RESOURCE AND PATIENT MANAGEMENT SYSTEM

Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 12
March 2014

Office of Information Technology
Division of Information Technology
Albuquerque, New Mexico

Table of Contents

1.0 Introduction 1
- 1.1 Eligibility 1
  - 1.1.1 Eligible Professionals 1
  - 1.1.2 Eligible Hospitals 2
- 1.2 Patient Volume Requirements 2
  - 1.2.1 Eligible Professionals 2
  - 1.2.2 Eligible Hospitals 2
  - 1.2.3 Patient Volume Reporting Period 2
  - 1.2.4 Patient Volume Logic 3

2.0 Summary of Changes 5
- 2.1 Patch 12 5
- 2.2 Patch 11 8
- 2.3 Patch 7 9

3.0 Report Setup 10
- 3.1 Site Parameter Set-up for Reports 10
- 3.2 View Report Parameters 12

4.0 Eligible Provider Class – List of Eligible Providers 14
- 4.1 RPMS Provider List 14

5.0 Patient Volume Report – Overview 16
- 5.1 Individual Eligible Professional 16
  - 5.1.1 Eligible Hospital 17
  - 5.1.2 Date Range Options 18

6.0 Patient Volume Report Options 19

7.0 Patient Volume Report for Eligible Providers 20
- 7.1 Report Selection Criteria 20
  - 7.1.1 Select the Facility 20
  - 7.1.2 Select the Report Type 21
  - 7.1.3 Select Eligible Providers 22
  - 7.1.4 Set the Participation Year 23
  - 7.1.5 Add, Remove, or Omit SCHIP Insurers 23
  - 7.1.6 Select a Reporting Period 24
  - 7.1.7 Select the Report Format 27
  - 7.1.8 Select the Output Device 27
- 7.2 EP Summary Report Samples 28
  - 7.2.1 Eligible Provider Report - Not Met Threshold 28
  - 7.2.2 Individual Eligible Provider Report – Met Threshold 29
- 7.3 EP Patient List Report Samples 31
  - 7.3.1 Patient List 31

7.3.2 Modified Patient List 32

8.0 Patient Volume Report for Eligible Hospital 34

8.1 Report Selection Criteria 34
8.1.1 Select the Facility 34
8.1.2 Set the Participation Year 35
8.1.3 Select a Reporting Period 35
8.1.4 Select the Report Format 38
8.1.5 Select the Output Device 38
8.2 EH Summary Report Samples 39
8.2.1 Sample Report Cover Page 39
8.2.2 Eligible Hospital Report – Met Threshold 40
8.3 EH Patient List Report Samples 41
8.3.1 Patient List 41
8.3.2 Modified Patient List 42

9.0 Facility EHR Incentive Report 43

9.1 Facility EHR Incentive Report 43
9.2 Hospital Calculation Incentive Report 43

10.0 Patient Counts & Percent by Eligibility Report 47

Appendix A: RPMS Provider Classes for Eligible Providers 49

Appendix B: Exporting Patient Volume Reports to Excel 51

B.1 Generate the Report 51
B.2 Retrieve the Report 52
B.3 Import the File to Excel 54

Appendix C: Verifying the Visits on the Patient Volume Reports 59

Appendix D: Validating Data on the Patient Volume Report 66

D.1 Patient Volume Modified Patient List 67
D.2 Bills Listing Report 68
D.3 Visit General Retrieval Report 68

Acronym List 70

Contact Information 71

Preface

This Addendum to User Manual is intended for use by staff members that are familiar with the Resource and Patient Management System (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 (ABM v2.6 p12).

1.0 Introduction

To be eligible to receive incentive payments as part of the Medicaid Electronic Health Record (EHR) Incentive Program, participants must meet minimum patient volume requirements as determined by specific calculations. With the release of the Centers for Medicare and Medicaid (CMS) Stage 2 Rule in fall 2012, changes to these patient volume calculations went into effect FY and CY 2013.

This Addendum documents the Patient Volume changes that were outlined in the Stage 2 rule that went into effect FY and CY 2013 and includes updated screen shots.

1.1 Eligibility

Participants in the Medicaid EHR Incentive Program must be eligible either as an Eligible Professional (EP) or an Eligible Hospital (EH) as outlined in Section 1.1.1 or Section 1.1.2.

1.1.1 Eligible Professionals

EPs who qualify to participate in the Medicaid EHR Incentive Program include:

- Doctors of medicine (MD)
- Doctors of osteopathy (DO)
- Doctors of dental medicine (DMD) or surgery (DDS)
- Nurse practitioners (NP)
- Certified midwives (CNM)
- Physician assistants (PA) working at Federally Qualified Health Centers (FQHC) or rural health centers (RHCs) when any of the following conditions are met:
  - The PA is the primary provider in the clinic
  - The PA is a clinical or medical director at the clinic
  - The PA owns the RHC

  For the purposes of the Medicaid EHR Incentive Program only, all tribal and urban clinics have been deemed an FQHC.

In addition, note that doctors of optometry, doctors of podiatric medicine, and chiropractors are not eligible to participate in the Medicaid EHR Incentive Program.

Hospital-based professionals, however, are not eligible to receive Medicaid payments as part of the EHR incentive program. A professional is considered hospital-based if at least 90 percent of his or her services are performed in a hospital inpatient or emergency room setting (Place of Service code 21 or 23).

1.1.2 Eligible Hospitals

EHs who qualify to participate in the Medicaid EHR Incentive Program include acute-care hospitals (including Critical Access Hospitals and cancer hospitals) and children's hospitals (no Medicaid patient volume requirements).

1.2 Patient Volume Requirements

For every participation year, EPs and EHs must meet minimum patient volume requirements as part of their ongoing eligibility. Specific thresholds are described in the following subsections.

1.2.1 Eligible Professionals

All EPs other than pediatricians must meet a minimum threshold of 30 percent Medicaid volume. (To reach their 30 percent patient volume, EPs who practice predominately at Tribal, Urban, FQHC, or RHC may use a "needy individual" calculation which allows the use of uncompensated care in the numerator.)

Pediatricians are only required to meet a threshold of 20 percent Medicaid patient volume.

EPs have the choice whether to meet their thresholds by attesting individually or according to a group calculation.

> **Note**: To be valid, the group calculation must include all of the EPs associated with that specific facility. Although the EPs do not have to work in the same clinic, they must store their patient encounters in the same database.

1.2.2 Eligible Hospitals

EHs must meet a threshold of 10 percent Medicaid patient volume.

1.2.3 Patient Volume Reporting Period

The calculation patient volume for the Medicaid EHR Incentive Program, may be based on the qualification year or the look back period, depending on the state's discretion. It is based on a 90-day period in either the qualifying year or the look back period.

The **participation** year for EPs is based on the calendar year (CY). For EHs, it is based on the federal fiscal year (FY) for which payment is applied.

The **qualification** year for EPs and EHs is the year that precedes the participation year.

The look back period is a 90-day period in the 12 months prior to the provider’s attestation.

> **Note**: For the 12-month look-back, the 90-day period may span multiple calendar or fiscal years. However, for the qualification year (the previous calendar year), the 90-day period may *not* span multiple calendar or fiscal years.

1.2.4 Patient Volume Logic

The definition of a Medicaid encounter changed effective CY and FY 2013. A Medicaid encounter now consists of service rendered on any one day to a Medicaid-enrolled individual regardless of payment liability. The expanded definition of Medicaid encounters include:

- Medicaid paid claims
- Zero-paid claims
- Medicaid patients enrolled at the time of service
- CHIP encounters for patients in Title 19 and Title 21 Medicaid expansion programs (***still cannot include CHIP stand-alone Title 21 encounters***)
- Uncompensated Care (FQHC, RHC, Tribal, or Urban only)

The 2013 patient volume calculations for EPs are:

- **Medicaid Expansion State (Federal Site)**:
  - Numerator = Medicaid Paid Claims + Zero Paid Claims + CHIP + Medicaid Enrolled
  - Denominator = All patient encounters
- **Non-Medicaid Expansion State (Federal Site)**:
  - Numerator = Medicaid Paid Claims + Zero Paid Claims + Medicaid Enrolled
  - Denominator = All patient encounters
- **Needy Individual (FQHC, RHC, Tribal, or Urban)**
  - Numerator = Medicaid Paid Claims + Zero Paid Claims + CHIP + Medicaid Enrolled + Uncompensated Care
  - Denominator = All patient encounters

The 2013 patient volume calculations for EHs are:

- **Medicaid Expansion State (Tribal and Federal Site)**:
  - Numerator = All Medicaid inpatient discharges and ER encounters (Medicaid Paid Claims + Zero Paid Claims + CHIP + Medicaid Enrolled)

- Denominator = All inpatient discharges and ER encounters

- **Non-Medicaid Expansion State (Tribal and Federal Site)**:
  - Numerator = All Medicaid inpatient discharges and ER encounters (Medicaid Paid Claims + Zero Paid Claims + Medicaid Enrolled)
  - Denominator = All inpatient discharges and ER encounters

2.0 Summary of Changes

2.1 Patch 12

- **HEAT100502**. Made change to EP and EP2 reports so that all provider classes will print. Would skip if entries had been removed in the middle of the list. ABMMUEP, ABMM2EP
- **HEAT120278**. Made change to CEMU PATIENT COUNTS & % BY ELIGIBILITY report to correct Railroad Member number. ABMMUELG
- **HEAT124020**. Made change to MU phase 1 report. PVP report was counting visit twice if provider was on visit twice. ABMMUPV1
- **HEAT134048**. For the EP Met report, if an FQHC, RHC, Tribal, or Urban site receives this report, they will NOT see the Uncompensated Care line at the top of the report anymore. Instead, uncompensated care will be included in their patient volume percentage, and will have a separate detail line with the count of uncompensated care visits. IHS sites shouldn't see any difference. For the EP Not Met report, if a FQHC, RHC, Tribal, or Urban site receives this report, they will now see a column for the uncompensated care count. This count will also be included in the patient volume calculation. IHS sites shouldn't see any difference. Regarding the EH report, NO changes were made regarding uncompensated care. It was determined that it only affected the EP reports. ABMM2PVP, ABMM2PV1, ABMM2PV2, ABMM2PV3, ABMM2PV4, ABMM2PV5

  Also made change to stop data from crossing over years, for example, if they are running the report for qualification year 2012, they should only see 90-day windows within year 2012. If they are running it using the attestation date, it should stay within the year of that date. ABMM2PV2, ABMM2PV4, ABMM2PV5

- **HEAT134651**. For PVP2 and PVH2 reports, changed option C so it will only allow 90 days or less to be selected. The point of this option is validation of data, and should not be used for attestation. Also removed check for qualification year so it can be run for both qualification year or attestation date, whichever they want to validate. ABMM2PVP
- **HEAT140525**. Issue reported where patient had same insurer twice, once in the past that had been terminated and another recent entry. Wrong entry was being used for report, so it was looking like they were ineligible. Re-wrote how it works so it will find the correct entry. Also fixed the PVH2 report so it would cross over years. ABMM2PV1, ABMM2PV7, ABMM2PH2
- **HEAT141419**. For the PVP2 report, report was getting stuck on a bill that had visits for the reporting period and before. Made change so it would quit trying to process it and move on to the next visit or bill. ABMM2PV1

- **HEAT142398**. For PHV2 report, made a change to correct the date range so it would use fiscal year, not calendar year, and would calculate the 90-day windows correct and not cross over participation years. ABMM2PH2
- Updated all text references from **FQHC/RHC/Tribal** to **FQHC/RHC/Tribal/Urban**. ABMM2DEF, ABMM2MUP, ABMM2PV5, ABMM2PV6, ABMM2PVH, ABMM2PVP
- When running the MU2 reports, if the user selected the Automated 90-Day option, and selected the Highest percent found, it wasn't printing an end date on the report. ABMM2PV5
- When using option D to look back one year, it wasn't working if the user selected H for Highest. It was still returning First all the time. ABMM2PV2
- Option E wasn't printing the date range on the report. Modified to print start and end date. ABMM2PV5
- End date wasn't printing for all options. Modified to print end date all the time. ABMM2PV5
- For PVP2 and PVH2 reports, updated descriptions for options A thru E to clarify what they do. ABMM2PVP
- Added denominator to Met report to clarify it is used in the calculation of the patient volume. This is for both the PVP2 and the PVH2 reports. ABMM2PH1, ABMM2PV3, ABMM2PV4
- Made change to selection of locations. Was letting a mix of FQHC, RHC, Tribal, or Urban and non-FQHC, RHC, Tribal, or Urban locations to be selected. ABMM2PVP
- On the Facility EHR Incentive Report when option HOSPITAL CALCULATION MU INCENTIVE REPORT is selected, changed the label 'IP Discharges' to 'IP Adult & Ped Discharges' and changed 'IP Bed Days' to 'IP Adult & Ped Bed Days'. ABMMUFAC
- Changed all references to 'CY' or 'FY' TO 'CY/FY'. (No routines changed; menu option titles only).
- Removed "Abbreviated" from output options. ABMM2PVP
- Modified option C so it would work correctly for calendar year and fiscal year (was only working for calendar). ABMM2PVP
- Made change where it checks bills. It was only looking at the first bill, so if the Medicaid bill wasn't first, it was skipping it for paid and zero paid checks. ABMM2PV2, ABMM2PV7
- Policy Holder ID was missing for SCHIP entries if entered as private insurance. ABMM2PV3

- If a private insurer was selected to be included as SCHIP, it wasn't flagging it as SCHIP on the patient list. ABMM2PV8
- Couldn't remove one or all SCHIP insurers from report. It was forcing them on even if user removed. ABMM2PH2, ABMM2PV1, ABMM2PV3, ABMM2PV8, ABMM2PVH, ABMM2PVP
- On the Facility EHR Incentive Report added IP SWINGBED DISCHARGES and IP SWINGBED BED DAYS. Paid visits will be counted here if service category is Hospitalization or In Hospital and either of the following:
  - In the V hospitalization file, ADMITTING SERVICE or DISCHARGE STATUS is 21 (for Swingbed)
  - Bill type is 18* and visit type is NOT 999

  ABMMUFAC, ABMMUFC1
- On the PVP2 report, if a patient is enrolled in both Medicaid and SCHIP, it will be counted as SCHIP only in the numerator. ABMM2PV3, ABMM2PV7
- For the PVP and PVP2 reports, made change so you can type a caret (^) at the facility prompt and exit the report. Previously it was giving a programming error, <SUBSCR>FAC+28. ABMMUPVP, ABMM2PVP
- For PVP2 and PVH2, removed participation year check from Option C. Now the user will be able to select any start date. The end date must be within 90 days of the start date. ABMM2PVP
- For the PVP2 report, if SEL option is used, and more than one provider was selected it would skip the calculation for the subsequent provider if the first provider met for attestation. Corrected so it will do calculation for all providers. ABMM2PV2
- Negative numbers were showing up for uncompensated care. This was being caused by several issues:
  - Payments being posted to ben and non-ben bills
  - Bills billed to non-Medicaid insurer types were being counted more than once
  - A flaw in the logic for calculating uncompensated care; the wrong variable was being used to figure out visits with non-Medicaid/CHIP eligibility
  - Visits were being counted twice if they had private insurance that had paid and Medicaid that hadn't been billed. This scenario should count the visit as Medicaid enrolled.

  ABMM2PV1, ABMM2PV2, ABMM2PV7
- Visits with one day of eligibility were showing up as needy individuals. Corrected so they would show up in the appropriate column for eligibility. ABMM2PV8

- Corrected wording on options D and E so, when selected, they redisplay the option correctly. ABMM2PP1
- If the FQHC LED BY A PA is set to NO, only insurer type D was showing up on report. ABMM2PVP
- For CEMU report, added prefix before RailRoad number. ABMMUEL1
- On the patient list, current policy numbers weren't being reported. ABMM2PV8, ABMM2PH1, ABMM2PV3, ABMM2PV4
- The PVH2 report was reporting 171%. Discharge date for visits was crossing over into another date range, increasing numerator. ABMM2PV7
- For PVP2 report, when run for the GRP option it was display RR in the header. Removed, raiload is reported as Medicare for this report. ABMM2PV3, ABMM2PH1

2.2 Patch 11

- Existing report menu was changed to include CY 2011-2012.
- Added message to 2011-2012 reports. If they select 2013 as the Participation Year they will receive a note that they should use the CY2013 reports and then it will exit out of the option.
- Added prompt to report when AUTOMATED is selected, asking if they want the HIGHEST or FIRST 90-day window that is found. This is for both the PVP2 and the PVH2 options.
- For the Not Met report, output was changed to only report one date range per line. The one line now has a breakdown of the numerator, including paid Medicaid/SCHIP, zero paid Medicaid/SCHIP, and enrolled Medicaid/SCHIP.
- For the FEIR Facility EHR Incentive Report, added LOOKBACK DATE prompt and FACILITY or HOSPITAL report. The LOOKBACK DATE will allow the user to select any date prior to today, and it will calculate back one year for the start date of the report. If selecting FACILITY, the output will be what it was before. If selecting HOSPITAL, the output will be a limited number of records from the facility report.
- Added two prompts to the PVP2 and the PVH2 report, D AUTOMATED 90-DAY PERIOD WITHIN THE LAST 12 MONTHS and E SPECIFIC 90-DAY PERIOD WITHIN THE LAST 12 MONTHS. D will use the attestation date look back through 12 months of data for the first or highest 90-day window. The report will also prompt for an end date, then calculate back 90 days.
- Updated checks for percentage to be 29.5 or greater for EPs, and 9.5 or greater for EHs. Sites are being allowed to round up on both reports.

- Added option MUPV to both MUS1 and MUS2 menus. Allows user to view what is in the 3P MU Parameters file both before and after setup is complete. ABMMUINQ
- Updated error 13 in the claim editor to display if the patient's sex is blank or UNKNOWN. ABMDE1X, ABMDE2X3
- Updated error 66 in claim editor to display if insured's sex is blank or UNKNOWN. ABMDE2XA
- Added option to output Patient List to Host File. This option will write a caret-delimited (^) file to the specified directory. It will include:
  - Visit Location
  - Full Patient Name
  - Chart Number
  - Policy Holder ID
  - Service Category
  - Clinic
  - Insurer Type
  - Billed to (Insurer)
  - Date of Service
  - Date Paid
  - Indicator (*) if claim was paid my Medicaid/SCHIP
  - Bill Number
  - Payment Amount
  - Primary Purpose of Visit (POV)
  - Eligibility flags for Private (PRVT), Medicare (MCR), Medicaid (MCD), Railroad insurance (RR), and Needy Individual

2.3 Patch 7

- The Patient Volume reports (and the parameter setup) are new report options for RPMS and the Third Party Billing package. This was released nationally in August 2011.
- Version 1.0 of the Patient Volume Report focused on qualifying individual EPs and EHs for the Medicaid Incentive Program.

3.0 Report Setup

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

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

Site parameters cannot be reset by the user. They must be changed at the database level by RPMS Administrator.

3.1 Site Parameter Set-up for Reports

3P > RPTP > MURP > MUS2 > MUP2

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

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
           +                   Report Parameters                     +
           |                   2011 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                        26-NOV-2013 9: 09 AM
You are setting up the Report Parameters.  Once completed, you will not be
able to edit.
Continue? N// YES
```

Figure 3-1: Setting up Report Parameters

The MUP2 menu choice allows the following report parameters to be set:

- The facility running the report is an FQHC/RHC/TRIBAL/URBAN site. [Y/N]
  - Facilities designated as an FQHC/RHC/TRIBAL/URBAN facility must answer Yes.
  - Facilities not designated as an FQHC/RHC/TRIBAL/URBAN facility must answer No.
  - If Yes is selected, a list of facilities will be displayed. Select the facilities designated as FQHC/RHC/TRIBAL/URBAN.
- If a site is designated as an FQHC/RHC/TRIBAL/URBAN setting, the site setup will ask if the site is led by a PA.
  - Answer **Yes** if the Physician Assistant is the Primary Lead at this site.

```
Do you wish to designate a Facility as an FQHC, RHC, Tribal or Urban
clinic? YES

  1.  2011 DEMO HOSPITAL
  2.  NASHVILLE ADMINISTRATION
  3.  2011 DEMO CO HCLINIC
  4.  2011 DEMO SB CLINIC
  5.  2011 DEMO NURSING HOME
  6.  2011 DEMO  CLINIC

Select one or more facilities to designate as an FQHC or RHC: 4  2011 DEMO
SB CLINIC
Is this FQHC led by a PA? ? YES
Select one or more facilities to designate as an FQHC, RHC, Tribal or Urban
clinic:

The following have been identified by you as FQHC/RHC/Tribal/Urban
facilities
  2011 DEMO SB CLINIC (FQHC/RHC/Tribal/Urban led by PA)

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

Are you sure? YES
```

Figure 3-2: Establishing FQHC/RHC/TRIBAL/URBAN Locations in Report Setup

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

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

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

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

Figure 3-3: Notification of the possibility of adding additional Eligible Provider entries

States have the flexibility to include additional providers to the EP list, such as optometrists and podiatrists. Setting the Additional EP types will allow the volume report to correctly include additional EP types for the state in which the report is being run.

- Additional types of providers (provider class code) 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/TRIBAL/URBAN facility led by a PA). Display this parameter only if Additional EP types = **Y**. Appendix A: contains a list of all RPMS Provider Class Codes.

3.2 View Report Parameters

3P > RPTP > MUS2 > MUPV

The MUS2 menu now includes an option to view the Meaningful Use (MU) report parameters. This displays what is in the 3P MU parameters file both before and after setup is complete. The report parameter will display the FQHC/RHC/Tribal/Urban location names, if applicable, and then display the EP. Regardless of which option the setup is completed at (MUS1 or MUS2), the system will reference the same setup.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p12         |
           +                 View Report Parameters                 +
           |                   2011 DEMO HOSPITAL                   |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                         2-DEC-2013 3: 19 PM

                        *** 3P MU PARAMETER FILE INQUIRY ***

===========================================================================
PATIENT VOLUME: PATIENT VOLUME          SETUP COMPLETE: YES
FQHC/RHC FACILITIES: 2011 DEMO CO HCLINIC
  FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO  CLINIC  FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO TEEN HEALTH CLINIC
  FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO WOMEN'S WELLNESS CTR
  FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011-DEMO SGI      FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO DIABETES CLINIC
  FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO HEALTH & MEDICAL DIV
  FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO BABY     FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO WOUND CARE
  FQHC facility led by a PA: NO
FQHC/RHC FACILITIES: 2011 DEMO SB CLINIC
  FQHC facility led by a PA: YES
PROVIDER CLASS: MD  00
PROVIDER CLASS: PHYSICIAN ASSISTANT  11 *At a PA Led FQHC/RHC only
PROVIDER CLASS: PEDIATRIC NURSE PRACTITIONER  16
PROVIDER CLASS: NURSE MIDWIFE  17
PROVIDER CLASS: CONTRACT PHYSICIAN  18
PROVIDER CLASS: NURSE PRACTITIONER  21
PROVIDER CLASS: CONTRACT OB/GYN  41
PROVIDER CLASS: TRIBAL PHYSICIAN  44
PROVIDER CLASS: OSTEOPATHIC MEDICINE  45
PROVIDER CLASS: DENTIST  52
PROVIDER CLASS: CONTRACT PSYCHIATRIST  49
PROVIDER CLASS: NUTRITION TECHNICIAN  97
PROVIDER CLASS: CARDIOLOGIST  70
PROVIDER CLASS: INTERNAL MEDICINE  71
PROVIDER CLASS: OB/GYN  72
PROVIDER CLASS: ORTHOPEDIST  73
PROVIDER CLASS: OTOLARYNGOL  74
PROVIDER CLASS: PEDIATRICIAN  75
PROVIDER CLASS: RADIOLOGIST  76
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: NEUROSURGERY  NS
PROVIDER CLASS: INFECTIOUS DISEASE  ID
PROVIDER CLASS: ENDOCRINOLOGY  EN
PROVIDER CLASS: RHEUMATOLOGY  RH
PROVIDER CLASS: MEDICAL ONCOLOGY  MO
PROVIDER CLASS: RADIATION ONCOLOGY  RO
PROVIDER CLASS: RETINAL  RT
PROVIDER CLASS: GENERAL SURGERY  GS
PROVIDER CLASS: NEPHROLOGIST  64
PROVIDER CLASS: EMERGENCY ROOM PHYSICIAN  68
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: BEHAVIOR ANALYST  D2
PROVIDER CLASS: SPORTS MEDICINE PHYSICIAN  A1
```

Figure 3-4: Viewing report parameters

4.0 Eligible Provider Class – List of Eligible Providers

3PB > RPTP > MURP > MUPV > EP

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

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
           +      PARTICIPATION CY/FY 2013+ PATIENT VOLUME RPT       +
           |                   2011 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                          2-DEC-2013 9: 57 AM

   MUP2   Report Parameters
   PVP2   Patient Volume Report for Eligible Professionals
   EP2    EP Class - List of Eligible Professionals
   PVH2   Patient Volume Report for Eligible Hospitals
   DEF2   EP Reports Definitions List
   MUPV   View Report Parameters

Select PARTICIPATION CY/FY 2013+ PATIENT VOLUME RPT Option: EP2
```

Figure 4-1: Patient Volume Reports Menu showing selection of EP Class – List of Eligible Professionals

Appendix A: provides a list of Provider Classes.

4.1 RPMS Provider List

Eligible Professionals for the Hospital will display from this list.

```
  +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
  |        THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
  +       EP Class - List of Eligible Professionals         +
  |                   2011 DEMO HOSPITAL                    |
  +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
  User: USER,DEMO                        23-DEC-2013 2: 31 PM

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

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

Print the list of providers with eligible provider classes as well? NO
```

1. At the “Print the list of providers with eligible provider classes as well?” prompt, do one of the following:

    - Type **Y** and press Enter. Provider classes and providers will print.

- Press Enter to accept the default (**N**). Only provider classes will print.

```
Output DEVICE: HOME//   VT
```

2. At the “Output DEVICE “ prompt, do one of the following:

- Press Enter to accept the default (**HOME**).
- Type the name of another output device and press Enter.

The List of Eligible Professionals report (Figure 4-2) displays (or prints).

```
             EP Class - List of Eligible Professionals               Page 1
              IHS Meaningful Use Patient Volume Report
                 Report Run Date:  12/23/2013@14: 32
PROVIDER CLASSES THAT WILL BE INCLUDED:
Code Provider Class                  Code Provider Class
00   MD                              81   PSYCHIATRIST
11   PHYSICIAN ASSISTANT             82   ANESTHESIOLOGIST
16   PEDIATRIC NURSE PRACTITIONER 83   PATHOLOGIST
17   NURSE MIDWIFE                   85   NEUROLOGIST
18   CONTRACT PHYSICIAN              86   DERMATOLOGIST
21   NURSE PRACTITIONER              NS   NEUROSURGERY
41   CONTRACT OB/GYN                 ID   INFECTIOUS DISEASE
44   TRIBAL PHYSICIAN                EN   ENDOCRINOLOGY
45   OSTEOPATHIC MEDICINE            RH   RHEUMATOLOGY
MO   MEDICAL ONCOLOGY                52   DENTIST
RO   RADIATION ONCOLOGY              49   CONTRACT PSYCHIATRIST
RT   RETINAL                         97   NUTRITION TECHNICIAN
GS   GENERAL SURGERY                 70   CARDIOLOGIST
64   NEPHROLOGIST                    71   INTERNAL MEDICINE
68   EMERGENCY ROOM PHYSICIAN

(REPORT COMPLETE):
```

Figure 4-2: List of Eligible Professionals

5.0 Patient Volume Report – Overview

5.1 Individual Eligible Professional

A limitation for the Individual EP version of the Patient Volume Report is that the date range entered is used for all selected EPs. If that strategy does not work, use a more limited list of EPs.

- Eligible Professionals; Included Service Categories
  - Ambulatory (excluding clinic code 30)
  - Day surgery
  - Observation
  - Nursing Home
- Eligible Professionals; Excluded Service Categories/Clinics
  - Chart review
  - Event (historical)
  - Not found
  - Pharmacy (Clinic Code 39)
  - Anticoagulation Therapy (Clinic Code D1)
  - Medication Therapy Management (Clinic Code D2)
  - Laboratory Services (Clinic Code 76)
  - Radiology (Clinic Code 63)
  - Telecommunications/Telephone Calls (Clinic Code 51)
  - Chart Review/Rec Mod (Clinic Code 52)
  - Mammography (Clinic Code 72)
  - School (Clinic Code 22)
  - Mail (Clinic Code 42)
  - Radio call (Clinic Code 54)
  - EPSDT (Clinic Code 57)
  - Follow up letter (Clinic Code 57)
  - Ultrasound (US) (Clinic Code 66)
  - Computed Tomography (CT) (Clinic Code 71)
  - Case management (Clinic Code 77)

- Nurse clinic (Clinic Code B5)
- Health Aid clinic (Clinic Code C6)

5.1.1 Eligible Hospital

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

All hospital discharges and ER encounters are calculated together.

- Eligible Hospitals– Included Service Categories
  - Hospital Discharges
  - Emergency Medicine Clinic
- Eligible Hospitals– Excluded Service Categories/Clinics
  - Ambulatory (excluding clinic code 30)
  - Day surgery
  - Observation
  - Nursing Home
  - Home
  - Chart review
  - Event (historical)
  - Not found
  - Telecommunications (calls)
  - School (Clinic Code 22)
  - Mail (Clinic Code 42)
  - Radio call (Clinic Code 54)
  - Follow up letter (Clinic Code 57)
  - US (Clinic Code 66)
  - CT (Clinic Code 71)
  - Case management (Clinic Code 77)
  - Nurse clinic (Clinic Code B5)
  - Health Aid clinic (Clinic Code C6)

5.1.2 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 year (calendar year for an EP or fiscal year for an EH). This process takes longer, but it will return the highest Patient Volume results for the number of samples selected in the report. If EPs or EHs fail to qualify for the Medicaid Incentive program with the automated date range option, the report output will serve as a worksheet to show what date ranges had the highest patient volumes for the year.

5.1.2.1 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 reaches the desired threshold. Specifying the start date for the report will greatly reduce the run time needed, as the calculation is only run once.

Running the report for the first day of a month or quarter will allow a snapshot of an EP’s or EH’s volumes, and then the specific start date for qualification can be narrowed from there.

6.0 Patient Volume Report Options

When generating Patient Volume reports to meet MU requirements, select the **MUS2** option from the **MEANINGFUL USE REPORTS** menu.

When generating reports to review previous data but not report Patient Volume, select the **MUS1** option.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |         THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
           +                 MEANINGFUL USE REPORTS                    +
           |                     2011 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                        22-NOV-2013 8: 37 AM

   CEMU   PATIENT COUNTS & % BY ELIGIBILITY
   FEIR   Facility EHR Incentive Report
   MUS1   PARTICIPATION CY/FY 2011/2012 PATIENT VOLUME RPT ...
   MUS2   PARTICIPATION CY/FY 2013+ PATIENT VOLUME RPT ...

Select MEANINGFUL USE REPORTS Option:
```

Figure 6-1: **MEANINGFUL USE REPORTS** menu

Within the **Participation CY/FY 2013+ Patient Volume Report** menu, the following options are available:

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |         THIRD PARTY BILLING SYSTEM - VER 2.6p12         |
           +       PARTICIPATION CY/FY 2013+ PATIENT VOLUME RPT      +
           |                 2011 DEMO HOSPITAL                      |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                         22-NOV-2013 8: 45 AM

   MUP2   Report Parameters
   PVP2   Patient Volume Report for Eligible Professionals
   EP2    EP Class - List of Eligible Professionals
   PVH2   Patient Volume Report for Eligible Hospitals
   DEF2   EP Reports Definitions List
   MUPV   View Report Parameters

Select PATIENT VOLUME REPORTS Option:
```

Figure 6-2: **Participation CY/FY 2013+ Patient Volume Report** menu

7.0 Patient Volume Report for Eligible Providers

3P > RPTP > MURP > MUS2 > PVP2

The Patient Volume Reports menu options are located in the RPMS Third Party Billing package Reports Menu. The package version must be at v2.6 p12 to see this menu.

The following sections display the report and explain the prompts.

7.1 Report Selection Criteria

7.1.1 Select the Facility

The Patient Volume Report for Eligible Professionals screen (Figure 7-1) displays a list of facilities available on the database.

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |        THIRD PARTY BILLING SYSTEM - VER 2.6p12            |
            +    Patient Volume Report for Eligible Professionals       +
            |                   2011 DEMO HOSPITAL                      |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            User: USER,DEMO                          2-DEC-2013 3: 42 PM

      Select one of the following:

           1         2011 DEMO HOSPITAL
           2         NASHVILLE ADMINISTRATION
           3         2011 DEMO CO HCLINIC (FQHC/RHC/Tribal/Urban)
           4         2011 DEMO SB CLINIC (FQHC/RHC/Tribal/Urban)
           5         2011 DEMO  CLINIC (FQHC/RHC/Tribal/Urban)
           6         2011 DEMO NURSING HOME
           7         2011 DEMO DENTAL SURGERY

Note: you cannot select a combination of FQHC/RHC/Tribal/Urban and non-
FQHC/RHC/Tribal/Urban data on this report

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

Figure 7-1: Selecting Locations to print while printing the Patient Volume Report

Note: "(FQHC/RHC/Tribal/Urban)" denotes a FQHC/RHC/Tribal/Urban site.

To select facilities, at the "Select one or more facilities to use for calculating patient volume" prompt, type the number or numbers corresponding to one or more facilities and press Enter.

Note: If an FQHC facility is on the database, do not select a combination of FQHCs and Non-FQHCs.

Sites that were selected for reporting are marked with an asterisk (*).

```
          1         2011 DEMO HOSPITAL *
          2         NASHVILLE ADMINISTRATION
          3         2011 DEMO CO HCLINIC (FQHC/RHC/Tribal/Urban)
          4         2011 DEMO SB CLINIC (FQHC/RHC/Tribal/Urban)
```

Figure 7-2: Display of asterisk to the right of the Location when selected for reporting

7.1.2 Select the Report Type

Two reports are available from this prompt:

- 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 (or MU EHR Incentive Program).
- GRP report is 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 (or MU 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:

In order for an Eligible Professional (EP) to participate in the Medicaid
EHR Incentive program EPs have to meet a patient volume requirement of 30%
or 20% minimum for pediatricians.  This can be accomplished as an
individual or as a group.

The SEL report is to be used to determine patient volume for an individual
EP.
The GRP report is to be used to determine patient volume for an entire
group practice.  If GRP report is utilized all EPs within the facility will
need to utilize the GRP report.

     Select one of the following:

          SEL       Encounter method for each EP
          GRP       Group method for facilities

Select report type: SEL
```

Figure 7-3: Selecting the Encounter method for each EP as the report criteria

To select the report type, at the “Select report type” prompt, do one of the following:

- Type **SEL** and press Enter to view the SEL report used to determine patient volume for an individual EP.
- Type **GRP** and press Enter to view the Group report used to determine patient volume for an entire group practice.

7.1.3 Select Eligible Providers

Each name entered here must correspond to an entry in the New Person file and must be a provider of an eligible provider class. The list of provider classes was determined in Section 3.0.

```
Select report type: SEL  Encounter method for each EP

Select NEW PERSON NAME: WALLCE,GRACE
Select NEW PERSON NAME: MCGOWN,SHARON A
Select NEW PERSON NAME: BAILEY,MATTHEW W
Select NEW PERSON NAME: BIRTHDAY,ELSA A CNM
Select NEW PERSON NAME: FOOT,BIG A DPM
Select NEW PERSON NAME:

For EPs, the Participation year is a calendar year.
```

Figure 7-4: Adding Eligible Provider entries using the Encounter method (SEL) Option

To enter one or more providers:

1. At the “Select NEW PERSON NAME” prompt, type an EP’s name and press Enter.
2. Repeat Step 1 to enter multiple EPs.

   The names of EPs are verified at the time they are entered in the Patient Volume report. Providers that are not considered to be EPs (based on their provider class and the site parameters) are rejected with an error message (Figure 7-6).

```
Select NEW PERSON NAME: PROVIDER,ERIN D

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

Figure 7-5: Error message; Provider Class is missing for the Provider

3. When all EPs have been entered, press Enter at the “Select NEW PERSON NAME” prompt.

7.1.4 Set the Participation Year

The Participation year must be specified for 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.

```
For EPs, the Participation year is based on a calendar year; this is the
same year that the EP would be demonstrating Meaningful Use. (Calendar year
is January 1 – December 31)

Enter the Participation year for this report:  2013
```

Figure 7-6: Entering the Participation year

To set the year, at the “Enter the Participation year for this report” prompt, type the year in four digits and press Enter.

7.1.5 Add, Remove, or Omit SCHIP Insurers

State Children’s Health Insurance Program (SCHIP) plans included in the Medicaid Expansion program can now be included in the patient volume reports. The reports will automatically include SCHIP Insurance Type ‘K’ billed as either Medicaid or Private Insurance. SCHIP payers may be added or removed, or the report can be set to not include any SCHIP entries.

Notes: There must be at least one SCHIP Insurance Type ‘K’ listed in the RPMS Insurer file in order to see the prompt to add additional SCHIP payers.
Visits for stand-alone SCHIP programs cannot be included in the calculation.
For EPs and EHs in non-Medicaid Expansion states, Kidscare cannot be included in the patient volume. Select the option to remove SCHIP payers.

```
EP calculations can include any SCHIP visits that are part of a Medicaid
expansion program.  Visits for stand-alone SCHIP programs cannot be
included in the calculation.  The following list of insurers will be
included unless otherwise specified.
A breakdown of categories will be provided.

Report will include the following insurers that hold the SCHIP Insurer
Type:
     1. DEMO C.Access

     Select one of the following:

          A         Add Additional SCHIP Payers
          R         Remove SCHIP Payers from List
          N         Do NOT count any SCHIP entries in the report

Would you like to Add or Remove (A/R/N):
```

Figure 7-7: SCHIP Insurer Type

To set SCHIP Insurer Type, At the “Would you like to Add or Remove (A/R/N)” prompt, do one of the following:

- Type A and press Enter to add additional SCHIP payers
- Type R and press Enter to remove SCHIP payers
- Type N and press Enter to not count any SCHIP entries
- Press Enter to include the listed SCHIP plans on the report.

7.1.6 Select a Reporting Period

The report supports five options for the date range as shown in Figure 7-8 Options B, C, D, and E require additional date entries to define the report date range.

```
Patient Volume is calculated based on a 90-day period. There are two
different time frame options that can be utilized to determine patient
volume.

  1. Qualification year - This is the year prior to the participation year.
     Any 90-day period can be selected within the qualification year to
     determine patient volume.
  2. Look-back period - This can be a 90-day period in the previous 12
     Months from attestation.

Note: All reports 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 which
required patient volumes are met or the 90-day period with the highest
volume percentage (first occurrence in the year).

Select A or B to run Patient Volume based on the Qualification year time
frame
Select C to Validate a 90-day or less time frame
Select D or E to run Patient Volume based on the Attestation date time
frame

Select one of the following:

     A   Automated 90-Day Period (using Qualification Year)
     B   User Specified Start Date 90-Day Period (using Qualification Year)
     C   Validation Report - user specified date range (validation)
     D   Automated 90-Day Period -12 month look back from Attestation Date
     E   User Specific 90-Day Period -12 month look back from Attestation
         Date

Enter selection:
```

Figure 7-8: Selecting the Report Criteria Options

The date range is used to look for the necessary threshold for each provider (20% for Pediatricians; 30% for all other provider classes). At the “Enter Selection” prompt, type the letter corresponding to one of the following options and press Enter:

- **Option A: Automated 90-day Period**. Starts with January 1 of the Qualification year and looks for any 90-day window during which the EP met the necessary threshold. This report may take a while to run as it looks through all visit and payment data.

  If this option is selected, a further option is presented to choose the First or the Highest 90-day window that is found (Figure 7-9).

```
Enter selection: A  Automated 90-Day Report

     Select one of the following:

          F         First 90-day period found
          H         Highest 90-day period found

Enter selection: F//
```

Figure 7-9: Selecting First or Highest 90-day period found

- **Option B: User Specified Start Date Period**. Takes the specified start date and calculates the end date (by adding 89 days to the start date). Displays a date range for the allowable start date. Select any start date within this range. This ensures that the end date will not be after the last day of the calendar year.

```
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 2013:  (1/1/2013 - 10/3/2013):
```

Figure 7-10: Option B: Specific 90-day reporting period

- **Option C: Validation Report**. Allows both the start date and the end date to be specified in order to validate a 90-day period or less. This report is for validation only and should not be used to report Patient Volume.

  If this option is selected, further prompts are presented to choose the report dates date (Figure 7-11).

```
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:  030113
Select a specific END date:  (3/1/2013 - 5/29/2013):
```

Figure 7-11: User specific report period

- **Option D: Automated 90-Day Period within the last 12 months**. Uses a specified Attestation Date and looks back through 12 months of data for the first/highest 90-day window.

  If this option is selected, two further prompts are displayed (Figure 7-12):

  – At the "Enter Attestation Date" prompt, type the Attestation Date and press Enter.

  – At the "Enter selection" prompt, do one of the following:

    - Type **F** and press Enter to return the first 90-day period during which the criteria are met.

    - Type **H** and press Enter to return information for the 90-day period having the highest rate.

```
Enter selection: D  Automated 90-Day Period within the last 12 months
Enter Attestation Date:  110113  (NOV 01, 2013)

     Select one of the following:

          F         First 90-day period found
          H         Highest 90-day period found

Enter selection: F//
```

Figure 7-12: Option D: Automated 90-Day Period within the last 12 months

- **Option E: User Specific 90-Day Period within the last 12 months**. Takes the specified end date and calculates the start date (by subtracting 89 days from the end date).

  If this option is selected, a further option is presented to choose the Summary Report or the Patient List (Figure 7-13).

```
Enter selection: E  Specific 90-Day Period within the last 12 months

Select a specific END date

Enter last day of 90-day period:  113013

     Select one of the following:

          S         Summary Report
          P         Patient List

Enter Report Format Choice:
```

Figure 7-13: Option E: Specific 90-day period within the last 12 months

7.1.7 Select the Report Format

The Volume Reports can be printed in several formats depending on the purpose for the report:

- **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 P** is the Patient List that includes all 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
          P         Patient List

Enter Report Format Choice:
```

Figure 7-14: Selection of the Patient List as the Report Criteria

At the "Enter Report Format Choice" prompt, type one of the following and press Enter:

- **S** (Summary Report)
- **P** (Patient List)

7.1.8 Select the Output Device

Regardless of the selection, the system will display the summary of what is being requested for the report. Examine the information presented by the report and make necessary changes.

```
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: 2014
Reporting Period: 90-day beginning 08/03/2013
Attestation Date: 08/03/2013

Report Method Type: Group

SCHIP insurers included:
     DEMO C.Access

Facility(s):
   2011 DEMO  CLINIC (FQHC/RHC/Tribal/Urban)

     Select one of the following:

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

```
selections

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

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

Output DEVICE: HOME//
```

Figure 7-15: Summary display of the Patient Volume Report to be generated

At "Do you want to print this report?" prompt, select one of the following:

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

By default, the Output device is HOME. The report can be queued to print on a terminal or a printer.

7.2 EP Summary Report Samples

7.2.1 Eligible Provider Report - Not Met Threshold

The Summary Report in Figure 7-16 and Figure 7-17 provides EP information for a Group practice where the facility did not meet the minimum threshold:

- Page 1 of the report provides a summary of the providers selected and the eligibility status.

```
   IHS Meaningful Use Patient Volume Report - Group Practice       Page 1
                      Minimum Patient Volume NOT Achieved
                       Report Run Date:  12/03/2013@14: 42
                      Report Generated by: USER,DEMO

Participation Year: 2014
Qualification Year: 2013
Reporting Period Identified: 04/01/2013 thru 06/29/2013
Facility(s):
          2011 DEMO SB CLINIC (FQHC/RHC/Tribal/Urban)
          2011 DEMO  CLINIC (FQHC/RHC/Tribal/Urban)

SCHIP insurers included:
     DEMO C.Access

Eligible Professionals:
   PROVIDER,MARY(MD)

Other Professionals:
   <NONE>
```

Figure 7-16: Report cover page

- Page 2 provides a list of dates for the reporting period selected, along with the Denominator and Numerator values.

Note: FQHC/RHC/Tribal/Urban sites will see a column on the report titled **Uncompensated**. IHS sites will not see this column.

```
   IHS Meaningful Use Patient Volume Report - Group Practice       Page 2
                      Minimum Patient Volume NOT Achieved
                       Report Run Date:  12/03/2013@14: 42
                      Report Generated by: USER,DEMO

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

Highest Patient Volume Met: 0%
First Day Highest Patient Volume Achieved: 04/01/2013

Total Patient Encounters of First Highest Patient Volume Period: 0
Total Medicaid/Needy Individual Encounters of First Highest Patient Volume
Period: 0
=============================================================================
MEDICAID/NEEDY INDIVIDUAL PATIENT VOLUME - QUALIFICATION YEAR 2013
                    Denom-  Numer-|    --Medicaid--     | --- Schip --- | Uncomp-
Report Period  Rate inator  ator  |   Pd    ZP     En  | Pd    ZP    En| ensated
=============================================================================

<< NO DATA FOUND FOR SELECTION>>

(REPORT COMPLETE):
```

Figure 7-17: Summary Report displaying Reporting Period, Numerator, and Denominator

7.2.2 Individual Eligible Provider Report – Met Threshold

The Summary Report in Figure 7-18 indicates that the EP met the threshold.

```
   IHS Meaningful Use Patient Volume Report - Eligible Professional    Page 1
                       Report Run Date:  12/02/2013@08: 36
                      Report Generated by: USER,DEMO

Participation Year: 2014
Attestation Date: 11/01/2013
First Reporting Period Identified: 11/01/2012 thru 01/29/2013
Automated 90-Day Period in last 12 months
Facility(s):
          2011 DEMO  CLINIC (FQHC/RHC/Tribal/Urban)

SCHIP insurers included:
     DEMO C.Access
Eligible Professional: PROVIDER,DEMO (MD)
-------------------------------------------------------------------------------
Patient Volume DEMO CLINIC: 66.7%

Total Patient Encounters (Denominator) DEMO CLINIC:                          6
Total Numerator Encounters DEMO CLINIC:                                      4
Total Medicaid Paid Encounters DEMO CLINIC:                                  0
Total Medicaid Zero Paid Encounters DEMO CLINIC:                             0
Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC:                 0
```

```
Total Kidscare/Chip Paid Encounters DEMO CLINIC:                              0
Total Kidscare/Chip Zero Paid Encounters DEMO CLINIC:                         0
Total Kidscare/Chip Enrolled (Not Billed) Encounters DEMO CLINIC:             0
Total Paid Other Encounters DEMO CLINIC (*not included in numerator):         2
Total Uncompensated Care DEMO CLINIC:                                         4
-------------------------------------------------------------------------------
Patient Volume all calculated Facilities:  66.7%

Total Patient Encounters (Denominator) All Facilities Total:                  6
Total Numerator Encounters All Facilities Total:                              4
Total Medicaid Paid Medicaid Encounters All Facilities Total:                 0
Total Medicaid Zero Paid Medicaid Encounters All Facilities Total:            0
Total Medicaid Enrolled (Not Billed) Medicaid Encounters All Facs Total:      0
Total Kidcare/Chip Paid Encounters All Facilities Total:                      0
Total Kidcare/Chip Zero Paid Encounters All Facilities Total:                 0
Total Kidscare/Chip Enrolled (Not Billed) Encounters All Facs Total:          0
Total Paid Other Encounters All Facilities Total (*not included in numerator):2
Total Uncompensated Care All Facilities Total:                                4

Enter RETURN to continue or '^' to exit:
```

Figure 7-18: Report displaying Met Threshold

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

Note: FQHC/RHC/Tribal/Urban sites will see a column on the report titled **Uncompensated**. IHS sites will not see this column.

In the example below, it can be determined if the threshold has been met by dividing the numerator by the denominator. (4/6 = 66.7%). The encounters are calculated as in the following table:

Description from Report	Count	Explanation
Total Patient Encounters (Denominator) DEMO CLINIC	6	All patient encounters
Total Numerator Encounters DEMO CLINIC	4	Sum of next 6 lines for Medicaid and Kidscare/CHIP
Total Medicaid Paid Encounters DEMO CLINIC	0	
Total Medicaid Zero Paid Encounters DEMO CLINIC	0	
Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC	0	
Total Kidscare/CHIP Paid Encounters DEMO CLINIC	0	
Total Kidscare/CHIP Zero Paid Encounters DEMO CLINIC	0	

Description from Report	Count	Explanation
Total Kidscare/CHIP Enrolled (Not Billed) Encounters DEMO CLINIC	0	
Total Paid Other Encounters DEMO CLINIC (*not included in numerator)	2	All other paid encounters that aren't Medicaid or Kidscare/CHIP
Total Uncompensated Care DEMO CLINIC	4	Visits with zero eligiblity

7.3 EP Patient List Report Samples

7.3.1 Patient List

The Patient List is provided when the Patient List option is selected as the Report Format. The report prints a summary sheet (Figure 7-19) followed by a list of the patient information (Figure 7-20).

```
          CONFIDENTIAL PATIENT INFORMATION COVERED BY THE PRIVACY ACT
    IHS Meaningful Use Patient Volume Report - Eligible Professional   Page 1
                                 PATIENT LIST
                      Report Run Date:  12/02/2013@08: 44
                     Report Generated by: USER,DEMO

Participation Year: 2014
Attestation Date: 11/01/2013
Highest Reporting Period Identified: 11/23/2012 thru 02/20/2013
Automated 90-Day Period in last 12 months
Facility(s):
          2011 DEMO  CLINIC (FQHC/RHC/Tribal/Urban)

SCHIP insurers included:
     DEMO C.Access
Eligible Professional: PROVIDER,MARY (MD)

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

Figure 7-19: Page 1 Summary Report

Page 2 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 of the Billed Insurer
- Date of Service, includes Time of visit
- Date Paid

```
           CONFIDENTIAL PATIENT INFORMATION COVERED BY THE PRIVACY ACT
    IHS Meaningful Use Patient Volume Report - Eligible Professional    Page 2
                                PATIENT LIST
                      Report Run Date:  12/02/2013@08: 46
                     Report Generated by: USER,DEMO

Eligible Professional: PROVIDER,MARY (MD)

VISIT LOCATION: DEMO CLINIC
================================================================================
                         Ser          I. Billed     Date of          Date
PATIENT NAME      CHART# Cat Clinic    T. To         Service          Paid
================================================================================
SMITH, OLLIE JOY  99911  AMB GENERAL   P  GEHA       01/05/2013@08: 00 05/12/13
DEMO, AMANDA      115523 AMB FAMILY P     NOT BILLED 11/27/2012@15: 00

(REPORT COMPLETE):
```

Figure 7-20: Page 2 Patient Detail Report

7.3.2 Modified Patient List

The modified Patient List format provides more detailed information for each patient encounter. This is available when printing the patient list to print a delimited report to a host file. This option will write a caret-delimited (^) file to the specified directory and includes:

- Visit Location
- Full Patient Name
- Chart Number
- Policy Holder ID for Medicaid/Kidscare/SCHIP
- Service Category
- Clinic
- Provider (displays when SEL report type is selected)
- Insurer Type
- Billed to (Insurer)
- Date of Service
- Date Paid
- Indicator (*) if claim was paid by Medicaid/SCHIP
- Bill Number
- Payment Amount
- Primary Purpose of Visit (POV)
- Eligibility flags for PRVT, MCR, MCD, RR, and Needy Individual

The Modified Patient List can be generated to validate the data on the summary report. See Appendix D: for additional information.

8.0 Patient Volume Report for Eligible Hospital

3P > RPTP > MURP > MUS2 > PVH2

Eligible Hospitals who qualify to participate in the Medicaid EHR Incentive Program can utilize the Patient Volume Report for Eligible Hospitals (PVH2) menu option to report their Patient Volume.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
           +      PARTICIPATION CY/FY 2013+ PATIENT VOLUME RPT       +
           |                   2011 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                         2-DEC-2013 9: 03 AM

   MUP2   Report Parameters
   PVP2   Patient Volume Report for Eligible Professionals
   EP2    EP Class - List of Eligible Professionals
   PVH2   Patient Volume Report for Eligible Hospitals
   DEF2   EP Reports Definitions List
   MUPV   View Report Parameters

Select PARTICIPATION CY/FY 2013+ PATIENT VOLUME RPT Option: PVH2
```

Figure 8-1: Selecting the Patient Volume Report for Eligible Hospitals

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

8.1 Report Selection Criteria

8.1.1 Select the Facility

At "Select one or more facilities to use for calculating patient volume: ", choose the hospital for which report data will be generated.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
           +      Patient Volume Report for Eligible Hospitals       +
           |                   2011 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                         2-DEC-2013 9: 04 AM

     Select one of the following:

          1         2011 DEMO HOSPITAL
          2         NASHVILLE ADMINISTRATION
          3         2011 DEMO CO HCLINIC (FQHC/RHC/Tribal/Urban)
          4         2011 DEMO SB CLINIC (FQHC/RHC/Tribal/Urban)
          5         2011 DEMO  CLINIC (FQHC/RHC/Tribal/Urban)
          6         2011 DEMO NURSING HOME
          7         2011 DEMO DENTAL SURGERY
```

```
Note: you cannot select a combination of FQHC/RHC/Tribal/Urban and non-
FQHC/RHC/Tribal/Urban data on this report

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

Figure 8-2: Selecting Locations to print while printing the Patient Volume Report

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

```
          1         2011 DEMO HOSPITAL *
```

Figure 8-3: Display of asterisk to the right of the Location when selected for reporting

8.1.2 Set the Participation Year

The Participation year must be specified for which to run the report. For EHs, the Participation year is a federal fiscal year. The Participation year is the year in which the EH expects to receive an Incentive payment.

```
In order for an Eligible Hospital (EH) to participate in the Medicaid EHR
Incentive program EHs have to meet a minimum patient volume requirement of
10%.

For EHs the participation year is based on a federal fiscal year, this is
the same year that the EH would be demonstrating Meaningful use. (Federal
Fiscal Year is October 1 - September 30.)
Enter the Participation Fiscal year for this report: 2013
```

Figure 8-4: Entering the Participation year

8.1.3 Select a Reporting Period

The report supports five options for the date range as shown in Figure 8-5. Options B, C, D, and E require additional date entries to define the report date range.

```
Patient Volume is calculated based on a 90-day period. There are two
different time frame options that can be utilized to determine patient
volume.

  1. Qualification year - This is the year prior to the participation year.
     Any 90-day period can be selected within the qualification year to
     determine patient volume.
  2. Look-back period - This can be a 90-day period in the previous 12
     months from attestation.

Note: All reports 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 which
required patient volumes are met or the 90-day period with the highest
volume percentage (first occurrence in the year).

Select A or B to run Patient Volume based on the Qualification year time
frame
```

```
Select C to Validate a 90-day or less time frame
Select D or E to run Patient Volume based on the Attestation date time
frame

Select one of the following:

     A   Automated 90-Day Period (using Qualification Year)
     B   User Specified Start Date 90-Day Period (using Qualification Year)
     C   Validation Report - user specified date range (validation)
     D   Automated 90-Day Period -12 month look back from Attestation Date
     E   User Specific 90-Day Period -12 month look back from Attestation
Date

Enter selection:
```

Figure 8-5: Selecting the Report Criteria Options

The date range is used to look for the necessary threshold of 10% for the EH. At the "Enter Selection" prompt, type the letter corresponding to one of the following options and press Enter:

- **Option A: Automated 90-day Period**. Starts with October 1 of the Qualification year and looks for any 90-day window during which the hospital met the necessary threshold. This report may take a while to run as it looks through all visit and payment data.

  If this option is selected, a further option is presented to choose the First or the Highest 90-day window that is found (Figure 8-6).

```
Enter selection: A  Automated 90-Day Report

     Select one of the following:

          F         First 90-day period found
          H         Highest 90-day period found

Enter selection: F//
```

Figure 8-6: Option A: Automated 90-day report

- **Option B: User Specified Start Date Period**. Takes the specified start date and calculates the end date (by adding 89 days to the start date). Displays a date range for the allowable start date. Select any start date within this range. This ensures that the end date will not be after the last day of the fiscal year.

```
Enter selection: B  Specific 90-Day Report Period

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

Enter first day of reporting period for 2013:  (10/1/2012 - 7/3/2013):
7/3/13
```

Figure 8-7: Option B: Specific 90-day report period

- **Option C: Validation Report**. Allows both the start date and the end date to be specified in order to validate a 90-day period or less. This report is for validation only and should not be used to report Patient Volume.

```
If this option is selected, further prompts are presented to choose the
report dates (Select a specific END date:
```

Figure 8-8).

```
Enter selection: C  User specified Report Period

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

Enter first day of reporting period for 2013:  (10/1/2012 - 9/30/2013):
100112
Select a specific END date:
```

Figure 8-8: Option C: User specified report period

- **Option D: Automated 90-Day Period within the last 12 months**. Uses a specified Attestation Date and looks back through 12 months of data for the first/highest 90-day window.

  If this option is selected, two further prompts are displayed (Figure 8-6):

  – At the "Enter Attestation Date" prompt, type the Attestation Date and press Enter.

  – At the "Enter selection" prompt, do one of the following:

    - Type **F** and press Enter to return the first 90-day period during which the criteria are met.
    - Type **H** and press Enter to return information for the 90-day period having the highest rate.

```
Enter selection: D  Automated 90-Day Period within the last 12 months
Enter Attestation Date:  110113  (NOV 01, 2013)

     Select one of the following:

          F         First 90-day period found
          H         Highest 90-day period found

Enter selection: F//
```

Figure 8-9: Option D: Automated 90-day period within the last 12 months

- **Option E: User Specific 90-Day Period within the last 12 months**. Takes the specified end date and calculates the start date (by subtracting 89 days from the end date).

If this option is selected, a further option is presented to choose the Summary Report or the Patient List (Figure 8-10).

```
Enter selection: E  Specific 90-Day Period within the last 12 months

Select a specific END date

Enter last day of 90-day period:  113013

     Select one of the following:

          S         Summary Report
          P         Patient List

Enter Report Format Choice:
```

Figure 8-10: Option E: Specific 90-day period within the last 12 months

8.1.4 Select the Report Format

The Volume Reports can be printed in several formats depending on the purpose for the report:

- **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 P** is the Patient List that includes all 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
          P         Patient List

Enter Report Format Choice:
```

Figure 8-11: Selection of the Patient List as the Report Criteria

At the “Enter Report Format Choice” prompt, type one of the following and press Enter:

- **S** (Summary Report)
- **P** (Patient List)

8.1.5 Select the Output Device

Regardless of the selection, the system will display the summary of what is being requested for the report. Examine the information presented by the report and make necessary changes.

```
SUMMARY OF PATIENT VOLUME REPORT TO BE GENERATED

Report Name: Patient Volume Report for Eligible Hospitals
The date ranges for this report are:
   Participation Year: 2013
Reporting Period: Automated First 90-day
Attestation Date: 11/01/2013

Report Method Type: Hospital/ER

SCHIP insurers included:
     DEMO C.Access

Facility(s):
   2011 DEMO HOSPITAL

     Select one of the following:

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

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

Output DEVICE: HOME//
```

Figure 8-12: Summary display of the Patient Volume Report to be generated

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

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

By default, the Output device is HOME. The report can be queued to print on a terminal or a printer.

8.2 EH Summary Report Samples

8.2.1 Sample Report Cover Page

The Summary Report in Figure 8-13 report provides EH information:

- Page 1 provides a summary of the facilities selected and the eligibility status.

```
        IHS Meaningful Use Patient Volume Report - Hospital        Page 1
                      Minimum Patient Volume NOT Achieved
                       Report Run Date:  12/02/2013@09: 28
                      Report Generated by: USER,DEMO

Participation Federal fiscal year: 2014
Attestation Federal fiscal year: 2013
Highest Reporting Period Identified: 11/01/2012 thru 01/29/2013
Automated 90-Day Period in last 12 months

SCHIP insurers included:
```

```
     DEMO C.Access
```

```
Hospital used in this report: 2011 DEMO HOSPITAL

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

Highest Patient Volume Met: 0
First Day Highest Patient Volume Achieved: 11/01/2012

Total Patient Encounters of First Highest Patient Volume Period: 1
Total Hospital Encounters of First Highest Patient Volume Period: 0

Enter RETURN to continue or '^' to exit:
```

Figure 8-13: Sample Summary report for the Eligible Hospitals

- Page 2 provides a list of dates for the reporting period selected, along with the Denominator and Numerator values.

```
      IHS Meaningful Use Patient Volume Report - Hospital          Page 2
                      Minimum Patient Volume NOT Achieved
                       Report Run Date:  12/02/2013@09: 29
                      Report Generated by: USER,DEMO

==============================================================================
HOSPITAL PATIENT VOLUME - QUALIFICATION YEAR 2013
Report Period  Rate  Denom-   Numer-  Mcd   Mcd     Mcd   Schip Schip   Schip
                     inator   ator   Paid ZeroPd Enrolled Paid ZeroPd Enrolled
==============================================================================
1 NOV-29 JAN       0%     1      0      0     0        0      0     0        0

(REPORT COMPLETE):
```

Figure 8-14: Page 2 displaying the Reporting Period with Numerator and Denominator Data

8.2.2 Eligible Hospital Report – Met Threshold

The Summary Report in Figure 8-15 indicates that the EH met the threshold.

```
          Participation Federal fiscal year: 2014
Attestation Federal fiscal year: 2013
Highest Reporting Period Identified: 11/01/2012
Automated 90-Day Period in last 12 months
SCHIP insurers included:
     KIDSCARE
     MSCHIP
     BLUECHIP
     BLUE CHIP

Enter RETURN to continue or '^' to exit:

         IHS Meaningful Use Patient Volume Report - Hospital         Page 2
                       Report Run Date:  12/02/2013@09: 44
                       Report Generated by: SMITH,CHERYL
```

```
Hospital used in this report: INDIAN HEALTH HOSPITAL

Patient Volume: 100%

Total Patient Encounters INDIAN HOSP:                                     4
Total Medicaid Paid Encounters INDIAN HOSP:                               0
Total Medicaid Zero Paid Encounters INDIAN HOSP:                          0
Total Medicaid Enrolled Encounters INDIAN HOSP:                           4
Total Kidscare/Chip Paid Encounters INDIAN HOSP:                          0
Total Kidscare/Chip Zero Paid Encounters INDIAN HOSP:                     0
Total Kidscare/Chip Enrolled Encounters INDIAN HOSP:                      0
Total Other Encounters INDIAN HOSP:                                       0

Enter RETURN to continue or '^' to exit
(REPORT COMPLETE):
```

Figure 8-15: Eligible Hospital indicating Met Threshold

8.3 EH Patient List Report Samples

8.3.1 Patient List

Two ways exist to generate a patient list: either in RPMS or to a delimited file which provides more data.

```
          CONFIDENTIAL PATIENT INFORMATIONCOVERED BY THE PRIVACY ACT
        IHS Meaningful Use Patient Volume Report - Hospital         Page 1
                                PATIENT LIST
                      Report Run Date:  12/02/2013@09: 54
                     Report Generated by: USER,DEMO

Participation Federal fiscal year: 2014
Attestation Federal fiscal year: 2013
First Reporting Period Identified: 11/01/2012 thru 01/29/2013
Automated 90-Day Period in last 12 months

SCHIP insurers included:
     DEMO C.Access

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

VISIT LOCATION: 2011 DEMO DB
```

Figure 8-16: Page 1 of Patient List Display

```
VISIT LOCATION: 2011 DEMO DB
==========================================================================
                         Ser            I. Billed     Date of          Date
PATIENT NAME      CHART# Cat Clinic     T. To         Service          Paid
==========================================================================
DEMO, PAMELA      108416 AMB EMERGENC                 01/13/2013@05: 00

(REPORT COMPLETE):
```

Figure 8-17: Page 2 of Patient List Display

8.3.2 Modified Patient List

The modified Patient List format provides more detailed information for each patient encounter. This is available when printing the patient list to print a delimited report to a host file. This option will write an “^”-delimited file to the specified directory and includes:

- Visit Location
- Full Patient Name
- Chart Number
- Policy Holder ID for Medicaid/Kidscare/SCHIP
- Service Category
- Clinic
- Insurer Type
- Billed to (Insurer)
- Date of Service
- Date Paid
- Indicator (*) if claim was paid by Medicaid/SCHIP
- Bill Number
- Payment Amount
- Primary POV
- Eligibility flags for PRVT, MCR, MCD, RR, and Needy Individual

The Modified Patient List can be generated to validate the data on the summary report. See Appendix D: for additional information.

9.0 Facility EHR Incentive Report

The Facility EHR Incentive Report (FEIR) has two report options which calculate the Covered Inpatient days and the Outpatient All-Inclusive Rate (AIR) bills. A detailed report can be generated to view the bills used in the calculations for both reports.

9.1 Facility EHR Incentive Report

ABM > RPTP > MURP > FEIR

The Facility EHR Incentive Report will calculate the number of Covered Inpatient days for Medicare, Medicaid, and Private Insurance. Outpatient AIR bills are also counted. A detailed report can be selected to view the bills used in the calculations. If FACILITY is selected, the output displays nine different record types.

9.2 Hospital Calculation Incentive Report

The Hospital Calculation Incentive Report provides data elements needed for the States to calculate an MU Incentive Payment. This report can be used instead of the Cost Reports if states permit it as an auditable data source. If HOSPITAL is selected, the report will display a limited number of records from the facility report.

Note: The abbreviations IP and OP used in this report stand for 'Inpatient' and 'Outpatient' respectively.

```
Select MEANINGFUL USE REPORTS Option: FEIR  Facility EHR Incentive Report

           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
           +             Facility EHR Incentive Report               +
           |                   2011 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                        18-DEC-2013 12: 02 PM

This report will calculate the number of Covered Inpatient days for
Medicare, Medicaid, and Private Insurance.  Outpatient All-Inclusive Rate
(AIR) bills are counted.  A report can be selected to view the bills used
in the calculations.

     Select one of the following:

          F         FISCAL YEAR
          D         DATE RANGE
          L         LOOKBACK DATE

Run report by FISCAL YEAR, DATE RANGE, or LOOKBACK DATE: FISCAL YEAR//
LOOKBACK
DATE

Enter ENDING Date:  093013  (SEP 30, 2013)
```

```
     Select one of the following:

          F         FACILITY EHR INCENTIVE REPORT (COST REPORT)
          H         HOSPITAL CALCULATION MU INCENTIVE REPORT

Select the type of report to run: FACILITY EHR INCENTIVE REPORT (COST
REPORT)

     Select one of the following:

          S         SUMMARY
          D         DETAIL
          B         BOTH

SUMMARY, DETAIL, or BOTH: SUMMARY// SUMMARY

Output DEVICE: HOME//   VT

===========================================================================
FACILITY EHR INCENTIVE REPORT               DEC 18,2013@12: 02: 22   Page 1
Lookback Date Range: 09/30/2012 to 09/30/2013
Billing Location: 2011 DEMO DB
===========================================================================
                                                               # Discharges
---------------------------------------------------------------------------
                             -- M E D I C A R E --
    # Paid MEDICARE IP Discharges                                         0
    # Paid MEDICARE IP Newborn Discharges                                 0
    # Paid MEDICARE IP Charges                                            0
    # Paid MEDICARE IP Bed Days                                           0
    # Paid MEDICARE IP Newborn Bed Days                                   0
    # Paid MEDICARE IP Bed Days Charges                                   0
    # Paid MEDICARE OP All-Inclusive                                     24
    # Paid MEDICARE OP Charges                                            0
    # Paid MEDICARE OP Itemized                                           0
                             -- M E D I C A I D --
    # Paid MEDICAID IP Discharges                                         0
    # Paid MEDICAID IP Newborn Discharges                                 0
    # Paid MEDICAID IP Charges                                            0
    # Paid MEDICAID IP Bed Days                                           0
    # Paid MEDICAID IP Newborn Bed Days                                   0
    # Paid MEDICAID IP Bed Days Charges                                   0
    # Paid MEDICAID OP All-Inclusive                                      0
    # Paid MEDICAID OP Charges                                            0
    # Paid MEDICAID OP Itemized                                           0

                     -- P R I V A T E   I N S U R A N C E --
    # Paid PRIVATE IP Discharges                                          0
    # Paid PRIVATE IP Newborn Discharges                                  0
    # Paid PRIVATE IP Charges                                             0
    # Paid PRIVATE IP Bed Days                                            0
    # Paid PRIVATE IP Newborn Bed Days                                    0
    # Paid PRIVATE IP Bed Days Charges                                    0
    # Paid PRIVATE OP All-Inclusive                                       0
    # Paid PRIVATE OP Charges                                             0
    # Paid PRIVATE OP Itemized                                           24

                        -- K I D S C A R E / C H I P --
    # Paid KIDSCARE/CHIP IP Discharges                                    0
    # Paid KIDSCARE/CHIP IP Newborn Discharges                            0
    # Paid KIDSCARE/CHIP IP Charges                                       0
```

```
    # Paid KIDSCARE/CHIP IP Bed Days                                    0
    # Paid KIDSCARE/CHIP IP Newborn Bed Days                            0
    # Paid KIDSCARE/CHIP IP Bed Days Charges                            0
    # Paid KIDSCARE/CHIP OP All-Inclusive                               0
    # Paid KIDSCARE/CHIP OP Charges                                     0
    # Paid KIDSCARE/CHIP OP Itemized                                    0

             -- V E T E R A N S  M E D I C A L  B E N  P R O G --
    # Paid VMBP IP Discharges                                           0
    # Paid VMBP IP Newborn Discharges                                   0
    # Paid VMBP IP Charges                                              0
    # Paid VMBP IP Bed Days                                             0
    # Paid VMBP IP Newborn Bed Days                                     0
    # Paid VMBP IP Bed Days Charges                                     0
    # Paid VMBP OP All-Inclusive                                        0
    # Paid VMBP OP Charges                                              0
    # Paid VMBP OP Itemized                                             0

                               -- O T H E R --
    # Paid OTHER IP Discharges                                          0
    # Paid OTHER IP Newborn Discharges                                  0
    # Paid OTHER IP Charges                                             0
    # Paid OTHER IP Bed Days                                            0
    # Paid OTHER IP Newborn Bed Days                                    0
    # Paid OTHER IP Bed Days Charges                                    0
    # Paid OTHER OP All-Inclusive                                       0
    # Paid OTHER OP Charges                                             0
    # Paid OTHER OP Itemized                                            0

(SUMMARY REPORT COMPLETE):
```

Figure 9-1: Selection Criteria for the Facility EHR Incentive Report

If HOSPITAL is selected, the report will display a limited number of records from the facility report.

```
==========================================================================
HOSPITAL CALCULATION MU INCENTIVE REPORT     DEC 18,2013@12: 02: 38  Page 1
For FISCAL YEAR: 2013
Billing Location: 2011 DEMO DB
===========================================================================
                                                               # Discharges
---------------------------------------------------------------------------
                            -- M E D I C A R E --
    # MEDICARE IP Adult & Ped Discharges                                0
    # MEDICARE IP Newborn Discharges                                    0
    # MEDICARE IP Adult & Ped Bed Days                                  0
    # MEDICARE IP Newborn Bed Days                                      0

                            -- M E D I C A I D --
    # MEDICAID IP Adult & Ped Discharges                                0
    # MEDICAID IP Newborn Discharges                                    0
    # MEDICAID IP Adult & Ped Bed Days                                  0
    # MEDICAID IP Newborn Bed Days                                      0

                    -- P R I V A T E  I N S U R A N C E --
    # PRIVATE IP Adult & Ped Discharges                                 0
    # PRIVATE IP Newborn Discharges                                     0
    # PRIVATE IP Adult & Ped Bed Days                                   0
```

```
    # PRIVATE IP Newborn Bed Days                                             0

                        -- K I D S C A R E / C H I P --
    # KIDSCARE/CHIP IP Adult & Ped Discharges                                 0
    # KIDSCARE/CHIP IP Newborn Discharges                                     0
    # KIDSCARE/CHIP IP Adult & Ped Bed Days                                   0
    # KIDSCARE/CHIP IP Newborn Bed Days                                       0

              -- V E T E R A N S  M E D I C A L  B E N  P R O G --
    # VMBP IP Adult & Ped Discharges                                          0
    # VMBP IP Newborn Discharges                                              0
    # VMBP IP Adult & Ped Bed Days                                            0
    # VMBP IP Newborn Bed Days                                                0

                                -- O T H E R --
    # OTHER IP Adult & Ped Discharges                                         0
    # OTHER IP Newborn Discharges                                             0
    # OTHER IP Adult & Ped Bed Days                                           0
    # OTHER IP Newborn Bed Days                                               0

(SUMMARY REPORT COMPLETE)
```

Figure 9-2: Printout of the Facility EHR Incentive Report by summary

After the Summary Report is printed, the printing criteria for the Detailed Report will display. The report will be sent to the Host File. This report can be imported into Excel as a delimited file to view.

```
Will now write detail to file

Enter Path: c: \pub//
Enter File Name: FEIR061913

Creating file...DONE
```

Figure 9-3: Running the Detailed Facility EHR Incentive Report to the Host File

10.0 Patient Counts & Percent by Eligibility Report

ABM > RPTP > MURP > CEMU

The Patient Counts & % By Eligibility Report (CEMU) can assist with validating the number of encounters for a specific time period. The report will also display the percent of patients with and without any third party eligibility.

```
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        THIRD PARTY BILLING SYSTEM - VER 2.6p12          |
           +           PATIENT COUNTS & % BY ELIGIBILITY             +
           |                   2011 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           User: USER,DEMO                        18-DEC-2013 3: 16 PM

The date range selected will be used for:
   1. Was the patient's record active during that range
   2. Did the patient have eligibility in that range
   3. How many encounters they had during that time

Detail information will be supplied for validation purposes but once
validated the summary option should be used.

 ============ Entry of Date Range =============

Enter STARTING Date:  010113  (JAN 01, 2013)

Enter ENDING Date:  020113  (FEB 01, 2013)

     Select one of the following:

          S         SUMMARY
          D         DETAIL (will include Summary)

SUMMARY OR DETAIL: SUMMARY// s  SUMMARY
Enter DEVICE: HOME//   VT

Searching....

==========================================================================
Meaningful Use Eligibility Report          DEC 18,2013@15: 23: 57   Page 1
For date range: 01/01/2013 to 02/01/2013
Billing Location: 2011 DEMO DB
==========================================================================

Practice Demographics
    22245 Patients
       45 Encounters
       44 Unique Patients

Patient Demographics
     2963 Patients with Medicaid ( 13.32% )
     3404 Patients with Medicare ( 15.30% )
        8 Patients with Railroad (  0.04% )
     7990 Patients with Private  ( 35.92% )
     9992 Patients Uninsured     ( 44.92% )
        0 Patients with VA Med B (  0.00% )
```

```
(REPORT COMPLETE)
```

Figure 10-1: Sample Patient Counts & Percent by Eligibility Report

After the Summary Report, the Detailed Report can be printed. The report will be sent to the Host File.

```
Will now write detail to file

Enter Path: c: \inetpub\ftproot\pub  Replace
Enter File Name: CEMU 121813

Creating file...

Creating file...DONE
```

Figure 10-2: Creating the host file

Appendix A: RPMS Provider Classes for Eligible Providers

Eligible Professionals for the EHR Incentive program are identified as MDs, DOs, DDSs, DMDs, CNMs, NPs, and PAs that work in an FQHC/RHC/TRIBAL/URBAN 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.

Provider Class Codes and Descriptions

Code	Provider Class
00	MEDICAL DOCTOR
11	PHYSICIAN ASSISTANT (at PA Led FQHC/RHC/TRIBAL/URBANONLY
16	PEDIATRIC NURSE PRACTITIONER
17	NURSE MIDWIFE
18	CONTRACT PHYSICIAN
21	NURSE PRACTITIONER
41	CONTRACT OB/GYN
44	TRIBAL PHYSICIAN
45	OSTEOPATHIC MEDICINE
49	CONTRACT PHYCHIATRIST
52	DENTIST
64	NEPHROLOGIST
68	EMERGENCY ROOM PHYSICIAN
70	CARDIOLOGIST
71	INTERNAL MEDICINE
72	OB/GYN
73	ORTHOPEDIST
74	OTOLARYNGOLOGIST
75	PEDIATRICIAN
76	RADIOLOGIST

Code	Provider Class
77	SURGEON
78	UROLOGIST
79	OPHTHALMOLOGIST
80	FAMILY PRACTICE
81	PHYCHIATRIST
82	ANESTHESIOLOGIST
83	PATHOLOGIST
85	NEUROLOGIST
86	DERMATOLOGIST
A1	SPORTS MEDICINE PHYSICIAN
A4	NATUROPATH PHYSICIAN
A9	HEPATOLOGIST
B1	GASTROENTEROLOGIST
B2	ENDOCRINOLOGIST
B3	RHEUMATOLOGIST
B4	ONCOLOGIST HEMATOLOGIST
B5	PULMONOLOGIST
B6	NEUROSURGEON

Appendix B: Exporting Patient Volume Reports to Excel

B.1 Generate the Report

Generate the PVP2 - Patient Volume Report for Eligible Professionals and PVH2 - Patient Volume Report for Eligible Hospitals, during non-peak hours.

When running the reports for the patient list three options display as shown in Figure B-1.

```
Select one of the following:

      P       Print Report
      H       Print Delimited Report to the HOST FILE
      R       Return to Selection Criteria -Erases ALL previous selections

<P> to Print, <H> to Host File, or <R> to Reselect:
```

Figure B-1: Print Delimited Report to the Host File

1. At the prompt, type H and press Enter. The following sequence displays.

```
Enter Path: c: \inetpub\ftproot\pub  Replace
```

Figure B-2: Host path

2. At the “Enter Path” prompt, type the path to the file location where the report is to be sent and press Enter. Some facilities have this prompt set up to automatically populate, but others do not. If this field doesn't automatically populate, contact the site supervisor for the facility's Path address.
   - On AIX the path would be similar to: /usr/spool/uucppublic/.
   - On a Windows system, the path would be similar to c: \pub.

```
Enter filename: Cindy_PatientVolume.txt
```

Figure B-3: File name

3. At the “Enter filename” prompt, type the file name of the report and press Enter.
   - Give the report a meaningful name so that it is easy to recognize.
   - At the end of the file name type **.txt**. This will make the file easier to open.

   A series of periods appears on the screen indicating that the report file is being created. When completed, the MU reports menu displays.

B.2 Retrieve the Report

To retrieve the report:

1. Open the facility’s File Transfer Software and find the recently created report.

> **Note**: The user’s facility's FTP Software might not be exactly the same software as in the following examples, but the steps in retrieving the report should be similar.

2. Save the file to the local workstation.

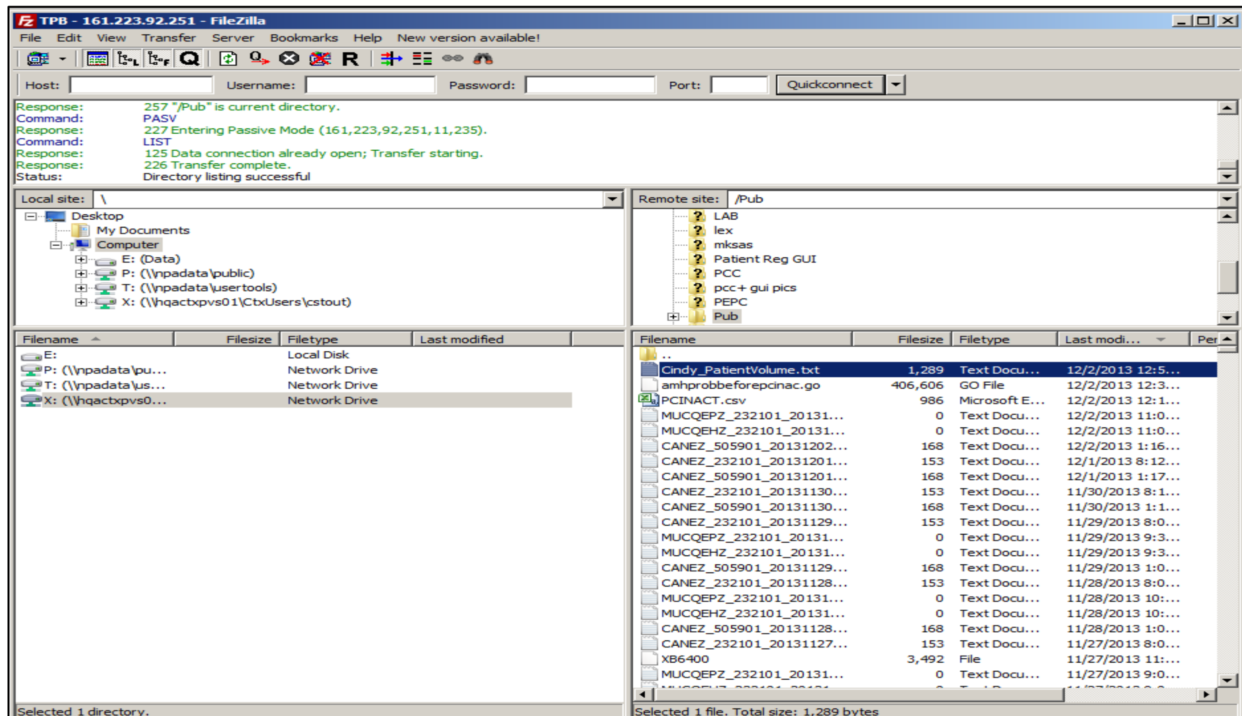

Figure B-4: FileZilla FTP Software

3. Click to highlight the newly created file.

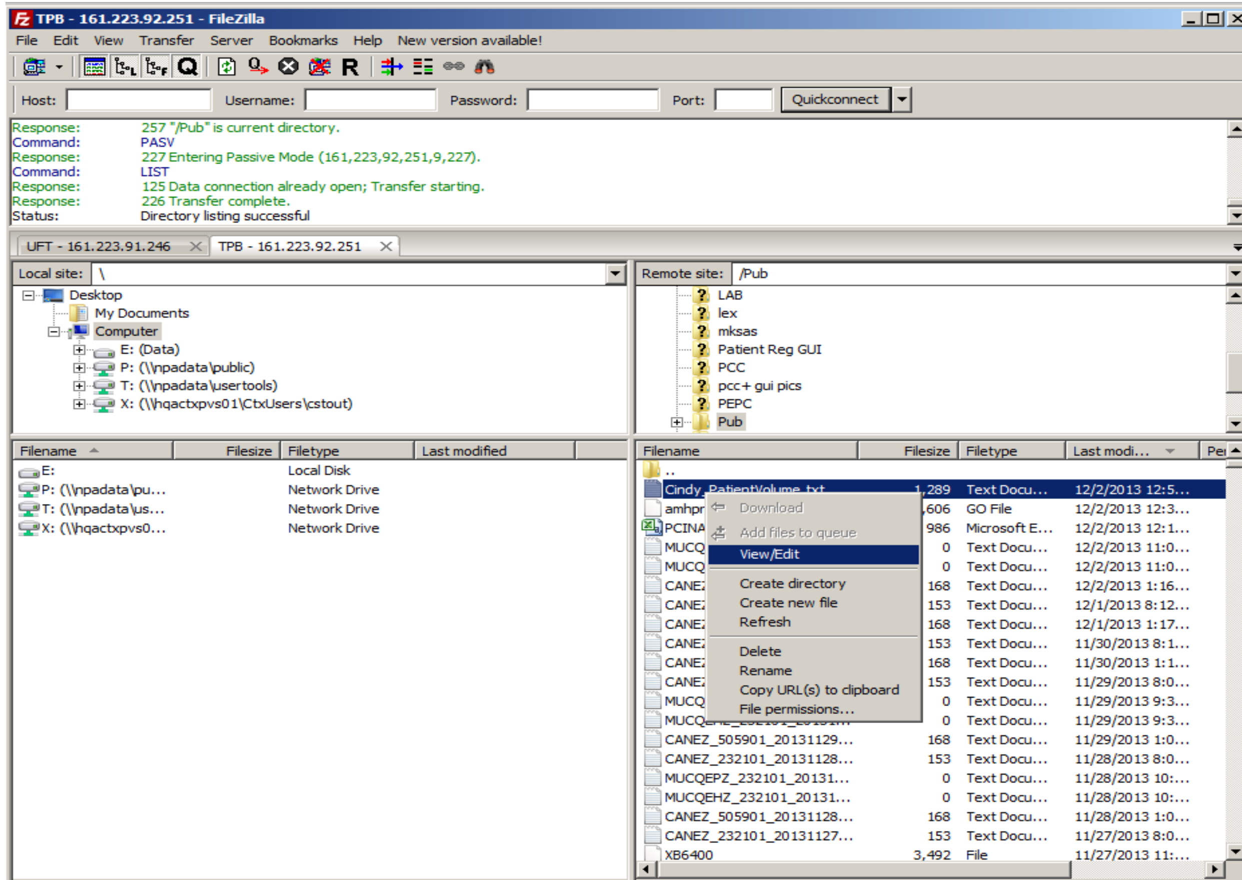

Figure B-5: Retrieving file

4. Right click to display the context menu.

5. Select **View/Edit**. The File will open in Notepad.

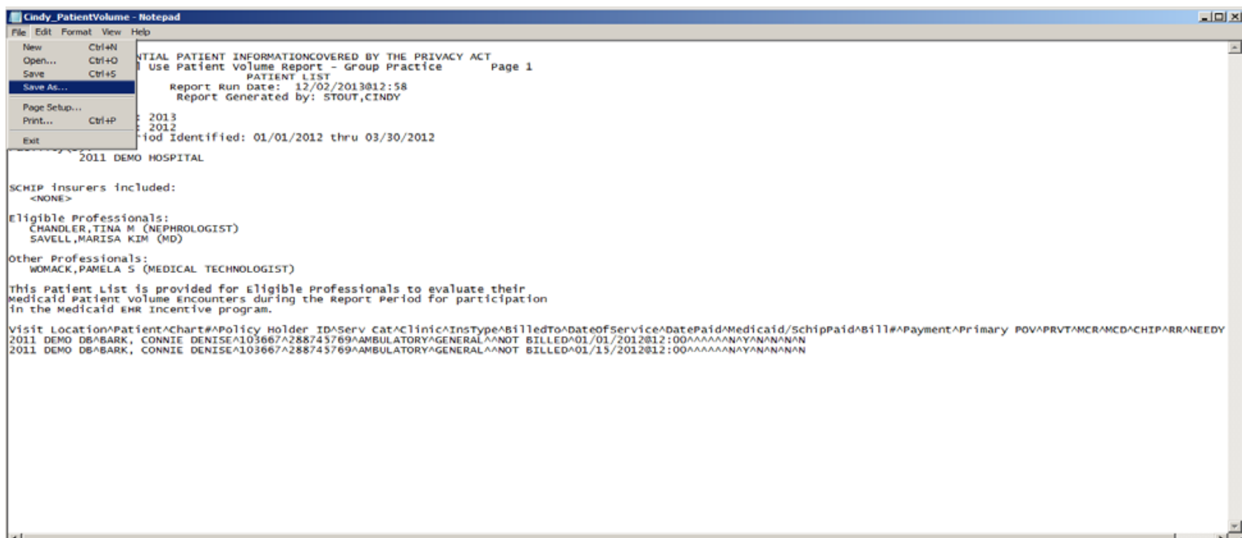

Figure B-6: Saving the file in Notepad

6. Click **File** to display the **File** menu.

7. Select **Save As**. The Save As dialog (Figure B-8) displays.

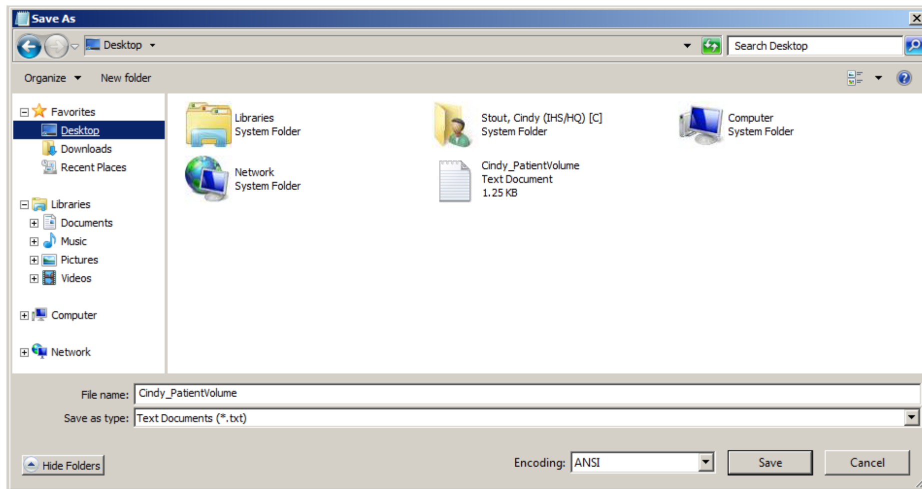

Figure B-7: Saving

8. Select **Desktop** from the file tree pane and click **Save**.

B.3 Import the File to Excel

1. Open Excel.

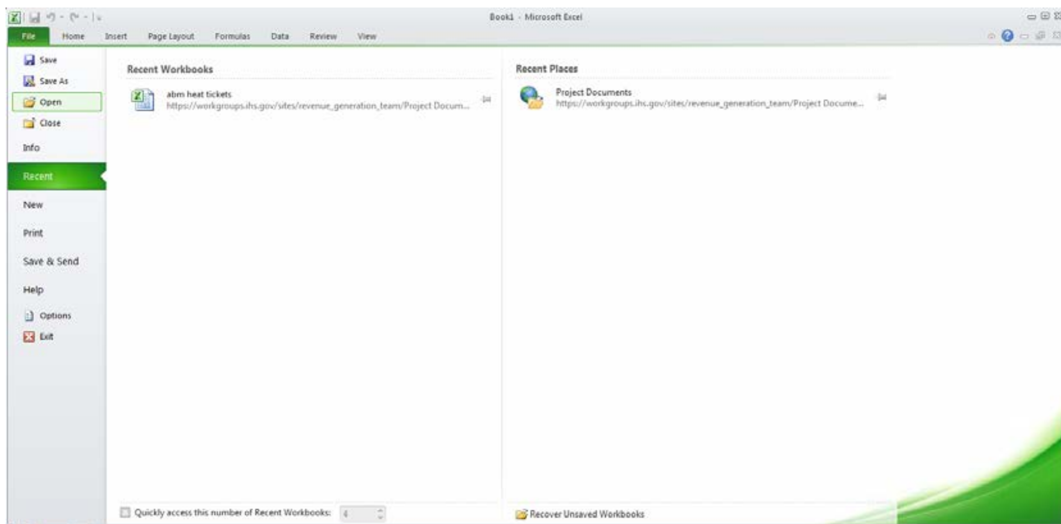

Figure B-8: Opening

2. Click **File** to display the **File** menu.

3. Click **Open**.

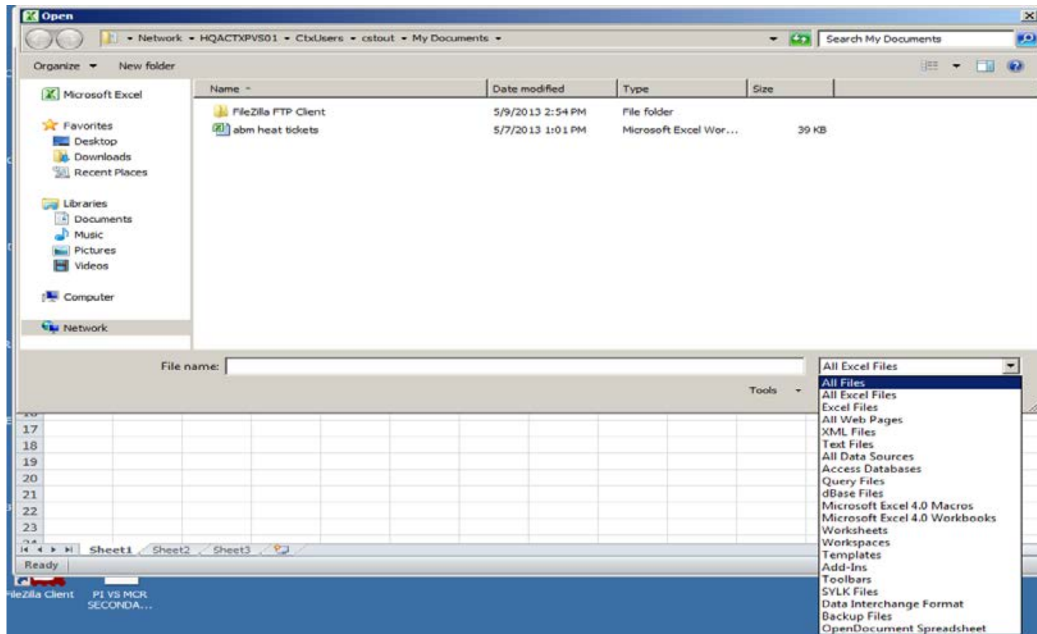

Figure B-9: Selecting All Files

4. Select **All Files** from the file type list.
5. Navigate to the **Desktop** folder.

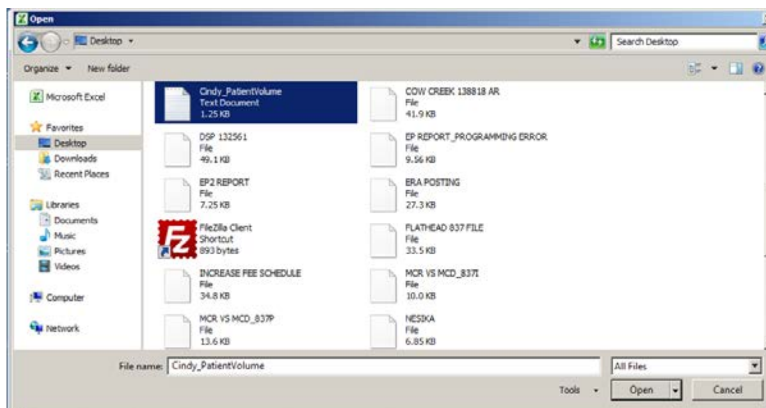

Figure B-10: Open file

6. Double click the file to open. The **Text Import Wizard** (Figure B-12) displays.

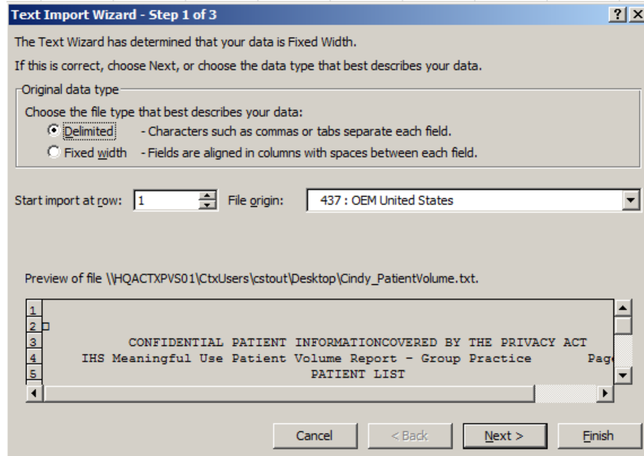

Figure B-11: Selecting **Delimited**

7. Select **Delimited** file type and click **Next**. The next page of the Wizard (Figure B-13) displays. For this particular report, the columns are delimited (separated) in RPMS by a caret (^).

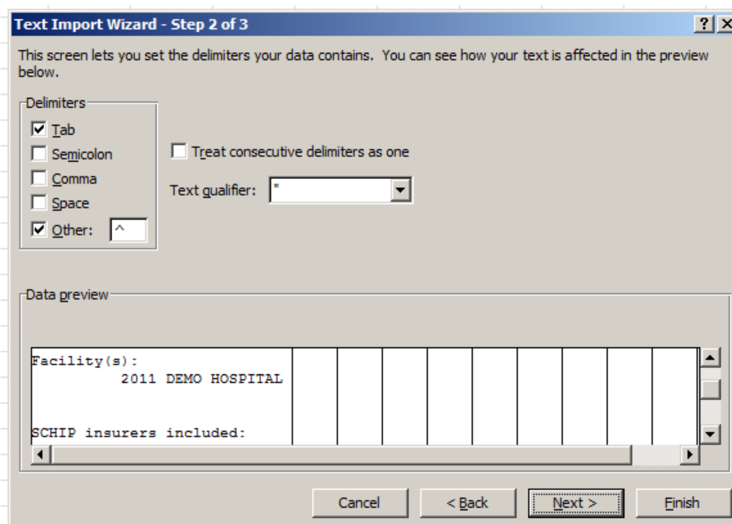

Figure B-12: Use the ^ Delimiter

8. Select **Other**.

9. Type a caret (^) in the adjacent field and click **Next**. The Text Import Wizard redisplays as in Figure B-14.

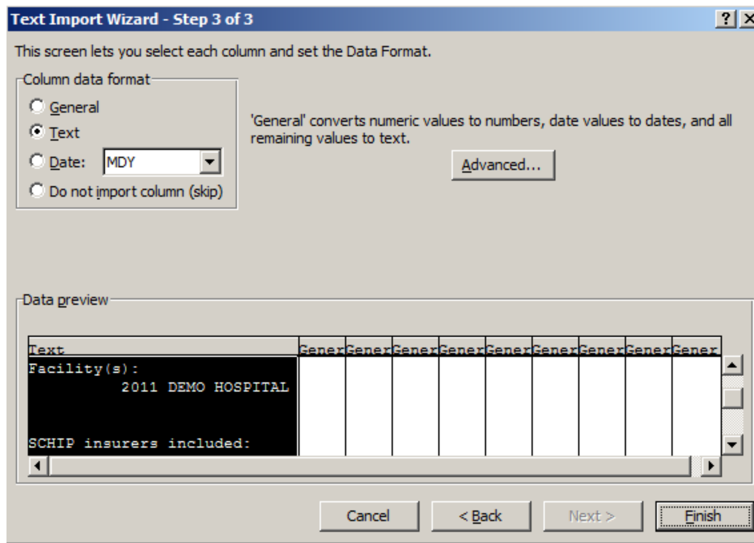

Figure B-13: Text Import Wizard

10. Click to select a column in the **Data preview** pane.

11. Select one of two options in the **Column data format** pane:

- **General**. Select if the column contains numbers only.
- **Text**. Select if the column contains letters or both letters and numerals.

12. Repeat for each column. When done, click **Finish**. The Excel workbook (Figure B-15) displays with the data organized into rows and columns.

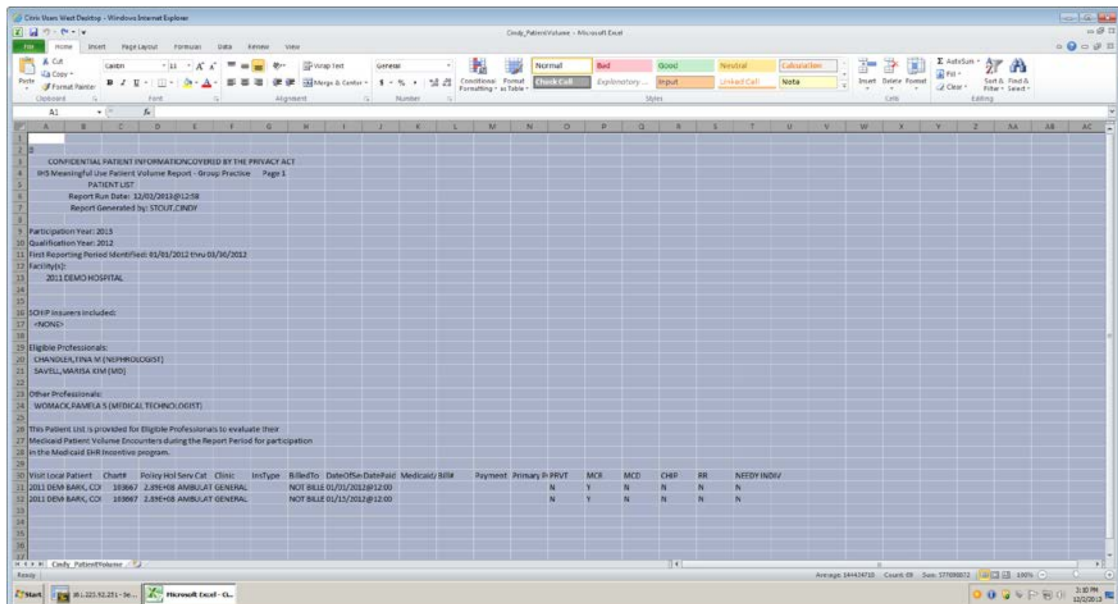

Figure B-14: Selecting the entire worksheet

13. Set each column's width to **20.00**.

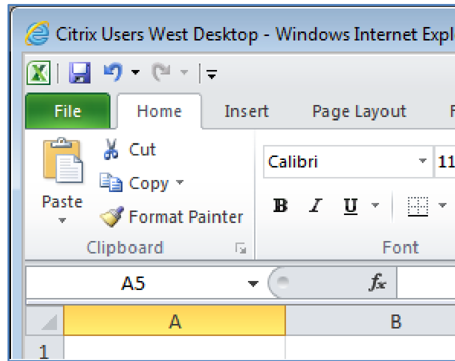

Figure B-15: Saving the Excel file

14. Select **Save As** from the **File** menu.

Appendix C: Verifying the Visits on the Patient Volume Reports

The patient encounters listed on the modified patient list can be verified by generating a PCC Visit General Retrieval (VGEN) report. The system will prompt the user, in three separate steps, to set the selection criteria, identify what to display for each visit, and set the sorting order for the list.

```
                          PCC VISIT GENERAL RETRIEVAL
This report will list or count visits  based on selection criteria entered
by the user.  You will be asked, in three separate steps, to identify your
selection criteria, what you wish displayed for each visit, and the sorting
order for your list.  You may save the logic used to produce the report for
future use.  If you design a report that is 80 characters or less in width,
it can be displayed on your screen or printed.  If your report is 81-132
characters wide, it must be printed - and only on a printer capable of
producing 132 character lines.  You may limit the visits  in your report to
pre-established Search Templates you have created in QMan, Case Management,
or other RPMS tools.  If your template was created in Case Management or in
QMan, using Patients as the Search Subject, this is a Search Template of
Patients.
If your template was created in QMan using Visits as the Search Subject,
this is a Search Template of Visits.
Select one of the following and then proceed to the Date Range and
Selection Criteria screens:

When the list of items for selection, print and sort are displayed to you
in list manager, would you like them sorted alphabetically or in a pre-
defined order.  The pre-defined order is set by the software and is how the
list has historically been displayed.

     Select one of the following:

          P         Predefined Order (the original ordering)
          A         Alphabetical Order
          G         Groups of Related Items

What order would you like the Items displayed in: P//
```

Figure C-1: The VGEN report

To generate the VGEN report for an individual provider:

1. At the “What order…” prompt, press Enter (accepting the default **P**. Predefined Order). The sequence in Figure C-2 displays.

```
What order would you like the Items displayed in: P// redefined Order (the
original ordering)

     Select one of the following:

          P         Search Template of Patients
          V         Search Template of Visits
          S         Search All Visits
```

```
          R         CMS Register of Patients

     Select Visit List from: S//
```

Figure C-2: Report options

2. At the “Select Visit List from prompt, press Enter (accepting the default S. Search All Visits). The sequence in Figure C-3 displays.

```
                              DATE RANGE SELECTION

This is a required response.  Remember, if you are using a Search Template
of Visits, the Date Range entered here must correspond to the date range
used to generate the template or be a subset of that date range.

Enter Beginning Visit Date for search:  10/1/2013  (OCT 01, 2013)

Enter Ending Visit Date for search: 12/29/2013  (DEC 29, 2013)

Do you want to use a PREVIOUSLY DEFINED REPORT? N// O
```

Figure C-3: Selecting the date range

3. At the corresponding prompts, type the Beginning Date and Ending Date, pressing Enter after each. These dates should match the reporting period identified on the Patient Volume report.

```
GENERAL RETRIEVAL            Feb 20, 2014 15: 43: 22          Page:    2 of    5
                        VISIT Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all visits hit Q.
+
15) Mlg Address-Zip        85) Discharge Type         155) Medications+SIG
16) Total Household Income 86) Appt/Walk-In           156) Medication Name/Qty/D
17) Total # in Household   87) Flag                   157) Any Medication Prescr
18) Living Pts             88) DRG                    158) Med List Reviewed?
19) Chart Facility         89) Level of Service       159) Medication List Updat
20) Community              90) Eval&Management CPT    160) No Active Medications
21) Tribe                  91) Length of Stay         161) Prov Rev MED List
22) County of Residence    92) Primary Prov Name      162) Prov Updating Med Lis
23) Preferred Language     93) Prim/Sec Prov Name     163) Prov Updating NAM
24) Preferred Reminder Met 94) Prim Prov Disc         164) Education Topics
25) Eligibility Status     95) Prim/Sec Prov Disc     165) Education Provider
26) Beneficiary Class      96) Prim Prov Affil        166) Education Length (min
27) Medicare               97) Prim/Sec Prov Affil    167) Education GOAL Status
28) Medicare Part B        98) Prim Prov Code         168) Education Objectives
+         Enter ?? for more actions
Select Action: S// s   Select Item(s)

Which visit item(s):  (1-207): 93
```

Figure C-4: The Visit Selection Menu

4. At the “Which visit items” prompt, type **93** (Prim/Sec Prov Name) and press Enter.

Note: Not all VGEN report Sort/Print criteria are the same. Double-check to ensure that the option selected matches the example shown.

```
93) Prim/Sec Prov Name Selection.           DEMOGRAPHIC ATTRIBUTES

Enter PROVIDER: DOCTOR,TRUDEL MD       TD
Enter ANOTHER PROVIDER:
```

Figure C-5: Entering a provider

5. At the "Enter PROVIDER" prompt, type the provider's name and press Enter.
6. At the "Enter ANOTHER PROVIDER" prompt, do one of the following:
   - Type a secondary provider's name and press Enter. Repeat as necessary.
   - Press Enter to end provider name input and to display the Visit Selection Criteria (Figure C-6).

```
      VISIT Selection Criteria:
            Encounter Date range:  OCT 01, 2013 to DEC 29, 2013
            Prim/Sec Prov Name:  DOCTOR,TRUDEL MD
Hit return to continue...:
```

Figure C-6: Selecting multiple providers

7. Press Enter. The Visit Selection Menu redisplays.

```
GENERAL RETRIEVAL             Feb 20, 2014 15: 47: 51          Page:    2 of    5
                        VISIT Selection Menu
Visits can be selected based upon any of the following items.  Select
as many as you wish, in any order or combination.  An (*) asterisk indicates
items already selected.  To bypass screens and select all visits hit Q.
+
15) Mlg Address-Zip        85) Discharge Type         155) Medications+SIG
16) Total Household Income 86) Appt/Walk-In           156) Medication Name/Qty/D
17) Total # in Household   87) Flag                   157) Any Medication Prescr
18) Living Pts             88) DRG                    158) Med List Reviewed?
19) Chart Facility         89) Level of Service       159) Medication List Updat
20) Community              90) Eval&Management CPT    160) No Active Medications
21) Tribe                  91) Length of Stay         161) Prov Rev MED List
22) County of Residence    92) Primary Prov Name      162) Prov Updating Med Lis
23) Preferred Language     93)*Prim/Sec Prov Name     163) Prov Updating NAM
24) Preferred Reminder Met 94) Prim Prov Disc         164) Education Topics
25) Eligibility Status     95) Prim/Sec Prov Disc     165) Education Provider
26) Beneficiary Class      96) Prim Prov Affil        166) Education Length (min
27) Medicare               97) Prim/Sec Prov Affil    167) Education GOAL Status
28) Medicare Part B        98) Prim Prov Code         168) Education Objectives
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S// QUIT
```

Figure C-7: Quit the selection criteria

8. If all Visit Selection Criteria have been set, type **Q** at the “Select Action” prompt and press Enter. The Report Criteria menu (Figure C-8) displays.

```
     Select one of the following:

          T         Total Count Only
          S         Sub-counts and Total Count
          C         Cohort/Template Save
          D         Detailed Visit Listing
          F         Flat file of Area Database formatted records
          P         Unduplicated Patient Cohort/Template
          L         Delimited Output File for use in Excel

     Choose Type of Report: D// D
```

Figure C-8: Report criteria

9. At the “Choose Type of Report” prompt, press Enter (accepting the default **D**. Detailed Visit Listing). The Print Item Selection Menu (Figure C-9) displays.

```
GENERAL RETRIEVAL              Feb 21, 2014 07: 58: 24          Page:    1 of    7
                        PRINT ITEM SELECTION MENU
The following data items can be printed.  Choose the items in the order you
want them to appear on the printout.  Keep in mind that you have an 80
column screen available, or a printer with either 80 or 132 column width.

1) Patient Name            87) External Acct #        173) Measurements/Qualifie
2) First, Last Name        88) PCC+ FORM?             174) Pain Measurement Valu
3) Chart #                 89) Visit IEN              175) Waist Circ Value
4) Terminal Digit #        90) Dependent Entry Count  176) BMI (Last calculated)
5) SSN                     91) Type (IHS,638,etc)     177) RX Ordering Provider
6) Sex                     92) Service Category       178) Dental ADA Codes
7) Date of Birth           93) Visit Location         179) Radiology Exam
8) Birth Month             94) Service Unit of PT     180) Any Immunization Admi
9) Birth Weight (grams)    95) Outside Location       181) Immunizations/Series
10) Birth Weight (Kgs)     96) Clinic Type            182) Immunization Provider
11) Race                   97) Visit Created By       183) Immunization Lot #
12) Ethnicity              98) User Last Update       184) VFC Eligibility
13) Age                    99) Chart Audit Status (Vi 185) Skin Tests/Readings
14) Age in Months          100) Visit Auditor         186) Immunizations
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S// S
```

Figure C-9: Selecting criteria

10. To choose items to print on the report, at the “Select Action” prompt, press Enter (accepting the default **S**. Select Item) and press Enter.

11. When prompted, type the number corresponding with each item to include and choose the default column width for each item. Items to select include:

- **1**. Patient Name
- **3**. Chart #

- **96**. Clinic Type
- **104**. Hospital Location
- **76**. Visit Date

12. When finished, type **Q** at the “Select Action” prompt and press Enter. The Sort Item Selection Menu (Figure C-10) displays.

```
GENERAL RETRIEVAL            Feb 21, 2014 08: 02: 15          Page:    1 of    7
                        SORT ITEM SELECTION MENU
The visits displayed can be SORTED by ONLY ONE of the following items.
If you don't select a sort item, the report will be sorted by visit date.

1) Patient Name            49) EDD (LMP)              97) DRG
2) First, Last Name        50) EDD (ULTRASOUND)       98) Level of Service
3) Chart #                 51) EDD (CLINICAL PARAMETE 99) Eval&Management CPT
4) Terminal Digit #        52) EDD (METHOD UNKNOWN)   100) Length of Stay
5) Sex                     53) EDD (Last Documented)  101) Primary Prov Name
6) Date of Birth           54) Last Menstrual Period  102) Prim Prov Disc
7) Birth Month             55) Internet Access Update 103) Prim Prov Affil
8) Birth Weight (grams)    56) Internet Access?       104) Prim Prov Code
9) Birth Weight (Kgs)      57) Internet Access-Method 105) Primary Provider IEN
10) Race                   58) Immun Register Status  106) Primary Dx (POV)
11) Ethnicity              59) Visit Date             107) Most Recent TOBACCO H
12) Age                    60) Visit Date&Time        108) Most Recent TB STATUS
13) Age in Months          61) Appt Date&Time         109) Most Recent ALCOHOL H
14) Father's Name          62) Check Out Date&Time    110) Most Recent STAGED DM
+         Enter ?? for more actions
S    Select Item(s)       +    Next Screen          Q    Quit Item Selection
R    Remove Item(s)       -    Previous Screen      E    Exit Report
Select Action: S//
```

Figure C-10: Quit selection criteria

13. At the “Select Action” prompt, press Enter (accepting the default **S**. Select Item) and press Enter.
14. When prompted, type 1 (Patient Name) and press Enter.
15. When finished, type **Q** at the “Select Action” prompt and press Enter. The following sequence (Figure C-11) displays.

```
Do you want a separate page for each Patient Name? N// O
Would you like a custom title for this report? N// YES
Enter custom title: MU PATIENT VOLUME
Do you wish to SAVE this SEARCH/PRINT/SORT logic for future use? N// YES
Enter NAME for this REPORT DEFINITION: SEL PT VOLUME020614

     Select one of the following:

          I          Include ALL Patients
          E          Exclude DEMO Patients
          O          Include ONLY DEMO Patients

Demo Patient Inclusion/Exclusion: E// E
```

Figure C-11: Exclude DEMO Patients

16. At the “Demo Patient Inclusion/Exclusion” prompt, press Enter (accepting the default of **E**. Exclude DEMO Patients). The Report Summary (Figure C-12) displays.

```
                                 REPORT SUMMARY

      VISIT Selection Criteria:
            Encounter Date range:  OCT 01, 2013 to DEC 29, 2013
            Prim/Sec Prov Name:  DOCTOR,TRUDEL

      REPORT/OUTPUT Type:
            PRINT Items Selected:
            Patient Name - column width 20
            Chart # - column width 11
            Clinic Type - column width 10
            Hospital Location - column width 10
            Visit Date - column width 10
            Total Report width (including column margins - 2 spaces):   71

      SORTING Item:
            Visits will be sorted by:  Patient Name

     Select one of the following:

          P         PRINT Output
          B         BROWSE Output on Screen

Do you wish to : P//
```

Figure C-12: Summary of selection criteria

17. At the “Do you wish to” prompt, do one of the following:

- Type **P** and press Enter to print the report.
- Type **B** and press Enter to display the report on the screen.

Figure C-13 displays a sample report.

```
                           MU PATIENT VOLUME                   Page 1
NAME                  HRN          CLINIC      HOSP LOC    DATE
-----------------------------------------------------------------------


BOOP,BETTY            IHH 1506     GENERAL     --          11/17/2013
BOOP,BETTY            IHH 1506     GENERAL     --          11/17/2013
BULLWINKLE,ROCKY      IHH 130214   GENERAL     --          10/02/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          10/02/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          10/10/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          10/20/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          11/03/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          11/23/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          12/02/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          12/12/2013
BULLWINKLE,ROCKY      NONE         GENERAL     --          12/20/2013
CRUSH,CANDY           NONE         GENERAL     --          12/15/2013
CRUSH,CANDY           NONE         GENERAL     --          11/15/2013
MEGABUCKS,SYLVIA      IHH 1122     GENERAL     --          12/22/2013
WEATHERS,STORMY       IHH 100214   GENERAL     --          11/29/2013
```

```
Total Visits:  15
Total Patients:  6

RUN TIME (H.M.S): 0.0.1
End of report.  HIT RETURN:
```

Figure C-13: VGEN report displaying results

The VGEN report displays the total number of visits (denominator) listed on the Patient Volume report. A list of excluded Service Categories and Clinics can be found in Section 4.1. Sort the list of visits generated to remove any categories or clinics which may not be eligible on the patient volume report.

Appendix D: Validating Data on the Patient Volume Report

Validate the data on the Patient Volume summary using the following reports:

- Patient Volume Modified Patient List
- Bills Listing Report (BLRP)
- VGEN

```
Patient Volume INDIAN HOSP: 80% (Numerator divided by the Denominator)

Total Patient Encounters (Denominator) INDIAN HOSP: 10 (all patient encounters)
Total Numerator Encounters INDIAN HOSP: 6 (sum of next 6 lines for
Medicaid/Kidscare/CHIP)
Total Medicaid Paid Encounters INDIAN HOSP: 1
Total Medicaid Zero Paid Encounters INDIAN HOSP: 2
Total Medicaid Enrolled (Not Billed) Encounters INDIAN HOSP: 2
Total Kidscare/Chip Paid Encounters INDIAN HOSP: 1
Total Kidscare/Chip Zero Paid Encounters INDIAN HOSP: 0
Total Kidscare/Chip Enrolled (Not Billed) Encounters INDIAN HOSP: 0
Total Paid Other Encounters INDIAN HOSP (*not included in numerator): 1 (all other
paid encounters that aren't Medicaid/Kidscare/CHIP)
```

Figure D-1: Non FQHC/RHC/Tribal/Urban PVP Summary Report

```
Patient Volume DEMO CLINIC: 75% (Numerator divided by the Denominator)

Total Patient Encounters (Denominator) DEMO CLINIC: 8 (all patient encounters)
Total Numerator Encounters DEMO CLINIC: 6 (sum of next 6 lines for
Medicaid/Kidscare/CHIP + Uncompensated Care total)
Total Medicaid Paid Encounters DEMO CLINIC: 0
Total Medicaid Zero Paid Encounters DEMO CLINIC: 0
Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC: 0
Total Kidscare/Chip Paid Encounters DEMO CLINIC: 0
Total Kidscare/Chip Zero Paid Encounters DEMO CLINIC: 0
Total Kidscare/Chip Enrolled (Not Billed) Encounters DEMO CLINIC: 0
Total Paid Other Encounters DEMO CLINIC (*not included in numerator): 2 (all other
paid encounters that aren't Medicaid/Kidscare/CHIP)
Total Uncompensated Care DEMO CLINIC: 6 (visits with zero eligibility)
```

Figure D-2: FQHC/RHC/Tribal/Urban PVP Summary Report

D.1 Patient Volume Modified Patient List

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Visit Location	Patient	Chart#	Policy Holder ID	Serv Cat	Clinic	InsType	BilledTo	DateOfService	DatePaid	Medicaid/SchipPaid	Bill#	Payment	Primary POV	PRVT	MCR	MCD	CHIP	NEEDY INDIV		
2	INDIAN HOSP	HEYNAS, CAPTAIN	35550	649161497	AMBULATORY	DENTAL	D	PRESBYTERI	03/23/2013@08:00	2/10/2014	*	31177A-IH-35550	2175	V72.2	N	N	Y	N	N		
3	INDIAN HOSP	SKY, LARK	3703	3289383402-49040	AMBULATORY	PEDIATRIC	K	BLUECHIP	02/25/2013@14:00	2/10/2014	*	31176A-IH-3703	106	784.7	N	N	N	Y	N		
4	INDIAN HOSP	MEGABUCKS, SYLVIA	1122	C123456874	AMBULATORY	GYNECOLOGY	P	BCBS OF NE	02/17/2013@14:30	2/10/2014		31175A-IH-1122	200	530.81	Y	N	Y	N	N		
5	INDIAN HOSP	CHAVEZ, HENRIETTA	1072	505841107	AMBULATORY	GENERAL	R	MEDICARE	04/28/2013@14:00	10/8/2013		31194A-IH-1072	45	490	Y	Y	Y	N	N		
6	INDIAN HOSP	MYKA, CARLEEN TARA	68677		AMBULATORY	ANTICOAGULATION THERAPY	R	MEDICARE	03/24/2013@11:00	8/15/2013		31190A-IH-68677	0	401.9	N	Y	N	N	N		
7	INDIAN HOSP	DEMO, JOHN	123567	A231456789	AMBULATORY	GENERAL		NOT BILLED	03/24/2013@09:00						Y	N	Y	N	N		
8	INDIAN HOSP	HEYNAS, CAPTAIN	35550	649161497	AMBULATORY	FAMILY PRACTICE		NOT BILLED	03/23/2013@10:0						N	N	Y	N	N		
9	INDIAN HOSP	MEGABUCKS, SYLVIA	1122	C123456874	AMBULATORY	GYNECOLOGY		NOT BILLED	02/17/2013@14:30						Y	N	Y	N	N		
10	INDIAN HOSP	SKY, LARK	3703	3289383402-49040	AMBULATORY	DENTAL		NOT BILLED	02/25/2013@10:0						N	N	N	Y	N		
11																					
12	Duplicate visits for this period: 1																				

Figure D-3: Modified Patient List

After running the summary report, generate a PVP2 patient list and print the delimited report to the host file using the same report parameters. Put the report into an excel file. See Appendix B: for additional instructions.

- Sort the data by Medicaid/SCHIP Paid – move all the records with an '*' into a separate sheet; these are your paid Medicaid/SCHIP encounters.
- Sort the Insurer Type D (Medicaid) billed visits into another separate sheet. These are your Medicaid/SCHIP zero paid.
- Move the other paid visits to another sheet. These are your Other Paid Encounters.
- The remaining visits with a 'Y' in the MCD eligibility flag are your Medicaid Enrolled (Not Billed). This should match what is on your summary report.

> **Note:** A counter has been included at the bottom of the patient list to show potential duplicate visits. These duplicates occur when one visit is billed to two different insurers as primary and secondary bills. This is a temporary work around. This issue will be fixed in a future patch.

D.2 Bills Listing Report

To verify the paid encounters, generate a BLRP using the same date range for Paid Bills. Compare the list with the paid bills on the patient list. Verify by matching the bill (claim) number on both reports.

```
=============================================================================
LISTING of PAID BILLS for ALL BILLING SOURCES   FEB 10,2014@12: 50: 22   Page 1
with VISIT DATES from 01/17/2013 to 04/16/2013
Billing Location: INDIAN HOSP
=============================================================================
                    Claim          Export        Billed    Date        Paid
     Insurer        Number   HRN    Date          Amount    Paid       Amount
-----------------------------------------------------------------------------
   Visit Location: INDIAN HEALTH HOSPITAL
       Visit Type: OUTPATIENT
BCBS OF NEW MEXICO  31175A  1122   03/19/2013     216.67  02/10/2014     200.00
BLUECHIP            31176A  3703   03/27/2013     106.00  02/10/2014     106.00
                    ------                    ----------             --------
     Sub-total:     2                             322.67               306.00
```

Figure D-4: Bills Listing Report

D.3 Visit General Retrieval Report

The visits on the patient list can be verified by generating a VGEN report. See Appendix C: for additional information and for information on how to sort the visits before comparing the visits to the patient list. Figure D-5 contains an example of the VGEN report and Figure D-6 an example of the patient list for the same time period.

```
                          PCC VISIT LISTING                         Page 1
NAME                  HRN          CLINIC       HOSP LOC     DATE
-----------------------------------------------------------------------


CHAVEZ,HENRIETTA      IHH 1072     GENERAL      --           04/28/2013
DEMO,JOHN             IHH 123567   GENERAL      OUTPATIENT   03/24/2013
HEYNAS,CAPTAIN        IHH 35550    DENTAL       --           03/23/2013
HEYNAS,CAPTAIN        IHH 35550    FAMILY PRA   --           03/23/2013
MEGABUCKS,SYLVIA      IHH 1122     GYNECOLOGY   PHARMACY     02/17/2013
MYKA,CARLEEN TARA     IHH 68677    ANTICOAGUL   OUTPATIENT   03/24/2013
SKY,LARK              IHH 3703     PEDIATRIC    --           02/25/2013
SKY,LARK              IHH 3703     DENTAL       --           02/25/2013

Total Visits:  8
Total Patients:  6

RUN TIME (H.M.S): 0.0.0
End of report.  HIT RETURN:
```

Figure D-5: VGEN Report

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
1	Visit Location	Patient	Chart#	Policy Holder ID	Serv Cat	Clinic	InsType	BilledTo	DateOfService	DatePaid	Medicaid/SchipPaid	Bill#	Payment	Primary POV	PRVT	MCR	MCD	CHIP	NEEDY INDIV		
2	INDIAN HOSP	HEYNAS, CAPTAIN	35550	649161497	AMBULATORY	DENTAL	D	PRESBYTERI	03/23/2013@08:00	2/10/2014	*	31177A-IH-35550	2175	V72.2	N	N	Y	N	N		
3	INDIAN HOSP	SKY, LARK	3703	3289383402-49040	AMBULATORY	PEDIATRIC	K	BLUECHIP	02/25/2013@14:00	2/10/2014	*	31176A-IH-3703	106	784.7	N	N	N	Y	N		
4	INDIAN HOSP	MEGABUCKS, SYLVIA	1122	C123456874	AMBULATORY	GYNECOLOGY	P	BCBS OF NE	02/17/2013@14:30	2/10/2014		31175A-IH-1122	200	530.81	Y	N	Y	N	N		
5	INDIAN HOSP	CHAVEZ, HENRIETTA	1072	505841107	AMBULATORY	GENERAL	R	MEDICARE	04/28/2013@14:00	10/8/2013		31194A-IH-1072	45	490	Y	Y	Y	N	N		
6	INDIAN HOSP	MYKA, CARLEEN TARA	68677		AMBULATORY	ANTICOAGULATION THERAPY	R	MEDICARE	03/24/2013@11:00	8/15/2013		31190A-IH-68677	0	401.9	N	Y	N	N	N		
7	INDIAN HOSP	DEMO, JOHN	123567	A231456789	AMBULATORY	GENERAL		NOT BILLED	03/24/2013@09:00						Y	N	Y	N	N		
8	INDIAN HOSP	HEYNAS, CAPTAIN	35550	649161497	AMBULATORY	FAMILY PRACTICE		NOT BILLED	03/23/2013@10:0						N	N	Y	N	N		
9	INDIAN HOSP	MEGABUCKS, SYLVIA	1122	C123456874	AMBULATORY	GYNECOLOGY		NOT BILLED	02/17/2013@14:30						Y	N	Y	N	N		
10	INDIAN HOSP	SKY, LARK	3703	3289383402-49040	AMBULATORY	DENTAL		NOT BILLED	02/25/2013@10:0						N	N	N	Y	N		
11																					
12	Duplicate visits for this period: 1																				

Figure D-6: Patient List

Acronym List

AIR	All-Inclusive Rate
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
DDS	Doctor of Dental Surgery
DMD	Doctor of Dental Medicine
DO	Doctor of Ophthalmology
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
FQHC	Fully Qualified Health Center
IHS	Indian Health Service
MCD	Medicaid (insurance)
MCR	Medicare (insurance)
MU	Meaningful Use
NP	Nurse Practitioner
PA	Physician Assistant
POV	Purpose of Visit
PRVT	Private (insurance)
RHC	Rural Health Centers
RPMS	Resource and Patient Management System
RR	Rail Road (insurance)
SCHIP	State Children’s Health Insurance Program

Contact Information

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

Phone: (888) 830-7280 (toll free)

Web: http: //www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov