RESOURCE AND PATIENT MANAGEMENT SYSTEM

IHS Meaningful Use Patient Volume Report Logic Document

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Office of Information Technology (OIT)

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Revision History

Note: The revision history cycle begins with original creation and then tracks changes or enhancements as requested they are developed.

Date	Revision	Description	Author
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Contents

1 IHS RPMS Patient Volume Report

The Indian Health Services (IHS) Resource and Patient Management System (RPMS) Patient Volume Reports are located in the Meaningful Use Reports section of the Third Party Billing (TPB) Package. These reports allow users to do necessary setup, print definition pages for important Meaningful Use (MU) information, and run reports for individual Eligible Professionals (EPs), groups of EPs, or Hospitals/Emergency Rooms (ERs). It also gives the user the option to print a patient list, to see what encounters were used to determine the percentages reported.

1.1 Purpose of this Document

The purpose of this document is to detail the logic used in determining Patient Volume for participation in the Medicaid Electronic Health Record (EHR) incentive programs for individual Eligible Professionals (EPs), groups of EPs, or Eligible Hospitals (EHs).

This logic is the basis for the Patient Volume Reports located in the IHS RPMS Third Party Billing Version 2.6 (ABM version 2.6, patches 7 and 8) software. Additional approved logic that is not included in the software is noted in the appropriate sections.

1.2 Use of the Report Logic Document

This document may be used by IHS RPMS TPB (ABM) users to understand the Patient Volume reports. It may also be used to develop Patient Volume Reports for users of other billing and EHR software packages.

1.3 Required Software

IHS Third Party Billing Version 2.6 (ABM version 2.6, patches 7 and 8) are required to run the IHS RPMS Patient Volume Reports.

Users of other software billing packages should contact their vendors for a list of required software.

2 Patient Volume Reports Basics

2.1 Navigation to the Patient Volume Reports Menu

1. Open an RPMS Roll and Scroll session
2. Select IHS Core Option: EXEC Administrative Systems Menu
   (or appropriate menu selection for your installation of RPMS – applies to each step)
3. Select Third Party Billing System: 3P
4. Select Reports Menu: RPTP
5. Select MEANINGFUL USE REPORTS: MURP
6. Select PATIENT VOLUME REPORTS: MUPV
7. Select PATIENT VOLUME REPORTS Option: PVP

2.2 MUP – Parameters Overview

The MUP – Parameters Setup allows sites to make the following designations: FQHC/RHC/Tribal site status, PA leadership, and additional EP types being added to the standard list.

2.3 VMUP – View Report Parameters Overview

This allows the user to view the parameters that have been set for their sites.

2.4 PVP – Patient Volume Report for Eligible Professionals Overview

This allows the user to run either the individual EP or the group EP report.

2.5 EP – EP Class - List of Eligible Professionals Overview

This lists the standard EP classes for the Medicaid EHR Incentive Program and for running the reports. There is an option for displaying a list of all the EPs and their class designation.

2.6 PVH – Patient Volume Report for Eligible Hospitals Overview

This allows the user to run the Hospital reports.

2.7 DEF – EP Reports Definitions List Overview

This is a quick guide to terminology used in the reports.

3 MUP – Parameter Details

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

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

After the setup is completed, users with access to the Third Party Billing Menu can run the Volume Reports.

3.2 ABMDZ Key Requirement

ABMDZ MU PV SETUP Security Key is required to run the MUP setup. The administrator of the system can give the user the rights to access the ABMDZ Security Key.

This limitation was put in place to prevent inadvertent changes to settings by general users.

3.3 Report Parameters

The MUP menu choices allow the user to set the following report parameters:

1. Designating the facility running the report is an FQHC/RHC site.
    a. Tribal facilities should use the FQHC designation.
    b. Selecting this parameter will use the Needy Individual calculation for the report.
2. Designating FQHC/RHC/Tribal sites as PA led.
3. Designating additional EP types – report will not run for non-EP providers.
4. The facility running the report is an FQHC/RHC site. [Y/N]
5. Facilities classified as an FQHC or RHC facility must answer Yes.

3.4 FQHC/RHC/Tribal Designation

Databases may have some sites designated as FQHC/RHC/Tribal and others that are not.

If database has both types of sites, the “All Facilities” selection will not appear when selecting which site(s) to run the report on.

The FQHC/RHC designation makes the report run the “Needy Individual” calculation

The report cannot perform the needy calculation for some sites and the regular calculation for others at the same time on the same report run.

3.5 Additional Provider Types

States license physicians, and may expand or reduce the list of health care providers in their state that are classified as Eligible Professionals. Additional types of providers 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) can be added when setting the report parameters. Some states consider Optometrists, Podiatrists, etc., as Physicians.

Setting the Additional EP types will allow the volume report to run for the additional EP types.

4 VMUP – View Report Parameters Details

This allows a user to view the status of the report setup (Yes/No) and the EP Provider Classes that are set in the database. There is no functionality associated with this option, it is informational only.

After the setup is completed, users with access to the Third Party Billing Menu can run the Volume Reports.

5 PVP – Patient Volume Report for Eligible Professionals Details

The PVP section allows a user to run both the individual and group reports for Eligible Professionals. The user may run an automated 90-day report that looks for the first 90-day period in which a provider meets the 30% minimum threshold during the year or may run a 90-day report where the user specifies the start date, or may run a report where both start and end dates are user specified.

The individual provider reports may be run for multiple providers at the same time, and a Summary or Abbreviated Summary report format may be selected. When the Automated report is selected, and a provider does not meet the minimum threshold, the Summary will display all the 275 different 90-day periods during the year and the volume data for each period. The Abbreviated Summary report will give the user the ability to select a smaller number of volume periods to display.

6 EP – EP Class - List of Eligible Professionals Details

This section lists the provider classes that are EPs, and it also allows the user to print the list of providers in their database, with eligible provider classes. Verifying this list will allow users to determine errors in provider class assignment for providers, so they can be fixed. There is no functionality associated with this option, it is informational only.

7 PVH – Patient Volume Report for Eligible Hospitals Details

The PVH section allows a user to run the report for Eligible Hospitals. The user may run an automated 90-day report that looks for the first period in which a hospital meets the 30% minimum threshold during the Federal Fiscal year or may run a 90-day report where the user specifies the start date, or may run a report where both start and end dates are user specified.

When the Automated report is selected, and the hospital does not meet the minimum threshold, the Summary will display all the 275 different 90-day periods during the Federal Fiscal year and the volume data for each period. The Abbreviated Summary report will give the user the ability to select a smaller number of volume periods to display.

8 DEF – EP Reports Definitions List Details

This section lists definitions of terminology used specifically for the EP reports, but many of the terms are generic to both reports. There is no functionality associated with this option, it is informational only.

9 Logic

9.1 MUP – Parameters Logic

9.1.1 Access to MUP Parameter

View Parameter – requires ABMDZ MU PV SETUP Security Key

9.1.2 MUP Parameter Setup Logic

Question	Responses	Navigation Logic	Program Logic
You are setting up the Report Parameters. Once completed, you will not be able to edit. Continue?	Yes/No	If Yes, FQHC/RHC question will display. If No, setup will close and the Patient Volume reports cannot be run until setup is completed.	RPMS will log responses
Do you wish to designate a Facility as an FQHC or RHC?	Yes/No	If Yes, FQHC/RHC selection question will display. If No, additional EP type question will display.	RPMS will log responses
Select one or more facilities to designate as an FQHC or RHC:	Select facility from dynamic list of facilities available in local RPMS database	After selection of a single facility, the question will move to the PA led? question. If no additional facilities are designated, pressing Enter will re-display question for selection of another facility, pressing Enter a second time will display a confirmation message of all facilities designated as FQHC/RHCs and then move to the designation confirmation question.	When the Patient Volume Report calculates for facilities designated as an FQHC or RHC, the Needy Individual calculation will be used automatically.
Is this FQHC led by a PA?	Yes/No	If Yes, selection of "PA Led" will be added to facility designation. If No, question for selection of another facility will display.	RPMS will log responses
By answering YES the entries below will be added and the list may not be edited without contacting OIT Are you sure?	Yes/No	If Yes, selection of additional EP types question will display. If No, selection of facility will re-display.	RPMS will log responses

Question	Responses	Navigation Logic	Program Logic
Are there additional EP types for your state?	Yes/No	If Yes, select Provider Class will display. If No, parameter completion will display.	RPMS will log responses
Select PROVIDER CLASS:	User will enter a class code from the RPMS PROVIDER CLASS table.	After entry of code, pressing Enter will display confirmation	RPMS will log responses
OK?	Yes/No	If Yes, select Provider Class will display. If No, selection will clear, and then select Provider Class will re-display. After last Provider Class selection, parameter completion will display.	Users will be able to run the Patient Volume Report for each of the additional EP classes that were added.
Parameter Completion			All parameter response changes will be saved as report parameters. These cannot be accessed by the site, but must be reset by OIT.

9.2 VMUP – View Report Parameters Logic

Action	Responses	Navigation Logic	Program Logic
Select VMUP	None Required	Display Only	Report Parameters selected in MUP Parameter Setup are displayed

9.3 PVP – Patient Volume Report for Eligible Professionals Logic – Report Criteria

9.3.1 Facility Selection

Action	Responses	Navigation Logic	Program Logic
Select one or more facilities to use for calculating patient volume:	Select number(s) for facilities to use for calculating patient volume for provider(s), separating numbers with a comma or selected number of "All Facilities"* to run for all facilities in database.	After selection of one or more facilities, pressing Enter will re-display question for selection of another facility, pressing Enter a second time will display a description of the Individual and Group reports and a selection for report type.	• If one or more facilities are selected, the report will pull data for either individual providers or the group from only those facilities. • If the "All Facilities" selection is selected, then data will be pulled from all facilities in the database. • If a facility is designated as an FQHC the report will use the "Needy Individual"** calculation method. • If a facility is not designated as an FQHC the report will use the straight Medicaid calculation method. • Reports may not be run for FQHC and non-FQHC facilities at the same time.

* An "All Facilities" selection will only appear if there are no facilities designated as an FQHC.

** The "Needy Individual" calculation in RPMS includes all Medicaid and all CHIPs/Kidscare encounters. Since this report was programmed, permission to include all encounters that are "Uncompensated Care" has been received from CMS. A workaround method had been developed that allows users to take the results of the reports and complete the calculation.

9.3.2 Report Type Selection

Action	Responses	Navigation Logic	Program Logic
Select report type:	Selecting SEL initiates the Encounter method for each EP, selecting GRP initiates the Group method for facilities	If SEL is selected, the Individual EP report is initiated for each EP designated in subsequent steps. If GRP is selected, the Group report is initiated for selected facilities and the Participation Year question is displayed.	RPMS will log responses

9.3.3 Individual Report

Action	Responses	Navigation Logic	Program Logic
Select NEW PERSON NAME:	Type full last name of provider or first few characters and select provider from displayed list	After selection of one or more providers, pressing Enter will re-display question for selection of another provider, pressing Enter a second time will display the Participation Year question.	RPMS will log responses

9.3.4 Participation Year and Date Range Selection

Action	Responses	Navigation Logic	Program Logic
Enter the Participation year for this report:	Enter a four digit calendar year	After entry of participation year, the report period question will display.	RPMS will log responses
Select one of the following: / Enter Selection:	A = Automated 90-Day Report B = Specific 90-Day Report Period C = Specified Report Period	If A is selected the Automated 90-Day Report will initiate and the Report Format Choice question will display. If B is selected the Specific 90-Day Report Period selection will initiate. If C is selected the specified Report Period selection will initiate.	RPMS will log responses

9.3.5 Specific 90-Day Report Period

Action	Responses	Navigation Logic	Program Logic
Enter first day of reporting period for [selected year]: (1/1/[selected year] - 12/31/[selected year]):	Select a specific start date in the calendar year for the 90-Day Report Period. Note: End Date must not be after December 31.*	After entry of date, Report Format Choice question is displayed	RPMS will log responses

* If the end date for the 90-day is after December 31, then the report cannot be used to attest for MU, but may be used for informational purposes.

9.3.6 Specified Report Period

If the report is not for a full 90-day period, or the end date for the 90-day is after December 31, then the report cannot be used to attest for MU, but may be used for informational purposes.

Action	Responses	Navigation Logic	Program Logic
Enter first day of reporting period for [selected year]: (1/1/[selected year] - 12/31/[selected year]):	Select a specific start date in the calendar year for the Report Period.	After entry of date, period end date question is displayed	RPMS will log responses
Enter last day of reporting period for [selected year]: (1/1/[selected year] - 12/31/[selected year]):	Select a specific end date in the calendar year for the Report Period.	After entry of date, Report Format Choice question is displayed	RPMS will log responses

9.3.7 Report Format Choice

Action	Responses	Navigation Logic	Program Logic
Enter Report Format Choice:	Select one of the following: S = Summary Report A = Abbreviated Summary Report P = Patient List	If S is selected, a summary of report parameters and the option to Print the report or Return to selection criteria will display. If A is selected, the Abbreviated Summary Report top date specification question will display. If P is selected, a summary of report parameters and the option to Print the report or Return to selection criteria will display.	RPMS will log responses

9.3.8 Abbreviated Summary Report

Action	Responses	Navigation Logic	Program Logic
Specify the number of top volume dates to display if minimum thresholds are not met Enter Number (1-275):	Enter a number from 1-275 to specify the number of top volume dates to display if minimum thresholds are not met.	After entry of number, a summary of report parameters and the option to Print the report or Return to selection criteria will display.	RPMS will log responses

9.3.9 Print/Return Selection

Action	Responses	Navigation Logic	Program Logic
<P> to Print or <R> to Reselect:	Select one of the following: P = Print Report R = Return to Selection Criteria -Erases ALL previous selections	If P is selected, report will run with selected criteria constraints. If R is selected, the Facility Selection question will display	Report will run according to selected criteria, or user will be returned to selection criteria routine.

9.3.10 PVP – Patient Volume Report for Eligible Professionals Logic – Report Calculations SEL Individual EP Report

9.3.10.1 Date Range Logic

If the user opts to let the system automatically find a 90-day threshold, the system will start on Jan1+89 days and see if the provider met the necessary threshold in that 90-day window. If they didn't, it will then go to Jan2+89 days and so on through the calendar year (but not to exceed Dec31 as the end date).

If the user selects the start date of the 90-day window, the system will calculate the end date and see if the provider met the threshold during the 90 days. The system will ensure the end date does not exceed Dec31.

If the user defines the date range, the system will make sure the start and end dates are within the same calendar year, and then check the date range to see if the provider has met the threshold in the defined window. Note this date range could be any number of days since the user is defining it. The system will only check to ensure the dates are within the same calendar year.

9.3.10.2 Encounter Types

9.3.10.2.1 Counted

The report will only look at encounters that have a service category of:

Ambulatory
Day Surgery
Home
Nursing Home
Observation

9.3.10.2.2 Excluded

The report will exclude the following clinic codes:

22 School
30 ER
39 Pharmacy
42 Mail
51 Telephone Call
52 Chart Rev/Rec Mod
54 Radio Call
57 EPSDT
63 Radiology
66 Ultrasound
71 Computed Tomography
72 Mammography
76 Laboratory Services
77 Case Management Services
B5 Nurse Clinic
C6 Health Aide Clinic
D1 Anticoagulation Therapy
D2 Medication Therapy Management

9.3.10.2.3 Denominator

If the encounter is within the date range and is one of the “Counted” service categories, the encounter will be counted in the denominator for every provider that is associated with that encounter (Primary, Secondary, Ordering, etc.).

9.3.10.2.4 Numerator

For the numerator, the report will go to Accounts Receivable (A/R) and look for all encounters that have been paid and count them in the appropriate grouping (Medicaid, Kidscare/CHIP, or Other) on the report. Any encounter on a given day that was paid will make all encounters on that day be considered paid (so three encounters on the same day will be counted as a paid encounter for each provider if any one of the three encounters was paid). Note: the total encounters may not add up to the total paid encounters, because there could be encounters that never generated a claim for one reason or another, or were never paid for whatever reason.

If any of the date ranges (or the specified date range) meets the necessary threshold (20% for Pediatricians; 30% for all others) the provider will be considered eligible and the eligible met output will print. If the provider did not meet the necessary threshold, the not eligible output will print, listing the date ranges and the percentages that were found.

9.3.10.3 Counting Encounters

The report will start in the Visit file, and count every encounter with a Date of Service within the requested date range. The report will stop looking at bills for that encounter once a payment for it has been found on any bill.

9.3.10.4 *EP Patient Volume Calculation*

Program Logic – EP Patient Volume Calculation	
Numerator =	(Encounters for that EP that occurred on a day when Medicaid paid for any service for that patient)
Denominator =	(All Encounters for that EP)

9.3.11 PVP – Patient Volume Group Report Logic – Report Calculations GRP Group Report

When running the PVP Patient Volume Report for Eligible Professionals and the user selects the GRP report, the same logic will be used as the individual report but with one variation. Instead of only looking at the select provider classes, it will look at all provider classes. One report will print with all providers, stating all providers that were found on a visit within the selected date range, separated by Eligible Professionals and Other Professionals and whether as a group they met, or didn't met the necessary threshold.

9.3.11.1 *Group Patient Volume Calculation*

Program Logic – Group Patient Volume Calculation	
Numerator =	(Encounters for all providers that occurred on a day when Medicaid paid for any service for that patient)
Denominator =	(All Encounters for all providers at facility)

9.3.12 PVP – Patient Volume Report Logic – Needy Individual Calculations

EPs practicing at FQHC/RHC and Tribal facilities may use the Needy Individual calculation for demonstrating patient volume. This calculation includes encounters that are paid by Medicaid, as well as those paid by CHIPS/KidsCare programs and all uncompensated care encounters.

At the time the report was being programmed, uncompensated care encounters had not been approved, so they must be calculated from the report. There is a workaround that has been developed, and the final volume must be calculated using the additional steps.

9.3.12.1 *EP Patient Volume Calculation – Needy Individual Calculation*

Program Logic – EP Patient Volume Calculation	
Numerator =	(Encounters for that EP that occurred on a day when Medicaid OR CHIPS/KidsCare paid for any service for that patient OR *Uncompensated Care)
Denominator =	(All Encounters for that EP)

* The Uncompensated Care number must be calculated using the workaround.

9.3.12.2 *Group Patient Volume Calculation – Needy Individual Calculation*

Program Logic – Group Patient Volume Calculation	
Numerator =	(Encounters for all providers that occurred on a day when Medicaid OR CHIPS/KidsCare paid for any service for that patient OR *Uncompensated Care)
Denominator =	(All Encounters for all providers at facility)

* The Uncompensated Care number must be calculated using the workaround.

9.3.13 Needy Individual Calculation – Workaround for TPB Patch 7/8 reports.

The Needy Individual calculation in the Third Party Billing Patch 7 and 8 Patient Volume Report for Eligible Professionals calculates and reports on Medicaid and CHIPs encounters. At the time of programming, the way to count other types of "Uncompensated Care" was still under debate.

Now, due to a CMS FAQ that was published, we are defining uncompensated care as care for which payment was not received from any specific source, i.e. Medicaid, CHIPs, or Other payment sources.

This data value is not directly reported on by the Patient Volume Report for Eligible Professionals, but can be calculated from the information that is reported.

These are the values reported by the report:

A. Total Patient Encounters
B. Total Paid Medicaid Encounters
C. Total Paid Kidscare/Chip Encounters
D. Total Paid Other Encounters

9.3.14 Calculating Unpaid Encounters

1. Add Total Paid Medicaid, Kidscare/Chip, and Other Encounters
   Equation: B + C + D = E (Total Paid)
2. Subtract Total Paid from the Total Patient Encounters.
   Equation: A - E = F (Total Uncompensated)
3. Add Total Paid Medicaid, Kidscare/Chip, and Total Uncompensated.
   Equation: B + C + F = G (Total Needy Individual)
4. Divide Total Needy Individual by Total Patient Encounters
   Equation: G / A = H (Needy Individual Patient Volume)

9.3.15 Calculator Spreadsheet

A spreadsheet has been developed that may be used to automate the final Needy Individual Patient Volume. Select the link for Microsoft Excel [XLS - 56KB] under Reports, Patient Volume Report, Needy Individual Calculation - Workaround for TPB Patch 7/8 Reports.

Go to this page: http://www.ihs.gov/meaningfuluse/index.cfm?module=toolkit

9.3.16 Additional Encounters – Reduced/Sliding Scale Fees

There are certain cases where beneficiaries have other insurance that paid part of the claim.

1. In the instance where a reduced cost was paid because the Medicaid or CHIP program covered part of the service, it can be considered needy individual.
2. In the instance where a reduced cost was paid because private insurance offset the cost, then the answer is no, it may not be counted.

In case #1, these encounters are counted when the Needy Individual calculations are used for the Patient Volume report, since Medicaid or CHIPs paid all or part of the encounter. In case #2, these visits are not included in the report.

9.4 EP – EP Class - List of Eligible Professionals Logic

Action	Responses	Navigation Logic	Program Logic
Print the list of providers with eligible provider classes as well?	Yes/No	If Yes, list of all providers with an EP provider class will display, if No, only list of EP provider class types will display	RPMS will log responses

9.4.1 Provider Classes

Only providers with the designated provider classes will be looked at. The starting list of provider classes will be:

00	PHYSICIAN	77	SURGEON
11	PHYSICIAN ASSISTANT	78	UROLOGIST
16	PEDIATRIC NURSE PRACTITIONER	79	OPHTHALMOLOGIST
		80	FAMILY PRACTICE
17	NURSE MIDWIFE	82	ANESTHESIOLOGIST
21	NURSE PRACTITIONER	83	PATHOLOGIST
41	CONTRACT OB/GYN	85	NEUROLOGIST
44	TRIBAL PHYSICIAN	86	DERMATOLOGIST
45	OSTEOPATHIC MEDICINE	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
72	OB/GYN	B4	ONCOLOGIST HEMATOLOGIST
73	ORTHOPEDIST	B5	PULMONOLOGIST
74	OTOLARYNGOLOGIST	B6	NEUROSURGEON
75	PEDIATRICIAN		

The site will be able to add any other provider classes not listed here that are considered providers by their state.

9.5 PVH – Patient Volume Report for Eligible Hospitals Logic

9.5.1 Facility Selection

Action	Responses	Navigation Logic	Program Logic
Select one or more facilities to use for calculating patient volume:	Select number(s) for facilities to use for calculating patient volume for hospital(s) and connected ERs, separating numbers with a comma or selected number of "All Facilities"* to run for all facilities in database.	After selection of one or more facilities, pressing Enter will re-display question for selection of another facility, pressing Enter a second time will display selection of the Participation Fiscal year.	• If one or more facilities are selected, the report will pull data from only those facilities. • If the "All Facilities" selection is selected, then data will be pulled from all facilities in the database.
Enter the Participation Fiscal year for this report:	Enter a four digit fiscal year	After entry of participation Fiscal year, the report period question will display.	RPMS will log responses
Select one of the following: / Enter Selection:	A = Automated 90-Day Report B = Specific 90-Day Report Period C = specified Report Period	If A is selected the Automated 90-Day Report will initiate and the Report Format Choice question will display. If B is selected the Specific 90-Day Report Period selection will initiate. If C is selected the specified Report Period selection will initiate.	RPMS will log responses

* An "All Facilities" selection will only appear if there are no facilities designated as an FQHC.

9.5.2 Specific 90-Day Report Period

Action	Responses	Navigation Logic	Program Logic
Enter first day of reporting period for [selected year]: (10/1/[selected year] - 09/31/[selected year]):	Select a specific start date in the fiscal year for the 90-Day Report Period. Note: End Date must not be after September 30.*	After entry of date, Report Format Choice question is displayed	RPMS will log responses

* If the end date for the 90-day is after September 30, then the report cannot be used to attest for MU, but may be used for informational purposes.

9.5.3 Specified Report Period

If the report is not for a full 90-day period, or the end date for the 90-day is after September 30, then the report cannot be used to attest for MU, but may be used for informational purposes.

Action	Responses	Navigation Logic	Program Logic
Enter first day of reporting period for [selected year]: (10/1/[selected year] - 09/31/[selected year]):	Select a specific start date in the fiscal year for the Report Period.	After entry of date, period end date question is displayed	RPMS will log responses
Enter last day of reporting period for [selected year]: (10/1/[selected year] - 09/31/[selected year]):	Select a specific end date in the fiscal year for the Report Period.	After entry of date, Report Format Choice question is displayed	RPMS will log responses

9.5.4 Report Format Choice

Action	Responses	Navigation Logic	Program Logic
Enter Report Format Choice:	Select one of the following: S = Summary Report A = Abbreviated Summary Report P = Patient List	If S is selected, a summary of report parameters and the option to Print the report or Return to selection criteria will display. If A is selected, the Abbreviated Summary Report top date specification question will display. If P is selected, a summary of report parameters and the option to Print the report or Return to selection criteria will display.	RPMS will log responses

9.5.5 Abbreviated Summary Report

Action	Responses	Navigation Logic	Program Logic
Specify the number of top volume dates to display if minimum thresholds are not met Enter Number (1-275):	Enter a number from 1-275 to specify the number of top volume dates to display if minimum thresholds are not met.	After entry of number, a summary of report parameters and the option to Print the report or Return to selection criteria will display.	RPMS will log responses

9.5.6 Print/Return Selection

Action	Responses	Navigation Logic	Program Logic
<P> to Print or <R> to Reselect:	Select one of the following: P = Print Report R = Return to Selection Criteria -Erases ALL previous selections	If P is selected, report will run with selected criteria constraints. If R is selected, the Facility Selection question will display	Report will run according to selected criteria, or user will be returned to selection criteria routine.

9.6 PVP – Patient Volume Report for Eligible Hospitals Logic – Report Calculations

If the user defines the date range, the system will make sure the start and end dates are within the same fiscal year, and then check the date range to see if the facility has met the threshold in the defined window. Note this date range could be any number of days since the user is defining it. The system will only check to ensure the dates are within the same fiscal year.

If the user selects the start date of the 90-day window, the system will calculate the end date and see if the facility met the threshold during the 90 days. The system will ensure the end date does not exceed Sept30.

If the user opts to let the system automatically find a 90-day threshold, the system will start on Oct1+89 days and see if the provider met the necessary threshold in that 90-day window. If they didn't, it will then go to Oct2+89 days and so on through the calendar year (but not to exceed Sept30 as the end date).

9.6.1 Denominator

For the denominator, the report will go through the Visit file looking for all encounters that have a discharge date within the date range. The report will only look at encounters that have a service category of Hospitalization or Ambulatory with a clinic code 30 (ER). If the encounter is within the date range and is one of the above service categories, the encounter will be counted in the denominator for the facility.

9.6.2 Numerator

For the numerator, the report will go to A/R and look for all encounters that have been paid and count them in the appropriate allowance category on the report. Any encounter on a given day that was paid will make all encounters on that day be considered paid.

9.6.3 Hospital Patient Volume Calculation

Program Logic – Hospital Patient Volume Calculation	
Numerator =	(Medicaid Paid Discharges) + (Medicaid Paid ER Encounters)
Denominator =	(All Discharges) + (All ER Encounters)

9.6.4 Output

If any of the date ranges (or the specified date range) meets the necessary threshold (10% for facilities) the facility will be considered eligible and the eligible met output will print. If the facility did not meet the necessary threshold, the not eligible output will print, listing the date ranges and the percentages that were found.

9.7 DEF – EP Reports Definitions List Logic

Action	Responses	Navigation Logic	Program Logic
Select DEF	None Required	Display Only	Report definitions used by the EP report will be displayed