



North Carolina Medicaid Electronic Health Record  
Incentive Program

Eligible Professional Modified Stage 2 Meaningful Use  
Attestation Guide for Program Year 2016

NC-MIPS 2.0

Issue Number 1.10

October 28, 2016



## EP Modified MU Attestation Guide



The North Carolina Medicaid Electronic Health Record (EHR) Incentive Program is providing this attestation guide as a reference for eligible professionals (EPs).

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

EPs attesting to Meaningful Use **must** submit their attestation via email to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov). Do not send a hard copy.



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## Using this Guide

### Introduction

This guide is a reference to help an eligible professional (EP) understand the information needed to attest for a Modified Stage 2 Meaningful Use (MU) NC Medicaid EHR incentive payment on the NC Medicaid Incentive Payment System (NC-MIPS). Step-by-step guidance and screenshots are provided throughout the attestation guide to assist participants with their attestation. Please note, this is not a static document and it is subject to updates, so please check NC-MIPS for the most up-to-date guide.

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

### Website Resources

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

- EPs may attest for incentive payments on the NC-MIPS Portal at <https://ncmips.nctracks.nc.gov/>.
- The NC Department of Health and Human Services (DHHS) administers this program. More information on the this program can be found on the NC Medicaid EHR Incentive Program website at <http://www2.ncdhhs.gov/dma/provider/ehr.htm>.
- Additional information on both the Medicare and Medicaid EHR Incentive programs is available from the Centers for Medicare & Medicaid Services' (CMS) EHR Incentive Program website at [www.cms.gov/Regulations- and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/](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](#). For any issues not covered in this guidance, please email our help desk at [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).

In addition to these resources, you can contact our technical assistance partners at your local [Area Health Education Center \(AHEC\)](#) to provide individualized on-site assistance at no cost to you.



AHEC contacts:

[MAHEC](#) – 828-257-4400 - serving Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, and Yancey counties

[Charlotte AHEC](#) -704-512-6523 - serving Anson, Cabarrus, Cleveland, Gaston, Lincoln, Mecklenburg, Stanly, and Union counties

[Northwest AHEC](#) - 336-713-7700 – serving Alexander, Alleghany, Ashe, Avery, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Iredell, Rowan, Stokes, Surry, Watauga, Wilkes, and Yadkin counties

[Greensboro AHEC](#) - 336-832-8025 – serving Alamance, Caswell, Chatham, Guilford, Montgomery, Orange, Randolph, and Rockingham counties

[Duke AHEC](#) - 919-684-8676 – serving Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, and Scotland counties

[Wake AHEC](#) - 919-350-8547 – serving Durham, Franklin, Granville, Johnston, Lee, Person, Vance, Wake, and Warren counties

[Southern Regional AHEC](#) - 910-323-1152 – serving Bladen, Cumberland, Harnett, Hoke, Moore, Richmond, Robeson, Sampson, and Scotland counties

[SEAHEC](#) - 910-343-0161 – serving Brunswick, Columbus, Duplin, New Hanover, and Pender counties

[Area L AHEC](#) - 252-972-6958 – serving Edgecombe, Halifax, Nash, Northampton, and Wilson counties

[Eastern AHEC](#) - 252-744-8214 – serving Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Gates, Greene, Hertford, Hyde, Jones, Lenoir, Martin, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, and Wayne counties

In addition to helping your practice meet Meaningful Use, the NC AHEC staff can also help select, implement and optimize EHRs, help the practice use EHRs to improve the quality of patient care and assist the practice in attesting for an NC Medicaid EHR Incentive payment.

### **Unsure of Eligibility?**

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



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

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

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

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

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

### Outreach and Denials

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

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

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

If an EP is denied, s/he may re-attest for the same program year without penalty prior to the close of the program year. If the EP is denied and the program year has closed, s/he can attest for the next program year. So long as the EP attests for a total of six years by 2021, s/he may earn the full incentive payment.

### EHR Incentive Program Overview

The NC Medicaid EHR Incentive Program awards MU incentive payments to EPs who 'meaningfully' use certified EHR technology in their day-to-day 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. Regardless of what is attested to in the first year of participation, the EP will be responsible for attesting to MU in participation years two through six (please reference the EP AIU Attestation Guide if attesting for AIU). To reiterate, the last year to attest to, and receive payment for, AIU is Program Year 2016.

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 the EP already has an account with NC-MIPS, do not complete another First Time Account Setup. If this is the EP's first year of participation and s/he does not have an NC- MIPS account, please refer to the EP AIU Attestation Guide for registration information.

Each attesting EP needs a working NCID username and password to complete an attestation. If the EP's NCID username has been updated since completing a First Time Account Setup, please select the NCID Username Update option in the Sign In box on the Welcome Page to update the EP's NCID username using the NC-MIPS NCID Username Update Tool. If you need to update your NCID or have questions about your NCID, please contact NCID. More information can be found at <https://ncid.nc.gov>.

Please update any updated/new information on [CMS' R&A System](https://ehrincentives.cms.gov/hitech/login.action) 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 that it takes at least 24 business hours for changes made with CMS to be reflected in NC-MIPS.



In 2016 and 2017, providers can choose to use technology certified to the 2014 Edition or the 2015 Edition. Please check [ONC's certified Health IT Product List](#) to ensure your EHR is 2014 or 2015 certified. Then you can update your CEHRT number on CMS' Registration & Attestation System before attesting on NC-MIPS. Although CMS doesn't require it, you must enter a valid 2014 or 2015 EHR Certification Number when prompted by CMS. EHR certification numbers are required by North Carolina.

Note: It is during CMS registration that you will assign the payment to a specific payee NPI/payee TIN. Please check to make sure that the payee NPI and payee TIN are correct and also 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, the EP realizes s/he does not meet the eligibility requirements for participation in this program, the attestation may be canceled on the status page within the NC-MIPS Portal (refer to the [Provider Status page](#) for more information). Please remember that even if an EP does not qualify for participation in the Medicaid EHR Incentive Program this Program Year, s/he may attest for a later program year. *EPs must successfully attest for six program years to earn the full incentive payment and must begin their first year of participation no later than Program Year 2016.*

### Attestation Tail Period

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

### Attesting for MU in Program Year 2016

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.

For Program Year 2016, EPs will attest to Modified Stage 2 MU. MU is no longer broken out between Stage 1 and Stage 2.

For 2016, all providers previously scheduled to be in Stage 1 may claim an alternate exclusion for the CPOE objective measure 2 (laboratory orders) and measure 3 (radiology orders). To reiterate, this alternate exclusions is only applicable if the EP was scheduled to attest to Stage



1 in Program Year 2016.

These alternate measures do not apply for EPs who

- were scheduled to attest to Stage 2 MU in Program Year 2016;
- who have already attested for two years of Stage 1 MU prior to Program Year 2016; and/or;
- for whom Program Year 2016 is their fourth, fifth, or sixth payment year.

If an EP attests to either of these alternate measures but was not eligible for Stage 1 MU for Program Year 2016, her/his attestation will be denied.

### Before Attesting

Before getting started, check the MU measures that will be collected during the MU reporting period and work with the EHR vendor to ensure the EHR is certified to capture those measures.

### Reporting Periods

PV ~~≠~~ MU

EPs will be required to report at least **two separate reporting periods**: PV and MU. These reporting periods are not synonymous. Pay particular attention when entering these reporting periods into NC-MIPS that the reporting periods are accurate based on the EP's auditable data source.

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

For example: If attesting on February 1, 2017 for Program Year 2016, the previous calendar year is 2015 and the 12 months immediately preceding the date attestation would be 2/1/16-1/31/17.
- **MU Reporting Period**– This is specific to the individual EP. It should be a consecutive 90-day or full calendar year reporting period from the Program Year for which you're attesting. For example: If attesting for Program Year 2016, the MU reporting period will be a consecutive 90-day period in 2016 or a full 2016 calendar year 1/1/16-12/31/16.

### Meaningful Use Summary Pages

Providers will need to print their MU summary pages (MU Objectives Summary Page and the Clinical Quality Measures Summary Page) during the attestation **before submitting** the attestation. An EP will not be able to access the MU Summary Pages to print once they submit the attestation without withdrawing and re-attesting.

### Recommended Documentation

After attesting, it is recommended that the following documents (if applicable) be emailed with

the EP's signed attestation:

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

### 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 Measures and Clinical Quality Measures.

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
- 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

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

The screenshot shows the NC-MIPS Provider Portal interface. At the top left is the North Carolina Health IT logo, and at the top right is the EHR Incentive Program logo. The main content area is titled "Welcome to the NC-MIPS Portal" and contains a message about the 2016 program year and instructions for updating NCID usernames. To the right is a "Sign In" form with fields for "NCID Username" (containing "Testmips127") and "NCID Password" (masked with dots), a "Login" button, and links for "First time Account Setup?", "Forgot Username?", "Forgot Password?", and "NCID Username Update". Below the sign-in form are three navigation boxes: "Click for Page Help", "For Additional Information" (with links to EP AIU Attestation Guide, EP Modified MU Attestation Guide, EH AIU/MU Attestation Guide, Download Adobe Acrobat to read guides, and DMA Incentive Program home page), and "Contact Information" (with a link to the NC-MIPS Help Desk and email address NCMedicaid.HIT@dhhs.nc.gov). At the bottom of the page, there is a footer with "Contact Us - Disclaimer - Version: 2.1.35.01" and "© Copyright 2016 State of North Carolina, all rights reserved."

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

## Sign In

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

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

## Trouble logging in?

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

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

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

## Page Help

The *Click for Page Help* link opens a PDF version of this attestation guide to the page that corresponds to the page the user is viewing. If the user does not have Adobe Acrobat to view the PDF, there is a link to download the free Adobe Reader software in the "Additional Information" area below.



## Jump to...

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

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

## Additional Information

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

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

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

## Contact Information

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

## Footer

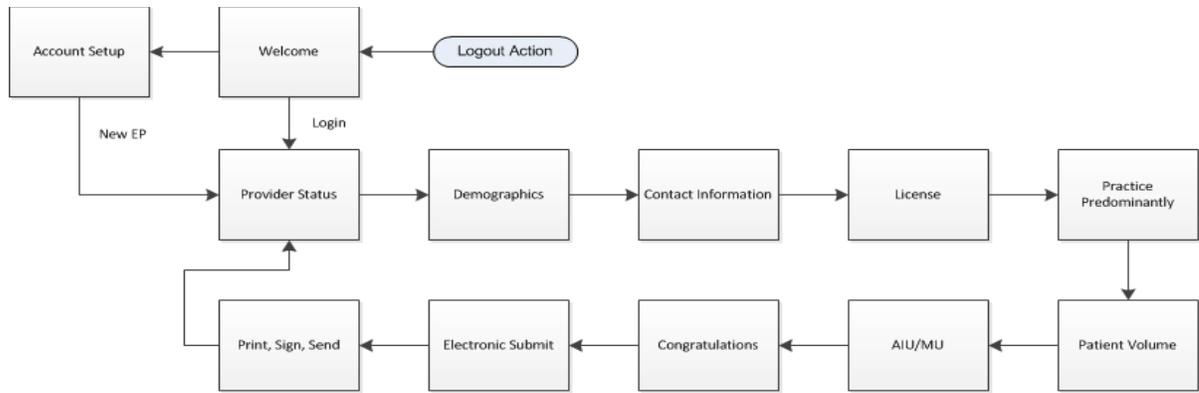
Found at the bottom of the page, the footer has a *Contact us* link to contact the NC-MIPS Help Desk. It also has a link to view the NC-MIPS Portal *Disclaimer*.

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

## Navigation

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

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



## Welcome

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



The screenshot shows the NC-MIPS Portal Welcome Page. At the top left is the North Carolina Health IT logo, and at the top right is the EHR Incentive Program logo. The main heading is "Welcome to the NC-MIPS Portal". Below this, there is a message about Program Year 2016 being the last year for EP attestation. A large text box provides instructions on updating NCID usernames. On the right side, there is a "Sign In" box with fields for "NCID Username" (containing "Testmips127") and "NCID Password" (masked with dots), a "Login" button, and links for "First time Account Setup?", "Forgot Username?", "Forgot Password?", and "NCID Username Update". Below the sign-in box is a "Click for Page Help" link. Further down, a "For Additional Information" section lists links to "EP AIU Attestation Guide", "EP Modified MU Attestation Guide", "EH AIU/MU Attestation Guide", "Download Adobe Acrobat to read guides", and "DMA Incentive Program home page". A "Contact Information" section includes the text "Can't find what you need in the NC-MIPS Attestation Guide?" and "NC-MIPS Help Desk" with the email "NCMedicaid.HIT@dhhs.nc.gov". At the bottom, a footer contains "Contact Us - Disclaimer - Version: 2.1.35.01" and "© Copyright 2016 State of North Carolina, all rights reserved."

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

First-time users:

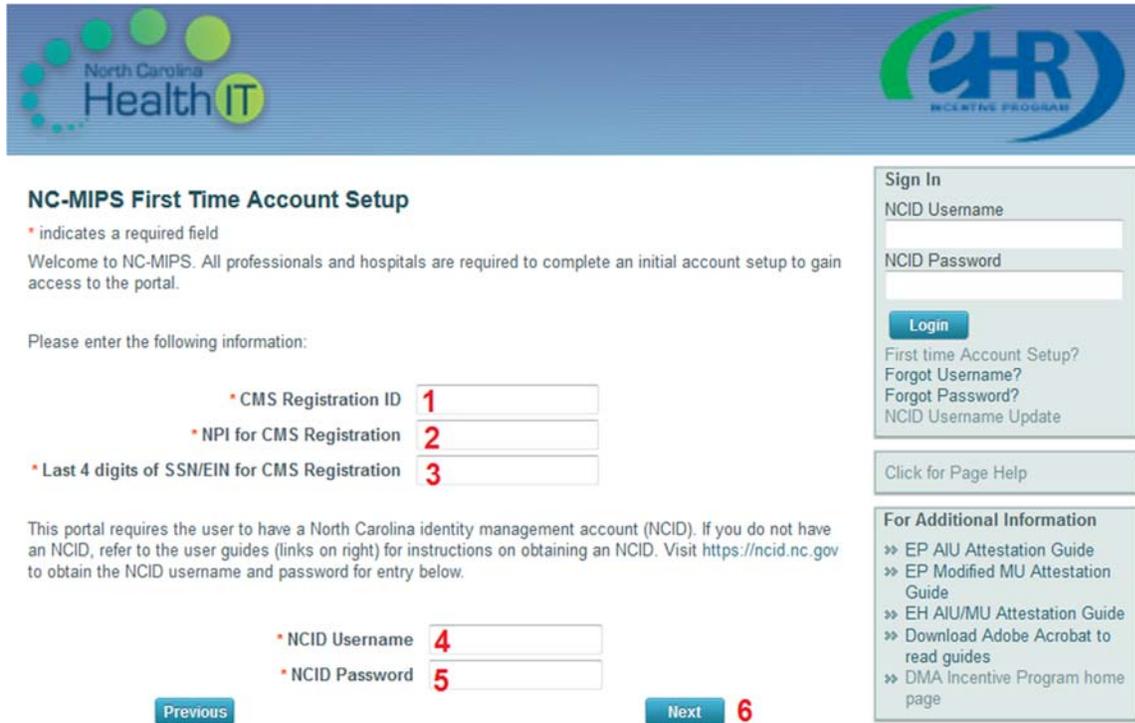
1. Click the link *First Time Account Setup*.
2. The [First Time Account Setup page](#) opens.

Returning users:

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

## First Time Account Setup

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



**NC-MIPS First Time Account Setup**

\* indicates a required field

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

Please enter the following information:

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

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

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

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

**Sign In**

NCID Username

NCID Password

[Login](#)

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

[Click for Page Help](#)

**For Additional Information**

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

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

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

**EPs may update the payee information at any time on CMS' R&A system.**
4. Enter the EP's unique NCID username.
5. Enter the EP's unique NCID password.
6. Click *Next*.
7. The [Provider Status](#) page opens.

## NCID Username Update Tool

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

### NC-MIPS NCID Username Update Tool

\* indicates a required field

Please note, this tool will allow an EP to login to NC-MIPS using their updated NCID username but is only applicable for those EPs who have already updated their NCID usernames on [ncid.nc.gov](http://ncid.nc.gov). If you need to update your NCID username and password, please do so on NCID's website at [ncid.nc.gov](http://ncid.nc.gov).

If you are having trouble with updating your NCID Username on this page, please send an email to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) and include the following information: CMS Registration ID, NPI, Provider's name, New NCID username and a screenshot of the information being entered and the error message being received, with a brief description of the issue.

\* CMS Registration ID

\* NPI for CMS Registration

3

Click for Page Help

Jump to...

**For Additional Information**

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

**Contact Information**

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

**NC-MIPS Help Desk**  
 Email: [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

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

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

### NC-MIPS NCID Username Update Tool

\* indicates a required field

Please note, this tool will allow an EP to login to NC-MIPS using their updated NCID username but is only applicable for those EPs who have already updated their NCID username on [ncid.nc.gov](http://ncid.nc.gov). If you need to update your NCID username and password, please do so on NCID's website at [ncid.nc.gov](http://ncid.nc.gov).

If you are having trouble with updating your NCID Username on this page, please send an email to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) and include the following information: CMS Registration ID, NPI, Provider's name, New NCID username and a screenshot of the information being entered and the error message being received, with a brief description of the issue.

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

\* CMS Registration ID

\* NPI for CMS Registration

Provider Name John Public

Current NCID Username youngc

\* New NCID Username

5

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

## Provider Status

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

### Status

<b>Provider Name</b>	Jose Four
<b>CMS Registration ID</b>	1000003024
<b>NPI</b>	2000003024
<b>MPN</b>	2154455

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	<a href="#">Proceed</a>
2014	1	Closed - No Attestation Submitted	

Provider Status page shows the:

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

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

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

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

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

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

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

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

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

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

To view or print an attestation:

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

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

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

**Status**

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

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	<a href="#">Proceed</a>
2014	1	Closed - No Attestation Submitted	

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

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

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

**Status**

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

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

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	<a href="#">Proceed</a>
2014	1	Attestation in Process	<a href="#">Proceed</a>
2013	1	Closed - No Attestation Submitted	

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

Program Year	Payment Year	Current Status	Activity Date
2015	1	Cancelled	<a href="#">Proceed</a>
2014	1	Attestation in Process	<a href="#">Cancel</a> <a href="#">Proceed</a>
2013	1	Closed - No Attestation Submitted	

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

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

**Status**

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

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

Program Year	Payment Year	Current Status	Activity Date
2015	1	Attestation in Process	<a href="#">Proceed</a>
2014	1	Attestation Denied	<a href="#">Re-attest</a>
2013	1	Closed - No Attestation Submitted	

## Demographics

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

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

**Demographics**

\* indicates a required field

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

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

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

Are the MPNs listed above correct?

Yes  No

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

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

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

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

Does the provider information above match?

Yes  No

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

Contact Us - Disclaimer - Version: 2.1.35.01  
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### Only the MPNs can be updated or corrected on this page.

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

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

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

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 XXXXXXXX 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.

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

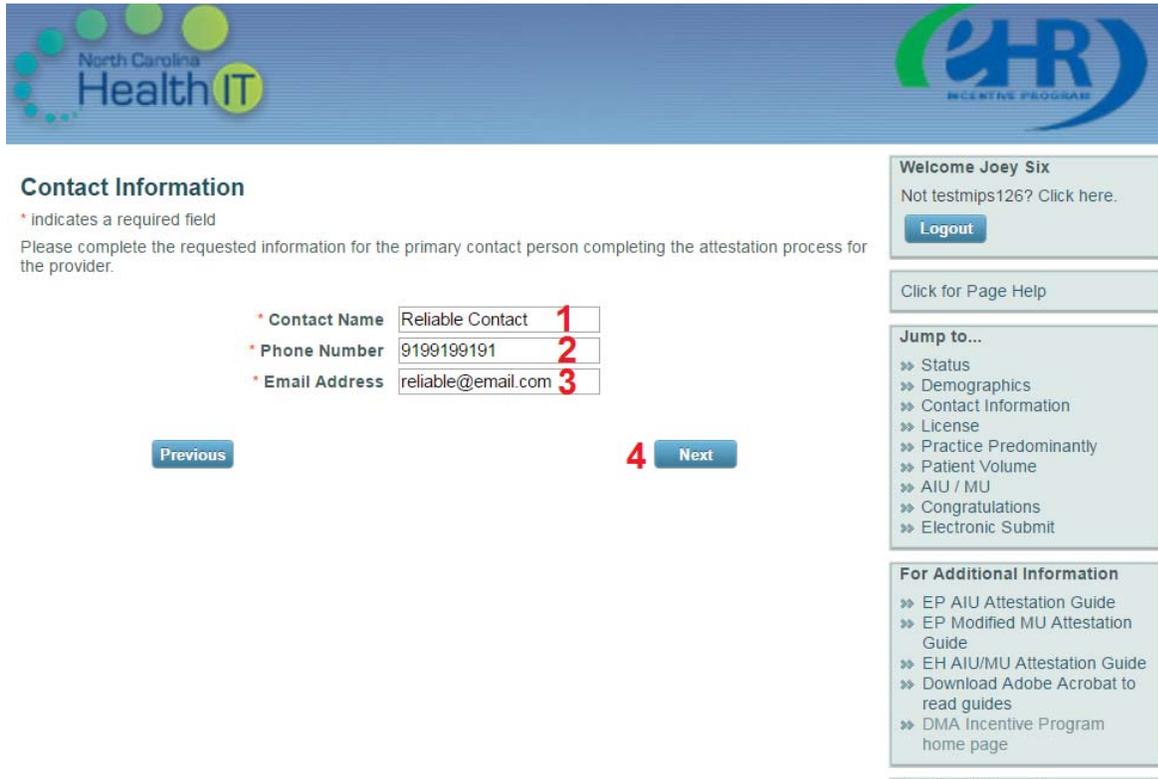
1. Go to <https://ehrincentives.cms.gov>
2. Click Continue
3. Check the box, click continue
4. Log in using the NPPES username & password
5. Click on the Registration tab to continue
6. Click on Modify in the Action column to continue
7. Click on Topic 2
8. Change the Payee TIN Type to Group Reassignment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

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

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

## Contact Information

This page is where you will enter the contact information for the person you want us to contact if there are issues with your attestation. If additional information is needed to validate your attestation, we will contact the person listed on this page. *The only way to update the contact person is to withdraw, update the information on this page, and resubmit the attestation.*



**Contact Information**

\* indicates a required field

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

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

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

[Click for Page Help](#)

**Jump to...**

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

**For Additional Information**

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

To enter the primary contact person's information:

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

## License

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

To enter the EP’s license information:

1. Select the EP’s License Type from the drop down list (for example, MDs will select *Medical*, nurse practitioners will select *Nurse Practitioner*, etc.). Note, if you select *Physician Assistant*, you must submit a PA-led memo – see instructions in the Recommended Documentation section.
2. Select the EP’s License State from the drop down list.
3. Enter the EP’s License Number. Be sure to enter the license number not the license approval number.
4. Enter the EP’s License Effective Date using the calendar tool or by typing the date.
5. Enter the EP’s License Expiration Date using the calendar tool or by typing the date.
6. Click *Next*.
7. The [Practice Predominantly/Hospital-Based page](#) opens.

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

## Practice Predominantly/Hospital-Based

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

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

\* Even if an EP practiced predominantly at an FQHC/RHC, s/he is not required to attest to practicing predominantly if s/he is not using non-Medicaid needy individual encounters to count toward her/his PV threshold.

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

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

The screenshot shows a web form titled "Practice Predominantly/Hospital-Based" with the following elements:

- Header:** North Carolina Health IT logo and DMA Incentive Program logo.
- Section:** Practice Predominantly/Hospital-Based. A note indicates that an asterisk (\*) denotes a required field.
- Question:** "Did you practice predominantly (greater than 50% of all patient encounters during a 6-month period) at a Federally Qualified Health Center or Rural Health Clinic?" with radio buttons for "Yes" (selected) and "No".
- Instruction:** "Please enter information for practice predominantly assertion:"
- Form Fields:**
  - "Select the date range" dropdown menu (labeled 2).
  - "Start Date of 6-month Period" text input with a calendar icon (labeled 3).
  - "End Date of 6-month Period" text input with a calendar icon.
  - "Total Patient Encounters at FQHC/RHC" text input (labeled 4).
  - "Total Patient Encounters at all Locations" text input (labeled 5).
- Summary:** "Your ratio of encounters at a Federally Qualified Health Center or Rural Health Clinic to your total patient encounters is 0% (labeled 6)." Below this are "Previous" and "Next" buttons (labeled 7).
- Right Sidebar:**
  - Welcome message for "Joey Six" with a "Logout" button.
  - "Click for Page Help" button.
  - "Jump to..." menu with links to Status, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, AIU / MU, Congratulations, and Electronic Submit.
  - "For Additional Information" menu with links to EP AIU Attestation Guide, EP Modified MU Attestation Guide, EH AIU/MU Attestation Guide, Download Adobe Acrobat to read guides, and DMA Incentive Program home page.

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

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

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

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

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



## EP Modified MU Attestation Guide



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

## Patient Volume

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

- Patient volume methodology (individual or group)
- Patient volume reporting period
- Practice(s) from which patient volume was drawn
- Number of patient volume encounters

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

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

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

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

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

EPs in a group practice may use either individual or group methodology for determining Medicaid patient volumes. However, encounters reported during a 90-day PV reporting period by an EP using individual methodology cannot be included in the group's number of encounters

using group methodology for the same 90-day PV reporting period. An EP in such a group who wishes to use her/his encounters at that group to attest with individual methodology may do so by selecting a different 90-day PV reporting period than the 90-day period used by the EP(s) attesting with group methodology. It is important that the members of a group practice reach consensus among their affiliated EPs on the methodology each EP will use, prior to the first attestation. If possible, we suggest using group methodology to calculate PV as it will only need to be calculated one time for the whole group.

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

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

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

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

For example: If attesting on February 1, 2017 for Program Year 2016, the previous calendar year is 2015 and the 12 months immediately preceding the date attestation would be 2/1/16-1/31/17.

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

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

### **PV tips**

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

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

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



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

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

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

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

## Individual Methodology

### Patient Volume

\* indicates a required field

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

\* Select the date range  ▾

\* Start Date

\* End Date

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

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

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

Yes **5**  No

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

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

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

If the EP is attesting using individual methodology:

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

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

encounters, you will need to answer question 27, “If another provider was listed as attending on any of the Medicaid-paid encounters included in your PV, enter that other provider’s NPI and the number of encounters attributable to that other provider.” For more information on reporting patient volume where incident to billing was used during the PV reporting period, you can view the incident to webinars or read the FAQs on our program website.

13. If Medicaid-paid encounters included in your reported patient volume were billed under more than one MPN or NPI, click the link for *Add another MPN for this Practice* and repeat steps 8 through 12.
14. If you are reporting patient volume from more than one practice, click the link for *Add another Practice Name* and repeat steps 6 through 13.
15. The numerator is automatically calculated and displayed. The numerator is all Medicaid encounters – Medicaid-paid encounters plus Medicaid zero-pay encounters.
16. The denominator is automatically displayed. The denominator is the total of all your patient encounters with this practice, no matter the payer.
17. The Medicaid Patient Volume Percentage is automatically calculated and displayed. The percentage is the numerator divided by the denominator. Your percentage must be at least 30 percent to qualify for the incentive. Or if you are a pediatrician, you can qualify for a reduced payment if your percentage is at least 20 percent. If your percentage does not meet the required threshold, your attestation will be denied.

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

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

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

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

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

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

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

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

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

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

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

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

19. Click the *Yes* or *No* button for “Did you report all NPI(s) under which the EP’s encounters were billed during the 90-day reporting period, even those not currently in use?” You

must enter all the NPIs that the practice(s) used as billing NPI on your Medicaid claims during your selected 90-day patient volume reporting period. The billing NPI used during your 90-day patient volume reporting period may be different than the billing NPI that you currently use. If you answer *No*, go back and click *Add another billing MPN for the practice* to report patient volume under additional billing MPNs/NPIs used during the PV reporting period.

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

personal NPI as attending/rendering on their Medicaid claims you must enter the name of that other provider and the number of Medicaid-paid encounters that belong to that other provider. For the other provider(s), include only Medicaid-paid encounters with the practice listed. If more than one provider used your NPI as rendering on their Medicaid claims, list all of those providers and the number of Medicaid-paid encounters billed under your NPI that belong to each.

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

## Group Methodology

### Patient Volume

\* indicates a required field

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

\* Select the date range **1**

\* Start Date **2**

\* End Date **3**

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

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

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

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

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

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

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

If the EP is attesting using group methodology:

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

comes from.

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

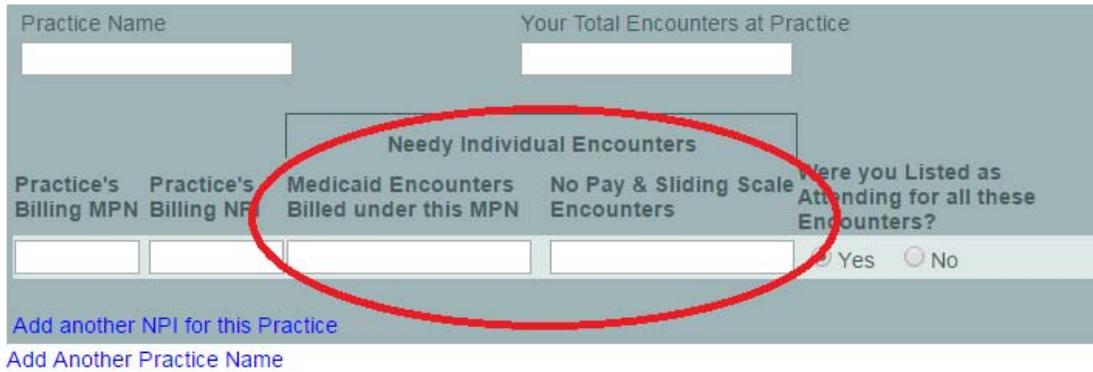
- 1) When using group methodology, the patient volume must include all patient encounters with both EPs and non-eligible provider types (e.g., RNs, phlebotomists). Did you include all encounters?  Yes  No **16**
- 2) A Medicaid encounter is defined as services rendered on any one day to an individual where Medicaid or a Medicaid demonstration project under Section 1115 of the Social Security Act paid for part or all of the service.
- a) Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service?  Yes  No **17**
- b) Did you exclude from the numerator denied claims that were never paid at a later date?  Yes  No **18**
- 3) Encounters included in the patient volume must have occurred during the 90-day reporting period, regardless of when claims were submitted or paid. Are your reported encounters based on date of service and not date of claim or date of payment?  Yes  No **19**
- 4) The denominator must include all encounters regardless of payment method. Did you include all encounters in the denominator where services were paid by Medicaid, by any payer other than Medicaid, self-paid, and provided at no charge?  Yes  No **20**
- 5) An encounter is one patient per provider per day and may be different from the number of claims. Do the numbers you entered represent encounters and not claims?  Yes  No **21**
- 6) If the group's reported encounters span more than one location and/or were billed with Medicaid under multiple NPIs, NC requires reporting of all NPIs associated with each location under which Medicaid claims were billed during the 90-day reporting period.
- a) If you are reporting patient encounters from multiple locations, have you provided all associated NPIs?  Yes  No  N/A **22**
- b) During the 90-day reporting period, did the group have a different (outdated) billing NPI or more than one billing NPI?  Yes  No  N/A **23**

16. Click the *Yes* or *No* button for “Did you include all encounters?” With group methodology, you must report encounters for EVERY professional in the group who provided services, not just the ones who are eligible to participate in the NC Medicaid EHR Incentive Program. If you cannot answer *Yes* to this question, you need to review your numbers and then report encounters for EVERY professional in the group who provided services.
17. Click the *Yes* or *No* button for “Did you include in the numerator all encounters covered by Medicaid, even where Medicaid paid for only part of a service?” Medicaid-paid encounters include encounters where Medicaid paid only part, e.g., where Medicaid was the secondary payer.
18. Click the *Yes* or *No* button for “Did you exclude from the numerator denied claims that were never paid at a later date?” The number you enter for Medicaid-paid encounters can include only encounters that were paid at least in part by Medicaid. If you answer *No*, please review your numbers and for *Medicaid encounters billed under this MPN*, enter only encounters paid at least in part by Medicaid. Some denied claims can be included as zero-pay Medicaid encounters. See the Patient Volume tab on our FAQ page for guidance on billable services.

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

### Practicing Predominantly

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



Practice Name:  Your Total Encounters at Practice:

Practice's Billing MPN	Practice's Billing NPI	Needy Individual Encounters	Were you Listed as Attending for all these Encounters?				
<input type="text"/>	<input type="text"/>	<table border="1"> <thead> <tr> <th>Medicaid Encounters Billed under this MPN</th> <th>No Pay &amp; Sliding Scale Encounters</th> </tr> </thead> <tbody> <tr> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </tbody> </table>	Medicaid Encounters Billed under this MPN	No Pay & Sliding Scale Encounters	<input type="text"/>	<input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No
Medicaid Encounters Billed under this MPN	No Pay & Sliding Scale Encounters						
<input type="text"/>	<input type="text"/>						

[Add another NPI for this Practice](#)  
[Add Another Practice Name](#)

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

## AIU or Meaningful Use Page

On the AIU/MU page, the EP reports her/his individual MU reporting period, as well as ALL of the locations where s/he worked at during the MU 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).

**Note:** Attesting to AIU can only be done in the first year of program participation. The last year to attest to AIU is Program Year 2016. In subsequent participation years, an EP will attest to MU. MU documentation needs to be emailed to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).

**AIU or Meaningful Use**  
\* indicates a required field

EHR Certification Number: 34000BR34567890

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

\* Please identify your Meaningful Use reporting period:  
 **2** 90-day reporting period     full calendar year  
 Please enter your reporting period date range  
 \* Start Date 1/1/2016 **3**  
 \* End Date 3/30/2016 **4**

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

* Practice Name	* Address	* EPs individual MU encounters for the MU reporting period (not PV encounters)	* EHR?
ABC Pediatric <b>5</b>	123 Main St <b>6</b>	100 <b>7</b>	<input checked="" type="radio"/> Yes <input type="radio"/> No <b>8</b>

Add a location

Percentage of encounters at a location with certified EHR technology: 100% **9**

[Previous](#) [Next \*\*10\*\*](#)

**Right Sidebar:**  
 Welcome Billy Four  
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 » Status  
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 » Practice Predominantly  
 » Patient Volume  
 » AIU / MU  
 » Meaningful Use  
 » Electronic Submit  
 For Additional Information  
 » EP AIU Attestation Guide  
 » EP Modified MU Attestation Guide  
 » EH AIU/MU Attestation Guide  
 » Download Adobe Acrobat to read guides  
 » DMA Incentive Program home page  
 Contact Information  
 Can't find what you need in the NC-MIPS Attestation Guide?  
 NC-MIPS Help Desk  
 Email: NCMedicaid.HIT@dhfs.nc.gov

Footer: Contact Us - Disclaimer - Version: 2.1.50.1  
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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 to which you are attesting. For Program Year 2016, an EP may only use a 90-day MU reporting period if this is the first year s/he attests for MU, otherwise, the EP is required to use a full calendar year MU reporting period. **Note: When attesting for Program Year 2016, the MU reporting period and MU data will come from calendar year 2016.**
3. Enter the 'Start Date' of the continuous 90-day or calendar year MU reporting period.



## EP Modified MU Attestation Guide



4. Enter the 'End Date' of the continuous 90-day or calendar MU reporting period.
5. Enter the 'Practice Name' for every practice where the individual EP had patient encounters during the MU reporting period.
6. Enter the 'Practice Address' for every practice where the EP had patient encounters during the MU reporting period.
7. Enter the individual EP's 'Total MU Encounters for the MU reporting period.' *NOTE: This number should reflect the individual EP's MU encounters at that practice location within the MU reporting period; this includes all payers and is completely separate from 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 EP's total MU encounters equipped with certified EHR technology will be automatically displayed. *NOTE: This percentage must be at least 50 percent to meet meaningful use requirements.*
10. Click *Next*.
11. The [Measure Selection Home page](#) will open.

## Meaningful Use Objectives and Measures

### Measure Selection Home Page

The Measure Selection Home page is where the user will go to begin attesting to the Meaningful Use Objectives and Clinical Quality Measures.

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



Measure Set	Actions	Complete	Valid
Meaningful use Objectives	<a href="#">Begin</a> <a href="#">Review</a>	✓	✓
Clinical Quality Measures	<a href="#">Begin</a> <a href="#">Review</a>	✗	✗

Previous Next

Welcome Mags Five  
Not testmips221? [Click here.](#)  
[Logout](#)

[Click for Page Help](#)

Jump to...

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

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

The Measure Selection Home page displays four columns:

1. **Measure Set:** These are the sets of objectives and measures that the EP will report.
2. **Actions:** The **Begin** action button will launch the user into the first page of the measure set. For the MU Objectives, the user will be directed to Objective 1 of 10. For the Clinical Quality Measures (CQMs), the user will be directed to the CQM Instructions page, where they will have the opportunity to select those measures they wish to report. 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 – **you must print the MU Summary Pages during the attestation prior to submission.** The EP is required to sign and date all applicable MU Summary Pages (MU Objective and CQM Summary Pages) and email them in with their signed attestation.

3. **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 objectives/measures within the measure set. A red 'x' indicates the user has not completed all required objectives/measures within the measure set.
4. **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 objectives/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.

***If the user sees a red 'x,' the user should review answers for accuracy and validity.***

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 s/he has not successfully met the meaningful use requirements for that measure set, and submitting the 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 Modified Stage 2 MU...

In October 2015, CMS released the Stage 3 and Meaningful Use in 2015 through 2017 (Modified Stage 2) Final Rule. This Final Rule changed the way EPs attest to MU in Program Year 2015 and beyond. EPs no longer attest to Stage 1 and Stage 2 objectives and measures. Instead, all EPs attesting to MU attest to the same 10 MU objectives.

For 2016, all providers previously scheduled to be in Stage 1 may claim an alternate exclusion for the CPOE objective measure 2 (laboratory orders) and measure 3 (radiology orders).

The alternate measures are only applicable for those EPs who were scheduled to attest to Stage 1 MU in Program Year 2016.

These alternate measures do not apply for EPs who

- were scheduled to attest to Stage 2 MU in Program Year 2016
- who have already attested for two years of Stage 1 MU prior to Program Year 2016
- for whom Program Year 2016 is their fourth, fifth, or sixth payment year

If an EP attests to either of these alternate measures or exclusions but was not eligible for Stage 1 MU for Program Year 2016, her/his attestation will be denied.

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.

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, you must print the MU Summary Pages after successfully completing the MU measure set and before submitting the attestations because once the EP submits the attestation, s/he will have to withdraw and re-attest to retrieve the MU Summary Pages.

EPs are required to submit a copy of their CQM report directly from their EHR demonstrating they have met the CQMs for which they are attesting. Please submit this report along with MU attestation documentation.

As a user navigates through the MU objectives, they are 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 *Review*.

## Meaningful Use Objectives Pages

There are 10 objectives for which all EPs are required to attest.

The user will be directed to Objective 1 of 10, and will navigate through the nine remaining objectives by clicking the *Next* button. Each MU page will display the requirements for meeting the objective and measure(s).

1. Some measures require a *Yes* or *No* answer to report whether the EP satisfied the measure criteria (Objectives 1, 2, and 10).
  - If after reading the measure, the criteria was met, click *Yes*.
  - If after reading the measure, the criteria was not met, click *No*. *Note, if the EP selects No, they will not meet the objective and will not meet MU.*
2. Other measures require the user to enter a numerator and denominator (Objectives 3, 4, 5, 6, 7, 8, 9).
  - The user may be asked to report on an entire population of patients, or just a subset.
  - The user should ensure the numerator(s) and denominator(s) they enter match exactly the reports produced by their EHRs (or combination of such reports and other data sources, where applicable). Keep all documentation for at least six years in case of post-payment audit.

The following pages will show users each of the 10 objectives for which they will be required to attest. Follow the guidelines listed above for each objective and follow the directions given on each page in NC-MIPS.

**If you have questions about meeting a [Meaningful Use objective](#), please contact CMS as they are the authority on all MU requirements and specifications.**

**Objective 1:** Protect electronic health information created or maintained by the CEHRT through the implementation of appropriate technical capabilities.

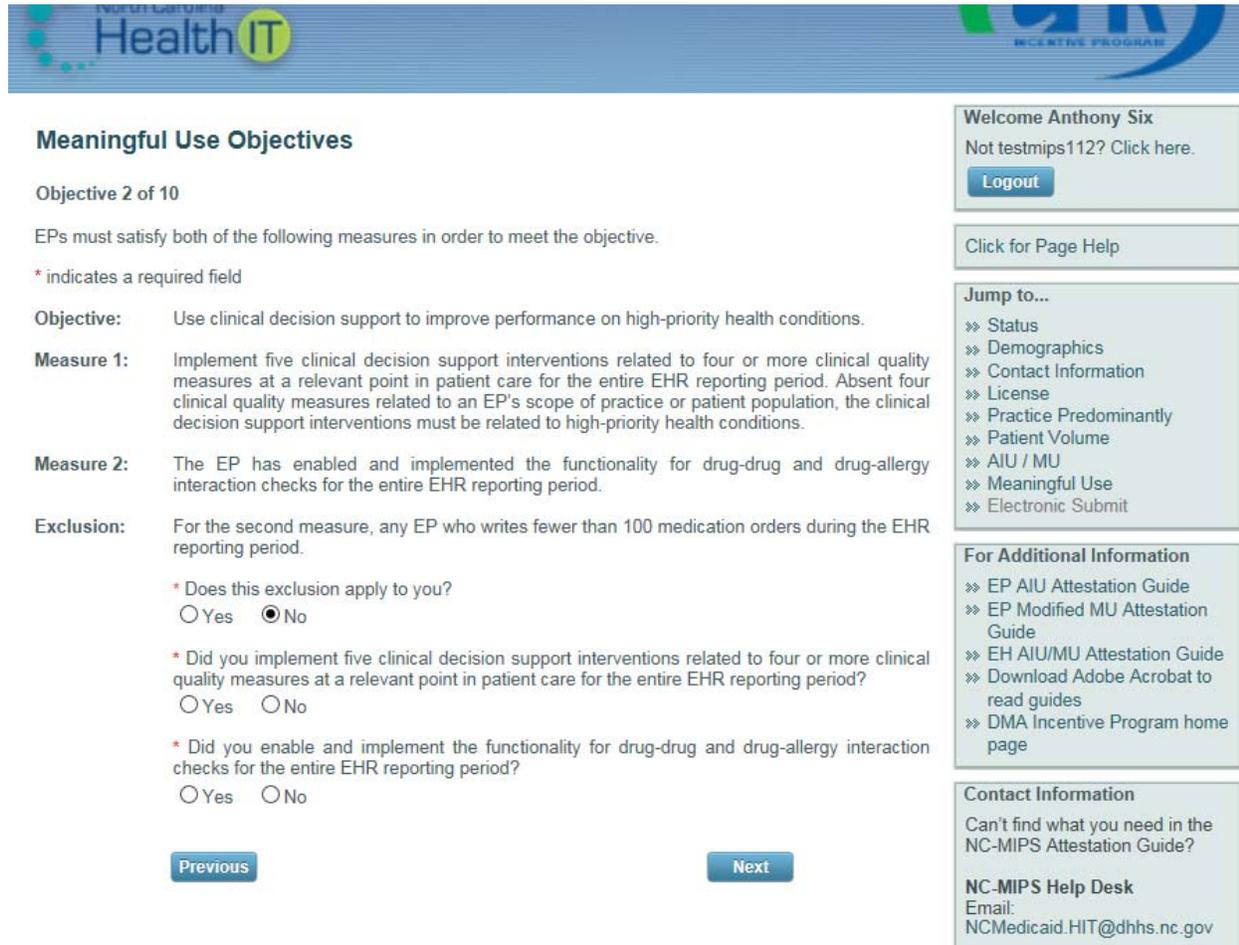


The screenshot shows a web interface for 'Meaningful Use Objectives'. At the top left is the 'North Carolina Health IT' logo, and at the top right is the 'EHR Incentive Program' logo. The main heading is 'Meaningful Use Objectives', with a sub-heading 'Objective 1 of 10'. A note states '\* indicates a required field'. The 'Objective' section describes protecting electronic health information. The 'Measure' section details requirements for security risk analysis and updates, with a question: '\* Did you conduct or review a security risk analysis and implement security updates as needed to meet this measure?'. Below this are radio buttons for 'Yes' (selected) and 'No'. Navigation buttons for 'Previous' and 'Next' are visible. On the right side, there are utility boxes: 'Welcome Mags Five' with a 'Logout' button, 'Click for Page Help', 'Jump to...' with a list of links (Status, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, AIU / MU, Meaningful Use, Electronic Submit), and 'For Additional Information' with links to 'EP AIU Attestation Guide' and 'EP MU Attestation Guide'.

NOTE: To meet Objective 1, EPs must have conducted or reviewed a security risk analysis and implemented security updates as necessary and corrected identified security deficiencies.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_1ProtectPatientHealthInfoObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_1ProtectPatientHealthInfoObjective.pdf).

**Objective 2:** Use clinical decision support to improve performance on high-priority health conditions.



The screenshot shows a web interface for the EP Modified MU Attestation Guide. At the top, there are logos for North Carolina Health IT and the EHR Incentive Program. The main content area is titled "Meaningful Use Objectives" and displays "Objective 2 of 10". Below this, it states that EPs must satisfy both of the following measures to meet the objective. A note indicates that an asterisk (\*) denotes a required field. The objective itself is to use clinical decision support to improve performance on high-priority health conditions. Two measures are listed: Measure 1, which requires implementing five clinical decision support interventions related to four or more clinical quality measures, and Measure 2, which requires enabling and implementing functionality for drug-drug and drug-allergy interaction checks. An exclusion section follows, asking if the exclusion applies to the user, with radio buttons for Yes and No. Below this are two more questions with radio buttons: "Did you implement five clinical decision support interventions..." and "Did you enable and implement the functionality for drug-drug and drug-allergy interaction checks...". At the bottom of the main content area are "Previous" and "Next" buttons. On the right side, there are several utility boxes: a "Welcome" box for Anthony Six with a "Logout" button; a "Click for Page Help" button; a "Jump to..." menu with links to Status, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, AIU / MU, Meaningful Use, and Electronic Submit; a "For Additional Information" box with links to EP AIU Attestation Guide, EP Modified MU Attestation Guide, EH AIU/MU Attestation Guide, Download Adobe Acrobat to read guides, and DMA Incentive Program home page; and a "Contact Information" box with a link to the NC-MIPS Attestation Guide and the NC-MIPS Help Desk email address.

NOTE: To meet Objective 2, if the exclusion does not apply, the EPs must have

- 1) implemented five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period (Measure 1); and,
- 2) enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period (Measure 2).

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_2ClinicalDecisionSupportObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_2ClinicalDecisionSupportObjective.pdf).

**Objective 3:** Use computerized provider order entry (CPOE) for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

Objective 3 of 10

EPs, eligible hospitals and CAHs that were scheduled to be in Stage 1 in 2016 may claim an alternate exclusion for an EHR reporting period in 2016 for Objective 3: Computerized Provider Order Entry, Measures 2 and 3 (lab and radiology orders), or choose the modified Stage 2 objective and measures.

\* Indicates a required field

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

**Measure 1:** More than 80% of medication orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**Measure 2:** More than 30% of laboratory orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**Measure 3:** More than 30% of radiology orders created by the EP during the EHR reporting period are recorded using computerized provider order entry.

**Exclusion 1:** Any EP who writes fewer than 100 medication orders during the EHR reporting period.

\* Does this exclusion apply to you?  
 Yes  No

**Exclusion 2:** Any EP who writes fewer than 100 laboratory orders during the EHR reporting period.

**Alternate Exclusion 2:** Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 2 (laboratory orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

\* Does this exclusion apply to you?  
 Yes  No

**Exclusion 3:** Any EP who writes fewer than 100 radiology orders during the EHR reporting period.

**Alternate Exclusion 3:** Providers scheduled to be in Stage 1 in 2016 may claim an exclusion for measure 3 (radiology orders) of the Stage 2 CPOE objective for an EHR reporting period in 2016.

\* 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.

**Measure 1: Medication**

\* **Numerator 1:**   
 The number of medication orders in the denominator recorded using CPOE.

\* **Denominator 1:**   
 Number of medication orders created by the EP during the EHR reporting period.

**Measure 2: Laboratory**

\* **Numerator 2:**   
 The number of laboratory orders in the denominator recorded using CPOE.

\* **Denominator 2:**   
 Number of laboratory orders created by the EP during the EHR reporting period.

**Measure 3: Radiology**

\* **Numerator 3:**   
 The number of radiology orders in the denominator recorded using CPOE.

\* **Denominator 3:**   
 Number of radiology orders created by the EP during the EHR reporting period.

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There is an alternate exclusion for Measure 2 and Measure 3 for this objective if an EP was scheduled to attest to Stage 1 MU in Program Year 2016. These alternate measures do not apply for EPs:

- who were scheduled to attest to Stage 2 MU in Program Year 2016;
- who have already attested for two years of Stage 1 MU prior to Program Year 2016; or,
- for whom Program Year 2016 is their fourth, fifth, or sixth payment year.

NOTE: To meet Objective 3, if the exclusions do not apply, EPs need to meet the following thresholds for each measure:

**Measure 1: More than 60%** of medication orders created by the EP during the EHR reporting period are recorded using CPOE.

**Measure 2: More than 30%** of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.

**Measure 3: More than 30%** of radiology orders created by the EP during the EHR reporting period are recorded using CPOE.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_3CPOEObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_3CPOEObjective.pdf).

**Objective 4:** Generate and transmit permissible prescriptions electronically (eRx).




### Meaningful Use Objectives

Objective 4 of 10

\* indicates a required field

**Objective:** Generate and transmit permissible prescriptions electronically (eRx).

**Measure:** More than 50% of all permissible prescriptions written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.

**Exclusion:** Any EP who:  
 1. Writes fewer than 100 permissible prescriptions during the EHR reporting period. OR  
 2. Does not have a pharmacy within his or her organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.

\* Do either of these exclusions 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 number of prescriptions in the denominator generated, queried for a drug formulary and transmitted electronically using CEHRT.

\* **Denominator:**   
 Number of permissible prescriptions written during the EHR reporting period for drugs requiring a prescription in order to be dispensed.

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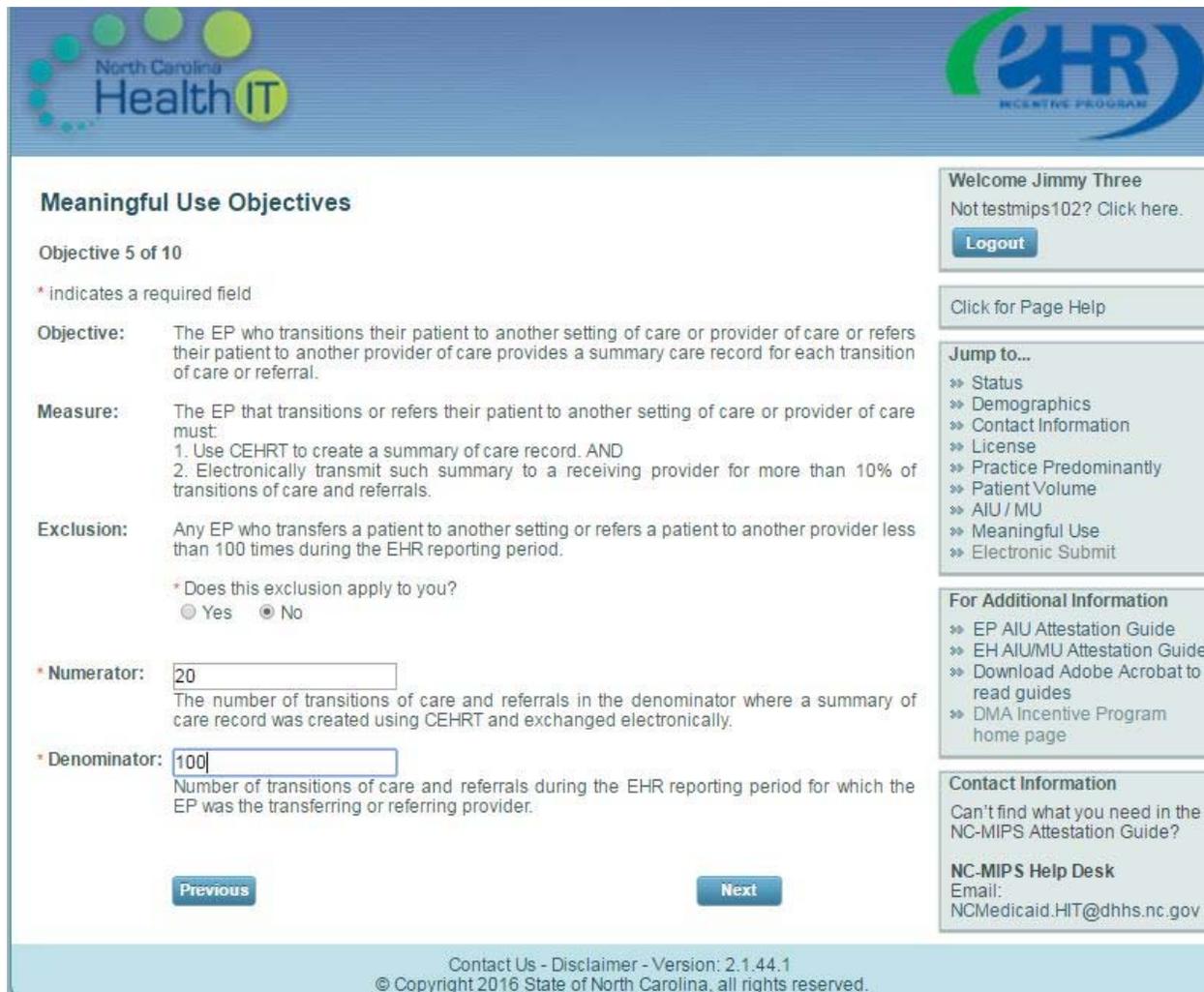
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NOTE: If the exclusions do not apply, an EP meets Objective 4 if **more than 50%** of all permissible prescriptions written by the EP during the EHR reporting period were queried for a drug formulary and transmitted electronically using CEHRT.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_4ePrescribingObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_4ePrescribingObjective.pdf).

**Objective 5:** The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.



**Meaningful Use Objectives**

Objective 5 of 10

\* indicates a required field

**Objective:** The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.

**Measure:** The EP that transitions or refers their patient to another setting of care or provider of care must:  
 1. Use CEHRT to create a summary of care record. AND  
 2. Electronically transmit such summary to a receiving provider for more than 10% of transitions of care and referrals.

**Exclusion:** Any EP who transfers a patient to another setting or refers a patient to another provider less than 100 times during the EHR reporting period.

\* Does this exclusion apply to you?  
 Yes  No

\* **Numerator:**   
 The number of transitions of care and referrals in the denominator where a summary of care record was created using CEHRT and exchanged electronically.

\* **Denominator:**   
 Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.

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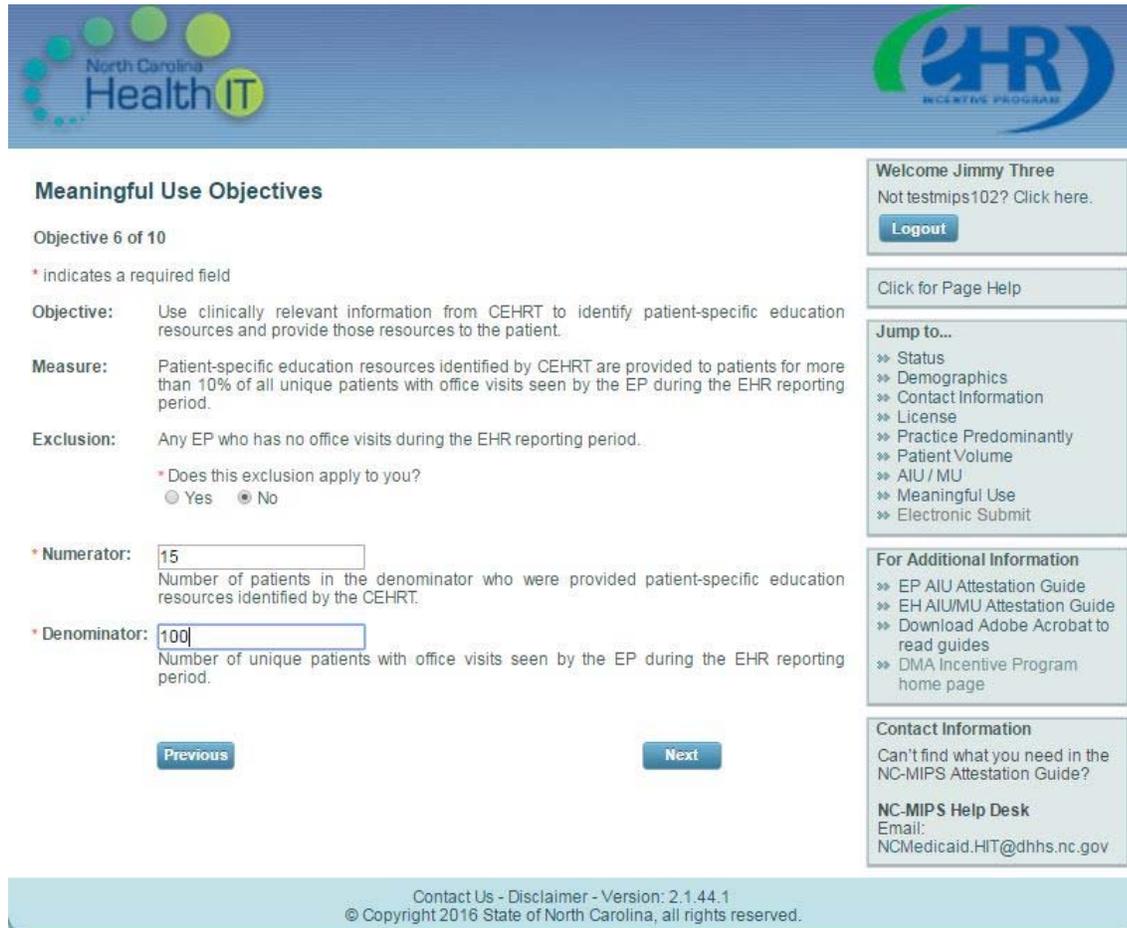
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NOTE: If the exclusion does not apply, the EP meets Objective 5 if **more than 10%** of transitions of care and referrals for which the EP was the transferring or referring provider had a summary of care record that was created using CEHRT and electronically transmitted to a receiving provider.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_5HealthInformationExchangeObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_5HealthInformationExchangeObjective.pdf).

**Objective 6:** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.



**Meaningful Use Objectives**

Objective 6 of 10

\* indicates a required field

**Objective:** Use clinically relevant information from CEHRT to identify patient-specific education resources and provide those resources to the patient.

**Measure:** Patient-specific education resources identified by CEHRT are provided to patients for more than 10% of all unique patients with office visits seen by the EP during the EHR reporting period.

**Exclusion:** Any EP who has no office visits during the EHR reporting period.

\* Does this exclusion apply to you?  
 Yes  No

\* Numerator:   
 Number of patients in the denominator who were provided patient-specific education resources identified by the CEHRT.

\* Denominator:   
 Number of unique patients with office visits seen by the EP during the EHR reporting period.

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NOTE: If the exclusion does not apply, the EP meets Objective 6 if **more than 10%** of all unique patients with office visits seen by the EP during the EHR reporting period were provided patient-specific education resources identified by CEHRT.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_6PatientSpecificEducationObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_6PatientSpecificEducationObjective.pdf).

**Objective 7:** The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.




### Meaningful Use Objectives

Objective 7 of 10

\* indicates a required field

**Objective:** The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.

**Measure:** The EP performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP.

**Exclusion:** Any EP who was not the recipient of any transitions of care during the EHR reporting period.

\* Does this exclusion apply to you?  
 Yes  No

\* Numerator:   
 The number of transitions of care in the denominator where medication reconciliation was performed.

\* Denominator:   
 Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.

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NOTE: If the exclusion does not apply, the EP meets Objective 7 if the EP performs medication reconciliation for **more than 50%** of transitions of care in which the patient was transitioned into the care of the EP during the EHR reporting period.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_7MedicationReconciliationObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_7MedicationReconciliationObjective.pdf).

**Objective 8:** Provide patients the ability to view online, download, and transmit their health information within 4 business days of the information being available to the EP.

### Meaningful Use Objectives

Objective 8 of 10

EPs must satisfy both measures in order to meet this objective.

\* indicates a required field

**Objective:** Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.

**Measure 1:** More than 50% of all unique patients seen by the EP during the EHR reporting period are provided timely access to view online, download and transmit to a third party their health information subject to the EP's discretion to withhold certain information.

**Measure 2:** For an EHR reporting period in 2016, at least one patient seen by the EP during the EHR reporting period (or patient-authorized representative) views, downloads or transmits his or her health information to a third party during the EHR reporting period.

**Exclusion 1:** Any EP who: Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information."

\* Does this exclusion apply to you?  
 Yes  No

**Exclusion 2:** Any EP who:  
 1. Neither orders nor creates any of the information listed for inclusion as part of the measures except for "Patient Name" and "Provider's name and office contact information." OR  
 2. Conducts 50% or more of his or her patient encounters in a county that does not have 50% or more of its housing units with 4Mbps broadband availability according to the latest information available from the FCC on the first day of the EHR reporting period.

\* Do either of these exclusions apply to you?  
 Yes  No

**Measure 1:**

\* Numerator 1:   
 The number of patients in the denominator who have access to view online, download and transmit their health information within 4 business days after the information is available to the EP.

\* Denominator 1:   
 The denominator is the number of unique patients seen by the EP during the EHR reporting period.

**Measure 2:**

\* Numerator 2:   
 The number of patients in the denominator (or patient-authorized representative) who view, download or transmit to a third party their health information.

\* Denominator 2:   
 Number of unique patients seen by the EP during the EHR reporting period.

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NOTE: To meet Objective 8, if the exclusions do not apply,

- 1) The EP must have provided timely access to **more than 50%** of all unique patients seen by the EP during the EHR reporting period to view online, download and transmit to a third party their health information subject to the EP's discretion to withhold certain information (Measure 1); and
- 2) **at least one** patient seen by the EP during the EHR reporting period (or patient-authorized representative) must have viewed, downloaded or transmitted her or his health information to a third party during the EHR reporting period. (Measure 2).

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_8PatientElectronicAccessObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_8PatientElectronicAccessObjective.pdf).

**Objective 9:** Use secure electronic messaging to communicate with patients on relevant health information.

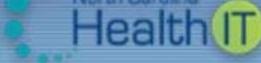
The screenshot shows a web page titled "Meaningful Use Objectives" for "Objective 9 of 10 - Secure Electronic Messaging". The page includes a header with the North Carolina Health IT and EHR Incentive Program logos. The main content area contains the objective description, measure details, exclusion criteria, and input fields for the numerator (90) and denominator (100). A "Previous" button is visible at the bottom left, and a "Next" button is at the bottom right. On the right side, there are several utility boxes: "Welcome Jimmy Three" with a "Logout" button, "Click for Page Help", "Jump to..." with a list of links (Status, Demographics, Contact Information, License, Practice Predominantly, Patient Volume, AIU / MU, Meaningful Use, Electronic Submit), "For Additional Information" with links to various guides and the DMA Incentive Program home page, and "Contact Information" with a help desk email address (NCMedicaid.HIT@dhhs.nc.gov). At the bottom of the page, there is a footer with contact information and a copyright notice for 2016.

NOTE: To meet Objective 9, if the exclusion does not apply, for **at least one** patient seen by the EP during the EHR reporting period, a secure message was sent using the electronic messaging function of CEHRT to the patient (or patient-authorized representative), or in response to a secure message sent by the patient (or patient-authorized representative) during the EHR reporting period.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_9SecureElectronicMessagingObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_9SecureElectronicMessagingObjective.pdf).

**Objective 10:** The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT except where prohibited and in accordance with applicable law and practice.

There are alternate exclusions for Measure 2 and Measure 3 for an EHR reporting period in 2016.




### Meaningful Use Objectives

Objective 10 of 10

\* indicates a required field

**Objective:** The EP is in active engagement with a public health agency to submit electronic public health data from CEHRT, except where prohibited and in accordance with applicable law and practice.

**Measure 1:** The EP is in active engagement with a public health agency to submit immunization data.

**Measure 2:** The EP is in active engagement with a public health agency to submit syndromic surveillance data.

**Measure 3:** EP is in active engagement to submit data to a specialized registry.

**Exclusion 1:** Any EP meeting one or more of the following criteria may be excluded from the immunization registry reporting measure if the EP:  
1. Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the EHR reporting period.  
2. Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period or  
3. Operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period.

\* Does this exclusion apply to you?  
 Yes  No

\* Is the attesting EP in active engagement with a public health agency to submit immunization data?  
 Yes  No

**Exclusion 2:** Any EP meeting one or more of the following criteria may be excluded from the syndromic surveillance reporting measure if the EP:  
1. Is not in a category of providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system.  
2. Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period, or  
3. Operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period.

**Alternate Exclusion 2:** EPs may claim an alternate exclusion for measure 2 (syndromic surveillance reporting) for an EHR reporting period in 2016.

\* Does this exclusion apply to you?  
 Yes  No

\* Is the attesting EP in active engagement with a public health agency to submit syndromic surveillance data?  
 Yes  No

Welcome Jimmy Three  
Not testmips102? [Click here.](#)

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**For Additional Information**

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- » Download Adobe Acrobat to read guides
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**Contact Information**

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

**NC-MIPS Help Desk**  
Email:  
[NCMedicaid.HIT@dhs.nc.gov](mailto:NCMedicaid.HIT@dhs.nc.gov)

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Exclusion 3:

Any EP meeting at least one of the following criteria may be excluded from the specialized registry reporting measure if the EP:

1. Does not diagnose or treat any disease or condition associated with, or collect relevant data that is required by a specialized registry in their jurisdiction during the EHR reporting period;
2. Operates in a jurisdiction for which no specialized registry is capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. or
3. Operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.

Alternate Exclusion 3:

EPs may claim an alternate exclusion for measure 3 (specialized registry reporting) for an EHR reporting period in 2016.

\* Does this exclusion apply to you?

Yes  No

\* Is the attesting EP in active engagement to submit data to a specialized registry?

Yes  No

\* Select your stage of active engagement:

**Completed Registration to Submit Data:** The EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

**Testing and Validation:** The EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

**Production:** The EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

\* Enter the name of the specialized registry that the attesting EP is in active engagement with to submit data.

10

Is the attesting EP actively engaged with more than one specialized registry?

Yes  No

Enter the name of the second specialized registry with which the attesting EP is actively engaged.

10

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An exclusion for a measure does not count toward the total of two measures. If an EP excludes from a measure, s/he must meet or exclude from the remaining measures in order to meet the objective. If the EP qualifies for multiple exclusions and the remaining number of measures available to the EP is less than two, EPs can meet the objective by meeting the one remaining measure available to them. If no measures remain available, the EP can meet the objective by meeting the requirements for exclusion from all three measures.

To meet Objective 10 without exclusions, the EP must:

- be in active engagement with a public health agency to submit immunization data (Measure 1)
- be in active engagement with a public health agency to submit syndromic surveillance data (Measure 2)
- be in active engagement to submit data to a specialized registry\* (Measure 3). If the EP is unable to meet Measure 1 or Measure 2, the EP may still meet Objective 10 if they are in active engagement with two specialized registries.

For more information, see [https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP\\_10PublicHealthObjective.pdf](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2016EP_10PublicHealthObjective.pdf)

\*North Carolina does not keep a list of all acceptable specialized registries. We leave it to each program participant to determine what registry is available and makes the most sense for their practice and patient population. It is up to the EP or EH to do the necessary due diligence to ensure the registry meets all of CMS' requirements for meeting meaningful use (MU) and to obtain any and all supporting documentation proving compliance.

Per CMS, for the purposes of MU, “public health registries” are those administered by, or on behalf of, a local, state, territorial, or national public health agency and which collects data for public health purposes. A variety of registries may be considered specialized registries, which allows providers the flexibility to report using a registry that is most helpful to their patients.

As stated in the Final Rule, active engagement may be one of the following:

*Proposed Active Engagement Option 1—Completed Registration to Submit Data:* The EP, eligible hospital or CAH registered to submit data with the Public Health Agency (PHA) or, where applicable, the Clinical Data Registry (CDR) to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP, eligible hospital, or CAH is awaiting an invitation from the PHA or CDR to begin testing and validation. This option allows providers to meet the measure when the PHA or the CDR has limited resources to initiate the testing and validation process. Providers that have registered in previous years do not need to submit an additional registration to meet this requirement for each EHR reporting period.

*Proposed Active Engagement Option 2—Testing and Validation:* The EP, eligible hospital, or CAH is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure.

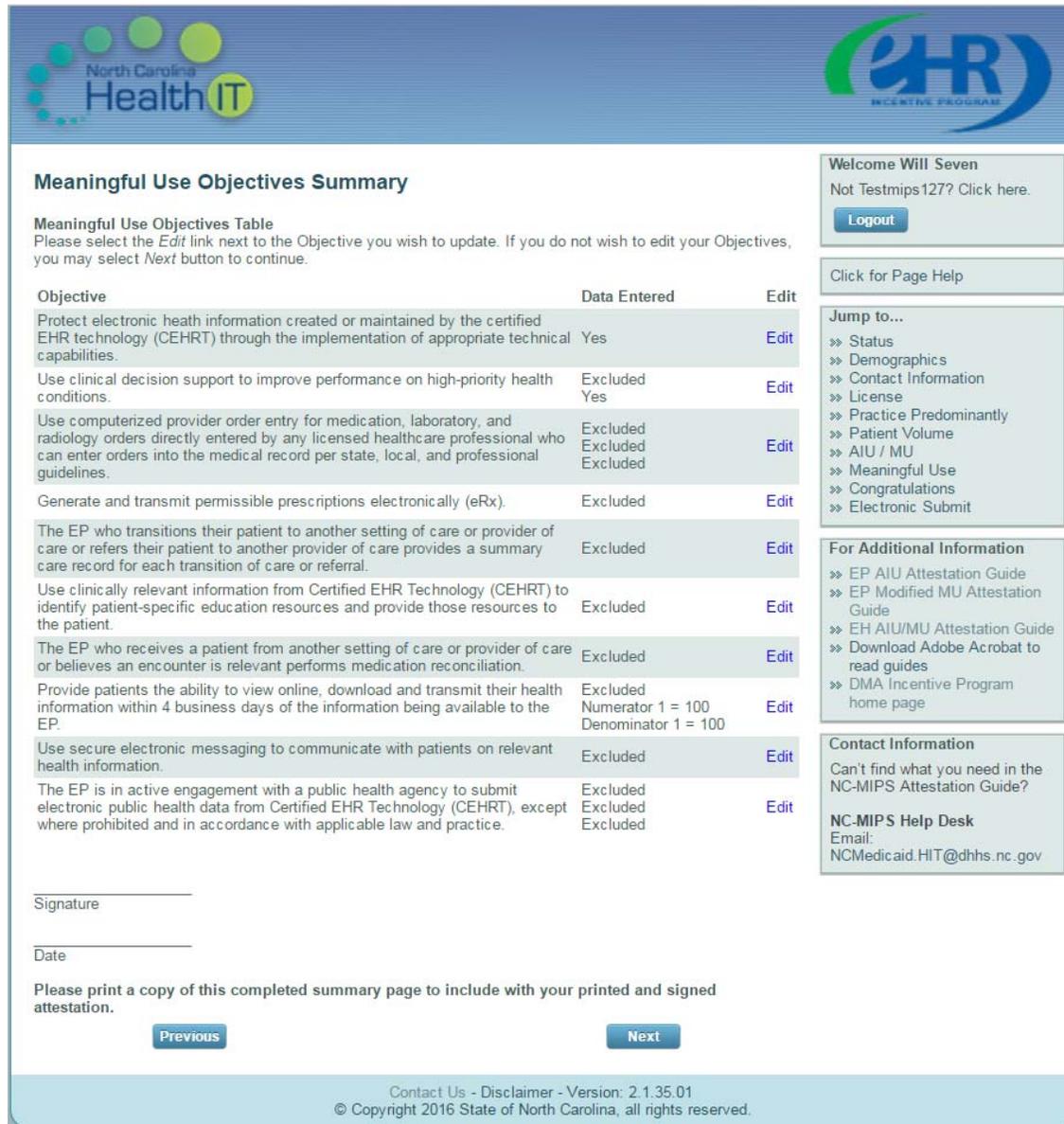


*Proposed Active Engagement Option 3—Production:* The EP, eligible hospital, or CAH has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.

This gives EPs a lot of flexibility in selecting a specialized registry to submit data. As long as the EP submits to us documentation demonstrating they are ‘actively engaged’ with a registry that collects public health data, they will meet Measure #3: Specialized Registry Reporting of Objective #10 for EPs: Public Health Reporting.

## Meaningful Use Objectives Summary Page

The Meaningful Use Objectives Summary Page will give the user an overview of their attested information for each of the 10 MU Objectives.



**Meaningful Use Objectives Summary**

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

Objective	Data Entered	Edit
Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.	Yes	<a href="#">Edit</a>
Use clinical decision support to improve performance on high-priority health conditions.	Excluded Yes	<a href="#">Edit</a>
Use computerized provider order entry for medication, laboratory, and radiology orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local, and professional guidelines.	Excluded Excluded Excluded	<a href="#">Edit</a>
Generate and transmit permissible prescriptions electronically (eRx).	Excluded	<a href="#">Edit</a>
The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care provides a summary care record for each transition of care or referral.	Excluded	<a href="#">Edit</a>
Use clinically relevant information from Certified EHR Technology (CEHRT) to identify patient-specific education resources and provide those resources to the patient.	Excluded	<a href="#">Edit</a>
The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant performs medication reconciliation.	Excluded	<a href="#">Edit</a>
Provide patients the ability to view online, download and transmit their health information within 4 business days of the information being available to the EP.	Excluded Numerator 1 = 100 Denominator 1 = 100	<a href="#">Edit</a>
Use secure electronic messaging to communicate with patients on relevant health information.	Excluded	<a href="#">Edit</a>
The EP is in active engagement with a public health agency to submit electronic public health data from Certified EHR Technology (CEHRT), except where prohibited and in accordance with applicable law and practice.	Excluded Excluded Excluded	<a href="#">Edit</a>

Signature \_\_\_\_\_

Date \_\_\_\_\_

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

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- Select *Edit* to change or modify any question within the measure set. If an objective is highlighted in red, this indicates the EP does not meet the objective. If the EP does not meet the objective, s/he will not meet MU and the attestation will be denied.
- Once the user reviews the page for accuracy, s/he will be required to **print, sign and email** the MU Objectives 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](#).

## Clinical Quality Measures Instruction Page

After clicking **Begin** for the Clinical Quality Measures Measure set on the Measure Selection Home Page, users will be routed to the Clinical Quality Measures Instruction Page where they will select nine of 64 CQMs for which they would like to attest.

Three of the nine CQMs must represent three of the six National Quality Strategy (NQS) domains.

### Clinical Quality Measure Instructions

From the 64 2014 Clinical Quality Measures (CQMs) listed below, check the box next to the nine CQMs to which the eligible professional (EP) would like to attest. Please note, three of the nine CQMs must represent three of the six National Quality Strategy (NQS) domains.

You will be prompted to enter numerator(s), denominator(s), and exclusion(s), for all selected CQMs after you select the "Next" button below.

#### NQS Domain 1: Patient and family engagement

<input type="checkbox"/>	NQF 0384	Oncology: Medical and Radiation – Pain Intensity Quantified
<input type="checkbox"/>	NQF 5001	Functional status assessment for knee replacement
<input type="checkbox"/>	NQF 5002	Functional status assessment for hip replacement
<input type="checkbox"/>	NQF 5003	Functional status assessment for complex chronic conditions

1. Click the box next to the CQMs for which you would like to attest.
2. After nine CQMs are selected, click 'Next' to route to the first of the nine selected CQMs.

The six National Quality Strategy (NQS) domains are:

1. [Person and Caregiver-Centered Experience Outcomes](#)
2. [Patient Safety](#)
3. [Efficiency and Cost Reduction Use of Healthcare Resources](#)
4. [Communication and Care Coordination](#)
5. [Community, Population and Public Health](#)
6. [Effective Clinical Care](#)

When the EP has completed the attestation, please send an email to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) with the following documentation:

1. The signed Clinical Quality Measures Summary Page;
2. A CQM report directly from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs; and,
3. The EP's signed attestation and MU Objective Summary Page.

## 2014 Clinical Quality Measures Summary Page

After completing nine Clinical Quality Measures, the user will be routed to the Clinical Quality Measures Summary Page.

### Clinical Quality Measures Summary

**Clinical Quality Measures Summary 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	Domain	Data Entered	Edit
NQF 0384	NQS Domain 1: Patient and family engagement	Numerator = 100 Denominator = 100	<a href="#">Edit</a>
NQF 5001	NQS Domain 1: Patient and family engagement	Numerator = 100 Denominator = 100	<a href="#">Edit</a>
NQF 5002	NQS Domain 1: Patient and family engagement	Numerator = 100 Denominator = 100	<a href="#">Edit</a>
NQF 0022	NQS Domain 2: Patient Safety	Numerator 1 = 100 Denominator = 100 Numerator 2 = 100 Denominator = 100	<a href="#">Edit</a>
NQF 0101	NQS Domain 2: Patient Safety	Numerator = 0 Denominator = 0	<a href="#">Edit</a>
NQF 5005	NQS Domain 3: Care Coordination	Numerator = 100 Denominator = 100	<a href="#">Edit</a>
NQF 0024	NQS Domain 4: Population/Public Health	Numerator 1 = 100 Denominator = 100 Numerator 2 = 100 Denominator = 100 Numerator 3 = 100 Denominator = 100	<a href="#">Edit</a>
NQF 0004	NQS Domain 5: Clinical Process/Effectiveness	Numerator 1 = 100 Denominator = 100 Numerator 2 = 100 Denominator = 100	<a href="#">Edit</a>
NQF 0002	NQS Domain 6: Efficient Use of Healthcare Resources	Numerator = 100 Denominator = 100	<a href="#">Edit</a>

Signature \_\_\_\_\_

Date \_\_\_\_\_

Please print a copy of this completed summary page now to include with your printed and signed attestation. You will not be able to print this at the end of the attestation.

With their signed attestation and signed MU summary pages, the EP will also be required to send the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs.

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- » DMA Incentive Program home page

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Email: [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

1. Select *Edit* to change or modify any question within the measure set.
2. Check to see that the Clinical Quality Measures covered at least three National Quality Strategy domains.
3. Once the user reviews the page for accuracy, they will be required to **print, sign and send** the Clinical Quality Measure Summary page to the NC-MIPS Help Desk to be eligible for an incentive payment. Print the summary before submitting your attestation. The EP will also be required to send the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs via email.
4. Click *Next* to be routed back to the [Measure Selection Home page](#).



# Attestation Statement Page



## 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 NEXT button to complete your attestation.

- \* The information submitted is accurate to the knowledge and belief of the EP.
- \* The information submitted for CQMs was generated as output from an identified EHR technology.
- \* 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.
- \* Of the nine selected CQMs, at least three of the six National Quality Strategy Domains are represented.

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

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 Email:  
 NCMedicaid.HIT@dhhs.nc.gov

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

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 s/he has 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.



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

**Congratulations**

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

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

Thank you for your participation in this program!

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**Welcome Joey Six**  
Not testmips126? [Click here.](#)  
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Email: [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

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

## Electronic Submission

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

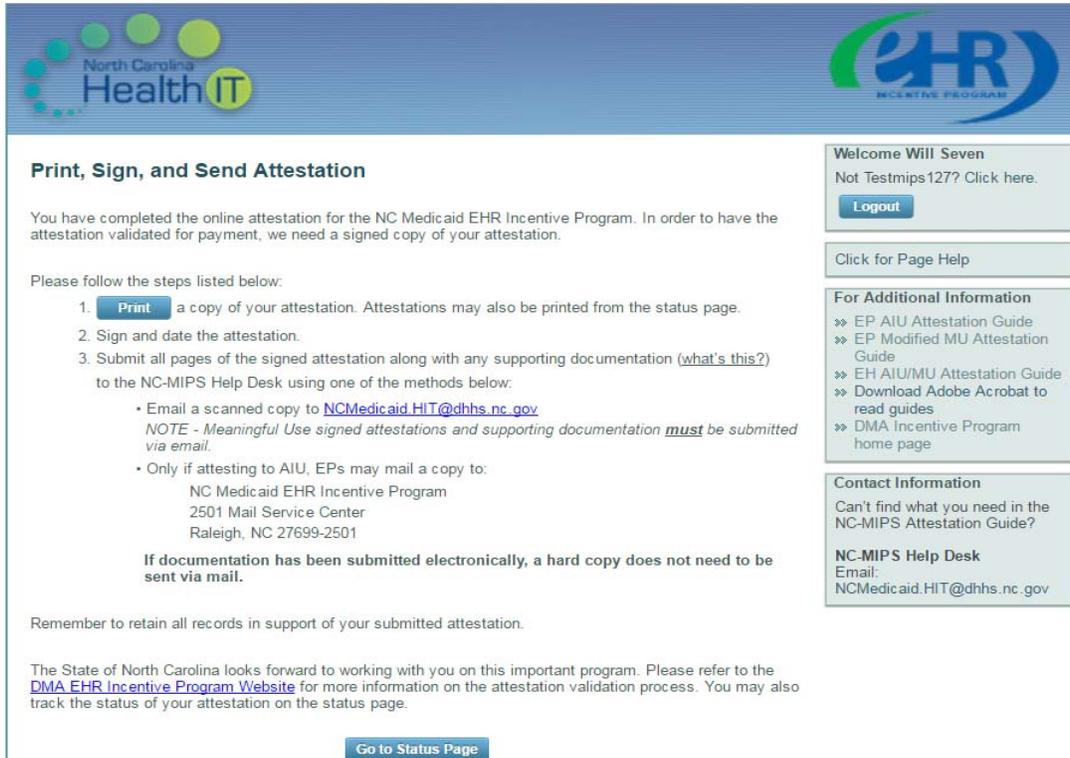
To attest to the accuracy of the reported information:

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

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

## Print, Sign, Send

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



The screenshot shows a web page titled "Print, Sign, and Send Attestation". It includes a header with the North Carolina Health IT logo and the EHR Incentive Program logo. The main content area contains instructions for printing, signing, and sending the attestation. A sidebar on the right contains a "Welcome Will Seven" message, a "Logout" button, a "Click for Page Help" button, and sections for "For Additional Information" and "Contact Information".

**Print, Sign, and Send Attestation**

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

Please follow the steps listed below:

1. **Print** a copy of your attestation. Attestations may also be printed from the status page.
2. Sign and date the attestation.
3. Submit all pages of the signed attestation along with any supporting documentation ([what's this?](#)) to the NC-MIPS Help Desk using one of the methods below:
  - Email a scanned copy to [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)  
*NOTE - Meaningful Use signed attestations and supporting documentation **must** be submitted via email.*
  - Only if attesting to AIU, EPs may mail a copy to:  
NC Medicaid EHR Incentive Program  
2501 Mail Service Center  
Raleigh, NC 27699-2501

**If documentation has been submitted electronically, a hard copy does not need to be sent via mail.**

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

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

[Go to Status Page](#)

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Email: [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov)

To finish the attestation process:

1. Click *Print* to print the attestation.
2. The attesting EP must sign and date the printed attestation her/himself and the date must reflect that of the most recently submitted attestation or later. Some tips:
  - a. Attestations signed with a date preceding that of the most recently submitted attestation will not be accepted;
  - b. A third party, such as a practice manager, **may not** sign the printed attestation on behalf of the EP; and,
  - c. Electronic signatures are not accepted in lieu of a manual signature.
3. Gather the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs.
4. 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.
5. Email the signed attestation, the signed MU Objectives Summary Page, the signed CQM Summary Page, the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs and any supporting documentation to the NC-MIPS Help Desk at [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov).



## Next Steps

Be sure to email the signed attestation, the signed MU Objectives Summary Page, the signed CQM Summary Page, the corresponding CQM report from the EP's certified EHR technology demonstrating the EP's compliance with the selected CQMs and any supporting documentation to the NC- MIPS Help Desk at [NCMedicaid.HIT@dhhs.nc.gov](mailto:NCMedicaid.HIT@dhhs.nc.gov) within seven days of submitting the attestation through NC – MIPS. We cannot begin the validation process until we have received the email with the required documents.

EPs can return to the NC-MIPS Portal at <https://ncmips.nctracks.nc.gov/> anytime to review the status of an attestation(s) on the Status Page.

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

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

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

While not guaranteed, error-free attestations (where no outreach is conducted) can be processed within roughly 10 weeks, excluding attestations received during our high-volume peak time of March and April, when validations and payment will take roughly 15-20 weeks from the date the signed attestation was received.

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

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

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



## Additional Resources

We have provided some additional resources which will 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 Open Data Certified Health IT Product List](#)

If you're having issues identifying which measure you should report or how you should report them, the best resource is your EHR vendor.

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