



North Carolina Medicaid Electronic Health Record Incentive Program

Eligible Professional Stage 1 Meaningful Use Attestation Guide

NC-MIPS 2.0

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The North Carolina Medicaid Electronic Health Record (EHR) Incentive Program is providing this guide as a reference for Eligible Professionals (EP). For additional information, please contact the NC-MIPS Help Desk by email, phone or mail.

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Using this Guide

Introduction

This guide helps an EP understand the information needed to attest for EHR Incentive Program payments on the NC Medicaid EHR Incentive Payment System (NC-MIPS). It provides step-by-step instructions to properly navigate and complete an EHR incentive attestation.

The NC-MIPS Portal is available online at <https://ncmips.nctracks.nc.gov/>. Through NC-MIPS, EPs enter the information needed to attest for an incentive payment. EPs should use this guide as a reference during the attestation process. For additional help, there is a link on each page of the Portal entitled *Click for Page Help*. Upon clicking 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.

Medicaid service providers 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 NC Medicaid EHR Incentive Program can be found on the NC Medicaid EHR Incentive Program website at <http://www.ncdhhs.gov/dma/provider/ehr.htm>.

Additional information on both EHR Incentive Programs is available from the Centers for Medicare & Medicaid Services' (CMS) EHR Incentive Program website at <http://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. If these resources are not sufficient in providing attestation assistance, please contact one of our technical assistance partners listed below or your local professional organization to provide you with more personalized attestation assistance.

The Carolinas Center for Medical Excellence
www.CCMEConsulting.org
919-461-5699
CCMEconsulting@thecarolinascenter.org

NC Area Health Education Centers (AHECs)/Regional Extension Centers (REC)
<http://www.ncahec.net>
919-966-2461
ncahec@med.unc.edu

NC Medical Society
<http://www.ncmedsoc.org>
919-833-3836

Unsure of Eligibility?

To determine program eligibility, CMS has developed an online tool that can be accessed at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligibility.html>.

To be eligible to receive an EHR incentive payment with NC Medicaid's EHR Incentive Program, 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 (new 2014 certification standards are issued, please see ONC's product health IT website for additional information); and,
3. Be an eligible provider type.

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

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

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. EPs may choose not to participate in consecutive years, but EPs need six years of participation to have the opportunity to earn the full incentive payment and must begin their first year of participation no later than Program Year 2016.

The first incentive payment 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 attest to MU in their first year of program participation, but do not need to attest to MU the first year they participate. The EP will be responsible for attesting to MU each remaining year of participation in the program (please reference the EP AIU Attestation Guide if attesting for AIU).

The American Recovery and Reinvestment Act of 2009 specifies three main components of MU:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and other measures.

Simply put, MU is the first step toward standardizing the way EPs use certified EHR technology so data can be shared among different entities.

Reminders to returning providers

If you already have an account with NC-MIPS, you do not need to complete a First Time Account Setup. If this is your first year of participation and you do not have an account with NC-MIPS, please refer to the EP AIU Attestation Guide for registration information.

You will need a working NCID username and password to complete an attestation. If

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your NCID username has been updated since completing a First Time Account Setup last year, please send us an email with the provider's name, NPI and new NCID username so we can manually update the provider's NC-MIPS username. If you need to update your NCID or have questions about your NCID, please contact NCID. Contact information can be found on the NCID website at <https://ncid.nc.gov>.

Please update any updated/new information on CMS' R&A System at <https://ehrincentives.cms.gov/hitech/login.action>. This includes having a new EHR certification number, site address, payee NPI/payee TIN type, etc.

Note: It is during CMS registration that you will assign the payment to a specific payee NPI/payee TIN. Please ensure you are entering the payee NPI/payee TIN type that you wish to assign the incentive payment and check to make sure that the payee NPI and payee TIN are on file with NCTracks.

The NC-MIPS Portal will save unfinished attestations for 30 days, during which time you will be able to return and complete your submission.

If at any point in the attestation process, it is determined the EP does not meet the eligibility requirements for participation in this program, the EP may cancel the attestation on the status page within the NC-MIPS Portal. Please remember that even if you do not qualify for participation in the Medicaid EHR Incentive Program this Program Year, you may re-attest. *EPs need six years of participation to have the opportunity to earn the full incentive payment and must begin their first year of participation no later than Program Year 2016.*

Attesting for MU

EPs have the option to attest to AIU or MU in their first year of participation, but MU is required in participation years two through six. Please use the EP AIU Attestation Guide if attesting to AIU. Figure 1 below is a visual of what providers typically attest to each year of participation.

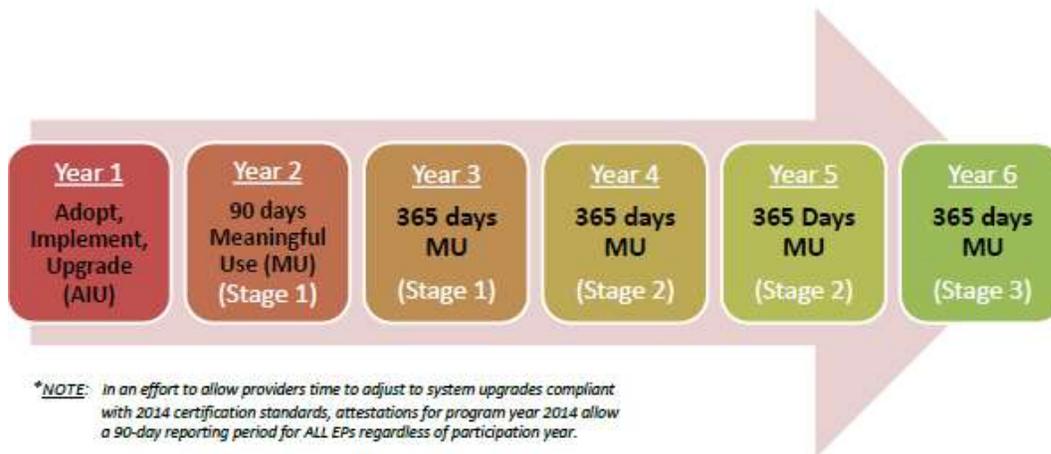


Figure 1 - Path to Payment

Before Attesting

Before getting started with your MU reporting period, check which MU measures you'll be attesting to and work with your EHR vendor to ensure you are able to collect and report those measures.

Reporting Periods

PV ~~=~~ MU

EPs will be required to report **at least two separate reporting periods** during attestation: PV & MU. These reporting periods are not synonymous.

- **PV Reporting Period** – A consecutive 90-day period in:
 1. The previous calendar year for which you're attesting; or,
 2. The 12 months immediately preceding the date of attestation.

For example: If attesting on January 13th, 2014 for Program Year 2013, the previous calendar year is 2012 and the 12 months immediately preceding the date attestation would be 1/12/13-1/12/14.

- **MU Reporting Period**– A consecutive 90- or 365-day in the current calendar year for which you're attesting.

For example: If attesting in Program Year 2014, the MU reporting period will be a consecutive 90 day period in 2014 or a full 2014 calendar year 1/1/14-12/31/14.

Summary Pages

Until enhancements are made to NC-MIPS, you will need to print your MU summary pages during the attestation.

NC-MIPS Portal

As a reminder, you can access NC-MIPS at <https://ncmips.nctracks.nc.gov/>. Once you are logged on, the Portal will take you through the attestation process one page at a time. NC-MIPS is compatible with Internet Explorer 7 (or later), as well as Firefox 8 (or later).

The following MU pages will be covered in this guide: Measure Selection Home Page, MU Measure Instructional Pages, Core Measures, Menu Measures, Core Clinical Quality Measures, Alternate Clinical Quality Measure, Additional Clinical Quality Measures and MU Measure Summary Pages.

If you have difficulty running EHR reports or have questions about which measures your EHR is capable of reporting, please work with your EHR vendor.

When attesting, the user will be guided through the following pages:

- Welcome
- First Time Account Setup (**for new users only!**)
- Provider Status
- Provider Demographics (Please note, if the North Carolina demographic information is not automatically populating within NC-MIPS, please verify your information on NCTracks. Refer to the EP AIU Attestation Guide for more information).
- Personal Contact
- Practice Predominantly/Hospital-Based
- Patient Volume
- AIU/MU
- MU Measure Selection Home Page
- Congratulations
- Submit
- Print, Sign, Send

NC-MIPS Provider Portal Layout

While EPs, should already be familiar with the look and feel of the NC-MIPS Portal, the

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following is a refresher of the basic layout and functionalities. To ensure consistent navigation, each page of the Portal has a similar look and feel. If you are ever stumped, or need additional guidance, help is always available. Refer to Figure 2.



Figure 2 - NC-MIPS Portal Page Layout

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.

For your convenience, the right side of the page contains five commonly used navigation tools:

- Sign In
- Page Help
- Jump to...
- Additional Information
- Contact Information

Sign In

First time users must first register with CMS. After receiving CMS' confirmation, log onto the NC-MIPS Portal and create an NC-MIPS Account by clicking *First Time Account Setup*. **If the provider already has an account with NC-MIPS please do not create another *First Time Account Setup*.**

Forgot your username or password? No problem! The *Forgot Username* link takes you to the NCID website for recovering your NCID and the *Forgot Password* link takes you to the NCID website for recovering your password.

If you have updated your NCID username since creating your NC-MIPS account, please send an email to NCMedicaid.HIT@dhhs.nc.gov and tell us the provider's name, NPI & NCID username so we can manually update the provider's NC-MIPS username.

Trouble logging in?

If you are still having difficulty logging into NC-MIPS, try some of the possible solutions:

1. Refer to the NC-MIPS EP AIU/MU Attestation User Guide and the [Quick Attestation Reference Guide](#) for guidance.
2. Please ensure your NCID is working with <http://ncid.nc.gov>. If you have updated your NCID since your last attestation, please email us the new NCID so we can link it to your account.
3. Finally, be sure to use the exact same CMS Registration ID, Social Security Number & NPI used during CMS Registration.

If you are still experiencing issues, please send an email to NCMedicaid.HIT@dhhs.nc.gov. To better serve you, please include the following information: The providers' name, NPI, NCID username, CMS Registration ID, MPN (if applicable), Program Year, a screenshot of the information being entered and the error message being received, and a brief description of your 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 you are viewing. If you do 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 you to follow the normal attestation process flow in the Portal. However, there may be occasions that you want to jump to a particular page. The *Jump to* area provides links to other pages so that you can easily navigate the Portal.

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NOTE: You will be able to jump only to the pages related to your attestation type (AIU or MU) where you have already entered data.

Additional Information

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

To download the free Adobe Reader software, click *Download Adobe Acrobat to read guides*, and it will take you to a free download.

To learn more about the NC EHR Incentive Program, click *DMA Incentive Program home page*.

Contact Information

This area contains the phone number and email for the NC-MIPS Help Desk. Please email if you have 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 you navigate more easily through NC-MIPS. Once you complete the information requested on a page, click *Next* to proceed to the next page. NOTE: If any required fields are left blank, you will see a message prompting you to complete the missing fields.

If you want to go back to change some previously entered information, you can click the *Previous* button and it will direct you back to the previous page.

The typical Portal page navigation is shown below in Figure 3.

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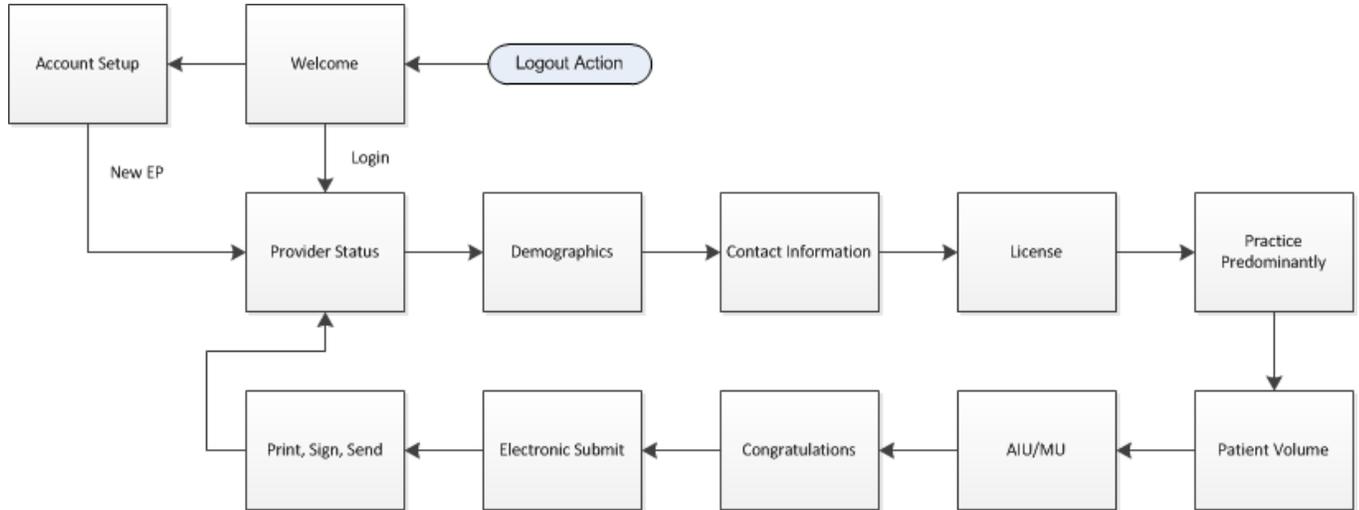


Figure 3 - Portal Navigation

Welcome

The Welcome page is the first page that you see when you access the NC-MIPS Portal via <https://ncmips.nctracks.nc.gov/>. Refer to Figure 4.



Figure 4 – Welcome Page

There may be important announcements at the top of the page, alerting you to attestation deadlines, EHR Program Updates and common issues being experienced.

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If you are a first-time user:

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

If you are a returning user:

1. Sign in by enter your NCID Username and NCID Password. (Please let us know if you've update your NCID since creating your NC-MIPS account).
2. Click *Login*.

The [Provider Status](#) page opens.

Provider Status

The Provider Status page shows a history of all attestations that you have completed, have in progress, or have available for you to attest. Refer to Figure 5.

Status

Provider Name Marge Three
 CMS Registration ID 1000001236
 NPI 2000001236
 MPN 3510056

Program Year	Payment Year	Current Status	Activity Date
2012	1	Attestation in Process	

Cancel Proceed

Welcome Marge Three
 Not Marge Three? Click here.
 Logout

Click for Page Help

For Additional Information
 » EP AIU Attestation Guide
 » EP MU Attestation Guide
 » EH AIU/MU Attestation Guide
 » Download Adobe Acrobat to read guides
 » DMA Incentive Program home page

Contact Information
 Questions on completing attestation?
 NC-MIPS Help Desk

Figure 5 - Provider Status Page

The Provider Status page shows the:

- Program Year – the calendar year for which you attested.
- Payment Year – the participation year (1 through 6).
- Status – an automatically updated description of where you are in the attestation validation process for a submitted attestation. We will send an outreach email if we need additional information.

NOTE: 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:

- Attestation in process – the EP is in the process of attesting.
- Closed – no attestation submitted – no attestation was submitted for that year.
- Validating – after the attestation is submitted, it will go through a series of validation checks and approvals at the state and federal levels.

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- Canceled – EP cancels their ‘in-process’ attestation, thereby signaling they would not like to participate for the current calendar year.
- Withdrawn – EP withdraws their ‘submitted’ attestation, thereby signaling they no longer wish to continue the attestation process for the current calendar year. Please note, when you withdraw, previously entered information will be saved in the system.
- Paid – the attestation has been paid.
- Attestation Denied – attestation resulted in a denial.
- Activity Date – date of your 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 so that you will not receive additional communication about it. This is not a permanent action. The EP may return to the attestation after you decide to cancel.
- Withdrawn – after submitting the attestation, stop this attestation so that you will not receive additional communication about it. This is not a permanent action. The EP may return to the attestation after you decide to withdraw. Please note, when you withdraw, previously entered information will be saved in the system.
- Re-Attest – The EP may re-attest with the Program at any point after being denied.
- View/Print – view the attestation in a form that can be printed.

If you are a new user, you will see only 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 you want to cancel participation in a given year:

1. Click *Cancel* for that program year.
2. You will see the following pop-up warning message: “Canceling participation will stop communications regarding activities for this program year. You can reinstate the attestation any time by clicking *Proceed*.”
3. If you want to cancel the program year, click *OK*. The status changes to “Canceled.”

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4. If you do not want to cancel the program year, click *Cancel*. The warning message box closes with no action performed.

If you want to view or print an attestation:

1. Click *View/Print* for the attestation you want to view or print.
2. A PDF version of the attestation opens for you to view.
3. If you want to print the attestation, use the window controls for printing.

Once they reach the Status page, EPs will see one of the scenarios described below.

Example 1: 'Program Year' 2012 has expired and the EP is ready to attest for 2013. The Program Year 2012 row will be marked as "Closed-No Attestation Submitted" and the Program Year 2013 row will be active.

Status

Provider Name	Marge Two
CMS Registration ID	1000001476
NPI	2000001476
MPN	1476147

Program Year	Payment Year	Current Status	Activity Date
2013	1	Attestation in Process	
2012	1	Closed - No Attestation Submitted	

[Proceed](#)

Figure 6 - Screenshot of Example 1

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Example 2: The Program Year 2011 row is marked as ‘paid,’ the Program Year 2012 row has expired, and the EP is ready to attest for Program Year 2013. The Program Year 2012 row will be marked as “Closed-No Attestation Submitted.”

Status

Provider Name: Big Chain Hospital
 CMS Registration ID: 1000001490
 NPI: 2000001490
 MPN: 1490149

Program Year	Payment Year	Current Status	Activity Date
2013	2	Attestation in Process	
2012	2	Closed - No Attestation Submitted	
2011	1	Paid	02/06/2013

Buttons: Proceed, View/Print

Additional information: Welcome Big Chain Hospital, Not Testmips416? Click here, Logout, Click for Page Help, For Additional Information (EP AIU, EP MU, EH AUI/MU guides, DMA Incentive), Contact Information (Questions on completing attestation?, NC-MIPS Help Desk).

Figure 7 - Screenshot of Example 2

Example 3: Program Year 2012 and Program Year 2013 are both active; therefore, the EP can choose to attest for either Program Year 2012 or Program Year 2013.

Status

Please complete your attestation with the current program year 2012 before attesting for 2013.

Provider Name: Meg One
 CMS Registration ID: 1000001475
 NPI: 2000001475
 MPN: 1475147

Program Year	Payment Year	Current Status	Activity Date
2013	2	Attestation in Process	
2012	2	Attestation in Process	
2011	1	Paid	02/04/2013

Buttons: Proceed, Proceed, View/Print

Figure 8 - Screenshot of Example 3

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The red message does not prevent an EP from moving forward with an attestation. Please click 'proceed' next to the Program Year for which you're attesting.

Example 3a: When the EP chooses to attest for Program Year 2012, the Program Year 2013 row will be deleted and the Program Year 2012 row will auto-populate to read "Attestation in Process."

Status

Please complete your attestation with the current program year 2012 before attesting for 2013.

Provider Name Meg One
CMS Registration ID 1000001475
NPI 2000001475
MPN 1475147

Program Year	Payment Year	Current Status	Activity Date	
2012	2	Attestation in Process		Cancel Proceed
2011	1	Paid	02/04/2013	View/Print

Figure 9 - Screenshot of Example 3a

Example 3i: The EP chooses to attest for Program Year 2013. When they do, a pop-up message will appear.

Status

Please complete your attestation with the current program year 2012 before attesting for 2013.

Message from webpage

ⓘ Please note that choosing to attest for the program year 2013 will close the previous year 2012 attestation. Do you wish to continue?

OK Cancel

Program Year	Payment Year	Current Status	Activity Date	
2013	2	Attestation in Process		Proceed
2012	2	Attestation in Process		Proceed
2011	1	Paid	02/04/2013	View/Print

Figure 10 – Screenshot of Example 3i

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Example 3ii: If the EP selects 'OK' to the pop-up message, the Program Year 2012 row will be marked as "Closed-No Attestation Submitted," and the Program Year 2013 row will auto-populate to read, "Attestation in Process."

Alternatively, the EP may choose to "Cancel" the pop-up message, which will keep them on the page.

Status

Provider Name Tony Seven
CMS Registration ID 1000001474
NPI 2000001474
MPN 1474147

Program Year	Payment Year	Current Status	Activity Date	
2013	2	Attestation in Process		Cancel Proceed
2012	2	Closed - No Attestation Submitted		
2011	1	Paid	02/04/2013	View/Print

Figure 11 - Screenshot of Example 3ii

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Example 4: If the previous payment year (i.e., Program Year 2012) has been ‘Denied’ the EP will be provided with two options:

- Scenario 1: Re-attest for the denied attestation (figure 14); or,
- Scenario 2: Attest for the current program year (figure 15/16).

Status

Provider Name: Anthony Five
CMS Registration ID: 1000001472
NPI: 2000001472
MPN: 1472147

Program Year	Payment Year	Current Status	Activity Date	
2013	2	Attestation in Process		Proceed
2012	2	Attestation Denied		Reattest
2011	1	Paid	02/04/2013	View/Print

Figure 12 – Screenshot of Example 4

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Scenario 1: Program Year 2012 has been denied; however, the EP is ready to attest for Program Year 2013. When the EP chooses to re-attest for a denied 2012 payment, a Program Year 2012 row will auto-populate and the Program Year 2013 row will be removed.

The EP chooses to re-attest by selecting the “Re-attest” button. A second Program Year 2012 row will auto-populate to read, “Attestation in Process.”

Status

Please complete your attestation with the current program year 2012 before attesting for 2013.

Provider Name	Anthony Five
CMS Registration ID	1000001472
NPI	2000001472
MPN	1472147

Program Year	Payment Year	Current Status	Activity Date	
2012	2	Attestation in Process		Cancel Proceed
2012	2	Attestation Denied		View/Print
2011	1	Paid	02/04/2013	View/Print

Figure 13 – Screenshot of Scenario 1

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Scenario 2: Provider chooses to attest for Program Year 2013. If the EP selects the “OK” button when the pop-up message displays, they will start with a Program Year 2013 attestation. The Program Year 2012 row will remain labeled as, “Attestation Denied.”



Figure 14 – Screenshot of Scenario 2

Scenario 2a: Alternatively, the EP can select the “Cancel” button on the warning pop-up message box, and they will remain on the same page.

Status

Please complete your attestation with the current program year 2012 before attesting for 2013.

Provider Name Marge Two
CMS Registration ID 1000001476
NPI 2000001476
MPN 1476147

Program Year	Payment Year	Current Status	Activity Date	
2013	2	Attestation in Process		Cancel Proceed
2012	1	Attestation Denied		View/Print
2011	1	Paid	02/04/2013	View/Print

Figure 15 – Screenshot of Scenario 2a

Demographics

The Demographics page allows EPs to review pertinent information from the CMS Registration & Attestation system and NC Medicaid’s NCTracks to ensure that the identifying information is accurate in both systems. Refer to Figure 17. **Please note, if the North Carolina demographic information is not automatically populating within NC-MIPS, please verify your information on NCTracks (more information found 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	<input type="text"/>	<input type="text"/>
* MPN	<input type="text"/>	<input type="text"/>

Are the MPNs listed above correct?

Yes No

Verify the accuracy of the data below. If the information does not match or if the NC data is blank, please update the information with CMS or NC’s EVC system as instructed before continuing.

	From CMS	From NC
First Name	<input type="text"/>	<input type="text"/>
Middle Name	<input type="text"/>	<input type="text"/>
Last Name	<input type="text"/>	<input type="text"/>
Address	<input type="text"/>	<input type="text"/>

Does the provider information above match?

Yes No

[Previous](#)

[Next](#)

Figure 16 – Demographics Page

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

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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 NCTracks, before continuing.

NCTracks (CSC) Call Center: 866-844-1113 or 800-688-6696

CMS EHR Information Center: 1-888-734-6433 or 1-888-734-6563

For questions, please email us at NCMedicaid.HIT@dhhs.nc.gov

To check the demographic information:

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

Contact Information

The Contact Information page is used to provide the contact information for the appropriate personnel in the event that there are questions about the attestation. Refer to Figure 18 below.

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	test
* Phone Number	1111111111
* Email Address	test@test.com

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Welcome Marge Three
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Figure 17 – Contact Information Page

To enter the personal contact 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 your professional license information. Refer to Figure 19 below.

Figure 18 – License Page

To enter your 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.

*Note - Please note the license number is not the same as the approval number.

Practice Predominantly/Hospital-Based

The Practice Predominantly/Hospital-Based page is used to indicate if the EP practiced predominantly at a Federally-Qualified Health Center (FQHC), or Rural Health Center (RHC) in the previous calendar year (for which you're attestation) or the 12 months immediately preceding the date of attestation.

An EP who has more than 50% of his/her total patient encounters at a FQHC/RHC during any continuous six-month period within the preceding calendar year (for which you're attestation) or the preceding 12-month period from the date of attestation, qualifies as "practicing predominately" at a FQHC/RHC. A single patient encounter is one or more services rendered to an individual patient on any one day.

If the EP practiced predominantly (greater than 50% of all patient encounters during a six-month period) at an FQHC/RHC and is not hospital-based, refer to Figure 20. If the EP did not practice predominantly at an FQHC/RHC and is not hospital-based, refer to Figure 21. If the EP did not practice predominantly at an FQHC/RHC and is hospital-based, refer to Figure 22.

This page is also used to determine if the EP is hospital-based, but means the EP provided 90% or more of his/her Medicaid-covered encounters in a 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 you practiced predominantly (greater than 50% of all patient encounters during a six-month period) at an FQHC/RHC (Figure 20):

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 you're 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

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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%.
7. Click *Next*.
8. The [Patient Volume](#) page opens.

Practice Predominantly/Hospital-Based
* indicates a required field

* 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?
 Yes No

Please enter information for practice predominantly assertion:

* Select the date range: 12 Months preceding b

* Start Date of 6-month Period: 05/17/2012

End Date of 6-month Period: 11/16/2012

* Total Patient Encounters at FQHC/RHC: 12

* Total Patient Encounters at all Locations: 12

Your ratio of encounters at a Federally Qualified Health Center or Rural Health Clinic to your total patient encounters is: 100%

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Figure 19 – Practice Predominantly/Hospital-Based Page if you answer “Yes” to practicing predominantly

If you **did not** practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a FQHC/RHC and **are not** hospital-based (Figure 21):

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*.
3. The [Patient Volume](#) page opens.

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Practice Predominantly/Hospital-Based

* indicates a required field

* 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?

Yes No

* Did you provide 90% or more of your Medicaid-covered patient encounters in a hospital setting?

Yes No

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Figure 20 – Practice Predominantly/Hospital-Based Page if you answer “No” to practicing at an FQHC/RHC

If you **did not** practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a FQHC/RHC and are hospital-based (Figure 22):

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 *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*.

4. The [Patient Volume](#) page opens.

Practice Predominantly/Hospital-Based

* indicates a required field

* 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?

Yes No

* Did you provide 90% or more of your Medicaid-covered patient encounters in a hospital setting?

Yes No

* Can you demonstrate that you have funded the acquisition, implementation and maintenance of certified EHR technology?

Yes No

Please NOTE: You will be required to submit documentation/proof to support this, along with your signed attestation.

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Figure 21 - Practice Predominantly/Hospital-Based Page if you answer “No” to practicing at an FQHC/RHC

Patient Volume

The Patient Volume page allows you to specify the reporting method, dates, locations, and number of patient encounters in order to meet program requirements.

On this page, the EP indicates if they are attesting to Medicaid patient volume using the individual or group methodology, as this will impact how Medicaid patient volumes are calculated. Under individual methodology, an EP will report on only his/her 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 affiliated EP wishing to participate. Please note, if using group methodology, you are not to limit the group in any way. When using group methodology, please include the encounters from all providers in the practice, including those who are ineligible to participate in the NC Medicaid EHR Incentive Program. For more information about patient volume please visit the [NC Medicaid EHR Incentive Program website](#), and watch the Understanding Patient Volume podcast or visit the PV tab. Also visit the [PV FAQ page](#) for frequently asked PV questions.

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

The formula to calculate patient volume is as follows:

All Medicaid-enrolled encounters in a continuous 90-day period* (includes zero paid claims)

Total encounters in the same continuous 90-day period

To calculate your Medicaid patient volume, providers have the option to 1. Select a continuous 90-day period from the previous calendar year (for which you're attesting) **OR** 2. A continuous 90-day period in the preceding 12-month period from the date of the attestation.

Providers practicing predominantly at a FQHC/RHC may use non-Medicaid needy patient encounters in addition to Medicaid-enrolled patient encounters to meet the 30% threshold. When calculating needy patient encounters, the provider will report needy individual encounters within any consecutive 90-day period within the prior calendar year (for which you're attesting) **OR** preceding 12-month period from the date of attestation.

To use group methodology for reporting Medicaid patient volume, the EP must have a **current** affiliation with the group practice. The 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. A group practice may use either individual or group methodology for determining Medicaid patient volumes for affiliated EPs. However, all EPs affiliated with the group practice should use

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the same methodology for a given year, as encounters reported during a 90-day PV reporting period by a practice group are not available to an individual EP wishing to use individual methodology at that same group for the same 90-day PV reporting period. An EP in such a group who wishes to use his/her encounters at that group to attest with individual methodology may do so by selected a different 90-day PV reporting period. **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.**

Refer to Figure 23 if you are attesting using individual methodology. Refer to Figure 24 if you are attesting using group methodology. For more information on calculating patient volume, please refer to the Patient Volume podcast or the 'Patient Volume' tab on our website.

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 Group

FQHCs and RHCs can reach the 30 percent threshold by including needy individuals, e.g., sliding scale and no pay, in addition to their Medicaid PV in their numerator. For more information on FQHCs and RHCs, visit the DMA EHR FAQ page at <http://www.ncdhhs.gov/dma/ehr/ehrfaq.htm>.

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 No

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing MPN/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		
test		100		
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?
222222	322222222	10	500	<input checked="" type="radio"/> Yes <input type="radio"/> No

[Add another MPN for this Practice](#)

[Add Another Practice Name](#)

Medicaid Patient Encounters (Numerator) 510
 Total Patient Encounters (Denominator) 100
 Medicaid Patient Volume Percentage (Medicaid / Total) 510%

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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

An EP must report all MPN(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 MPN(s) is no longer used. Did you report all MPN(s) under which the EP's encounters were billed during the 90-day reporting period, even those not currently in use? Yes No

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

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

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

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

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

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

If any other EP(s) used your MPN during the 90-day period, list the name(s) and number of encounters attributable to that EP.

If another EP was listed as attending on any of the encounters you included in your patient volume, enter that EP's MPN and number of encounters attributable to that EP.

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Figure 22 - Patient Volume Page using Individual Methodology

If you are attesting using individual methodology:

1. Enter the Start Date of the continuous 90-day PV reporting period, using the calendar tool or by typing the date.
2. Enter the End Date of the continuous 90-day PV reporting period, using the calendar tool or by typing the date.
3. Click the *Individual* button.
4. Click on *Yes* or *No* for "Do your patient volume numbers come from your work with more than one practice?"
5. Enter the Practice Name – the name of your individual practice or group.

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6. Enter your Total Encounters at Practice – total of all patient encounters, no matter the payer.
7. Enter the Practice’s Billing MPN.
8. Enter the Practice’s Billing NPI.
9. Enter your Medicaid Encounters Billed under this MPN – total Medicaid-enrolled encounters.
10. Enter the number of Medicaid Enrolled Zero Pay Encounters (regardless of payment liability).
11. Click the *Yes* or *No* button for “Were you Listed as Attending for all these Encounters?”
12. If you have billed encounters under more than one MPN, click the link for [Add another MPN for this Practice](#) and repeat steps 7 through 10.
13. If you have billed encounters under Another Practice Name, click the link for [Add another Practice Name](#) and repeat steps 5 through 10.
14. The Numerator, Denominator, and Percentage are calculated and displayed.
15. 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?”
16. Click the *Yes* or *No* button for “Did you report all MPN(s) under which the EP’s encounters were billed during the 90-day reporting period, even those not currently in use?”
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?”
18. Click the *Yes* or *No* button for “Did you exclude from the numerator denied claims that were never paid at a later date?”
18. 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?”
19. Click the *Yes* or *No* button for “Do the numbers you entered represent encounters and not claims?”
20. Click the *Yes* or *No* button for “Did you include encounters in the denominator where services were provided at no charge?”
21. If you had a different MPN or more than one MPN during the 90-day PV reporting period, enter that number in the text field.

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22. If any other provider billed encounters under your MPN during the 90-day PV reporting period, list the name(s) and number of encounters attributable to that provider.
23. If another provider was listed as attending on any of the encounters you included in your patient volume, enter that provider’s MPN and number of encounters attributable to that provider.
24. Click *Next*.
25. The [AIU/MU](#) page opens.

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 Group

FQHCs and RHCs can reach the 30 percent threshold by including needy individuals, e.g., sliding scale and no pay, in addition to their Medicaid PV in their numerator. For more information on FQHCs and RHCs, visit the DMA EHR FAQ page at <http://www.ncdhhs.gov/dma/ehr/ehrfaq.htm>.

Enter the patient volume information for your selected 90-day period below. Add a separate line for each billing MPN/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	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Group's Billing MPN	Group's Billing NPI	Medicaid Encounters Billed under this MPN	Medicaid Enrolled Zero Pay Encounters
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Add another Group MPN			

Medicaid Patient Encounters (Numerator) 0
 Total Patient Encounters (Denominator) 0
 Medicaid Patient Volume Percentage (Medicaid / Total) 0%

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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

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

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

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

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

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

If the group's reported encounters span more than one location and/or were billed with Medicaid under multiple MPNs, NC requires provision of all MPNs 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 MPNs? Yes No N/A

b) During the 90-day reporting period, did the group have a different (outdated) billing MPN or more than one billing MPN? Yes No N/A

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Figure 23 – Patient Volume Page using Group Methodology

If you are attesting using group methodology:

1. Enter the Start Date of the continuous 90-day PV reporting period, using the calendar tool or by typing the date.
2. Enter the End Date of the continuous 90-day PV reporting period, using the calendar tool or by typing the date.
3. Click the *Group* button.
4. Enter the Group Name.
5. Enter the *Number of Group Members*. In doing so, please specify the total number of providers in your group. Please be sure to count all eligible and non-eligible provider types at the practice, and include ALL their encounters in your reported patient volume.

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NOTE: This number includes ALL providers in the group, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program.

6. Enter the Group's Billing MPN. Leave blank is N/A.
7. Enter the Group's Billing NPI.
8. Enter the "Medicaid Encounters Billed under this MPN/NPI" – total Medicaid-enrolled encounters.
9. Enter the number of Medicaid Enrolled Zero Pay Encounters (regardless of payment liability).
10. If the group has billed encounters under more than one MPN/NPI, click the link for [Add another Group MPN](#) and repeat steps 6 through 9.
11. The Numerator, Denominator, and Percentage are calculated and displayed.
12. Click the *Yes* or *No* button for "Did you include all encounters?"
13. 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?"
14. Click the *Yes* or *No* button for "Did you exclude from the numerator denied claims that were never paid at a later date?"
15. Click the *Yes* or *No* button for "Are the patient volume numbers based on date of service and not date of claim or date of payment?"
16. 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?"
17. Click the *Yes* or *No* button for "Do the numbers you entered represent encounters and not claims?"
18. Click the *Yes* or *No* button for "If you are reporting patient encounters from multiple locations, have you provided all associated MPNs?"
19. Click the *Yes* or *No* button for "During the 90-day PV reporting period, did the group have a different (outdated) billing MPN or more than one billing MPN?"
20. Click *Next*.
21. The [AIU/MU](#) page opens.

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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: Prior Calendar Year

* Start Date: 2/1/2012

* End Date: 5/1/2012

* Patient Volume Reporting Method: Individual Group

FQHCs and RHCs can reach the 30 percent threshold by including needy individuals, e.g., sliding scale and no pay, in addition to their Medicaid PV in their numerator. For more information on FQHCs and RHCs, visit the DMA EHR FAQ page at <http://www.ncdhhs.gov/dma/ehr/ehrfaq.htm>

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 No

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

Practice Name	Your Total Encounters at Practice
ABC Practice	51654

Needy Individual Encounters				
Practice's Billing MPN	Practice's Billing NPI	Medicaid Encounters Billed under this MPN	No Pay & Sliding Scale Encounters	Were you Listed as Attending for all these Encounters?
2464564	6513513136	35135	515	<input checked="" type="radio"/> Yes <input type="radio"/> No

Add another MPN for this Practice

Add Another Practice Name

Medicaid Patient Encounters (Numerator)	35650
Total Patient Encounters (Denominator)	51654
Medicaid Patient Volume Percentage (Medicaid / Total)	69%

Figure 24 - Practicing Predominantly Patient Volume Screenshot

If you are attesting to practicing predominantly:

1. On the drop down menu, select the date range, “Prior Calendar Year” or “Preceding 12-months.”
2. Enter the Start Date of the continuous 90-day PV reporting period, using the calendar tool or by typing the date.
3. Enter the End Date of the continuous 90-day PV reporting period, using the calendar tool or by typing the date.

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4. Select the Patient Volume Reporting Method, individual or group.
5. Select *Yes* or *No* when asked if your patient volume numbers have come from your work with more than one practice.
6. Enter the Practice Name.
7. Enter the number of total encounters at your practice.
8. Enter the Practice's MPN.
9. Enter the Practice's Billing NPI.
10. Enter the number of Medicaid encounters billed under the practice's MPN.
11. Enter the number of no pay or sliding scale encounters
12. Select *Yes* or *No* when asked if you were listed as Attending for all the encounters
13. If attesting as a group and the group has billed encounters under more than one MPN, click the link for "Add another MPN for this practice" and repeat steps 8-12.
14. The numerator, denominator and percentage are calculated and displayed.
15. Given the methodology selected, group or individual patient volume questions will populate. Answer all the questions on the Patient Volume screen.

Note: The questions on the PV screen are there in an effort to reduce the likelihood of needing to perform outreach.

If you require additional information on calculating the Medicaid Patient Volume, please see our website, or [click here](#) for the Patient Volume podcast.

AIU or Meaningful Use Page

The AIU/MU page identifies the EPs individual MU reporting period, as well as ALL of the locations an EP worked at during the reporting period. Please note, the information submitted on the attestation from this point forward **will reflect that of the individual EP** (even if the EP used group methodology to calculate PV). Refer to Figure 25.

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.

AIU or Meaningful Use
* indicates a required field

EHR Certification Number: 34000BR34567890

* Please indicate your approach:
 Adopt, Implement, Upgrade Meaningful Use

* Please identify your Meaningful Use reporting period:
 90-day reporting period 365-day reporting period

Please enter your reporting period date range
 * Start Date: 01/01/2012
 * End Date: 03/30/2012

Please enter all locations where you had patient volume for the given reporting period.

* Practice Name	* Address	* Total Encounters for reporting period	* EHR?
test	test	100	<input checked="" type="radio"/> Yes <input type="radio"/> No

Add a location

Percentage of encounters at a location with certified EHR technology: 0%

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 Questions on completing attestation?

Figure 25 - AIU or MU Page

To enter Meaningful Use activities:

1. Under “Please indicate your approach,” click the *Meaningful Use* radio button.
2. Under “Please indicate your Meaningful Use reporting period”, select a button to indicate the reporting period you are attesting for: *90-day reporting period* or *365-day reporting period*.
Note: this will be a 90 or 365 day period in the calendar year for which you’re attesting. If attesting for Program Year 2014, the MU reporting period will come from calendar year 2014.
3. Enter the ‘Start Date’ of the continuous 90 or 365-day MU reporting period.
4. Enter the ‘End Date’ of the continuous 90 or 365-day MU reporting period.
5. Enter the ‘Practice Name’ for every practice the individual EP had patient encounters during the continuous 90- or 365-day MU reporting period.

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6. Enter the 'Practice Address' for every practice where the EP had patient encounters during the continuous 90- or 365-day MU reporting period.
7. Enter the individual EPs 'Total MU Encounters for the MU reporting period.' *NOTE: This number should reflect the individual EPs MU encounters at that practice location within the continuous 90-day MU reporting period; this includes all payers and should be different than the information submitted on the PV page.*
8. Select *Yes* if the practice location was equipped with certified EHR technology. Select *No* if the practice location was not equipped with certified EHR technology.
9. The percentage of the EPS total MU encounters equipped with certified EHR technology will be automatically displayed. *NOTE: This percentage must be 50 percent or greater to meet meaningful use requirements.*
10. Click *Next*.
11. The [Measure Selection Home page](#) will open.

Measure Selection Home Page

The Measure Selection Home page is where the user will go to begin each measure set. These Measure Sets are: Meaningful Use Core Measures, Meaningful Use Menu Measures, Core Clinical Quality Measures, Alternate Clinical Quality Measures, and Additional Clinical Quality Measures.

This page will also allow the user to track their progress as they attest to meaningful use. The user can jump to this page at any time by selecting the 'Meaningful Use' link on the right rail.

Measure Selection Home Page

Measure Set	Actions	Complete	Valid
Meaningful Use Core Measures	Begin Review	✘	✘
Meaningful Use Menu Measures	Begin Review	✔	✔
Core Clinical Quality Measures	Begin Review	✘	✘
Alternate Clinical Quality Measures	Begin Review		
Additional Clinical Quality Measures	Begin Review	✘	✘

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Figure 26 - Measure Selection Home Page

NOTE: If at any time the user has any questions on what to enter (numerator, denominator, exclusion, etc.) for a particular measure, or has difficulty determining what measure they should attest to, they should contact their EHR vendor.

If the user is experiencing technical difficulties within the NC-MIPS system, they should contact the NC-MIPS Help Desk.

The Measure Selection Home page displays four columns:

Measure Set – These are the sets of objectives and measures that the user will be reporting on.

Actions – The **Begin** action button will launch the user into the first page of the measure set. For the MU Core & MU Core Clinical Quality Measures, the user will be directed to the first question in the measure set. For all other measure sets, the user will be directed to a Measure Instructions page, where they will have the opportunity to select those measures they wish to report on.

The **Review** button will direct the user to the measure set summary page, and allow the user to review and edit their attested information.

NOTE: Once the attestation is submitted, EPs will not be able to go back into the system to print these summary pages – so please print the MU Summary Pages during the attestation. The EP is required to sign and date all applicable MU Summary Pages and send them in with their signed attestation.

Complete – The user will see either a green check or a red ‘x’ in this column. A green check indicates the user has completed all required measures within the measure set. A red ‘x’ indicates the user has not completed all required measures within the measure set.

Valid – The user will see either a green check or a red ‘x’ in this column. A green check indicates the user has entered valid responses for all measures within the measure set. A red ‘x’ indicates the user has entered at least one invalid response to a measure within the measure set.

Common reasons for invalid responses:

- Measure threshold not met.
- The user did not enter responses for the required number of measures.
- The user entered only partial data for one or more measures.

Helpful Hint - If the user sees a red ‘x,’ the user should review answers for accuracy and validity. If the user continues to experience issues with reporting, they should contact their EHR vendor.

The user will be permitted to submit their attestation even if there is a red ‘x’ in the ‘Valid’ column. However, if a red ‘x’ displays under the ‘Valid’ column, a warning message will display telling the user that they have not successfully met the meaningful use requirements for that measure set, and submitting their attestation at that time **will result in a denial of payment.**

On the Measure Selection Home page, the *Next* button will only be enabled once the user enters all required measures, and the ‘Complete’ column displays a green check mark in all applicable measure sets.

Things to keep in mind while attesting to MU...

On the Measure Selection Home page, the *Next* button will only be enabled once the user enters all required measures, and the 'Complete' column displays a green check mark beside all measure sets.

Please note, for each Core Clinical Quality Measures attested with zeros, the user will be required to report on the same number of Alternate Clinical Quality Measures. The user will only see the Alternate Clinical Quality Measure page enabled if zeros have been entered in all the numerator and denominator fields of a Core Clinical Quality Measure.

For example: the user enters zeros for all the numerators and denominators for two Core Clinical Quality Measures, the Alternate Clinical Quality Measure link will be enabled, and the user will be required to report on two Alternate Clinical Quality Measures.

After completing a measure set, the user will be routed to the respective MU Summary page. Here the user can review and edit their attested information. If the user clicks the *Next* button, they will be routed back to the Measure Selection Home page. At that time, the Complete and Valid columns will populate a green check or a red 'x' based on the completeness and validity of all the attested measures within a measure set. To reiterate, please print and sign the MU Summary Pages after successfully completing the MU measure set because once the EP submits the attestation, they need to withdraw & re-attest to retrieve the MU pages.

Please note, as a user navigates through the meaningful use measures, the user is permitted to click the *Previous* button at any time during their attestation; however, all information entered on the page will not be saved. It is not until the user clicks the *Next* button that a particular page's information will be saved in the system. A user will have the opportunity to alter any entered information after completing a measure set, by clicking on *Review*.

Meaningful Use Core Measures Pages

The user is required to report on all 13 Core Measures.

Meaningful Use Core Measures

Question 1 of 15

* indicates a required field

Objective: Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.

* Please select the measure you are attesting to:

Original Measure: More than 30% of all unique patients with at least one medication in their medication list seen by the EP have at least one medication ordered entered using CPOE.

Alternate Measure: More than 30% of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

Exclusion : Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use.

* Does this exclusion apply to you?

Yes No

Patient Records: The provider is permitted, but not required, to limit the measure of this objective to those patients whose records are maintained using certified EHR technology.

* Please select whether the data used to support the measure was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

This data was extracted from ALL patient records, not just those maintained using certified EHR technology.

This data was extracted only from patient records maintained using certified EHR technology.

* **Numerator:**

The numerator is the number of patients in the denominator that have at least one medication order entered using CPOE.

* **Denominator:**

The denominator is the number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period.

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Figure 27 – Core Measure Page Example

1. The user will be directed to Core Measure Question 1 of 15, and will navigate through the remaining 14 Core Measure pages by clicking the *Next* button. Each question will always display the Objective and Measure. These definitions will tell the user what the objective is and how they can meet the measure.
2. Per the Stage 2 Final Rule, MU Core Measure 1 & 8 gives a provider the option to select the original or alternate measure. Users will select the 'Original Measure' or 'Alternate Measure' radio button for the measure set they are attesting to.

3. If an objective contains *Exclusion* criteria, the criteria will be displayed.
 - If after reading the *Exclusion* criteria, the exclusion applies to you, click 'Yes.' If Yes is selected, no additional information will displayed.
 - If after reading the *Exclusion* criteria, the exclusion does not apply to you, click 'No.' If No is selected, additional fields will populate.
4. Some measures require entering the source of the measure data being reported.
 - If the measure data being reported is from all patient records, select the first radio button.
 - If the measure data is from patient records maintained using certified EHR technology, select the second radio button.
5. Some measures require the user to enter a numerator and denominator.
 - The user may be asked to report on an entire population of patients, or just a subset.
 - A user should ensure the numerators and denominators they enter align with the numerator and denominator descriptions provided and match exactly the reports produced by their EHRs (or combination of such reports and other data sources, where applicable).
6. At the end of Question 15 of 15, the user will click *Next* and the [Core Measure Summary page](#) opens.
7. Per the Stage 2 Final Rule, Core Measures 10 and 14 are no longer required, and will see the screenshot below.

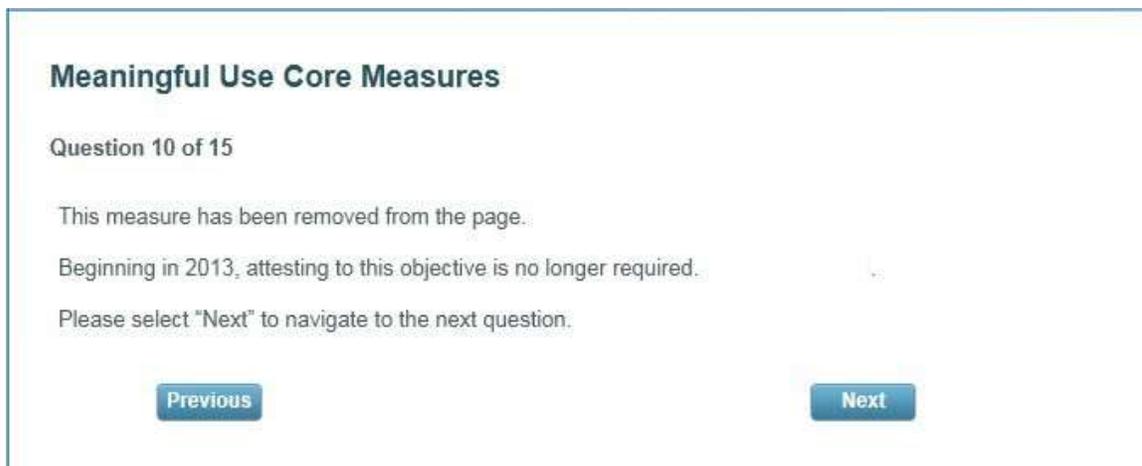


Figure 28 - Screenshot of a measure which is no longer required

Meaningful Use Core Measure Summary Page

The Meaningful Use Core Measure Summary page will give the user an overview of their attested information for each of the 13 Core Measures in the Core Measure Set.

Meaningful Use Core Measures Summary

Meaningful Use Core Measures Table
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

Objective	Data Entered	Edit
Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	Excluded	Edit
Implement drug-drug and drug-allergy interaction checks.	Yes	Edit
Maintain an up-to-date problem list of current and active diagnoses.	Denominator = 100 Numerator = 90	Edit
Generate and transmit permissible prescriptions electronically (eRx).	Excluded	Edit
Maintain active medication list.	Denominator = 100 Numerator = 90	Edit
Maintain active medication allergy list.	Denominator = 100 Numerator = 90	Edit
Record all the following demographics: <ul style="list-style-type: none"> ⇒ Preferred Language ⇒ Gender ⇒ Race ⇒ Ethnicity ⇒ Date of Birth 	Denominator = 100 Numerator = 90	Edit
Record and chart changes in the vital signs: <ul style="list-style-type: none"> ⇒ Height ⇒ Weight ⇒ Blood pressure ⇒ Calculate and display body mass index (BMI) ⇒ Plot and display growth charts for children 2-20 years, including BMI. 	Excluded	Edit
Record smoking status for patients age 13 and older.	Excluded	Edit
Report ambulatory clinical quality measures to the State of the North Carolina.	Yes	Edit
Implement one clinical decision support (CDS) rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.	Yes	Edit
Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request.	Excluded	Edit
Provide clinical summaries for patients for each office visit.	Excluded	Edit
Capability to exchange key clinical information (for example, problem list, medication list, medication allergies, and diagnostic test results), among providers of care and patient authorized entities electronically.	Yes	Edit
Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.	Yes	Edit

Signature _____
Date _____

Please print a copy of this completed summary page to include with your printed and signed attestation.

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Figure 29 - Core Summary Page

- Select *Edit* to change or modify any question within the measure set.
- Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Core Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Print the summary page before submitting the attestation.
- Click *Next* to be routed back to the [Measure Selection Home page](#).

Stage 1 MU EP Attestation Guide

Meaningful Use Menu Measure Instructions Page The Menu Measure Instructions page will give the user the opportunity to select the measures that they would like to attest for. A user is required to attest to five Menu Measures.

NOTE: The user must select at least one Public Health Menu Measure, but may be able to claim an exclusion. Please refer to the guidance at the top of this page for more timely information.

Meaningful Use Menu Measure Instructions

EPs must report on a total of five (5) MU menu measures, one of which must be a public health measure. Currently, the North Carolina Division of Public Health is neither able to accept electronic submission of immunization data nor syndromic surveillance data from EPs; therefore, an exclusion may be claimed for either of these public health measures. To successfully report on a public health measure, you must enter an exclusion response in the measure reporting space. CMS encourages EPs to select menu measures that are relevant to their scope of practice and to claim an exclusion for a menu measure only in cases where there are no remaining menu measures for which they qualify or if there are no remaining menu measures that are relevant to their scope of practice.

Public Health Menu Measures

Selection Objective

- Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission except where prohibited and in accordance with applicable law and practice.
- Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission in accordance with applicable law and practice.

If an EP claims an exclusion for one of the public health measures above, the EP must select four of the remaining MU menu measures. If an EP claims an exclusion for both of the public health measures above, the EP must select three of the remaining MU menu measures. You must select additional menu measures until a total of five MU menu measure objectives have been selected, even if exclusions apply.

Additional Menu Measures

Selection Objective

- Implement drug formulary checks.
- Incorporate clinical lab-test results into EHR as structured data.
- Generate lists of patients by specific condition to use for quality improvement, reduction of disparities, research or outreach.
- Send reminders to patients per patient preference for preventative/ follow-up care.
- Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within four business days of the information being available to the EP.
- Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.
- The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.
- The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

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Figure 30 - Menu Measure Instructions Page

Click *Next* to route to the first of the five selected [Menu Measures](#).

Meaningful Use Menu Measures

A user is required to attest to five Menu Measures.

Meaningful Use Menu Measures

Question 1 of 6

* indicates a required field

Objective:	Capability to submit electronic data to immunization registries or immunization information systems and an actual submission except where prohibited and in accordance with applicable law and practice.
Measure:	Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP submits such information has the capacity to receive the information electronically). Simulated transfers of information are not acceptable to satisfy this objective.
Exclusion 1:	An EP who does not perform immunizations during the EHR reporting period would be excluded from this requirement. Exclusion from this requirement does not prevent an EP from achieving meaningful use. * Does this exclusion apply to you? <input type="radio"/> Yes <input type="radio"/> No

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Figure 31 - Menu Measure Screenshot

1. The user will be directed to Menu Measure Question 1 of 5, and will navigate through the remaining four Menu Measure pages by clicking the *Next* button.
2. Each question will always display the Objective and Measure. These definitions will tell the user what the objective is and how they can meet the measure.
3. If an objective contains exclusion criteria, the criteria will be displayed.
 - If after reading the exclusion criteria, the exclusion applies to you, click 'Yes.' If *Yes* is selected, no additional information will displayed.
 - If after reading the exclusion criteria, the exclusion does not apply to you, click 'No.' If *No* is selected, additional fields will populate.
4. Some measures require entering the source of the measure data being reported.
 - If the measure data being reported is from all patient records, select the first radio button.
 - If the measure data is from patient records maintained using certified EHR technology, select the second radio button.

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5. Some measures require the user to enter a numerator and denominator.
 - The user may be asked to report on an entire population of patients, or just a subset.
 - The user should ensure the numerators and denominators they enter align with the numerator and denominator descriptions provided.
6. At the end of Question 5 of 5, the user will click *Next* and the [Menu Measure Summary page](#) opens.

Menu Measures Summary Page

The Menu Measure Summary page will give the user an overview of their attested information for each of the five Menu Measures in the Menu Measure Set.

Meaningful Use Menu Measures Summary

Meaningful Use Menu Measures Table
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

Objective	Data Entered	Edit
Capability to submit electronic syndromic surveillance data to public health agencies and an actual submission in accordance with applicable law and practice.	Yes	Edit
Capability to submit electronically syndromic surveillance data to public health agencies and actual submission according to applicable law and practice.	Excluded	Edit
Implement drug formulary checks.	Excluded	Edit
Incorporate clinical lab-test results into EHR as structured data.	Excluded	Edit
Generate lists of patients by specific condition to use for quality improvement, reduction of disparities, research or outreach.	Yes	Edit
Send reminders to patients per patient preference for preventative/ follow-up care.	Excluded	Edit
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, and allergies) within four business days of the information being available to the EP.	Excluded	Edit
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate.	Numerator = 10 Denominator = 10	Edit
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	Excluded	Edit
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	Excluded	Edit

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Figure 32 - Menu Measure Summary Page

1. Select *Edit* to change or modify any question within the measure set.
2. Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Menu Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Print the summary before submitting your attestation.
3. Click *Next* to be routed back to the [Measure Selection Home page](#).

Core Clinical Quality Measures Page

The user will be required to enter information for all three of the Core Clinical Quality Measures (CQM). **NOTE:** Zeros in the numerator and denominator are considered valid; however, the user must attest to an Alternate CQMs or every CQM with zeros entered in all numerator and denominator fields. It is permissible to have zeros for a subset of the population in a measure.

For example: If the user enters zeros in all numerator and denominator fields for two of the Core CQMs, they will be required to attest to two Alternate CQMs.

CQM exclusions are unique data specifications that your certified EHR technology vendor has programmed into your particular EHR product. For instance, in the Adult Weight Screening and Follow-up Core Clinical Quality Measures (NQF 0421), the certified EHR would exclude pregnant individuals from the measure data through specific programming logic. The reports that your EHR produces should contain these exclusion numbers for you to enter into the appropriate attestation data fields.

Core Clinical Quality Measures

Question 3 of 3

* indicates a required field

Instructions: All three core Clinical Quality Measures (CQM) must be submitted. For each Core CQM that has a denominator of zero, an Alternate Core CQM must also be submitted.

NQF 0421/PQRI 128: Adult Weight Screening and Follow-Up

Description: Percentage of patients age 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside the parameters, a follow-up plan is documented.

Population Criteria 1

* Numerator 1:

* Denominator:

* Exclusion:

Population Criteria 2

* Numerator 2:

* Denominator:

* Exclusion:

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Figure 33 - Core Clinical Quality Measure Page Example

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1. The user will be directed to Core Clinical Quality Measure Question 1 of 3, and will navigate through the two remaining Core Clinical Quality Measure pages by clicking the *Next* button.
2. Each question will always display instructions, the NQF identifier and a description of the measure. Instructions remind the user that the number of zeros entered as denominators in the Core Clinical Quality Measures will need to correspond to the number of Alternate Clinical Quality Measures submitted. Some measures will prompt the user to insert all additional required information (numerator, denominator, exclusion, etc.).
3. Only on Question 3 of 3 the user will click *Next* and the [Core Clinical Quality Measure Summary page](#) opens.

Core Clinical Quality Measure Summary Page

The Core Clinical Quality Measure Summary page will give the user an overview of their attested information for each of the three Core Clinical Quality Measures in the Core Clinical Quality Measure Set.

Core Clinical Quality Measures Summary

Core Clinical Quality Measures Table
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

NQF Number and Title	Data Entered	Edit
NQF 0013: Hypertension	Numerator = 10 Denominator = 10	Edit
NQF 0028: Preventative Care and Screening Measure Pair (Tobacco)	a) Tobacco Use Assessment: Numerator = 10 Denominator = 10 b) Tobacco Cessation Intervention: Numerator = 10 Denominator = 10	Edit
NQF 0421: Adult Weight Screening and Follow-Up	Population Criteria 1: Numerator = 10 Denominator = 10 Exclusion = 0 Population Criteria 2: Numerator = 10 Denominator = 10 Exclusion = 0	Edit

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Figure 34 - Core Clinical Quality Measure Summary Page

1. Select *Edit* to change or modify any question within the measure set.
2. Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Core Clinical Quality Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Please print the summary page before submitting your attestation.
3. Click *Next* to be routed back to the [Measure Selection Home page](#).

Alternate Clinical Quality Measure Instructions Page

For every Core Clinical Quality Measure with zeros entered in all its numerator and denominator fields, the system will prompt the user to select an Alternate Clinical Quality Measure. The Alternate Clinical Quality Measure Instructions page will give the user the opportunity to select the measures for which they would like to attest.

Alternate Core Clinical Quality Measures Instructions

You have entered a denominator of zero for one or more of your Core Clinical Quality Measures

Please select Alternate Core Clinical Quality Measures from the list below.

Note: An Alternate Clinical Quality Measure with a denominator of zero should only be selected if the remaining Alternate Clinical Quality Measures do not have a denominator value greater than zero.

Selection	Measure Number	Measure Title
<input type="checkbox"/>	NQF 0024	Weight Assessment and Counseling for Children and Adolescents
<input type="checkbox"/>	NQF 0041	Preventative Care and Screening: Influenza Immunization for patients >= 50 years old.
<input type="checkbox"/>	NQF 0038	Childhood Immunization Status

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Figure 35 - Alternate Clinical Quality Measure Instructions Page

1. Select the Alternate Clinical Quality Measure (s) to which the user will attest.
2. Click *Next* to route to the first [Alternate Clinical Quality Measure](#).

Alternate Clinical Quality Measure Page

If zeros were entered in all of the numerator and denominator fields of ANY Core Clinical Quality Measure, the system will prompt the user to select an Alternate Clinical Quality Measures.

Alternate Clinical Quality Measures

Question 1 of 2

* indicates a required field

Instructions: For each Core CQM that had a denominator of zero, an Alternate Core CQM must also be submitted.

NQF ID: 0024

Description: Weight Assessment and Counseling for Children and Adolescents
Percentage of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.

Population Criteria 1

* Numerator 1:

* Denominator:

* Numerator 2:

* Denominator:

* Numerator 3:

* Denominator:

Population Criteria 2

* Numerator 1:

* Denominator:

* Numerator 2:

* Denominator:

* Numerator 3:

* Denominator:

Population Criteria 3

* Numerator 1:

* Denominator:

* Numerator 2:

* Denominator:

* Numerator 3:

* Denominator:

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Figure 36 - Alternate Clinical Quality Measure Page Example

1. The user will be directed to the first Alternate Clinical Quality Measure, and will navigate through the remaining Alternate Clinical Quality Measure pages by clicking the *Next* button.
2. Each question will always display instructions, the NQF identifier and a description of the measure. Instructions remind the user that for each Core Clinical Quality Measure that had a denominator of zero, an Alternate Clinical Quality Measure must also be submitted.
3. Some measures will prompt the user to enter additional required information (numerator, denominator, exclusion, etc.).
4. Only on the last Alternate Clinical Quality Measures, the user will click *Next* and the [Alternate Clinical Quality Measure Summary page](#) opens.

Alternate Clinical Quality Measure Summary Page

The Alternate Clinical Quality Measure Summary page will give the user an overview of their attested information for all Alternate Clinical Quality Measures.

Alternate Clinical Quality Measures Summary

Alternate Clinical Quality Measures Table
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

NQF Number and Title	Data Entered	Edit
	Population Criteria 1: Numerator 1 = 0 Denominator = 0 Numerator 2 = 0 Denominator = 0 Numerator 3 = 0 Denominator = 0 Population Criteria 2: Numerator 1 = 0 Denominator = 0 Numerator 2 = 0 Denominator = 0 Numerator 3 = 0 Denominator = 0 Population Criteria 3: Numerator 1 = 0 Denominator = 0 Numerator 2 = 0 Denominator = 0 Numerator 3 = 0 Denominator = 0	
NQF 0024: Weight Assessment and Counseling for Children and Adolescents		Edit
NQF 0041: Preventative Care and Screening	Numerator = 0 Denominator = 0 Exclusion = 0	Edit

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Figure 37 - Alternate Clinical Quality Measure Summary Page

1. Select *Edit* to change or modify any question within the measure set.
4. Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Alternate Clinical Quality Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Please print the summary page before submitting your attestation.
2. Click *Next* to route back to the [Measure Selection Home page](#).

Additional Clinical Quality Measure Instructions

The user is required to report on three of 38 Additional Clinical Quality Measures. The Additional Clinical Quality Measure Instructions page will give the user the opportunity to select the measures for which they would like to attest.

Additional Clinical Quality Measure Instructions

Instructions: Select three Additional Clinical Quality Measures from the list below. You will be prompted to enter numerator(s), denominator(s), and exclusion(s), if applicable for all three Additional Clinical Quality Measures after you select the Next button below."

Selection	Measure Number	Measure Title
<input type="checkbox"/>	NQF 0059	Diabetes: HbHemoglobin A1c Poor Control
<input type="checkbox"/>	NQF 0064	Diabetes Low Density Lipoprotein (LDL) Management and Control
<input type="checkbox"/>	NQF 0061	Diabetes: Blood Pressure Management
<input type="checkbox"/>	NQF 0081	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
<input type="checkbox"/>	NQF 0070	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
<input type="checkbox"/>	NQF 0043	Pneumonia Vaccination Status for Older Adults
<input type="checkbox"/>	NQF 0031	Breast Cancer Screening
<input type="checkbox"/>	NQF 0034	Colorectal Cancer Screening
<input type="checkbox"/>	NQF 0067	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
<input type="checkbox"/>	NQF 0083	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
<input type="checkbox"/>	NQF 0105	Anti-depressant Medication Management: a) Effective Acute Phase Treatment, b) Effective Continuation Phase Treatment
<input type="checkbox"/>	NQF 0086	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
<input type="checkbox"/>	NQF 0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
<input type="checkbox"/>	NQF 0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
<input type="checkbox"/>	NQF 0047	Asthma Pharmacologic Therapy
<input type="checkbox"/>	NQF 0002	Appropriate Testing for Children with Pharyngitis
<input type="checkbox"/>	NQF 0387	Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIc Estrogen Receptor /Progesterone Receptor (ER/PR) Positive Breast Cancer
<input type="checkbox"/>	NQF 0385	Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
<input type="checkbox"/>	NQF 0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
<input type="checkbox"/>	NQF 0027	Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies
<input type="checkbox"/>	NQF 0055	Diabetes: Eye Exam
<input type="checkbox"/>	NQF 0062	Diabetes: Urine Screening
<input type="checkbox"/>	NQF 0056	Diabetes: Foot Exam

Figure 38 - Additional Clinical Quality Measure Instructions Page

1. Select the Additional Clinical Quality Measure (s) for which the user will attest.
2. Click *Next* to route to the first of the selected [Additional Clinical Quality Measures](#).

Additional Clinical Quality Measures Page

The user will be required to enter information on three of the 38 Additional Clinical Quality Measures.

Additional Clinical Quality Measures

Question 3 of 3

* indicates a required field

NQF 0036: Use of Appropriate Medication for Asthma

Description: Percentage of patients age 5-50 who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).

Population Criteria 1

* Numerator 1:

* Denominator:

* Exclusion:

Population Criteria 2

* Numerator 2:

* Denominator:

* Exclusion:

Population Criteria 3

* Numerator 3:

* Denominator:

* Exclusion:

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

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Figure 39 - Additional Clinical Quality Measure Page Example

1. The user will be directed to the first Additional Clinical Quality Measure, and will navigate through the remaining Additional Clinical Quality Measure pages by clicking the *Next* button.
2. Each question will always display the NQF identifier and a description of the measure.
3. Some measures will prompt the user to insert all additional required information (numerator, denominator, exclusion, etc.).
4. Only on the last of the Additional Clinical Quality Measure Question, the user will click *Next* and the [Additional Clinical Quality Measure Summary page](#) opens.

Additional Clinical Quality Measure Summary Page

The Additional Clinical Quality Measure Summary page will give the user an overview of their attested information for all Additional Clinical Quality Measures.

Additional Clinical Quality Measures Summary

Additional Clinical Quality Measures Table
Please select the *Edit* link next to the measure you wish to update. If you do not wish to edit your measures, you may select *Next* button to continue.

NQF Number and Title	Data Entered	Edit
NQF 0031: Breast Cancer Screening	Numerator = 10 Denominator = 10	Edit
NQF 0385: Oncology Colon Cancer	Numerator = 10 Denominator = 10 Exclusion = 0	Edit
NQF 0055: Diabetes	Numerator = 10 Denominator = 10 Exclusion = 0	Edit

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

Welcome William Five
Not William Five? [Click here.](#)
[Logout](#)

[Click for Page Help](#)

Jump to...

- » Status
- » Demographics
- » Contact Information
- » License
- » Practice Predominantly
- » Patient Volume
- » AIJ / MU
- » Meaningful Use
- » Congratulations
- » Electronic Submit

For Additional Information

- » [Eligible Professional Attestation Guide](#)

Figure 40 - Additional Clinical Quality Measure Summary Page

1. Select *Edit* to change or modify any question within the measure set.
2. Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Additional Clinical Quality Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Please print the summary page before submitting your attestation.
3. Click *Next* to route back to the [Measure Selection Home page](#).

Attestation Statement Page

Please ensure you have printed off all the MU Summary Pages before submitting the attestation. An EP will not be able to access the MU Summary Pages once they submit the attestation without withdrawing and re-attesting. Once a user has successfully attested to meaningful use (all measures are complete and valid), they will be routed to the Attestation Statement page. The user will confirm that the attested information is complete and accurate.

Attestation Statements

* indicates a required field

You are about to submit your Meaningful Use Attestations.

Please check the box next to each statement below to attest then select the SUBMIT button to complete your attestation.

- * The information submitted for CQMs was generated as output from an identified EHR technology.
- * The information submitted is accurate to the knowledge and belief of the EP.
- * The information submitted is accurate and complete for numerators, denominators, and exclusions for measures that are applicable to the EP.
- * The information submitted included information on all patients to whom the measure applies.
- * A zero was reported in the denominator of a measure when an EP did not care for any patients in the denominator population during the EHR reporting period.
- * As a meaningful EHR user, at least 50% of my patient encounters during the Meaningful Use reporting period occurred at practice locations equipped with certified EHR technology and these practices were listed in the attestation information.
- If applicable, I reported three Core CQMs, and three Alternate CQMs and three Additional CQMs all with zero denominators and all of the 35 remaining CQMs calculated by my certified EHR technology have a value of zero in the denominator.

I understand that I must have, and retain, **for six years after the last incentive payment is received**, documentation to support my eligibility for incentive payments and that the Division of Medical Assistance (DMA) may ask for this documentation. I further understand that DMA will pursue repayment in all instances of improper or duplicate payments. I certify that I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from DMA for this year.

* Initials

* NPI

Figure 41 - Attestation Statement Page

1. Select all the check boxes that apply.
2. Click *Next*.
3. The [Congratulations](#) page opens.

Attestation Not Accepted Page

The user will be routed to the Attestation Not Accepted page when they have submitted an invalid measure within any measure set. The user will be permitted to submit their attestation; however, submittal of an attestation with invalid measures will result in a denial of payment.



Figure 42 - Attestation Not Accepted Page

- Click *Previous* to route back to the Measure Selection Home page.
- The [Measure Selection Home page](#) opens.

OR

- Click *Next* to submit the attestation.
- The Congratulations page opens.

Congratulations

Congratulations! You have completed the attestation questions. Refer to Figure 43 below. Click *Next* to continue to the [Electronic Submission](#) page.

The screenshot shows a web page for the North Carolina Health IT program. At the top, there is a banner with the 'North Carolina Health IT' logo on the left, a photo of four healthcare professionals in the center, and the 'MIP' (Meaningful Use Incentive Program) logo on the right. The main content area is titled 'Congratulations' and contains the following text: '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/fax/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!'. Below this text are two buttons: 'Previous' on the left and 'Next' on the right. On the right side of the page, there is a sidebar with several sections: 'Welcome John Smith' with a 'Logout' button and a link for 'Not John Smith? Click here.'; 'Click for Page Help'; 'Jump to...' with a list of links including Status, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, AIU / MU, Congratulations, and Electronic Submit; 'For Additional Information' with links to Eligible Professional Attestation Guide, Eligible Hospital Attestation Guide, Download Adobe Acrobat to read guides, and DMA Incentive Program home page; and 'Contact Information' with a link for 'Questions on completing attestation? NC-MIPS Help Desk'.

Figure 43 – Congratulations Page

Electronic Submission

The Electronic Submission page is used to submit your electronic attestation and formally attest to the accuracy of the reported information. Refer to Figure 44 below.

Electronic Submission

Concealment or falsification of material facts regarding incentive payment can result in Medicaid Provider Payment suspension, civil prosecution pursuant to the False Claims Act (31 USC 3729-3733), Medical Assistance Provider Fraud (N.C.G.S. 108A-63), Medical Assistance Provider False Claims Act (N.C.G.S. 108A-70.10 to 70-16), the North Carolina False Claims Act (N.C.G.S. 1-605 to 1-618), and/or criminal prosecution pursuant to criminal fraud statutes of North Carolina.

This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State law.

I have read the above statements and attest my responses.

[Previous](#) [Submit](#)

Welcome John Smith
Not John Smith? [Click here.](#)
[Logout](#)

[Click for Page Help](#)

Jump to...

- » Status
- » Demographics
- » Contact Information
- » License
- » Practice Predominantly
- » Patient Volume
- » AIJ / MU
- » Congratulations
- » Electronic Submit

For Additional Information

- » Eligible Professional Attestation Guide
- » Eligible Hospital Attestation Guide
- » Download Adobe Acrobat to read guides
- » DMA Incentive Program home page

Contact Information
Questions on completing attestation?
[NC-MIPS Help Desk](#)

Figure 44 – Submission Page

To attest to the accuracy of the reported information:

1. Read all the statements on the page.
2. If you agree, 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.

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 sent to the NC-MIPS Help Desk. Refer to Figure 45 below.

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 listed:
 - Email a scanned copy to NCMedicaid.HIT@dhhs.nc.gov
 - Mail a copy to:
NC Medicaid EHR Incentive Program
2501 Mail Service Center
Raleigh, NC 27699-2501

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.

Figure 45 – Print, Sign, Send Page

To finish the attestation process:

1. Click *Print* to print the attestation.
2. The attesting EP must sign and date the printed attestation him/herself and the date must reflect that of the most recently submitted attestation. A third party, such as a practice manager, **may not** sign the printed attestation on behalf of the EP. *Electronic signatures 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. Send the signed attestation and supporting documentation to the NC-MIPS Help Desk using one of the following methods:

*Email:	NCMedicaid.HIT@dhhs.nc.gov
Phone Number:	919-814-0180
Mailing Address:	NC Medicaid EHR Incentive Program 2501 Service Center Raleigh, NC 27699-2501

**Email is the preferred method of contact.*

Stage 1 MU EP Attestation Guide

Please note, effective June 1, 2013, the N.C. Medicaid EHR Incentive Program no longer accepts documentation via fax.

4. Retain copies of your signed attestation and supporting documents for at least six years in case of post-payment audit.
5. To see the status of an attestation, click *Go to Status Page* from the Print, Sign, Send Page.
6. Once you have finished, close the browser tab and wait for your payment to arrive. This takes roughly six to 10 weeks for an error-free attestation.

Additional Resources

We have provided some additional resources which may help a user during the attestation process below:

[NC Medicaid EHR Incentive Program website](#)

[CMS Meaningful Use EHR Overview](#)

[CMS Meaningful Use Clinical Quality Measures](#)

[HealthIT.gov](#)

[ONC's Health IT Product List](#)

Having issues identifying which measure you should report or how you should report them? Call your EHR vendor!