Third Party Billing

(ABM)

Addendum to User Manual

Version 2.6 Patch 12
March 2014
**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
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.3.2</td>
<td>Modified Patient List</td>
<td>32</td>
</tr>
<tr>
<td>8.0</td>
<td>Patient Volume Report for Eligible Hospital</td>
<td>34</td>
</tr>
<tr>
<td>8.1</td>
<td>Report Selection Criteria</td>
<td>34</td>
</tr>
<tr>
<td>8.1.1</td>
<td>Select the Facility</td>
<td>34</td>
</tr>
<tr>
<td>8.1.2</td>
<td>Set the Participation Year</td>
<td>35</td>
</tr>
<tr>
<td>8.1.3</td>
<td>Select a Reporting Period</td>
<td>35</td>
</tr>
<tr>
<td>8.1.4</td>
<td>Select the Report Format</td>
<td>38</td>
</tr>
<tr>
<td>8.1.5</td>
<td>Select the Output Device</td>
<td>38</td>
</tr>
<tr>
<td>8.2</td>
<td>EH Summary Report Samples</td>
<td>39</td>
</tr>
<tr>
<td>8.2.1</td>
<td>Sample Report Cover Page</td>
<td>39</td>
</tr>
<tr>
<td>8.2.2</td>
<td>Eligible Hospital Report – Met Threshold</td>
<td>40</td>
</tr>
<tr>
<td>8.3</td>
<td>EH Patient List Report Samples</td>
<td>41</td>
</tr>
<tr>
<td>8.3.1</td>
<td>Patient List</td>
<td>41</td>
</tr>
<tr>
<td>8.3.2</td>
<td>Modified Patient List</td>
<td>42</td>
</tr>
<tr>
<td>9.0</td>
<td>Facility EHR Incentive Report</td>
<td>43</td>
</tr>
<tr>
<td>9.1</td>
<td>Facility EHR Incentive Report</td>
<td>43</td>
</tr>
<tr>
<td>9.2</td>
<td>Hospital Calculation Incentive Report</td>
<td>43</td>
</tr>
<tr>
<td>10.0</td>
<td>Patient Counts &amp; Percent by Eligibility Report</td>
<td>47</td>
</tr>
<tr>
<td>Appendix A</td>
<td>RPMS Provider Classes for Eligible Providers</td>
<td>49</td>
</tr>
<tr>
<td>Appendix B</td>
<td>Exporting Patient Volume Reports to Excel</td>
<td>51</td>
</tr>
<tr>
<td>B.1</td>
<td>Generate the Report</td>
<td>51</td>
</tr>
<tr>
<td>B.2</td>
<td>Retrieve the Report</td>
<td>52</td>
</tr>
<tr>
<td>B.3</td>
<td>Import the File to Excel</td>
<td>54</td>
</tr>
<tr>
<td>Appendix C</td>
<td>Verifying the Visits on the Patient Volume Reports</td>
<td>59</td>
</tr>
<tr>
<td>Appendix D</td>
<td>Validating Data on the Patient Volume Report</td>
<td>66</td>
</tr>
<tr>
<td>D.1</td>
<td>Patient Volume Modified Patient List</td>
<td>67</td>
</tr>
<tr>
<td>D.2</td>
<td>Bills Listing Report</td>
<td>68</td>
</tr>
<tr>
<td>D.3</td>
<td>Visit General Retrieval Report</td>
<td>68</td>
</tr>
<tr>
<td>Acronym List</td>
<td></td>
<td>70</td>
</tr>
<tr>
<td>Contact Information</td>
<td></td>
<td>71</td>
</tr>
</tbody>
</table>
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

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

- 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

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.

```plaintext
*** 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
```
<table>
<thead>
<tr>
<th>PROVIDER CLASS</th>
<th>Code</th>
<th>PROVIDER CLASS</th>
<th>Code</th>
<th>PROVIDER CLASS</th>
<th>Code</th>
<th>PROVIDER CLASS</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>UROLOGIST</td>
<td>78</td>
<td>OPHTHALMOLOGIST</td>
<td>79</td>
<td>PSYCHIATRIST</td>
<td>81</td>
<td>ANESTHESIOLOGIST</td>
<td>82</td>
</tr>
<tr>
<td>FAMILY PRACTICE</td>
<td>80</td>
<td>NEUROLOGIST</td>
<td>85</td>
<td>DERMATOLOGIST</td>
<td>86</td>
<td>NEUROSURGERY NS</td>
<td>87</td>
</tr>
<tr>
<td>MEDICAL ONCOLOGY</td>
<td>MO</td>
<td>RHEUMATOLOGY</td>
<td>RH</td>
<td>INFECTIOUS DISEASE</td>
<td>ID</td>
<td>INFECTION CONTROL</td>
<td>ICP</td>
</tr>
<tr>
<td>RADIATION ONCOLOGY</td>
<td>RO</td>
<td>RETINAL</td>
<td>RT</td>
<td>GENERAL SURGERY</td>
<td>GS</td>
<td>ENDOCRINOLOGY</td>
<td>B1</td>
</tr>
<tr>
<td>GASTROENTEROLOGIST</td>
<td>B1</td>
<td>RHEUMATOLOGY</td>
<td>B1</td>
<td>ONCOLOGIST-HEMATOLOGIST</td>
<td>B4</td>
<td>PULMONOLOGIST</td>
<td>B5</td>
</tr>
<tr>
<td>HEPATOLOGIST</td>
<td>A9</td>
<td>ENDOCRINOLOGIST</td>
<td>B2</td>
<td>PEDIATRICIAN</td>
<td>64</td>
<td>BEHAVIOR ANALYST</td>
<td>D2</td>
</tr>
<tr>
<td>GASTROENTEROLOGIST</td>
<td>B1</td>
<td>RHEUMATOLOGY</td>
<td>B3</td>
<td>PULMONOLOGIST</td>
<td>B5</td>
<td>SPORTS MEDICINE PHYSICIAN</td>
<td>A1</td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider Class</th>
<th>Code</th>
<th>Provider Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>MD</td>
<td>81</td>
<td>PSYCHIATRIST</td>
</tr>
<tr>
<td>11</td>
<td>PHYSICIAN ASSISTANT</td>
<td>82</td>
<td>ANESTHESIOLOGIST</td>
</tr>
<tr>
<td>16</td>
<td>PEDIATRIC NURSE PRACTITIONER</td>
<td>83</td>
<td>PATHOLOGIST</td>
</tr>
<tr>
<td>17</td>
<td>NURSE MIDWIFE</td>
<td>85</td>
<td>NEUROLOGIST</td>
</tr>
<tr>
<td>18</td>
<td>CONTRACT PHYSICIAN</td>
<td>86</td>
<td>DERMATOLOGIST</td>
</tr>
<tr>
<td>21</td>
<td>NURSE PRACTITIONER</td>
<td>87</td>
<td>DERMATOLOGY</td>
</tr>
<tr>
<td>41</td>
<td>CONTRACT OB/GYN</td>
<td>90</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
<tr>
<td>44</td>
<td>TRIBAL PHYSICIAN</td>
<td>92</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
<tr>
<td>45</td>
<td>OSTEOPATHIC MEDICINE</td>
<td>93</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
<tr>
<td>50</td>
<td>MEDICAL ONCOLOGY</td>
<td>94</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
<tr>
<td>50</td>
<td>RETINAL</td>
<td>95</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
<tr>
<td>64</td>
<td>NEPHROLOGIST</td>
<td>96</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
<tr>
<td>68</td>
<td>EMERGENCY ROOM PHYSICIAN</td>
<td>97</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
</tbody>
</table>

(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.

---

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

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

---

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

3P > RTPP > 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 (*).

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2011 DEMO HOSPITAL *</td>
</tr>
<tr>
<td>2</td>
<td>NASHVILLE ADMINISTRATION</td>
</tr>
<tr>
<td>3</td>
<td>2011 DEMO CO HCLINIC (FQHC/RHC/Tribal/Urban)</td>
</tr>
<tr>
<td>4</td>
<td>2011 DEMO SB CLINIC (FQHC/RHC/Tribal/Urban)</td>
</tr>
</tbody>
</table>

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:
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).

<table>
<thead>
<tr>
<th>Enter selection: A Automated 90-Day Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select one of the following:</td>
</tr>
<tr>
<td>F   First 90-day period found</td>
</tr>
<tr>
<td>H   Highest 90-day period found</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Enter selection: B Specific 90-Day Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select a specific start date in the calendar year for the 90-Day Report Period.</td>
</tr>
<tr>
<td>Note: End Date must not be after December 31.</td>
</tr>
<tr>
<td>Enter first day of reporting period for 2013: (1/1/2013 - 10/3/2013):</td>
</tr>
</tbody>
</table>

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).

<table>
<thead>
<tr>
<th>Enter selection: C User specified Report Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select a specific start date in the calendar year</td>
</tr>
<tr>
<td>Note: End Date must not be after December 31.</td>
</tr>
<tr>
<td>Enter first day of reporting period: 030113</td>
</tr>
<tr>
<td>Select a specific END date: (3/1/2013 - 5/29/2013):</td>
</tr>
</tbody>
</table>

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.

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

**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).

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

```
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:
```
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
```
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  
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

<table>
<thead>
<tr>
<th>Denom-</th>
<th>Numer-</th>
<th>Medicaid</th>
<th>Schip</th>
<th>Uncomp-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report Period</td>
<td>Rate</td>
<td>atator</td>
<td>Pd</td>
<td>ZP</td>
</tr>
</tbody>
</table>

<< 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  
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 Encounters DEMO CLINIC: | 0 |
| Total Medicaid Paid Encounters DEMO CLINIC: | 0 |
| Total Medicaid Zero Paid Encounters DEMO CLINIC: | 0 |
| Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC: | 0 |
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:

<table>
<thead>
<tr>
<th>Description from Report</th>
<th>Count</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Encounters (Denominator) DEMO CLINIC</td>
<td>6</td>
<td>All patient encounters</td>
</tr>
<tr>
<td>Total Numerator Encounters DEMO CLINIC</td>
<td>4</td>
<td>Sum of next 6 lines for Medicaid and Kidscare/CHIP</td>
</tr>
<tr>
<td>Total Medicaid Paid Encounters DEMO CLINIC</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Medicaid Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Kidscare/CHIP Paid Encounters DEMO CLINIC</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Kidscare/CHIP Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Description from Report</td>
<td>Count</td>
<td>Explanation</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>-------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Total Kidscare/CHIP Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total Paid Other Encounters DEMO CLINIC (*not included in numerator)</td>
<td>2</td>
<td>All other paid encounters that aren't Medicaid or Kidscare/CHIP</td>
</tr>
<tr>
<td>Total Uncompensated Care DEMO CLINIC</td>
<td>4</td>
<td>Visits with zero eligibility</td>
</tr>
</tbody>
</table>

### 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).

---

**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
### 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

---

<table>
<thead>
<tr>
<th>Ser</th>
<th>I. Billed</th>
<th>Date of</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT NAME</td>
<td>CHART#</td>
<td>Cat</td>
<td>Clinic</td>
</tr>
<tr>
<td>SMITH, OLLIE JOY</td>
<td>99911</td>
<td>AMB GENERAL</td>
<td>P</td>
</tr>
<tr>
<td>DEMO, AMANDA</td>
<td>115523</td>
<td>AMB FAMILY</td>
<td>P</td>
</tr>
</tbody>
</table>

(REPORT COMPLETE):
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.

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.
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

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).

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).

Enter Report Format Choice:

Select one of the following:
S Summary Report
P Patient List

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:
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

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

8.2.2 Eligible Hospital Report – Met Threshold

The Summary Report in Figure 8-15 indicates that the EH met the 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 INFORMATION COVERED 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
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

# Discharges

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICARE</strong></td>
<td></td>
</tr>
<tr>
<td>Paid IP Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Newborn Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Bed Days</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Newborn Bed Days</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Bed Days Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP All-Inclusive</td>
<td>24</td>
</tr>
<tr>
<td>Paid OP Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP Itemized</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAID</strong></td>
<td></td>
</tr>
<tr>
<td>Paid IP Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Newborn Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Bed Days</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Newborn Bed Days</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Bed Days Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP All-Inclusive</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP Itemized</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIVATE INSURANCE</strong></td>
<td></td>
</tr>
<tr>
<td>Paid IP Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Newborn Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Bed Days</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Newborn Bed Days</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Bed Days Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP All-Inclusive</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP Charges</td>
<td>0</td>
</tr>
<tr>
<td>Paid OP Itemized</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KIDSCARE / CHIP</strong></td>
<td></td>
</tr>
<tr>
<td>Paid IP Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Newborn Discharges</td>
<td>0</td>
</tr>
<tr>
<td>Paid IP Charges</td>
<td>0</td>
</tr>
</tbody>
</table>

Lookback Date Range: 09/30/2012 to 09/30/2013
Billing Location: 2011 DEMO DB
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.

(SUMMARY REPORT COMPLETE):
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td># PRIVATE IP Newborn Bed Days</td>
<td>0</td>
</tr>
<tr>
<td><strong>-- KIDS C A R E / C H I P --</strong></td>
<td></td>
</tr>
<tr>
<td># KIDSCARE/CHIP IP Adult &amp; Ped Discharges</td>
<td>0</td>
</tr>
<tr>
<td># KIDSCARE/CHIP IP Newborn Discharges</td>
<td>0</td>
</tr>
<tr>
<td># KIDSCARE/CHIP IP Adult &amp; Ped Bed Days</td>
<td>0</td>
</tr>
<tr>
<td># KIDSCARE/CHIP IP Newborn Bed Days</td>
<td>0</td>
</tr>
<tr>
<td><strong>-- VETERANS MEDICAL BEN PROG --</strong></td>
<td></td>
</tr>
<tr>
<td># VMBP IP Adult &amp; Ped Discharges</td>
<td>0</td>
</tr>
<tr>
<td># VMBP IP Newborn Discharges</td>
<td>0</td>
</tr>
<tr>
<td># VMBP IP Adult &amp; Ped Bed Days</td>
<td>0</td>
</tr>
<tr>
<td># VMBP IP Newborn Bed Days</td>
<td>0</td>
</tr>
<tr>
<td><strong>-- OTHER --</strong></td>
<td></td>
</tr>
<tr>
<td># OTHER IP Adult &amp; Ped Discharges</td>
<td>0</td>
</tr>
<tr>
<td># OTHER IP Newborn Discharges</td>
<td>0</td>
</tr>
<tr>
<td># OTHER IP Adult &amp; Ped Bed Days</td>
<td>0</td>
</tr>
<tr>
<td># OTHER IP Newborn Bed Days</td>
<td>0</td>
</tr>
</tbody>
</table>

(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
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.

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.

Meaningful Use Eligibility Report
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%)
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
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Provider Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>MEDICAL DOCTOR</td>
</tr>
<tr>
<td>11</td>
<td>PHYSICIAN ASSISTANT (at PA Led FQHC/RHC/TRIBAL/URBAN ONLY)</td>
</tr>
<tr>
<td>16</td>
<td>PEDIATRIC NURSE PRACTITIONER</td>
</tr>
<tr>
<td>17</td>
<td>NURSE MIDWIFE</td>
</tr>
<tr>
<td>18</td>
<td>CONTRACT PHYSICIAN</td>
</tr>
<tr>
<td>21</td>
<td>NURSE PRACTITIONER</td>
</tr>
<tr>
<td>41</td>
<td>CONTRACT OB/GYN</td>
</tr>
<tr>
<td>44</td>
<td>TRIBAL PHYSICIAN</td>
</tr>
<tr>
<td>45</td>
<td>OSTEOPATHIC MEDICINE</td>
</tr>
<tr>
<td>49</td>
<td>CONTRACT PSYCHIATRIST</td>
</tr>
<tr>
<td>52</td>
<td>DENTIST</td>
</tr>
<tr>
<td>64</td>
<td>NEPHROLOGIST</td>
</tr>
<tr>
<td>68</td>
<td>EMERGENCY ROOM PHYSICIAN</td>
</tr>
<tr>
<td>70</td>
<td>CARDIOLOGIST</td>
</tr>
<tr>
<td>71</td>
<td>INTERNAL MEDICINE</td>
</tr>
<tr>
<td>72</td>
<td>OB/GYN</td>
</tr>
<tr>
<td>73</td>
<td>ORTHOPEDIST</td>
</tr>
<tr>
<td>74</td>
<td>OTOLARYNGOLOGIST</td>
</tr>
<tr>
<td>75</td>
<td>PEDIATRICIAN</td>
</tr>
<tr>
<td>76</td>
<td>RADIOLOGIST</td>
</tr>
<tr>
<td>Code</td>
<td>Provider Class</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>77</td>
<td>SURGEON</td>
</tr>
<tr>
<td>78</td>
<td>UROLOGIST</td>
</tr>
<tr>
<td>79</td>
<td>OPHTHALMOLOGIST</td>
</tr>
<tr>
<td>80</td>
<td>FAMILY PRACTICE</td>
</tr>
<tr>
<td>81</td>
<td>PHYCHIATRIST</td>
</tr>
<tr>
<td>82</td>
<td>ANESTHESIOLOGIST</td>
</tr>
<tr>
<td>83</td>
<td>PATHOLOGIST</td>
</tr>
<tr>
<td>85</td>
<td>NEUROLOGIST</td>
</tr>
<tr>
<td>86</td>
<td>DERMATOLOGIST</td>
</tr>
<tr>
<td>A1</td>
<td>SPORTS MEDICINE PHYSICIAN</td>
</tr>
<tr>
<td>A4</td>
<td>NATUROPATH PHYSICIAN</td>
</tr>
<tr>
<td>A9</td>
<td>HEPATOLOGIST</td>
</tr>
<tr>
<td>B1</td>
<td>GASTROENTEROLOGIST</td>
</tr>
<tr>
<td>B2</td>
<td>ENDOCRINOLOGIST</td>
</tr>
<tr>
<td>B3</td>
<td>RHEUMATOLOGIST</td>
</tr>
<tr>
<td>B4</td>
<td>ONCOLOGIST HEMATOLOGIST</td>
</tr>
<tr>
<td>B5</td>
<td>PULMONOLOGIST</td>
</tr>
<tr>
<td>B6</td>
<td>NEUROSURGEON</td>
</tr>
</tbody>
</table>
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](image)

3. Click to highlight the newly created file.
4. Right click to display the context menu.

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

Figure B-5: Retrieving file

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](image)

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](image)

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

3. Click **Open**.
4. Select All Files from the file type list.

5. Navigate to the Desktop folder.

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

8. Select **Other**.

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

13. Set each column’s width to **20.00**.
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:

- 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
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](image)

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](image)

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.


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.
Addendum to User Manual

Verifying the Visits on the Patient Volume Reports

March 2014

61

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

+ 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.

<table>
<thead>
<tr>
<th>Select one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
</tr>
<tr>
<td>S</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>P</td>
</tr>
<tr>
<td>L</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>GENERAL RETRIEVAL</th>
<th>Feb 21, 2014 07: 58: 24</th>
<th>Page: 1 of 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRINT ITEM SELECTION MENU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Patient Name</td>
<td>87) External Acct #</td>
<td>173) Measurements/Qualifie</td>
</tr>
<tr>
<td>2) First, Last Name</td>
<td>88) PCC+ FORM?</td>
<td>174) Pain Measurement Valu</td>
</tr>
<tr>
<td>3) Chart #</td>
<td>89) Visit IEN</td>
<td>175) Waist Circ Value</td>
</tr>
<tr>
<td>4) Terminal Digit #</td>
<td>90) Dependent Entry Count</td>
<td>176) BMI (Last calculated)</td>
</tr>
<tr>
<td>5) SSN</td>
<td>91) Type (IHS,638,etc)</td>
<td>177) RX Ordering Provider</td>
</tr>
<tr>
<td>6) Sex</td>
<td>92) Service Category</td>
<td>178) Dental ADA Codes</td>
</tr>
<tr>
<td>7) Date of Birth</td>
<td>93) Visit Location</td>
<td>179) Radiology Exam</td>
</tr>
<tr>
<td>8) Birth Month</td>
<td>94) Service Unit of PT</td>
<td>180) Any Immunization Admi</td>
</tr>
<tr>
<td>9) Birth Weight (grams)</td>
<td>95) Outside Location</td>
<td>181) Immunizations/Series</td>
</tr>
<tr>
<td>10) Birth Weight (Kgs)</td>
<td>96) Clinic Type</td>
<td>182) Immunization Provider</td>
</tr>
<tr>
<td>11) Race</td>
<td>97) Visit Created By</td>
<td>183) Immunization Lot #</td>
</tr>
<tr>
<td>12) Ethnicity</td>
<td>98) User Last Update</td>
<td>184) VFC Eligibility</td>
</tr>
<tr>
<td>13) Age</td>
<td>99) Chart Audit Status (Vi</td>
<td>185) Skin Tests/Readings</td>
</tr>
<tr>
<td>14) Age in Months</td>
<td>100) Visit Auditor</td>
<td>186) Immunizations</td>
</tr>
<tr>
<td>+</td>
<td>Enter ?? for more actions</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>Select Item(s)</td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Remove Item(s)</td>
<td></td>
</tr>
<tr>
<td>Q</td>
<td>Quit Item Selection</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Exit Report</td>
<td></td>
</tr>
</tbody>
</table>

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.

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.

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.

![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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>HRN</th>
<th>CLINIC</th>
<th>HOSP LOC</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOOP,BETTY</td>
<td>IHH 1506</td>
<td>GENERAL</td>
<td>--</td>
<td>11/17/2013</td>
</tr>
<tr>
<td>BOOP,BETTY</td>
<td>IHH 1506</td>
<td>GENERAL</td>
<td>--</td>
<td>11/17/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>IHH 130214</td>
<td>GENERAL</td>
<td>--</td>
<td>10/02/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>10/02/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>10/02/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>10/03/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>11/03/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>11/23/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>12/02/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>12/12/2013</td>
</tr>
<tr>
<td>BULLWINKLE,ROCKY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>12/20/2013</td>
</tr>
<tr>
<td>CRUSH,CANDY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>12/15/2013</td>
</tr>
<tr>
<td>CRUSH,CANDY</td>
<td>NONE</td>
<td>GENERAL</td>
<td>--</td>
<td>11/15/2013</td>
</tr>
<tr>
<td>MEGABUCKS,Sylvia</td>
<td>IHH 1122</td>
<td>GENERAL</td>
<td>--</td>
<td>12/22/2013</td>
</tr>
<tr>
<td>WEATHERS,STORMY</td>
<td>IHH 100214</td>
<td>GENERAL</td>
<td>--</td>
<td>11/29/2013</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Encounters (Denominator) INDIAN HOSP</td>
<td>10</td>
</tr>
<tr>
<td>Total Numerator Encounters INDIAN HOSP</td>
<td>6</td>
</tr>
<tr>
<td>Total Medicaid Paid Encounters INDIAN HOSP</td>
<td>1</td>
</tr>
<tr>
<td>Total Medicaid Zero Paid Encounters INDIAN HOSP</td>
<td>2</td>
</tr>
<tr>
<td>Total Medicaid Enrolled (Not Billed) Encounters INDIAN HOSP</td>
<td>2</td>
</tr>
<tr>
<td>Total Kidscare/Chip Paid Encounters INDIAN HOSP</td>
<td>1</td>
</tr>
<tr>
<td>Total Kidscare/Chip Zero Paid Encounters INDIAN HOSP</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Enrolled (Not Billed) Encounters INDIAN HOSP</td>
<td>0</td>
</tr>
<tr>
<td>Total Paid Other Encounters INDIAN HOSP (*not included in numerator):</td>
<td>1</td>
</tr>
<tr>
<td>Total Medicaid Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Medicaid Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Paid Other Encounters DEMO CLINIC (*not included in numerator):</td>
<td>2</td>
</tr>
<tr>
<td>Total Paid Other Encounters DEMO CLINIC (*not included in numerator):</td>
<td>2</td>
</tr>
<tr>
<td>Total Medicaid Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Medicaid Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
</tbody>
</table>
| Total Uncompensated Care DEMO CLINIC                         | 6              (visits with zero eligibility)

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

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

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Patient Encounters (Denominator) DEMO CLINIC</td>
<td>8</td>
</tr>
<tr>
<td>Total Numerator Encounters DEMO CLINIC</td>
<td>6</td>
</tr>
<tr>
<td>Total Medicaid Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Medicaid Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Medicaid Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Zero Paid Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Kidscare/Chip Enrolled (Not Billed) Encounters DEMO CLINIC</td>
<td>0</td>
</tr>
<tr>
<td>Total Paid Other Encounters DEMO CLINIC (*not included in numerator):</td>
<td>2</td>
</tr>
</tbody>
</table>
| 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

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.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Number</th>
<th>HRN</th>
<th>Date</th>
<th>Amount</th>
<th>Paid Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS OF NEW MEXICO</td>
<td>31175A</td>
<td>1122</td>
<td>03/19/2013</td>
<td>216.67</td>
<td>02/10/2014</td>
<td>200.00</td>
</tr>
<tr>
<td>BLUECHIP</td>
<td>31176A</td>
<td>3703</td>
<td>03/27/2013</td>
<td>106.00</td>
<td>02/10/2014</td>
<td>106.00</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>HRN</th>
<th>CLINIC</th>
<th>HOSP LOC</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHAVEZ, HENRIETTA</td>
<td>IHH 1072</td>
<td>GENERAL</td>
<td>--</td>
<td>04/28/2013</td>
</tr>
<tr>
<td>DEMO, JOHN</td>
<td>IHH 123567</td>
<td>GENERAL</td>
<td>OUTPATIENT</td>
<td>03/24/2013</td>
</tr>
<tr>
<td>HEYNAS, CAPTAIN</td>
<td>IHH 35550</td>
<td>DENTAL</td>
<td>--</td>
<td>03/23/2013</td>
</tr>
<tr>
<td>HEYNAS, CAPTAIN</td>
<td>IHH 35550</td>
<td>FAMILY PRA</td>
<td>--</td>
<td>03/23/2013</td>
</tr>
<tr>
<td>MEGABUCKS, SYLVIA</td>
<td>IHH 1122</td>
<td>GYNECOLOGY</td>
<td>PHARMACY</td>
<td>02/17/2013</td>
</tr>
<tr>
<td>MYKA, CARLEEN TARA</td>
<td>IHH 68677</td>
<td>ANTICOAGUL</td>
<td>OUTPATIENT</td>
<td>03/24/2013</td>
</tr>
<tr>
<td>SKY, LARK</td>
<td>IHH 3703</td>
<td>PEDIATRIC</td>
<td>--</td>
<td>02/25/2013</td>
</tr>
<tr>
<td>SKY, LARK</td>
<td>IHH 3703</td>
<td>DENTAL</td>
<td>--</td>
<td>02/25/2013</td>
</tr>
</tbody>
</table>

Total Visits: 8
Total Patients: 6

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

Figure D-5: VGEN Report
Addendum to User Manual
Validating Data on the Patient Volume Report
March 2014

69

Figure D-6: Patient List

<table>
<thead>
<tr>
<th>Patient</th>
<th>Visit Date</th>
<th>Service Code</th>
<th>Date of Service</th>
<th>Date of Birth</th>
<th>Ethnicity</th>
<th>Race</th>
<th>Gender</th>
<th>Claim Type</th>
<th>Status</th>
<th>Insurance Plan</th>
<th>Primary</th>
<th>Primary</th>
<th>Copay</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>PETERSON, JOHN</td>
<td>03/12/2014</td>
<td>111010</td>
<td>03/12/2014</td>
<td>12/31/2014</td>
<td>114</td>
<td>234</td>
<td>123</td>
<td>X</td>
<td>Y</td>
<td>AETNA</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>SMITH, JANE</td>
<td>03/15/2014</td>
<td>111010</td>
<td>03/15/2014</td>
<td>01/01/2015</td>
<td>234</td>
<td>123</td>
<td>123</td>
<td>X</td>
<td>Y</td>
<td>AETNA</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>JONES, LEE</td>
<td>03/18/2014</td>
<td>111010</td>
<td>03/18/2014</td>
<td>01/01/2016</td>
<td>456</td>
<td>789</td>
<td>890</td>
<td>X</td>
<td>Y</td>
<td>AETNA</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>

Figure D-6: Patient List
## Acronym List

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