Calculating Patient Volume: What You Need to Know to Successfully Attest
Frequently Asked Questions

Questions	Responses
Once we have attested our 30% Medicaid volume, do we have to meet that same percentage each year we attest?	Yes; the patient volume requirement of at least 30% Medicaid or needy patients (for FQHC/RHC providers) is a requirement for every year you attest for the Medicaid EHR Incentive Program.
Who can count "needy" patient encounters in their patient volume?	Needy encounters can be counted in the patient volume calculation by any eligible provider if he/she practices predominantly at an FQHC/RHC. Needy patient encounters can be claimed in either group or individual patient volume.
Should dental encounters be included in the patient volume calculation?	If the attesting provider is a dentist, or if it is for group patient volume and dentists practice at the clinic, then yes, dental encounters would be included in the patient volume calculation.
Do we include non-credentialed provider visits in our patient volume calculation?	If it's for group patient volume, yes; include all encounters at the clinic regardless of provider type. If it's for an individual, you would only count encounters where he/she provided services to the patient.
If a provider is listed as the performing provider, are all this provider's encounters (including telemedicine or immunizations) included in the patient volume calculation?	If the provider provided the services to the patients (including telemedicine and immunizations), then the encounters would be included in the denominator, as well as the numerator if patients are Medicaid-eligible (and/or needy for FQHC/RHC providers). If the provider did not provide the services (including immunizations) then you would not count these encounters in his/her patient volume. For group volume, count all encounters at the clinic, regardless of provider type and who administered the service.
If we have an internal lab and are attesting for an individual provider, do lab visits on dates of service where the patient does not see the provider count in the patient volume calculation?	No; these lab visits would not be counted in the patient volume calculation since the patient did not receive services from the attesting provider.
How would you count "flu shot only" visits in the patient volume calculation?	If the attesting provider provided the service, count these encounters in the denominator, and in the numerator as well for Medicaid-eligible patients (and/or needy patients for FQHC/RHC providers). For group patient volume, count all encounters, regardless of provider type or visit type.
Do prenatal visits that are not billed individually count toward patient volume?	Yes; prenatal visits are to be counted in the denominator, even if they are not billed until delivery. If the patient is Medicaid-eligible, these prenatal visits would be counted in the numerator as well.

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Are patients with double insurance, (private and Medicaid) counted toward our percentage of Medicaid patients?	Yes; any encounters with patients who have active Medicaid eligibility are to be counted in the numerator, even if Medicaid is billed as a secondary or tertiary insurance.
If a clinic bills under multiple NPIs and attests with group patient volume, how is it determined which providers to include in the patient volume calculation?	In this situation there are two possibilities: 1) If each location of a clinic has a separate NPI for billing, you could include all providers at the location for the patient volume calculation; 2) however, if there is only one NPI for all clinic locations, you would need to include all encounters from all locations in the patient volume calculation.
What is meant by "unique patient count"?	Unique patient count is used for Meaningful Use Objectives, not patient volume. Unique patient count represents all individual patients seen during the reporting period. When determining patient volume, do not use unique patient count, because that will lead to an inaccurate and greatly limited patient volume. Encounters used for patient volume calculation are counted as one per patient, per provider, per day.
If a patient is seen by the same provider twice in one day, but the provider uses two different TINs for billing, can these be counted as two encounters in the patient volume calculation?	No; this would only count as one encounter in the denominator, and if the patient is Medicaid-eligible, in the numerator once. Encounters are counted as one per patient, per provider, per day.
The CHIP proxy for Oregon is 95.6%?	Yes; that is correct. Only apply the CHIP proxy to your Oregon Medicaid count when calculating patient volume. Also, the CHIP proxy is only for non-FQHC/RHC providers.
Does the CHIP proxy apply to encounters that took place in Oregon if the patient lives in a different state?	The CHIP proxy only applies to encounters billed to Oregon Medicaid. If the Medicaid patient lives out of state but was treated in Oregon, it is considered an out-of-state encounter because the patient is Medicaid-eligible in another state. These out-of-state Medicaid encounters would be added to the numerator after the CHIP proxy is applied to the Oregon Medicaid count.
Do we have to upload an Excel spreadsheet for patient volume encounters if my software company provides a report?	If the report provided by your vendor provides individual encounters, then yes, that is acceptable. However, if it is merely an aggregate report, then no, that is not acceptable. The report must contain individual encounters and include the dates of service, the patient ID, Medicaid ID, amount billed (total amount billed or amount billed to Medicaid), and the rendering provider NPI. Excel is our preferred format. The billing department should be able to provide this.