IDAHO MEDICAID ELECTRONIC HEALTH RECORDS (EHR): PATIENT VOLUME
FREQUENTLY ASKED QUESTIONS

Question	Answer
1. How is patient volume calculated for eligible professionals (EPs)?	Patient volume for EPs is calculated by dividing the numerator, which is the total number of paid Medicaid (Title XIX) encounters (or needy individuals), by the denominator, which is the total number of paid patient encounters over a representative, continuous 90-day period (beginning the first day of the month) in the preceding calendar year. The Medicaid patient volume calculation should not include claims data with zero dollar payments. The data needed for this calculation should be available through your practice's billing system or by tallying numbers from your paper charts. If you serve Medicaid patients from bordering states, or if one of your practice locations is in a state that borders Idaho, you may include the Medicaid patient volume from that state or location only if that additional encounter volume is needed to meet the patient volume threshold. Please note that all out-of-state patient encounters must be included in the denominator. Idaho must be the only state that you are requesting an incentive payment from during that participation year. If an EP aggregates Medicaid patient volume across states, Idaho may audit any out-of-state encounter data before making an incentive payment. The EP must maintain auditable records for six years. Except for EPs practicing predominantly in a federally qualified health center (FQHC) or rural health clinic (RHC), patient volume from Children's Health Insurance Program (CHIP) participants must be excluded from your Medicaid patient volume calculations. If your practice does **not** differentiate CHIP patients from Medicaid patients, you must apply the CHIP patient factor from the Idaho Medicaid EHR Incentive Program. The CHIP patient factor will adjust your total Medicaid patient volume to reflect CHIP patients. The adjusted Medicaid patient volume data should be used when you register in the Idaho Medicaid EHR Incentive Program. Details about the CHIP patient volume factor is provided on the website.

Question	Answer
2. How is patient volume calculated for eligible hospitals (EHs) in the Idaho Medicaid EHR Incentive Program?	All EHs must meet patient volume thresholds based on a ratio where the numerator is the total number of Medicaid (Title XIX) inpatient discharges and emergency department encounters in any representative, continuous 90-day period in the previous fiscal year and the denominator is all inpatient discharges and emergency department encounters during the same period. The Medicaid patient volume calculation should not include claims data with zero dollar payments. If an EH serves Medicaid patients from a state that borders Idaho, the EH may include the Medicaid patient volume from that state. Idaho must be the only state from which the hospital is requesting an incentive payment. If an EH aggregates Medicaid patient volume across states, Idaho may audit any out-of-state encounter data before making an incentive payment. CHIP patient volume must be excluded from the EH's Medicaid patient volume calculations. After the EH has registered with the Centers for Medicare and Medicaid Services (CMS) for an Idaho Medicaid incentive payment, Idaho will ask the EH for the 90-day period they wish to use. Idaho will run a report for the identified 90-day period to determine the total number of discharges and emergency room visits that were for patients whose services were funded by CHIP (Title XXI) funds and send the report to the EH. These services are not eligible to be included in the number of Medicaid encounters to be used to determine the 10% patient volume. The adjusted Medicaid patient volume data should be used when the hospital registers in the Idaho Medicaid EHR Incentive Program.
3. What are the patient volume requirements for EHs?	To calculate the 10% patient volume for EHs, an EH must divide the total Medicaid patient encounters in any representative, continuous 90-day period in the preceding fiscal year by the total encounters in the same 90-day period. A Medicaid encounter means services rendered to an individual (per patient discharge) or in an ED where Medicaid paid for part or all of the service or for the individual's premiums, co-payments, and cost-sharing.

Question	Answer
4. How is EP patient volume calculated for an EP practicing predominantly through an FQHC or RHC?	EPs that practice predominantly through an FQHC or RHC must have a minimum of 30% patient volume attributable to needy individuals. Needy individual patient volume is calculated by dividing the total needy individual patient encounters in any representative, 90-day period in the preceding calendar year by the total patient encounters in the same 90-day period.
5. What is the CHIP deduction for the Idaho Medicaid EHR Incentive Program?	For purposes of calculating patient volume, only Medicaid encounters funded by Title XIX may be counted. CHIP encounters, which are funded by Title XXI, cannot be included. Because providers can't always distinguish between different funding sources, the following will apply: • For EPs, the state is providing a multiplier of 7%, calculated from statewide data, so EPs may deduct that average estimation of CHIP encounters from the general Medicaid encounters they have on record. EPs must identify their total number of Medicaid encounters and reduce that by the CHIP proxy percentage when applying for incentives. • For EHs, the state will calculate the CHIP encounters for each hospital for the 90-day period identified using claims data. After the EH has registered with CMS for an Idaho Medicaid incentive payment, Idaho will ask the EH for the 90-day period it wishes to use. Idaho will run a report for the identified 90-day period to determine the total number of discharges and emergency room visits that were for patients whose services were funded by CHIP funds and send the report to the EH. The adjusted Medicaid patient volume data should be used when the hospital applies/attests with the Idaho Medicaid EHR Incentive Program.
6. What if an EP disagrees with the CHIP factor applied to their Medicaid patient volume by the Idaho Medicaid EHR Incentive Program?	Using this method will benefit some EPs whose actual CHIP patient encounters are higher than the statewide average and may disadvantage those whose CHIP volume is lower than average. Idaho wants to work with EPs to ensure that they are not falsely denied eligibility based on the statewide average. EPs can ask the state to give them the actual number of Medicaid and CHIP encounters for the 90-day period of their choosing if they are unable to meet the 30% patient volume (or 20% for pediatricians) with the CHIP proxy percentage reductions and believe that they could meet it otherwise. The EHR staff will get the actual number and give it to the EP making the request.

Question	Answer
7. How long must new physicians work with the group before we can apply for the incentive payments? **8. Can we apply now for a new provider at our clinic using our group proxy or do we have to wait until the following year?**	Based on recent clarifications from CMS regarding using the group proxy, a new provider is allowed to use a group proxy if they have had at least one paid Medicaid encounter between the start of the 90-day group volume period and the date of attestation/application. The one paid Medicaid encounter no longer has to be within the 90-day volume period. This change allows new providers to the group to participate in the program. Examples: • If a nurse practitioner joins a practice on June 1, 2012, and sees one Medicaid patient on June 1, that practitioner may apply for a Medicaid EHR incentive payment on June 2 **if** that practice is using a proxy calculation for patient volume. That nurse practitioner would use the proxy patient volume calculation to meet the patient volume requirement. • If an EP joins the practice on December 31, 2012, and sees one Medicaid patient that day **and** that practice has used a proxy calculation to meet the patient volume requirement, that EP may use that proxy to meet the patient volume requirement. • If the new EP begins work on January 1, 2013, the EP would have to wait until either there is a proxy calculation for the prior completed calendar year (2012) that will be used at that practice by all practitioners, **or** that EP has 90 days of encounters in the **previous** calendar year that can be used to meet the patient volume threshold. In the former scenario, that EP could not apply until 2013 so they could use 2012 patient encounter data.
9. If a group is applying for the Medicaid incentive payment using the group proxy for volume, does documentation have to be uploaded for each provider or can it just be sent once for all group members?	Each provider participating in the program must register, apply, and attest as an individual. Group proxy only applies to being able to use the group's volume to meet program requirements. Each individual application must have the required documentation uploaded, even if it is the same for each provider.

Question	Answer
10. Does the 10% Medicaid volume for EHs have to be met each year?	Yes, the 10% Medicaid volume for a 90-day period must be met in each fiscal year a payment is made to an EH.
11. How is a Medicaid encounter defined?	Services provided by a single EP to a single patient on a single day for which Medicaid (Title XIX) paid all or part of the individual's premiums, co-pays, or other cost-sharing. Even if the encounter includes multiple services, it is only counted once. If the individual receives services from another EP who is a part of the same group, each EP can count the services provided as a separate encounter. Individuals receiving assistance from CHIP (Title XXI) do not count toward the Medicaid patient volume.
12. Can an EP use patient volume from the first three quarters of 2012 for the 2012 payment year?	No. To be eligible for the EHR incentive payments in any given year, providers need to meet the patient volume requirements in any 90 consecutive days in the **previous** calendar year. The period does not necessarily need to fall within a specific quarter; it just needs to be a consecutive 90-day period.
13. Can I use the continuous 90-day period from December 1, 2011, through February 28, 2012, to establish eligibility?	No. The continuous 90-day period must begin and end within a single calendar year, beginning January 1 and ending December 31.
14. If I need to choose a 90-day period for my representative period, how should I designate it?	When choosing a 90-day representative period, you must first determine that the entire period, both the start and end dates, are within a single calendar year. If the start date is on the first day of the month, you must then count 90 days, including the first day and the last day. You should be aware that a 90-day period is not necessarily the same as a three-month period; thus, the last day of the period may not coincide with the last day of a month. For example, if the beginning of your 90-day period is March 1, the end of the 90-day period will be May 29, **not** May 31. Likewise, if your period begins February 1, 2012, the period will end on May 1, 2012, **not** April 30 (February 2012 contains 29 days).

Question	Answer
15. Is there a requirement for an EP to have a full year of encounters for program eligibility and, if so, when does it apply?	The first payment year for EPs may be determined on a continuous 90-day period within the previous calendar year when based on adopting, implementing, or upgrading (AIU) to a certified EHR system. In the EP's second payment year, which will be the first year for establishing meaningful use, the EP may again base eligibility on a continuous 90-day period within the previous calendar year. Starting with the EP's third payment year and after (or second year for meaningful use) the EP's eligibility must be based on the entire calendar year.
16. If I work part time at two different clinics, can I include Medicaid encounters from both clinics?	To meet the 30% Medicaid individual patient volume requirement, the encounters from both clinics may be combined if all providers from both clinics choose individual patient volume. However, if either clinic chooses to use the group proxy patient volume, you can't use patient encounters from the clinic that is using the group proxy to calculate your individual patient volume.
17. Will an EH's incentive amount be refigured every year to account for changes in Medicaid volume?	We will recalculate the incentive payment for subsequent years if the data changes. This might also cause a decrease in the overall payment amount.
18. How is an emergency department (ED) encounter defined?	An ED encounter is a visit on any one day. If a patient shows up twice in one day, that is considered one encounter. If the patient shows up twice on different days, those are two encounters.
19. If a nurse practitioner (NP) works in an office where the physician's patient volume threshold meets 30%, but the NP's Medicaid patient volume is only 28% and bills under the physician, does the NP qualify for an incentive without meeting the 30% patient volume?	No, not individually. But the NP may be eligible if the clinic is using a group proxy approach to calculate patient volume. Clinic level information is only used when an individual uses the group patient volume to meet eligibility. This example is not based on a group scenario as the two individuals have different patient volumes.

Question	Answer
20. If an NP works in a pediatrician's office and the pediatrician only meets the 20% Medicaid patient volume, does the requirement for the NP to meet the 30% patient volume still apply?	Yes, the NP must meet the 30% patient volume requirement. Medicaid patient volume required for program eligibility must be consistent with the type of professional applying. If the NP meets the 30% patient volume, then the NP qualifies for the full incentive and the pediatrician qualifies for 2/3 of the incentive. We suggest the EP explore what the group proxy patient volume level would be for all practitioners (EPs and non-EPs) at the clinic or group. If that comes to 30%, all EPs in the practice would qualify for the full incentive payment.
21. Can Medicaid be the secondary insurer when determining total Medicaid patient encounters?	When calculating an EP's or EH's Medicaid patient encounters, Medicaid must pay for all or part of the service or pay for all or part of the individual's premiums and copayments. If Medicaid pays nothing toward the service, the encounter cannot be counted in the Medicaid numerator. There is no consideration if Medicaid is a secondary insurer, only if Medicaid paid something. When calculating an EP's patient volume at an FQHC or RHC location, Medicaid must pay for all or part of the service or pay for all or part of the individual's premiums and copayments, unless the service is offered to an underserved individual at no cost or at a reduced cost based on a sliding scale determined by the individual's ability to pay.
22. Can we include out-of-state Medicaid encounters in the Medicaid patient threshold eligibility to attain the 10% for EHs or 30% for EPs?	Idaho's decision is that out-of-state encounters will only be allowed in the patient volume calculation when in-state encounters alone are not sufficient to meet the patient volume threshold needed. During attestation, providers will be asked to identify all out-of-state encounters and the state where those encounters occurred during the 90-day period in a patient encounter report. The Idaho, Washington, Utah, Montana, and Oregon EHR programs are collaborating to establish appropriate data-sharing relationships for purposes of validating Medicaid volume tallies across state borders. If an EP includes Medicaid patient volume across states, Idaho may audit any out-of-state encounter data before making an incentive payment. The EP must maintain auditable records for six years.

Question	Answer
23. What are the group proxy patient volume requirements for EPs in a group practice or clinic?	Group proxy may be completed at the clinic level or at the organizational level. It can be used by providers who are basing their patient volume calculations on Medicaid or needy encounters. The following conditions, defined by CMS and Idaho Medicaid, apply: • The group practice's or clinic's patient volume is appropriate as a patient volume methodology calculation for the EP. • There is an auditable data source to support the group practice's or clinic's patient volume determination. • All EPs in the group practice or clinic must use the same methodology for the payment year. • The group practice or clinic must use the entire group practice's or clinic's patient encounters and does not limit it in any way. Any proxy level patient volume calculation must include the encounters of all practitioners, both eligible and non-eligible. • If an EP works inside and outside of the group practice or clinic, the patient volume calculation includes only those encounters associated with the group practice or clinic; not the EP's outside encounters. • If using an organizational level proxy calculation, the clinics that are included cannot be an arbitrary group of clinics to maximize patient volumes. An organizational level proxy must include all of the organization's clinics that are within the state of Idaho. No out-of-state clinics will be allowed to be included in the organizational level proxy.
24. Our clinic would like to use January 1, 2011 – March 31, 2011, as our 90-day period for patient volume but hired new	An EP whose date of hire by a clinic/group falls after the 90-day period selected for the clinic/group patient volume calculation can use the clinic's or group's patient volume as a proxy for their own patient volume, as long as it is appropriate as a patient volume methodology calculation for the EP. For example, a newly hired EP who sees Medicaid patients may use the clinic's calculated Medicaid patient volume

Question	Answer
doctors in August of 2011; can they use our clinic volume as a proxy?	as a proxy for their own. **Note**: a newly hired EP can only use a clinic's needy patient volume if the EP meets the requirement of having practiced predominantly in an FQHC or RHC (as determined by practice activity in the previous calendar year).
25. If our clinic is using the group proxy patient volume calculation and one of the EPs from the 90-day period is no longer employed here, are that EP's encounters still included?	Yes. When calculating clinic group proxy volume, the clinic or practice must use the entire practice's encounters and not limit it in any way; so, the clinic would include the EP's encounters when calculating the group proxy patient volume. It's the same thing if you have a non-eligible professional like an RN; you would use their volumes, but they are not eligible to receive a payment.
26. If an EP in the Idaho Medicaid EHR Incentive Program wants to use a clinic or group proxy patient volume, how should a clinic or group practice account for EPs practicing part-time and/or applying for the incentive through a different location (e.g., where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics)?	EPs may use a clinic or group proxy patient volume as a proxy for their own under three conditions: 1. The clinic's or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation). 2. There is an auditable data source to support the clinic's patient volume determination. 3. The practice and EPs decide to use one methodology in each year (clinics can't 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 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. Furthermore, if the EP works in both the clinic and outside the clinic, then the group proxy level determination includes only those encounters associated with the clinic. For Example: If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume

Question	Answer
	associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such an EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from Clinic A in calculating his or her individual patient volume. CLINIC A (with a fictional EP and provider type) • EP #1 (physician): individually had 40% Medicaid encounters (80/200) • EP #2 (nurse practitioner): individually had 50% Medicaid encounters (50/100) • Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200) • Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100) • EP #3 (physician): individually had 10% Medicaid encounters (30/300) • EP #4 (dentist): individually had 5% Medicaid encounters (5/100) • EP #5 (dentist): individually had 10% Medicaid encounters (20/200) Totals: • 1,200 encounters in the selected 90-day period for Clinic A • 415 encounters attributable to Medicaid – 35% of the clinic's volume This means that five of the seven professionals would meet the Medicaid patient volume under the rules of the EHR Incentive Program. Two of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included. (The registered nurse and pharmacist are not EPs for the EHR Incentive Program as defined by CMS.)

Question	Answer
27. Can I include part-time professional's volumes when using the group volume calculations?	In using the group calculation, the practice and EPs must decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume (including part-time professionals) and not limit it in any way.
28. When calculating patient volume, do we use patient encounters from all locations where we see patients?	You may use multiple locations and they would need to represent the group criteria used to define the group for the volume calculation. In using the group calculation, the practice and EPs must 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 (including part-time providers and non-eligible professionals) and not limit it in any way. If using the group methodology when calculating Medicaid patient volume, practices would use the group NPI number. If this NPI number encompasses multiple locations, include those locations.
29. What is the difference between clinic level group proxy and organizational level group proxy?	In Idaho, if using an organizational level group proxy calculation, all of the organization's clinics that are physically located within the state of Idaho must be included. No out-of-state clinics will be allowed to be included in the group proxy. The clinics that are included cannot be an arbitrary group of clinics selected to maximize patient volumes. The clinic level group proxy must use the entire practice's or clinic's patient volume and cannot limit it in any way. If an EP works inside and outside of the clinic, the patient volume calculation includes only those encounters associated with the clinic or group practice and not the EP's outside encounters.

Question	Answer
30. Last calendar year our clinic had a total of 20 providers. This year we have 17 providers, 15 of which are eligible for the EHR Incentive. If we apply as a group, how do we count patient volume from the previous calendar year?	The 30% threshold is based on any 90-day period in the previous calendar year. In a group calculation you would calculate patient volume as a snap shot from all providers who had direct contact with patients for any 90-day period from the previous calendar year. The previous year's patient volume should be calculated using the encounters from all 20 of the EPs employed at the time. The current year's patient volume should be calculated using the encounters from all 15 EPs employed in the current year.
31. If we have multiple NPIs with a variety of specialists, but all use the same tax identification number (TIN), can we include everyone in the group volume calculation?	When the EPs attest at the state level, they will have the option to identify the NPI associated with the group calculation. Information will be collected based on the group NPI number and not the TIN. For clarification purposes, assigning payment (using a payee tax ID) and using a group proxy calculation for patient volume are mutually exclusive options for EPs.
32. How does the Idaho Medicaid EHR Incentive Program define a group/clinic?	A group is defined as a group of healthcare practitioners organized as one entity. Prior to attesting, a group must submit to the Idaho EHR Incentive Program how the group(s) will be defined and the criteria used for the definition. The grouping must not be arbitrarily inclusive or exclusive for any reason. There must be a logical reason to the grouping such as location, NPI, etc.
33. Are the patient volume calculations specific to the group of the site?	If you are using the group proxy calculation method, patient volume will be calculated using patient encounters from the group, which could include more than one site, depending on how the group is organized. *If you are using the individual patient volume method, patient encounters should include all sites where the EP sees patients. ***Note:** the exception is if one of the locations is using a group proxy, then the patient volume from that clinic cannot be used in the EPs individual method.

Question	Answer
34. Does the EHR incentive program apply to individual providers or only to a group provider (per office)?	The Idaho Medicaid EHR Incentive Program applies to individuals, but those individuals may be eligible based on their individual volumes or that of a group (if they belong to one). Individuals who belong to a group will decide with their group if they will be participating individually or as a group.
35. If I have a group practice, how will I register and enroll the physicians in the group?	When setting up a group, all participating members must agree to attest to patient volume as a group. To be eligible to receive the incentive, all EPs in the group must have some Medicaid encounters during the period of time being attested to. When calculating both the numerator and denominator, all Medicaid encounters are considered for every practitioner in the group regardless of whether the practitioner is eligible for the incentive program. If an EP chooses not to participate in the group, the encounters generated by that EP are still used in the calculation for that particular group. The EP cannot use those encounters for calculating volumes for another practice or individually.
36. What happens to payments that are assigned to a medical group when physicians transfer in or out of the practice during the reporting period?	Every year, each individual provider must attest and assign payment. They can change payment assignment designations each year if they wish.
37. Are providers required to prove patient volume with documentation?	EPs are required to submit a 90-day patient encounter report (in PDF format) as part of the attestation process in the Idaho Incentive Management System (IIMS) to support their attestation for Medicaid or needy patient volume. The patient volumes for Medicaid encounters will be validated pre-payment against available data in Idaho's Medicaid Management Information System (MMIS). Needy encounters and total patient encounters will be validated on a post-payment basis during audit. Providers must keep documents from auditable sources for six years.

Question	Answer
38. If the physicians in a group practice are the owners of the practice, will their ownership affect receipt of the incentive payment?	No, the physician owners of the group may apply for the incentive payment individually or as a group. If the physicians apply as a group practice, the first EP affiliated with the group practice that attests to the affiliation will set the methodology for the entire group practice. Following that first attestation, every subsequent EP from the group must use that methodology. It is important that the members of the group reach a consensus among their affiliated EPs about the methodology they will use before the first attestation.
39. Are swing bed discharges included in the total discharges when calculating the 10% Medicaid volume for EHs?	No, only inpatient and ED discharges are counted in the calculation for determining the 10% Medicaid volume for EHs.
40. Is it correct that when determining the figures for inpatient bed days and discharges, nursery and swing bed days must be excluded?	Yes. The final rule specifically states that nursery and swing beds must not be included in an EH's count of inpatient bed days and discharges.
41. The group I am a part of has changed ownership and has a new NPI and TIN. Can we still use the practice information under the old group in our application?	• If you are applying as an individual EP, you may use your encounter information from the old group, the new group, or both depending on how your continuous 90-day period falls. If your 90-day period overlaps the change in ownership, you may still use that information. • If your group is applying, the group must be a current Idaho Medicaid provider. If your old group is still a current Idaho Medicaid provider and you wish to be a part of that group's application, you may do so; but only the encounters that occurred under that prior group may be counted as part of that group. If that group is not a current Idaho Medicaid provider, then there can be no group application under that name. • If your group wishes to apply under the current group organization, the current group must be a current Idaho Medicaid provider and must have been operating as such for the required, continuous 90-day period.

Question	Answer
42. Are professional fees included in total hospital charges in the calculation for EHs?	Professional fees billed directly to the patient by the professional are not included in the total hospital charges.
43. If an EP renders services to a patient in a nursing home as a nursing home visit and the point of service (POS) code is 31, will that count as an encounter?	Yes, services with a POS 31 are not excluded (by POS alone) from being counted as an encounter.
44. When do a physician's services with POS 21 not count as encounters?	Services with POS 21 and 23 are not automatically excluded from being counted as encounters by virtue of the POS. The POS 21 and 23, individually or in combination, are used to determine if 90% of the physician's encounters are in a hospital to establish that the physician is hospital-based. Hospital-based physicians do not qualify as EPs.
45. If I don't have a full year of encounters can I still qualify for the program?	You don't need a full year of encounters to establish eligibility and qualify for an incentive payment in the first and second payment years; you only need to have encounters within a continuous 90-day period within the previous calendar year.
46. Are there a minimum number of encounters required?	No. However, professionals and hospitals should be prepared to provide supporting documentation if requested.
47. How do we calculate patient volume for part-time EPs?	The patient volume for part-time and full-time EPs is calculated the same. Divide the part-time EP's Medicaid patient encounters over a consecutive 90-day period in the previous calendar year by the total number of the EP's encounters for that same 90-day time period.

Question	Answer
48. If I am a member of a group and I have the option of applying for an incentive payment as an individual EP, is there an advantage to me in being included as part of the group instead?	When a group applies for the incentive payments, it will aggregate the patient volumes of all members of the group. That total will then be evenly apportioned to each member of the group. Therefore, each member will receive the benefit of the group's total to ensure each member meets the patient volume requirement. This will benefit an individual member whose practice within the group does not provide sufficient Medicaid volume to otherwise qualify.
49. I am a physician and more than 50% of my services are rendered in a hospital setting. I am in the process of starting my own practice or joining a group. Must I wait until I can establish my patient volume outside the hospital to apply?	As long as the EP has less than 90% hospital-based services, the physician may apply for an incentive payment. Therefore, you may apply now and count your hospital-based encounters as long as they are less than 90% of your practice.
50. Can we include self-pays in our patient volume (people not on Medicaid, but have no insurance)?	Self-pays cannot be included in the numerator of the patient volume calculation, but they should be included in the denominator.
51. We have several outpatient facilities (non-inpatient, non-emergency) as part of our health system. Can we include any of our outpatient encounters for our Medicaid eligibility calculation?	You can include your discharges and ED visits for your patient volume calculations. Outpatient encounters are not included in the hospital patient volume calculation. A provider at an outpatient facility may be eligible to meet criteria as an EP and apply separately from the hospital under EP guidelines.

Question	Answer
52. If a Medicaid patient is admitted through the ED, does that visit count as an encounter too or just the discharge?	For calculating volume, each patient is counted once per 24-hour period. So, if a patient is admitted through the ED on day one and discharged the next day, this is counted as two encounters.
53. Do zero pay dual-eligibles meet the definition of a payment and can they be included in the encounter volume?	Dual-eligibles are allowed in the encounter volume. If Medicaid paid any part of the encounter (co-pay or cost-share), then it would be included in the patient volume calculation.
54. Are nursery discharges included in patient volume?	A baby who has had a normal stay in a nursery is not technically a discharge and is not included in inpatient bed days in the calculation of patient volume. However, if the baby is admitted to the hospital (NICU, for example), those discharges are included in patient volume.
55. How is volume validated?	All EPs are required to upload a copy of their billing system report that indicates the number of encounters by payer as well as totals. This report should delineate the individual provider of service as well. The reported volume, as well as the information from the billing report, is validated against data in the Medicaid system. Volumes not available for validation in the Medicaid system (such as needy and total patient volumes) will be subject to post-payment audit validation efforts.
56. When patients go into a clinic for lab work, x-rays, or imaging services, they are considered separate encounters in the EHR and are billed under the ordering provider. Should the ancillary encounters be included in the calculation for Medicaid EHR incentive eligibility?	Encounters must be face-to-face. If a patient sees a technician but never sees the provider, that visit cannot be counted by that provider even if it is billed under that person as the ordering provider. The same holds true for providers that supervise others (e.g., a psychiatrist). If the psychiatrist only has one face-to-face encounter with a patient in the 90-day period, but supervises a social worker or intern who sees that same patient an additional six times in that same period, that psychiatrist may only count the one face-to-face encounter.

Question	Answer
57. How are global services counted as encounters?	One global claim equals one encounter.
58. If I work at more than one clinical site, am I required to use data from all practices to support my demonstration of meaningful use and the minimum patient volume thresholds for the Idaho Medicaid EHR Incentive Program?	No. You are only required to use the data from the site that will support the minimum patient volume threshold. You are not required to use the data from all practices as long as you can meet the requirements under one clinic. However, you may use data from other clinics to demonstrate meaningful use, or if you're using a group proxy calculation for patient volume.
59. Can I include encounters in my Medicaid patient volume calculation if Medicaid did not pay for the service?	No. Medicaid must pay for all or part of the service.
60. Does uncompensated care for an EH include bad debt?	No.