

## Patient Volume Memorandum – Revised January 2016

The N.C. Division of Medical Assistance (DMA) is providing this revised guidance on the patient volume (PV) requirements for the N.C. Medicaid EHR Incentive Program to supplement guidance available on the program website. The goal is to help eligible professionals (EPs) apply for, and receive, Electronic Health Record (EHR) incentive payments. This document supersedes the Eligible Professional Patient Volume memorandum that was published December 12, 2011, revised and re-published October, 2012 and September, 2013.

According to the Final Rule governing the Medicaid EHR Incentive Program, Section 495.306(c) Establishing Patient Volumes, a state must submit through their State Medicaid Health Plan (SMHP) the option or options it has selected for measuring patient volume. N.C. Medicaid has selected the following option:

*(c) Methodology, patient encounter.*

(1) *EPs.* To calculate Medicaid PV, an EP must divide: (i) The total Medicaid-enrolled patient encounters in any representative, continuous 90-day period in the preceding calendar year or in the 12 months preceding date of attestation; by (ii) The total patient encounters in the same 90-day period.

For EPs, a Medicaid encounter is defined as services rendered to an individual on a unique day where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under Section 1115 of the Social Security Act) at the time the billable service was provided.

Examples of billable services include:

1. Encounters denied for payment by Medicaid or that would be denied if billed due to exceeding the allowable limitation for the service/procedure;
2. Encounters denied for payment by Medicaid or that would be denied if billed because of lack of following correct procedures as set forth in the state's Medicaid clinical coverage policy such as not obtaining prior approval prior to performing the procedure;
3. Encounters denied for payment due to not billing in a timely manner;
4. Encounters paid by another payer which exceed the potential Medicaid payment; and,
5. Encounters that are not covered by Medicaid such as some behavioral health services, HIV/AIDS treatment, or other services not billed to Medicaid for privacy reasons, oral health services, immunizations, but where the provider has a mechanism to verify Medicaid eligibility.

Further, the Final Rule defines billable as follows:

1. Concurrent care or transfer of care visits;
2. Consultant visits; and,
3. Prolonged physician service without direct, face-to-face patient contact (for example, tele-health).

Billable services do not include:

1. Encounters denied for payment by Medicaid or that would be denied if billed because of absence of medical necessity under the state's Medicaid clinical coverage policy; or,

2. Encounters denied for payment by Medicaid because the patient was not enrolled in Medicaid at the time the service was rendered.

It is important to note that EPs must count actual encounters, defined as a unique patient on a unique day with a unique provider. These encounters must be counted from their own auditable data source, defined as an electronic or manual system that an external entity can use to replicate the data from the original data source to support their attested information.

If there is a problem verifying the data, Medicaid may request additional information to assist in the validation process.

The Medicaid PV percentage should be calculated in the following way in Program Year 2013 and beyond:

**Medicaid PV (Numerator):** In any continuous 90-day period, all unique Medicaid-enrolled encounters.

**Total PV (Denominator):** In the same 90-day period, all unique encounters no matter the payment method.

Clarifications that apply include the following:

#### **General**

- The attestation guides available on the program website and in NC-MIPS provide detailed instructions for completing the PV section in NC-MIPS.
- EPs may choose either the group or individual methodology for patient volume reporting.
- Per Member Per Month fees paid by Medicaid or another payer do not constitute encounters.
- Global billing situations such as OB/GYN visits should be counted on the date of service, not the date of billing. Each individual date of service is considered to be one encounter. In these situations, Medicaid will account for multiple visits per global billing during the validation process.
- A patient seen for multiple services by the same professional on the same day counts as only one encounter.
- A patient seen by more than one professional on one day may be counted as individual encounters by each professional for either group or individual methodology.
- Use the date of service, not the date of claim payment when counting encounters.
- Encounters for billable services whose Medicaid claims were denied and not paid by Medicaid may be reported as zero-pay encounters but cannot be included as Medicaid-paid encounters as part of the patient volume numerator. Zero-pay encounters must be included in the denominator (total encounters). See examples of billable services on page one.
- All encounters must be reported in the denominator regardless of payer, including all encounters reported in the numerator, encounters paid by the patient or any other source, and all encounters for which no money was received such as services provided at no charge and services provided where a claim was denied.
- An EP can use a group practice's PV as a proxy for her/his own if the EP has a current affiliation with the group whose PV s/he is using to attest and the group practice's PV is appropriate as a PV methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation). An EP does not need to have been with the group during the group's selected reporting period.

- Health Choice encounters may not be included in the numerator of the Medicaid patient volume calculation, except in the case of EPs who practice predominantly at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC), where it can be reported as non-Medicaid needy.

### **Group Methodology**

- Group methodology allows a group to calculate one patient volume for a single 90-day period and apply that calculation and reporting period apply to all EPs in the group.
- A group is defined as one or more EPs practicing together at one practice location or at multiple practice locations within a logical geographical region under the same healthcare organization.
- An EP attesting using group methodology must include all encounters for that group's practice.
- If an EP has attested using group methodology, individual methodology is not available to other EPs who were in the group in the same 90-day period. In this scenario, the first provider to attest has essentially set the methodology for all providers in that group for that reporting period and has claimed the entire group's encounters for that reporting period for use by EPs within that group using group methodology only. An individual EP whose encounters were included in that group methodology calculation who does not have a current affiliation with that group can attest using individual methodology by either demonstrating sufficient Medicaid patient volume outside of the group (if using the same reporting period) or by using her/his personal encounter data at the group with a different reporting period or if the EP is currently affiliated with a new group, s/he could attest using the new group's PV if appropriate.
- When using the group methodology, only one group affiliation may be specified. EPs may not report patient volumes from multiple groups when using the group methodology. However, if a practice defines its group as including multiple locations that when combined see the requisite Medicaid patient volume, that group must report the patient volume for each location.

### **Individual Methodology**

- An EP may use numbers from multiple locations to meet the threshold, but is not required to report on more than one location.
- DMA asks the EP for the location(s) of her/his encounters by use of billing NPI to ensure the provider does not use encounters being reported elsewhere under group methodology.
- If an EP who was part of a group practice has attested using individual methodology, group methodology is not available for other providers at the same group for the same 90-day period.
- If an attesting EP's reported Medicaid-paid encounters were billed using another provider's NPI as rendering or if another provider billed Medicaid using the attesting EP's NPI as rendering during the PV reporting period, the attesting EP must report this information in NC-MIPS by answering one of the last two questions in the PV section.

DMA uses the information reported by the EP in NC-MIPS to validate the EP's reported number of Medicaid-paid encounters. DMA uses paid Medicaid claims as a proxy to estimate Medicaid-paid encounters and will search for paid NC Medicaid claims under the individual NPI and/or practice billing NPI(s) reported by the EP in NC-MIPS, depending on the methodology the EP chose.

EPs are encouraged to submit with the attestation additional documentation when the EP's billing practices are outside of the scope of the information requested in NC-MIPS. For example, when a provider, such as a behavioral health provider, who billed Medicaid indirectly through an LME attests for an incentive payment, s/he will need to submit the behavioral health template with the signed attestation. The behavioral health template is required as additional documentation because DMA will not find claims paid to the EP's reported billing NPI where the EP billed Medicaid indirectly through an LME. Other examples include submitting a memo if the EP included in her/his numerator encounters that were paid for by another state's Medicaid program or encounters for billable services where no claim was submitted to Medicaid because the visit was covered by the Carolina ACCESS management fee. All memos must be on the EP's practice letterhead and submitted to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).

If you have further questions about PV or other program requirements, please visit <http://www2.ncdhhs.gov/dma/provider/ehr.htm> or contact [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).