

Tips for Eligible Professionals Selected for a Post Payment Review of their Medicaid Electronic Health Record (EHR) Incentive Program Payment

Who is eligible for an incentive payment?

Physicians, Nurse Practitioners, Certified Nurse-Midwives, Dentists, and Physician Assistants working in a FQHC/RHC that is led by a PA.

What is the eligibility threshold that EPs must meet?

Medicaid Percentage Greater than or Equal to 30%.

Exception: Pediatricians can receive a reduced incentive payment (2/3 the standard EP incentive) with a Medicaid Percentage Greater than or Equal to 20%.

How is the Medicaid percentage calculated?

Non-FQHC/RHCs –

Numerator: Medicaid Patient Encounter Volume

Divided by

Denominator: Total Patient Encounter Volume

Patient Volume = count a person receiving multiple services on one day as 1 Encounter

FQHC/RHCs –

Numerator: Needy Individual Encounter Volume

Divided by

Denominator: Total Patient Encounter Volume

Needy Volume = a) individuals where services were paid by Medicaid, b) individuals who were furnished uncompensated care, c) individuals who are furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Patient Volume = count a person receiving multiple services on one day as 1 Encounter

Criteria	Program Years 2011 and 2012		Program Years 2013 and forward	
	Medicaid Encounters (Numerator)	Total Encounters (Denominator)	Medicaid Encounters (Numerator)	Total Encounters (Denominator)
Medicaid Patient Volume	✓	✓	✓	✓
Zero Paid Medicaid Services	✗	✓	✓	✓
Denied Medicaid Services	✗	✓	✓	✓
Dually Eligible (Medicaid and Medicare) Services	✓	✓	✓	✓
CHIP (Children's Health Insurance Program)	✗	✓	✗	✓
90 day eligibility period	Must select a 90-day period during the prior calendar year.		Option to select a 90-day period during the prior 12 months preceding the date of attestation; or select a 90-day period during the prior calendar year.	

Individual vs. Group Proxy

Individual Proxy: An EP in a sole practice or a group practice (see note below) uses just their own volume, which can be from multiple servicing addresses, to calculate their Medicaid Share

Group Proxy: EPs that are part of a group practice can use their entire group's volume, which can be from multiple servicing addresses, to calculate their Medicaid share.

- *The methodology used must be consistent for all group members. (i.e., if one group member attests using Individual proxy then other group members must attest with their individual proxy.)*
- *If an EP works in multiple practices, the group volume can only include the volume for that EP that are associated with the practice attesting as a group.*
- *The encounters for all eligible and non-eligible providers servicing patients during the 90-day period are to be included in the calculation of the Medicaid share. (i.e., contracted employees, part-time employees, providers with no Medicaid patients, etc...)*

Resource documents available to assist in post payment audit process:

1. Stage 1 Final Rule - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2010-Final-Rule-Home-Page-Items/CMS1227477.html?DLPage=1&DLSort=0&DLSortDir=ascending>
2. Stage 2 Final Rule - http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

What should provider be able to document?

All information under attestation is subject to audit. Copies (preferably in electronic format like Excel or text file) of the **detailed support** should be **maintained for 6 years** following the date of attestation. At a minimum, the detailed information to validate eligibility should include patient first and last name, Medicaid member ID, if applicable, date of service, payer source, and servicing physician. Documentation should support the attested:

- **Numerator:** A detailed list of Medicaid encounters during the selected 90-day period.
- **Denominator:** A detailed list of all encounters (the numerator should be an identifiable sub-set of the denominator) that occurred during the 90-day period.
- **Locations:** If encounter volume being attested to is for more than one location, the documentation should include all locations included in the attestation.
- **Group Proxy:** If the attestation utilizes the group proxy methodology, there will need to be documentation for all providers with the group during the selected 90-day period. Personnel or other records (tax documents, payroll documents) should be maintained to validate the group proxy was calculated using encounters from all providers and was not limited in any way.
- **Practice Predominantly:** If the attestation utilized needy patient encounters and the EP practices at more than one location which is not an FQHC/RHC, documentation should be maintained that supports that the EP practices predominantly at an FQHC or RHC. An EP practices predominantly when the clinical location for over 50% of the EP's total patient encounters over a six-month period occurs at an FQHC or RHC.
- **Physician Assistant:** If physician assistant attests for an incentive payment, there will need to be documentation that the FQHC or RHC was led by a physician assistant. This can be supported by showing the physician assistant owns the practice, works as the medical director, services the majority of patients, or by way of an organizational chart.

There are several documents that can be used to assist in calculating the patient volume percentage, as long as the documentation adheres to standards of the Final Rule, the following are **examples of acceptable documents**:

- Appointment Sheets: Must be able to document cancellations, no-shows, walk-ins, the date of service along with the servicing provider, and paid amount for the Medicaid patients.
- Accounts Payable Log, Activity Reports and Billing Journals: Must calculate encounter volume based on a unique encounter, not based on units billed or procedure codes.
- Supporting documentation should be maintained in an audit friendly format such as Excel or text file.
- If a change in billing companies, EHR or EMR software vendors or software companies from which detailed documentation was generated, a copy of the data should be saved so that prior records can be retrieved in the event a provider is selected for an audit. The documentation should be readily available.

Audits of Meaningful Use Measures and Clinical Quality Measures

It is important to maintain detailed documentation supporting eligibility and meaningful use attestations. This documentation includes the information listed above for eligibility plus detailed documentation to support meaningful use core and menu objectives and clinical quality measures (CQMs). Documentation must be maintained for the percentage based measures, "yes"/"no" measures, excluded measures and CQMs.

Acceptable forms of Meaningful Use Documentation:

- Percentage based measures – System generated report which contains the provider name, system name, and the MU reporting period.
- "Yes/No" measures –
 - Screenshots which include time stamp for the appropriate reporting period under review, contain the provider or practice name and measure title,
 - For certain measures copies of email transmissions or specification sheet from CEHRT vendor validating if a measure is always on and never can be turned off.
- Exclusions – Letters from the State, Letters from CEHRT vendor, copies of emails.
- Clinical Quality Measures – System generated report which contains the provider name, system name, and the MU reporting period.

For meaningful use attestations, group patient volume is allowable to meet the patient volume criteria; however, each provider attesting for a meaningful use incentive payment should attest to their own individual meaningful use measures (core, menu and CQMs).