The Chicago HIT Regional Extension Center

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Pre-Approve Medicaid Patient Volume

Step-By-Step Guide to Validating your Medicaid Encounter Percentage Prior to Attestation for Program Year 2018

Agenda

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- About pre-approval
- Step-by-step calculation instructions
- How to submit for pre-approval
- Additional tips

About Pre-Approval

Medicaid Patient Encounter Volume

- Promoting Interoperability Program (*formerly known as Meaningful Use*) participants must demonstrate eligibility every year
- Eligibility requirements include showing that at least 30% of patient encounters (20% for pediatricians) were with Medicaid patients
- Volume may be calculated at either the individual provider or the group level
- Encounter volume is attestation-based and subject to pre- and post-payment audit

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Why Pre-Approve?

- Program adjudicators are required to verify Medicaid patient encounter volume
- Even if you treat 100% Medicaid patients, you must prove it through billing records
- Bad volume calculation is the most common reason for rejection
- Pre-approval allows you to work with adjudicators on proper calculation and confirm eligibility in advance of attestation

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Step-by-Step Calculation Instructions

Step 1: Reporting Period

Select a 90-day billing period:

- Option A (preferred):
  - 90 consecutive days from calendar year 2017
  - Anything between 1/1/17 and 12/31/17
- Option B:
  - 90 consecutive days from the 12-month period prior to the day your attestation is submitted (i.e. if attesting on 2/1/19 then the 90-day period can begin no earlier than 2/1/18)
  - Rolling window that depends on when you submit the attestation and whether it is approved*
  - Optimally, choose a period beginning no earlier than 6/1/18

* If your attestation is rejected, your 90-day period must be within the 12-months prior to the day you re-submit!

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Step 2: Generate Report

Run billing report for period chosen in Step 1, including the following:

- Date of service
- Provider name
- Patient name/MRN
- All CPT codes billed on date
- Primary, secondary, tertiary insurance active on date

Step 3: Calculate Total Encounters

For this purpose:

- “Encounter” is defined as one patient on one day, regardless of number of services or payment method
- Encounters should only be included if at least one applicable CPT code occurred on the date of service
- Visit http://www.chitrec.org/wp-content/uploads/2017/11/CPT-Codes.pdf for a list of applicable CPT codes

Step 4: Calculate Medicaid Encounters

For this purpose:

- “Medicaid encounter” is defined as an encounter with a patient enrolled in Medicaid on the date of service
- Medicaid may be primary, secondary or tertiary insurance
- Include in calculation if patient was enrolled in Medicaid, even if another insurance paid for the encounter (i.e. dual eligible)
- Encounters should only be included if at least one applicable CPT code occurred on the date of service

Step 5: Calculate Medicaid Managed Care Encounters

For this purpose:

- "Medicaid Managed Care encounter" is defined as an encounter with a patient enrolled in a Medicaid Managed Care plan on the date of service
- Medicaid Managed Care may be primary, secondary or tertiary insurance
- Include in calculation if patient was enrolled in Medicaid Managed Care, even if another insurance paid for the encounter (e.g. dual eligible)
- Do not include in Medicaid Managed Care calculation if encounter was already included in Medicaid calculation
- Encounters should only be included if at least one applicable CPT code occurred on the date of service

How to Submit for Pre-Approval

Respond to Request

If applicable, respond to email notification that HFS is accepting pre-approval numbers:

Dear EHR Attestation Coordinator,

I am reaching out to you in regards to your 2018 EHR Attestation. Now is the time to get your patient volume pre-approved. This will not only allow you to concentrate on making sure your providers will meet Meaningful Use, but it will also help you avoid a bottleneck of requests that delay your provider or group from getting processed later.

Please reply to this email and fill in the blanks below. I will review your data and reply back to you with the results.

If you have any questions, please don't hesitate to reply to this email.

- **TIN = _____**
- **Are you providing group or individual numbers? _____**
- **Provider type: (physician, hospital, dentist) _____**
- **Selecting a Date Range: Select Calendar Year 2017 Only For Pre-Approval**
  - **Date Range: Calendar year, any 90-day period in 2017_____**
  - **Cannot use the same date or overlap date used for Attestation Year 2017**
- **Straight Medicaid (only traditional Medicaid & All Kids) = _____**
- **Medicaid Managed Care = _____**
- **Total Encounters for all payees = _____**

Primary Contact:
Primary Phone:
Primary Email:

Mecky Lang
Illinois Medicaid EHR Attestation Program

Submit Proactively

Request approval via email:

- Send to: hfs.ehrincentive@Illinois.gov
- Subject line: Encounter Volume Pre-Approval
- Body of message:
  - Organization name(s) and TIN(s)
  - Group vs. individual (include provider names and NPIs if electing group)
  - Provider type (physician, hospital, dentist)
  - 90-day reporting period (date range)
  - Results of calculation:
    - Total encounters (all payers)
    - Medicaid encounters
    - Medicaid Managed Care encounters
  - Primary contact information:
    - Name
    - Phone and Email
- For best practices in accordance with HIPAA, do NOT include patient identifiers in body of message or attachments

Review and Follow-Up

After email has been sent:

- Your calculation for total encounters will be assumed to be accurate, as Illinois HFS cannot verify encounters with non-Medicaid payers
- Your calculations for Medicaid + Medicaid Managed Care will be compared against claims analysis during the 90-day period
- Your calculations must match analysis within a reasonable degree of variation
- Confirmation of a match = pre-approved for attestation
- Inability to match = adjust calculations based on instructions from reviewer, send new numbers for review
- Please be patient for a response! Requests are addressed on a first-come, first-serve basis

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Additional Tips

General

Pay attention to following:

- Include encounters from all TIN, including inpatient/nursing home/etc. (unless choosing group volume calculation)
- Exclude encounters if none of the applicable CPT codes were billed for on date of service
- Include encounters in Medicaid/Medicaid Managed Care if patient was enrolled on date of service, even if another insurance paid for that encounter
- Include encounters where another provider was rendering care but the claim was billed under supervising provider (e.g. PA/NP treats patient but bills under NPI of MD)
- (Medicaid + Medicaid Managed Care) ÷ Total must be greater than 30% (20% for pediatricians)
- Exclude rejected claims; include pending claims

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Group Volume

If reporting volume as a group:

- Follow same steps, but include encounters for all providers in the group and sum total, Medicaid, Medicaid Managed Care
- Do not exclude any providers from calculation, even if they are not participating in Promoting Interoperability Program (*formerly known as Meaningful Use*) or attesting this year
- Limit to encounters billed to TIN for the group
- Include name/CMS ID of all providers included in calculation when sending pre-approval email

FQHC

If reporting volume under FQHC rules:

- Include sliding fee scale (based on income) and charity care (no cost) with “Medicaid” encounters
- Attach copy of UDS Table 4 (patient characteristics) to email sent for pre-approval
- UDS can be for 2017 calendar year if you cannot produce one for the same 90-day period chosen in Step 1

OB/GYN

If reporting volume for OB/GYN:

- Each pregnant patient seen during the period should be counted as having a single encounter, even if there are many global OB visits
- If the patient also delivered during the period, that is considered an additional encounter
- If the patient had any device insertion/removal procedures, those are considered additional encounters
- If patient had office visits billed separately from global OB, those should be considered additional encounters

Dentists

If reporting volume as dental practice:

- Although list of applicable CPT codes is short, do not include any other common dental codes
- Do not use DentaQuest billing report; this will not match the claims history HFS uses for validation
- Break Medicaid Managed Care encounters down further by each specific plan (i.e. 20 CountyCare, 12 Harmony, 5 IlliniCare, etc.)

Help Desk Information

For any Promoting Interoperability Program related questions, please use the contact information below:

- Support Line: 855-684-3571 (855-68-HELP-1)
- E-mail: muhelpdesk@chitrec.org

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