

On September 4, 2012, CMS released the Stage 2 Final Rule. As a result of the new rule, there have been changes to the patient volume requirements for the NC Medicaid EHR Incentive Program. These changes will take effect January 1, 2013 for eligible professionals (EPs).

The new definition of patient volume allows the patient volume reporting period to be any consecutive 90-day period within the prior calendar year or preceding 12-month period from the date of the attestation.

In addition, effective January 1, 2013, EPs who calculate “practicing predominantly” for patient volume may choose a consecutive six-month period in the most recent calendar year or preceding 12-month period from the date of the attestation.

Also effective January 1, 2013, when calculating needy individuals, the EP’s patient volume reporting period can be any consecutive 90-day period within the prior calendar year or preceding 12-month period from the date of the attestation.

The new patient volume definition also allows the numerator in the patient volume calculation to include a billable service rendered on any one day to a Medicaid-enrolled individual, regardless of payment liability. This includes zero-pay claims.

Examples of billable services include:

1. Encounters denied for payment by Medicaid or that would be denied if billed due to exceeding the allowable limitation for the service/procedure;
2. Encounters denied for payment by Medicaid or that would be denied if billed because of lack of following correct procedures as set forth in the state’s Medicaid clinical coverage policy such as not obtaining prior approval prior to performing the procedure;
3. Encounters denied for payment due to not billing in a timely manner;
4. Encounters paid by another payer which exceed the potential Medicaid payment; and,
5. Encounters that are not covered by Medicaid such as some behavioral health services, HIV/AIDS treatment, or other services not billed to Medicaid for privacy reasons, oral health services, immunizations, but where the provider has a mechanism to verify Medicaid eligibility.

Further, the Final Rule defines billable as follows:

1. Concurrent care or transfer of care visits;
2. Consultant visits; or,
3. Prolonged physician service without direct, face-to-face patient contact (for example, tele-health).

A consultant visit occurs when a provider is asked to render an expert opinion/service for a specific condition or problem by a referring provider. The visit does not have to be individually billable in instances where multiple visits occur under one global fee.

Billable services do not include:

1. Encounters denied for payment by Medicaid or that would be denied if billed because of absence of medical necessity under the state's Medicaid clinical coverage policy; and,
2. Encounters denied for payment by Medicaid because the patient was not enrolled in Medicaid at the time the service was rendered.

Finally, under the new Stage 2 Final Rule, providers will now be able to count MCHIP encounters toward their patient volume requirements. MCHIP recipients are children covered under a Medicaid expansion program. This requires no action on the part of the provider, since these patients have historically been reported by the provider as a part of their numerator in the patient volume calculation. The State will no longer subtract them from the reported numerator.

The Stage 2 Final Rule also altered the meaning of hospital-based. EPs who can demonstrate they funded the acquisition, implementation and maintenance of the certified EHR technology (CEHRT), including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an EH or CAH; and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT), are now eligible for incentive payments.

The 120-day tail period for program year 2012 allows EPs until April 30, 2013 to attest for an incentive payment. If you are a provider attesting for a program year 2012 payment during the 120-day tail period, the new definitions explained above do not apply to you.

EPs attesting for program year 2013 (January 1, 2013 – December 31, 2013) will be able to utilize the new definitions.