

## Frequently Asked Questions & Answers

If at any time you go back to the CMS Registration & Attestation System web site, whether you go there to review your information or we send you there to correct a problem, there are very specific instructions you need to follow. These instructions can be found at the [end](#) of these FAQs.

 **IMPORTANT: All Program Year 2016** Provider Incentive Payment Program (PIPP) attestations are due to TennCare by March 31, 2017, at 11:59 PM CT. This means that if you have never registered before to participate, you must register at CMS, and then get that first attestation to TennCare by March 31, 2017. This web site has all the information you need to register and then begin attesting. However, if you have additional questions, you can contact us through the “Resources” link on Home Page of our web site.

**Attention Returning Providers:** CMS has issued a rule (effective November 14, 2016) which allows ALL providers to use a consecutive 90-day period for MU data reporting in both 2016 AND 2017. This is in lieu of the previous requirement that providers report 365 days of MU data in both years.

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## I – Provider Eligibility for EHR Incentive Payments

**Q I-1:** Who is **eligible to participate** in the TennCare Medicaid EHR Provider Incentive Program?

**A I-1:** An **Eligible Professional (EP)** is a

- Physician (Medical or Osteopathic)
- Dentist
- Nurse Practitioner
- Certified Nurse Midwife
- Physician’s Assistant (PA) who practices in an FQHC led by a PA, or in an RHC so led by a PA.

An **Eligible Hospital (EH)** is

- An Acute Care Hospital
- A Critical Access Hospital (CAH)
- A Children’s Hospital – CMS will work with children’s hospitals that are not separate entities to assign a pseudo-CCN to allow these hospitals to participate in the EHR incentive Program.

Both EPs and EHs can enroll to participate in the TennCare Medicaid EHR Incentive Program **through 2016**. The usual process is to attest for Adoption, Implementation, or Upgrade (AIU) to a certified EHR system in the first year (see question III-1). Acute care hospitals and CAHs will attest through Medicare first, and then attest through the TennCare Medicaid EHR Incentive Program. Medicaid-only and children’s hospitals are to attest through the TennCare Medicaid EHR Incentive Program.

**Q I-2: What is a Hospital-Based Eligible Professional?**

**A I-2:** An EP is considered “hospital-based” when he provides substantially all of his professional services in a hospital setting. “Substantially all” is defined as 90% or more of the EP’s professional services are performed in a hospital setting (patients seen as an inpatient (POS 21) or emergency department (POS 23)). *(See also Q I-8)*

An EP who meets the definition of being a hospital-based EP but who can demonstrate that the EP funds the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and interfaces needed for MU without reimbursement from an eligible hospital or CAH, and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital’s CEHRT), may be determined by CMS to be a nonhospital-based EP. This determination is made by CMS, not by TennCare. For more information, contact CMS at 1-888-734-6433.

**Q I-3: What does it mean to Practice Predominately in an FQHC/RHC?**

**A I-3:** An EP is considered to “practice predominately in an FQHC/RHC” when over 50% of his total encounters in the most recent 12 months prior to the attestation are provided in an FQHC or RHC. This requirement will be validated during the post-payment audit if the provider is selected for audit. *(See also Q I-8)*

**Q I-4: A Physician’s Assistant (PA) is only eligible to participate in the EHR Incentive Program if he works in an FQHC that is led by a PA or an RHC so led by a PA. What does “so led” mean?**

**A I-4:** An FQHC/RHC is “so led” by a PA when:

- A PA is the primary provider in the clinic (for example, when there is a part-time physician and full-time PA, CMS considers the PA as the primary provider); or
- A PA is a clinical or medical director at a clinical site of practice (being the director of a department **within** the FQHC/RHC **does not** qualify the PA as being the lead); or
- A PA is the owner of the RHC.

**Q I-5: I am a pediatrician, but my Medicaid patient volume is 35%. Am I eligible for the full incentive payment or will I still receive only the reduced incentive amount?**

**A I-5:** Any EP, including pediatricians, whose Medicaid patient volume is equal to or exceeds 30% is eligible for the full EHR incentive payment. Pediatricians whose patient volume is equal to or greater than 20%, **but less than 30%** are eligible for a reduced incentive payment equal to two-thirds of the full incentive payment. **(NOTE:** Question 6 on the Provider Questions page asks whether you are a pediatrician. Tennessee only recognizes physicians as pediatricians. **ALL** other EPs must respond “No” to this question or your attestation will be returned. When attesting for meaningful use, an EP selects the specialty that best describes his/her scope of practice.)

**Q I-6:** What if I choose **not to** participate in the EHR Incentive Program? Will my TennCare Medicaid reimbursements be reduced?

**A I-6:** If an EP chooses not to participate in the EHR Incentive Program, his **TennCare Medicaid** reimbursements **will not** be reduced, as the payments relate to the EHR Incentive Program. However, EPs who are also **Medicare** providers and choose not to acquire and use certified EHR technology **are now** seeing their **Medicare** reimbursements reduced.

**Q I-7:** What are the most common problems that providers are having with attestation?

**A I-7:** There are a number of areas that providers are having problems with when starting the attestation process. The TennCare Units responsible for the EHR Incentive Program make every effort to assist you and to resolve problems before we have to deny your attestation.

- ⊕ The enrollment process begins at the CMS Registration & Attestation System web site. During the completion of the questions on this web site, providers are asked for the CMS Certification Number of their certified EHR system and/or module(s). CMS has this marked “Optional.” However, TennCare **requires** that this information be present. If you fail to include this number, we will send you back to CMS before we can process your attestation.
- ⊕ Also during the registration process, you are requested to give us the Payee NPI ( and Tax ID) of who is to receive your TennCare EHR Incentive Payment (the individual provider or the group). If the incentive payment goes to you, this would be your NPI. If you are having the payment go to your Group Practice or Clinic, enter the practice or clinic NPI as the Payee NPI.
- ⊕ When TennCare receives your registration information from CMS, we send you an email inviting you to establish a User Account. In order to find your information, you must enter your CMS Registration number, your **individual** NPI, and your Tax ID Number. **For EPs, that is your Social Security Number.**
- ⊕ Following the establishment of your User Account, we will send an activation email. You must click on the word “**here.**” Some providers are not able to do this, which may be due to the security settings on your computer. If that link fails to work, this URL is also present in the email. You may click on this URL and you will be taken to the PIPP portal: <https://pipp.tennCare.tn.gov/Default.aspx>
- ⊕ Some providers have informed us that they cannot see the entire page, and/or they are not able to scroll through the whole page. Again, this relates to the settings on your computer. The easiest fix is to lower your Zoom to between 75% & 85% (Look under ‘Tools’).
- ⊕ Many times, we return attestations to providers stating that you are not connected to the group practice or clinic where you want your incentive payment sent, and especially where using the group patient volume for attestation purposes. TennCare requires that providers and practices to be “linked” in our provider profiles in order to make payment. If you have a question as to whether you are linked to a group, you can call 1-800-852-2683 x 4 and ask the operator to check. You will need

your NPI and the group/clinic's NPI.

- ⊕ Another problem we often encounter is the lack of an internal accounting number for a provider. Providers never know that they have this number. Most providers have this number as they receive Medicare/Medicaid crossover payments, which come directly from the Bureau – not the MCOs. Providers that usually do not have this number are dentists, pediatricians, and some OB-GYNs. Why? Because as stated above, these providers' services are not normally covered by Medicare and do not need this internal accounting number. If during the course or reviewing your attestation it is discovered that you lack this accounting number, we now have an internal process to obtain this number for you and place it our files. Occasionally, we may ask you to go through the process of obtaining this number, especially if we have to return your attestation for other reasons.
  - If we return your attestation for either of the immediate two problems above, you will need to go to this web site, <https://tn.gov/tenncare/topic/provider-registration>, and follow the instructions there. The instructions are designed for new providers, but this is the only process we have now to resolve the above problems. If you need to be connected to a group or clinic, include the service location with the group tax number. Provider Enrollment will do the rest (as far as making the connection). If our instructions are to complete an application for a group practice or clinic, please follow the instructions given for these entities.
- ⊕ By and large over the years, **the number 1 problem** has been insufficient EHR documentation. On the EHR Questions screen and in the User Manual, a link is available on each page of the attestation, are the requirements for EHR documentation. Please read that information carefully. CMS requires the states to verify that providers have a legal/financial contractual obligation to either purchasing/owning a CEHRT, or to have access to one of the “free” on-line CEHRTs. Basically the requirement is to show this contractual relationship with a document signed by both the vendor and the provider, that document identifies your CEHRT, and that you have or are making payment for your CEHRT. This also includes updates, such as from the 2011 Edition to the 2014 Edition CEHRT, and the upcoming upgrade to the 2015 Edition.

For the “free” on-line CEHRTs, we will accept a signed letter on the vendor's letterhead, but must **also** have a copy of your User Agreement with appropriate dated signatures.

What we will **NOT** accept:

- A screenshot of the CHPL web site showing the CMS certification number of your CEHRT
- A screenshot of your computer showing your CEHRT
- Requests for Proposals or Responses (including bids) to such Proposals
- A signed letter from the vendor on the vendor's letterhead
- A contract/purchase agreement, etc. that is not signed by both parties to the contract

Some vendors will try to convince you that the letter or other documentation they give you will be sufficient for your attestation. And some states may indeed accept those as documentation. If your

EHR documentation does not meet our requirements, your attestation **will be returned** for insufficient EHR documentation, delaying your EHR Provider Incentive Payment. Also see Q III-2.

**Q I-8:** Is a provider who is **Hospital-Based and Practices Predominately in an FQHC or RHC** eligible for the EHR Incentive Payment?

**A I-8:** Yes, a provider who practices predominately at an FQHC or RHC is excluded from the definition of being a hospital-based provider, per CMS regulations. Such a provider is eligible for an EHR Incentive Payment even if 90% or more of his professional services are performed in a hospital setting (Place of Service Codes 21 (Inpatient) and 23 (Emergency Department)).

## II – Determination of EHR Incentive Payments

**Q II-1:** Can an EP receive both the **TennCare Medicaid EHR Incentive Payment** and the **Medicare EHR Incentive Payment**? What about an EH?

**AII-1:** No, EPs may receive an EHR Incentive Payment from either TennCare Medicaid or Medicare, but not both in the same year. Payments are tracked by CMS to ensure that duplicate payments are not made.

**Note:** it is no longer possible to switch from the Medicare program to the Medicaid program or vice versa. You are now locked into the program in which you last attested. **Second Note:** 2016 is the last year you can enroll in and begin attesting as a part of the EHR Provider Incentive Program. After December 31, 2016, no additional providers will be allowed into the EHR Incentive Program.

EHs **can** receive EHR incentive payments from both the Medicare and the TennCare Medicaid EHR Incentive Programs, **IF** the hospital is enrolled as a dually eligible hospital on the CMS Registration & Attestation System web site.

**Q II-2:** I participate in the TennCare Medicaid program and the **Medicaid program of another state**. Can I receive an EHR Incentive Payment from both states?

**A II-2:** No, providers (EPs & EHs) can only receive an EHR Incentive Payment from one state in a program year. A provider can switch between the states programs in which he chooses to participate. However, the total payment received during the EHR Incentive Program cannot exceed the amount the provider would have received had he remained in one program throughout, per CMS.

**QII-3:** What is a **payment year for hospitals**?

**A II-3:** Hospital payment years are now based on the Calendar Year (2015). The **patient volume qualifying period** for an EH must be a 90-day period in the **previous FFY** (October 1 - September 30).

**Q II-4:** How is an EHR Incentive **payment assigned** (regarding groups)?

**A II-4:** For EPs, the EHR Incentive is based on individual EPs. However, during enrollment at the CMS Registration & Attestation System web site, the provider has the ability to direct where the payment is to be made. It can be made directly to the provider or to the group practice or clinic in which he is a member. During the registration process at the CMS Registration & Attestation System web site, you will be asked the Payee NPI and Payee Tax ID to which you want payment made. This can be changed each year.

**Q II-5:** What if our group/clinic hires a provider in mid-year, and this provider has already received an EHR Incentive payment through his previous group? Can we apply for this new (to us) provider in that same year and still receive an incentive payment for this provider? How do we ensure that the previous group does not get the incentive payment for this provider in the next year?

**A II-5:** This new provider to your practice cannot receive an additional incentive payment in the same year for which an incentive payment has already been made. Each EP may be eligible to receive an incentive payment once per year for the duration of the program. An EP may have the payment made to him, or assign his incentive payment to the group. That is between the group practice/clinic and the provider and whatever agreement they may have. TennCare makes the EHR Incentive Payment as directed by the information received through the registration process.

Once the new provider starts working at a new practice, he would need to update this information at the CMS Registration & Attestation System web site to reflect the new practice prior to the next attestation. To have an EHR Incentive Payment directed elsewhere, the Payee NPI and Payee Tax ID must be changed. Every year, EPs are required to validate and attest to EHR program criteria.

Payments are tracked by CMS to ensure that duplicate payments are not made.

### III – Understanding Adopt, Implement, and Upgrade, and Meaningful Use

**Q III-1:** I hear the term **Adopt, Implement, and Upgrade** in reference to a certified EHR system. What does that mean to me?

**A III-1:** EPs and EHs who meet minimum patient thresholds qualify for the first year TennCare Medicaid incentive payment by demonstrating they have adopted, implemented, or upgraded (AIU) to certified EHR technology – either a complete system and/or module(s).

- **Adopt** – means the provider has acquired and installed EHR technology (must show evidence of acquisition & installation)

- **Implement** – a provider has commenced utilization of certified EHR technology (staff training, data entry of patient data, data use agreements, etc.)
- **Upgrade** – A provider has expanded the functionality of a current system (with certified modules; Version 2.0, etc.)

**Q III-2: What EHR documentation or proof must I show?**

**A III-2:** Providers are required to submit proof of a legal and/or financial obligation showing that they have adopted, implemented, or upgraded to certified EHR technology (CEHRT). Documentation must be submitted each year in which you attest for an incentive payment. This includes upgrading from a previous CEHRT to an updated CEHRT (for example, from the 2011 Edition to the 2014 Edition). **CMS requires** the states to verify that each attesting provider does have this legal and/or financial contractual obligation for a CEHRT system. The following list is acceptable documentation of a legal and/or financial contractual obligation.

- The page of an executed contract or lease agreement **clearly showing the CEHRT**, vendor, and provider, **AND** the executed dated signature page showing both the provider’s and vendor’s names and signatures.
- If your current contract/lease requires the vendor to provide you with appropriate updates/upgrades to your system to qualify it as CEHRT, executed upgrade agreements for which a cost and timeframe are stated, **AND identifies your CEHRT**.
- A copy of the vendor’s invoice **clearly identifying your CEHRT**, **AND** proof of payment
- A copy of your purchase order identifying the vendor and **the CEHRT being acquired**, **AND** proof of payment
- If using one of the free CEHRT, documentation requirements are a signed letter on the vendor’s letterhead **identifying the provider and CEHRT**, **AND** a copy of the User Agreement.

NOT acceptable as documentation:

- A screenshot of CHPL showing the CMS certification number of your CEHRT
- A screenshot of your computer showing your CEHRT
- Requests for Proposals (RFPs) or vendor bids

In addition to these items, we will not accept letters from your CEHRT vendor, or any other such documentation. The reason being is that these documents do not prove a legal/financial obligation to access to a CEHRT system. Again, **CMS requires** that we verify that you have a legal/financial obligation to a CEHRT. CMS has reviewed our list of required documents, and if your documentation does not meet one of these items, your attestation will be returned to you for correction.

### Q III-3: What is **Meaningful Use**?

**A III-3:** “Meaningful Use” (MU) of certified EHR technology is that which attains specific procedural and clinical benchmarks. For the first year of an EP’s or EH’s participation in the TennCare Medicaid EHR Provider Incentive program, attesting to MU is **not** required. EPs and EHs are only required to demonstrate AIU (see above). Beginning in the second payment year of an EP’s/EH’s participation, demonstration of MU is required.

EPs have the option to attest for AIU or MU in their first year of attestation. This is important for providers who participate in both Medicare and Medicaid, in order to avoid Medicare payment reductions.

Visit TennCare’s MU web pages, beginning with the [Meaningful Use Overview](#) to learn more about the MU criteria and attestation process.

## IV – Calculating Patient Volume

### Q IV-1: What defines a **Medicaid Encounter** for EPs when determining patient volume?

**A IV-1:** Children enrolled in CHIP (CoverKids) **do not** count toward the Medicaid patient volume criteria.

A “Medicaid encounter” means services rendered to an individual on any one day where:

- ◆ Medicaid (or a Medicaid demonstration project – TennCare) paid for part or all of the service
- ◆ Medicaid (or a Medicaid demonstration project – TennCare) paid all or part of the individual’s cost sharing
- ◆ The individual is enrolled in a Medicaid program (or a Medicaid demonstration project – TennCare, or the Medicaid program of another state) at the time the billable service was provided. (42 CFR § 495.306(e)(1))

All services rendered on a single day to a single individual by a single EP counts as one encounter. If the individual receives services from another EP who is a part of the same group, each EP can count his services provided as a separate encounter.

At the start of the EHR Provider Incentive Program, denied claims were not allowed to be included in the Medicaid patient volume count. Now, if you have provided a billable service to an individual who was enrolled in TennCare (or the Medicaid program of another state), that encounter is to be included in your patient volume data, even if your claim was denied for reasons such as

- ◆ timely filing,
- ◆ the service is not covered by the Tennessee Medicaid State Plan (or that of another state in which the individual is enrolled), or

- ◆ the individual has exceeded benefit limits (TennCare's or that of the state in which he is enrolled)

those encounters are now allowed to be counted to determine your eligibility to receive an EHR Incentive Payment (both in the numerator and denominator). What **cannot** be counted are claims that were denied because the individual was not enrolled in any Medicaid program on the date of service. Nor can claims be counted if the provider was not enrolled in the TennCare Medicaid provider on the date the service was rendered.

**Q IV-2: How is a Medicaid Hospital Encounter defined?**

**A IV-2:** Children enrolled in CHIP (CoverKids) **do not** count toward the Medicaid patient volume criteria.

For the purposes of calculating hospital patient volume, both (inpatient and emergency department) the following definitions apply.

A Medicaid encounter means services rendered to an individual per inpatient discharge when any of the following occur:

- ◆ Medicaid (or a Medicaid demonstration project – TennCare) paid for all or part of the service
- ◆ Medicaid (or a Medicaid demonstration project – TennCare) paid for all or part of the individual's cost sharing
- ◆ The individual was enrolled in Medicaid (TennCare or the Medicaid program of another state) at the time the billable service was provided. (42 CFR § 495.306(e)(2))

A Medicaid encounter means services rendered in an emergency department on any one day if any of the following occur:

- ◆ Medicaid (or a Medicaid demonstration project – TennCare) paid for all or a part of the service
- ◆ Medicaid (or a Medicaid demonstration project – TennCare) paid for all or part of the individual's cost sharing
- ◆ The individual was enrolled in Medicaid (TennCare or the Medicaid program of another state) at the time the billable service was provided. (42 CFR § 495.306(e)(2))

At the start of the EHR Provider Incentive Program, denied claims were not allowed to be included in the Medicaid patient volume count. Now, if you have provided a billable service to an individual who was enrolled in TennCare (or the Medicaid program of another state), that encounter is to be included in your patient volume data, even if your claim was denied for reasons such as

- ◆ timely filing,
- ◆ the service is not covered by the Tennessee Medicaid State Plan (or that of another state in which the individual is enrolled), or
- ◆ the individual has exceeded benefit limits (TennCare's or that of the state in which he is enrolled)

those encounters are now allowed to be counted to determine your eligibility to receive an EHR Incentive Payment (both in the numerator and denominator). What **cannot** be counted are claims that

were denied because the individual was not enrolled in any Medicaid program on the date of service. Nor can claims be counted if the provider was not enrolled in the TennCare Medicaid provider on the date the service was rendered.

**Q IV-3: Can Medicaid be the secondary insurer when determining total Medicaid patient encounters?**

**A IV-3:** When calculating an EP's or EH's Medicaid patient encounter, TennCare Medicaid must pay for all or part of the services or pay all or part of the individual's cost sharing, or the individual was enrolled in TennCare or the Medicaid program of another state at the time the billable service was performed. When the primary insurer (commercial insurance, Medicare, etc.) pays as much or more than TennCare Medicaid would, TennCare Medicaid pays the claim at zero dollars (the claim is considered paid by TennCare). If TennCare Medicaid denies the claim because the individual was not enrolled in any Medicaid program on the date of service, then the encounter **cannot** be counted as a Medicaid encounter.

When calculating the EP's patient volume at an FQHC/RHC, TennCare Medicaid must pay for

- ❖ all or part of the service rendered to the Needy Individual (see below); or
- ❖ all or part of the Needy Individual's cost sharing; or
- ❖ **unless** the service is offered to an individual at no cost or at a reduced cost based on a sliding scale determined by the individual's ability to pay; or
- ❖ the individual was enrolled in TennCare or the Medicaid program of another state on the date the billable service was provided.

Patient encounters where Medicare or other TPL have paid as much or more than TennCare are still considered "paid" encounters by TennCare and are includable in your patient volume count.

**Q IV-4: If an EP wants to leverage a clinic's or group practice's patient volume as a proxy for the individual EP's patient volume, how should a clinic or group practice account for EPs practicing part-time and/or applying for the incentive through a different location? (That is, where an EP is practicing both inside and outside the clinic/group practice, such as part-time in two clinics.)**

**A IV-4:** EPs may use a clinic's or group practice's patient volume as a proxy for their own under three conditions:

- (1) The clinic or group practice's patient volume is appropriate as a patient volume 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 patient volume determination; and
- (3) As long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works both in the clinic

and outside the clinic (or with and outside the group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

If Clinic A uses the clinic's patient volume as a proxy for all EPs practicing in Clinic A, this would not preclude the part-time EP from using the patient volume associated with Clinic B and claiming the incentive for the work performed in Clinic B. In other words, such an EP would not be required to use the patient volume of Clinic A simply because Clinic A chose to invoke the option to use the proxy patient volume. However, such an EP's Clinic A patient encounters are still counted in Clinic A's overall patient volume calculation. In addition, the EP could not use his or her patient encounters from Clinic A in calculating his or her individual patient volume.

**CLINIC A (with a fictional EP and provider type)**

- EP #1 (physician): individually had 40% Medicaid encounters (80/200)
- EP #2 (nurse practitioner): individually had 50% Medicaid encounters (50/100)
- Practitioner at the clinic, but not an EP (registered nurse): individually had 75% Medicaid encounters (150/200)
- Practitioner at the clinic, but not an EP (pharmacist): individually had 80% Medicaid encounters (80/100)
- EP #3 (physician): individually had 10% Medicaid encounters (30/300)
- EP #4 (dentist): individually had 5% Medicaid encounters (5/100)
- EP #5 (dentist): individually had 10% Medicaid encounters (20/200)

**Totals:**

- ✓ 1,200 encounters in the selected 90-day period for Clinic A
- ✓ 415 encounters attributable to Medicaid – 35% of the clinic's volume

This means that five (5) of the seven (7) professionals would meet the Medicaid patient volume under the rules of the EHR Incentive Program. Two (2) of the professionals are not eligible for the program on their own, but their clinical encounters at Clinic A should be included. (The Registered Nurse and Pharmacist are not EPs for the EHR Incentive Program as defined by CMS.)

**Q IV-5: Can I count **out-of-state Medicaid** patient encounters in the patient volume threshold?**

**A IV-5:** Out-of-State Medicaid encounters are to be counted in both the numerator and in the denominator. In the attestation process, you are asked if you are including out-of-state Medicaid encounters in your calculation. If so, we ask that you give us the state, number of encounters, and your Medicaid ID number for that state. This applies to both EPs and EHS.

**Q IV-6: Who is considered as a **Needy Individual**?**

**A IV-6:** A Needy Individual is an individual who meets **any** of the following criteria:

Effective January 1, 2013, a Needy Individual encounter means services rendered to an individual on any one day if any of the following occur:

- ◆ Medicaid (TennCare) or CHIP (CoverKids) paid for part or all of the service

- ◆ Medicaid (TennCare) or CHIP paid all or part of the individual's cost sharing
- ◆ The individual was enrolled in a Medicaid program (TennCare or the Medicaid program of another state) at the time the billable services was provided
- ◆ The services were furnished at no cost consistent with 42 CFR § 495.310(h)
- ◆ The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay. (42 CFR § 495.306(e)(3))

The inclusion of Needy Individuals in the threshold calculation applies **only** to meeting the patient volume requirements for EPs practicing predominately in **FQHCs or RHCs**. All services rendered on a single day to a single individual by a single EP counts as one encounter. If the individual receives services from another EP practicing in the same FQHC or RHC on the same day, it counts as an encounter for each EP.

At the start of the EHR Provider Incentive Program, denied claims were not allowed to be included in the Medicaid patient volume count. Now, if you have provided a billable service to an individual who was enrolled in TennCare (or the Medicaid program of another state), that encounter is to be included in your patient volume data, even if your claim was denied for reasons such as

- ◆ timely filing,
- ◆ the service is not covered by the Tennessee Medicaid State Plan (or that of another state in which the individual is enrolled), or
- ◆ the individual has exceeded benefit limits (TennCare's or that of the state in which he is enrolled)

those encounters are now allowed to be counted to determine your eligibility to receive an EHR Incentive Payment (both in the numerator and denominator). What **cannot** be counted are claims that were denied because the individual was not enrolled in any Medicaid program on the date of service. Nor can claims be counted if the provider was not enrolled in the TennCare Medicaid provider on the date the service was rendered.

**Q IV-7: What makes up the **numerator** and **denominator** used to determine the patient volume ratio?**

**A IV-7:** EPs must have a Medicaid patient volume of 30% or more (20% for pediatricians) in the qualifying period of 90 consecutive days in the **previous calendar year** to qualify for an EHR incentive payment.

EHs must have a Medicaid patient volume of 10% or more in the qualifying period of 90 consecutive days in the **previous federal fiscal year**. Children's hospitals **do not** have a minimum patient volume requirement. **Note:** The Final Rule published in the October 16, 2015 (effective December 14, 2015) *Federal Register* only changed the reporting period for EHs. EHs now attest on a calendar year basis, the same as EPs, **but the patient volume still comes from the previous federal fiscal year**.

The **numerator** = total number of Medicaid encounters in the qualifying period.

The **denominator** = total number of all encounters regardless of payer in the qualifying period.

Providers (both EPs and EHs) must still meet the patient volume percentages as stated above. Nothing about this requirement has changed because of the September 4, 2012 Final Rule published in the

*Federal Register*. What has changed is the fact that denied Medicaid encounters are now includable, **unless** the denial is because the individual was not enrolled in the Medicaid program of any state on the date of service, or the provider was not enrolled in the TennCare Medicaid Program as a Medicaid provider.

**QIV-8:** What makes up the **numerator** and **denominator** used to calculate the patient volume ratio for OB/GYNs?

**AIV-8** When reporting OB-GYN encounters for the purpose of the EHR attestation program, EPs should only report one encounter for each child **delivered** during the 90-day qualifying period. EPs would then add to that total the number of other office visits for which patients are seen, such as check-ups, infections, injuries, etc. Prenatal visits, to be billed under the global encounter code, are not to be counted or reported during the 90-day qualifying period.

For example, using July 1 – September 28, the EP

Delivered a total of	35 babies	out of which 15 were TennCare Medicaid babies
Provided well check-ups	40 women	out of which 15 were TennCare Medicaid enrollees
Sick Office Visits	<u>15</u> women	out of which <u>8</u> were TennCare Medicaid enrollees
Totals	90	38

For ATTESTATION purposes, this EP would have a Patient Volume percentage of 42%, assuming all other criteria are met.

Please be sure to review the above questions about being able to count denied Medicaid encounters.

## V – Audit Information

**Q V-1:** Are EHR incentive payments subject to audit after the payment has been received?

**A V-1:** Yes. The Division of Audit & Investigations within the Bureau of TennCare is responsible for performing audits of payments made to providers who have qualified under the EHR Provider Incentive Payment Program. **All** payments are potentially subject to audit.

**Q V-2:** Who is subject to EHR incentive payment audits?

**A V-2:** Any provider, i.e., Eligible Professional (EP) or Eligible Hospital (EH), that has received an EHR incentive payment is subject to being audited. Providers are selected for audit based on risk assessment and random sampling.

**Q V-3:** How will I know if I am being audited?

**A V-3:** You will receive a notification from the Bureau of TennCare’s Division of Audit & Investigations in the form of an email or a letter. An audit may take the form of either a desk audit or an on-site audit.

**Q V-4:** What will be reviewed during an audit?

**A V-4:** You or a representative may be asked to provide documentation to support any of the information in the attestation for Adopt, Implement, or Upgrade (AIU)/Eligibility and/or Meaningful Use (MU). For example, you may be asked to generate a system report(s) used to support your patient volume and/or meaningful use measures. If any information used for your attestation cannot be systematically reproduced or replicated, a copy of the original documentation should be maintained. If the audit takes place on-site, the auditor(s) may also physically inspect your EHR system and/or vendor contract.

**Q V-5:** If I am audited in one year, am I automatically subject to being audited for another payment year?

**A V-5:** No. An audit in one year does not automatically subject a provider to audit in future payment years. However, all payments made to providers are potentially subject to audit.

**Q V-6:** What happens after an audit is conducted?

**A V-6:** You will receive written notification regarding the results of the audit.

**Q V-7:** If I am being audited for any Program Year, will this affect my ability to attest to a subsequent Program Year?

**A V-7:** No. If you are being audited for any Program Year, you may still attest to a subsequent Program Year.

**Please continue to next page for important information about returning to the CMS Registration & Attestation System web site when changes are needed.**

## Returning to the CMS Registration & Attestation System web site

As stated at the beginning, sometimes providers return to the CMS R&A web site just to check the information they provided when registering. Other times, we may direct you to return to this web site to add information or to make a change or correction. This section is to provide you with important information that you must follow when returning to the CMS R&A web site or your status with us will be changed **by** CMS to “*In Progress*.” CMS **does not** tell us why you are in this status, but we cannot process your attestation as long as it remains “*In Progress*.”

When going back to the CMS R&A web site, you will need the registration number given you when you registered for the EHR Incentive Program.

CMS has informed us that if you go to their R&A web site, enter your registration number, and hit “enter” or “modify,” your status is automatically changed to *In Progress* **EVEN** if you do nothing more, including only reviewing previously entered information.

To avoid being placed in this status and delaying the processing of your attestation by TennCare, you **MUST** do the following:

- Go to the CMS R&A System web site
- Enter your CMS Registration Number you were originally given
- Click on “Modify”
- On **EACH** page, click “Save & Continue”
- On the appropriate page(s), make the change(s), if needed, and click “Save and Continue” (*even if you are only reviewing the information previously entered*)
- On the last page, click “Submit”

Once you have done this, CMS will forward your information to TennCare within 24 – 48 hours, and take you out of the “*In Progress*” status. If you stop the process short of “Submit,” your revised information will not be saved and sent to TennCare and you will be placed, or remain, in the “*In Progress*” status. We will send you email reminders, but that is all we can do. We will not be able to process your attestation.