RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 8
November 2011

Office of Information Technology (OIT)
Division of Information Resource Management
Albuquerque, New Mexico

Table of Contents

Preface

The Third Party Billing System (ABM) is designed to automate the creation of a claim using existing RPMS data.

The modifications and enhancements in this Addendum have been released to allow the Business Office billing staff to submit claims electronically in the v5010 format. Details have been outlined that will help Meaningful Use Coordinator staff to run the newly released Group Report.

Thanks to the Third Party Billing/Accounts Receivable Technical Advisory Group, the IHS OIT Meaningful Use Team and the Beta Test Sites with specifications and testing.

1.0 Introduction

1.1 Summary of Changes

Patch 8 provides enhancements to Version 2.6 of the Third Party Billing system. The first allows the user to use and bill with the ASC X12 837 Institutional Version 5010 and the ASC X12 837 Dental Version 5010. The changes made to the system are mainly in the Claim Editor and the EMC File creation process.

The second enhancement provides the third Meaningful Use Group report. 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.

1.1.1 Patch 8

Patch 8 includes the following modifications:

- New Group reports for the Patient Volume Report for Eligible Professionals (PVP), listed in the Patient Volume Reports menu.

- New ASC X12N/005010X223A2 Health Care Claim: Institutional format. The Version 5010 format for the 837 Institutional export mode has been added.

  - Added REF*LU segment for Auto Accident State

  - Added CRC Segment for EPSDT Referral using the Special Program prompt on Page 3 to gather data

  - ICD-9 Diagnosis and Procedure codes have been split into multiple segments.

  - A new error code (#240) has been added to warn the user if the Present on Admission code 1 is used. This code is no longer used in version 5010.

  - Added Line Item Control numbers which populate for each charge or flat rate fee and also is set to Accounts Receivable for future processing.

- New ASC X12N/005010X224A1 Health Care Claim: Dental format. The Version 5010 format for the 837 Dental export mode has been added.

  - Addition of PWK segment

  - Addition of Supervisory Physician loop

  - Addition of Loop 2420A to populate the Service Line Rendering Provider and its supporting elements along with fields on the Dental Page in the Claim Editor to allow the provider to be entered.

- Addition of Loop 2420C to populate the Service Line Supervising Provider and its supporting elements along with fields on the Dental Page in the Claim Editor to allow the provider to be entered.

- Fixes for reported issues logged at the RPMS Helpdesk.

  - NO HEAT: Removed duplicate lines from ABMDF29B

  - NO HEAT: Modification to the CMS-1500 export mode to use the location NPI in Form Locator 33A when billing to South Dakota Medicaid.

  - NO HEAT: Correction to the Bills Awaiting Export Report (AWPR) to print even if an insurer entry does not exist. Prior to this fix, the user was being exited from RPMS with an error.

  - NO HEAT: Modification to UB-04 export mode to print the Provider's Taxonomy code in Form Locator 81D when billing to Iowa Medicaid.

  - NO HEAT: Correction made to the following errors:

    - 122 - PROCEDURE(S) MISSING CORRESPONDING DIAGNOSIS(SES)

    - 217 - DX HAS BEEN DELETED THAT IS BEING REFERENCED

    - 220 - NPI UNSPECIFIED IN NEW PERSON FILE FOR PROVIDER

    - 221 - NPI UNSPECIFIED IN NEW PERSON FILE FOR PROVIDER

    - 239 - Prescription Number missing

  These corrections allow the error to correctly display the line number if a prior line number was deleted.

  - HEAT 14200 – Correction to the alignment made for the CMS-1500 (08/05) export mode to print the provider number in Form Locator 24I and 24J in the correct location on the claim form. Prior to this fix, the provider number was printing too far to the left.

  - HEAT 19236 – Correction to Fee Schedule Listing in Table Maintenance to print the fees based upon the effective date, not the updated date.

  - HEAT 28427 – Modification to UFMS Grand Total Report to separately reflect the Medicare Supplement (M) Insurer Type and the Medicare Part D (MD) Insurer Type when printing the report.

  - HEAT 28632 – Correction to 837 v4010 formats to correctly populate the SBR06 element. The element was populating with "1" when it should have been blank.

  - HEAT 28891- Modification to Clearinghouse Setup Option to allow for Receiver Name to be populated by Insurer. Setting up the Receiver Name by Insurer allows NM103 with a "40" qualifier can be populated.

  - HEAT 40129 – Modification to the 837 Professional v5010 to allow the DTP segment to populate to reflect the Accident Date.

- HEAT 41190 – Error <SUBSCR>E+17^ABMDE8C has been corrected. This error occurred when a user would put a CPT code on Page 8C that did not contain a CPT category.
- HEAT 42572 – Correction to Error Code #001 to allow remove the error from displaying if an ICD Surgical Procedure code displays on Page 5B but Page 8B is missing a Surgical CPT code.
- HEAT 42737 – Addition of Tribal Payment report which will find all payments for a date range and report by Tribe then sorted by either Insurer or Insurer Type based upon the user's selection.
- HEAT 43653 – Remove 2010AB loop of the 837 Professional if the insurer is Oregon Medicaid.
- HEAT 45044 – Modifications made for the Clearinghouse option to correctly display fields when using the Clearinghouse.
- HEAT 49305 – Modification to 837 P v5010 to print the PRV segment in loop 2000A for Washington Medicaid
- HEAT 49932 – Correction to Bills Listing Report (BLRP) to remove zeroes when printing the Itemized Cost Report when there are amounts to print.

2.0   Patch 8 Details

2.1   Modifications to the Electronic Media Claims (EMC)

The following section will explain the changes made to electronic billing and will guide the user in setting up the Clearinghouse functionality.

2.1.1   ASC X12 837 Institutional Export Mode, Version 5010

A new export mode has been added to Third Party Billing to allow sites to submit electronic claims to payers that accept the 837 Institutional Version 5010 (#31) export mode. The user should see the new format in the Claim Editor as well as other options that utilize the export mode.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,PAUL  [HRN:3948]                          Claim Number: 30932
........................... (CLAIM IDENTIFIERS)............................

                [1] Clinic.............: URGENT CARE
                [2] Visit Type.........: OUTPATIENT
                [3] Bill Type..........: 131
                [4] Billing From Date..: 04/11/2011
                [5] Billing Thru Date..: 04/11/2011
                [6] Super Bill #.......:
                [7] Mode of Export.....: 837I (UB) 5010
                [8] Visit Location.....: INDIAN HEALTH HOSPITAL

Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```
Figure 2-1: Claim Editor Page 1 screen showing 837P Version 5010 export mode

2.1.2   ASC X12 837 Dental Export Mode, Version 5010

A new export mode has been added to Third Party Billing to allow sites to submit electronic claims to payers that accept the 837 Dental Version 5010 (#33) export mode. The user should see the new format in the Claim Editor as well as other options that utilize the export mode.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 1  ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,PAUL  [HRN:3948]                          Claim Number: 30932
........................... (CLAIM IDENTIFIERS) ...........................

                [1] Clinic.............: URGENT CARE
                [2] Visit Type.........: OUTPATIENT
                [3] Bill Type..........: 131
                [4] Billing From Date..: 04/11/2011
                [5] Billing Thru Date..: 04/11/2011
                [6] Super Bill #.......:
                [7] Mode of Export.....: 837D (ADA) 5010
                [8] Visit Location.....: INDIAN HEALTH HOSPITAL
```

```
Desired ACTION (Edit/View/Next/Jump/Back/Quit): N//
```

Figure 2-2: Claim Editor Page 1 screen showing 837P Version 5010 export mode

2.2 Claim Editor Modifications

Main Menu→ABM→EDTP→EDCL

The following will detail the changes made as a result of adding the 837 Institutional and Dental Export Mode, Version 5010 to Third Party Billing. Many of the options appear when the export mode is *837I (HCFA) 5010 or 837D (ADA) 5010*. Billing staff must be aware of the payer requirements. Populating data into a new field will send the data to the payer.

2.2.1 Page 3, Questions

New questions have been added to Page 3 of the Claim Editor. This allows the user to define and update criteria for each claim that is created.

Many of the new questions added may not print on the paper UB-04 or the ADA-2006 unless indicated.

To Add/Edit Page 3, follow these steps:

1. At the Third Party Billing System "Select menu option" prompt, type EDTP and press the enter key.

2. At the "Add/Edit Claim Menu option" prompt, type EDCL and press the enter key. (User will need to key in a billable visit via a generated claim)

3. Jump to Page 3 by typing "J3". Use the following table for Page 3 as a guide to Add/or Edit.

The newly added questions will appear on the claim page depending on the Export Mode selected. If a question is populated with data, that data will be sent to the payer when billing electronically. This data will also populate in the corresponding segment that contains the data set.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MEGABUCKS,SYLVIA  [HRN:1122]                        Claim Number: 31560
.............................. (QUESTIONS)..............................

 [1] Release of Information..: YES
 [2] Assignment of Benefits..: YES
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.: NO
 [6] Outside Lab Charges.....: NO  $0.00
 [7] Blood Furnished.(pints).: NO
 [8] Date of First Symptom...:
 [9] Date of Similar Symptom.:
```

```
[10] Referring Phys. (FL17)  :
[11] Case No. (External ID)..:
[12] Resubmission(Control) No:
[13] PRO Approval Number.....:
[14] HCFA-1500B Block 19.....:
[15] Type of Admission.......:
[16] Source of Admission.....:
[17] Discharge Status.........:
[18] Admitting Diagnosis.....:
[19] Supervising Prov.(FL19).:     NPI:
       Date Last Seen:
[20] Prior Authorization #...:
[21] Delayed Reason Code.....:
[22] Reference Lab CLIA#.....: 12T1234567  THE REFERENCE LAB INC.
[23] In-House CLIA#..........: 12A3456789

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 2-3: Claim Editor Page 3-Questions Page with the 837I as the Export Mode

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~  PAGE 3~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: MEGABUCKS,SYLVIA  [HRN:1122]                      Claim Number: 32194
.............................. (QUESTIONS)................................

 [1] Release of Information..: YES   From: 11/01/1999
 [2] Assignment of Benefits..: YES   From: 11/01/1999
 [3] Accident Related........: NO
 [4] Employment Related......: NO
 [5] Emergency Room Required.:
 [6] Case No. (External ID)..:
 [7] Radiographs Enclosed....: NO
 [8] Orthodontic Related.....: NO
 [9] Init Prosthesis Placed..: NO
[10] PRO Approval Number.....:
[11] Prior Authorization #...:
[12] Reference Lab CLIA#.....: 12T1234567  THE REFERENCE LAB INC.
[13] In-House CLIA#..........: 12A3456789

Desired ACTION (Edit/Next/View/Jump/Back/Quit): N//
```

Figure 2-4: Claim Editor Page 3-Questions Page with the 837D as the Export Mode

Accident Related Question

Modifications were made in the Auto Accident State field to ask the State where the accident occurred. The "ACCIDENT RELATED" prompt was added to capture this information.

```
[3] Was the Visit Related to an Accident? Y// ES

     Select one of the following:

          1          AUTO ACCIDENT
          2          AUTO-NO FAULT INSURANCE INVOLVED
          3          COURT ACTION POSSIBLE
          5          OTHER ACCIDENT

Type of Accident: 5//   OTHER ACCIDENT
```

```
Accident Date:  05/01/2011//   (MAY 01, 2011)

Accident Hour:  (0-23): 12//
ACCIDENT STATE: ARIZONA//
```

Figure 2-5: Claim Editor Page 3 Displaying the Accident Date, Hour and State

Special Program Question

The Special Program Question has been updated to allow "EPSDT/CHAP" to be selected as a reason.

```
[6] Was visit related to a SPECIAL PROGRAM? Y// ES

Select SPECIAL PROGRAM: ??

   Choose from:
   80        NON-THERAPUTIC STERILIZATION
   01        EPSDT/CHAP
   02        PHYSICALLY HANDICAPPED CHILDREN'S PROGRAM
   03        SPECIAL FEDERAL FUNDING
   04        FAMILY PLANNING
   05        DISABILITY
   06        PVV/MEDICARE 100% PAYMENT PROGRAM
   07        INDUCED ABORTION-DANGER TO LIFE
   08        INDUCED ABORTION-RAPE/INCEST VICTIM
   09        Second Opinion or Surgery
```

Figure 2-6: Claim Editor Page 3 Special Program Question Showing EPSDT/CHAP

2.2.2   Page 4, Provider Data

The Provider Data has been updated to add Supervising Provider indicator. This may be required when the rendering provider is supervised by a physician or dentist.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 4 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: CANE,CANDY  [HRN:8765]                          Claim Number: 32459
..............................(PROVIDER DATA)...............................

                PROVIDER                NPI              DISCIPLINE
       ==========================  ============ ===========================
(attn) DOCTOR,ALEXANDRA              9999999999   PHYSICIAN


Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N// A

Select Provider: PROVIDER,ALAN


     Select one of the following:

          A         Attending
          O         Operating
          T         Other
          F         Referring
          R         Rendering
```

```
         P          Purchased Service
         S          Supervising


~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 4~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: CANE,CANDY  [HRN:8765]                          Claim Number: 32459
.......................... (PROVIDER DATA)...............................


              PROVIDER                  NPI               DISCIPLINE
       ========================== ============ ==========================
(attn)  DOCTOR,ALEXANDRA              9999999999   PHYSICIAN
(suprvs)PROVIDER,ALAN                 1234567893   PHYSICIAN



Desired ACTION (Add/Del/View/Next/Jump/Back/Quit): N//
```

Figure 2-7: Indicating the Supervising Provider on Page 4 – Provider Data Page

2.2.3   Page 5A, Diagnosis

Version 5010 removes the usage requirement for the Present on Admission (POA)
value indicator of 1 (UNREPORTED/NOT USED). If the 1 is used as the Present on
Admission indicator (as entered by PCC), the system will display Error #240 - POA
VALUE 1 NOT APPLICABLE FOR THIS EXPORT MODE and will display on
Page 5A of the Claim Editor. This error will only display if a Version 5010 export
mode is used.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 5A ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: PATIENT,GORDO  [HRN:5557]                       Claim Number: 32434
.............................. (DIAGNOSIS)..............................


BIL    ICD9
SEQ    CODE   POA     Dx DESCRIPTION               PROVIDER'S NARRATIVE
=== ======= === ========================== ================================
 1   250.00   N  DIABETES II/UNSPEC NOT      DIABETES II/UNSPEC NOT UNCONTR
                    UNCONTR
 2   401.9    N  HYPERTENSION NOS            HYPERTENSION NOS
 3   786.2    N  COUGH                       COUGH
 4   784.0    1  HEADACHE                    HEADACHE
------------------------------------------------------------------------
  ERROR:240 - POA VALUE 1 NOT APPLICABLE FOR THIS EXPORT MODE
------------------------------------------------------------------------
Desired ACTION (Add/Del/Edit/Seq/View/Next/Jump/Back/Quit): N//
```

Figure 2-8: Error #240 Displaying on Page 5A Notifying the User of an Invalid POA Indicator

2.2.4   Page 6, Dental Services

The Dental Services Page has been updated to add the Service Line Provider and the
supporting segments for 837D 5010. This includes the new prompt on Page 6 of the
Claim Editor to capture the provider.

When adding the provider entry, the user must indicate whether the provider is a
Rendering or Supervising provider. The entry selected will ensure the correct segment
is populated on the 837D.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 6 ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: CANE,CANDY  [HRN:8765]                         Claim Number: 32459
.......................... (DENTAL SERVICES)..............................


    VISIT                                           ORAL OPER
    DATE                   DENTAL SERVICE           CAV  SITE SURF  CHARGE
   =====  ========================================= ==== ==== ===== ======
[1] 07/08  1110 PROPHYLAXIS - ADULT                                   97.00
                                                                     =======
                                                                     $97.00


Desired ACTION (Add/Del/Edit/View/Next/Jump/Back/Quit): N// E

DATE of SERVICE: JUL 8,2011//

                   DIAGNOSES
      Seq   ICD9
      Num   Code              Diagnosis Description
      ===  ======   =============================================
       1   525.9    DENTAL DISORDER NOS
UNITS: 1//
CHARGE: 97.00//

     ALEXIS,ALEXANDRA                    RENDERING

Select SERVICE LINE PROVIDER: DOCTOR,TRUDEL      TD
    SERVICE LINE PROVIDER: DOCTOR,TRUDEL//
   SERVICE LINE PROVIDER TYPE: RENDERING// ??

     Choose from:
       R        RENDERING
       S        SUPERVISING
```

Figure 2-9: Display of Dental Page where the User Indicates a Rendering Provider

2.2.5   Page 9G, Claim Attachments

The PWK-Claim Supplemental information segment was added to Page 9G-Claim
Attachments, of the claim editor.

This is required when the payer is notified of an attachment following the claim.

```
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ PAGE 9G ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Patient: CANE,CANDY  [HRN:8765]                         Claim Number: 32459
......................... (CLAIM ATTACHMENTS)............................

   REPORT TYPE            TRNS TYPE          CONTROL NUMBER
=================== ================== ============================


Desired ACTION (Add/Del/Edit/Next/Jump/Back/Quit): N// A


=============== ADD MODE - CLAIM ATTACHMENTS  ===============
Select Claim Attachment: 05       Treatment Diagnosis

   CLAIM ATTACHMENTS Transmission Code: FT  FILE TRANSFER
```

```
       CLAIM ATTACHMENTS Control Number: TESTINGDENTAL123
```

Figure 2-10: Page 9G – Claim Attachments Indicating an Attachment being Sent to the Payer

2.3   Inquire About an Approved Bill

Main Menu→ABM→MGTP→IQMG

The 837 Implementation Guide indicates that the Line Item Control Number (LICN)
is required when the submitter needs a line item control number for subsequent
communications to or from the payer. Submitters are encouraged to routinely send a
unique line item control number on all services lines, particularly if the submitter
automatically posts their remittance advice. Submitting a unique line item control
number allows the capability to automatically post by service line.

The Third Party Billing System has been modified to create a Line Item Control
Number for every charge billed on the claim when itemizing to the payer. If
itemization isn't used (Flat Rate or All-Inclusive Billing is set), the user will only see
one LICN for the Flat Rate. The user may view LICN by using the Inquire to an
Approved Bill (IQMG) option:

```
==============================================================================
BILL NUMBER: 32435A                        BILL TYPE: 111
  VISIT LOCATION: INDIAN HEALTH HOSPITAL
  BILL STATUS: BILLED                      PATIENT:
  EXPORT MODE: 837I (UB) 5010              VISIT TYPE: INPATIENT
  ACTIVE INSURER: BCBS OF NEW MEXICO (FEP)
  PROCEDURE CODING METHOD: CPT             CLINIC: GENERAL
.
.
REVENUE CODE: 120                          UNITS: 2
  UNIT CHARGE: 725.00
  LINE ITEM CONTROL NUMBER: 000000009044250001
MEDICAL (CPT): 99221                       REVENUE CODE: 510
  UNITS: 1                                 UNIT CHARGE: 137.00
  SERVICE FROM DATE/TIME: APR 28, 2011  SERVICE TO DATE/TIME: APR 28, 2011
  DATA SOURCE: M
  LINE ITEM CONTROL NUMBER: 000000009044270001
MEDICAL (CPT): 99231                       REVENUE CODE: 510
  UNITS: 1                                 UNIT CHARGE: 72.00
  SERVICE FROM DATE/TIME: APR 28, 2011  SERVICE TO DATE/TIME: APR 28, 2011
  DATA SOURCE: M
  LINE ITEM CONTROL NUMBER: 000000009044270002
MEDICAL (CPT): 99238                       REVENUE CODE: 510
  UNITS: 1                                 UNIT CHARGE: 86.00
  SERVICE FROM DATE/TIME: APR 28, 2011  SERVICE TO DATE/TIME: APR 28, 2011
  DATA SOURCE: M
  LINE ITEM CONTROL NUMBER: 000000009044270003
```

Figure 2-11: Using Inquire on an Approved Bill (IQMG) to View the Line Item Control Number

The user may also see the LICN when viewing the Bill data in the Accounts
Receivable system.

2.4   Table Maintenance

2.4.1   Clearinghouse Modifications

TMTP→ECTM→CHEC

Changes have been made to the Clearinghouse option in Table Maintenance to allow for the user to set up for additional fields that allow for the successful processing of electronic claim files.

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |           THIRD PARTY BILLING SYSTEM - VER 2.6p8          |
            +                   Clearinghouse Setup                     +
            |                  INDIAN HEALTH HOSPITAL                   |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: LUJAN,ADRIAN M                        4-NOV-2011 11:50 AM


Enter the clearinghouse name: CAPITAL CLEARINGHOUSE
CLEARINGHOUSE: CAPITAL CLEARINGHOUSE  Replace

Setting up Header Data...

INTERCHANGE SENDER ID (ISA06): 1234567
RECEIVER ID (ISA08/GS03): 02903910
APPLICATION SENDER CODE (GS02): 1230949
INTERCHANGE ID QUAL (ISA07): ZZ  MUTUALLY DEFINED
```

Figure 2-12: Setting up the Header for the Clearinghouse Option

The first section allows for the setup of the Header data. The Header data is used to populate the ISA or the GS segments in the 837 formats. The changes work for both version 4010 and version 5010 of the 837. The prompts are clearly marked to let the user know which Data Element the information will populate.

The second part of the Clearinghouse Setup option allows the user to populate data for the individual payer that will be sent. After selecting the payer to work with, the system will prompt the user to enter the Payer ID. This field is clearly marked to let the user know which Data Element on the 837 will be populated. The user must reference the Companion Document available from the Clearinghouse Entity to get the payer identifier needed. Once entered, the user will be prompted to enter the Receiver Name. Adding the name will ensure the payer's name is populated on the 837 file. Once all information has been added, the user can add the next payer along with the payer identifier and the receiver name.

```
Select Insurer: NEVERPAY INSURANCE        NEW JERSEY      84728
         ...OK? Yes//   (Yes)

   INSURERS PAYER ID (NM109): 501234
INSURERS: NEVERPAY INSURANCE//
PAYER ID (NM109): 501234//
RECEIVER NAME: NEVERPAY INSURANCE
```

```
Select Insurer: ALWAYSAGING INSURANCE      NEBRASKA      92391
         ...OK? Yes//   (Yes)

    INSURERS PAYER ID (NM109): 501233
INSURERS: ALWAYSAGING INSURANCE//
PAYER ID (NM109): 501233//
RECEIVER NAME: ALWAYS AGING INS

Select Insurer: TIME INSURANCE          CALIFORNIA    90210
         ...OK? Yes//   (Yes)

    INSURERS PAYER ID (NM109): 501932
INSURERS: TIME BOMB INSURANCE//
PAYER ID (NM109): 501932//
RECEIVER NAME: TIME BOMB INSURANCE

Select Insurer:
```

Figure 2-13: Adding the Insurer Data to the Clearinghouse Option

2.5   Tribal Payment Report

TPB→RPTP→TPRP

A new report has been added to the Reports Menu to allow for reporting of Billing
and/or Payment data by the Tribe the patient is enrolled into. This new report does not
require a Security Key.

```
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      |         THIRD PARTY BILLING SYSTEM - VER 2.6p8        |
      +                       Reports Menu                    +
      |                   INDIAN HEALTH HOSPITAL              |
      +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
       User: LUJAN,ADRIAN M                    3-OCT-2011 9:28 AM


   BRRP   Brief (single-line) Claim Listing
   DERP   Detailed Display of Selective Claims
   PRRP   Employee Productivity Listing
   BLRP   Bills Listing
   STRP   Statistical Billed-Payment Report
   PTRP   Billing Activity for a Specific Patient
   DXRP   Listing of Billed Primary Diagnosis
   PXRP   Listing of Billed Procedures
   CHRP   Charge Master Listing
   PARP   PCC Visit Tracking/Audit
   VPRP   View PCC Visit
   CCRP   Cancelled Claims Report
   CLRP   Closed Claims Report
   PCRP   Pending Claims Status Report
   SURP   Summarized (multi-line) Claim Listing
   MURP   MEANINGFUL USE REPORTS ...
   TPRP   Tribal Payment Report

Select Reports Menu Option: TPRP  Tribal Payment Report
```

Figure 2-14: Reports Menu Displaying the Tribal Payment Report Option

Selecting the report will require the user to select specific facilities to report for.

```
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         |           THIRD PARTY BILLING SYSTEM - VER 2.6p8         |
         +                    Tribal Payment Report                 +
         |                    INDIAN HEALTH HOSPITAL                |
         +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
         User: LUJAN,ADRIAN M                      3-OCT-2011 9:28 AM


     Select one of the following:

         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: 1  INDIAN HEALTH HOSPITAL

     Select one of the following:

         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:
```

Figure 2-15: Selecting the Location for the Tribal Payment Report

Once facilities have been selected, the user will need to indicate if they want the report to print by Insurer or by Insurer Type. Printing by Insurer will print statistics for each payer. Printing by Insurer Type will print statistics by the Type of Insurer for each payer entry in the Insurer File

```
     Select one of the following:

         1          INSURER
         2          INSURER TYPE

Sort by INSURER or INSURER TYPE: 1  INSURER

Select Insurer: ALL//
```

Figure 2-16: Selecting the Insurer or Insurer Type

The user will next indicate the Tribe they wish to print data for. If the user wishes to print for all Tribes, they may press Enter and proceed to the next field.

```
Select Tribe: ALL//
```

Figure 2-17: Selecting All Tribes

If the user wishes to print statistics for a number of Tribes, they may type the name of the Tribe, Enter, then type the next Tribe Name.

```
Select Tribe: ALL// TAOS PUEBLO, NM        121
Select Tribe: ZUNI TRIBE RESERVATION, NM        124
Select Tribe: NAVAJO TRIBE OF AZ, NM AND UT        084
Select Tribe:
```

Figure 2-18: Printing Multiple Tribes

The system will next prompt for the Visit Date Range. Enter the Begin and End Dates for the visits to include in the report. Once the visit dates have been entered, the user can proceed to the next prompt.

```
 ============ Entry of Visit Date Range =============

Enter STARTING Visit Date for the Report:  1/1/2011   (JAN 01, 2011)

Enter ENDING DATE for the Report:  T  (OCT 03, 2011)
```

Figure 2-19: Entering the Visit Begin and End Dates for the Report

The next prompt requires the user to indicate whether they want to print data for all bills, regardless of payment status. The other option will be to print Posted Bills that have a Payment or Payment Credit transaction posted to the bill. A selection may be made based on the data needed.

```
     Select one of the following:

         A          ALL bills
         P          POSTED bills w/pymts and pymt credits

All bills, or just bills with payments/payment credits posted?: ALL//
POSTED bills w/pymts and pymt credits
```

Figure 2-20: Selecting Between All Bill or Bills with Posted Payments/Payment Credits

The user may also indicate if they want the report to print by Clinic Type or Visit Type. Once selected, the user may indicate the Device they wish to print the report to.

```
Sort Report by [V]isit Type or [C]linic: V// ISIT TYPE
Select Visit Type: ALL// ALL
```

```
Output DEVICE: HOME//    Virtual
```

Figure 2-21: Selecting Visit or Clinic Type and Device

Once a device has been selected, the user will see a report similar to the following.

```
TRIBAL PAYMENT REPORT                         OCT 3,2011@09:28:39   Page 1
for Visit Dates from 01/01/2011 to 11/03/2011
Billing Location: INDIAN HOSP
==============================================================================
PATIENT                      CLAIM    DOS      AMOUNT BILLED AMOUNT PAID
==============================================================================
Location: INDIAN HEALTH HOSPITAL

   Tribe: APACHE, MESCALERO TRIBE, NM
     Visit Type: OUTPATIENT
       Insurer: NEW MEXICO BC/BS INC
BULLWINKLE,ROCKY             32400    04/19/2011     250.00       125.00
                                                ============ ============
                               Visit Type Totals    250.00       125.00
                                                ============ ============
                               Tribe Totals         250.00       125.00

   Tribe: ISLETA PUEBLO, NM
     Visit Type: INPATIENT
       Insurer: BCBS OF NEW MEXICO (FEP)
GETWEL,VINCENT               32331A   01/14/2011   1,834.00     1,600.00
                                                ============ ============
                               Visit Type Totals  1,834.00     1,600.00
     Visit Type: OUTPATIENT
       Insurer: BCBS OF NEW MEXICO (FEP)
GETWEL,VINCENT               32411A   06/11/2011      25.46        20.00
       Insurer: BCBS OF NEW MEXICO
SALUDS,RICKY                 32402A   04/26/2011      48.48        40.00
                                                ============ ============
                               Visit Type Totals     73.94        60.00
                                                ============ ============
                               Tribe Totals       1,907.94     1,660.00

   Tribe: NAVAJO TRIBE OF AZ, NM AND UT
     Visit Type: OUTPATIENT
       Insurer: BCBS OF NEW MEXICO
GREEN,FLOWER                 32413A   06/02/2011     110.20         1.00
       Insurer: MEDICARE
GREEN,FLOWER                 32420A   07/06/2011     230.00       200.00
                                                ============ ============
                               Visit Type Totals    340.20       201.00
                                                ============ ============
                               Tribe Totals         340.20       201.00

                                                ============ ============
                               Report Totals      2,498.14     1,986.00

(REPORT COMPLETE):
```

Figure 2-22: Output of the Tribal Payment Report for All Posted Bills by Visit Type

3.0 Background – Meaningful Use Reports

3.1 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.

3.2 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).

3.3 Certified EHR

RPMS was 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). 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).

3.4   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.

3.5   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). 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.

4.0   Patient Volume Report-Overview

4.1   Medicaid EP Volume Requirements

EPs must adopt, implement, or upgrade to a Certified EHR. EPs 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.

4.1.1   Qualification Year

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

4.1.2   Participation Year

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

4.1.3   EP Years

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

4.2   Product Scope for Version 2.0

Version 2.0 of the Patient Volume Report focuses on qualifying groups of EPs for the Medicaid Incentive Program using the Group Method calculation.

4.2.1   Group EP Report

The Group EP version of the Patient Volume Report can be run for all providers at a clinic. The EPs entered do not have to work in the same clinic but must have their patient encounters stored in the same database.

Encounters – 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

4.2.2   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 the provider did not meet the necessary threshold. If the group fails 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.

4.2.1.1   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 a group's volumes, and then the specific start date for qualification can be narrowed from there.

4.2.2   Facility Options

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

> **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.

5.0   Patient Volume Reports Option

ABM→RPTP→MURP→MUPV

Group reports are accessed using the option for the Meaningful Use Menu labeled
Patient Volume Reports.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM - VER 2.6p8          |
        +                  MEANINGFUL USE REPORTS                  +
        |                  INDIAN HEALTH HOSPITAL                  |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: LUJAN,ADRIAN M                      4-OCT-2011 2:32 PM


   CEMU   PATIENT COUNTS & % BY ELIGIBILITY
   FEIR   Facility EHR Incentive Report
   MUPV   PATIENT VOLUME REPORTS ...

Select MEANINGFUL USE REPORTS Option:
```

Figure 5-1: Meaningful Use Reports Option

Within the Patient Volume Reports Menu (MUPV), the follow options are available.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |          THIRD PARTY BILLING SYSTEM - VER 2.6p8          |
        +                  PATIENT VOLUME REPORTS                  +
        |                  INDIAN HEALTH HOSPITAL                  |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: LUJAN,ADRIAN M                      4-OCT-2011 2:33 PM


   MUP    Report Parameters
   VMUP   View Report Parameters
   PVP    Patient Volume Report for Eligible Professionals
   EP     EP Class - List of Eligible Professionals
   PVH    Patient Volume Report for Eligible Hospitals
   DEF    EP Reports Definitions List

Select PATIENT VOLUME REPORTS Option:
```

Figure 5-2: Patient Volume Reports Option

6.0   Report Setup

The Report Setup should be a one-time activity for an RPMS site. Please see Patch 7 Addendum for detailed directions for setting the parameters.

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

6.1   Security Key Requirement

The *ABMDZ MU PV SETUP* Security Key must be assigned before the MUP setup can be ran. The RPMS Systems Administrator may provide the user rights to access the *ABMDZ MU PV SETUP* Security Key. This limitation was put in place to prevent inadvertent changes to settings by general users.

6.2   View Report Parameters

3P→RPTP→MURP→MUPV→VMUP

A new option has been added to allow the report parameters to be viewed once the Setup has been completed.

The user may view the parameters by using the View Report Parameters option.

```
                     *** 3P MU PARMETER FILE INQUIRY ***


==============================================================================
PATIENT VOLUME: PATIENT VOLUME            SETUP COMPLETE: YES
PROVIDER CLASS: PHYSICIAN  00
PROVIDER CLASS: PHYSICIAN ASSISTANT  11 *At a PA Led FQHC/RHC only
PROVIDER CLASS: PEDIATRIC NURSE PRACT.  16
PROVIDER CLASS: NURSE MIDWIFE  17
PROVIDER CLASS: PHYSICIAN (CONTRACT)  18
PROVIDER CLASS: OB/GYN (CONTRACT)  41
PROVIDER CLASS: PHYSICIAN (TRIBAL)  44
PROVIDER CLASS: OSTEOPATH  45
PROVIDER CLASS: CONTRACT PSYCHIATRIST  49
PROVIDER CLASS: DENTIST  52
PROVIDER CLASS: NEPHROLOGIST  64
PROVIDER CLASS: EMERGENCY ROOM PHYSICIAN  68
PROVIDER CLASS: CARDIOLOGIST  70
PROVIDER CLASS: INTERNAL MEDICINE  71
PROVIDER CLASS: ORTHOPEDIST  73
PROVIDER CLASS: OTOLARYNGOLOGIST  74
PROVIDER CLASS: PEDIATRICIAN  75
PROVIDER CLASS: RADIOLOGIST  76


Enter RETURN to continue or '^' to exit:
PROVIDER CLASS: SURGEON  77
PROVIDER CLASS: UROLOGIST  78
PROVIDER CLASS: OPHTHALMOLOGIST  79
PROVIDER CLASS: FAMILY PRACTICE  80
PROVIDER CLASS: PSYCHIATRIST  81
```

```
PROVIDER CLASS: ANESTHESIOLOGIST  82
PROVIDER CLASS: PATHOLOGIST  83
PROVIDER CLASS: NEUROLOGIST  85
PROVIDER CLASS: DERMATOLOGIST  86
PROVIDER CLASS: HEPATOLOGIST  A9
PROVIDER CLASS: GASTROENTEROLOGIST  B1
PROVIDER CLASS: ENDOCRINOLOGIST  B2
PROVIDER CLASS: RHEUMATOLOGIST  B3
PROVIDER CLASS: ONCOLOGIST-HEMATOLOGIST  B4
PROVIDER CLASS: PULMONOLOGIST  B5
PROVIDER CLASS: NEUROSURGEON  B6
PROVIDER CLASS: NURSE PRACTITIONER  21
PROVIDER CLASS: OB/GYN     72
PROVIDER CLASS: SPORTS MEDICINE  A1
==========================================================================
```

Figure 6-1: Viewing the Set Up Parameters

7.0   Patient Volume Group Report for 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 8 to see this menu. The Group reports are selected within the PVP report.

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

7.1   Report Selection Criteria

7.1.1   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/RHC/Tribal facility is on the database, the user may not select a combination of FQHCs and Non-FQHCs due to calculations that are done.

```
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        |           THIRD PARTY BILLING SYSTEM - VER 2.6p8       |
        +    Patient Volume Report for Eligible Professionals    +
        |                    INDIAN HEALTH HOSPITAL              |
        +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
        User: LUJAN,ADRIAN M                       4-OCT-2011 2:40 PM


     Select one of the following:

         1          2010 DEMO HOSPITAL
         2          AREA ADMINISTRATION
         3          INDIAN CO HCLINIC (FQHC/RHC)
         4          WHITE SANDS CLINIC
         5          OLD CARE NURSING HOME
         6          WHITE TOOTH DENTAL

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 7-1: Selecting Locations to Print while Printing the Patient Volume Report

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

```
         3          INDIAN CO HCLINIC (FQHC/RHC)
```

Figure 7-2: Display of Facility Name with the FQHC/RHC Indicator

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

```
          1          2010 DEMO HOSPITAL *
```

Figure 7-3: Display of Asterisk to the Right of the Location when Selected for Reporting

7.1.2   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 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 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: GRP  Group method for facilities
```

Figure 7-4: Selecting the Encounter Method for Each EP as the Report Criteria

7.1.3   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 7-5: Entering the Participation Year

7.1.4   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 7-6: 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 the first 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 7-7: 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.

```
Enter selection: C  User specified Report Period

Select a specific start date in the calendar year
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

Select a specific end date in the calendar year
Note:  End Date must not be after December 31.

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

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

7.1.5   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:

          S          Summary Report
          A          Abbreviated Summary Report
          P          Patient List


Enter Report Format Choice:
```

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

7.1.6   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.

```
                   SUMMARY OF PATIENT VOLUME REPORT TO BE GENERATED


Report Name: Patient Volume Report for Group Practice
The date ranges for this report are:
    Participation Year: 2011
    Qualification Year: 2010
Reporting Period: 01/01/2010 thru 03/31/2010

Report Method Type: Group

Facility(s):
    2010 DEMO HOSPITAL
    WHITE SANDS CLINIC

      Select one of the following:

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

<P> to Print or <R> to Reselect: Print Report

Note: This report will take a while to run based on the amount of data you
have


Output DEVICE: HOME//
```

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   EP Patient Volume Report Logic

7.2.1   Eligible Professionals

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

7.2.1.1   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.

7.2.1.2   Exception for FQHC/RHC/Tribal Settings – PA Eligibility

PAs working in an FQHC/RHC/Tribal 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/Tribal setting led by a PA are considered to be EPs.

7.2.2   Patient Volume Calculation Methods

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

7.2.2.1   Group EP Method

The Group EP Method calculates the patient volume for all providers at a facility, based on their Medicaid encounters and total encounters. Each EP at the facility can then use this volume as a "proxy" for participating in the Medicaid EHR Incentive program.

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. 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.

7.2.3.2   FQHC, RHC and Tribal – Needy Individual Encounters

The Needy Individual Patient Volume will be used for EPs who work predominately at an FQHC or RHC or Tribal facility. 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)

SCHIP-insurance type 'K' billed as either Medicaid or Private Insurance

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   Group Volume Report – Included Service Categories

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

7.2.4.2   Group 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

7.3   Group Provider Report Samples

7.3.1   Sample Report Cover Page – Group

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

```
      IHS Meaningful Use Patient Volume Report - Group Practice       Page 1
                       Minimum Patient Volume NOT Achieved
                        Report Run Date:  10/07/2011@07:53
                        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
          CIHA SNOWBIRD CLINIC


Eligible Professionals:
   DIETITIAN,KIMBERLY D (PHYSICIAN)
   BRENNER,MARY E (PHYSICIAN)
   WALLCE,GRACE (PEDIATRICIAN)
   GARBER,DAVID (INTERNAL MEDICINE)
```

```
    BIRTHDAY,ELSA A CNM (NURSE MIDWIFE)

Other Professionals:
    BARNES,ADELA V (PHARMACY STUDENT)
    PHYSICIAN,GEORGE E (PHYSICAL THERAPY STUDENT)
    FOOT,BIG A DPM (PODIATRIST)
```

Figure 7-11: Report Cover Page

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

```
     IHS Meaningful Use Patient Volume Report - Group Practice      Page 2
                     Minimum Patient Volume NOT Achieved
                      Report Run Date:  10/07/2011@07:53
                      Report Generated by: LUJAN,ADRIAN


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: 3%
First Day Highest Patient Volume Achieved: 01/01/2010

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

Total Patient Encounters of First Highest Patient Volume Period: 26294
Total Medicaid Encounters of First Highest Patient Volume Period: 792
============================================================================
MEDICAID PATIENT VOLUME - QUALIFICATION YEAR 2010
Report Period   Rate  Denom-   Numer-   Report Period    Rate  Denom- Numer-
                      inator   ator                            inator ator
============================================================================
1 JAN - 31 MAR  3.0%  26294     792


(REPORT COMPLETE):
```

Figure 7-12: Summary Report Displaying Reporting Period, Numerator and Denominator

7.3.2   Group Report – Met Threshold

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

```
     IHS Meaningful Use Patient Volume Report - Group Practice      Page 1
                      Report Run Date:  10/07/2011@09:45
                      Report Generated by: RENDER,SHONDA

Participation Year: 2011
Qualification Year: 2010
Reporting Period Identified: 03/16/2010 thru 06/13/2010
Facility(s):
          INDIAN HEALTH CENTER
```

```
          INDIAN HEALTH HOSPITAL
          MERCY MEDICAL CENTER HOSPITAL
          HOME
          AMBULANCE

Eligible Professionals:
   GEORGE,T K (DENTIST)
   CIES,LUCIA (DENTIST)
   CROSSETT,CLAY D (DENTIST)
   DOCTOR,TRUDEL (PHYSICIAN)

Other Professionals:
   JACKSON,FONDA ()
```

Figure 7-13: Group Report Met Threshold Cover Page

The cover page will print first along with the statistics.

```
     IHS Meaningful Use Patient Volume Report - Group Practice     Page 2
                    Report Run Date:  10/07/2011@09:45
                    Report Generated by: RENDER,SHONDA


Patient Volume for the Qualification Year was calculated using the Medicaid
calculation method.
---------------------------------------------------------------------------
Patient Volume INDIAN HL.C: 100%

Total Patient Encounters INDIAN HL.C:                            1
Total Paid Medicaid Encounters INDIAN HL.C:                      1
Total Paid Kidscare/Chip Encounters INDIAN HL.C:                 0
Total Paid Other Encounters INDIAN HL.C:                         0
---------------------------------------------------------------------------
Patient Volume INDIAN HOSP: 33.3%

Total Patient Encounters INDIAN HOSP:                            3
Total Paid Medicaid Encounters INDIAN HOSP:                      1
Total Paid Kidscare/Chip Encounters INDIAN HOSP:                 1
Total Paid Other Encounters INDIAN HOSP:                         0


---------------------------------------------------------------------------
Patient Volume all calculated Facilities:  50%

Total Patient Encounters All Facilities Total:            4
Total Paid Medicaid Encounters All Facilities Total:      2
Total Paid Kidscare/Chip Encounters All Facilities Total: 1
Total Paid Other Encounters All Facilities Total:         0


(REPORT COMPLETE):
```

Figure 7-14: Report Displaying 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 INFORMATIONCOVERED BY THE PRIVACY ACT
     IHS Meaningful Use Patient Volume Report - Group Practice      Page 1
                         PATIENT LIST BY PROVIDER
                    Report Run Date:  10/07/2011@10:44
                    Report Generated by: RENDER,SHONDA

Participation Year: 2011
Qualification Year: 2010
Reporting Period Identified: 03/16/2010 thru 06/13/2010
Facility(s):
          INDIAN HEALTH CENTER
          INDIAN HEALTH HOSPITAL
          MERCY MEDICAL CENTER HOSPITAL
          HOME
          AMBULANCE

Eligible Professionals:
   GEORGE,T K (DENTIST)
   CIES,LUCIA (DENTIST)
   CROSSETT,CLAY D (DENTIST)
   DOCTOR,TRUDEL (PHYSICIAN)

Other Professionals:
   JACKSON,FONDA ()
```

Figure 7-15: 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 INFORMATIONCOVERED BY THE PRIVACY ACT
    IHS Meaningful Use Patient Volume Report - Group Practice      Page 3
                         PATIENT LIST BY PROVIDER
                    Report Run Date:  11/07/2011@10:44
                    Report Generated by: RENDER,SHONDA
```

```
VISIT LOCATION: INDIAN HL.C
================================================================================
Ser             I. Billed     Date of         Date
PATIENT NAME    CHART# Cat Clinic   T. To         Service        Paid
================================================================================
JONES, CHIPPER          AMB GENERAL   D  NEW MEXICO 03/16/2010@08:00
06/08/11*

VISIT LOCATION: INDIAN HOSP
================================================================================
Ser             I. Billed     Date of         Date
PATIENT NAME    CHART# Cat Clinic   T. To         Service        Paid
================================================================================
JOHNSON, RANDY  321445 AMB GENERAL   D  MISSISSIPP 06/01/2010@08:00
05/23/11*
KLESKO, RYAN    43555  AMB           K  KIDSCARE   05/22/2010@08:00
06/07/11
JONES, CHIPPER  12770  AMB GENERAL      NOT BILLED 05/22/2010@08:00

(REPORT COMPLETE):
```

Figure 7-16: Patient Detail Report –Page 2

Appendix A: RPMS Provider Classes 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.

Code	Provider Class	Code	Provider Class
00	MEDICAL DOCTOR	76	RADIOLOGIST
11	PHYSICIAN ASSISTANT	77	SURGEON
	– at PA Led FQHC/RHC ONLY	78	UROLOGIST
16	PEDIATRIC NURSE PRACTITIONER	79	OPHTHALMOLOGIST
17	NURSE MIDWIFE	80	FAMILY PRACTICE
18	CONTRACT PHYSICIAN	81	PHYCHIATRIST
21	NURSE PRACTITIONER	82	ANESTHESIOLOGIST
41	CONTRACT OB/GYN	83	PATHOLOGIST
44	TRIBAL PHYSICIAN	85	NEUROLOGIST
45	OSTEOPATHIC MEDICINE	86	DERMATOLOGIST
49	CONTRACT PHYCHIATRIST	A1	SPORTS MEDICINE PHYSICIAN
52	DENTIST	A4	NATUROPATH PHYSICIAN
64	NEPHROLOGIST	A9	HEPATOLOGIST
68	EMERGENCY ROOM PHYSICIAN	B1	GASTROENTEROLOGIST
70	CARDIOLOGIST	B2	ENDOCRINOLOGIST
71	INTERNAL MEDICINE	B3	RHEUMATOLOGIST

Code	Provider Class	Code	Provider Class
72	OB/GYN	B4	ONCOLOGIST HEMATOLOGIST
73	ORTHOPEDIST	B5	PULMONOLOGIST
74	OTOLARYNGOLOGIST	B6	NEUROSURGEON
75	PEDIATRICIAN		

Contact Information

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