Physical therapist can use a number of tests and measures to determine a patient / client's risk of falling. Many of these risk factors can be evaluated as part of the typical physical therapist examination but there are a number of commonly used examinations / tools used specifically for falls. Some of the more commonly used test and measures are: Berg Balance Scale, Timed Get Up and Go Test, Tinetti Performance Oriented Mobility Assessment: Balance Test and Gait Test, Dynamic Gait Index, Falls Efficacy Scale (FES), and the Activities-specific Balance Confidence Scale. It is important to match the correct tool(s) with the correct patient/client and setting to aptly measure falls risk. This may require using more than one tool to take into account the multiple factors that may contribute to the patient's/client's fall risk.

As part of the Physical Fitness for Special Populations project, the Neurology Section, the Section on Geriatrics, and APTA National have developed a **Physical Fitness and Fall Risk Reduction Pocket guide** which will be provided to all members **free of charge** in the July PT Magazine polybag. The resource will include detailed information on the risk factors associated with falls, common tests and measures, and interventions used by physical therapists to reduce the risk of falling. Additional resources will also be available on the APTA website at www.apta.org/pfsp, in the Falls Prevention section.

Q: Is Medicare going to pay for balance treatments on a shoulder patient who screened positive for a fall risk?

A: If a physical therapist conducts a falls screening assessment for a patient who presents with shoulder problems as part of the initial evaluation and determines that the patient has fallen and that balance treatments may be appropriate, Medicare will cover the cost of these services. In order for Medicare to cover any costs associated with physical therapy, the therapist must document the medical necessity of the services provided and a physician will need to sign the plan of care.

MEASURES FOR OCCUPATIONAL THERAPISTS & SPEECH THERAPISTS

Q: For occupational therapists and speech language pathologists will there be measures/CPT codes they can use for reporting by July 2007?

A: [At this time there are no measures for OT and SLP. However, CMS will be revising its specifications prior to July 1, 2007. It is possible that when they revise these specifications there could be a quality measure that OTs could report on. Please check CMS's PQRI website prior to July 1 to determine whether the specifications have been revised to apply measures \(e.g. falls risk assessment\) to OT.](#)

1.5% BONUS PAYMENT

Q: If a PT qualifies for the bonus, that bonus will be 1.5% of the allowed amount of all Medicare claims performed by that PT in the specified time frame. Correct?

A: Yes.

Q: In order to decide cost effectiveness of having software modified it's necessary to know how the incentive will continue to work in 2008. For 2007 we have the one quality measure from which we must report on at least 80% of those that are reportable. If, in 2008, we have 4 quality measures available to report on we then must report on 3 of the 4 measures at an 80% rate of those that are reportable for the same 1.5% incentive. Is that correct? We don't get 1.5% for each one of the quality measures we meet the criteria on for a total of 4.5%, do we?

A: The Tax Relief and Health Care Act of 2006 primarily established the regulations regarding program structure for 2007 and new legislation will need to be introduced to ensure the program continues in 2008. In terms of meeting the 80% threshold requirement for multiple measures, for instance three, the 1.5% bonus payment is contingent upon the physical therapist reporting on at least three measures 80% of the time for a total 1.5% bonus payment. The provider would receive a total lump-sum payment 1.5% on all

claims submitted during the 6 month period. If a provider met the 80% threshold on 3 measures, the provider would still receive a 1.5% bonus payment, not a 4.5% bonus.

Q: I understand that the bonus is 1.5% of the allowable billed from July-December 2007. Does that mean that if I received for example \$100,000 from Medicare during that time, the bonus would be \$1,500?

A: The answer to your question depends. As you noted, 1.5% of \$100,000 would be \$1500. So, it is possible that you might receive \$1500; however, payment to the provider is subject to a cap. This cap varies depending on the frequency of reporting on a particular quality measure. The purpose of the cap is to ensure that there is not a large reward for a provider that only reports a small amount of times. For example, if you only reported 10 times in the 6 month period on the quality measures, you would not receive the full \$1500.00. However, if you reported many times on the quality measure, there is a likelihood that you will receive the full \$1500.00.

FUTURE OF PQRI

Q: From the presentation my understanding is that the APTA commented on four potential measures that could apply to PT. Most of the discussion was focused on the Screening for Future Fall Risk. Is this the only measure that PTs can report on for the 2007 period?

A: While APTA submitted a request for four measures for 2007, only the screening for future falls risk was approved for use by physical therapists. The other measures are more physician oriented. The association will work through the regulatory process this year in order to develop more measures for 2008 and we will update our membership as to what measures physical therapists can report on for 2008 as the information becomes available.

OTHER

Q: You mentioned "Appendix H" in the beginning of the conference and I failed to hear what it was. What is the "Appendix H" and what should I do with it?

A: Appendix H can be found in the 2007 CPT guide produced by the American Medical Association. Appendix H defines the 1P and 8P modifiers that can be used.

Q: Slide # 10 is very small "Integrating PQRI Measures into practice", the Work Flow Process and not readable on the downloaded printout. Can I find it somewhere else online and actually read it?

A: Please see below. The original slide presentation will also be included on the CD-Rom which registered participants will be receiving shortly.

Integrating PQRI Measures into Practice Work Flow Process

