

# Provider Patient Encounter Report

## For Eligible Professionals Only

Idaho Medicaid Electronic Health Record (EHR) Incentive Program  
Created June 2012

*Note to Providers: There is a good possibility that business processes will change after the program is launched. Potential efficiencies as well as potential problems are likely to become evident. This paper describes the business as of spring 2012. Please be sure to return to the information on the website and in the provider handbook often for updates. Creation dates will be noted on each paper.*

### Introduction

In the Medicaid EHR Incentive Program, all eligible professionals (EPs) are required to submit a 90-day patient encounter report to support their attestation for Medicaid or needy patient volume. The report must be generated from the practice administrative or clinic care system and be auditable.

### Contents of Report

The content of the report is intended to provide the state with sufficient information to validate reported patient encounters. The particular format of the report is not as important as the content; however, it is critical to use **headings and column labels** to make the content clear on the report. The following are definitions of the data points or content we require in the report:

- **Date:** The date the report was generated.
- **Clinic or Organization NPI:** the NPI for the clinic if a group proxy approach is being used and is at the clinic level, or the NPI for the organization if a group proxy approach is being used and is at the organizational level.
- **90-day period:** The start and end date of the 90 consecutive calendar days used to determine patient volume. Remember, 90 days is not always equal to three months. Please be specific. The 90-day period must be in the most recent completed calendar year (January-December) prior to the year you are completing the application/attestation.
- **Provider Name:** The name of the individual eligible professional the encounters support. Or if using a group proxy, include the names of **all of the professionals** who are a part of that group. This includes all eligible professional types (doctors, nurse practitioners, dentists, etc.) as well as non-eligible professionals such as social workers. If you bill for their services they must be included in the proxy and thus in the patient encounter report.
- **National Provider Identifier (NPI):** The NPI associated with the individual eligible professional, or if using a Group Proxy, the NPI associated with each professional that is a part of that group.
- **Total Medicaid or Needy Encounters:** The total number of Medicaid or needy encounters attributable to the provider during that 90-day period. Or, if using a proxy calculation, include the total number of Medicaid or needy encounters attributable to each of the

practitioners at the clinic/group practice. The report could show daily, weekly, or monthly sub-totals if the provider desires.

- **Total Patient Encounters:** The total number of patient encounters attributable to the provider. Or if using a group proxy calculation, include the total number of patient encounters attributable patient encounters of ALL practitioners at the clinic/group practice that bill for services, eligible professionals and non-eligible professionals.
- **Out of State Encounters:** If the report includes out-of-state Medicaid/needly encounters, identify how many of the total number of encounters per provider were with patients from out of state. Please see note below on out-of-state encounters.

### Note on Out-of-State Encounters

If a provider has out-of-state encounters for the period, Medicaid will include them only if this is needed to meet the patient volume threshold. Identify the number of out of state encounters in the report and if they are needed for you to meet the patient volume threshold, Medicaid will contact you to get the details of those encounters.

### Submission of Provider Patient Volume Report

The Provider Patient Volume Report is uploaded as part of the attestation process in the Idaho Incentive Management System (IIMS). The report must be in PDF format.

### State Validation Process

The patient volumes will be validated pre-payment against available data in Idaho's Medicaid Management Information System (MMIS) for Medicaid encounters. "Needly Encounters" and "Total Patient" encounters will be validated on a post-payment basis during audit.

### Additional Information

For questions about this or other issues concerning the Idaho EHR Incentive Program, please go to [www.MedicaidEHR.dhw.idaho.gov](http://www.MedicaidEHR.dhw.idaho.gov). There you will find an "Ask the Program" feature that will allow you to send questions to program staff. You can also call the Idaho Medicaid EHR Program Helpdesk at (208) 332-7989.