



Calculating Medicaid Patient Encounter Volume

A Guide to Pre-Approving Eligibility



About Pre-Approval



Medicaid Patient Encounter Volume

- Medicaid Promoting Interoperability Program participants must demonstrate eligibility every year
- Eligibility requirements include demonstrating a 30% Medicaid patient encounter volume (20% for pediatricians)
- Volume is based on billing data for a 90-day period
- Volume may be calculated at either the individual provider or the group level
- Encounter volume is attestation-based and subject to audit



Why Pre-Approve?

- Program adjudicators are required to verify Medicaid patient encounter volume
- Even if you treat 100% Medicaid patients, you must prove it
- 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





Step-by-Step Calculation Instructions



Step 1: Reporting Period

Select a 90-day billing period:

- Option A (preferred):
 - 90 consecutive days from calendar year 2020
 - Anything between 1/1/20 and 12/31/20
- Option B (only if option A is impractical/impossible):
 - 90 consecutive days from the 12-month period prior to the day you attest
 - Supports use of patient volume from calendar year 2021
 - Ideally, period should begin as early in the year as possible



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 occurring with one patient per doctor per day, regardless of number of services or payment method
- Generally limited to office visits, surgeries and inpatient discharges
 - Include claims with one or more of these procedures
 - Mostly CPT codes 99xxx
 - Additional, limited set of CPT for Dentists and OB-GYN (see slides 20-21)
- Do not count immunizations, fillings, labs or tests



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
- Must have at least one applicable CPT code 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)



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
- Must have at least one applicable CPT code 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



How to Submit for Pre-Approval



Respond to Request

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

Dear EHR Attestation Coordinator,

I am reaching out to you in regards to your 2021 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 2020 Only For Pre-Approval**
 - **Date Range: Calendar year, any 90-day period in 2020** _____
 - **Cannot use the same date or overlap date used for Attestation Year 2020**
- Straight Medicaid (only traditional Medicaid & All Kids) = _____
- Medicaid Managed Care = _____
- Total Encounters for all payees = _____

Primary Contact:

Primary Phone:

Primary Email:

Meeky Lang

Illinois Medicaid EHR Attestation Program

Submit Proactively

Request approval via email to: dfs.ehrincentive@Illinois.gov:

- Subject: Encounter Volume Pre-Approval
- Body:
 - 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
- 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



Additional Tips



General

Pay attention to following:

- If using individual volume and practicing/billing at multiple practices (based on TIN), include encounters from all practices
- Exclude encounters if no applicable CPT codes occurred on date of service
- Include encounters as 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 rendered care but the claim was billed under supervising provider (e.g. PA/NP bills under NPI of MD)
- (Medicaid + Medicaid MCO) ÷ Total must be >30%, or >20% for pediatricians
- Exclude rejected claims; include pending claims

Group Volume

If reporting volume as a group:

- Follow same steps, aggregating total, Medicaid and Medicaid MCO encounters for all providers in the group
- Include data for all providers, even those who do not participate in the Promoting Interoperability Program or will not be attesting this year
- Limit to encounters billed to TIN for the group
- May be helpful to provide name/NPI 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) as “Medicaid” encounters
- Attach copy of UDS Table 4 (patient characteristics) to email sent for pre-approval
- UDS can be for 2020 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.)

Contact the **Illinois Medicaid Promoting Interoperability* Help Desk** with questions on Attestation, Registration, and Meeting the Measures.

1-855-68-HELP-1

(855-684-3571)

Monday – Friday
8:30 a.m. – 5:00 p.m.

**formerly Meaningful Use*

muhelpdesk@chitrec.org



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