HealthCare
Kentucky Regional Extension Center

KY REC Tip for the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability)

PATIENT VOLUME

What does the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability) require for Patient Volume?

To qualify for a Medicaid Incentive Payment, an Eligible Provider (EP) must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume*
- Be a Pediatrician* and have a minimum 20% Medicaid patient volume
- Practice predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) and have a minimum 30% patient volume attributable to needy individuals
- Children's Health Insurance Program (CHIP) patients do not count toward the Medicaid patient volume criteria

Exclusion:

- None

Helpful Links:

- 90 Day Patient Volume Report

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Common Errors:

- Not using most recent Kentucky EHR Incentive Program 90 Day Patient Volume Report
- Form errors:
    - Leaving blanks on form
    - Not saving form as PDF to upload to attestation site
    - Miscalculations on the form
    - Medicaid percentage miscalculated
    - Enter Line 3 from Volume form into attestation, not line 1
- Not requesting KCHIP report and/or omitting KCHIP information on volume form (if required). This is not required for FQHC/RHC, but is required for all others. Must pull report and then add to KCHIP line on volume form.
- Entering 90-day volume dates that are less than 90 days.
- When reporting as a group, not using same 90 day volume period for each provider in the group in the same payment year.
- If you select to report for preceding 12 months, you cannot choose dates before State Level Repository (SLR) was live. The dates you choose cannot be over 1 year from the date of submitting the attestation. EX: If you are entering your attestation on March 1, 2020, you cannot choose 90 day volume period that starts before February 28, 2019.
- 90 day volume cannot cross into next year so the latest you could start your 90 day volume in 2019 is October 3, 2019.
- You cannot use the same 90 day patient volume for more than one program year.
- Practice does not update information on provider in CMS site. CMS registration site must have up to date information on the provider. Any changes to name, practice, location must be updated on CMS site.
- CMS registration site has provider in status other than active, payment cannot be made. Go into registration site and check all entries for the provider and hit submit to correct.

Best Practices:

- Review the Resources on the Kentucky Medicaid EHR Incentive Program website; online manuals and Monthly EHR Fact Sheets will keep you informed on the latest Promoting Interoperability Program information.
- Do not wait to the end of the year to start thinking about Promoting Interoperability; run volume, PI and CQM reports at least quarterly to see how you are doing.
- Put important program deadlines on your calendar with reminders so you do not miss any critical deadlines.
- All documentation supporting volume and your attestation must be retained for six years. Keep electronic information/paper documentation in a secure central location. If left on an individual staff computer it could be lost if person leaves the practice.

- Remember EPs may use a clinic or group practice's patient volume as a proxy for their own under three conditions:
    - The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (EX: if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
    - There is an auditable data source to support the clinic's patient volume determination;
        - Practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).
        - The clinic or practice must use the entire practice's patient volume and not limit it in any way.
        - EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year.
    - If the EP works in both the clinic and outside the clinic (or with an outside group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.
- For preceding 12 months and 90 day timeframes you cannot use a date before the State Level Registry was available to enter attestations.
- For prior calendar year the practice should prepare a payer mix report on the Kentucky Regional Extension Center (KY REC) provided template for the 90 day time period; a breakdown with percentages and practice info and who prepared the report. The practice can use this form to upload when they attest.
- The 90 day period is from the previous calendar year, or 90 days out of the 12 months preceding the submission of the attestation. EX: 2019 PY volume could be pulled from 90 days in 2018 – prior calendar year or 90 days out of the 12 months preceding the submission of the attestation (i.e. cannot use dates when the DMS EHR Incentive system was not live for attestations).
- Group Volume – for all participants in same program year
    - Must use same patient volume
    - Providers must be enrolled with KY Medicaid and linked to the group (if applicable)
    - Provider must have been with the practice 45 consecutive days of the 90 day period
    - Example:
        - All Year 1 participants must use the same 90 day period
        - All Year 2 must use the same 90 day period OR
        - All participants (any years) can use the same 90 day period
- KCHIP is required to be removed from non-RHC, non-FQHC practices.
- A request to determine KCHIP encounters will be submitted before attestation through the SLR – see instructions in separate attachment.

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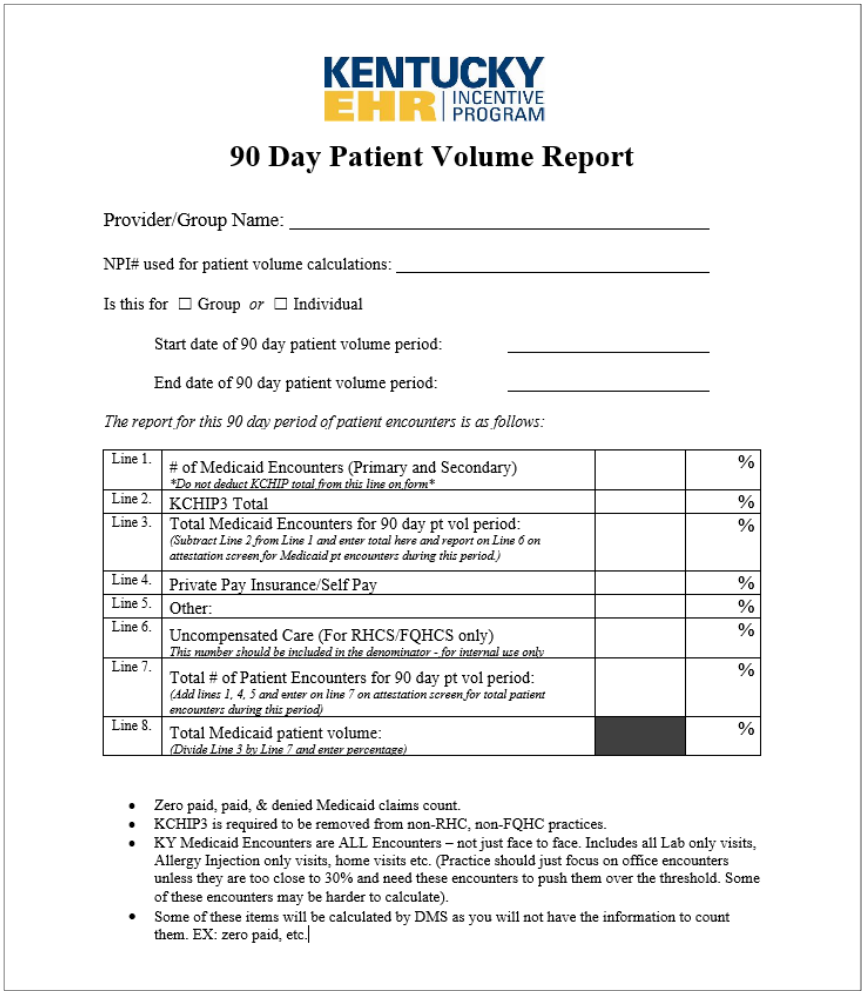
- REMEMBER – the KCHIP report is “UNIQUE Patients”, the report will breakdown the number of encounters for each patient.
- In some cases, volume will not match what KY Medicaid has on file for the NPI # that was submitted. This is known as an eligibility issue.
- KY REC tracks these issues for our customers and meets with KY Medicaid on a monthly basis to review them.
- Most cases are resolved by the practice submitting new volume data utilizing a different date range, or a different volume methodology calculation.
- Some customers have credentialing or billing related issues that have caused their volume not to match or be denied. In these situations, the issue will require a more thorough analysis with KY Medicaid to get the provider paid.
- If there is a credentialing or billing issue, KY REC will work with you, the practice, and KY Medicaid to resolve.

Sample: Patient Volume Report



KENTUCKY EHR INCENTIVE PROGRAM

90 Day Patient Volume Report

Provider/Group Name: _____

NPI# used for patient volume calculations: _____

Is this for ☐ Group *or* ☐ Individual

Start date of 90 day patient volume period: _____

End date of 90 day patient volume period: _____

The report for this 90 day period of patient encounters is as follows:

Line 1.	# of Medicaid Encounters (Primary and Secondary) **Do not deduct KCHIP total from this line on form**		%
Line 2.	KCHIP3 Total		%
Line 3.	Total Medicaid Encounters for 90 day pt vol period: *(Subtract Line 2 from Line 1 and enter total here and report on Line 6 on attestation screen for Medicaid pt encounters during this period.)*		%
Line 4.	Private Pay Insurance/Self Pay		%
Line 5.	Other:		%
Line 6.	Uncompensated Care (For RHCS/FQHCS only) *This number should be included in the denominator - for internal use only*		%
Line 7.	Total # of Patient Encounters for 90 day pt vol period: *(Add lines 1, 4, 5 and enter on line 7 on attestation screen for total patient encounters during this period)*		%
Line 8.	Total Medicaid patient volume: *(Divide Line 3 by Line 7 and enter percentage)*		%

- Zero paid, paid, & denied Medicaid claims count.
- KCHIP3 is required to be removed from non-RHC, non-FQHC practices.
- KY Medicaid Encounters are ALL Encounters – not just face to face. Includes all Lab only visits, Allergy Injection only visits, home visits etc. (Practice should just focus on office encounters unless they are too close to 30% and need these encounters to push them over the threshold. Some of these encounters may be harder to calculate).
- Some of these items will be calculated by DMS as you will not have the information to count them. EX: zero paid, etc.