



North Carolina Department of Health and Human Services
Division of Medical Assistance

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MEMORANDUM

TO: Medicaid Providers

FROM: Christy Fitch, Medicaid Health Information Technology Program Manager

DATE: December 12, 2011

RE: Eligible Provider Patient Volume Requirements for the EHR Incentive Program

In an effort to alleviate confusion and help eligible professionals (EPs) apply for and receive Electronic Health Record (EHR) incentive payments, the Division of Medical Assistance (DMA) has issued this memo to explain the patient volume requirements for the NC Medicaid EHR Incentive Program. The formula is simple: paid Medicaid encounters divided by total encounters in a continuous 90-day period from the previous year. This formula was established by the Centers for Medicare and Medicaid Services (CMS) Final Rule governing the Medicaid EHR Incentive Program.

According to the Final Rule, 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. North Carolina Medicaid has selected the following option:

(c) Methodology, patient encounter.

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

For EPs, a Medicaid encounter is defined as services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under Section 1115 of the Social Security Act paid for part or all of the service as stated in the Final Rule.

At the time of attestation, NC Medicaid does not request any information on how EPs count their encounters and calculate their Medicaid patient volume. It is important to note that EPs must count actual encounters, defined as a unique patient on a unique day, from their own auditable data source. Using records from external sources is not recommended. If there is a problem verifying the data, Medicaid may request additional information to assist in the validation process.

While the EHR Incentive Program utilizes paid Medicaid claims to validate EP attestations using a complex formula, DMA will not provide claims data documentation to providers for use in



calculating encounters. Using claims data alone to calculate patient volume is an incorrect interpretation of the Final Rule as, by nature, claims are not always encounter-based. This practice may result in delays in the validation process and the receipt of an incentive payment.

Rather, Medicaid patient volume should be calculated in the following way:

Numerator: In any continuous 90-day period, any unique encounter (an EP sees a patient for any service) that is covered in part or whole by Medicaid.

Denominator: In the same 90-day period, all unique encounters (a patient seen by an EP for any service), no matter the payment method.

The following clarifications apply:

Participation

- Professionals must be enrolled with Medicaid to be eligible for an incentive payment.
- Physician Assistants (PAs) may participate if they are in an FQHC/RHC that is led by a PA.

General

- EPs may choose either the group or individual methodology for patient volume reporting.
- Patients must have office visits to be considered encounters. Phone calls with patients do not constitute encounters.
- 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.
- Services provided at no charge must be included in the denominator (total encounters).
- 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.
- Encounters whose Medicaid claims were denied but later paid should be included as Medicaid encounters for the date of service, not the date of payment.
- Encounters whose Medicaid claims were denied and not paid by Medicaid may not be included in the numerator, but must still be included in the denominator (total encounters).
- The denominator of the patient volume calculation may not be limited in any way. Any encounter included in the numerator must also be included in the denominator, and all patient encounters must be included.
- If attesting under individual methodology, an EP must have sufficient Medicaid history to meet the patient volume reporting requirement.
- If participating with a practice group using group methodology, an EP does not need to have been with the group during the group's selected reporting period.



Group Methodology

- Group methodology allows a group to calculate one patient volume for a single 90-day period and have that calculation and reporting period apply to all EPs in the group.
- All EPs attesting as part of a group must attest using the same patient volume calculation and the same reporting period.
- If a provider has attested using group methodology, the individual methodology is not available to other providers within the group for that same group encounter data set. In this scenario, the first provider has essentially set the methodology for that group and has claimed the entire group's encounters for use by EPs at that group using group methodology only. Theoretically, an individual at such a group could choose to attest using individual methodology; however, to be eligible, that provider would need to demonstrate sufficient Medicaid patient volume outside of the group. This EP would not include the group's numbers in the numerator or denominator.
- 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 group practices in multiple locations that when combined see the requisite Medicaid patient volume, that group may combine the patient volumes across all locations to enter one composite volume when attesting in NC-MIPS. In this case, additional documentation on group letterhead stating each location's numerator and denominator will be needed. The group may send this documentation in to NC-MIPS once for the entire group.

Individual Methodology

- North Carolina asks the EP for the location of their encounters by use of MPN to ensure the provider does not use encounters being reported elsewhere under group methodology.
- An EP may use numbers from multiple locations to meet the threshold, but are not required to report on more than one location.
- If a provider has attested using individual numbers from a location, group method is not available for other providers for that location for that same year.

Because DMA uses paid Medicaid claims and the provider identification information provided at attestation to validate patient volume, EPs are encouraged to submit any additional documentation that explains non-standard billing practices at the time of attestation. For example, if an EP bills for Medicaid under a supervising provider or group whose MPN or NPI is not listed within the attestation, a letter detailing billing practices and associated encounters would help to expedite processing and payment.

If you need help with the attestation process or have a question regarding the status of your payment, please contact the NC-MIPS Call Center at 1-866-844-1113.

If you have further questions about the patient volume calculation or other program requirements, please contact NCMedicaid.HIT@dhhs.nc.gov or 919-855-4200.

