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1.0 Introduction
The Patient Volume Report supports the Medicaid EHR Meaningful Use Incentive program for Eligible Professionals and Eligible Hospitals. The Medicaid Patient Volume generated by the report is used in the attestation process at the CMS website. The Patient Volume report has several options that will produce different results based on who the EPs are and where they practice.

1.1 Summary of Changes
Patch 7 provides report enhancements to Version 2.6 of the Third Party Billing system.

The Patient Volume reports (and the parameter setup) are new software for RPMS and the Third Party Billing package.

1.1.1 Patch 7
Patch 7 includes the five applications listed on the Patient Volume Reports menu; Report Parameters (MUP), Patient Volume Report for Eligible Professionals (PVP), Patient Volume Report for Eligible Hospitals (PVH), EP Class-List of Eligible Professionals (EP) and the EP Reports Definitions List (DEF).
2.0 Background

2.1 Incentive Program

On July 28, 2010, the Centers for Medicare & Medicaid Services (CMS) published its Final Rule explaining how it will implement the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009. The ARRA legislation provides incentive payments from both Medicare and Medicaid for the adoption and meaningful use of certified electronic health record (EHR) technology.

This EHR incentive program will provide payments to eligible professionals (EPs) and eligible hospitals (EHs), including Critical Access Hospitals (CAHs). EPs, Hospitals and CAHs are required to meet auditable minimum patient volume thresholds in order to participate in the Medicaid EHR Incentive Program.

The stated purpose of the CMS Final Rule is to qualify as many EPs/Hospitals as possible for the Medicaid/Medicare Incentive programs. The Patient Volume Report is an integral part of the Attestation process for the EPs and therefore a major step in qualifying for the Medicaid Incentive Program.

2.2 Purpose of this Document

The Addendum/User’s manual is intended for use by staff members that are familiar with RPMS and the Third Party Billing system. The Patient Volume Report is only available to RPMS sites that have installed the latest patches for the system (TPB version 2.6p7).

This document is broken into several parts:
- Purpose for the Patient Volume Report (Chapter 1)
- Patch #7 Details (Chapter 2)
- Overview of the Patient Volume Report (Chapter 3)
- Site Setup for the Patient Volume Report (Chapter 4)
- Running the EP report (Chapter 5)
- Interpreting the results printed in the EP report (Chapters 6-7)
- Running the EP report (Chapter 8)
- Interpreting the results printed in the EP report (Chapters 9-10)
- EP Classes & Definitions (Chapters 11-12)
2.3 **Certified EHR**
RPMS has been certified for outpatient and inpatient use April 1, 2011. A list of Certified EHRs can be viewed at the CMS Website ([http://onc-chpl.force.com/ehrcert](http://onc-chpl.force.com/ehrcert)). The certification process is specific to the version of the software that CMS tested. Only the certified version of the EHR can be used to participate in the Incentive programs (older versions of RPMS have a different table structure and cannot run the Patient Volume Report).

2.4 **Who is an Eligible Professional?**
For the Medicaid EHR incentive program, the CMS Final Rule (referred to as the Final Rule in the remainder of this document) defines Eligible Professionals (EPs) as MDs, DOs, DDSs, DMDs, NPs, and CNMs. Physician Assistants (PAs) are considered Eligible Professionals if they practice in an FQHC/RHC setting led by a PA. Podiatrists, Optometrists and other health care providers may be EPs if state statutes classify them as “physicians”. Additional Provider Classes may be added in the site setup process.

2.5 **Who is an Eligible Hospital?**
For the Medicaid EHR incentive program, the CMS Final Rule defines Eligible Hospitals as Subsection-D/Acute Care Hospitals and Critical Access Hospitals. Emergency Room encounters are counted as a part of hospital volume.

2.6 **Registration/Attestation at the CMS website**
EPs may register for the Medicaid EHR Incentive Program at the CMS website ([http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp](http://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp)). After they are registered, EPs must attest that they have adopted, implemented, or upgraded to a Certified EHR and that they have met the required Medicaid Patient Volume Thresholds in order to qualify for the year one Medicaid Incentive Payment. EPs can delegate the attestation process to another person. The person chosen as a delegate must register at the I&A Security Check website ([https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do](https://nppes.cms.hhs.gov/NPPES/IASecurityCheck.do)).

EHs may register and participate in both the Medicaid and Medicare EHR Incentive Program. CMS requests that EHs register for both programs at the same time on the website to keep records of the registrations together. Registration does NOT require participation – so EHs may register for both programs and then choose if and when to begin participation in either program. Participation in the two programs does not have to be simultaneous.
3.0 Patient Volume Report-Overview

3.1 Medicaid EP and EH Volume Requirements

EPs and EHs must adopt, implement, or upgrade to a Certified EHR. EPs and EHs do not need to meet Meaningful Use in year one of the Medicaid Incentive program, but must meet volume thresholds to participate. EPs must also be a Medicaid EP type, which is defined by law.

3.1.1 Qualification Year

The Qualification Year is the year immediately prior to the year the EP or EH wants to participate in the Medicaid incentive program. The EP or EH must show sufficient patient volume for to qualify for participation in the following year. Qualification of patient volume must be demonstrated for each year they participate in the program.

3.1.2 Participation Year

The Participation Year is the year the EP or EH applies to participate in the Medicaid incentive program.

3.1.3 EP and EH Years

EP Qualification and Participation years are calculated using a calendar year. EH years are calculated using a federal fiscal year.

3.2 Product Scope for Version 1.0

Version 1.0 of the Patient Volume Report focuses on qualifying individual EPs and EHs for the Medicaid Incentive Program. The Group Method Volume report will be released as separate patches in the summer of 2011.

3.2.1 Individual EP

The Individual EP version of the Patient Volume Report can be run for one or more EPs. The EPs entered do not have to work in the same clinic but must have their patient encounters stored in the same database. A limitation for the Individual EP version of the Patient Volume Report is that the date range entered is used for all selected EPs. If that strategy does not work, use a more limited list of EPs.

Eligible Professionals– Included Service Categories

- Ambulatory (excluding clinic code 30)
- Day surgery
• Observation
• Nursing Home
• Home
• Eligible Professionals– Excluded Service Categories
• Chart review
• Event (historical)
• Not found
• Telecommunications – calls
• Hospitalizations & In Hospital Service
• School – Clinic Code 22
• ER: Ambulatory – Clinic Code 30
• Mail – Clinic Code 42
• Radio call – Clinic Code 54
• Follow up letter – Clinic Code 57
• US (Ultrasound) – Clinic Code 66
• CT – Clinic Code 71
• Case management – Clinic Code 77
• Nurse clinic – Clinic Code B5
• Health Aid clinic – Clinic Code C6

3.2.2 Eligible Hospital

The EH version of the Patient Volume Report can be run for one or more hospitals stored in the same database. A limitation for the EH version of the Patient Volume Report is that the date range entered is used for all selected EHs. If that strategy does not work, use a more limited list of EHs.

All hospital discharges and ER encounters are calculated together.

Eligible Hospitals– Excluded Service Categories
• Ambulatory (excluding clinic code 30)
• Day surgery
• Observation
• Nursing Home
3.2.3 Date Range Options
There are three date range options for the patient volume report:

- Specific 90 day date range
- Automated date range
- Specific date range (start and end dates specified)

A 90 day date range can be specified to identify the encounter sample used for the volume report. The Automated Date Range option tries every 90 day sample during the entire calendar year. This process takes longer, but it will return the highest Patient Volume results for the number of samples selected in the report. If EPs or EHs fail to qualify for the Medicaid Incentive program with the automated date range option, the report output will serve as a worksheet to show what date ranges had the highest patient volumes for the year.

3.2.3.1 Run Time Mitigation
For facilities with large databases, the automated report may take a significant amount of time to run, as it calculates volume for each 90 day period of the year until it reached the desired threshold. Specifying the start date for the report will greatly reduce the run time needed, as the calculation is only run once.
Running the report for the first day of a month or quarter will allow a snapshot of an EP or EH’s volumes, and then the specific start date for qualification can be narrowed from there.

3.2.4 Facility Options

EPs practicing at FQHC/RHC facilities can use a “needy individual” definition for which paid encounters to use for the Patient Volume report. Non FQHC/RHC facilities may only count paid Medicaid encounters for the Medicaid Incentive program. FQHC/RHC facilities may use the “needy individual” definition to identify encounters for the report (needy individual = Medicaid + CHIP paid encounters).

No option for “needy individual” calculation is available for EHs.

**Note:** The FQHC Needy Individual report includes Medicaid paid and SCHIP paid encounters. Other Needy Individual encounters will need to be counted outside of the Patient Volume report and then added to the totals reported to CMS.

Please check with your state to confirm other types of “needy” encounters which are authorized to be included in the final volume counts for your site.
4.0  **New Patient Volume Reports Option**

**ABM→RPTP→MURP→MUPV**

A new option has been added to the Meaningful Use Menu labeled Patient Volume Reports.

Figure 4-1: Meaningful Use Reports Option

Within the Patient Volume Reports Menu, the following options are available.

Figure 4-2: Patient Volume Reports Option
5.0 Report Setup

The Report Setup should be a one-time activity for an RPMS site. Unless the profile for the facility changes (change to FQHC/RHC status or PA leadership) the original values entered in the setup should continue to be valid. After the setup is completed, anyone with access to the Third Party Billing Menu can run the Volume Reports.

Site Setup has no bearing on the EH reports, but must be completed prior to running any reports for the first time.

Site parameters cannot be reset by the user. They must be changed at the database level by an administrator.

5.1 Site Parameters for Reports (MUP)

3P→RPTP→MURP→MUPV→MUP

The Patient Volume reports utilize several site parameters that are set in RPMS by a site administrator.

You are setting up the Report Parameters. Once completed, you will not be able to edit.

Continue? N// YES

Do you wish to designate a Facility as an FQHC or RHC? NO

Figure 5-1: Setting up Report Parameters

The MUP menu choice allows the user to set the following report parameters:

- The facility running the report is an FQHC/RHC site. [Y/N]

Facilities classified as an FQHC or RHC facility must answer Yes.

If Yes is selected, a list of facilities will be displayed. Select the facilities designed at FQHC or RHC.

If a site is designated as an FQHC/RHC setting, the site setup will ask if the site is led by a PA. Answer Yes if the Physician Assistant is the Primary Lead at this site.
Do you wish to designate a Facility as an FQHC or RHC? YES

1. INDIAN HEALTH HOSPITAL
2. INDIAN HEALTH CENTER
3. TEST HOSPITAL
4. MERCY MEDICAL CENTER HOSPITAL
5. HOME
6. AMBULANCE

Select one or more facilities to designate as an FQHC or RHC: 4 MERCY MEDICAL CENTER HOSPITAL
Is this FQHC led by a PA? ? YES
Select one or more facilities to designate as an FQHC or RHC:

The following have been identified by you as FQHC/RHC facilities
MERCY MEDICAL CENTER HOSPITAL (FQHC led by PA)

By answering YES the entries below will be added and the list may not be edited without contacting OIT
Are you sure? YES

Figure 5-2: Establishing FQHC/RHC Locations in Report Setup

- Facilities not designated as an FQHC/RHC location must answer No.

Additional types of providers (provider class code) that are recognized in the state where the report is being run (beyond MDs, DOs, DDSs, DMDs, NPs, and CNMs and PAs working in an FQHC/RHC led by a PA). [XX]

Some states consider Optometrists, Podiatrists, etc., as Physicians.

The next prompt will allow the identification of these provider classes as EP types to generate volume reports.

Please note: Defaults have been provided so there are already entries in this file that don't need to be entered again.
Are there additional EP types for your state? NO

Figure 5-3: User Notification of the Possibility of Adding Additional Eligible Provider Entries

States license physicians and can expand or reduce the list of health care providers in their state that are classified as physicians. Optometrists and Podiatrists are Physicians in some states. Setting the Additional EP types will allow the volume report to correctly include additional EP types for the state in which the report is being run.

Display this parameter only if Additional EP types = Y. To see a list of all RPMS Provider Class Codes see Figure 8-2.
6.0 Patient Volume Report for Eligible Providers

3P→RPTP→MURP→MUPV→PVP

The Patient Volume Reports Menu options are located in the RPMS Third Party Billing (TPB) package Reports Menu. The system must be at TPB Version 2.6 Patch 7 to see this menu.

The following sections will display the report and explain the prompts.

6.1 Report Selection Criteria

6.1.1 Facility Section

At “Select one or more facilities to use for calculating patient volume:”, a list of facilities available on the database will display. Select one or more facilities to generate report data for. If an FQHC facility is on the database, the user may not select a combination of FQHCs and Non-FQHCs due to calculations that are done.

FQHC/RHC sites will have a (FQHC/RHC) indicator to the right of the facility name.

Figure 6-1: Selecting Locations to Print while Printing the Patient Volume Report

Figure 6-2: Display of Facility Name with the FQHC/RHC Indicator
Selecting individual locations will also be marked with an Asterisk (*).

| 1 | 2010 DEMO HOSPITAL * |

Figure 6-3: Display of Asterisk to the Right of the Location when Selected for Reporting

### 6.1.2 Report Type Selection

“Select report type:” provides two choices:

**SEL** report determines if INDIVIDUAL Eligible Professionals have met the minimum patient volume requirements on their own patient encounters during a continuous 90-day period in order to be eligible for the Medicaid EHR Incentive Program (Meaningful Use EHR Incentive Program).

**GRP** (This option is **NOT** available at this time) report may be used for EPs who wish to use encounters of all providers at a facility to meet the minimum patient volume requirements during a continuous 90-day period in order to be eligible for the Medicaid EHR Incentive Program (Meaningful Use EHR Incentive Program). When used, all EPs at the facility must use the Group Method. All provider encounters for the entire facility are included in the calculation.

**Note:** The Encounter method for each EP (the only option available at this time)

Select one or more facilities to use for calculating patient volume:

The SEL report determines if INDIVIDUAL Eligible Professionals have met the minimum patient volume requirements on their own patient encounters during a continuous 90-day period in order to be eligible for the Medicaid EHR Incentive Program (Meaningful Use EHR Incentive Program).

The GRP report may be used for EPs who wish to use encounters of all Providers at a facility to meet the minimum patient volume requirements during a continuous 90-day period in order to be eligible for the Medicaid EHR Incentive Program (Meaningful Use EHR Incentive Program). When used, all EPs at the facility must use the Group Method. All provider encounters for the entire facility are included in the calculation.

Select one of the following:

| SEL       | Encounter method for each EP |
| GRP       | Group method for facilities  |

Select report type: SEL

Figure 6-4: Selecting the Encounter Method for Each EP as the Report Criteria
6.1.3 Eligible Provider List Entry

Enter the provider name at the Select New Person Name prompt. The name entered must contain an entry in the New Person file and must be a provider with an eligible provider class. The list of provider classes was determined at the Report Setup section.

| Select report type: SEL  Encounter method for each EP |
| Select NEW PERSON NAME: WALLCE, GRACE |
| Select NEW PERSON NAME: MCGOWN, SHARON A |
| Select NEW PERSON NAME: BAILEY, MATTHEW W |
| Select NEW PERSON NAME: BIRTHDAY, ELSA A CNM |
| Select NEW PERSON NAME: FOOT, BIG A DPM |
| Select NEW PERSON NAME: |

For EPs, the Participation year is a calendar year.

Figure 6-5: Adding Eligible Provider Entries using the Encounter Method (SEL) Option

The names of EPs are verified at the time they are entered in the Patient Volume report. Providers that are not considered to be EPs (based on their provider class and the site parameters) are rejected with an error message.

| Select NEW PERSON NAME: PROVIDER, ERIN D |
| Provider PROVIDER, ERIN D does not have a Provider Class so they can't be considered for this report |
| Please enter a different Eligible Professional's name. |

Figure 6-6: Display of Message Indicating the Provider Class is Missing for the Provider

6.1.4 Participation Year

The Participation Year must be specified for which to run the report. For EPs, the Participation year is a calendar year. The Participation year is the year in which the EP expects to receive an Incentive payment. The Qualification year is the previous year. In this case the Participation year is 2011 which makes the Qualification year 2010.

For EPs, the Participation year is a calendar year.

Note: The qualification year is the year prior to the participation year. Patient Volume is calculated on encounters that occurred in the qualification year, which is the year prior to the participation year. To view volume for the current year, select next year as the participation year.

Enter the Participation year for this report: 2011

Figure 6-7: Entering the Participation Year
6.1.5 Reporting Period Options

The report supports three options for the date range. Options B and C require additional date entries to define the report date range.

- **Report will be run for a 90-day reporting period. The 90-day period may be automatically calculated or user may select a specific start date.**

  The automated calculation will return the first 90-day period in the 2011 Year in which required patient volumes are met or the 90-day period with the highest volume percentage (first occurrence in the year).

  Select one of the following:
  
  - A Automated 90-Day Report
  - B Specific 90-Day Report Period
  - C User specified Report Period

Enter selection:

**Figure 6-8: Selecting the Report Criteria Options**

This date range will be used to look for the necessary threshold for each provider (20% for Pediatricians; 30% for all other provider classes). There are three options for the date range:

**Option A** is the Automated 90-day Report and will start with 1/1 of the Qualification year and look for any 90-day window that the provider met the necessary threshold. This report may take a while to run as it looks through all visit and payment data.

**Option B** is the Specific 90-day Report and will allow the user to specify the start date and will automatically calculate the end date (by adding 89 days to the start date). If the beginning date is less than 90 days from the end of the calendar year, an error message is displayed.

Enter selection: B Specific 90-Day Report Period

Select a specific start date in the calendar year for the 90-Day Report Period.
Note: End Date must not be after December 31.

Enter first day of reporting period for 2010: (1/1/2010-12/31/2010): 1/1/2010

**Figure 6-9: Selection of the Specific 90-Day Report Period**

**Option C** is the User specified Report and will allow the user to specify the start and end date. It does not verify it is a 90-day window.
Addendum to User Manual Patient Volume Report for Eligible Providers
August 2011

6.1.6 Report Output Selection

The Volume Report can be printed in several formats depending on the purpose for the report. The Summary format is focused on meeting the patient volume threshold and the dates when that goal was reached. The Patient List format provides detail information for each patient encounter.

Report Format choice. The options are:

Option S is the Summary Report that reports per provider, if they met the threshold (and when), or what percentage they did have during the selected date range.

Option A is the Abbreviated Summary Report and will give the user the ability to select how many date ranges to print if the provider did not meet the threshold (instead of printing every date range when automated 90-day is selected).

Option P is the Patient List and will be all the patients found that generated the numbers for the report. This should be used for validation purposes only, since it will contain a large amount of data (one line for each patient the provider saw).

Select one of the following:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Summary Report</td>
</tr>
<tr>
<td>A</td>
<td>Abbreviated Summary Report</td>
</tr>
<tr>
<td>P</td>
<td>Patient List</td>
</tr>
</tbody>
</table>

Enter Report Format Choice:

6.1.7 Selecting the Device

Regardless of the selection, the system will display the summary of what is being requested for the report. The user can view the information and decide if changes need to be made.
<table>
<thead>
<tr>
<th>Report Name: Patient Volume Report for Eligible Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>The date ranges for this report are:</td>
</tr>
<tr>
<td>Participation Year: 2011</td>
</tr>
<tr>
<td>Qualification Year: 2010</td>
</tr>
<tr>
<td>Reporting Period: 10/01/2010 thru 11/30/2010</td>
</tr>
<tr>
<td>Report Method Type: Individual</td>
</tr>
<tr>
<td>Eligible Professional(s):</td>
</tr>
<tr>
<td>WALLCE, GRACE (PEDIATRICIAN)</td>
</tr>
<tr>
<td>Facility(s):</td>
</tr>
<tr>
<td>2010 DEMO HOSPITAL</td>
</tr>
<tr>
<td>Select one of the following:</td>
</tr>
<tr>
<td>P Print Report</td>
</tr>
<tr>
<td>R Return to Selection Criteria - Erases ALL previous selections</td>
</tr>
</tbody>
</table>

Do you want to print this report?: P

Output DEVICE: HOME//

Figure 6-12: Summary Display of the Patient Volume Report to be Generated

At “Do you want to print this report?:” prompt, the user may select from one of the following:

- **P**: Print Report
- **R**: Return to Selection Criteria - Erases ALL previous selections

At Device, HOME is the default. You can queue report to print on a terminal or a printer.

### 6.2 EP Patient Volume Report Logic

#### 6.2.1 Eligible Professionals

EPs can receive the full Incentive payment if their Medicaid patient volume is 30% or more of their patient encounters.

#### 6.2.1.1 Exception to the EP Incentive Thresholds - Pediatricians

Pediatricians may participate in the EHR Incentive program if they have 20% Medicaid patient volume (the Incentive payment will be 2/3 of the full Incentive payment). This lower threshold was created to encourage Pediatricians to participate in the EHR incentive program. If a Pediatrician reaches the 30% Medicaid patient volume, they will be entitled to the full Incentive payment.
6.2.1.2 Exception for FQHC/RHC Settings – PA Eligibility

PAs working in an FQHC/RHC setting led by a PA are included in the list of Eligible Professionals in the Final Rule. “Led By” includes clinics that are owned by a PA or where the PA is in charge of the clinic. A site report parameter must be set to designate clinics that are led by a PA. All PAs in the FQHC/RHC setting led by a PA are considered to be EPs.

6.2.2 Patient Volume Calculation Methods

There are two methods used to calculate the EP patient volume; Individual EP or Group Method. The Group Method option will be released in the summer of 2011. All EPs at a facility must agree to use the Group Method in order for any of them use it.

6.2.2.1 Individual EP Method

The Individual EP Method calculates the patient volume for each EP based on their Medicaid encounters and total encounters. The report can be run for one or more EPs (each EP will have their own Patient Volume percentage listed).

6.2.3 Encounter Definitions

6.2.3.1 Paid Medicaid Encounters

The Final Rule considers paid Medicaid encounters and all encounters to determine the Medicaid patient volume percentage. Paid Medicaid encounters are all patient encounters paid for in full or in part by Medicaid. The definition is expanded when 1115 waiver programs pay for care delivered by EPs (encounters covered by 1115 Waiver programs are included in the Medicaid encounter total in RPMS). For states where a single Medicaid payment is made to an EP even though other EPs treated that patient for unrelated problems on the same date, each EP encounter with the patient will be counted as a paid Medicaid encounter.

6.2.3.2 FQHC and RHC – Needy Individual Encounters

The Needy Individual Patient Volume will be used for EPs who work predominately at an FQHC or RHC. An EP is considered to work predominantly at an FQHC or RHC when the FQHC/RHC is the clinical location for over 50% of all of the provider’s total encounters for six (6) months in the most recent calendar year. The 50% cannot be determined by RPMS, as it is based on the provider’s encounters in the RPMS facility and those outside.

In RPMS, Needy Individual encounters will include all patient encounters paid in part or in full for by:
Medicaid-insurance type ‘D’ (includes 1115 Waivers)

CHIP-insurance type ‘K’ billed as either Medicaid or Private Insurance

6.2.4 RPMS Patient Encounters

RPMS users are familiar with the categories listed below. Facilities that use other applications will need to use a similar methodology for their volume reports.

6.2.4.1 EP Volume Report – Included Service Categories

• Ambulatory (excluding clinic code 30)
• Day surgery
• Observation
• Nursing Home
• Home

6.2.4.2 EP Volume Report – Excluded Service Categories

• Chart review
• Event (historical)
• Not found
• Telecommunications – calls
• Hospitalizations & In Hospital Service
• School – Clinic Code 22
• ER: Ambulatory – Clinic Code 30
• Mail – Clinic Code 42
• Radio call – Clinic Code 54
• Follow up letter – Clinic Code 57
• US (Ultrasound) – Clinic Code 66
• CT – Clinic Code 71
• Case management – Clinic Code 77
• Nurse clinic – Clinic Code B5
• Health Aid clinic – Clinic Code C6
6.3 Eligible Provider Report Samples

6.3.1 Sample Report Cover Page – Individual EP

The following report provides EP information based on the S Option – Summary Report. The first page of the report will provide a summary of the provider(s) selected and the eligibility status.

<table>
<thead>
<tr>
<th>IHS Meaningful Use Patient Volume Report - Eligible Professional</th>
<th>Page 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Patient Volume NOT Achieved</td>
<td></td>
</tr>
<tr>
<td>Report Run Date: 08/10/2011@14:13</td>
<td></td>
</tr>
<tr>
<td>Report Generated by: LUJAN, ADRIAN</td>
<td></td>
</tr>
</tbody>
</table>

Participation Year: 2011
Qualification Year: 2010
Reporting Period Identified: 01/01/2010 thru 03/31/2010
Facility(s):
2010 DEMO HOSPITAL

Eligible Professional: WALLCE, GRACE (PEDIATRICIAN)

The Patient Volume Threshold (30% for EPs, or 20% for Pediatricians) was not met for the MU Qualification year.
Details for the volumes that were achieved are provided for your information.

Highest Patient Volume Met: 17.7%
First Day Highest Patient Volume Achieved: 01/01/2010

Patient Volume for the Qualification Year was calculated using the Medicaid calculation method.

Figure 6-13: Report Cover Page

The second page provides a list of dates for the reporting period selected, along with the Denominator and Numerator values.

<table>
<thead>
<tr>
<th>IHS Meaningful Use Patient Volume Report - Eligible Professional</th>
<th>Page 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Patient Volume NOT Achieved</td>
<td></td>
</tr>
<tr>
<td>Report Run Date: 08/10/2011@14:35</td>
<td></td>
</tr>
<tr>
<td>Report Generated by: LUJAN, ADRIAN</td>
<td></td>
</tr>
</tbody>
</table>

Eligible Professional: WALLCE, GRACE (PEDIATRICIAN)

Total Patient Encounters of First Highest Patient Volume Period: 361
Total Medicaid Encounters of First Highest Patient Volume Period: 64

MEDICAID PATIENT VOLUME - QUALIFICATION YEAR 2010

<table>
<thead>
<tr>
<th>Report Period</th>
<th>Rate</th>
<th>Denom-</th>
<th>Numer-</th>
<th>Report Period</th>
<th>Rate</th>
<th>Denom-</th>
<th>Numer-</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 JAN - 31 MAR</td>
<td>17.7%</td>
<td>361</td>
<td>64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.3.2 Individual EP Report – Met Threshold

The following report displays when the EP met the threshold and is provided if the user selects the A Option – Abbreviated Summary Report.

IHS Meaningful Use Patient Volume Report - Eligible Professional  Page 1
Report Run Date:  08/10/2011@14:50
Report Generated by: LUJAN, ADRIAN

Participation Year: 2011
Qualification Year: 2010
Reporting Period Identified: 01/01/2010 thru 12/31/2010
Facility(s):
  2010 DEMO HOSPITAL

Number of top volume dates to display if minimum thresholds are not met: 100

Eligible Professional: BIRTHDAY, ELSA A CNM (NURSE MIDWIFE)

Patient Volume for the Qualification Year was calculated using the Medicaid calculation method.
----------------------------------------------------------------------------
Patient Volume 2010 DEMO DB: 57.1%
Total Patient Encounters 2010 DEMO DB:                       7
Total Paid Medicaid Encounters 2010 DEMO DB:                 4
Total Paid Kidscare/Chip Encounters 2010 DEMO DB:            0
Total Paid Other Encounters 2010 DEMO DB:                    0
----------------------------------------------------------------------------
Patient Volume all calculated Facilities:  57.1%
Total Patient Encounters All Facilities Total:               7
Total Paid Medicaid Encounters All Facilities Total:         4
Total Paid Kidscare/Chip Encounters All Facilities Total:    0
Total Paid Other Encounters All Facilities Total:            0
----------------------------------------------------------------------------

(Report Complete):

Figure 6-15: Report Displaying Met Threshold

6.3.3 Patient List

The Patient List is provided when the Patient List option is selected as the Report Format. The report prints a summary sheet along with a list of the patient information. The following displays Page 1 of the report which provides summary information of the report criteria.
CONFIDENTIAL PATIENT INFORMATION COVERED BY THE PRIVACY ACT
IHS Meaningful Use Patient Volume Report - Eligible Professional Page 1
PATIENT LIST BY PROVIDER
Report Run Date: 08/10/2011@15:00
Report Generated by: LUJAN, ADRIAN

Participation Year: 2011
Qualification Year: 2010
Reporting Period Identified: 01/01/2010 thru 03/31/2010
Facility(s):
2010 DEMO HOSPITAL

Eligible Professional: BIRTHDAY, ELSA A CNM (NURSE MIDWIFE)

This Patient List is provided for Eligible Professionals to evaluate their Medicaid Patient Volume Encounters during the Report Period for participation in the Medicaid EHR Incentive program.

Figure 6-16: :Page 1 Summary Report

Page two provides the listing of patient names used to calculate the report. This may be used to provide data needed to show visits used. The report will display

- Patient Name
- Chart Number
- Service Category from the PCC Visit
- Insurer Type (I.T.) of the Billed Insurer
- Date of Service, includes Time of visit
- Date Paid

CONFIDENTIAL PATIENT INFORMATION COVERED BY THE PRIVACY ACT
IHS Meaningful Use Patient Volume Report - Eligible Professional Page 2
PATIENT LIST BY PROVIDER
Report Run Date: 08/10/2011@15:01
Report Generated by: LUJAN, ADRIAN

Eligible Professional: BIRTHDAY, ELSA A CNM (NURSE MIDWIFE)

VISIT LOCATION: 2010 DEMO DB

<table>
<thead>
<tr>
<th>SER</th>
<th>PATIENT NAME</th>
<th>CHART#</th>
<th>CAT</th>
<th>CLINIC</th>
<th>I. BILLED</th>
<th>DATE OF</th>
<th>DATE PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE, CYNTHIA</td>
<td>121635</td>
<td>AMB OBSTETRI</td>
<td>D</td>
<td>NC MEDICAID</td>
<td>01/22/2010@08:00</td>
<td>05/12/11</td>
<td></td>
</tr>
<tr>
<td>PATIENT, JAYLEN</td>
<td>112817</td>
<td>AMB OBSTETRI</td>
<td>D</td>
<td>NC MEDICAID</td>
<td>01/22/2010@08:30</td>
<td>05/12/11</td>
<td></td>
</tr>
<tr>
<td>SAMPLE, CLARA</td>
<td>123012</td>
<td>AMB OBSTETRI</td>
<td>D</td>
<td>NC MEDICAID</td>
<td>01/22/2010@09:00</td>
<td>05/12/11</td>
<td></td>
</tr>
<tr>
<td>SICKLY, SUZANNE</td>
<td>170825</td>
<td>AMB OBSTETRI</td>
<td>D</td>
<td>NC MEDICAID</td>
<td>01/22/2010@10:00</td>
<td>05/12/11</td>
<td></td>
</tr>
<tr>
<td>DEMOS, LUCINDA A</td>
<td>132313</td>
<td>AMB WOMEN’S</td>
<td></td>
<td>NOT BILLED</td>
<td>01/06/2010@08:30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOL, CAMMY J</td>
<td>117015</td>
<td>AMB OBSTETRI</td>
<td></td>
<td>NOT BILLED</td>
<td>01/22/2010@09:30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit:
Figure 6-17: Patient Detail Report – Page 2
7.0 Patient Volume Report for Eligible Hospital

3P→RPTP→MURP→MUPV→PVH

The Patient Volume Reports Menu will be added to the RPMS Third Party Billing (TPB) package Reports Menu. The system must be at TPB Version 2.6 Patch 7 to see this menu.

The following sections will display the report and explain the prompts.

7.1 Report Selection Criteria

7.1.1 Facility Selection

At “Select one or more facilities to use for calculating patient volume:”, a list of facilities available on the database will display. Select one or more facilities to generate report data for. If an FQHC facility is on the database, the user may not select a combination of FQHCs and Non-FQHCs due to calculations that are done.

Select one of the following:
1. 2010 DEMO HOSPITAL
2. AREA ADMINISTRATION
3. INDIAN CO HCLINIC (FQHC/RHC)
Note: you cannot select a combination of FQHC/RHC and non-FQHC/RHC data on this report.

Select one or more facilities to use for calculating patient volume: 1

Figure 7-2: Selecting Locations to Print while Printing the Patient Volume Report

FQHC/RHC sites will have a (FQHC/RHC) indicator to the right of the facility name.

Figure 7-3: Display of Facility Name With the FQHC/RHC Indicator

Selecting individual locations will also be marked with an Asterisk (*).

Figure 7-4: Display of Asterisk to the Right of the Location when Selected for Reporting

7.1.2 Participation Year

The Participation Year must be specified for which to run the report. For EHs, the Participation year is a federal fiscal year. The Participation year is the year in which the EH expects to receive an Incentive payment. The Qualification year is the previous year. In this case the Participation year is FFY 2011 which makes the Qualification year FFY 2010.

Hospital/ER Participation year for the Meaningful Use EHR incentive program

For Hospitals/ERs, the Participation year is a federal fiscal year, which begins on October 1, and ends on the following September 30.

Note: The qualification year is the year prior to the participation year. Patient Volume is calculated on encounters that occurred in the qualification year, which is the year prior to the participation year. To view volume for the current year, select next year as the participation year.

Enter the Participation Fiscal year for this report: 2011

Figure 7-5: Entering the Participation Year

At “Enter the Participation year for this report:” enter the Participation year. The system will automatically calculate the Qualification year based on this (which is the Participation year-1).
7.1.3 Reporting Period Options

The report supports three options for the date range. Options B and C require additional date entries to define the report date range.

- Option A is the **Automated 90-day Report** and will start with 1/1 of the Qualification year and look for any 90-day window that the provider met the necessary threshold. This report may take a while to run as it looks through all visit and payment data.

- Option B is the **Specific 90-day Report** and will allow the user to specify the start date and will automatically calculate the end date (by adding 89 days to the start date). If the beginning date is less than 90 days from the end of the calendar year, an error message is displayed.

- Option C is the **User specified Report** and will allow the user to specify the start and end date other than the 90-day range required for the Medicaid Incentive Program. It does not verify it is a 90-day window but the begin and end dates must be in the same fiscal year.

Enter selection: B  Specific 90-Day Report Period

Select a specific start date in the fiscal year for the 90-Day Report Period.  
Note:  End Date must not be after September 30.

Enter selection: C  User specified Report Period

Select a specific start date in the fiscal year for the 90-Day Report Period.  
Note:  End Date must not be after September 30.


Select a specific start date in the fiscal year for the 90-Day Report Period.  
Note:  End Date must not be after December 31.

Enter last day of reporting period for 2010: (10/1/2009-9/30/2010): 9/30/2010

Figure 7-8: Selection of the User-Specified Report and Entering the Report Date Ranges

7.1.4 Report Output Selection

The Volume Report can be printed in several formats depending on the purpose for the report. The Summary format is focused on meeting the patient volume threshold and the dates when that goal was reached. The Patient List format provides detail information for each patient encounter.

Report Format choice. The options are:

**Option S** is the **Summary Report** and reports for each group of Hospital and/or ER’s in the facility selection, indicating if and when the threshold was met, or what percentage the facility met during the selected date range.

**Option A** is the **Abbreviated Summary Report** and will give the user the ability to select how many date ranges to print if the Hospital and/or ER’s did not meet the threshold (instead of printing every date range when automated 90-day is selected).

**Option P** is the **Patient List** and will be all the patients found that generated the numbers for the report. This should be used for validation purposes only, since it will contain a large amount of data (one line for each patient the used in the Hospital and/or ER counts).

Select one of the following:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Summary Report</td>
</tr>
<tr>
<td>A</td>
<td>Abbreviated Summary Report</td>
</tr>
<tr>
<td>P</td>
<td>Patient List</td>
</tr>
</tbody>
</table>

Enter Report Format Choice:

Figure 7-9: Selection of the Patient List as the Report Criteria
7.1.5 Selecting the Device

Regardless of the selection, the system will display the summary of what is being requested for the report. The user can view the information and decide if changes need to be made.

<table>
<thead>
<tr>
<th>SUMMARY OF PATIENT VOLUME REPORT TO BE GENERATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Name: Patient Volume Report for Eligible Hospitals</td>
</tr>
<tr>
<td>The date ranges for this report are:</td>
</tr>
<tr>
<td>Participation Year: 2011</td>
</tr>
<tr>
<td>Qualification Year: 2010</td>
</tr>
<tr>
<td>Reporting Period: Automated 90-day</td>
</tr>
<tr>
<td>Report Method Type: Hospital/ER</td>
</tr>
<tr>
<td>Facility(s):</td>
</tr>
<tr>
<td>2010 DEMO HOSPITAL</td>
</tr>
<tr>
<td>Select one of the following:</td>
</tr>
<tr>
<td>P Print Report</td>
</tr>
<tr>
<td>R Return to Selection Criteria -Erases ALL previous selections</td>
</tr>
<tr>
<td>Do you want to print this report?: P</td>
</tr>
<tr>
<td>Output DEVICE: HOME//</td>
</tr>
</tbody>
</table>

Figure 7-10: Summary Display of the Patient Volume Report to be Generated

At “Do you want to print this report?:” prompt, the user may select from one of the following:

- **P**: Print Report
- **R**: Return to Selection Criteria -Erases ALL previous selections

At Device, HOME is the default. You can queue report to print on a terminal or a printer.

7.2 EH Patient Volume Report Logic

7.2.1 Eligible Hospitals

EHs can receive the full Incentive payment if their Medicaid patient volume is 10% or more of their patient encounters for hospital discharges and Emergency Room encounters.

7.2.2 Patient Volume Calculation Methods

There is one method used to calculate the EH patient volume.
7.2.3 Encounter Definitions

7.2.3.1 Paid Medicaid Encounters
The Final Rule considers paid Medicaid encounters and all encounters to determine the Medicaid patient volume percentage. Paid Medicaid encounters are all patient encounters paid for in full or in part by Medicaid. Each hospital discharge and Emergency Room encounter with the patient will be counted.

7.2.4 RPMS Patient Encounters
RPMS users are familiar with the categories listed below. Facilities that use other applications will need to use a similar methodology for their volume reports.

7.2.4.1 EH Volume Report – Included Service Categories
- Hospitalizations & In Hospital Service
- ER: Ambulatory – Clinic Code 30

7.2.4.2 EH Volume Report – Excluded Service Categories
- Ambulatory (excluding clinic code 30)
- Day surgery
- Observation
- Nursing Home
- Home
- Chart review
- Event (historical)
- Not found
- Telecommunications – calls
- School – Clinic Code 22
- Mail – Clinic Code 42
- Radio call – Clinic Code 54
- Follow up letter – Clinic Code 57
- US (Ultrasound) – Clinic Code 66
- CT – Clinic Code 71
- Case management – Clinic Code 77
- Nurse clinic – Clinic Code B5
- Health Aid clinic – Clinic Code C6

7.3 Eligible Hospital Report Examples

7.3.1 Sample Report Cover Page – EH

The following report provides the EH information based on the A Option – Abbreviate Summary Report. The first page of the report will provide a summary of the facilities selected and the eligibility status.

The Patient Volume Threshold (10% for Hospitals) was not met for the MU Qualification year. Details for the volumes that were achieved are provided for your information.

Highest Patient Volume Met: 7.7
First Day Highest Patient Volume Achieved: 01/01/2010

Patient Volume for the Qualification Year was calculated using the Medicaid calculation method for the hospital and includes ER encounters.

Total Patient Encounters of First Highest Patient Volume Period: 4205
Total Hospital Encounters of First Highest Patient Volume Period: 322

The second page provides a list of dates for the reporting period selected, along with the Denominator and Numerator values.
<table>
<thead>
<tr>
<th>Report Period</th>
<th>Rate</th>
<th>Denominator</th>
<th>Numerator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 JAN - 31 MAR</td>
<td>%</td>
<td>4205</td>
<td>322</td>
</tr>
</tbody>
</table>

(REPORT COMPLETE):

Figure 7-12: Page 2 Displaying the Reporting Period along with Numerator and Denominator Data

### 7.3.2 Eligible Hospital Report – Met Threshold

The following report displays when the EP met the threshold and is provided if the user selects the A Option – Abbreviated Summary Report.

IHS Meaningful Use Patient Volume Report - Hospital
Report Run Date: 08/12/2011@11:17
Report Generated by: LUJAN, ADRIAN

Participation Federal fiscal year: 2010
Qualification Federal fiscal year: 2009
Reporting Period Identified: 10/01/2008 thru 12/29/2008

Hospital used in this report: 2010 DEMO HOSPITAL

Patient Volume: 15.1%

Patient Volume for the Qualification Year was calculated using the Medicaid calculation method for the hospital and includes ER encounters

Total Patient Encounters: 5011
Total Medicaid Encounters: 756
Total Kidscare/Chip Encounters: 0
Total Other Encounters: 1687

Enter RETURN to continue or '^' to exit:

(REPORT COMPLETE):

Figure 7-13: Eligible Hospital Indicating Met Threshold

### 7.3.3 Patient List

The Patient List is provided when the Patient List option is selected as the Report Format. The report prints a summary sheet along with a list of the patient information. The following displays Page 1 of the report which provides summary information of the report criteria.

CONFIDENTIAL PATIENT INFORMATION COVERED BY THE PRIVACY ACT
Participation Federal fiscal year: 2011
Qualification Federal fiscal year: 2010
Reporting Period Identified: 10/01/2009 thru 12/29/2009

This Patient List is provided for Eligible Hospitals to evaluate their Medicaid Patient Volume Encounters during the Report Period for participation in the Medicaid EHR Incentive program.

**VISIT LOCATION: 2010 DEMO DB**

<table>
<thead>
<tr>
<th>Ser</th>
<th>I. Billed</th>
<th>Date of</th>
<th>Date</th>
<th>T. To</th>
<th>Service</th>
<th>Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGING, SALLY</td>
<td>136726</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>12/02/2009@13:35</td>
<td>12/29/09 *</td>
</tr>
<tr>
<td>AGING, DANITA</td>
<td>171898</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>12/15/2009@01:07</td>
<td>01/13/10 *</td>
</tr>
<tr>
<td>AGING, ELIAS K</td>
<td>174594</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>10/27/2009@14:27</td>
<td>12/10/09 *</td>
</tr>
<tr>
<td>HOSPITAL, VAUG</td>
<td>172846</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>10/19/2009@17:12</td>
<td>11/04/09 *</td>
</tr>
<tr>
<td>PATIENT, CLIF</td>
<td>107649</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>11/19/2009@15:46</td>
<td>12/29/09 *</td>
</tr>
<tr>
<td>PATIENT, CLIF</td>
<td>107649</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>11/23/2009@20:05</td>
<td>12/29/09 *</td>
</tr>
<tr>
<td>PATIENT, CLIF</td>
<td>107649</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>11/30/2009@11:39</td>
<td>12/29/09 *</td>
</tr>
<tr>
<td>SOMEBODY, JENN</td>
<td>167902</td>
<td>AMB EMERGENC</td>
<td>D</td>
<td>NC MEDICAI</td>
<td>10/01/2009@07:29</td>
<td>12/10/09 *</td>
</tr>
</tbody>
</table>

Figure 7-14: Patient List Display
8.0 Eligible Provider (EP) Class – List of Eligible Providers

3PB→RPTP→MURP→MUPV→EP

The Provider Class List in RPMS includes the codes for 34 provider types used in RPMS. Running this list will display both the RPMS Provider Class List and a listing of all providers in the database and their class listing.

Figure 8-1: Patient Volume Reports Menu showing selection of EP Class – List of Eligible Professionals

8.1 RPMS Provider Classes

Eligible Professionals for the EHR Incentive program are identified as MDs, DOs, DDSs, DMDs, CNMs, NPs, and PAs that work in an FQHC/RHC setting led by a PA. A “crosswalk” was done between the provider types in RPMS and the broader categories listed in the CMS Final Rule (Final Rule pg 44317). Below are the Provider Type and Class used in the RPMS EHR.

States may recognize other providers as “physicians” in their state (licensing is done at the state level). These additional “physicians” classes may be added to the site parameters for each site.

Provider types must be in the RPMS Provider Class table or added manually to the site parameters to be included in the Patient Volume report.

Appendix A of this manual provides a list of Provider Classes.
8.2 RPMS Provider List

Eligible Professionals for the Hospital will display from this list. Use the following to print your report:

At “Print the list of providers with eligible provider classes as well?” [Y/N]

- **Yes** will print provider classes and providers.
- **No** will print provider class only.

At “Output DEVICE: HOME” prompt, HOME is the default. You can queue report to print on a terminal or a printer.

---

The output for this report will contain a list of eligible provider classes.

You can also print providers that have an eligible provider class. This could be a lengthy list!

Print the list of providers with eligible provider classes as well? YES

Output DEVICE: HOME/ Virtual

EP Class - List of Eligible Professionals Page 1

IHS Meaningful Use Patient Volume Report
Report Run Date: 07/21/2011 15:45

PROVIDER CLASSES THAT WILL BE INCLUDED:

<table>
<thead>
<tr>
<th>Code Provider Class</th>
<th>Code Provider Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 PHYSICIAN</td>
<td>75 PEDIATRICIAN</td>
</tr>
<tr>
<td>11 PHYSICIAN ASSISTANT</td>
<td>76 RADIOLOGIST</td>
</tr>
<tr>
<td>16 PEDIATRIC NURSE PRACT.</td>
<td>77 SURGEON</td>
</tr>
<tr>
<td>17 NURSE MIDWIFE</td>
<td>78 UROLOGIST</td>
</tr>
<tr>
<td>18 PHYSICIAN (CONTRACT)</td>
<td>79 OPHTHALMOLOGIST</td>
</tr>
<tr>
<td>21 NURSE PRACTICIONER</td>
<td>80 FAMILY PRACTICE</td>
</tr>
<tr>
<td>41 OB/GYN (CONTRACT)</td>
<td>81 PSYCHIATRIST</td>
</tr>
<tr>
<td>44 PHYSICIAN (TRIBAL)</td>
<td>82 ANESTHESIOLOGIST</td>
</tr>
<tr>
<td>45 OSTEOPATH</td>
<td>83 PATHOLOGIST</td>
</tr>
<tr>
<td>49 CONTRACT PSYCHIATRIST</td>
<td>85 NEUROLOGIST</td>
</tr>
<tr>
<td>52 DENTIST</td>
<td>86 DERMATOLOGIST</td>
</tr>
<tr>
<td>64 NEPHROLOGIST</td>
<td>A1 SPORTS MEDICINE PHYSICIAN</td>
</tr>
<tr>
<td>68 EMERGENCY ROOM PHYSICIAN</td>
<td>A9 HEPATOLOGIST</td>
</tr>
<tr>
<td>70 CARDIOLOGIST</td>
<td>B1 GASTROENTEROLOGIST</td>
</tr>
<tr>
<td>71 INTERNAL MEDICINE</td>
<td>B2 ENDOCRINOLOGIST</td>
</tr>
<tr>
<td>72 OB/GYN</td>
<td>B3 RHEUMATOLOGIST</td>
</tr>
<tr>
<td>73 ORTHOPEDIST</td>
<td>B4 ONCOLOGIST-HEMATOLOGIST</td>
</tr>
<tr>
<td>74 OTOLARYNGOLOGIST</td>
<td>B5 PULMONOLOGIST</td>
</tr>
<tr>
<td>75 PEDIATRICIAN</td>
<td>B6 NEUROSURGEON</td>
</tr>
</tbody>
</table>

---

Figure 8-2: List of Eligible Provider Classes
Answering YES to view the list of providers will display the following list from Page 2 of the report.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Class</th>
<th>Provider</th>
<th>Class</th>
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<tbody>
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<td>SPONGE, BOB</td>
<td>52</td>
<td>SNOW, WHITE</td>
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<tr>
<td>STARFISH, PATRICK</td>
<td>00</td>
<td>MOUSE, MICKY</td>
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<td>SNOW, MAN</td>
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<td>MINNIE, MOUSE</td>
<td>00</td>
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<tr>
<td>BUCKS, STAR</td>
<td>00</td>
<td>DALLY, DUCK</td>
<td>81</td>
</tr>
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</table>

(REPORT COMPLETE):

Figure 8-3: List of Eligible Professionals
# 9.0 EP Reports Definitions List

**3P→RPTP→MURP→MUPV→DEF**

The EP Reports Definition List provides definitions for terms used in the Patient Volume Report. Running this list will display this list.

To print the report, type HOME at the “Output DEVICE:HOME” prompt. The report may be queued to print on the terminal or a printer.

## Definitions used in this Report:

- **CONTINUOUS 90-DAY PERIOD:** Any rolling 90-day period within the reporting year.

- **MINIMUM PATIENT VOLUME:** Medicaid or Needy Volume greater than or equal to 30% for EPs and 20% for Pediatricians.

- **Participation year:** The calendar year (Jan. 01 - Dec. 31) in which the EP is participating in the Medicaid EHR Incentive program.

- **Qualification year:** The calendar year (Jan. 01 - Dec. 31) immediately prior to the Participation year. Patient Volume is calculated on encounters that occurred during the Qualification Year.

- **MEDICAID PATIENT VOLUME ENCOUNTERS:** Medicaid encounters include all patient visits paid for by Medicaid or an 1115 waiver program. For states where a single payment is made to a facility without regard to the number of encounters a patient has during a single day, each EP who has an encounter with the patient that day will have the encounter included in their Patient Volume calculation.

- **MEDICAID INDIVIDUALS:** Medicaid individuals are patients where Medicaid or a Medicaid demonstration project paid for part or all of any of the following: Service, Premiums, Co-payments and/or cost sharing. They may be:
  1. Individuals enrolled in Medicaid, or
  2. Individuals enrolled in a Medicaid managed care plan, which includes patients enrolled in Managed Care Organizations (MCO's), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs).

- **NEEDY INDIVIDUAL PATIENT VOLUME ENCOUNTERS:** The Needy Individual Patient Volume will be used for EPs who work predominately at an FQHC or RHC. An EP is considered to work predominantly at an FQHC or RHC when the FQHC/RHC is the clinical location for over 50% of all of the provider's total encounters for six (6) months in the most recent calendar year. FQHCs and RHCs use the...
Needy Individual encounter definition (expanded from the basic Medicaid encounter) for their encounters.

NEEDY INDIVIDUALS: Needy Individual encounters include all patient encounters paid for by:
1. Medicaid-insurance type 'D' (includes 1115 Waivers)
2. CHIP-insurance type 'K' billed as either Medicaid or Private Insurance
3. Discounted (sliding scale) encounters
4. Uncompensated care

Note on Discounted Sliding Scale Encounters: Discounted (sliding scale) encounters are not included in this version of the report, as they are not currently captured in RPMS.

Note on Uncompensated Care: Uncompensated care includes all unpaid encounters. Unpaid Encounters = Encounters which were billed, but for which no payment was received for the report period. Unpaid Encounters are not affected by beneficiary status.

(REPORT COMPLETE):

Figure 9-1: Definitions List for EP Reports
Appendix A: RPMS Provider Classes for Eligible Providers

Eligible Professionals for the EHR Incentive program are identified as MDs, DOs, DDSs, DMDs, CNMs, NPs, and PAs that work in an FQHC/RHC setting led by a PA. A “crosswalk” was done between the provider types in RPMS and the broader categories listed in the CMS Final Rule (Final Rule pg 44317). Below are the Provider Type and Class used in the RPMS EHR.

States may recognize other providers as “physicians” in their state (licensing is done at the state level). These additional “physicians” classes may be added to the site parameters for each site.

Provider types must be in the RPMS Provider Class table or added manually to the site parameters to be included in the Patient Volume report.

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider Class</th>
<th>Code</th>
<th>Provider Class</th>
</tr>
</thead>
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<td>MEDICAL DOCTOR</td>
<td>76</td>
<td>RADIOLOGIST</td>
</tr>
<tr>
<td>11</td>
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<td>77</td>
<td>SURGEON</td>
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<td></td>
<td>– at PA Led FQHC/RHC ONLY</td>
<td>78</td>
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<tr>
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<td>OPHTHALMOLOGIST</td>
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<td>FAMILY PRACTICE</td>
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<td>CONTRACT PHYSICIAN</td>
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<td>PHYCHIATRIST</td>
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<td>NURSE PRACTITIONER</td>
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<td>CONTRACT OB/GYN</td>
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<td>DERMATOLOGIST</td>
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<td>A4</td>
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<td>NEPHROLOGIST</td>
<td>A9</td>
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<tr>
<td>68</td>
<td>EMERGENCY ROOM PHYSICIAN</td>
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<td>GASTROENTEROLOGIST</td>
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<tr>
<td>70</td>
<td>CARDIOLOGIST</td>
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<td>ENDOCRINOLOGIST</td>
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<td>B3</td>
<td>RHEUMATOLOGIST</td>
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<td>ONCOLOGIST HEMATOLOGIST</td>
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<td>PULMONOLOGIST</td>
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<td>NEUROSURGEON</td>
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<td>75</td>
<td>PEDIATRICIAN</td>
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</tbody>
</table>

Addendum to User Manual
August 2011

EP Reports Definitions List

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Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

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