



North Carolina Medicaid Electronic Health Record
Incentive Program

Eligible Professional Adopt, Implement, Upgrade
Attestation Guide
Year 1 Only

NC-MIPS 2.0

Issue 1.24

October 28, 2016



EP Stage AIU Attestation Guide



The North Carolina Medicaid Electronic Health Record (EHR) Incentive Program is providing this attestation guide as a reference for Eligible Professionals (EP).

For additional information, please visit the NC Medicaid EHR Incentive Program website, <https://www2.ncdhhs.gov/dma/provider/ehr.htm> or email our help desk at NCMedicaid.HIT@dhhs.nc.gov.

*EPs attesting to adopt, implement, upgrade (AIU) have the option to submit their attestation through the mail or email. If submitting an attestation via email, a hard copy is NOT required. Please note, an EP attesting to Meaningful Use **must** submit their attestation via email.

***Email:** NCMedicaid.HIT@dhhs.nc.gov

Mail: NC Medicaid EHR Incentive Program
2501 Mail Service Center
Raleigh, NC 27699-2501



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Using This Guide

Introduction

This guide can be used as a reference to help an eligible professional (EP) understand the information needed to register and attest for an NC Medicaid EHR incentive payment on the NC Medicaid Incentive Payment System (NC-MIPS). Step by step guidance and screenshots are provided throughout the attestation guide to assist participants with their attestation. Please note, this is not a static document and it is subject to updates, so please check NC-MIPS for the most up-to-date guide each year of participation.

The NC-MIPS Portal is available online at <https://ncmips.nctracks.nc.gov/>. Please check the NC-MIPS Home Page for important program updates and announcements. For additional help, there is a link on each page of the Portal entitled *Click for Page Help*. When you click the link, a PDF version of this attestation guide will appear, showing the section of the guide that pertains to the Portal page in use.

Website Resources

The links below contain additional information regarding program requirements, important program announcements and more.

- EPs may attest for incentive payments on the NC-MIPS Portal at <https://ncmips.nctracks.nc.gov/>.
- The NC Department of Health and Human Services (DHHS) administers this program. More information on the this program can be found on the NC Medicaid EHR Incentive Program website at <http://www2.ncdhhs.gov/dma/provider/ehr.htm>.
- Additional information on both the Medicare and Medicaid EHR Incentive programs is available from the Centers for Medicare & Medicaid Services' (CMS) EHR Incentive Program website at www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/.

Technical Assistance

We provide program resources on [NC-MIPS](#), our [incentive program website](#), and our [frequently asked questions page](#). In addition to these resources, you can contact our technical assistance partners at your local Regional Extension Center to provide more personalized attestation assistance.

NC Area Health Education Centers (AHECs)/Regional Extension Centers (REC)

<http://www.ncahec.net>

919-966-2461

ncahec@med.unc.edu



As a federally-designated Regional Extension Center (REC), the North Carolina Area Health Education Center's Program (NC AHEC), provides individualized, on-site electronic health record (EHR) consulting tailored practice's specific needs. Consultants from the REC can help practices:

- Assess and redesign current office systems.
- Identify and enhance workflows within a practice.
- Evaluate and select the certified EHR system that meets a practice's needs and are equipped to help that practice meet requirements of EHR "meaningful use".
- Evaluate and adjust new processes within a practice and support implementation of the new EHR system or an upgrade to a certified EHR system.
- Establish and follow an EHR implementation plan to help meet target "go-Live" dates, avoid common challenges and minimize disruptions in order to successfully implement and EHR.
- Achieve state and federal standards to qualify for "meaningful use" of EHR incentive payments.
- Analyze a practice's readiness to apply for the HITECH Act "Meaningful Use" Incentive payments.
- Use the EHR as a tool to help improve care and satisfaction of the physician, staff and patients.

Unsure of Eligibility?

To determine program eligibility, CMS has developed an online tool that can be accessed at <http://cms.gov/apps/ehealth-eligibility/ehealth-eligibility-assessment-tool.aspx>.

To be eligible to receive an NC Medicaid EHR incentive payment, a provider must:

1. Meet the 30% Medicaid Patient Volume (PV) threshold (this needs to be calculated every year of program participation);
2. Have a certified EHR technology (In 2016 and 2017, providers can choose to use technology certified to the 2014 Edition or the 2015 Edition. Please see [ONC's product health IT website](#) for additional information); and,
3. Be an eligible provider type.

***Please note, eligibility requirements must be met every year of program participation.**

Please see the [NC Medicaid EHR Incentive Program website](#) for more information about these eligibility requirements. The website also contains helpful program announcements, program guidance, requirements, resources, useful links and more.

If the user is experiencing NC-MIPS issues, please email NCMedicaid.HIT@dhhs.nc.gov. Please include the provider name, NCID, NPI, program year, a screenshot of the error message being received (if applicable) and a brief explanation of the problem.



Outreach and Denials

For attestations submitted at least 30 days prior to the close of the program year tail period, we will conduct outreach via email with guidance to correct any issues we find with the attestation that would not result in automatic denial. An EP will have up to 15 calendar days to address the discrepancies.

There are some situations that result in automatic denial, including when an EP attests that s/he

- does not meet the Medicaid patient volume requirement (reports less than the required Medicaid patient volume)
- cannot demonstrate meaningful use (MU attestations submitted with an incomplete/invalid MU Measure Set or attesting to AIU in participation years two through six)

If an EP is denied, s/he may re-attest without penalty. So long as the EP attests for a total of six years, s/he may earn the full incentive payment. Please note, if the EP is denied and the program year has closed, s/he will need to re-attest for the next available program year.

EHR Incentive Program Overview

The NC Medicaid EHR Incentive Program awards incentive payments to EPs who use certified EHR technology in their daily operations.

As a part of the federally-funded Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, the goal of the program is to provide more effective health care by encouraging EPs to adopt, implement, or upgrade (AIU) to a certified EHR technology, and then to demonstrate Meaningful Use (MU) of that technology. The program is slated to continue through 2021.

EPs may receive up to \$63,750 in incentive payments over six years of program participation. Participation years do not need to be consecutive, but EPs must successfully attest for six program years to earn the full incentive payment. So, EPs must begin their first year of participation no later than Program Year 2016.

The first incentive payment for those who meet the 30 percent Medicaid PV threshold is \$21,250. Five additional payments of \$8,500 are available for providers who successfully demonstrate MU. For the first program year, EPs will only need to attest that they adopted, implemented, or upgraded (AIU) to a certified EHR technology. EPs may elect to bypass AIU and attest to MU in their first year of program participation, but every participant will be required to attest to MU in participation years two through six (please reference the EP MU Attestation Guide if attesting for MU).

AIU is defined as:



EP Stage AIU Attestation Guide



Adopt – acquired, purchased or secured access to certified EHR technology.

Implement – installed or commenced utilization of certified EHR technology.

Upgrade – expanded the available functionality of certified EHR technology.

Attestation Tail Period

North Carolina has a 120-day attestation tail period to allow for attestation beyond the end of the calendar year. This means, EPs have until April 30, 2017 to attest for Program Year 2016. That being said, **please attest before March 31, 2017** so there is time to address any attestation discrepancies. The information submitted on NC-MIPS must be complete and valid by April 30th. We will not accept memorandums in lieu of accurate information submitted through NC-MIPS. NC-MIPS will close for Program Year 2016 on April 30th, so no changes may be made to the attestation after this date.



Before You Begin Attesting

Registering for the Program

If new to the program, the first step is to register on [CMS' Registration & Attestation System](#) (CMS' R&A) at <https://ehrincentives.cms.gov/hitech/login.action>.

Although CMS doesn't require it, you must enter a valid 2014 or 2015 EHR Certification Number when prompted by CMS. EHR certification numbers are required by North Carolina. In 2016 and 2017, providers can choose to use technology certified to the 2014 Edition or the 2015 Edition.

NOTE: It is during CMS registration that an EP will assign payment to a specific payee NPI/payee TIN. Please check to ensure that the payee information is correct and that the payee NPI and payee TIN are on file with NCTracks.

If the provider has never attested for an incentive payment with NC, but has registered with CMS, set up an account in NC-MIPS by completing a **one-time** First Time Account Set-up. EPs will be prompted to enter the following information to create an NC-MIPS account:

- CMS Registration ID;
- Same provider National Provider Identifier (NPI) used when registering with CMS;
- Last four digits of the payee TIN used when registering with CMS (SSN or EIN); and,
- Same North Carolina individual Medicaid Provider Number (MPN) used when registering with CMS. *NOTE: If the EP does not know their MPN or registered with NC Medicaid on or after July 1, 2013, please enter an MPN of XXXXXXXX for that provider.*

NCID Username and Password

NCID is the standard identity management and access service used by the state. To access NC-MIPS, a unique working NCID username and NCID password is required. **Groups cannot share a username and password.** Before attesting, please check to ensure the NCID username and NCID password are valid by logging onto NCID's website at <https://ncid.nc.gov>. If an EP does not have a NCID account, follow these instructions:

1. Visit NCID's website at <https://ncid.nc.gov>.
2. The NCID login website displays.
3. Click on the *Register!* Link.
4. Select the type of account from the drop down list.
5. Click *Submit*.
6. Enter information in the required fields.
7. Click *Create Account*.

If there are any issues with an EP's NCID, please contact the NCID help desk by email at its.incidents@its.nc.gov or by phone at 919-754-6000 or 1-800-722-3946.

If you have forgotten your NCID password, click the *Forgot Password* link, which will take you to the NCID website for recovering the password. If you need assistance with setting up an NCID



account, or for login or password assistance, please call the NCID Customer Support Center at 800-722-3946 or 919-754-6000.

If the EP's NCID username has been updated since completing a First Time Account Setup, please select the NCID Username Update option in the Sign In box on the Welcome Page in NC-MIPS to update the EP's NCID username using the NC-MIPS NCID Username Update tool.

Additional Tips

NC-MIPS will save unfinished attestations for 30 days, during which time a user will be able to return and complete a submission.

If at any point in the attestation process, the EP realizes s/he does not meet the eligibility requirements for participation in this program, the attestation may be canceled on the status page within the NC-MIPS Portal (refer to the [Provider Status page](#) for more information). Please remember that even if an EP does not qualify for participation in the Medicaid EHR Incentive Program this Program Year, s/he may attest for a later program year. *EPs must successfully attest for six program years to earn the full incentive payment and must begin their first year of participation no later than Program Year 2016.*

Supporting Documentation

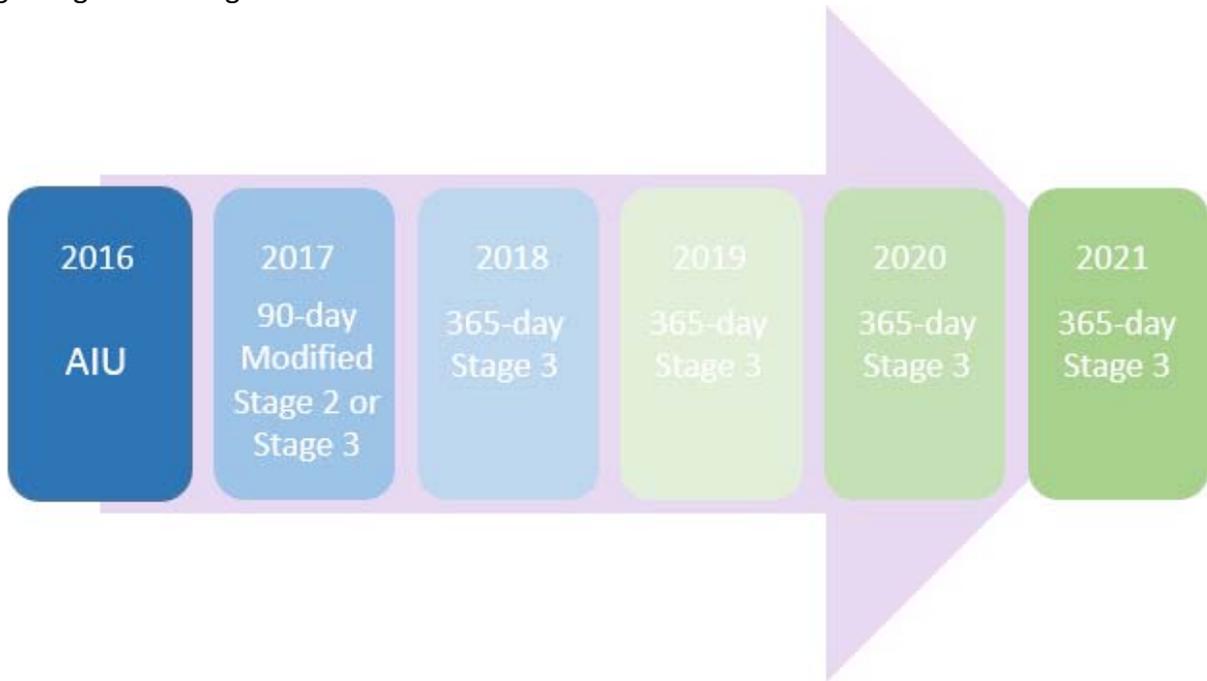
After attesting, it is recommended that the following documents (if applicable) be emailed with the EP's signed attestation:

- A copy of the EP's medical license;
- Documentation illustrating that an EP has adopted, implemented, or upgraded to certified EHR technology (for example: a purchase order or contract);
- PAs are only eligible to participate if they furnish services at a PA-led FQHC/RHC. This applies to all PAs in a practice. If an EP is attesting to meeting PA eligibility requirements, s/he must submit on letterhead a memo explaining s/he meets one of the three following criteria:
 1. When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider);
 2. When a PA is a clinical or medical director at a clinical site of practice; or,
 3. When a PA is an owner of an RHC.

Attestation Process Overview

The purpose of attesting to AIU is to show that an EP has adopted, implemented, or upgraded to certified EHR technology. After the first program year, the EP will need to demonstrate meaningful use (MU) of that certified EHR technology. Please use the EP MU Attestation Guide if attesting to MU.

The figure below reflects what EPs may attest to each year of program participation when beginning AIU in Program Year 2016.





NC-MIPS Portal

The NC-MIPS Portal consists of interactive web pages that will guide a user through the attestation process, prompting the user to provide information and answer questions about their use of certified EHR technology. Dialog boxes and messages help a user enter the required information and will provide tips when the system recognizes a problematic entry. Required information is marked with a red asterisk.

The NC-MIPS Portal is compatible with Internet Explorer 7 (or later), as well as Firefox 8 (or later).

The NC-MIPS Portal can be accessed online at <https://ncmips.nctracks.nc.gov/>. When attesting for the first time, users will be guided through the following pages:

- [Welcome](#)
- [First Time Account Setup](#)
- [Provider Status](#)
- [Demographics](#)
- [Contact Information](#)
- [License](#)
- [Practice Predominantly/Hospital-Based](#)
- [Patient Volume](#)
- [AIU/MU](#)
- [Congratulations](#)
- [Electronic Submission](#)
- [Print, Sign, Send](#)

Each one of these steps will be covered in detail in this guide. The goal is to help EPs attest properly so that incentive payments are made as quickly as possible, without the need to request additional information after the attestation is completed.



NC-MIPS Portal Page Layout

To ensure consistent navigation, each page of NC-MIPS has a similar look and feel.

The top left logo is a link to the North Carolina Health Information Technology (HIT) website. The top right logo is a link to the CMS website for the EHR Incentive Program.

The right side of the page contains five commonly used navigation tools:

- Sign In (once the EP has signed in this box will change to *Logout*)
- Page Help
- Jump to... (*Jump to* is available once the EP is logged in)
- Additional Information
- Contact Information
-



Sign In

First time users must first [register](#) with CMS. After receiving CMS confirmation, EPs will receive a Welcome Letter from the NC Medicaid EHR Incentive Program inviting them to attest in NC-MIPS. Then, the EP should log onto the NC-MIPS Portal and create an NC-MIPS Account by clicking *First Time Account Setup*. **If an EP already has an account with NC-MIPS, do NOT complete another *First Time Account Setup*.**

The *First Time Account* link takes the user to the *First Time Account Setup* page. Here the EP enters their unique NCID username and NCID password along with other identifying information to create a unique provider record within NC-MIPS.

Trouble logging in?

This NC-MIPS attestation guide will walk you through each step of creating an account, updating an account, and logging in. Please carefully review the sections of this guide on First Time Account Set-up, NCID Username Update Tool, and NCID Username and Password. You can also review these five questions as they address the most common issues with logging in.

1. Did you register on CMS' Registration & Attestation portal & indicate that you want to participate in the NC Medicaid EHR Incentive Program? You must register for the Medicaid EHR Incentive Program through CMS at <https://ehrincentives.cms.gov/hitech/login.action>
2. Do you have a unique NCID? If not, please visit www.ncid.nc.gov.
3. Have you completed the NC-MIPS 'First Time Account Set-Up' using the exact same NPI, Social Security Number, CMS confirmation number, and NCID/Username used during CMS registration?
4. Has the EH's NCID username been updated since completing a First Time Account Setup? If so, use the NC-MIPS NCID Username Update Tool to update the EH's NCID username in NC-MIPs.
5. Does your information provided with CMS match exactly the information provided on NCTracks? If not, visit www.nctracks.nc.gov or <https://ehrincentives.cms.gov> to update the information.

If the user has issues with NC-MIPS, please send an email to NCMedicaid.HIT@dhhs.nc.gov and include the following information: Provider's name, NPI, NCID username, CMS Registration ID, Program Year, a screenshot of the information being entered and the error message being received, and a brief description of the issue.

Page Help

The *Click for Page Help* link opens a PDF version of this attestation guide to the page that



corresponds to the page the user is viewing. If the user does not have Adobe Acrobat to view the PDF, there is a link to download the free Adobe Reader software in the “Additional Information” area below.

Jump to...

Clicking Next will allow a user to follow the normal attestation process flow in the Portal. However, there may be occasions that a user wants to jump to a particular page. Jump to provides links to other pages so that a user can easily navigate the Portal.

NOTE: A user is only able to jump only to the pages where data has been entered.

Additional Information

This area provides links to attestation guides and helpful web sites.

The *Eligible Professional Attestation Guide* link opens this attestation guide in a new browser.

To download the free Adobe Reader software, click *Download Adobe Acrobat*.

To learn more about the NC Medicaid EHR Incentive Program, visit <http://www2.ncdhhs.gov/dma/provider/ehr.htm>.

Contact Information

This area contains the email address for the NC-MIPS Help Desk. Please email NCMedicaid.HIT@dhhs.nc.gov if there are questions about the attestation process that cannot be answered using the resources provided.

Footer

Found at the bottom of the page, the footer has a *Contact us* link to contact the NC-MIPS Help Desk. It also has a link to view the NC-MIPS Portal *Disclaimer*.

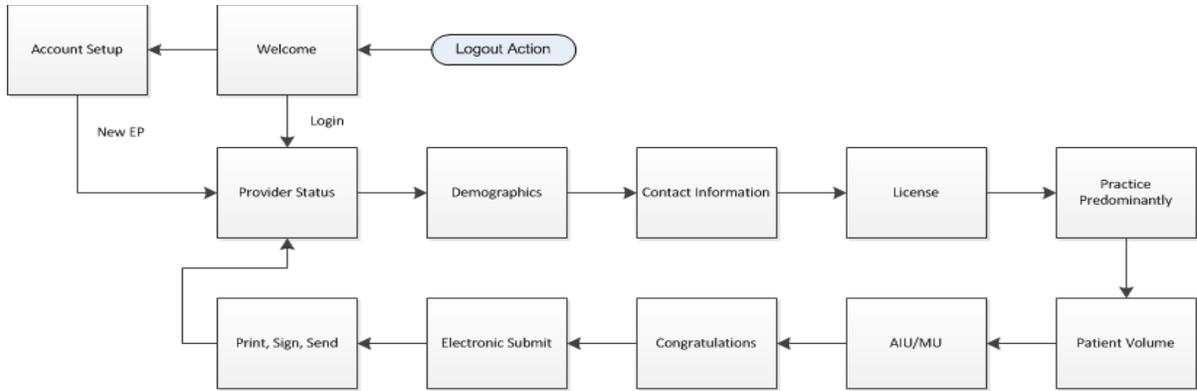
The version number is the release number of the NC-MIPS Portal software.

Navigation

The NC-MIPS Portal is designed to help a user navigate seamlessly through NC-MIPS. Once you have completed the information requested on a page, click *Next* to proceed to the next page. NOTE: If any required fields are left blank, a message will prompt the user to complete the missing fields.

To change previously entered information, you can click the *Previous* Button to navigate a user back to the previous page. The typical Portal page navigation is shown in the figure below.

EP AIU Attestation Guide



Welcome

The Welcome page is the first page that a user will see when accessing the NC-MIPS Portal.



The screenshot shows the NC-MIPS Portal Welcome page. At the top left is the North Carolina Health IT logo, and at the top right is the EHR Incentive Program logo. The main heading is "Welcome to the NC-MIPS Portal". Below this, there is a text box stating: "Program Year 2016 is the last year an EP may begin participating in the NC Medicaid EHR Incentive Program and the last year an EP may attest to AIU." Another text box follows: "If your NCID username has been updated on ncid.nc.gov since creating your First Time Account Setup with NC-MIPS, please use the NC-MIPS NCID Username Update tool to update your NCID with NC-MIPS. This tool will allow an EP to login to NC-MIPS using their updated NCID username. Please note, the NC-MIPS NCID Username Update Tool will only allow you to update an already updated NCID username on NC-MIPS. If you need to update your NCID username and password, please do so on NCID's website at ncid.nc.gov." Below this, it says "NC-MIPS is North Carolina's Medicaid EHR Incentive Payment System." and "The NC-MIPS Portal will guide Eligible Professionals (EPs) and Eligible Hospitals (EHs) through the attestation process for the North Carolina Medicaid Electronic Health Record (EHR) Incentive Program. For more information on NC-MIPS or the EHR Incentive Program, please refer to the links on the right." There is a "Tips for Navigation" section: "We have designed the NC-MIPS 2.0 Portal to be intuitive and user-friendly, but if at any point during your attestation you have a question, click on the [Click for Page Help](#) link on the right rail. This link will take you to the page in the Attestation Guide that corresponds to the page of the Portal you are viewing. If after viewing the guide, you still have questions, please let us know. Throughout the Portal, the contact information for the NC-MIPS Help Desk will be displayed on the right rail." On the right side, there is a "Sign In" box with fields for "NCID Username" (containing "Testmips127") and "NCID Password" (masked with dots), a "Login" button, and links for "First time Account Setup?", "Forgot Username?", "Forgot Password?", and "NCID Username Update". Below the sign in box is a "Click for Page Help" button. Further down is a "For Additional Information" section with links: "EP AIU Attestation Guide", "EP Modified MU Attestation Guide", "EH AIU/MU Attestation Guide", "Download Adobe Acrobat to read guides", and "DMA Incentive Program home page". At the bottom right is a "Contact Information" section: "Can't find what you need in the NC-MIPS Attestation Guide?" "NC-MIPS Help Desk" "Email: NCMedicaid.HIT@dhs.nc.gov". At the very bottom, it says "Contact Us - Disclaimer - Version: 2.1.35.01" and "© Copyright 2016 State of North Carolina, all rights reserved."

There may be important announcements at the top of the page, so please read that section carefully before attesting.

First-time users:

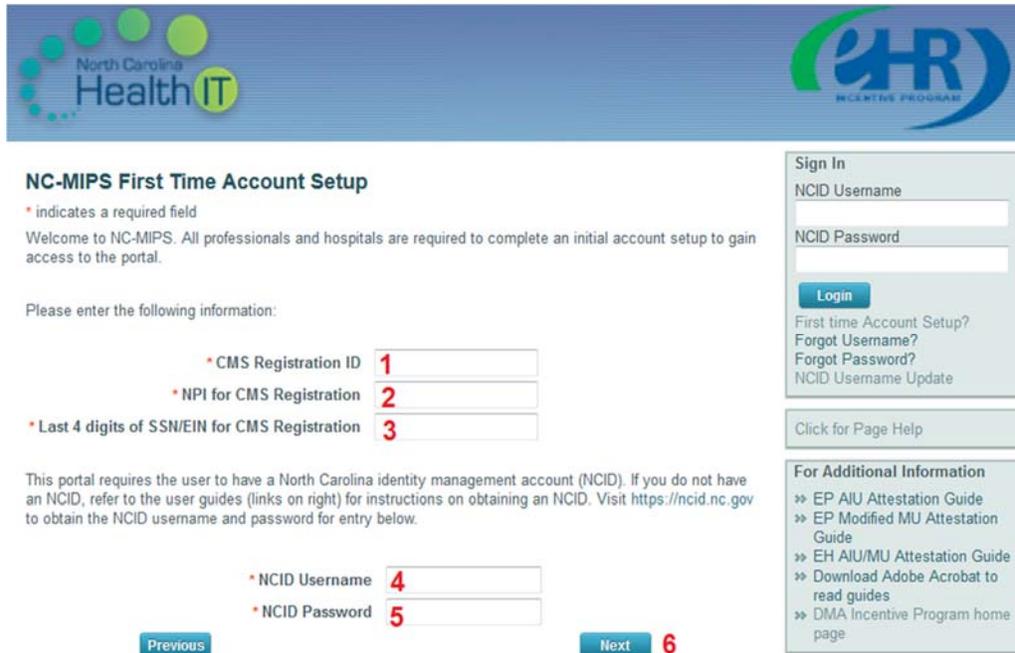
1. Click the link [First Time Account Setup](#).
2. The [First Time Account Setup page](#) opens.

Returning users:

1. Sign in by entering the EP's unique NCID Username and NCID Password. (If the EP's NCID username has been updated since completing a First Time Account Setup, please select the NCID Username Update option in the Sign In box on the Welcome Page to update the EP's NCID username using the NC-MIPS NCID Username Update Tool.)
2. Click *Login*.
3. The [Provider Status](#) page opens.

First Time Account Setup

The First Time Account Setup page is used for setting up an NC-MIPS account for the first time. This will only be done **one time**.



NC-MIPS First Time Account Setup

* indicates a required field

Welcome to NC-MIPS. All professionals and hospitals are required to complete an initial account setup to gain access to the portal.

Please enter the following information:

- * CMS Registration ID **1**
- * NPI for CMS Registration **2**
- * Last 4 digits of SSN/EIN for CMS Registration **3**

This portal requires the user to have a North Carolina identity management account (NCID). If you do not have an NCID, refer to the user guides (links on right) for instructions on obtaining an NCID. Visit <https://ncid.nc.gov> to obtain the NCID username and password for entry below.

- * NCID Username **4**
- * NCID Password **5**

[Previous](#) [Next](#) **6**

Sign In

NCID Username

NCID Password

[Login](#)

[First time Account Setup?](#)
[Forgot Username?](#)
[Forgot Password?](#)
[NCID Username Update](#)

[Click for Page Help](#)

For Additional Information

- » EP AIU Attestation Guide
- » EP Modified MU Attestation Guide
- » EH AIU/MU Attestation Guide
- » Download Adobe Acrobat to read guides
- » DMA Incentive Program home page

To complete a First Time Account Setup with NC-MIPS:

1. Enter EP's CMS Registration ID. This number is always provided by CMS after an EP registers on CMS' Registration & Attestation (R&A) System.
2. Enter the same **provider** NPI used during CMS registration.
3. Enter the same Last 4 digits of payee TIN type used on CMS' R&A system.
 - a. Generally speaking, if an EP is assigning the payment to themselves, they will use their social security number as the payee TIN type.
 - b. Generally speaking, if an EP is assigning the payment to the group, they will use the group's EIN number as the payee TIN type.

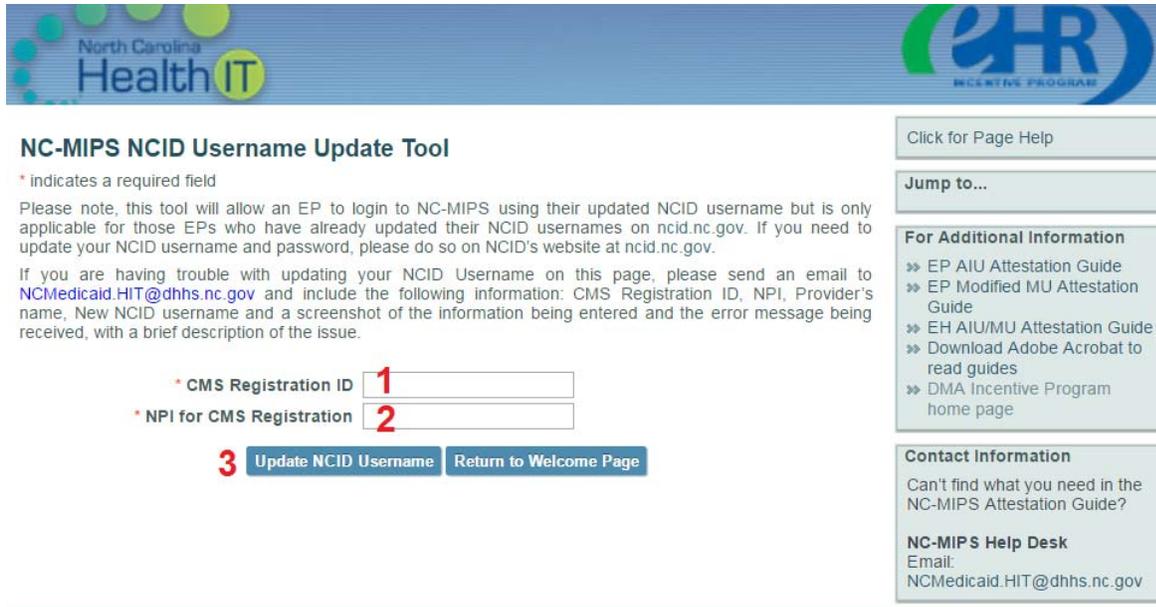
EPs may update the payee information at any time on CMS' R&A system.

4. Enter EP's NCID unique username.
5. Enter EP's NCID unique password.
6. Click *Next*.
7. The [Provider Status](#) page opens.



NCID Username Update Tool

If the EP’s NCID username has been updated since completing a First Time Account Setup, use the NC-MIPS NCID Username Update Tool to update the EP’s NCID username in NC-MIPS.



To update the EP’s NCID username in NC-MIPS

1. Enter EP’s CMS Registration ID. This number is always provided by CMS after an EP registers on CMS’ Registration & Attestation (R&A) System.
2. Enter the same NPI used during CMS registration.
3. Click the *Update NCID Username* button.

NC-MIPS NCID Username Update Tool

* indicates a required field

Please note, this tool will allow an EP to login to NC-MIPS using their applicable for those EPs who have already updated their NCID username your NCID username and password, please do so on NCID’s website at [n](#)

If you are having trouble with updating your NCID Username on [NCMedicaid.HIT@dhhs.nc.gov](#) and include the following information: name, New NCID username and a screenshot of the information being received, with a brief description of the issue.

4. Enter the EP’s new NCID username
5. Click *Save*.

* CMS Registration ID

* NPI for CMS Registration

Provider Name John Public

Current NCID Username youngc

* New NCID Username

5

Then the [Welcome](#) page will open so the EP can sign in by entering the updated NCID Username and the EP’s NCID Password.

Provider Status

The Provider Status page shows a history of the EP’s past and present attestations.

Status

Provider Name	Jose Four
CMS Registration ID	1000003024
NPI	2000003024
MPN	2154455

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	Proceed
2014	1	Closed - No Attestation Submitted	

Provider Status page shows the:

- **Program Year:** the program year for which the EP attested (up to six years from 2011 – 2021).
- **Payment Year:** the participation year (1 through 6).
- **Status:** an automatically updated description of where the EP is in the attestation validation process for a submitted attestation.

The Status page will pre-populate the providers’ status based on their history of participation.

Users are able to track their attestation as it moves through the attestation validation process, by logging into NC-MIPS and visiting the Status page. Possible statuses are:

- **Closed – no attestation submitted:** no attestation was submitted for that Program Year.
- **Attestation in process:** the EP is in the process of attesting.
- **Waiting for Signed Attestation:** the signed attestation has not yet been received. We cannot begin validations without a signed attestation (signed by the attesting EP).
- **Validating Attestation:** after the attestation is submitted, it will go through a series of validation checks and approvals at the state and federal levels.
- **Awaiting Provider Information:** additional information was requested and we are waiting for the discrepancy to be addressed before moving forward with validations.
- **Canceled:** EP cancels her/his ‘in-process’ attestation, thereby signaling s/he would not like to participate for the current program year.
- **Withdrawn:** EP withdraws her/his ‘submitted’ attestation, thereby signaling s/he no longer wishes to continue the attestation process for the current program year. Please note, when an attestation is withdrawn, previously entered information will be saved in the system.
- **Paid:** the attestation has been paid.
- **Attestation denied:** attestation was denied because the EP did not demonstrate that s/he met all of the program requirements.

- Activity Date: date of the last activity.

There are five buttons that may be available for each attestation:

- Proceed: proceed to the attestation.
- Cancel: before submitting the attestation, stop this attestation. The contact person will no longer be contacted about a canceled attestation. This is not a permanent action. The EP may return to the attestation after the attestation is canceled.
- Withdraw: after submitting the attestation, stop this attestation. The contact person will no longer be contacted about an attestation that was withdrawn. This is not a permanent action. The EP may return to the attestation after the attestation is withdrawn.
- Re-Attest: If denied, the EP may re-attest at any point before the end of the tail period.
- View/Print: view the attestation in a form that can be printed.

If the EP has not attested in years past, there will only be one attestation for the current program year. To proceed with an attestation:

1. Click *Proceed* for the attestation you want to continue.
2. The [Demographics page](#) opens, and from here NC-MIPS will lead the EP through the attestation process.

If the EP wants to cancel participation in a given year:

1. Click *Cancel* for that program year.
2. There will be a pop-up warning message: "Canceling participation will stop communications regarding activities for this program year. The attestation can be reinstated any time by clicking *Proceed*."
3. To cancel the program year, click *OK*. The status changes to "Canceled."
4. If the EP does not wish to cancel the program year, click *Cancel*. The warning message box closes with no action performed.

To view or print an attestation:

1. Click *View/Print* to view or print a particular attestation.
2. A PDF of the attestation opens.
3. To print the attestation, use the window controls for printing.

Once reaching the Status page, users will see one of the scenarios described below. Please note, these examples are not from the current program year.



EP AIU Attestation Guide



Example 1: 'Program Year' 2014 has expired and the EP is ready to attest for 2015. The Program Year 2014 row will be marked as "Closed-No Attestation Submitted" and the Program Year 2015 row will be active.

Status

Provider Name	Jose Four
CMS Registration ID	1000003024
NPI	2000003024
MPN	2154455

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	Proceed
2014	1	Closed - No Attestation Submitted	

Example 2: The Program Year 2012 has expired and 2013 program year has been "Paid". EP didn't return for program Year 2014 and is ready to attest again for Program Year 2015.

Program Year	Payment Year	Current Status	Activity Date
2015	2	Attestation in Process	Cancel Proceed
2014	2	Closed - No Attestation Submitted	
2013	1	Paid	03/28/2013 View/Print
2012	1	Closed - No Attestation Submitted	

Example 3: Program Year 2014 and Program Year 2015 are both active; therefore, the EP can choose to attest for either Program Year 2014 or Program Year 2015. The red message does not prevent an EP from moving forward with an attestation. Please click 'Proceed' next to the Program Year for which they're attesting.

Status

Please complete your attestation with the current program year 2014 before attesting for 2015.

Provider Name	General Hospital
CMS Registration ID	1000003081
NPI	2000003081
MPN	4764376

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	Proceed
2014	1	Attestation in Process	Proceed
2013	1	Closed - No Attestation Submitted	

Example 4: Two program years (2014 & 2015) are active. When the EP chooses to attest for Program Year 2014, the status for Program Year 2015 becomes “Cancelled”.

Program Year	Payment Year	Current Status	Activity Date
2015	1	Cancelled	<input type="button" value="Proceed"/>
2014	1	Attestation in Process	<input type="button" value="Cancel"/> <input type="button" value="Proceed"/>
2013	1	Closed - No Attestation Submitted	

Example 5: If the Program Year 2014 has been ‘Denied’, the EP will be provided with two options:

- Re-attest for the denied attestation; or,
- Attest for the current program year.

Status

Please complete your attestation with the current program year 2014 before attesting for 2015.

Provider Name John13569 Public13569
CMS Registration ID 1000535274
NPI 1740201458
MPN 7006259

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	<input type="button" value="Proceed"/>
2014	1	Attestation Denied	<input type="button" value="Re-attest"/>
2013	1	Closed - No Attestation Submitted	



Demographics

The Demographics page allows EPs to clearly see the demographic and payee information that was submitted on CMS' R&A system. EPs are encouraged to cross reference the information on NC Medicaid's NTracks to ensure they match between both sources prior to attesting.

Please note, if the North Carolina demographic information is not automatically populating within NC-MIPS, please verify the information on NTracks (additional information below).

Demographics
* indicates a required field

For successful participation in this program, NC requires each provider's demographic data to match the provider data received from the CMS EHR Incentive Program Registration ([Details](#)).

Please verify the NPI and MPN information below. If a MPN is not specified or is incorrect, please update it here. Please note that Payee NPI cannot be changed once the attestation has been approved and submitted for payment. If a NPI is not correct, please update it with [CMS](#) before proceeding.

	Provider	Payee
NPI	2000003027	3000003027
* MPN	<input type="text" value="003027"/>	<input type="text" value="003027"/>

Are the MPNs listed above correct?
 Yes No

If the information in the NC column is not automatically populating within NC-MIPS, please reference NTracks to verify your information. If there are any discrepancies between the information on file with CMS or NTracks, please contact them to update your information.

NTracks (CSC) Call Center: 866-844-1113 or 800-688-6696
 CMS EHR Information Center: 1-888-734-6433 or 1-888-734-6563

If the information matches between what was entered on CMS' R&A system & NTracks, you may continue with your attestation even if the information is not displayed in the NC column on this page.

	From CMS	From NC
First Name	Will	
Middle Name	Joyce	
Last Name	Seven	
Address	1027 Provider Street Waltham NC 27609	

Does the provider information above match?
 Yes No

[Previous](#) [Next](#)

Welcome Will Seven
Not Testmips127? Click here.
[Logout](#)

[Click for Page Help](#)

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- » Congratulations
- » Electronic Submit

For Additional Information

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- » EP Modified MU Attestation Guide
- » EH AIU/MU Attestation Guide
- » Download Adobe Acrobat to read guides
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Contact Information

Can't find what you need in the NC-MIPS Attestation Guide?

NC-MIPS Help Desk
Email: NCMedicaid.HIT@dhhs.nc.gov

Only the MPNs can be updated or corrected on this page.

Unmatched demographic information may result in the delay or denial of an incentive payment. If the information does not match, please update the information with CMS or NTracks, before continuing:

NTracks (CSC) Call Center: 800-688-6696

CMS EHR Information Center: 1-888-734-6433 or 1-888-734-6563 (*Updates made with CMS take at least 24 hours to populate in NC-MIPS*)



To check the demographic information:

1. Review the EP's NPI and MPN numbers. *If the EP does not know their MPN or was enrolled with Medicaid on or after July 1, 2013, enter XXXXXXX for the provider's MPN.* If the MPN is blank or incorrect, type in the correct MPN.
2. Answer the question "Is the MPN listed above correct?" by clicking the *Yes* button.
3. Compare the information from CMS and NC. **The NC column will not auto-populate, so check NCTracks and verify the information matches between CMS & NCTracks.**
4. If the CMS information does not match, or is incorrect, please update the information with CMS or NCTracks before continuing (contact information can be found on the NC-MIPS Welcome Page).
5. If the information matches and is correct, click the *Yes* button for "Does the provider information above match?" **Proceed even if the NC column is blank.**
6. Click *Next*.
7. The [Contact Information page](#) opens.

To update a payee TIN type on CMS' R&A system, please follow the guidance below:

1. Go to <https://ehrincentives.cms.gov>
2. Click Continue
3. Check the box, click continue
4. Log in using the NPPES username & password
5. Click on the Registration tab to continue
6. Click on Modify in the Action column to continue
7. Click on Topic 2
8. Change the Payee TIN Type to Group Reassignment
9. Enter the Group information
10. Click Save & Continue
11. Click Save & Continue
12. Click on Proceed with Submission
13. Review the information then click Submit Registration
14. Click Agree

If you have questions about making this update, please contact the CMS EHR Information Center, Monday through Friday at 1-888-734-6433 or 1-888-734-6563 (TTY number) (Hours of Operation 7:30 a.m. – 6:30 p.m – CST – excluding Federal Holidays).

It takes at least 24 business hours for an update made with CMS to be reflected in NC-MIPS.



Contact Information

This page is where you will enter the contact information for the person you want us to contact if there are issues with your attestation. If additional information is needed to validate your attestation, we will contact the person listed on this page. *Email requests to update the contact person are not accepted. To update the contact person, withdraw, re-attest and update the information on this page.*

Contact Information

* indicates a required field

Please complete the requested information for the primary contact person completing the attestation process for the provider.

* Contact Name	Reliable Contact	1
* Phone Number	9199199191	2
* Email Address	reliable@email.com	3

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Welcome Joey Six
Not testmips126? Click here.
[Logout](#)

[Click for Page Help](#)

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For Additional Information

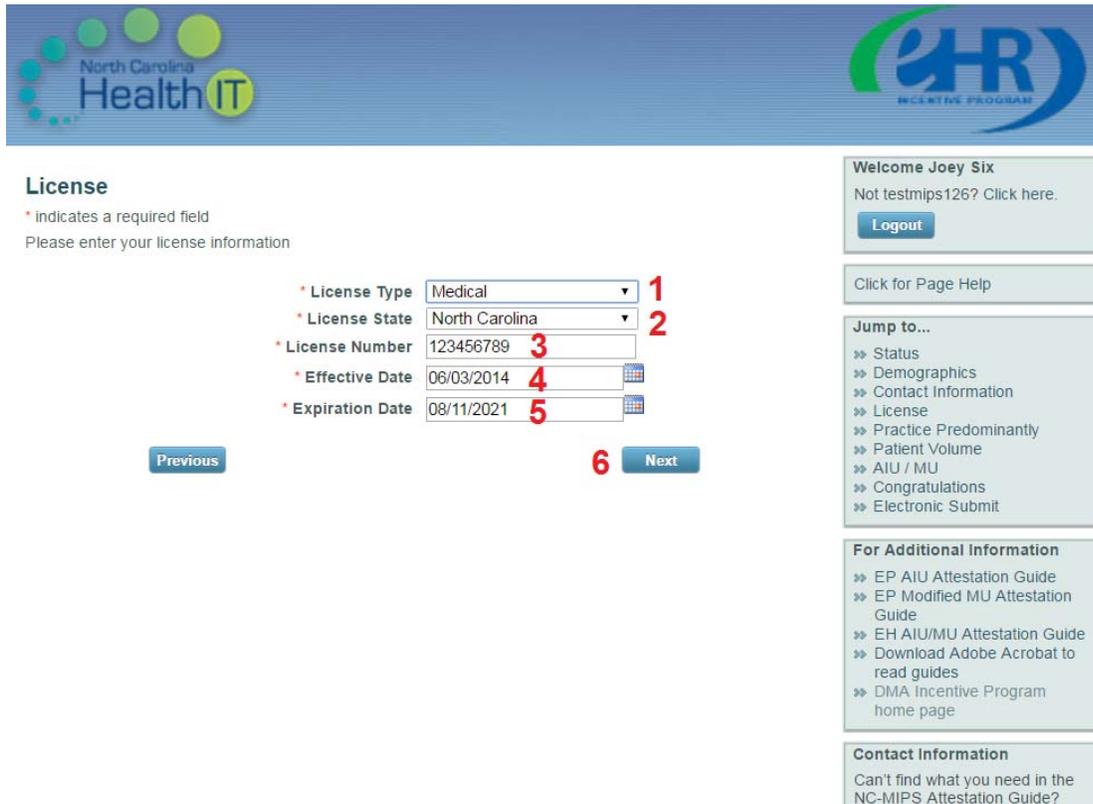
- » EP AIU Attestation Guide
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To enter the primary contact person’s information:

1. Enter the Contact’s Name.
2. Enter the Contact’s Phone Number.
3. Enter the Contact’s Email Address.
4. Click *Next*.
5. The [License page](#) opens.

License

The License page is used to enter an EP's professional license information.



License

* indicates a required field
Please enter your license information

* License Type **1**

* License State **2**

* License Number **3**

* Effective Date **4**

* Expiration Date **5**

6

Welcome Joey Six
Not testmips126? Click here.

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Contact Information
Can't find what you need in the NC-MIPS Attestation Guide?

To enter the EP's license information:

1. Select the EP's License Type from the drop down list.
2. Select the EP's License State from the drop down list.
3. Enter the EP's License Number*.
4. Enter the EP's License Effective Date using the calendar tool or by typing the date.
5. Enter the EP's License Expiration Date using the calendar tool or by typing the date.
6. Click *Next*.
7. The [Practice Predominantly/Hospital-Based page](#) opens.

*Please be sure to enter the license number not the license approval number. The license number cannot be expired on the date of attestation.



Practice Predominantly/Hospital-Based

The Practice Predominantly/Hospital-Based page is used to report whether the EP practiced predominantly at an FQHC/RHC and whether the EP is hospital-based.

An EP who has more than 50 percent of her/his total patient encounters at an FQHC/RHC during any continuous six-month period within the calendar year prior to the program year for which the EP is attesting or in the preceding 12-month period from the date of attestation, qualifies as “practicing predominately” at an FQHC/RHC. If an EP meets the requirement for practicing predominately, they are permitted to use non-Medicaid needy individual encounters toward their 30 percent Medicaid PV threshold.

* Even if an EP practiced predominantly at an FQHC/RHC, they are not required to attest to practicing predominantly if they are not using non-Medicaid needy individual encounters to count toward their PV threshold.

Hospital-based means the EP provided 90 percent or more of his/her Medicaid-covered encounters in an inpatient or emergency room hospital setting. A hospital-based EP is only eligible to participate in the NC Medicaid EHR Incentive Program if they can demonstrate they funded the acquisition, implementation and maintenance of certified EHR technology. This includes the purchase of supporting hardware and any interfaces necessary to meet MU, without reimbursement from an EH or CAH.

If the EP practiced predominantly (greater than 50 percent of all patient encounters during a six-month period) at an FQHC/RHC :

The screenshot shows a web form titled "Practice Predominantly/Hospital-Based". It includes a header with "North Carolina Health IT" and "DMA INCENTIVE PROGRAM" logos. A welcome message for "Joey Six" is visible in the top right. The main form area contains a question: "Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a Federally Qualified Health Center or Rural Health Clinic?". Below this are radio buttons for "Yes" (selected) and "No". A section for "Please enter information for practice predominantly assertion:" includes a date range dropdown menu, a start date field with a calendar icon, an end date field, and two text input fields for "Total Patient Encounters at FQHC/RHC" and "Total Patient Encounters at all Locations". A calculated ratio of "0%" is shown below. Navigation buttons for "Previous" and "Next" are at the bottom. A sidebar on the right contains a "Logout" button, a "Click for Page Help" link, a "Jump to..." menu with links to Status, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, AIU / MU, Congratulations, and Electronic Submit. A "For Additional Information" section contains links to EP AIU Attestation Guide, EP Modified MU Attestation Guide, EH AIU/MU Attestation Guide, Download Adobe Acrobat to read guides, and DMA Incentive Program home page.

1. Select the *Yes* button for “Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at an FQHC, or RHC?”
2. Select the date range on the drop down list. Providers can choose to report on a continuous 90-day period from the previous calendar year (for which the EP is attesting) or from the 12 months preceding the date of attestation.
3. Enter the Start Date of the 6-Month Period using the calendar tool or by typing the date.
4. Enter the number of Total Patient Encounters at FQHC/RHC during the 6-Month Period reported in Step 1. Note that these are the individual EP’s encounters only, not those of a practice group.
5. Enter the number of Total Patient Encounters at all locations. Note that these are the individual EP’s encounters only, not those of a practice group.
6. Review the ratio of encounters that is automatically calculated and displayed to ensure it is greater or equal to 50 percent.
7. Click *Next*.
8. The [Patient Volume](#) page opens.



If the EP **did not** practice predominantly (greater than 50 percent of all patient encounters during a 6-month period) at a FQHC/RHC and **is not** hospital-based:

1. Select *No* when asked “Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at an FQHC, or RHC?”
2. Select *No* for “Did you provide 90% or more of your Medicaid-covered encounters in an emergency or inpatient setting?”
3. Click *Next*.
4. The [Patient Volume](#) page opens.

If the EP **did not** practice predominantly (greater than 50 percent of all patient encounters during a 6-month period) at a FQHC/RHC and **is** hospital-based:

1. Select *No* when asked “Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at an FQHC, or RHC?”



EP AIU Attestation Guide



2. Select *Yes* for “Did you provide 90% or more of your Medicaid-covered encounters in an emergency or inpatient setting?”
3. Select *Yes* or *No* when asked, “Can you demonstrate that you have funded the acquisition, implementation and maintenance of certified EHR technology?”
4. Click *Next*.
5. The [Patient Volume](#) page opens.

Patient Volume

On the Patient Volume page, the EP reports her/his patient volume information including:

1. Patient volume methodology (individual or group)
2. Patient volume reporting period
3. Practice(s) from which patient volume was drawn
4. Number of patient volume encounters

Under individual methodology, an EP will report on only her/his personal patient encounters.

Under group methodology, a practice will calculate the entire group's patient encounters and may use the same patient volume numbers and 90-day patient volume reporting period for every EP that is currently affiliated with the group. So long as s/he has a current affiliation and the group practice's PV is appropriate as a PV methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation), an EP may use the group's PV even if s/he wasn't with the group during the PV reporting period.

Group methodology uses the patient encounter information for the entire group practice (including non-eligible provider types, such as lab technicians) to determine Medicaid patient volume, and may not be limited in any way. The EP must report encounters from all providers in the practice, including those who are ineligible to participate in the NC Medicaid EHR Incentive Program.

EPs may use a clinic or group practice's PV as a proxy for their own under four conditions:

1. The clinic or group practice's PV is appropriate as a PV methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's PV determination;
3. The EP has a current affiliation with the groups' PV they are using to attest; and, **had a current affiliation at the time of attestation**; and,
4. So long as the practice and EPs decide to use one methodology for a 90-day reporting period (in other words, clinics could not have some of the EPs using their individual PV for patients seen at the clinic, while others use the clinic-level data during the same 90-day reporting period). The clinic or practice must use the entire practice's PV and not limit it in any way. EPs may attest to PV under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

EPs in a group practice may use either individual or group methodology for determining Medicaid patient volumes. However, encounters reported during a 90-day PV reporting period

by an EP using individual methodology cannot be included in the group's number of encounters using group methodology for the same 90-day PV reporting period. An EP in such a group who wishes to use her/his encounters at that group to attest with individual methodology may do so by selecting a different 90-day PV reporting period than the 90-day period used by the EP(s) attesting with group methodology. It is important that the members of a group practice reach consensus among their affiliated EPs on the methodology each EP will use, prior to the first attestation. If possible, we suggest using group methodology to calculate PV as it will only need to be calculated one time for the whole group.

To be eligible to participate in the NC Medicaid EHR Incentive Program, EPs are required to have a minimum of 30 percent Medicaid-enrolled patient encounters. Pediatricians not meeting the 30 percent threshold may participate for a reduced payment by meeting a 20 percent threshold.

The formula to calculate patient volume for a consecutive 90-day PV reporting is as follows:
(All Medicaid-paid encounters + all Medicaid-enrolled zero-pay encounters)/Total encounters

To calculate the Medicaid patient volume, providers have the option to:

1. Select a consecutive 90-day period from the calendar year prior to the program year for which they're attesting (so if attesting for Program Year 2016, this would be a 90-day period in 2015 regardless of the date of attestation); **OR,**
2. A consecutive 90-day period in the 12-month period preceding the date of the attestation.

Providers practicing predominantly at an FQHC/RHC may use non-Medicaid needy patient encounters in addition to Medicaid-enrolled patient encounters to meet the required 30 percent Medicaid patient volume threshold. Non-Medicaid needy individuals include:

1. Individuals receiving assistance from Medicare or Health Choice;
2. Individuals provided uncompensated care by the EP; and,
3. Individuals who received services at no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

PV tips

Please carefully read and answer the questions at the bottom of the PV page as they will help mitigate the need for outreach.

If an EP (or a group) has unique billing practices, please include a memo on practice letterhead explaining the situation and submit it with the signed attestation.

If the EP bills any of their Medicaid claims indirectly through another entity, such as a behavioral health provider billing through an LME, please complete the behavioral health template (available under the Resources and Webinars tab on our [website](#)) and then submit the completed template with the signed attestation.



EP AIU Attestation Guide



If some of your Medicaid encounters were for patients covered by another state's Medicaid program, please submit a billing memo on practice letterhead regarding this with your signed attestation. Include a break-out of Medicaid encounters by state. If the EP had both Medicaid-paid and zero-pay, please break out each category of encounter by state. An EP must include any identifiers (similar to North Carolina's MPN) that were used on claims for the other state(s). We will reach out to the other state(s) to verify the encounters reported.

When calculating PV, use an auditable data source and keep all documentation for at least six years post-payment in case of audit.

For more information about patient volume, please see the Patient Volume tab on the [NC Medicaid EHR Incentive Program website](#). Also visit the [FAQ page](#) for frequently asked PV questions. For more information on calculating patient volume, please refer to the Patient Volume podcasts or the 'Patient Volume' tab on [our website](#).

If the EP is having difficulty calculating patient volume, please contact one of our [technical assistance partners](#) for hands-on patient volume assistance.

Individual Methodology

Patient Volume

* indicates a required field

Enter the start and end dates of the continuous 90-day period for your patient volume reporting period.

* Select the date range ▼

* Start Date

* End Date

* Patient Volume Reporting Method Individual **4** Group

You may use your individual patient volume from multiple practices where you worked to meet the threshold. It is not required to report on more than one practice.

* Do your patient volume numbers come from your work with more than one practice?

Yes **5** No

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing NPI if the practice used more than one during the 90-day period.

Medicaid patient volume from eligible billable services that were not billed or were not reimbursed ('zero-pay') should be included separately from Medicaid patient volume from paid claims. Enter the 'zero-pay' portion of your numerator in the 'zero-pay' column below.

Practice Name		Your Total Encounters at Practice		
<input type="text" value="6"/>		<input type="text" value="7"/>		
Practice's Billing MPN	Practice's Billing NPI	Medicaid Encounters Billed under this MPN	Medicaid Enrolled Zero Pay Encounters	Were you Listed as Attending for all these Encounters?
<input type="text" value="8"/>	<input type="text" value="9"/>	<input type="text" value="10"/>	<input type="text" value="11"/>	<input checked="" type="radio"/> Yes <input type="radio"/> No 12
Add another NPI for this Practice 13				
Add Another Practice Name 14				
Medicaid Patient Encounters (Numerator)	0	15		
Total Patient Encounters (Denominator)	0	16		
Medicaid Patient Volume Percentage (Medicaid / Total)	0%	17		

If the EP is attesting using individual methodology:

1. Select the date range. From the drop down box, choose either *12 months preceding today* (any consecutive 90-day range from the 12 months preceding today) or *previous calendar year* (any consecutive 90-day range from the calendar year preceding the program year for which you are attesting, e.g., if you are attesting for program year 2016, previous calendar year would be 2015 regardless of today's date).
2. Enter the Start Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. Your start date must fall within your selected date range.

3. Enter the End Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. The PV reporting period must be exactly 90 days including the start date and end date. Your end date must fall within your selected date range.
4. Click the *Individual* button to report that you used individual methodology to calculate your patient volume.
5. Click on *Yes* or *No* for “Do your patient volume numbers come from your work with more than one practice?” Your PV numbers do not need to be across all of your sites of practice. However, at least one of the locations where the EP is adopting/implementing/upgrading or meaningfully using certified EHR technology should be included in the PV.
6. Enter the Practice Name – the name of the individual practice or group practice where your patient volume comes from.
7. Enter the Total Encounters at Practice – total of all your patient encounters with this practice, no matter the payer. Enter only YOUR encounters (Do not enter encounters that were billed with your NPI as rendering on Medicaid claims but that belong to another provider. Do not enter the number of encounters for all providers at the practice.)
8. Enter the NPI that this practice used as billing MPN on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal MPN unless you used your personal MPN as both billing and rendering on Medicaid claims.) If your practice joined Medicaid after 6/30/13 and does not have an MPN, enter XXXXXXXX (must be all uppercase Xs).
9. Enter the NPI that this practice used as billing NPI on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal NPI unless you used your personal NPI as both billing and rendering on Medicaid claims.)
10. Enter the Medicaid Encounters Billed under this MPN - This is the number of encounters that you personally had with this practice during your selected 90-day PV reporting period that were paid for at least in part by Medicaid. Enter only YOUR Medicaid-paid encounters with this practice (Do not enter encounters that were billed with your NPI listed as rendering but that belong to another provider. Do not enter the number of encounters for all providers at the practice.) Note: Health Choice cannot be included here.
11. Enter the number of Medicaid Enrolled Zero Pay Encounters. Zero-pay Medicaid encounters are encounters with Medicaid patients that were billable services but where Medicaid did not pay. Enter only YOUR zero-pay encounters with this practice (Do not enter encounters that were billed with your NPI listed as rendering but that belong to another provider. Do not enter the number of encounters for all providers at the practice.) See the Patient Volume tab on our FAQ page for guidance on billable services. Note: Health Choice cannot be included here.

12. Click the *Yes* or *No* button for “Were you Listed as Attending for all these Encounters?”
If you were not listed as attending/rendering on Medicaid claims for all of your Medicaid encounters, you will need to answer question 27, “If another provider was listed as attending on any of the Medicaid-paid encounters included in your PV, enter that other provider’s NPI and the number of encounters attributable to that other provider.” For more information on reporting patient volume where incident to billing was used during the PV reporting period, you can view the incident to webinars or read the FAQs on our program website.
13. If Medicaid-paid encounters included in your reported patient volume were billed under more than one MPN or NPI, click the link for *Add another MPN for this Practice* and repeat steps 8 through 12.
14. If you are reporting patient volume from more than one practice, click the link for *Add another Practice Name* and repeat steps 6 through 13.
15. The numerator is automatically calculated and displayed. The numerator is all Medicaid encounters – Medicaid-paid encounters plus Medicaid zero-pay encounters.
16. The denominator is automatically displayed. The denominator is the total of all your patient encounters with this practice, no matter the payer.
17. The Medicaid Patient Volume Percentage is automatically calculated and displayed. The percentage is the numerator divided by the denominator. Your percentage must be at least 30 percent to qualify for the incentive. Or if you are a pediatrician, you can qualify for a reduced payment if your percentage is at least 20 percent. If your percentage does not meet the required threshold, your attestation will be denied.

1) When using individual methodology, the numerator and denominator should include only encounters where the EP was the attending or supervising provider. Did you enter only those encounters attributable to the individual EP in the numerator and denominator, NOT the patient volume numbers for the entire group? Yes No **18**

2) An EP must report all NPI(s) under which encounters were billed during the 90-day reporting period from all locations on which the EP is reporting, even if one or more NPIs is no longer used. Did you report all NPI(s) under which the EP's encounters were billed during the 90-day reporting period, even those not currently in use? Yes No **19**

3) A Medicaid encounter is defined as services rendered on any one day to an individual where Medicaid or Medicaid demonstration project under Section 1115 of the Social Security Act paid for part or all of the service.

a) Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service? Yes No **20**

b) Did you exclude from the numerator denied claims that were never paid at a later date? Yes No **21**

4) Encounters included in the patient volume numbers must have occurred during the 90-day period attested to above, regardless of when any claims were submitted or paid. Are your patient volume numbers based on date of service and not date of claim or date of payment? Yes No **22**

5) An encounter is one patient per provider per day and may be different from the number of claims. Do the numbers you entered represent encounters and not claims? Yes No **23**

6) The denominator must include all encounters regardless of payment method. Did you include encounters in the denominator where services were provided at no charge? Yes No **24**

7) If you had a different NPI (from the NPI you listed for the provider on the demographics screen) or more than one NPI during the 90-day period, enter that NPI here. **25**

8) If any other provider(s) used your NPI as rendering on Medicaid claims during the 90-day period, list the name(s) and number of encounters attributable to that other provider. If none, enter NA. **26**

9) If another provider's NPI was listed as rendering on any of the encounters you included in your patient volume, enter that other provider's NPI and number of encounters attributable to that other provider. If none, enter NA. **27**

18. Click the *Yes* or *No* button for “Did you enter only those encounters attributable to the individual EP in the numerator and denominator, NOT the patient volume numbers for the entire group?” With individual methodology, you should enter only YOUR encounters - NOT encounters that were billed under your NPI but that belong to another provider, NOT the group’s encounters. If your answer is *No*, you need to review your numbers and then enter only YOUR encounters.

19. Click the *Yes* or *No* button for “Did you report all NPI(s) under which the EP’s encounters

were billed during the 90-day reporting period, even those not currently in use?” You must enter all the NPIs that the practice(s) used as billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period. The billing NPI used during your 90-day patient volume reporting period may be different than the billing NPI that you currently use. If you answer *No*, go back and click *Add another billing MPN for the practice* to report patient volume under additional billing MPNs/NPIs used during the PV reporting period.

20. Click the *Yes* or *No* button for “Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service?” Medicaid-paid encounters include encounters where Medicaid paid only part, e.g., where Medicaid was the secondary payer.
21. Click the *Yes* or *No* button for “Did you exclude from the numerator denied claims that were never paid at a later date?” The number you enter for Medicaid-paid encounters can include only encounters that were paid at least in part by Medicaid. If you answer *No*, please review your numbers and for *Medicaid encounters billed under this MPN*, enter only encounters paid at least in part by Medicaid. Some denied claims can be included as zero-pay Medicaid encounters. See the Patient Volume tab on our FAQ page for guidance on billable services.
22. Click the *Yes* or *No* button for “Are your patient volume numbers based on date of service and not date of claim or date of payment?” All of your encounters must have a date of service that falls within your selected 90-day PV reporting period, regardless of when any claims were submitted or paid. If you answer *No*, please revise your numbers to report only encounters with date of service that falls within your selected 90-day PV reporting period.
23. Click the *Yes* or *No* button for “Do the numbers you entered represent encounters and not claims?” An encounter is one patient per provider per day and may be a lower number than the number of claims. For example, a provider could have two paid claims for a patient for the same date of service (e.g., one claim for a physical and one claim for a flu shot) but this counts as only one encounter. If you answer *No*, please revise your numbers to report encounters.
24. Click the *Yes* or *No* button for “Did you include encounters in the denominator where services were provided at no charge?” Your denominator must include all encounters during the PV reporting period with the listed practice, regardless of payment. If you answer *No*, please revise the number you entered in the *Your Total Encounters at Practice* box (box #7) to include ALL of your encounters with the listed practice.
25. If the EP had different NPIs or more than one NPI during the 90-day period, enter that number in the text field. If you had another personal NPI that you used as attending/rendering on Medicaid claims during your selected 90-day PV reporting period, list all here.
26. If any other provider billed encounters under the attesting EP’s NPI during the 90-day period, list the name(s) and number of encounters attributable to that other provider. If this does not apply to you, enter N/A. Even if they are not eligible to participate in the

program, if any other provider such as a nurse practitioner that you supervised or a physician that was new to your practice or did not have her/his own NPI, used your personal NPI as attending/rendering on their Medicaid claims you must enter the name of that other provider and the number of Medicaid-paid encounters that belong to that other provider. For the other provider(s), include only Medicaid-paid encounters with the practice listed. If more than one provider used your NPI as rendering on their Medicaid claims, list all of those providers and the number of Medicaid-paid encounters billed under your NPI that belong to each.

27. If another provider was listed as attending/rendering on any of the encounters included in the attesting EP's patient volume, enter that provider's NPI and number of encounters attributable to the other provider. If this does not apply to you, enter N/A. If another provider was listed as attending/rendering on any or all of the Medicaid-paid encounters included in your numerator, enter that other provider's NPI and number of Medicaid-paid encounters attributable to that other provider (even if they are not eligible to participate in the program). For the other provider, include only Medicaid-paid encounters with the practice listed. If your Medicaid-paid encounters were billed using more than one provider's NPI as rendering, list all.
28. Click *Next*.
29. The [AIU/MU](#) page opens.

Group Methodology

Patient Volume

* indicates a required field

Enter the start and end dates of the continuous 90-day period for your patient volume reporting period.

* Select the date range **1**

* Start Date **2**

* End Date **3**

* Patient Volume Reporting Method Individual **4** Group

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing NPI if the group used more than one during the 90-day period.

Medicaid patient volume from eligible billable services that were not billed or were not reimbursed ('zero-pay') should be included separately from Medicaid patient volume from paid claims. Enter the 'zero-pay' portion of your numerator in the 'zero-pay' column below.

Group Name	Number of Group Members During 90-day Period	Total Encounters for All Group Members	
5 <input type="text" value="5"/>	6 <input type="text" value="6"/>	7 <input type="text" value="7"/>	
Group's Billing MPN	Group's Billing NPI	Medicaid Encounters Billed under this MPN	Medicaid Enrolled Zero Pay Encounters
8 <input type="text" value="8"/>	9 <input type="text" value="9"/>	10 <input type="text" value="10"/>	11 <input type="text" value="11"/>
Add another Group NPI 12			

Medicaid Patient Encounters (Numerator) 0 **13**

Total Patient Encounters (Denominator) 0 **14**

Medicaid Patient Volume Percentage (Medicaid / Total) 0% **15**

If the EP is attesting using group methodology:

1. Select the date range. From the drop down box, choose either *12 months preceding today* (any consecutive 90-day range from the 12 months preceding today) or *previous calendar year* (any consecutive 90-day range from the calendar year preceding the program year for which you are attesting, e.g., if you are attesting for program year 2016, previous calendar year would be 2015 regardless of today's date).
2. Enter the Start Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. Your start date must fall within your selected date range.
3. Enter the End Date of your selected 90-day PV reporting period, using the calendar tool or by typing the date. The PV reporting period must be exactly 90 days including the start date and end date. Your end date must fall within your selected date range. Click the *Group* button to report that you used group methodology to calculate your patient volume.
4. Click the *Group* button to report that you used group methodology to calculate your patient volume.



5. Enter the Group Name – the name of the group practice where your patient volume comes from.
6. Enter the Number of Group Members During the 90-day Period. This is the total number of providers that were in the group during your selected 90-day patient volume reporting period. *NOTE:* This number includes EVERY professional in the group who provided services, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program.
7. Enter the Total Encounters for All Group Members. This is the number of encounters during your selected 90-day patient volume reporting period for all group members regardless of payer. *NOTE:* This number includes ALL encounters with ALL payers for EVERY professional in the group who provided services, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program.
8. Enter the Group's Billing MPN. This is the MPN that your group used as billing MPN on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal MPN unless you used your personal MPN as both billing and rendering on Medicaid claims.) If your group joined Medicaid after 6/30/13 and does not have an MPN, enter XXXXXXX (must be all uppercase Xs).
9. Enter the NPI that your group used as billing NPI on Medicaid claims during your selected 90-day patient volume reporting period. (This will not be your personal NPI unless you used your personal NPI as both billing and rendering on Medicaid claims for this group.)
10. Enter the Medicaid Encounters Billed under this MPN - this is the number of encounters for all group members that were paid for at least in part by Medicaid. Note: Health Choice cannot be included here.
11. Enter the number of Medicaid Enrolled Zero Pay Encounters (regardless of payment liability). This is the number of encounters for all group members with Medicaid patients that were billable services but Medicaid did not pay.
12. If the group has billed encounters under more than one MPN/NPI, click the link for *Add another Group MPN* and repeat steps 8 through 11.
13. The numerator is automatically calculated and displayed. The numerator is all Medicaid encounters – Medicaid-paid encounters plus Medicaid zero-pay encounters.
14. The denominator is automatically displayed. The denominator is the total of all patient encounters for this group, no matter the payer.
15. The Medicaid Patient Volume Percentage is automatically calculated and displayed. The percentage is the numerator divided by the denominator. Your percentage must be at least 30 percent to qualify for the incentive. Or if you are a pediatrician, you can qualify for a reduced payment if your percentage is at least 20 percent. If your percentage does not meet the required threshold, your attestation will be denied.



EP AIU Attestation Guide



1) When using group methodology, the patient volume must include all patient encounters with both EPs and non-eligible provider types (e.g., RNs, phlebotomists). Did you include all encounters?

Yes No **16**

2) A Medicaid encounter is defined as services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under Section 1115 of the Social Security Act paid for part or all of the service.

a) Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service?

Yes No **17**

b) Did you exclude from the numerator denied claims that were never paid at a later date?

Yes No **18**

3) Encounters included in the patient volume must have occurred during the 90-day reporting period, regardless of when claims were submitted or paid. Are your reported encounters based on date of service and not date of claim or date of payment?

Yes No **19**

4) The denominator must include all encounters regardless of payment method. Did you include all encounters in the denominator where services were paid by Medicaid, by any payer other than Medicaid, self-paid, and provided at no charge?

Yes No **20**

5) An encounter is one patient per provider per day and may be different from the number of claims. Do the numbers you entered represent encounters and not claims?

Yes No **21**

6) If the group's reported encounters span more than one location and/or were billed with Medicaid under multiple NPIs, NC requires reporting of all NPIs associated with each location under which Medicaid claims were billed during the 90-day reporting period.

a) If you are reporting patient encounters from multiple locations, have you provided all associated NPIs?

Yes No N/A **22**

b) During the 90-day reporting period, did the group have a different (outdated) billing NPI or more than one billing NPI?

Yes No N/A **23**

16. Click the *Yes* or *No* button for “Did you include all encounters?” With group methodology, you must report encounters for EVERY professional in the group who provided services, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program. If you cannot answer *Yes* to this question, you need to review your numbers and then report encounters for EVERY professional in the group who provided services.

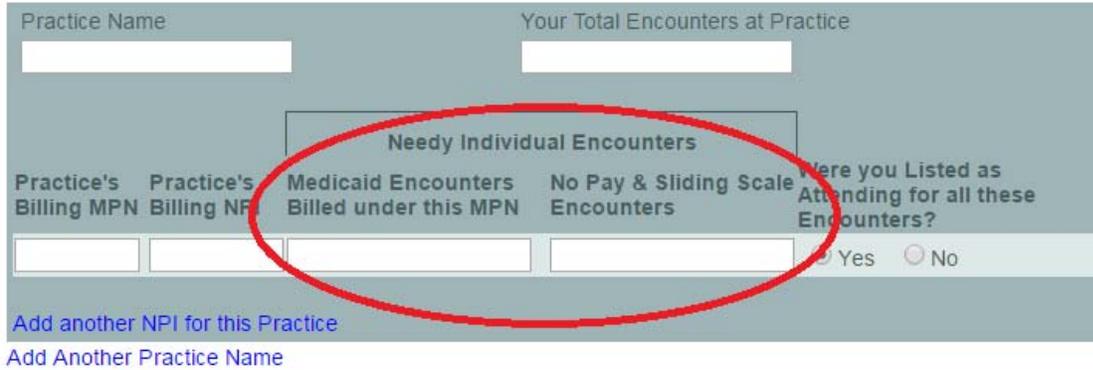
17. Click the *Yes* or *No* button for “Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service?” Medicaid-paid encounters include encounters where Medicaid paid only part, e.g., where Medicaid was the secondary payer.

18. Click the *Yes* or *No* button for “Did you exclude from the numerator denied claims that were never paid at a later date?” The number you enter for Medicaid-paid encounters can include only encounters that were paid at least in part by Medicaid. If you answer *No*, please review your numbers and for *Medicaid encounters billed under this MPN*, enter only encounters paid at least in part by Medicaid. Some denied claims can be included as zero-pay Medicaid encounters. See the Patient Volume tab on our FAQ page for guidance on billable services.

19. Click the *Yes* or *No* button for “Are your patient volume numbers based on date of service and not date of claim or date of payment?” All encounters must have a date of service that falls within your group’s 90-day PV reporting period, regardless of when any claims were submitted or paid. If you answer *No*, please revise your numbers to report only encounters with date of service that falls within your group’s selected 90-day PV reporting period.
20. Click the *Yes* or *No* button for “Did you include all encounters in the denominator where services were paid by Medicaid, by any payer other than Medicaid, self-paid and provided at no charge?” Your denominator must include all encounters for all group members during the PV reporting period with the listed practice, regardless of payment. If you answer *No*, please revise the number you entered in the *Your Total Encounters at Practice* box (box #7) to include ALL of your encounters with the listed practice.
21. Click the *Yes* or *No* button for “Do the numbers you entered represent encounters and not claims?” An encounter is one patient per provider per day and may be a lower number than the number of claims. For example, a provider could have two paid claims for a patient for the same date of service (e.g., one claim for a physical and one claim for a flu shot) but this counts as only one encounter. If you answer *No*, please revise your numbers to report encounters.
22. Click the *Yes* or *No* button for “If you are reporting patient volume from multiple locations, have you provided all associated NPIs?” You define your group based on location(s). [note: Guidance on defining your group is available under the Patient Volume tab on our [website](#).] If you are using patient volume from multiple locations, you must enter all the NPIs that the group used as billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period for those locations. The billing NPI used during your 90-day patient volume reporting period may be different than the billing NPI that you currently use. If you answer *No*, go back and click *Add another Group MPN* to report patient volume under additional billing MPNs/NPIs used during the PV reporting period.
23. Click the *Yes* or *No* button for “During the 90-day reporting period, did the group have a different (outdated) billing NPI or more than one billing NPI?” You must enter all the NPIs that the group used as billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period. The billing NPI used during your 90-day patient volume reporting period may be different than the billing NPI that you currently use. If you answer *Yes*, go back and click *Add another Group MPN* to report patient volume under additional billing MPNs/NPIs used during the PV reporting period.

Practicing Predominantly

Providers practicing predominantly at an FQHC/RHC may use non-Medicaid needy patient encounters in addition to Medicaid-enrolled patient encounters to meet the required 30 percent Medicaid patient volume threshold.



Practice Name		Your Total Encounters at Practice	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Practice's Billing MPN	Practice's Billing NPI	Needy Individual Encounters	Were you Listed as Attending for all these Encounters?
<input type="text"/>	<input type="text"/>	Medicaid Encounters Billed under this MPN <input type="text"/>	No Pay & Sliding Scale Encounters <input type="text"/>
			<input type="radio"/> Yes <input type="radio"/> No
Add another NPI for this Practice Add Another Practice Name			

If the EP is a provider attesting to practicing predominantly, on the patient volume screen in MIPS they will see that their numerator is called Needy Individual Encounters (circled in red above), which is broken out into Medicaid Encounters Billed under this MPN and No Pay & Sliding Scale Encounters. When attesting, complete the patient volume page using individual or group methodology (see instructions above) but as a provider who practices predominantly the EP has the option to report non-Medicaid needy encounters in the box labeled No Pay & Sliding Scale Encounters. Non-Medicaid needy individuals include: 1) Individuals receiving assistance from Medicare or the Children’s Health Insurance Program (Health Choice); 2) Individuals provided uncompensated care by the EP; and, 3) Individuals who received services at no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay.

AIU/MU

The Adopt, Implement, or Upgrade (AIU) or Meaningful Use page is used to collect information on the activities the EP undertook to adopt, implement, or upgrade to a certified EHR technology. In 2016 and 2017, providers can choose to use technology certified to the 2014 Edition or the 2015 Edition. For the definition of AIU, see page 7 of this guide.

NOTE: Attesting to AIU can only be done in the first year of program participation. In subsequent participation years, an EP will attest to Meaningful Use.

To enter AIU activities:

1. When it asks “Please indicate your approach,” click the *Adopt, Implement, Upgrade* button.
2. Select a button to indicate which activity was undertaken during the program year: *Adopt, Implement* or *Upgrade*.
3. Enter details of the EP’s AIU activities. For example, purchasing an EHR for the first time, upgrading an existing EHR product, training staff on new functionalities, adapting workflow or any number of other related activities.
4. Click *Next*.
5. The [Congratulations Page](#) opens.



Congratulations

Congratulations! The attestation questions are now complete. Click *Next* to continue to the [Electronic Submission page](#).

Congratulations

Congratulations! You have completed all the attestation questions. Only two steps remain: submitting the attestation electronically (next screen) and submitting a signed copy of the attestation (by mail/e-mail).

The State of North Carolina looks forward to working with you as our State moves towards improving patient care through the adoption of electronic health records and health information exchange.

Thank you for your participation in this program!

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[Click for Page Help](#)

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- » Status
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- » Patient Volume
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- » Electronic Submit

For Additional Information

- » EP AIU Attestation Guide
- » EP Modified MU Attestation Guide
- » EH AIU/MU Attestation Guide
- » Download Adobe Acrobat to read guides
- » DMA Incentive Program home page

Contact Information

Can't find what you need in the NC-MIPS Attestation Guide?

NC-MIPS Help Desk
Email:
NCMedicaid.HIT@dhs.nc.gov

1. Click *Next* to move to the Electronic Submission page.
2. The [Electronic Submission Page](#) opens.

Electronic Submission

The Electronic Submission page is used to submit the electronic attestation and formally attest to the accuracy of the reported information.

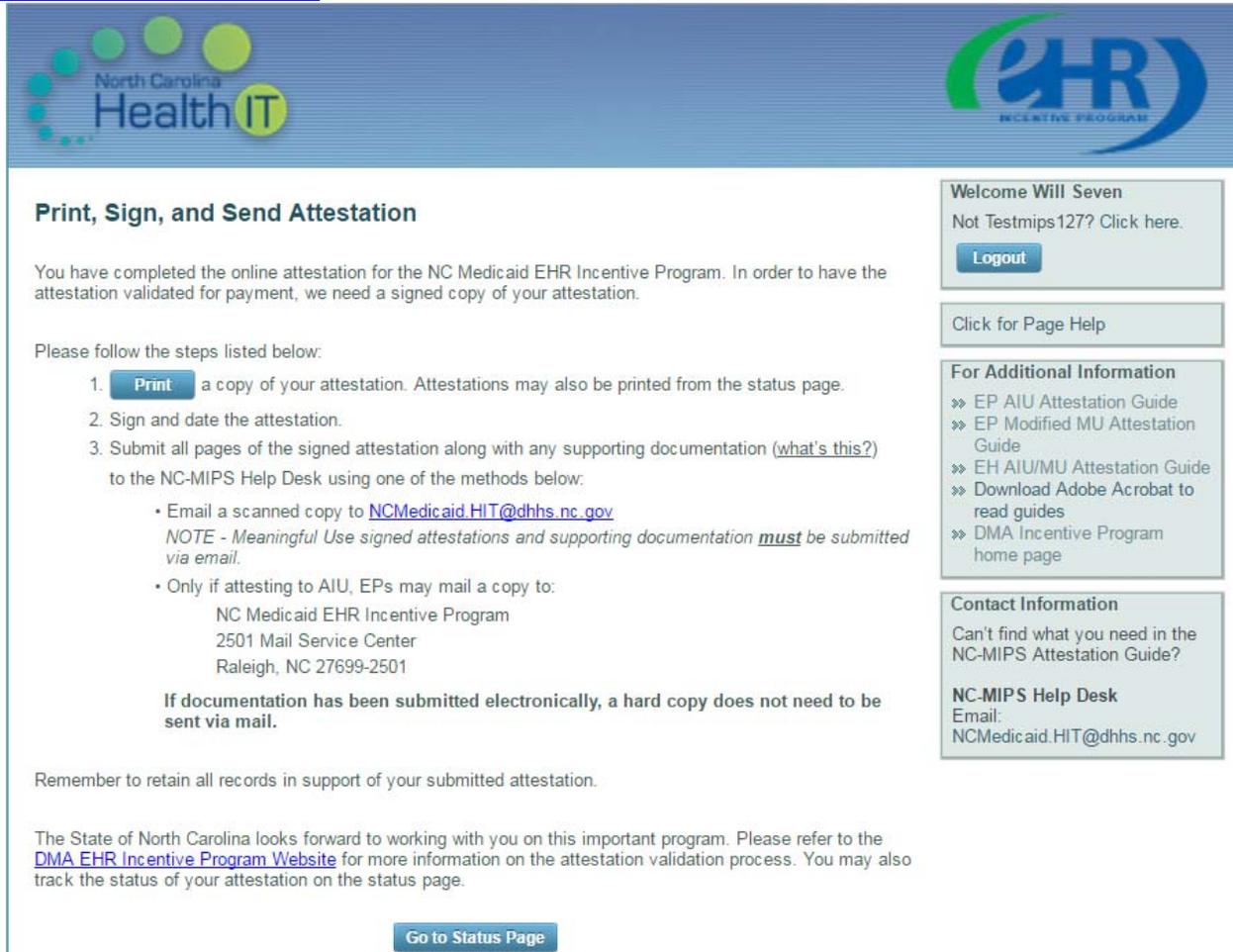
To attest to the accuracy of the reported information:

1. Read all the statements on the page.
2. If the EP agrees, check the box for “I have read the above statements and attest to my responses.”
3. Click *Next*.
4. The [Print, Sign, Send](#) page opens.

NOTE: If you have entered XXXXXXX for an MPN on your attestation and receive either of the two following pop-up messages, you can ignore the pop-up and continue to the Print, Sign, Send page.

Print, Sign, Send

Use the Print, Sign, Send page to print the attestation. The printed attestation must be signed and dated by the EP (reflecting the date of the most recently submitted attestation) and emailed NCMedicaid.HIT@dhhs.nc.gov (the NC-MIPS Help Desk).



Print, Sign, and Send Attestation

You have completed the online attestation for the NC Medicaid EHR Incentive Program. In order to have the attestation validated for payment, we need a signed copy of your attestation.

Please follow the steps listed below:

1. **Print** a copy of your attestation. Attestations may also be printed from the status page.
2. Sign and date the attestation.
3. Submit all pages of the signed attestation along with any supporting documentation ([what's this?](#)) to the NC-MIPS Help Desk using one of the methods below:
 - Email a scanned copy to NCMedicaid.HIT@dhhs.nc.gov
*NOTE - Meaningful Use signed attestations and supporting documentation **must** be submitted via email.*
 - Only if attesting to AIU, EPs may mail a copy to:
NC Medicaid EHR Incentive Program
2501 Mail Service Center
Raleigh, NC 27699-2501**If documentation has been submitted electronically, a hard copy does not need to be sent via mail.**

Remember to retain all records in support of your submitted attestation.

The State of North Carolina looks forward to working with you on this important program. Please refer to the [DMA EHR Incentive Program Website](#) for more information on the attestation validation process. You may also track the status of your attestation on the status page.

[Go to Status Page](#)

Welcome Will Seven
Not Testmips127? [Click here.](#)
[Logout](#)

[Click for Page Help](#)

For Additional Information
» [EP AIU Attestation Guide](#)
» [EP Modified MU Attestation Guide](#)
» [EH AIU/MU Attestation Guide](#)
» [Download Adobe Acrobat to read guides](#)
» [DMA Incentive Program home page](#)

Contact Information
Can't find what you need in the NC-MIPS Attestation Guide?
NC-MIPS Help Desk
Email: NCMedicaid.HIT@dhhs.nc.gov

To finish the attestation process:

1. Click *Print* to print the attestation.
2. The attesting EP must sign and date the printed attestation her/himself and the date must reflect that of the most recently submitted attestation or later. Some tips:
 - a. Attestations signed with a date preceding that of the most recently submitted attestation will not be accepted;
 - b. A third party, such as a practice manager, may **not** sign the printed attestation on behalf of the EP; and,
 - c. Electronic signatures and stamps **are not** accepted in lieu of a manual signature.
3. Collect any supporting documentation to send with the signed attestation (optional). This may include a copy of the EP's medical license, a purchase order or contract with an EHR vendor, and/or any additional information in support of attested information.



EP AIU Attestation Guide



4. Email the signed attestation and any supporting documentation to NC-MIPS Help Desk at NCMedicaid.HIT@dhhs.nc.gov (if submitting via email, a hard copy is NOT required) within seven days. We cannot begin the validation process until we have received the email with the signed attestation.

EPs attesting to adopt, implement, upgrade (AIU) have the option to submit their attestation through the mail or email. Email is the preferred method of contact.

Mailing Address: NC Medicaid EHR Incentive Program
2501 Service Center
Raleigh, NC 27699-2501

Faxes are not accepted.



Next Steps

Be sure to email the signed attestation and any supporting documentation to the NC- MIPS Help Desk at NCMedicaid.HIT@dhhs.nc.gov within seven days of submitting the attestation through NC-MIPS. We cannot begin the validation process until we have received the email with the required documents.

EPs can return to the NC-MIPS Portal at <https://ncmips.nctracks.nc.gov/> anytime to review the status of an attestation(s) on the Status Page. It typically takes 12 – 15 weeks to complete the validation process, however, it can be longer for attestations received during our high-volume peak time of March through April.

If we find issues while validating an attestation, we will conduct outreach via email if time allows. Then an EP will have up to 15 calendar days to address any issues. Attestations submitted within 30 days of the close of the tail period are not guaranteed to be reviewed prior to that deadline, so **it is extremely important that EPs review their attestation before submitting.**

The deadline to attest for the NC Medicaid EHR Incentive Program for Program Year 2016 is April 30, 2017. All Program Year 2016 attestations must be submitted through NC-MIPS. The information submitted on NC-MIPS must be complete and valid by April 30th. We will not accept memorandums in lieu of accurate information submitted through NC-MIPS. NC-MIPS will close for Program Year 2016 on April 30th, so no changes may be made to the attestation after this date. We encourage eligible providers to attest as early as possible so that there will be time to find and resolve any issues before the system closes on April 30th.

If the EP withdraws and re-attests, they must submit a new, updated signed attestation.

Typically speaking, payments are made via electronic funds transfer (EFT). If in the rare case a paper check has to be issued, the check will be sent to the address associated with the payee NPI that is on file with NCTracks. Please be sure the address on file with NCTracks is accurate.

Once the payment has been processed, the payment will be noted in the Financial Summary section of the Medicaid Remittance Advice.

You must keep all documentation for at least six years in case of post-payment audit.

EPs will attest to MU in participation years two through six. Please refer to the EP MU Attestation Guide for attestation assistance.

Thank you for participating in the NC Medicaid EHR Incentive Program. We look forward to working with you to achieve meaningful use and improve patient care.